

12**AUTOPSY REPORT**

No.

2010-01700

JONES, WREN

I performed an autopsy on the body of 
at _____
the DEPARTMENT OF CORONER

Los Angeles, Californiaon MARCH 12, 2010 @ 1100 HOURS

(Date)

(Time)

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

(A) CONGENITAL PHEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(B) MATERNAL BACTERIAL VAGINOSIS

DUE TO, OR AS A CONSEQUENCE OF

(C) GROUP B STREPTOCOCCI

DUE TO, OR AS A CONSEQUENCE OF

(D)

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

Anatomical Summary:

Term White male newborn delivered at home via midwife at 1212 hours on 03/09, sudden unexpected death at 0023 hours on 03/10.

410-gram, mildly edematous, intact placenta received with the body.

No trauma found at autopsy.

2+ edema of the body wall and internal tissues.

Clotted blood.

Accelerated autolysis.

Bilateral adrenal hemorrhage.

1 cm secundum-type atrial septal defect.

Patent ductus arteriosus.

Cerebral edema.

Please see separate lung culture report, Microscopic Report, Toxicology Report, and Neuropathology Report.

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Page 2**EXTERNAL DESCRIPTION:**

The body is that of a full-term newborn White male. The weight on the autopsy scale is 3.3 kg. The crown-heel length is 50 cm, the crown-rump length 36 cm, the chest circumference 30 cm, the abdominal circumference 30 cm, the head circumference 35 cm, and the foot length 80 mm. There is no external evidence of trauma or malformation. There is trace peripheral edema. There are petechiae on the upper face. The oral cavity is unremarkable. The tongue does not protrude. The frenula are intact. The skin is pale. There is an umbilical tape on the umbilicus. There is no inflammation of the umbilicus. The back and buttocks show no lanugo. There is no vernix and no meconium staining, and the abdomen is not distended.

Received in a separate container with the body is a fresh placenta, membranes and cord. The cord length is 52 cm. The placenta measures 17 x 18 x 2 cm, and the weight of the placenta shorn of the membranes and cord is 410 grams. The cord as I said is 52 cm long. There is 1+ edema of the placental cotyledons and the umbilical cord, and there is erythema of the cord within the first 8 cm of the placental insertion. The cord insertion is eccentric. The membranes are circummarginate. The placenta is red. The cord is three-vessel. There are no knots. The fetal face of the placental disc is dull, dark red. The maternal face is flat with normal cotyledons. There are no tears or depressions. There is only a trace of thin dark red adherent clot, about 3.5 cm x 1 cm, less than 1 mm thick, which is adherent. There are no focal lesions or infiltrates of the placenta. There are no hemorrhages or infarcts. Dissection of the placental parenchyma is uniformly dark red and congested. A membrane roll is prepared, and representative sections of the cord and disc are kept in one can of formalin. Representative sections will be taken in the laboratory after complete fixation; please see separate Microscopic Report.

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Page 3**PRIMARY INCISION:**

A Y-shaped incision is used to enter the body cavities. The abdominal fatpad is 2 mm. We find 1+ edema of the body wall and 2+ edema of the internal organs and tissues. There are bilateral cloudy watery pleural effusions, 5 cc each side, and 2 cc very markedly cloudy or turbid pericardial effusions. There is trace ascites which is clear. The lungs have traces of pleural fibrinous exudate, and there are small traces of stringy fibrinous peritoneal exudate in the upper abdomen. The right lung has three lobes, and the left lung has two lobes. The lungs are poorly inflated and do not completely fill the chest cavities. The left lung is dark red and markedly congested and hemorrhagic. The right lung is pink and edematous. There is advanced autolysis of the internal organs and tissues. There is no odor. At this time, the surface of the left upper lobe is seared with a red hot blade, and, using a flame scalpel blade, an incision is made, and a cotton-tip culturette is used to take a bacterial culture of the lung parenchyma. This is marked for GBS; please see separate culture report.

CARDIOVASCULAR SYSTEM:

The heart has a normal configuration. It is not enlarged or dilated. The systemic venous return is entirely to the right atrium. The pulmonary venous return is entirely to the left atrium. The great arteries have a normal anatomy. The chamber situs is situs solitus throughout. The right atrium is markedly dilated. There is a 1 cm secundum-type atrial septal defect which is widely patent. There is no VSD. The valvular and mural morphology is normal. The myocardium is pale pink and soft. There are no focal myocardial or endocardial lesions. The tricuspid annulus is 3.0 cm, the pulmonic 2.0 cm, the mitral 3.0 cm, and the aortic 1.8 cm. The blood is completely clotted. The ductus arteriosus is patent.

