CONTINUING LEGAL EDUCATION

FALL 2015

OCTOBER 8, 2015

ROLE OF THE MEDICAL EXAMINER AND TOXICOLOGIST IN LITIGATION

MARK TAFF, M.D., DONALD HOFFMAN, PH.D., AND MICHAEL ALPERSTEIN, ESQ.

SPONSORED BY:
APPELLATE DIVISION, FIRST DEPARTMENT
AND
THE ASSIGNED COUNSEL PLAN FOR THE FIRST DEPARTMENT
OFFICE OF MEDICAL EXAMINER

REPORT OF AUTOPSY

Name of Decedent: ____________________________ M.E. Case #: _______________________

Autopsy Performed by: Medical Examiner, M.D. Date of Autopsy: November 25, 2010

FINAL DIAGNOSES

I. MULTIPLE BLUNT FORCE INJURIES OF HEAD, TORSO AND EXTREMITIES
   A. ABRASIONS, CONTUSIONS AND LACERATIONS OF SCALP AND FACE
   B. NASAL FRACTURE
   C. SUBARACHNOID HEMORRHAGE
      1. SEE SEPARATE NEUROPATHOLOGY REPORT
   D. ANTERIOR RIB FRACTURES
   E. CONTUSIONS ON LOWER LEGS

II. ADULT HUMAN BITE MARK ON CHEEK
   A. SEE SEPARATE FORENSIC ODONTOLOGY REPORT

III. SUBMERSION IN WATER
   A. WATERY FLUID IN SPHENOID SINUSES
   B. WATERY FLUID AND SAND IN STOMACH
   C. WET LUNGS

CAUSE OF DEATH: BLUNT FORCE INJURIES OF HEAD WITH NASAL FRACTURE, SUBARACHNOID HEMORRHAGE AND SUBMERSION IN WATER

MANNER OF DEATH: HOMICIDE
REPORT OF AUTOPSY

CASE NO. _______________________________________

I hereby certify that I, ____________, MD, City Medical Examiner, have performed an autopsy on the body of ____________ on November 25, 2010 commencing at 9 am in the Morgue.

This autopsy was performed in the presence of Drs. Moe, Larry and Curly.

EXTERNAL EXAMINATION
The body is that of a well-developed, well-nourished, average-framed, dark-skinned female measuring 5'7" long and weighing 141 pounds. The decedent's appearance is consistent with the given age of 35 years. The curly black hair measures up to 5". The ears and auditory canals are unremarkable. The torso and extremities do not show injuries. Needle track marks are not present. Each hand is wrapped in a brown paper bag that in turn is secured with red evidence tape. The bags are removed, labeled with the case number, and submitted to evidence. There is an intact, approximately 1" long, clear with gray designs, artificial fingernail on all but the right index and left middle fingers, the fingernails on these two fingers are intact. There are no fibers, hairs or blood stains on the uninjured hands, although there are focal areas of blood-soaked sand on each hand which easily wash away. The unremarkable external genitalia are female. The vagina and anus are atraumatic. The entire body is covered with fine, light-colored sand.

POSTMORTEM CHANGES
Rigor mortis is absent. Lividity is ambiguous. The body is cool.

TATTOOS
The following professional-appearing, polychromatic tattoos are present. There are 1/2" to 3" in greatest dimension birds associated with the phrase "this too shall pass" around the left arm. There is an up to 1" wide, circumferential belt design around the left arm.

CLOTHING
The decedent is clothed in 1) a polka dot print bra, 2) a white, short-sleeve shirt, 3) a pair of blue/yellow/green socks and 4) a black thong. Each item is covered with abundant, fine, light-colored sand. There are no fabric defects. The bra, shirt and socks are labeled with the case number and submitted to evidence and the thong is submitted to Forensic Biology as part of the Vitullo sex assault kit.

INJURIES, EXTERNAL AND INTERNAL
There are blunt force injuries of the head, at least one human bite mark is on the face, some ribs are fractured, and there are contusions on the lower extremities.

