April 20, 2021

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Open Letter to Political Leadership,

The purpose of this letter is to bring your attention to the recent sworn testimony provided by the former Chief Medical Examiner for the State of Maryland in Trial 27-CR-20-12646: State vs. Derek Chauvin. The testimony, proffered by David Fowler, MB, ChB.Med.Path, on April 15, 2021, revealed a highly questionable cause of death opinion. The cause of death opinion, particularly the portion that suggested open-air carbon monoxide exposure as contributory, was baseless, revealed obvious bias, and raised malpractice concerns. The cause of death statement of any individual should be an injury, disease, or combination thereof, reached to a reliable degree of medical certainty. We believe the unsubstantiated opinion that carbon monoxide exposure may have contributed to the death of George Floyd is far outside that standard and is grounds for an immediate investigation into the practices of the physician as well as the practice of the Maryland State Office of the Chief Medical Examiner (OCME) while under his leadership. In addition, Dr. Fowler's stated opinion that George Floyd's death during active police restraint should be certified with an "undetermined" manner is outside the standard practice and conventions for investigating and certification of in-custody deaths. This stated opinion raises significant concerns for his previous practice and management.

A brief review of the medical literature for Death in Custody epidemiology occurring within the State of Maryland uncovered two significant journal articles. Both articles, *Police custody deaths in Maryland, USA: An examination of 45 cases* and *Excited Delirium Deaths in Custody: Past and Present,* provides insight into the Maryland State OCME practices regarding cause and manner of death designation for these types of cases. There is a genuine concern that there may be an inappropriate classification of deaths in custody by the Maryland OCME as either Accident or Undetermined to purposefully usurp a manner of death classification of Homicide.

Our disagreement with Dr. Fowler is not a matter of opinion. Our disagreement with Dr. Fowler is a matter of ethics. The disingenuous testimony of Dr. David Fowler exposes the frailty of the current Medical Examiner/Coroner System and illustrates the lack of existing oversight and uniformity of practice. If forensic pathologists can offer such baseless opinions without penalty, then the entire

criminal justice system is at risk. This testimony was given on camera and in view of the entire world, shining a light on what has occurred and will likely continue to occur in less visible trial testimony. Currently there is no oversight, path for formal professional reprimand, or accountability for giving expert forensic medical testimony that falls outside the reasonable standard of medical certainty. This is not an isolated incident and is in fact a longstanding issue in the US system of justice. While Dr. Fowler is not the first and is unfortunately not likely to be the last forensic pathologist to testify in such a manner, his being named in a current lawsuit for questionable certification of an in-custody death raises the concern of a pattern of bias in practice.

For these reasons, we are demanding:

- State of Maryland
    - An immediate review of ALL the deaths in custody investigated by the Maryland OCME from 2003-2020 by an appointed independent international panel of expert forensic pathologists, to specifically look at the determination of both cause and manner of death. Although the National Association of Medical Examiners (NAME) is the professional body of US medical examiners and can be approached for recommendations of US medical examiners to undertake the review, we believe that the organization is compromised to do so, in light of its now retracted statement which was issued following the performance of the second autopsy of George Floyd.
    - Investigation into the medical license of David Fowler, MB, ChB.Med.Path for possible ethical violations associated with death in custody diagnosis.
    - Immediate establishment of a state-wide multidisciplinary Death in Custody Review Board
    - Addition of a Death in Custody Check Box on the State of Maryland electronic death certificate.
    - Annual Report of Death in Custody occurring within the State of Maryland
- United States
    - An immediate investigation into ALL the deaths in custody investigated by the Maryland OCME from 2003-2020.
    - Impanel a task force tasked with implementing The National Science and Technology Council (NSTC) and Office of Science Technology and Policy (OSTP) 2016 recommendations for the complete reform of the Medical Examiner/Coroner System.
    - Immediate addition of a Death in Custody Check Box on the US Standard Death Certificate by the National Center for Health Statistics.
    - Immediate nationwide enforcement of the Death in Custody Reporting Act HR. 1447.
    - Annual Report of national data for ALL Deaths in Custody.
    - Mandatory peer-review of all deaths in custody cases by a different medical examiner's office prior to issuance of the final report, as a quality assurance measure.

On behalf of physicians across many specialties, we are requesting a swift response to this letter. Thank you for your consideration.

Sincerely,

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