

UNIVERSITY of CALIFORNIA - IRVINE
HEALTHCARE
BRAIN DEATH DECLARATION FORM

RESULTS

Check Box

☒ Yes ☐ No☒ Yes ☐ No☒ Yes ☐ No

☒ Yes ☐ No

☒ Yes ☐ No

☒ Yes ☐ No☒ Yes ☐ No☒ Yes ☐ No☒ Yes ☐ No☒ Yes ☐ No☒ Yes ☐ No☐ Yes ☐ No

☐ Yes ☐ No☒ Yes ☐ No

☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No

AN APNEA OF

I certify that the above tests have been performed and that according to hospital policy this patient is brain dead

I certify that the above tests have been performed and that according to hospital policy this patient is brain dead

109 24

License Number

7/10/18

Date _____

137b

Time

Indicate if examination is first or second examination.

If second exam, indicate: Identity of the first examiner Scholz / Engele

Date and time of the first exam 7/9/11 2200

Notes: The second page of this form is for information only and does not need to be placed in the medical record. All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification (Rev. 4/2/08)

UC IRVINE MEDICAL CENTER
9059017 INPATIENT
9000321134
DOE, RAYCH 35053
R 04/05/1974
ALIAS KELLY, THOMAS
PT PHONE 999-999-9999
AOR DT/DOB 07/05/2011

UNIVERSITY of CALIFORNIA - IRVINE
HEALTHCARE
REPORT OF DEATH OR STILLBIRTH

This information is required for the completion of the Death Certificate.
PLEASE FILL OUT CLEARLY AND COMPLETELY

A. MEDICAL STAFF michelle mclendoe
CORONER'S CASES: [Phone: 714.847.7400]
(108) Death Reported to Coroner: ☒ Yes ☐ N/A (Go to section (107), Case number issued: 11-82-643-MH)
REGULAR / FETAL DEATH: (107) Death was caused by (Enter only one cause per line):
(A) Immediate Cause: RAW - DEATH
(B) Due To: NO TISSUES
(C) Due To: ASSAULT
(D) Due To: _____

(7) Date: 7/10/11
(8) Time Pronounced Dead: 11:00 am ☐ pm
(102) Place of death (circle one) (IP)
Inpatient, ER / OP, DOA
Notified Organ / Tissue Bank 213.0319
1.800.398.8112
☐ Accepted ☒ Declined
Spoke To: K. Hea
Time interval between onset and death
7/10/11
7/5/11

(112) Other significant conditions contributing to the death, but not related to cause given in (107):
REGARDING FAILURE, EMBRYONIC, INCOMPLETE, 2ND FAILURE, 3RD FAILURE, 4TH FAILURE
(109) Was biopsy performed? ☐ Yes ☒ No
(113) Was an operation performed for any of the conditions listed in (107) or (112)? ☐ Yes ☒ No
If yes, list type of operation: _____ Operation Date: / /
FETAL DEATH: (Please attach the pink copy of the labor and Delivery sheet and provide the following information.)
Complications and procedures of pregnancy and concurrent illnesses. ☐ None
Complications and procedures of Labor and Delivery. Abnormal conditions and clinic procedures related to Fetus ☐ None

(114) DECEDENT ATTENDED SINCE Date 7/5/11 DECEDENT LAST SEEN ALIVE Date 7/10/11
Autopsy permit obtained ☐ Yes ☐ No If No, why? _____ ☐ Pending
Pathology (x6141) Notified: ☐ Yes ☐ No (Notify pathologist ONLY if autopsy granted AND NOT to be performed by coroner For after hours services contact the hospital operator to page Pathology Residents on call.)

