



Autopsy.

“John Douglas Agnew”

[Part One. Introduction.]

A small townhouse in a small suburb of the city of Winston-Salem in Forsyth County, North Carolina. Outside, like so many homes, it is unassuming. This humble home belongs to John Douglas Agnew. Age: 75 years old. It is Sunday, April 9th, 2017. A very cool spring day in the southeast. Mr. Agnew's daughter arrives at her father's residence to see and check in on him. She had last spoken to him two days prior on April 7th. Having not heard from him since then, she decides to stop by. But she does not get to meet her father this date. Instead, oddly, she is met by a handwritten note on the front door. It reads: “Not feeling well. Do not knock. Do not ring the doorbell.”

Not only is this unlike her father, the handwriting does not appear to be her father's, either. She attempts entry but the door is locked and she has no key. She also notices her father's car appears to be missing. She is highly suspicious, but still, she departs the residence. And returns the following day with a locksmith, who is able to make entry through the back door of the home. The locksmith enters the door into the kitchen and is immediately met with a horrific site. On the floor of the kitchen is what appears to be profuse amounts of blood. The locksmith goes no further and 911 is now contacted.

Also noteworthy on the kitchen floor is a small safe that typically resides upstairs. It has been pried open from the back. Mr. Agnew's daughter states that the safe only contained a .45 caliber handgun. Police search the residence and an even more disturbing scene is soon discovered.

In the downstairs bathroom, a duffel bag is found. It is black and new with its Walmart tag still attached. And inside, the remains of Mr. John Douglas Agnew.

Most of them, anyway.

I'm Your Friendly Death Investigator. Let's do an Autopsy.

[Part Two. External.]

“External examination. The body is that of an African American male received in two sealed body bags labelled ‘John Doe’, one containing the torso with attached segment of neck and proximal thighs and the other containing the head/proximal neck, upper extremities, and distal lower extremities. Winston Salem

Police Department subsequently confirmed the decedent's identity by visual means."

Something we've only briefly talked about before are the various ways a deceased person can be identified. Different medical examiner offices have different policies. Some are perfectly okay with identification being confirmed via photographs. Still, there are exceptions and you would be hard-pressed to find any ME office that doesn't fingerprint every homicide case such as Mr. Agnew's. And, of course, there are ME offices that take a more blanket approach and fingerprint each and every decedent who comes through their office. As a side note, this is actually a microcosm for how different agencies approach investigations in general, but that's more a subject for a future discussion episode. Otherwise, ID can be confirmed via dental x-ray comparison and by DNA which, even if fast-tracked, can take quite a while. Birth marks and tattoos can be used as well, but almost always as a last resort in the absence of other means.

For Mr. Agnew, at least as a preliminary for the exam, his visual identification by the police department was accepted. And in case anyone might be wondering, no, medical examiner offices do not use any computer facial recognition software. Visual ID is, most times, as simple as comparing a driver's license or military ID photo to the deceased.

I mention all of this because Mr. Agnew had been dismembered and identification becomes especially important in cases such as this, especially when not all body parts are found at a singular location. Before we get into that, let's look at what exactly the pathologist is working with.

"The head and proximal neck are severed at the level of the thyroid cartilage with complete transection through the cervical vertebra and spinal cord posteriorly and associated fractures of the bilateral superior horns. The scalp hair is gray and sparse and in the distribution of male pattern baldness. The irides appear light with overlying cloudy cornea. The sclerae are white. Inferior palpebral petechiae are present bilaterally. The nose and ears are not unusual. The lips and gums are pink and atraumatic. The teeth are in natural condition. Facial hair consists of a gray beard.

"The torso portion consists of the neck distal to the thyroid cartilage plane of section; right shoulder with attached segment of humeral head and shaft; left shoulder with attached segment of humeral head and shaft; and both thighs which are severed through the distal femur. The thorax is symmetrical. The abdomen is flat.

"The upper and lower extremities are well-developed and symmetrical after reapproximation of all segments. A[n] incised wound is on the lateral thigh below the buttock with no surrounding hemorrhage, consistent with a postmortem injury at or around the time of dismemberment.

“The appositional segments of neck, upper extremities, lower extremities, and amputated digits all correspond in body location and cut surface and comprise that of a single individual.”

