

Department of Legislative Services  
Maryland General Assembly  
2026 Session

FISCAL AND POLICY NOTE  
Third Reader - Revised

House Bill 1012  
Health

(Delegate Fair, *et al.*)

Finance

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**Public Health - Local Suicide Fatality Review Teams - Authorization**

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This bill authorizes a county or municipality to establish a multidisciplinary and multiagency suicide fatality review team to prevent suicide deaths by (1) reviewing suicide deaths of county residents or that occur within the county; (2) identifying systemic, service, and policy factors associated with risk of suicide; (3) promoting coordination between entities involved in suicide prevention, crisis response, treatment, and postvention; and (4) developing recommendations to prevent suicide. Two or more counties may establish a single multicounty team, but they must execute a memorandum of understanding on membership, staffing, and operation. The bill outlines (1) membership of a local team; (2) requirements and recommendations for local team operations; and (3) requirements for use of records and data. An individual guilty of violating the bill's meeting or data privacy restrictions is subject to a fine of up to \$500 and/or imprisonment for up to 90 days. The bill does not supersede, limit, interfere with, or otherwise affect the authority or duties of a local child fatality review team. The Maryland Department of Health (MDH) may adopt regulations, as specified.

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**Fiscal Summary**

**State Effect:** This analysis assumes that any potential impact on MDH can likely be absorbed within existing budgeted resources, as discussed below. Penalty provisions are not anticipated to materially affect State finances or operations.

**Local Effect:** Local health department (LHD) and municipal government expenditures may increase indeterminately, as early as FY 2027, for any jurisdiction that chooses to establish a local suicide fatality review team, as discussed below. Revenues are not affected.

**Small Business Effect:** None.

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## Analysis

### Bill Summary:

#### *Local Team Membership*

The membership of a local suicide fatality review team must be drawn from the following, if available:

- the county health officer (or their designee);
- the director of the local department of social services (or their designee);
- the director of the local behavioral health authority (or their designee);
- the superintendent of schools for the county (or their designee);
- a State, county, or municipal law enforcement officer;
- the director of behavioral health services in the county (or their designee);
- an emergency medical services provider in the county;
- a representative of a hospital;
- a health care professional who specializes in the prevention, diagnosis, and treatment of mental or behavioral health conditions;
- a member of the public with interest or expertise in suicide prevention, appointed by the county health officer; and
- any other individual necessary for the work of the local team, recommended by the team and appointed by the county health officer.

Each team must elect a chair from among its members.

#### *Local Team Operations*

Each local suicide fatality review team must:

- meet at least quarterly to (1) review the status of suicide fatality cases; (2) recommend actions to improve the coordination of services and investigations among agencies; and (3) recommend actions to relevant agencies to prevent suicide deaths;
- collect and maintain data as required by the State Suicide Fatality Review Committee (State team);
- ensure safe and secure storage for protected information and records;
- provide any reports required by the State team, including (1) reports on individual cases; (2) steps taken to improve coordination of services and investigations among agencies; (3) steps taken to implement the recommendations of local teams by

- applicable agencies; and (4) recommendations for changes to State and local law, policy, and practices designed to prevent suicide deaths;
- coordinate with local child fatality review teams and local drug overdose fatality review teams to ensure the efficiency of each local team's operations;
  - coordinate with the State team, including to establish operating protocols; and
  - operate subject to State and national standards and subject to guidance issued by the State team.

Each local suicide fatality review team may (1) examine trends in suicide and factors that contribute to risk; (2) share information with other public health authorities or their designees as necessary; (3) identify gaps in systems of care or coordination between entities involved in suicide prevention, crisis response, treatment, and postvention; and (4) submit recommendations to the State team or other local entities as appropriate.

For a suicide death involving an individual younger than 18, a local child fatality review team retains primary authority to conduct the review. Nevertheless, a local child fatality review team may coordinate or conduct a joint review with the local suicide fatality review team.

A local suicide fatality review team is a public health authority, conducting public health activities in accordance with the Federal Health Insurance Portability and Accountability Act.

Except when discussing individual cases of suicide, meetings of a local suicide fatality review team must be open to the public and subject to the Open Meetings Act. During a public meeting, information may not be disclosed that either discloses the involvement of an agency with or identifies (1) a deceased individual; (2) an individual who has experienced suicide or a suicide attempt; (3) a family member, guardian, or caretaker of an individual described above; or (4) an individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality. This does not prohibit a local team from requesting the attendance of a person who has information relevant to the team's exercise of its purpose and duties at a meeting.

### *Data and Records*

A local suicide fatality review team may request records under the authority of the State team. On request of the chair of a local team and as necessary, a health care provider or local government agency must immediately provide any records necessary to complete the review of a specific fatality, including hospital records; outpatient clinic, health care provider, and laboratory records; police investigative data; medical examiner investigative data; cause of death information in vital records; social services records; and other records from local offices, agencies, and departments.

A local suicide fatality review team may request that a person with direct knowledge of the circumstances surrounding a fatality provide the local team with necessary information to complete review of the fatality, including information from a health care provider or staff involved in the care of the decedent, and the person who first responded to a report concerning the decedent.

Generally, all information and records acquired by a local team are confidential, exempt from disclosure under the Public Information Act (PIA), and not subject to discovery; further, they may not be introduced as evidence in any proceeding and may only be disclosed as necessary to carry out the team's purpose and duties. Mental health and substance abuse treatment records are subject to additional limitations under State and federal law.

Statistical compilations of data and reports of a local suicide fatality review team that do not contain any information that would allow the identification of any person to be ascertained are public records.

