September 30, 2022

Governor Larry Hogan
Attorney General Brian E. Frosh

RE: Proposed Design for Audit of the Maryland Office of Chief Medical Examiner (OCME): Rationale and Audit Procedures

Overview

In 2021, following the trial of Officer Derek Chauvin for the murder of George Floyd, concerns were raised about the work of the Office of the Chief Medical Examiner (OCME) in Maryland during the tenure of its former Chief, Dr. David Fowler. The concerns arose in part from Dr. Fowler's testimony during Chauvin's trial. An open letter to the Attorney General of Maryland, signed by over 400 medical experts, asserted that Dr. Fowler deviated from standard medical practice in assessing the cause of death and in classifying the manner of Mr. Floyd's death as "undetermined" rather than "homicide". The letter called for an investigation to determine whether the OCME's practices for investigating in-custody deaths under Dr. Fowler's leadership were also inappropriate. In response, the Attorney General announced that his office will conduct an audit of in-custody cause and manner of death determinations made by the OCME during Dr. Fowler's tenure.

In September 2021, the Attorney General appointed an Audit Design Team (ADT)[1] to "develop the process for reviewing in-custody death determinations made by the Office of the Chief Medical Examiner (OCME)…" He asked the ADT to "1) assist in refining the questions to be answered by the audit; 2) develop the audit's scope and methodology, including the manner in which cases for review will be selected; 3) make recommendations regarding the make-up and roles of case managers; 4) outline the

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recommended deliverables…; 5) present the proposed audit design to the [Office of the Attorney General (OAG) and the Governor's Office of Legal Counsel (OLC)]; and 6) make refinements based on suggestions or questions from OAG and OLC as needed." .

The ADT assessed information provided by OCME staff on over 1300 deaths in custody that were examined by the OCME during Dr. Fowler's tenure.[2] Subsequently, we focused particular attention on cases in which the death occurred during or shortly after the decedent was physically restrained, and for which no obvious medical cause of death, such as a knife wound, was discerned during the autopsy. For each of these cases, of which there were approximately 100, we obtained the complete OCME file and conducted a preliminary review. We also conducted two interviews with the current Acting Chief Medical Examiner and Deputy Chief Medical Examiner concerning the history, policies and practices of the OCME. Additionally, we reviewed academic publications and guidelines issued by professional societies that bear on the examination and the determination of the cause and manner of deaths in custody.

Based on our preliminary assessment, we recommend that an independent group of experts in forensic pathology be asked to perform a detailed review of the OCME files of the restraint-associated deaths in custody. This review will determine whether independent experts agree or disagree with the OCME's determination of cause and manner of death, whether such experts believe the OCME's determinations were based on adequate investigations, and more broadly whether changes are needed to improve the OCME's practices so that they better serve the public interest.

In this interim report we first provide background information on medicolegal death investigation and the key factors to be examined in the audit. We also identify major questions to be addressed by the audit; and offer procedures for conducting the audit.

[2] Most of these cases were identified by the OCME. A few additional cases were identified by review of three public databases on police related homicides: (1) a spreadsheet called Fatal Encounters managed by D. Brian Burghart (at www.fatalencounters.org); (2) a dataset known as Mapping Police Violence (found at www.mappingpoliceviolence.org); and (3) a dataset called "TheCounted" maintained by the Guardian newspaper (http://www.theguardian.com/thecounted).

Background

1. The purpose of medicolegal death investigation and its function in the criminal justice system and public health.

The importance of medicolegal death investigation, including the postmortem examination of a decedent, is broadly recognized as a critical facet of a just, fair, and safe society. Postmortem examinations play a vital role in the investigation of deaths arising from crime and are also essential in civil litigation when questions arise about the cause and manner of deaths. Families of decedents have a right to know why and how a loved one died. This knowledge is valuable in itself, may present direct health benefits for the family (*e.g.,* when inheritable or transmissible disease is discovered), and can also be of great help in the process of grieving the loss of a loved one, especially when the death has been sudden or unexpected.

It is crucial that medicolegal postmortem examinations are carried out appropriately and adequately to ensure the correct determination of the cause and manner of death. Those who use the system, including prosecutors and defense attorneys, as well as those who have a personal interest in the death, such as the family of the deceased, must have confidence in the death investigation process. Accordingly, pathologists who undertake these investigations must do so thoroughly and without bias or prejudice. This is particularly important when the actions of law enforcement officers or other agents of the State may have contributed to the death.