(115) Death Certificate to be signed by:
C WASHINGTON MD (116) California License # A1112304 Responder # (Licensed MD) 714.506.6547
(Aa) Report Completed by: (Print Name) CHRIS WASHINGTON Signature: [Signature] Responder # 714.506.6547

UC Irvine Healthcare Paging Operator: 714.456.7890

B. NURSING UNIT: (Location) 5124 (Extension) 5311
☒ The deceased had no valuables or belongings at the time of death.
☒ All valuables and/or belongings have been removed from the deceased.
Valuable disposition completed ☐ Yes ☒ No N/A
Belongings: ☐ Returned to Family ☐ Hold
Authorization form given to legal next of kin. ☐ Yes ☐ No
Signature: [Signature] RN Date 7/10/11 Time: 11:00
Mortuary's selected ☐ No ☐ Yes (If yes, list Mortuary)

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification
81478 (Rev 10/2/09) WHITE - Funeral Director YELLOW - Decedent Affairs PINK - Patient Chart

REPORT DEATH STILLBIRTH - Page 1 of 2	UNIVERSITY OF CALIFORNIA IRVINE	Printed: 08/17/2011 10:59
Patient: THOMAS, KELLY	MRS: 9059017	Discharged: 07/10/2011 Service Dates: -
Copy for: DOE MGT CHARGE	REQ: 281611, DET: 1812847 JK: 21770299 JTK: 23090 EK: 8280764 VER: 1	

OUTPATIENT CONSULTATION

Referring Physician: Cristobal Barrios, MD(A)

Date of Consultation: 07/07/11

Admitting Physician: Mauricio Gomez, MD(A)

Reason for Consultation: Rule Out Status epilepticus.

History of Present Illness: The patient is a 30-year-old male who had an altercation with the police. He was tased multiple times during his altercation and suffered multiple facial fractures. After being tased multiple times, the patient apparently went into an asystolic event and had to be resuscitated for approximately 15 to 20 minutes. He recovered after that time, into sinus tachycardia, he received blood products including FFP. He was discovered at the hospital to have rhabdomyolysis as well as renal failure as a result of his injuries. It was discovered in the surgical ICU that the patient was demonstrating some convulsive like activity and was started on Dilantin 150 mg every 8 hours. These episodes demonstrated in an extended posture in the bed, and the Neurology service was consulted.

Past Medical History: Mother states that the patient had schizophrenia.

Past Surgical History: None.

Social History: Positive tobacco, occasional alcohol, and a past history of drug use per the mother

Inpatient Medications:

1. Neo-Syneprine.
2. Ativan drip.
3. Fentanyl drip.
4. Synthroid drip.
5. Dilantin 150 mg IV every 8 hours.
6. Zofran as needed.
7. Fluids per the rhabdo protocol.

Vital Signs: BP 140-155/80-95, Pulse 90-105, Temperature 36.3-36.7 Celcius, SaO2 96-100 FiO2 50%, PIP 25, PEEP 8, EtCO2 30-32

Objective: Patient is sedated and intubated. GCS 3. Dolls Eyes absent, Corneal reflex absent bilaterally, No response to noxious stimuli, decreased tone of upper and lower extremities, No babinski response, Right pupil response to light 2mm to 1mm, left eye hyphema makes it difficult to visualize the pupil

Diagnostic Studies: EEG performed at bedside demonstrated globally reduced activity not accounted for by level of current sedation. MRI demonstrated Diffuse supratentorial gray matter infarction consistent with diffuse anoxic brain injury.

Diagnostic Data: Labs: WBC 28.1, hemoglobin 13.9, and platelets 95. Sodium 136, potassium 4.5, chloride 104, CO2 19, BUN 41, creatinine 3.4, glucose 313, calcium 4.9, magnesium 3.2, phosphorus 10.9, total protein 5.2, albumin 2.9, alkaline phosphatase 94, total bilirubin 1.6, AST 1485, and ALT 366. INR 2.43, ionized calcium is 3.2, and CK greater than 24,000.