Except as necessary to carry out a local team's purpose and duties, team members and those who attend a meeting may not disclose (1) any proceeding at a nonpublic meeting or (2) any information that may not be disclosed as outlined above.

Team members, those who attend a team meeting, and those who present information to a local suicide fatality review team may not be questioned in a civil or criminal proceeding about information presented or opinions formed because of a meeting. However, an individual is not prohibited from testifying to independently obtained information or public information. Information, documents, or records of a local team are not subject to subpoena, discovery, or introduction into evidence in a civil or criminal proceeding, but if the information, documents, or records are otherwise available from other sources, they are not immune solely because of presentation in a local team meeting.

A person has immunity from liability under § 5-637 of the Courts Article for any action as a member of the local suicide fatality review team or for giving information to, participating in, or contributing to the function of the local team.

### *Regulations*

MDH may adopt regulations to carry out the bill, including (1) protocols, procedures, and methods for, and the manner and extent of, investigations by local suicide fatality review teams; (2) the manner in which data provided by MDH is to be stored and secured; and (3) the manner and extent to which information based on data provided by MDH may be disseminated.

**Current Law:** Chapters 80 and 81 of 2022 established the State Suicide Fatality Review Committee to identify and address the factors contributing to suicide deaths and facilitate system changes in the State to prevent suicide deaths. The State team must:

- meet at least quarterly to review suicide deaths;
- make determinations regarding (1) issues related to individuals at risk for suicide, specifically trends, risk factors, current best practices in suicide prevention, lapses in systemic responses, and barriers to safety and well-being and (2) strategies for the prevention of suicide deaths;
- report at least annually to the Governor and the General Assembly on its activities and its recommendations as specified;
- undertake annual specified statistical studies; and
- disseminate findings and recommendations based on the studies conducted to policymakers, health care providers, health care facilities, and the public.

In general, all information and records acquired by the State team are confidential, exempt from disclosure under PIA, and not subject to discovery or introduction into evidence in any proceedings. Mental health records are subject to additional limitations. Meetings of the State team must be closed to the public and are not subject to the Open Meetings Act. The meetings are subject to specified confidentiality requirements for disclosure of a medical record.

### *Local Fatality Review Teams*

Under Maryland law, there are three types of local fatality review teams: local child fatality review teams (Title 5, Subtitle 7 of the Health-General Article); local drug overdose fatality review teams (Title 5, Subtitle 9 of the Health-General Article); and local domestic violence fatality review teams (Title 4, Subtitle 7 of the Family Law Article). Each county is required to have a child fatality review team (or a multicounty local team), while counties are authorized to establish a drug overdose fatality review team or a domestic violence fatality review team.

### *Child Fatality Review Teams*

There is a State Child Fatality Review Team, which is assisted by local child fatality review teams. The State Child Fatality Review Team helps prevent child deaths by (1) developing an understanding of the causes and incidence of child deaths; (2) developing plans for and implementing changes within the agencies on the team to prevent child deaths; and (3) advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths.

Local child fatality review teams help prevent child deaths by (1) promoting cooperation and coordination among agencies involved in investigating child deaths or in providing services to surviving family members; (2) developing an understanding of the causes and incidence of child deaths in the county; (3) developing plans for and recommending changes within the agencies the members represent to prevent child deaths; and (4) advising the State team on changes to law, policy, or practice to prevent child deaths.

A local child fatality review team must (1) in consultation with the State team, establish and implement a protocol for the local team; (2) set as its goal the investigation of child deaths in accordance with national standards; (3) meet at least quarterly to review the status of child fatality cases, recommend actions to improve coordination of services and investigations among member agencies, and recommend actions within member agencies to prevent child deaths; (4) collect and maintain data as required by the State team; (5) provide requested reports to the State team, including discussion of individual cases, steps taken to improve coordination of services and investigations among member agencies, and recommendations on needed changes to State and local law, policy, and practice to prevent child deaths; and (6) in consultation with the State team, define “near fatality” and develop procedures and protocols that State and local teams may use to review cases of near fatality. A local team may also investigate the information and records of a child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

**State Expenditures:** MDH advises that it would require one data analyst and one program administrator to collaborate with the local teams and set up a secure system for data sharing. Under these assumptions, MDH general fund expenditures would increase by \$163,289 beginning in fiscal 2027.

However, as the bill is authorizing in nature and local jurisdictions would bear most of the cost of establishing a local suicide fatality review team if they elect to do so, this analysis assumes that MDH can likely handle any responsibilities under the bill with existing budgeted resources. To the extent several jurisdictions establish teams and MDH requires a secure way to transmit data to local teams, MDH general fund expenditures increase indeterminately for a vendor contract or contractual staff to establish a data sharing system.

**Local Expenditures:** The Maryland Municipal League advises that expenditures for municipal governments may increase indeterminately, to the extent that a municipal government chooses to form a local review team, depending on the number of staff, supplies, and operational support a municipality provides to the team.

The Maryland Association of County Health Officers (MACHO) similarly advises that, for any jurisdiction that opts to establish a local suicide fatality review team, LHD expenditures would increase to set up the review team. Based on the cost of establishing

other fatality review teams at the county level, MACHO advises that expenditures would increase by \$30,000 to \$50,000 to establish a local review team.

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### **Additional Information**

**Recent Prior Introductions:** Similar legislation has not been introduced within the last three years.

**Designated Cross File:** None.

**Information Source(s):** Maryland Department of Health; Maryland Association of County Health Officers; Maryland Municipal League; Office of the Attorney General; Department of Legislative Services

**Fiscal Note History:** First Reader - February 22, 2026  
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