BLUNT FORCE INJURIES OF HEAD: There is a 2", horizontally-oriented laceration in the left scalp, approximately 3" above the top of the left ear, which is associated with a 1-1/2" x 1" area of full-thickness scalp hemorrhage. There is a 1/2", crescent-shaped laceration in the skin of the upper left forehead, approximately 1" below the hairline, which is associated with a 3-1/2" x 2" area of full-thickness scalp hemorrhage. There are three areas of mottled purple and red skin discoloration, ranging from 1" to 1-1/2" in greatest dimension, on the middle forehead. The largest area is located on the lower middle forehead and at its inferior edge; approximately 1-
1/4" above the glabella and 1/2" right of midline, there is a 1/4" skin laceration which is without underlying scalp hemorrhage. Soft tissue swelling with purple/red skin discoloration is present in and around the orbits, over the nasal bridge and on the nasal tip, and over the cheek bones. There are superimposed, punctate abrasions in the skin over the lateral orbits and the cheekbones, more on the left than on the right. There is a 1/2" in greatest dimension, stellate laceration in the skin over the upper nasal bridge in the midline, approximately 1/2" below the glabella, and the underlying nasal bones are palpably fractured. There is a 3/4" in greatest dimension, stellate defect that perforates the upper lip just right of midline, with a 1" to 1-1/2" in greatest dimension purple contusion around the defect on both the external and internal lip. The oral mucosa is otherwise atraumatic and the native dentition is in good repair without chipped or absent front teeth. The conjunctivae are congested but there are no petechiae. The skull is not fractured and there is no epidural or subdural hemorrhage. There is a film of dark red subarachnoid hemorrhage over the lateral cerebral hemispheres.

**BITE MARK(S) OF FACE:** There is an approximately 1" diameter, slightly ovoid array of multiple, adjacent, up to 1/8" long by 1/32" wide, rectangular to triangular, red purple skin indentations and superficial puncture marks on the lateral right cheek which surround an erythematous center. Swabs of the indentations are taken and are submitted to Forensic Biology. There are a few, 1/8" to 1/4" in greatest dimension, rectangular, triangular and slightly rounded, abrasions and superficial puncture defects in the skin over the middle to lateral right nare and nasal tip (Comment: these two clustered pattern injuries, and particularly the one on the right cheek, are suggestive of human bite marks; Forensic Odontology will consult on these injuries and their findings will be separately reported).

**RIB FRACTURES:** Anterior right ribs #2-4 and anterior left rib #2 are fractured and there is slight associated hemorrhage in the adjacent intercostal soft tissues. There are no injuries to the thoracic viscera.

**CONTUSIONS OF LOWER EXTREMITIES:** There are a few, 1/4" to 3/4" in greatest dimension, purple red contusions on and around the anterior right knee and on the left shin. There is a 2-1/2" x 1-1/2" purple contusion on the medial right lower leg and ankle.

*The injuries listed above, having been described once, will not be repeated.*

**INTERNAL EXAMINATION**

**GENERAL FINDINGS AND BODY CAVITIES:** The subcutaneous fat is 1" thick. The tissues and organs are moist. The organs are in their normal situs. The pleural, pericardial and peritoneal surfaces are smooth and glistening. There are no abnormal fluid collections or hemorrhages. The retroperitoneum is unremarkable.

**HEAD:** The brain weighs 1170 grams and is retained in formalin for neuropathologic consultation. The sphenoid sinuses contain clear, watery fluid.

**NECK:** The cervical vertebrae, hyoid bone, tracheal and laryngeal cartilages and paratracheal soft tissues are without trauma. The upper airway is patent. The tongue and epiglottis are unremarkable.
CARDIOVASCULAR SYSTEM: The heart weighs 250 grams. The epicardial fat is normal in amount and the epicardial surface is smooth and glistening. The epicardial coronary arteries demonstrate their usual distributions and calibers, and the coronary circulation is right-predominant. The coronary ostia are patent and unremarkable. The left anterior descending, left circumflex, and right coronary arteries show minimal atherosclerotic stenosis of their proximal to middle lumens (up to 20%) and do not contain thrombus. The myocardium is homogeneous, brown and approximately firm without pallor, hemorrhage, softening or fibrotic scars. The chambers do not appear dilated. The left and right ventricles are 1 and 0.3 cm thick, respectively. The endocardium is smooth and transparent. The four cardiac valves are unremarkable. The aorta shows slight atherosclerosis. The vena cava and hepatic, portal and mesenteric vessels are patent and do not contain thrombus or emboli.

RESPIRATORY SYSTEM: The right and left lungs weigh 560 and 500 grams, respectively. The right lung has three lobes and the left lung has two lobes. The pleural surfaces are smooth and glistening. Cut surfaces are orange/red, soft and airy with congestion in the lower and posterior upper lobes. A moderate amount of frothy clear fluid is expressed from the lung surfaces with lung compression. There are no masses, hemorrhages, areas of consolidation or emphysematous changes. The small airways are unremarkable. The vessels are patent and without thrombi or emboli. The trachea and bronchi contain scant brown/red fluid and their mucosae are unremarkable.

LIVER, GALLBLADDER, Pancreas: The liver weighs 1240 grams and has an intact, smooth capsule. Cut surfaces are homogeneous, brown and smooth without slippery or fibrous texture. No lesions are identified. The gallbladder contains 20 cc of green bile and no stones. The pancreas is unremarkable in lobulation, color and texture.

