Mortality and Quality Review Committee Summation of Activities

2024

Health-General Article §5–808 (a)

Maryland Department of Health

March 2025

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Executive Summary

In 2023, the Mortality Quality Review Committee (MQRC) reviewed 346 reports of death, of which 225 were administrative review cases. All cases examined were from the Developmental Disabilities Administration (DDA), with no cases from the Behavioral Health Administration (BHA). Some deaths occurred in prior years but were reviewed in 2023.

The MQRC also reviewed incident data for the year but noted the absence of statewide data for Maryland. The data showed a slight decrease in deaths for individuals receiving care in DDA-run facilities, from 271 deaths (1.1%) in 2022 to 262 (1.07%) in 2023. Similarly, deaths in facilities licensed by BHA decreased from 26 (0.008%) in 2022 to 18 (0.006%) in 2023.

In 2023, respiratory failure shifted to the leading cause of death in both DDA and BHA facilities from COVID-19, compared to heart disease in 2022. Additionally, the MQRC identified several instances where the Health Risk Screening Tool had not been updated for two or more years, even after significant changes in individuals' health conditions.

This report highlights these findings and includes MQRC's recommendations for improving care and oversight.

Introduction and Overview

I. The Mortality And Quality Review Committee

The Mortality and Quality Review Committee (MQRC) is responsible for reviewing the deaths of individuals in programs or facilities operated, licensed, or approved by the Developmental Disabilities Administration (DDA) and the Behavioral Health Administration (BHA) within the Maryland Department of Health (MDH) [1].

The primary goal of the MQRC is to identify patterns and systemic issues within the DDA and BHA provider community. It aims to recommend actions to the Secretary of MDH that can help prevent avoidable injuries and deaths and improve the quality of care.

The MQRC holds meetings four times a year. These meetings are closed to the public, and all discussions are confidential. All records and files related to the MQRC, including its deliberations, findings, recommendations, and database, are confidential. Members are prohibited from disclosing details of the meetings and are not allowed to communicate directly with providers, state facility directors, family members, or guardians of individuals being reviewed in death cases. MQRC members have immunity from liability for their actions as committee members and for providing information, participating in, and contributing to the functions of the MQRC or its subcommittees. Members [2]do not receive compensation for their service on the MQRC.

The BHA and DDA provide staffing support for the MQRC within MDH. However, these employees are not members of the MQRC or its subcommittees.

II. Reporting Requirements

The MQRC is required to prepare an annual report for public distribution once a year. This report must include aggregated information detailing the number of deaths reviewed, the ages of the deceased, the causes and circumstances of these deaths, a review of aggregate incident data, a summary of the MQRC's activities, and a summary of findings. The summary of findings should highlight patterns and trends, goals, problems, concerns, final recommendations, and preventive measures. Notably, the report cannot identify specific individuals or entities. The DDA will distribute the public report to all service providers licensed by the DDA and those operating under waivers according to Health-General Article § 7–903(b) of the Annotated Code of Maryland.

In addition to the annual report, the MQRC may, at its discretion, issue preliminary findings or make preliminary recommendations at any time to the Secretary of the MDH, the Secretary of the Department of Disabilities, the Deputy Secretary of DDA, the Executive Director of BHA,

[1] See Attachment 1, Title 5, Subtitle 8, of the Health-General Article of the Annotated Code of Maryland (2020), infra, p. 12–17.
[2] See Attachment 2, 2020 MQRC Membership, infra, at 18.

and the Director of the Office of Health Care Quality (OHCQ). These preliminary findings and recommendations are confidential and are not discoverable or admissible.[3]

III. The Death And Incident Data Review Process

The MQRC is one link in the process of reviewing deaths and reportable incidents in the programs and facilities licensed or operated by DDA and BHA. The review process begins with a report of a death or a reportable incident to OHCQ and other appropriate agencies.

DDA has reporting requirements for deaths and incidents in their programs and facilities governed by statute or policy. DDA issued a Policy on Reportable Incidents and Investigations which became effective July 29, 1999 [4]. The purpose of the policy is to protect individuals from harm and to enhance the quality of services provided to them. The policy applies to all State Residential Centers, Forensic Residential Centers, and community-based agencies licensed by DDA.[5] All deaths and certain other incidents in programs covered by the policy must be reported to the following entities:

- OHCQ;
- DDA;
- family, legal guardian, or advocate(s);
- case manager or coordinators of community support;
- Disability Rights Maryland (the state protection and advocacy agency);
- local health department;
- law enforcement; and
- Office of the Chief Medical Examiner.

