

**MINNEHAHA COUNTY OFFICE OF THE MEDICAL EXAMINER**

220 W. Sixth Street, Suite 140 | Sioux Falls, SD 57104 | (605) 367-4300

**DEATH INVESTIGATION REPORT – INVESTIGATOR NARRATIVE**

Case No. 2015-ME-0447 | MARSH, Eleanor Anne | DOB: 03/22/1969 | Page 1 of 5



ME Case #:	2015-ME-0447	Date/Time Opened:	10/14/2015 – 0312 hrs CDT
Decedent:	MARSH, Eleanor Anne	Date of Death (est.):	10/13/2015 (exact TBD)
Investigator:	S.L. Kowalczyk (MEI-09)	Report Prepared:	10/14/2015
Pathologist:	Dr. R.G. Adeyemi, MD	Status:	PRELIMINARY – Cause/Manner DEFERRED

**1. NOTIFICATION AND INITIAL INTAKE**

**1.1 – Notification Details**

On October 14, 2015, at approximately 0248 hours Central Daylight Time, this investigator was contacted via the Minnehaha County Medical Examiner Office after-hours dispatch line by SFPD Patrol Dispatch Operator Christine M. Dell. Operator Dell relayed that SFPD patrol units and Sioux Falls Fire Rescue had responded to 4200 South Western Avenue, Suite 712, on the seventh floor of the Hartwell and Marsh Financial Partners building, regarding a reported unresponsive person. She advised that the individual had been pronounced dead on scene by EMS at approximately 2303 hours on October 13, 2015, and that the attending patrol officers considered the circumstances unclear and potentially suspicious in nature. Operator Dell reported that SFPD Detective Marcus J. Orre had been paged and was en route to assume scene authority as of the time of the notification call to this office.

F/U – access log?  
confirmed Orre

Operator Dell provided the following information at initial notification: the decedent was described as a white female, approximately 40 to 50 years of age, found seated at or near her office desk by building maintenance personnel during a routine after-hours cleaning assignment. She was described as fully clothed and in no immediately obvious state of physical distress or gross external trauma per the initial EMS field report as relayed. No witnesses to the event of collapse or loss of consciousness had been identified at that time. No known medical emergency contacts or treating physicians had been identified by the initial patrol responders, and no emergency medical alert devices or current prescription medications were observed on scene at the time of EMS arrival, per Operator Dell's relay of the SFFR field report summary.

This investigator contacted on-call pathologist Dr. Raymond G. Adeyemi by telephone at 0250 hours and relayed the notification information in full. Dr. Adeyemi authorized this investigator to respond to the scene and provisionally accepted ME jurisdiction pending scene assessment. Dr. Adeyemi noted that the described circumstances – specifically an unattended death of a middle-aged individual in a workplace setting, occurring outside of normal business hours, without any identified treating physician and without any apparent immediate natural cause – were consistent with South Dakota Codified Law §23-14-1 criteria

for medical examiner jurisdiction and directed that the case be opened accordingly. A case number was assigned (2015-ME-0447) and the case was entered into the ME office case management system at 0251 hours.

### **1.2 - Investigator Response and Scene Arrival**

This investigator departed the ME office at 0304 hours and arrived at the scene address, 4200 South Western Avenue, Sioux Falls, South Dakota, at approximately 0321 hours. The exterior of the building was secured by two SFPD patrol vehicles, units 214 and 237, positioned at the main lobby entrance and the south parking structure access road respectively. Building security personnel, subsequently identified as Kevin T. Molander, employed by Summit Property Security Services as the overnight shift supervisor for the building, met this investigator at the front lobby entrance and escorted this investigator to the seventh floor via the service elevator at the direction of Detective Orre, who had communicated instructions to building security by radio prior to this investigator's arrival.

Upon arrival on the seventh floor, this investigator was met by Detective Marcus J. Orre at the elevator lobby at approximately 0325 hours. Detective Orre confirmed that the scene had been secured since approximately 0010 hours on October 14 and that no individuals other than SFPD patrol personnel, building security staff, and the SFFR first responders had been permitted access to Suite 712 or the immediately surrounding hallway following the initial discovery. Detective Orre provided an overview of available information as known at that time, summarized in Section 3 of this report. Detective Orre also advised that SFPD's Crime Scene Unit had been notified and was expected on scene within the hour; CSU personnel arrived at approximately 0412 hours and conducted concurrent scene documentation, which is not further described herein as it falls within SFPD jurisdiction and documentation responsibility.

no CCTV south corridor — key gap

### **1.3 - Additional Notifications Made by This Office**

Following the initial scene assessment, this investigator contacted Dr. Adeyemi by telephone at approximately 0430 hours to provide an updated account of scene conditions and decedent presentation. Based on the reported findings, Dr. Adeyemi directed this investigator to proceed with full scene documentation, obtain all available history from LE sources and any available next-of-kin or employer contacts, and to arrange transport of the body to the ME facility following release by LE scene authority. Dr. Adeyemi advised that a Priority-1 autopsy would be scheduled for 0900 hours the same morning, pending no change in circumstances.

