From the anatomic findings and pertinent history I ascribe the death to:

(A) Sequelae of alcohol intoxication

From the anatomic findings and pertinent history I ascribe the death to:

(B) Bilateral pneumonia.
   1. Lungs diffusely firm.
   2. Focal tan exudate on pleural surface of right lung lower lobe.
   3. See separate microscopic examination report and culture report.

(C) Encephalomalacia.
   1. Involves most of the right cerebral parenchyma including the basal ganglia.
   2. Focally involves the left occipital lobe.

(D) Nephrosclerosis.
   1. Multiple bilateral simple renal cysts, the largest measures 1.8 cm.
   2. Increased pelvic fat.

IV. Fatty change of liver with prominent passive congestion.

V. Diverticuli, colon.

VI. Diminutive right coronary ostia and artery.

VII. Status-post appendectomy, remote, site unremarkable.
VIII. Dwarfism.
IX. See separate culture reports.
X. See separate microscopic examination report.

CIRCUMSTANCES:
See Investigator Report Form #3.

EXTERNAL EXAMINATION:
The body is identified by ankle bands and toe tags and is that of an unembalmed refrigerated adult male Caucasian who appears about the reported age of 49 years. The body weighs 55 pounds, measures 32 inches (per Form 1) and appears well-nourished. The general appearance of the skin is as diagrammed on Form 20. Focal areas of superficial skin breakdown are noted to the posterior scalp, right upper extremity, penis and scrotum. None of the sites show exudates or evidence of infection. Wrist scars are absent. Tattoos are present and identified as diagrammed on Form 20. Rigor mortis has presumably been altered. Livor mortis is posterior, dependent and nearly fixed. The head has short brown hair. Frontal and vertex balding is present. A mustache is present. Patchy facial stubble is noted. Examination of the eyes reveals irides that appear to be blue in color and sclerae that are congested with purpura and focal drying. The oronasal passages are unobstructed and the nasal septum is intact. Upper and lower teeth are present. Dentures are not present. The skin of the neck is unremarkable and the neck is without abnormality to range of motion testing. There are no palpable fractures of the chest. The abdomen appears mildly distended but without a palpable fluid wave. The genitalia are those of an adult male. The penis appears circumcised, scrotal and soft tissue edema is present. The bilateral lower extremities show prominent pitting edema up to the level of the thighs. The extremities show no abnormal mobility, non-therapeutic punctures or needle tracks.
EVIDENCE OF THERAPEUTIC INTERVENTION:

The following are present and are in proper location: Intravenous line at the right groin. There are no signs of recent surgical procedures. Discrete signs of cardiopulmonary resuscitation are not appreciated. There is evidence of old surgeries. Abdominal scars are present and the appendix is absent. There are scant fibrous adhesions present at the site, and the site is otherwise unremarkable. There has not been post-mortem intervention for organ procurement.

EVIDENCE OF TRAUMATIC INJURY:

There are no fatal blunt force or penetrating traumatic external or internal injuries present.

CLOTHING:

The body was not clothed, and I did not see the clothing. No clothing accompanied the decedent from the hospital.

INITIAL INCISION:

The body cavities are entered through the standard coronal incision and the standard Y-shaped incision. No foreign material is present in the mouth, upper airway and trachea.

NECK:

The neck organs are removed en bloc with the tongue. No lesions are present nor is trauma of the gingiva, lips or oral mucosa demonstrated. Prominent drying of the anterior tongue and lips is noted. There is no edema of the larynx. The hyoid bone, larynx and superior horns of the thyroid cartilage are without fractures. No hemorrhage is present in the adjacent throat organs, investing fascia, strap muscles, thyroid or visceral fascia. There are no prevertebral fascial hemorrhages. The tongue when sectioned shows no trauma.
CHEST/ABDOMINAL CAVITY:

Both pleural cavities contain no fluid, blood or adhesions. Focal adherent tan exudates are present at the right lobe lower lung inferior aspect. The parietal pleurae are intact. The lungs are well expanded. Soft tissues of the thoracic and abdominal walls are well preserved. The subcutaneous fat of the abdominal wall measures 0.9 cm. The breasts are examined in the usual manner and show no abnormalities. A supernumerary nipple is present on the left. The organs of the abdominal cavity have a normal arrangement. There is an estimated 50 cc of tan serous non-purulent ascites present. The peritoneal cavity is without evidence of peritonitis. There are no adhesions.

