

ADVISORY BOARD

William D. Haglund, PhD
Forensic Anthropology

Nizam Peerwani, MD
Forensic Pathology

Yvonne Milewski, MD
Forensic Pathology

Robert Bux, MD
Forensic Pathology

David Coffman, BS
DNA Databases and Analysis

Mary Ellen Keough
*Psycho-Social and Victim
Support*

Forensic Examination Report

Case No: TOGOAGB20080907

Name: Atsutsè Kokouvi AGBOBLI

Approximate Age: 67 years

Sex: Male

Height: 67 inches

Weight: 170-180 lbs (est)

Executive Summary: On August 15, 2008, around 10 am in the morning, a lifeless body was found on Lomé's beach by fishermen. The body was later identified by National Police Force as that of Atsutsè Kokouvi AGBOBLI (Minister AGBOBLI), who had disappeared more than twenty four hours earlier. Minister AGBOBLI was an academician, historian, journalist and political scientist. He was also a former Minister of Communication and Culture, former Minister for Relations with Parliament, and more recently the president and founder of the National Development Movement (MODENA), an opposition party.

On August 16, 2008, Professor Gado NAPO-Kura in Lomé performed an autopsy and subsequently issued a written report stating that the death was not due to drowning or by violence means but probably due to a "toxic death, by drug intoxication".

On August 29, 2008, Physicians For Human rights (PHR) in Cambridge, Massachusetts (USA) received an official request from Mr. Musa Gassama, Représentant du Haut Commissariat des Nations Unies aux droits de l'homme au Togo, OHCHR-Togo Office, Lomé, to assist in performing a second autopsy on the remains of Minister. AGBOBLI.

Senior Forensic Consultant for PHR, Nizam Peerwani, MD, who conducted independent interviews, review of medical records as well as second autopsy on the remains of Minister AGBOBLI concluded:

1. Minister Atsutsè Kokouvi AGBOBLI suffered a minor acute myocardial infarction prior to death
2. Death of Minister Atsutsè Kokouvi AGBOBLI is **not** due to acute drug intoxication or traumatic injuries
3. The most probable cause of death is drowning
4. Minister AGBOBLI was depressed and had attempted suicide at least on one occasion. This investigation cannot explain why the body was discovered naked on the beach – this remains an enigma.

BACKGROUND: On August 15, 2008, around 10 am in the morning, a lifeless body was found on Lomé's beach by fishermen. The body was later identified by National Police Force as that of Atsutsè Kokouvi AGBOBLI, who had disappeared more than twenty four hours earlier.

Atsutsè Kokouvi AGBOBLI (Minister AGBOBLI) was an academician, historian, journalist and political scientist. He was also a former Minister of Communication and Culture, former Minister for Relations with Parliament, and more recently the president and founder of the National Development Movement (MODENA), an opposition party.

An official communiqué issued by the Minister of Safety and Civil Protection in Togo stated that the Minister AGBOBLI had been admitted to the Clinic Biasa on August 13, 2008 around midday, "following an absorption (*ingestion*) of harmful substances in order to commit suicide". At the clinic, Minister AGBOBLI was appropriately treated but early next morning, at approximately 4:00 am on Thursday, August 14, 2008, he discharged himself (without medical authorization) and was driven by his driver to the Hotel Mercure Sarakawa after a small stopover in the Palm Beach hotel. Minister AGBOBLI apparently dropped off some 100 meters from the Hotel Sarakawa and was never seen again until his body was discovered on the beach the following morning. Following the discovery of the body, the Prosecutor at the Court of First Instance of First Class at Lomé, Professor Gado NAPO-Kura, Chief of Anatomy Pathology university hospital centre of Lomé was requested to conduct an autopsy on the body of Minister AGBOBLI in order to establish the exact cause of death. On August 16, 2008, Professor Gado NAPO-Kura performed an autopsy and subsequently issued a written report stating that the death was not due to drowning or by violence means but probably due to a "toxic death, by drug intoxication".

On August 29, 2008, Physicians For Human rights (PHR) received an official request from Mr. Musa Gassama, Représentant du Haut Commissariat des Nations Unies aux droits de l'homme au Togo, OHCHR-Togo Office, Lomé, to assist in performing a second autopsy on the remains of Minister. AGBOBLI,

I travelled to Lomé, Togo arriving on Sunday, September 7, 2008. To assist me in my investigation, I was provided following:

1. Hospitalization report generated by Dr. M.K. FIADJOE of Clinique Biasa
2. Medico-legal autopsy report generated by Professor Gado NAPO-Kura
3. Access to local physicians, next-of-kin, members of the military police who examined the body at the beach as well autopsy material including histology slides and radiographs
4. Shipment by DHL on September 26, 2008 including
 - a. Thirteen (13) paraffin blocks
 - b. Wet tissue in 10% formalin

- c. Three vials one each with post-mortem urine, gastric contents and blood obtained from Minister AGBOBLI at the time of first autopsy
- d. A vial with blood from Ayaoui AGBOBLI (for DNA studies – to establish paternity)
5. Investigative report by OHCHR Togo on the death of Mr Atsutse (English translation) (received on October 29, 2008 by electronic mail).

I performed a second comprehensive autopsy on Minister AGBOBLI in the morgue at the University hospital in Lomé on Monday, September 8, 2008 starting at 1530 hours, documenting findings both with notes as well as photographs. This report and my conclusions are based on what I observed, what I gathered from my independent interviews as well as reports I have received and examined.

