EXHIBITS

EXHIBITS AVAILABLE TO BOTH PARTIES

The parties have stipulated to the authenticity of the trial exhibits listed below. The Court will, therefore, not entertain objections to authenticity of these trial exhibits. The parties have reserved any objections to the admissibility of any of these exhibits until the trial of the above-captioned matter. The trial exhibits may be introduced by either party, subject to the Rules of Evidence and the stipulations of the parties contained in the materials.

EXHIBIT #	EXHHIBIT DESCRIPTION
1	911 Phone Transcript
2	Initial Police Incident Report
3	Investigative Report
4	Emergency Room Record
5	Record of Coroner
6	Photograph of the ESE House
7	Photograph of Red Plastic “Solo” Brand Cup used by Victim
8	Photograph of Water Coolers used by ESE in the Basement
9	News Report of Hyponatremia Fatality
10	WebMD.com Medical Report on Hyponatremia
11	Medical Release Form
12	ESE Pledge Rules
13	Death Certificate of Jessica Bateson
14	Dr. Paulsen’s Report

The parties reserve the right to dispute any other legal or factual conclusions based on these items and to make objections to these items based on other evidentiary issues.

EXHIBIT #1: 911 Phone Transcript (page 1 of 2)

08-29-2009 17:06

Dispatch: "Emergency 911. Is your emergency Police, Fire, or Medical?"

Caller 1: **"**I'm at the ESE house at 313 Senate Street in Tega Cay. One of the pledges has passed out. We need an ambulance in a hurry."

Dispatch: "I need your name and location, please."

Caller 1: "My name is Alex Richards."

Dispatch: "Can you confirm the address?"

Caller 1: "It's the ESE house on Senate Street. 313 Senate."

Dispatch: **"**EMS (Emergency Medical Service) 4, Prepare to copy."

EMS 4: **"**EMS 4. Go ahead dispatch."

Dispatch: "Report of a person unconscious at 313 Senate Street, Tega Cay. No further information available at this time. Your incident number is 46-108290911, and time of dispatch is 17:07."

EMS 4: "EMS 4 copies. We are in route to 313 Senate Street for report of an unconscious person. We have an ETA (estimated time of arrival) of ten minutes."

Dispatch: "Good copy."

Dispatch: "DMPD (Daniel Morgan University Police Department) 33, prepare to copy."

DMPD 33: "DMPD 33. Go ahead dispatch."

Dispatch: "Report of a person unconscious at 313 Senate Street, Tega Cay. No further information available at this time. EMS en route. Your incident number is 46-108290911, and time of dispatch is 17:08."

DMPD 33: "DMPD 33 copies. En route to 313 Senate Street for report of person unconscious. 33 also copies EMS en route. Time is 17:09."

Dispatch: "Good copy."

Dispatch: "I've dispatched police and EMS to 313 Senate Street, but it's a long street. Do you know the nearest cross-street?"

Caller 1: "We're near the intersection of North Pope Street. It's a big white two-story house with columns. They can't miss it."

EXHIBIT #1: 911 Phone Transcript (page 2 of 2)

Dispatch: **"**OK, I just want you to stay on the line with me. We need to know what's going on."

Caller 1: "OK."

Dispatch: "Do you know the name of the individual who passed out?"

Caller 1: "Yes, it's Jessica Bateson."

Dispatch: "Do you know whether Jessica has any medical conditions? Is she on any medications?"

Caller 1: "I don't know."

Dispatch: "Is Jessica conscious?"

Caller 1: "No she's not, but she's breathing really shallow."

EMS 4: "Dispatch, EMS 4."

Dispatch: "Go ahead EMS 4."

EMS 4: "EMS 4 on scene."

Dispatch: "Copy. EMS 4 on scene at 17:26."

DMPD 33: "Dispatch, DMPD 33."

Dispatch: "Go ahead DMPD 33."

DMPD 33: "DMPD 33 on scene."

Dispatch: **"**Copy. DMPD 33 on scene at 17:27."

Caller 1: "Thank goodness, EMS is here. Thank you. Thank you. I'm going now." – CALL ENDS

EMS 4: "Dispatch, EMS 4."

Dispatch: "Go ahead EMS 4."

EMS 4: "One unconscious female, respiratory distress. En route York Regional Medical Center cleared from 313 Senate Street."

Dispatch: "Copy. EMS 4 clear from 313 Senate Street at 17:34, en route to York Regional Medical Center with one unconscious female, respiratory distress."

EXHIBIT #2: Initial Police Incident Report (page 1 of 2)

AGENCY ID
SC04619

DANIEL MORGAN UNIVERSITY POLICE DEPARTMENT

Tega Cay, South Carolina (803) 555-1234

INCIDENT #
46-108290911

INCIDENT REPORT

PRINT OR TYPE ALL INFORMATION

EVENT

INCIDENT TYPE	COMPLETED	FORCED ENTRY	PREMISE TYPE	UNITS ENTERED	TYPE VICTIM
Assisting other Agencies – York County EMS	☑YES ☐NO	☐YES ☑NO	Res.	1	☑ Individual ☐ Business ☐ Government ☐ Other
	☐YES ☐NO	☐YES ☐NO			
	☐YES ☐NO	☐YES ☐NO			

INCIDENT LOCATION (SUBDIVISION, APARTMENT AND NUMBER, STREET NAME AND NUMBER)	ZIP CODE	WEAPON TYPE
313 Senate Street,	29708	

INCIDENT DATE	24 HOUR CLOCK	TO	DATE	24 HOUR CLOCK
8/29/2009	17:27		8/29/2009	19:05

COMPLAINTANT'S NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO SUBJECT	DAYTIME PHONE	EVENING PHONE
Richards, Alex	NA	803-555-0789	803-555-0789
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
313 Senate Street	Tega Cay	SC	29708

SUBJECT NO.1

NAME (LAST, FIRST, MIDDLE)	AKA
NA	

FACIAL HAIR, SCARS, TATOOS, GLASSES, CLOTHING, PHYSICAL PECULARITIES, ETC.