At approximately 0705 hours on October 14, 2015, Dr. Adeyemi contacted Chief Medical Examiner Dr. Paula H. Reinholt and provided notification of the case. Dr. Reinholt authorized the Priority-1 autopsy and confirmed ME case acceptance. This investigator also contacted the Minnehaha County Attorney's Office death notification line at 0712 hours as required by office protocol for all cases assigned a suspicious designation; an on-call representative of that office acknowledged receipt and indicated no immediate action on their part was required at that stage. South Dakota Division of Criminal Investigation (DCI) was not

contacted by this office at intake, as the determination of whether to involve DCI rests with SFPD; this investigator noted for the record that Detective Orre indicated he would be assessing that question independently and would keep this office informed.

check pharmacy records

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**2. CIRCUMSTANCES OF DISCOVERY**

**2.1 – Initial Discovery Account**

Based on information relayed to this investigator by Detective Orre at the scene, and supplemented by a brief and limited discussion with the individual who discovered the body, the following represents the ME office's current understanding of how the decedent was found. This account is considered preliminary and subject to revision pending formal recorded witness interviews by SFPD Investigations.

At approximately 2248 hours on October 13, 2015, a building custodial employee subsequently identified as Roberto J. Fuentes, employed by Paramount Commercial Cleaning Services (PCCS), was conducting routine after-hours janitorial services on the seventh floor of 4200 South Western Avenue. Mr. Fuentes was reportedly working along the south hallway of the floor when he used his issued access passkey to enter Suite 712 for the purpose of emptying wastebaskets and vacuuming. <sup>critical</sup> <sub>3-9 hr window</sub> The suite, a private corner office occupied by the decedent, was described by Mr. Fuentes as having its interior office lights on – specifically both the overhead fluorescent panel lights and the desk lamp – which Mr. Fuentes indicated he interpreted at first as an indication that someone was working late, a circumstance he described as not uncommon on this floor during certain periods. Mr. Fuentes reportedly called out a verbal greeting upon entering the suite antechamber and received no response.

Mr. Fuentes reportedly proceeded to the inner office doorway and observed the decedent seated in her office chair, which was positioned facing the desk. He described her as appearing slumped slightly forward and to the right, with her right forearm and the outer aspect of her right hand resting on the desk surface and her head inclined toward her right shoulder. He described her eyes as partially open and her skin color as pale. He stated that she did not respond to his repeated verbal greetings or to his approach, at which point he touched her left shoulder and stated she felt cold and did not move. Mr. Fuentes exited the suite and immediately contacted building security via the interior phone system located in the hallway. This investigator notes that the foregoing account was relayed secondhand through Detective Orre and is not the product of a direct formal interview by this office; the account is documented here for completeness and is explicitly preliminary.

Building security supervisor Kevin T. Molander responded to the seventh floor within approximately four minutes and entered Suite 712 to assess the situation. Molander confirmed the decedent's unresponsive state, observed no immediate signs of physical distress or obvious injury, and contacted SFPD dispatch and SFFR

simultaneously at approximately 2256 hours. Molander stated he did not relocate the decedent, administer any intervention, or remove any items from the office prior to the arrival of emergency services. SFFR Unit 1 arrived on scene at approximately 2301 hours. EMS personnel confirmed unresponsiveness and the absence of pulse, respiratory effort, and pupillary response. Based on their assessment of body temperature and preliminary gross postmortem changes – the degree of which was not formally specified in their run report as reviewed by this investigator – SFFR Paramedic Supervisor Thomas Kiedrowski, NRP, determined that resuscitation efforts were not indicated and pronounced the decedent deceased at 2303 hours, October 13, 2015. No resuscitation was attempted. SFPD patrol units (Officer L.D. Harmon, Badge #1142, and Officer B.T. Schraeder, Badge #2078) arrived at approximately 2304 hours and secured the floor pending the arrival of a detective.

