



Glenoaks Pathology Medical Group, Inc.

LA CAÑADA, CALIFORNIA 91011

AUTOPSY REPORT

GP-810-09

Stanislaus County Coroner Office 09-04-24

RE: CRAIG EDWARD PRESCOTT

Modesto, CA 95358

REPORTED DATE AND TIME OF DEATH: Monday, April 13, 2009, 1120 hours.

DATE, TIME & PLACE OF EXAMINATION: Wednesday, April 15, 2009, 1900 hours.
Salas Brothers Funeral Chapel
419 Scenic Drive
Modesto, CA 95354

AUTOPSY FINDINGS

1. Craig Edward Prescott, a 38 year old gentleman, was in police custody when according to investigation reports, there was an altercation with the jail staff where he was tased multiple times, hit with pepper ball projectiles; administered lorazepam by intramuscular injection; and soon thereafter found unresponsive and not breathing. He was resuscitated and admitted to Doctors Medical Center in Modesto CA where he passed away on the second hospital day.
2. Recent onset of depressive disorder, bipolar psychotic disorder, by history.
3. History of recent in custody psychotic break, confrontation and altercation with:
 - a. Sudden loss of consciousness:
 - (1) Pulmonary arrest.
 - (2) Successful resuscitation, re-established sustainable heart rhythm.
 - (3) Severe metabolic acidosis, treated.
 - b. Complicated by:
 - (1) Recent severe hypoxic changes in brain (please see attached Neuropathology Report) and clinical brain death.

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- (2) Shock and systemic inflammatory response syndrome with multiorgan system failure involving:
 - (a) Heart (also see diagnosis 5c below).
 - (b) Rhabdomyolysis, clinical with CPK 53,040 units/L (04/12/09).
 - (c) Kidneys.
 - (d) Liver.
4. Status post employment/deployment of nonlethal weapons:
 - a. By history:
 - (1) Tasers:
 - (a) Wounds on extremities suggestive of/consistent with Taser wounds.
 - (b) No Taser wounds on anterior or posterior torso or head.
 - (2) Nonlethal projectiles (see diagnosis 4b(1) below).
 - b. Skin injuries manifest by:
 - (1) Multiple target-like abrasions/contusions, consistent with ASP and/or nonlethal projectiles (see diagnosis 4a(2) above).
 - (2) Patterned healing abrasions, wrists and ankles, consistent with recent restraint devices.
 - c. Multiple healing abrasions, primarily right lower extremity.
5. Hypertensive cardiovascular disease, manifest by:
 - a. Mild cardiomegaly.
 - b. No coronary artery atherosclerosis.
 - c. Congestive heart failure, clinical (also see diagnosis 3b(2)(a) above), characterized by:
 - (1) Moderately dilated hypertensive cardiomyopathy.
 - (2) Moderate to marked pulmonary congestion and edema.
 - (3) Congestive hepatomegaly.
6. Status post: Cardiopulmonary resuscitation with multiple rib fractures, bilateral.

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7. Toxicology findings on comprehensive postmortem cavity blood screen (tests performed by Quest Diagnostics Laboratory, Las Vegas, Nevada):
 - a. Ethanol: Negative.
 - b. Phenytoin (Dilantin): 4.1 $\mu\text{g/ml}$ (Therapeutic Reference Range: 10-20 $\mu\text{g/ml}$).
 - c. Lorazepam (Ativan): 61 ng/ml (Therapeutic Reference Range: 10-240 ng/ml).

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CONCLUSION AND OPINION: Based on these autopsy findings and the historical and clinical information available to me, in my opinion, Craig Edward Prescott, a 38 year-old gentleman, died as a result of an acute psychotic episode complicated by altercation, use of nonlethal weapons, prolonged apnea, sudden unresponsiveness, hypoxic/ischemic brain injury, and brain death.

Mr. Craig Prescott had a recent diagnosis (February 2, 2009) of depressive disorder with probable underlying bipolar psychosis. Mr. Prescott was in police custody and he is reported per medical records to have displayed "bizarre and violent" behavior (possible psychotic break). Because of his behavior, the jail staff decided to move him to a "safety cell" on Saturday, April 11, 2009, and at circa 1345 hours the jail staff began a cell extraction using eight (8) deputies.