SYSTEMIC AND ORGAN REVIEW

The following observations are limited to findings other than injuries if described above.

MUSCULOSKELETAL SYSTEM:

No acute abnormalities of the visualized bony framework or muscles are present in the setting of dwarfism.

CARDIOVASCULAR SYSTEM:

The aorta is elastic and of even caliber throughout with vessels distributed normally from it. The abdominal and thoracic aorta have minimal atherosclerosis. There is no tortuosity or widening of the thoracic segment. There is no dilation of the lower abdominal segment. No aneurysm is present. The major branches of the aorta show no abnormality. Within the pericardial sac there is a minimal amount of serous fluid. The heart weighs 210 grams. It has a normal configuration. The right ventricle is 0.4 cm thick, the left ventricle is 1.0 cm thick and the septum is 1.0 cm thick. The chambers are normally developed and are without mural thrombosis. The valves are
thin, leafy and competent. Circumference of the valve rings are: tricuspid valve 10.3 cm, pulmonic valve 6.8 cm, mitral valve 7.6 cm, aortic valve 6.8 cm. There is no endocardial discoloration. The myocardium has a pale appearance, but no focal lesions are identified. There is no abnormality of the apices of the papillary musculature. There are no defects of the septum. The great vessels enter and leave in a normal fashion. The ductus arteriosus is obliterated. The coronary ostia are widely patent. The right coronary artery ostia and right coronary artery are diminutive with both the ostia and the vessel diameter averaging 1 mm. The left coronary artery and ostia are unremarkable. There is no significant atherosclerosis of the major coronary arteries. The blood within the heart and large blood vessels is liquid and clotted.

RESPIRATORY SYSTEM:

Scant secretions and edema fluid are present in the lower bronchial passages. There is no apparent obstruction. The mucosa is intact and mildly congested. The lungs are atelectatic and diffusely firm with dependent congestion. The left lung weighs 300 grams. The right lung weighs 425 grams. The visceral pleurae are smooth and intact. Sectioning through the lung parenchyma reveals no focal lesions or masses. The pulmonary vasculature is without thromboembolism.

GASTROINTESTINAL SYSTEM:

The esophagus is intact throughout. The stomach is not distended. It contains an estimated 10 cc of tan-pink fluid. The mucosa shows early postmortem changes and focal superficial mucosal pinpoint erosions at the gastroduodenal junction. No active bleeding is present. Tablets and capsules cannot be discerned in the stomach. The external and in situ appearance of the small intestine and colon are unremarkable. The small intestine and colon are opened along the entire mesenteric border revealing tan-to-tan-green small bowel contents, soft green stool in the colon and there are numerous colon diverticuli, most prominent at the distal portion. The appendix is absent. The pancreas occupies a normal position. There is
no necrosis or trauma. The parenchyma is lobular and firm. The pancreatic ducts are not ectatic and there is no parenchymal calcification.

HEPATOBILIARY SYSTEM:

The liver weighs 860 grams and is tan-brown. The capsule is intact and the consistency of the parenchyma is soft. The cut surface is smooth with prominent passive congestion. There is a normal lobular arrangement. The gallbladder is present. The wall is thin and pliable. It contains liquid and sludge bile with no calculi. There is no obstruction or dilation of the extrahepatic ducts. The periporal lymph nodes are not enlarged.

URINARY SYSTEM:

The left kidney weighs 90 grams; the right kidney weighs 80 grams. The kidneys are normally situated and the capsule strips easily revealing a surface that is markedly granular, scarred and pale. The corticomedullary demarcation is preserved and the cortex appears attenuated. The pyramids are not remarkable. There is increased peripelvic fat. Both kidneys have multiple simple cysts. The largest is in the left kidney measuring up to 1.8 cm in diameter. The urinary bladder is contracted and contains no urine.

GENITAL SYSTEM:

The prostate is without enlargement or nodularity. Both testes are in the scrotum and are unremarkable and without trauma.

HEMOLYMPHATIC SYSTEM:

The spleen weighs 70 grams and is of average size. The capsule is intact. The parenchyma is dark red. There is no increased follicular pattern. Lymph nodes throughout the body are small and inconspicuous except for a focus of small matted lymph nodes
at the carina. The bone is brittle. The bone marrow of the rib is red and moist.

