G25

AGGETT INQUEST

	GLUCKMAN FILE	
	1	Affidavit by Charl Vorster
	2	Affidavit by Dr Aggett
	3	Autopsy report by Dr Botha dated 21 February 1982
	4	Letter from W Lane to Dr Gluckman
	5	Material sent to Dr Gluckman
	6	Autopsy report by Dr Botha dated 25 March 1982
	7	Psychiatric report by JA Plomp
	8	Pathology report by Professor JD Loubser
	9	Psychiatric report by Zalmon Wolf
	10	Post-Mortem examination report by VD Kemp
	11	SAP Circular re handling of detainees

G25.1

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NADOODSE ONDERSOEK - N H AGGETT

BEëDIGDE VERKLARING

Ek, die ondergetekende,

CHARL VORSTER,

verklaar onder eed soos volg:

1. Ek is versoek om 'n sielkundige beeld te probeer opbou met betrekking tot wyle dr Neil Aggett en om kommentaar te lewer oor sy beweerde selfmoord-handeling. Na my meegedeel is, is die verslag vir gebruik by die komende nadoodse ondersoek van dr Aggett.

2. Ek is 'n geregistreerde Kliniese Sielkundige in deeltydse private praktyk en verbonde as mede-professor aan die Departement Sielkunde van die Randse Afrikaanse Universiteit. My kwalifikasies is M.A. (Kliniese Sielkunde) Cum Laude en D.Phil. My gebied van spesialisering is menslike aanpassing by die omgewing en psigoterapie.

3. Die volgende bronne is tot my beskikking gestel:

   'n Knipsel/Aantekeninge-boek wat dr Aggett gehou het in sy adolessentejare;

'n Aantal briewe aan sy ouers en suster in die sewentiger jare tot 1978;

Verslae deur lede van die Polisie oor sy aanhouding en ondervraging en mediese verslae;

Dr Aggett se twee verklarings aan die Veiligheidspolisie;

'n Verklaring deur dr B.U. Lombard, Industriële Sielkundige;

Dr Aggett se aansoek om die beurs wat hy ontvang het.

4. Benewens die bogenoemde bronne, het ek ook onderhoude gevoer met die volgende persone:

Mnr J.A.E. Aggett en mev J.N. Aggett, ouers van die oorledene;

Mev E.J. Burger, suster van die oorledene;

Mej Yvette Breytenbach, goeie vriendin van die oorledene;

Mnr D.S. Dison, vriend en regsadviseur van die oorledene;

Dr Liz Floyd, vriendin van die oorledene met wie hy saam gewoon het.

5. Dit is 'n erkende en aanvaarde gebruik in kliniese praktyk om hipoteses te formuleer oor die

sielkundige funksionering van 'n individu deur gebruikmaking van skriftelike of getekende produksies van die betrokke individu. Daar word sodoende gesoek na bepaalde temas of tendense om 'n psigodinamiese beeld te probeer opbou. Hierdie werkswyse is gevolg met betrekking tot dr Aggett se knipsel/aantekeninge-boek en sy briewe, terwyl aandag ook vanuit hierdie raamwerk geskenk is aan dr Aggett se verklarings.

6. Die onderhoude wat gevoer is, is op 'n kliëntgesentreerde wyse gevoer waardeur gepoog is om moontlike kontaminasie deur die Klinikus tot die minimum te beperk. Deur interaksie-analise van die betrokkene met wie die onderhoud gevoer is, deur te let op inhoudelike mededelings en ook deur afleidings te maak oor die gebeure waarvan in die onderhoud melding gemaak is, is telkens hipoteses geformuleer met betrekking tot die spesifieke onderhoud. Op ground van die hipoteses van die verskillende onderhoude is weer gepoog om sekere algemene temas of tendense te ontdek, wat dan 'n sielkundige beeld van dr Aggett kon saamstel.

