County of Los Angeles, Department of Coroner
Investigator's Narrative

Case Number: 2007-08227 Decedent: WEST, DONDA C.

Information Sources:

1. Medical record #5019747, Centinela Freeman Regional Medical Center, Marina Campus, 4650 Lincoln Boulevard, Marina Del Rey, CA, 90292, 310-823-8911
2.
3.

Investigation:

On 11-12-2007 at 0746 hours E. Alonzo of Centinela Freeman Regional Medical Center reported this death to Lieutenant C. MacWillie of the Coroner's Office. The death occurred at a hospital facility and the decedent was transported to the FSC on 11-12-2007 at 0935 hours by Forensic Attendant A. Scott. Supervisor MacWillie assigned this case to me on 11-12-2007 at approximately 0900 hours.

Location:

Injury: surgical center- 11819 Wilshire Boulevard, Suite 215, Los Angeles, CA, 90025

Death: hospital- 4650 Lincoln Boulevard, Marina Del Rey, CA, 90292

Informant/Witness Statements:

Medical records were received with the decedent's incoming paperwork. The paramedic runsheet that was received was poorly copied and illegible, but it appears that when Los Angeles City Fire Department RA 63 responded to the home the decedent was in an asystolic cardiac arrest. The decedent was still in cardiac arrest when she presented to the emergency room at 2020 hours. At the time of her arrival she had been intubated and ACLS medications, including Narcan, had been administered in the field. The paramedic reported that coffee ground emesis was present to the decedent's nose. When the physician confirmed the endotracheal tube placement breath sounds were greater on the right side of the chest. The endotracheal tube was pulled back and breath sounds were then equal. Additional ACLS medications were administered, but the decedent remained asystolic throughout the resuscitative efforts. Dr. Mickey Kolodny pronounced death at 2029 hours. It was reported that the decedent had been discovered unresponsive while lying supine in bed. She had recently undergone cosmetic surgery to her breasts and abdomen. The decedent had been prescribed Keflex and Vicodin. Dr. Kolodny discussed the death with the surgeon, Dr. Jan Adams, who stated that the death should be referred to the Coroner's Office.

On the evening of 11-12-2007 I spoke with Stephen Scoggins by telephone. Mr. Scoggins is an experienced nurse and has an advanced degree in Public Health. He informed me that the decedent went for cosmetic surgery at a surgery center on 11-09-2007. The surgery started at approximately 1230 hours and at 1800 hours the decedent was in the recovery room. Mr. Scoggins received a telephone call from the decedent's friend who was concerned that she was not waking up soon enough so he responded to the surgery center. At the time of his arrival the decedent was groggy, but was oriented to person, place and time. Ms. West had arranged for caregivers to stay with her during the night and the group returned to the decedent's home. Mr. Scoggins also stayed at the home and stated that the decedent ambulated during the night to prevent a deep vein thrombosis from forming. She was in pain and was medicated with Vicodin. In the morning the decedent stated that she felt better and was able to ambulate without assistance. Mr. Scoggins stated that the decedent appeared to be doing well so he left for the day with the intention to return and spend the night with his aunt. The decedent was left with caregivers Diana and Nubia who had been referred by Dr. Adams in addition to her friend, Glenda. At the time Mr. Scoggins left he stated that the decedent did not appear to be diaphoretic and had no symptoms of peritonitis or bleeding. Mr. Scoggins stated that the

decedent had no known cardiac problems or peptic ulcer disease. There is no history of substance abuse.