ADDRESS	CITY	STATE	ZIP CODE

SUBJECT (NO.1) USING:	ARRESTED NEAR OFFENSE SCENE	DATE / TIME OF OFFENSE	DATE / TIME OF ARREST
ALCOHOL ☐YES ☐NO ☐UNKNOWN DRUGS ☐YES ☐NO ☐UNKNOWN	☐YES ☐NO		

NARRATIVE

Responding Officer (RO) arrived on scene at the above date and time in reference to an unresponsive female at the Epsilon Sigma Epsilon house. In the basement area of the house, EMS was working on what appeared to be an unconscious teenage female. RO made contact with Chapter President Alex Richards, Pledge Master Taylor Durden, and pledge Tammy Canes. Based upon experience, RO had probable cause to believe that this was an alcohol based initiation. RO inquired with both Richards and Durden as to the age of the female and whether or not alcohol was being used. Both denied any alcohol and stated that Ms. Bateson merely passed out. During this time EMS cleared the scene to York Regional Hospital with Bateson. RO requested and was granted permission to search the premises for alcohol. Additional officers arrived on scene shortly thereafter. Once additional officers were at the residence, RO and Cpl. Dechane conducted a thorough search of the premises. 500 ml. of tequila was discovered in the room of one resident who was above 21. No other illicit substances were discovered. RO interviewed Tammy Canes following the consent search for alcohol. Canes stated that

PROPERTY

TYPE (GROUP)				TOTAL VALUE
STOLEN				
DAMAGED				
BURNED				
RECOVERED				
SEIZED				

ADMINISTRATIVE

SUBJECT IDENTIFIED ☐ YES ☐ NO	SUBJECT LOCATED	☐ ACTIVE ☐ ADM. CLOSED ☐ UNFOUNDED	☐ ARRESTED UNDER 18 ☐ ARRESTED 18 AND OVER	☐ EX-CLEAR UNDER 18 ☐ EX-CLEAR 18 AND OVER

REASON FOR EXCEPTIONAL CLEARANCE: 1. ☐ OFFENDER DEATH. 2. ☐ NO PROSECUTION 3. ☐ EXTRACTION DENIED 4. ☐ VICTIM DECLINES OPERATION 5. ☐ JUVENILE NO CUSTODY

REPORTING OFFICER	DATE	24 HOUR CLOCK	APPROVING OFFICER	DATE	UNIT NUMBER
Sgt. Chris Knight	8/29/2009	20:11	Lt. Solomon	8/29/2009	4618

FOLLOW-UP INVESTIGATION REQUIRED ☑YES ☐ NO

EXHIBIT #2: Initial Police Incident Report (page 2 of 2)

AGENCY ID
SC04619

DANIEL MORGAN UNIVERSITY POLICE DEPARTMENT

Tega Cay, South Carolina (803) 555-1234

INCIDENT #
46-108290911

SUPPLEMENTAL INCIDENT REPORT

PRINT OR TYPE ALL INFORMATION)

INCIDENT LOCATION (SUBDIVISION, APARTMENT AND NUMBER, STREET NAME AND NUMBER)	ZIP CODE	CASE #
313 Senate Street	29708	1879320

INCIDENT DATE	24 HOUR CLOCK	TO	DATE	24 HOUR CLOCK
8/29/2009	17:27		8/29/2009	19:05

COMPLAINTANT'S NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO SUBJECT	DAYTIME PHONE	EVENING PHONE
Richards, Alex	NA	803-555-0789	803-555-0789

ADDRESS	CITY	STATE	ZIP CODE
313 Senate Street	Tega Cay	SC	29708

SUBJECT NO.2

NAME (LAST, FIRST, MIDDLE)	AKA
NA	

FACIAL HAIR, SCARS, TATOOS, GLASSES, CLOTHING, PHYSICAL PECULARITIES, ETC.

ADDRESS	CITY	STATE	ZIP CODE

SUBJECT (NO.2) USING:	ARRESTED NEAR OFFENSE SCENE	DATE / TIME OF OFFENSE	DATE / TIME OF ARREST
ALCOHOL ❒YES ❒NO ❒UNKNOWN DRUGS ❒YES ❒NO ❒UNKNOWN	❒YES ❒NO		

SUPPLEMENTAL NARRATIVE

DATE	8/29/2009	24 HOUR CLOCK	19:05

the game in which all pledges were playing required them to drink water as punishment if they answered questions wrong. RO asked if this was hazing, and Canes stated that she felt it was, but she quit the game, so maybe it was not. RO asked why Canes felt this was hazing, and Canes stated that she heard in nursing class that too much water was harmful. Seeing nothing that constituted a criminal violation, RO cleared the scene, and drove to York Regional Hospital to interview Ms. Bateson as to the circumstances of her collapse. Upon arrival at York Regional Hospital, RO met with ER doctor on call, Cory White. Dr. White stated that Ms. Bateson never regained consciousness and died subsequent to her arrival at York Regional. RO inquired about signs of trauma indicative of criminal intervention in her death. Dr. White stated that there was no evidence of any overt trauma which would have resulted in her death. As with state law, an autopsy would be performed. The body was transported by the York County Coroner's Office to the Medical Examiner's Office at MUSC. RO consulted with Lt. Solomon regarding the fatality of a student, and RO was assigned to attend the autopsy. RO then made contact with the Student Life Coordinator at the University and made contact with Aiken County Sheriff's Office (ACSO). ACSO along with a local grief counselor handled death notification to the parents.

REPORTING OFFICER	DATE	24 HOUR CLOCK	SUPERVISING OFFICER
Sgt. Chris Knight	8/29/2009	20:11	Lt. Solomon

EXHIBIT #3: Investigative Report (page 1 of 2)

AGENCY ID SC04619

DANIEL MORGAN UNIVERSITY POLICE DEPARTMENT

Tega Cay, South Carolina (803) 555-1234

INCIDENT # 46-108290911

INCIDENT REPORT

PRINT OR TYPE ALL INFORMATION

EVENT

INCIDENT TYPE	COMPLETED	FORCED ENTRY	PREMISE TYPE	UNITS ENTERED	TYPE VICTIM
Manslaughter	☑YES ☐NO	☐YES ☑NO	Res.	1	☑ Individual
Hazing	☑YES ☐NO	☐YES ☑NO	Res.	1	☐ Business
	☐YES ☐NO	☐YES ☐NO			☐ Government
					☐ Other

INCIDENT LOCATION (SUBDIVISION, APARTMENT AND NUMBER, STREET NAME AND NUMBER)	ZIP CODE	WEAPON TYPE
313 Senate Street, Tega Cay, SC	29708	UNK

INCIDENT DATE	24 HOUR CLOCK	TO	DATE	24 HOUR CLOCK
8/29/2009	17:27		8/29/2009	19:05

VICTIM'S NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO SUBJECT	DAYTIME PHONE	EVENING PHONE
Bateson, Jessica	In Care Of	UNK	UNK
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
603 Moore Tower, Daniel Morgan University	Tega Cay	SC	29708

SUBJECT NO.1

NAME (LAST, FIRST, MIDDLE)	AKA
Durden, Taylor L	None

FACIAL HAIR, SCARS, TATOOS, GLASSES, CLOTHING, PHYSICAL PECULARITIES, ETC.

None

ADDRESS	CITY	STATE	ZIP CODE
313 Senate Street	Tega Cay	SC	29708

SUBJECT (NO.1) USING:	ARRESTED NEAR OFFENSE SCENE	DATE / TIME OF OFFENSE	DATE / TIME OF ARREST
ALCOHOL ☐YES ☑NO ☐UNKNOWN DRUGS ☐YES ☐NO ☑UNKNOWN	☑YES ☐NO	8/29/2009 17:27	9/2/2009 15:30

NARRATIVE

Following the homicide ruling of the Coroner's Office in re: Jessica Bateson, Investigating officer questioned Durden and Richards. Based upon the further questioning, this officer did arrest and charge Durden and Richards with manslaughter, and hazing. Tammy Canes was out of town when contacted, but agreed to an interview upon her return to the campus. Interview was set for 9/19/2009 at 09:00 at the DMU PD.

