

**Office of the State's Attorney for Baltimore City  
120 East Baltimore Street  
Baltimore, Maryland 21202**

**MEMORANDUM**

**To: Ivan J. Bates, State's Attorney for Baltimore City**

**From: BCSAO Homicide Unit**

**Date: September 25, 2025**

**Re: Department of Public Works Pedestrian Fatality (AIU#24-60/CC#7-241102489)**

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**Executive Summary**

On November 8, 2024, DPW employee Timothy Cartwell was tragically struck and killed by a DPW garbage truck operated by Othella Capri Gough in a narrow alley on the 1600 block of N. Monroe Street. An investigation by the Baltimore City Police Department and the State's Attorney's Office for Baltimore City revealed that the alley was extremely constricted, the truck's path was stable, and there was no evidence of distraction or excessive speed. Mr. Cartwell's positioning beside the truck, combined with the truck's size and limited maneuverability, may have contributed to the collision. The only indication of potential impairment came from a delayed breathalyzer administered to Mr. Gough; however, DPW allowed him to leave the scene before a full investigation could be conducted by the Baltimore Police, and the test results are inadmissible. Based on the facts and the limitations of the investigation, no criminal charges can be brought.

**Synopsis**

On November 8, 2024, at approximately 10:20 a.m. members of the Baltimore City Fire Department ("Fire Department") responded to the odd side alley of the 1600 Blk. of N. Monroe Street for a "person who passed out while working." Medic 27 responded to the scene and transported the pedestrian, a DPW employee named Timothy Cartwell (DOB: 06/03/77) ("Mr. Cartwell") to the R. Adams Cowley Shock Trauma Center ("Shock Trauma"). Due to the fact that the initial call was for a "sick case," units from the Baltimore City Police Department ("Police Department") did not initially respond. However, personnel from DPW later contacted the Police Department requesting that an officer respond because DPW required a police report.

Ofc. Wilnick Marius (“Ofc. Marius”) from the Western District responded and spoke with DPW manager, Michael Anderson (“Mr. Anderson”). Mr. Anderson was the first DPW supervisor to arrive on scene. Mr. Anderson informed Ofc. Marius that a DPW worker had been struck by a garbage truck and was transported to Shock Trauma. Ofc. Marius coded the call “DN” (no police services necessary) and left the scene. The entire interaction lasted approximately 51 seconds. As the result of coding the call “DN” notification to the Baltimore Police Department’s Crash Team was delayed.

There were two other DPW employees present at the time of the incident. They were Othella Capri Gough (“Mr. Gough”), the driver of the garbage truck, and Anthony Epps (“Mr. Epps”) who along with Mr. Cartwell, were responsible for loading refuse into the truck. Mr. Gough had been employed by DPW for approximately six (6) months prior to the incident. For two (2) months prior to the incident, Mr. Gough had an assigned route, which included the location of the incident. Mr. Gough possessed a valid Maryland Class B driver’s license with the following restrictions: corrective lenses; automatic transmission vehicles only; driver enforcement; no manual transmission equipped commercial motor vehicles; and an alcohol restriction.

Mr. Epps had been employed by DPW for approximately two (2) months prior to the incident. It was reported that Mr. Gough, Mr. Cartwell, and Mr. Epps had a good working relationship. Mr. Cartwell was the most senior employee and had been employed by DPW for approximately twenty (20) years. No other DPW employees were at or near the scene at the time of the incident.

### **The Dimensions of the Vehicle and Alley**

Based on the photographs in the Baltimore Police Department’s file and a site visit to examine a similar truck, it was determined the truck at issue was a 2021 Kenworth model K270/K370 (“Kenworth”) with the standard chassis configuration. (Ex. 1). The Kenworth is essentially a do it all urban vehicle. In other words, it can be configured with a cargo bed or in this case, a rear loader to function as a garbage truck. Due to its compact size, the Kenworth has what is known as a “cab over” design. Cab over vehicles can increase driver fatigue and depending on the size of the vehicle, can make it harder for a driver to hear what is going on around the vehicle. The manner in which the rear loader was installed on the Kenworth chassis was not determined.

The truck involved in this incident had the following dimensions: length 334 inches; width 95 inches; and height 127 inches. The measured distance between the *bottom* of the passenger side mirror and the ground was found to be 73 inches. (Ex. 2). This is pertinent because the decedent Mr. Cartwell, was reported to be 63 inches tall per his MVA records.

The alley where the incident occurred runs north to south and is extremely narrow. It measures between 9.42 feet and 10.17 feet wide in different sections. (Ex. 3). There are two telephone poles in the area of the incident that run along the southwest side of the alley, Pole Nos. 113142 & 113143. *Id.* The measurement from the east side of the alley (odd side) to the concrete base of the

west side of the alley is 9.95 feet. (Ex. 4). The measurement from the east side of the alley to the outer portion of Pole No.: 113142, the pole that at issue in this case, is 8.75 feet. *Id.* This left just 1.2 feet of space for the 7.9 foot garbage truck to pass through. (See Ex. 5 for reference). If the truck was centered, it would have just 7.2 inches of clearance on each side of the alley.

During an interview with Mr. Anderson it was learned that drivers often turn their side mirrors toward the truck's cab so as not to strike fences and other objects that run adjacent to alleys such as this. On a site visit to a DPW yard, in which an identical Kenilworth truck was examined, the mirrors were found to be turned inward. (Ex. 6). Additionally, Mr. Anderson stated that DPW had previously requested that the occupants of the homes whose backyards abut the alley, agree to put their garbage in front of their homes. After some discussion, the occupants elected not to do so because many of the residents are elderly.

### **The Incident and Immediate Aftermath**

As stated, on November 8, 2024, the Fire Department responded to the location of the incident to find Mr. Cartwell suffering from pelvic fractures and life-threatening injuries. The initial call was upgraded to a vehicle vs. pedestrian incident and the Crash Team was eventually notified. Unfortunately, the scene was not preserved and therefore investigators had to rely on measurements, interviews, and surveillance footage. According to multiple interviews and video obtained from a local business, which is located across Baker Street at the south end of the alley, the trash truck was traveling slowly down the alley while Mr. Epps and Mr. Cartwell were retrieving trash bins and loading the trash into the rear compactor.

As the garbage truck continued southbound, its operator, Mr. Gough, honked the horn to alert two pedestrians at the end of the alley near Baker Street to remove trash bins from its path. While the truck was passing an adjacent alley, Mr. Cartwell was seen walking toward Pole No. 113142, located west of the odd side of the alley. (Ex. 7 – diagram created from video). The audio quality of the recovered video is poor, however, Mr. Cartwell can be heard saying “go go,” and then the garbage truck slowly moves forward. Immediately, after the truck moves forward, Mr. Cartwell collapses between the truck and the fence. After Mr. Cartwell collapses, a different voice, presumably Mr. Epps, is heard saying “go forward.” Mr. Gough and Mr. Epps then approached Mr. Cartwell, and Mr. Gough called 911.

