IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JENNELL BLACK, individually and
as Personal Representative of the
ESTATE OF ANTON BLACK
27999 Old Morgnec Road
Chestertown, MD 21620

ANTONE BLACK, individually and
as Personal Representative of the
ESTATE OF ANTON BLACK
27999 Old Morgnec Road
Chestertown, MD 21620

KATYRA BOYCE, as mother and
next friend of W. B.
201 Church Street
P.O. Box 201
Greensboro, MD 21639

and

COALITION FOR JUSTICE FOR ANTON BLACK,
1712 Blue Heron Drive
Denton, MD 21229

Plaintiffs,

v.

RUSSELL ALEXANDER, individually,
and in his official capacity as
Assistant Medical Examiner for the
State of Maryland,
900 West Baltimore Street
Baltimore, MD 21223

JOHN D. STASH, in his official
capacity as Interim Chief Medical Examiner
for the
State of Maryland,
900 West Baltimore Street
Baltimore, MD 21223

Civil Action No.: 1:20-cv-03644-CCB

JURY TRIAL DEMANDED

DAVID FOWLER, in his individual capacity as former Chief Medical Examiner for the State of Maryland,
224 West 30th Street, Ste. 806
New York, NY 10001

STATE OF MARYLAND
Office of the Medical Examiner
900 West Baltimore Street
Baltimore, MD 21223

Defendants.

SECOND AMENDED COMPLAINT AND ELECTION OF JURY TRIAL

Plaintiffs Jennell Black, individually and as Personal Representative of the Estate of Anton Black; Antone Black, individually and as Personal Representative of the Estate of Anton Black; Katyra Boyce, as mother and next friend of W.B. (together, "Family Plaintiffs"); and the Coalition for Justice for Anton Black (collectively "Plaintiffs"), by and through undersigned counsel, bring this civil action against Defendants State of Maryland, John D. Stash, in his official capacity as Interim Chief Medical Examiner for the State of Maryland; David Fowler, in his individual capacity; and Russell Alexander, individually and in his official capacity as Assistant Medical Examiner for the State of Maryland, (collectively "Defendants"), and for cause state:

INTRODUCTION

1. Two years before George Floyd died after being restrained and pinned down by police, 19-year-old Anton Black ("Anton" or "Decedent") was killed by three white law enforcement officials and a white civilian in a chillingly similar manner on Maryland's Eastern Shore. This lawsuit arises from the wrongful death of Anton Black at the hands of officers from three different police departments on September 15, 2018, and the ensuing efforts by Defendants to protect the officers and agencies involved from the consequences of their excessive use of force

against a Black teenager, consistent with their longstanding practice of concealing the truth about how police caused civilian deaths.

2. The gravity of this failure cannot be overstated: Defendants are the official arbiters of the government's account of how a death occurred; their findings dictate how police understand their actions; how state's attorneys decide whether to prosecute; whether decedents and their families are treated as victims; the hurdles survivors must clear to obtain relief; the scope of any given public health crisis; and how our society determines which deaths can be prevented.

3. As a direct consequence of Defendants' actions, public officials and all Marylanders have been repeatedly misled into believing that civilian deaths in police custody cannot be prevented. And the brunt of these failures has been borne disproportionately by Black Marylanders and, often, people with disabilities.

4. The Office of Chief Medical Examiner ("OCME"), guided by policies set by Defendant Fowler as Chief and, upon information and belief, continued by his successors, repeatedly disregarded or misrepresented obvious facts, medical evidence and basic principles of their profession, concealed the truth about police-involved deaths in misleading statements and conclusions cloaked in medical terminology and purported uncertainty. Professional standards, as laid out by the National Association of Medical Examiners ("NAME"), establish basic principles for determining causation. But, in Maryland, OCME has selectively disregarded these principles, deflecting the causal relationship between law enforcement officials' conduct and deaths in their custody. The OCME's handling of the death of Anton Black illustrates these failures.

5. On September 15, 2018, Greensboro Police Department officer Thomas Webster IV, an officer with a documented history of violence and excessive force against Black people, confronted Anton while he was in the midst of a mental health crisis. Officer Webster ("Webster")

was aware that Anton was a well-known high school athlete experiencing mental health issues. However, instead of attempting to help Anton, Webster joined with Chief Gary Manos of the Ridgley Police Department and Officer Dennis Lannon of the Centreville Police Department (collectively, the "Officers"), as well as a random white bystander dressed in racist attire who Webster deputized, and together the group chased Anton to his home, where Webster, without warning, smashed a car window near his head with a police baton, and fired a Taser at him; then the group forced Anton to the ground, pinning his slight frame beneath the collective weight of their bodies. While immobilized in a face-down position on the ground with Chief Manos' body and weight upon his back and the other officers and the civilian assisting in holding him down, Anton's pulmonary ventilation was compromised, resulting in cardiac stress. Even after Anton was handcuffed, the officers ignored the danger they were causing and kept Anton in a prone restraint for approximately six minutes as he struggled to breathe, lost consciousness and suffered cardiac arrest. Anton, 19, while handcuffed and terrified, died from positional asphyxia as a direct and proximate result of the officers' excessive force and racial bias. Anton's mother witnessed her son's tragic death on the front porch of her home.

6. Even as he died, the Officers began developing the false story they would use to defend their actions: on the contemporaneous video of the incident, they can be heard falsely claiming that Anton was high on marijuana laced with another drug and exhibiting "superhuman" strength. This was the story the Officers fed to the State of Maryland, through the Maryland State Police, the state agency charged with investigating Anton's death. Rather than investigating Anton's death as a potential homicide, searching for evidence of wrongdoing, the State treated its "investigation" as an investigation into Anton himself, and in particular an effort to corroborate the false claim by officers that Anton was on drugs at the time of his death.

7. As was their practice, the OCME seized on this false claim by law enforcement officials, and pursued it even after their own comprehensive toxicology results confirmed, within days of his death, that Anton did *not* have controlled substances in his system. Rather than rely on what the video evidence showed, Defendants delayed for months in releasing the autopsy report, until inquiries from the Governor himself forced them to release it. Even then, Defendants stalled, apparently in the hopes that a second toxicology screen would corroborate the narrative they hoped to tell, that Anton was, as police claimed, on "spice" (synthetic cannaboids). Even before receiving this second report, Defendants had determined, utterly improperly and in contravention of medical evidence and the standards of their profession, that they would rule Anton's death was an "accident" and blame it on a heart condition and drug use and *not* police restraint.

8. In fact, Defendants knew that the heart conditions did not cause Anton's death and it was a gross misrepresentation of medical evidence to suggest that they did. One, myocardial tunneling or bridging, is a condition found in nearly a third of all autopsies and largely regarded as benign by cardiologists. The other is extremely unlikely to have caused sudden death in the case of a 19-year-old all-star athlete like Anton.

9. On January 21, Defendants received this second toxicology lab report explicitly confirming that there were no synthetic cannaboids, in Anton's system – a finding they further confirmed in a follow up telephone call with the lab that such drugs were "**definitely not there**."

10. Two days later, notwithstanding these results, Defendants released an autopsy report falsely claiming that Anton "may have recently smoked spice," and concluding that his death was an "accident" from preexisting medical conditions. His death, they claimed, was not caused by police restraint, but due to a heart condition, with his bipolar disorder as a contributing

cause. In other words, the Defendants reported that the Officers' brutal actions in chasing, tasing, and forcibly pinning Anton down in a prone position with their weight for six minutes until he lost consciousness and stopped breathing did not "cause or significantly contribute" to Anton's death. These conclusions contradicted the medical evidence, professional standards, and common sense.

11. Further, when given opportunities to clarify their findings with the State's Attorney and the media, Defendants instead doubled down on their misrepresentations of the facts and medical evidence.

12. Both the OCME's obfuscation of the obvious cause of death – police chasing, Tasing, and holding Anton in a prolonged prone restraint that prevented him from breathing – as well as the MSP report downplaying the role of police in Anton's killing, were used to justify the State's Attorney's decision *not* to pursue criminal charges against the officers and to decline to convene a grand jury to investigate Anton's death. Without a homicide, there was no crime, or potential crime, to investigate.

13. Further, as a direct result of the OCME's false report, the position of every law enforcement officer and agency involved has been that Anton's death was not caused by law enforcement officers' conduct and thus that there was no reason to consider any kind of accountability or alternate practices. Rather than a death that could be avoided by changing police conduct, Maryland law enforcement administrators have been misled into believing that deaths like Anton's cannot be prevented; that they are unavoidable, perpetuating the likelihood of future deaths.

14. Indeed, as detailed herein, the State of Maryland Office of Chief Medical Examiner, particularly under the leadership of Defendant Fowler, has a long and disgraceful history of falsely concluding that law enforcement actors did not cause the deaths of people in their custody,

particularly in the deaths of Black persons, and those with disabilities. For example, in 2009 an Attorney General task force noted concerns about the OCME's mischaracterizations of deaths following tasing as "excited delirium," and recommended that the Office change its practice. It did not.

15. More recently, the OCME gained national attention when Defendant Fowler elected to serve as the only medical expert to testify on behalf of the defense of Officer Derek Chauvin, the officer who murdered George Floyd. Defendant Fowler's testimony in that case (contending that the cause of Mr. Floyd's death was "undetermined" and citing clearly insubstantial contributing factors such as alleged drug use and car exhaust) was so outrageous and caused such an uproar in the medical community that the State of Maryland agreed to conduct a review of OCME's practices in death in custody cases during Defendant Fowler's two-decade tenure as Chief Medical Examiner.

16. In October 2022, the team responsible for conducting the review released a report stating that based on its review of records, there was a need for an exhaustive reexamination of about 100 cases where, as in Anton's case, the decedent was physically restrained and there was no obvious cause of death such as a gunshot wound. The contents of the report also suggested that under Defendant Fowler's tenure, OCME had systemic issues with its methods of review in restraint cases, including failing to properly apply standards approved by the National Academy of Medical Examiners.

17. Based on data released in conjunction with this review, **the OCME has almost never concluded that deaths in police custody are homicides absent a gunshot wound**. Plaintiffs have identified 57 cases where the decedent was in police custody and did not die of a gunshot wound or injuries from a police pursuit. Of these 57 cases, the OCME concluded the

death was not a homicide 88 percent of the time, even when the decedent had been Tased, pepper sprayed, subject to police baton strikes, prone restraint, or other uses of force deployed by law enforcement. These cases also show a significant racial disparity, with OCME examiners far more likely to conclude a death in state custody was a homicide when the decedent was white (21% of the time), than Black (8% of the time).

18. One such medical examiner whose data reflects significant racial disparities is Defendant Alexander, who conducted 34 death investigations of individuals in custody where the cause of death was not obvious (such as a gunshot or a suicide). In the 11 cases Dr. Alexander investigated where the decedent was white, he concluded that six were homicides. Of the 23 cases Dr. Alexander investigated where the decedent was Black, he concluded that ***none*** were homicides. This includes Anton's case, in which Defendant Fowler was also closely involved.

19. Upon knowledge and belief, the OCME has not, to date, taken any corrective actions to address the systemic issues in conjunction with its death in custody investigations, nor to correct its longstanding practice of deflecting and avoiding acknowledging the causal relationship between law enforcement officials' conduct and deaths in their custody.

JURISDICTION AND VENUE

20. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331, as it is a civil action brought under the United States Constitution and federal laws. The Court has supplemental jurisdiction over Plaintiffs' state-law claims pursuant to 28 U.S.C. § 1367 because those claims form part of the same case or controversy as Plaintiffs' claims under federal law.

21. Venue is properly in this District pursuant to 28 U.S.C. § 1391 because all the events giving rise to Plaintiffs' claim occurred in Caroline County, Maryland.

NOTICE

22. To the extent that certain of Plaintiffs' state law claims are governed by provisions of the Maryland Tort Claims Act and/or the Local Government Tort Claims Act, Plaintiffs provided notice of their claims to Defendants on August 28, 2019.

PARTIES

23. Plaintiff Jennell Black ("Ms. Black") is a Black adult citizen of the State of Maryland. Ms. Black is the surviving mother of the Decedent, Anton Black. She appears both individually and as the personal representative of the Estate of Anton Black, pursuant to Letters of Administration issued by the Register of Wills for Caroline County, Estate No. 9946.

24. Plaintiff Antone Black ("Mr. Black") is a Black adult citizen of the State of Maryland. Mr. Black is the surviving father of the Decedent, Anton Black. He appears both individually and as the personal representative of the Estate of Anton Black, pursuant to Letters of Administration issued by the Register of Wills for Caroline County, Estate No. 9946.

25. Plaintiff Katyra Boyce is a Black adult citizen of the State of Maryland. She sues as mother and next friend of W.B., Anton Black's daughter.

26. Plaintiff Coalition for Justice for Anton Black ("CJAB" or "the Coalition") is a grassroots membership organization, formed in the immediate aftermath of the 2018 killing of Anton Black, with the mission of promoting accountability for law enforcement misconduct and preventing police violence on the Eastern Shore. CJAB works toward these goals by organizing its members to engage in advocacy for police reform and accountability at state and local levels. The Coalition advocates for reform to address discrimination and violence against Black people, including specifically people with disabilities. Among the advocacy efforts that CJAB has undertaken since its founding are: Organizing, public education and lobbying for reform of state

laws, policies and practices that shield law enforcement from accountability, including those affecting information transparency, investigation and medical examiner review of deaths in custody; lodging complaints about police abuse; pushing for diversion of resources from policing to medical and social services; and supporting families of police abuse survivors, including specifically, the family of Anton Black. As to the Defendant Medical Examiners' specifically, CJAB has engaged in many activities aimed at calling attention to the problematic State policies, practices, misconduct, and cover ups challenged in this lawsuit, and seeking investigation of these abuses. This has included organizing community protests, meetings and community forums, lobbying the Maryland General Assembly, holding press conferences, issuing press releases and creating social media posts, engaging in media appearances on local, state and national television and radio broadcasts, speaking with and providing background information to print reporters, and appearing on podcasts.

27. Among others, CJAB members include members of the Black family who were directly injured by the events described in this action, and who have themselves suffered from racial and disability discrimination as a result of Defendants' misconduct. The organization consists of several dozen members living across the Eastern Shore, and one of its founders and officers is LaToya Holley, the sister of Anton Black. CJAB has very few resources and operates on a volunteer basis. CJAB participates in this action on behalf of itself and its members, seeking only declaratory and injunctive relief addressing Defendants' individual and collective misconduct in falsifying the causes and their conspiracy to prevent police accountability in the death of Anton Black and other individuals who died in police custody.

28. Anton was, at the time of his death, a Black resident and citizen of Caroline County, Maryland. Anton was the father of W.B.. Anton died on September 15, 2018 as a result of the

excessive force used by Officers Thomas Webster IV, Gary Manos, and Dennis Lannon, acting as agents of the Greensboro, Ridgley, and Centreville Police Departments, respectively.

29. Russell Alexander, who is white, is Assistant Medical Examiner, and in this capacity is an agent of the State of Maryland. Dr. Alexander was responsible for conducting the death investigation and certifying the cause of death of Anton Black. As sued in his official capacity, Dr. Alexander is a "person" within the meaning of 42 U.S.C. §1983 on Plaintiffs' claims for declaratory and prospective injunctive relief. Defendant Alexander is also sued in his individual capacity for monetary damages.