7. Die hipoteses wat uit die genoemde bronne na vore getree het, asook die geformuleerde hipoteses op grond van die onderhoude, in samehang met die verklaring van dr Lombard, wat die gewig gehad het van 'n opgeleide sielkundige, is vervolgens gepoog om 'n geïntegreerde geheelbeeld te formuleer.

8. Ten einde 'n bykomende wetenskaplike grondslag vir

hierdie kliniese indrukke te probeer verseker, is, bykomstig, ook gebruik gemaak van die hulp van twee kliniese kollegas, nl Prof Dave Beyers en mej M.F. Joubert, albei geregistreerde Kliniese Sielkundiges en verbonde aan die Departement Sielkunde van die Randse Afrikaanse Universiteit. Aan hierdie twee kollegas is, afsonderlik, die genoemde bronne beskikbaar gestel, asook die feitelike opsommings van die onderhoude met mnr en mev Aggett, mej Breytenbach en die bandopname van die onderhoud met dr Floyd. Die twee klinici is versoek om hul eie psigodinamiese beeld van dr Aggett se funksionering kortliks te formuleer sodat ek dit met my eie, onafhanklike, formulering kon vergelyk. Hierdie was 'n blote interne maatreël om my eie 'objektiwiteit' te verseker en die bedoeling was geensins dat die twee klinici volledige stukke vir die verhoor moes voorberei nie. Die twee klinici se onafhanklike formulerings het my eie kliniese beeld van dr Aggett inderdaad bevestig.

9. Die beskikbare inligting het dit moontlik gemaak om 'n redelike beeld van dr Aggett te kan formuleer, wat strek van sy ongeveer laat-adolessente fase tot kort voor sy dood, terwyl minder volledige inligting ook beskikbaar is oor sy vroeëre jeug.

10. Dit wil blyk dat dr Aggett na alle waarskynlikheid 'n vroeëre jeugtydperk gehad het, wat relatief vry was van ernstige konflik en trauma, maar die verhouding tussen hom en sy ouers was waarskynlik

van redelik vroeg af redelik gedistansieërd. Die feit dat hy later weg beweeg en 'sy eie lewe' gelei het, versterk hierdie indruk. Geen aanduidings kon egter gevind word dat daar noemenswaardige patologie in die gesin was nie en geen psigiatriese toestande is gerapporteer nie. Hierdie distansie in die verhouding met die ouers het sekerlik ook bygedra tot die bevordering van 'n bepaalde onafhanklikheid by dr Aggett en die vermoë tot selfstandige optrede en eie oordeel. Hy was klaarblyklik nie afhanklik van heelwat steun en onderskraging van andere nie en het sy eie kop gevolg.

11. In sy adolessente fase worstel dr Aggett, soos veral uit sy knipsel/aantekeninge-boek blyk, met bepaalde filosofiese beginsels en is hy soekende na die diepere sin van die lewe en basiese lewenswaardes. Hy ondersoek veral Godsdiens intensief en dit is duidelik dat hy hom nie op konvensionele wyse hierop kan verlaat nie. Sy waardes verskil van dié van veral sy vader en, sonder verwerping van sy kant af, breek hy dan weg van laasgenoemde en wil hy poog om sy eie, vir hom aanvaarbare, lewensfilosofie uit te werk. Dit is duidelik dat hy 'n diep denker is wat 'n sensitiewe gevoelsbelewenis het en betrokke is by diepere filosofiese lewensvraagstukke, en wel tot so 'n mate dat hy, in hierdie adolessente tydperk, redelik afgesonderd is van andere en as 'n 'loner' bestempel kan word. Sy mediese opleiding intensifiseer waarskynlik hierdie soeke na basiese waarhede en die sin van die lewe.