### **3. SCENE DESCRIPTION**

#### **3.1 – Building and Floor Layout**

The scene of death is located at 4200 South Western Avenue, Sioux Falls, South Dakota, a seven-story commercial office building of modern steel-frame and glass construction, identified by exterior signage and building records as the Hartwell and Marsh Financial Partners corporate headquarters. The building is set back approximately forty feet from South Western Avenue with a secured enclosed lobby and a parking structure situated to the south. The seventh floor is the uppermost occupied floor and is occupied entirely by Hartwell and Marsh Financial Partners. Access to the seventh floor is controlled via electronic key-card readers at each stairwell door and at both elevator banks; a log of after-hours access events was requested by Detective Orre from building management and was not made available to this investigator at the time of the scene examination.

The seventh floor layout, as observed and described to this investigator by building security supervisor Molander, consists of a central elevator lobby leading to an open reception and administrative work area, with a perimeter ring of private offices along the north, east, south, and west walls. Suite 712 is located in the southwest corner of the floor. The hallway immediately outside Suite 712 is a secondary corridor running east-west along the south side of the building. This corridor is not monitored by interior CCTV. Building management confirmed that a camera is positioned at the south stairwell door, approximately thirty feet east of Suite 712, and another at the south end of the main elevator lobby, approximately sixty feet to the north. The status and retrieval of recorded footage from these cameras was outside the scope of this investigator's role at the scene and is a matter for SFPD Investigations.

#### **3.2 – Suite 712: Antechamber and Inner Office**

Suite 712 consists of two rooms: a small rectangular antechamber, approximately twelve by eight feet, which serves as an assistant or reception area and contains a secondary workstation, two guest chairs, and a lateral filing cabinet; and an inner private office accessed through a connecting interior doorway fitted with a solid wood door, hinged to swing inward. At the time of this investigator's

**PRELIMINARY – NOT FINAL**

arrival, the door to the inner office was in the open position, consistent with what SFPD patrol reported.

The inner office measures approximately eighteen by fifteen feet. The room is furnished with a large executive desk positioned centrally, oriented so that the occupant would face north toward the entry doorway when seated. Behind the desk to the west, a credenza holds a printer, a desktop computer docking station, and a series of labeled binders. Along the east wall, a rectangular conference table with six chairs is positioned. The south wall contains floor-to-ceiling windows overlooking the south parking structure. At the time of this investigator's arrival, interior blinds were open, ceiling fluorescent lighting and desk lamp were both illuminated, and the wall thermostat read 71°F.

The desk surface contained, as observed without disturbance: a closed laptop computer (company-issued per coworkers; retained by SFPD CSU), a legal-sized notepad with handwritten notes (retained SFPD CSU), a ceramic coffee mug on a coaster approximately twelve inches to the left of the laptop containing a liquid substance consistent with coffee (collected by SFPD CSU for laboratory analysis; not submitted to ME office), an uncapped ballpoint pen resting on the notepad, and a telephone handset on the right side of the desk surface. No food packaging, prescription medication bottles, over-the-counter medications, or visible chemical substances were identified on the desk surface, in the visible portions of the credenza, or in any immediately accessible location in the office. The waste receptacle beneath the right side of the desk was empty, consistent with having been recently serviced per Mr. Fuentes.

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**4. INFORMATION SOURCES AND WITNESS / CONTACT SUMMARY**

The following table summarizes individuals from whom information was obtained or attempted at scene or during initial intake on October 14, 2015. This table does not constitute a witness list for prosecutorial purposes, which remains the exclusive responsibility of SFPD. Information here reflects only what was relayed to the ME investigator in the context of death investigation intake and is qualified accordingly. Formal recorded statements were conducted separately by SFPD and are not reproduced here.

Name / Role	Affiliation	Contact Method	Information Provided to ME Investigator
Det. Marcus J. Orsini (SFPD Investigations)	Sioux Falls Police Dept.	in person	Overview of scene conditions; decedent ID by employees;
Para. Sup. T. Kiehl (SFFR Station 1)	Sioux Falls Fire Dept.	in person	Confirmed (prior) uncrement time 2303 hrs 10/13/2015; descri
Roberto J. Fuentes (Custodial)	Saramount Commercial Cleaning Services	Via Det. Orsini	Discussed discovery; reported lights on; no response to
Kevin T. Molander (Security Supervisor)	Summit Property Security	in person	Confirmed after-hours access control; provided floor lay
Karla J. Brennan (Building Mgmt. Rep.)	Pinnacle Property Mgmt.	Phone - 605-401-1420	Confirmed 14/2015 schedule and 7th-floor temp. range (70-72
Gregory R. Whitfield (Managing Partner, H&M)	Hartwell & Marsh Financial	in person	Discussed decedent 445 identity and CFO role (approx. 9 yr
Thomas R. Marsh (Adult Son / NOK)	Decedent's family	Via Det. Orsini	Denial of post-diplomas medical conditions; denied know
Company Legal Counsel (name not provided to ME)	Hartwell & Marsh Financial	in person	Provided SSN (last 4) for identification purposes. No ot