HEMIC AND LYMPHATIC SYSTEMS: The spleen weighs 60 grams and has an intact, purple and slightly wrinkled capsule. Cut surfaces are red and appropriately firm. The white pulp is inconspicuous. No lesions are identified. Lymph nodes throughout the body are unremarkable. The hilar lymph nodes show anthracosis. The bone marrow is red.

URINARY AND REPRODUCTIVE SYSTEMS: The kidneys weigh 220 grams combined. The capsules strip with ease. The surfaces are red/brown and smooth. Cut surfaces are congested and show the usual corticomedullary architecture. The vessels are unremarkable. The calyces and pelvis are not dilated. The ureters have normal calibers. The unremarkable bladder is empty and there are no stones. The uterus contains a 4 cm diameter, subserosal uterine leiomyoma that has firm, tan, whorled cut surfaces without hemorrhage or necrosis. The ovaries and fallopian tubes are unremarkable. The vaginal canal is atraumatic. The breasts show no abnormality.

ENDOCRINE SYSTEM: The pituitary, thyroid and adrenal glands are normal size, color, and consistency.

DIGESTIVE SYSTEM: The esophagus and gastroesophageal junction are unremarkable. The stomach contains 150 cc of light brown, watery fluid and some tan/white particulate matter and fine, lightly colored sand that settles to the bottom of the container after standing for one hour. The small bowel contains brownish fluid and the large bowel contains semifluid, brown/green stool. The esophageal, gastric and intestinal mucosae are unremarkable. The small and large bowel are unremarkable. The vermiform appendix is present.
MUSCULOSKELETAL SYSTEM: The vertebrae, clavicles, sternum and pelvis are without fracture. The unremarkable musculature is normal color and consistency.

NEUROPATHOLOGY
The results of neuropathologic examination of the brain will be separately reported.

FORENSIC ODONTOLOGY
Analysis and documentation of the facial bite mark(s) was performed by Drs. Cheech and Chong and the results are separately report and incorporated into the final diagnoses.

TOXICOLOGY
Specimens are submitted for toxicologic analysis and the results will be separately reported.

FORENSIC BIOLOGY
Blood, a Vitullo kit, and swabs of the bite mark on the cheek are submitted to Forensic Biology and their results will be separately reported.

POSTMORTEM RADIOGRAPHY
Radiographs are taken and are retained.

POSTMORTEM PHOTOGRAPHY
Photographs are taken and are retained. (Comment: The photographs of the right hand were inadvertently obtained after the synthetic fingernails had been cut off by Dr. ________).

EVIDENCE
Two (2) brown paper bags in which the hands are wrapped and three (3) items of clothing are submitted to evidence.
AUTOPSY NOTES

NAME OF DECEDENT: ____________________________ M.E. #: ____________-

SKIN COLOR: _______ WD/WN: _______ HEIGHT: _____ FT _____ IN WEIGHT:_____ LB AGE: _____

HAIR: TXTR____ CLR_____ IN M____ IN B_____ IN EYES: IRIDES____ CONJ____ TEETH/ORAL____

TORSO: ANT____ POST_____ GENITALIA +/- __________ EXTREMITIES: UPPER_____ LOWER____

RIGOR MORTIS: __________ LIVOR MORTIS FNF __________ TEMPERATURE: __________

SCARS:

TATTOOS:

CLOTHING:

THERAPEUTIC PROCEDURES:

INJURIES:

Head
Brain_________ gm

NecK
Cavities______

Vessels
Heart_________ gm
L.V._________ cm
R-Lung_________ gm
L-Lung_________ gm
Liver_________ gm
Bile_________ ml

Pancreas

Spleen_________ gm

Lymph nodes
Thymus: Y/N
R-Kidney_________ gm
L-Kidney_________ gm
Urine_________ ml

Gonads

Endocrine

Digestive Tract
Gastric_________ ml

App. Y/N

Musc-Skel: __________

DIAGNOSES:

________________________

________________________

________________________

EXAMINED BY: ____________________________ DATE: ____________ TIME: ____________
OFFICE OF MEDICAL EXAMINER

REPORT OF AUTOPSY

Name of Decedent: 

Autopsy Performed by: Medical Examiner, M.D. 

M.E. Case #: 

Date of Autopsy: November 25, 2010 

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NEUROPATHOLOGY
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EVIDENCE
Two (2) brown paper bags in which the hands are wrapped and three (3) items of clothing are submitted to evidence.