The reporting requirements for deaths occurring in an inpatient or residential treatment setting, residential crisis services, group home (including assisted living unit), residential rehabilitation program, personal support services, shared living services, and psychiatric rehabilitation program[6] is governed by Health-General Article § 10–713 (2015). If a death of an individual in any of the aforementioned programs occurs, and the person is not on hospice care, the administrative head of the program or facility must report the death:

- Immediately to the Secretary of MDH and the sheriff, police, or chief law enforcement official in the jurisdiction in which the death occurred; and
- By the close of business of the next working day to:
    - the Executive Director of BHA;
    - the health officer in the local jurisdiction where the death occurred; and
    - the state protection and advocacy agency, Disability Rights Maryland.

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[3] Health-General Article § 5–809; Health-Occupations Article § 14–501 (2001).

[4] -Developmental Disabilities Administration, Policy on Reportable Incidents and Investigations (Jan. 15, 2013), online at https://dda.health.maryland.gov/Pages/Developments/2015/10220201%20FINAL%20PORII.pdf (all Internet materials as last visited December 7, 2018) (the Policy on Reportable Incidents and Investigations was revised and reissued in December 2001, April 2003, October 2003, July 2005, July 2006, August 2006, October 2007, and January 2013).

[5] The reporting requirements also apply to those agencies operating by waiver under Health-General Article § 7–903(b) (2000).

[6] Effective October 1, 2015, psychiatric rehabilitation programs are no longer listed in statute as required to report deaths to the Department of Health.

Under the provisions of Health-General Article § 5–801 *et seq*., OHCQ performs a review of each death of an individual with a developmental disability or mental illness who, at the time of death, resided in or was receiving services from programs or facilities covered under § 10–713. The purpose of the review is to consider whether additional investigation is needed, especially if the incident is a death, to determine whether regulations have been violated. Two exceptions apply to the power of OHCQ to conduct an investigation: (1) OHCQ may not review the care or services provided in an individual's private home, except to the extent needed to investigate whether the services were provided in the home by a licensed provider; and (2) unless a member of the Committee requests a review, OHCQ may choose not to complete an on-site investigation of death if the circumstances, based on review and reasonable judgment, are readily explained and require no further investigation.

Once OHCQ completes its review or investigation, the case is presented to the MQRC. The MQRC then reviews each death case, including any deficiency statements and documents pertinent to the case. If further investigation is warranted, it may request additional information and documentation, including individual records, service of care records, medical records, discharge summaries, autopsy reports, medication administration records, and any deficiency statements and plans of corrections. Once a request for information has been made, a provider of medical, dental, or mental health care, and of residential or other services, whether private, State, or local governments, must provide access to that information. The MQRC may prepare questions for the provider agency, state facility director, or other relevant person.

In accordance with Health-General Article § 5–806.1, OHCQ provides aggregate incident data[7] to the MQRC every three months. A subcommittee of the MQRC reviews the aggregate incident data. Findings and recommendations for 2020 are included in this report.[8]

Data

IV. MQRC Activities And Statistical Information

In 2023, the MQRC met five times: February 10, May 8, August 14, November 16, and December 11. In calendar year 2023, the MQRC reviewed a total of 346 reports of death, with 225 being administrative review cases. Of the cases reviewed by the MQRC in 2023, all were from DDA. There were no BHA cases reviewed by the MQRC in 2023. Please note that not all cases reviewed in calendar year 2023 involved a death that occurred in calendar year 2023; the death may have occurred before 2023. The MQRC also reviewed aggregate incident data for the calendar year 2023.

Part One: Mortality

Table 1 compares the number of deaths that occurred in Calendar Year 2023 among individuals receiving DDA or BHA services to the number of deaths among all Maryland residents by age

[7] "Aggregate incident data" means information or statistics maintained by OHCQ on the reported incidents of Level III serious injuries at health care facilities. Health-General Article § 5–801.
[8] See *infra*, at 9–10.

group. Data indicates that among all Maryland residents, the majority of deaths that occurred in 2023 were in the age range of (NO MARYLAND DATA FOR 2023) followed by those in the range of (NO MARYLAND DATA FOR 2023). By comparison, among people served by DDA, the majority of deaths in 2023 were in the age group of 55-64, followed by the age group 65-74. Among the people served by BHA, the majority of deaths in 2023 were in the age group of **55-64** followed by the age group of (**65-74**). **Table 2** and **Figures 1–2** list the top 10 leading causes of death that occurred in Calendar Year 2023 among individuals receiving DDA and BHA services and compare those causes of death to the top 10 leading causes of death among all Maryland residents.