PROPERTY

TYPE (GROUP)				TOTAL VALUE
STOLEN				
DAMAGED				
BURNED				
RECOVERED				
SEIZED				

ADMINISTRATIVE

SUBJECT IDENTIFIED	SUBJECT LOCATED			
☑YES ☐ NO	YES	☑ ACTIVE ☐ ADM. CLOSED ☐ UNFOUNDED	☐ ARRESTED UNDER 18 ☑ ARRESTED 18 AND OVER	☐ EX-CLEAR UNDER 18 ☐ EX-CLEAR 18 AND OVER

REASON FOR EXCEPTIONAL CLEARANCE: 1. ☐ OFFENDER DEATH. 2. ☐ NO PROSECUTION 3. ☐ EXTRACTION DENIED 4. ☐ VICTIM DECLINES OPERATION 5. ☐ JUVENILE NO CUSTODY

REPORTING OFFICER	DATE	24 HR CLOCK	APPROVING OFFICER	DATE	UNIT NUMBER
Sgt. Chris Knight	9/2/2009	16:50	Lt. Solomon	9/2/2009	4618

FOLLOW-UP INVESTIGATION REQUIRED ☑ YES ☐ NO

EXHIBIT #3: Investigative Report (page 2 of 2)

AGENCY ID SC04619

DANIEL MORGAN UNIVERSITY POLICE DEPARTMENT

Tega Cay, South Carolina (803) 555-1234

INCIDENT # 46-108290911

SUPPLEMENTAL INCIDENT REPORT

PRINT OR TYPE ALL INFORMATION)

INCIDENT LOCATION (SUBDIVISION, APARTMENT AND NUMBER, STREET NAME AND NUMBER)				ZIP CODE	CASE #
313 Senate Street				29708	1879320
INCIDENT DATE	**24 HOUR CLOCK**	**TO**	**INCIDENT DATE**		**24 HOUR CLOCK**
8/29/2009	17:27		8/29/2009		19:05
COMPLAINTANT'S NAME (LAST, FIRST, MIDDLE)		**RELATIONSHIP TO SUBJECT**	**DAYTIME PHONE**		**COMPLAINTANT'S NAME (LAST, FIRST, MIDDLE)**
Richards, Alex		NA	803-555-0789		Richards, Alex
ADDRESS		**CITY**	**STATE**		**ADDRESS**
313 Senate Street		Tega Cay	SC		313 Senate Street

SUBJECT NO.2

NAME (LAST, FIRST, MIDDLE)		AKA	
Alex Richards			
FACIAL HAIR, SCARS, TATOOS, GLASSES, CLOTHING, PHYSICAL PECULARITIES, ETC.			
None			
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
313 Senate Street	Tega Cay	SC	29708
SUBJECT (NO.2) USING:	**ARRESTED NEAR OFFENSE SCENE**	**DATE / TIME OF OFFENSE**	**DATE / TIME OF ARREST**
ALCOHOL ☐YES ☑NO ☐UNKNOWN DRUGS ☐YES ☑NO ☐UNKNOWN	☑YES ☐NO	8/29/2009 17:27	9/2/2009 15:30

SUPPLEMENTAL NARRATIVE

DATE	9/2/2009	24 HOUR CLOCK	16:50

Alex Richards identified as second subject.

REPORTING OFFICER	DATE	24 HOUR CLOCK	SUPERVISING OFFICER
Sgt. Chris Knight	9/2/09	16:50	Lt. Solomon

EXHIBIT #4: Emergency Room Record

York Regional Hospital

3505 York Highway
York, SC 29354
555-353-7131

EMERGENCY ROOM REPORT

PATIENT NAME: Jessica Bateson
BILLING ADDRESS: 603 Moore Tower, Daniel Morgan University, SC 29708
CONTACT NUMBER: NA

DATE: 8/29/2009
TIME OF ARRIVAL: 17:50
TIME OF TREATMENT: 17:51

INSURANCE COMPANY: Blue Cross Blue Shield of South Carolina
INSURANCE PHONE NUMBER: 803-555-9615

DATE OF BIRTH: 05/22/1990
POLICY NUMBER: SC 998405667-1

EMPLOYER: None/Student

EMPLOYER NUMBER: N/A

IF UNDER AGE OF 18, GUARDIAN NAME: N/A

CONTACT NUMBER: N/A

VITAL SIGNS: **BLOOD** PRESSURE 101/50 **PULSE** 68bpm **AGE** 19 years old **WEIGHT** 134lbs

BLOOD TYPE: B+

CURRENT MEDICATIONS: None known at admission

ALLERGIES: None known at admission

PHYSICIAN OF RECORD: Dr. Cory White

NURSE ON DUTY: Amanda Adams, RN

REASON FOR VISIT NOTED BY PATIENT: N/A – Patient arrived unconcious via York EMS

OBSERVATIONS MADE BY PHSICIAN: Patient arrived by York County EMS. Patient was in an unresponsive state with fixed pupils and labored breathing.

TREATMENT PERFORMED: Administered steroid to allow for ease of breathing, Immediately following injection, patient's heart stopped. Code alarm triggered, immediate resuscitation efforts began, Shot of Adreneline injected, AED paddles charged and executed four times, RN Adams administered rebreathing bag for approximately 20 minutes. Following 20 minutes of unsuccessful life support, Time of Death was called and resuscitation efforts ceased.

DIAGNOSIS: Acute respiratory arrest

MEDICATIONS PERSCRIBED: Anabolic Steroid, Adrenaline,

ADMITTANCE DATE / TIME: 17:50

RELEASE DATE / TIME: Time of Death Notated at 18:40. Subsequent release to the York County Coroner's Office.

FOLLOW-UP NEEDED: N/A

REFERRED TO: York County Coroner's Office

Cory White, MD 8/29/2009

PHYSICIAN'S SIGNATURE DATE

PATIENT'S SIGNATURE DATE

EXHIBIT #5: Record of Coroner (page 1 of 3)

STATE OF SOUTH CAROLINA
SOUTH CAROLINA BUREAU OF INVESTIGATIONS
DIVISION OF FORENSIC SCIENCES
RECORD OF CORONER

City	Tega Cay	**County**	York	**Case No.**	2009-470152
Name of Deceased		Jessica Bateson			
Residence of Deceased		603 Moore Tower, Daniel Morgan University, SC 29708			
Age	19 years, 3 months, 7 days			**DOB**	5/22/90
Race	Caucasian			**Height/Weight**	70" 131lbs, 5oz

MANNER OF DEATH

( ) Natural (**X**) Homicide ( ) Suicide ( ) Accident ( ) Undetermined ( ) Other

CAUSE OF DEATH

Swollen brain stem as a result of acute Hyponatremia

LAST SEEN	**Date**	8/29/2009	**Hour**	n/a	**Place**	313 Senate Street
FOUND	**Date**	8/29/2009	**Hour**	17:26	**Place**	313 Senate Street
INJURY	Set forth below.					
PRONOUNCED	**Date**	8/29/2009	**Hour**	18:40	**Place**	Dr. Cory White
NOTIFIED	**Date**	8/30/2009	**Hour**	11:25	**By**	Lt. Clarice Starling, ACSO