__________________________________________, MD
City Medical Examiner – 1
January 20, 2011

__________________________________________, MD
DRAFT: 11/26/10
FINAL: 1/20/11
AUTOPSY NOTES

NAME OF DECEDENT: ____________________ M.E. #: ____________________

SKIN COLOR: _______ WD/WN: _______ HEIGHT: ___ FT ___ IN WEIGHT: ___ LB AGE: ______

HAIR: TXTR___ CLR___ IN M IN B IN EYES: IRIDES ___ CONJ ___ TEETH/ORAL ___

TORSO: ANT ___ POST ___ GENITALIA +/- ___ EXTREMITIES: UPPER ___ LOWER ___

RIGOR MORTIS: _______ LIVOR MORTIS F/NF _______ TEMPERATURE: ______

SCARS: __________________

TATTOOS: __________________

CLOTHING: __________________

THERAPEUTIC PROCEDURES: __________________

INJURIES: 

Head 

Brain _______ gm 

Neck 

Cavities 

Vessels 

Heart _______ gm 

L.V. _______ cm 

R-Lung _______ gm 

L-Lung _______ gm 

Liver _______ gm 

Bile _______ ml 

Pancreas 

Spleen _______ gm 

Lymph nodes 

Thymus: Y/N 

R-Kidney _______ gm 

L-Kidney _______ gm 

Urine _______ ml 

Gonads 

Endocrine 

Digestive Tract 

Gastric _______ ml 

App. Y/N 

Musc-Skel: __________________

DIAGNOSES: 

______________________________ 

______________________________ 

______________________________ 

______________________________ 

______________________________ 

______________________________ 

______________________________

EXAMINED BY: __________________ __ DATE: ___________ TIME: ___________
NEUROPATHOLOGY REPORT
CASE NUMBER:_____

NAME OF DECEDENT:
DR.____________ PERFORMED AUTOPSY ON 11/25/10
DR.____________ EXAMINED BRAIN ON 12/18/10

GROSS EXAMINATION:
Brain weight: 1170 gm.

The specimen consists of the brain and intracranial dura of an adult. Prior to fixation, a portion of the right occipital lobe has been removed for possible toxicology studies.

The intracranial dura is not remarkable. All venous sinuses are patent.

The leptomeninges reveal recent, thin-layered subarachnoid hemorrhage over bilateral orbital gyri, temporal poles, inferior surface of the left temporal lobe and the left temporal and parietal convexities. The cerebral gyri are of normal size, configuration and consistency. There is no sign of herniation. The external aspects of the brainstem and cerebellum are not remarkable. The arteries at the base of the brain follow a normal distribution and are free of atherosclerosis, aneurysmatic dilations or sites of occlusion. All cranial nerve stumps identified are not remarkable.

Coronal sections of the cerebrum reveal no focal lesions in the cortex, white matter or deep nuclear structures. There is no shift of the midline structures. Sections of the midbrain, pons, medulla oblongata and cerebellum show no focal abnormalities. Myelination is normal for age. The substantia nigra is well pigmented. The ventricular system and cerebral aqueduct are patent, and normal in size and configuration. The ependymal lining is smooth and glistening.

PHOTOGRAPHS: YES

MICROSCOPE EXAMINATION: NO

DIAGNOSIS:
1. HISTORY OF RECENT TRAUMATIC INJURY WITH:
   A. SUBARACHNOID HEMORRHAGE, CEREBRAL HEMISPHERES

__________________________
NEUROPATHOLOGIST, M.D.  12/18/10
FORENSIC TOXICOLOGY LABORATORY

Deceased: M.E. Case No.: Lab. No.: 

Autopsy By: Dr. Medical Examiner Autopsy Date: 11/25/10

Specimens Received:
- Bile, Blood, Brain, Gastric Content, Liver, Vitreous Humor

Specimens Received in Laboratory By: [COORS LIGHT] Date Received: 11/27/10

Equivalents: 1.0 mcg/mL = 1.0 mg/L = 0.1 mg/dL = 1000 ng/mL 1.0 mcg/g = 1.0 mg/kg = 0.1 mg/100g = 1000 ng/g

Results

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<td>Caffeine</td>
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<table>
<thead>
<tr>
<th>Substance</th>
<th>Concentration</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethanol</td>
<td>0.379%</td>
<td>GC</td>
</tr>
</tbody>
</table>

\[ EI = Enzyme Immunoassay \]
\[ GC = Gas Chromatography \]
\[ GC/MS = GC/Mass Spectrometry \]
\[ LC = Liquid Chromatography \]
\[ LC/MS = LC/Mass Spectrometry \]

CT = Color Test
TLC = Thin Layer Chromatography
ISE = Ion Selective Electrode
SP = Spectrophotometry
< = Less than

