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

Case Number: 2007-08227 Decedent: WEST, DONDA C.

Information Sources:

1. Medical record #5019747, Centinela Freeman Regional Medical Center, Marina Campus, 4650 Lincoln Boulevard, Marina Del Rey, CA, 90292, 310-823-8911
2.
3.

Investigation:

On 11-12-2007 at 0746 hours E. Alonzo of Centinela Freeman Regional Medical Center reported this death to Lieutenant C. MacWillie of the Coroner's Office. The death occurred at a hospital facility and the decedent was transported to the FSC on 11-12-2007 at 0935 hours by Forensic Attendant A. Scott. Supervisor MacWillie assigned this case to me on 11-12-2007 at approximately 0900 hours.

Location:

Injury: surgical center- 11819 Wilshire Boulevard, Suite 215, Los Angeles, CA, 90025

Death: hospital- 4650 Lincoln Boulevard, Marina Del Rey, CA, 90292

Informant/Witness Statements:

Medical records were received with the decedent's incoming paperwork. The paramedic runsheet that was received was poorly copied and illegible, but it appears that when Los Angeles City Fire Department RA 63 responded to the home the decedent was in an asystolic cardiac arrest. The decedent was still in cardiac arrest when she presented to the emergency room at 2020 hours. At the time of her arrival she had been intubated and ACLS medications, including Narcan, had been administered in the field. The paramedic reported that coffee ground emesis was present to the decedent's nose. When the physician confirmed the endotracheal tube placement breath sounds were greater on the right side of the chest. The endotracheal tube was pulled back and breath sounds were then equal. Additional ACLS medications were administered, but the decedent remained asystolic throughout the resuscitative efforts. Dr. Mickey Kolodny pronounced death at 2029 hours. It was reported that the decedent had been discovered unresponsive while lying supine in bed. She had recently undergone cosmetic surgery to her breasts and abdomen. The decedent had been prescribed Keflex and Vicodin. Dr. Kolodny discussed the death with the surgeon, Dr. Jan Adams, who stated that the death should be referred to the Coroner's Office.

On the evening of 11-12-2007 I spoke with Stephen Scoggins by telephone. Mr. Scoggins is an experienced nurse and has an advanced degree in Public Health. He informed me that the decedent went for cosmetic surgery at a surgery center on 11-09-2007. The surgery started at approximately 1230 hours and at 1800 hours the decedent was in the recovery room. Mr. Scoggins received a telephone call from the decedent's friend who was concerned that she was not waking up soon enough so he responded to the surgery center. At the time of his arrival the decedent was groggy, but was oriented to person, place and time. Ms. West had arranged for caregivers to stay with her during the night and the group returned to the decedent's home. Mr. Scoggins also stayed at the home and stated that the decedent ambulated during the night to prevent a deep vein thrombosis from forming. She was in pain and was medicated with Vicodin. In the morning the decedent stated that she felt better and was able to ambulate without assistance. Mr. Scoggins stated that the decedent appeared to be doing well so he left for the day with the intention to return and spend the night with his aunt. The decedent was left with caregivers Diana and Nubia who had been referred by Dr. Adams in addition to her friend, Glenda. At the time Mr. Scoggins left he stated that the decedent did not appear to be diaphoretic and had no symptoms of peritonitis or bleeding. Mr. Scoggins stated that the

decedent had no known cardiac problems or peptic ulcer disease. There is no history of substance abuse.

On the evening of 11-12-2007 I spoke with the decedent's long-time friend, Glenda Lee, by telephone. She informed me that the decedent had consulted with four doctors before selecting Dr Adams to perform a breast augmentation, "tummy tuck" and liposuction of her lower back. The decedent had a history of thyroid problems and took Synthroid. At one time she had been diagnosed with hypertension, but said that it had gone away; she was not taking anti-hypertensive medication The decedent was also a border-line diabetic. She had seen physicians in the past at UCLA Medical Center in Westwood and Cedars-Sinai Medical Center. Two weeks before the surgery the decedent had experienced some leg pain, but did not see a doctor and the cause was unknown Ms. Lee reported that heart problems run in the family and the decedent's sister died two years ago of a "heart attack." Her brother has a history of hypertension. It is unknown whether Ms. West had undergone any specialized tests prior to her surgery. Ms. Lee stated that she had arrived at the decedent's home on 11-10-2007 at 1600 hours. The two caregivers had gotten her out of bed and a few blood spots were seen on the abdominal dressing. The decedent had been ambulated every two hours and she was receiving Vicodin for her pain. At the time of Ms. Lee's arrival the decedent stated that her throat was hurting and her chest was hurting. The chest discomfort was felt to be the result of the breast augmentation and the tight bandages. The decedent felt warm to touch and at 1630 hours she ate some chicken soup, crackers, water and pineapple juice before her medications were given. The decedent was described as having "a lot of pain." Ms. Lee stated that she sat with her friend and rubbed her neck. She noticed that the decedent was "breathing heavy." At 1700 hours Ms. West went to bed and at that time she said that her chest was tight and her throat was sore. The decedent again got out of bed, but was not described as being anxious or confused. When she went back to bed pillows were beneath her legs and a single pillow was beneath her head. The decedent was able to tolerate lying flat. Ms. Lee went to the kitchen for a short while and when she returned the decedent had "black stuff on her face" and was cold and clammy. When her pulse was noted to be absent 911 was called. As rescue breaths were given more "blood" drained from the decedent's nose.

Scene Description:

The scene was not visited by coroner personnel.

Evidence:

No physical or medical evidence was collected for this report.

Body Examination:

The decedent was seen lying on a tray inside the FSC service floor. She is an adult female approximately 65-inches in length and weighs approximately 188 pounds. She has brown braided hair, brown eyes and natural teeth. An endotracheal tube was secured in her mouth and electrocardiogram patches and defibrillator pads were noted to her torso. The decedent had steri-striped incisions to her breasts and lower abdomen. Jackson-Pratt drains were intact to both anterior hip areas and the umbilicus had sutures. Viewing the decedent's back was deferred to the pathologist due to the instability of the tray.

Identification:

The decedent was identified by her nephew, Stephen Scoggins, while at the hospital