OCME AUDIT CASE REVIEW PROCESS

2025 ANNUAL REPORT

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December 29, 2025

The Honorable Wes Moore
Governor
100 State Circle
Annapolis, Maryland 21401

Re: First Annual Report on OCME Audit Case Reviews Pursuant to Executive Order 01.01.2025.11 (MSAR # 16578)

Dear Governor Moore,

I am pleased to submit the first annual report on our review of cases identified in the Maryland Office of the Chief Medical Examiner (OCME) Audit, as required by Section B(1) of Executive Order 01.01.2025.11.

Your leadership in issuing this Executive Order represents a historic commitment to equity and accountability in Maryland's justice system. By directing this comprehensive review, you have ensured that questions of fairness in death investigations—particularly those involving restraint-related deaths in custody—receive the independent, rigorous examination they deserve.

This report documents the establishment of our independent case review process for the 41 cases warranting examination, our collaboration with State's Attorneys' Offices across 13 jurisdictions, and our commitment to transparency and accountability. All 41 cases remain under review. While significant progress has been made, substantial work remains. My office is committed to fulfilling the mandate you established through justice, transparency, and thoroughness.

Sincerely,

Anthony G. Brown

TABLE OF CONTENTS

1. Executive Summary 2

2. Background: The OCME Audit 3

3. Scope and Mandate of the Executive Order 4

4. Current Status of the 41 Cases 5

4.1 Review Methodology and Standards 5

4.2 Legal Implications and Risk Mitigation 5

4.3 Challenges Identified 6

5. State's Attorneys Offices (SAOs) Communication and Collaboration 7

5.1 Collaboration with SAOs 7

5.2 Notification and Engagement Process 7

5.3 Status of SAOs' Responses 7

6. Conflict of Interest Management 8

7. Public Reporting, Engagement and Transparency Measures 8

8. Conclusion and Future Commitments 9

9. Appendix 11

1. EXECUTIVE SUMMARY

Overview

This report marks the first annual submission to the Governor pursuant to Executive Order 01.01.2025.11 which mandates that the Office of the Attorney General (OAG) review cases identified in the comprehensive audit of Maryland's Office of the Chief Medical Examiner (OCME). The audit examined OCME's death investigations during former Chief Medical Examiner Dr. David Fowler's tenure (2003-2019), with particular focus on restraint-related deaths in custody.

Key Audit Findings

The OCME Audit report, released on May 15, 2025, identified significant concerns regarding the manner of death classification of restraint-related deaths. OCME classifies manner of death into five categories:

1. **Homicide** – Death resulting from the intentional actions of another person. A homicide determination does not necessarily mean criminal culpability, but it indicates that, but for the actions of another human being, the decedent would still be alive. This classification flags the case for potential further criminal investigation by prosecutors.
2. **Suicide** – Death resulting from an intentional, self-inflicted injury or action.
3. **Accidental** – Death resulting from a traumatic or non-traumatic event that caused death in an otherwise healthy individual, where the death was unintentional. This includes circumstances where injuries were inflicted unintentionally, whether recreational or vehicular in nature.
4. **Natural** – Death occurring due to illness and its complications, or internal body malfunctions, not directly caused by external forces other than infectious diseases.
5. **Undetermined** – Death where there is insufficient evidence to reach a firm conclusion about the way the death occurred. This classification is used when the available evidence does not allow the medical examiner to determine whether the death was natural, accidental, suicidal, or homicidal with reasonable medical certainty.

Among 87 cases reviewed by 12 independent forensic pathologists, 41 cases emerged as warranting review: 36 cases where all three independent reviewers unanimously determined the manner of death should have been classified as "homicide," and 5 cases where two of three reviewers reached this conclusion. In all 41 cases, OCME had determined the manner of death was accidental, natural, or undetermined. The OAG will limit our review to these 41 cases.

Executive Order Mandate and Case Review Process

Executive Order 01.01.2025.11, signed by Governor Wes Moore on May 15, 2025, grants the Attorney General explicit authority to review the audited cases in consultation with local State's

Attorneys Offices (SAOs) to determine whether cases should be reopened for investigation. The OAG has assembled a multidisciplinary team of attorneys with prosecutorial, regulatory, and policymaking expertise to conduct comprehensive case reviews. All 41 identified cases remain under review as of this reporting period, with no determinations yet made regarding further investigative or prosecutorial activity.

