The In-Custody Death Investigation Regarding Daniel Christian Taylor

August 13, 2021

State Attorney's Office
Fourth Judicial Circuit of Florida
Duval County

September 1, 2022

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I. THE FACTS OF THIS IN-CUSTODY DEATH

A. EXECUTIVE SUMMARY

This report outlines the investigation of the heart attack and death of Daniel Christian Taylor, an inmate in the Duval County Pretrial Detention Facility ("PTDF").

Taylor was arrested in the early morning hours of August 13, 2021. He pled no contest in first appearance court that same day and was sentenced to "time served," or the hours he had been in custody since his arrest. Following his plea, Taylor returned to the PTDF to be processed for release. PTDF protocols mandated a medical evaluation as part of the release process. Around 5:38 pm, corrections officers instructed Taylor to go a temporary cell, but Taylor refused. A struggle ensued between Taylor and an officer which quickly escalated. Additional corrections officers came to assist. Taylor resisted and fought the officers. Indeed, he fought multiple officers for over 30 minutes and repeatedly banged his head on the ground, cutting his forehead. The officers were unable to restrain Taylor. One officer described Taylor's strength as "superhuman."[1] Unbeknownst to the correctional staff, Taylor had a cocktail of drugs in his system, likely giving rise to his stamina and surge in strength. The corrections staff attempted to control Taylor using only their hands. They used no weapons or pepper spray, and there was no inappropriate or excessive force used against Taylor.

Taylor needed medical care for the self-inflicted cut on his forehead, so the PTDF called Jacksonville Fire and Rescue ("JFRD") to transport Taylor to the hospital. Because Taylor continued to be combative, JFRD made the decision to medically sedate Taylor to safely transport him to the hospital. JFRD injected Taylor with ketamine. Upon injection, Taylor stopped resisting. Shortly thereafter, Taylor lost consciousness and went into cardiac arrest. While at the hospital, Taylor was absentee booked for multiple felonies including Resisting with Violence and Battery on a Law Enforcement Officer. Taylor died a week later.

Toxicology revealed that Taylor had various drugs in his system, including amphetamine, methamphetamine, and cannabis. The toxicological evidence indicates that Taylor ingested these drugs in recent time to the time he fought the officers (Taylor had been at the PTDF for over 12 hours and did not display this type of behavior earlier in the day, it is believed he must have ingested the drugs while at the PTDF).[2]

Two forensic pathologists, Drs. Buchsbaum and Nelson, reviewed this case, including the autopsy results, the toxicological results, Taylor's hospital records, and the relevant PTDF

[1] Much of the incident was captured on PTDF surveillance video, but there is no audio. Though the extent of Taylor's resistance is difficult to discern on the video recording, one of the officers appears to be struggling to even stand upright on his own after struggling with Taylor for 10 minutes. PTDF video, 10:40

[2] It is unknown where or from whom Taylor got the drugs. JSO initiated an investigation into the source.

surveillance videos. Both pathologists were clear that Taylor did not suffer any injury from the struggle with correctional staff that contributed to his death. And both pathologists concluded that the ketamine injection was not a contributing factor in Taylor's death.

Despite not attributing any injury or the ketamine dose as a cause for Taylor's cardiac arrest, one pathologist (Dr. Buchsbaum) ruled Taylor's death a homicide. The second pathologist (Dr. Nelson), on the other hand, ruled Taylor's death accidental, concluding that Taylor's death was the result of physical exertion, and the illegal drugs he had ingested.

Simply stated, Dr. Buchsbaum opined that the fight – not any injuries sustained from it – was a contributing cause to Taylor's cardiac arrest. Dr. Nelson disagreed. In light of these conflicting medical opinions, and the facts that 1) there was no inappropriate use of force by any of the correctional staff and 2) the ketamine was not a contributory cause of death, we will take no further action in this matter.

B. ADDITIONAL FACTS

Daniel Christian Taylor was arrested in the early morning hours of August 13, 2021, for trespassing at the Omni Hotel, in Downtown Jacksonville. Taylor had a history of trespassing,[3] and this was the second time officers responded to the Omni that night due to complaints about Taylor. He was arrested without incident. After being booked at the PTDF, Taylor refused all medical screening procedures and a mental health evaluation.

Taylor appeared in court in the afternoon, pled no contest, and was sentenced to time served. Prior to his release and according to PTDF protocols, officers instructed Taylor to go to a temporary cell on the second floor. Taylor refused.

At 5:38 pm, Taylor and Corrections Officer Marsys Law exchanged words. Officer Marsy shoved paperwork into Taylor's chest.[4] Taylor eventually went up the stairs to the second floor. Officer Marsy raced up the stairs, and a physical struggle ensued between Officer Marsy and Taylor on the second-floor landing. Corrections Officer Marsys Law went upstairs to assist Officer Marsy. Taylor physically resisted both officers.

[3] On August 11, 2021, officers were called to the Jacksonville Regional Transportation Center as Taylor was threatening security guards and would not leave the property. On August 8, 2021, officers were called to the Hilton Garden Inn, 1201 King Ave., regarding Taylor trespassing. On June 16, 2021, officers were called to the Omni Hotel. The hotel complained that over the past few days, Taylor was on the property and had slept on the second-floor multiple times over the prior days. Each time, the responding officer advised Taylor he was trespassing, and if he returned, he would be arrested. Taylor said he understood the officers' warnings.

[4] There is no attendant audio to the surveillance video and thus, we do not have independent evidence of the words exchanged between Taylor and Mars.

A call went out over the radio, and per PTDF protocol,[5] over 20 officers responded to the second-floor landing. Although 20 officers responded, approximately 6-8 were involved in the struggle with Taylor. For the safety and security of the officers and other inmates, the cellblock went into lockdown, and inmates were ordered to their cells.

Taylor was screaming and yelling and fought multiple officers. Officers attempted to gain control of Taylor but were unable to do so. Taylor continued to resist, fighting multiple officers and bashed his head on the floor, cutting his forehead.[6] Taylor bit an officer who went to the hospital for his injuries.[7] It took multiple attempts for the officers to restrain Taylor.

Finally, at 5:46 pm, officers were able to use a 4-point restraint and carry Taylor to the first floor. They also put a spit mask on his face. Even restrained, Taylor continued to resist and fight and bash his head against the floor. PTDF medical staff was called but could not get close to Taylor to evaluate him because he continued to thrash about. Believing Taylor needed to go to the hospital for stitches to his forehead, correctional staff called JFRD to transport Taylor to the hospital.

JFRD arrived at approximately 5:56 pm. Taylor was in 4-point restraint, lying face down. JFRD Lt. Curran told the JSO officers to "back off" to see if Taylor would calm down. But Taylor remained combative and continued to resist.

Lt. Curran and JFRD Engineer/Rescue Officer Griggs made the decision to sedate Taylor in order to safely transport him to the hospital. At 6:08 pm, Taylor was injected with ketamine, per JFRD protocols,[8] and according to Lt. Curran "settled down." Ketamine is an injectable, short-acting anesthetic for use in humans and animals. It can induce a state of sedation (feeling calm and relaxed), immobility, relief from pain, and amnesia (no memory of events while under the influence of the drug). Drug Fact Sheet: Ketamine (dea.gov).

Taylor was transported to the hospital; while in the ambulance, he went into cardiac arrest. CPR was initiated. On August 20, 2021, he was pronounced dead.

Multiple witnesses—inmate, law enforcement, and JFRD—said Taylor appeared to be on drugs. Sead Ahmetovic, an inmate in cell 18, stated "I don't know if he was on meth or something. I think he was high when he came in." Corrections Officer Bloodworth described Taylor as

[5] When there is active resistance to officers, JSO sends all available staff to the cell block to secure the other inmates and assist to avoid a potential riot situation.

[6] Corrections Officer Harris said Taylor resisted the efforts of "10 plus officers" trying to restrain him.

[7] Taylor bit Corrections Officer Ma during the struggle; Officer Ma was transported to Baptist Hospital for his injuries.

[8] Before loading the syringe with ketamine, JFRD Engineer Griggs reviewed the JFRD protocol for dealing with combative patients and administering ketamine. Based on Taylor's behavior, Engineer Griggs gave him the maximum dosage of 400 mg. The JFRD's dosage is 4mg per kg of the patient with a maximum dosage of 400 mg. Ketamine comes in vials of 500 mg. Engineer Griggs put the full 500 mg into the syringe but only gave Taylor 400 mg. The syringe was then put in a "sharps" bag in their medical kit. The syringe was later reviewed and contained 100 mg of ketamine.

"bugging out," with enhanced strength. Corrections Officer Harris said Taylor was "thrashing around," "profusely sweating," screaming unintelligible remarks, and was able to resist the efforts of "10 plus officers" trying to restrain him. JFRD Engineer Griggs described Taylor's behavior as "being on something." JFRD Engineer Arianna Lopez thought Taylor seemed "high as a kite." Corrections Officer Pike said Taylor was exhibiting "superhuman strength" and was believed he was under the influence of "something."

At 5'5", 139 pounds, Taylor fought 10 plus officers and remained combative for over 30 minutes. JFRD Engineer Griggs said, "in my 8 years, I had never seen someone resisting like that for so long." Taylor was the "most combative patient in my career."

All witnesses said officers held Taylor with their hands.[9] No officers deployed their tasers or used pepper spray during the struggle with Taylor.

An autopsy was conducted. Dr. Buchsbaum, Associate Medical Examiner, District IV Medical Examiner's Office, determined the cause of death to be "Anoxic Encephalopathy Due to Cardiac Dysrhythmia Following Violent Physical Altercation,"[10] or in other words, a heart attack. Dr. Buchsbaum found that ketamine was not a factor in Taylor's death and did not find that any physical injury from the struggle with guards contributed to his death. CT scans did not show injury to his brain or spinal column. Toxicology revealed that Taylor had amphetamine, methamphetamine, and cannabis in his system. Dr. Buchsbaum determined the manner of death a homicide.