12. Dr Aggett se adolessente worsteling en bevraagtekening kristalliseer toenemend uit in 'n bepaalde lewensstyl, waarin hy toenemend betrokke raak by die welsyn van andere en veral die ongeluk en lyding van die minderbevoorregte werker spreek hom baie sterk aan. Sy verantwoordelikheidsin as mediese dokter verbreed dan blykbaar ook om meer in te sluit as blote simptomatiese, mediese behandeling en omvat uiteindelik dan ook die sosio-ekonomiese konteks waarbinne hierdie werker leef en wat verband hou met sy lewenskwaliteit as geheel. Naastediens en 'n sterk identifisering met die lot van die minderbevoorrregte werker raak die fondament waarop dr Aggett sy bestaan basseer.

13. Dr Aggett raak aktief betrokke by arbeids-aangeleenthede en voel hom geroepe om 'n persoonlike bydrae tot verbetering van die werker se lot te probeer lewer. Op 'n besielde wyse werk hy, soms tot sewe dae per week, op arbeids sowel as mediese terrein om dan so 'n bydrae te probeer maak. Die aanduidings is dat dr Aggett hierdie taak baie effektief verrig met 'n groot mate van insig en die vermoë tot realistiese beplanning en onderhandeling. Hy vertoon die vermoë om homself effektief te handhaaf in interpersoonlike verhoudings op 'n genuanseerde wyse, sodat hy, afhangende van die konteks en omstandighede, wel daarin slaag om nouere of meer gedistansieërde kontak aan te knoop. Hy word dan ook deur sommige beleef as warm, gevoelvol, empaties en sensitief, maar ook, in 'n ander konteks, as meer gedistansieërd, veeleisend, intellektueel en

begeesterd, selfs tot die punt van irritasie. Daar bestaan geen aanduidings dat hy wanaangepas is nie en geen ernstige patologie tree na vore nie. Hy vertoon wel 'n sterk mate van onafhanklikheid, eie denke en selfs hardkoppigheid.

14. Ten tyde van sy aanhouding, wil dit dus blyk dat dr Aggett aktief besig was om gestalte te gee aan sy lewenswaardes en ideale op 'n besielde wyse. Volgens alle aanduidings funksioneer hy effektief, hy is toekomsgerigd, daar is nie aanduidings van patologie nie en die hipotese kan sterk gestel word dat hy dan ook baie bevrediging put uit dit waarmee hy, vrywilliglik en gemotiveerd besig is, dat sy lewe vir hom sinvol is. Geen aanduidings bestaan dat hy 'n risiko tot selfmoord is nie - trouens hy toon 'n diep respek en agting vir andere en is ook intens betrokke by nood-chirurgie, waar hy letterlik lewens red. Daar is ook aanduidings dat hy, tot so kort as 'n maand voor sy dood, goed geïntegreerd is, in beheer van homself, rustig en ook toekomsdgerig, wat 'n teen-indikasie vir selfmoord is.

15. Binne die totale konteks van dr Aggett se lewensontplooiing, soos dit uit beskikbare inligting blyk, kom die beweerde selfmoordhandeling as 'n oënskynlike uiterste teenstrydigheid. Indien dr Aggett wel selfmoord gepleeg het ontstaan 'n ernstige vraagteken oor die aard en impak van die veranderlike of veranderlikes wat so drasties op hom moes ingewerk

het dat dit hom gedryf het tot 'n daad van selfvernietiging, oënskynlik geheel en al strydig met 'n persoon wat na vore tree as intelligent, sensitief, empaties met 'n besielde betrokkenheid by naastediens en naasteliefde.

16. Nadat ek die voorafgaande verslag opgestel het maar voordat ek dit geteken het is my aandag gevestig aan 'n getuigskrif deur ene dr Neil Anderson geteken op 11 Maart 1982 wat ek hierby aanheg. Hierdie getuigskrif bevestig, na my mening, die menings wat ek hierbo uitspreek.

Die verklaarder erken dat hy ten volle op hoogte is van die inhoud van hierdie verklaring en dat hy dit verstaan. Geteken en beëdig voor my te Johannesburg hede die 19de dag van April 1982.