ENDOCRINE SYSTEM:

The thyroid is unremarkable. The parathyroid glands are not identified. The adrenal glands are unremarkable. The thymus is not identified. The pituitary gland is unremarkable.

SPECIAL SENSES:

The eyes are not dissected. The middle and inner ear are not dissected.

HEAD AND CENTRAL NERVOUS SYSTEM:

There is no subcutaneous or subgaleal hemorrhage in the scalp. There are no fractures of the calvarium or base of the skull. There are no tears of the dura mater. There is no epidural, subdural or subarachnoid hemorrhage. The brain weighs 1310 grams. The leptomeninges are thin and transparent. No exudates are appreciated. There is a flattened convolutionary pattern and global postmortem softening. Coronal sectioning demonstrates prominent marked softening with a friable consistency of the brain parenchyma involving the right cerebrum extending from the occipital lobe to the frontal lobe obliterating the right basal ganglia. Similar findings are seen focally in the left occipital lobe. Sectioning through the brain reveals no intraparenchymal hemorrhage or other focal lesions. The global softening and encephalomalacia limits examination of symmetry and herniation. Small vessel congestion is noted throughout. Pons, medulla and cerebellum are unremarkable except for softening. Discrete evidence of uncal or cerebellar herniation is not appreciated. The vessels at the base of the brain have a normal pattern of distribution. There are no aneurysms. The visualized cranial nerves are intact, symmetrical and normal in size, location and course. The cerebral arteries are without arteriosclerosis.
SPINAL CORD:

The entire cord is not dissected. The superior portion of the cervical spinal cord is examined through the foramen magnum and is unremarkable. The spinal fluid is clear.

HISTOLOGIC SECTIONS:

Representative sections from various organs are preserved in two storage jars containing 10% formalin. Representative sections of viscera are submitted for slides. The slide key is as listed on Form 14.

TOXICOLOGY:

Bile, blood, liver tissue, stomach contents and vitreous humor have been submitted to the lab. No screen was requested secondary to hospitalization of greater than 24 hours.

PHOTOGRAPHY:

At-scene photos are not available. Photographs have been taken prior to and during the course of the autopsy. Photographs taken tableside include Y-incision and reflected scalp to demonstrate no trauma. The pleural exudates of the right lung and encephalomalacia were photographed.

RADIOLOGY:

The body is fluoroscoped and full body x-rays are taken (24).

WITNESSES:

None.
DIAGRAMS USED:

Diagram Forms #16 and 20 were used during the performance of the autopsy. The diagrams are not intended to be facsimiles.

OPINION:

This 49 year old man died due to sequelae of alcohol intoxication.

Examination and histology findings are consistent with the provided medical history. The nasopharyngeal swab is negative for common respiratory viral pathogens. The lung cultures reveal no bacterial growth.

A urine toxicology screen performed during hospitalization was negative. A blood alcohol level performed on 4-2-18 at 2130 was reported as >300 mg/dL and further quantification was not performed. Post mortem toxicology was not performed due to prolonged hospitalization and admission blood specimens were not available.

Per review of the available medical records and the Los Angeles Police Department Mental Evaluation Unit report (Incident number 4848) the decedent reportedly made suicidal ideations. There is a reported history of depression and chronic alcohol use with recent relapse.

Based on the history and circumstance, as currently known, the manner of death is suicide.

MARTINA KENNEDY, M.D.
DEPUTY MEDICAL EXAMINER

MK:MK
D: 04/22/2018 11:58:00
T: 04/26/2018 17:27:00
14

I performed a microscopic examination on 08/05/2018 at THE DEPARTMENT OF CORONER Los Angeles, California

2018-03122
Troyer, Verne

Diagnosis:
Lungs: Diffuse organizing pneumonia with patchy squamous metaplasia and occasional mucus plugs
Kidneys: Acute and chronic pyelonephritis and occasional glomerulosclerosis
Liver: Steatosis, minimal
Pancreas: Foci of peripancreatic fat necrosis, no significant fibrosis.
Heart: No significant abnormality.