On the evening of 11-12-2007 I spoke with the decedent's long-time friend, Glenda Lee, by telephone. She informed me that the decedent had consulted with four doctors before selecting Dr. Adams to perform a breast augmentation, 'tummy tuck' and liposuction of her lower back. The decedent had a history of thyroid problems and took Synthroid. At one time she had been diagnosed with hypertension, but said that it had gone away; she was not taking anti-hypertensive medication. The decedent was also a border-line diabetic. She had seen physicians in the past at UCLA Medical Center in Westwood and Cedars-Sinai Medical Center. Two weeks before the surgery the decedent had experienced some leg pain, but did not see a doctor and the cause was unknown. Ms. Lee reported that heart problems run in the family and the decedent's sister died two years ago of a "heart attack." Her brother has a history of hypertension. It is unknown whether Ms. West had undergone any specialized tests prior to her surgery. Ms. Lee stated that she had arrived at the decedent's home on 11-10-2007 at 1600 hours. The two caregivers had gotten her out of bed and a few blood spots were seen on the abdominal dressing. The decedent had been ambulated every two hours and she was receiving Vicodin for her pain. At the time of Ms. Lee's arrival the decedent stated that her throat was hurting and her chest was hurting. The chest discomfort was felt to be the result of the breast augmentation and the tight bandages. The decedent felt warm to touch and at 1630 hours she ate some chicken soup, crackers, water and pineapple juice before her medications were given. The decedent was described as having "a lot of pain." Ms. Lee stated that she sat with her friend and rubbed her neck. She noticed that the decedent was "breathing heavy." At 1700 hours Ms. West went to bed and at that time she said that her chest was tight and her throat was sore. The decedent again got out of bed, but was not described as being anxious or confused. When she went back to bed pillows were beneath her legs and a single pillow was beneath her head. The decedent was able to tolerate lying flat. Ms. Lee went to the kitchen for a short while and when she returned the decedent had "black stuff on her face" and was cold and clammy. When her pulse was noted to be absent 911 was called. As rescue breaths were given more "blood" drained from the decedent's nose.

Scene Description:

The scene was not visited by coroner personnel.

Evidence:

No physical or medical evidence was collected for this report.

Body Examination:

The decedent was seen lying on a tray inside the FSC service floor. She is an adult female approximately 65-inches in length and weighs approximately 188 pounds. She has brown braided hair, brown eyes and natural teeth. An endotracheal tube was secured in her mouth and electrocardiogram patches and defibrillator pads were noted to her torso. The decedent had steri-striped incisions to her breasts and lower abdomen. Jackson-Pratt drains were intact to both anterior hip areas and the umbilicus had sutures. Viewing the decedent's back was deferred to the pathologist due to the instability of the tray.

Identification:

The decedent was identified by her nephew, Stephen Scoggins, while at the hospital.

County of Los Angeles, Department of Coroner
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Next of Kin Notification:

The decedent's next of kin is her son. Family members notified mother's death on 11-12-2007. is reportedly the decedent's durable power of attorney.

Tissue Donation:

One Legacy was notified by hospital personnel.

Autopsy Notification:

Private pathologist, Dr. Posey, has requested a two-hour notification for autopsy. He can be reached by calling 818-249-1911 or paged at 888-394-1019.

DENISE BERTONE 419432 SUPERVISOR

11-12-2007

Date of Report

COUNTY OF LOS ANGELES
DEPARTMENT OF CORONER

HOSPITAL AND NURSING
CARE FACILITY REPORT

1104 NORTH MISSION ROAD
LOS ANGELES, CALIF. 90033

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TO REPORT A DEATH — PHONE (213) 343-0711

COMPLETE ALL LINES. USE INK. IF UNKNOWN OR NOT APPLICABLE.

CC# 2007-08227

SO STATE Citrus La Freeman Regional Medical Center - Marina Campus
NAME OF FACILITY

ADDRESS 4650 Lincoln Blvd. PHONE 310-823-8911

NAME OF DECEDENT Dana West
HOW IDENTIFIED family DOB 7-12-49 AGE 58 SEX F RACE
DATE OF DEATH 11-10-07 TIME 2024

PRONOUNCED BY Dr. Hickey Kolodny MEDICAL RECORD OR PATIENT FILE # 5019747

☑ EMERGENCY ROOM PATIENT
☐ HOSPITAL IN PATIENT

ORGAN/TISSUE DONATION INFORMATION
WAS THE NEXT-OF-KIN APPROACHED REGARDING ORGAN/TISSUE DONATION?
NO ☑ YES ☐ IF YES WHAT WAS THEIR RESPONSE?