Assessment:

CONSULT NOTE UP - Page 1 of 1 Part 1/2	UNIVERSITY OF CALIFORNIA IRVINE	Printed: 08/17/2011 10:55
Patient: THOMAS, KELLY	MRN: 8058017	Discharged: 07/10/2011 Service Dates: 07/07/2011-07/07/2011
Copy for: ROI MET CROBLE	REQ: 202611, DET: 1023607 IK: 21916806 IYK: 22197 EK: 5608483 VER	

1. 30 year old male with past medical history of schizophrenia with anoxic brain injury and diffuse axonal injury after 20 minutes asystole post resuscitation. At this point it is difficult to accurately evaluate the patient considering his multiple sedatives.

Plan

1. Turn off all Ativan, fentanyl, and recommend to continue Dilantin.
2. Order an EEG and MRI and an MRA with gadolinium.
3. We will await results of these studies, and we will continue to follow.

Electronically Reviewed by
Brian L Kaiser 07/22/2011 02:27 P

Electronically Signed by
Cristobal Barrios 07/27/2011 10:19 P

Brian L Kaiser MD(R)
Dept. of Neurology

Cristobal Barrios MD(A)
Dept. of Surgery
Division of Trauma and Critical Care

cc: Cristobal Barrios
Mauricio Gomez
Brian L Kaiser

1439420/443968/44076
DD: 07/07/2011 03:12 P
DT: 07/08/2011 03:38 A

CONSULT NOTE OF - Page 1 of 1 Part 2/2	UNIVERSITY OF CALIFORNIA IRVINE	Printed: 08/17/2011 10:59
Patient: THOMAS, KELLY	MRN: 9058017	Discharged: 07/10/2011 Service Dates: 07/07/2011-07/07/2011
Copy for: ROI NET CHONLE	REQ: 283411, DET: 1813607 IX: 21916886 IIX: 22197 IX: 5608482 V	

MRN: 9058017
Visit: 9000321134
Age: 37y (04-05-1974)

THOMAS, KELLY
Gender: Male

UC Irvine Healthcare
Location: SCU2 6232-01
Surgical ICU 2

Trauma Run Report [07-06-2011 08:19], Visit: 9000321134, KAISER, MEGHAN L (MD);
LEKAWA, MICHAEL E (MD) [Signed: 08-01-2011 00:35] , Final, Revised, Signed in Full, General

TRAUMA RUN

Date of Service: 07/05/11

AKA: Kelly Thomas.

History of Present Illness: The patient is a 30-year-old male who was arrived as a critical trauma at around 22:10 in the evening. The patient had been involved in an altercation with 3 policemen. The altercation became quite violent, and the patient was also tasered during the incident. The patient was initially taken to St. Jude's Hospital where he was intubated, but per paramedics, it was a very difficult intubation and there was some concern for tracheal injury. The patient subsequently suffered a period of asystole and required chest compressions, which lasted per paramedics for several minutes. He was then re-triaged to UCI for higher level of care.

Past medical history, past surgical history, medications, and allergies are all unknown at this time; however, per police, the patient does have a known history of psychiatric illness and is homeless.

Social History: Unknown at this time.

Physical Examination

Vital Signs: At the time of arrival to Trauma Bay, heart rate is 130s and systolic blood pressure 70s.

General: This is a thin male with extremely poor grooming

() social history, who is not responsive but does appear to exhibit occasional seizure-like activity. He has a matted beard and scalp covered with blood. He has obvious facial trauma.

HEENT: There are lacerations overlying the patient's forehead and nasal bridge. Eyes have bilateral ecchymoses. The patient does occasionally open his eyes spontaneously but has a dysconjugate gaze. Pupils are round and equal with the right measuring of 5 mm and reactive whereas the left is around 3 and nonreactive. There is noted to be a significant epistaxis coming from the bilateral nostrils and some blood from the mouth. The endotracheal tube is examined by direct laryngoscopy, and noted to be in good position.

Neck: Reveals trachea to be midline without palpable crepitus. The patient arrives in C-spine precautions.

Chest: There is a taser in the left chest. There is bilateral breath sounds. There is no palpable crepitus or subcutaneous emphysema.

