

FRANKLIN COUNTY

OHIO

Office Of
 Bradley J. Lewis, M.D.
 520 King Avenue
 Columbus, OH 43201
 Ph 614-462-5290 Fax 614-462-6002
 Coroner

Coroner's Report: Finding of Facts and Verdict

In Compliance with the Ohio Revised Code, Chapter 313, the Coroner's Report and Findings of Fact and Verdict are supplied. This is not a certified copy of a death certificate. This is for the Coroner's use only. To obtain a certified copy of a death certificate, contact the County Board of Health, Bureau of Vital Statistics, 240 Parsons Avenue, Columbus OH 43215, Phone (614) 645-7331, Fax (614) 645-0730.

Case No: [REDACTED]

DECEASED'S IDENTIFICATION

Last Name	First	Middle	Date of Death	Time of Death
[REDACTED]	[REDACTED]	[REDACTED]	01-06-2008	14:00
Call Taken By	Person Reporting Death	Title	Pronounced By/Competent Observer	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
Facility or Address of Death			Phone at Scene	Place of Death
Children's Hospital, Columbus, OH 43205				ER/Outpatient
Decedent's Address (Number and Street)				County of Death
[REDACTED]				Franklin
City	County of Residence		State	Zip Code
[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]
Race	Sex	Age	Date of Birth	
White	Female	2	[REDACTED]	

CAUSE AND MANNER OF DEATH

Immediate Cause	Time Interval
Seizure activity.	Months
As Consequence Of:	Time Interval
As Consequence Of:	Time Interval
As Consequence Of:	Time Interval
Other Significant Conditions	Autopsy?
	Yes
Manner of Death	Name, Title and License Number of Person Who Completed Cause of Death
Natural	[REDACTED]
Address of Certifier	
[REDACTED]	

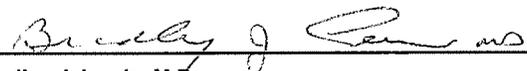
PATHOLOGY

Date Body Viewed 01-07-2008	Time Body Viewed 9:00	Tattoos/Scars	Teeth Natural	Eye Brown	
Body Heat Cool	LIVOR Ant-Post/Fixed		RIGOR Full		
Pathologist's Notes See Autopsy Report.		Hair Color Blonde	Height 54.5	Weight 23	Body Appearance

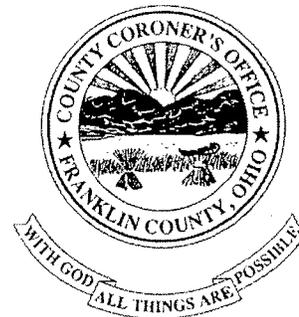
INVESTIGATION

Investigating Agency [REDACTED]	Phone [REDACTED]	Date of Injury	Time of Injury
Injury Location (Address, City, State, Zip)			Injury at Work No
How Injury Occurred			Place of Injury
Next of Kin [REDACTED]	Phone [REDACTED]	Relationship Mother	
Next of Kin Address [REDACTED]			
Funeral Home [REDACTED]	Phone [REDACTED]	Funeral Home Representative [REDACTED]	
Funeral Home Address [REDACTED]			

In Witness Whereof, I have hereunto set by
hand and affixed my seal at Columbus, Ohio
This 26th day of 02/26/2008



Bradley J. Lewis, M.D.
Coroner



FRANKLIN COUNTY CORONER'S OFFICE
BRADLEY J. LEWIS, M.D.
Columbus, Ohio

Autopsy: [REDACTED]

Name: [REDACTED] female age 2 years

Date of Death: January 6, 2008 – 1400 hours

Date of Autopsy: January 7, 2008 – 0900 hours

Autopsy performed by: [REDACTED] M.D., Forensic Pathologist
Franklin County, Columbus, Ohio

Autopsy performed for: Bradley J. Lewis, M.D., Coroner
Franklin County, Columbus, Ohio

CAUSE OF DEATH: Cardiorespiratory arrest due to seizure activity.