Because Dr. Buchsbaum's conclusion that Taylor's death was a homicide was inconsistent with the District IV Medical Examiner's conclusions in other similarly situated in-custody deaths, JSO sought a second opinion from District Medical Examiner Stephen Nelson for the 10th Judicial Circuit, and the Chairman of the State Medical Examiner's Commission.[11] After reviewing the entire file, including autopsy results, the toxicological results, Taylor's hospital records, the relevant PTDF surveillance videos, and Dr. Buchsbaum's opinion, Dr. Nelson noted that Dr. Buchsbaum failed to give any value to the drugs in Taylor's system. Dr. Nelson found Taylor's death was an accident and not a homicide.

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[9] Nurse Adrieene Robinson said officers were holding him with their hands on his head, back, and legs. Nurse Michael Pederi said officers were holding Taylor's arms and legs with their hands and were holding his head in their hands to try to prevent him from beating it against the ground.

[10] Anoxic encephalopathy, or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning (for example, carbon monoxide or drug overdose), vascular injury or insult, or cardiac arrest. Anoxic Encephalopathy - PubMed (nih.gov)

[11] Nelson has been the Chief Medical Examiner for the 10th Judicial Circuit for over 26 years. He was appointed to his first term by Gov. Lawton Chiles and has been reappointed by every subsequent governor. The state's Medical Examiners Commission, for which he serves as Chair, is the oversight board for Medical Examiner's offices across the state of Florida.

II. EVIDENCE REVIEWED

The evidence in this case included the following and has been reviewed in the course of our independent investigation:

- On-view observations of the scene;
- Scene photographs;
- Investigatory reports;
- Rescue reports;
- Security Video from the Pretrial Detention Facility;
- Medical Examiner's Report;
- Letter from Dr. Stephen Nelson.

III. KEY WITNESSES

A. DECEASED'S BACKGROUND and HISTORY

Daniel C. Taylor was a 33-year-old male.[12] Taylor had been arrested more than 15 times in Florida and in Texas. In 2017, he was convicted of Attempted Robbery and Possession of Cocaine. In 2009, he was convicted of four counts of Uttering a Forged Check. He had 11 misdemeanor convictions in Texas, and arrests in Jacksonville dating back to 2006. In the months leading to his arrest on August 13, 2021, police had responded to multiple calls of Taylor trespassing at various hotels and businesses in and around downtown Jacksonville.

Taylor was Baker Acted on February 12, 2021, for "drug-induced psychosis." A drug screen found both amphetamine and cannabinoids. On May 3, 2021, JSO brought Taylor to the hospital for bizarre behavior although he was not Baker Acted.

B. WITNESS STATEMENTS

All witness interviews were consistent with the other reliable evidence in the case and the facts set forth in Section I of this report.

1. Inmates

Sead Ahmetovic, Inmate

Sead Ahmetovic, an inmate in cell 18, stated that Officer Marsy told Taylor to get out of his face and shoved paperwork in Taylor's face. Taylor then went to the second floor, and Officer Marsy followed him, and a struggle ensued. Officer Marsy put Taylor in a chokehold. He fought

[12] This was Taylor's height and weight in the ME's report. Other arrest records list his height and weight as 5'6", 145 pounds and 5'8", 165 pounds.

with officers and then was taken downstairs. Ahmetovic believed Taylor was purple. Ahmetovic said "I don't know if he was on meth or something. I think he was high when he came in." Ahmetovic said Taylor did not "look like he was tweaking" when he was originally brought in from booking. He also said it was "real easy" to get meth in the jail.[13]

Aaron White, Inmate

Aaron White, an inmate in cell 18, stated Taylor told officers something to the effect of "I don't want to go in there because the judge released me, and I'm supposed to go home." He said Taylor seemed agitated. He did not see the incident from his cell but heard it. He saw officers running towards Taylor and heard Taylor say ouch and stop it and continued to yell. After the incident, he heard Officer Marsys say, "I hit him so hard I broke my hand." And Officer Marsy turned to Taylor and said, "Do I seem like a bitch now?"

2. <u>Duval County Jail staff</u>

Nurse Michael Pederi

Nurse Michael Pederi worked at the PTDF; when he arrived on scene, he saw Taylor on the first floor, beating his head against the ground. The officers were holding his arms and legs with their hands and were holding his head in their hands to try to prevent him from beating it against the ground. Pederi was not able to get near Taylor because he continued to fight.

Nurse Adrieene Robinson

Nurse Adrieene Robinson worked at the PTDF; when she arrived on the first floor, she noticed an injury to Taylor's face. Taylor was on his stomach and officers were holding him with their hands on his head, back, and legs. Taylor continued to fight even while officers were holding him down. When JFRD arrived, Taylor was placed on a stretcher but continued to fight.

Corrections Officer Bloodworth, JSO

Corrections Officer Bloodworth described Taylor as "bugging out;" veins were "popping out" of his head and said he had enhanced strength.

Corrections Officer Harris, JSO

Corrections Officer Harris said Taylor was "thrashing around," "profusely sweating," screaming unintelligible remarks, and was able to resist the efforts of "10 plus officers" trying to restrain him.

Corrections Officer Pike, JSO

Corrections Officer Pike said Taylor was exhibiting "superhuman strength" and was

[13] It is unknown where or from whom Taylor got the drugs. JSO initiated an investigation into the source without success.

yelling and "not making any sense" which led him to believe that Taylor was under the influence of "something."

Corrections Officer Marsys JSO

Corrections Officer Mar said Officer Marsys arm was pinned under Taylor's body. Officer Mars attempted to free Officer Marsys arm and in doing so, Taylor bit him on his right hand. He went to the hospital for treatment.

3. JFRD

Lt. M. Curran, JFRD

When JFRD Lt. Curran arrived, Taylor was "fighting and kicking and banging his head." Taylor was being held down by his arms, legs, shoulders, and knees. Lt. Curran told the JSO officers to "back off" to see if Taylor would calm down. Taylor did not. He remained combative.

Lt. Curran and Engineer Griggs decided to sedate Taylor to safely transport him. Taylor was injected with ketamine which caused him to "settle down." Once in the ambulance, Taylor went into cardiac arrest; CPR was initiated.

When asked about the amount of ketamine administered, Lt. Curran stated the amount was "determined by (JFRD) protocol" for a combative patient.

Engineer M. Griggs, JFRD

When JFRD Engineer Griggs arrived on the floor, he "noticed chaos;" Taylor was being restrained by 10 officers but was still fighting them. It was determined that Taylor would need to be sedated with ketamine to transport him to the hospital. Engineer Griggs described Taylor's behavior as "being on something."

Engineer Griggs went downstairs to get the ketamine from the JFRD rescue unit. Before loading the syringe, Engineer Griggs reviewed the JFRD protocol for dealing with combative patients and administering ketamine. Based on Taylor's behavior, Engineer Griggs gave him the maximum dosage of 400 mg. The JFRD's dosage is 4mg per kg of the patient with a maximum dosage of 400 mg. Ketamine comes in vials of 500 mg. Engineer Griggs put the full 500 mg into the syringe but only gave Taylor 400 mg. The syringe was then put in a "sharps" bag in their medical kit. The syringe was later reviewed and contained 100 mg of ketamine.

Engineer Griggs said, "in my eight years, I had never seen someone resisting like that for so long," adding that Taylor was the "most combative patient in my career."

Engineer Arianna Lopez, JFRD

Engineer Arianna Lopez responded to the scene with JFRD. She said officers were "just holding him down" and "not choking" Taylor. "Every time the officers eased up, he started

fighting again." She thought Taylor seemed "high as a kite."

Firefighter Patrick Walden, JFRD

Firefighter Patrick Walden saw Taylor "struggling" and "screaming" with approximately 12 officers holding him down. Walden tried to tell Taylor to calm down. Taylor calmed down long enough to be put on the stretcher but then he fought again. After the ketamine was given, Taylor calmed down. When they got to the rescue unit, Taylor went into cardiac arrest, and CPR was initiated.

IV. MEDICAL EXAMINERS

A. Ketamine

Ketamine is an injectable, short-acting anesthetic for use in humans and animals. It can induce a state of sedation (feeling calm and relaxed), immobility, relief from pain, and amnesia (no memory of events while under the influence of the drug). Drug Fact Sheet: Ketamine (dea.gov). JFRD policy allows for the use of ketamine in dealing with a combative patient.

Before loading the syringe with ketamine, JFRD Engineer Griggs reviewed the JFRD protocol for dealing with combative patients and administering ketamine. The JFRD's dosage is 4mg per kg of the patient with a maximum dosage of 400 mg. Ketamine comes in vials of 500 mg. Based on Taylor's behavior, Engineer Griggs gave him the maximum dosage of 400 mg. Engineer Griggs put the full 500 mg into the syringe but only gave Taylor 400 mg. The syringe was then put in a "sharps" bag in their medical kit. The syringe was later reviewed and contained 100 mg of ketamine.

Neither Dr. Buchsbaum nor Dr. Nelson found that the ketamine was a factor in Taylor's death. "Dr. Buchsbaum is correct that the 400 mg intramuscular injection of ketamine… administered to Mr. Taylor by JFRD personnel was precisely because of his sudden erratic, non-compliant, behavior. Ketamine played no role in Mr. Taylor's death." Dr. Nelson Letter, pg. 7.

B. Conflicting Expert Reports Regarding Manner of Death

Both Dr. Buchsbaum and Dr. Nelson agree the cause of death was "Anoxic Encephalopathy Due to Cardiac Dysrhythmia Following Violent Physical Altercation"—or a heart attack. Both found ketamine was not a factor in Taylor's death. Both found that most of the abrasions and contusions on Taylor were superficial and did not cause his death. And they both recognized that Taylor had amphetamine, methamphetamine, and cannabis in his system.