Subsequent interviews revealed that when Mr. Cartwell walked beside the truck, Mr. Epp heard Mr. Cartwell scream “ahhhhhh” and observed him on the ground. Mr. Epps then told Mr. Gough to “ease up...go forward” in an attempt to create space between Mr. Cartwell and an adjacent fence. There is no evidence that Mr. Gough backed the truck up during, or prior to, striking Mr. Cartwell.

Shortly after the incident, Mr. Anderson appeared on scene in a white DPW pick-up truck. According to Mr. Anderson, Mr. Gough was very upset, stating “I quit, I quit,” and, against DPW

policy, he was allowed to leave the scene in a Lyft. This was a significant error, as law enforcement could have mandated that Mr. Gough provide a blood sample using a Maryland State Police blood kit if responding officers suspected impairment. The Lyft operator was interviewed and indicated that Mr. Gough was on his phone and very upset, stating “I’m done with this job, I’m going to quit.” Mr. Gough was dropped off at the front gate of the DPW lot on Redbird Avenue at which time he was permitted to retrieve his personal car and respond to Shock Trauma. After Mr. Gough left the scene, DPW Division Manager Michael Lucas arrived, which prompted the call to police and the response by Ofc. Marius. The truck was then removed by DPW personnel as if nothing had occurred.

### **The Breath Test**

After Mr. Gough arrived at Shock Trauma, he left Shock Trauma and responded to the Northwest District Station (“Station”) at the request of police to give a statement. Mr. Gough spoke with Michael Ortiz (“Ofc. Ortiz”) and reiterated the chain of events described above. In speaking with Mr. Anderson, who also responded to the Station, Ofc. Ortiz indicated that Mr. Gough showed no signs of impairment. Detective Edgardo Mercado (“Det. Mercado”) then arrived, and after speaking with counsel, Mr. Gough elected not to provide a statement. Mr. Gough was then accompanied by Mr. Anderson to Mercy Medical Center (“Mercy”) for a drug and alcohol test. It should be noted that the first 911 call was placed at approximately 10:20 a.m., and Mr. Gough was not tested until approximately 5:50 p.m.

The technician who administered the breath test to Mr. Gough, was initially interviewed by police on January 17, 2025, and later re-interviewed on July 23, 2025. The purpose of the second interview was to determine if the results of Mr. Gough’s breath test would have been admissible if the test had been administered within the two-hour time period mandated by Cts. & Jud. Proc. § 10-303(a)(2). Not only would the test have been inadmissible in a court proceeding, there is a question of whether or not it would be admitted during an administrative proceeding.

In addition to the time lapse, the technician did not perform a confirmatory test but instead allowed Mr. Gough to leave the hospital after unsuccessfully attempting to contact his supervisor, as required. The technician was questioned at length regarding the machine used, the calibration of same, paperwork for the machine issued by the State Toxicologist and/or the Maryland State Police Forensic Laboratory, and his training. The technician was able to provide some details regarding calibration of the machine and indicated he received “on the job” training; however, he had no certifications. Additionally, there is no evidence that the machine used in this case, which the technician described as “Inspector Gadget” like and from the “70s,” fully complied with any known Maryland statutes or COMAR provisions. Intoximeters Inc., which produces the Intox EC/IR II used by law enforcement, also produces a Department of Transportation (“DOT”) machine, which, if used properly, may have provided early detection of an alcoholic beverage on Mr. Gough’s breath.

In summary, the breath test administered in this case was of no value. As an aside, Mr. Gough's drug test was negative.

### **Administrative Issues within DPW**

During the course of this investigation there were lengthy interviews conducted with safety personnel from DPW. It is clear from these interviews that DPW has some infighting that has nothing to do with whether or not charges should be filed against Mr. Gough. Accordingly, any dispute regarding authority and delegation within DPW has largely been omitted from this memorandum.

### **Legal Analysis**

In a collision involving death, in which there is no evidence of impairment and no evidence of flight, the only remaining incarcerable offenses to consider are Grossly Negligent Manslaughter (Criminal Law Article, Section 2-209) and Criminally Negligent Manslaughter (Criminal Law Article, Section 2-210). Grossly Negligent Manslaughter does not apply, as there is no evidence that Mr. Gough showed a reckless disregard for human life. This assertion primarily rests on the fact that Mr. Gough maintains he did not see Mr. Cartwell, and even if he had seen him, his perception reaction time, discussed *infra*, would likely not have been fast enough to prevent the incident.

Criminally Negligent Manslaughter is a misdemeanor and a lesser included offense to Grossly Negligent Manslaughter. In order to prove Criminally Negligent Manslaughter, the State must prove: that the defendant drove the motor vehicle; that the defendant drove the motor vehicle in a criminally negligent manner; and that the criminally negligent driving caused the death of the decedent. "Criminally negligent" means that the defendant should have been aware but failed to perceive that his or her driving created a substantial and unjustifiable risk to human life. The failure to perceive the risk must constitute a gross departure from the conduct of a reasonable person under similar circumstances. Simple carelessness is insufficient to establish guilt.

There is no evidence of criminal negligence or any other moving violation in this case. The DPW has draft operating procedures that indicate when a truck enters an alley or tight space, workers are to walk behind the truck within view of the side mirrors. (Ex. 8). There was no reason for Mr. Cartwell to walk alongside the truck other than to perhaps "get ahead" in staging trash cans for future pickup. Unfortunately, Mr. Cartwell was likely never trained on the dangers of this practice as the investigation revealed evidence, contained in the MOSH investigation file, indicating that DPW had not provided standard operating procedure training and certification. (Ex. 9). Additionally, based on the video footage, there is no evidence that Mr. Gough was traveling at an

excessive speed or distracted. The garbage truck maintains a path without discernable lateral movement prior to the collision.

Mr. Gough's likely eye movement while operating the garbage truck in the alley was also taken into consideration. The driver of any vehicle has three (3) primary tasks: (1) guide the vehicle—that is, follow the path of the road and stay within lane boundaries; (2) maintain appropriate spacing with other vehicles; and (3) avoid obstacles. It is well accepted in the field of driver perception and response that most of a driver's attention is given over to the guidance task. In this case, it is likely that all of Mr. Gough's attention was given to guiding the garbage truck through the narrow alley in which he had just inches of clearance on each side.