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Page _____

RESPIRATORY SYSTEM:

The larynx and epiglottis are unremarkable. The right lung, weighing 29 grams, is pale pink and edematous. The left lung, weighing 31 grams, is hemorrhagic, mottled and collapsed. As noted, there are turbid pleural effusions and fibrinous exudates of the pleurae. The lungs are inflated with formalin at the autopsy table, and sections will be taken in the laboratory after complete fixation. Please see separate Microscopic Report. The diaphragms are intact. The parietal pleura is slightly dull. There are no rib fractures.

GASTROINTESTINAL SYSTEM:

The esophagus is unremarkable. There is no TEF. The stomach contains a trace of brown mucus. The pylorus is normal. The intestinal tract is empty. It has no hemorrhages or other abnormalities. The left colon contains meconium. The mesentery is thin.

HEPATOBIILIARY SYSTEM:

The liver is dark red, soft and uncongested. It weighs 154 grams. The bile ducts and pancreas are autolytic.

URINARY SYSTEM:

The kidneys are dark red and markedly congested. Each weighs 19 grams. They occupy a normal position in the retroperitoneum. The ureters are normal. The urinary bladder contains less than 2 cc of urine which I was able to collect for toxicology. The bladder outlet is unremarkable.

GENITAL SYSTEM:

Normal uncircumcised infant male.

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Page 5**ENDOCRINE SYSTEM:**

The thymus gland, weighing 21 grams, is autolytic, dusky pink and has no petechiae. The spleen, weighing 12 grams, is firm. The adrenal glands are enlarged, each weighing 4 grams, and are hemorrhagic bilaterally. Photographs are taken. The thyroid and pituitary gland are unremarkable.

CENTRAL NERVOUS SYSTEM:

Reflection of the scalp discovers caput succedaneum which was noted externally. There is no cephalhematoma. The cranial bones are intact and non-united and non-overriding. Opening the skull reveals no intracranial hemorrhage. The CSF is clear. The leptomeninges are clear and markedly edematous. The brain is edematous and weighs 490 grams. It has a normal-term gyral pattern and has advanced autolytic softening. The brain is placed in formalin solution for further fixation and later neuropathologic examination; please see separate Neuropathology Report.

TOXICOLOGY:

Blood, bile, liver and urine are collected, and a SIDS screen is requested. Please see separate Toxicology Report.

HISTOLOGY:

Representative sections from various organs are collected in two cans of formalin, and sections will be taken in the laboratory after complete fixation. Please see separate Microscopic Report.

CULTURES:

A lung culture is sent for GBS; please see separate report.

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Page 6

DIAGRAMS USED:

Diagram Form 20 was used.

PHOTOGRAPHY:


The body was photographed prior to autopsy, and I took photographs of the adrenal glands.

RADIOLOGY:

Seventeen (17) pre-autopsy x-rays were made which showed white out of lungs and no other abnormality.

OPINION:

Wren died of congenital Group B Strep infection due to maternal bacterial vaginosis.



JAMES K. RIBE, M.D.
SENIOR DEPUTY MEDICAL EXAMINER4. 29. 10
DATEJKR:am/brr:c/f
T-03/17/10

20

telem harbora mule

WT	3300	gm
CHL	50	cm
CBL	35	cm
C	30	"
A	30	"
atc	35	"
FL	80	cm

2118-01700
BANK ROY JONES
NAT

417

+ petechiae face

+ lanugo
no vitellix
no mec

umb tege

cord 52cm
PLA 17x18x2
410 gms

PLA



21
190
20
29
31
156
12
+ 1
17

Date 3. 12. 10

[Signature] M.D.
Deputy Medical Examiner

14

I performed a microscopic examination on



at THE DEPARTMENT OF CORONER

Los Angeles, California

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BABY BOY JONES
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Brown-Brenn stain of liver and spleen shows numerous small Gram-positive cocci in the tissue.