In contrast to its well-recognized role in the administration of justice, the critical role and contribution of medicolegal death investigation to public health is less widely appreciated. New community hazards may be identified through the analysis of death certification data obtained from medicolegal death investigation. So-called diffuse disasters – the same fatal hazard occurring in different places and at different times – can be recognized by analysis of registries and databases maintained by Medical Examiner/Coroners (ME/C). ME/C data has helped identify and draw attention to such

diverse hazards as tractor roll-overs amongst farmers, poorly run methadone programs, dangerous roadway designs, toddler drownings in domestic pools, Legionnaires Disease associated with inadequately maintained cooling towers, and many others. The information gleaned from surveillance of ME/C investigation can be used to identify important risks to public health and devise strategies to save lives.

Consequently, systemic problems in medicolegal death investigation not only undermine the justice system, they also result in missed opportunities to identify preventable deaths. Inappropriately labelling a natural death, accident or suicide as a homicide, or conversely, mistaking a homicide for a natural death, may result in a miscarriage of justice whereby either an innocent person is wrongly accused of a serious crime, or a guilty person escapes justice. These problems may also undermine the ability of public officials to recognize diffuse disasters and result in missed opportunities to identify preventable deaths.

2. Death Certification

Medical examiners in the United States are expected to make two key determinations on completion of a postmortem examination: the cause of death and the manner of death.

The cause of death is largely a medical determination. A position paper on investigating and reporting deaths in custody, issued by the National Association of Medical Examiners (NAME)[3] in 2017, explained that: *"the cause of death should be diagnosed as the underlying physical injury, disease, or combination thereof responsible for the death."*[4] Although the findings of the postmortem examination are vital in this diagnosis, an understanding of the circumstances surrounding the death is also important to ensure accurate clinicopathological consideration and determination of the cause and

[3] The Office of the Attorney General informed NAME of this audit and invited the organization to contribute and have a representative on the Audit Design Team. NAME declined this offer.

[4] Mitchell, et al. National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody. *Acad Forensic Pathol*. 2017 7(4): 604-618.

manner of death. In cases of restraint-related death, it is particularly important that the medical examiner is fully knowledgeable about the circumstances of the death, including the nature, method of application and duration of the restraint, as well as the body position(s) while restrained (*i.e.,* prone versus supine or seated).

Manner of death is a determination that is made largely to assist with public health statistics, although it may also have implications for subsequent criminal investigations. Classification of cases according to manner of death is an American invention. Standard US death certificates began requiring a statement about manner of death in 1910. Medical examiners outside the United States rarely make manner of death determinations, as these determinations are viewed as matters for legal or judicial authorities. In Maryland, like most states, the acceptable options for manner of death are:

- Natural
- Accident
- Suicide
- Homicide
- Undetermined

Manner of death determinations depend on the circumstances of the case. The same cause of death may be classified differently as to manner based on the known circumstances of the death. A fatal gunshot wound to the head might be classified as suicide, homicide or accident depending on contextual factors, such as the decedent's medical/ psychiatric history, the anatomical site of the entrance wound (e.g., intraoral, submental, temporal and glabellar region as known sites of election for self-inflicted wounds versus other non-election sites such as the occipital region), the range of fire of the entrance wound (contact/near contact versus intermediate or distant range) which can give an indication of whether or not the entrance wound could be self-inflicted, and other investigative information about the circumstances of the shooting.

In 2002, NAME issued *"A Guide for Manner of Death Classification,"*[5] *which* provides the following "general rules" for classification:

- Natural deaths are due solely or nearly totally to disease and/or the aging process
- Accident applies when an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional.
- Suicide results from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.
- Homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but is not required for classification as homicide… It is to be emphasized that the classification of Homicide for the purposes of death certification is a "neutral" term and neither indicates nor implies *criminal* intent, which remains a determination within the province of legal processes.
- Undetermined or "could not be determined" is a classification used when the information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of all available information.
- In general, when death involves a combination of natural processes and external factors such as injury or poisoning, preference is given to the non-natural manner of death.