DISCUSSION: Sudden, unexpected and unexplained death of Minister AGBOBLI and the manner in which his body was discovered have justifiably raised issues and suspicions concerning his death. There are four distinct possibilities that may account for his death including:

1. Drowning
2. Acute drug intoxication
3. Traumatic injuries or other unnatural causes including electrocution
4. Natural causes

1. Drowning: Drowning deaths are determined by process of elimination or exclusion of other causes. Non-specific physical findings and circumstances or manner surrounding the discovery of the body rather than specific tests performed at autopsy are the usual determinants. Bloody, foamy fluid may be present or absent in the respiratory tract. Bloating from decomposition gases varies with time and temperature. Skin wrinkling, stomach contents and degree of rigor can all be used in the analysis. Bodies may impact solid objects after death, causing post-mortem wounds. In the past, changes in blood electrolytes were performed – these are not generally considered as unreliable indicators. Chloride level differences in the heart, often cited as evidence, are not always present or specific to drowning. Also “floatation” test, i.e. trying to float lungs recovered from the body in a bucket of water, is likewise regarded as unreliable as is “diatom” test” or presence of blood in the middle ear etc.. Fluid inhalation or suffocation by water usually results in heavy fluid-filled lungs (pulmonary edema). Alternatively, the lungs may appear relatively “normal,” and it is hypothesized that temporary muscle spasm or obstruction of the larynx by mucous or vomit during submersion can cause “dry drowning.” Finally, determination of whether a water-related death is intentional or accidental can be difficult and this provides fodder for the imagination of creative minds.

There are no reliable laboratory tests that can be performed to prove or disprove “drowning”. Ultimately, it is a diagnosis by exclusion, although,

presence of wrinkling of palms and soles as well as purging of frothy fluid from mouth and or nostrils are generally accepted as reliable “**indicators**” (although **not** diagnostic) of drowning. Finally, it is important to note that bodies of a drowning victim do wash ashore without necessarily being decomposed, although it is rather unusual for a fully-clad person to wash ashore “naked”. In conclusion, although there are reliable indicators present on the body of Minister AGBOBLI that suggest drowning as the mechanism of death, the fact that he was naked remains an enigma.

2. Acute drug intoxication: The local medical examiner, Professor Gado NAPO-Kura, concluded that the death of Minister AGBOBLI was due to “toxic death, by drug intoxication”. Comprehensive post-mortem toxicology can definitely assist us in putting this matter to rest. There were no drugs present in the blood of Minister AGBOBLI at the time of his and his death is **not due to drug overdose**,

3. Traumatic injuries or other unnatural causes including electrocution: Speculations regarding the Minister’s death were due not only because of the manner in which his body was recovered, but also because of the concerns voiced by Minister AGBOBLI about his personal safety prior to his death.

A thorough second post-mortem examination reveals **absence** of blunt force or sharp force trauma. In particular there is no empirical evidence to suggest or support that Minister AGBOBLI was strangled, smothered, electrocuted, struck on the head, chest or abdomen or bound. Low voltage electrocution may be identified by presence of crater-like cutaneous electric burns at the point of entry as well as exit of electric current, although, in a moist body, these may not be evidenced. In the absence of electric burns on the body, absence of scene evidence or eyewitness account, death due to electrocution will remain a mere speculation. In summary, there is no empirical evidence to suggest that Minister AGBOBLI died of traumatic injuries or was electrocuted.

The only cutaneous injuries present include:

- a. Focal abrasion without scab of left forehead above brow ridge
- b. Abrasion without scab along right forehead above brow ridge
- c. Abrasion without scab along right upper mid-forehead

These injuries are not of the type that suggest assault and importantly their distribution on protruding facial surfaces are consistent with injuries commonly observed in submerged victims where the forehead rubs on lake or sea bed.

4. Natural causes: Minister AGBOBLI was a diabetic and hypertensive and post-mortem examined revealed significant ischemic heart disease with multi-focal moderate-to-severe occlusive coronary atherosclerosis characterized by segmental 50-60% right coronary artery stenosis mainly along the distal third, focal 50% stenosis of left circumflex branch along the proximal

segment and finally, critical narrowing of proximal left anterior descending branch, up to 70-80% accompanied by focal hemorrhage into the plaque. The myocardium revealed focal acute myonecrosis with early neutrophilic infiltrate and presence of contraction bands (acute myocardial infarction). Myonecrosis and streaming of neutrophils all suggest that the myocardial ischemic episode occurred several hours before his death, probably as much 15-18 hours.

The Issue of Suicide: There are many studies that describe suicide by drowning. For instance the Australian Institute of Health and Welfare report said older men had the highest rates of suicide by drowning, particularly those aged 70 and over. During

the period 1999-2000 and 2003-2004, there was an average of 56 drowning deaths due to “intentional self harm”. Suicide is defined as a death resulting from the use of force against oneself when a preponderance of the evidence indicates that the use of force was intentional (Center for Disease Control, Atlanta GA).

Ruling of suicide necessitates demonstration of both self injury and “intention” to die. Intention may be expressed explicitly or implicitly. Frequently, a decedent may leave behind a suicide note or a suicide voice or electronic message. But such explicit expression of intent is present in 20-30% of cases – in vast majority of cases ruled suicide, intention is inferred by demonstrating implicit intent including presence of psychiatric disorders such as severe depression, past attempted or threatened suicide, and certain actions including preparing for a funeral or writing down a will etc. Minister AGBOBLI’s actions prior to death including attempted suicide by ingestion of drugs are a clear indication that he was despondent. It is therefore not inconceivable that Minister AGBOBLI committed suicide by drowning except for the enigmatic issue of why his remains were found naked on the beach.