Table 4 compares the number of deaths that occurred in Calendar Year 2022 among individuals receiving DDA or BHA services to the number of deaths among all Maryland residents by age group. Data indicates that among all Maryland residents, the majority of deaths that occurred in 2022 were in the age range of no Maryland Data available for 2022, followed by those in the range no Maryland Data available for 2022. By comparison, among people served by DDA, the majority of deaths in 2022 were in the age group of 55–64, followed by the age group 65–74. Among the people served by BHA, the majority of deaths in 2022 were in the age group of 65-74, followed by the age group of 55-64. **Tables 7** and **8** list the top 10 primary causes of death for years 2020 and 2019 among all residents of Maryland, and those served by DDA and BHA.

Part Two: Aggregate Incident Data

For providers supporting individuals with developmental disabilities, incidents are reportable according to guidelines established by DDA's Policy on Reportable Incidents and Investigations.[9] From the many incidents reported, the OHCQ Triage Unit and the weekly Incident Screening Committee must determine which incidents are to be further investigated, and the priority for on-site investigation, with an immediate jeopardy priority investigation initiated within 2 working days of assignment, a high priority investigation initiated within 10 working days, and a medium level investigation initiated within 30 working days of assignment. Discriminations employed for investigation include the severity and type of incident reported, the track record of the licensee, characteristics and number of people served, 21-day internal reports, etc. Additionally, it should be noted that, although mandatory, incidents are self-reporting, resulting in some incidents going unreported.

Those incidents that are assigned for on-site investigation by OHCQ may yield a "substantiated" or "unsubstantiated" classification. In this context, "substantiated" means that the alleged incident (abuse, medication error, fracture, etc.), upon investigation, was found to have occurred. "Unsubstantiated" means that the alleged incident, upon investigation, did not occur. Each investigation may also result in a report called a Statement of Deficiencies. If no noncompliance issues are noted during the investigation, a closure letter stating that no deficient practices were noted is sent to the provider agency. When deficiencies are cited, the provider-licensee must submit for approval a plan of correction. If the agency's plan of correction is determined by OHCQ to be acceptable, no further action is required. If the plan of correction is not deemed acceptable, a revised plan of correction for the cited deficiencies is required. All immediate

[9] Policy on Reportable Incidents and Investigations at 12–13. (Reportable incidents are reviewed within OHCQ according to guidelines formalized in the Report Incidents Section).

jeopardy priority investigations must receive follow-up review from OHCQ.[10] A 10% targeted sample of incidents with a high-priority classification will receive a follow-up review.[11]

V. Findings And Recommendations

This area is broken down into categories to address new findings and findings that have been recurring over the past several years. With these findings, the MQRC committee has provided recommended solutions to assist with trying to remedy these issues. Below are those findings and recommendations.

New Findings and Recommendations

Finding: There have been several cases where the Health Risk Screening Tool has not been updated in two or more years, including after a person's health condition has changed considerably.

Recommendation: That protocols be developed to ensure that appropriate updates and clinical reviews of the HRST occur.

Finding: For several years, the causes of death listed in the DDA mortality report have been diagnoses of the deceased person (*e.g.*, Cerebral Palsy, Down Syndrome, etc.) as the primary cause of death. The information in the DDA mortality report, generated by OHCQ, is drawn from the official death certificates that were furnished to DDA and in many cases do not address the actual death event.

Recommendation: Listing a diagnosis as a primary cause of death may conceal a clear end-of-life event that has not been addressed in the case of the person who died. The MQRC recommends greater clarity regarding the primary cause of death as recorded on death certificates for persons served by DDA. It is imperative that the real end-of-life event be captured on the death certificate as opposed to the diagnosis of the deceased person.

Finding: The committee has found there has been a trend of citations and errors surrounding staff administering CPR or failing to perform CPR. It is a violation of the individual's rights when it is performed in error and is negligent when it is not performed when it should be.