FINAL ANATOMIC DIAGNOSES:

1. Acute congestion, right lung 120 gm; left 127 gm.
2. Clear fluid in the bronchial tree, bilaterally.
3. Minimal patchy interstitial inflammatory infiltrate with no evidence of myocyte necrosis, left ventricle and interventricular septum.
4. Occasional foci of hepatocellular necrosis accompanied by a lymphomononuclear inflammatory infiltrate.
5. 24 cc of pinkish tinged fluid in the right pleural cavity.
6. 6 cc of straw colored fluid in the pericardial sac.
7. History of febrile seizures.

IDENTIFICATION:

Positive identification of the remains was established through examination of a red plastic band secured to the left ankle with the number [REDACTED] beneath this is the name [REDACTED]

There is a yellow tag secured to the left great toe with the number [REDACTED] beneath this is the name [REDACTED] 02Y; beneath this is the date [REDACTED]. There are two yellow tags secured to the right ankle with the number [REDACTED] beneath this is the name [REDACTED] beneath this is [REDACTED].

Toxicology specimens are retained.

EXTERNAL EXAMINATION:

The body is that of a well-developed, apparently well-nourished Caucasian female infant who appears to be compatible with her stated age of 2 years. The deceased measures 54.5 inches in length, and weighs 23 pounds. When examined, the body is cool to the touch. Rigor mortis is full in the extremities and jaw. Diffuse, fixed, violaceous, postmortem lividity is present over the anterior-posterior surface of the body.

The scalp hair is blonde in color, of fine texture, straight, showing the normal distribution, and measuring 5-1/2 inches in length. The face is unremarkable.

The corneae are clear; the irides are brown. The pupils are equal, round and regular measuring 3 mm in diameter. The sclerae and conjunctivae are pale.

The nose is normally formed. The nasal passages are patent to probe. The external auditory canals are patent. There are no lesions about the lips or buccal mucosa and the palate is intact. The frenula are intact. No foreign matter is present in the ears, nose or mouth.

The lips and gums are pale. The teeth are natural and in good condition.

The neck is of normal configuration and there are no palpable lymph nodes or masses. The larynx is in the midline. The thorax is well developed and symmetrical. The region of the nipples shows no evidence of significant diagnostic pathology. The abdomen is normal. The external genitalia are those of a normal female child. There is no evidence of significant diagnostic pathology involving the labia majora, minor, clitoris, vaginal opening or anal opening. The back is unremarkable. The upper and lower extremities are well developed and symmetrical and the joints are not deformed. All digits are accounted for.

The skin is of normal pliability and texture and presents with no significant lesions. There is no icterus. Axillary, inguinal, epitrochlear, and popliteal lymph nodes are not palpably enlarged. There is no dependent edema.

SCARS AND IDENTIFYING MARKS:

There are no apparent marks or scars readily identified.

EVIDENCE OF MEDICAL THERAPY:

There is no evidence of medical therapy.

EVIDENCE OF INJURY - EXTERNAL:

Head and Neck: There is no evidence of apparent injury.

Torso: There is no evidence of apparent injury.

Upper Extremities: There is no evidence of apparent injury.

Lower Extremities: There is no evidence of apparent injury.

EVIDENCE OF INJURY – INTERNAL:

There is no evidence of traumatic injuries involving the internal organs including the ribs or vertebrae.

INTERNAL EXAMINATION:**NECK ORGANS:**

There is no evidence of hemorrhage involving the cervical muscles. There is no evidence of a fracture of the thyroid, hyoid, cricoid, laryngeal, epiglottic, or tracheal cartilages. The laryngeal, epiglottic, and tracheal lumens are patent.

The tongue is unremarkable grossly and upon sectioning.

The thymus weighs 22 gm and has its usual prominent location. It appears to be of the usual size and shape for the age. On section, it has a pale pinkish-tan coloration.