Signed: Dr. 
Date: 12/30/10
**CASE WORKSHEET**

| NAME OF DECEDENT: | M.E. CASE #:
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>AGE: 35</td>
</tr>
</tbody>
</table>

**MEDICAL EXAMINER:**

**DATE:** November 25, 2010

----

**PART I: DEATH WAS CAUSED BY:**

- **Immediate cause:** Blunt force injuries of head with nasal fracture, subarachnoid hemorrhage and submersion in water.
- **Due to or as a consequence of:**
  - Hemorrhage
  - Submersion

**PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in part 1:**

**MANNER OF DEATH:**

- Pending studies
- Natural
- Therapeutic Complication
- Accident
- Suicide
- Homicide
- Undetermined

**Place of Death:**

- Beach

**DATE & TIME OF DEATH:** November 25, 2010 02:40 AM

**Any Hospice care in the last 30 days:** No

**TYPE OF PLACE:**

- Hospital in-patient
- Hosp ED/Outpatient
- Hosp DOA
- Other: Beach

---

**INJURY:**

- Date: November 25, 2010
- Time: 02:20 AM

**AT WORK:**

- Yes
- No
- Unknown

**TYPE OF PLACE (Home, Street, etc.):** Beach

**LOCATION:**

- Beach, Brooklyn, N.Y.

**HOW INJURY OCCURRED:**

- See Above

**IF TRANSPORTATION INJURY:**

- Driver/operator
- Pedestrian
- Passenger
- Other, specify

---

**IF FEMALE:**

- Not pregnant within one year of death
- Pregnant at time of death
- Not pregnant at time of death, but pregnant within 42 days of death
- Not pregnant at time of death, but pregnant 43 days to 1 year before death
- Unknown if pregnant within one year of death

**Did tobacco use contribute to death?**

- Yes
- No
- Probably
- Unknown

---

**If within one year of death, outcome of pregnancy:**

- Live birth
- Spontaneous termination
- Induced termination
- None

**Date of outcome:**

- mm/dd/yyyy

**For infant under 1 year: Name and address of hospital or other place of birth:**
OFFICE OF MEDICAL EXAMINER
SCENE INVESTIGATION FORM

INVESTIGATOR: ____________________________ ME CASE # ____________________________
NOTIFIED 11-25-2010 AT 10:26 HOURS
POLICE AGENCY: ____________________________ COMMAND ____________________________
ON SCENE 11-25-2010 AT 08:01 HOURS
DEPARTURE 11-25-2010 AT 06:15 HOURS 1ST PO ____________________________ SHIELD __________
DISPOSITION 11-25-2010 AT 06:15 HOURS REPORTED BY ____________________________
DETECTIVE ____________________________ SHIELD # ____________________________ UNIT ____________________________
_________________________ SHIELD # ____________________________ UNIT ____________________________

PRONOUNCED/FOUND 11-25-2010 AT 02:40 HOURS BY EMS SHIELD #: ____________________________
PLACE OF DEATH Beach ____________________________ PHONE NUMBER: ____________________________
PHYSICIAN CONTACTED ____________________________

NAME OF DECEASED: ____________________________ LAST ____________________________ FIRST ____________________________ MI ____________________________
ADDRESS: ____________________________ APT: ____________________________ CITY: ____________________________ STATE: ____________________________ ZIP: ____________________________
AGE: 35 RACE: Black SEX: Female DOB: ____________________________ SSN: ____________________________ PHONE #: ____________________________
BIRTH PLACE: Unknown VETERAN Unknown MARITAL STATUS: Unknown
OCCUPATION: ____________________________ EDUCATION: ____________________________
NEXT OF KIN: Unknown RELATIONSHIP: ____________________________
ADDRESS: ____________________________ APT: ____________________________ CITY: ____________________________ STATE: ____________________________ ZIP: ____________________________
PHONE #: ____________________________ ALT. PHONE#: ____________________________ NOTIFICATION STATUS ____________________________

IDENTIFIED AT SCENE BY: Pending RELATIONSHIP: ____________________________
ADDRESS: ____________________________ APT: ____________________________ CITY: ____________________________ STATE: ____________________________ ZIP: ____________________________
PHONE #: ____________________________ ALT. PHONE#: ____________________________ REASON IF NO ID: Nobody Present

CASE DISPOSITION: ____________________________ RECEIVING FACILITY Medical Examiner Office

KNOWN AUTOPSY OBJECTIONS
OR REQUESTS (MUST DOCUMENT SUPPORTING REASONS AND RELIGION)