REINHARD le ROUX
Commissioner of Oaths
Patent Attorney R.S.A.
D. M. Kisch Incorporated
9th Floor Corporation Building
Commissioner Street
Johannesburg.

KOMMISSARIS VAN EDE

VOLLE NAAM _____

BESIGHEIDSADRES _____

_____

HOEDANIGHEID _____

WORLD HEALTH ORGANIZATION

1211 GENEVA 27 - SWITZERLAND

ORGANISATION MONDIALE DE LA SANTÉ

1211 GENÈVE 27 - SUISSE

Télégr.: UNISANTÉ, GENÈVE
Tél. 34 60 61 Télex. 27821

TO WHOM IT MAY CONCERN

I knew Neil Aggett from our first days as medical students at the University of Cape Town where we began our studies together in 1971. Even from those early days in our friendship, but moreso in the years which followed, I came to know and understand his personal philosophy and ways of doing things.

I can declare without reservation that he was a very clear thinker who analysed with care every path of action before embarking upon it; that he was a mild person, in manner and method, who never took an extreme course where a moderate one was open; that although capable of deep and rigorous philosophical thought, he was not given to rumination followed by emotional outbursts; that he never suffered from depression nor showed signs of manic behaviour; that he had no deep-seated character abnormalities and that he was not given to alcohol or drug abuse in any form. In short there was no single aspect in all the years I knew him which would lead me to believe him capable of taking his own life. This possibility goes against everything I came to know about him in what were, for both of us, formative years.

N. Andersson

11 March 1982

Dr Neil Andersson
Consultant
Strengthening Health Services

1609 Lister Buildings,
195 Jeppe Street
JOHANNESBURG
2001

Date of Death 5/02/82
Report No. HS3169
Date of Report 21/02/82
ML 82/1/13

Messrs. Bell, Dewar & Hall
~~Mr. G. Disony~~
10th Floor Norwich Union House,
91 Commissioner Street,
JOHANNESBURG,
2001

AUTOPSY REPORT - NEIL HUDSON AGGETT

I attended an autopsy performed on the above deceased at the State Mortuary, Hillbrow, on the 5th of February, 1982, as well as a further dissection performed on the 10th of February, 1982. The body was identified to me by Dr. D. Kemp who also performed the autopsy.

I arrived at the Mortuary at approximately 09.45. The autopsy had been semicompleted, the neck dissection not yet having been done. I was informed that Dr. Kemp had immediately ceased his dissection on being told that another Pathologist would attend the autopsy. I estimated that the dissection already performed would have taken approximately 30 - 45 minutes.

The body was that of a young white male of medium build, the deceased being about 30 years of age. No identity tags were attached to the corpse. I was informed that he had died about 9 hours earlier.

Examination of the head showed the presence of some fresh blood in both external auditory meati and nostrils, this being attributed to the post mortem dissection. The nose was intact and showed no evidence of swelling or bruising. The eyes failed to reveal any sign of conjunctival haemorrhage and examination of the oral cavity revealed the teeth to be intact and firmly embedded in their sockets. There was no evidence of any contusions of the buccal mucosa or lips and the tongue, which was not protruding, showed no sign of any laceration. A small area of discolouration measuring approximately 5 mm in maximum diameter was seen just below the left eye; this was incised but no haemorrhage or damage to the dermis and subcutaneous fat could be seen. This "lesion" was considered to represent an artefact. There was no evidence of any trauma to the face.

The scalp had been incised and the skull had been opened in the conventional manner. No scalp lesions were detected and there was no evidence of subaponeurotic or subdural bleeding. The dura had been stripped and the bones of the skull were intact. There was no evidence of any haemorrhage within either the cranial cavity or the foramen magnum. The brain had been

sectioned; no sign of any subarachnoid, intracerebral or intraventricular bleeding could be detected nor was there any evidence of cerebral trauma. Selected samples of cerebral tissue were taken for microscopic examination and these showed the presence of mild to moderate congestion of the capillary vessels; there was no evidence of disruption of blood vessels, extravasation of erythrocytes or inflammation and the neurones and neuroglial cells appeared normal.