**5. MEDICAL AND SOCIAL HISTORY – INTAKE STATUS**

**5.1 – Medical History**

At the time of case intake and scene response, no formal medical history was available to this investigator. No treating physician was identified by any source contacted during the initial intake process. Both the decedent's adult son, Thomas R. Marsh, and managing partner Gregory R. Whitfield independently stated they had no knowledge of the decedent's being under active physician care, though neither was in a position to confirm or deny the existence of a primary care or specialist relationship with certainty. No medical alert bracelet or identification was observed on the decedent's person or in her purse contents. No prescription medication bottles were identified at the scene, in the decedent's

personal effects, or in any location on the seventh floor accessible to this investigator or described by SFPD as identified during the scene search. The decedent's personal physician, if any, has not been identified as of the close of this investigator's scene and intake activities.

No emergency medical services history was available at intake. SFPD was requested to inquire whether the decedent had any prior SFFR transport history; that inquiry was pending as of the preparation of this report. No hospital discharge records, outpatient clinic visit records, or pharmacy records were obtained at intake; acquisition of such records, to the extent they are available and accessible, is a pending investigative action for both this office and SFPD, subject to applicable legal process.

## **5.2 – Psychiatric, Behavioral, and Substance History**

No information was available at intake regarding psychiatric history, prior mental health treatment, known behavioral health conditions, or substance use history. Gregory Whitfield and Thomas Marsh were each, independently, asked whether the decedent had expressed any ideation of self-harm or any unusual personal distress in the period preceding her death; both stated no without apparent hesitation. Whitfield added that the decedent had appeared at work in normal functional capacity through, to his knowledge, the end of the prior business day, October 13, 2015, though he stated he had not spoken with her personally that afternoon. A partial empty bottle consistent with a commercially available wine varietal was noted by SFPD CSU personnel in the inner-office waste receptacle of an adjacent suite (Suite 708); no alcoholic beverage containers were identified in Suite 712 or associated with the decedent. This information is recorded for completeness and does not establish any connection to the decedent.

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**6. KNOWN LIMITATIONS OF INTAKE INFORMATION**

The following limitations are identified as of the date of this investigator's report and are noted for the record to ensure appropriate caution in interpreting all preliminary findings:

**(a) No identified treating physician.** The absence of a known primary care physician or specialist at intake significantly limits this investigator's ability to obtain a clinical history, recent laboratory values, active medication list, or any documented conditions relevant to the cause of death. This limitation is considered material and will require active follow-up by both this office and SFPD.

**(b) No eyewitness to collapse or loss of consciousness.** The decedent was discovered postmortem. No individual has come forward who observed the decedent's condition deteriorate, collapse, or become unresponsive. The last known observation of the decedent in an ambulatory or conscious state has not been confirmed at the time of this report, representing a critical chronological gap.

**(c) No medication list.** Neither the scene nor any source contacted at intake yielded a current or historical medication list for the decedent. The absence of observed medications at the scene is notable but does not rule out the possibility that the decedent maintained medications at her residence or elsewhere, or that any medications present at the scene may have been removed prior to or after discovery by an unknown party.

**(d) Building access record not yet reviewed.** The electronic key-card access log for the seventh floor was not available to this investigator or SFPD at the time of the scene examination. This leaves the exact time of the decedent's last documented entry onto the floor, and the presence or absence of other individuals on the floor after normal business hours, presently unconfirmed.

**(e) CCTV footage not reviewed.** Interior CCTV coverage of the building's lobby, elevator banks, and some hallways was not reviewed by this investigator; review and retrieval are an SFPD Investigations function. Gaps in CCTV coverage, specifically along the south corridor where Suite 712 is located, are a material limitation to establishing movement on that floor after business hours.