30. John D. Stash, who is white, is Interim Chief Medical Examiner, and in this capacity is a supervisor, agent and final decision and policy maker for the State of Maryland. Dr. Stash is responsible for ensuring the accuracy and integrity of all death investigations and certifications of causes of death in Maryland. As sued in his official capacity, Dr. Stash is a "person" within the meaning of 42 U.S.C. §1983 on Plaintiffs' claims for declaratory and prospective injunctive relief.

31. David Fowler, who is white, was, during all relevant times, Chief Medical Examiner, and in this capacity is a supervisor, agent, and final policy maker for the State of Maryland. Dr. Fowler was responsible for approving, certifying, and ensuring the accuracy and integrity of all death investigations, including that of Anton Black. Defendant Fowler is sued in his individual capacity for monetary damages.

32. Defendant State of Maryland, through the Office of the Medical Examiner, is responsible for ensuring the accuracy and integrity of all death investigations and certifications of causes of death in Maryland. The State of Maryland is a "public entity" as defined under Title II of the ADA. 42 U.S.C. §12131, and further, qualifies as a program or activity receiving federal

financial assistance, covered by the Rehabilitation Act. The State of Maryland is named as a Defendant on Plaintiffs' claims seeking declaratory and prospective injunctive relief as a covered entity under the ADA and the Rehabilitation Act, and as the responsible entity for state constitutional violations and torts committed by its agents under the Maryland Tort Claims Act.

ADDITIONAL RELEVANT PEOPLE

33. Thomas Webster IV was, at relevant times, an officer of the Greensboro Police Department and an agent and employee of the Town of Greensboro.

34. Michael Petyo was, at relevant times, Police Chief of the Town of Greensboro.

35. Gary Manos was, at relevant times, the Chief of the Ridgley Police Department.

36. Dennis Lannon was, at relevant times, is an officer of the Centreville Police Department.

37. Jeannette L. Cleveland, formerly known as Jeannette L. Delude, was, at relevant times, Town Manager of the Town of Greensboro.

38. The Town of Greensboro is a municipal corporation organized under Article XI of the Maryland Constitution. The Town of Greensboro organizes, operates, and maintains the Greensboro Police Department ("Greensboro PD"), the primary law enforcement agency of the Town of Greensboro.

39. The Town of Ridgley is a municipal corporation organized under Article XI of the Maryland Constitution. The Town of Ridgley organizes, operates, and maintains the Ridgley Police Department ("Ridgley PD"), the primary law enforcement agency of the Town of Ridgley.

40. Town of Centreville is a municipal corporation organized under Article XI of the Maryland Constitution. The Town of Centreville organizes, operates, and maintains the Centreville

Police Department ("Centreville PD"), the primary law enforcement agency of the Town of Centreville.

41. Plaintiffs have previously reached a settlement with Webster, Peyto, Manos, Lannon, Cleveland, and the Towns of Greensboro, Ridgely, and Centerville.

42. Howard Kennard, at relevant times, was a Maryland State Police trooper. He was the lead investigator for the Maryland State Police into the circumstances of Anton's death.

43. Stephen Hallman, at relevant times, was a Maryland State Police trooper. He participated in the Maryland State Police investigation into the circumstances of Anton's death.

FACTS COMMON TO ALL COUNTS

Background Concerning Officer Thomas Webster IV, Including the Role of the State of Maryland in Certifying Webster

44. In early 2018, Thomas Webster IV was hired by Michael Petyo, Jeannette Cleveland, and Town of Greensboro to join the Greensboro Police Department as an officer, pending certification and training by the State of Maryland.

45. In connection with the Town's hiring of Webster, Petyo filed an application with the State of Maryland's Police Training and Standards Commission (PTSC) to have Webster certified as a police officer. In preparing this application, Petyo falsified and intentionally omitted records relating to Webster's previous use of excessive force and racial bias against Black residents he was charged with protecting and serving. Plaintiffs aver, on information and belief, that as Town Manager and supervisor of Chief Petyo and the Greensboro Police Department, Cleveland ratified and condoned Petyo's criminal misconduct in connection with Webster's certification application.

46. In April 2018, the Defendant State of Maryland, through PTSC, granted Petyo's application and wrongfully certified Officer Webster as a police officer, based upon the falsified

application submitted by Petyo and Cleveland. Upon certification, Petyo and Cleveland moved Webster to active duty with the Greensboro Police Department (hereafter Greensboro PD).

47. The Greensboro PD was not the first police department to employ Officer Webster. He had previously been an officer with the Dover, Delaware police department.

48. Officer Webster's employment with the Dover police gained national attention in 2015 when he was criminally charged with second-degree assault against a Black man, stemming from an incident on August 24, 2013 that was captured on a police dashboard camera video.

49. In the video, Officer Webster can be seen with his gun drawn approaching 29-year-old Lateef Dickerson, a Black man, who had his hands raised. Officer Webster yells at Mr. Dickerson to get on the ground, and Mr. Dickerson begins to comply. When Mr. Dickerson is on his hands and knees, Officer Webster, with his gun still drawn, brutally kicks Mr. Dickerson in the face, shattering his jaw. Mr. Dickerson collapses to the ground, unconscious, and Officer Webster cuffs Mr. Dickerson's hands.

50. The incident illustrated Officer Webster's misconduct as a member of the Dover police, which began recording issues with Officer Webster as early as 2006. A performance evaluation in August of that year noted that "Officer Webster is very fit and strong. There have been times when he should have [attempted] lesser degrees of force to accomplish an objective," *i.e.*, he was prone to use excessive force.

51. This evaluation came shortly after Officer Webster punched a Black man in the face several times following a car chase.

52. Despite the evaluation's note that Officer Webster had been "spoken to regarding this issue," Officer Webster continued to engage in disturbing and violent behavior against Black people he encountered on the job.

53. In September 2010, for example, Officer Webster punched a Black man in the face during a drunk-driving arrest with such force that it shattered the man's nose and bruised Officer Webster's knuckles.

54. A few months later, in 2010, Officer Webster punched another Black man four times in the face after shocking him with a Taser electronic control device.

55. These sorts of actions led Officer Webster's superiors to note in an August 27, 2012 performance evaluation that "[Officer] Webster has made some poor decisions and he obviously does not think of the consequences of his actions."

56. Officer Webster made another "poor decision" early in 2013, when he took two men, Quinton Henry and Chris Baccoro, one of whom had asked to be brought to a hospital, from a convenience store in Dover, where Webster claimed they were loitering, to Port Mahon, a rural area five miles away and left them there.

57. For stranding the two men with no reason, Officer Webster received a ten-day suspension and nine months of disciplinary probation. Officer Webster was on probation and in the middle of this disciplinary period when he smashed Mr. Dickerson's jaw.

58. Officer Webster's assault on Mr. Dickerson was the last of **29** use of force incidents by Officer Webster for which the Dover police department filed a report. Plaintiffs aver, on information and belief, that most, if not all, of the 29 use of force incidents involved Black victims, and that this information was known to municipal officials and is reflected in the records recording complaints about Webster's misconduct.

59. Following a trial in which Officer Webster claimed that he had intended to kick Mr. Dickerson in the upper body rather than the head, and had feared for his safety when he kicked

Mr. Dickerson in the face, an all-white jury deliberated for three days before shockingly acquitting Officer Webster of the felony assault charges.

60. Shortly thereafter, the City of Dover settled a lawsuit filed by the American Civil Liberties Union on behalf of Mr. Dickerson for $300,000. The following year, the City also reached a settlement with Officer Webster, paying him $230,000 over the next six years in exchange for Officer Webster's resignation and agreement never to seek further employment with the City of Dover.

61. All of the foregoing facts about Officer Webster's past misconduct and racial bias were well-known and publicly available at the time the Town of Greensboro hired him in 2018, and this information was known to Petyo and Cleveland.

62. Indeed, the extensive national reporting on Officer Webster's violent conduct led to an outcry when the Town of Greensboro announced his hire, both from residents of Greensboro and from civil rights advocates like La Mar Gunn, the president of the Central Delaware chapter of the NAACP, who reached out to the Greensboro Town Council in an effort to dissuade the Town from hiring Officer Webster.

63. Among those who expressed concern about Webster's troubled background at the time of his hiring was Anton Black. Months before his death, Anton informed his mother that he was worried about Webster and how he might treat Black community members, given his abusive background as a police officer in Delaware.

64. Despite Officer Webster's long and well-documented history of improper, abusive, violent conduct and use of excessive force against Black people, Greensboro Town Manager Jeannette Cleveland told the Delaware News Journal in February 2018 that Officer Webster "was

found innocent of everything, **there is no history**," apparently referring only to the criminal charges brought as a result of Webster's brutal assault on Lateef Dickerson.

65. Michael Petyo, Jeannette Cleveland and the Town of Greensboro decided to take it upon themselves to ensure that in considering Officer Webster's certification, the PTSC would agree there was "no history" worth considering, by knowingly omitting records of Webster's long history of abuse from its application. When the Town submitted its application to the State of Maryland, through PTSC, to hire Officer Webster, Petyo, acting as the Town's Chief, and Cleveland, as Town Manager and Petyo's supervisor, falsified the certification application by disclosing only information regarding the 2015 trial and acquittal, while intentionally withholding all other information in their possession relating to Officer Webster's numerous infractions, disciplinary measures, and use of excessive force reports – criminal misconduct under Maryland law.

66. The Defendant State of Maryland, through PTSC either did not conduct any further inquiry into Officer Webster's background—despite the fact that some uses of force and disciplinary measures were disclosed during his criminal trial and thus could have been known to the State of Maryland—or determined that the particulars of Officer Webster's time with the Dover police did not preclude certification.

67. After the Town of Greensboro announced Officer Webster's hiring, concerned Black citizens raised objections at a March 1, 2018 Town Council meeting. Citizens told the Town Council that they were "worried about the message the town was sending . . . especially to people of color," and asked if Webster's hire indicated a shift to a more "militarized" style of policing.

68. Town officials, including Petyo and Cleveland, responded that Officer Webster was "the strongest applicant" interviewed, and stated that he had passed all background checks and evaluations and was "eager to work with the community."

69. Then-Mayor of Greensboro, Joseph Noon, admitted that the video footage of Officer Webster breaking Mr. Dickerson's jaw "looked bad," but reiterated that Webster had been acquitted and told citizens that the Town was "giving [Officer Webster] a second chance."

70. Petyo also answered questions about Officer Webster. Then-Chief Petyo stated that he had "personally performed a deep background check" on Webster, including visiting Dover and speaking to Dover residents and police officers.

71. Petyo told the crowd that he had decided to recommend Officer Webster because "This is someone not afraid to do his job."

72. When a citizen expressed concern that Officer Webster's conduct demonstrated a failure to implement sufficient training, Chief Petyo responded that after Officer Webster completed the Maryland state certification training, he would get "much more" training, as "training is paramount for everyone in" the Greensboro PD.

73. The final question regarding Officer Webster came from a citizen who, after noting the settlement amounts paid by the City of Dover to Mr. Dickerson and Officer Webster, asked "who would be responsible" if there were another similar incident while Officer Webster was employed by the Town of Greensboro.

74. The Town of Greensboro's attorney advised the citizens that Greensboro would be responsible for any future damages arising out of Officer Webster's violent conduct.

75. The controversy exposed deep racial divisions in the Town, given white officials' dismissal of concerns about police abuse voiced by Black residents.

76. Officer Webster graduated from the State of Maryland's certification training on April 13, 2018. Despite Chief Petyo's insistence that Officer Webster would undergo extensive training following his certification, Town Manager Cleveland informed the Town Council at a subsequent meeting that, pursuant to Chief Petyo's report to her, Officer Webster was "on his own"—that is, not supervised—by May 12, 2018, less than a month after he was improperly certified by the State based on the Town's false application.

77. Moreover, it does not appear that formal policies and procedures, to the extent that they existed at all, were well-established within the Greensboro PD.

78. At a Town Council meeting on June 7, 2018—the month after Officer Webster was sent out on his own—Petyo advised the Council that he had "constructed a Rules and Regulations handbook" (the "Handbook") for distribution to Greensboro PD officers.

79. It is unclear whether any formalized set of rules and regulations existed within the Greensboro PD prior to that time.

80. Chief Petyo told the Town Council that "all the officers [had] received and acknowledged receipt" of the Handbook prior to the June 7 meeting.

81. There is no indication that the officers were required to do anything more than "acknowledge receipt." In particular, there is no indication in the Handbook that officers were required to complete any training with respect to the contents of the Handbook.

82. It does not appear that Petyo, Cleveland, nor any other Town of Greensboro policymaker made any effort to ensure that Greensboro PD officers actually read and understood the policies contained within the Handbook, nor consulted with officers regarding their adherence to those policies.

83. At the relevant time, the Handbook appeared to be a stock handbook prepared by a private company, Lexipol LLC. It is 659 pages long.

84. Despite the bare promulgation of the Handbook, the Greensboro PD continued to operate largely using informally established practices and procedures or ad hoc decisions by individual officers, even where those practices, procedures, or decisions directly contradicted the guidelines set forth in the Handbook.

85. On July 28, 2018, approximately two months after Officer Webster was sent out on his own by Petyo and Cleveland, C. L., a mixed race, 15-year-old experiencing a mental health issue, was allegedly Tased and brutally beaten by Officer Webster and Maryland State Police Trooper Kevin Carabello, an employee of Defendant State of Maryland. The body-worn camera ("BWC") footage shows the child, C. L., never did anything to warrant being tased and repeatedly beaten, punched and kicked in the head. Plaintiffs aver, on information and belief, that neither Petyo, Cleveland, nor the Town of Greensboro took any action to investigate or discipline Webster's abuse of his Taser or beating of C.L., and that Webster continued on the job with no consequences whatsoever for his actions. Plaintiffs further aver that the State of Maryland, through PTSC, did not revoke Officer Webster's certification following this incident.

86. Less than six months after Petyo and Cleveland facilitated the Town of Greensboro's hiring of Webster over the objections of Black residents by falsifying his certification application; less than [six] months after the Defendant State of Maryland certified Webster to work as a law enforcement officer in the State of Maryland; less than three months after Petyo informed the Town Council that Greensboro PD officers had received the Handbook; and just weeks after Webster is alleged, in the presence of a Maryland State Trooper, to have misused his Taser and used excessive force in a violent attack of another local teenager, the Town's

hiring and retention of Officer Webster and its failure to train officers in accordance with the practices in the Handbook would prove fatal.

The Killing of Anton Black

87. Anton Black was 19 years old. He was a former champion athlete at North Caroline High School, an aspiring model and actor, and an expectant father. Anton attended Wesley College in Dover, Delaware.

88. Unfortunately, during the late summer of 2018, Anton had developed serious mental health issues. In August 2018, Anton began behaving erratically, talking about having an "epiphany."

89. On August 29, 2018, Antone Black, Anton's father, called police and told them that Anton was at his home and was acting strangely. The Kent County Sheriff's officer who responded to the call treated the matter as a mental health matter and safely took Anton into custody without incident for an Emergency Petition and behavioral health screening.

90. Based on the Emergency Petition, Anton was involuntarily admitted to the hospital for psychiatric evaluation and treatment. Medical staff noted that he was manic and displayed grandiose delusions, euphoria, disjointed thinking and speech, and agitation. The doctors diagnosed Anton with a severe form of bipolar disorder.

91. Anton stayed in the hospital until September 5, 2018, at which point he was discharged after the judge overseeing his case concluded that Anton did not present a danger to himself or anyone else.

92. Anton was released from the hospital and returned home, still learning how to manage his severe bipolar disorder.

93. On September 15, 2018, Anton went to a basketball court not far from his mother's home in Greensboro. There he met X. B., who was 12 years old at the time.