CONCLUSION: It is my opinion, based upon reasonable medical probability that:

1. Minister Atsutsè Kokouvi AGBOBLI sustained acute myocardial infarction prior to death. This was detected in just one histologic slide and was a localized lesion. Significant occlusive coronary atherosclerosis was present and this myocardial ischemic injury was most likely stress related. It is unlikely that this would have resulted in his death.
2. Death of Minister Atsutsè Kokouvi AGBOBLI was **not** from acute drug intoxication or traumatic injuries including strangulation, smothering, blunt or sharp force trauma or electrocution
3. Finally, there are sufficient signs that indicate Minister Atsutsè Kokouvi AGBOBLI drowned to death. This is supported by presence of wrinkling of palms and soles, boggy edematous lungs both grossly and microscopically as well as scene evidence of purging of frothy

(“mousse”) fluid from the nostrils and or oral cavity. It is once again important to stress that diagnosis of drowning in the absence of reliable eyewitness account can only be made by exclusion.

4. Preponderance of evidence suggests that Minister AGBOBLI was depressed and had attempted suicide at least on one occasion. This investigation, however, cannot explain why the body was discovered naked on the beach – this remains an enigma.

Nizam Peerwani, MD
Senior Consultant
Physicians For Human Rights
Chief Medical Examiner, Tarrant County, Texas

November 4, 2008

Addendum I

Investigative Details

Activities on Monday, September 8, 2008

1. Five (5) interviews
2. Visited Clinique Biasa – walked through out-patient clinic, patient interview room, pre-admission exam room and hospital room where the decedent admitted on August 13, 2008
 - a. Location: 30, Rue Pasteur, BAETA, B.P. 2160, Lomé.
 - b. Adjoining hospital wing
3. Drove from Clinique Biasa to the Palm Beach Hotel – it is approximately 3 km and took about 5 minute to drive
4. Reviewed thirteen (13) histologic slides at Professor Gado NAPO-KOURA 's office at the University hospital
5. Examined three (3) radiographs at Professor Gado NAPO-KOURA's office at the University hospital
6. Performed second autopsy at the Central Morgue at Hopital Tokoin (University Hospital)

Interviews:

1. Professor Gado NAPO-KOURA on 9/8/200 at 0900 at OHCHR-Togo Office, Lomé and again at the University hospital at 1530 hours
2. Docteur Kwasivi Moise FIADJOE on 9/8/08 at 1000 at OHCHR-Togo Office, Lomé and again at Clinique Biasa at 12:30 PM
3. Carmen AHOOMEY-ZUNU, Assistant Director at Clinique Biasa at 1245 hours
4. Mme Solange SENOU, Chief of Staff-midwife at Clinique Biasa at 1315 hours
5. Ms. Leonie AGBOBLI at Palm Beach Hotel at 1400 PM (sister of decedent) accompanied by Ayaqui AGBOBLI (son of decedent)

DETAILS OF INTERVIEWS:

- I. **Professor Gado NAPO-KOURA** : According to Dr. Napo-Koura, he received a call from Monsieur le Procureur de la Republique pres le Tribune de Premiere Instance to perform at autopsy on a body recovered on the beach at "Foyer des Marins" . He summarized his activities as follows:
 1. He initiated radiographic studies: 3 X-Rays were taken and these failed to reveals trauma or fractures
 2. He did not take postmortem photos
 3. His autopsy was restricted to torso (chest and abdomen)
 4. He prepared Histologic slides but did not report the findings
 5. He also collected and preserved postmortem biologic samples including cardiac blood, urine and gastric contents for toxicology but was unable to analyze them

6. **Professor Gado NAPO-KOURA** conclusions:
- a. No evidence of trauma except for two small areas of “ ecchymosis” of forehead above the eyebrow
 - b. No evidence to support drowning: No fluid in lungs; “lung floatation” test negative
 - c. Absence of natural disease: Just one kidney (right)
 - d. Death most probably due to drug overdose

II. **Docteur Kwasivi Moise FIADJOE**: According to Dr. FOADJOE, Minister AGBOBLI was not his regular patient – but just a “friend” (acquaintance)

1. Minister AGBOBLI arrived at the Clinique Biasa between 1200 and 1300 hours on August 13, 2008 through the clinic street entrance
2. Minister AGBOBLI claimed he was despondent and had taken too many medications and he was seeking medical assistance. The decedent also gave history of adult onset diabetes mellitus (Type-2) and hypertension.
3. On admission, Dr. Fiadjoe found him alert, cognizant and oriented to time and place. At 1310 hours, his blood pressure was 190/110 mmHg and pulse of 110 b/minute which later stabilized to approximately 130/80 mmHg and a pulse of 70-75 b/minute.
4. In the pre-admission room, the patient was lavaged twice. Before the first lavage, the decedent vomited. The first lavage was at 1310 hours and accomplished with approximately 15 L. The gastric return did not indicate presence of medication, although white creamy material was observed towards the end of the process. At the same time, the patient was given mannitol (10%) intravenously as well as 2 ampoules of Lasix to induce diuresis. The second lavage was carried out at approximately 1600 hours and accomplished with 12-15L.
5. Minister AGBOBLI requested to be released, but he was advised to stay overnight for observation. At 1700 hours, he was transported to the clinic hospital where he was admitted to a room on the second floor.
6. At 1900 hours, he was seen by a clinic neurologist who found no neurologic deficit. He recommended that activated charcoal treatment be instituted which was carried out at 1930 hours.
7. Between 1930 hours on August 13, 2008 and 0330 hours on August 14, 2008, his vitals were taken 6 more time. At 0430 hours, he was noted to be absent.
8. Mr. Agbobli’s departure from the floor was not observed by the floor nurse. The two security guards, however, noted him departing from the front gate some time after 0330 hours. He was apparently picked up by his driver at the front gate.

