Official Report

Division of Forensic Sciences
Georgia Bureau of Investigation
State of Georgia

Headquarters
DOFS Case #: **2022-1031305**
Report Date: **03/19/2023**

Cleveland Miles
Deputy Director

* NAME Accredited *

Requested Service: Autopsy
Agency: Clayton Co. Medical Examiner's Office
Agency Ref#:
Requested by: T. Johnson

Case Individuals:
Victim: Candi Miller

Evidence:
On 11/12/2022, the laboratory received the following evidence from the Clayton Co. Medical Examiner's Office.
2022-1031305-001 DECEDENT

Results and Conclusions:
Evidence Submission: 001

A complete examination was performed on the body of CANDI MILLER at the Georgia Bureau of Investigation, Division of Forensic Sciences, in Decatur, Georgia on the 17th day of November 2022 commencing at 0945 hours, pursuant to the Georgia Death Investigation Act. The examination was performed by Rochelle A. Simon, M.D.

EXTERNAL EXAMINATION:
The body was received in the supine position in a white plastic transport bag that was inscribed with decedent's name. Hospital identification tags were attached to the right wrist and left first toe.

The body was that of a well-developed, well-nourished, Black female that weighed 159 pounds and was 60" in length. The reported age was 41 years. The body had been refrigerated and was cold to the touch. Rigor was present to an equal degree in all extremities. Lividity was present and fixed on the posterior surface of the body, except in areas exposed to pressure.

The body was received clad in a hospital gown and gray underwear (bearing an adhesive, absorbent, blood-soaked pad), and was accompanied by sheets and a white metal ring with green and clear stones. The hospital gown, sheets, and adhesive pad were discarded. The clothing and personal effects were returned with the body.

Evidence of medical therapy included: an endotracheal tube; defibrillator pads on the torso and left thigh; a blood pressure cuff around the right arm; an intravascular catheter in the dorsal right wrist; an intraosseous catheter in the anterior left leg; and a pulse oximeter sensor on the left earlobe. A circular dried abrasion on the mid chest was consistent with resuscitative efforts.

The head was normocephalic and the face was morphologically unremarkable. The facial bones and mandible were free of palpable fracture. The scalp hair was black, curly to wavy, up to 1-1/2" in length, and partially styled in 15" long black/brown braided extensions at the lower occipital scalp. The irides appeared brown. The corneae were cloudy/opaque. There were rare petechial hemorrhages of the lower right palpebral conjunctiva. The sclerae were unremarkable. The external auditory canals, external nares, and oral cavity were free of abnormal secretions. The nasal skeleton was palpably intact. The lips and gingivae were without evident injury. The teeth appeared to be natural and were in adequate condition. Examination of the neck revealed no evidence of injury.

The chest was symmetrical. No injury of the ribs or sternum was evident externally. The breasts were without palpable masses. The abdomen was slightly rounded and soft to

palpation; horizontal healed surgical scars were on the lower abdomen/pelvis (6" and 8"). The external genitalia were atraumatic and those of an adult female. The posterior torso was without note. The anus was unremarkable.

The extremities were symmetrical and well-developed. The appendicular skeleton was stable to palpation and manipulation. All digits were present. The fingernails were intact and exhibited multicolored polish. On the right knee was a 3/4" hypopigmented scar.

Tattoos were noted on the back, left upper extremity, and bilateral lower extremities.

EVIDENCE OF INJURY:
There was no evidence of significant recent injury.

INTERNAL EXAMINATION:
HEAD (CENTRAL NERVOUS SYSTEM):
The scalp was reflected. The calvarium of the skull was noted to be intact and was removed. The dura mater and falx cerebri were intact. There was no epidural, subdural, or subarachnoid hemorrhage present. The leptomeninges were thin and delicate. The cerebral hemispheres were symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, were intact. There was no significant atherosclerosis of the cerebral vasculature. Coronal sections through the cerebral hemispheres revealed no lesions. Transverse sections through the brainstem and sagittal sections through the cerebellum were unremarkable. The ventricular system was normally formed and the cerebrospinal fluid was translucent. The brain weighed 1150 grams.

BODY CAVITIES:
The body was opened by the usual thoraco-abdominal incision and the chest plate was removed. No adhesions or abnormal collections of fluid were present in any of the body cavities. All body organs were present in the normal anatomical position and exhibited mild putrefactive changes. The subcutaneous fat layer of the abdominal wall was 1-1/4" thick. There was no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

NECK:
Examination of the soft tissues of the neck, including strap muscles, thyroid gland, and large vessels, revealed no abnormalities. The hyoid bone and larynx were intact. The epiglottis was unremarkable.

CARDIOVASCULAR SYSTEM:
The pericardial surfaces were smooth, glistening, and unremarkable; the pericardial sac was free of significant fluid or adhesions. The coronary arteries arose normally, followed the usual distribution, and were widely patent, without evidence of significant atherosclerosis or thrombosis. The chambers and valves exhibited the usual positional relationships, with biventricular dilatation; the left ventricular lumen diameter measured 5.5 cm, and trabeculations of the right ventricle extended to the apex of the heart. The left ventricular free wall measured 1.0 cm, the interventricular septum 1.1 cm, and the right ventricle 0.2 cm in thickness. The myocardium was dark red-brown and firm; rare thin tan streaks that measured up to 2 cm were noted in the left ventricular wall; the atrial and ventricular septa were intact. The aorta and its major branches arose normally, followed the usual course, and were widely patent, free of significant arteriosclerosis and other abnormality. The venae cavae and major tributaries returned to the heart in the usual distribution and were free of thrombi. The heart weighed 370 grams.