In the process of moving Mr. Prescott and cell extraction, there was an altercation with the jail staff where he was tased multiple times; hit by projectiles from a pepper ball gun; placed in restraints; given 2 mg lorazepam (Ativan) by intramuscular injection; moved to the "safety cell," and while removing the restraints in the "safety cell" Mr. Prescott went limp and he was found to have a faint pulse, but he was not breathing. Cardiopulmonary resuscitation was initiated by the staff, and the EMT's were called. This chain of events is constructed from data in (1) the October 5, 2009 letter from the Office of the District Attorney to Sheriff Adam Christianson and (2) the EMT Prehospitalization Care Report. It is unclear from all of the available data the length of time Mr. Prescott was not breathing, but it is clear he suffered a respiratory arrest and not a cardiopulmonary arrest.

When the EMTs arrived they reported Mr. Prescott was in ventricular fibrillation (as a result of his respiratory arrest causing a decrease in oxygen available to his heart, i.e. prolonged period of cardiac hypoxic/anoxic insult). They defibrillated him resulting in asystole (no heart beat) followed by PEA (pulseless electrical activity), and then restoration of a sustainable cardiac rhythm. As the resuscitation continued, he was transported to Doctors Medical Center in Modesto, California where he was admitted to the Emergency Department in a severe state of metabolic acidosis. The initial blood gas results highly suggest a long period of resuscitation, and the initial CT scan on April 11th was essentially negative, but the CT scan on April 13th demonstrated severe generalized cerebral edema, consistent with anoxic brain injury and the findings were suggestive of impending uncal herniation. Despite all therapeutic efforts Mr. Prescott passed away on the second hospital day, Monday, April 13, 2009.

Mr. Prescott suffered severe anoxic brain injury due to the unknown period of apnea (not breathing) or respiratory arrest during the altercation in the jail. The nurses in the jail report he had "a weak pulse, but was not breathing." Mr. Prescott did respond to resuscitation by regaining a stable heart rhythm until he was removed from the ventilator on April 13, 2009, but he never regained consciousness. It is clear the period of apnea resulted in severe anoxic brain injury ultimately causing brain death and the death of Mr. Prescott. Although he had a history of hypertension, and hypertensive heart disease was documented at autopsy, in the opinion of this examiner, Mr. Prescott's heart disease was stable and was not the cause of his sudden respiratory arrest and period of apnea suffered during the cell extraction and movement to the "safety cell."

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Mr. Prescott's heart disease was stable, and he did not have a "heart attack" and cardiopulmonary arrest as a direct sequela of the altercation as purported by the first examiner's cause of death. Had his heart disease been the underlying cause of his sudden loss of consciousness (when he went "limp") there (1) would have been no pulse or respiration; (2) the resuscitative efforts in the jail and hospital would not have been successful; and (3) with a very high degree of medical certainty his heart would not have responded to resuscitation. The EMT's found him in ventricular fibrillation (due to the prolonged period of cardiac hypoxic/anoxic insult), and when he was defibrillated and with continued resuscitative efforts he regained a pulse and his cardiac rhythm remained stable throughout his hospital course (see Doctors Medical Center Death Summary, page two, second paragraph, first sentence).

The prolonged period of apnea had devastating effects on both Mr. Prescott's heart and brain. His heart had the physiologic reserve capacity to respond with resuscitation and he was able to sustain an independent cardiac rhythm until his death; however, the physiology of the brain is much different and the brain cannot withstand hypoxic/anoxic insults of greater than about five minutes without sustaining severe irreversible injury resulting in devastating neurologic sequelae or death. Mr. Prescott's death was caused by the irreversible hypoxic/anoxic insult to his brain. Once brain death was established and he was taken off of the ventilator, he stopped breathing (because the cardiorespiratory center in the brain was no longer functioning and there was no neurologic drive to breath), and subsequently within a short period of time his heart was starved for oxygen causing it to go into a fatal arrhythmia and stop.