Slide Key:
1/9: Heart
2/9: Kidneys
3/9: Liver
4/9: Lung, right upper lobe
5/9: Lung, right middle lobe
6/9: Lung, right lower lobe
7/9: Lung, left upper lobe
8/9: Lung, left lower lobe
9/9: Pancreas

Martina Kennedy, D.O.
Deputy Medical Examiner

10-7-18
Date:
DEATH WAS CAUSED BY: (Enter only one cause per line for A, B, C, and D)

IMMEDIATE CAUSE:
A) Sequelea of alcohol intoxication
B) 
C) 
D) 

JUE TO, OR AS A CONSEQUENCE OF:

OTHER CONDITIONS CONTRIBUTING BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH:

NATURAL
SUICIDE
ACCIDENT
COULD NOT BE DETERMINED

OTHER THAN NATURAL CAUSES, HOW DID INJURY OCCUR?

ALCOHOL INTAKE

WAS OPERATION PERFORMED FOR ANY CONDITION STATED ABOVE? Yes No

TYPE OF SURGERY

ORGAN PROCUREMENT

PREGNANCY IN LAST YEAR

WITNESS TO AUTOPSY

EVIDENCE RECOVERED AT AUTOPSY

Item Description:

no family objection to autopsy,

hospital specimen with body collected 4/21 0423

Mr. histo + cultures

TOXICOLOGY SPECIMEN

COLLECTED BY: Kennedy

TOXICITY SPECIFICATION

Biopsy:

REGISTRATION

AUTOPSY CLASS: A B C D Examination Only D

FAMILY OBJECTION TO AUTOPSY

Date: 4-22-15 Time: 1158 Dr. Kennedy (Pnt)

FINAL ON: 10-9-18 By: Kennedy (Pnt)

DEPARTMENT OF MEDICAL EXAMINER-CORONER

2018-03122

TROYER, VERNE JAT

A/S

SECTION

AGE: 49 Gender: Male Female

PRIOR EXAMINATION REVIEW BY DME

DEBUNKED

CASE CIRCUMSTANCES

EMBALMED

DECOMPOSED

-24 HRS IN HOSPITAL

OTHER: (Reason)

TYPING SPECIMEN

TYPING SPECIMEN TAKEN BY: Kennedy

SOURCE: Heart

HISTOLOGY

REGULAR (No. 2) Oversize (No. )

Histopath Cut: Autopsy Lab

TOXICOLOGY REQUESTS

SELECT TOXICOLOGY REQUESTED

SCREEN: C H T S D

ALCOHOL ONLY
CARBON MONOXIDE
OTHER (Specify drug and tissue)

REQUESTED MATERIAL ON PENDING CASES

POLICE REPORT
MED HISTORY
TOX FOR COD
HISTOLOGY
TOX FOR R/O
INVESTIGATIONS
MICROBIOLOGY
RADIOLOGY CONS.
CONSULT ON:

BRAIN SUBMITTED
NEURO CONSULT
DME TO CUT
CRIMINALISTICS
GSR
SEXUAL ASSAULT
OTHER

WHITE - File Copy CANARY - Forensic Lab PINK - Certification GOLDENROD - DME (Res. 9/13)
SEX: Male

RACE: Caucasian

AGE: 41

HEIGHT: 5'7"

WEIGHT: 165 lbs

HAIR: Brown

EYES: Blue

SCERA: Clear and dry

TEETH: Natural

MOUTH: Normal

TONGUE: Anterior dry

NOSE: Septum intact

CHEST: No palpable EKG's

BREASTS: Symmetrical

ABDOMEN: No scars

DECUBITUS: None at sacrum

PERITONEUM

Fluid est 50cc tan serous fluid

Adhesions:

LIVER Wt. 240g T+B, S5

Capsule

Lobules

Fibros

G B uq +sludge

Calculus

Bile ducts

SPLEEN Wt. 70g

Color

Consistency

Capsule

Malpigment

PANCREAS

ARID LESIONS FROM

ADRENALS

KIDNEYS Wt.

R 40 L 30

> largest left 1.8cm

Cortex markedly granular 2 scars pale

Vessels

Pelvis

Ureters empty

BLADDER

GENITALIA

Prostate

Testes

Uterus

Tubes

Ovaries

OESOPHAGUS

STOMACH

Contents est 10cc tan-pink fluid

DUOD. & SM. INT.

APPENDIX absent, scant fibroadipose

LARGE INT. soft green stool.