94. X.B. and Anton knew each other well. Their families were close, and X.B. had grown up around Anton and his family. X.B.'s cousin is married to Anton's sister, and X.B.'s brother was on Anton's track team. The boys regularly spent time together.

95. Anton waited at the basketball court for a while, then asked if X.B. was ready to leave. The two of them left the basketball court and walked to X.B.'s home, and then roamed around town, still on foot. During this period, they were seen together both by Lannon[1] and Webster. As Webster told witnesses, including Anton's mother, he saw Anton and X.B. together earlier in the day at the park, walking on Greensboro's main street, and riding a bike around town, making clear that Webster was well aware the two were spending time together voluntarily.

96. X.B. noticed that Anton was acting strangely on the walk. He was talking to himself incoherently and making very little sense. Other witnesses also noticed Anton's odd behavior.

97. At one point, it was reported that Anton grabbed X.B. and began pulling him along. A woman passing by witnessed this and asked X.B. if he wanted her to call the police. Upset by Anton's strange behavior, X.B. said that he did.

98. The witness called 911 and reported that an "older boy," a teenager, was dragging a younger boy along.

99. Notably, however, Dennis Lannon, who saw Anton and X.B. that day in Greensboro, said his view was that the boys were just engaged in ordinary roughhousing.[2]

100. Officer Webster responded to the 911 call. At approximately 7:10 p.m., Officer Webster arrived on the scene to speak with Anton and X.B., and turned on his body-worn camera ("BWC") to record the interaction. Both the BWC video and surveillance video from a store across

---

[1] G. Kazanjian, "Questions linger one year after Anton Black's death," Maryland Matters, Sept. 13, 2019, available at https://www.marylandmatters.org/2019/09/13/questions-linger-one-year-after-anton-blacks-death/

[2] *See* fn 1.

the street showed the two boys standing side-by-side, with no physical contact, in a similar fashion to when Webster had seen them earlier, and contrary to the report that Anton was dragging X.B.

101. X.B. told Officer Webster that Anton had been acting strangely and was "schizophrenic."

102. While not an accurate medical diagnosis, these statements and Anton's demeanor made clear to Officer Webster, if he was not already aware, that Anton was experiencing a mental health crisis.

103. In response to Officer Webster's questions, Anton stated that he was X.B.'s brother. The two were not actually brothers, and X.B. told Officer Webster as much. Anton, appearing confused, repeated that he and X.B. were brothers. This behavior was similar to Anton's behavior on August 29, 2018 - the date he was Emergency Petitioned. On that date, when looking at a large group military photograph from the 1970's of his father and others, Anton insisted it was he in the photograph instead of his father. Anton also had claimed he was Adam of Adam and Eve.

104. After Anton and X.B. disagreed about whether they were brothers, Officer Webster told Anton to put his hands behind his back. In response, Anton strangely said "I love you" to Officer Webster, and then slowly turned away and began jogging in the other direction. Officer Webster did not see any weapon on Anton during their encounter and no person had alleged Anton was armed.

105. Kevin Clark, a white civilian wearing a helmet emblazoned with a Confederate flag, had been watching the interaction on his motorcycle from across the street. As Anton jogged away, Officer Webster told Mr. Clark to "hang with him", improperly enlisting the aid of a random civilian with no law enforcement or mental health training.

106. As any reasonable police officer or official would know, it was plainly improper for Officer Webster to deputize a passerby dressed in racially offensive attire to chase after a frightened Black teenager experiencing a mental health crisis. But Webster took this action nevertheless, and Mr. Clark obeyed Officer Webster's instructions and began chasing after Anton on his motorcycle.

107. Officer Webster then entered his car and called in to update dispatch, repeating X.B.'s statement that Anton was "schizophrenic."

108. Meanwhile, Anton encountered Lannon, who works for the Centreville Police Department but was not on duty and not in uniform. Frightened, Anton turned and ran back toward Officer Webster, and on toward his mother's home, chased by Lannon and the Confederate motorcyclist.

109. Officer Webster jumped out of his vehicle and pursued Anton on foot.

110. The Greensboro Police Handbook then in effect stated that "surveillance and containment are generally the safest tactics for apprehending fleeing persons," particularly where "the identity of the suspect is known or there is information available that would likely allow for later apprehension."

111. Officer Webster knew Anton's identity, as well as X.B.'s.

112. Officer Webster, who had acknowledged receipt of the Handbook a few months before, did not follow its guidelines, because he had not been adequately trained in its practices despite his history of racist violence and "poor" decision-making as a police officer.

113. Instead of following the guidelines in the Handbook, Officer Webster, knowing or having reason to believe Anton was mentally ill, treated Anton like a criminal suspect and, improperly leaving his patrol car unlocked with the keys inside, ran after Anton. No reasonable

officer would leave their vehicle vulnerable this way in order to chase a teenager known to him and experiencing a mental health crisis.

114. Chief Manos was off duty at the time, and happened to be traveling through Greensboro. He saw Officer Webster pull over, speak with Anton, enlist the help of Mr. Clark to chase Anton, and then begin his own foot pursuit.

115. Noting that Officer Webster had left his police car unsecured in the middle of the street, he got in Officer Webster's car and drove after Officer Webster, Mr. Clark, and Anton. Chief Manos was not in uniform.

116. Officer Lannon also pursued Anton joining Mr. Clark, who was on his motorcycle with his helmet on.

117. Anton ran into the mobile home community where his mother lived, pursued by the three officers and Mr. Clark. From Anton's perspective, four white men, one wearing a Confederate flag helmet, and only one in uniform were chasing him. Anton did not turn to confront the men, never uttered any threat and did not brandish any weapon. Instead, frightened, he jumped into a family vehicle and locked the doors from inside. The car was disabled and stuck in the driveway with a flat tire, and Anton did not have keys to drive it anyway.

118. Notably, in following Anton to his mother's home, Webster knowingly chased him outside Webster's Greensboro jurisdiction.

119. Anton was now locked in a vehicle, surrounded by three police officers and Mr. Clark, outside his mother's home. He did not present a threat to anyone, and was making no effort to leave the locked car. He did not utter any threat or brandish any weapon. He was simply experiencing a mental health crisis, as known and reported to dispatch by Officer Webster.

120. Officer Webster stated several times during the confrontation that they were not arresting Anton and only taking him into custody because he was having a mental health crisis.

121. The Handbook reminds Greensboro PD officers that "mental health issues, mental health crises and unusual behavior are not criminal offenses. Individuals may benefit from treatment as opposed to incarceration."

122. The Handbook notes that "taking no action or passively monitoring the situation may be the most reasonable response to a mental health crisis." It instructs officers to make an effort to de-escalate mental health crisis situations by being "patient, polite, calm, courteous and [not] overreacting," to "speak and move slowly and in a non-threatening manner," and to "remove distractions or disruptive people from the area."

123. The Handbook also states that officers should not "Use stances or tactics that can be interpreted as aggressive," "allow others to interrupt or engage the person," "**corner a person who is not believed to be armed, violent, or suicidal**," or "argue, speak with a raised voice or use threats to obtain compliance."

124. Finally, the Handbook represents that the Greensboro PD intended to "develop and provide comprehensive education and training to all department members to enable them to effectively interact with persons in crisis."

125. On information and belief, no such education or training was ever developed, let alone provided to Officer Webster.

126. Officer Webster instead proceeded in accordance with his own troubled, *ad hoc* and racially biased behavior.

127. Officer Webster knew that Anton was having a mental health crisis, and had stated this information over the radio, informing Chief Manos and Officer Lannon who were present.

Yet despite this knowledge, Webster deputized a random civilian wearing a racist emblem widely known to offend Black people, to assist police in chasing down the frightened Black teen. Chief Manos and Officer Lannon stood by, never once objecting to Webster's aggressive actions nor discouraging the untrained Mr. Clark from engaging in the chase. To the contrary, the four white men ganged up and conspired together in aggressively pursuing Anton, knowing full well of his mental distress.

128. Given applicable rules, Anton's presence in a locked disabled vehicle without keys, the officers' knowledge of Anton's identity and home address, Anton's slight build, the fact that Anton was a teenager who was not being arrested for committing any crime, the presence of multiple officers, the option to call for emergency medical or mental health intervention services, and the lack of any indication that Anton presented a danger to himself or anyone else, any reasonable police officer would have recognized that it was a controlled situation, and was an ideal time to de-escalate in order to seek a peaceful resolution and the provision of mental health services.

129. Any reasonable police department would have trained its officers to de-escalate in such a situation, as Greensboro PD's own Handbook makes clear.

130. Greensboro PD never provided such training to Officer Webster. On information and belief, Ridgley PD never provided such training to Chief Manos, and Centreville never provided such training to Officer Lannon.

131. Officer Webster took no steps to de-escalate. Instead, Officer Webster violently and tragically escalated the situation beyond his control, deliberately employing force as a primary resort, a predictable approach in light of his lengthy prior record of excessive force. Chief Manos and Officer Lannon failed to intervene or de-escalate the situation.

132. Officer Webster ran to the driver's side of the vehicle, next to Anton, who was sitting in the driver's seat, drew his baton and, without any warning to Anton, smashed the window next to Anton's head. At no time did Webster or Manos instruct Anton to exit the vehicle, show his hands or give him any command before Webster smashed the car window.

133. The Handbook instructs that "control devices" such as batons should be used *only* "when a decision has been made to control, restrain, or arrest a person who is violent or who demonstrates the intent to be violent."

134. No reasonable police officer would believe that smashing a window next to a nonviolent teenager having a mental health crisis is an acceptable use of a control device.

135. As the window shattered next to his head, Anton, terrified, moved to the passenger side of the vehicle, attempting to exit the car.

136. Officer Webster then drew his Taser and told the other officers "I'm Tasing him" as he reached into the broken window and fired the Taser at Anton. At no time did Webster or Manos instruct Anton to exit the vehicle, show his hands or give him any command before Webster tased him.

137. The Handbook states that a Taser should only be used "to control a violent or potentially violent individual." It clarifies that "Mere flight from a pursuing officer . . . is not good cause for the use of the Taser to apprehend an individual."

138. Anton was not violent, and Officer Webster had no reason to believe that Anton might be violent, especially while Anton was locked in the vehicle and had done nothing but flee.

139. The Handbook states that "A verbal warning of the intended use of the Taser should precede its application," in order to "[p]rovide the individual with a reasonable opportunity to voluntarily comply."

140. Officer Webster gave no such advance warning, nor did he afford Anton a reasonable opportunity to voluntarily comply.

141. During the June 7, 2018 Greensboro Town Council meeting, Chief Petyo stated that all officers had been "recertified on their TASERS."

142. That Officer Webster misused the Taser just after receiving the Handbook and training on Greensboro PD procedures, while contrary to Handbook guidelines and appropriate policing practices, illustrates that his actions were plainly in accordance with the established practices of the Greensboro PD.

143. The Handbook, which sets forth standards for police use of force, directs an officer "present and observing another officer using force that is clearly beyond that which is objectively reasonable under the circumstances" to "intercede to prevent the use of unreasonable force."

144. Neither Chief Manos nor Officer Lannon took any steps to intervene when Officer Webster clearly used unreasonable force, escalating a nonviolent mental health crisis into a fatal confrontation. Instead, they joined Officer Webster, and further escalated the situation. Likewise, neither Manos nor Lannon intervened to prevent the random civilian improperly deputized by Webster from joining in the altercation with Anton.

145. Officer Webster's Taser use was not only improper, but ineffective. Only one of the two barbs struck Anton. The Taser barb embedded itself in Anton's skin, likely causing pain, but did not incapacitate him.

146. Understandably, being struck by the Taser and likely in pain, Anton attempted to get out of the other side of the car, and ran right into the arms of Chief Manos, who was in plainclothes and not identifiable to Anton as a police officer.

147. Anton and Chief Manos struggled as Officer Webster and Officer Lannon ran over. The officers pinned Anton against the outside wall of his mother's home.

148. As Anton began to scream for his mother and cry hysterically, Officer Webster told Chief Manos that "He's schizophrenic." Chief Manos replied "Yeah, yeah, yeah."

149. Mr. Clark then came over to the officers. Officer Webster instructed Mr. Clark, an untrained passerby, to "grab [Anton's] leg, pull it out from under him."

150. On Officer Webster's body camera, Mr. Clark—identifiable by his Confederate flag helmet—can be seen following Officer Webster's instructions. At the 3:37 mark of the body camera footage, Anton fell to the ground, with the officers restraining him.

151. "Let's prone him out," Chief Manos commanded, directing the others in the controversial practice of restraining a person lying face down while applying physical pressure to areas of their torso, including the back, shoulders or neck.

152. The body camera video shows that as the officers pinned Anton down, fearful for his life, he pleaded for his mother, repeating "I love you" and "" and calling out "You were always there! Thank you!"

153. The officers forced Anton into a prone position, so that his face, chest and stomach were pressed to the ground, and Chief Manos laid across Anton's back, using his body weight to hold him down and pin him to the ground.

154. Chief Manos, who is much larger than Anton was, would remain with his weight atop Anton's slight, 159-pound body *for the next six minutes or more*, even when Anton stopped moving, and even with the other men further restraining him in additional ways, such as by holding his legs.

155. Greensboro's Police Handbook at the time clearly provided that a person should not be "placed on his/her stomach for an extended period, as this could reduce the person's ability to breathe."

156. Shortly after pinning Anton in a prone position, the officers handcuffed him, and Officer Webster told everyone to "**take a breather**," indicating that no one was in fear for their safety and that Anton was under their control. The officers nevertheless continued using their weight to hold Anton down. Unfortunately, Anton was not allowed to "take a breather" or breathe and the officers while taking a breather did not show that same level of concern for Anton.

157. Approximately two minutes after the officers handcuffed Anton, Officer Webster told Officer Lannon that "This is gonna be an EP"—an Emergency Petition, similar to the Emergency Petition that had resulted in Anton's earlier admission to the hospital—indicating that none of the officers regarded Anton as anything other than a person experiencing a mental health crisis.

158. Officer Webster even asked if emergency medical services should transport Anton and in response Officer Lannon told him that "you're gonna have to."

159. None of the officers attempted to call for medical assistance.

160. At this point, Anton was still on the ground, facedown, with his hands cuffed behind his back. He did not pose any risk and he was outnumbered four to one. However, during this entire time, Chief Manos did not remove his weight from Anton's body, and all three officers continued to hold Anton, bending his legs back so that his feet were facing the sky in a position that made it harder for him to breathe, as his mother came out of her home, having heard him scream "Mommy, help!"

161. Anton, terrified and struggling to breathe, began trying to move his legs and trying to speak to his mother, but the officers forcefully held him down with their collective weight.

162. Anton cried out "I love you" and **"please,"** apparently pleading with the men on top of him and holding him down to stop.

163. As Anton screamed and cried, a Caroline County Sheriff's Deputy, at Officer Webster's direction, searched for shackles. It took another **four minutes** for the officers to locate shackles, during which time Chief Manos continued pinning an already handcuffed Anton face down with his body.

164. Despite the well-documented dangers of prolonged prone restraint and maintaining heavy, sustained pressure on a person's upper body, the officers made no effort to check whether Anton was having trouble breathing, nor to roll him over to his side although he was already handcuffed as required by their police protocols. Instead, as Anton lay dying the Officers began joking among themselves about how hard it was for them to keep up with Anton, a star athlete, during the foot pursuit.

165. In response to questions from Anton's mother, the officers assured her that they understood Anton's mental health issues. Officer Webster told her that "This is a mental health emergency, we're not treating this like a crime."