BODY CAVITIES:

Chest: The thoracic panniculus measures 0.8 cm. There is 24 cc of pinkish tinged fluid in the right pleural cavity. The contour of the pleural cavities is of normal character. The pleura is smooth, glistening and free of adhesions and fibrosis. The lungs are normally expanded.

Pericardial Sac: The middle mediastinum measures 6.8 cm. The anterior, middle, superior, and posterior mediastinum are without note. There is 6 cc of straw colored fluid present within the pericardial sac. The mediastinum is in normal position, and its contents are anatomically distributed. There are no abnormal masses or lymph nodes present.

Abdomen: The abdominal panniculus measures 1 cm. The peritoneum is smooth and glistening. There is no evidence of adhesions, fibrosis or fluid. The abdominal viscera occupy their normal anatomic positions. The diaphragmatic leafs are normally situated. The inferior border of the left lobe of the liver projects 5 cm below the xiphoid process. The inferior border of the right lobe of the liver projects 4.5 cm below the lower border of the right rib cage in the mid clavicular line. The spleen is in proper relationship to its costal margin. The appendix is present and is unremarkable.

CARDIOVASCULAR SYSTEM:

Heart: The heart is normal in configuration. The heart weighs 62 gm. The coronary arteries have the normal anatomic distribution. Multiple cross sections show no evidence of significant diagnostic pathology involving the left coronary artery, the left anterior descending, the diagonal branches, the left circumflex or the right coronary artery.

The epicardium is smooth and glistening. The great vessels enter and leave the heart in the normal manner. When the heart is opened, the cardiac chambers have a normal configuration. The septae are intact, and there are no congenital abnormalities. The foramen ovale is anatomically sealed. The left and right ventricles measure 0.8 – 1 cm, and 0.2 – 0.4 cm in thickness, respectively. The interventricular septum measures 1 cm in thickness. The heart valves are normally shaped with the usual number of leaflets and show no evidence of significant diagnostic pathology. The valvular measurements are as follows: aortic 3.7 cm, mitral 6 cm, pulmonic 3.7 cm, and the tricuspid 5.5 cm in circumference. The endocardium is smooth and glistening. The myocardium is of normal consistency and appearance. Sections of myocardium reveal a red-brown unremarkable parenchyma with no evidence of infarction, hemorrhage, or fibrosis.

The aorta and its major branches: The aorta and its primary branches arise normally, follow the normal course and are widely patent. There is no evidence of aortic coarctation or patent ductus arteriosus.

The vena cava and its major tributaries: The superior and inferior vena cava and their major tributaries are patent throughout. There are no significant areas of extrinsic or intrinsic stenosis identified.

RESPIRATORY SYSTEM:

Lungs: The right lung weighs 120 gm, and the left lung weighs 127 gm. The right and left lungs have normal lobar configurations. The visceral pleura is smooth, glistening and free of adhesions and fibrosis. There are no subpleural emphysematous blebs or bullae. The lungs are semi-firm in consistency with no areas of consolidation. The pulmonary arteries show no evidence of significant diagnostic pathology.

Sections of lung parenchyma reveal evidence of acute congestion involving the right upper lobe, right lower lobe, left upper lobe and left lower lobe.

The trachea and major bronchi are free of obstruction. Clear fluid is noted within the bronchial tree, bilaterally. The trachea and major bronchi have a normal caliber.

The laryngeal airway is unobstructed. No intrinsic lesions are identified.

ABDOMINAL CAVITY:

HEPATOBIILIARY SYSTEM:

Liver: The liver weighs 460 gm. Its capsule is smooth and glistening. The liver configuration is normal. Multiple cross sections reveal a red-brown, semi-firm parenchyma with normal lobular patterns. The intrahepatic bile ducts and blood vessels at the porta hepatis are without note.