The differential diagnosis of the sudden unresponsiveness in the jail includes the following: (1) restraint asphyxia; (2) excited delirium; (3) respiratory depression and failure due to the intramuscular injection of lorazepam (Ativan), (the most adverse clinical events associated with lorazepam injection are hypotension, somnolence, and respiratory failure); (4) effects of Taser application; or (5) a combination of the above.

The EMT's Prehospital Care Report and the District Attorney's letter of October 5, 2009 to Sheriff Christianson both state Mr. Prescott was tased multiple times. No definitive Taser wounds were found on the torso by either examiner and only a rare wound on his extremities was suggestive of Taser usage. If a Taser was employed during the cell extraction, the effects of Taser should have caused a cardiopulmonary arrest at or immediately after being applied. In the opinion of this examiner, the Taser application did not contribute to Mr. Prescott's sudden unresponsiveness or to his cause of death.

In a man the size of Mr. Prescott, it is highly unlikely one 2 mg intramuscular injection of lorazepam caused any adverse effects unless more lorazepam was used than reported in the medical records provided and/or it was given intravenously. Based on the incident scenario (1) lorazepam was not given intravenously; (2) lorazepam given by intramuscular injection will not take affect immediately; and (3) lorazepam was administered in the hospital with no adverse affects. It is highly unlikely lorazepam contributed to his sudden loss of consciousness and death.

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Excited delirium is excluded from the differential of diagnoses because (1) there are no pathologic criteria for this diagnosis, (2) there is no evidence to suggest his mental state was caused by or associated with toxic substances or illicit drugs, and (3) all the clinical criteria are not met to include the absence of hyperthermia.

Eight deputies were used to extract and move Mr. Prescott from his cell to the "safety cell," and with a high degree of medical certainty, restraint asphyxia is the cause or mechanism of Mr. Prescott's sudden respiratory arrest and prolonged period of anoxia/hypoxia resulting in irreversible brain injury and death. To confirm restraint asphyxia as the underlying cause or mechanism resulting in Mr. Prescott's sudden unresponsiveness and respiratory arrest, additional investigative information is needed to specifically define the actions of each of the deputies involved in the cell extraction and movement of Mr. Prescott.

Mr. Prescott developed systemic inflammatory response syndrome (SIRS) and multiorgan system failure due to the sequelae of the severe metabolic acidosis and hypoxic/anoxic brain injury.

This case was discussed with the original examiner, Eugene Carpenter, Jr. MD on circa October 12, 2009, and his report numbered 09-04-24 (the Stanislaus County Sheriff-Coroner's Autopsy Report) is attached. There is essential agreement in the gross autopsy findings, but there is discordance with the cause of death, and discordance with Stanislaus County Sheriff-Coroner's manner of death. Any variation in organ weights and measurements of the thickness of the cardiac chambers is explained by samples removed by the first examiner and passive changes in the organs between the time of the first and second examinations. The first examiner found mild to moderate coronary artery atherosclerosis, but this was not found on the second examination. Mild to moderate atherosclerosis is not uncommon in hypertensive patients (especially the age of Mr. Prescott) and the fact it was not found on the second examination attests to (1) the focal nature of this specific finding in young hypertensive individuals and (2) the original examiner kept the diseased vessels to preserve the medical evidence.

Based on the need for additional clinical and investigative information not available at this time (more than seven months following the incident and death), the manner of death is undetermined. If sufficient additional information is provided to establish a definite manner of death, the cause and manner of death will be amended.

CAUSE OF DEATH: An acute psychotic episode complicated by altercation, use of nonlethal weapons, sudden unresponsiveness, prolonged apnea, hypoxic/ischemic brain injury, and brain death

MANNER OF DEATH: Undetermined.

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AUTOPSY PROTOCOL

This autopsy is performed by Dr. David M. Posey with the assistance of Mr. Michael Cormier. The autopsy authorization is signed by Rachel Prescott, wife, and there are no limitations or restrictions.

