MEDICAL EXAMINER REPORT
HERMAN TITUS JR.

ME 17-02847

A postmortem examination is performed by Kendall V. Crowns, M.D., Deputy Medical Examiner, beginning at 1030 hours on June 20, 2017 at the Travis County Medical Examiner's Office, Austin, Texas.

Other persons present: Detective Paul Salo, Travis County Sheriff's Office
Ranger Michael Smith, Texas Rangers

DECLARATION

The death of HERMAN TITUS JR. was investigated by the Travis County Medical Examiner's Office under the statutory authority of the Travis County Medical Examiner.

I, Kendall V. Crowns MD, a board certified anatomic and forensic pathologist licensed to practice medicine in the State of Texas, do declare that I personally performed or supervised the tasks described in this Medical Examiner Report. It is only after careful consideration of all the data available to me at the time this report was finalized that I attest to the diagnoses and opinions stated herein.

Numerous photographs were obtained along the course of the examination. I have personally reviewed those photographs and attest that they are representative of findings reported in this document.

Should you have questions after review of this material, please feel free to contact me at the Travis County Medical Examiner's Office.
CAUSE OF DEATH

HYPERTENSIVE CARDIOVASCULAR DISEASE

MANNER OF DEATH

NATURAL

KENDALL VON CROWNS, MD
Deputy Medical Examiner

9.6.17
Date
SUMMARY AND OPINION

According to the investigative report, a 21 year old black male suffered a witness arrest in his jail cell. 911 was contacted and Emergency medical services (EMS) responded and initiated cardiopulmonary resuscitation (CPR) efforts. The decedent was transported to a hospital where CPR was continued to no avail. The decedent was declared dead in the emergency room.

The decedent had a medical history of having been possibly struck by another inmate in the face while in the recreational yard. After this incident the decedent began to complain of arm and back pain, numbness of the hands and generalized weakness.

Upon examination, the decedent was a well-developed well-nourished male appearing the reported age. There was hypertensive cardiovascular disease as evidenced by cardiomegaly (enlarged heart) and left ventricular hypertrophy (thickening of the left ventricle of the heart). There were pleural effusions (fluid in the chest cavity) and the adrenal glands exhibited hemorrhage.

Toxicology testing on postmortem blood revealed ibuprofen. Testing of vitreous fluid (fluid taken from the eye) demonstrated no abnormalities of electrolytes or glucose.

It is my opinion that the decedent died a natural death as a result of hypertensive cardiovascular disease (heart disease due to high blood pressure). Based on the apparently sudden nature of this death, the cause of death is most likely related to problems with the cardiovascular system. As the heart muscle (myocardium) becomes greater in thickness (hypertrophies) sudden death can occur because the increase in muscle mass creates a diminished blood supply to the heart muscle which can result in abnormal heart rhythms (arrhythmias) and thus, sudden death.
EXTERNAL EXAMINATION

Body length (inches, cm): 69 175.3
Body weight (pounds, kg): 168 76.1
Body mass index (kg/m²): 24.8

Development: Well-developed
Stature: Well-nourished
Age: Appears to be stated age

Anasarca: No
Edema localized: No
Dehydration: No
Skin: Normal
Scalp hair color: Black
Scalp hair length: Short
Eyes: Both eyes present
Irides: Brown
Eyes cornea: Translucent
Eyes sclera: White
Eyes conjunctiva: Translucent
Petechiae: No
Nose: Normally formed
Ears: Normally formed
Lips: Normally formed
Facial hair: Mustache and goatee
Facial hair color: Black
Maxillary dентition: Natural
Mandibular dентition: Natural
Condition of dентition: Good
Neck: Unremarkable
Trachea midline: Yes
Chest development: Normal
Chest symmetrical: Yes
Chest diameter: Appropriate
Abdomen: Flat
Anus: Unremarkable
Back: Unremarkable
Spine: Normal
External genitalia: Male
Breast development: None
Breast masses: None
Right hand digits complete: Yes
Left hand digits complete: Yes
Right foot digits complete: Yes
Left foot digits complete: Yes
Extremities: Well-developed and symmetrical
Muscle group atrophy: No
Senile purpura: No
Pitting edema: No