Gallbladder: The gallbladder is of normal size and configuration. The wall is thin, and the mucosa is bile stained. The gallbladder contains 8 cc of green-black bile. No calculi are identified. The cystic duct, right and left hepatic ducts, and the common duct are free of calculi and other intrinsic lesions.

Gastrointestinal Tract: The esophagus is patent and lined with a normal appearing mucosa. The esophagus is free of lesions. The stomach is of normal configuration. Its serosa is smooth and glistening. The wall is of normal thickness, and the mucosa is thrown into rugal folds. There are no acute ulcerations. The stomach contains no evidence of either liquid or solid material. The duodenum is free of ulceration and other intrinsic lesions. The jejunum and ileum are normal in appearance. The colon and rectum are unremarkable. The anus is normal.

RETICULOENDOTHELIAL SYSTEM:

Spleen: The spleen weighs 52 gm. The spleen measures 10.3 cm in length, 5.3 cm in width and has a depth of 2 cm. Its configuration is normal. The capsule is blue-gray and smooth without areas of thickening. On section, the splenic pulp is of normal consistency and appearance. Malpighian corpuscles are identified.

Lymph Nodes: No abnormal lymph nodes are encountered in the cervical, mediastinal, peribronchial, gastric, mesenteric, retroperitoneal, axillary, or inguinal lymph node collections.

Bone Marrow: The vertebral bone marrow presents with a normal appearance.

GENITOURINARY SYSTEM:

Kidneys: The right kidney weighs 34 gm, and the left kidney weighs 31 gm. The right kidney measures 7 cm in length, and the left kidney measures 6.8 cm in length. The right and left kidneys have a normal configuration. The capsules strip with ease to reveal a normal, smooth somewhat lobulated subcapsular surface. The renal arteries and veins are patent and free of stenotic lesions. On section, the renal cortices measure 5 mm in thickness, and the

corticomedullary demarcations are distinct. The medullae are unremarkable. The pelvocalyceal systems are normal in appearance. The ureters are unremarkable.

Urinary Bladder: The bladder is of normal configuration. The mucosa is intact and free of ulcerations or other lesions. The muscular layer of the bladder wall is of normal thickness. The bladder contains 120 cc of clear, yellow urine.

REPRODUCTIVE SYSTEM:

The uterus, tubes and ovaries: The uterus with attached cervix weighs 1 gm. It measures 1.2 cm across the fundus, 1.2 cm in length, and has a myometrial thickness of 0.3 cm. The cervix measures 1.2 cm in length and has a diameter of 0.8 cm. The vagina is unremarkable. The cervical os and cervical mucosa are unremarkable. The endometrial cavity is of normal configuration, and the endometrium is unremarkable. The endometrium measures less than 1 mm in thickness. The myometrium is normal. There are no parametrial lesions. The fallopian tubes are thin walled, pliable, and free of lesions. The ovaries are unremarkable.

ENDOCRINE SYSTEM:

Pancreas: The pancreas is of a normal size and location. The pancreas weighs 21 gm. The pancreas measures 9.5 cm in length and varies in width between 1.5 and 3.2 cm and in depth between 1.1 and 1.8 cm. The pancreas is of firm consistency and normally lobulated. No intrinsic lesions are discovered on multiple cross sections.

Adrenal Glands: The left and right adrenal glands, each, weigh 3 gm. The adrenals are of normal configuration. On section, the cortices are golden yellow in color and of normal thickness. The medullae are unremarkable.

Thyroid Gland: The thyroid weighs 6 gm. Multiple cross sections of the lateral lobes and isthmus reveal no apparent parenchymatous nodules or other lesions.

Parathyroid Glands: The parathyroid glands are identified adjacent to the thyroid gland. They are grossly unremarkable.

Pituitary Gland: The pituitary is unremarkable.

Musculoskeletal System: The axial and appendicular skeleton shows no abnormalities. The exposed musculature is unremarkable.