166. Instead of treating him like a person and a teen experiencing a mental health crisis, however, tragically all three officers treated Anton like a non-person or a dangerous suspect, utterly failing to use de-escalation techniques or to follow policies and procedures suited to mental health emergencies. Worse still, they continued to use force to hold Anton down long after he was handcuffed and subdued, heedless of the obvious dangers posed to Anton by their conduct.

167. Approximately six minutes after taking Anton to the ground and placing him in a prone position, after his legs were shackled, Chief Manos finally lifted himself off of Anton's body.

168. Finally at this point, long after such warning and action were required by police protocol, Chief Manos stated, "Let's get him on his side **so he can breathe**," illustrating that he was aware that pinning Anton facedown could impede his breathing.

169. At that point, Anton was no longer responsive and he had not spoken for minutes.

170. The officers propped Anton into a sitting position, but Anton remained nonresponsive, his head dangling to the side.

171. Approximately three minutes after the officers had propped Anton up against the wall while assuring his mother that everything was fine, Ms. Black looked into her son's face and saw that he was turning dark. She asked the officers for help.

172. As the officers finally uncuffed Anton and laid him down for medical assistance, they also finally acknowledged that he was no longer breathing, and did not have a pulse.

173. Approximately a minute and a half after his mother said he was turning dark and over four minutes after the officers had finally propped him up after holding him in a prone position for approximately six minutes, the officers, and others on site, finally began administering CPR. The Officers looked around to determine if anyone had AED equipment, but no one did.

174. As they did so, Katyra Boyce, who was then six months pregnant with Anton's daughter, arrived to discover that the father of her child was dying.

175. Emergency medical personnel then arrived and attempted to resuscitate Anton.

176. They were unsuccessful. Anton was pronounced dead shortly after being taken to the hospital. The medical evidence shows that the cause of Anton's death was homicide by

asphyxiation. Anton Black died at the age of 19 as a direct and proximate result of the Town of Greensboro and Petyo knowingly hiring an officer with a proclivity for violence against Black people; the State of Maryland's knowing certification of an officer who had neither the character nor the temperament for employment as a police officer; the failure of all three towns to adequately train and supervise their officers; Officer Webster's unjustified and unconscionable escalation of a mental health crisis into a fatal confrontation; and the excessive force used by the officers, specifically including Chief Manos. Worse still, Anton's death has gone unpunished because the very entities sanctioned to avenge his death conspired together to instead protect police and public officials, and evade accountability, risking future lives.

How Defendants State of Maryland, Alexander and Fowler Perpetuated the Officers' False Claims that Anton Was Responsible for His Own Death, to Protect Law Enforcement Officials

177. In the immediate aftermath of the incident, the Officers began developing a narrative to absolve themselves of any wrongdoing or responsibility for Anton's death. Just after Manos and a Caroline Sheriff's Office sergeant began trying to resuscitate Anton, an emergency medical technician, Manos, Webster, Lannon, and possibly other officers began shifting blame to Anton for his own death.

178. Even as Anton lay dying on the ramp outside his mother's house, the Officers – without any evidence whatsoever – began claiming that Anton had smoked marijuana laced with something ("spice"), and exhibited "superhuman" strength. While various law enforcement personnel were trying to revive Anton, one of the officers stated "he's been smoking laced marijuana." Four minutes later, an officer asked "what was he doing, spice?" And two minutes later, an officer stated "he's been smoking marijuana laced with something." After Anton was taken into the ambulance, an officer stated "there was just nothing we could do. He had superhuman strength."

179. As later recounted despairingly in a Baltimore Sun editorial:[3]

> At another point in the video, an officer asserts that Black was on drugs. He wasn't, according to the autopsy. Do Greensboro police automatically assume every young African-American man they meet is high? It's all part of a dehumanization of Black that is perhaps best illustrated by one of the officers when he calls his chief to say the incident "turned into a real show."

180. Notwithstanding the falsity of the allegations that Anton was on drugs, the involved Officers repeated these misstatements to the Maryland State Police investigators, who in turn repeated them, without corroborating them, to the Office of Medical Examiner. For example, during his September 15, 2018 interview with MSP's Sergeant Kennard, Chief Manos stated "his eye[s] were . . . dazed . . . they found drugs on [Anton] at the hospital. And they-- I don't know what they found. But supposedly he was doing something, smoking something. Some weed that was laced or something. . . he was abnormally strong." Officers Lannon and Webster subsequently repeated these claims during their recorded interviews on September 24 and 25, 2018 respectively, with Lannon telling Kennard "the suspect was smoking something, it was marijuana but laced with something" and Webster reporting "he had been using some sort of altered marijuana or marijuana-like substance."

181. The Maryland State Police repeated these assertions to the Office of Medical Examiner on-site investigator. The ME's September 16, 2018 investigative report states that Maryland State trooper Stephen Hallman told the investigator Anton "was known to smoke reefer" "and may have smoked spice." Following this interaction, the investigator also reported that Anton's "medical history" was "drug use" and "ETOH [alcohol] abuse."

182. The Office of Medical Examiner's initial report reflects other statements that put the blame for the incident on Anton and suggested law enforcement conduct had nothing to do

[3] Baltimore Sun Editorial: *The more we learn, the worse police look in the death of Anton Black,* Available at: https://www.baltimoresun.com/news/opinion/editorial/bs-ed-0125-anton-black-investigation-20190124-story.html

with his death. For example, the investigative report states that Anton "was reported to be involved in a possible child abduction," and that Corporal Hallman reported that after he was tased, Anton was involved in "an altercation . . . which led to [Anton] being handcuffed" and there was a "scuffle while [Anton was] being handcuffed." The medical examiner also reported that the officers "placed [Anton] in the seated position leaning against the residence when he slumped over and was reported to be in cardiac arrest." The State investigative report fails to mention that the Officers had brought Anton to the ground and kept him in a prone restraint position face down for almost six minutes.

183. Defendant Alexander performed the autopsy on September 16, 2018. During that procedure, he commented to Maryland State Police Corporal Nathan Wilson that "Black's neck looked good." This reflects that the Office of Medical Examiner, along with the Maryland State Police, wished to rule out evidence of physical violence and asphyxiation by police. Once armed with the knowledge provided by Defendant Alexander that there was no obvious physical injury to Anton's neck, MSP investigators were free to develop a narrative that absolved the Officers of wrongdoing and denied asphyxiation as the cause of death.

184. Even after his death, Anton continued to be treated as a suspect rather than a victim. Indeed, during witness interviews and throughout the Maryland State Police "investigation" file, Maryland State troopers characterize Anton as a criminal "suspect" or "subject" of the investigation, rather than a potential homicide victim, although the officers on the scene had stated that Anton was *not* being taken into custody for any crime. Conversely, the State's "investigation" file asserts that Officer Manos "was identified as a witness in the investigation," rather than a subject of the investigation. Similarly, the investigative file identifies Officer Lannon as a someone "who was identified as a witness who observed Anton Black fleeing on foot" and there

is no indication in the file that Lannon was treated as a suspect, such as by administration of his *Miranda* rights.

185. During their interviews, the Maryland State Police invited witnesses to speculate whether Anton was on spice at the time of the incident. For example, in his interview of Denise Williams (the civilian who made the 911 call), Sergeant Kennard invited the witness to speculate whether Anton was high and mentioned that they were waiting to "do the toxicology," and after the witness said "her daughter told her something about there was a little bit of talk about K2," Kennard said "the spice stuff . . . it's like really bad. The synthetic marijuana type that they make, and we have a lot of overdoses because of that." Similarly, in his interview of Kevin Clark, the civilian who participated in the attack, Sergeant Kennard asked several times whether Anton was "super strong," and after Clark said he had heard rumors that Anton was "on drugs," Kennard promised to discuss the toxicology report with him. And in the immediate aftermath of the incident, Trooper Hallman asked Anton's sister whether Anton "used any illegal drugs." Similarly, Sergeant Kennard conducted an interview of Anton's friend Thomas Latney, who did not witness the events, the focus of which was Anton's marijuana use and whether Anton was smoking marijuana laced with PCP. Sergeant Kennard's interview of Daniel Rittenhouse similarly focused on whether Anton had smoked marijuana prior to the incident. And during Detective Clark's interview with Renee Smith, they discussed whether Anton was "on something" and she noted she had heard rumors that people had observed Anton "walking up and down the street smoking blunts."

186. Sergeant Kennard conducted his investigation apparently unaware that the Officers were actively trying to obstruct his investigation by communicating with witnesses and potential witnesses. For example, on September 17, 2018, Manos and Petyo contacted a Caroline County

resident and NAACP official Berl L. Lovelace, Sr. who was not involved in the case in any way, and privately shared a version of BWC footage with him, while simultaneously contending that the video was highly confidential and was being withheld from the family and all other members of the public. Mr. Lovelace viewed the video with Manos and Petyo, and informed Plaintiffs' representatives that he had done so.

187. The October 4, 2018 Maryland State Police investigative report prepared by Sergeant Kennard states that "Anton Black was restrained without the use of any open or closed hand strikes and without the use of pepper spray" and that after Anton "was secured by leg shackles, he became unconscious." This summary of the event is word-for-word verbatim the same as Sergeant Kennard's summary of his interview with Thomas Webster, *i.e.,* he presented Webster's account of the event as the official conclusions of the Maryland State Police. Notably absent in this summary of events is any reference to the length of time that Anton was restrained with the weight of multiple officers after he was handcuffed.

188. Notwithstanding the MSP's efforts to drum up evidence of Anton's drug use, the Medical Examiner Defendants knew, almost immediately after Anton's death, that he was *not* high at the time of his death. Defendant Alexander performed the autopsy on Anton's body on September 16, 2018, and on September 20, 2018, the Office of Medical Examiner performed a toxicology screen on Anton which included a "comprehensive" drug test. This test was negative, confirming that Anton did not have controlled substances in his body at the time of death.

189. Even though the autopsy was complete on September 16, the toxicology drug test came back negative on September 20, Sergeant Kennard had completed his investigative report by October 6, 2018, and the neuropathology and cardiovascular pathology report were all complete by November 15, 2018, the Defendants did not release the autopsy report.

190. As police tried to obfuscate the events, Anton's grieving family and CJAB members started raising questions and launched efforts to hold the government accountable for its wrongdoing. On September 22, 2018, the family held a candlelight vigil attended by over 200 supporters mourning Anton's death and calling on law enforcement to investigate his killing. Two days later, Caroline County State's Attorney Joseph Riley shared a version of the BWC footage that had been shown to Burl Lovelace a week before to lawyers for Family Plaintiffs, although the family was not invited to view, and counsel was not provided with a copy of the footage, nor allowed to record it when it was shown to them.

191. On October 4, 2018, the family and supporters asked the Greensboro Town Council to take action.[4]

192. Notwithstanding the fact that toxicology reports performed immediately after his death showed no drugs in Anton's system, the Officers and Town officials continued to falsely claim to media that they believed laced drugs were involved. The false police narrative that Anton had used laced drugs became pervasive and spread in the media. Despite having full knowledge there were no drugs in Anton's system, the Defendants made no efforts to release toxicology reports, choosing instead to aid the Officers in further developing the false narrative that Anton had smoked marijuana laced with something or "spice,", and exhibited "superhuman" strength, by incorporating the false claims into the State's "investigation".

193. Months passed, and still public officials took no action and refused to release records. On December 17, 2018, the family and Coalition members organized and held a press

[4] *See, e.g.*, "Family of Greensboro teen speaks publicly over death while in police custody," WBOC, Oct. 5, 2018, available at http://www.wboc.com/story/39236992/family-of-greensboro-teenager-speaks-publicly-over-death-while-in-police custody?fbclid=IwAR28XENNDL4z-A8r_L-GIOJJEbT0b9k1iYjPkNUe-GC3j1KVRX7ACSvMHz8#.XCbQQ_Z1v0Q.facebook

conference in Denton, Maryland calling for justice, including requesting an investigation by Maryland State Police and asking for release of BWC footage, the toxicology report, and autopsy.

194. Officer Manos, who was one of the persons responsible for Anton's death and therefore conflicted, decided for the Ridgely Police Department that no investigation was warranted, notwithstanding his personal involvement and Ridgely Police Department rules to the contrary.[5] Centreville Police Chief Kenneth Rhodes stated publicly that Centreville Police Department policy did not require an investigation. No Town officials from Ridgely or Centreville took any action at this time to override the Chiefs' decisions.

195. On December 28, 2018, Plaintiff CJAB set up social media accounts on Facebook and Twitter, aimed at organizing supporters of the Family Plaintiffs in seeking justice for Anton's killing. Through social media, CJAB made urgent and extensive efforts to alert mainstream media to Anton's death, and to circulate and amplify this attention to bring pressure to bear on the government to investigate and act. Through these means and by joining town meetings, filing public records requests and issuing calls to action, CJAB, its members, and the Family Plaintiffs urged state and local public officials to investigate and hold police accountable for Anton's killing.

196. In late December, through CJAB's social media and outreach efforts, its leadership connected with a prominent columnist at the Washington Post, Cortland Milloy. CJAB invited Mr. Milloy to attend its next event on January 3, 2019, when CJAB and the Family Plaintiffs convened at the Greensboro Town Council meeting. Among demands CJAB made at the meeting were calls 1) decrying the government's delay and stonewalling in release of body camera footage, the autopsy report, and investigative results four months after the ME's completion of the actual

[5] G. Kazanjian, "Prosecutor Won't Seek Police Officers' Indictments in Eastern Shore Teen's Death," Maryland Matters, Jan. 24, 2019, available at https://www.marylandmatters.org/2019/01/24/prosecutor-wont-seek-police-officers-indictments-in-eastern-shore-teens-death/

autopsy; and 2) urging that Officer Webster, who had been on duty the entire time since Anton's death, be placed on leave. While CJAB and the Black family were allowed to speak at the Town meeting, the Council refused to discuss the matter at all, contending that delay in the State's investigation and its continued withholding of the autopsy report tied their hands and precluded them from taking any action

197. As a direct result of CJAB outreach efforts, on January 8, 2019, in what became a pivotal moment for Plaintiffs' effort to call attention to Anton's death, the Washington Post prominently featured a column by Cortland Milloy that garnered enormous public interest around the State. C. Milloy, "*A Young Man Died After Being Stopped by Police. Four Months Later, No One Knows Why,*" Washington Post, Jan. 8, 2019.[6] Notably, the column focused attention on the State of Maryland's responsibility for the mystery and silence surrounding Anton's death:

> So far, there hasn't been a medical examiner's report. At last week's council meeting, Anton's family asked why a report had not been completed in four months. … There have been no public updates or briefings on the investigation being conducted by the state police nor provided to family members by the Caroline County state's attorney.

198. On January 8, 2019, the same day the Post column appeared, CJAB organized a standing-room-only community meeting in Chestertown aimed at increasing pressure on the State to release the autopsy report and body camera footage.

199. CJAB's public advocacy campaign continued on January 11, 2019, with a CJAB representative appearing on the Eastern Shore Radio Station Power 101.7, again promoting the message that officials were stonewalling the Black family and covering up critical information about Anton's death. As with other media appearances, CJAB promoted and linked to this interview on its Facebook page, to spread the message as broadly as possible.