Abdomen: Soft and scaphoid.

Pelvis: Stable to anterior and posterior compression.

Musculoskeletal: There are no gross deformities, ecchymoses, or abrasions.

Genitalia: Normal male. The patient arrives with Foley placed at an outside institution. Urine output is initially clear in yellow but subsequently darkens to red consistent with myoglobinuria.

Neck: Reveals no evidence of trauma and no palpable step-offs.

Neurological: The patient exhibits occasional seizure-like movement particularly of the bilateral upper extremities. Pupillary exam is as given above. GCS is significant for a spontaneous eye opening, no organized motor activity including posturing and no verbal response,

Requested by: NOBLE, CYNTHIA S (Other), 08-17-2011 12:49

Page 1 of 2

MRN: 9058017
Visit: 9000321134
Age: 37y (04-05-1974)

THOMAS, KELLY
Gender: Male

UC Irvine Healthcare
Location: SCU2 6232-01
Surgical ICU 2

although he is intubated for a GCS of ().
Rectal: Significant for incontinence of stool. No gross blood and very poor tone.
Vascular: Reveals very thready extremity pulses consistent with hypertension at the time of presentation.

Radiologic Studies: Significant for chest x-ray in Trauma Bay, which reveals the endotracheal tube to be in good position and is otherwise unremarkable. Pelvis is negative for evidence of fracture and plain lateral films of the C-spine were negative. CT scans of the head, C-spine, chest, abdomen and pelvis, thoracic and lumbar recones, face and CT angio of the neck are significant for facial fractures including left zygoma, bilateral nasal, and right maxillary sinus fracture, significant aspiration, and intestine changes consistent with "shock bowel." FAST scan is negative x2 in Trauma Bay.

Laboratory Studies: Significant for a formal CBC with white count 12.9, hemoglobin 12.1 over hematocrit 37.7, and platelets 224. ETOH and toxicology screen, both negative. Sodium is 146, chloride is 114, bicarbonate 10, BUN 15, creatinine 1.2, and glucose 336. PTT is 119 and INR is 1.2. Lactate is greater than 11, calcium is 6.9, and albumin 2.7. ABG is severely deranged with PH of 6.49, PCO2 of 46, PAO2 of 346.2, bicarbonate 3.4, and base deficit negative 38.

Assessment: This is a ()-year-old male, status post blunt trauma. Pertinent diagnoses include facial fractures, prolonged anoxia, facial lacerations, severe metabolic acidosis, hemorrhagic shock, aspiration, and psychiatric history.

Plan: Aggressive resuscitation including writ protocol, face consult, laceration closed, and frank discussion with family regarding poor prognosis.