Where they disagree is the manner of death. Dr. Buchsbaum ruled Taylor's death a homicide. Conversely, Dr. Nelson ruled it accidental. "I concur—in part—with the cause of death, but I disagree with the manner of death." Nelson Letter, pg.4.

Dr. Nelson stated that Dr. Buchsbaum failed to assign any value to the amphetamine and methamphetamine in Taylor's cause of death. "Had Mr. Taylor simply been found dead somewhere with the same toxicology findings, I'm certain amphetamine and/or methamphetamine would have been listed as having played a role in the cause of death." Nelson Letter, pg. 6.

"Because Mr. Taylor has insufficient traumatic injuries to explain his death, I would not certify his death is a homicide. Because, in my opinion, amphetamine and methamphetamine played a role in his death, his death is an accident." Nelson Letter, pg. 7.

Dr. Nelson also noted that Taylor's behavior was sudden and came on after more than 12 hours in jail, he opined that Taylor obtained the drugs while in the jail. Taylor did not exhibit this erratic behavior during his afternoon court appearance or when he entered the jail. "I don't believe that Mr. Taylor had ingested amphetamine/methamphetamine prior to his arrest and that amphetamine/methamphetamine failed to manifest itself until almost 12 hours after his arrest…. It is more likely that Mr. Taylor obtained amphetamine/methamphetamine while incarcerated." Nelson Letter, pg. 7.

Dr. Nelson also detailed four other JSO in custody deaths where the deceased had drugs in their system. In those cases, the District IV Medical Examiner ruled the deaths accidents and not homicides.

The doctors agree on two key points: First, both doctors agreed the correctional staff did not use deadly force during Taylor's lengthy, considerable struggle against them. And second, both doctors agreed the sedative Taylor was administered to calm his combativeness did not contribute to his fatal heart attack.

V. LEGAL ANALYSIS

The actions taken by the corrections officers complied with the rules, regulations, and protocols, and were necessary to maintain order and safety in the jail. Both doctors agree deadly force was not used. "Fourth Amendment jurisprudence has long recognized that the right to make an arrest or investigatory stop necessarily carries with it the right to use some degree of physical coercion or threat thereof to effect it." *Graham v. Connor,* 490 U.S. 386, 396, (1989) (citing *Terry v. Ohio*, 392 U.S. 1, 22–27 (1968)).

The correctional officers' actions were reasonable in light of the situation they faced—a "hostile, belligerent, and uncooperative" individual who was on drugs. *See Draper v. Reynolds*, 369 F.3d 1270, 1278 (11th Cir. 2004) (Officer did not use excessive force when he tased an unrestrained suspect who was "hostile, belligerent, and uncooperative" and refused to comply with the officer's verbal commands); *Mann v. Taser Int'l, Inc.*, 588 F.3d 1291, 1306 (11th Cir. 2009) (Tasing a woman three times, which led to her eventual death, did not amount to excessive

force where the plaintiff actively resisted the deputies' efforts at a lawful arrest. Such “violent” and “aggressive” behavior demonstrated that the suspect was a threat to the officers and herself.).

Even if Dr. Buchsbaum’s opinion is correct, and the manner of death was a homicide, the actions of law enforcement were reasonable and constituted legal, nondeadly force. Alternatively, if the illegal drugs in his system played a role in Taylor’s death as Dr. Nelson’s found, then his death was an accident.

Since the use of force by law enforcement was appropriate and lawful under the circumstances, and there are conflicting expert medical opinions as to the manner of death, we will take no further action in this matter.

VI. CONCLUSION

Our role is to evaluate, review, and pursue criminal charges when law enforcement use of force is not justified. We have conducted a thorough review of the evidence in this matter. Based on this, and our review of applicable Florida law, we will take no further action in this matter.

Exhibit A

OFFICE OF THE MEDICAL EXAMINER

2100 JEFFERSON STREET
JACKSONVILLE, FLORIDA 32206

EXAMINATION REPORT

NAME OF DECEASED:	Taylor, Daniel Christian
M.E. NO.:	21-02190
DATE OF DEATH:	8/20/2021
DATE OF AUTOPSY:	8/23/2021 and 8/24/2021
TIME OF AUTOPSY:	10:33 AM on 8/23/2021 and 9:45 AM on 8/24/2021
COUNTY OF DEATH:	Duval

EXTERNAL EXAMINATION

The body is that of a 5-foot 5-inch, 139-pound, adult white male appearing the stated age of 30-years. (Body mass index is 23.1.) No rigor is in the cool body and fixed lividity is posterior. The scalp hair is brown and 1/16 inch in length with receding frontal hairline. The irides are brown. Pupil diameters are 6-millimeters. There are rare tiny conjunctival petechiae in the right lower eyelid. Dentition is natural and in fair condition. The frenula are intact. Facial hair consists of early growth of moustache and beard. The external genitalia are those of a circumcised adult male and both testes are intrascrotal.

MEO ID is on the right wrist (Daniel Christian Taylor 21-02190) and is observed and noted on both days of the autopsy (8/23/21 and 8/24/21). Hospital ID is on the right ankle (Taylor, Daniel Christian 20653736 10147714552) and detached from the left big toe (Taylor, Daniel Christian 20653736 10147377580). The right ankle has a donor ID (KHAG and bar code). The left wrist has a donor ID (Donor AIHS455).

The distal anterior left forearm has a 2-1/2 inch well healed scar.

Tattoos are present on the right arm, right forearm, left arm, left forearm, right chest, left chest,

The upper back has numerous pinpoint size pustules.

The upper medial back has hypopigmented spots up to ¼ inch. The right abdomen has a 1-1/4 inch well healed scar. The posterior proximal right leg has a linear well healed scar 5-1/4inches in length. The anterior right leg has well healed scars up to ½ inch. The distal posterior left thigh has a

1/8 inch well healed scar. The proximal posterior left leg has a 1/8 inch well healed scar. The distal posterior left leg has well healed scars up to 1/8 inch in size. The left knee and anterior proximal left leg have well healed scars up to ½ inch in size.

Clothing is not received. There are no paper bags on the hands.

Postmortem x-rays are reviewed. No overt fractures of the major bones are seen. The hyoid is difficult to evaluate on initial x-rays but a later x-ray of the hyoid by itself shows a small discontinuity at one of the joints that does not look like a hyoid fracture.

Also received at MEO is a large white cardboard box with "2190 Taylor" and "21-02190 Taylor" and "didn't use kidney OPO". Inside this box is a large Styrofoam type container. Within the container are several plastic bags containing a left kidney with adrenal gland resting inside one of the bags within a fluid milieu, a plastic bag with paper documents and a microscopy slide, and a plastic bag containing test tubes and blue top vials. There is ice and water surrounding the bag that has the left kidney and left adrenal. There is a tag on the kidney stating "left kidney" The donor number is AIHS455.

The left kidney and left adrenal have gross descriptions as noted below.

The bag with specimens contains 1 red top tube, 2 yellow top tubes, and 2 blue top vials, all with ID given as AIHS455. For MEO storage.

The microscopy slide (which has a stiff paper type cover labeled Donor ID: AIHS455 ABO:A DOB: 04/28/1991 Donor Initials DCT Local ID: Collected 08/21/2021 19:39 EDT Bu: SC, and the slide labeled Taylor D left kidney) is reviewed and turned over to histotech for microscopy slide storage at MEO.

Received at MEO are 2 other plastic bags.

One contains MEO paperwork for Taylor, Daniel Christian requesting admission specimens. It also contains 2 tubes of hospital blood and one leaky small container of hospital urine. As a result of the leakage of the urine container, only about 2 ml of clear yellow urine is found still inside this container. The blood tubes both lave labels with Taylor, Daniel Christian 20653736. One is a blue top tube and the other a purple top tube. Both show collection dates and times of 8/13/21 at 6:42 p.m. The urine container is also labeled Taylor Daniel Christian 20653736 and has collection date and time of 8/13/21 at 6:42 p.m. Due to its ongoing leakage, the remaining contents of the urine container are transferred to a new (unused) red top tube and labeled properly including MEO case number.

The other plastic bag contains 8 OPO (organ procurement organization) donor specimens, all of which are labeled Taylor, Daniel Christian 20653736, and all of which have collection date 8/21/21. There are 6 tubes of donor blood (4 gray top, 1 purple top, 1 red top) all collected at 1635. There is 1 red top tube of bile collected at 1935. There is 1 red top tube of urine collected at 1635.

Of these, the 2 hospital tubes of blood and 1 tube of hospital urine that was transferred from the leaky hospital container to a nonleaky red top tube, are to go to NMS for toxicology testing. The other specimens are to go to MEO storage.

EVIDENCE OF MEDICAL THERAPY:

The right abdomen has a pinpoint abrasion with surrounding discoloration that is possibly a needle puncture mark with extravasation. The dorsal right foot to ankle has needle puncture marks with extravasations.

According to forensic tech documentation, the following medical devices or dressings are on the decedent's body: EKG pads on the upper right and left chest and left lateral lower chest. Endotracheal tube. Urinary catheter with no collection bag. Wraps on lower right and left legs. Pulse oximeter on right middle fingertip. Band-Aid on right index finger. Intravenous lines in proximal right forearm, distal right forearm, right wrist, distal left forearm, and left arm. Band-Aid on left hand. Blood pressure cuff on left arm.