BODY IDENTIFIED BY

(X) Fingerprints (X) State ID Card ( ) Photographs ( ) Family

AUTOPSY

AUTHROIZED BY	Coroner Eppes	**CORONER NOTIFIED**	Yes
PRESENT AT AUTOPSY	Sgt. Chris Knight, Daniel Morgan University Police Dept., Investigating Officer		

SUSPECT(S)

MORGUE INFORMATION

NAME	York Regional Hospital	**Date Received**	8/29/2009	**Hour**	19:05
BODY REMOVED FROM	York Regional Hospital				
TRANSPORTED BY	J.P. Dawson				

PURPOSE

(**X**) Autopsy ( ) Limited Dissection ( ) External Exam ( ) History Review

PERFORMED BY	Dr. Jamie Chessler	**Date**	8/31/2009	**Hour**	10:15
SIGNED	Dr. Jamie Chessler	**Date**	8/31/09		
APPROVED	Dr. Randall Gentry	**Date**	8/31/09		

EXHIBIT #5: Record of Coroner (page 2 of 3)

In accordance with the South Carolina Death Investigation Act, an autopsy is performed on the body of Jessica L. Bateson at the Medical University of South Carolina, Charleston, South Carolina, on Monday, August 31, 2009, commencing at 10:15 hours.

EXTERNAL, EXAMINATION: Body is that of an adult female, approximately 70" in height, and weighing 131 lbs. 5oz, consistent with the documented age of 19 years. Body is received wrapped in a black zippered disaster bag, and is identified by an attached name tag and clad in the following articles of clothing:

1. White shirt and tan colored shorts with multiple pockets were worn. ESE pin worn at the upper right of shirt. Gas station receipt and one container of Soft Lips lip gloss were located in the front right pocket. No other contents found.
2. Tan colored flip flops.

Body was refrigerated, and is cool to the touch. The blood from the body pooled evenly in the lower portions of the body as it presents on the examination table. Rigor mortis is fully fixed in the extremities and jaw.

Red scalp hair ranges to an estimated 14 inches. Irises are hazel. Equal pupils are .118 inch. Whites of the eyes do not show blood vessels indicative of strangulation. Ears and nose are without discharge. Mouth is in good condition. Lips, gums, and tongue are moist. Symmetric neck is mildly pinched but otherwise without note.

Chest is normal size and is without lesion. Upper chest area still has medical leads attached from resuscitation efforts at York Regional Hospital.

Hands have moderate length, irregular nails red in color, with minimal dirt underneath. Dorsal right forearm has multiple purple contusions extending from the dorsal hand to the forearm. A 1-inch group of blue ink lines is on the left outer hand. Bilateral shins lack significant edema. An indistinct 6-inch purple contusion is around the left knee and matching on the right knee. Skin of the bilateral shins, extending to the feet is without note. Additional superficial healed scars range to 1 inch. Varicose veins of both feet are prominent at the arches and insteps. Toenails are short to moderate in length, painted red, and minimally irregular. Pooling of blood in the upper back is prominent with multiple blotchy spots. Remaining extremities and back are without lesion.

EVIDENCE OF MEDICAL INTERVENTION: A single electrocardiographic lead is on the upper left chest. Injection site is visible where IV port is still present and in place on the inside of the right forearm. Marks from AED paddles are visible on the opposing chest sides in locations consistent with emergency cardiac resuscitation efforts. Intubation tube is still present in upper trachea extending out of the mouth. Patient identification is still present on left wrist.

EVIDENCE OF INJURY: A 1-inch group of abrasions is on the dorsal right elbow, indicative of a fall of intermediate height.

INTERNAL EXAMINATION: The following excludes the described injuries. Soft tissues and typically positioned internal organs lack unusual odor or color. Soft tissues and internal organs have mild breakdown of cells/tissue by self produced enzymes.

CAVITIES: The serosal cavities have usual smooth glistening tan-pink lining. Tissues around the heart have no fibrous adhesions and contain estimated 110 ml of fluid without clot. Remaining cavities are without excess fluid accumulation.

CARDIOVASCULAR: The 360-gram heart is smooth and glistening with mildly increased fat tissue. The valves, delicate cords, and papillary muscles are without note. The chambers of the heart that receive blood from the veins are acutely dilated.

EXHIBIT #5: Record of Coroner (page 3 of 3)

LIVER / GALLBLADDER: The 2260-gram liver has a smooth glistening capsule. The pale yellow-brown tissue is soft and without discreet gross lesion. The liver is without note. The typically positioned gallbladder contains an estimated 15 ml of green sticky bile without stone; the duct is open and unobstructed.

RESPIRATORY: The examination of neck musculature lacks blood or lesion. The intact typically minimally hyoid bone is situated between the base of the tongue and the larynx supporting the tongue, larynx and their muscles are without note. The typically branching tracheobronchial tree has a smooth glistening tan-pink mucosa without lesion. A moderate quantity of pink froth is within the lower bronchial tree. The typically formed 560-gram right and 530 gram left lung have smooth glistening membranes. Each is well aerated, deep purple red to pink parenchyma which issues a small quantity of pink froth but which otherwise has no discreet gross lesion. The pulmonary blood vessels are without note.

GASTROINTESTINAL: The typically formed tongue, esophagus, junction involving the stomach and the esophagus, and lining of the digestive tract are without note. The stomach contains an overabundance of water. The gastric tubular organ contains an estimated 550 ml of yellow-green thick opaque fluid and includes partially digested pizza. The small and large bowels are enlarged from excessive water presence but are without significant gross lesion.

GENITOURINARY: The 190-gram right and 210 gram left kidney have smooth red-brown outward appearances and distinct junctions. The pelvis contains no stone and drains freely to the unobstructed organs, which empty typically to the bladder. The urinary bladder contains an estimated 750 ml of clear pale to clear urine. The urinary bladder is markedly grossly enlarged.

NEUROLOGICAL: The 1420-gram brain has a distinct grey-white matter. The symmetric hemispheres are without gross lesion. The grey-white matter separation is distinguishable. The brainstem and the cerebellum located between the brain stem and the back of the cerebrum have significant swelling. Further detail notes excessive fluid in the area. At the brain stem area, excessive swelling noted. Likely nerve damage.

MUSCULOSKELETAL:
The typically formed skeleton is without note. The intact vertebrae, ribs, pelvis and extremity long bones are without note.

OTHER PROCEDURES:

1. Documentary photographs obtained.
2. Blood, urine, bile, and other fluids submitted for toxicological analysis.
3. Blood submitted for blood analysis.
4. Head and body hair submitted.
5. Clothing submitted for chemical determination.

AUTOPSY FINDINGS: At the time of death, this was a healthy adult female, showing no natural cause of death or traumatic injury. Toxicological testing per report: no alcohol, nor narcotics – prescription.