DATE ADMITTED 11-10-07 TIME 2020

TO HOSPITAL BY: ☐ POLICE ☐ RELATIVES ☐ FRIENDS ☐ SELF ☑ AMBULANCE (Name or R.A. #) RA #5

FROM Home - 7220 Ridge Ave. Playa del Rey, CA 90293
(STATE WHETHER HOME, HOSPITAL OR OTHER) GIVE ADDRESS (IF HOSPITAL ATTACH THEIR HISTORY)

ADMITTED BY: Dr. Mickey Kolodny MD M.D. PRIMARY ATTENDING PHYSICIAN [illegible] M.D.
PHONE # 310-823-4911 X4-5100 PHONE # 310-[illegible]-[illegible]

INJURIES DATE TIME PLACE CAUSE (TRAFFIC, FALL ETC.)

DESCRIBE INJURIES:

CLINICAL HISTORY: S/P Breast Implantation S/P Tummy Tuck. YESTERDAY GV OR ROMAS AT SURGICENTER. WAS SEEN BY FAMILY ZUMA & BEEN FOUND PULSE

SURGICAL PROCEDURES: STATE TYPE, DATE, TIME AND RESULTS OF ANY OPERATION OR AMPUTATION PERFORMED
S/P Breast Implantation, S/P Tummy Tuck 11/9/07

PARAMEDICS NOTED ORAL AIRWAY FULL OF COFFEE GROUNDS SUSPECT ASPIRATION
ASYSTOLIC FULL ARREST 5 RETURNED TO ROOM

WAS A BULLET OR OTHER FOREIGN OBJECT RECOVERED? SPECIFY

LABORATORY: SPECIFY SPECIMENS TAKEN Ø DATE & TIME
LABORATORY RESULTS:

RETAIN LABORATORY SPECIMENS

X-RAY REPORT: Ø

REMARKS: ESPECIALLY SYMPTOMS PRECEDING AND DURING TERMINAL EPISODE

IN MY OPINION, THE IMMEDIATE CAUSE OF DEATH IS UNKNOWN

BY [signature] M.D. —OR— ALICIA RN
NURSE/HOSPITAL ADMINSTRATOR

PHONE # [illegible]

78H85S (REV. 9/91)

THE BODY WILL NOT BE REMOVED BY THE CORONER WITHOUT THIS COMPLETED REPORT AND COPIES OF ALL CHARTS.

COUNTY OF LOS ANGELES

12 AUTOPSY REPORT

No. 2007-08227

WEST, DONDA

I performed an autopsy on the body of

at the DEPARTMENT OF CORONER

Los Angeles, California on NOVEMBER 13, 2007 @ 0920 HOURS
(Date) (Time)

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

(A) CORONARY ARTERY DISEASE AND MULTIPLE POST-OPERATIVE FACTORS

DUE TO OR AS A CONSEQUENCE OF

(B) LIPOSUCTION AND MAMMOPLASTY

DUE TO OR AS A CONSEQUENCE OF

(C)

DUE TO OR AS A CONSEQUENCE OF

(D)

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

Anatomical Summary:

I. History of belt lipectomy and bilateral augmentation mammoplasty with right breast reduction, clinical.

A. Breast reduction to include areola region, clinical.

1. At autopsy no evidence of abscess formation or trauma to the chest soft tissue or chest cavity.

2. Breast implants bilateral, intact unremarkable.

B. Circumferential abdominoplasty to include the waist and back into the soft tissue and anterior rectus abdominus muscle, unremarkable with no evidence of abscess formation or trauma to the peritoneal cavity.

1. Jackson-Pratt drain tubes intact, right and left lower abdomen with serosanguineous fluid. No pus is observed.

C. Umbilical area with sutures present and intact.

II. Autopsy findings: No evidence of external or internal trauma to explain cause of death.

A. No evidence of pulmonary embolism or clots in the tertiary arteries off the pulmonary trunk.

AUTOPSY REPORT

1. Slight pulmonary congestion and edema.

   a. No evidence of fat embolism, microscopic studies.

B. Increased epicardial fat. No cardiomegaly otherwise.

   1. Right coronary artery and left circumflex coronary artery with fibrointimal hyperplasia, assessed about 50-70% occlusion, microscopically.

      a. Increased perivascular fibrosis and some small vessel disease (arterioles).

      b. Left circumflex coronary artery hypoplasia.

C. Thyroid hypoplasia with fibrosis, and thyroiditis.

D. Fatty liver, slight.

E. Uterine leiomyomata.

III. See Neuropathology Report.

IV. See Toxicology Report.

V. See Microscopic Report.

HOSPITAL DATES: 11-10-07, Centinela Freeman Regional Medical Center

CIRCUMSTANCES:

See the Investigator's Narrative Report.