In cases of death occurring during restraint, death may arise from a complex "intermingling of natural and non-natural factors." The NAME Guide states that medical examiners should distinguish natural deaths from non-natural deaths (homicide, suicide, accident) in such cases by applying the *"but-for"* principle. That is, if death would not have occurred "but for" the unnatural factor, then the manner of death *should be* classified as unnatural:

[5] Hanzlick, et al. A Guide for Manner of Death Classification, First Edition. Approved by the NAME Board of Directors, February 2002.

> Regardless of whether the non-natural factor (a) unequivocally precipitated death, (b) exacerbated an underlying natural pathological condition, (c) produced a "natural" condition that constitutes the immediate cause of death, or (d) contributed to the death of a person with natural disease typically survivable in a non-hostile environment, this principle remains: the manner of death is unnatural when injury hastened the death of one already vulnerable to significant or even life-threatening disease. (NAME, 2002, p. 7)

The NAME guide commented specifically on restraint deaths, saying:

> **Deaths due to positional restraint induced by law enforcement personnel or to choke holds or other measures to subdue** *may be* classified as **homicide**. In such cases, there may not be an intent to kill, but the death results from one or more intentional, volitional, potentially harmful acts directed at the decedent (without consent, of course). Further, there is some value to the homicide classification toward reducing the public perception that a "cover up" is being perpetrated by the death investigation agency. (p. 11, emphasis in original).

Another important reason to classify such cases as homicide is that such deaths may be preventable. If it is recognized that such deaths result from intentional actions of the police, then questions can be raised about whether those actions were truly necessary or whether other less dangerous police procedures might be adopted.

It is important to realize, of course, that the NAME guidelines are somewhat vague and leave considerable room for professional judgment. As the Guide itself explains: "It must be realized that when differing opinions occur regarding manner-of-death classifications, there is often no "right" or "wrong" answer or specific classification…" Nevertheless, some practices for classification may fail to serve the public interest if, for example, a practice results in failure to identify preventable deaths or criminal behavior.

Classification practices may also be unacceptable if they result in similar cases being classified differently, or if they vary across categories of cases in ways that reflect bias. While there may be debate about how much certainty is required to reach a finding of homicide in a restraint death case, there can be no debate that the threshold should be the same regardless of the race of the decedent or the identity of the person or persons applying the restraint. We have designed the audit to detect inconsistencies of this nature that may arise from bias, if they occur.

DETAILS OF AUDIT

Goals of the Audit

The audit proposed here will solicit the views of experts from outside the OCME on several key topics related to the OCME's assessment of restraint deaths:

(1) Were these cases adequately investigated? Does the information included in the files indicate that there was a sufficient and appropriate investigation of the scene, circumstances, and medical issues? Did the police investigation provide details of the duration and type of restraint used? Is it clear when - in relation to the restraint - collapse/death occurred? Did the autopsy include all appropriate examinations and observations for each case? Were appropriate post mortem investigations conducted (*e.g.*, toxicology, radiology, neuropathology, biochemistry, microbiology).

(2) Were the OCME's operations and procedures, as described in the case files, consistent with best practices? For example, if police information was inadequate, was further information from police sought? Was there appropriate consultation and review? Is there room for improvement: could the examination (as described in the case files) have been done better? If so, how?

(3) What role did restraint play in each death? Would the decedent have lived *but for* the application of restraint? How certain are the reviewers

that various possible factors (*e.g.*, underlying medical condition; application of restraint) caused the death? Might the death have been prevented had those applying the restraint used methods that were less forceful or aggressive? Are there changes in training, policy or procedure regarding the application of restraint that might reduce the risk of death in such cases?

(4) What determination should the OCME have reached in each case concerning cause and manner of death?

(5) If the OCME's determination of cause or manner of death differed from that of the reviewers, what do the reviewers make of that discrepancy? Is it a question on which reasonable experts might differ, do the reviewers believe that the OCME's determination deviated either from standard practice in the field, or from their own ideas of best practice? Was the OCME's determination consistent with the underlying goals of the medical examination system, particularly with respect to identifying possible criminal misconduct and preventable deaths? Is there reason to believe that the OCME's determinations were influenced by inappropriate factors?

Audit Procedures

The audit will occur in two phases. In the first phase, reviewers will be given access to OCME case files and asked to give their own initial opinion about each case. In the second phase, the reviewers assigned to each case will meet as a panel via an online platform such as Zoom to discuss the case and to make a series of consensus judgments about it, including the quality of the investigation and case workup by the OCME, the completeness of the anatomical examination performed, and so on. They will also reach a consensus or majority opinion on both cause and manner of death.