Recommendation: It is recommended that agencies provide thorough training on the process to include what is a DNR, where it is kept, the MOLST, what to expect, and periodic Mock Drills to reduce staff panicking in an emergency and to improve efficiency. It was also recommended that DDA look into a way to discreetly identify individuals with a DNR for the staff such as a small sticker on the door.

Conclusion

[10] See *id.*, at 14.
[11] *Ibid.*

The MQRC has been consistent with its mandate to identify patterns and systemic problems within the DDA and BHA provider community and make recommendations to the Secretary of MDH regarding actions to prevent avoidable injuries and deaths and to improve the quality of care. However, these efforts could be more effective with unfettered access to accurate data, especially in Maryland State as noted in the committee findings and recommendations.

Appendix 1

Table 1. Number of Deaths Among Individuals Receiving DDA or BHA Services to Total Deaths Among Marylanders by Age Group in 2023

Age Group (years)	Deaths of All Marylanders in 2023	Deaths of Individuals Receiving DDA Services in 2023	Deaths of Individuals Receiving BHA Services in 2023
<1		0	**0**
1–4		1	**0**
5–14	NO MARYLAND	2	**0**
15–24		21	**0**
25–34	DATA	30	**1**
35–44		28	**1**
45–54	AVAILABLE	31	**1**
55–64		72	**9**
65–74	AS OF	48	**5**
75–84		20	**1**
85+	OCTOBER 15, 2024	10	**0**
Not stated		0	**0**
Male (all ages)		158	**16**
Female (all ages)		104	**2**
Total Deaths		**262**	**18**
Total Population		**24,342**	**317,174**

Table 2. Top 10 Individual Causes Of Death In 2023

Rank	Leading Causes of All Marylanders Deaths 2023	Leading Causes of DDA Deaths 2023	Leading Causes of BHA Deaths 2023
1		Respiratory Failure	COVID-19 Respiratory Failure
2	NO MARYLAND	Diseases of the Heart	Diseases of the Heart
3		Pneumonia	Drug Intoxication
4	DATA	Sepsis	Sepsis
5		Malignant Neoplasm (Cancer)	Renal Failure
6	AVAILABLE	Dementia/Alzheimer's Disease	Accident
7		Aspiration	Diabetes
8	AS OF	Seizure Disorders	Malignant Neoplasm (Cancer)
9		Renal Failure	
10	OCTOBER 15, 2024	Failure to Thrive	