III. **Carmen AHOOMEY-ZUNU**, Assistant Director at Clinique Biasa: Ms. Carmen AHOOMEY-ZUNU was called by the receptionist to intervene Minister AGBOBLI who had arrived unannounced to see Dr. FIADJOE. Minister AGBOBLI expressed to her the necessity and urgency of meeting

Dr. FIADJOE because he seeking medical attention for drug overdose. He was taken to the clinic out-patient exam room where he was subsequently examined by Dr. FIADJOE.

IV. **Mme Solange SENOU**, Chief of Staff-midwife at Clinique Biasa: Mme Solange SENOU, Chief of Staff-midwife saw Minister AGBOBLI in the pre-admission exam room, where the Minister stayed until he was transferred to the clinic hospital bed. During his stay, he was monitored by her. She assisted with inserting intravenous (IV) line, initially for mannitol and later for lactated ringer solution, administering Lasix, drawing blood for chemistry and hematology, and helping insert NG tube as well as performing two lavages.

V. **Ms. Leonie AGBOBLI** (sister of decedent) at Palm Beach Hotel at 1400 hours accompanied by **Ayaoui AGBOBLI** (son of decedent): Ms. Leonie AGBOBLI stated that she received a call from her older brother, M. Maurille AGBOBLI around 1200 to 1230 hours on August 15, 2008. M. Maurille AGBOBLI was the former Minister in Togo and currently a member of the ruling party.

1. She was asked to go the beach where the body of her brother Atsutsè Kokouvi AGBOBLI had been discovered. The purpose was to identify the remains.
2. She observed and identified the remains of her brother Atsutsè Kokouvi AGBOBLI, who was essentially nude, clad just in socks and shoes, and face down with upper extremities flexed and with purging of fluid from left side of mouth and blood along right forehead. Ms. Leonie AGBOBLI demonstrated on the floor, the position of her brother when she first observed him on the beach.
3. The body was turned face up. It did not show significant rigidity and appeared intact without notable postmortem changes such as discoloration or significant bloating. The whites of the eyes appeared hyperemic.
4. There were many persons from the Ministry of National Defense including Komivi AFATASAWQ, MD, Medecin Commandant.

Activities on Tuesday, September 9, 2008

I. Interview at OHCHR-Togo Office, Lomé between 0900 – 1000 hours including:

1. Ambassador Lizeth Satumbo PENA, wife of decedent
2. Ayaoui AGBOBLI, son of decedent
3. Muriel AGBOBLI, DDS, daughter of decedent
4. Ayao AGBOBLI, son of decedent

The purpose of the meeting was to explain the procedure, discuss some of the findings and defer all conclusions until all the reviews and tests are completed. Family members had many questions and appeared

satisfied with the strategy explained. Present at the meeting: Mr. Musa GASSAMA, Representant HCDH-TOGO

II, **Interview of Mr. Koffi KOUNTE** at OHCHR-Togo Office, Lomé at 1030 hours: Mr. Koffi KOUNTE, Magistrate et President, Commission Nationale des Droits de l'Homme. Discussed the progress of the case and preliminary autopsy findings.

III, **Interview of Komivi AFATASAWQ, MD** at OHCHR-Togo Office, Lomé 1300 hours : Komivi AFATASAWQ, MD, Medecin Commandant at UNHCHR Office. Dr. AFATASAWQ received a death call 1100 hours on August 15, 2008 and he arrived at the beach near Hotel Sarakawa in Lomé He observed the body supine with left side of face on the sand and with arms tucked under the body. He observed injury to the forehead along the left side with blood and purging of frothy (“mousse”) from the nostrils. There was nothing in the mouth. The body was naked except for pair of socks and shoes. When he turned the body over, he observed two hemorrhagic spots on the sol where the face had laid. There were no clothes or personal belongings in the vicinity of the body. The body was approximately 5-6 meters from the waterline and parallel to the waterline. It was his impression that the tide was rising. He estimated that Minister AGBOBLI was dead probably 8-9 hours based upon the rigidity pattern. According to the doctor, rigidity is complete in 13 hours – Minister AGBOBLI demonstrated incomplete rigidity with the rigor confined to small muscle groups including the digits as well as the jaw. He felt the teeth and they appeared intact. He compressed the abdomen and could not extrude water. He observed the body being wrapped in a white sheet and placed in a body bag for transport. Both the shoes and the socks were left on the body. He did not know if Minister AGBOBLI was “rejected” by the sea and he is not certain whether he died on the beach or his body was dumped. Also, at the scene, he observed some 10-15 persons including police officers, Mr. Maurille AGBOBLI, the brother of the decedent as well as a female person that he was not able to identify.

IV. **Interview of Adj. Tunindjotobe KIDIKOUNE** at OHCHR-Togo Office, Lomé at 1500 hours: Adj. Tunindjotobe KIDIKOUNE, Commandant de Brigade Terri-towale de Lome. Present also were Awi ADJOLI from the office of Procureur and N'Sagna MOHKPEBOR from the Brigade Territoriale de Lomé. Officer KIDIKOUNE shared scene photographs and provided a set of copies.

V. **Interview of Dr. Ayikoe AYITE**, a general surgeon and cousin of the decedent, at OHCHR-Togo Office, Lomé at 1600 hours. Dr. Ayikoe AYITE provided the general medical background of the Minister AGBOBLI.