To hopefully paint a clearer picture for you, imagine all of these body parts laid out anatomically correct on an exam table. From top to bottom, starting with the head, which itself is intact and is attached to most of the neck, which is severed near the bottom. The next piece begins with what is left of the lower neck and is attached to the torso. This torso piece itself is intact but both arms have been severed in the area where the upper arms attach to the shoulder. It doesn't note here but it is something that will come up later: several of the fingers have been cut off as well from both hands. Also attached to the torso are the thighs. The rest of both legs have been severed off just above the kneecap areas.

Now, let's think back to the crime scene and the black duffel bag. Inside this bag were the head, arms, and legs. The torso was not present at this scene. Instead, some thirty miles southeast of Mr. Agnew's residence, in Randolph County, Department of Transportation workers discovered the torso in a wooded area off of Canter Road, near Woody Creek. Now we have different jurisdictions. A consultation had to be made between the Forsyth County medical examiner and the Randolph County medical examiner and it was decided that Forsyth County would take jurisdiction for the autopsy for all of the body segments. Thus, the torso was transferred from Randolph County Sheriff's Office over to Winston-Salem PD. All of the body parts were collected together and delivered to Forsyth County ME.

With all of the parts laid out, the pathologist was able to determine that everything matched to a single individual, which also plays into helping quickly make identification for all of the parts.

And with all of that documented and taken care of, the doctor can now move on to...

“Evidence of injury. Two red contusions are over the back of the head. A red contusion is on the right side of the head.

“On the right side of the head above the ear, centered below the top of the head and right of the anterior midline, is a[n] oblique, incised wound. The hemorrhagic wound track involves skin and soft tissue only, to an approximate depth of 3/8-inch.”

For the head we have both blunt force injuries and sharp force injuries. “Contusions”, that is, “bruising,” fall into blunt force injuries. Essentially evidence that Mr. Agnew was beat on. Then we have his “incise” wounds noted, which are sharp force injuries and can be thought of more as a slice-type injury

or, simply, cuts. And while they are fairly deep cuts for the head, they are not fatal. There appear to be no penetrations of the skull.

Now, you're going to be hearing me repeat the terms "anterior midline" and "posterior midline" quite a bit. Just for clarification, midline refers to the center area of the body. A good way to think of it is that it's your body's line of symmetry. From head to toe, right down the center. So "anterior midline" would refer to the center area of the front of the body, and "posterior midline" will be the center area of the back of the body.

"On the back of the neck, below the top of the neck dismemberment site and left of the posterior midline, is a horizontal stab wound. Also on the back of the neck, below the top of the neck dismemberment site and left of the posterior midline, is a[n] oblique stab wound. The paths of stab wounds overlap, sequentially perforating the skin and soft tissue of the neck with hemorrhage into the paravertebral musculature, left transverse process of vertebra C7 and one penetrates the cervical spinal cord.

"On the right side of the neck posteriorly, below the top of the neck dismemberment site and right of the posterior midline, is a slightly oblique stab wound. The hemorrhagic wound track has an approximate depth of 2 1/2-inches."

Now we have documented stab wounds. Just here in the neck there are three different wounds, with some overlapping others. All are hemorrhagic so they were made while the victim was still alive and thus are likely contributors to the cause of death.

You'll also hear the term "oblique" used quite a bit to describe stab wounds. It simply means that the wound is neither straight up and down nor left to right. So it appears more slanted.

"On the left side of the chest, below the top of the neck dismemberment site and to the left of the anterior midline, is a[n] oblique stab wound. The hemorrhagic wound track has an approximate depth of 4 1/4-inches and travels from the decedent's front-to-back, left-to-right, and downwards.

"On the back, 13 3/4-inches below the top of the neck dismemberment site and to the right of the posterior midline, is a[n] oblique stab wound. The hemorrhagic wound track has an approximate depth of 1 3/4-inches and travels from the decedent's back-to-front, left-to-right, and downwards."

Two more stab wounds: one to the left chest and one on the upper- mid-back, just to the right. All told between the neck, chest, and back, there are a total of five stab wounds. Before we get to the damage these wounds caused internally, we'll briefly finish up the other, less lethal injuries.