RESPIRATORY SYSTEM:
The upper airway was clear of debris and foreign material; the mucosal surfaces were smooth, yellow-tan, and unremarkable. The pleural surfaces were smooth, glistening, and unremarkable bilaterally. The pulmonary parenchyma was maroon-purple, exuding abundant bloody fluid; no focal lesions were noted. The pulmonary arteries were normally developed, patent, and without thrombus or embolus. The right lung weighed 610 grams; the left 520 grams.

LIVER & BILIARY SYSTEM:
The hepatic capsule was smooth, glistening, and intact, covering dark red-brown, moderately congested parenchyma with no focal lesions noted. The liver weighed 1380 grams. The gallbladder contained green-brown, mucoid bile; the mucosa was velvety and unremarkable. The extrahepatic biliary tree was patent, without evidence of calculi.

ALIMENTARY TRACT:
The tongue exhibited no evidence of recent injury. The esophagus was lined by gray-white, smooth mucosa. The gastric mucosa was autolyzed; the lumen contained 20 ml of green-brown viscous material. The mesenteric soft tissue and the serosal surfaces of the small and large bowel were unremarkable. The pancreas had a normal pink-tan lobulated appearance and the ducts were clear. The appendix was unremarkable.

GENITOURINARY SYSTEM:
The renal capsules were smooth and thin, semi-transparent, and stripped with ease from the underlying smooth, red-brown cortical surfaces. The cortices were slightly congested and sharply delineated from the medullary pyramids, which were red-purple to tan and unremarkable. The calyces, pelves, and ureters were unremarkable. The right kidney weighed 80 grams; the left 90 grams. The urinary bladder was empty of urine; the mucosa was gray-tan, focally hemorrhagic, and trabeculated. The uterus exhibited areas of raised, soft, thickened endometrium at the anterior and posterior fundus (2 x 1 cm each). Within the vaginal canal was an 8 x 2 x 2 cm tubular maroon-red and tan portion of tissue and blood clot. The ovaries and fallopian tubes were without note.

RETICULOENDOTHELIAL SYSTEM:
The spleen had a smooth, intact capsule covering red-purple, soft parenchyma; the lymphoid follicles were unremarkable. The spleen weighed 160 grams. The regional lymph nodes appeared normal.

ENDOCRINE SYSTEM:
The thyroid and adrenal glands were unremarkable.

MUSCULOSKELETAL SYSTEM:
Muscle development was normal. No palpable bone or joint abnormalities were noted.

MICROSCOPIC EXAMINATION:
HEART: myocyte hypertrophy; mild perivascular and interstitial fibrosis
LUNGS: sparse intra-alveolar neutrophils (present in one of five sections submitted, right lung); congestion; patchy edema
LIVER: congestion; apparent extramedullary hematopoiesis (sparse)
KIDNEYS: rare tubular atrophy; congestion; early autolysis
SPLEEN: expanded red pulp; early autolysis
PANCREAS: autolysis
UTERUS: decidualized endometrium with implantation site changes
TISSUE FROM VAGINAL CANAL: immature chorionic villi and decidualized tissue, consistent with products of conception

OTHER PROCEDURES:
1. Documentary photographs were obtained
2. Small portions of uterine tissue were retained; the remainder of the organs were returned to the body
3. Specimens/ evidence submitted: blood, blood-stain card
4. Vitreous chemistry (Grady):
   Beta-hydroxybutyrate: 0.22 mmol/L
   Urea nitrogen: "too viscous"
   Glucose: 39 mg/dL
   Creatinine: "too viscous"
   Sodium: 134 meq/L
   Potassium: >10.0 meq/L

Chloride: 106 meq/L

5. Materials reviewed: investigative report (MEO), toxicology reports (GBI), medical records (Southern Regional Medical Center, 11/12/2022), PDMP query

PATHOLOGIC DIAGNOSES:

I. COMBINED DRUG (FENTANYL, ACETAMINOPHEN, DIPHENHYDRAMINE) INTOXICATION
   A. Postmortem heart blood positive for (see separate report):
      1) Fentanyl, 0.34 mg/l
      2) Diphenhydramine, 5.3 mg/l
      3) Acetaminophen, 330 mg/l
II. RECENT PREGNANCY
   A. Uterus with decidualized endometrium and implantation site changes
   B. Products of conception present in vaginal canal

OPINION:
This 41-year-old, Black female, CANDI MILLER, died of COMBINED DRUG (FENTANYL, ACETAMINOPHEN, DIPHENHYDRAMINE) INTOXICATION. Per report, she was found unresponsive in her residence by her partner; emergency medical services responded to the scene and she was transported to a local hospital where, despite resuscitative efforts, she was subsequently pronounced deceased. Investigation evealed no suspicions of foul play. Autopsy examination revealed no evidence of significant recent injury. Postmortem toxicology testing was positive for the above-listed substances and negative for alcohol (see separate reports). Due to the high levels of substances detected on toxicology analysis, and the unclear circumstances surrounding the drug toxicity, based on information available at this time, the manner of death COULD NOT BE DETERMINED.

CAUSE OF DEATH:
Combined Drug (Fentanyl, Acetaminophen, Diphenhydramine) Intoxication

MANNER OF DEATH:
Undetermined

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Related Agencies:

Clayton Judicial Circuit
GBI-Medical Examiner-HQ DOFS ACN: SIMON

Clayton Co. District Attorney

End of Official Report