EXTERNAL EXAMINATION

General: Craig Edward Prescott is identified by a band on his right ankle. He measures 70 inches in length and weighs an estimated 270 pounds, and is a well-developed, well-nourished, mildly obese Black gentleman who appears younger than the listed age of 38 years. He has been previously autopsied with the standard sutured thoracoabdominal "Y" shaped incision on the anterior torso. The right and left upper arms of the "Y" measure 11.5 and 12 inches, respectively, and the inferior third of the "Y" measures 18 inches. On the head is a 17 inch sutured intermastoid scalp incision. He is disrobed, not embalmed, and his body is the temperature of the room. Rigor mortis has dissipated from the jaw and extremities, and fixed, deep purple livor mortis is noted on the dependent posterior portions of the body with relative sparing in the weight bearing areas.

Personal property: No personal property accompanies the body.

Skin: The skin is unremarkable, except for findings listed below under evidence of injury.

Head, hair, and scalp: The scalp is unremarkable. The head is covered by curly black hair with streaks of gray hair measuring up to 1.5 inches. There is one day's growth of beard on the face. The remainder of the body hair is of normal male distribution.

Face, eyes, ears, mouth, teeth, and nose: The sclerae are white, the irides are brown, and the pupils are dilated at 3 mm, bilaterally. The natural maxillary and mandibular teeth are in good repair.

Neck, chest, pectoral, breasts, abdomen, back, and anus: Unremarkable.

Genitalia: Are those of a normal adult circumcised male.

Upper and lower extremities: Unremarkable.

Identifying marks: On the right mid back is a diagonally oriented $\frac{3}{4}$ by $\frac{1}{4}$ inch well healed scar and on the dorsum of the right hand is a $\frac{3}{4}$ inch well healed scar. On the dorsum of the left wrist is a $\frac{1}{4}$ inch well healed scar.

Evidence of medical treatment: A triple lumen intravenous access line is in the right neck and recent needle puncture marks are in the right antecubital fossa.

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Evidence of injury:

1. There are 16 similar appearing skin injuries found predominantly on the left posterior torso and the posterior aspect of the left upper arm with one similar appearing injury on the apex of the right shoulder. The injuries in general are round to oval abrasions measuring $\frac{3}{4}$ by $\frac{1}{2}$ inch with a central area of uninjured skin measuring on average $\frac{3}{16}$ of an inch. Approximately 50% of these similar appearing target-like lesions are surrounded by an irregular area of deep purple contusion ranging from $1\frac{1}{4}$ by $\frac{3}{4}$ inches to confluent areas of contusion measuring up to $2\frac{3}{4}$ by $1\frac{1}{2}$ inches, respectively.

Within the area of deep purple contusion, some target-like lesions demonstrate multiple small punctate crusted abrasions measuring on average $<\frac{1}{16}$ of an inch. On the left upper back there are 5 of these lesions and one lesion is placed in cassette #12 for microscopic examination.

On the medial left buttock are 3 of these similar appearing lesions and on the dorsal aspect of the left upper extremity there are 7 similar appearing lesions and the most superior lesion on the left shoulder is placed in cassette #13 for microscopic examination. As previously noted, there is a similar appearing lesion on the apex of the right shoulder.

Incision of the target-like regions discloses recent acute hemorrhage in the deep subcutaneous tissues.

2. On the left mid back is a curvilinear 6 inch superficial thin abraded laceration (scratch) abrading only the superficial epidermis and does not penetrate the dermis into the subcutaneum.
3. The back is opened by using a modified "Y" shaped incision, and the incision is extended to expose the ribs and deep musculature of the back. No recent or old hemorrhage or other abnormalities are identified on this extensive examination of the deep musculature and soft tissues. The posterior and lower extremities are opened up by almost full length vertical incisions on the posterior legs, respectively exposing the deep musculature and subcutaneous tissue. No recent or old hemorrhage or other abnormalities are identified.
4. On the lower lip is a curvilinear $\frac{1}{2}$ inch crusted healing laceration.
5. On the dorsum of the left hand is a $\frac{3}{4}$ by $\frac{1}{8}$ inch healing abrasion, and on the volar surface of the left lower arm and wrist is a $4\frac{1}{4}$ by $3\frac{1}{2}$ inch area of parallel, somewhat curvilinear healing brush-burn abrasions.
6. On the anterior lateral aspect of the right thigh is a 6 by $1\frac{1}{2}$ inch area of healing brush-burn abrasion and on the right knee is a 1 by $\frac{3}{4}$ inch area of healing brush-burn abrasions.