Electronically Signed by
Michael Lekawa 08/01/2011 12:35 A

Meghann L Kaiser MD(R)
Dept. of Surgery

Michael Lekawa MD(A)
Dept. of Surgery

cc: Meghann L Kaiser
Michael Lekawa

1438599/428445/44076
DD: 07/06/2011 08:19 A
DT: 07/06/2011 03:07 P

Requested by: NOBLE, CYNTHIA S (Other), 08-17-2011 12:49

Page 2 of 2

0258

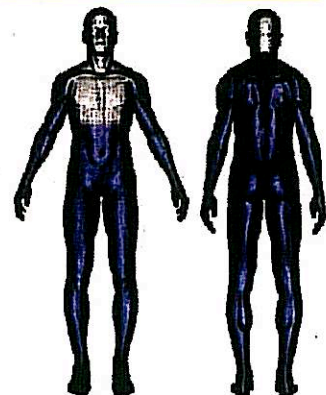


- The risk of an adverse cardiac event related to a TASER ECD discharge is deemed to be extremely low. However, it is not possible to predict nor test against the entire spectrum of potential human physiologies or conditions such as unpredictable combinations of drugs of unknown concentration or origin in the presence of underlying cardiac or other disease. Furthermore, a law enforcement officer will have no means to diagnose these factors in any event.
- Sudden Cardiac Arrest (SCA) is a leading cause of death in the United States, claiming an estimated 325,000 lives each year. These deaths occur on golf courses, in airports, during physical exertions, from startle or other stimuli, or just about anywhere. Should Sudden Cardiac Arrest occur in a scenario involving a TASER discharge to the chest area – it would place the law enforcement agency, the officer, and TASER International in the difficult situation of trying to ascertain what role, if any, the TASER ECD could have played in a unique situation that cannot be replicated in human clinical safety evaluations. In order to reduce the risk of such an event, and in light of the fact that frontal applications of TASER ECDs have been found to be more effective when the probes are targeted at the lower torso (engaging the balancing muscles of the pelvic triangle) we have lowered the recommended point of aim from the center of mass to the lower center of mass for frontal discharges. We believe this recommendation will improve the effective use of TASER ECDs while also further increasing safety margins and enhancing the ability to defend such cases in post event legal proceedings.

Overview and Training Implications

1. **We have issued a new TASER Targeting Guide that will apply for the new XREP Impact munition as well as ECDs such as the X26, M26 and X3.** Note, we have lowered the recommended point of aim from center of mass to lower-center of mass for front shots. The blue highlighted area in the adjacent target man represents the preferred target area. There are three reasons:
 - a. Simplify targeting for all TASER systems to one easy to remember map, avoiding chest shots when possible and the risk of a head/eye shot in a dynamic situation, as is standard for impact munitions
 - b. When possible, avoiding chest shots with ECDs avoids the controversy about whether ECDs do or do not affect the human heart.
 - c. Close-spread ECD discharges to the front of the body are more effective when at least one probe is in the major muscles of the pelvic triangle or thigh region.

Preferred Target Areas In Blue



Back shots remain the preferred area when practical.

2. **When dealing with exhausted individuals or persons exhibiting symptoms of distress or agitated/excited delirium:**
 - a. **Once officers engage in capture procedures, it is important to minimize the duration of the physical struggle.** New research shows that physical struggle, simulated by punching a heavy bag at full intensity, can cause acidosis that can reach dangerous levels in only 45 seconds of intense exertion, starting from a resting state. Accordingly, officers engaging subjects in a physical struggle or in an exhaustive state should develop a plan to capture and restrain the subject as expeditiously as possible to minimize



human subject experience of CEW exposure with continuous ECG monitoring and includes 28 full 5-s exposures¹⁸.

- Relatively large variations about the X26 operating level were found not to result in fibrillation or asystole¹⁹.
- CEW exposure produced no detectable dysrhythmias and a statistically significant increase in heart rate. Overall, TASER CEW exposure appears to be safe and well tolerated from a cardiovascular standpoint in this population. This study increases the cumulative human subject experience of CEW exposure with continuous ECG monitoring and includes 28 full 5-s exposures²⁰.

Conclusion regarding the potential for cardiac effects: Researchers have been able to demonstrate changes in heart rate and rhythm consistent with cardiac pacing and, in some cases, ventricular fibrillation (VF) in small swine, an arrhythmia that can be fatal without intervention, and have concluded that the close distance between the ECD dart and the heart is the primary factor in determining whether an ECD will affect the heart. The threshold for VF has been estimated to be 12.6 times that for cardiac pacing²¹. This risk is judged to be extremely low in field use. In order to increase the safety margin and since field experience shows that ECD discharges are effective when deployed to the large muscles of the back, abdomen, legs and pelvic triangle, users should aim for the back or (when practical) toward the mid lower abdomen and avoid intentionally targeting the chest area with probe applications to increase effectiveness and avoid the remote potential risk of cardiac effect.

Revised Warnings

Attached are the new Product Warnings which have been updated based on this new human medical research. Go to www.TASER.com for the complete Product Warnings document and glossary of terms for Law Enforcement.

Any questions regarding this Training Bulletin should be directed to the TASER International Training Department at (800) 978-2737 or by email to Training@TASER.com.