OPINION: Based upon the medical science reports, as well as physical observation, this otherwise healthy 19-year-old female, Jessica L. Bateson, died from an overdose of water resulting in an acute case of hyponatremia. The volume of water found in the decedent's system was sufficient to alter the sodium serology balance, and would undoubtedly be lethal for someone of Bateson's height and weight. Based upon this information, a lethal overdose of water was neither accidental nor self-inflicted.

MANNER OF DEATH: Deceased died of acute hyponatremia through criminal intervention.

EXHIBIT #6: Photograph of the ESE House

EXHIBIT #7: Photograph of Red Plastic 16oz. "Solo" Brand Cup used by the Victim

EXHIBIT #8: Photograph of Water Coolers used by ESE in the Basement

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EXHIBIT #9: News report of Hyponatremia Fatality[3]

(CBS/AP) Homicide detectives are investigating the death of a woman believed to have been killed by drinking too much water in a radio station contest.

On a tape of the Jan. 12 show, disc jockeys on KDND-FM's "Morning Rave" joke about the possible dangers of consuming too much water, at one point alluding to a college student who died during such a stunt in 2005.

During the contest, a listener - self-identified as a nurse - called the live radio broadcast and warned that the game was dangerous, CBS News station KOVR-TV reported.

"I want to say that those people drinking all that water can get sick and die from water intoxication," said the caller.

"Yeah, we're aware of that," one of them said.

Another DJ laughed: "Yeah, they signed releases, so we're not responsible. We're OK."

"And if they get to the point where they have to throw up, then they're going to throw up, and they're out of the contest before they die, so that's good, right?" another one said.

The Sacramento County Sheriff's Department decided to pursue the investigation Wednesday after listening to the tape, obtained by The Sacramento Bee newspaper, sheriff's spokesman Sgt. Tim Curran said.

Jennifer Lea Strange, a 28-year-old mother of three, was one of about 18 contestants who tried to win a Nintendo Wii gaming console by determining how much water they could drink without going to the bathroom. The show's DJs called the contest "Hold your Wee for a Wii."

"Hey, Carter, is anybody dying in there?" a DJ asked during the show. "We got a guy who's just about to die," the other responded, and all the DJs laughed.

"I like that we laugh about that," another said.

"Make sure he signs the release. ... Get the insurance on that, please."

Strange participated in the contest during the morning in the studio and was found dead that afternoon. The county coroner said preliminary autopsy findings indicate she died of water intoxication.

Other contestants said Strange may have ingested as much as two gallons of water. Several hours into the contest, Strange was interviewed on the air and complained that her head hurt.

"They keep telling me that it's the water. That it will tell my head to hurt and then it will make me puke," she said.

Strange won the second-place prize, tickets to a Justin Timberlake concert. She commented on the tape that she looked pregnant, and a female DJ agreed.

"Oh, my gosh, look at that belly. That's full of water. ... Come on over, Jennifer, you OK?" the DJ asked. "You going to pass out right now? Too much water?"

The winner of the contest, Lucy Davidson, said she collapsed just 15 minutes after leaving the station with her prize. "I didn't know what was wrong with me. I just knew I had never felt so sick in my life," Davidson told KOVR.

Davidson said Strange's stomach protruded over her waist as the contest ended.

"As soon as we went to the bathroom we both came out of the stalls. I looked over at her and she probably looked as pale as I did," Davidson said.

On Tuesday, KDND's parent company, Entercom/Sacramento, fired 10 employees connected to the contest, including three morning disc jockeys. The company also took the morning show off the air.

Station spokesman Charles Sipkins said Wednesday that the company had not yet heard from the sheriff's department but that it would cooperate with the investigation.

Attorneys for the Strange family said Wednesday they plan to file a wrongful death lawsuit against the radio station.

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[3]

EXHIBIT #10: WebMD.com Medical Report on Hyponatremia[4] (page 1 of 3)

Background
Serum sodium concentration and serum osmolarity normally are maintained under precise control by homeostatic mechanisms involving stimulation of thirst, secretion of antidiuretic hormone (ADH), and renal handling of filtered sodium. Clinically significant hyponatremia is relatively uncommon and is nonspecific in its presentation; therefore, the physician must consider the diagnosis in patients presenting with vague constitutional symptoms or with altered level of consciousness. Irreparable harm can befall the patient when abnormal serum sodium levels are corrected too quickly or too slowly. The physician must have a thorough understanding of the pathophysiology of hyponatremia to initiate safe and effective corrective therapy. The patient's fluid status must be accurately assessed upon presentation, as it guides the approach to correction.

Hypovolemic hyponatremia
Total body water (TBW) decreases; total body sodium (Na+) decreases to a greater extent. The extracellular fluid (ECF) volume is decreased.

Euvolemic hyponatremia
TBW increases while total sodium remains normal. The ECF volume is increased minimally to moderately but without the presence of edema.

Hypervolemic hyponatremia
Total body sodium increases, and TBW increases to a greater extent. The ECF is increased markedly, with the presence of edema.

Redistributive hyponatremia
Water shifts from the intracellular to the extracellular compartment, with a resultant dilution of sodium. The TBW and total body sodium are unchanged. This condition occurs with hyperglycemia or administration of mannitol.

Pseudohyponatremia
The aqueous phase is diluted by excessive proteins or lipids. The TBW and total body sodium are unchanged. This condition is seen with hypertriglyceridemia and multiple myeloma.

Pathophysiology
Serum sodium concentration is regulated by stimulation of thirst, secretion of ADH, feedback mechanisms of the renin-angiotensin-aldosterone system, and variations in renal handling of filtered sodium. Increases in serum osmolarity above the normal range (280-300 mOsm/kg) stimulate hypothalamic osmoreceptors, which, in turn, cause an increase in thirst and in circulating levels of ADH. ADH increases free water reabsorption from the urine, yielding urine of low volume and relatively high osmolarity and, as a result, returning serum osmolarity to normal. ADH is also secreted in response to hypovolemia, pain, fear, nausea, and hypoxia.

Aldosterone, synthesized by the adrenal cortex, is regulated primarily by serum potassium but also is released in response to hypovolemia through the renin-angiotensin-aldosterone axis. Aldosterone causes absorption of sodium at the distal renal tubule. Sodium retention obligates free water retention, helping to correct the hypovolemic state. The healthy kidney regulates sodium balance independently of ADH or aldosterone by varying the degree of sodium absorption at the distal tubule. Hypovolemic states, such as hemorrhage or dehydration, prompt increases in sodium absorption in the proximal tubule. Increases in vascular volume suppress tubular sodium reabsorption, resulting in natriuresis and helping to restore normal vascular volume. Generally, disorders of sodium balance can be traced to a disturbance in thirst or water acquisition, ADH, aldosterone, or renal sodium transport.