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7. Rare small 1/8 to 1/4 inch puncture-like wounds are found on the extremities suggestive of Taser probe wounds.
8. On the anterior surface of the right ankle is a 1 1/2 by 1/4 inch healing abrasion and on the anterior surface of the left ankle is a mirror-like 1 by 1/8 inch healing abrasion. On the posterior left lower leg and ankle area is a 1 1/4 by 1 1/8 inch healing brush-burn abrasion.
9. No internal injuries are identified.

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INTERNAL EXAMINATION

The autopsy is performed utilizing the previous described thoracoabdominal and posterior intermastoid scalp incisions.

Head: The scalp, subgalea, and skull are unremarkable. There is no evidence of injury, hemorrhage, or skull fracture, and the dura mater and leptomeninges are unremarkable.

Brain: The previously sectioned brain weighs 1181 grams. The brain sections are placed in formalin, and for the remainder of the gross examination of the brain, please see the attached Neuropathology Report.

The vessels at the base of the brain where found are normally disposed and demonstrate no atherosclerotic changes. The proximal spinal cord, as viewed through the foramen magnum, is unremarkable. The remainder of the spinal cord is not examined.

Neck: The organs of the neck, to include the laryngeal cartilages, hyoid bone, and cervical spine, are intact and normal. The larynx and trachea have been previously opened, and their lumina show no evidence of obstruction. Their cream-tan mucosal surfaces are congested, hemorrhagic and are covered by a layer of blood tinged mucoid secretions.

Body cavities: The abdominal panniculus measures 3.5 cm at the umbilicus. Internal evidence of cardiopulmonary resuscitation is evidenced by acute hemorrhage in the anterior mediastinum and fracture of right anterior ribs 2-3 and left anterior ribs 3-5, respectively. The sternum is fractured at the level of the fifth intercostal space with associated subpleural acute hemorrhage. The organs of the body cavities have been previously removed and are found in a plastic bag in the torso. The organs are removed and examined individually.

Cardiovascular system: The previously sectioned empty heart weighs 441 grams (normal heart weight for body length: 336 ± 40 grams) with the right and left ventricles measuring 0.5 and 1.5 cm, respectively, and the ventricular septum measures up to 1.5 cm in greatest thickness. The heart weight from the first autopsy was recorded as 500 grams with the left ventricular wall and septum recorded as 2 cm in thickness, respectively.

The pericardium is not found, but the epicardium is unremarkable. The cardiac chambers appear to be mildly dilated, with the right heart more dilated than the left. There is no evidence of recent or remote myocardial infarct or damage. The circumferences of the tricuspid, pulmonary, mitral, and aortic valves are 14.0 cm, 8.5 cm, 11.0 cm, and 7.5 cm, respectively. The valve leaflets and chordae tendineae of the tricuspid and mitral valves are thin and pliable, as are the valve leaflets of the pulmonary and aortic valves.

The coronary ostia are patent, and the coronary arteries are of normal distribution. The epicardial coronary circulation is right dominant. There is no appreciable narrowing or occlusion of either the right or left coronary artery systems. The right coronary artery, the left main coronary artery, and the anterior descending and circumflex branches of the left coronary artery

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all demonstrate no evidence of atherosclerosis. No acute thrombi are found in the coronary artery lumina.

The aorta, great vessels, and veins are of normal distribution, and the aorta demonstrates no atherosclerotic changes, most predominant in the distal abdominal segment.

Respiratory system: The lumina of the trachea and bronchi have been previously opened, and there is no evidence of obstruction. Their light tan-brown mucosal surfaces are congested, hemorrhagic and covered by a layer of blood tinged mucoid secretions.