**(f) Wide postmortem interval estimate.** Given available environmental temperature data, the absence of a witnessed time of collapse, and the degree of postmortem changes grossly observed at scene, a preliminary estimate of the postmortem interval at the time of this investigator's scene arrival (approximately 0325-0500 hrs, October 14, 2015) is conservatively in the range of three to nine hours. This range is broad and subject to significant revision based on autopsy findings and ancillary data. Any estimation of time of death beyond this range is

not supported by currently available information.

## 7. EXTERNAL OBSERVATION AT SCENE - SUMMARY

The following is a summary of this investigator's external observations of the decedent at the scene prior to transport. These observations are preliminary in nature, made under field conditions, and are not a substitute for the formal autopsy examination. All measurements and weights referenced are approximations pending formal measurement at autopsy.

The decedent was found seated in an ergonomic executive desk chair on the inner side of the desk, in a position consistent with normal working posture. The chair had rotated slightly to the right (east) from a direct forward-facing orientation, approximately fifteen to twenty degrees. The decedent's torso was slumped forward and to the right, right forearm and outer hand resting on the desk surface, left arm in the lap. Head inclined rightward and slightly forward, right cheek resting lightly on the right shoulder. Feet rested on the floor beneath the desk. No evidence of significant postmortem or perimortem extremity repositioning was apparent, though this is a limited field assessment.

The decedent was wearing a white collared blouse, dark-charcoal dress slacks, a blazer, and low-heeled dress shoes. Clothing was in place and did not appear rearranged, disordered, or torn. The collar button was open at the second button from the top. No acute trauma, external hemorrhage, ligature marks, petechial hemorrhage (to the extent visible), or gross deformity was identified on external examination at the scene. These observations are explicitly limited by body position, clothing coverage, and ambient lighting conditions, and shall not be interpreted as ruling out findings that will be assessed at formal autopsy.

Postmortem changes observed at the scene: Lividity was present and appeared fixed along the posterior and right lateral surfaces of the decedent as accessible to examination without disrobing; the pattern was generally consistent with the observed seated position but this correlation requires autopsy confirmation. Rigor mortis was present and appeared well-established in the upper extremities, jaw, and neck; lesser development was noted in the lower extremities based on passive manipulation. Skin temperature was assessed with a handheld infrared thermometer at 77.4°F at the right forearm at approximately 0345 hours; ambient room temperature was 70.8°F at the same time. No decomposition changes were identified on gross external examination at the scene. Taken together, these postmortem changes are consistent with an estimated postmortem interval in the range described in Section 6(f) above, subject to formal analysis at autopsy.

## 8. PRELIMINARY CHRONOLOGY

The following chronology reflects information available as of the preparation of this report and is explicitly preliminary, incomplete, and subject to revision.

Date/Time (CDT)	Event	Source / Notes
10/13/2015 - Business hours (approx. 8:00)	Decedent reported at work in normal capacity;	Last who finished (employee) confirmed with
10/13/2015 - After Decedent's remains on 7th floor after normal business hours	Decedent's remains on 7th floor after normal business hours	Building security - Mulanda G. Perkins

Date/Time (CDT)	Event	Source / Notes
10/13/2015 - 2248	Decedent discovered unresponsive by R.J. Fuentes (Rushville) via Deing Court in relay cleaning	Res.( Rushville) via Deing Court in relay cleaning
10/13/2015 - 2252	Building security supervisor Molander arrives	Kort.7 Molander; -conf isced precedent unres
10/13/2015 - 2301	SFPD Unit 1 arrives on scene; EMS confirms un-	SFPD Incident Report #SFR-2015-09449 Spirati
10/13/2015 - 2303	Decedent pronounced deceased on scene by Paramedics	SFPD ME records T. Kiedrowski, NRP.N
10/13/2015 - 2304	SFPD patrol units 214 and 237 (Officers Harmon	SFPD Dispatch records; secure scene
10/14/2015 - 0248	ME office notified by SFPD dispatch (Operator	ME dispatch log (2015-ME-0447)
10/14/2015 - 0250	ME investigator contacts Dr. Adeyemi; ME jurisdic-	ME records authorized; P-1 autopsy tenta
10/14/2015 - 0321	ME investigator Kowalczyk arrives at scene; me	Investigator log
10/14/2015 - 0412	SFPD Crime Scene Unit arrives; concurrent scene	SFPD CSU log (not ME document)
10/14/2015 - 0430	ME investigator contacts Dr. Adeyemi with scene	ME update's transport and autopsy confi
10/14/2015 - 0538	Body released from scene by Det. Orre; transfe	ME record book DMTS Mortuary sheet transport (Ha
10/14/2015 - 0622	Body received at ME facility by Mortuary Tech	ME facility receipt log; stored C
10/14/2015 - 0705	Dr. Adeyemi notifies Chief ME Dr. Reinholt; P	ME autopsy authorized
10/14/2015 - 0900	Autopsy performed, Suite A, by Dr. Adeyemi (p	ME Autopsy Report 2015-ME-0447 (ver) -