Figure 1. Percent Distribution of Leading Causes of Death—DDA 2023

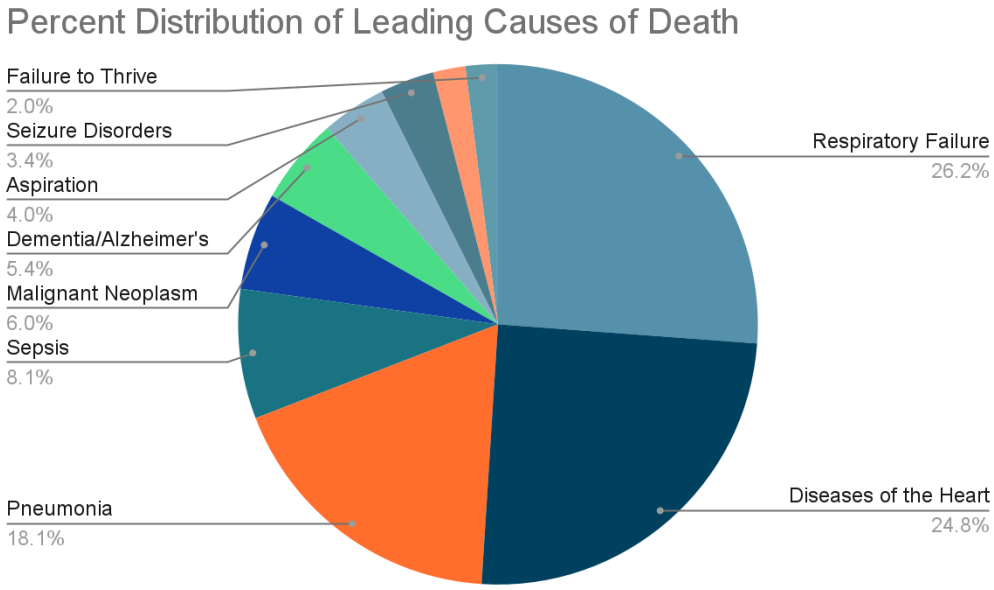

Figure 2.Percent Distribution of Leading Causes of Death—BHA 2023

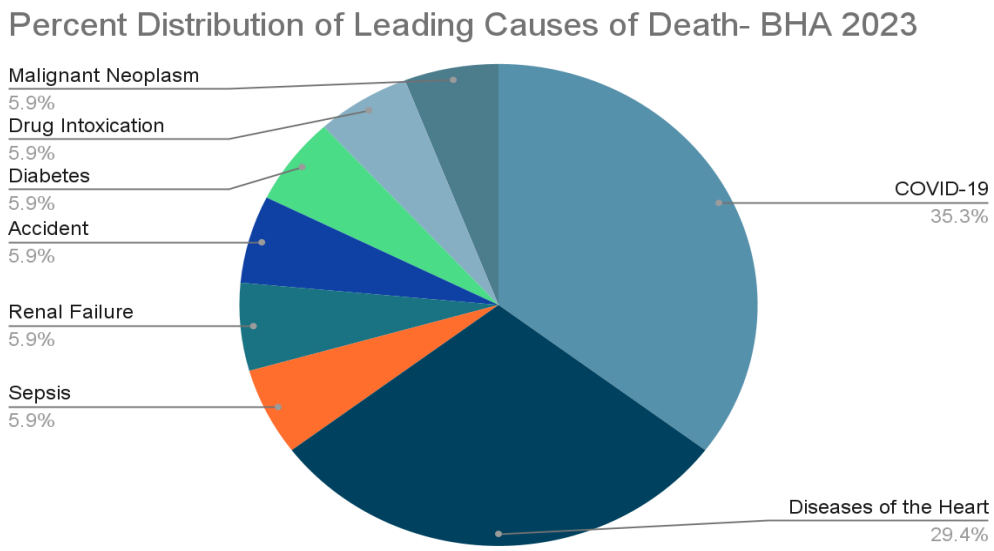

Table 4. Number of Deaths Among Individuals Receiving DDA or BHA Services to Total Deaths Among Marylanders by Age Group in 2022

Age Group (years)	Deaths of All Marylanders in 2022	Deaths of Individuals Receiving DDA Services in 2022	Deaths of Individuals Receiving BHA Services in 2022
<1		0	0
1–4		1	0
5–14	NO MARYLAND	0	0
15–24		14	0
25–34	DATA	24	0
35–44		40	1
45–54	AVAILABLE	26	3
55–64		76	9
65–74	AS OF	60	12
75–84		24	1
85+	OCTOBER 15, 2024	6	0
Not stated		1	0
Male (all ages)		167	22
Female (all ages)		103	4
Total Deaths		**271**	**26**
Total Population		**24,758**	**302,822**

Table 5. Number of Deaths Among Individuals Receiving DDA or BHA Services to Total Deaths Among Marylanders by Age Group in 2021

Age Group (years)	Deaths of All Marylanders in 2021	Deaths of Individuals Receiving DDA Services in 2021	Deaths of Individuals Receiving BHA Services in 2021
<1	415	0	0
1–4	64	1	0
5–14	100	3	0
15–24	650	8	0
25–34	1518	23	0
35–44	2200	36	0
45–54	3,579	39	2
55–64	8149	76	9
65–74	11,692	70	7
75–84	13,620	23	0
85+	16,138	9	0

Not stated	5	0	0
Male (all ages)	30,090	165	15
Female (all ages)	28,037	123	3
Total Deaths	58,130	**288**	**18**
Total Population	6,174,610	**24,517**	**284,735**

Table 7. Top 10 Individual Causes Of The Deaths 2021

Rank	Leading Causes of All Marylanders Deaths 2021	Leading Causes of DDA Deaths 2021	Leading Causes of BHA Deaths 2021
1	Diseases of Heart	Diseases of the Heart	Diseases of the Heart
2	Pneumonia	Respiratory Failure	COVID-19
3	Respiratory Failure	Pneumonia	Malignant Neoplasm
4	Malignant Neoplasm	Sepsis	Sepsis
5	Sepsis	COVID-19	Cerebrovascular Disease
6	Dementia	Malignant Neoplasm	
7	Seizure Disorder	Cerebral Palsy	
8	Cerebral Palsy	Seizures	
9	Hypoxia	Dementia	
10	Failure to Thrive	Pulmonary Embolism	