Collaboration with SAOs

The 41 cases under review occurred across 13 Maryland counties and Baltimore City. Between September and November 2025, the OAG requested case files from all 13 SAOs in those jurisdictions. Nine SAOs responded promptly with full file production: Baltimore County, Baltimore City, Frederick County, Washington County, Worcester County, Prince George's County, Wicomico County, Caroline County, and Carroll County. Three offices—Montgomery County, Anne Arundel County, and Charles County—have provided status updates and are actively working on file compilation. One office—Harford County—has not yet responded to OAG's written notification and follow-up communications. The OAG remains committed to working with all jurisdictions and will utilize all available mechanisms, including invoking the Executive Order's authority, to ensure complete access to necessary case materials.

Current Status and Challenges

All 41 cases remain under preliminary investigatory review. The primary challenges identified include:

1. **File Access and Completeness**: Incomplete file production from some jurisdictions delays comprehensive review and may impact ability to make fully informed determinations
2. **Resource Constraints**: Absence of dedicated funding requires strategic allocation of existing resources that may extend the review timeline
3. **Complexity of Historical Cases**: Cases spanning 2003-2019 present challenges related to witness availability, evidence preservation, and case file organization

Transparency and Public Engagement

The OAG established the OCME Audit Hotline for family support and engagement. The Office also conducted briefings with impacted families (May 15, 2025, and June 25, 2025), presented audit findings to the National Academy of Sciences (May 16, 2025), and briefed the Maryland House of Delegates' Judiciary Committee (June 25, 2025).

2. BACKGROUND: THE OCME AUDIT

In Spring 2021, concerns emerged regarding the practices of Maryland's Office of the Chief Medical Examiner (OCME) during the tenure of former Chief Medical Examiner Dr. David Fowler. These concerns were prompted in part by Dr. Fowler's testimony in the trial of Officer Derek Chauvin for the murder of George Floyd. An open letter signed by more than 450 medical experts questioned

whether OCME had followed standard medical practice in determining the manner of death in cases involving individuals who died in police custody.

In May 2021, former Governor Larry Hogan and former Attorney General Brian Frosh directed the Office of the Attorney General, in consultation with the Governor's Office of Legal Counsel, to sponsor an independent audit of OCME's death investigations during Dr. Fowler's tenure. The audit was specifically designed to evaluate whether OCME's determinations of cause and manner of death were appropriate and whether any patterns of pro-law enforcement or racial bias existed.

In September 2021, Attorney General Frosh appointed an Audit Design Team (ADT) comprising international experts in forensic medicine, pathology, social science, and research methodology. The ADT developed a scientifically rigorous audit process to promote objectivity and minimize bias.

The ADT initially reviewed approximately 1,300 OCME death-in-custody cases that spanned Dr. Fowler's tenure from 2003 – 2019. The ADT identified 87 cases involving deaths during or shortly after physical restraint to include in the audit. After reviewing OCME policies, interviewing leadership, and consulting professional guidelines, the ADT issued an interim report in Fall 2022 highlighting concerns that OCME may have systematically classified certain restraint-related deaths as "undetermined" when generally accepted standards would classify them as homicides.

Following this interim report, the OAG and the Governor's Office of Legal Counsel secured funding and recruited 12 experienced, independent forensic pathologists to conduct detailed reviews of 87 OCME case files involving deaths during or after restraint.

In August 2024, orientation sessions were held for the independent case reviewers on August 27 and August 30. Phase 2 of the audit commenced on September 9, 2024, when the selected OCME case files were circulated to the medical examiners for review. Case reviews were completed by the end of January 2025. Concurrently, between January through April 2025, the OAG began coordinating with the ADT to finalize and release the OCME Audit report.

Between December 2024 and May 2025, the OAG met with a cross-section of stakeholders involved in the medicolegal death investigation system in Maryland and nationally, including public health officials, legislators, attorneys, law enforcement, academics, and community advocates. The final audit report was released on May 15, 2025. This comprehensive audit aimed to assess OCME's investigative practices, identify areas for improvement, and ensure that Maryland's death investigation system serves public health and justice.

3. SCOPE AND MANDATE OF THE EXECUTIVE ORDER

Executive Order 01.01.2025.11, signed by Governor Wes Moore on May 15, 2025, grants the Attorney General explicit authority to review the cases included in the OCME Audit to determine whether they should be reopened for investigation. This review authority is to be exercised in

consultation with the appropriate local SAO whose jurisdictions correspond with the county where the restraint occurred in each case.