The final issue to consider is Mr. Gough's likely perception reaction time if he saw Mr. Cartwell at any time prior to the collision. There are generally four (4) accepted stages one goes through behind the wheel between the appearance of a hazard and his or her reaction, they are: detection; identification; decision; and response. Many factors can affect one's perception reaction time including, but not limited to, age, time of day, size of hazard, and cognitive load. Perception reaction time has been highly debated and tested; however, 1.6 seconds between detection and response is generally accepted in the field of collision reconstruction. Given the proximity of Mr. Cartwell to the garbage truck and the truck's mass, which would cause it to take longer to stop because of greater inertia, it is unlikely that Mr. Cartwell would have been unharmed if the truck's brakes had been applied.

## **Conclusion**

The investigation in this case revealed the following chain of events surrounding Mr. Cartwell's tragic death:

\*Times referencing certain events taking place at the scene are from the business' surveillance camera which contains a time-stamp that is *approximately* eight (8) minutes fast EST.

- 5:13 a.m. – DPW Trash Truck leaves 701 Redbird Avenue yard
- 10:12 a.m. – The Truck is first scene on surveillance footage in the alley
- 10:18 a.m. – Mr. Cartwell is scene on the passenger side of the truck
- 10:20 a.m. – A 911 call was made initially indicating that someone had passed out while working
- 10:22 a.m. – Emergency response units are dispatched to the scene
- 10:26 a.m. – 10:28 a.m. – Fire Department arrives on scene
- 10:38 a.m. – Mr. Cartwell is transported to Shock Trauma
- 10:39 a.m. – DPW supervisor Mike Anderson arrives on scene
- 10:41 a.m. – Mr. Gough can be seen on his cell phone behind Mr. Anderson's truck
- 10:46 a.m. – Mr. Gough is picked up by a Lyft driver

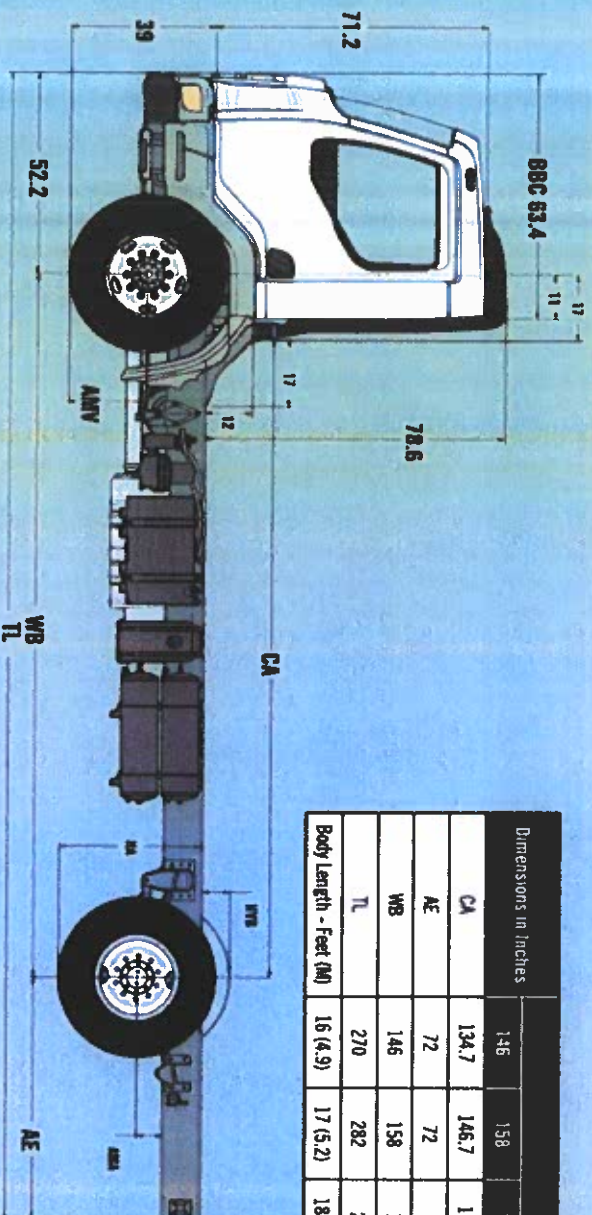
- 10:46 a.m. – Mr. Cartwell arrives at Shock Trauma
- 10:51 a.m. – A DPW coupe with two (2) occupants arrives on scene
- 11:03 a.m. – DPW Division Chief Michael Lucas arrives on scene
- 11:10 a.m. – Mr. Gough is dropped off at the Redbird Avenue DPW yard
- 11:13 a.m. – A call for service is placed to the Baltimore Police Department
- 11:29 a.m. – Officer Wilnick Marius arrives on scene
- 11:41 a.m. – License Plate Reader captures Mr. Gough's vehicle traveling northbound on South Hanover Street
- After 11:41 a.m. and before 1:33 p.m. – Mr. Gough arrives at Shock Trauma speaks briefly with Mr. Cartwell's family, and leaves
- 11:51 a.m. -12:00 p.m. – The Truck is returned to the yard on Redbird Avenue
- Prior to 2:53 p.m. – Mr. Gough arrives at Northwest District Station and is joined by Mr. Anderson
- 4:57 – Mr. Gough leaves the Northwest District Station and is accompanied to Mercy Hospital by Mr. Anderson
- 5:50 p.m. – Mr. Gough is given a breathalyzer test at Mercy Hospital using Mr. Anderson's identification because he did not have his license in his possession. He is then allowed to leave.
- 7:05 p.m. – Time of death is declared for Mr. Cartwell

Unfortunately, due to the gross negligence of DPW's actions, this investigation is tainted, and our office cannot proceed and cannot make a determination.