James K. Ribe
James K. Ribe, MD

April 29, 2010

14

I performed a microscopic examination on



at THE DEPARTMENT OF CORONER

Los Angeles, California

2010-01700
BABY BOY JONES
NAT

417

Slide 1 Frontal lobe unremarkable

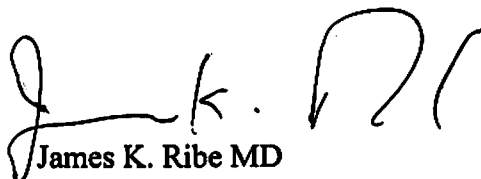
Slide 2 Cerebral ventricle with basal ganglia. There is a small area of blood in the ventricle. The ependyma has edema and inflammation. The germinal matrix is edematous. There are numerous bacterial colonies in the vasculature and in the brain parenchyma. The bacteria are apparent cocci.

Slide 3 Pons unremarkable

Slide 4 Pons unremarkable

Slide 5 Cerebellum unremarkable

Diagnosis: Ependymitis with intraventricular hemorrhage
Septic overgrowth


James K. Ribe MD

April 14, 2010

14

I performed a microscopic examination on


2010-01700
BABY BOY JONES
NAT
at **THE DEPARTMENT OF CORONER****417****Los Angeles, California**

- Slide 1 Right and left ventricles showing numerous nucleated red blood cells in the vasculature
- Slide 2 Liver and spleen showing numerous nucleated red blood cells and polys in the sinusoids
- Slide 3 Thymus gland showing starry-sky change
- Slide 4 Pituitary gland, epiglottis, trachea, carina, lymph node unremarkable
- Slide 5 Trachea with thyroid gland unremarkable
Tail of pancreas unremarkable
Immature kidney with capsule showing congestion
- Slide 6 Fetal adrenal glands showing marked congestion
- Slide 7 Umbilical cord and membrane roll unremarkable
- Slide 8 Term placenta unremarkable
- Slide RUL Right upper lobe showing aspirated squames, numerous cocci, and interstitial inflammation
- Slide RML Right middle lobe showing aspirated squames, numerous cocci, and interstitial inflammation with some polys in alveoli
- Slide RLL Right lower lobe showing aspirated squames, numerous cocci, and polys in alveoli
- Slide LUL Left upper lobe showing hemorrhage of the visceral pleura and the alveoli packed with polys
- Slide LLL Left lower lobe showing hemorrhage of the visceral pleura and the alveoli packed with polys

continued next page

14

I performed a microscopic examination on



at THE DEPARTMENT OF CORONER

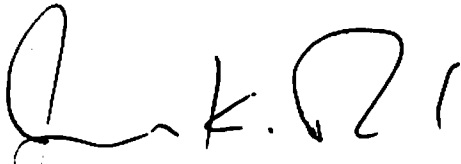
Los Angeles, California

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Continued from page 1

Diagnosis: congenital pneumonia



James K. Ribe MD

April 14, 2010

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AUTOPSY CLASS: A B C Examination Only D

FAMILY OBJECTION TO AUTOPSY

Date: 3.12.10 Time: 1100 Dr. RIBE
(Print)

FINAL ON: 4.1.10 By: RIBE
(Print)

2010-01700

417

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

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

IMMEDIATE CAUSE:

(A) CONGENITAL PNEUMONIA DAYS

DUE TO, OR AS A CONSEQUENCE OF:

(B) MATERNAL BACTERIAL VAGINOSIS UNK

DUE TO, OR AS A CONSEQUENCE OF:

(C) GROUP B STREPTOCOCCI UNK

DUE TO, OR AS A CONSEQUENCE OF:

(D)

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

Age: 0 Gender: Male Female

PRIOR EXAMINATION REVIEW BY DME

BODY TAG CLOTHING
 X-RAY (No. 17) FLUORO
 SPECIAL PROCESSING TAG MED. RECORDS
 AT SCENE PHOTOS (No. _____)

CASE CIRCUMSTANCES

EMBALMED
 DECOMPOSED
 >24 HRS IN HOSPITAL
 OTHER: _____ (Reason)

TYPING SPECIMEN

TYPING SPECIMEN TAKEN BY: _____
SOURCE: _____

TOXICOLOGY SPECIMEN

COLLECTED BY: R
 HEART BLOOD STOMACH CONTENTS
 FEMORAL BLOOD VITREOUS
TECHNIQUE: _____
 _____ BLOOD SPLEEN
 _____ BLOOD KIDNEY
 BILE _____
 LIVER _____
 URINE _____

URINE GLUCOSE DIPSTICK RESULT: 4+ 3+ 2+ 1+ 0
TOX SPECIMEN RECONCILIATION BY: R

HISTOLOGY

Regular (No. 25) Oversize (No. _____)
Histopath Cut: Autopsy Lab

TOXICOLOGY REQUESTS

FORM 3A: YES NO
 NO TOXICOLOGY REQUESTED
SCREEN C H T S D
 ALCOHOL ONLY
 CARBON MONOXIDE
 OTHER (Specify drug and tissue)