Table 8. Top 10 Individual Causes Of The Deaths 2020

Rank	Leading Causes of All Marylanders Deaths 2020	Leading Causes of DDA Deaths 2020	Leading Causes of BHA Deaths 2020
1	Diseases of the Heart	Diseases of the Heart	Diseases of the Heart
2	Malignant Neoplasm	Pneumonia	COVID-19
3	COVID 19	Sepsis	Sepsis
4	Cerebrovascular Disease	Respiratory Failure	Malignant Neoplasm
5	Accidents	COVID-19	Intoxication
6	Chronic Lower Respiratory Diseases	Malignant Neoplasm	Respiratory Failure
7	Diabetes	Cerebral Palsy	
8	Alzheimer’s Disease	Aspiration	
9	Septicemia	Epilepsy	
10	Influenza and Pneumonia	Alzheimer’s/Dementia	

Table 6. Number of Deaths Among Individuals Receiving DDA or BHA Services to Total Deaths Among Marylanders by Age Group in 2020

Age Group (years)	Deaths of All Marylanders in 2020	Deaths of Individuals Receiving DDA Services in 2020	Deaths of Individuals Receiving BHA Services in 2020
<1	391	0	0
1–4	60	0	0
5–14	82	3	0
15–24	666	18	0
25–34	1,591	44	1
35–44	2,087	31	1
45–54	3,560	41	3
55–64	8,126	80	6
65–74	11,654	73	8
75–84	13,964	36	2
85+	17,882	7	0
Not stated	12	3	0
Male (all ages)	30,961	215	14
Female (all ages)	29,107	117	7
Total Deaths	**60,075**	**336**	**21**
Total Population	**6,055,802**	**23,993**	**285,576**

Appendix 2

2022

Annotated Code of Maryland

HEALTH-GENERAL ARTICLE

TITLE 5. DEATH
SUBTITLE 8. MORTALITY AND QUALITY REVIEW COMMITTEE.

§ 5-801. Definitions
(a) In general. -- In this subtitle the following words have the meanings indicated.
(b) Aggregate incident data. -- "Aggregate incident data" means information or statistics maintained by the Office of Health Care Quality on the reported incidents of Level III serious injuries at healthcare facilities. (c) Committee. -- "Committee" means the Mortality and Quality Review Committee.
HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-802. Established; purpose
(a) Established. -- There is a Mortality and Quality Review Committee established within the Department.
(b) Purpose. -- The purpose of the Committee is to prevent avoidable injuries and avoidable deaths and to improve the quality of care provided to persons with developmental disabilities.
HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-803. Duties
The Committee shall:
(1) Evaluate causes or factors contributing to deaths in facilities or programs:
(i) Operated or licensed by the Developmental Disabilities Administration;
(ii) Licensed by the Behavioral Health Administration to provide mental health services; or
(iii) Operating by waiver under § 7-903(b) of this article;
(2) Review aggregate incident data regarding facilities or programs that are licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article;
(3) Identify patterns and systemic problems and ensure consistency in the review process; and
(4) Make recommendations to the Secretary and the Secretary of Disabilities to prevent avoidable injuries and avoidable deaths and improve the quality of care.
HISTORY: 2000, ch. 470; 2001, ch. 640; 2006, ch. 268; 2014, ch. 460; 2015, ch. 469.

§ 5-804. Composition; terms; removal; expenses; staff; chairperson; quorum; meetings

(a) Composition. -- The Committee shall consist of 18 members appointed by the Secretary, including the following:

(1) A licensed physician who is board-certified in an appropriate specialty;

(2) A psychopharmacologist;

(3) A licensed physician on staff with the Department;

(4) Two specialists, one in the field of developmental disabilities and one in the field of mental health;

(5) Two licensed providers of community services, one for persons with developmental disabilities and one for persons with mental illnesses;

(6) Two consumers, one with a developmental disability and one with a mental illness;

(7) Two family members, one representing a consumer with a developmental disability and one representing a consumer with a mental illness;

(8) The Deputy Secretary of Behavioral Health and Disabilities or the Deputy Secretary's designee;

(9) The Director of the Office of Health Care Quality;

(10) A licensed physician representative from the Medical Examiner's Office;

(11) A licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community;

(12) A member of an advocacy group for persons with disabilities; and

(13) Two members of advocacy groups, one for persons with developmental disabilities and one for persons with mental illnesses.

(b) Terms. --

(1) The term of each member appointed under subsection (a) (1), (2), (4), (5), (6), and (10) of this section is 3 years.

(2) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed.