# KENWORTH K270 AND K370 DIMENSIONS

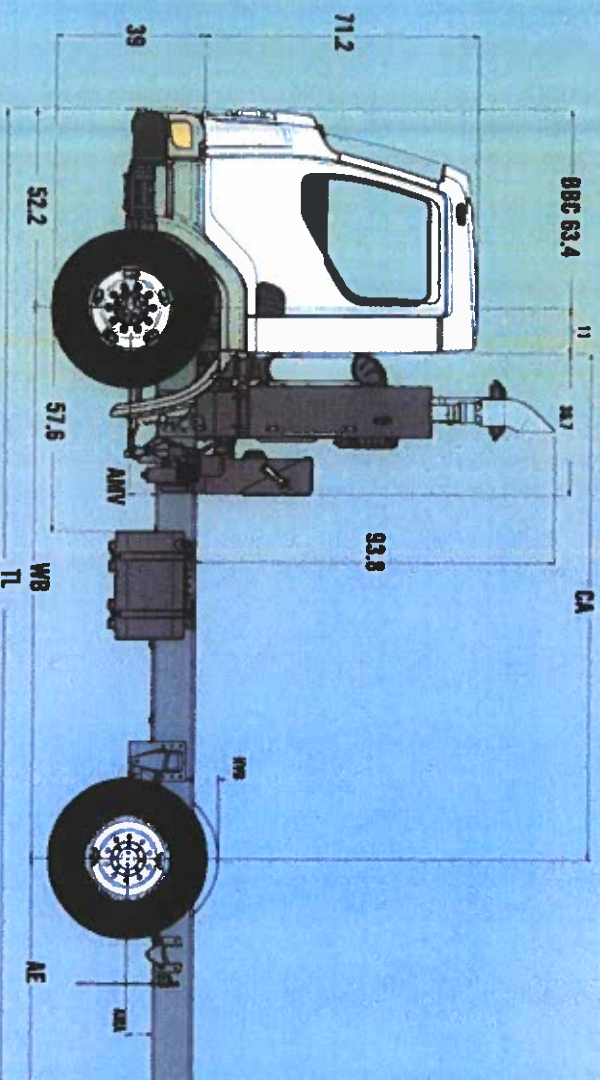
## Standard Chassis Configuration



| Dimensions in inches    | Standard Chassis Wheelbases |          |          |          |          |          |          |          |          |
|-------------------------|-----------------------------|----------|----------|----------|----------|----------|----------|----------|----------|
|                         | 146                         | 158      | 170      | 182      | 194      | 206      | 218      | 230      | 242      |
| CA                      | 134.7                       | 146.7    | 158.7    | 170.7    | 182.7    | 194.7    | 206.7    | 218.7    | 230.7    |
| AE                      | 72                          | 72       | 72       | 84       | 96       | 108      | 120      | 120      | 120      |
| WB                      | 146                         | 158      | 170      | 182      | 194      | 206      | 218      | 230      | 242      |
| TL                      | 270                         | 282      | 294      | 318      | 342      | 366      | 390      | 402      | 414      |
| Body Length - Feet (in) | 16 (4.9)                    | 17 (5.2) | 18 (5.5) | 20 (6.1) | 22 (6.7) | 24 (7.3) | 26 (7.9) | 27 (8.2) | 28 (8.5) |

| Dimension in Inches | Spring Suspension |       | Air Suspension |       |
|---------------------|-------------------|-------|----------------|-------|
|                     | Unladen           | Laden | Unladen        | Laden |
| AMA                 | 9.0               | 7.5   | 8.5            | 8.3   |
| AMV                 | 20.0              | 18.5  | 20.0           | 18.5  |
| HA                  | 39.5              | 37.0  | 38.5           | 36.0  |
| HBV                 | —                 | 1.5   | —              | 0.2   |

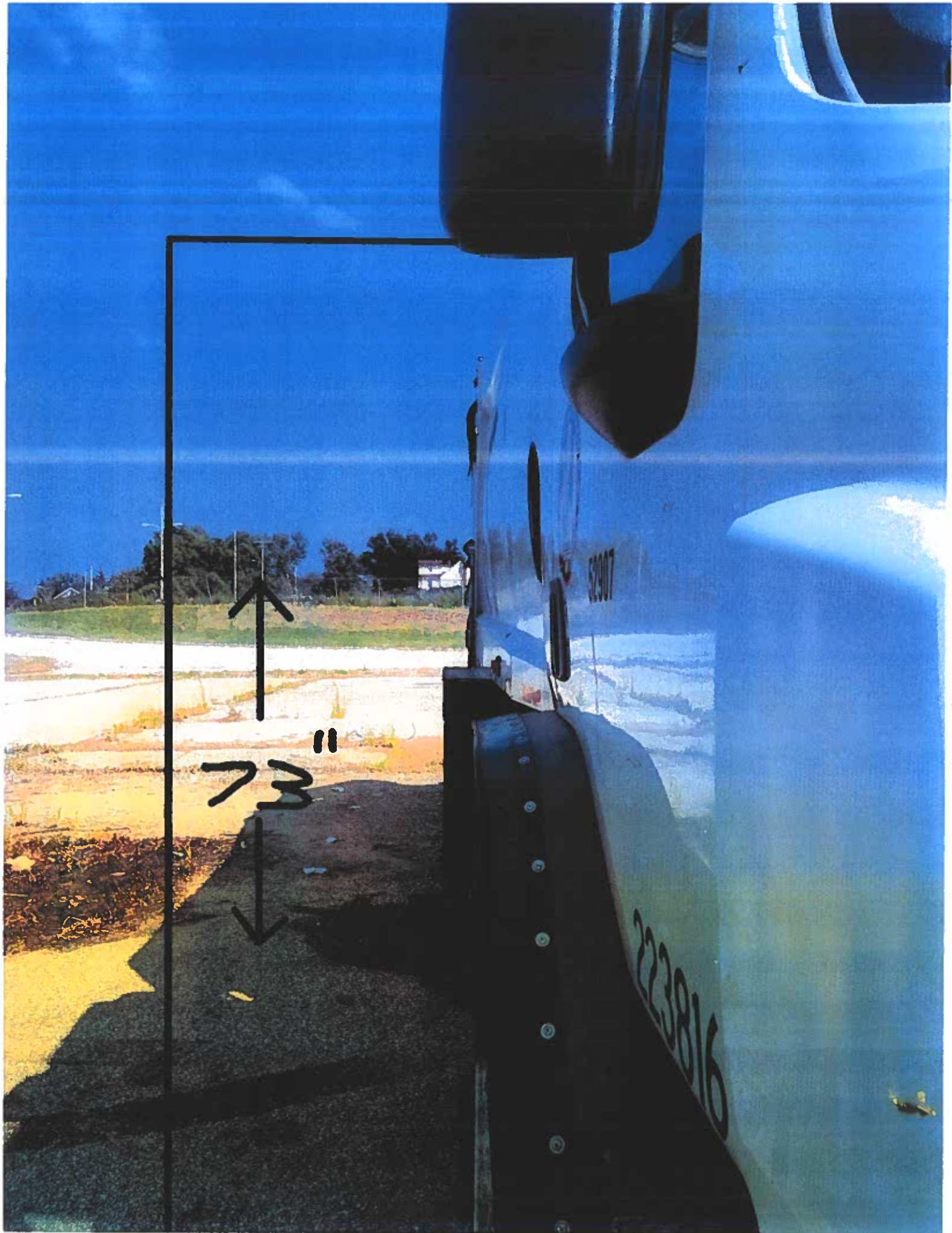
## Clear Frame Rail Chassis Package Configuration



| Dimensions in Inches    | Clear Rail Chassis Wheelbases |          |          |
|-------------------------|-------------------------------|----------|----------|
|                         | 142                           | 146      | 158      |
| CA                      | 130.7                         | 134.7    | 146.7    |
| AE                      | 72                            | 72       | 72       |
| WB                      | 142                           | 146      | 158      |
| TL                      | 266                           | 270      | 282      |
| Body Length - Feet (in) | 13 (3.8)                      | 16 (4.9) | 17 (5.2) |

| Dimension in Inches | Spring Suspension |       | Air Suspension |       |
|---------------------|-------------------|-------|----------------|-------|
|                     | Unladen           | Laden | Unladen        | Laden |
| AMA                 | 9.0               | 7.5   | 8.5            | 8.3   |
| AMV                 | 20.0              | 18.5  | 20.0           | 18.5  |
| HA                  | 39.5              | 37.0  | 38.5           | 36.0  |
| HBV                 | —                 | 1.5   | —              | 0.2   |