EXTERNAL EXAMINATION:

The body is identified by toe tags and is that of an unembalmed, refrigerated adult female Black who appears about the reported age of 58 years. The body weighs 188 pounds, measures 62 inches

and is obese. The lower right and left abdominal quadrant shows a horizontal recent incision surgical line that measures 22 inches with right and left Jackson-Pratt drains. The right drain shows about 100 ml of serosanguineous fluid. A swab is taken for culture at the end of the autopsy. The left side Jackson-Pratt drain shows about 15 ml of serosanguineous fluid. There is a surrounding slight purple ecchymosis around this incision area that measures about 12 x 1 inches. The back shows a continuation of the front circumferential abdominal incision which measures 16 inches with no erythematous reaction or abscess formation observed. The right breast area shows a curvilinear 9-1/2 inch recent surgical incision and around the areola region is about a 3-1/2 inch circumferential recent incision line. Vertically oriented to the curvilinear line is a 2-1/2 inch recent incision. The left breast shows a similar approximate 8-1/2 inch curvilinear and surgical incision line with a approximate 4 inch circumferential areola recent incision line and a 2-1/2 inch vertically oriented from the areola to the curvilinear surgical line also. All incisions show focal surrounding purple contusions. There is no pus or abscess formation or erythematous process involving the skin. There is also noted bilateral saline implants containing 325 ml of saline that are intact with fibrous tissue present. The right lateral profile shows a continuum of the abdominoplasty as shown on Diagram #20 with adjacent surrounding ecchymosis as shown again on Diagram #21.

There are no abrasions, lacerations or burns. Tattoos are not present. Rigor has presumably been abolished. Livor mortis is posterior, slight red and fixed on the lower back and on the posterior legs also. The head is normocephalic and covered by brown hair. There is no balding and the hair can be described as long and braided with an average length of 20 inches. Mustache and beard are absent. Examination of the eyes reveals irides that appear to be brown and sclerae that are non-icteric. There are no petechial hemorrhages of the conjunctivae of the lids or sclerae. The oronasal passages are unobstructed. Upper and lower teeth are present. The frenulum is intact. The neck is unremarkable. There is no chest deformity. There is no increased anterior-posterior diameter. The abdomen is not unusual except for the recent surgical procedure as described above. The genitalia are those of an adult female. The external genitalia are without trauma or lesions. The extremities show no edema, joint deformity, abnormal mobility or needle tracks.

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WEST, DONDA

EVIDENCE OF THERAPEUTIC INTERVENTION:

The following are present and are in proper position: EKG pads, defibrillator pads, steri-strips around the surgical incision areas around the breast and abdomen that are intact and secured, and a previously cut endotracheal tube. There is also an IV catheter of the right antecubital fossa and recent puncture marks of the left antecubital fossa about 3+. The Jackson-Pratt drains are described above.

Signs of cardiopulmonary resuscitation are as follows: Sparse intercostal space rib contusions. There are no rib fractures. There is serosanguinous pericardial fluid.

There has not been postmortem intervention for organ procurement.

EVIDENCE OF EXTERNAL TRAUMATIC INJURY:

None observed.

CLOTHING:

The body was not clothed and I did not see the clothing.

INITIAL INCISION:

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

EVIDENCE OF INTERNAL INJURIES:

None observed.

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. There is no edema of the larynx. Both hyoid bone and larynx are intact and without fractures. There are no prevertebral fascial hemorrhages. The tongue when sectioned shows no trauma.

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CHEST/ABDOMINAL CAVITY:

Both pleural cavities contain no fluid or adhesions. The parietal pleura are intact. The lungs are expanded. Soft tissues of the thoracic and abdominal walls are well preserved. The subcutaneous fat of the abdominal wall measures 3 cm in thickness and the chest wall measures 4 cm. The breasts are examined and palpated in the usual manner and show no abnormalities. The organs of the abdominal cavity have a normal arrangement and none are absent. There is no fluid collection. 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:

There are no abnormalities of the bony framework or muscles present other than for the surgical intervention involving the breasts, lower abdomen and back regions.