(3) A member may not be appointed for more than two consecutive full terms.

(4) The terms of the members are as follows:

(i) One-third of the members shall be appointed for terms of 3 years commencing October 1, 2000;

(ii) One-third of the members shall be appointed for terms of 2 years commencing October 1, 2000; and

(iii) One-third of the members shall be appointed for terms of 1 year commencing October 1, 2000.

(5) At the end of a term, a member continues to serve until a successor is appointed.

(c) Removal of member. -- The Secretary may remove any member of the Committee for good cause.

(d) Reimbursement for expenses. -- A member of the Committee:

(1) May not receive compensation for service on the Committee; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as

provided in the State budget.
(e) Staff. -- The Committee shall be staffed by the Department.
(f) Membership limitations. --
(1) An employee of the Developmental Disabilities Administration or the Behavioral Health Administration may not be a member of the Committee or any subcommittee of the Committee.
(2) The Director of the Office of Health Care Quality may not serve on a subcommittee of the Committee or vote on the disposition of an individual mortality review that was previously reviewed by the Office of Health Care Quality.
(g) Chairperson. -- The Secretary shall select a chairperson from among the members of the Committee.
(h) Quorum. -- A quorum of the Committee shall be a majority of the appointed membership of the Committee.
(i) Frequency of meetings. -- The Committee shall meet not less than three times a year.
HISTORY: 2000, ch. 470; 2001, ch. 640; 2006, ch. 268; 2009, chs. 48, 49; 2014, ch. 460; ch. 539.

§ 5-805. Evaluation of deaths of certain service recipients with developmental disabilities
(a) Review of the death of certain service recipients. --
(1) Except as provided in paragraph (3) of this subsection, the Office of Health Care Quality shall review each death of an individual with developmental disabilities or with a mental illness who, at the time of death, resided in or was receiving services from any program or facility licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903 (b) of this article, or any program approved, licensed, or operated by the Department under § 10-406 of this article or any program identified in § 10-713(A) of this article.
(2) The Office of Health Care Quality may not review the care or services provided in an individual's private home, except to the extent needed to investigate a licensed provider that offered services at that individual's home.
(3) Unless a member of the Committee requests a review, the Office of Health Care Quality may choose not to review a death if the circumstances, based on reasonable judgment, are readily explained and require no further investigation.
(b) Final report -- Submission. -- Within 14 days of the completion of each investigation, the Office of Health Care Quality shall submit to the Committee its final report for each death.
(c) Final report -- Review by Committee. -- The Committee shall:
(1) Review each death report provided by the Office of Health Care Quality; or
(2) Appoint a subcommittee of at least four members, one of whom shall be a licensed physician or nurse, to review death reports and report and make recommendations to the full Committee.
(d) Further investigation. --
(1) On review of the death report, if the Committee or its subcommittee determines that further investigation is warranted, the Committee or subcommittee may request additional information, including consumer records, medical records, autopsy reports, and any deficiency statements and

plans of correction.
(2) The Committee or subcommittee may choose to prepare questions for the provider, State residential center director, or other relevant person or may request the attendance of the provider, director, or other relevant person at a Committee or subcommittee meeting.
(3) Except as provided in paragraph (2) of this subsection, Committee members may not communicate directly with the provider, a State residential center director, a State psychiatric superintendent, or a family member or guardian of the individual who is the subject of a death report.
HISTORY: 2000, ch. 61, § 7; ch. 470; 2001, ch. 29, § 1; ch. 640; 2006, ch. 268; 2014, ch.460; 2015, ch. 469.

§ 5-806. Requests for information
Upon request of the chairman of the Committee or subcommittee, and as necessary to carry out the purpose of the Committee, the following shall immediately provide the Committee or subcommittee with access to information and records regarding an individual whose death is being reviewed:
(1) A provider of medical care, including dental and mental health care;
(2) A State or local government agency; and
(3) A provider of residential or other services.
HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-806.1. Office of Health Care Quality to provide and review aggregate incident data;
(a) Periodic data. --
(1) The Office of Health Care Quality shall provide aggregate incident data to the Committee once every 3 months.
(2) When providing aggregate incident data to the Committee, to the extent practicable, the Office of Health Care Quality shall identify trends and patterns that may threaten the health, safety, or well-being of an individual.
(b) Review. -- The Committee shall review the aggregate incident data and make findings and recommendations to the Department on system quality assurance needs.

