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PRESS RELEASE

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Attorney General Brown Announces Findings of Independent Audit of the Maryland Office of the Chief Medical Examiner (OCME)

Audit Identifies Significant Misclassifications of Deaths, Calls for Review of Cases and Systemic Reforms

BALTIMORE, MD (May 15, 2025) – Attorney General Anthony G. Brown today announced the findings of the Office of the Attorney General's independent audit of the Maryland Office of the Chief Medical Examiner (OCME). The 70-page report found that in more than half of the cases reviewed, the case reviewers disagreed with the OCME's original determination of manner of death. The audit identified 36 deaths originally classified as undetermined, accidental, or natural that the panel concluded should have been ruled homicides, found patterns consistent with racial disparities in death classifications, and documented the use of discredited diagnoses such as "excited delirium."

Key findings include:

- In 44 out of 87 cases (more than half), independent forensic reviewers disagreed with OCME's original determination of the manner of death.
- In 36 cases, the reviewers unanimously, 3 out of 3, concluded the death should have been classified as a homicide.
- In 5 additional cases, 2 out of 3 reviewers concluded the death should have been classified as a homicide.
- Deaths involving Black individuals and deaths involving law enforcement restraint were significantly less likely to be ruled homicides compared to others.
- "Excited delirium" – a diagnosis now rejected by leading medical organizations – was cited as a cause of death in nearly half of the reviewed cases, contributing to misclassification.
- Auditors found systemic deficiencies in autopsy documentation, including missing photographs, incomplete incident information such as the absence of available body camera footage, and inconsistent acknowledgment of restraint-related injuries.

"Marylanders deserve a justice system built on transparency, accountability, and equity. This audit's findings pave the way for meaningful reform in how medical examiners approach death investigations and propose changes that could address systemic inequities that have persisted for too long," **said Attorney General Brown.** "Maryland's leadership in conducting this audit, the first of its kind in the nation, gives other states a blueprint on how to safeguard their death investigations against bias, ensure

accountability across our legal institutions, and guarantee that when someone dies in law enforcement custody, the case is handled according to the highest professional standards of fairness and impartiality."

The audit, initiated in 2021, followed widespread concerns raised after Maryland's former Chief Medical Examiner, Dr. David Fowler, testified for the defense in the murder trial of former Minneapolis Police Officer Derek Chauvin. Dr. Fowler asserted that George Floyd's death should be classified as "undetermined," despite the widely seen video showing Chauvin's knee pressed against Floyd's neck for more than nine minutes. Dr. Fowler's testimony prompted more than 450 medical experts to call for an independent review of OCME's practices during his tenure (2003–2019). In response, the Office of the Attorney General, in consultation with the Governor's Office of Legal Counsel, convened an international Audit Design Team of leading forensic pathologists, psychologists, and research scientists and undertook an exhaustive and independent examination of OCME's determinations in deaths occurring during or shortly after restraint. The audit used internationally recognized scientific methods to ensure impartiality, and case reviewers were experienced, credentialed experts with no ties to OCME.

"This audit is a groundbreaking collaboration between social scientists and forensic medical experts who carefully designed and executed it in line with sound research principles, including best practices for protecting against bias," **said Dr. Jeff Kukucka, who managed the audit.** "We have the utmost confidence that its findings can and will improve the quality of medicolegal death investigations, advance social justice, and reduce the risk of preventable deaths."

From a pool of more than 1,300 in-custody deaths investigated by OCME, the Audit Design Team selected 87 cases involving deaths during or after restraint. The OAG hired 12 independent forensic pathologists, who were initially blinded to the decedent's race and OCME's original conclusions. Three reviewers were randomly assigned to review each case and make their own independent determinations of the manner of death. If the reviewers' conclusions were not unanimous, they discussed the case in an attempt to reach a consensus.

The following table lists the 41 decedents, 36 whose cases were – unanimously – deemed as homicides by all 3 independent case reviewers assigned to those cases as well as 5 cases in which 2 out of 3 reviewers concluded that the manner of death should have been determined as a homicide.

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

***County, as listed above and in the report, is the jurisdiction that OCME listed on the cover page of the decedent's autopsy report, which may differ from the county in which the decedent died or where the restraint occurred.**

When medical examiners determine a death a "homicide," it means that someone's actions contributed to the death of the individual. **It is critical to note that a manner of death determination of "homicide"**

does not automatically indicate police misconduct or suggest criminal culpability. It does, however, suggest that the case should be reviewed to assess whether additional investigation is appropriate.

The audit report provides several recommendations.

- **For the Office of the Chief Medical Examiner:**
  - Adopt clear standards for determining cause and manner of death.
  - Stop using "excited delirium" as a diagnosis, which medical organizations have rejected.
  - Improve documentation in autopsies, especially for deaths in custody.
  - Create standardized procedures for investigating restraint-related deaths.
  - Implement external peer review and ongoing education for medical examiners.

- **For Law Enforcement:**
  - Require body cameras to document all restraint situations.
  - Provide better training on the dangers of improper restraint techniques.
  - Include mental health professionals in crisis responses.
  - Document witness statements thoroughly.

- **For Accountability:**
  - Review all 41 cases that the panel concluded should have been classified as homicides.
  - Implement periodic audits to ensure improvements are made.
  - Establish a system to identify troubling patterns before they become systemic.

Today, Governor Wes Moore announced several executive actions in response to the results of the OCME audit, including granting the Office of the Attorney General the authority to perform a comprehensive review of the 36 cases where the reviewers – unanimously – concluded the manner of death should have been homicide. The Governor is also establishing the *Maryland Task Force on In-Custody Restraint-Related Death Investigations*, led by the Governor's Office of Crime Prevention and Policy (GOCPP), to evaluate the OCME audit's policy recommendations and develop a plan to implement them.

"Maryland will continue to be a national leader in accountability, action, and equal justice under law. This executive order takes us one step closer to a more just and transparent system and was crafted with the same values that have guided our approach to public safety since Day One—true partnership with both law enforcement and the communities they protect; a close, objective examination of the facts; and an abiding commitment to making Maryland safer and uplifting the brave public servants who keep us safe," **said Gov. Moore**. "Maryland was the first state in the nation to launch a comprehensive, methodical, and objective audit of our Office of the Chief Medical Examiner. And today, we become the first state in the nation to respond to such an audit with responsible action that brings everyone to the table."

To support impacted families, the Office of the Attorney General has launched an OCME audit hotline. If you believe your loved one is a decedent whose case was impacted by the OCME audit, please e-mail OCMEAuditHotline@oag.state.md.us. You can also call our OCME audit Hotline Number: 833-282-0961.

Maryland is the first state in the nation to conduct an independent, scientific audit of in-custody death determinations made by a state medical examiner's office. Tomorrow, on Friday, May 16, the findings of this independent audit will be presented to a **National Academies of Sciences, Engineering, and Medicine** study committee that is examining how the nation's medicolegal death investigation system handles deaths in custody and exploring ways to improve scientific standards, reduce diagnostic bias, and strengthen public trust in forensic pathology. The National Academies are private, nonprofit institutions that provide independent, objective analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, engineering, and medicine.

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