Hyponatremia is physiologically significant when it indicates a state of extracellular hyposmolarity and a tendency for free water to shift from the vascular space to the intracellular space. Although cellular edema is well tolerated by most tissues, it is not well tolerated within the rigid confines of the bony calvarium. Therefore, clinical manifestations of hyponatremia are related primarily to cerebral edema. The rate of development of hyponatremia plays a critical role in its pathophysiology and subsequent treatment. When serum sodium concentration falls slowly, over a period of several days or weeks, the brain is capable of compensating by extrusion of solutes and fluid to the extracellular space. Compensatory extrusion of solutes reduces the flow of free water into the intracellular space, and symptoms are much milder for a given degree of hyponatremia.
When serum sodium concentration falls rapidly, over a period of 24-48 hours, this compensatory mechanism is overwhelmed and severe cerebral edema may ensue, resulting in brainstem herniation and death.

> **Frequency United States:** Hyponatremia is the most common electrolyte disorder, with a marked increase among hospitalized and nursing home patients. A 1985 prospective study of inpatients in a US acute care hospital found an overall incidence of approximately 1% and a prevalence of approximately 2.5%. On the surgical ward, approximately 4.4% of postoperative patients developed hyponatremia within 1 week of surgery. Hyponatremia has also been observed in approximately 30% of patients treated in the intensive care unit.
>
> **International:** Though clearly not indicative of the overall prevalence internationally, hyponatremia has been observed in as high as 42.6% of patients in a large acute care hospital in Singapore and in 30% of patients hospitalized in an acute care setting in Rotterdam.

[4] http://emedicine.medscape.com/article/907841-overview, excerpt reprinted with permission from eMedicine.com, 2009.

EXHIBIT #10: WebMD.com Medical Report on Hyponatremia[5] (page 2 of 3)

Mortality/Morbidity

Pathophysiologic differences between patients with acute and chronic hyponatremia engender important differences in their morbidity and mortality.

- Patients with acute hyponatremia (developing over 48 h or less) are subject to more severe degrees of cerebral edema for a given serum sodium level. The primary cause of morbidity and death is brainstem herniation and mechanical compression of vital midbrain structures. Rapid identification and correction of serum sodium level is necessary in patients with severe acute hyponatremia to avert brainstem herniation and death.
- Patients with chronic hyponatremia (developing over more than 48 h) experience milder degrees of cerebral edema for a given serum sodium level. Brainstem herniation has not been observed in patients with chronic hyponatremia. The principal causes of morbidity and death are status epilepticus (when chronic hyponatremia reaches levels of 110 mEq/L or less) and cerebral pontine myelinolysis (an unusual demyelination syndrome that occurs in association with chronic hyponatremia).
- The distinction between acute hyponatremia and chronic hyponatremia has critical implications in terms of morbidity and mortality and in terms of proper corrective therapy.

Sex

Overall incidence of hyponatremia is approximately equal in males and females, though postoperative hyponatremia appears to be more common in menstruant females.

Age

Hyponatremia is most common in the extremes of age; these groups are less able to experience and express thirst and less able to regulate fluid intake autonomously. Specific settings that have been known to pose particular risk include the following:

- Infants fed tap water in an effort to treat symptoms of gastroenteritis
- Infants fed dilute formula in attempt to ration
- Elderly patients with diminished sense of thirst, especially when physical infirmity limits independent access to food and drink

Clinical

History

- The number and severity of symptoms increase with the degree of hyponatremia and the rapidity with which it develops. When the serum sodium level falls gradually, over a period of several days or weeks, sodium levels as low as 110 mEq/L may be reached with minimal symptomatology. In contrast, an equivalent fall in serum sodium level over 24-48 hours may overwhelm compensatory mechanisms, leading to severe cerebral edema, coma, or brainstem herniation.
- Symptoms range from mild anorexia, headache, and muscle cramps, to significant alteration in mental status including confusion, obtundation, coma, or status epilepticus.
- Hyponatremia is often seen in association with pulmonary/mediastinal disease or CNS disorders. Hyponatremia must be considered in patients with pneumonia, active tuberculosis, pulmonary abscess, neoplasm, or asthma, as well as in patients with CNS infection, trauma, or neoplasm. Patients with carcinoma of the nasopharynx, duodenum, stomach, pancreas, ureter, prostate, or uterus also have an increased risk.
- Hyponatremia is associated with numerous medications. The patient's medication list should be examined for drugs known to cause hyponatremia.
- Hyponatremia has been noted in patients with poor dietary intake who consume large amounts of beer (called beer potomania) and after use of the recreational drug *N*- methyl-3,4-methylenedioxyamphetamine (ie, MDMA or ecstasy). MDMA-induced hyponatremia occurs via multiple mechanisms; these include the induction of syndrome of inappropriate antidiuretic hormone (SIADH), the encouragement to drink large amounts of water to prevent unpleasant side effects of the drug, and the tendency among those intoxicated to be involved in vigorous physical activity that results in heavy sweating.
- A history of hypothyroidism or adrenal insufficiency should be sought because each is associated with hyposmolar hyponatremia.
- Patients with clinically significant hyponatremia present with nonspecific symptoms attributable to cerebral edema. These symptoms, especially when coupled with a recent history of altered fluid balance, should suggest the possibility of hyponatremia.
    - Anorexia
    - Nausea and vomiting
    - Difficulty concentrating
    - Confusion
    - Lethargy
    - Agitation
    - Headache
    - Seizures

[5] http://emedicine.medscape.com/article/907841-overview, excerpt reprinted with permission from eMedicine.com, 2009.

EXHIBIT #10: WebMD.com Medical Report on Hyponatremia[6] (page 3 of 3)

Physical

Physical findings are highly variable and dependent on the degree and the chronicity of hyponatremia. Patients with acutely developing hyponatremia are typically symptomatic at a level of approximately 120 mEq/L. Those patients with chronic hyponatremia tolerate much lower levels.

- Most abnormal findings on physical examination are characteristically neurologic in origin.
    - Level of alertness ranging from alert to comatose
    - Variable degrees of cognitive impairment (eg, difficulty with short-term recall; loss of orientation to person, place, or time; frank confusion or depression)
    - Focal or generalized seizure activity
    - In those patients with acute severe hyponatremia, signs of brainstem herniation, including coma; fixed, unilateral, dilated pupil; decorticate or decerebrate posturing; sudden severe hypertension and respiratory arrest
- In addition to neurologic findings, patients may exhibit signs of hypovolemia or hypervolemia. Determining the hydration status of the patient may help establish the etiology of the hyponatremia and direct subsequent treatment.
    - Dry mucous membranes, tachycardia, diminished skin turgor, and orthostasis suggest hypovolemic hyponatremia due to excessive loss of body fluids and replacement with inappropriately dilute fluids.
    - Pulmonary rales, S3 gallop, jugular venous distention, peripheral edema, or ascites suggest hypervolemic hyponatremia due to excess retention of sodium and free water (ie, cirrhosis, nephrotic syndrome, congestive heart failure).
    - Patients who lack findings of hypovolemia or hypervolemia are considered to have euvolemic hyponatremia, which is consistent with such etiologies as exogenous free water load, hypothyroidism, cortisol deficiency, or SIADH.
- Other nonspecific signs include muscle weakness and cramping. Rhabdomyolysis is an occasional consequence of hyponatremia and should be considered in patients with muscle pain or tenderness.

