Task Force on In-Custody Restraint-Related Death Investigations Minutes

December 3, 2025

10am - 12pm

In person at the Governor's Office of Crime Prevention and Policy

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Commission Attendees: Tiffany Dayemo, Julie Shapiro, Jessica Williams, Vijay Ramasamy, Brian DeLeonardo, Hunter Marsh (for Del. Luke Clippinger), Donald Bauer, Lt. William Gleason, Sheriff Joe Gamble, Steven Trostle, Tracy Robsinson (for Michael Dunty), Lt. Stephen Thomas, Natasha Dartigue, Lt. Mary Chappell, Dr. Roger Mitchell, Dorothy Lennig, Dr. Stephanie Dean, Col. Andrew Rohrer

Staff Attendees: June Chung, Jeffrey Zuback, Ainsley Moench, Arinze Ifekauche, Allison Badger, Elisa Nicoletti, Kim Barranco

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1. ***Welcome and Opening Remarks***

The meeting was called to order at 10:02am.

Commission members introduced themselves.

Dorothy Lennig clarified the charge of the Task Force, stating that the Executive Order establishing the Task Force was three-pronged: one, the Office of the Attorney General is instructed to re-evaluate the audit cases in consultation with the local State's Attorney's Offices to determine whether any cases needed to be reopened for investigation; two, the Maryland Department of Health is to review the current policies and procedures of the Office of the Medical Examiner (OME) and make recommendations on what changes have taken place and if any new changes should be enacted; and third, establishing the Task Force. The Task Force is specifically in charge of identifying ways to improve restraint-related in-custody death investigations, making recommendations on establishing a fatality review team, and working with the Maryland Police Training Standards Commission to evaluate the current standards for law enforcement training and recommend improvements.

2. ***Review of October Meeting Minutes***

The Task Force approved the October Meeting Minutes.

Dorothy Lennig announced that the Task Force would wait until April to split into subcommittees. In the meantime, the Task Force would focus on creating a solid knowledge base.

3. ***Presentation from the Office of the Medical Examiner***

Dr. Stephanie Dean gave a presentation on the Office of the Medical Examiner.

4. ***Reflections/Discussion/Questions***

Allison Badger asked when the policy of requiring consensus conferences for in-custody restraint-related deaths was formalized. Dr. Stephanie Dean replied that the practice was informally done before 2023, but the policy requiring the consensus conference was formalized in 2023.

Tiffany Dayemo asked who the administrative Medical Examiners were. Dr. Stephanie Dean answered that the administrative Medical Examiners consisted of the Chief Medical Examiner and the two Deputy Chief Medical Examiners.

Dr. Roger A. Mitchell Jr. asked what would happen in challenges to case determinations where law enforcement discovers new information about the case, especially when the case was initially ruled a homicide. Dr. Stephanie Dean replied that the statistics mentioned in her presentation on challenged cases only referred to cases that were challenged by a member of the public, and not cases that had new information coming from a law enforcement agency. Another pathway to changing the determination of the cause of death would apply in such a circumstance.

Allison Badger asked if there was a formal way to track the underlying cause of death in a cause-of-death certification. Dr. Stephanie Dean said that theoretically, tracking would be possible by including a box on the certificate of death form, and the inclusion of one is recommended by the Association of Medical Examiners; however, this has not been done yet.

Dorothy Lennig asked if the Office of the Medical Examiner (OME) could bring in outside consultants, such as a neighboring state, to offer peer review for difficult cases. Dr. Stephanie Dean replied that it might be difficult due to confidentiality and liability issues. Dorothy Lennig posited that perhaps new statutory protections could cover those issues, as the number of cases that could benefit from peer review is small.

Steven Trostle asked why there could not be two manners of death listed as a cause of death, where the origin of the five manners of death is, and if there are other classifications that may be useful. Dr. Stephanie Dean answered that the five categories come from public health standards. Two manners of death would confuse the system, and one box is needed for analysis of trends. New York has a sixth box for “medical misadventure,” such as a surgery with a complication.

Natasha Dartigue asked if disagreements in consensus conference are documented, and how agreements are made if there is not a consensus. Dr. Stephanie Dean replied that disagreements are not documented; only the conference itself and its attendees are documented to protect privacy and discretion. Consensus conferences are held with the goal everyone will come into agreement. Natasha Dartigue followed up asking if the need for several consensus conferences is documented in the case file. Dr. Stephanie Dean answered that the case file will note if there are multiple consensus conferences. Dorothy Lennig added that, for a lot of the cases in the audit had to go to a consensus conference. Dr. Stephanie Dean remarked that this indicates the cases in the audit were complex.

Tiffany Dayemo asked who is present during a consensus conference. Dr. Stephanie Dean answered that the Chief Medical Examiner or the Deputy Chief Medical Examiners are present at all consensus conferences. Tiffany Dayemo then asked if the 180 day contestation period applies when law enforcement find new, relevant information, and Dr. Stephanie Dean said that those circumstances would be outside the scope of the statute.