---

[6] Available at: https://www.washingtonpost.com/local/a-young-man-died-after-being-stopped-by-police-four-months-later-no-one-knows-why/2019/01/08/514f3b92-1370-11e9-90a8-136fa44b80ba_story.html?utm_term=.b47fe9dea20c

200. During this same period, CJAB called for immediate release of the autopsy, body camera footage, and State investigation into Anton's death. For example, CJAB posted a link to the alert on its social media accounts, explaining that the situation was urgent and imploring people to take action:

> We need everyone to please stop what they're doing at this very moment and go vote please for the body camera footage that was worn the night of Anton Black's death to be released. Anton was 19 years old when he died unexpectedly in police custody and police and medical examiners are "unsure" of how he died. It's been over 4 months since his death and there is still no toxicology report, this killing of this young man was injustice and we need your support to go to the link below and help us get the body camera footage released to the public.
> #JusticeForAntonBlack 💔👶🏽 #SHARE #REPOST

201. In response to the significant publicity the Black family and CJAB had generated through their advocacy, a reporter for the Baltimore Sun called in to ask Governor Larry Hogan about his views on the controversy during a radio appearance. Hogan responded that he had heard about the matter and expressed concern about the State's nonresponsiveness to the Black family. The following day, on January 22, 2019, the Sun reported on these comments in a news article.[7]

202. Governor Hogan's office followed up his radio comment and the Sun report through issuance of a written statement made available more broadly to the media:

> As the Governor has said, he believes that the family, the community and all citizens deserve the highest degree of transparency possible, and continues to call for all information to be released swiftly and responsibly.

203. Only then, after months of effort by the Black family, extensive media attention garnered through CJAB advocacy, prompting this extraordinary personal intervention by the Governor, were the autopsy and body camera footage finally released. The body camera footage initially was offered to the media in a controlled viewing at Greensboro Town Hall.

---

[7] L. Broadwater, "Anton Black case: Maryland Governor Larry Hogan wants answers about teen's death in police custody on Eastern Shore," Baltimore Sun, Jan. 22, 2019, available at https://www.baltimoresun.com/news/crime/bs-md-hogan-anton-black-20190121-story.html

204. Discovery has since confirmed that the reason for the four-month delay between Anton's death and the release of the autopsy report was due to almost entirely to the efforts of Defendant Fowler, Defendant Alexander, and their colleagues at OCME to delay release of the report in failed attempts to corroborate the Officers' false story that Anton was high on marijuana laced with another drug. Plaintiffs aver the Medical Examiner declined to release its report based on the September 20, 2018 toxicology report showing an absence of drugs in Anton's system precisely because that report contradicted law enforcement officials' claims that his death was the result of laced drug use.

205. Notwithstanding that the Office of Medical Examiner had determined months earlier that Anton's drug test was negative at the time of his death, following a meeting with Sergeant Kennard on January 11, 2019 (almost four months after Anton's death), Defendant Alexander reported to Defendant Fowler that he did not want to release the autopsy until he received duplicate drug test results. Defendant Alexander requested a second drug screen, and Defendant Fowler later (on January 21, 2019) interceded directly with the testing agency. While they were waiting for the results of the additional drug screen, Defendants Alexander and Fowler were told that an official of the State of Maryland had advised the Office of Medical Examiner that they "didn't want a Freddy [sic] Gray incident on the [Eastern] shore."

206. On the same day Defendant Alexander met with Officer Kennard (January 11), Defendant Alexander recorded in his case activity notes that in a meeting with four other employees of the State of Maryland, it was collectively agreed that the autopsy would conclude that the "MOD [method of death] = A [accident]" and would conclude there was "no clear indication that restraint played a critical role in death. COD [cause of death] will include ♥ dxs [heart defect] . . . +/- synthetic cannab." In other words, even before the results of the second drug

screen were known, Defendant Alexander and his OCME colleagues had concluded that the Officers were not responsible for Anton's death, Anton was.

207. On January 21, Defendants Fowler, Alexander, and other employees of the State of Maryland received a report from the toxicology lab that "there is no indication of a syn cann in the specimen," *i.e.,* this drug test, like the earlier one, was negative.

208. During a phone call the following day (January 22), the testing lab director advised Defendant Fowler that he was "confident the drugs we are concerned about are definitely not there. . . ." Defendant Fowler reported this to Defendant Alexander and other employees of the State of Maryland.

209. On January 23, 2019, after Governor Larry Hogan's personal intervention and the ME's receipt of the second toxicology test confirming the absence of any drugs in Anton's system, Defendants finally released the autopsy report. The four-month delay in the release of the Medical Examiner's autopsy report without intervention by Governor Hogan was inexplicable on grounds other than obstruction, given that the autopsy had been conducted and a primary report issued on September 16, 2018, with the neuropathology report conducted on October 10, 2018, and signed on October 24, 2018, and the cardiology report dated November 1, 2018. Indeed, the State's Attorney for Caroline County acknowledged the fact that the ME's report was not made available until January 23, 2019 was "troubling" and caused the family "a great deal of anguish."

210. The Medical Examiner's report was written to obfuscate the otherwise obvious and inescapable conclusion that the involved police officers caused Anton's death by interfering with his ability to breathe—creating positional asphyxia.

211. Notwithstanding having the results of two toxicology reports that showed that Anton was not high at the time of his death, the autopsy report of investigation stated that Anton's death was an "accident" and falsely contended he "may have recently smoked spice."

212. In other words, despite having two negative toxicology reports and having been advised by the testing lab "the drugs we are concerned about are definitely not there," Defendants Alexander and Fowler knowingly repeated the same false claim that the Officers had concocted on September 15, 2018 in the immediate aftermath of Anton's death and the same false claim that Maryland State Police troopers repeated and used to coach witnesses for months after the incident, all as a part of an effort to blame Anton for his own death. Because if Anton was to blame for his death, that would help avoid a "Freddy Gray incident on the shore."

213. Defendant Alexander and Fowler also provided other demonstrably false information in their autopsy report, to further suggest that the Officers were not responsible for Anton's death, Anton was. For example, in describing the cause of Anton's death, the ME report stated that "[a] **significant** contributing condition was **bipolar disorder**." Bipolar is a psychiatric illness. No reasonable medical professional would opine that bipolar disorder contributed to a person's death.

214. The Medical Examiner also falsely asserted that Anton's heart had failed suddenly and that he died due to "anomalous right coronary artery and myocardial tunneling of the left anterior descending coronary artery" when the medical literature, the physical evidence, and the video of the incident clearly contradict these findings.

215. Although the autopsy report documents **43 blunt force trauma wounds** and acknowledges that "the stress of the struggle contributed to his death," the ME's description of events does not acknowledge the significance of Taser use or other force by police, nor that for

more than six minutes, at least one officer was lying on Anton, interfering with his ability to breathe.

216. The autopsy report unreasonably states that "no evidence was found that restraint by law enforcement directly caused or significantly contributed to the decedent's death; in particular no evidence was found that restraint led to the decedent being asphyxiated."

217. In making these findings, Plaintiffs aver, on information and belief, the Medical Examiner conspired with and relied upon involved law enforcement officers and the false narrative they presented, rather than actual evidence in the case, such as the body camera footage available for the ME independently to review. Specifically, based on the narrative relayed in the Medical Examiner's opinion, Plaintiffs aver that Defendant Alexander did not view or rely upon the best evidence of what happened to Anton, namely the video, relying instead on a timeline prepared by the MSP, interviews conducted by Sergeant Kennard, and facts as characterized by police who falsely claimed Anton was drugged and minimized their tasing and prolonged prone restraint of Anton.

218. The autopsy report ignores that the findings of the petechiae and hemorraghing of Anton's eyes could be indicative of asphyxia. Further, the autopsy report deliberately ignores general, well-established medical knowledge that in many cases there is little or no physical evidence when a person dies of mechanical or positional asphyxia. It is a basic precept of forensic pathology – and common sense – that in addition to physical findings, there must be consideration of the external evidence of the circumstances prior to the death. It was objectively unreasonable for the ME to treat the absence of a major neck injury on Anton's body as a basis for ruling out positional asphyxia as the cause of Anton's death, particularly in light of the known prolonged

prone restraint of Anton in the moments leading up to his death and the well-established risks of positional asphyxia.

219. As every schoolchild learns, breathing is essential for survival and human beings rely on the delivery of oxygen to our brain, heart and other organs to function. Interfering with a person's ability to breathe necessarily puts their survival at risk. It is well-known that when a person's upper body is compressed by pressure – such as the weight of another person – so is their ability to breathe. The ability to breathe can be further compromised when a person is face down with their legs bent back while this pressure is on their body.

220. As noted, the autopsy report states that Anton died of "sudden cardiac death due to anomalous right coronary artery and myocardial tunneling of the left anterior descending coronary artery." However, the medical evidence shows that it is extremely unlikely that an otherwise healthy and athletic 19-year old teenager, with absolutely no history of heart problems, would spontaneously die from this type of heart condition.

221. The correct term for "myocardial tunneling" is myocardial bridging. It is an extremely common physical variation, and studies estimate it is found in at least one third of all autopsies. Myocardial bridging does not impact the flow of blood to the heart muscle and cardiologists generally consider it to be a benign condition. It is objectively unreasonable to claim that myocardial bridging (or tunneling) would cause Anton's sudden death.

222. It would be exceptionally rare for anomalous right coronary artery ("ACA") to spontaneously cause sudden cardiac death and it is impossible for any medical professional to conclude after the fact that ACA caused Anton's death. Based on well-recognized and accepted standards of forensic pathology Dr. Alexander should have simply concluded that ACA was present, not that it caused Anton's death.

223. As a trained forensic pathologist, Defendant Alexander and his colleagues in the OCME knew that it was improper under these facts and circumstances to conclude that Anton "died of sudden cardiac death due to anomalous right coronary artery and myocardial tunneling of the left anterior descending coronary artery." Thus, Anton's cause of death was intentionally misstated.

224. It defies both common sense and basic standards of forensic pathology to suggest that the actions of law enforcement, and particularly their restraint, did not "directly cause" or "significantly contribute" to Anton's death in light of video footage depicting Anton being chased, assaulted with a police baton, tased, taken to the ground, and restrained in a prone position with significant compression of his upper body for approximately six minutes.

225. As such, the *Baltimore Sun* condemned the Defendants' autopsy report and so-called "investigation" as "baffling" and "unbelievable." The *Sun* editorialized that the ME's findings that Anton's death was caused by a latent heart defect but not police use of force and prone restraint:[8]

> lets the police off way too easy. Even without the meticulous cataloging of the 43 cuts, bruises and abrasions on Black's body that his family's attorneys compiled from the autopsy, we can say that had police done their jobs responsibly, he would be alive.

226. Plaintiffs will present experts who will opine that Anton Black died because police employed excessive force, laying him out prone on his stomach, lying on him and forcibly restraining him in a prone position for approximately six minutes **and approximately five minutes after he was handcuffed**, and folding his legs towards the sky in a manner that further compromised his ability to breathe. The pressure and positioning prevented him from being able

[8] See fn. 3.

to breathe, depriving him of the oxygen necessary for his heart to function correctly. It was objectively improper for the OCME to intentionally omit this glaringly obvious consideration.

227. Internal inconsistencies within the OCME's report further call its conclusions into doubt. For example, even though the OCME referenced a heart condition as the cause of death, which would suggest the appropriate category as "natural causes," the OCME categorized Anton's death as an "accident." In fact, Plaintiffs experts will testify that Anton's death was a homicide—a death caused at the hands of another. But for the use of force by police in pursuing and restraining him, Anton would be alive.

228. As a direct result of the OCME's improper and false characterization of the cause of death, the State's Attorney for Caroline County determined that there was no basis for any criminal prosecution of the officers responsible for Anton's death.

229. The day after the release of the autopsy report, in response to questions from the Caroline County State's Attorney about the toxicology report drug test, Defendant Alexander misrepresented that the sample was "unfit for testing," without disclosing (i) the negative September 20 toxicology report, or (ii) the lab that conducted the test had advised that the "drugs we were concerned about are definitely not there." Dr. Alexander also told the Caroline County State's Attorney that Anton's cardiac conditions were "things that [Anton] was born with and "congenital" without advising that these common conditions could not have caused Anton's death.

230. In a January 24, 2019 press release recounting the factors considered in declining to prosecute, as well as declining to bring the case to a grand jury as the Family Plaintiffs and CJAB requested, State's Attorney Joseph Riley expressly and repeatedly relied on the false, erroneous and misleading assertions made in the OCME report, particularly that "Anton Black's cause of death was a Sudden Cardiac Death resulting from a congenital heart defect"; "no evidence

was found that restraint by law enforcement directly caused or significantly contributed" to Anton's death; that Anton's "mental health status" was a contributing factor in his death; and that the OCME "found that the force used was not a direct cause or a significant contributor to Anton Black's death" in declaring "the cause of death was determined to be accidental."[9]

231. Further, the OCME's improper and false characterization of the cause of death, burdened and continues to burden Plaintiffs' ability to mount a civil action because of the cost to retain multiple experts, and forcing Plaintiffs to continue expending significant resources on multiple experts to disprove the Medical Examiner's misrepresentations in order to gain access to legal redress.

232. Following release of the autopsy report, CJAB and the Black family continued to speak out against the unfair cover up the medical examiners had engaged in, but felt stymied by the wall against accountability police, prosecutors and the medical examiners had collectively erected against them, unable to discern what they could do to overcome it.

233. Despite public pressure and media inquiries about obvious flaws in the death investigation, Defendants Fowler and Alexander refused to rescind the autopsy report and made repeated affirmative misrepresentations about their analysis. For example, Defendants Fowler and/or Alexander told other State of Maryland officials, knowing that those officials would relay the information to the news media the following in response to media inquiries:

- In response to a question about the statement that "no evidence was found that restraint led to the decedent being asphyxiated," Fowler responded there were "no signs of asphyxia" and "no signs of any of the causes of asphyxia." This was false: there were petechiae and hemorrhages around Anton's eyes, both of which are indicia of asphyxia. And it was further false because an obvious "cause of asphyxia" was the Officers keeping Anton face down in a prone restraint position for almost six minutes with the weight of the Officers on him.

[9] https://www.baltimoresun.com/news/bs-md-states-attorney-joseph-riley-news-release-0125-pdf-20190124-htmlstory.html.

- In response to a question about whether the "petechiae and hemorrhages of the eyes" being indicia of asphyxia, Fowler responded that these could be indicia of "drug cases." Fowler wrote this knowing that that the toxicology drug tests had come back negative.

- In response to a question about the consistency of statements in the report that there were "multiple abrasions and purple contusions . . . on the adjacent posterolateral neck" and the statement "there was no neck hemorrhage," Fowler minimized the significance of the neck injury, writing Anton "has some minor abrasions and small bruises." He did not address that the neck injuries could be another sign of asphyxia.

- In response to a question whether "the stress of a person lying across [Anton's]" could have contributed to his death, Alexander responded "the restraint by law enforcement neither caused nor significantly contributed to the death . . . no evidence was found that suffocation, strangulation or mechanical asphyxia caused or significantly contributed to the death." Alexander, like Fowler, ignored the evidence of asphyxia.

- In response to a question "how does a History of Bipolar Disorder lead to a death," Fowler wrote "it is a diagnosis that may lead to a person believing in an unusual way." Fowler wrote this knowing that there were intervening events -- namely the Officers keeping Anton face down in a prone restraint position for almost six minutes.

- In response to a media inquiry about the significant delay in the release of the autopsy report, Dr. Fowler stated that the delay was due to the timing of the cardiopathology and neuropathology reports, writing that the cardio pathology "normal turn around is 3 months" and "neruopath we buy 1 day a week … this is not clinical medicine where real time answers are needed . . . Accuracy and quality is what we do." This was false: the neuropathology report was completed on October 10, 2018, and signed on October 24, 2018, and the cardiology report dated November 1, 2018. Yet Defendants Fowler and Alexander delayed releasing the autopsy report for two additional months while they attempted to corroborate the Officers' allegations of Anton's drug use.