Tattoos: Chest and upper extremities

Cosmetic piercing: None

Scars: Upper and lower extremities

Other: Brown paper bags secured with adhesive tape about the hands. Upon removal of the bags the hands are unremarkable. The body is received wrapped in a white sheet. Upon removal of the sheet the body is clothed in gray and black stripped scrub pants.
POSTMORTEM CHANGES

Body temperature: Cool subsequent to refrigeration
Rigor mortis: Fully fixed
Livor mortis – color: Purple
Livor mortis – fixation: Fully fixed
Livor mortis – position: Posterior
State of preservation: No decomposition

Funeral Preparation(s): None

Organ/tissue procurement: None
MEDICAL INTERVENTION

Evidence of medical intervention:

1. Nasal cannula in the nose
2. Mouth guard in the mouth
3. Cervical collar about the neck
4. Defibrillation pads about the chest
5. Electrocardiographic pads about the torso
6. Blood pressure cuff about the left arm
7. Intravenous catheter in the left antecubital fossa
8. Intraosseous catheter in the anterior left leg
9. Medical identification band about the left leg

Injuries related to resuscitative attempts:

1. Abrasions along the midline of the chest
EVIDENCE OF INJURIES

Conventions used in description of injuries:

1. The body is described in the Standard Anatomic Position. Reference is to this position only.
2. Clock-face references are from the perspective of the observer viewing the body in the Standard Anatomic Position, with the 12 o'clock position corresponding to the top of the head.
3. Injuries are numbered or lettered for reference purposes only and will occasionally correspond to labeled injuries in the autopsy photographs. This is arbitrary and does not correspond to any order in which they have been incurred or degree of severity.

1. 2 x 2 cm red bruise of the mid right side of the back
**INTERNAL EXAMINATION**

**BODY CAVITIES**

<table>
<thead>
<tr>
<th>Chest cavities examined:</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal cavity examined:</td>
<td>Yes</td>
</tr>
<tr>
<td>See Evidence of Injury section:</td>
<td>No</td>
</tr>
<tr>
<td>Organs in normal anatomic position:</td>
<td>Yes</td>
</tr>
<tr>
<td>Diaphragm:</td>
<td>Intact</td>
</tr>
<tr>
<td>Serosal surfaces:</td>
<td>Smooth and glistening</td>
</tr>
<tr>
<td>Body cavity adhesions:</td>
<td>No</td>
</tr>
<tr>
<td>Fluid accumulation present:</td>
<td>275 cc straw colored clear fluid in the right chest cavity. 300 cc straw colored fluid in the left chest cavity</td>
</tr>
</tbody>
</table>

**HEAD**

<table>
<thead>
<tr>
<th>Brain examined:</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Evidence of Injury section:</td>
<td>No</td>
</tr>
<tr>
<td>See Evidence of Medical Intervention:</td>
<td>No</td>
</tr>
<tr>
<td>See Postmortem Changes section:</td>
<td>No</td>
</tr>
<tr>
<td>Brain weight fresh (g):</td>
<td>1375</td>
</tr>
<tr>
<td>Facial skeleton:</td>
<td>No palpable fractures</td>
</tr>
<tr>
<td>Calvarium:</td>
<td>No fractures</td>
</tr>
<tr>
<td>Skull base:</td>
<td>No fractures</td>
</tr>
<tr>
<td>Dura mater:</td>
<td>Unremarkable and without masses</td>
</tr>
<tr>
<td>Dural venous sinuses:</td>
<td>Patent</td>
</tr>
<tr>
<td>Leptomeninges:</td>
<td>Thin and transparent</td>
</tr>
<tr>
<td>Epidural hemorrhages/hematomas:</td>
<td>Absent</td>
</tr>
<tr>
<td>Subdural hemorrhages/hematomas:</td>
<td>Absent</td>
</tr>
<tr>
<td>Subarachnoid hemorrhages:</td>
<td>Absent</td>
</tr>
<tr>
<td>Cerebral hemispheres:</td>
<td>Symmetrical</td>
</tr>
<tr>
<td>Gyral and sulcal patterns:</td>
<td>Unremarkable</td>
</tr>
<tr>
<td>Gyral convolutions and sulci:</td>
<td>No widening or flattening of gyri and no narrowing of sulci</td>
</tr>
<tr>
<td>Uncal processes:</td>
<td>Unremarkable</td>
</tr>
</tbody>
</table>
Cerebellar tonsils: Unremarkable
Cranial nerves: Unremarkable
Basilar arterial vasculature: Unremarkable
Cerebral cortex: Unremarkable
White matter: Unremarkable
Corpus Callosum: Unremarkable
Deep gray matter structures: Unremarkable
Brainstem: Unremarkable
Cerebellum: Unremarkable