Among the cases subject to review are 41 cases where at least two out of three case reviewers determined the manner of death should have been homicide (including 36 cases where all three independent reviewers unanimously determined the manner of death should have been homicide), while OCME had determined the manner of death was accidental, natural, or undetermined.

The Executive Order establishes a collaborative framework for this review process, providing that the Maryland State Police may assist the Attorney General in conducting any resulting investigations upon request, while preserving the independent authority of local SAOs to reopen and investigate any Audit cases on their own initiative. The Attorney General is required to prepare an annual report by December 31st of each calendar year on the status of the review of Audit cases until each case has been reviewed.

4. CURRENT STATUS OF THE 41 CASES

The OAG has identified 41 cases for review post-audit. All 41 cases remain under preliminary investigatory review, and the OAG has not yet determined whether any case warrants formal criminal investigation.

4.1 Review Methodology and Standards

The OAG has assembled a multidisciplinary team of attorneys with prosecutorial, regulatory, and policymaking expertise to conduct the OCME Audit case reviews. This team is currently working in consultation with local SAOs to locate and obtain the relevant case files for all 41 cases under review. Once all these files have been received, the OAG will begin conducting thorough assessments to document the inventory and make initial determinations about whether sufficient information exists to warrant formal investigation and potential prosecution of each case.

The review process is guided by a commitment to legal sufficiency and thoroughness. Each case assessment will be comprehensively documented, including the team's determination regarding whether further investigation is needed and the factual and legal basis for that decision. This documentation ensures transparency and accountability in the review process while maintaining appropriate confidentiality for ongoing or potential investigations.

4.2 Legal Implications and Risk Mitigation

The case review process addresses significant legal and public trust implications arising from the audit findings. The OAG has implemented several risk mitigation measures:

- **Independence Protocols**: Formal conflict walls between attorneys representing state agencies and case review staff ensure unbiased review

- **Documentation Standards**: Thorough documentation of all determinations, including factual and legal bases, ensures defensibility and transparency
- **Confidentiality Protections**: Appropriate confidentiality during preliminary review preserves the integrity of potential future proceedings
- **Consultation Framework**: The process respects the independent authority of local State's Attorneys while fulfilling the statewide review mandate
- **Evidentiary Protocols: Garrity-Protected Statements:** To ensure constitutional compliance with officers' Fifth Amendment rights against self-incrimination as established in *Garrity v. New Jersey*, 385 U.S. 493 (1967), the OAG has established protocols for handling Garrity-protected statements, including screening team structures, procedural safeguards, and mandatory training requirements.

4.3 Challenges Identified

The OAG has encountered three primary challenges in the case review process:

- **File Access and Completeness**: Incomplete file production from some jurisdictions delays comprehensive review and may impact the ability to make fully informed determinations. The OAG continues proactive engagement with all jurisdictions to secure necessary materials.
- **Resource Constraints**: The absence of dedicated funding requires strategic allocation of existing resources across multiple OAG priorities. The review team has leveraged multidisciplinary expertise within the OAG and adopted phased implementation to maximize efficiency, though these constraints may extend the overall review timeline.
- **Complexity of Historical Cases**: Cases spanning 2003-2019 present challenges related to witness availability, evidence preservation, and case file organization. Some jurisdictions have had trouble locating complete investigative files for cases that predate current record-keeping systems.

Despite these challenges, the OAG remains committed to conducting thorough, independent reviews of all 41 cases.

5. STATE'S ATTORNEYS OFFICES (SAOs) COMMUNICATION AND COLLABORATION

5.1 Collaboration with SAOs

The OAG has established a systematic process for reviewing cases identified in the OCME Audit, consistent with Executive Order 01.01.2025.11. This process involves coordination with local prosecutors and implementation of protocols to ensure independent and thorough review.

5.2 Notification and Engagement Process

The OAG initiated formal communication with SAOs in the 13 jurisdictions where incidents occurred. Beginning on July 28, 2025, through November 18, 2025, relevant offices received electronic notification letters that:

- Informed them of the OAG's review authority under the Executive Order
- Requested case files and investigative materials to enable comprehensive review
- Established a 30-day response timeline from receipt of the letter
- Outlined a consultation framework consistent with the Executive Order's requirements

5.3 Status of SAOs' Responses

As of this reporting period, the SAOs responses fall into three categories:

Full File Production

The OAG extends sincere appreciation to nine SAOs that responded promptly and comprehensively with complete case files: Baltimore City, Baltimore County, Caroline County, Carroll County, Frederick County, Prince George's County, Washington County, Wicomico County, and Worcester County. Their collaborative approach—including timely file production, designation of points of contact, and willingness to engage in consultation—exemplifies the interagency cooperation necessary to ensure justice and accountability.