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**9. INVESTIGATOR OPINION AND PRELIMINARY ASSESSMENT**

The following represents this investigator's preliminary assessment based solely on information available at the time of scene examination and intake, prior to completion of the autopsy and ancillary studies. This section does not constitute a final determination of cause or manner of death. All conclusions contained herein are provisional, may be revised or retracted in whole or in part based on subsequent findings, and should not be cited or relied upon as a final medical or legal determination.

The decedent, Eleanor Anne Marsh, a 46-year-old female with no identified medical history at the time of intake, was found deceased in her private office at 4200 South Western Avenue, Suite 712, Sioux Falls, SD, after normal business hours on October 13, 2015. The circumstances of her death as known at intake include the following notable features: (1) the death was unwitnessed, with no individual identified who observed the decedent's condition deteriorate or who last saw the decedent in a confirmed living state at a specific documented time; (2) no obvious acute external trauma was identified on gross scene examination, though this examination was limited; (3) no prescription medications or acute toxicological exposures were identified at the scene, though this absence is not dispositive; (4) postmortem changes at the scene were grossly consistent with a multi-hour interval, with fixedness of lividity and well-established rigor; and (5) the setting and circumstances do not immediately suggest a clear natural, accidental, or intentional etiology on the basis of scene information alone.

This investigator does not, based on scene examination and intake information, identify a single leading hypothesis for manner of death. The absence of obvious trauma, the discovery in a private locked-access office after business hours, the absence of identified witnesses, and the absence of any known medical history collectively support the determination that a thorough autopsy examination with full toxicological screening and appropriate ancillary studies is necessary before any preliminary opinion regarding cause or manner of death can be responsibly offered. The designation of 'suspicious' circumstances at intake is based on process criteria – specifically the unattended nature of the death, the absence of a known treating physician, and the features described above – and does not constitute a finding or allegation that the death was caused by the action or omission of any third party.

Pending results of the autopsy (performed October 14, 2015, see separate Autopsy Report for Case 2015-ME-0447), toxicology (specimens submitted October 14, 2015, see Toxicology Submission Form), histological examination, and any further information developed by SFPD Investigations, this investigator's opinion regarding cause and manner of death is deferred in its entirety. No preliminary

death certificate will be issued pending these results. The case remains open and active.

**10. PENDING ACTIONS – ME OFFICE**

Action Item	Responsible Party	Target / Status
Obtain formal autopsy report and Toxicology specimen submission and Histology slides preparation and Identify decedent's treating physician Obtain pharmacy and medical records Review decedent's residential address Obtain and review building electrical CCTV footage review – lobby, elevators Next-of-kin release authorization Final death certificate issuance	Dr. Adeyemi / Chief ME Investigator ME Tracking ME Histology Tech / Dr. SFPD (primary) / ME Investigator SFPD Investigator SFPD Investigations (residential) SFPD Key investigations SFPD Investigations ME Investigator Dr. Adeyemi / Chief ME	PRELIMINARY: within 5 business days; Final: Pending Submitted 10/14/2015 (see Tox Submission Form) Pending; tissue blocks submitted at autopsy Pending; SFPD physician identified at intake Pending) SFPD subpoena or records request; ME Pending) SFPD subpoena (TDD) and any warrant Pending; geolog held by building ownership; SFPD Pending – SFPD to retrieve; coverage gaps on Pending (SFPD contact initiated via SFPD; release PENDING – pending tox, histo, and final cause

**INVESTIGATOR CERTIFICATION:** I certify that the foregoing Death Investigation Report is an accurate account of my observations, the information obtained at the scene and during initial intake, and my preliminary assessment, to the best of my knowledge as of the date of preparation. This report is PRELIMINARY. No final determination of cause or manner of death is made herein. All opinions are subject to revision upon receipt of autopsy, toxicology, histology, and investigative findings.

Investigator Signature:	Date:	10/14/2015	Time:	1022 hrs
Print Name / Badge:	Reviewer:	Dr. Adeyemi	Date:	MD
Reviewer Signature:	Case Status:	OPEN / PRELIMINARY		