Examination of the neck revealed the presence of a broad but irregular area of discolouration on the anterior surface of the neck extending from ear to ear, this being more pronounced in the vicinity of the right angle of the mandible, while further discolouration of the skin was observed in the left occipital region. I was informed that the changes seen in the vicinity of the one angle of the mandible corresponded to the position of the knot in the garment found around the deceased's neck.

On dissection of the neck little soft tissue bruising was found, this being attributable to the broad width of the ligature. A small haemorrhage approximately 2 cm across was seen on the posterior aspect of the right carotid sheath, this haemorrhage underlying the bruise which corresponded with the knot under the angle of the mandible. The hyoid bone was intact; this structure was congenitally asymmetrical, the one horn being slightly longer and "flared". A small haemorrhagic focus approximately 0,5 cm across was seen on the posterior aspect of the tip of the abnormal horn. The cricothyroid

and normal in appearance. The prevertebral fascia was dissected and the anterior surface of the vertebral bodies examined; these appeared normal. The posterior surfaces of the cervical vertabrae were exposed and found to be intact; the posterior portions of the vertebra were sawn off and the spinal canal and the cervical portion of the spinal cord exposed and examined. There was no evidence of any fracture/dislocation of the cervical spine nor was there evidence of haemorrhage or any injury to the spinal cord. No sign of haemorrhage or bruising of the soft tissues around the cervical spine could be demonstrated. (The dissection of the spinal cord was performed on the 10th Feb, 1982)

Microscopic examination of skin and underlying soft tissue from the neck showed the epidermis to be intact, but this was "stretched" and thin and the cellular detail was blurred due to damage to the individual epidermal cells. Extravasation of erythrocytes into both the upper dermis and subcutaneous fat was noted while the dermal capillaries and venules within the subcutaneous adipose tissue were dilated and engorged. Free-lying polymorphonuclear leucocytes were noted amongst the extravasated erythrocytes and similar cells were present within the vascular lumina, the polymorphonuclear leucocytes being situated near the periphery of the vascular lumina suggesting early margination.

Examination of the anterior surface of the trunk showed no evidence of abnormality but the posterior aspect of the trunk showed the presence of residual post mortem lividity across the shoulder girdle as well as five small puckered scars. These

measured approximately 1,5 cm across and were ill-defined, two being situated on the left side, one lying over and another just below the left scapula while two similar scars were seen near the tip of the right scapula. A similar but less well demarcated scar was noted over the sacrum. These scars were slightly depressed and of considerable duration. Microscopic examination of one of these scars showed the presence of mild epidermal hyperkeratosis and acanthosis, the upper and mid dermis being microscopically unremarkable. There was no evidence of haemorrhage, acute or chronic inflammation, vascular dilatation or fibrin deposition. The significance of these scars was uncertain; they resembled those seen at the sites of insertion of chest drains but the postion of some of these scars over the scapula and upper sacrum indicated that they were due to some other cause.

The chest and abdominal cavities showed no sign of any haemorrhagic or effusive process. The ribs of the thoracic cage were intact. The lungs were mildly congested and slightly oedematous, especially in the basal portions of the pulmonary lobes. Several small irregular subpleural haemorrhages measuring about 0,5 cm across were seen while the cut surface of the lungs revealed the presence of an encapsulated abscess measuring 1,5 cm in diameter in the upper lobe of the right lung. The bronchi and pulmonary vessels appeared normal. Microscopic examination of the pulmonary tissues revealed the presence of early mild centrilobular emphysematous changes, some of the alveolar walls around the terminal bronchioles having disintegrated.

The alveolar capillaries were slightly dilated and engorged while aggregates of carbon-laden macrophages were observed within the alveolar spaces. The epithelial lining of the bronchi was intact and small amounts of mucus containing entrapped cellular debris were seen within the bronchial lumina. Occasional alveoli also contained small amounts of fluid. There was no evidence of any inflammatory process and no erythrocytes were seen within the alveolar spaces. The abscess cavity was not included in the tissue removed for histological examination.