The review will incorporate a bias-reduction procedure known as unmasking, in which potentially biasing information in the files is withheld from reviewers until they need it. For example, to avoid any suggestion or concern that reviewers' attitudes toward the

OCME might affect their assessments, the OCME's determinations of cause and manner of death will initially be redacted from the files, so that reviewers can make their own independent evaluations of these issues without knowing the OCME's determinations. Certain other details, such as the race or identity of certain participants involved in the death, or their law enforcement affiliation, may also be withheld temporarily to reduce any perception that reviewers could have been biased by this information. In all cases, however, the masking of information will only be temporary. At the end of the process, the complete files will be available to the reviewers. Reviewers will have the opportunity to indicate whether any of the information that was initially withheld changes their opinions (and if so why). Unmasking of the OCME's cause and manner determinations will also allow reviewers to comment on the OCME's results with full knowledge of the content of the case file and the exact language of the OCME's findings.

Case Reviewers. We propose that the Office of the Attorney General contact and formally invite applications from suitable forensic pathologists to participate in an independent review of the OCME's work. The pool of forensic pathologists to be contacted will consist of current and retired practitioners who have *either* qualified *and/or* work(ed) in medicolegal death investigation in the USA, Canada, United Kingdom of Great Britain (England, Wales, Scotland, Northern Ireland), Republic of Ireland, Australia and New Zealand. Assuming a sufficient number of US practitioners agree to participate in the audit, the international reviewers will be distributed so that US practitioners constitute the majority of each consensus group.

The Attorney General will invite potential participants to participate in a review of OCME casework, offering suitable professional remuneration for doing so. Those who express interest in participating will be reviewed to assure they meet the requirements listed below:

1. US-based forensic pathologists/medical examiners with recognized postgraduate training and certification in both anatomical pathology and forensic pathology from the

American Board of Pathology (ABPath) **and** at least five (5) years post-qualification experience in forensic pathology. Current Chief Medical Examiners or retired Chief Medical Examiners who fulfill this criterion will be welcomed.

2. Alternatively, non US-based forensic pathologists from Canada, the United Kingdom, Australia and New Zealand, with recognized equivalent training and certification in both anatomical pathology/histopathology and forensic pathology as obtained from either the Royal College Physicians and Surgeons of Canada (RCPSC), Royal College of Pathologists of the United Kingdom (RCPath), or the Royal College of Pathologists of Australasia (RCPA), **and** at least five (5) years post-qualification experience in forensic pathology. Steps should be taken, however, to ensure that US-based forensic pathologists constitute a majority of each consensus panel.

3. To reduce any perception of partisanship, the pool of reviewers should not include signatories to the letter of complaint that was sent to the Attorney General for the State of Maryland by Dr Roger Mitchell Jnr, former Chief Medical Examiner for Washington DC.

4. Additionally, the pool of reviewers should not include forensic pathologists/medical examiners who have had any **direct** professional relationship with the Office of the Chief Medical Examiner for Baltimore i.e. current/former medical examiner/fellow of the OCME Baltimore, co-authors of any academic publications out of the OCME Baltimore.

5. All reviewers must be in good standing with their medical licensing authority.

6. Potential reviewers must not be under investigation by a professional regulatory body or otherwise ***in any jurisdiction*** at the time of appointment as a case reviewer. Practitioners will be required to sign a declaration to this effect.

7. Potential reviewers must not have been either disciplined or sanctioned by a professional regulatory body anytime in their careers. Practitioners will be required to sign a declaration to this effect.

Confidentiality

The review/audit will be administered such that individual responses by reviewers cannot be associated with them. Those conducting the audit must know the identities of participating reviewers. However, if a reviewer prefers it, even the fact that they participated in the audit can be held in confidence by those involved in the audit and the Office of the Attorney General after the completion of the audit, to the extent allowed under the law.

Reviewers will, of course, become aware of the identity of other reviewers when they are assigned to consensus panels to evaluate cases, but information about the identity of reviews will not be disclosed voluntarily by the Attorney General without permission of the participant. In reports on the review, the Attorney General's Office will release general information about the backgrounds and qualifications of participants without identifying each or any participant, unless the participant specifically authorizes the OAG to do so.

Respectfully submitted,

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