- In response to a media inquiry about the inclusion of "facts from the police report in the [medical examiner report], Fowler wrote this was "Totally normal practice standard." Yet, the Attorney General's audit team report emphasizes that the "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 response to a question "why was the role of the civilian omitted from Dr. Fowler's report . . . in the video, it can be clearly seen that the civilian was also

> restraining Mr. Black," Alexander responded "the critical issue is that law enforcement was involved in the restraint."

234. All of these statements by Defendants Fowler, Alexander, and other agents of the State of Maryland were in furtherance of their objectives to keep the Officers from being held accountable for Anton's death, and to avoid a "Freddy [sic] Gray incident on the [Eastern] shore."

235. As CJAB Vice President LaToya Holley later reflected in the aftermath of the 2021 decision by the Maryland Attorney General to investigate OCME's misconduct in custodial deaths: "We have been trying to get someone to listen, someone to care. We weren't taken seriously, and all other families weren't taken seriously as well."

236. Notwithstanding the obstacles Defendant's erected in their path, CJAB and the Black family persisted in their advocacy. For example, in February of 2019, they worked with a Baltimore television station to air their concerns about the medical examiners' collaboration in covering up for police in Anton's death and the deaths of other victims in police custody, in a news piece "Police-Involved Deaths: A Family's Fight for Change" that the station advertised on a giant billboard with Anton's picture overlooking the Jones Falls Expressway through Baltimore City.

237. On September 15, 2019, the first anniversary of Anton's death, CJAB and the family organized a vigil, where attendees, including CJAB's Richard Potter and LaToya Holley spoke out about the false findings in the State's autopsy and its prevention of police accountability for Anton's killing, and the role of the State in preventing police accountability in other deaths in police custody.

238. Similarly, Ms. Holley worked with the Real News Network in the immediate aftermath of George Floyd's killing by Minnesota police on a June 2020 episode of the Police Accountability Report entitled "The I Can't Breathe Video Police Don't Want You to See," again

exposing the failure of the Maryland Medical Examiner to properly attribute Anton's killing to police actions.[10]

239. As reflected in these reports, the State's complicity in covering up the true causes of Anton's death has itself caused great anguish to the Family Plaintiffs, and burdened the advocacy efforts of CJAB. Through delays and denials in access to records, false assertions by law enforcement officials that Anton's death was drug-related, the ME's false report of the cause of death and the State's Attorney's reliance on that report to reject Plaintiffs' request to convene a grand jury to look into the matter, and the overall failure to act except under extraordinary pressure, the government shirked all responsibility for investigating and prosecuting the officers involved in Anton's death, leaving it to Plaintiffs to do the government's job. Indeed, in his press release, State's Attorney Joseph Riley even noted that if the Family Plaintiffs were able to uncover proof of police wrongdoing through their own private efforts, he might possibly reconsider his refusal to convene a grand jury.

The Defendants' Pattern and Practice of Covering Up Police Custody Homicides

240. As detailed herein, the State of Maryland Office of Medical Examiner, under the leadership of Defendant Fowler, had a long and disgraceful history of falsely concluding that law enforcement actors did not cause the deaths of people in their custody, particularly in the deaths of Black and disabled persons. Anton's death is only one example of how Defendant Fowler and his subordinates helped minimize police responsibility for such deaths.

241. The history of Defendant Fowler's tenure at the Office of Medical Examiner has only recently begun to come to light following his role as the only medical expert to testify on behalf of the defense of Officer Derek Chauvin, the officer who murdered George Floyd.

[10] Available at: https://therealnews.com/the-i-cant-breathe-video-police-dont-want-you-to-see

Defendant Fowler's testimony in that case (contending that the cause of Mr. Floyd's death was "undetermined" and citing clearly insubstantial contributing factors such as drug use and car exhaust) was so outrageous and caused such an uproar in the medical community that the State of Maryland agreed to conduct a review of the Office of Medical Examiner's practices in death in custody cases during Defendant Fowler's two-decade tenure as Chief Medical Examiner.

242. In October 2022, the team responsible for conducting the review released an interim report stating that based on its review of records, there was a need for an exhaustive reexamination of about 100 cases where, as in Anton's case, the decedent was physically restrained and there was no obvious cause of death such as a gunshot wound. The contents of that report also suggested that the Office of Medical Examiner under Defendant Fowler's tenure, had systemic issues with its methods of review in restraint cases, including failing to properly apply standards approved by the National Academy of Medical Examiners (NAME), including the "but-for" principle.

243. NAME is the primary professional association for medical examiners. The publications of NAME clearly establish that in death investigations, medical examiners should consider the "but-for" principle: "But-for the injury (or hostile environment), would the person have died when he/she did?" Equally important, NAME provides that "[i]n general, when a 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*."[11]

244. Moreover, "[r]egardless 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

[11] NAME, A Guide for Manner of Death Classification at 6 (Feb. 2002), https://name.memberclicks.net/assets/docs/4bd6187f-d329-4948-84dd-3d6fe6b48f4d.pdf

remains: the manner of death is unnatural when injury hastened the death of one already vulnerable to significant or even life-threatening disease." [12]

245. In addition, NAME publications repeatedly encourage medical examiners to categorize deaths at the hands of others based on volitional actions as "homicides": "In general, if a person's death results at the 'hands of another' who committed a harmful volitional act directed at the victim, the death may be considered a homicide from the death investigation standpoint."[13] NAME's longstanding guide to death investigations also explicitly addresses classifications of deaths following police uses of restraint: "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 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."[14]

246. Defendant Fowler ought to have been familiar with NAME standards. He was the President of NAME in 2015 and Chairman of the Board in 2016. In 2001, he was a member of NAME's Network of Death Investigation Affairs. He's been a Fellow with NAME since 1997. He's held several other positions with NAME (and still holds committee positions) and is currently a board member.

247. In 2017, NAME adopted a position paper laying out recommended practices for, among other things, investigations of deaths occurring in police encounters. In that paper, NAME again explicitly reiterated that medical examiners should "consider homicide as the manner of

---

[12] *Id.* at 7.

[13] *Id.* at 8.

[14] *Id.* at 11.

death in cases similar to those that would otherwise meet the threshold of 'death at the hands of another.'"[15]

248. The Office of Medical Examiner's disregard for well-established principles of forensic pathology in police deaths-in-custody cases, is not unique to Anton's case. Rather, it is part of a broader pattern of relying on police narratives (which Dr. Fowler wrote was OCME's "normal practice standard") of events *even when police are directly involved,* and of allowing medical examiners to be unduly influenced by their close working relationship with law enforcement officials and their desire to absolve official actors of any claim of wrongdoing.

249. The OCME, guided by policies set by Fowler as Chief, repeatedly disregarded or misrepresented obvious fact evidence, medical evidence and NAME principles, burying the truth about such deaths in misleading statements and conclusions cloaked in medical terminology and purported uncertainty.

250. There exist numerous examples of this pattern and practice of Defendants' covering up police responsibility for deaths in their custody.

251. On November 18, 2007, police accosted Jarrel Gray, a 20-year-old Black man who was deaf in one ear, tasing him multiple times, and causing him to fall to the ground and become unresponsive. The OCME concluded that the manner of death was undetermined, and the cause of death was "sudden death associated with restraint and alcohol intoxication," as well as "natural anatomic deviations." The report did not identify the Taser as a cause of or even contributing factor in Mr. Gray's death.

[15] NAME, National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody (2017), https://name.memberclicks.net/assets/docs/2e14b3c6-6a0d-4bd3-bec9-fc6238672cba.pdf

252. On October 14, 2010, Mr. Kareem Ali, a 65-year-old Black man, was subjected to police strikes with a baton, pepper spray, Taser and restraint. The OCME claimed his cause of death was "undetermined," citing, among other things, his diagnosis of schizophrenia, slightly enlarged heart, and obesity.

253. On April 19, 2013, Anthony Howard, a Black man, was Tased nine times by police for 37 seconds, including after he had fallen to the ground. Police falsely claimed that he had thrown "boulders" at them, but video later proved this to be false. The Medical Examiner concluded that the cause of death was "undetermined." The manner of death, according to the OCME, was "Delirium Associated With Cocaine Use During Police Restraint."

254. On December 5, 2013, the OCME completed an autopsy report for Tyrone West, a 44-year-old Black man who died during a traffic stop after multiple police officers maced him, struck him repeatedly with a baton, and restrained him in a prone position, limiting his ability to breathe for an extended period of time. Despite NAME's guidance for medical examiners to use the "but for" principle in death investigations, and to classify death at the hands of another as homicide, the Medical Examiner falsely claimed that due to possible dehydration, warm temperatures and minor cardiac abnormalities, the cause of Mr. West's death could not be determined. As a result of the OCME's actions, Mr. West's family was forced to secure an independent forensic investigation. The forensic pathologist opined that the main cause of death was positional asphyxia—Mr. West's inability to breathe while being restrained by police.

255. Similarly, the OCME again disregarded well-established principles of forensic pathology when Defendant Alexander performed an autopsy on Tawon Boyd, a 21-year-old Black man who died during a police encounter in which one officer punched him in the face twice and three officers held him prone on the ground for five minutes; medics also administered Haldol.

Ignoring NAME's "but for" principle and its guidance that death at the hands of another should be classified as a homicide, the Medical Examiner ruled Mr. Boyd's death an accident caused by drugs. As a result, the family of Mr. Boyd was forced to secure an independent forensic investigation. The forensic pathologist opined that Mr. Boyd's death was a homicide resulting from positional asphyxia.

256. Anton's death investigation by Defendants followed this same unlawful and discriminatory pattern.

257. As the Attorney General's team reviewing OCME practices noted in its October 2022 report:

- "The importance of medicolegal death investigation, including the postmortem examination of a decedent, is broadly recognized as a critical face 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 prevent 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 and 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."

- "[T]he 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). . . . 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."

- "[S]ystemic problems in medicolegal death investigation not only undermine the justice system, they also result in missed opportunities to identify preventable deaths. Inappropriately labelling . . . homicide for a natural death, may result in a miscarriage of justice whereby . . . 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."

258. In every case, whether or not the Medical Examiner personally believed police acted *improperly*, the Medical Examiner's responsibility was to opine based on reasonable medical and professional standards as to what caused the person's death, not to cover up for the officers' actions. The OCME has failed to do so. But for the volitional actions of the Officers, Anton would be alive, but upon information and belief and consistent with its practice in other cases Defendants knowingly and intentionally misrepresented his death as, alternately, one of "natural" causes or "accident." This intent, which exhibits wanton or grossly reckless behavior, was demonstrated, among other things, in part by the Medical Examiner's assurance to the Maryland State Police that Anton's neck "looked good," and by stating in the autopsy report that Anton "may have recently smoked spice" when they had two toxicology reports that showed that Anton was not high at the time of his death, falsely claiming there was no evidence of asphyxia, falsely claiming that bipolar disorder contributed to Anton's death, making false representations about the significance of Anton's myocardial bridging; misrepresenting and exaggerating the role of anomalous right coronary artery, etc. By ignoring overwhelming and irrefutable evidence of Anton's prolonged restraint by police as captured on body camera footage; failing to acknowledge the basic principle that compressing a person's body interferes with their ability to breathe; failing to acknowledge that positioning a person face down with their legs bent back further interferes with their ability to breathe; making misleading statements suggesting that asphyxia due to restraint must be ruled out due to the absence of a major neck injury; making false representations about the significance of Anton's myocardial bridging; misrepresenting and exaggerating the role of anomalous right

coronary artery; claiming that bipolar disorder contributed to Anton's death; and departing from well-established customs in the field that deaths at the hands of another should be characterized as homicide, the OCME sought to and did intentionally mask the true cause and police culpability for Anton's death.

259. Anton's case is part of a pattern and practice of the Office of Medical Examiner, during Defendant Fowler's tenure, of covering up policy custody homicides, even disregarding recommendations from other governmental officials, and disparately finding cases were not homicides when the Decedent was Black and/or disabled.

260. Additionally, there exist longstanding problems with OCME's handling of death investigations involving Taser use. In 2009, the Maryland Attorney General released a study and report of a Task Force on Electronic Weapons, along with comprehensive recommendations to learn from and limit future deaths. That study specifically identified concerns that the OCME, under Defendant Fowler, engaged in questionable practices concerning deaths in custody involving electronic weapons (*e.g.,* Tasers), noting repeated omissions of these weapons as a causal factor in deaths, recommending that "*When a death occurs in temporal proximity to an ECW discharge, the State Medical Examiner should specifically indicate whether the use of the ECW may have or did contribute to the death. 'Excited delirium' should not be cited as the cause of death where there is a known direct cause. The Medical Examiner should explain in the autopsy and death certification the cluster of symptoms that led to the findings of 'excited delirium*.'"[16] It is apparent that the OCME and Defendant Fowler disregarded this vital recommendation.

261. Based on data made available in conjunction with the ongoing medical review being conducted by the Attorney General's panel of experts, the OCME almost never concluded

[16] Report of the Maryland Attorney General's Task Force on Electronic Weapons (Dec. 2009) at 5, available at: https://www.aclu-md.org/sites/default/files/field_documents/atty_gen_electronic_weapons_0.pdf

that deaths in police custody are homicides absent a gunshot wound. While the Attorney General's review team has not identified the 100 cases where it has recommended exhaustive reexamination, based on contemporaneous news stories and the medical examiner's press releases, Plaintiffs have identified 57 cases where the decedent was in police custody and did not die of a gunshot wound or injuries from a police pursuit. Of these 57 cases, the OCME concluded the death was not a homicide 88 percent of the time, even when the decedent had been Tased, pepper sprayed, subject to police baton strikes, prone restraint, or other uses of force.

262. These cases also show a significant racial disparity, with OCME examiners far more likely to conclude a death in state custody was a homicide when the decedent was white (21% of the time), than Black (8% of the time).

263. One such medical examiner whose data reflects major racial disparities is Defendant Alexander.

264. According to the data released in conjunction with the ongoing review, during the time that Defendant Fowler served as Chief Medical Examiner (2002-2019), Defendant Alexander conducted 68 death investigations of individuals in state custody. Thirty-four of these investigations involved a death where the cause of death was not obvious (such as a gunshot or a suicide). These included findings where the cause of death was asphyxia, cardiovascular conditions, drug use, and other injuries. In the 11 cases Dr. Alexander investigated where the decedent was white, he concluded that six were homicides.

CaseNum	Name Last	Name Fir	Race	Death Date	County Of Death	Manner	COD
09-04586	Trail	Howard	White	6/9/2009 9:54	Washington	Natural	Hypertensive Atherosclerotic Cardiovascular Disease
12-07631	Jones	Nathan	White	10/8/2012 18:26	Montgomery	Homicide	Asphyxia
13-09243	Allen	Brian	White	11/9/2013 4:40	Prince George's	Homicide	Complications of traumatic asphyxia
14-02844	Shackleford	David	White	3/25/2014 23:22	Baltimore City	Natural	Atherosclerotic Cardiovascular Disease
16-08892	O'Sullivan	John	White	8/14/2016 11:05	Anne Arundel	Homicide	Multiple Sharp Force Injuries
17-05036	Schaedel	Robert	White	5/3/2017 13:42	Anne Arundel	Natural	Hypertensive Atherosclerotic Cardiovascular Disease
18-03833	Lee	Raymond	White	3/25/2018 10:30	Montgomery	Homicide	Complications of Cardiac Arrest,Restraint, Blunt Force Trauma and Dilated Cardiomyopathy
18-05919	Gawronski	William	White	5/11/2018 15:04	Baltimore City	Accident	Mixed Drug (Heroin, Fentanyl and Cocaine) Intoxication
18-07084	Robey	Robert	White	6/8/2018 19:18	Frederick	Natural	Complications of Asthma
18-13015	Stephenson	David	White	11/2/2018 4:01	Anne Arundel	Homicide	Multiple Injuries
19-03656	Moyer	Wilbur	White	3/24/2019 2:36	Allegany	Homicide	Multiple Injuries

265. Of the 23 cases Dr. Alexander investigated where the decedent was Black, he concluded that ***none*** were homicides.