(c) Consultants. -- The Committee may consult with experts as needed to carry out the provisions of this section.
HISTORY: 2006, ch. 268.

§ 5-807. Immunity from liability.
A person shall have immunity from liability under § 5-637 of the Courts Article for any action as a member of the Committee or for giving information to, participating in, or contributing to the function of the Committee or subcommittee.
HISTORY: 2000, ch. 470; 2006, chs. 44, 268

§ 5-808. Annual public report; preliminary findings or recommendations

(a) Annual public report. --

(1) At least once in a calendar year, the Committee shall prepare a report for public distribution.

(2) The report shall include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a review of aggregate incident data, a summary of the Committee's activities, and a summary of findings.

(3) Summary findings shall include patterns and trends, goals, problems, concerns, final recommendations, and preventative measures.

(4) Specific individuals and entities may not be identified in any public report.

(5) The Developmental Disabilities Administration shall provide the report to the facilities or programs that are operated or licensed by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article.

(b) Preliminary findings or recommendations. --

(1) In addition to the public report issued under subsection (a) of this section, the Committee or its subcommittee may at any time issue preliminary findings or make preliminary recommendations to the Secretary, the Secretary of Disabilities, the Director of the Developmental Disabilities Administration, the Director of the Behavioral Health Administration, or the Director of the Office of Health Care Quality.

(2) Preliminary findings or recommendations shall be confidential and not discoverable or admissible under §1-401 of the Health Occupations Article.

HISTORY: 2000, ch. 470; 2002, ch. 19, §9; 2006, ch. 268; 2014, ch.460.

§5-809. Record keeping; confidentiality; discovery

(a) Maintenance of records. -- The Committee shall maintain records of its deliberations including any recommendations.

(b) Records generally confidential; independent information. --

(1) Except for the public report issued under §5-808(a) of this subtitle, any records of deliberations, findings, or files of the Committee shall be confidential and are not discoverable under §1-401 of the Health Occupations Article.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

(c) Testimony of involved persons; independent information. --

(1) Members of the Committee or a subcommittee of the Committee, persons attending a Committee or subcommittee meeting, and persons who present information to the Committee or subcommittee may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information obtained independently of the Committee or subcommittee or that is public information.

(d) Prohibition on disclosure by involved persons. -

(1) Except as necessary to carry out the Committee's purpose and duties, members of the Committee or subcommittee and persons attending a Committee or subcommittee meeting may not disclose:
(i) What transpired at a meeting that is not public under this subtitle; or
(ii) Any information that is prohibited from disclosure by this section.
(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.
HISTORY: 2000, ch. 470; 2002, ch. 19, § 9; 2006, ch. 268.

§ 5-810. Closed meetings
Meetings of the Committee and subcommittees shall be closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article.
HISTORY: 2000, ch. 470; 2006, ch. 268.

Attachment

2022 MQRC MEMBERSHIP

Committee Chair

- Kimberly Breton Iaquinta, DDA Provider

Committee Membership

- Patricia T. Nay, OHCQ Director
- Allan Sheahen, DD Specialist, term ended on September 30, 2022
- Dr. Eric Levey, Physician, term ended on September 30, 2022
- Jed L. Miller, Physician, MDH, resigned from MDH and MQRC January 26, 2022
- Sohail Qarni, Physician, MDH, appointed to replace Dr. Miller on February 17, 2022
- Sarah Benner, Psychopharmacologist
- Candace Harris, MH Specialist
- Curtis Royster, Jr., DDA Family Representative
- Samantha Peel, Designee of BHA Dep. Sec.
- Rosamond Dove, Mental Health Family Member
- Kimberly Albert, DD Specialist
- Patrice O'Toole, MH Consumer
- Helayne Sweet, DD Advocate
- Laura Doherty, DD Advocacy Group
- Maria del Carmen Lopez-Arvizu, Physician
- Vacant, Nurse
- Dr. Victor Weedn, Chief Medical Examiner, resigned from the OCME and MQRC on February 22, 2022
- Vacant, OCME representative after February 22, 2022
- Vacant, MH Provider
- Vacant, DD Self Advocate/Consumer
- Vacant, MH Advocacy Group

References

Maryland Developmental Disabilities Administration. (2015). Policy on Reportable Incidents and Investigations [PDF]. Retrieved from https://dda.health.maryland.gov/Pages/Developments/2015/10220201%20FINAL%20PORII.pdf