Medical background :

Minister. AGBOBLI apparently visited different physicians for medical support, including physicians in France. Locally, here in Togo, he frequently visited his

cousin, Dr. Ayikoe AYITE, who is a general surgeon and who frequently renewed Minister AGBOBLI medical prescription. According to Dr. AYITE Minister AGBOBLI past medical history included:

1. Adult onset diabetes mellitus for which he was treated with oral hypoglycemics
2. Hypertension treated with anti-hypertensive (ACE-inhibitor)
3. Gout
4. High cholesterol

Minister AGBOBLI did not smoke and did not abuse alcohol. Minister AGBOBLI was a private person and did not share history of depression or of past threatened or attempted suicide. He was not aware if he had been seeing a psychiatrist in Lomé or in France. Dr. Ayikoe AYITE had not renewed prescription for any anti-depressant medications. Finally, Dr. Ayikoe AYITE was out of the country having departed on August 5, 2008 and was unaware of the current problems experienced by Minister AGBOBLI.

VII. Drove to the beach in Lomé where the body was discovered. Took scene photos.

Addendum II

Autopsy Report

Name: Atsutsè Kokouvi AGBOBLI
Approximate Age: 67 years
Height: 67 inches
(estimated)

CASE NO: TOGOAGB20080907
Sex: Male
Weight: 170-180 lbs

I hereby certify that on the **eighth** day of **September 2008**, beginning at **1530** hours, I, Nizam Peerwani, M.D., pursuant to request made by and authorization obtained by United Nations High Commission for Human Rights in Lomé, Togo, performed a comprehensive **second** autopsy on the embalmed and refrigerated body of **Atsutsè Kokouvi AGBOBLI** at the Hospital Morgue, in Lomé, Togo, and upon investigation of the essential facts concerning the circumstances of the death and history of the case as known to me, I am of the opinion that the findings, cause and manner of death are as follows:

Summary of Findings:

- I. Body discovered nude on the beach in Lomé, Togo with:
 - A. Acute pulmonary vascular congestion, bilateral, severe, with edema
 - B. Purging of frothy blood tinged fluid (scene photos)
 - C. Generalized visceral congestion
 - D. Wrinkling of palms and soles consistent with body immersed in water
- II. Atherosclerotic cardiovascular disease with:
 - A. Left ventricular hypertrophy with hypertensive changes of myocardium
 - B. Multi-focal moderate-to-severe occlusive coronary atherosclerosis with:
 1. Segmental 50-60% right coronary artery stenosis mainly along the distal third
 2. Focal 50% stenosis of left circumflex branch along the proximal segment
 3. Critical narrowing of proximal left anterior descending branch, up to 70-80% accompanied by focal hemorrhage into the plaque
 - C. Focal acute myonecrosis with early neutrophilic infiltrate and presence of contraction bands
 - D. Arteriolonephrosclerosis, bilateral, mild
 - E. Generalized atherosclerosis, moderate-to-severe

- III. Clinical history of adult onset diabetes mellitus and hypertension (on therapeutic drugs)
- IV. Investigative history of recent suicide attempt by drug ingestion
- V. Superficial perimortem cutaneous injuries including:
 - A. Focal abrasion without scab of left forehead above brow ridge
 - B. Abrasion without scab along right forehead above brow ridge
 - C. Abrasion without scab along right upper mid-forehead
- VI. DNA verification of postmortem putative blood sample from decedent:
 - A. Male DNA profile
 - B. Fifteen Short Tandem Repeat (STR) match those of known sample from son, AGBOBLI, Ayaoui
- VII. Postmortem toxicology:
- VIII. Blood Ethanol: Negative
- IX. Urine Ethanol: Negative
- X. Urine Drugs of Abuse: Negative
- XI. Urine base screen: Negative
- XII. Gastric acid and base screen: Negative
- XIII. No evidence of trauma or foul play including:
 - A. Blunt or sharp force trauma of head or torso
 - B. Absence of craniocerebral trauma
 - C. Absence of trauma to the viscera
 - D. No evidence to indication smothering or strangulation
 - E. Absence of evidence to suggest binding or ligature impression of wrists or ankles
 - F. Absence of electric burns
- XIV. No evidence of defensive wounds
- XV. Remains previous autopsied and embalmed

Gross Anatomic Findings

- I. **CLOTHING AND PERSONAL EFFECTS:** The body is presented to the Morgue nude secured in a body bag. There are no personal effects present.
- II. **IDENTIFICATION OF THE BODY:** Achieved by two means:
 - 1. A wrist band bearing the name *Atsutsè* AGBOBLI
 - 2. Visually identified by Dr. Ayikoe AYITE, a general surgeon and cousin of the decedent.
- III. **THERAPEUTIC INTERVENTION:** None observed.

IV. EVIDENCE OF PREVIOUS POSTMORTEM PROCEDURES:

1. A sutured “Y”-shaped thoraco-abdominal incision is present. The prior autopsy examination was confined to the chest and abdominal regions only. The neck had not been dissected. Likewise, the cranium and its contents were not previously examined.
2. Sutured embalmer’s incision along peri-clavicular and groin regions are present.

V. EXTERNAL BODY DESCRIPTION: The body is that of a normally developed elderly African male appearing the stated age of 67 years with a body length of 67 inches (170 centimeters) and estimated body weight of 160-170 pounds (approximately 72 to 77 kilograms). Body presents medium build with average nutrition, normal hydration and good preservation. There is faded rigor with developed anterior fixed and displaced posterior fixed lividity of normal color. The assessment of lividity is primarily ascertained by internal examination of soft tissues. Body is embalmed and cold to touch post refrigeration. Head is covered by short, curly black hair with receding anterior hairline and with patchy male-pattern balding. Face is cyanotic and shaven. There is average body hair of male pattern distribution. Eyes are closed with cloudy bulbar and palpebral conjunctivae and without tache noire. Bulbar conjunctival edema is present. Irides are brown with white sclerae. Cataracts are not identified. Arcus senilis are absent. Pupils are equal at 5 mm. There are no bulbar or palpebral sub-conjunctival petechial hemorrhages or ecchymosis. Orbits appear normal without peri-orbital ecchymosis. Nasal cavities are unremarkable with intact septum. Oral cavity presents natural teeth with good oral hygiene characterized by absence of caries. Partial upper denture is noted in place. There are no intra-oral hemorrhages noted with intact mucosa of both upper and lower lips as well as intact both upper and lower frenulum. Ears are unremarkable with no hemorrhage in the external auditory canal. Neck is supple and there are no palpable masses. Chest is symmetrical without barrel configuration. There is absence of palpable soft tissue emphysema. Abdomen is scaphoid and palpation non-revealing. Upper and lower extremities are equal and symmetrical presenting cyanotic nail beds without clubbing. Edema is absent. There are no fractures, deformities or amputations present. There are no defensive wounds. External genitalia present descended testicles with circumcised penis. The back reveals dependent lividity with poorly discernible contact pallor. There are no external cutaneous injuries of the back.