CARDIOVASCULAR SYSTEM:

The aorta is elastic and of even caliber throughout with vessels distributed normally from it. The abdominal and thoracic aorta has slight atherosclerosis. There is no tortuosity or widening of the thoracic segment. There is no dilatation 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 serosanguinous fluid. The heart weighs 300 grams and has a normal configuration. The right ventricle is 0.4 cm thick and the left ventricle is 1.1 cm thick. The septal wall measures 1.5 cm. 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 10.5 cm, pulmonic valve 7.4 cm, mitral valve 10 cm, and aortic valve 7 cm. There is no endocardial discoloration. There are no infarcts of the myocardium seen grossly. There is no abnormality of the apices of the papillary musculature. There are 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 is the dominant vessel. There is a focal area of narrowing involving the right mid coronary artery, see separate Microscopic Report. The left circumflex coronary artery is hypoplastic. No focal endocardial, valvular or myocardial lesions are seen grossly. The blood within the heart and large blood vessels is liquid.

RESPIRATORY SYSTEM:

A slight amount of edema fluid is found in the upper respiratory and lower bronchial passages. The mucosa is intact and pale. The lungs are subcrepitant and there is no dependent congestion. The left lung weighs 380 grams. The right lung weighs 520 grams. The visceral pleura are smooth and intact. The parenchyma is slightly congested and edematous. The pulmonary vasculature is without thromboembolism. Thromboemboli are not present in the distal tertiary branches. Thromboemboli are not present in the extrapulmonic portions of the pulmonary artery.

GASTROINTESTINAL SYSTEM:

The esophagus is intact throughout. The stomach is not distended. It contains 200 ml of well digested green food material with no liquid in which the exact contents cannot be identified. The mucosa is otherwise gray and smooth with no erosions or ulcerations. Portions of tablets and capsules cannot be discerned in the stomach. The small intestine and colon are examined by inspection, palpation and multiple incisions and show soft green stool in each region. The appendix is present. 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 1520 grams, is of average size and is tan-brown. The capsule is intact and the consistency of the parenchyma is soft. The cut surface is fatty. There is a normal lobular arrangement. The gallbladder is present. The wall is thin and pliable. It contains green liquid bile and no calculi. There is no obstruction or dilatation of the extrahepatic ducts. The periportal lymph nodes are not enlarged.

URINARY SYSTEM:

The left kidney weighs 130 grams and the right kidney weighs 140 grams. The kidneys are normally situated, and the capsules strip easily revealing a surface that is red and smooth. The corticomedullary demarcation is preserved. The pyramids are not remarkable. The peripelvic fat is not increased.

The ureters are without dilatation or obstruction and pursue their normal course. The urinary bladder is contracted. It contains about less than 1 cc of cloudy urine. The urine is not tested by dipstick method.

GENITAL SYSTEM (FEMALE):

The uterus is generally symmetrical and the uterine cavity is not enlarged, however there are numerous whorled white fibrous lesions that are subserosal and intramural consistent with leiomyomata. The fallopian tubes are unremarkable. The endometrium is light gray and moist with no polyps or lesions observed. The cervix and vagina have a normal appearance for the age. The ovaries are normal for the age.

HEMOLYMPHATIC SYSTEM:

The spleen weighs 70 grams and is smaller than of average size. The capsule is intact. The parenchyma is soft. There is no increased follicular pattern. Lymph nodes throughout the body are small and inconspicuous. The bone is not remarkable. The bone marrow of the rib is red moist and unremarkable. The vertebrae is aligned appropriately.

ENDOCRINE SYSTEM:

The thyroid gland is decreased in size and grossly shows fibrosis. The parathyroid glands are not identified. The adrenal glands are unremarkable. The thymus gland is not identified. The pituitary gland is of normal size and 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. The external periosteum and dura mater are stripped showing 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 fresh brain weighs 1250 grams. The leptomeninges are thin and transparent. A normal convolutionary pattern is observed. See separate Neuropathology Report to follow. Cerebral contusions are not present of the cortical surface observed. Vessels at the base of the brain have a normal pattern of distribution. There are no aneurysms. The 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.

NEUROPATHOLOGY:

Brain is placed in formalin solution for further fixation and later neuropathology consultation.

HISTOLOGICAL SECTIONS:

Representative sections from various organs are preserved in two storage jars in 10% formalin. Sections are to follow.