Spinal Cord
Spinal cord examined: No
Spinal dura: Not examined
Spinal cord: Not examined

Neck examined: Yes
See Evidence of Injury section: No
See Evidence of Medical Intervention: No
See Postmortem Changes Section: No

Subcutaneous soft tissues: Unremarkable
Strap muscles: Unremarkable
Jugular veins: Unremarkable
Carotid arteries: Unremarkable
Tongue: Unremarkable
Epiglottis: Unremarkable
Hyoid bone: Unremarkable
Larynx: Unremarkable
Palatine tonsils: Not examined

Heart examined: Yes
See Evidence of Injury section: No
See Evidence of Medical Intervention: No
See Postmortem Changes Section: No
Heart weight fresh (g): 425

Right coronary ostium position: Normal
Left coronary ostium position: Normal
Supply of the posterior myocardium: Right coronary artery
Coronary artery stenosis:
- Right coronary ostium - 0%
- Right coronary artery - 0%
- Left coronary ostium - 0%
- Left mainstem coronary artery - 0%
- Left anterior descending coronary artery - 0%
- Left circumflex coronary artery - 0%

Cardiac chambers: Unremarkable
Tricuspid valve: Unremarkable
Pulmonic valve: Unremarkable
Mitral valve: Unremarkable
Aortic valve: Unremarkable
Right ventricular myocardium:
- No fibrosis, erythema, pathologic infiltration of adipose tissue or areas of accentuated softening or induration
Left ventricular myocardium:
- No fibrosis, erythema, or areas of accentuated softening or induration
Atrial septum: Unremarkable
Ventricular septum: Unremarkable
Right ventricular free wall thickness (cm): 0.5
Left ventricular free wall thickness (cm): 2.0
Intraventricular septal thickness (cm): 2.0
Other comments: Petechial hemorrhages of the epicardial surface

Aorta examined: Yes
Orifices of the major vascular branches: Patent
Coarctation: No
Vascular dissection: No
Aneurysm formation: No
Complex atherosclerosis: No
Other aortic pathology: No
**Vena Cava**

Great vessels examined: Yes  
Vena cava and major tributaries: Patent

**RESPIRATORY SYSTEM**

Lungs examined: Yes  
See Evidence of Injury section: No  
See Evidence of Medical Intervention: No  
See Postmortem Changes Section: No

Right lung weight (g): 1000  
Left lung weight (g): 1000

Upper and lower airways: Unobstructed and the mucosal surfaces are smooth and yellow-tan
Pulmonary parenchyma color: Dark red-purple  
Pulmonary congestion and edema: Marked amounts of blood and frothy fluid  
Pulmonary trunk: Free of saddle embolus  
Pulmonary artery thrombi: None  
Pulmonary artery atherosclerosis: None

**HEPATOBIILIARY SYSTEM**

Liver examined: Yes  
See Evidence of Injury section: No  
See Evidence of Medical Intervention: No  
See Postmortem Changes Section: No

Liver weight (g): 1800

Hepatic parenchyma (color): Red-brown  
Hepatic parenchyma (texture): Unremarkable  
Hepatic vasculature: Unremarkable and free of thrombus  
Gallbladder: Unremarkable  
Gallstones: No  
Intrahepatic biliary tree: Unremarkable  
Extrahepatic biliary tree: Unremarkable
### Gastrointestinal System

<table>
<thead>
<tr>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alimentary tract examined</td>
<td>Yes</td>
</tr>
<tr>
<td>See Evidence of Injury section</td>
<td>No</td>
</tr>
<tr>
<td>See Evidence of Medical Intervention</td>
<td>No</td>
</tr>
<tr>
<td>See Postmortem Changes Section</td>
<td>No</td>
</tr>
<tr>
<td>Stomach contents volume (ml)</td>
<td>30</td>
</tr>
<tr>
<td>Stomach contents description</td>
<td>Tan mucoid fluid</td>
</tr>
<tr>
<td>Appendix</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### Esophagus

- **Course:** Normal course without fistulae
- **Mucosa:** Gray-white, smooth and without lesions