Multiple linear incisions of wrist and ankles are made – these show absence of subcutaneous or soft tissue hemorrhage. Also, long incisions of back and flank are made and these fail to demonstrate subcutaneous or soft tissue injury

EXTERNAL CUTANEOUS INJURIES:

- a. Focal abrasion without scab measuring 6 x 2 cms along left forehead above brow ridge
- b. Abrasion without scab along right forehead above brow ridge measuring 3 x 2 cms
- c. Abrasion without scab along right upper mid-forehead measuring 1 cm in diameter

SCARS: None

TATTOOS: None

VI. INTERNAL EXAMINATION

1. INTEGUMENTS: A Y-shaped thoraco-abdominal sutured incision is released and the chest and abdominal cavities are examined. The subcutaneous fat is normally distributed, moist and dirty yellow. The musculature of the chest and abdominal area appear beefy brown and firm post embalming.

2. SEROUS CAVITIES: The chest wall is intact without rib, sternal or clavicular fractures. The pleura and peritoneum are congested, smooth glistening and essentially dry, with evidence of posterior adhesions. There is no scoliosis, kyphosis or lordosis present. The left and right diaphragms are previously dissected. Pericardial sac is absent. Pubic symphysis is intact. The visceral cavities are filled comingled with previously dissected internal organs.

3. NECK STRUCTURES: The chest incision is extended to expose the previously unexamined neck structures. Postmortem hemorrhage is encountered along the left and right anterior neck regions in the vicinity of embalmer's incisions. The hyoid bone, the thyroid cartilage and cricoid cartilage are intact. Larynx is comprised of unremarkable vocal cords and folds, appearing widely patent without foreign material, and is lined by smooth, glistening membrane. Epiglottis is a characteristic plate-like structure without edema, trauma or pathological lesions. Both the musculature and the vasculature of the anterior neck are unremarkable. Patchy areas of atherosclerosis of the common carotid arteries are present with approximately 20-30% stenosis. Trachea and spine are in the midline presenting no traumatic injuries or pathological lesions.

3. VISCERAL ORGANS: Previously dissected visceral organs are comingled and located within the chest and abdominal cavities. These are segregated, lavaged and examined. They appear reasonably well preserved but with variable degree of postmortem autolysis. They include:

A. Heart: The weight of the heart cannot be ascertained. Left ventricular wall is 1.9 cms and the right 0.5 cms. Cardiac valves are unremarkable with the aortic, mitral, pulmonary and tricuspid valves present normal circumference

of. The coronary ostia are in the normal anatomical location. The epicardial branches of the coronary arteries appear pristine not having been previously dissected. These were serially sectioned at 1-2 mm distance. Following lesions are observed:

- d. Right coronary artery: segmental 50-60% stenosis due to atherosclerosis mainly along the distal third
- e. Left circumflex branch: Focal 50% stenosis due to atherosclerosis along the proximal segment
- f. Left anterior descending branch : Critical narrowing up to 70-80% stenosis due to atherosclerosis accompanied by focal hemorrhage into the plaque

Right dominant circulation is present. The endocardial surface is smooth without thrombi or inflammation. The myocardium presents no gross evidence of myocardial scars. Also examined are great vessels including the arch of the aorta, thoracic aorta and previously unexamined abdominal segment of the aorta. They all reveal moderate generalized atherosclerosis with ulcerated and calcified plaques. There are no aneurismal changes noted.

B. Lungs: The weight of the lungs cannot be ascertained. Both the lungs appear severely congested, boggy and edematous and on sectioning frothy edema fluid are easily expressed. There are no gross pneumonic lesions or abnormal masses identified. Mild centrilobular emphysema is present. The tracheobronchial tree has been previously dissected and pulmonary arterial system is unremarkable without thrombo-emboli. Pleural surface is black with patchy anthracosis.

C. Liver: The weight of the liver cannot be established. The surface appears brown and smooth without nodules. The cut surface of the liver presents a brown, homogeneous and congested appearance. Gallbladder is previously dissected and there is no cholesterolosis. Pancreas is absent.

D. Kidney and bladder: One previously dissected kidney is present. Its weight cannot be ascertained. The capsule strips with slight difficulty and the cortical surfaces are granular, brown, glistening and congested. On sectioning the cortex presents a reduced thickness of 0.3 cms above the medulla. The renal columns of Bertin extend between the well demarcated pyramids and appear unremarkable. The medulla presents normal renal pyramids with unremarkable papillae. The pelvis is of normal size and lined by gray glistening mucosa. There are no calculi. Renal artery and vein are normal. The urinary bladder is devoid of urine having been previously dissected and reveals no gross pathologic lesions. The prostate appears grossly unremarkable.