Active Engagement

Three SAOs have provided status updates and are actively compiling requested files: Montgomery County, Charles County and Anne Arundel County. The OAG appreciates their communication and continues working collaboratively with these offices to ensure timely access to necessary materials.

Pending Response

One SAO—Harford County—has not responded to the OAG's written notification despite multiple follow-up communications. The Executive Order grants the Attorney General explicit authority to review these cases, and complete access to case files is essential to fulfill this mandate.

The OAG will continue outreach efforts with these offices. However, if cooperation is not forthcoming, the OAG will invoke the full authority granted under Executive Order 01.01.2025.11 and pursue all available legal mechanisms to obtain the necessary case materials. Any delays in obtaining complete files from these jurisdictions will be documented in subsequent annual reports, along with their impact on the thoroughness and timeliness of case reviews.

6. CONFLICT OF INTEREST MANAGEMENT

Several cases under review involve state agencies that the OAG represents in other legal matters. To preserve the independence and integrity of the review process, the OAG implemented formal conflict walls (ethical barriers) between:

- OAG attorneys who regularly represent state agencies in their usual legal matters, and
- OAG staff conducting the OCME Audit case reviews

Upon identifying affected client agencies, the OAG provided written notification and established these ethical walls. Additionally, executive leadership was strategically divided, with certain Deputy Attorneys General walled off from the case review process. This allows OAG attorneys representing client agencies to seek supervisory guidance from uninvolved leadership without compromising review independence.

These protocols ensure the case review remains independent and unbiased, demonstrate compliance with rules of professional responsibility, and enable the OAG to fulfill both its review responsibilities under the Executive Order and its ongoing representation obligations in unrelated matters.

7. PUBLIC REPORTING, ENGAGEMENT AND TRANSPARENCY MEASURES

As the case review process continues, the OAG will fulfill all statutory reporting requirements while maintaining transparency with stakeholders and the public. This commitment includes full compliance with Public Information Act (PIA) obligations, timely responses to inquiries from impacted families and communities through the dedicated OCME Audit Hotline, and ongoing engagement with affected families, legislators, regulatory bodies, and academic partners to provide comprehensive briefings on the audit findings and review process.

The OAG has received and responded to six PIA requests that collectively sought information about eleven of the decedents. The OAG's public engagement regarding the OCME Audit centers primarily on supporting impacted families through the OCME Audit Hotline. To assist families who believe their loved one's case may have been affected by the audit, the Office established a dedicated hotline accessible by email OCMEAuditHotline@oag.state.md.us and by phone 833-282-0961. Through this hotline, the Office provides impacted families with information related to their loved one's case, including state and grief support resources.

Additionally, the OAG has conducted briefings on the OCME Audit report with impacted families, regulators, lawmakers, and academics to ensure transparency and facilitate understanding of the audit findings. These briefings, led by our former Case Manager and current consultant Dr. Jeffery "Jeff" Kukucka, have included presentations to the National Academy of Sciences on May 16, 2025 and the Maryland House of Delegates' Judiciary Committee on June 25, 2025. The OAG also provided a report briefing to the families whose loved ones were among the 41 cases on May 15, 2025, prior to the OCME Audit report's release. The OAG held a second briefing for the families who were unable to join the first briefing, as well as their legal representatives, on June 25, 2025.

8. CONCLUSION AND FUTURE COMMITMENTS

The OAG remains steadfastly committed to justice, transparency, and public accountability in reviewing OCME Audit cases. This commitment has taken on renewed urgency following the National Academy of Sciences' (NAS) October 2025 publication of *Strengthening the U.S. Medicolegal Death Investigation System: Lessons from Deaths in Custody*.

The NAS report elevated the audit's findings and confirmed concerns about the reliability in OCME manner of death determinations. The report further emphasized that transparency is essential for identifying trends in deaths in custody and improving outcomes—a principle that will guide the OAG's assessment of systemic reform needs.