Organization

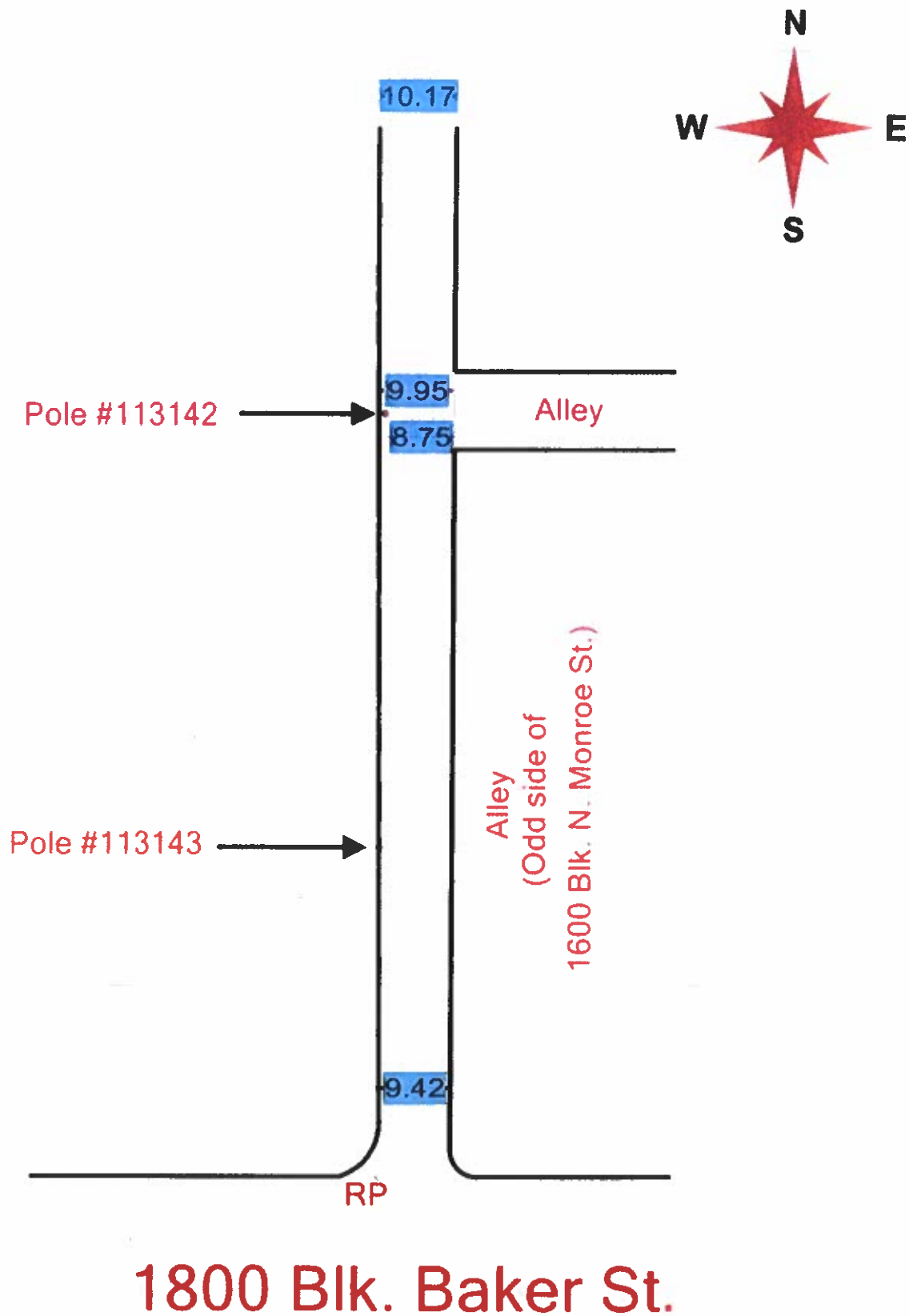
Drawn By

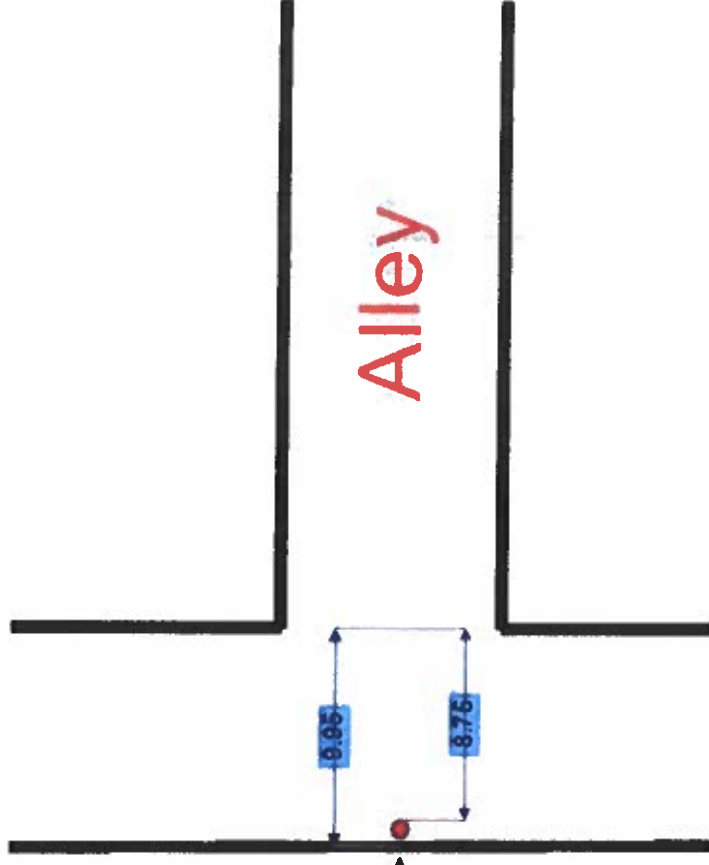
Scale

BPD - Crash Team