Unknown

FUNERAL HOME: Unknown

Page 1 of 3
IF UNNATURAL DEATH: 
ME CASE #

INCIDENT LOCATION: Beach

INCIDENT DATE: 11-25-2010 TIME: AT WORK CRIMINAL CHARGES: Yes

HOW INJURY OCCURRED: Multiple Gunshot Wounds to The Head

IF FEMALE: PREGNANT LAST 6 MONTHS RESULT

TIME FRAME OF DEATH: □ OR WITNESSED COLLAPSE

LAST SEEN ALIVE 11-25-2010 AT HOURS LOCATION Beach BY Boyfriend

FOUND DEAD 11-25-2010 AT 0240 HOURS LOCATION Beach BY Police

DATED ITEMS AT SCENE None

SCENE DESCRIPTION:

LOCATION Beach

DESCRIPTION Beach Shoreline

DECEDeNT’S RELATIONSHIP TO SCENE Unknown

ILlicit DRUGS OR ETOH AT SCENE No DESCRIPTION

CONDITION OF SCENE Beach Shoreline Cold And Clear

SECURITY DEVICES IN USE AT TIME OF DISCOVERY: x

□ N/A □ DOorman/Guard □ BUZZ-IN ENTRY □ CCTV CAMERAS □ DOOR LOCKED
□ SECURE □ SLAM LOCK □ DEAD BOLT □ CHAIN □ WINDOWS CLOSED □ WINDOWS LOCKED

BODY LOCATION AND POSITION ________________________________

CLOTHING DESCRIPTION ________________________________

JEWELRY/VALUABLES ON DECEDeNT ________________________________

VOUCHERING PO SHIELD # COMMAND ________________________________

PHYSICAL EXAM:

RIGOR MORTIS ________________________________ DESCRIPTION ________________________________

LIVOR MORTIS ________________________________ ________________________________
BODY TEMPERATURE 60°F DATE 11-25-2010 TIME 05:20 METHOD Rectal
AMBIENT TEMPERATURE 48°F DATE 11-25-2010 TIME 05:20 METHOD Thermoster Outdoor
OTHER POSTMORTEM CHANGES: ☐ NONE DRYING OF: ☐ EYES ☐ LIPS ☐ FINGER/TOES
☐ PURGE FROM NOSE/MOUTH ☐ GREEN ABDOMEN ☐ SKIN DISCOLORATION
☐ EPIDERMAL SKIN SLIPEOR BULLAE ☐ BLOAT ☐ MUMMIFICATION ☐ ADIPOCERE ☐ MARBLING
☐ SKELETONIZATION ☐ MAGGOTS ☐ EVIDENCE OF POSTMORTEM ANTHROPOPHAGY
ADDITIONAL INFO: ____________________________________________________________
IDENTIFYING MARKS: ________________________________________________________

EXTERNAL EVIDENCE OF DISEASE OR INJURY: Gunshot Wound To The Left Frontal
Area Of The Head Above The Left Orbit, Bridge Of The Nose
And Upper Lip

WEATHER INFO: Clear Cool OUTDOOR TEMPERATURE (F) 48° WATER TEMPERATURE (F) N/A

DECEASED MEDICAL HISTORY ____________________________________________ ☐ HYPERTENSION ☐ DIABETES MELLITUS
☐ HIV ☐ AIDS ☐ HEP-C ☐ HEP-B ☐ PSYCH ☐ CAD ☐ MI ☐ CVA ☐ CHF ☐ ASTHMA ☐ CANCER
☐ IVDA ☐ POLYSUBSTANCE ABUSE ☐ ETOH ABUSE ☐ COPD ☐ TOBACCO USE- (PACK YEARS) __________

ADDITIONAL INFO:

PRESCRIPTIONS (PROVIDE DRUG, DATE AND NUMBER OF PILLS DISPENSED/PILLS LEFT [OR
INDICATE IF PILL COUNT APPROPRIATE FOR DATE], DOCTOR, PHARMACY NAME/PHONE NUMBER,
USE SUPPLEMENTAL FORM IF NECESSARY):

OTHER MEDICAL
DOCUMENTATION
AT SCENE

DATE 11-25-2010 INVESTIGATOR SIGNATURE _____________________________ PAGE 3 OF 3
HOMICIDE
SUPPLEMENTAL CASE INFORMATION

NAME OF DECEASED: CASE #:

SUPPLEMENTAL INFORMATION DATE: NOVEMBER 25, 2010

INFORMATION SOURCE: SCENE INVESTIGATION

ADDRESS: BEACH

CONTACT VIA: TELEPHONE: PERSONAL INTERVIEW: X

CONTACT INITIATED BY: INFORMANT: UNDERSIGNED: X

THIS IS A 35 YEAR OLD BLACK FEMALE WITH UNKNOWN MEDICAL HISTORY. THE DECEDED WAS FOUND WITH MULTIPLE GUNSHOT WOUNDS TO THE HEAD UNDER THE FOLLOWING CIRCUMSTANCES. ACCORDING TO THE POLICE, THE BOYFRIEND OF THE DECEDED WAS DRIVING HIS CAR ERRATICALLY, BLOWING HIS HORN AND TURNING THE HEADLIGHTS ON AND OFF. HE WAS STOPPED BY POLICE. THEY NOTED THAT HE HAD ALCOHOL IN HIS BREATH AND WAS ACTING BIZARRE. HE TOLD POLICE THAT HIS GIRLFRIEND COMMITTED SUICIDE AT BEACH AND THEN TOLD THEM THAT "I DID SOMETHING I SHOULDN'T OF DONE". POLICE ARRESTED THE BOYFRIEND AND THEN WENT TO THE LOCATION THE BOYFRIEND HAD GIVEN THEM. WHEN THEY GOT THERE, THEY FOUND NOTHING. POLICE WENT TO A LOCAL HANGOUT AND THEY DISCOVERED THE DECEDED ON THE BEACH. THEY IMMEDIATELY CALLED 911, EMS RESPONDED AND PRONOUNCED THE DECEDED DEAD ON ARRIVAL AT 02:40 HOURS. DETECTIVE IS ASSIGNED TO THE CASE. CRIME SCENE DETECTIVE RESPONDED TO THE SCENE.

FORENSIC MEDICAL INVESTIGATOR
Notice Of Death

Report #: Borough: Brooklyn Report Date: 11/25/10 Time: 04:20 M.E. #: 
Decedent Information:
Name: Female Age: 35 Years
Sex: Black DOB: 
Race: 
Place of Death: Beach Tel Place of Death: 
Residence: 

Reporter Information:
From: Police Facility: 
Caller Name: unk Shield #: 
Sixty-One #: unk Aided #: 

Circumstances of Death:
App. Manner: Homicide History: Unknown
Other Circumstances Are Unknown Deceased Was Found on a Beach
Info: Homicide Police Had Limited Inform Gunshot Wound To The Head

Hospital and Physician Information:
Facility: 
Date: 11/25/2010 Time: 02:40
Physician: 

MLI Contact, Scene and Disposition:
1. Shield #: Date: 11/25/10 Time: 04:29 Investigator On Case: Aware Of The Case
2. Shield #: Date: 11/25/10 Time: 04:44 ME Case To OCME

Scene Investigation: No
Case Disposition: Transport to OME Date: 11/25/10 Time: 04:44

Transportation:
1. By: METT Member Assigned: Date: 11/25/10 Time: 04:45
2. By: METT at Scene, No Custody: Date: 11/25/10 Time: 05:23
3. By: METT Takes Custody of Body: Date: 11/25/10 Time: 05:23

Autopsy Objection:
Date: Time: Who Objected: 
Why: 

OCME Notes:

Initial Call Recorded By: 
Printed: 11/25/10 - 08:23
COMPLAINT FOLLOW-UP  
MEDICAL EXAMINER CASE  

<table>
<thead>
<tr>
<th>DATE OF REPORT</th>
<th>DAY OF WEEK</th>
<th>DATE REPORT</th>
<th>DATE ASSIGNED</th>
<th>MP CASE NUMBER</th>
<th>UNFP REPORTING SQUAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/25/10</td>
<td>THURS</td>
<td></td>
<td></td>
<td>ME CASE NUMBER</td>
<td></td>
</tr>
</tbody>
</table>

HOMICIDE

NAME OF DECEASED (LAST, FIRST, MIDDLE)

AGE: 35Y  
RACE: BLACK  
SEX: FEMALE

ADDRESS:

DATE OF OCCURRENCE: 11/25/10  
TIME OF OCCURRENCE: 02:20  
PLACE OF OCCURRENCE: BEACH

EXPIRED AT: SCENE  
DATE: 11/25/10  
TIME: COMMAND

MOST IDENTIFYING

FAMILY MEMBER IDENTIFYING

ADDRESS

PHOTO PRINTS

DOCTOR PERFORMING AUTOPSY

DR. MEDICAL EXAMINER  
DATE: 11/25/10  
LOCATION: ME OFFICE

CAUSE OF DEATH

Bullets Recovered During Autopsy

DESCRIPTION OF CRIME: THE ABOVE DECEASED WAS SHOT BY HER BOYFRIEND (PERP) FOR REASONS UNKNOWN

MEANS EMPLOYED:  X BLUNT INSTRUMENT  
PHYSICAL FORCE  
SHOTGUN  
MACHINE GUN  
OTHER

KNIFE  
HANDGUN  
RIFLE  
STRANGULATION (DESCRIBE)