These findings underscore the necessity and urgency of the case review process established under Executive Order 01.01.2025.11. The next annual report will provide a robust update on case review status, with particular attention to:

1. **Initial Assessments**: Finalizing preliminary determinations for each of the 41 cases regarding whether sufficient information exists to warrant formal investigation and potential prosecution

2. **Enhanced Documentation**: Implementing comprehensive documentation standards for preliminary reviews that ensure transparency and accountability while maintaining appropriate confidentiality

3. **Sustained Collaboration**: Deepening consultation with local SAOs to enable coordinated review of cases warranting further investigation

4. **Transparency and Public Accountability**: Providing detailed public reporting on findings, including any gaps in the review process resulting from incomplete file production and their impact on determinations

The case review process established this year represents a critical step toward accountability and systemic improvement. By honoring the memory of those who died in custody through rigorous investigation and transparent reporting, we serve the living—working to build a death investigation system that prevents future tragedies and ensures every loss receives the thorough, unbiased examination it deserves.

9. APPENDIX

Appendix A: List of the 41 cases under OAG's review

***County, as listed below and in the OCME Audit report (see p. 58-61), is the jurisdiction that OCME listed on the cover page of the decedent's autopsy report, which may differ from the county where the decedent died or where the restraint occurred.**

Name	Year of Death	County	OCME MOD	Audit MOD
Shawn Floyd	2018	Anne Arundel	Undetermined	Homicide
Gregory Williams	2003	Baltimore City	Undetermined	No Consensus (2 out of 3 reviewers determined Homicide)
Shawn Bryant	2004	Baltimore City	Undetermined	No Consensus (2 out of 3 reviewers determined Homicide)
Rodney Wilson	2005	Baltimore City	Undetermined	Homicide
Dondi Johnson	2005	Baltimore City	Accident	Homicide
William Washington	2006	Baltimore City	Undetermined	Homicide
Carlos Branch	2007	Baltimore City	Undetermined	Homicide
Thomas Campbell	2007	Baltimore City	Undetermined	Homicide
Eric Dorsey	2011	Baltimore City	Natural	Homicide
Don Thomas	2011	Baltimore City	Undetermined	Homicide
Jontae Daughtry	2011	Baltimore City	Undetermined	Homicide
Tyrone West	2013	Baltimore City	Undetermined	Homicide
Ricky Artis	2014	Baltimore City	Undetermined	Homicide
George King	2014	Baltimore City	Natural	Homicide

Antonio Moreno	2014	Baltimore City	Undetermined	Homicide
Thomas Rawls	2006	Baltimore County	Undetermined	Homicide
Ryan Meyers	2007	Baltimore County	Undetermined	Homicide
Carl Johnson	2010	Baltimore County	Undetermined	Homicide
Mary Croker	2010	Baltimore County	Undetermined	Homicide
Tawon Boyd	2016	Baltimore County	Accident	Homicide
Dominic Edwards	2018	Carroll	Undetermined	Homicide
Jarrel Gray	2007	Frederick	Undetermined	Homicide
Anthony Casarella	2007	Frederick	Undetermined	Homicide
Terrance Watts	2018	Frederick	Accident	Homicide
David Matarazzo	2007	Harford	Undetermined	No Consensus (2 out of 3 reviewers determined Homicide)
George Barnes	2007	Montgomery	Undetermined	Homicide
Kareem Ali	2010	Montgomery	Undetermined	Homicide
Delric East	2011	Montgomery	Accident	Homicide
Anthony Howard	2013	Montgomery	Undetermined	Homicide
Ricardo Manning	2019	Montgomery	Undetermined	Homicide
Cedric Gilmore	2004	Prince George's	Undetermined	Homicide
James Jackson	2003	Prince George's	Undetermined	Homicide
Marcus Skinner	2007	Prince George's	Undetermined	No Consensus (2 out of 3 reviewers determined Homicide)
Alexis Caston	2007	Prince George's	Undetermined	Homicide
Deontre Dorsey	2015	Prince George's	Undetermined	Homicide
Anton Black	2018	Talbot	Accident	Homicide

Theodore Rosenberry	2006	Washington	Undetermined	Homicide
James Adell	2013	Washington	Undetermined	No Consensus (2 out of 3 reviewers determined Homicide)
Darrell Brown	2015	Washington	Undetermined	Homicide
Ronald Byler	2005	Wicomico	Undetermined	Homicide
Yekuna McDonald	2012	Wicomico	Undetermined	Homicide