E. Gastro-intestinal System: The esophagus is not present. Stomach is previously incised, devoid of contents, presenting autolyzed gastric mucosa. There

are no foci of gastritis or ulcers. Loops of small and large bowel appear grossly unremarkable except for diverticulosis of sigmoid colon. Feces is present in the distal large bowel.

F. Hematopoietic System: Spleen is absent. There is hilar lymphadenopathy with reactive soft reactive anthracotic nodes measuring up to 1-cm in diameter. Bone marrow is red and firm. Thymus gland is involuted.

G. Endocrine System: Thyroid gland is of normal size and shape presenting two well-defined lobes with connecting isthmus and a beefy brown cut-surface. There are no goitrous changes or adenomas present. Adrenal glands are absent Pituitary gland is encased within and intact sella turcica and presents no gross pathological lesions.

H. Central Nervous System: A scalp incision, craniotomy and evacuation of the brain is carried out in the usual fashion. There are patchy areas of subgaleal hemorrhage of left frontal area measuring 4 x 3 cms, right frontal area measuring 6 x 4 cms and left parietal region measuring 5 x 4 cms. The cranium is intact without bony abnormalities or fractures. There are no diastatic fractures,

Weight of brain cannot be established because of lack of organ scale. The brain presents severe congestion of the leptomeninges. Overlying dura is intact and unremarkable. Cerebral hemispheres reveal a normal gyral pattern with moderate global edema. Brainstem and cerebelli show similar changes with bilateral mild-to-moderate uncal and cerebellar tonsillar notching. Circle of Willis is patent presenting no evidence of thrombosis or berry aneurysm. On coronal sectioning of the brain the ventricular system is massively dilated, the left side greater than right and contains clear cerebrospinal fluid. There are no space occupying lesions present. There are no spinal cord injuries noted.

VII. HISTOLOGIC EXAMINATION: I examined in Lome thirteen (13) histologic slides I received from Dr. NAPO-KOURA, all stained H&E (hematoxylin and eosin) and each slide appropriately labeled and designated with a corresponding slide index. The slides bore the case number 0891 and were marked "A" through "K". I also received thirteen (13) corresponding wax blocks. These were re-embedded, cut and re-stained (H&E). In addition, I took three samples of coronary blood vessels previously omitted from examination. These too were embedded in wax, cut and stained with H&E.

1. Slide "A": Slide "A" is a section of the liver depicting severe passive congestion with dilated sinusoids and central vein along with cholestasis both intracytoplasmic and canalicular. The portal triads appeared unremarkable with intact limiting plates. The overall hepatic architecture was preserved with absence of hepatocellular necrosis or fibrosis.
2. Slide "B": Slide "B" is a section of the spleen with passive congestion. Both red and white matter is preserved without germinal centers.

3. Slide "C": Slide "C" is of the myocardium and reveals focal area of myonecrosis with early neutrophilic infiltrates as well as focal streaming of neutrophils. Also noted are "contraction bands" as well as myocardial fiber hypertrophy with presence of lipofuscin in the peri-nuclear zones.
4. Slide "D": Slide "D" is a section of the kidney revealing mild arteriolonephrosclerosis with scattered sclerosed glomeruli and arteriolosclerosis. The tubular structures appeared intact except for autolysis. There was no casts within the tubules. The interstitium appeared unremarkable.
5. Slide "E": Slide "E" is a section of the lung with prominent congestion, atelectasis as well variable amount of anthracosis. Section was too thick to evaluate bronchiolar morphology. There was no evidence of thromboemboli. Re-cuts with thin slices show once again prominent congestion, edema as well as atelectasis. Inflammation or fibrosis is not apparent. Patchy anthracosis is noted.
6. Slide "F": Slide "F" is a section of the stomach. Postmortem autolysis was noted without pathologic lesions
7. Slide "G": Slide "G" is a section of gallbladder. Postmortem autolysis was noted without pathologic lesions
8. Slide "H": Slide "H" is also a section of lung and showed similar changes as noted above.
9. Slide "I": Slide "I" is a section of left adrenal gland. Postmortem autolysis was noted without pathologic lesions
10. Slide "J": Slide "J" is a section of the urinary bladder. Postmortem autolysis was noted without pathologic lesions
11. Slide "K": Slide "K" is a section of the pancreas. Postmortem autolysis was noted without pathologic lesion.
12. Slide "L": Section too poor for accurate identification
13. Slide "M": Slide "M" is a section of right adrenal gland. Postmortem autolysis was noted without pathologic lesions

There were three additional slides prepared of tissues collected during the second autopsy. These are sections of epicardial branches of coronary blood vessels and reveal moderate to severe occlusive coronary atherosclerosis.

VIII. RADIOGRAPHY: There X-rays were made available. Each was identified appropriately with the name of the decedent.

1. Head: Antero-posterior and lateral views (two X-rays) revealed absence of facial or calvarial fractures. The sinuses were intact with normal air pattern. There was no evidence to suggest intracranial mass or foreign objects. Face revealed partial upper denture with dental work.

2. Chest: One X-ray of chest revealed normal heart shadow with variable amount of air in the lungs and atelectasis. There were no fractures of the ribs, clavicles or sternum noted. The diaphragm appeared in the normal position with normal gas pattern of the stomach.

IX. EVIDENCE COLLECTED

1. Tissues in formalin
2. Multiple autopsy photos

Exam Date: September 8, 2008

Dictated/Typed: September 9, 2008

Completed: November 3, 2008

NSP:np

Addendum III

Toxicology Report

Comprehensive postmortem toxicology was performed by the Toxicology Lab at Tarrant County Medical's Office on the postmortem specimens collected during the first autopsy including:

1. Blood from the heart
2. Urine
3. Gastric contents

Prior to the actual postmortem toxicology, DNA test was also performed by the Forensic Biology Lab at the Tarrant County Medical Examiner's Office on the postmortem heart blood to ensure that the specimen did belong to the decedent, Minister AGBOBLI..