REQUESTED MATERIAL ON PENDING CASES

POLICE REPORT MED HISTORY
 TOX FOR COD HISTOLOGY
 TOX FOR R/O INVESTIGATIONS
 MICROBIOLOGY EYE PATH. CONS.
 RADIOLOGY CONS.
 CONSULT ON: _____
 BRAIN SUBMITTED
 NEURO CONSULT DME TO CUT
 CRIMINALISTICS
 GSR SEXUAL ASSAULT OTHER

NATURAL SUICIDE HOMICIDE
 ACCIDENT COULD NOT BE DETERMINED

If other than natural causes, HOW DID INJURY OCCUR? _____

WAS OPERATION PERFORMED FOR ANY CONDITION STATED ABOVE: YES NO

TYPE OF SURGERY: _____ DATE: _____

ORGAN PROCUREMENT TECHNICIAN: AC

PREGNANCY IN LAST YEAR YES NO UNK NOT APPLICABLE

WITNESS TO AUTOPSY EVIDENCE RECOVERED AT AUTOPSY
Item Description: _____

Lung cultured for GBS

Autopsy report dictated 3.12.10

[Handwritten signature]

RESIDENT

DME

16

2110-01700
ROY JOYNS
NAT

417

EXTERNAL EXAM

Sex C
 Race Id
 Age
 Height 50 cm FL 80
 Weight 3.3 kg
 Hair
 Eyes
 Sclera
 Teeth
 Mouth
 Tongue
 Nose
 Chest
 Breasts
 Abdomen
 Scar
 Genitals
 Edema +
 Skin
 Decubitus
 HEART Wt. 20
 Pericardium RV 3
 Hypertrophy
 Dilation LV 5
 Muscle pale Septum 5
 Valves
 Coronaries
 AORTA
 VESSELS
 LUNGS Wt.
 R 29
 L 31
 Adhesions
 Fluid ++
 Atelectasis +
 Oedema +
 Congestion +
 Consolidation
 Bronchi
 Nodes
 PHARYNX
 TRACHEA
 THYROID
 THYMUS 21
 LARYNX
 HYOID
 ABDOMINAL WALL FAT 2 mm

PERITONEUM

Fluid trace
 Adhesions 0
 LIVER Wt. 154
 Capsule
 Lobules
 Fibros
 G B
 Calculus
 Bile ducts 12
 SPLEEN Wt.
 Color
 Consistency
 Capsule
 Malpignent

PANCREAS

ADRENALS + / +

KIDNEYS Wt.

R 19
 L 19
 Capsule
 Cortex
 Vessels
 Pelvis
 Ureters

BLADDER 2 cc

GENITALIA

Prostate
 Testes
 Uterus
 Tubes
 Ovaries

OESOPHAGUS

STOMACH

Contents 0

DUOD. & SM. INT.

APPENDIX

LARGE INT.

ABDOM. NODES

SKELETON

Spine
 Marrow
 Rib Cage
 Long bones
 Pelvis

SCALP caput succedaneum

CALVARIUM

BRAIN Wt. 490

Dura
 Fluid
 Ventricles
 Vessels
 Middle ears
 Other

PITUITARY

ok

SPINAL CORD

TOXICOLOGY SPECIMENS

blood bile liver urine

SECTIONS FOR HISTOPATHOLOGY

2 cases

MICROBIOLOGY

lung BACT

DIAGRAMS 20

X-RAYS

17

OTHER PROCEDURES

autopsy photography

GROSS IMPRESSIONS

on form #2

black = normal or none

Date

3. 12. 00

Time

11 -

Deputy Medical Examiner

[Signature]



Department of Coroner, County of Los Angeles
FORENSIC SCIENCE LABORATORIES
 Laboratory Analysis Summary Report



To: Dr. Ribe
 Deputy Medical Examiner

PendingTox

The following results have been technically and administratively reviewed and are the opinions and interpretations of the Analyst:

Coroner Case Number: 2010-01700 Decedent: JONES, WREN

<u>SPECIMEN</u>	<u>SERVICE</u>	<u>DRUG</u>	<u>LEVEL</u>	<u>UNITS</u>	<u>ANALYST</u>
Blood, Heart					
	Alcohol	Ethanol	Negative		M. Schuchardt
	Barbiturate	Barbiturates	ND		J. Lintemoot
	Cocaine	Cocaine and Metabolites	ND		J. Lintemoot
	ELISA	Acetaminophen	ND		J. Lintemoot
	ELISA	Salicylate	ND		J. Lintemoot
	Methamphetamine	Methamphetamine	ND		J. Lintemoot
	Opiates	Codeine	ND		J. Lintemoot
	Opiates	Morphine	ND		J. Lintemoot
	Phencyclidine	Phencyclidine	ND		J. Lintemoot
	Volatiles	Acetone/Methanol/Isopropanol	ND		M. Schuchardt

Legend:

g	Grams	ND	Not Detected
g%	Gram Percent	ng/gm	Nanograms per Gram
Inc.	Inconclusive	ng/ml	Nanograms per Milliliter
mg	Milligrams	QNS	Quantity Not Sufficient
mg/dl	Milligram per Deciliter	TNP	Test Not Performed
mg/l	Milligram per Liter	ug	Micrograms
		ug/g	Micrograms per Gram
		ug/ml	Microgram per Milliliter

D Anderson

Administratively reviewed by: Daniel T. Anderson, M.S., FTS-ABFT, D-ABC
 Supervising Criminalist II
 TOXICOLOGY

DTA
 4-14-10

CASE REPORT BIRTH# 125456

Ribe A

APPEARANT MOOSE	NATURAL	SPECIAL CIRCUMSTANCES	2010-01700
CASE NO	2010-01700	CRYPT	417

LAST, FIRST MIDDLE	JONES, WREN	AAA	BABY BOY JONES	#			
ADDRESS	427 CALIFORNIA AVENUE #1	CITY	SANTA MONICA	STATE	CA	ZIP	90403
SEX	MALE	RACE	CAUCASIAN	DOB	3/9/2010	AGE	1 DY
HT	19 in.	WT	7 lb.	HAIR	BROWN	EYES	BROWN
TEETH	NO TEETH	NO TEETH	NO TEETH	HAIR	BROWN	HAIR	BROWN
CONDITION	FAIR	VIEW	FAIR	VIEW	FAIR	VIEW	FAIR

MARK TYPE	MARK LOCATION	MARK DESCRIPTION					
RELATIONSHIP	PARENT OF MINOR CHILD	NOTIFIED BY	PHONE	(310) 980-4668	DATE	3/10/2010	
SSN	DL ID	PENDING BY					
LA #	MAIN #	CII #	FBI #	MILITARY #	POB	CALIFORNIA	
IDENTIFIED BY NAME (PRINT)	TWENNY KAU	RELATIONSHIP	MOTHER	PHONE	(310) 980-4668	DATE	3/10/2010

PLACE OF DEATH / PLACE FOUND	HOSPITAL	ADDRESS OR LOCATION	1225 15TH STREET	CITY	SANTA MONICA	ZIP	90404
PLACE OF INJURY	AT WORK	DATE		TIME		LOCATION OR ADDRESS	
FOUND OR PRONOUNCED BY	DR. MINA GARG	REPORT NO.	10-24671	NOTIFIED BY			

DOO	3/10/2010	TIME	02:03
OTHER AGENCY INV. OFFICER	SANTA MONICA P.D. - M. BAMBRICK	PHONE	(310) 395-9931
TRANSPORTED BY	LARRY CERVANTES	TO	LOS ANGELES FSC
DATE	3/10/2010	TIME	22:15

FINGERPRINTS	No	CLOTHING	No	HA RPT	No	MORTUARY	Yes
MED. EV.	No	INVEST. PHOTO #	1	SEAL TYPE	NOT SEALED	HOSP RPT	Yes
PHYS. EV.	No	EVIDENCE LOG	Yes	PROPERTY	No	HOSP CHART	Yes
SUICIDE NOTE	No	GSR NO		RCPY. NO.	245907	PP NO.	407-37-43

SYNOPSIS

THE DECEDENT WAS 37-WEEKS GESTATION WHEN HE WAS DELIVERED AT HOME BY A NURSE MIDWIFE. HE WAS BORN AT 1212 HOURS ON 03-09-2010. HIS APGAR SCORES WERE NINE AND TEN. THE BABY NURSED AND HE WAS PINK AND DOING WELL WHEN THE MIDWIFE LEFT AT 1500 HOURS. THE BABY WAS LYING ON HIS FATHER'S CHEST AND MAKING A WHIMPERING NOISE BEFORE HE WAS DISCOVERED UNRESPONSIVE. 911 WAS CALLED AT 0023 HOURS. IN THE EMERGENCY ROOM THE INFANT HAD A TRANSIENT PULSE, BUT IT COULD NOT BE SUSTAINED. NO AUTOPSY NOTIFICATION WAS REQUESTED.