EVIDENCE OF ORGAN DONATION

There is a long, linear, vertical incision along the anterior midline of the torso from just below the base of the neck to the lower abdomen, with coarse sutures. Beneath this can be seen a vertical linear sternotomy. On internal exam, there are small amounts of red liquid in the right and left pleural cavities (approximately 15 ml on each side) and approximately 5 ml of red liquid in the peritoneal cavity. The pericardium is open and not evaluable for liquid. The spleen consists of a major part that is still in place and multiple (four) small pieces of spleen that are loosely located in the torso spaces. The bowel mesentery is noted to have been partially mobilized. Absent whole organs/tissues (absent from the torso) are the liver and gallbladder, pancreas, both kidneys and adrenals. It is also presumed that a portion or portions of the spleen were obtained by the OPO. As noted above, the left kidney and adrenal which the OPO obtained were returned to the MEO in a container separate from decedent's body.

EVIDENCE OF INJURY:

1. Possible mechanical or positional asphyxia
    a. The right lower conjunctiva has rare (two) fine, tiny petechiae.
2. Head and neck
    a. External head: The left lower occipital scalp has a 3/8-inch healing contused abrasion. The left upper occipital scalp has a ¾ inch healing contusion. The right mid occipital scalp has a 1-3/4-inch healing contused abrasion. The right external ear has a complex pattern of healing contusions 1-3/4 inch in aggregate on both the right ear lobe and main part of the external right ear. The left frontal scalp and left lateral face, lateral to the left orbital area, have two healing contusions up to ¾ inch. The right low frontal scalp (upper right forehead) has a curved 1-inch sutured laceration.
    b. Internal head: The right frontal and right temporal galea have focal contusions up to 1.8 cm in size. The right temporalis muscle has foci of contusions up to 1.7 cm in size. The left temporalis muscle has focal contusions up to 3.2 cm in size. The skull is intact. The atlantooccipital joint is stable. The dura is negative for trauma, but it is

noted that the great vein of Galen has red clot and there is detached clot found during the head exam that may be also from the vein of Galen but has a mixture of red and pale tan dry areas. The pale or tan clots are 2 in number and up to 3.5 x 0.4 cm in size. The arachnoid is without hemorrhage. The brain is diffusely edematous, with flattened cerebral surfaces, and has a fragile, soft texture suggestive of respirator brain effect, giving the appearance of mild autolysis. The cerebellar tonsils are somewhat distorted by softening and edema and thus difficult to evaluate. The uncinate areas are full, suggestive of herniation. The brain and brainstem parenchyma are soft and autolytic and distorted but do not show any foci of hemorrhage.

c. External neck:
    i. Anterior: None.
    ii. Posterior: None.
d. Internal neck
    i. Anterior layered neck exam: The carotids are patent and intact. The platysma fat is intact. The tongue has a 1.3 cm defect in the distal tongue with partial dark discoloration, which extends to the floor of the mouth. The thyroid gland is unremarkable and intact. The esophagus is intact. There is mucus in the patent trachea and larynx. The epiglottis is intact except for a yellowish, nonhemorrhagic swelling of the left aryepiglottic fold which is not obstructive of the airway. The superficial left sternocleidomastoid muscle at its inferior aspect has a focal contusion 1.8 cm in size. The deeper layers of the strap muscles show extensive contusions of the inferior aspect of the strap muscles that merge with extensive soft tissue hemorrhages of the superior part of the anterior mediastinum. The tracheal rings and cricoid are intact and without trauma. The thyroid cartilage is intact but it is noted that its medial promontory (also known as the laryngeal incisura or laryngeal prominence or "Adam's apple") has a tiny focus of minimal soft tissue hemorrhage. The right perithyroid soft tissue covering the thyroid gland and right peripharyngeal soft tissue have focal hemorrhage. The soft tissue covering the tip of the right hyoid, near the right cornu of the thyroid cartilage, has a small, focal contusion, but the hyoid bone itself is intact. The base/inferior aspect of the left hyoid (near its joint with the mid portion of the hyoid) has a 1.2 cm soft tissue hemorrhage but there is no step off of the hyoid bone and re-x-ray of the hyoid bone shows a discontinuity consistent with an intact hyoid joint without fracture. The prevertebral soft tissues of the cervical spine are intact and the surfaces of the anterior bodies of the cervical vertebrae are intact. The atlanto-occipital joint as viewed and

palpated from below is stable. Unroofing the anterior cervical vertebral bodies from C3 to C6 shows a soft, autolytic cervical spinal cord that is intact and no spinal canal hemorrhage but some increase in spinal canal cerebrospinal fluid, which is clear and nonbloody. The joint spaces/ligaments are intact.

ii. Posterior layered neck exam: On 8/24/21 (day 2 of autopsy exam) a limited layer wise examination of the posterior neck shows no trauma of the posterior neck superficial to deep soft tissues. The cervical vertebrae as palpated posteriorly are stable.

3. Torso
   a. External torso
      i. Anterior: None, other than a probable needle puncture mark with extravasation of the right abdomen.
      ii. Posterior: The right upper back has a 7/8-inch linear healing abrasion. The left upper to mid back has two linear purple healing abrasions that are 3-1/4 and 1/3/4 inches respectively.
   b. Internal torso
      i. Thorax: The disc at T8-9 has a hyperemic appearance with extension of the hyperemia to the left posterior 9th intercostal space soft tissues. The 9th thoracic prevertebral soft tissues and periaortic soft tissues in that area have hemorrhage. The left pectoralis muscle has a focal 2.2 cm contusion. The left lateral 2nd intercostal space soft tissues have subpleural hemorrhage.
         1. Unroofing the anterior vertebral bodies from T1 to T12 shows a soft, autolytic spinal cord (similar to that noted above for the cervical spinal cord but less soft than for the cervical levels) with increased spinal CSF fluid (clear, nonbloody) and no spinal canal hemorrhages. There is slight hyperemia of the posterior disc at T8-9 with extension to the left 9th interspace soft tissues posteriorly. There are no palpable step offs.
      ii. Abdomen: The stomach has a few purpuras.
      iii. Pelvis: The urinary bladder has a few purpuras.
      iv. Posterior torso (back): On 8/24/21 (day 2 of autopsy exam), a limited internal layered exam of the back is done. It shows several areas of soft tissue hemorrhage. Palpation and observation of the posterior vertebral column shows a stable spinal column. The soft tissue injuries are sampled for additional histology and have observed findings as follows:
         1. Superficial back soft tissues, upper mid back has a 1.3 cm hemorrhage mainly of the superficial muscle tissue.

2. Superficial back soft tissues, lower back has a 1.6 cm hemorrhage in the subcutaneous fat layer.
3. Mid depth back soft tissues, right lower back has a 1.6 cm hemorrhage mainly of mid depth muscle tissue.
4. Mid depth back soft tissues, right medial back has a 0.8 cm hemorrhage mainly of mid depth muscle tissue.
5. Mid depth back soft tissues, right of midline back has an area of hemorrhage 13 cm x 1 cm in size, mainly of the mid depth muscle tissue.
6. Deep layer back soft tissues, left lower back, medially, has a 0.5 cm hemorrhage mainly of muscle tissue.

4. Extremities
   a. Upper right: The posterior right hand has a ¾ inch healing contusion near the base of the 5thfinger and two healing abrasions up to ¼ inch on the index finger. The posterior right wrist has a 1-1/4-inch healing contusion. The posterior distal right forearm has a 1/8-inch healing abrasion. The anterior upper right extremity has no cutaneous injuries. No step offs are palpable.
   b. Upper left: None. No step offs are palpable. It is also noted that the left hand is edematous.
   c. Lower right: The posterior proximal right leg has healing abrasions up to 3/8-inch in size. The distal anteromedial right thigh has linear excoriations up to 3-1/2inches. The right knee has a 3/8-inch healing contusion. No step offs are palpable.
   d. Lower left: The left popliteal fossa has a ¼ inch healing abrasion. The distal posterior left leg has two purple healing abrasions up to 2-1/4 inches in size. The left heel has a 3/4inch contusion. The anterior mid left leg has a ¼ inch healing abrasion. The distal anterior left leg to ankle has healing abrasions to 2-1/4 inches in size. The dorsal left foot has a 5/16-inch healing abrasion and a ¼ inch healing contusion. No step offs are palpable. The left ankle is not swollen.

INTERNAL EXAMINATION:

The panniculus is 1.4 cm.

The scalp has cutaneous and galeal injuries as noted above. The calvarium and base of skull are intact. There is no epidural, subdural, or subarachnoid hemorrhage but, as noted above, the great vein of Galen has some clotted blood and there is detached clot which may also be from the same source. The 1700-gram brain is soft, autolytic and has diffuse cerebral edema, features suggestive of so-called "respirator brain" but does not have any parenchymal hemorrhages. The cranial nerves are within normal limits. The cortical ribbon is without punctate hemorrhages. There is no white

matter hemorrhage. The substantia nigra is pale. The Ammons horns do not show sclerosis but are distorted. The ventricles are distorted. The pons, midbrain, cerebellum, and medulla have autolysis, edema, and obscured/obliterated tonsillar detail and distorted softening of the vermis, but otherwise are unremarkable. The unci have a full appearance suggestive of uncal herniation. The vessels at the base of the brain do not have aneurysms or grossly observed vascular malformations. The atlanto-occipital joint is stable.

The tongue has a 1.3 cm left distal defect as noted above. The anterior soft tissues of the neck have injuries as noted above. The hyoid bone, thyroid cartilage, and cervical spine are all intact. The posterior soft tissues of the neck are intact. The atlanto-occipital joint is stable. The posterior cervical vertebral bodies are stable.

The pericardial sac is open or not prominent and thus evaluation for presence or absence of pericardial fluid is not feasible. The right and left pleural cavities each have approximately 15 ml of red liquid and no adhesions. The peritoneal cavity has approximately 5 ml of red liquid and no adhesions.