ABDOM. NODES

SKELETON

Spine

Marrow

Rib Cage

Long bones

Pelvis

SCALP no trauma

CALVARIAL no acute's

BRAIN Wt. 1310g

Dura

Fluid

Ventricles

Vessels

Middle ears

Other including brain

PITUITARY

and nasal septum

Mid cerebrum

tractionphotod

SPINAL CORD

Sup corv=0

TOXICOLOGY SPECIMENS

heart, fem, EOTA, vit, liver, bile, gastric

SECTIONS FOR

HISTOPATHOLOGY

1. Heart

2. Storage jars 2 kidneys

1 cassette jar 3 liver

Microbiology

nose pharyngeal swab

FLU positive

Liver

Liver lobe swab 7 LLV

12 cultures 2 killers 2 LLV

3. DIAGRAMS

X-RAYS

29 No acute trauma

OTHER PROCEDURES

Lung exsudate photo

abdomen photo

GROSS IMPRESSIONS

See Form 12

Date 4-22-16

Time 1158

Deputy Medical Examiner

MedicalFORMS - medical diviform #16.doc
To: LOS ANGELES COUNTY CORONER

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH LABORATORY - 12750 ERICKSON AVENUE, DOWNEY, CA 90242
NICOLE M. GREEN, PhD, D(ABMM), DIRECTOR (562) 658-1330

NAME: TROYER, VERNE
PATIENT ID# LACCO-201803122
REQ'D BY: REFERRED

DOB: 01/01/1969  AGE: 49Y  SEX: M

COLLECTED: 04/22/2018 12:10
ACC. NO.: M2574

RECEIVED: 04/23/2018  16:45
Order Comment: KENNEDY

TEST NAME
Multiplex Respiratory Panel PCR w/Reflex

<table>
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<tr>
<th>SPECIMEN DESCRIPTION</th>
<th>NASOPHARYNGEAL SWAB</th>
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<td>Adenovirus</td>
<td>NOT DETECTED</td>
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<tr>
<td>Result date,time: 04/24/2018, 07:35</td>
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<tr>
<td>Coronavirus 229E</td>
<td>NOT DETECTED</td>
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<tr>
<td>Coronavirus HKU1</td>
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<td>Result date,time: 04/24/2018, 14:52</td>
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<tr>
<td>Coronavirus NL63</td>
<td>NOT DETECTED</td>
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<td>Result date,time: 04/24/2018, 14:52</td>
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<tr>
<td>Coronavirus OC43</td>
<td>NOT DETECTED</td>
</tr>
<tr>
<td>Result date,time: 04/24/2018, 14:52</td>
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<tr>
<td>Human Metapneumovirus</td>
<td>NOT DETECTED</td>
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<td>Result date,time: 04/24/2018, 14:52</td>
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<tr>
<td>Human Rhinovirus/Enterovirus</td>
<td>NOT DETECTED</td>
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<tr>
<td>Result date,time: 04/24/2018, 14:52</td>
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<tr>
<td>Influenza A</td>
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<tr>
<td>Influenza B</td>
<td>NOT DETECTED</td>
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<tr>
<td>Result date,time: 04/24/2018, 14:52</td>
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<tr>
<td>Parainfluenza Virus 1</td>
<td>NOT DETECTED</td>
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<tr>
<td>Parainfluenza Virus 2</td>
<td>NOT DETECTED</td>
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<td>Result date,time: 04/24/2018, 14:52</td>
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<tr>
<td>Parainfluenza</td>
<td>NOT DETECTED</td>
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TROYER, VERNE
CLIENT REPORT
CONTINUED

AUTOPSYFILES.ORG - Verne Troyer Autopsy Report
The FilmArray Respiratory (RP) panel is a qualitative, multiplex, nucleic acid-based test capable of the simultaneous detection and identification of multiple viruses and bacteria directly from nasopharyngeal samples obtained from individuals with signs and/or symptoms of respiratory infection. This test is intended as an aid in the diagnosis of specific agents of respiratory illness, and results are meant to be used in conjunction with other clinical, laboratory, and epidemiologic data. Positive results do not rule out co-infection with other organisms not included on the panel, and the agent detected may not be the definitive cause of disease.

Rarely, multiple analytes may be detected. If four or more distinct organisms are detected in a specimen, an additional
### Multiplex Respiratory Panel PCR w/Reflex (CONTINUED)

**Result date, time:** 04/24/2018, 14:52

**Additional Comments**

Sample may be requested to confirm polymicrobial result. This test does not differentiate Rhinovirus and Enterovirus. Additional testing is required for Influenza subtyping. This test is not intended to be used to monitor treatment and results do not necessarily detect live organisms. For equivocal results, please submit additional specimen.