#### Stomach

- **Mucosa:** Usual rugal folds
- **Pylorus:** Patent and without muscular hypertrophy

#### Small Intestines

- **Luminal contents:** Partially digested food
- **Mucosa:** Duodenal mucosa unremarkable; remaining bowel mucosa not examined
- **Caliber and continuity:** Appropriate caliber without interruption of luminal continuity

#### Colon

- **Luminal contents:** Formed stool
- **Mucosa:** Rectal mucosa unremarkable; remaining colonic mucosa not examined
- **Caliber and continuity:** Appropriate caliber without interruption of luminal continuity

#### Pancreas

- **Form:** Normal tan, lobulated appearance

### Genitourinary System

- **Genitourinary system examined:** Yes
Kidneys

- Right kidney weight (g): 200
- Left kidney weight (g): 200
- Kidney capsules: Thin, semitransparent
- Cortical surfaces: Smooth
- Cortices: Normal thickness and well-delineated from the medullary pyramids
- Calyces, pelves, and ureters: Non-dilated and free of stones and masses

Urinary bladder

- Urine volume (ml): 50
- Urine description: Clear yellow
- Urinary bladder mucosa: Gray-tan and smooth

Male

- Testicle location: Bilaterally scrotal
- Testicle size: Unremarkable
- Testicle consistency: Homogeneous
- Prostate gland size: Unremarkable
- Prostate gland consistency: Homogeneous

Reticuloendothelial system

- Reticuloendothelial system examined: Yes
- See Evidence of Injury section: No
- See Evidence of Medical Intervention: No
- See Postmortem Changes Section: No

Spleen

- Spleen weight (g): 175
- Spleen parenchyma: Moderately firm
- Spleen capsule: Intact
- Spleen white pulp: Indiscernible
### Bone Marrow

**Color:**
Red-brown, homogeneous and ample

### Lymph nodes

**Regional adenopathy:**
No adenopathy

### Endocrine System

**Endocrine system examined:**
Yes
**See Evidence of Injury section:**
No
**See Evidence of Medical Intervention:**
No
**See Postmortem Changes Section:**
No

### Pituitary gland

**Size:**
Not examined

### Thyroid gland

**Thyroid gland position:**
Normal
**Thyroid gland size:**
Normal
**Thyroid gland parenchyma:**
Normal

### Adrenal glands

**Adrenal gland size:**
Normal
**Adrenal gland parenchyma:**
Hemorrhagic

### Musculoskeletal System

**Musculoskeletal system examined:**
Yes
**See Evidence of Injury section:**
No
**See Evidence of Medical Intervention:**
No
**See Postmortem Changes Section:**
No

**Bony framework:**
No evidence of injury along the musculature. The wrist and ankles are incised and reveal no evidence of hemorrhage.

**Supporting musculature:**
Unremarkable
**Subcutaneous tissue:**
Increased fat pad along the posterior aspect of the neck.
SLIDE KEY
A. Heart
B. Brain

*Unless otherwise indicated, sections are stained only with hematoxylin and eosin (H&E).

MICROSCOPIC DESCRIPTION

HEART: Mild myocyte hypertrophy and vascular congestion

BRAIN: Vascular congestion
## PROCEDURAL NOTES

### APPROACH TO AUTOPSY DISSECTION

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rokitansky evisceration:</td>
<td>No</td>
</tr>
<tr>
<td>Virchow evisceration:</td>
<td>Yes</td>
</tr>
<tr>
<td>Modified evisceration:</td>
<td>No</td>
</tr>
<tr>
<td>Pericranial membrane removal:</td>
<td>No</td>
</tr>
<tr>
<td>Anterior neck dissection:</td>
<td>No</td>
</tr>
<tr>
<td>Posterior neck dissection:</td>
<td>No</td>
</tr>
<tr>
<td>Facial dissection:</td>
<td>No</td>
</tr>
<tr>
<td>Vertebral artery dissection (in situ):</td>
<td>No</td>
</tr>
<tr>
<td>Cervical spine removal:</td>
<td>No</td>
</tr>
<tr>
<td>Layered anterior trunk dissection:</td>
<td>No</td>
</tr>
<tr>
<td>Anterolateral rib arc dissection:</td>
<td>No</td>
</tr>
<tr>
<td>Back dissection:</td>
<td>Yes</td>
</tr>
<tr>
<td>Posterior rib arc dissection:</td>
<td>No</td>
</tr>
<tr>
<td>Extremity soft tissue dissection:</td>
<td>Yes</td>
</tr>
<tr>
<td>Eye enucleation:</td>
<td>No</td>
</tr>
<tr>
<td>Inner middle ear evaluation:</td>
<td>No</td>
</tr>
<tr>
<td>Maxilla or mandible resection:</td>
<td>No</td>
</tr>
<tr>
<td>Spinal cord removal (anterior):</td>
<td>No</td>
</tr>
<tr>
<td>Spinal cord removal (posterior):</td>
<td>No</td>
</tr>
</tbody>
</table>
# Toxicology Report