Causes

- Hypovolemic hyponatremia develops as sodium and free water are lost and replaced by inappropriately hypotonic fluids, such as tap water, half-normal saline, or dextrose in water. Sodium can be lost through renal or nonrenal routes. Nonrenal routes include GI losses, excessive sweating, third spacing of fluids (eg, ascites, peritonitis, pancreatitis, burns), and cerebral salt-wasting syndrome.
    - Excess fluid losses (eg, vomiting, diarrhea, excessive sweating, GI fistulas or drainage tubes, pancreatitis, burns) that have been replaced primarily by hypotonic fluids
    - Acute or chronic renal insufficiency, in which the patient may be unable to excrete adequate amounts of free water
    - Salt-wasting nephropathy
    - Cerebral salt-wasting syndrome seen in patients with traumatic brain injury, aneurysmal subarachnoid hemorrhage, and intracranial surgery. Cerebral salt-wasting must be distinguished from SIADH because both conditions can cause hyponatremia in neurosurgical patients, and yet the pathophysiology and treatment are different.
    - Prolonged exercise in a hot environment, especially in patients who hydrate aggressively with hyposmolar fluids during exertion. Severe symptomatic hyponatremia has been reported in marathon runners and in recreational hikers in the Grand Canyon.
- Euvolemic hyponatremia implies normal sodium stores and a total body excess of free water. This occurs in patients who take in excess fluids.
    - Psychogenic polydipsia, often in psychiatric patients
    - Administration of hypotonic intravenous or irrigation fluids in the immediate postoperative period
    - In a recent meta-analysis, administration of hypotonic maintenance intravenous fluids to hospitalized children has been associated with an increased incidence of acute hyponatremia compared with administration of isotonic maintenance fluids.
    - Infants who may have been given inappropriate amounts of free water
    - Ingestion of sodium phosphate or sodium picosulfates and magnesium citrate combination as a bowel preparation before colonoscopy or colorectal surgery
    - SIADH
- Hypervolemic hyponatremia occurs when sodium stores increase inappropriately.
    - This may result from renal causes such as acute or chronic renal failure, when dysfunctional kidneys are unable to excrete the ingested sodium load. It also may occur in response to states of decreased effective intravascular volume.
    - History of hepatic cirrhosis, congestive heart failure, or nephrotic syndrome, in which patients are subject to insidious increases in total body sodium and free water stores
- Uncorrected hypothyroidism or cortisol deficiency (adrenal insufficiency, hypopituitarism)
- Consumption of large quantities of beer or use of the recreational drug MDMA (ecstasy)
- Hyponatremia can be caused by many medications. Known offenders include acetazolamide, amiloride, amphotericin, aripiprazole, atovaquone, thiazide diuretics, amiodarone, basiliximab, angiotensin II receptor blockers, angiotensin-converting enzyme inhibitors, bromocriptine, carbamazepine, carboplatin, carvedilol, celecoxib, cyclophosphamide, clofibrate, desmopressin, donepezil, duloxetine, eplerenone, gabapentin, haloperidol, heparin, hydroxyurea, indapamide, indomethacin, ketorolac, levetiracetam, loop diuretics, lorcainide, mirtazapine, mitoxantrone, nimodipine, oxcarbazepine, opiates, oxytocin, pimozide, propafenone, proton pump inhibitors, quetiapine, sirolimus, ticlopidine, tolterodine, vincristine, selective serotonin reuptake inhibitors, sulfonylureas, trazodone, tolbutamide, venlafaxine, zalcitabine, and zonisamide.

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[6] http://emedicine.medscape.com/article/907841-overview, excerpt reprinted with permission from eMedicine.com, 2009.

EXHIBIT #11: Medical Release Form

EMERGENCY MEDICAL/GENERAL RELEASE/WARNING

EPSILON SIGMA EPSILON (ESE) **CHI SI Chapter**

Name of Participant: Jessica Bateson Phone: (803) 555-2600

Address: 603 Moore Tower, Daniel Morgan University, Tega Cay, SC 29708

Date of Birth: 5/22/1990

Name of Emergency Contact: Linda Bateson Phone : (803) 555-0102

1.	I hearby certify that I am physically fit to participate in Epsilon Sigma Epsilon (ESE). JB I hereby consent to be said participant competing in events sponsored by ESE Fraternity and/or the Epsilon Sigma Epsilon Foundation. JB
2.	By signing this contract, I agree to abide by the rules and regulations of ESE and events. I understand that signing this contract releases from liability: ESE Fraternity, its chapters and the ESE Foundation. I understand that signing this contract releases from liability: ESE Fraternity's and ESE Foundation's members, employees, officers, agents, sponsors, judges, coaches and managers, in connection with any injury to or death of the above named participant. JB

WARNING: I am aware that playing or practicing to play/participate in any sport can be dangerous activity involving many risks of injury. I understand that the dangers and risks of playing or practicing to play/participate in the above mentioned event(s) include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, injury to virtually all bones, joints, ligaments, muscles, tendons and other aspects of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well being. I understand that the dangers of playing or practicing to play/participate in the above mentioned event may result not only in serious injury, but in serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and generally enjoy my life.

ACKNOWLEDGEMENT OF WARNING: I (student) Jessica Bateson, hereby acknowledge that I have been properly advised, cautioned, and warned by the proper personnel of ESE Taylor Durden, that by participating in such event, I am exposing myself to the above described risks.

Signature of Participant: Jessica Bateson **Date:** 8/19/2009

Signature of Witness: Taylor Durden **Date:** 8/19/2009

GENERAL RELEASE OF ALL CLAIMS:

General Release made August 19, 2009 by Jessica Bateson student of Daniel Morgan University residing at 603 Moore Tower city of Tega Cay, county of York.

In consideration of permission granted by me by ESE Fraternity to participate in ESE, Jessica Bateson, I hereby release and discharge ESE Fraternity, its chapters and ESE Foundation, and their members, employees, officers, agents, sponsors, coaches, judges and managers, from all claims, demands, actions, judgments, and executions which the undersigned's heirs, executors, administrators, or assigns may have or claim to have against ESE Fraternity, its chapters and ESE Foundation, their members, employees, officers, agents, sponsors, coaches, judges, and managers for all injuries or death to me, Jessica Bateson, including personal injuries or death caused by negligence, or otherwise, known or unknown, and injuries to property, real or personal, caused by, or arising out of the above event(s). I, the undersigned, have read this general release and understand all of its terms. I execute it voluntarily and with full knowledge of its significance. In witness whereof, I have executed this general release the day and year set forth above written.

