COUNTY OF LOS ANGELES

DEPARTMENT OF CORONER

12b

AUTOPSY REPORT

No. 2010-05522

CARPENTER, SHARON

An autopsy was performed on the body of the DEPARTMENT OF CORONER

at

Los Angeles, California on August 23, 2010 @ 0940 Hours
(Date) (Time)

From the anatomic findings and pertinent history I ascribe the death to:

(A) LIDOCAINE, FENTANYL, AND OXYCODONE TOXICITY
DUE TO OR AS A CONSEQUENCE OF

(B)
DUE TO OR AS A CONSEQUENCE OF

(C)
DUE TO OR AS A CONSEQUENCE OF

(D)
OTHER CONDITIONS CONTRIBUTING BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH:
CORONARY ARTERY ATHEROSCLEROSIS

SUPPLEMENTAL REPORT

Supplemental Opinion:

Additional information regarding aspects of the surgeons medical practice, past history and various reviews and investigations of the surgery on decedent Sharon Carpenter are presented to the two assigned Deputy Medical Examiners, Raffi Djabourian, M.D. and Job Augustine, M.D. on 9/19/2011. The information is presented by Robin Allen, Deputy District Attorney with County of Los Angeles Office of District Attorney; Detective Joel Price of LAPD West Valley and Julie Escat , California Medical Board investigator. They stated that they wanted to present this new information to Drs. Augustine and Djabourian who had not had most of this information at the time the initial manner of death was determined. Several prior complaints filed with the California medical board by previous patients were presented. Also mentioned was that the surgeon had reportedly performed multiple procedures on himself, resulting in a large wound of his abdomen requiring grafting. The doctor in fact had the wound at the time of the surgery on Mrs. Carpenter. In addition, there were documented letters from physicians who had treated the surgeon from 2007-2010, stating that he posed a risk to patients lives if he continued to practice medicine in his condition. The additional information was subsequently reviewed in conjunction with Chief Medical Examiner/Coroner Dr. Lakshmanan, as well as with the Los Angeles County Department of Coroner surgical consultant, Dr. Denis Astarita.

The initial accidental manner was ruled based on the available information at that time. The surgeon appeared to be a licensed physician who had performed the procedure several times without fatal consequences prior to operating on Mrs. Carpenter. At the time of our initial opinion, there was no indication that he thought he was putting the decedent in harm's way, nor did he intentionally cause her death. Further review of the above materials in addition to the surgical consultation sheds some doubt to the former assumption; that is, during the surgery the physician had concerns about the safety of Mrs. Carpenter but may have knowingly failed to properly address those concerns and unnecessarily put her in harm's way. The main issue revolves around the concern that the decedent appeared to require intravenous access. When it became clear that it could not be obtained, the surgery should have been stopped and the patient should have been admitted to an acute care hospital. This is regardless of whether the final outcome was related to dehydration or drug toxicity, as admission to a hospital could have addressed both issues.

An additional concern regards the consent obtained for the procedure. Review of the submitted materials shows a pattern of falsely representing to various individuals his academic association with Harvard Medical School and joint involvement in clinical studies. There were also prior claims that he created surgical techniques or instruments which spawned a multi-billion dollar industry. Specifically in regard to the decedent's surgery, it was discounted in exchange for a clinical trial which in fact did not exist. In fact, the decedent signed the consent to the study which included the statement "minimally invasive permanent treatment of overweight and obesity", in direct contradiction to the VASER informed consent which indicates the procedure "is not a substitute for weight reduction". All of these suggest uninformed consent, in that the decedent would think the surgery was safer that it actually was.

Finally, the physician seemingly ignored his own physical wounds in undertaking such a lengthy procedure, and in the past had been warned that his self-surgery put his own life in danger. By

extension, it would seem that a reasonable physician would realize a compromise in safety not only to himself but to his patients as well, particularly given the length and physical demands of the surgery.

To reiterate, though clearly there was no intent to harm Mrs. Carpenter, it cannot be ruled out that the physician may have knowingly disregarded the safety of the patient, thus the manner of death is changed from accident to undetermined. The cause of death is unchanged.

RAFFI DJABOURIAN, M.D.
DEPUTY MEDICAL EXAMINER

DATE 11/23/11

J. DANIEL AUGUSTINE, M.D.
DEPUTY MEDICAL EXAMINER

DATE 11/23/11

RD:JDA/mtm
t-11/23/11