**ME 17-02847**  
**Titus, Herman Jr.**  
Pathologist: Dr. Kendall V. Crowns  
Date Completed: 7/7/2017

<table>
<thead>
<tr>
<th>Assay/SPECIMEN</th>
<th>Substance</th>
<th>Result</th>
<th>Units</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACID/NEUTRAL DRUGS</strong></td>
<td>Blood, femoral</td>
<td>Ibuprofen</td>
<td>Detected</td>
<td></td>
</tr>
<tr>
<td><strong>ALKALINE DRUGS</strong></td>
<td>Blood, femoral</td>
<td>ND</td>
<td></td>
<td>GC/MS</td>
</tr>
<tr>
<td><strong>ETHANOL/VOLATILES</strong></td>
<td>Blood, femoral</td>
<td>ND</td>
<td></td>
<td>Headspace GC/FID</td>
</tr>
<tr>
<td><strong>IMMUNOASSAY</strong></td>
<td>Blood, femoral</td>
<td>Amphetamine</td>
<td>ND</td>
<td>ELISA</td>
</tr>
<tr>
<td></td>
<td>Blood, femoral</td>
<td>Barbiturate</td>
<td>ND</td>
<td>ELISA</td>
</tr>
<tr>
<td></td>
<td>Blood, femoral</td>
<td>Benzodiazepine</td>
<td>ND</td>
<td>ELISA</td>
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<tr>
<td></td>
<td>Blood, femoral</td>
<td>Cocaine Metabolite</td>
<td>ND</td>
<td>ELISA</td>
</tr>
<tr>
<td></td>
<td>Blood, femoral</td>
<td>Fentanyl</td>
<td>ND</td>
<td>ELISA</td>
</tr>
<tr>
<td></td>
<td>Blood, femoral</td>
<td>Opiate</td>
<td>ND</td>
<td>ELISA</td>
</tr>
<tr>
<td></td>
<td>Blood, femoral</td>
<td>Oxytocin</td>
<td>ND</td>
<td>ELISA</td>
</tr>
<tr>
<td></td>
<td>Blood, femoral</td>
<td>Cannabinoid</td>
<td>ND</td>
<td>ELISA</td>
</tr>
<tr>
<td><strong>SYNTHETIC CANNABINOIDS</strong></td>
<td>Blood, femoral</td>
<td>ND</td>
<td></td>
<td>LC/MS/MS</td>
</tr>
<tr>
<td><strong>Vitreous Panel</strong></td>
<td>Vitreous</td>
<td>Sodium</td>
<td>137</td>
<td>mmol/L</td>
</tr>
<tr>
<td></td>
<td>Vitreous</td>
<td>Potassium</td>
<td>10.7</td>
<td>mmol/L</td>
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<tr>
<td></td>
<td>Vitreous</td>
<td>Chloride</td>
<td>120</td>
<td>mmol/L</td>
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<td></td>
<td>Vitreous</td>
<td>Urea Nitrogen</td>
<td>16</td>
<td>mg/dL</td>
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<tr>
<td></td>
<td>Vitreous</td>
<td>Glucose</td>
<td>22</td>
<td>mg/dL</td>
</tr>
<tr>
<td></td>
<td>Vitreous</td>
<td>Creatinine</td>
<td>0.6</td>
<td>mg/dL</td>
</tr>
</tbody>
</table>

ND = None Detected  
UFA = Unsuitable for Analysis

Comment:  

Brad J. Hall, Ph.D., F-ABFT, Chief Forensic Toxicologist

Medical Examiner  
7-7-17

Page 1 of 1