INVESTIGATOR

DATE

3/11/2010

TIME

16:37

REVIEWED BY

DATE

3/11/10

TIME

3/11/10

419432

DENISE BERTONE

FORM #3 NARRATIVE TO FOLLOW?



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



Case Number: 2010-01700

Decedent: JONES, WREN

Information Sources:

1. Seannie Gibson, licensed nurse midwife, 323-394-5332
2. Joseph Jones and Tweeny Kau, parents, 427 California Avenue #1, Santa Monica, CA, 90403, 310-980-4668
3. Medical record #026/s407-37-43, Santa Monica-UCLA Health Center, 1225 15th Street, Santa Monica, CA, 90404, 310-319-4870

Investigation:

On 03-10-2010 at 0405 hours Officer Skogh of the Santa Monica Police Department reported this death to Lieutenant Larry Dietz of the Coroner's Office. The death occurred at a hospital facility and the decedent was transported to the FSC on 03-10-2010 at 2215 hours. Lieutenant Larry Dietz assigned this case to me on 03-10-2010 at 0700 hours.

In a routine check of the JDIC system no arrest history was seen for either parent.

Location:

Cardiac arrest: residence- 427 California Avenue #1, Santa Monica, CA, 90403

Death: Santa Monica-UCLA Health Center, 1225 15th Street, Santa Monica, CA, 90404

Informant/Witness Statements:

On the morning of 03-10-2010 I spoke with Seannie Gibson in my office. She has been a licensed nurse midwife for 6½-years. She is currently in private practice and has not had any significant problems with other deliveries. She met the parents when the mother was 20-21-weeks gestation and there was concurrent care with an obstetrician. This was the mother's first pregnancy and it was uneventful. On 03-09-2010 the mother called at 0730 hours to say that she had experienced some leaking of amniotic fluid at 0030 hours in addition to some irregular uterine contractions. She spoke with Ms. Gibson's partner and was advised to call back when her contractions increased. The mother was 37-weeks gestation; her estimated date of confinement was 04-01-2010. At 0930 hours the mother called again and her contractions had increased and she was walking to help them progress. The mother was told to call back in 15-20 minutes and at that time the contractions were strong and every 3-4 minutes. Ms. Gibson arrived at the parents' home at 1115 hours. When she arrived the mother was in labor while in the living room. She reported that there was pelvic pressure and the uterine contractions were strong. The mother was moved into the bedroom and fetal heart tones were in the 140's. There was some bloody show and during the examination the mother was completely effaced and completely dilated. The mother was told to hold on her pushing so the set up for the delivery could be prepared. During the delivery/decent the baby had some mild bradycardia around 110 and oxygen was placed on the mother. There was a loose nuchal cord and the baby came out through the loop. After the delivery no suctioning was required and the infant was "squalling." He was born on 03-09-2010 at 1212 hours and his Apgar scores were nine and ten. The infant looked "fantastic." He was not interested in breast feeding, but his eyes were open, his skin was pink, he was calm and had good respirations. The infant was swaddled and given to his father while the mother's laceration was sutured. Afterward the baby received a newborn examination and the baby sucked on Ms. Gibson's finger. Nothing abnormal was seen on examination. The baby then nursed. He latched well and ate for 30 minutes. Ms. Gibson provided instructions for the newborn and discussed normal newborn behavior. She left the home at 1500 hours. The placenta was left with the family as is required because as a nurse Ms. Gibson cannot transport biohazard material. No newborn screening studies were performed.