Det. Edgardo Mercado

1 in = 20.0 ft





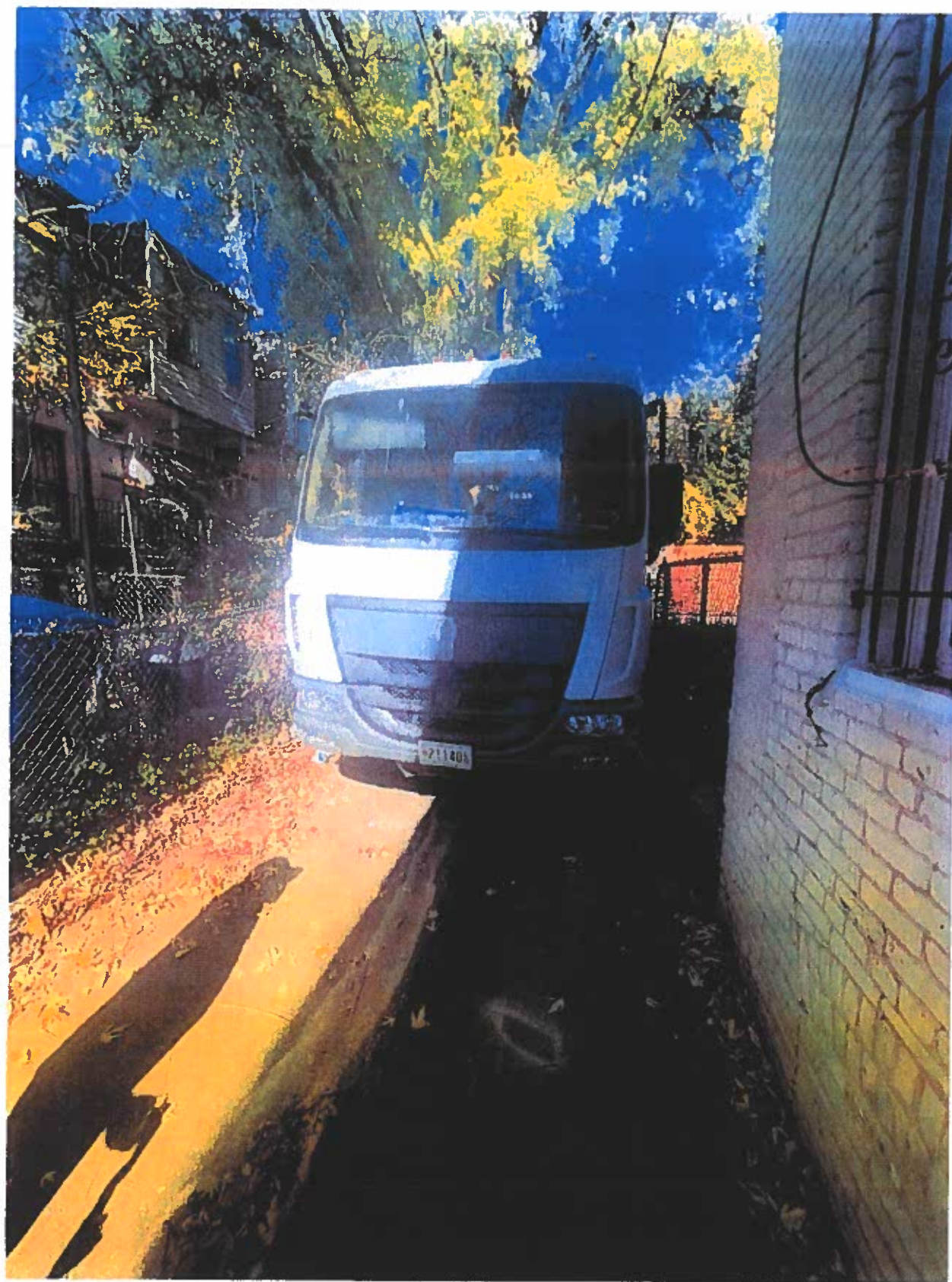
Alley

0.95

0.75

Pole #113142



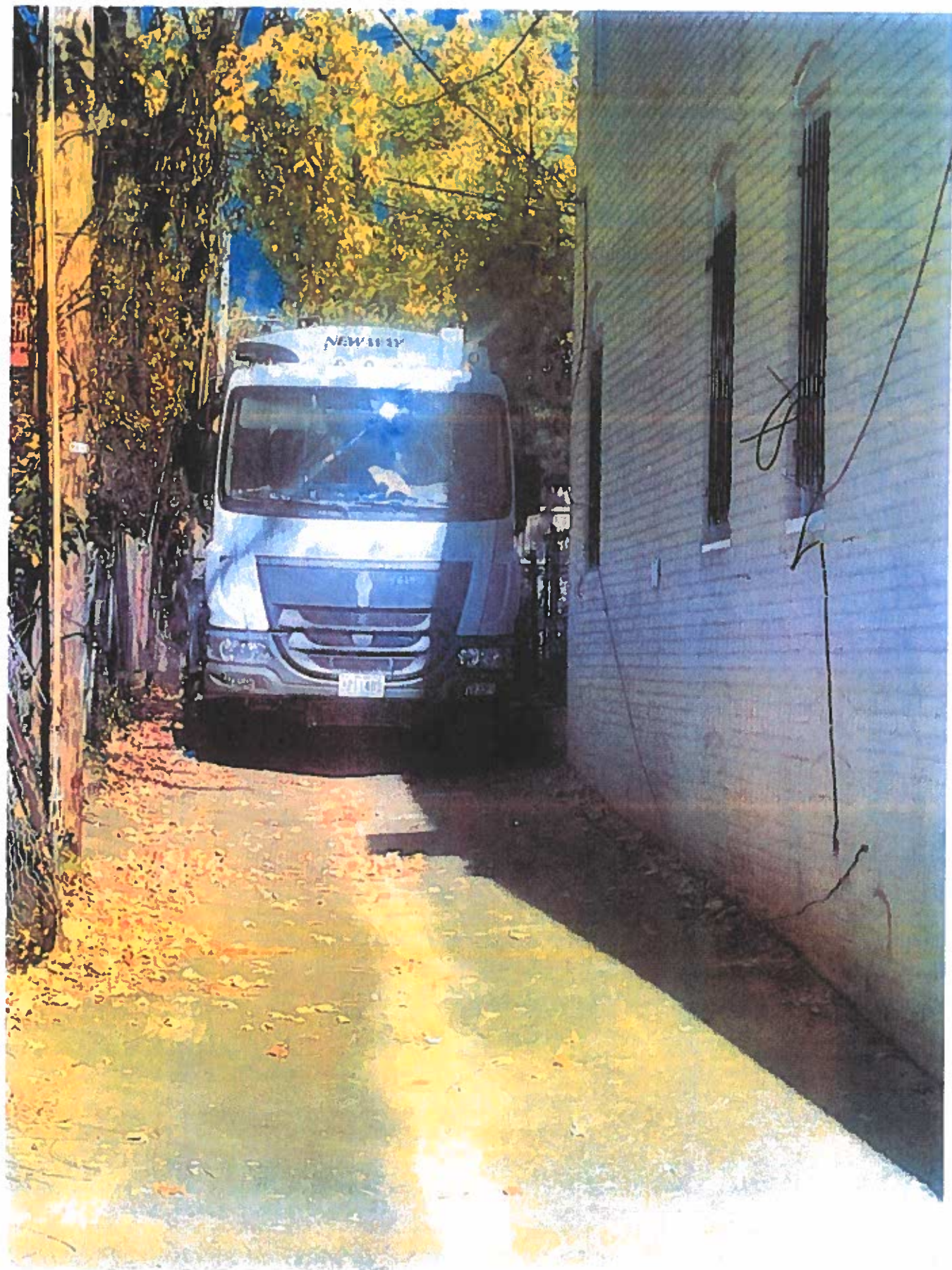