The heart was of normal size; the cardiac chambers were unremarkable, no sign of hypertrophy, dilatation or fibrosis being seen. A few small subpericardial haemorrhages were noted as well as a single subendocardial haemorrhage, the latter being about 2,5 cm across and situated over the intraventricular septum. The cardiac valves were normal and the coronary arteries were fully patent throughout; a single ~~small~~ atheromatous plaque was observed near the origin of one coronary artery. The microscopic sections of cardiac tissue examined fail to reveal any evidence of inflammation, fibrosis, cellular degeneration or oedema.

The trachea was macroscopically unremarkable.

The aorta and other major vessels were fully patent.

The oesophagus was normal while the stomach showed the presence

of mild mucosal oedema; the gastric lumen was empty. No erosions or ulcers were seen within the stomach. The small bowel contained partially digested food; there was no evidence of intraluminal haemorrhage nor was there any sign of serosal or mesenteric injury.

The liver was of normal size; the capsular surface showed no macroscopic sign of abnormality and sections through the hepatic substance similarly failed to reveal any features of note. The gall bladder and pancreas were unremarkable. The spleen was of normal size, non-reactive and the splenic capsule was intact.

The kidneys were symmetrical and moderately congested; the capsular surfaces were normal while sections through the renal substance confirm the presence of diffuse congestion. There was no evidence of perirenal or intracalyceal haemorrhage. The urinary bladder appeared normal. The genitalia were normal in appearance; there was no evidence of recent or past injury to the penis or scrotum.

Examination of the arms showed the presence of a faint roughly triangular scar 1,5 cm in maximum diameter situated about 5 cm above the right wrist. This had a pinkish white appearance was difficult to see, the scar being largely obscured by the hair on the skin surface. No needle marks were found on the arms or hands nor were there any abrasions, lacerations or contusions on the upper limbs. The palms were normal and no material was

found under the fingernails. No blisters, ulcers or erythematous foci were present. Examination of the legs revealed the presence of a small scab approximately 0,5 cm across behind the right medial malleolus. This lesion was estimated to be of approximately one weeks duration. No other lesions were found on the lower limbs.

I was also shown an irregular piece of striped cloth with a fringe on one side, the longest side measuring approximately one metre. This material had been removed from the deceased's neck by Dr. Kemp. I obtained a sample of approximately 10 ml of cardiac blood which was examined for traces of ~~barbiturates~~ phenobarbital, ~~and benzodiazepam derivatives; these investigations yielded negative results.~~) Secobarbital and Carbamazapine these investigations yielded negative results

COMMENT

In a situation where an individual is found dead and suspended by the neck, four possibilitues usually have to be considered:

(i) Homicide and post mortem suspension to simulate suicide

(ii) Homicidal hanging ("lynching")

(iii) Accidental hanging

(iv) Suicidal hanging

There was no evidence at autopsy to suggest that the deceased had been murdered and then suspended; no recent external or internal injuries were demonstrable other than those around the neck and the presence of a vital reaction in the soft tissues of the neck precluded this possibility.

There were no features to suggest homicidal hanging; the victim in such circumstances would almost certainly struggle violently and several assailants would be required to subdue and silence the victim. In the course of such a struggle soft tissue injuries such as contusions, abrasions and lacerations would amost certainly be sustained. An alternative method would be to induce a nearcomatose state prior to hanging but no drugs were demonstrable in the blood sample nor were any needle marks found on the body.

Accidental hanging may occur in both domestic and industrial situations but these are usually obvious and not applicable in this case. Accidental hanging also occasionally occurs in the course of masochistic exercises for purposes of sexual gratification, the individual deliberately inducing a nearasphyxial state. This possibility needs no further consideration, such an event being highly unlikely in an environment which precludes any privacy and where the individual is subject to regular and possibly unexpected observation.