Vijay Ramasamy asked how cases reach OME, and if there are any automatic processes in place to send flagged cases. Dr. Stephanie Dean responded that it is up to the hospitals and correctional facilities to send any cases that might fall under OME's purview to OME, and each institution should have their own policies about how and when to send cases. Sometimes, cases that should have been sent to OME are not, and OME is able to catch them when reviewing the Vital Record System, such as a death certificate certified by a penal institution. Additionally, practitioners signing off on death certificates err on the side of caution when submitting cases to OME.

Allison Badger clarified that the definition of police-involved death does not automatically trigger a case to go to the OME, and Dr. Stephanie Dean confirmed yes.

Steven Trostle asked if, when the cause of death is determined as natural causes, the pre-existing conditions (both physical and mental) that may have lead to the death and if they had recieved proper medical care are documented. Dr. Stephanie Dean said that information may be listed in the autopsy report, but typically the OME does not determine what qualifies as appropriate medical care unless it rises to the level of medical neglect.

Dr. Roger Mitchell inquired if every case recieved an autopsy. Dr. Stephanie Dean confirmed yes. Situations where an autopsy may not be performed is if the family has concerns or if an incarcerated person was in hospice care and the cause of death is undisputed. Dr. Roger Mitchell mentioned that it is not standard practice to do autopsies on suicide cases for the general population. Dr. Stephanie Dean responded that any case of an officer-involved death where a suicide occurs would receive an autopsy.

Joe Gamble asked if there had been any changes in how police-involved pursuits are handled, specifically in cases of pit maneuvers. Dr. Stephanie Dean answered that usually those cases

would be documented as accidents, though each case ther emust be a review to see if there were any out-of-policy procedures done in consultation with the police departments.

Dorothy Lennig asked if OME has access to body worn cameras often. Dr. Stephanie Dean replied that OME recieves body worn camera footage very often and they are extremely helpful in assessing causes of death, as prior to body worn cameras the investigation relied solely on witness statements. Allison Badger followed up asking if there were any trends identified with body worn camera footage. Dr. Stephanie Dean replied that it is a warning sign when a decedent starts calming down, as it often precedes death. Often, there should be a stronger sense of urgency rather than relaxing from the officer or medical professional. Allison Badger and Dorothy Lennig commented that this information could be useful for training.

Jessica Williams asked how OME engages with law enforcement. Dr. Stephanie Dean said that OME has both city and county investigators who undergo training and certification by the American Legal Death Investigators to know what questions must be asked, how to approach a death scene, what pictures to take, and how to perform an overal external assessment. The OME investigators are first responders to a scene and can provide information on a decedent's environment, rather than the sterile environment that a medical examiner may see them in.

Joe Gamble asked how a death would be ruled if someone went into minor surgery but the doctor accidentally killed them. Dr. Stephanie Dean replied that a medical examiner would have to look into the case and determine whether the cause of death was a recognized complication of the surgery and natural, or accidental. Dr. Roger Mitchell added that the case may be ruled a homicide in some jurisdictions if the surgeon was under the influence or committing medical malpractice.

Allison Badger asked if EMTs may add insight to the Task Force. Dr. Stephanie Dean replied that reaching out to EMTs may be helpful, as they may have the same challenges that law enforcement encounter.

Tiffany Dayemo asked if certain sources are more prioritized when evaluating cases, such as body camera footage. Dr. Stephanie Dean agreed that body camera footage is a high priority source of information, then witness statements and law enforcement interviews. Police reports can be helpful. Allison Badger followed up asking if the state is regularly supplying the body camera footage and information needed for examiners. Dr. Stephanie Dean replied that the state was headed in a good direction, and since the creation of the Internal Investigative Division of the Attorney General's Office, they are often able to get all the information needed for the OME. Lt. William Gleason asked Dr. Stephanie Dean's opinion on the use of tasers, and if you can see effects of taser use on the body. Dr. Stephanie Dean responded that in most cases, you cannot see any biological or physical evidence of taser use other than the taser mark and changes in the skin associated with electrical currents, unless there is an extreme case such as a taser penetrating the

heart. There is still a lot unknown about how tasers affect the body; however, there are some areas where a taser should not be used.

Lt. William Gleason then asked how we should train law enforcement to use defensive tactics. Dr. Stephanie Dean reiterated that she is not an expert on use of force tactics, but the prone position should be avoided. Dorothy Lennig added that the Task Force will work with the Police Training Standards Commission to provide some recommendations. Dr. Roger Mitchell also added that getting someone on their butt is the best position, as even getting someone on their side can create limitations in being able to breathe. Col. Andrew Rohrer continued saying multidisciplinary evaluations are great, however unfunded mandates to change procedures will not provide good results. Dorothy Lennig responded that that was the reason behind creating the Task Force, to gather all the stakeholders and come up with something that will actually work.

Joe Gamble inquired about the use of ketamine by EMS. He noted that there are over 160 police departments in the state and five times as many paramedic squads, so collaboration between law enforcement and paramedics is key. Dorothy Lennig mentioned that GOCPP is a great agency to staff the Task Force, as GOCPP can get the resources and education needed out to partners.

Dorothy Lennig concluded the meeting by announcing that the next meeting would be focusing on law enforcement. The next meeting will be in February.

5. ***Adjournment***

The meeting was adjourned at 11:59am.