Employer  
Photographs

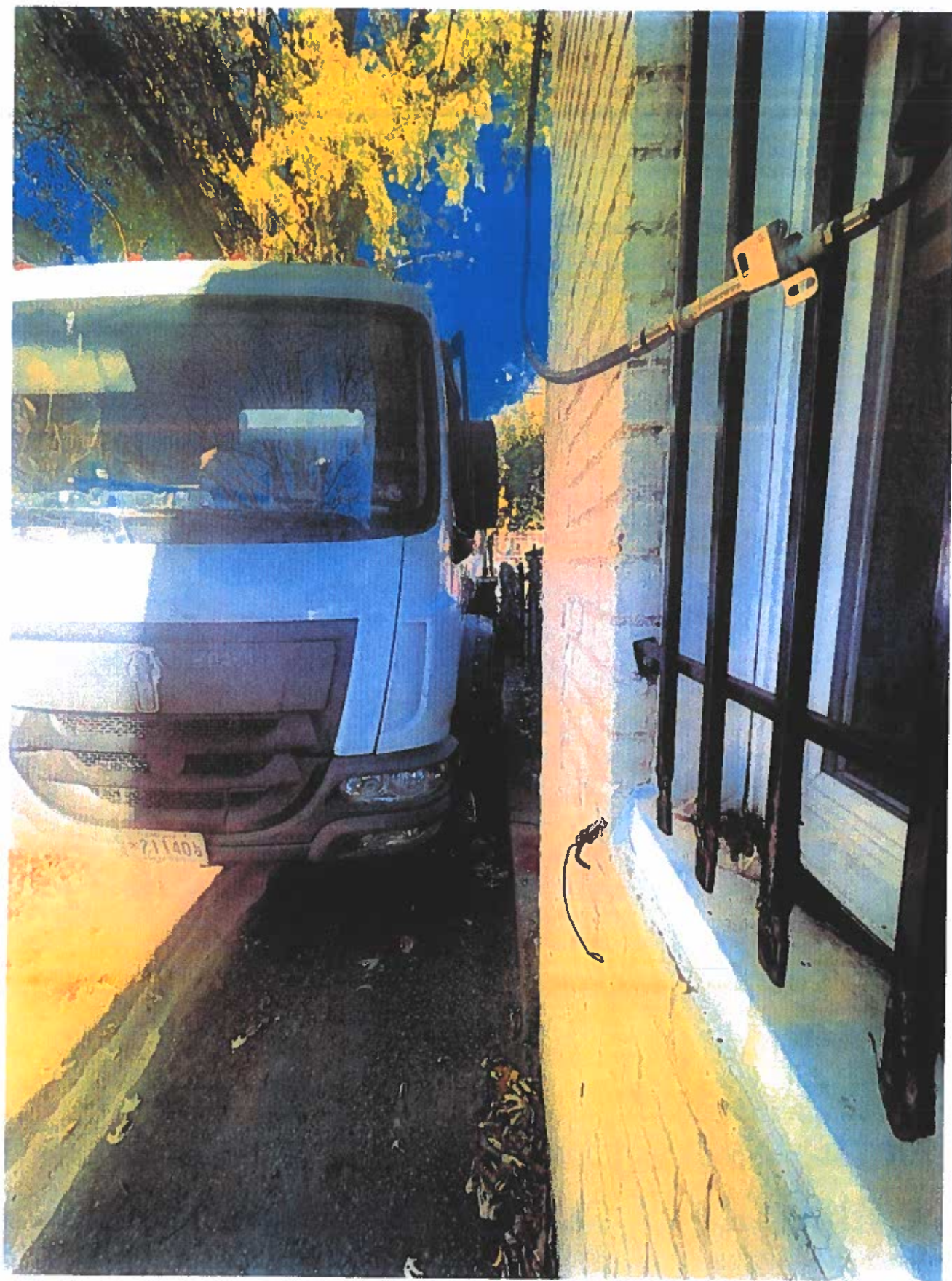
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CASE NUMBER