DB



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



Case Number: 2010-01700

Decedent: JONES, WREN

On the afternoon of 03-11-2010 I spoke with the decedent's parents, Joseph Jones and Tweeny Kau, while at their home. Their friend was present and they were comfortable discussing the history of their child in his company. The father is 33-years old, has a history of good health and he works in an office. The mother is 33-years old, has a history of good health and she works from her home doing wedding flowers. The couple has been together for seventeen years and they have been married for five years. The decedent lived in a home with his parents and there have been no visitors staying over in the home. There were no sick contacts. This was the mother's first pregnancy and she began receiving prenatal care at 14-weeks gestation. She was seen by both an obstetrician and a midwife. There were no complications with the pregnancy. The mother took prenatal vitamins; no other medicines, alcohol or drugs were ingested. The mother's estimated date of confinement was 04-01-2010 and she was 37-weeks gestation when she went into labor. The parents decided on a home birth because they thought it would be nicer to bring the baby into the world in their home. The parents explained that on 03-09-2010 the mother had a rupture of membranes at 0030 hours and some uterine contractions every 15-20 minutes. It was suggested that the mother walk so the contractions would increase. The midwife arrived at 1115 hours and 20 minutes after her arrival the mother was told to push. The infant was born at 1212 hours. He was healthy and crying. No medicines were given for the labor or the delivery, but a shot of Pitocin was given for the delivery of the placenta. When asked if there were any complications the father explained that the heart rate decreased during the birth and the umbilical cord was around the baby's neck, but it had not caused any problems. After the delivery the baby breast fed wife when the midwife was present, but he did not eat again. When the infant slept he made an "uh-uh" noise per the father. The mother described the sound as a whimpering. A recording had been made by the father and it was forwarded to my email. The father stated that he had changed a wet diaper, but the baby had not had a bowel movement. After the midwife left the parents were "hanging out" in bed. The father was lying flat on the bed with the baby's chest against his chest. The infant's face was turned to the side. The father stated that the baby had twitched a little, like he was having a dream. The father was reading and on the phone. Both parents remained awake. The infant was on the father's chest for approximately one hour and he was whimpering a little bit and then he stopped. The father was reaching for something on the bed and leaned to grab it. He noticed that the infant did not stir and thought the baby was sleeping soundly. The mother looked over at the infant and saw that his face was darker. The mother first thought the color was due to the lighting or his red shirt or jaundice. The father then went to move the infant to the bassinet so he could get ready for bed. It was then that a small amount of blood was seen on the baby's finger that was near his nose. The infant was not breathing. 911 was called. At the time of discovery the mother noticed that the child's hands were cool and white, his chest was warm and his face was purple. When I asked if there was any time the parents noted any cyanosis or pallor the father stated that when he changed the diaper (before putting the baby on is chest) the infant was pink. He had taken a picture with his phone and forwarded the photo to my email. The mother stated that a few hours after the midwife left she was looking at the baby's hands. In noticing that the baby had his father's fingernails she saw that the nailbeds were slightly blue and his hands might have been cool. The discoloration was very subtle and did not make an impression at the time.

Medical records were received with the decedent's incoming paperwork. The records indicate that Santa Monica Fire Engine 6 was dispatched on 03-10-2010 at 0023 hours and arrived at the scene at 0026 hours. The paramedic's documentation reflects that the decedent had been born at 1212 hours. He was in cardiac arrest with CPR being given by the mother as instructed by the 911 operator. The child was apneic and his skin was mottled, but warm. CPR was in progress when the newborn presented to the emergency room at 0033 hours. He was initially noted to be

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



Case Number: 2010-01700

Decedent: JONES, WREN

in pulseless electrical activity, but a rate/rhythm was not documented. The baby was intubated at 0038 hours. At 0040 hours the child's glucose was measured at the bedside; it was 17. Dextrose was administered. ACLS measures were continued. At 0056 hours the child had a heart rate of 57 and at 0100 hours it was 63. A pulse continued to be transient and pacing was attempted. The resuscitation was unsuccessful. Dr. Garg pronounced death on 03-10-2010 at 0203 hours.

Scene Description:

The location is a large condominium in a residential area of Santa Monica. The home was of newer construction and it was clean and well furnished. I was only in the living room of the home to speak with the parents.

Evidence:

No physical or medical evidence was collected for this investigation.

Body Examination:

The decedent was seen lying supine on a table inside the FSC service floor. He is a male newborn with brown hair, brown eyes and no teeth. A string was around the umbilical cord stump. No obvious deformities or trauma were noted.

Identification:

The decedent was identified by his mother, Tweeny Kau, while at the hospital.

Next of Kin Notification:

The decedent's next of kin is his parents, Joseph Jones and Tweeny Kau. The parents were at the hospital at the time of their son's death.

Tissue Donation:

One Legacy was notified by hospital personnel.

Autopsy Notification:

No autopsy notification was requested for this report.



DENISE BERTONE 419432


SUPERVISOR

03-11-2010

Date of Report

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TO REPORT A DEATH - PHONE (323) 343-0711 FAX (323) 222-7041
COMPLETE ALL LINES, USE INK; IF UNKNOWN OR NOT APPLICABLE, SO STATE.