The previously sectioned right and left lungs weigh 644 and 466 grams, respectively. Both lungs are gray pink anteriorly and dark red-purple posteriorly with mild subpleural anthracotic mottling. The lungs are soft, but hypocrepitant to palpation. On sectioning, the soft, dark red beefy parenchyma demonstrates moderate congestion and edema with no demonstrable anthracotic mottling. There is no evidence of consolidation, emphysema, tumor, abscess formation, thrombosis, or other abnormalities. The pulmonary vessels are of normal distribution and are without note.

Hepatobiliary system: The dark red brown liver weighs 2246 grams, and on sectioning, retains the usual lobular architecture, and demonstrates both acute and chronic passive congestion. The unremarkable gallbladder is distended by 125 cc of thick, dark green, viscid bile. The bile ducts are anatomically patent.

Lymphoreticular system: The bone marrow is red and moist. The unremarkable previously sectioned dark red-purple spleen weighs 177 grams. The lymph nodes are of normal size and consistency, and the thymus is not found.

Genitourinary system: The previously sectioned dark red-purple right and left kidneys weigh 224 and 246 grams, respectively. Their capsules strip with ease, and the subcapsular surfaces are smooth with no pitting or scarring. Sectioning demonstrates the usual uniform corticomedullary architecture. The calyces, pelves, ureters, and renal vessels are without note.

The urinary bladder is contracted and contains no fluid. The bladder mucosa is trabecular and gray-white.

The prostate gland weighs 32 grams, and on sectioning, the cut surface demonstrates smooth light tan-brown parenchyma with no evidence of nodularity or tumor. The testicles are of normal size and consistency.

Gastrointestinal system: The external surfaces of the tongue, esophagus, stomach, small bowel, vermiform appendix, and colon are unremarkable. The mucosal surfaces of the gastrointestinal tract are somewhat autolyzed but otherwise unremarkable. The stomach has been previously opened and is void of contents. The contents of the small and large bowel are appropriate. The vermiform appendix is not found.

Endocrine system: The gray-tan pituitary, dark red thyroid gland, gray-tan parathyroid glands, gray-tan pancreas, and yellow-brown adrenal glands are unremarkable.

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Musculoskeletal system: The red-brown skeletal musculature is without note. Except for the recent rib fractures described above, the long bones of the extremities, the bony thorax, and the vertebral column are unremarkable and without evidence of fracture.

The gross autopsy examination is completed on Wednesday, April 15, 2009 at 2130 hours.

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FORENSIC ELEMENTS AND CONSULTATIONS

Witnesses: None present, except for the autopsy assistant noted above.

Photographs: There are 56 photographs taken before and during the autopsy.

Roentgenology: None taken.

Diagrams: GPMG diagrams 1 and 2 are used.

Stock container and preservation of evidence: Representative tissue samples from all body systems are preserved for a period of six months after completion and distribution of the autopsy report.

Toxicology: The following samples will be retained for potential toxicology studies for 60 days after completion and distribution of the autopsy report:

- a. Cavity blood (sodium fluoride preservative, total 40 cc).
- b. Vitreous humor (1 red topped tube, total 2 cc).

Evidence: Glenoaks Pathology Medical Group, Inc., 2222 Foothill Boulevard, Suite E565, La Cañada, CA 91011, is the custodian and repository for all reports, records, paraffin blocks, and microscopic slides. These items are preserved and maintained at the offices of Glenoaks Pathology Medical Group, Inc. for a period of ten years.

Consultations: Neuropathology report, Roscoe D. Atkinson, MD, Neuropathologist, The Keck School of Medicine, University of Southern California, Los Angeles, California and toxicology report from Quest Diagnostics Laboratory, Las Vegas, Nevada.

Investigative reports: Stanislaus Sheriff Coroner's Autopsy report with toxicology findings and investigative report.

Medical records: Received, reviewed, abstracted and returned to the family.