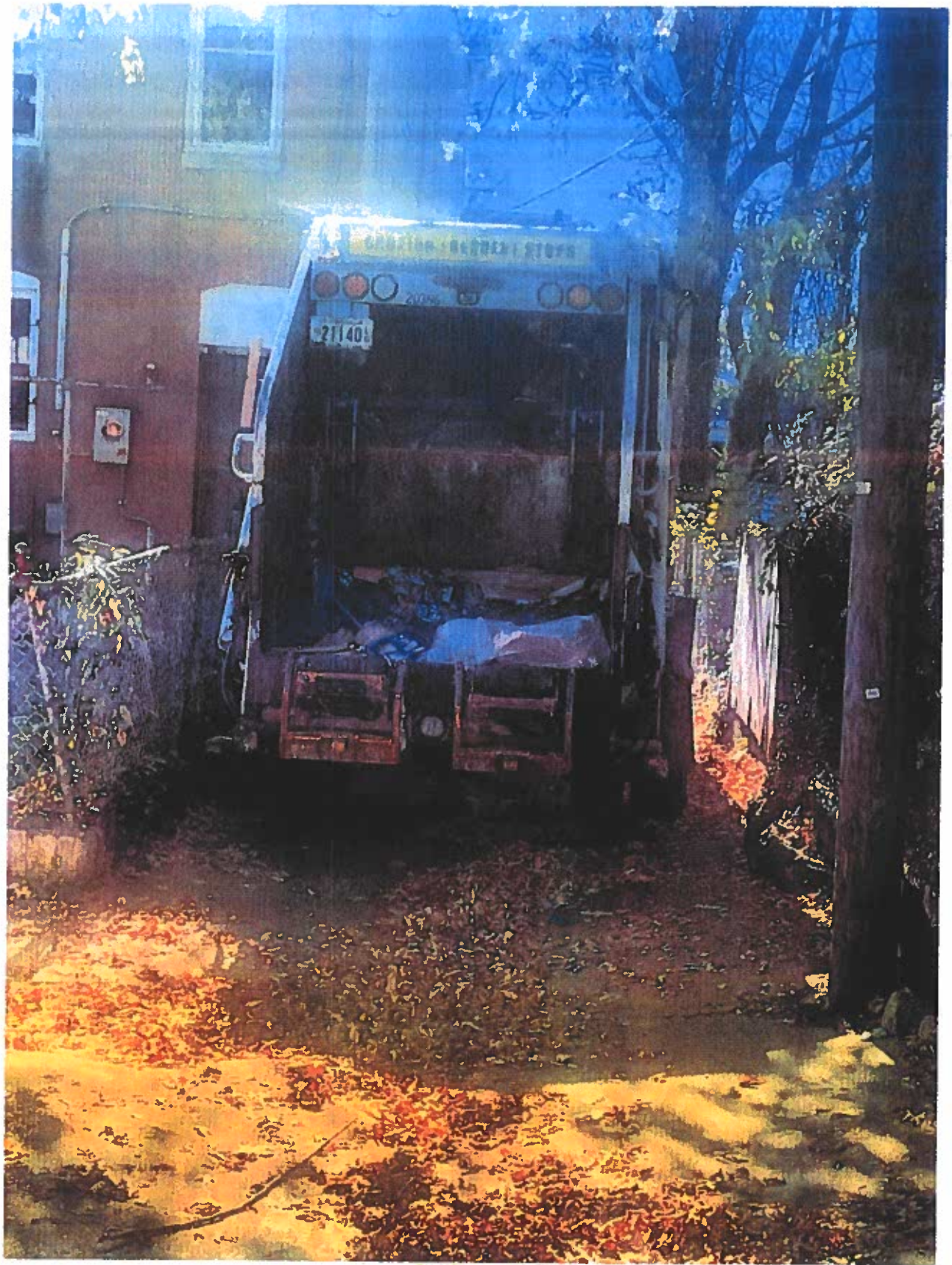




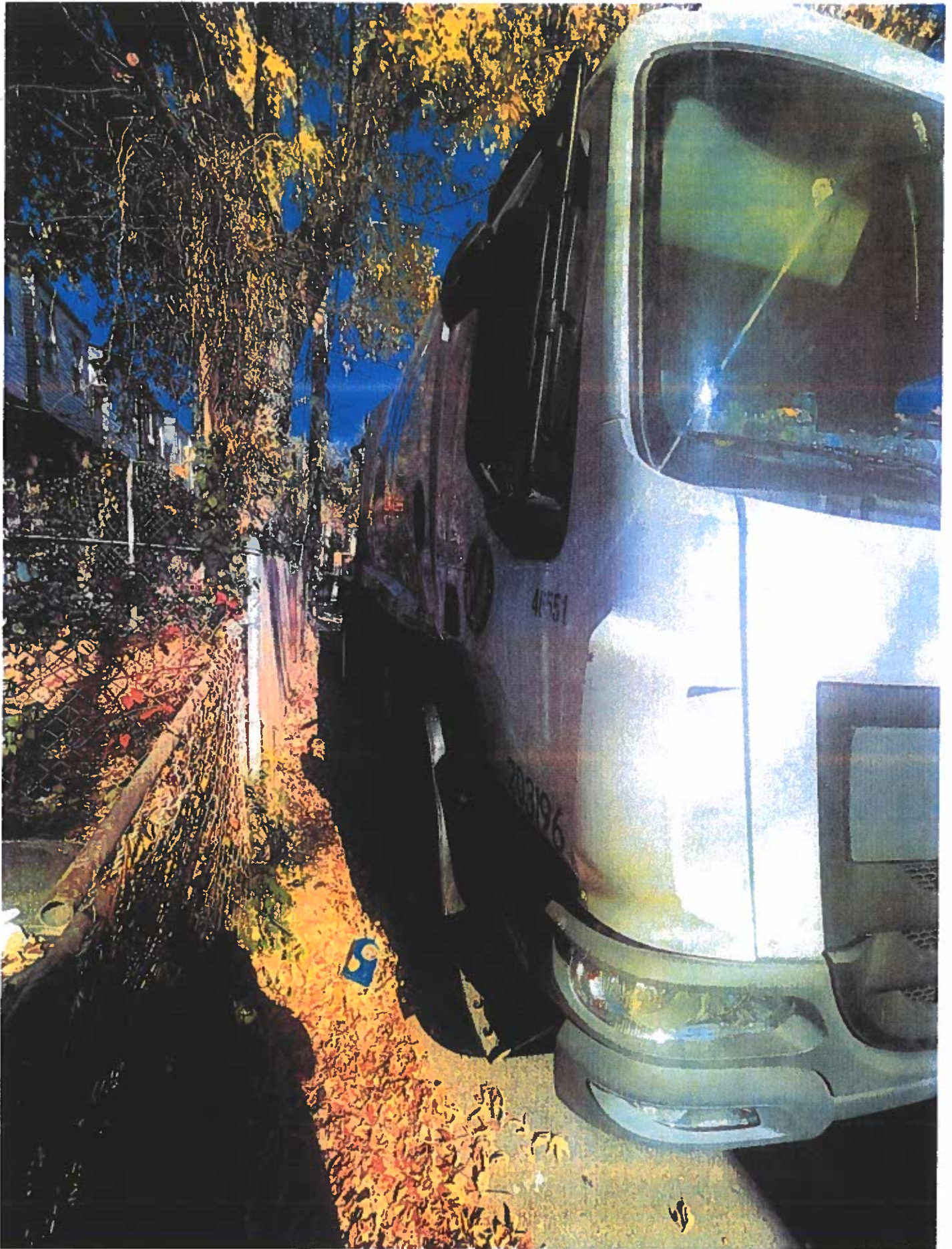
















| Organization     | Drawn By             | Scale          |
|------------------|----------------------|----------------|
| BPD - Crash Team | Det. Edgardo Mercado | 1 in = 20.0 ft |