The 295-gram heart has a smooth glistening epicardial surface and fat pad. (Zeek reference range for heart weight is 271 to 351 grams.) The free wall of the left ventricle and the interventricular septum each measure 1.7 and 1.9-centimeters, respectively. The right ventricular wall measures 0.5 cm. There is no hyperemia or fibrosis in the myocardium. The endocardium and heart valves are without note. The foramen ovale is closed and fused. The tricuspid valve is 10.9-centimeters, the mitral valve is 9.2-centimeters, and the pulmonic and aortic valves are 5.8-centimeters and 5.4-centimeters, respectively. The coronary artery supply is of the left dominant type. The left anterior descending, left circumflex, and right coronary arteries are patent. The aorta has no atherosclerosis. There is periaortic soft tissue hemorrhage as noted above. The carotids are patent and without injury.

The right and left lungs are 280-grams and 335-grams, respectively. The pleural surfaces are smooth and glistening. Both lungs are atelectatic and have a mixture of subcrepitance and congestion. The bronchi are unremarkable. The larynx and trachea contain mucus. The peritracheal lymph nodes are not enlarged. The pulmonary artery and veins are free of emboli and thrombi. The postmortem blood is decreased in volume.

The liver and gallbladder are not present for autopsy evaluation due to organ donation prior to autopsy. The spleen has approximately more than half still attached to its usual location but there are several (four) detached pieces. The combined weight of the attached main part of spleen and detached small parts of spleen is 180 grams. Collectively, the main attached and smaller detached pieces of spleen have purple capsular surfaces and purple cut surfaces. The pancreas is not present for autopsy evaluation, having been collected by the OPO.

The right kidney is not present for autopsy evaluation, having been collected by the OPO.

The left kidney (with left adrenal) was originally collected by OPO but subsequently returned with left adrenal gland. The left kidney weighs 170 gm. The pale tan cortical surface is smooth. There is normal corticomedullary definition. The calyces and pelvis are patent.

The urinary bladder contains approximately less than 2-cubic centimeters of tan-yellow, turbid/opaque urine and the mucosa has a few purpuras; the bladder wall is thick but without focal lesion.

The prostate gland is of the usual size and consistency.

The testes are tan and the parenchyma strings with ease.

The pharynx has right peripharyngeal injury and left aryepiglottic swelling as noted above. The esophagus has no trauma. The stomach mucosa has a few purpura but is otherwise unremarkable; the stomach contains approximately less than 5-cubic centimeters of green-yellow mucusy liquid. There is no pill residue. The stool and chyme are unremarkable. The duodenum and the remainder of the small and large bowel are without evident abnormality except OPO artifact of partial mobilization of the mesentery. The serosa is smooth and glistening. The appendix is not present, but the usual location of the appendix has a focal brown discoloration (possibly old hemorrhage) at the post-appendectomy stump area.

The thyroid is dark red/brown. The right adrenal is not present for autopsy evaluation, having been collected by OPO prior to autopsy. The left adrenal is part of the kidney/adrenal returned by OPO as not being used for transplantation; the left adrenal has a yellow cortex and brown medulla.

The red/brown muscle is injured as noted above. The long bones of the extremities, bony thorax and vertebral column are intact except for the disc area at T8-9 as noted above.

MISCELLANEOUS ITEMS (INCLUDING TOXICOLOGY)

Toxicology: Sent to NMS lab are 2 tubes (1 pink top, 1 blue top) of hospital blood from 8/13/21, and 1 tube of hospital urine from 8/13/21. [Note: The hospital urine is initially received as a small container but is noted to be leaking urine and so the remainder in the container is poured over into an MEO red top tube and afterward is part of the NMS send out.]

Testing performed at NMS labs. See attached NMS Labs Toxicology Report.

Stored at MEO, in addition to a stock jar, are a red top tube of autopsy vitreous, OPO specimens of blood, bile, and urine from 8/21/21, and tubes and vials of specimens related to the OPO-collected-and-returned left kidney and left adrenal.

FTA cards x 2 are collected with heart blood, 1 card for records room and 1 card for evidence.

Evidence collected:

1. Right fingernail clippings and clipper.
2. Left fingernail clippings and clipper.
3. Buccal smears x 2.
4. Hair, collected from head.
5. FTA card, collected with heart blood.

Histology:

Submitted in cassettes are sections of 1) inferior left sternocleidomastoid muscle with grossly observed hemorrhage; 2) left pectoralis muscle with grossly observed focal hemorrhage; 3) right temporalis muscle and right temporal/right frontal galea with grossly observed hemorrhage; 4) left temporalis muscle with grossly observed hemorrhage, 5) vein of Galen with clot, 6) detached clot from intracranial location; [Note: No cassette number 7, per histotech on 8/24/21.]; 8) strap muscles with grossly observed hemorrhage, 9) grossly observed soft tissue hemorrhage at T9 prevertebral, 10) random cortex (frontal) of brain, 11) random pons, 12) random vermis, 13) random hippocampus, 14) random basal ganglia, 15) defect in right dorsal tongue, 16) right perithyroid/perihyoid soft tissue with grossly observed focal hemorrhage, 17) right perithyroid/pharynx soft tissue with grossly observed focal hemorrhage, 18) base of left hyoid near joint with grossly observed soft tissue hemorrhage, and 19) C3 cervical spinal cord with grossly observed softening and spinal dura. Submitted without cassettes are sections of vertebral marrow, lungs, heart, liver, and left kidney.

Received and reviewed are 25 hematoxylin and eosin-stained glass microscopic slides labeled 21 02190 Taylor and numbered from 1 to 6 and 8 to 26. [Note: There is no block or slide #7.] [Note: #26 is a decal slide, from hard tissue that has been decalcified prior to slide making.].

Slide 1, inferior left sternocleidomastoid muscle with grossly observed hemorrhage: Soft tissues, including muscle and connective tissue, with patchy hemorrhage that is without inflammatory response or organization.

Slide 2, left pectoralis muscle with grossly observed focal hemorrhage: Soft tissues, including muscle, connective tissue, and adipose tissue, with attached and artifactually detached blood that is without inflammatory response or organization.

Slide 3, right temporalis muscle and right temporal/right frontal galea with grossly observed hemorrhage: Soft tissue, mainly muscle, with patchy hemorrhage that has a few inflammatory cells in places, but no organization. There are also incidentally noted foci of apparent muscle cell degeneration/inflammation not related to the hemorrhage seen.

Slide 4, left temporalis muscle with grossly observed hemorrhage: Similar to slide 3, above.

Slide 5, vein of Galen with clot: Fragments of clotted blood with mild inflammatory response, and lines of Zahn, suggestive of a premortem thrombus. No organization is seen.

Slide 6, detached clot from intracranial location: Mainly fibrin with inflammatory cells. Tiny fragments of blood also noted.

[No slide #7]

Slide 8, strap muscle with grossly observed hemorrhage: Soft tissue, mainly muscle, with hemorrhage that is without inflammatory response or organization.

Slide 9, prevertebral soft tissue at 9th thoracic vertebral level with grossly observed hemorrhage: Soft tissues, mainly adipose and connective tissues, with patchy hemorrhages that are without inflammatory response or organization.

Slide 10, random of frontal cortex of brain: Unremarkable brain parenchyma except for focal congestion in a sulcal area. The arachnoid layer is not seen.

Slide 11, random of pons: Patchy mild congestion. One focus of extravasation of blood, probably due to artifact.

Slide 12, random of vermis: Focal congestion.

Slide 13, random of hippocampus: Markedly dilated crowded plexiform blood vessels with foci of blood extravasation, and foci of parenchymal necrosis are noted. The necrotic changes are consistent with respirator brain. The plexiform dilated blood vessels raise the possibility of an arteriovenous malformation with slight hemorrhage. The blood vessels are not excessively thick and do not show perivasculitic inflammatory pattern.

Slide 14, random of basal ganglia: Congestion. Rare tiny focus of slightly thin neuropil.

Slide 15, grossly observed defect in right side of dorsal aspect of tongue: The deep soft tissues of the tongue and lingual tonsils have a prominent purulent exudate with numerous neutrophils suggestive of a purulent, acute lingual tonsillitis/glossitis.

Slide 16, right perithyroid/perihyoid soft tissue with grossly observed hemorrhage: Mixed soft tissues and squamous epithelial lined tissues, possibly from pharynx, with focal small area of hemorrhage without inflammatory response or organization. Also noted are a few tiny foci of apparent degenerative inflammatory changes of muscle tissue.

Slide 17, right perithyroid/pharyngeal soft tissue with grossly observed hemorrhage: Soft tissues (including muscle) with area of inflammatory/degenerative change in muscle tissue. Also noted is a miniscule focus of hemorrhage or blood extravasation with a few inflammatory cells and no organization.

Slide 18, base of left hyoid, near joint, with grossly observed soft tissue hemorrhage: Soft tissue with focal inflammatory/degenerative change of muscle tissue and tiny focus of hemorrhage without inflammatory response or organization.

Slide 19, cervical spinal cord and dura at 3rd cervical vertebral level with grossly observed softening of spinal cord: Abnormal appearing spinal cord parenchyma with possible loosened neuropil and distorted anatomy.

Lungs, right and left, slides 20-22: Unremarkable bronchi. Areas of expanded and collapsed air spaces possibly ventilator artifact vs true atelectasis. The collapsed areas are very prominent in slide 21. In slide 22 there is lung tissue with patchy parenchymal hemorrhage adjacent to normally expanded air space parenchyma. Also in slide 22 are detached fragments of blood without inflammatory response or organization.

Heart, left ventricle and septum, slide 23: No myocarditis, myocardial fibrosis, enlarged myocardial nuclei, or hemorrhage.

Kidney (left side, returned from OPO collection to MEO), slide 24: A rare hyalinized glomerulus is noted. The arteries, and tubules are unremarkable. Rare small groups of chronic inflammatory cells are noted in the interstitium, nonspecific observation.