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MICROSCOPIC EXAMINATION

SLIDE KEY: 1-Bone marrow, anterior descending branch of left coronary artery, and aorta; 2-Heart and right ventricle; 3-Heart and left main coronary artery; 4-Left lung; 5-Right lung; 6-Liver, spleen, and pancreas; 7-Right and left kidneys; 8-Prostate gland, circumflex branch of left coronary artery, trachea and bronchi; 9-Adrenal gland, thyroid gland, parathyroid glands, pituitary gland and lymph node; 10—Esophagus, stomach, and colon; 11-Additional left lung, stomach, and duodenum; 12-Skin from left upper back; and 13-Skin from left upper posterior shoulder.

Central nervous system: Please see attached Neuropathology Report.

Cardiovascular system: Multiple samples of heart demonstrate myocyte hypertrophy and mild interstitial edema. There is no evidence of recent or remote myocardial infarct or damage or interstitial fibrosis. The atrioventricular node is unremarkable. Sections of the right coronary artery demonstrate approximately 20% luminal compromise by intimal fibroplasia, but the left main coronary artery with its anterior descending and circumflex branches demonstrate minimal intimal fibroplasia and there is no atherosclerotic plaquing. A section of aorta is unremarkable.

Respiratory system: The trachea and a separate section of bronchi are unremarkable except for focal squamous metaplasia, submucosal acute congestion, and minimal submucosal inflammation. Multiple samples from both lungs demonstrate moderate congestion and edema, very mild peripheral emphysematous changes that are most likely artifactual or due to ventilation therapy, and very mild scattered aggregates of anthracotic pigment-laden macrophages in subpleural and perivascular distribution patterns. A separate section of lung from slide #11 shows a focal area of intra-alveolar acute hemorrhage without inflammatory infiltrates. This is most likely an agonal event due to the paucity of inflammatory response.

Hepatobiliary system: Liver sections are unremarkable, except for very minimal macrosteatosis with mild to moderate sinusoidal congestion.

Lymphoreticular system: The bone marrow, spleen, and lymph node are unremarkable, except for acute hemorrhage and congestion in the lymph nodes.

Genitourinary system: The kidneys demonstrate acute congestion, but are otherwise unremarkable for age. The prostate gland is unremarkable for age.

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Gastrointestinal system: Sections of esophagus, stomach, duodenum and colon are unremarkable, except for focal areas of submucosal acute congestion and mild mucosal postmortem autolytic changes.

Endocrine system: The pancreas is autolyzed, while sections of adrenal, thyroid, parathyroid, and pituitary glands are unremarkable.

Skin: A section of skin from the left upper back demonstrates epidermal erosion with central preservation of epidermis. The eroded crater shows superficial necrosis and mild dermal congestion, but in the underlying subcutaneous tissue, there is recent, acute hemorrhage with no significant inflammatory response observed. A section of skin from the posterior left upper shoulder has a similar histologic appearance although the eroded craters demonstrate more extensive necrosis with adherent red blood cells and minimal inflammation. In the underlying dermis there is very mild congestion, but in the subcutaneous tissues there is recent/acute hemorrhage with focal areas of agglutination of red blood cells, but no significant inflammatory cell infiltrates.



DAVID M. POSEY, M.D., BCFE, BCFM

August 15, 2009

Date Autopsy Completed

November 6, 2009

Date Autopsy Signed

Nota Bene: In the event that new information or evidence is provided to me pertaining to the above-entitled case, the CAUSE and MANNER of death may be amended. This information may come from the family, attending physician(s), hospital or obtained from any OFFICIAL or PRIVATE investigations to include such sources as the Medical Examiner's Office, Coroner, or District Attorney.