The post mortem findings in this case are entirely consistent

with those of suicidal hanging. The marks on the surface of the neck, the nature of the soft tissue injuries in the neck and the absence of any other injuries all support this contention. The pallor of the face, absence of cyanosis or protrusion of the tongue, as well as the absence of subconjunctival haemorrhage suggest that the mechanism of death was cerebral vascular insufficiency rather than airway obstruction and slow asphyxia. The passage of blood through the carotid and vertebral arteries being cut off due to the pressure of the ligature around the neck. (A force of 16,6 kg is sufficient to occlude both the carotid and vertebral vessels). Fracture dislocation of the neck is uncommon in suicidal hanging, this usually being encountered in cases where the deceased jumped or fell from a considerable height as also occurs in judicial executions. A further possible mechanism is a cardiac arrythmia resulting from vagal inhibition due to pressure on the carotid bodies; however, this possible mechanism can neither be proved or disproved under the present circumstances.

J.B.C. BOTHA

M.B., Ch.B., M. Med. Path (Cape Town)

F.F. Path. (S.A.)

jb/gg

22nd February, 1982

4 G25.3

W. Lane, BA, LLB
R.O. Gush, B Com, LLB
K.F. Gill, B Com, LLB
M.J. Simpson, BA, LLB
D.K. Sinclair, BA, LLB
Assisted by
V. Mtetwa, BA, B Proc

K.D. Finegan, BA, LLB
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Your reference

Our reference Mr W Lane/TJM

25 November 1982

Dr Jonathan Gluckman
Lister Building
Jeppe Street
Johannesburg

By hand

Dear Dr Gluckman

Inquest - Late N H Aggett

As you have probably heard already, the hearing of evidence and argument in the inquest ended on Thursday, 4 November 1982, when the magistrate adjourned the proceedings until 20 December on which date he will give his verdict and full reasons for it.

On behalf of ourselves and the Aggett family, we would like to thank you most sincerely for the assistance which you gave to us in the handling of this matter. It has been a great experience for us to work with you and with many other professional colleagues of yours.

If we still have in our possession any books or other material which you may have left with us, please let us know. In the same way, we shall be glad if you could let us have a note of any fees which may still be outstanding.

Yours sincerely

William Lane

W LANE
BELL DEWAR & HALL

MATERIAL SENT TO DR GLUCKMAN

1. Copy of affidavit of Professor Plomp.

2. Copy of Lane's translation of affidavit of Professor Plomp.

3. Copy of affidavit of Professor Vorster.

4. Copy of Dr Zalmon Wolf's report.

5. Copy of medical evidence given at the inquest.

6. Circular instructions from the Commissioner of Police re handling of detainees dated 14 August 1978.

7. Copy of Dr West's affidavit.

8

G265

Dr

INSTITUUT VIR PATOLOGIE
INSTITUTE OF PATHOLOGY

UNIVERSITEIT VAN PRETORIA
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ZOUTPANSBERGWEG
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Verw.
Ref.

Department Geregtelike Geneeskunde
Department

POSBUS 2034
P.O. BOX 2034
PRETORIA

14 Mei 1982.

T.J. Smit-Lord.
W3100/7W/B/0.

INSAKE: GEREGTELIKE DOODSONDERSOEK:
OORLEDENE NEIL HUDSON AGGETT

Johann David Loubser verklaar:-

Ek is 'n geregistreerde geneeskundige praktisyn heeltyds in diens van die Staat met drieledige aanstelling as Hoofstaatspatoloog/Professor verbonde aan Regsmediesedienste van Departement Gesondheid en die Fakulteit Geneeskunde, Universiteit van Pretoria.

Ek het 'n studie gemaak van die lykskouingsverslae van dokters Kemp en Botha asook van die histologiese verslae van dokter Botha en professor Schepers. Ek het ook die fotos wat van oorledene geneem was bestudeer en ek was in die hof teenwoordig op 13 April toe dokter Kemp getuienis in hoof gelewer het in hierdie geregtelike doodsondersoek.