### INFLUENZA A AND B VIRUS BY RT PCR

**Specimen Source**

NASAL PHARYNGEAL SWAB

**Result date, time:** 04/24/2018, 07:36

**INFLUENZA A RNA**

NOT DETECTED

**Result date, time:** 04/24/2018, 15:04

**INFLUENZA B RNA**

NOT DETECTED

**Result date, time:** 04/24/2018, 15:04

**Interpretation**

NEGATIVE FOR INFLUENZA A AND B VIRUS

**Result date, time:** 04/24/2018, 15:04
**Bacteriology**

**Procedure:** Wound Culture with Gram

**Source:** Left Lobe CC 2018-03122

**Body Site:** Liver Lobe

**Free Text Source:** Liver Lobe CC 2018-03122

**ORDERING PHYSICIAN:** Kennedy, Martina

***FINAL REPORTS***

**Final Report**

Verified Date/Time: 04/27/2018 12:30

No growth at 5 days.

***STAINS***

**Gram Stain**

Verified Date/Time: 04/22/2018 02:06

- +: polymorphonuclear leukocytes
- Cell debris
- Red Blood Cells
- No organisms observed

Performing Locations

*1: This test was performed at:

LAC+USC Medical Center Laboratory, Ira A. Shulman MD, Laboratory Director, CLIA Certificate 05DO0543401, 1200 N. State Street, Los Angeles, CA, 90033-1083, US, (323) 409-7148
**Bacteriology**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Accession</th>
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<tr>
<td>Ground Culture with Gram</td>
<td>30-18-112-02985</td>
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<tr>
<th>Source</th>
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<tr>
<td>Source</td>
<td>Body Site</td>
<td>Free Text Source</td>
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<tr>
<td>Pathology</td>
<td>Lung R</td>
<td>Liver Lobe CC 2018-03122</td>
<td>Kennedy, Martina</td>
</tr>
</tbody>
</table>

***FINAL REPORTS***

Final Report
Verified Date/Time: 04/27/2018 16:29
No growth at 5 days.

***STAINS***

Gram Stain
Verified Date/Time: 04/22/2018 12:00

- <1+ polymorphonuclear leukocytes
- Red Blood Cells
- Cell debris
- No organisms observed.

Performing Locations

- This test was performed at:
  LAC+USC Medical Center Laboratory, Ira A. Shulman MD, Laboratory Director.
  CLIA Certificate 05D0543401, 1200 N. State Street, Los Angeles, CA, 90033-1083, US, (323) 409-7148
The decedent was brought from his residence into the hospital by ambulance on 04/02/2018. A urine toxicology test was completed at the hospital on 04/02/2018 showing an alcohol level of greater than 300.0 mg/dl. During his hospital course the decedent reportedly went into respiratory distress and became vent dependent. Despite life saving measures the decedent was pronounced on 04/21/2018 at 11:27 hours. The decedent has a reported medical history of dwarfism, alcohol abuse and depression.
Information Sources:
Medical Record: Valley Presbyterian Hospital, 15107 Vanowen Street, Van Nuys, CA, 91405, Patient file # 001228653.

Investigation:
On 04/21/2018 at 1919 hours, Register Nurse Kalie reported this apparent suicide death to Coroner Clerk K. Stone. It was reported that the decedent was taken to the hospital for alcohol intoxication and was admitted on 04/03/2018. The decedent reportedly went into respiratory failure and became vent dependent. The decedent was pronounced at the hospital. The decedent has a reported medical history of dwarfism and chronic alcoholism. It was reported that the decedent apparently called 911 himself saying he wanted to die. It was reported that the decedent just kept repeating it on his 911 call and in the emergency room. When the decedent arrived at the hospital, his alcohol level was reportedly above 300. The decedent reportedly came into the hospital approximately one year ago for the same thing. There was no note found. The decedent reportedly had prior suicide ideations in the past. It was unknown at the time of the call which police department was handling this case. There was no other further information reported.

I received this case for investigation from Lieutenant B. Kim on 04/21/2018. Supervisor Forensic Attendant C. Garcia and Forensic Attendant A. Jaime transported the decedent from the hospital to the Forensic Science Center on 04/21/2018 at 2220 hours.

A criminal history search for the decedent showed no prior arrests on file.