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CALIFORNIA 91011

NEUROPATHOLOGY REPORT

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Stanislaus County Sheriff Coroner No.: 2009-04-24

RE: CRAIG EDWARD PRESCOTT

REPORTED DATE AND TIME OF DEATH: Monday, April 13, 2009, 1120 hours

DATE AND TIME OF EXAMINATION: Thursday, April 23, 2009, 1300 hours

GROSS EXAMINATION: The specimen is submitted in an appropriately labeled specimen container. The specimen consists of multiple fragments that are assembled to form most of the brain. The leptomeninges are thin and translucent. There is no apparent cerebral edema or herniation of the cerebellar tonsils although fragmentation makes the analysis challenging. There is also no cerebral atrophy involving the frontal lobe or other areas. 1-cm coronal sections show a normal cortical ribbon. The subcortical white matter is normal with good grey-white matter demarcation. There is no softening, discoloration, mass, stroke, or hemorrhage. The striatum, lentiform nuclei, and thalami are normal. The midbrain and medulla cannot be identified. The pons is unremarkable. The substantia nigra shows normal pigmentation. Significant cerebral atherosclerosis is not present.

SLIDE SUMMARY:

- N1 - FRONTAL LOBE
- N2 - TEMPORAL LOBE
- N3 - HIPPOCAMPUS
- N4 - PARIETAL LOBE
- N5 - BASAL GANGLIA
- N6 - PONS
- N7 - THALAMUS
- N8 - WHITE MATTER
- N9 - CEREBELLUM

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MICROSCOPIC DESCRIPTION: The pyramidal neurons throughout the neocortex and hippocampus and many of the Purkinje neurons of the cerebellum show marked eosinophilic degeneration. Some areas of neocortex also contain associated extraneuronal vacuolization. The vascular structures of the subcortical white matter contain perivascular hemosiderin. There is no evidence of neurodegeneration in the frontal cortex or elsewhere. The Bielschowsky silver-stained sections show no neuritic plaques, neurofibrillary tangles, or Pick bodies. The remaining sections are unremarkable.

COMMENT: These findings are consistent with severe recent global hypoxia. There is no evidence of neuropathologic disease or process that accounts for the clinical history of bizarre behavior. The white matter changes are non-specific but are often present in cases of hypertension.

FINAL DIAGNOSIS:

1. Recent severe hypoxic changes.



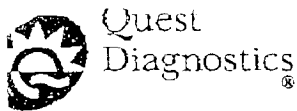
ROSCOE ATKINSON, M.D., NEUROPATHOLOGIST

May 31, 2009

Date Neuropathology Report Completed

May 31, 2009

Date Neuropathology Report Signed



PATIENT PRESCOTT GP-810-09, CRAIG ROUTE PHONE# 17571
 REferred BY GLENOAKS PATHOLOGY MED GRP INC
 AGE/SEX 38Y M ACCESSION NO. [REDACTED] ATTN: DAVID POSEY, MD
 COLLECTED 04/15/2009 20:45 MED. RECORD NO. [REDACTED]
 RECEIVED 04/27/2009 10:20 CHART NO. [REDACTED]
 090008466 CORON

TEST	RESULTS	ABN	REFERENCE RANGE	UNITS	LOW	NORMAL	HIGH
COMPREHENSIVE BLOOD SCREEN							
RESULTS: ETHANOL =	NEGATIVE						
PHENYTOIN =	4.1 UG/ML.						
LORAZEPAM =	61 NS/ML.						
TESTING PERFORMED ON	CAVITY BLOOD.						
THE FOLLOWING BLOOD SCREEN FOR ACIDIC, NEUTRAL AND BASIC DRUGS INCLUDES BUT IS NOT LIMITED TO:							
Amitriptyline	Amphetamine						Benzylecgonine
Cocaine	Codeine						Desipramine
Diphenhydramine	Hydrocodone						Hydromorphone
Imipramine	Lidocaine						Meperidine
Methadone & Metabs	Methamphetamine						Methaqualone
Morphine	Nortriptyline						Oxycodone
Pentazocine	Phencyclidine						Phenylpropanolamine
Propoxyphene & Metabolites							
Acetaminophen	Amobarbital						Barbital
Butabarbital	Butalbital						Carbamazepine
Chlorodiazepoxide	Diazepam						Ethchlorvynol
Ethosuximide	Glutethimide						Mephobarbital
Meprobamate	Methaqualone						Methsuximide
Methyprylon	Nordiazepam						Pentobarbital
Phenobarbital	Phenytoin						Salicylate
Secobarbital	Theophylline						Valproic Acid