Case Number	Name Last	Name First	Race	Death Date	County Of Death	Manner	COD
09-00809	Thomas	Larry	African American	1/27/2009 16:17	Howard	Natural	Verapamil Toxicity due to Decreased Liver Function in the Setting of Cirrhosis
09-06107	Snipe	Dion	African American	8/5/2009 7:00	Baltimore City	Accident	Complications of Choking
10-03968	Oladeinde	Folahan	African American	5/24/2010 12:48	Montgomery	Undetermined	Cocaine Intoxication
10-04468	Evans	Walter	African American	6/12/2010 19:29	Anne Arundel	Natural	Hypertensive Atherosclerotic Cardiovascular Disease
10-05182	Reese	Kenneth	African American	7/10/2010 20:36	Allegany	Natural	Pericardial Hemorrhage with Tamponade (Non-Traumatic)
12-07830	Wilson	Rashem	African American	10/15/2012 19:28	Prince George's	Natural	Sickle Cell Disease
12-08279	Crawford	Lawrence	African American	11/2/2012 5:44	Wicomico	Natural	Asthma
12-09189	Winward	Wesley	African American	12/3/2012 0:55	Anne Arundel	Natural	Hypertensive Atherosclerotic Cardiovascular Disease
13-01330	McCrimmon	Curtis	African American	2/11/2013 15:25	Prince George's	Natural	Acute Bronchopneumonia and Sepsis
13-07013	Mosley	Albert	African American	8/23/2013 14:32	Baltimore County	Undetermined	Complications of Cervical Spinal Cord Injury with Quadriplegia
14-02438	Adams	Ronnie	African American	3/12/2014 16:13	Baltimore City	Natural	Hypertensive Cardiovascular Disease
14-03787	Booth	John	African American	4/27/2014 4:32	Allegany	Natural	Hypertensive Atherosclerotic Cardiovascular Disease
14-05029	Butler	Larry	African American	6/9/2014 8:40	Allegany	Natural	Ruptured Abdominal Aortic Aneurysm
16-08614	Weston	Jerry	African American	8/7/2016 3:44	Worcester	Accident	Cocaine Intoxication
16-10397	Boyd	Tawon	African American	9/21/2016 11:15	Baltimore County	Accident	Complications of N-Ethylpentylone Intoxication
16-13283	Mitchell	Bernice	African American	12/4/2016 12:36	Baltimore City	Accident	Morphine and Despropionyl Fentanyl Intoxication
17-07112	Henry	Robert	African American	6/25/2017 1:21	Allegany	Natural	Acute Cerebellar Hemorrhage,Hypertensive Atherosclerotic Cardiovascular Disease
17-12273	Carr	William	African American	10/28/2017 0:59	Baltimore City	Accident	Multiple Blunt Force Injuries
18-01547	Cooper	Devin	African American	2/1/2018 20:05	Anne Arundel	Accident	Fentanyl Intoxication
18-09450	Solomon	Rodney	African American	8/4/2018 18:58	Allegany	Natural	Metastatic Renal Cell Carcinoma with Complications
18-11079	Black	Anton	African American	9/15/2018 20:36	Talbot	Accident	Sudden Cardiac Death,Anomalous Right Coronary Artery and Myocardial Tunneling of
18-11652	Wilson	Mukengi	African American	9/30/2018 21:46	Baltimore City	Accident	Fentanyl Intoxication
18-14584	Mobley	Ricky	African American	12/9/2018 8:53	Allegany	Natural	Post-Inflammatory Mitral Valve Disease

266. This includes Anton's case, as well as Tawon Boyd's case, discussed above.

Plaintiffs' Advocacy Seeking Reform of State Practices to Promote Police Accountability Actively Continued Following Their Filing of this Lawsuit.

267. In addition to the enormous organizational resources devoted to pursuit of this lawsuit, since its filing CJAB and the Black Family have engaged in numerous additional efforts and expended Coalition resources demanding reform of State practices and policies aimed at cover

up of police responsibility and prevention of police accountability for deaths in custody. There are too many such efforts to list them all here, but such actions include, among numerous others:

January 2020 – April, 2021, CJAB advocacy to enact "Anton's Law," state legislation aimed at increasing transparency and accountability in cases of police abuse;

February 17, 2021 – *The Protest . . . Now What?* African American History Month Panel Discussion at Salisbury University and available virtually, organized by CJAB, featuring Richard Potter and LaToya Holley among other speakers, and focusing on Anton's Law and reform of practices at OCME;

February 20, 2021 – *Thinking Freely: Coverup, Police Killing and the Medical Examiner: Anton Black should still be alive today* – CJAB Podcast Appearance (Richard Potter) focusing attention of the role of the Medical Examiners' Office in preventing accountability for police killings, available at: https://podcasts.apple.com/us/podcast/coverup-police-killing-and-the-medical-examiner/id1473066516?i=1000509971924

April 16, 2021 – *Democracy Now: Medical Examiner Accused of Covering Up Police Killing in Maryland Becomes Witness for Derek Chauvin* -- CJAB Appearances (Richard Potter and LaToya Holley) parallels between David Fowler misconduct in cases of police killings of George Floyd and Anton Black, available at https://www.democracynow.org/2021/4/16/anton_black_david_fowler_lawsuit

April 27, 2021 – *Baltimore Sun: 3 Maryland families for years criticized David Fowler's rulings as medical examiner. Then came Derek Chauvin's trial*. Interview with LaToya Holley, available at: https://www.baltimoresun.com/maryland/baltimore-city/bs-pr-md-ci-fowler-medical-examiner-folo-20210427-qdd4g42ytzh7zj5bbnhvbi56ge-story.html

April 30, 2021 – *Thinking Freely: The Derek Chauvin Verdict, Anton Black, and Protecting Black Lives* – CJAB Podcast Appearance (LaToya Holley) calling for investigation and reform of Maryland Medical Examiner's Office, available at: https://podcasts.apple.com/us/podcast/the-derek-chauvin-verdict-anton-black-and/id1473066516?i=1000519502009

September 30, 2021 – *Anton Black Day of Remembrance Press Conference* organized by CJAB to celebrate implementation of "Anton's Law" opening police disciplinary records to public scrutiny under the Maryland Public Information Act.

August 8, 2022 – *DATELINE NBC: What Happened to Anton Black?* (Interview with CJAB's LaToya Holley and other family members about Anton's killing by police, as well as with Dr. Roger Mitchell, discussing issues with the Maryland Medical Examiners' Office, available at: https://www.nbcnews.com/dateline/watch-dateline-episode-what-happened-anton-black-now-n1297781.

September 4, 2022 – *MEET THE PRESS: Policing in America* through a deep dive in the death of Anton Black – developed with the collaboration of CJAB and the Black family and Dr. Roger Mitchell, exposing issues concerning problems in the Maryland Medical Examiners' Office.

CAUSES OF ACTION

COUNT 1

Violation of the Fourteenth Amendment Equal Protection Guarantee and Art. 24 Decl. Rts. (All Plaintiffs v. John D. Stash, David Fowler, and Russell Alexander)

268. Plaintiffs incorporate and reallege the foregoing paragraphs as if fully set forth herein.

269. At all relevant times, Defendants Stash, Fowler and Alexander were acting under the color of state law.

270. Defendants Fowler, and Alexander have, under color of law, implemented an unconstitutional system of intentional race discrimination in investigating police custody deaths in the State of Maryland that has caused grave injury to Black community members, including Anton Black, his family, CJAB and its members.

271. By engaging in a longstanding pattern and practice of conducting police custody death investigations in a discriminatory manner where the death of white decedents are considered homicides and while the death of Black decedents are not, by wantonly and recklessly disregarding national standards for conducting death investigations, and by falsely claiming law enforcement conduct was not the cause of death in the death investigations of Black decedents, including Anton Black, Defendants engaged in deliberate, knowing and intentional race discrimination, in violation of the Equal Protection Clause, 42 U.S.C. §1983, and Art. 24 of the Maryland Declaration of Rights.

272. Race is a motivating factor in how the State of Maryland has conducted its custodial death investigations. With regard to Anton Black, Defendants Fowler and Alexander engaged in

a racially discriminatory death investigation. This discriminatory conduct included: delaying the release of Anton's autopsy report, knowingly falsifying his autopsy report to state that Anton "may have recently smoked spice," falsely claiming there was no evidence of asphyxia, falsely claiming that bipolar disorder contributed to Anton's death, disregarding the effect of Taser use in Anton's death, misrepresenting the significance of Anton's myocardial bridging; misrepresenting and exaggerating the role of anomalous right coronary artery, failing to acknowledge the basic principle that compressing a person's body interferes with their ability to breathe, failing to acknowledge that positioning a person face down with their legs bent back further interferes with their ability to breathe, and departing from well-established customs in the field that deaths at the hands of another should be characterized as homicide, the OCME sought to and did intentionally mask the true cause and police culpability for Anton's death. These actions are all consistent with the longstanding pattern and practice of the OCME concluding that police custody deaths of Black people are not homicides. In so doing, Defendants violated Plaintiffs' rights to equal protection under the law, in violation of the Fourteenth Amendment to the U.S. Constitution, 42 U.S.C. §1983, and Art. 24 of the Maryland Declaration of Rights.

273. The importance of nondiscriminatory medicolegal death investigations, including the postmortem examination of a decedent, is broadly recognized as a critical face of a just, fair, and safe society. Families of decedents have a right to know why and how a loved one died. This knowledge is valuable in itself, may prevent 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 and unexpected. Moreover, the family of the deceased must have confidence in the death investigation process,

particularly when the actions of law enforcement officers or other agents of the State may have contributed to the death.

274. Nondiscriminatory medicolegal death investigations, including the postmortem examination of a decedent, are also important to the community, including members of the Coalition. The systemic problems in OCME's medicolegal death investigations have undermined public confidence in the justice system, have allowed guilty police officers to escapes justice, have delayed the ability of public officials to recognize an epidemic of police violence against Black civilians in the State of Maryland, and have resulted in missed opportunities to identify preventable deaths, including Anton's.

275. As proximate and foreseeable results of the Defendants' collective actions, Plaintiffs, including Anton Black's family and CJAB members, have suffered, are suffering, and will continue to suffer injuries, including but not limited to violation of their constitutional rights, loss of equal protection of the law, loss of life, liberty, extreme emotional distress, anxiety, stigma, and outrage.

COUNT 2

Violation of First and Fourteenth Amendments and Arts. 19, 24 and 40, Md. Decl. Rts.
Right to Access to the Courts and Legal Redress
All Plaintiffs v. Defendants Russell Alexander, David Fowler, and John D. Stash)

276. Plaintiffs incorporate and reallege the foregoing paragraphs as if fully set forth herein.

277. Plaintiffs aver, on information and belief, that Defendants Russell Alexander, David Fowler, and John D. Stash, while acting under color of state law and as final decision makers for the Office of the Medical Examiner of the State of Maryland, through intentional, wanton, or grossly negligent conduct, covered up and obscured police responsibility for Anton Black's death,

by intentionally withholding toxicology results contradicting police claims that Anton had been using laced drugs and falsely attributing the cause of death to a heart condition, bipolar disorder and/or other natural causes, thereby "blaming the victim" for his own death and obscuring official responsibility, resulting in significant impairment and denial of Plaintiffs rights to seek legal redress for their harms under the First and Fourteenth Amendments to the Constitution of the United States and Arts. 19, 24 and 40 of the Maryland Declaration of Rights.

278. Specifically, Plaintiffs aver, on information and belief, that in the months following Anton's death, the false police narrative of a suspected criminal, high on laced drugs, exhibiting "superhuman" strength grew stronger and stronger in the media. Despite having toxicology results contradicting this narrative and calling into question the credibility of the police officers involved, Defendants Alexander and Fowler, through intentional, wanton, or grossly negligent conduct, aided police in promoting this false narrative by intentionally withholding these results and reasserting the false claims regarding "spice" in the autopsy narrative, consistent with the ME's broader practice of obfuscating police responsibility in investigations of death during police encounters. In reaching the false conclusion attributing Anton's death to natural causes or accident rather than homicide, Defendants Alexander and Fowler through intentional, wanton, or grossly negligent conduct, violated well-established principles of forensic pathology requiring them a) to rely upon the best available evidence of what happened as captured on body camera footage, showing Anton's prolonged restraint by multiple officers, rather than misleading police narratives; b) to acknowledge that compression of the upper body compromises a person's ability to breathe; c) to understand that holding a person facedown with their legs bent back further compromises their ability to breathe; d) to accept that a major neck injury is not necessary for a finding of positional asphyxia; e) to acknowledge that myocardial bridging by itself would not cause death

in an otherwise healthy 19-year-old and that anomalous right coronary artery would be extremely unlikely to cause sudden cardiac death; f) to understand and acknowledge that bipolar disorder does not cause death; and g) to accept that deaths resulting from the volitional acts of others are properly characterized as homicides. By intentionally promoting the false police narrative of Anton's death and disregarding these basic principles, Defendants Alexander and Fowler, through intentional, wanton, or grossly negligent conduct, concealed police responsibility in causing Anton Black's painful death, and instead falsely ruled, on behalf of the State of Maryland, that a Black teenager who died through asphyxiation at the hands of four white men resulted from "natural causes," or "accident" thereby improperly insulating police officials from responsibility for Anton's death.

279. As direct and proximate results of Defendants' practice of obscuring police responsibility in investigations of deaths during police encounters, resulting in the false reporting of Anton's death as an accident attributable to natural causes rather than homicide, Defendants Alexander, Fowler and Stash, through intentional, wanton, or grossly negligent conduct, created enormous, state-imposed obstacles to Plaintiffs' ability to seek legal redress for the harms they suffered as a result of Anton's killing and to hold police accountable for his death.

280. First, as a direct and proximate result of Defendant Alexander's false ruling as to Anton's cause of death, the OCME burdened the Plaintiffs' filing of suit and ensured that the only way Plaintiffs could mount and litigate a civil action seeking monetary compensation and equitable relief for their grievous losses was to engage medical and police experts to dispute Defendants' erroneous ruling, creating an unconstitutional financial tax on Plaintiffs' right to access to the courts, which if allowed to stand by Defendant Stash, would reinforce a two-tiered system of justice for victims of police killings. Indeed, the Plaintiffs were burdened in filing this civil action

because of the expense of retaining multiple experts. Though the Plaintiffs have initiated suit, the OCME's intentional erroneous ruling conditions the Plaintiffs' ability to meaningfully access the courts on their ability to continue paying the high cost of multiple experts throughout the life of the case.