> [Note: Also received from OPO as noted above is a glass microscopy slide of the left kidney which has the shape of a core biopsy. It is also reviewed and the slide, as noted above, goes to MEO histotechnologist (Cecilia Valdes) for storage at MEO histology slide inventory. Review of this slide shows that its appearance is similar to that described above for the MEO's slide of the left kidney, except no inflammatory cells and no hyalinized glomeruli are seen on the OPO slide.]

Dura, slide 25: Unremarkable dura. No hemorrhage seen.

Vertebral marrow, slide 26 (decal): Marrow cellularity is near upper limit of normal for age. There is trilinear hematopoiesis.

Additional histology: On 8/24/21, additional tissue sections are submitted in cassettes for histology as follows: 1) upper mid back superficial layer; 2) lower back superficial layer; 3) right lower back mid depth layer; 4) right mid back, mid depth layer; 5) right of midline back, mid depth layer; and 6) left lower back, medial, deepest layer.

Subsequently received are 6 additional hematoxylin and eosin-stained glass microscopic slides labeled 21-02190 Taylor and numbered (ADD) 1 to (ADD) 6.

Slide (ADD) 1, upper mid back, at superficial muscle level, with grossly observed hemorrhage of muscle tissue: Soft tissue (mainly muscle) with patchy hemorrhage that has a few inflammatory cells and no organization.

Slide (ADD) 2, lower back, at superficial muscle level, with grossly observed hemorrhage of fatty tissue. Soft tissue, mainly adipose tissue, with interstitial increase in red blood cells, possibly either due to minimal hemorrhage or extravasation of congested tiny blood vessels. No inflammatory response or organization seen.

Slide (ADD) 3, right lower back, at mid depth level, with grossly observed hemorrhage of muscle tissue: Soft tissue (mainly muscle) with small amount of adipose tissue with tiny focus of hemorrhage in interstitial component, without inflammatory response or organization.

Slide (ADD) 4, right mid back, at mid depth level, with grossly observed hemorrhage of muscle tissue: Soft tissue (mainly muscle) with few tiny foci of interstitial hemorrhage without inflammatory response or organization.

Slide (ADD) 5, right midline back, at mid depth level, with grossly observed hemorrhage of muscle tissue: Soft tissue, mainly muscle and adipose tissues, with coalescing broad areas of hemorrhage that have a few accompanying inflammatory cells, and no organization.

Slide (ADD) 6, left lower back, medial, at deepest level, with grossly observed hemorrhage of muscle tissue: Soft tissue, mainly muscle, with tiny focus of hemorrhage with a few accompanying inflammatory cells and no organization.

Autopsy Technician: Raiyna Lanclos on 8/23/21 and 8/24/21
Photographer: James Brown on 8/23/21 and Jacqueline Roberts on 8/24/21

MEDICAL EXAMINER REPORT

NAME OF DECEASED:	Taylor, Daniel Christian
M.E. NO.:	21-02190
DATE OF DEATH:	8/20/2021
DATE OF AUTOPSY:	8/23/2021 and 8/24/2021
TIME OF AUTOPSY:	10:33 AM on 8/23/2021 and 9:45 AM on 8/24/2021
COUNTY OF DEATH:	Duval

AUTOPSY FINDINGS:

1. Toxicology shows presence of methamphetamine, amphetamine, ketamine, and caffeine. See NMS report
2. Anamnestic history of being administered ketamine during altercation and attempt at restraint by law enforcement
3. Possible acute exudative lingual tonsillitis/glossitis
4. Microhemorrhage of brain parenchymal focus possibly representing arteriovenous malformation of hippocampal area
5. Soft, edematous brain with uncal herniation and autolytic features, and clotted great vein of Galen, consistent with respirator brain following anoxic encephalopathy
6. Trauma of soft tissues of anterior neck (but not hard tissues)
7. Trauma of soft tissues of back (but not vertebral column or ribs)
8. Focal hemorrhage of prevertebral soft tissue at T9 level
9. Rare, fine petechiae of right conjunctiva (right lower eyelid)
10. Cutaneous injuries of head, torso and limbs
11. Purpura of stomach, suggestive of therapeutic artifact
12. Purpura of urinary bladder, suggestive of therapeutic artifact. Scant mucopurulent urine in bladder
13. Atelectatic lungs with mixture of congestion and subcrepitance
14. Status post organ procurement (by organ procurement organization) of pancreas, part(s) of spleen, kidneys and adrenals, lower aorta, inferior vena cava, liver, and gallbladder; and return by OPO to MEO of left kidney and left adrenal
15. Status post remote appendectomy

CAUSE OF DEATH	Anoxic Encephalopathy Due To Cardiac Dysrhythmia Following Violent Physical Altercation
MANNER OF DEATH	Homicide

Robert M Buchsbaum

Robert Buchsbaum, M.D., J.D.
Associate Medical Examiner
Dated: 12/16/2021
RB: rb

Exhibit B

OFFICE OF THE
DISTRICT MEDICAL EXAMINER

10TH JUDICIAL CIRCUIT OF FLORIDA
In & For Polk, Hardee and Highlands Counties

1021 JIM KEENE BOULEVARD
WINTER HAVEN, FLORIDA 33880-8010

(863) 298-4600
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Stephen J. Nelson, M.A., M.D.
District Medical Examiner

March 29, 2022

Lt. J.D. Stronko
Jacksonville Sheriff's Office Headquarters
Police Memorial Building
501 East Bay Street
Jacksonville, FL 32202-2975

In Re: Daniel Christian TAYLOR, deceased 30 WM (DOB: 4/28/1991)
Your CCR #: 2021-483224

Dear Lt. Stronko:

In early January, at the suggestion of Assistant State Attorney Mark Caliel, you contacted me to explore my willingness to provide the Jacksonville Sheriff's Office and the 4th Judicial Circuit State Attorney's Office with my opinion of the cause and manner of Daniel Christian Taylor's death on August 20, 2021. I subsequently had multiple telephone conversations with you, Sgt. Harry Goldstein, and Det. Dennis Sullivan concerning Mr. Taylor's death.

On January 14, 2022 Sgt. Goldstein provided me with a 1-page synopsis letter, the decedent's 14-page autopsy report (Case No. 2021-02190) authored by Dr. Robert M. Buchsbaum II, and the decedent's 4-page toxicology report (Workorder #21293416) from NMS forensic toxicologist Michael E. Lamb. Sgt. Goldstein also provided me with the decedent's paper records from CorEMR (correctional electronic medical records), the Jacksonville Fire and Rescue Department, and UF Health Jacksonville. He also provided me with eight (8) DVD+Rs of medical records, video, and photographs.

You've asked my opinion on the decedent's cause of death and his manner of death. Deaths resulting from a decedent's interaction with law enforcement or occurring in law enforcement custody are two of the most high-profile investigations faced by a medical examiner. A death in law enforcement custody invariably leads to allegations of neglect or brutality or even torture. And, depending on the circumstances, an initial question is whether or not the use of force was justified. These custodial deaths generate intense community interest.

At first glance the manner of death appears quite simple: the death is natural, accidental, suicidal or homicidal. However, this particular area has generated a great deal of discussion, confusion, and controversy regarding death certification. In part, this is the result of undefined criteria and the fact that certification of the manner of death is as much a function of tradition as it is of logic. No uniform criteria exist for certifying the manner of death.

Manner of death is an expressed opinion based upon all available knowledge of the particular case. This includes the autopsy findings, toxicology results, scene of death, terminal events, and social and medical background information. Since the manner of death is based upon the sum total of information known up to a particular point in time, it may change upon the subsequent discovery of additional genuine information.

The major reason for expressing a manner of death is for statistical purposes. For insurance purposes, contract law will determine the outcome of any settlement, which will be partially based on the particular manner of death. For criminal purposes, the law will also dictate a course of action. A manner of death ascribed to homicide may be regarded, legally, as excusable, justifiable, first-degree, etc. But these are legal definitions and proceedings properly beyond the scope of the forensic pathologist. Likewise, a manner of death listed is accident does not preclude prosecution for manslaughter, should the circumstances be appropriate for that charge.

The manner of death explains how the cause of death came about. The autopsy findings may contradict or agree with the account of how the death occurred. Just because a forensic pathologist makes a ruling as to the manner of death does not mean that it is accepted by either families or other agencies. Some forensic pathologists will rule a death a homicide, even if there is no physical struggle, but just sufficient psychological stress to have precipitated an arrhythmia and death. This is controversial.

A death resulting from an unintentional overdose of a drug(s) is generally regarded as an accidental death. When death occurs as the result of the deliberate action of another, the manner of death (for the death certificate) is homicide. The key phrase is "deliberate action" and must be distinguished from accidental, intentional, and unintentional. Intent is not a prerequisite for classifying a death as homicide. Rather, intent is the purview the courts and the degree of intent will determine if the homicide is excusable or justifiable, or whether it is murder. Culpability is the province of the courts and will be determined by subsequent criminal and civil judicial proceedings.

I have reviewed the materials you provided to me related to the death of Daniel Christian TAYLOR.

On August 13, 2021, Mr. Taylor was arrested for trespassing and booked into the PreTrial Detention Facility at 4:34 AM. He had refused all medical screening procedures upon his entrance into the jail, including medical and mental health history evaluation. After an afternoon court appearance at the jail, he was placed in a temporary dorm area of the PTDF while awaiting his release.

Later that same day, at 5:38 PM while awaiting his release, he became non-compliant and combative with multiple corrections personnel who were monitoring his dorm area. He physically resisted, requiring additional correctional personnel to help control and restrain him. For approximately half an hour he continued to be combative. Mr. Taylor's interaction with JSO corrections officers is documented with CCTV video.