MOTIVE:  X ROBBERY  
NARCOTICS  
DISPUTE  
UNK  
OTHER

BURGLARY  
SEX CRIME  
ORG CRIME  
JUSTIFIABLE (DESCRIBE)

PERP 1:  X ARRESTED  
UNKNOWN  
NAME (LAST, FIRST, MI)

PERP 2:  X ARRESTED  
UNKNOWN  
NAME (LAST, FIRST, MI)

PERP 3:  X ARRESTED  
UNKNOWN  
NAME (LAST, FIRST, MI)

RELATIONSHIP:  
X BOYFRIEND  
INTFAMILY  
UNKNOWN

THE ABOVE INFO WAS REC'D BY DET. ABBOTT OF THE PCT SQD.
OFFICE OF MEDICAL EXAMINER

Name of the deceased: 

Address: 

Date and place of birth: 
Mother's Birthplace: 
Father's Birthplace: 

Closest known family member name: 
Address: 

Phone (____) 

Did the deceased live with another person? ______ If yes:
Name: ___________________________ Relationship: ___________________________
Address: ___________________________

Phone (____) 

To your knowledge did the deceased have any of the following conditions:

☐ High blood pressure ☐ Cancer ☐ Pregnant in the last 6 months: 
☐ Heart problems ☐ Venereal Disease ☐ If yes, the outcome was:
☐ Diabetes ☐ AIDS ☐ Live Birth 
☐ Seizures ☐ Alcohol Abuse ☐ Induced termination 
☐ Lung problems ☐ Drug Abuse ☐ Spontaneous termination 
☐ Tuberculosis ☐ Hepatitis ☐ None 
☐ Psychiatric Illness ☐ Other: ___________________________
☐ Other: ___________________________

If the deceased was treated for any of the above conditions, please list the doctor's name, hospital, clinics, and dates of treatment:

___________________________________________________________________________
___________________________________________________________________________

_________________________    ___________________________    ____________
Signature                    Relationship                       Date
Identification Form

M.E. #: ________

I, ________, residing at ________

Phone number: ________ NYS/DL #: ________

State that:

I am the relationship to deceased of the person whose body was found at location ________

On date ________ and subsequently sent to the Office of Chief Medical Examiner, that I have seen the Photo of the said deceased, and believe that the body recorded at said office as:

name of deceased ________

of AGE: ________ RACE: ________ SEX: ________

to be:

name of deceased ________

address of deceased ________

of AGE: ________ RACE: ________ SEX: ________

Signed: ____________________________

Given to me this ________ day of ________, ________

Identified to ________ at Office of Medical Examiner
CERTIFICATE OF DEATH

DECEDED'S LEGAL NAME

<table>
<thead>
<tr>
<th>NEW YORK</th>
<th>CITY</th>
<th>TYPE OF PLACE</th>
<th>ANY HOSPICE</th>
<th>NAME OF HOSPITAL OR OTHER FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOROUGH</td>
<td></td>
<td>HOSPITAL INPATIENT</td>
<td>CARE IN 30 DAYS</td>
<td>BEACH</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE AND TIME OF DEATH OR FOUND DEAD</th>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
<th>TIME</th>
<th>SEX</th>
<th>OCME CASE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOVEMBER 25, 2010</td>
<td>25</td>
<td>2010</td>
<td>02:40 AM</td>
<td>FEMALE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CAUSE OF DEATH</th>
<th>IMMEDIATE CAUSE</th>
<th>DUE TO OR AS A CONSEQUENCE OF</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART I</td>
<td></td>
<td>BLUNT FORCE INJURIES OF HEAD WITH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NASAL FRACTURE SUBARACHNOID</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART II</th>
<th>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>INJURY DATE</th>
<th>TIME</th>
<th>AT WORK</th>
<th>PLACE OF INJURY</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-25-2010</td>
<td>02:20 AM</td>
<td>NO</td>
<td>BEACH</td>
<td>BROOKLYN, NEW YORK</td>
</tr>
</tbody>
</table>

IF TRANSPORTATION INJURY SPECIFY:
- Driver/Operator
- Passenger
- Other Specify

MANNER OF DEATH:
- Pending further study
- Natural
- Homicide
- Accident
- Suicide
- Undetermined

AUTOPSY:
- Yes
- No Autopsy Pursuant to Law
- No Autopsy

On the basis of examination and/or investigation, in my opinion, death occurred due to the causes and manner as stated:

Certifier Signature: __________________________
Certifier Name: __________________________
Date: 11-30-2010