281. Second, the Medical Examiner's false finding as to cause of death and its accompanying vindication of the police officers who killed Anton directly thwarted the family's and CJAB's ability to hold police officials accountable through governmental disciplinary and criminal processes. All governmental agencies involved in investigating Anton's death relied upon the OCME's Autopsy findings as a basis to reject Plaintiffs' pleas to discipline and prosecute the individual Defendants for their roles in Anton's killing, including the refusal by the Towns of Greensboro, Ridgely and Centreville to investigate or discipline Officers Webster, Manos and Lannon, and the refusal by the State's Attorney for Caroline County even to convene a grand jury to consider the matter. Rather, Caroline County State's Attorney Joseph Riley stated that only if the Plaintiffs could develop independent evidence – again, requiring them to acquire and expend significant financial resources to engage experts – to dispute the OCME's findings would the State reconsider Riley's decision not to convene a grand jury to investigate Anton's killing.

282. Due to the Medical Examiner's Autopsy ruling improperly concealing police wrongdoing in Anton's death and misrepresenting the death as attributable to natural causes or accident, Defendants Alexander, Fowler and Stash, through intentional, wanton, or grossly negligent conduct, have directly interfered with Plaintiffs' rights to access to the Courts and to seek legal redress for their harms under the First and Fourteenth Amendments and Arts. 19, 24 and 40, causing them to incur significant expenses in order to gain access to civil justice, and denying

them access to fair and equal treatment by the criminal justice system, and causing them significant emotional distress and mental anguish, giving rise to their claims for relief under 42 U.S.C. §1983.

COUNT 3

ADA TITLE II (Survival Action)
(All Plaintiffs v. State of Maryland)

283. Plaintiffs incorporate by reference the allegations of all preceding paragraphs as if fully set forth herein.

284. Defendant State of Maryland is a "public entity" as defined under Title II of the ADA. *See* 42 U.S.C. §12131, 28 C.F.R. 35.104.

285. On information and belief, although it is responsible for establishing practices and procedures and ensuring compliance with those practices and procedures, the State of Maryland did not provide adequate education or training for the Maryland State Police or the Office of Chief Medical Examiner in investigating police violence against individuals experiencing a mental health crisis as a result of their mental health disability.

286. The failure of the State of Maryland to properly train the Maryland State Police investigators or the individual Defendants in how to investigate police assaults against individuals with mental health disabilities violated Title II of the ADA.

287. In light of the well-documented frequency of police encounters with people with mental health disabilities and the disproportionately lethal outcomes of those encounters,[17] the

[17] *See, e.g.,* Gary Cordner, Community Oriented Policing Services, U.S. Department of Justice, People with Mental Illness, at 1 (noting police "frequently encounter people with mental illness" and compiling statistics, https://cops.usdoj.gov/RIC/Publications/cops-p103-pub.pdf; Fatal Force, Washington Post, https://www.washingtonpost.com/graphics/national/police-shootings-2017/; Doris Fuller, Richard Lamb M.D., Michael Biasotti and John Snook, Treatment Advocacy Center, Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters, Dec. 2015, at 1, https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf; David M. Perry and Lawrence Carter-Long, Ruderman Foundation, The Ruderman White Paper on Media Coverage of Law

State of Maryland's failure to establish adequate practices and procedures and failure to provide training relating to investigations of police violence against people experiencing mental health crises creates a highly predictable risk that State employees will fail to adequately consider the rights of individuals with mental health disabilities, and that a person with a mental health disability would be harmed in a police encounter as a result.

288. The Defendant State of Maryland discriminated against Anton and violated Title II of the ADA when its agents failed to adequately investigate his death and caused his bipolar disorder to be attributed as being a "significant contributing cause" of Anton's death. Anton's death was caused by excessive force by police, not mental illness. If anything, the contributing cause of his death was the *inappropriate response of police to symptoms of his disability*, not his disability. The Defendant State of Maryland has similarly blamed other decedents for their mental illness, including Mr. Ali where OCME attributed his death to schizophrenia. As a result of these failures, Anton's disability as well as the disabilities of others, has been improperly cited as a contributing cause of death, akin to "blaming the victim" as a result of disability.

289. Defendants' violation of Title II of the ADA helped facilitate their cover-up as to the true cause of death, injuring his family and the Coalition.

290. Defendants' violations of the ADA caused harm to Plaintiffs by intentionally failing to disclose the police responsibility in causing Anton Black's painful death, and by falsely claiming his death was caused in significant part by his mental disability.

291. Defendants' actions further injured Plaintiff CJAB as a representative of its members who also have qualified disabilities under the ADA. Defendants' conduct creates a real and present danger to its members, as they are similarly situated to Anton Black due to their

Enforcement Use of Force and Disability, Mar. 2016, at 1, https://rudermanfoundation.org/wp-content/uploads/2017/08/MediaStudy-PoliceDisability_final-final.pdf.

disabilities and are now at risk of their disabilities being utilized as a justification for police excessive force against them.

COUNT 4

Section 504 of the Rehabilitation Act – Survival Action
(All Plaintiffs v. State of Maryland)

292. Plaintiffs incorporate and reallege the foregoing paragraphs as if fully set forth herein.

293. Decedent Anton Black's bipolar disorder qualified him as an individual with a "disability" as protected by Section 504 of the Rehabilitation Act. *See* 29 U.S.C. § 794(a); 45 C.F.R. § 84.3(j).

294. The Rehabilitation Act dictates that "[n]o otherwise qualified individual with a disability …shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…" *See* 29 U.S.C. § 794(a).

295. Upon information and belief, the State of Maryland receives federal financial assistance and is, therefore, covered by the Rehabilitation Act. It is liable under Section 504 for the discriminatory acts of their employees.

296. On information and belief, although it is responsible for establishing practices and procedures and ensuring compliance with those practices and procedures, the State of Maryland did not provide adequate education or training for the Maryland State Police or the Office of Medical Examiner in investigating police violence against individuals experiencing a mental health crisis as a result of their mental health disability.

297. The failure of the State of Maryland to properly train the Maryland State Police investigators or the individual Defendants in how to investigate police assaults against individuals with mental health disabilities violated Section 504.

298. In light of the well-documented frequency of police encounters with people with mental health disabilities and the disproportionately lethal outcomes of those encounters, the State of Maryland's failure to establish adequate practices and procedures and failure to provide training relating to investigations of police violence against people experiencing mental health crises creates a highly predictable risk that State employees will fail to adequately consider the rights of individuals with mental health disabilities and that a person with a mental health disability would be harmed in a police encounter as a result.

299. Likewise, Defendant State of Maryland discriminated against Anton and violated Section 504 when its agents failed to adequately investigate his death and caused his bipolar disorder to be attributed as being a "significant contributing cause" of Anton's death. Anton's death was caused by excessive force by police, not mental illness. If anything, the contributing cause of his death was the *inappropriate response of police to symptoms of his disability*, not his disability. As a result of these failures, Anton's disability was improperly cited as a contributing cause of his death, akin to "blaming the victim" as a result of his disability.

300. Defendants' violation Section 504 helped facilitate the cover-up as to the true cause of Anton Black's death, injuring his family and the Coalition.

301. Defendants' violations of Section 504 caused harm to Plaintiffs by intentionally failing to disclose the police responsibility in causing Anton Black's painful death, and by falsely claiming his death was caused in significant part by his mental disability.

302. Defendants' actions further injured Plaintiff CJAB as a representative of its members who also have qualified disabilities under the ADA, or who are associated with those who have such disabilities, as is the Black family. Defendants' conduct creates a real and present danger to its members, as they are similarly situated to Anton Black due to disability and are now at risk of their disabilities, or their loved ones, being utilized as a justification for police excessive force against them.

COUNT 5
Civil Conspiracy
Md. Decl. Rights, Articles 19, 24 and 40
(All Plaintiffs v. All Defendants)

303. Plaintiffs incorporate and reallege the foregoing paragraphs as if fully set forth herein.

304. Pursuant to Maryland common law, Plaintiffs aver, on information and belief, that Defendants conspired together, among themselves, with other agents of the State of Maryland, and with the Officers, to violate Plaintiffs' rights to due process and access to the courts under Articles 19, 24 and 40 of the Maryland Declaration of Rights by intentionally and falsely misrepresenting facts and events that led to the death of Anton Black in a collective effort to protect themselves, evade accountability and obscure official responsibility for Anton's death.

305. Officers Manos, Webster and Lannon, among other unnamed police and emergency services personnel, conspired and conferred together immediately following Anton's death and began constructing a false narrative of use of "spice" and abnormal strength to minimize and try to justify and conceal their prolonged, unconstitutional restraint of Anton by multiple officers applying direct pressure to his torso and binding his legs in ways that prevented him from breathing. In turn, they fed this false narrative to the Maryland State Police.

306. The State of Maryland, through the Maryland State Police, relied upon and perpetuated this false narrative in their purported "investigation" into Anton's death, which was not an investigation but rather a rubber stamping of the false narrative concocted by Officers Manos, Webster and Lannon. The State of Maryland disregarded contrary evidence plainly available on video Body Worn Camera footage showing that Anton was restrained face down by multiple officers, on his stomach with his knees bent back, for approximately five minutes after he had been handcuffed. There is no mention in the Body Worn Camera footage that drugs or abnormal strength contributed in any manner whatsoever to the death of Anton until he died.

307. The Medical Examiner Defendants, through intentional, wanton, or grossly negligent conduct, further aided police in developing and spreading the false narrative of laced drug use and abnormal strength by intentionally withholding, for several months, toxicology results directly contracting police claims. Moreover, Defendant Russell Alexander through intentional, wanton, or grossly negligent conduct, inappropriately conferred and conspired, on behalf of the State of Maryland, with MSP investigators in a manner suggesting a mutual desire to avoid findings of police misconduct by the Medical Examiner in connection with Anton's death. The Medical Examiner's autopsy achieved this goal by departing from basic reasonable standards of forensic pathology and falsely absolving Defendant officers of actual or criminal responsibility, thus enabling Defendant officers to evade criminal charges for their unlawful conduct, burdening Plaintiffs ability to mount a civil action because of the cost to retain multiple experts, and forcing Plaintiffs to continue expending significant resources on multiple experts to disprove the Medical Examiner's misrepresentations in order to gain access to legal redress.

308. Defendants' unlawful conspiracy harmed the Plaintiffs by exacerbating their severe mental anguish and emotional distress, by thwarting their access to civil justice and their efforts to ensure official accountability for Anton's wrongful death as guaranteed by Articles 19, 24 and 40.

PRAYER FOR RELIEF

Wherefore Plaintiffs respectfully request that the Court:

A. Award compensatory damages to Plaintiffs Jennell Black, individually and as Personal Representative of the Estate of Anton Black, Antone Black, individually and as Personal Representative of the Estate of Anton Black, and Katyra Boyce, as mother and next friend of W.B., in an amount in excess of $75,000, jointly and severally, against all Defendants;

B. Declare, pursuant to 28 U.S.C. § 2201, that through their acts and omissions, Defendants Russell Alexander, David Fowler and John D. Stash deprived Plaintiffs of their rights to access to the Courts and legal redress, as guaranteed by the First and Fourteenth Amendments to the Constitution of the United States and Articles 19, 24 and 40 of the Maryland Declaration of Rights;

C. Declare, pursuant to 28 U.S.C. § 2201, that through their acts and omissions, Defendants violated the Americans with Disabilities Act and the Rehabilitation Act of 1973;

D. Declare, pursuant to 28 U.S.C. § 2201, that through their acts and omissions, Defendants engaged in race-based discrimination, in violation of the equal protection guarantees of the Fourteenth Amendment to the Constitution of the United States and Article 24 of the Maryland Declaration of Rights;

E. Issue a permanent injunction that (i) prohibits Defendants, their officers, agents, employees, and successors from engaging in the discriminatory, unconstitutional and

abusive practices complained of herein, and (ii) imposes a prohibition of similar conduct in the future;

F. Issue an injunction to the State of Maryland, David Fowler, and Russell Alexander that permanently enjoins David Fowler and Russell Alexander from engaging in the practice of medicine in the State of Maryland;

G. Grant such additional equitable relief as is proper and just, including but not limited to, requiring Defendants to immediately enter into a plan to eliminate the practices noted in this Complaint at OCME, including:

(i) Requiring OCME to adopt new policy and guidance expressly governing police custody cases;

(ii) Enhancing and making known to OCME employees and potential employees, OCME policies prohibiting racial discrimination;

(iii) Requiring the re-training of OCME staff and employees on proper application of the NAME "but for" standard and OCME policies prohibiting racial discrimination;

(iv) Requiring the rescission and issuance of new reports for all police custody death investigation reports where the finding was not a homicide, including the investigation report concerning Anton Black; and

(v) Appoint an independent monitor to ensure OCME's compliance with the orders of this Court.

H. Award Plaintiffs Jennell Black, individually and as Personal Representative of the Estate of Anton Black, Antone Black, individually and as Personal Representative of the Estate of Anton Black, and Katyra Boyce, as mother and next friend of W.B., appropriate punitive

damages, against Defendants in their individual capacities, in an amount to be proven at trial that would punish Defendants for their knowing, intentional, willful, and reckless disregard of clearly established federal constitutional and statutory rights as alleged herein and enter any and all injunctive decrees and relief necessary to effectively prevent Defendants from engaging in similar unlawful misconduct in the future;

I. Award all Plaintiffs reasonable attorneys' fees, expert witness fees and costs under 42 U.S.C § 1988 and 12205;

J. Award such other and further relief in any form that this Court deems just and proper under the facts and circumstances as proved at trial.

JURY DEMAND

Plaintiffs demand a trial by jury of any and all claims so triable.

Respectfully Submitted,

/s/ Tomeka G. Church, Esq.
Tomeka G. Church, Bar No. 25311
The Law Offices of Tomeka G. Church, LLC
711 St. Paul Street
Baltimore, MD 21202
PH: 410-878-0705
E: tchurch@churchlawfirm.com

/s/ Leslie D. Hershfield, Esq.
Leslie D. Hershfield, Bar No. 08255
Schulman, Hershfield & Gilden, P.A.
One E. Pratt Street, Suite 904
Baltimore, Maryland 21202
P: 410-332-0850 / F: 410-332-0866
E: lhershfield@shg-legal.com

/s/ Rene C. Swafford, Esq.
Rene C. Swafford, Bar No. 26309
Law Office of Rene C. Swafford, LLC
P.O. Box 392
Greensboro, Maryland 21639

P: 410-482-4794
E: rswaffordster@gmail.com

/s/ Deborah A. Jeon, Esq.
Deborah A. Jeon, Bar No. 06905
ACLU of Maryland
3600 Clipper Mill Road, Suite 350
Baltimore, Maryland 21211
P: 410-889-8550
E: jeon@aclu-md.org

/s/ Sonia Kumar, Esq.
Sonia Kumar, Bar No. 07196
ACLU of Maryland
3600 Clipper Mill Road, Suite 350
Baltimore, Maryland 21211
P: 410-889-8550
E: kumar@aclu-md.org

/s/ John A. Freedman
John A. Freedman, D. Md. No. 20276
Jayce Born (*pro hac forthcoming*)
Florence Bryan (*pro hac forthcoming*)
Arnold & Porter Kaye Scholer LLP
601 Massachusetts Ave, N.W.
Washington, DC 20001
P: 202-942-5000
E: john.freedman@arnoldporter.com
E: jayce.born@arnoldporter.com
E: Florence.bryan@anroldporter.om

Ryan D. Budhu (*pro hac forthcoming*)
Joseph P. Klemme (*pro hac forthcoming*)
Arnold & Porter Kaye Scholer LLP
250 West 55th Street
New York, NY 10019-9710
P: 212-836-8000
E: ryan.budhu@arnoldporter.com
E: joseph.klemme@arnoldporter.com