More blunt force trauma in the form of bruising was noted to both the left and right shoulders, both arms, wrists, and hands. The right leg has bruising over the thigh, ankle, and foot. The left leg has bruising only on the foot.

Incised wounds are noted on the right hands. Two more are noted on the left thigh, near the genitals. The genitals also have multiple incise wounds – the doctor does not note an exact amount which likely indicates either too many to count, or the area was mutilated to the point of not being able to determine an exact amount.

Finally, let's detail a heretofore unmentioned injury type: chop force. Starting with the right hand...

“...chop force injuries of the proximal phalanges include complete amputation of the fingers #2 and #3, as well as adjacent skin avulsion of finger #4 posteriorly. A partial amputation of the finger #2 is also present and involves the fingernail.”

Chop force injuries are a bit of a combination of sharp force and blunt force. Though a sharp-ended weapon is used, the wounds are not cleanly pierced or sliced into and are thus more messy. This is usually because the object being struck is solid, such as a bone in this case. A weapon causing chop force injuries is also usually fairly heavy, which contributes to the blunt, crushing-type parts of the injury. More force is also required which also contributes to the blunt force injuries more collaterally. Now, the left hand.

“...chop injury of the proximal phalanges. Underlying injuries include metacarpal fractures of fingers #3 and #5 as well as complete amputation of finger #4.”

Any number of weapons can be used for these types of wounds. A knife and hacksaw were found in the kitchen. But in the living room on the couch... a hatchet...

[Part Three. Internal.]

“Internal examination. The skull has no fractures. The dura mater and falx cerebri are intact. The leptomeninges are thin and delicate. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact and free of abnormality. Sections through the cerebral hemispheres reveal no lesions within the cortex, subcortical white matter, or deep parenchyma of either hemisphere. The basal ganglia, thalami, and Ammon's horn are unremarkable. The cerebral ventricles are normal caliber. Sections through the brain stem and cerebellum are unremarkable.”

We know there were contusions and incised wounds on the head. They were surely painful and contributed to at least some of the massive blood loss of the victim. But the injuries did not go any further than external trauma. No injuries penetrated through the skull bone and everything inside the head is found to be unremarkable.

“The hyoid bone is intact. The lingual mucosa is intact; the underlying firm red-brown musculature is devoid of hemorrhage.”

For the neck, we’ve actually already noted the internal injuries in the external section. There were two stab wounds on the neck, both penetrated the vertebra bone and one of these actually penetrated the spinal cord. A third stab wound was also noted on the side of the neck, penetrating into it approximately two and a half inches. These wounds likely would contribute heavily to the blood loss noted on scene.

Otherwise here the hyoid bone is noted to be intact and there is no hemorrhage in the surrounding muscle, which could suggest that there was no strangulation. But not always. Again, another discussion.

“The pericardial surfaces are smooth, glistening and unremarkable; the pericardial sac is free of significant fluid or adhesions. The coronary arteries arise normally, follow the usual right dominant distribution and are widely patent, without significant atherosclerosis or thrombi.

“The aorta and its major branches arise normally, follow the usual course and are widely patent, free of significant atherosclerosis and other abnormality. The vena cava and its major tributaries return to the heart in the usual distribution and are free of thrombi.”

When you hear the term “pericardial”, simply think of the heart. The pericardial sac thus is a protective “sack” that surrounds the heart. Fluid can build up in this sack for various reasons, none of which are relevant here since it is noted to have no fluid. In fact, this area is fairly unremarkable and external injuries have not caused any harm.

Now, moving on to the lungs, we can go back to the stab wound of the chest and see what damage that caused internally.

“The path of the stab wound sequentially perforates skin, soft tissues, left rib #4 and penetrates the upper lobe of the left lung. The hemorrhagic wound track has an approximate depth of 4 1/4-inches and travels from the decedent’s front-to-back, left-to-right, and downwards.”

So the stab wound of the chest penetrated far enough into the body that it was able to strike one of the left ribs, continued on and penetrated into the left lung.

The left and right lungs both have what is referred to as left and right pleural cavities, which simply refer to their respective areas of the chest. These areas, save for the lungs, are hollow, which is necessary for the lungs to properly expand during breathing. This report doesn't note these cavities and I only mention them as, often when a lung suffers an injury, it can cause bleeding that can fill up these cavities, what some might refer to as internal bleeding. This also applies to the pericardial sac. For Mr. Agnew, though, this does not appear to be the case, which is likely a result of his dismemberment, the blood having dispersed the body via other larger wounds.