Ondergetekende stem saam met dokter Kemp dat die dood in hierdie geval waarskynlik die gevolg van ophang was.

Omdat ophang met verskillende sterfwyses die lewe kan beeindig - bv. asfiksie, of belemmering van bloedtoevoer na brein, of belemmering van bloedafvoer van brein, of beskadiging van rugmurg, of as gevolg van neurogene hartarres deur vagusprikkeling, is dit nodig om in die geval van hierdie oorledene wel te besin watter van hierdie sterfwyses ter sprake kan kom.

Dit is my oorwoë mening dat ons volgens waarskynlikhede hier te make het met 'n akute onderbreking van die bloedtoevoer na die brein as gevolg van arteriële obstruksie veroorsaak deur die manier van hang en dat daar ook waarskynlik ter gelyke tyd 'n aansienlike vagusprikkeling van die halsstrukture uitgegaan het (vandaar die bevinding van 'n subendokardiale bloeding). - death by asphyxiation - confirming what we already know

Omdat ek 'n oorwegend asfiktiese sterfwys grotendeels hier wil uitsluit is dit vir my minder belangrik om hier in die abstrak te wil besin of daar nie moontlik ander oorsake van dood as ophang gepostuleer kan word nie.

J.D. Loubser.

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Volgens my mening sou die ophang ook (verwys na die fotos) vir die merke op die rug verantwoordelik wees aangesien redelik puntige druk deur die tralies op gedeeltes van die rug veroorsaak kon gewees het, as in aanmerking geneem word hoe die liggaam gehang gevind was. Die meganisme van hierdie beserings kan op waarskynlikhede teruggevoer word na konwulsiewe spiersametrekkings in die akute fase van die ophang.

Dat daar 'n nie-gelykluidende rapport komende is van professor Schepers en dokter Botha oor die histologiese beeld wat in verband met die velsnitte van die halsgebied gevind was, wil ek voorstel dat dit waarskynlik op die basis berus dat elk van hierdie patoloë 'n eie snit van vel ondersoek het en dat hulle nie 'n mening gevorm het oor dieselfde snit nie. Uit die lykskouingsprotokol blyk dit duidelik dat dokter Kemp aan dokter Botha 'n monster van die vel van die halsgebied voorsien het vir histologiese evaluering asook 'n monster uit hierdie gebied aan professor Schepers vir dieselfde doel. Dit is bekend dat daar regionale verskille kan wees, en dus kan die skynbare verskil tussen die verslae op hierdie basis verklaar word.

„A difference to be a difference must make a difference" moet hier egter ons gulde stelreël wees: Ek vind nie soveel wesensverskil in die verslae van die twee patoloë dat ek dit as in konflik met mekaar sal beskou nie: trouens daar kon ook onderskeie norme toegepas wees om te besluit of marginasie van leukosiete wel bestaan het, en of daar enigsins meer dan normale witbloedselle in die perivaskulêre gebiede waargeneem was. Ek wil daarop wys dat Raekallio saamstem met Gordon et al, en dat hierdie mening deur my onderskryf word dat die randstandigheid van akute ontstekingselle asook die perivaskulêre teenwoordigheid daarvan ook as perimortale verskynsel kan intree en dus nie op 'n premortale of intravitale genese van hierdie verandering dui nie.

SAMEVATTEND:

Dit is my oorwoë mening dat die dood van dokter Neil Aggett volgens die patologiese bevindinge wél deur ophang veroorsaak kon gewees het, en dat geen ander redelike verklaring uit die patologiese getuienis komende is nie.

Selfmoord v ophang?

Verklaarder is op hoogte met die inhoud van hierdie verklaring en doen dit wel wetende dat dit onder eed is. Ek beskou ook verdermeer my eed as bindend vir my gewete.

Is daar 'n verskil?

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