NERVOUS SYSTEM:

Head: The cranial cavity is entered through a bitemporal scalp incision with reflection of the scalp and removal of the calvarium. No hematomas are present in the scalp. The dura is examined with the brain. The superior sagittal sinus is patent. There is no evidence of hemorrhage in the epidural or subdural space. The leptomeninges are transparent and free of

inflammation and hemorrhage. There are no fractures of the calvarium or base of the skull. The venous sinuses are without note.

Examination of the vessels overlying the cerebral convexities as well as their inferior surface reveals them to be of normal distribution and dimension. There is no evidence of significant diagnostic pathology. The vessels of the circle of Willis and those overlying the anterior surface of the brain stem including those supplying the cerebellar hemispheres exhibit no evidence of a congenital abnormality.

The fresh brain weighs 1269 gm. The brain is placed in formaldehyde for neuropathology consultation.

Spinal Cord: A 2 cm segment of the proximal cervical spinal cord is examined. No epidural masses are noted. There is no evidence of subarachnoid hemorrhage. The leptomeninges are clear and the vascular pattern is unremarkable. The spinal nerve roots exit and enter the cord in the usual manner and are of normal appearance. There are no focal areas of deformity or discoloration externally of the spinal cord. Transverse sections of the cervical cord at 5 mm intervals show normal demarcation of gray and white matter. No focal lesions are identified.

MICROSCOPIC DESCRIPTION:

HEART, Right Ventricle: There is no evidence of significant diagnostic pathology.

Left Ventricle: Minimal patchy interstitial inflammatory infiltrate consisting of neutrophils, lymphocytes, histiocytes and eosinophils. There is no evidence of myocyte necrosis.

Interventricular Septum: Rare focus of an interstitial inflammatory infiltrate. There is no evidence of myocyte necrosis.

LUNGS, Right Upper Lobe, Right Middle Lobe, Right Lower Lobe, Left Upper Lobe and Left Lower Lobe: Acute congestion and intra-alveolar edema.

LIVER: There are occasional foci of hepatocellular necrosis and a lymphomononuclear inflammatory infiltrate.

PANCREAS: There is no evidence of significant diagnostic pathology.

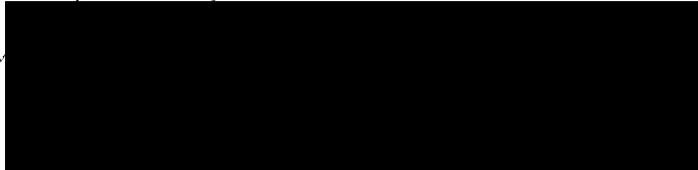
KIDNEY, Right and Left: Acute congestion.

ADRENAL GLANDS, Right and Left: There is no evidence of significant diagnostic pathology.

SPLEEN: Acute congestion.

THYMUS: There is no evidence of significant diagnostic pathology.

THYROID: There is no evidence of significant diagnostic pathology.



**Forensic Pathologist / Neuropathologist
Deputy Coroner**

MICROSCOPIC DESCRIPTION:

CENTRAL NERVOUS SYSTEM, Hippocampus and Amygdala, Right: There is no evidence of a decrease in the number of neurons in the amygdala or the hippocampus.

Hippocampus and Amygdala, Left: There is no evidence of a decrease in the number of neurons in the amygdala or the hippocampus. There is evidence of spongiosis of the neuropil consistent with edema.

Basal Ganglia, Head of Caudate and Putamen, Level of Anterior Commissure, Right: There is patchy spongiosis of the neuropil consistent with edema.

Cerebellar Hemisphere, right: There is evidence of patchy spongiosis of the neuropil consistent with edema.

NEUROPATHOLOGY DIAGNOSES:

1. There is evidence of brain swelling manifested by flattening of the gyri, narrowing of the sulci, grooving of the right uncus, minimal tonsillar grooving and complete collapse of the ventricles, brain weight 1232 gm.