When Jacksonville Fire Rescue Department (JFRD) personnel arrived, they administered a typical 400 mg dose of ketamine which allowed him to calm down so he could be properly secured on their stretcher. During EMS transport to UF Health/ Jacksonville he went into cardiac arrest. While hospitalized, he never improved and was pronounced dead a week later on August 20, 2021.

According to Mr. Taylor's UF Health Shands Jacksonville medical records on August 13, 2021 he was going "crazy" in the jail and required 10 guards to hold him down. Pulses were lost en route to the hospital. On arrival, CPR was being performed, king tube in place, GCS 3, in a C-collar, with a left tibial intraosseous catheter in place. Return of spontaneous circulation was achieved shortly after arrival after 1 round of advanced cardiac life support. Notable injuries were periorbital edema/ecchymosis with a right forehead 3cm laceration. Also noted was an obvious right 5th digit deformity. His oral temperature in the ER was 97.8°F. His earlier leukocytosis, elevated creatinine, and hypokalemia documented on his February 12-13, 2021 admission had resolved. His 8/13/2021 urine toxicology screen at 2119 hours (9:19 PM) was presumptively positive for amphetamines, benzodiazepines, and cannabinoids.

Mr. Taylor was admitted with profound metabolic and respiratory acidosis that improved with resuscitation. Initially he was not breathing, and his pupils were fixed and dilated. With CPR and life support, he began breathing over the ventilator and his pupils became 3 mm and reactive with resuscitation. He was admitted to the SICU for treatment. A chest X-ray was non-contributory. A CT scan of his head and abdomen/

pelvis, with and without contrast agent, were also non-contributory.

After two evaluations of brain death criteria, he was pronounced dead on August 20, 2021 at 11:32 AM; 6 days, 17 hours, 26 minutes after he went unresponsive at the PTDF. Mr. Taylor was an organ donor.

Associate Medical Examiner Dr. Buchsbaum certified Mr. Taylor's death after autopsy as "*anoxic encephalopathy due to cardiac dysrhythmia following violent physical altercation*" and he indicated the manner of death was, in his opinion, a homicide. I concur – in part – with the cause of death, but I disagree with the manner of death.

Mr. Taylor's prior medical records from 2021 indicate that he was admitted on February 12, 2021 under Florida's Baker Act for "drug-induced psychosis." His hospital admission urine drug screen at that time found both amphetamine and cannabinoids. His was a known abuser of cannabinoids, amphetamine, and methamphetamine. His laboratory values demonstrated hypokalemia (2.9 mmol/L) and leukocytosis (21.1 KmcL, with 87.6% neutrophilia), along with borderline elevation of salicylate (31 mg/L) and creatinine (1.29 mg/dL). He was brought to the hospital by EMS because he was running away from a group of people who, he believed, were chasing him and trying to hurt him. At the hospital he attacked a food delivery person and took the food and was exhibiting very odd behavior. He stated that people were trying to harm him. He underwent psychiatric evaluation and was cleared for discharge the following day, February 13, 2021.

On May 3, 2021 he was again brought to the hospital brought in by JSO for bizarre behavior. He was found running down street without a shirt on stating he thought people were chasing after him. He used marijuana the day prior, but he denied any other drug use. JSO did not Baker Act him as they felt he did not meet criteria and they initially brought him into the hospital for medical clearance. Then JSO decided not to arrest him and left the hospital "*...without speaking to the staff.*" According to his medical records, Mr. Taylor "*logically explained that a couple cars had flashed a gun at him and that he was trying to run away from them and find a cop. He took his shirt off while running and states he lowered his pants when cops had found him to show he did not have a gun.*" He was alert and oriented to person, place and situation and had full capacity at that time. He did not meet Baker Act criteria and he signed himself out against medical advice.

Later that same year he was admitted for seizure vs. syncope, Covid-19 infection, and for right lower abdomen/hip pain. He was reported to be sober on those occasions and his laboratory evaluation parameters were essentially unremarkable.

It goes without saying that if a methamphetamine user dies and there is an antemortem hospital specimen available, the antemortem hospital specimen should be relied upon for of the cause of death, rather than any post-mortem blood obtained at autopsy.

In Mr. Taylor's case a pink top tube (EDTA anticoagulant) of "hospital blood" from "8/13/2021" and labeled with both "1833" and "1842" hours, along with a blue top (sodium citrate anticoagulant) labeled "hospital serum or plasma" from "8/13/2021" at "1842" hours, and a red top (no additives) labeled "hospital urine" from "8/13/2021" at "1842" hours were submitted by the medical examiner's office to NMS Labs for analysis in lieu of any specimens procured at autopsy.

His autopsy on August 23rd was performed after consented postmortem organ donation. Autopsy demonstrated no fractures to Mr. Taylor's body. Dr. Buchsbaum described "cutaneous injuries of head, torso and limbs," and "Trauma of soft tissues of anterior neck", and "Trauma of soft tissues of back." None were sufficient to cause death, as they are not indicated as the cause of death by Dr. Buchsbaum. Instead, Dr. Buchsbaum uses the non-specific and non-defined term "violent physical altercation" to explain M. Taylor's death. Mr. Taylor's other non-abrasion/non-contusion autopsy findings are consistent with anoxic-ischemic encephalopathy resulting from cardio-pulmonary arrest.

Mr. Taylor's "anoxic encephalopathy due to cardiac dysrhythmia" is likely due to the presence of amphetamine and methamphetamine in his system at the time of his PTDF altercation. Dr. Buchsbaum failed to assign any value to amphetamine and/or methamphetamine in determining the cause of death.

In the District 4 Medical Examiner's Office Case Progress Notes (prior to un-pending the cause and manner of death) dated *12-9-21, 4:49 PM, "RB"* (Dr. Buchsbaum) writes, *"The tox results were also disc'd* (discussed). *On Thurs. a.m. (12-9) I briefly disc'd c BP* (with B. Robert Pietak, M.D., the District Medical Examiner) *incl. the previous day's meeting opinion. BP also concurs. The relatively minor levels of meth + ket* (ketamine) *not high enough to be contributory."*

I disagree. Had Mr. Taylor simply been found dead somewhere with the same toxicology findings, I'm certain amphetamine and/or methamphetamine would have been listed as having played a role in the cause of his death. Death from methamphetamine may be associated with very low or very high post-mortem drug concentrations. Yet, ironically, amphetamine and/or methamphetamine played no role in this death as determined by Dr. Buchsbaum?

There is no correlation between death and levels of methamphetamine in the blood.[1] Tolerance to stimulant drugs cannot be assessed at autopsy.

Deaths attributed to cocaine for example, whether they are or are not associated with excited delirium syndrome, have cocaine levels in the blood that overlap those using cocaine but who die of trauma with cocaine as an incidental finding.[2-3]

It is not possible to attribute any particular significance to isolated high concentration measurements (unless, of course, no methamphetamine is detected in the hair, which would prove that the decedent was naïve and, therefore, not tolerant). This is especially true for methamphetamine, where the measured concentration is highly dependent on where in the body the sample was obtained. Low concentrations are equally difficult to interpret.

If there is a documented history of long-term methamphetamine abuse, death could be attributed to methamphetamine, even when blood drug concentrations are low or nonexistent. Mr. Taylor's 295 gram heart weight is normal (within one standard deviation; normal range 272-352 grams) for his 65 inch height.[4]

With every passing month the brain's response to abused drugs becomes better characterized and receptors easier to measure.[5] Receptor measurements are already used to identify stimulant abusers who die of excited delirium, and it could possibly be adapted to other types of stimulant-related deaths as well.[6]

The most important and potentially useful analytic technique, one that could be implemented immediately, would be to measure brain drug levels. There is substantial experimental evidence that drug concentration measurements provide a more accurate portrayal of the situation at the time of death than is achievable by isolated blood drug measurements.

Dr. Buchsbaum is correct that the 400 mg intramuscular injection of ketamine (an NMDA receptor antagonist used as a dissociative anesthetic) administered to Mr. Taylor by JFRD personnel was precisely because of his sudden erratic, non-compliant, behavior. Ketamine played no role in Mr. Taylor's death. Mr. Taylor's sudden erratic, non-compliant, behavior was not evident during his earlier arrest or during his afternoon court appearance. I don't believe that Mr. Taylor had ingested amphetamine/methamphetamine prior to his arrest and that amphetamine/methamphetamine failed to manifest itself until almost 12 hours after his arrest at 5:38 PM while in the PTDF awaiting his release. That scenario defies logic. It's more likely that Mr. Taylor obtained amphetamine/methamphetamine while incarcerated.

Because Mr. Taylor has insufficient traumatic injuries to explain his death, I would not certify his death is a homicide. Because, in my opinion, amphetamine and methamphetamine played a role in his death, his death is an accident.

In none of the previous four (4) custody-related deaths, and this instant case of Mr. Taylor's, are sufficient injuries documented in each decedent's autopsy to explain death. And Mr. Taylor's interaction with JSO corrections officer is documented with video. The largest subcutaneous hematoma documented at autopsy was 5.1 inches long. Most abrasions and contusions were described as superficial.

As was indicated to me on the telephone, the District 4 Medical Examiner's Office has certified numerous prior deaths under similar law enforcement-related "in-custody" circumstances as accident, not homicide. JSO provided me with the following four examples dating back to April 2019. They are:

> **JSO Case No. 2019-0305393-05 (Jalen Lybrian MAYS, 26 BM; Medical Examiner Case No. 2019-1009):** Dispatched as a Mental Illness Report for erratic behavior at a convenience store knocking over shelves and arguing with customers. JSO placed him in handcuffs when he refused to leave the store as requested. He went unresponsive after being placed inside an ambulance under Baker Act because of his erratic behavior. He went to nearby ER and then transferred to Orange Park Medical Center where he died. Autopsy by Dr. Robert R. Pfalzgraf indicated that there were no signs of trauma to his body. Postmortem toxicology analysis of his blood found both psychoactive and non-psychoactive cannabinoid metabolites, along with the opioid reversal agent naloxone (Narcan) and the ultrashort-acting anesthetic etomidate (Amidate). His urine contained both cannabinoids and cocaine metabolites. Dr. Pfalzgraf certified his death as hypoxic encephalopathy following resuscitation for cardiopulmonary arrest, due to vaso-occlusive crisis following strenuous physical activity, due to hemoglobin SC disease. A contributory cause of death drug (cannabinoids) intoxication associated with psychosis and excited delirium. The manner of death was accident.