CC# 2010-01700
10.1700

Sm-UCLA Health center
NAME OF FACILITY

ADDRESS: 1225 15th Street Santa Monica PHONE: 310-319-4870

NAME OF DECEDENT Jones, Wren

HOW IDENTIFIED: Parents DOB: 3/9/2010 AGE: 12hrs. SEX: M RACE: White/Asian

DATE OF DEATH: 3/10/2010 TIME: 0203

PRONOUNCED BY: Dr. Dabney Dr. Gary MEDICAL RECORD OR PATIENT FILE # 407-37-43

ORGAN/TISSUE DONATION INFORMATION

WAS THE NEXT-OF-KIN APPROACHED REGARDING ORGAN/TISSUE DONATION?
NO YES IF YES, WHAT WAS THEIR RESPONSE? Wished to think about it

DATE ADMITTED: 3/10/2010 TIME: 0033

SELF AMBULANCE (Name or R.A.#) Santa Monica Fire Eng. 6
FROM: 427 California Ave. #1 Santa Monica CA 90402
(STATE WHETHER HOME, HOSPITAL OR OTHER) GIVE ADDRESS (IF HOSPITAL, ATTACH THEIR HISTORY)

ADMITTED BY: _____, M.D. PRIMARY ATTENDING PHYSICIAN: _____, M.D.

OFFICE PHONE # _____ OFFICE PHONE # _____

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

DESCRIBE INJURIES: No injuries noted

CLINICAL HISTORY: NSVD born @ 37 weeks GA, @ home via midwife

026/8407-37-43 9 E 03/10/10
JONES, WREN
M 1D 03/09/2010

VN# 6001

SURGICAL PROCEDURES: STATE TYPE, DATE, TIME AND RESULTS OF ANY OPERATION OR AMPUTATION PERFORMED

WAS A BULLET OR OTHER FOREIGN OBJECT RECOVERED? SPECIFY

LABORATORY: REPORT ON PATHOLOGY SPECIMENS TAKEN: DATE & TIME _____

LABORATORY PHONE NUMBER: _____

MICROBIOLOGY CULTURE RESULTS: ___ NO ___ YES (ATTACH REPORT)

TOXICOLOGY SCREEN: ___ NO ___ YES (ATTACH RESULTS)

RADIOLOGICAL STUDIES: ___ NO ___ YES (ATTACH RESULTS)

REMARKS: ESPECIALLY SYMPTOMS PRECEDING AND DURING TERMINAL EPISODE

IN MY OPINION, THE IMMEDIATE CAUSE OF DEATH IS: Cardiopulmonary arrest

BY: _____, M.D. OR Linda Tipton
NURSE/HOSPITAL ADMINISTRATOR

OFFICE PHONE # _____ OFFICE PHONE # 310 319 4747

1. THE BODY WILL NOT BE REMOVED BY THE CORONER WITHOUT THIS COMPLETED REPORT AND COPIES OF ALL CHARTS.
2. ALL ADMISSION BLOOD SAMPLES/SPECIMENS NEED TO ACCOMPANY THE REMAINS.

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MISCELLANEOUS WORK SHEET

2010-01700
BABY BOY JONES
NAT

417

Neuropathology report

The formalin-fixed brain is dissected in the laboratory on March 27, 2010.

This neonatal brain is so soft that it has required special handling, both at autopsy and in the laboratory. At this time the brain has moderate flattening and left-to-right deformation due to postmortem gravitational effects. No hemorrhages, trauma marks, or herniation is seen. No external malformation is seen. The gyral pattern is term. The leptomeninges are clear & transparent throughout. The leptomeningeal veins are markedly congested.

On dissection, we find intraventricular hemorrhage of the left lateral cerebral ventricle with a soft red blood clot resting along the floor of the left lateral cerebral ventricle all the way from the frontal horn to the occipital horn, and a focal 3mm area of subependymal hemorrhage at the level of the body of the caudate. The remainder of the internal examination is within normal limits. Representative sections are submitted in five pink cassettes as follows:

- | | |
|---|---|
| 1 | left superior parasagittal frontal lobe |
| 2 | left lateral ventricle with body of caudate |
| 3 | rostral pons |
| 4 | midpons |
| 5 | cerebellum |

Please see separate microscopic report on form 14. Representative areas are retained in formalin storage.

Diagnosis: term neonatal brain with unilateral intraventricular hemorrhage

Date 3 . 27 . 10


Deputy Medical Examiner M.D.