COMMENT: In the experimental study concerning seizure induced neuronal injury and in particular the vulnerability to febrile seizures in an immature rat model, it was noted that a significant proportion of neurons in the central nucleus of the amygdala and in the hippocampal CA3 and CA1 pyramidal layer showed evidence of physiochemical alterations. There was no such evidence of physiochemical alterations in this patient's hippocampal and amygdala neurons. There was also no evidence of a dropout of neurons in the amygdala or the hippocampus.



**Forensic Pathologist / Neuropathologist
Deputy Coroner**

NEUROPATHOLOGY CONSULT REPORT



GROSS BRAIN: The formalin fixed brain weighs 1232 gm. The dura is received with the brain. There is no evidence of epidural or subdural hemorrhage. The superior sagittal sinus is patent. The leptomeninges are thin and delicate. There is no evidence of acute subarachnoid hemorrhage.

At the time of autopsy, there was no evidence of a fracture of the calvarium or the base of the skull.

Examination of the vessels overlying the cerebral convexities as well as their inferior surface reveals them to be of normal distribution and dimension. There is no evidence of significant diagnostic pathology. The vessels of the circle of Willis and those overlying the anterior surface of the brain stem including those supplying the cerebellar hemispheres exhibit no evidence of a vascular anomaly.

The cerebrum presents with a normal convolitional pattern with evidence of flattening of the gyri and narrowing of the sulci. There is no evidence of atrophy or focal lesions. The corpus callosum is intact and in the midline. There is no cingulate gyral herniation. There is a groove of the right uncus 4 mm lateral to its medial surface. There is no groove of the left uncus. There is evidence of minimal tonsillar grooving.

Multiple coronal sections through the cerebral hemispheres at approximate 1 cm intervals shows a normal cortical ribbon with no abnormality of the gray white matter relationship. The cortical ribbon and centrum semiovale display no abnormality with the exception of expansion of the latter due to edema.

The basal ganglia, internal capsule and thalami are unremarkable.

The ventricular system is of normal distribution and dimension showing evidence of 100% collapse. The ventricular system is lined by a smooth, glistening ependyma. The choroid plexus displays no abnormality. The corpus callosum is of normal thickness.

Serial coronal sections through the brain stem and cerebellum at 5 mm intervals fails to reveal any evidence of significant diagnostic pathology.

FORENSIC TOXICOLOGY DIVISION



Office of Bradley J. Lewis, M.D.
520 King Avenue
Columbus, OH 43201
Ph 614-462-5290 Fax 614-462-6002

EXAMINATION REPORT

NAME: _____

DATE COMPLETED: _____

February 07, 2008

A Comprehensive Analysis Has Been Performed.

The Following Agents Were Detected:

BLOOD:

Ethanol	Not Detected *
Acetaminophen	Not Detected *
Caffeine	Positive *
Phenobarbital	Not Detected *
Phenytoin	Not Detected *
Valproic Acid	Not Detected *
Carbamazepine	Not Detected *
Cotinine (nicotine metabolite)	Positive *

URINE:

Caffeine	Positive
Nicotine	Positive

VITREOUS:

Other Chemical Pathology:

Sodium	131 mmol/L
Potassium	17 mmol/L
Chloride	114 mmol/L

FORENSIC TOXICOLOGY DIVISION



Office of Bradley J. Lewis, M.D.
520 King Avenue
Columbus, OH 43201
Ph 614-462-5290 Fax 614-462-6002

EXAMINATION REPORT

NAME: _____

DATE COMPLETED: _____

February 07, 2008

Calcium	1.0 mmol/L
Magnesium	0.65 mmol/L
Glucose	24 mg/dL
Lactate	16 mmol/L
Urea	10 mg/dL
Creatinine	0.9 mg/dL

No Other Agents Were Detected.

NOTE: * Testing Performed on Femoral Blood



Ph.D.

Chief Toxicologist