TOXICOLOGY:

Blood (heart, femoral from the iliac vein), bile, liver tissue, urine, stomach contents, vitreous humor, red top femoral blood

and two containers with right and left lung tissue for freezing are submitted to the laboratory. A comprehensive screen was requested.

SPECIAL PROCEDURES:

Anesthesia consultation was requested.

PHOTOGRAPHY:

At-scene photographs are not available. Photographs have been taken prior to the course of the autopsy.

RADIOLOGY:

The body is fluoroscoped and x-rays are taken of the head, neck, chest and abdomen (six).

WITNESSES:

Dr. David Posey witnessed the autopsy.

DIAGRAMS USED:

Diagram Forms #20 (2) and 21 were used during the performance of the autopsy. The diagrams are not intended to be facsimiles.

OPINION:

This previously healthy 58-year-old Black woman died as a result of coronary artery disease and multiple post-operative factors following liposuction and mammoplasty.

She went in for elective cosmetic surgery on 11-9-2007. Following surgery, per the medical records, she opted to return to her home for care even though she was advised that she receive post-operative care at another facility. There is no documentation of temperature readings, arterial oxygen levels, hematocrit level, or fluid balance records to evaluate her status on discharge or subsequently.

AUTOPSY REPORT

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WEST, DONDA

At home she was ambulatory and was there about 24 hours post-surgery. She was in pain but doing well over the evening of 11-9-07 to 11-10-07. She had chest discomfort, thought to be from the secured bandaging of the torso. At the end of the post-operative day #1 at home in the evening she was breathing heavily. She was left unattended and found unresponsive on the bed. LAPD responded and she was taken to Centinela Freeman Regional Medical Center where despite ACLS protocol she was pronounced dead.

The autopsy showed no pulmonary emboli. There was evidence of pulmonary scant micro fat embolization. However, this is not enough to explain the cause of death. There was no evidence of a surgical procedure problem leading to hemorrhage or infection postoperatively or during the procedure. The autopsy blood cultures were negative for bacterial organisms. The anesthesia management was uneventful per our Anesthesiology consultant.

The autopsy shows a multifactorial cause for her sudden demise. The microscopic studies confirm significant perivascular fiorosis and small arteriolar disease and some occlusion/narrowing of the coronary arteries varying from 50-70%. Microcalcifications were seen within the fibrointimal hyperplasia of the vessels examined. The left circumflex coronary artery was involved with plaque formations and was hypoplastic also. At the time of intubation emesis fluid was noted in the nose and airway. One lung section shows focal acute bronchopneumonia. This aspiration event may have triggered the cardiac event due to the decreased oxygen supply to the lungs and increased oxygen demand to the heart, as described above with some pre-existing disease. The thyroid gland shows a nonspecific thyroiditis and fibrosis which correlates with her use of synthroid and hypothyroidism. It is difficult from the autopsy to evaluate the effects that the bandage constriction around her torso had on her breathing.

Her post-operative hematocrit is not known. It is also not known or proven whether her hematocrit level was low following surgery from hemodilution because she received a large volume of fluid for a long procedure, which is expected.

Toxicology studies showed hydrocodone levels that were consistent with postmortem therapeutic levels. However, the effects of hydrocodone cannot be ruled out in combination with other medications present which may have contributed to some hypotension or respiratory depression events.

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Mild sickling tendency of the erythrocytes was noted by the Neuropathologist prompting a hemoglobin variant test which showed an abnormal hemoglobin variant (not hemoglobin S). The clinical significance is not known.

In summary, it is my opinion Ms. West died from some pre-existing coronary artery disease and multiple post-operative factors following surgery. The contributing factors were aspiration of emesis, focal pneumonia, bandaging of torso with constriction, probable hemodilution, and medication use for pain and an abnormal hemoglobin variant.

Based on the history and available information, as currently known, the manner of death could not be determined.

Dr. Lakshmanan Sathyavagiswaran, Chief Medical Examiner-Coroner, reviewed this case and concurs.

Louis A. Pena M.D.

LOUIS A. PENA, M.D.
DEPUTY MEDICAL EXAMINER

1-8-2008

DATE

LAP:mtm:c
D-11/13/07 - 1430 Hours
T-11/14/07