Blood cards were prepared from two vials of blood received including the sample labeled "AGBOBLI, decedent" and AGBOBLI, Ayaoui" (decedent's son). Human DNA was recovered and quantified from each of the blood cards. The recovered DNA was amplified using Polymerase Chain Reaction (PCR) and the AMPISTR Identifiler Kit for amelogenin (sex typing) and for fifteen Short Tandem Repeat (STR) genetic loci.

Result of DNA Testing:: Postmortem putative blood sample from decedent revealed a male DNA profile with fifteen Short Tandem Repeat (STR) loci matching those of known sample received from son, AGBOBLI, Ayaoui

It was alleged that the Minister AGBOBLI may have overdosed on following medication including:

1. **Noliprel** or Perindopril or is an angiotensin converting enzyme (ACE) inhibitor (marketed in USA as ACEON) indicated for the treatment of essential hypertension. It offers continuous 24-hour blood pressure control with once-daily dosing for hypertensive patients. ACE inhibitors are recommended as first-line therapy for hypertension in certain patient populations, because of their safety and efficacy.

The most frequently reported side effect is cough. In animals, doses of perindopril up to 2,500 mg/kg in mice, 3,000 mg/kg in rats and 1,600 mg/kg in dogs were non-lethal. Past experiences were scant but suggested that overdosage with other ACE inhibitors was also fairly well tolerated by humans. The most likely manifestation is hypotension, and treatment should be symptomatic and supportive. Therapy with the ACE inhibitor should be discontinued, and the patient should be observed. Dehydration, electrolyte

imbalance and hypotension should be treated by established procedures.

2. **Dolipran** or Acetaminophen (marketed in USA as Tylenol) belongs to a class of drugs called analgesics (pain relievers) and antipyretics (fever reducers). The exact mechanism of action of acetaminophen is not known. Acetaminophen relieves pain by elevating the pain threshold, that is, by requiring a greater amount of pain to develop

before a person feels it. It reduces fever through its action on the heat-regulating center of the brain. Specifically, it tells the center to lower the body's temperature when the temperature is elevated. The FDA approved acetaminophen in 1951. A single oral dose of 1000 mg produces plasma concentration of 9 ug/mL in 1 hour.

The T-1/2 is 1-3 hours with a volume of distribution of 0.8-1.0 L/Kg. When used appropriately, side effects with acetaminophen are rare. The most serious side effect is liver damage due to large doses, chronic use or concomitant use with alcohol or other drugs that also damage the liver. Chronic alcohol use may also increase the risk of stomach bleeding. Concentration in fatalities range from 160 – 387 ug/mL.

3. **Ditropan** or Oxybutynin is an anticholinergic medication used to relieve urinary and bladder difficulties, including frequent urination and inability to control urination (urge incontinence), by decreasing muscle spasms of the bladder. A single oral 5 mg dose in a healthy elderly produces a peak plasma concentration of 17 ug/mL at 0.7 hours. T-1/2 is 2 – 5 hours and the volume of distribution is 1.3 – 2.8 L/Kg. Common adverse effects associated with oxybutynin and other anticholinergics include: dry mouth, difficulty in micturition constipation, blurred vision, drowsiness and dizziness. Anticholinergics have also been known to induce delirium. These are dose-related and sometimes severe; in one population studied, after six months more than half of the patients had stopped taking the medication due to side effects. According to PDR, ingestion of 100 mg by an adult causes stupor, disorientation, agitation, cardiac arrhythmia, mydriasis and urinary retention.

4. **Diamicron** or Acetohexamide is a first-generation sulfonylurea medication used to treat diabetes mellitus type 2, particularly in people whose diabetes cannot be controlled by diet alone. It lowers blood sugar by stimulating the pancreas to secrete insulin and helping the body use insulin efficiently. The pancreas must produce insulin for this medication to work. For this reason, acetohexamide is not used to treat diabetes mellitus type 1. Most oral hypoglycemic drugs, including acetohexamide, have been associated with increased cardiovascular mortality. A single dose of 750 mg results in a plasma peak of 30 mg/L at 4 hours post-administration. T-1/2 is 0.3 – 1.3 hours and volume of distribution is 0.2 L/Kg. Fatal blood levels are generally not recognized.

5. **Nivaquine** or Chloroquine has long been used in the treatment or prevention of malaria. As it also mildly suppresses the immune system, it is used in some autoimmune disorders, such as rheumatoid arthritis and lupus erythematosus.

Chloroquine has a very high volume of distribution, as it diffuses into the body's adipose tissue. Chloroquine and related quinines have been associated with cases of retinal toxicity, particularly when provided at higher doses for longer time frames. Accumulation of the drug may result in deposits that can lead to blurred vision and blindness. With long term doses, routine visits to an ophthalmologist are recommended. Chloroquine is also a lysosomotropic agent, meaning that it

accumulates preferentially in the lysosomes of cells in the body.

T-1/2 is 3 – 14 days (dose dependent) and volume of distribution is 116 – 285 L/Kg. Patients receiving a once weekly oral dose of 500 mg attain a plasma peak of 0.094 ug/mL at 6 hours.

Comprehensive postmortem toxicology with GC/Mass Spectrometry confirmation revealed:

1. Blood Ethanol: Negative
2. Urine Ethanol: Negative
3. Urine Drugs of Abuse: Negative
4. Urine base screen: Negative
5. Gastric acid and base screen: Negative

The list also included **Lessive**. Lessive is a laundry detergent and not a medication.

End of Report