JSO Case No. 2019-0462028-02 (Joshua Adam LAVACEK, 27 WM; Medical Examiner Case No. 2019-1570): Dispatched as a stabbing. When JSO deputies arrived, they found Mr. Lavacek naked and acting erratically. Both he and his wife indicated they had used LSD (lysergic acid diethyamide) and that Lavacek suddenly became very agitated and started acting out, breaking a glass table, resulting in the bleeding and sharp force trauma to his body (though his wife subsequently indicated that she had stabbed him). He violently grabbed his wife, causing her to flee their residence and run to a neighbor's home Protected Protected Lavacek was disoriented, sweating profusely, and screamed "Help me" before he attempted to flee JSO deputies. He was then placed in handcuffs and could be heard moaning before he went silent and unresponsive. He was transported by EMS to the hospital where he subsequently died. Autopsy by Dr. Peter Gillespie indicated his death was due to anoxic encephalopathy, excited delirium-associated cardiac arrest and acute combined drug intoxication (LSD and mitragynine). The manner of death was accident. Mitragynine (Kratom) is found in the leaves of the South East Asian tree *Mitragyna speciosa*. Kratom leaves are chewed, smoked, or consumed in tea. Leaves from this tree have traditionally been used for both their stimulant properties and as an opium substitute.

JSO Case No. 2020-0593982-04 (Dexter Gustavius HOWARD, 51 BM; Medical Examiner Case No. 2020-02910): Dispatched as a disturbance. Mr. Howard, a known alcoholic, was exhibiting signs of medical distress. He was on his way to his brother's residence (coming home from a party) and claimed that he had been assaulted (he was bleeding) and that person(s) unknown had slipped a "*mickey*"[1] into his drink. When he became aggressive and paranoid at his brother's residence, pushing the brother's 26-year-old daughter and striking the brother's wife, JSO deputies were called. He was seen eating food from the trash outside someone's apartment. He resisted deputies' commands to cooperate while being handcuffed. He then stopped resisting and went limp. EMS transported him to UF Health/Jacksonville where he was pronounced dead in their ER. Autopsy by Dr. Robert F. Pfalzgraf certified his death as drug (cocaine) intoxication, and the manner of his death was accident.

JSO Case No. 2020-0517966-02 (Timothy Shawn SMITH, 32 WM; Medical Examiner Case No. 2020-2631): Dispatched as assisting rescue and someone chasing with gun. The decedent was known to his mother to have a drug addiction. He was located by JSO deputies who responded to a nearby call of someone attempting to break into an apartment. When he was located, he was screaming and making erratic movements that appeared to be signs of excited delirium. They attempted to take him into custody for his own safety. He failed to comply with deputies' commands and was running near traffic. He was physically restrained and placed in handcuffs. A handgun was located nearby. Smith was transported by EMS to a local hospital where he was pronounced dead. Autopsy by Dr. Peter Gillespie indicated his death was due to complications of excited delirium syndrome, with cardiac arrest and anoxic encephalopathy, due to acute combined drug intoxication (methamphetamine, cocaine, and fentanyl). The manner of death was accident.

The Centers for Disease Control & Prevention and the National Center for Health Statistics have for years provided education and outreach to medical examiners and coroners to improve national mortality surveillance by: Promoting quality and ***consistency***

in death investigations and death certification (my emphasis); Promoting collection, automation, and distribution of medicolegal death investigation data; Facilitating information sharing among the medicolegal death investigation community; and Coordinating public health surveillance efforts.

The National Association of Medical Examiners commissioned an *ad hoc* committee to provide recommendations for the investigation, examination, and reporting of deaths in custody.[7] Deaths in custody, whether occurring in jail/prison or during an altercation with law enforcement, is a complex issue and requires the forensic pathologist to be knowledgeable and deliberative about his/her diagnosis. That manuscript provides recommendations for the forensic pathologist as it relates to 1) categorization of deaths in custody, 2) critical information required during investigation, 3) enhanced autopsy procedures, 4) guidance on death certification, 5) parameters for statistical reporting, and 6) release of information to the public. A *uniform approach by medical examiners and coroners to the investigation and evaluation of deaths in custody is critical* (my emphasis). The establishment of recommendations has the potential to ensure consistency and reliability to the definition, investigation, and certification of these cases. Such uniformity and consistency will instill confidence in the independence of the medical examiner/forensic pathologist/coroner by the criminal justice system, public health system, and community at large.

More than 2000 years ago, Aristotle attempted to prevent individuals from confusing temporal proximity of an action with causality. Decisions should be based on factual analysis, not flawed reasoning.

Sincerely yours,

Stephen J. Nelson, M.A., M.D., F.C.A.P.
District Medical Examiner

Certified by the American Board of Pathology
Promoting Excellence in the Practice of Pathology

SJN:jkb

[1] Karch, S.B. and Stephens, B.G.: Acute excited states and sudden death. Acute excited states are not caused by high blood concentrations of cocaine. *British Medical Journal* 1998; 316: 1171.

[2] Spiehler, V.R. and Reed, D.: Brain concentrations of cocaine and benzoylecgonine in fatal cases. *Journal of Forensic Science* 1985; 30: 1003-1011.

[3] Michael "Mickey" Finn was a bartender in Chicago at The Lone Star Saloon and Palm Garden Restaurant from 1896 to 1903. He was known for putting "knockout drops" into people's drinks, taking them into the back room to rob them, then leaving them in the alley. Allegedly, he even went as far as advertising the "Mickey Finn special" (without saying what was in it, of course). Mickey Finn used chloral hydrate, a sedative-hypnotic drug, to incapacitate his victims. They'd become unresponsive and usually have no memory of what happened. While the restaurant was shut down in 1903, more than 100 waiters were arrested 15 years later for slipping "Mickey Finn powder" into people's drinks. A couple of waiters sold it at the waiter's union headquarters. Herbert Asbury wrote about Mickey Finn in his book "*Gem of the Prairie: An Informal History of the Chicago Underworld.*" He based his information on news sources such as the *Chicago Daily Tribune* and *Chicago Daily News*, which told of the bartender's arrest for poisoning his patrons.

[4] Zeek, P.M.: Heart weight. I. The weight of the normal human heart. *Archives of Pathology* 1942; 34: 820-832.

[5] Staley, J.K. and Mash, D.C.: Adaptive increase in D3 dopamine receptors in the brain reward circuits of human cocaine fatalities. *Journal of Neuroscience* 1996; 16: 6100-6106.

[6] Karch, S.B., Stephens, B.G., and Ho, C.H.: Relating cocaine blood concentrations to toxicity: an autopsy study of 99 cases. *Journal of Forensic Sciences* 1998; 44: 359-368.

[7] Mitchell, R.A. Jr, Diaz, F., Goldfogel, G.A., Fajardo, M., Fiore, S.E., Henson, T.V., Jorden, M.A., Kelly, S., Luzi, S., Quinn, M., and Wolf, D.A.: National Association of Medical Examiners position paper: Recommendations for the definition, investigation, postmortem examination, and reporting of deaths in custody. *Academic Forensic Pathology* 2017; 7: 604-618.

Redaction Date: 9/1/2022 10:30:08 AM

Redaction Log

Total Number of Redactions in Document: 21

Redaction Reasons by Page

Page	Reason	Description	Occurrences
4	Marsys Law	The public records provision of "Marsy's Law" has been invoked by the victim in this case. Please refer to Article I, Section 16, Florida Constitution - "Rights of Accused and of Victims" for more information.	7
5	Marsys Law	The public records provision of "Marsy's Law" has been invoked by the victim in this case. Please refer to Article I, Section 16, Florida Constitution - "Rights of Accused and of Victims" for more information.	2
7	Marsys Law	The public records provision of "Marsy's Law" has been invoked by the victim in this case. Please refer to Article I, Section 16, Florida Constitution - "Rights of Accused and of Victims" for more information.	3
8	Marsys Law	The public records provision of "Marsy's Law" has been invoked by the victim in this case. Please refer to Article I, Section 16, Florida Constitution - "Rights of Accused and of Victims" for more information.	2
9	Marsys Law	The public records provision of "Marsy's Law" has been invoked by the victim in this case. Please refer to Article I, Section 16, Florida Constitution - "Rights of Accused and of Victims" for more information.	5
34	Protected	§ “Protected” may include: Substance of a Confession 119.071(2)(e); Emergency / 911 Caller 365.171(12); HIV Test Results or ID of Person on Whom a Test has been Performed 381.004(2)(d)4 & 381.004(2)(e); or Confidential Informant 119.071(2)(f)	2

Redaction Log

Redaction Reasons by Exemption

Reason	Description	Pages (Count)
Marsys Law	The public records provision of "Marsy's Law" has been invoked by the victim in this case. Please refer to Article I, Section 16, Florida Constitution - "Rights of Accused and of Victims" for more information.	4(7) 5(2) 7(3) 8(2) 9(5)
Protected	§ “Protected” may include: Substance of a Confession 119.071(2)(e); Emergency / 911 Caller 365.171(12); HIV Test Results or ID of Person on Whom a Test has been Performed 381.004(2)(d)4 & 381.004(2)(e); or Confidential Informant 119.071(2)(f)	34(2)