MEDICAL HISTORY / IMPAIRMENTS: **Please note any prior injuries or medical history which would preclude you from participating in ESE activities.**

none

Signature of Participant: Jessica Bateson **Date:** 8/19/2009

Signature of Witness: Taylor Durden **Date:** 8/19/2009

EXHIBIT #12: ESE Pledge Rules

PLEDGE RULES FOR EPSILON SIGMA EPSILON
CHI SI Chapter
Daniel Morgan University

1. Wear pledge pin all of the time (this includes on pajamas, towel to and from the shower etc).
2. Carry pledge book at all times (this includes to and from the shower etc).
3. Address members as "Ms." and “Mr.”; a pledge may never address a member by their first name.
4. All pledges will wear tan shorts and white shirts without logos or graphics on them during pledge week.
5. Possession of cell phones by pledges during pledge week is prohibited.
6. Pledges are not allowed in any portion of the ESE House except the basement via a basement entrance until full membership status is attained.
7. Mandatory pop quizzes initiated by members at any time.
8. Must carry backpacks to and from classes for members with the same course.
9. Must transport home at any time any member who calls upon a pledge to do so from any location within the metro area.
10. Massive memorization of every song, local chapter affiliation and large portions of the ESE constitution is required.
11. Prepare a pledge class song and skit and perform it on request whenever and wherever requested.
12. Wear a pledge clothing item to all University sponsored athletics activities.

Demerits may be received for any rule infraction.
Demerits must be atoned for before full initiation

- Atonement for demerits may include any of the following at a member’s request: washing laundry, picking up meals at the Student Union, washing member’s cars, singing the ESE song during lunch in the Student Union, swimming through the reflecting pool at the library, or any other appropriately formulated task assigned by a full member.

EXHIBIT #13: Death Certificate of Jessica Bateson

STANDARD CERTIFICATE OF DEATH
STATE OF SOUTH CAROLINA
Bureau of Vital Statistics
State Board of Health

File No – For State Registrar Only
SC-55513

1. Place of Death
County of York

Township of
or
City of Tega Cay

Registration District No. 46-055-89

(No. ____ St.: _____ (Ward)

Registered No. _____
(For use of Local Registrar) (If death occurred in a Hospital or institution give its NAME instead of street and Number.)

Home Address: 603 Moore Tower, Daniel Morgan University, Tega Cay, SC 29708

Residence NA
In City 19 Yrs 3 Mos 7 Days

2. FULL NAME Jessica Bateson

PERSONAL AND STATISTICAL PARTICULARS

3. Sex	4. Color of Race	5. Single, Married, Widowed, or Divorced (write the word)
F	Caucasian	Single

a. If married, widowed, or divorced HUSBAND or WIFE of

6. DATE OF BIRTH (month, day, year) May 22, 1990

7. AGE 19 Years | 3 Months | 7 Days

OCCUPATION

8. Trade, profession or particular kind of work done as spinner, lawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year)_____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Aiken
(State or Country) South Carolina

FATHER

13. NAME William Bateson

14. BIRTHPLACE (city or town) Easley, South Carolina

MOTHER

15. NAME Linda Bateson

16. BIRTHPLACE (city or town) Douglass, Georgia

17. Information _____
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place_____ Date_____

19. UNDERTAKER _____
(Address)

20. FILED ___/___/___ _____
(Registrar Signature)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year)
August, 29, 2009

22. I HEREBY CERTIFY, That I attended deceased from 8/29/2009 to 8/29/2009. I last saw Jessica Bateson alive on 8/29/2009, death is said to have occurred on the date stated above, at 18:40. The principal cause of death and related

cause of importance in order of onset were as follows:	Date of Onset
Severe Respiratory Distress	8/29/2009
Unrecovered Cardiac Arrest	8/29/2009

Was this death due to pregnancy or to childbirth? If so, state which.

Contributory causes of importance not related to principal cause.
Respiratory arrest

Name of operation_____ Date_____

What test confirmed diagnosis?_____ Was there an autopsy?Yes

23. If death was due to external causes (violence) fill in the following:

Accident, suicide, or homicide?____ Date of Injury _____
Where did the injury occur?_____
(Specify city or town and state)
Specify whether injury occurred in industry, in home, or in public place
_____
Manner of Injury_____ Nature of Injury_____

24. Was disease or injury in any way related to occupation of deceased?
no If so, specify_____
(Signed) Cory White M.D.
Address 3505 York Highway, York, SC 29354

EXHIBIT #14: Dr. Paulsen's Report

Ryan Paulsen, M.D.

180 Glen Burnie Drive, Baltimore, MD 21282 – Phone: 301.555.1298

Pathology Report - CONFIDENTIAL – Defense Work Product

SUBJECT NAME:	Jessica Bateson	**DATE OF DEATH:**	8/29/2009
DECEDANT'S ADDRESS:	603 Moore Tower Daniel Morgan University Tega Cay, SC 29708		
LOCATION OF DEATH:	York Regional Hospital	**ATTENDING PHYSICIAN:**	Dr. White
DATE OF AUTOPSY:	8/31/2009	**AT BEHEST OF:**	State of South Carolina
AUTOPSY CONDUCTED BY:	Dr. Jamie Chessler		

RECORDS AVAILABLE FOR EXAMINATION:
Medical Waiver, Emergency Room Records, Death Certificate, Autopsy Record, E-911 Transcript, Family Medical History and Limited Records from Primary Care Physician

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Pursuant to defense counsel request, I have reviewed all of the above listed records to ascertain the cause of death for Jessica Bateson. In particular, I reviewed the report of the Coroner's Office and autopsy report due to the rare cause of death listed.

Jessica Bateson died at York Regional Hospital on August 29, 2009. Immediately prior to her death, she had been a pledge at the Epsilon Sigma Epsilon Honors Society, and was participating in events termed as "Pledge Week." At one of these events, she collapsed and was transported to York Regional Hospital by York County EMS.

The cause of death was listed as acute hyponatremia and was ruled as a homicide by the Coroner's Office. Due to an excess amount of water in the system, the brain stem became swollen to the point that it destroyed impulse transmission from the brain to the rest of the nervous system. In a teenager this would be a very rare diagnosis. In the autopsy findings, no mention is made of testing for hypothyroidism. This would be an intervening factor that could cause acute hyponatremia with a much lower volume of water than would normally be fatal for anyone outside of infants and the extremely elderly. In the documents provided by the State, a medical release for Jessica Bateson was included. The medical release indicates in her own handwriting no medical conditions or impairments that would preclude her from activities. The family history and medical records from the primary care physician both indicate a genetic history of thyroid related illnesses. This strongly suggests that a thyroid condition existed in Ms. Bateson and was missed by the autopsy. A family history of thyroid problems would be a condition necessary to disclose on any medical release.

Additionally, there was no treatment or diagnosis of acute hyponatremia either by the paramedic with the EMS unit or by the treating emergency room physician. Had either of these professionals made the correct diagnosis, Ms. Bateson could have been rapidly treated with an IV solution that would bring the body chemistry back into balance. This treatment would have prevented the coma and death. The treatment could have even averted brain damage, but definitely would have prevented the coma and death.

In my professional medical opinion, the ineptness of the paramedic and ER attending physician in addition to the lack of disclosure by Ms. Bateson led to her death. The autopsy report was incomplete and thus negligent by not conducting serology tests to determine if an underlying thyroid condition could have contributed to or been the root cause for the acute hyponatremia which resulted in the brain stem swelling and death.