This case was originally moded as a suicide and after review of the informant statements; the mode was changed to an accident versus suicide death.

Criminalists call out criteria was reviewed and was not met at the time of my investigation.

Location:
Place of Injury: Residence: 8005 Teesdale Avenue, North Hollywood, CA, 91605.
Place of Death: Hospital: 15107 Vanowen Street, Van Nuys, CA, 91405.

Informant/Witness Statements:
The medical record and the form 18 had the following information. The decedent was brought from his residence into the hospital by ambulance on 04/02/2018. A urine toxicology test was completed at the hospital on 04/02/2018 showing an alcohol level of greater than 300.0 mg/dl. Despite life saving measures the decedent was pronounced on 04/21/2018 at 1127 hours by Dr. Gordon. The decedent has a reported medical history of alcohol abuse and depression.

On 04/21/2018, I conducted a telephone interview with the decedent's father and he stated the following information. The decedent was not married and did not have any adult children. The decedent was not known to use any illicit drugs. The decedent did have a history of alcohol abuse and had reportedly completed time at a treatment center approximately one year ago. The decedent had no known medical history. The decedent was taking prescription medication but the family did not know what they were being prescribed for. The decedent did have a primary doctor (Dr. Kroop). The decedent had a medical history of depression but was reportedly not seeking any medical treatment. The decedent had no known prior suicide attempts or ideations.

Scene Description:
There was no scene investigation by Coroner personnel as this was a hospital case.
Evidence:
The there was no evidence collected by Coroner personnel in this case.

Body Examination:
The decedent is a 49-year-old male Caucasian adult dwarf with blue eyes and brown hair. He was seen unshaven and with apparent natural teeth. There was a hospital identification band seen to the decedent's left arm. There was a red band seen to the decedent's left arm. A hospital identification tag was seen to the decedent's right arm. A bandage was seen to the decedent's left foot, right foot, left arm, right thigh, back of the head, and buttocks. An intravenous line was seen coming from the decedent's right thigh. There were no other medical appliances seen. Abrasions were seen to the decedent's genitals, right hand, mouth, tongue, and back of his head. Purple discoloration was seen to the decedent's arms. There was no other obvious evidence of trauma seen or palpated. A mole was seen to the decedent's right chest. Tattoos were seen to the decedent's arms, left chest, right leg, and back. A scar was seen to the decedent's right abdomen. There were no deformities seen.

Identification:
The decedent was positively identified by his driver's license issued by the California Department of Motor Vehicles as Verne Jay Troyer, date of birth 01/01/1969.

Next of Kin Notification:
[Redacted] father, was notified of the death by hospital personnel on 04/21/2018. I confirmed notification with him on 04/21/2018. The decedent was not married and did not have any adult children.

Tissue Donation:
Unknown if a One Legacy representative addressed tissue donation.

Autopsy Notification:
There were no autopsy requests made by law enforcement in this case.

MELISSA MUNOZ #638999

Date of Report
04/21/2018
<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Name of Decedent</td>
<td>Bob Hughes</td>
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<tr>
<td>Address</td>
<td>15107 Van Nuyn St, Van Nuyn, CA 91402</td>
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<tr>
<td>Hospital Phone #</td>
<td>818-702-8772-702-8772</td>
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<tr>
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<td>Valley Presbyterian Hospital</td>
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<tr>
<td>Pronounced by</td>
<td>Dr. Erin Gordon</td>
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<tr>
<td>Medical Record or Patient File #</td>
<td>MR 001228653</td>
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<td>Organ/Tissue Donation Information</td>
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<td>Next of Kin Approached Regarding</td>
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<td>Organ/Tissue Donation Information</td>
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<td>Injuries</td>
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<td>Describe Injuries</td>
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<td>Clinical History</td>
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<td>Surgical Procedures</td>
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<td>Laboratory Report on Pathology Specimens</td>
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<td>Microbiology Culture Results</td>
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<td>TOXICOLOGY SCREEN</td>
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<td>REMARKS</td>
<td>Multisystem Organ Failure / Terminal Extubation by family.</td>
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<td>Cause of Death</td>
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<td>Medical Examiner</td>
<td>Dr. Erin Gordon</td>
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<tr>
<td>MD</td>
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</table>

1. The body will not be removed by the coroner without this completed report and copies of all charts.
2. All admission blood samples/specimens, including Gastric Lavage, need to accompany the remains.