And now the damage done from the stab wound of the back.

“The path of the stab wound sequentially perforates skin, soft tissues, and penetrates the spinous process of vertebra S1 without penetration of the underlying spinal cord. The hemorrhagic wound track has an approximate depth of 1 3/4-inches and travels from the decedent's back-to-front, left-to-right, and downwards.”

A painful wound again, to be sure, but it doesn't hit anything vital. It penetrates a spinal bone on the lower spine/hip area but not deep enough to penetrate to the spinal cord.

And that's really it for internal injuries. The examination continues on throughout the abdominal area, including the liver, spleen, kidneys, et cetera, but there are no other significant findings. Toxicology specimens are ran but the only thing that it shows in Mr. Agnew's system is blood pressure medication. Histology samples are collected for microscopic inspection but there are no more specific or explicit findings than what the autopsy itself has already shown.

[Part Four. Opinion.]

We've talked about postmortem versus antemortem injuries previously but this case bares a little further discussion. If a pathologist dictates an injury to be postmortem, that's a fairly cut and dry statement. Since there is no hemorrhage in these types of injuries, it serves as a pretty clear indication. For an injury to be dictated as antemortem, however, there would have to be evidence of some form of healing having taken place over a certain length of time. For example, the color of the injury itself could be a determinate factor. A darker more coagulate hemorrhage area can often indicate it to be older. I bring this up because Mr. Agnew has injuries to his body that are hemorrhagic and thus indicate he was alive to some degree when they occurred, but they are not referred to as antemortem in this case. Instead the doctor uses the term “perimortem.” Perimortem denotes injuries that occurred around the time the decedent passed away. It may seem like splitting hairs, but it can become very relevant when these cases go to court. Let's say that a victim is found to have a broken arm and

it appears to have been healing for a few weeks. That would be an antemortem injury. If this victim was beaten to death, they would have many perimortem injuries noted but the healing broken arm would be antemortem, and thus something that could not be pinned on a suspect.

All of Mr. Agnew's injuries are noted as perimortem and at the very least dictate that they occurred around the time he was murdered. This includes his dismemberment injuries, which likely indicate that Mr. Agnew was not long deceased before the suspect started on them....

Cause of death: Stab wounds of neck and torso. Manner: homicide. Report date: April 21, 2018. Signed, Anna Greene McDonald, MD.

[Part Five. Postmortem.]

The alleged suspect in this case is Adrian Demare Whorley. The investigation has noted that Mr. Agnew and Mr. Whorley were acquaintances but did not state to what degree or what their relationship was. Mr. Agnew himself seems an otherwise kind and decent person with no noted history of malevolence. It is currently unknown if the crime was premeditated or occurred in the heat of the moment. A new duffel bag could suggest premeditation, but it could also simply suggest a poor attempt to clean up a crime, which itself was half abandoned. The investigation hasn't yet noted whether the knife, hacksaw or hatchet were recent purchases themselves.

The genital wounds and/or mutilations could be suggestive of... many things. None of them appropriately conclusive, however.

In fact, as of this date, it does not appear that Mr. Whorley's trial has completed and so many details are currently in a nebulous state.

Mr. Agnew's car was found near the area where his torso was discovered, apparently having run out of gas. Was this a mistake? Did the suspect dump the torso and then decide not to return and flee? The car having run out of gas seems likely to indicate a wrench in the work...but who knows?

As I'll say time and again, this isn't a program that sorts through a courts legal process. Certainly there could be more to the Why's of what led up to the incident and how it all played out. But we can only know what the examination of the body tells us. In this case: a vicious, painful murder by stabbing. It seems like a simple and obvious truth to be sure, and in many ways it very much is.

But it's a simple truth that takes a lot of work to confirm. And it's a truth that we can only arrive at from an autopsy.

Autopsy is an educational program. All information is culled from actual autopsy reports, and read, as written, out of respect for both the deceased, and the living who speak for them. Opinions and interpretations of these reports are solely those of the reader.

The End.

