

IN THE MATTER OF THE CORONERS ACT 1988

-and-

IN THE MATTER OF THE DEATH OF DR DAVID KELLY

To Her Majesty's Attorney-General

THE HUMBLE MEMORIAL OF DR STEPHEN FROST

SHEWETH:

1. Your memorialist is Dr Stephen Frost. He acts as memorialist as the lead representative of a group of four other eminent doctors: Dr David Halpin; Dr Christopher Burns-Cox; Dr Martin Birnstingl; and Dr Andrew Rouse.
2. On 18 July 2003 – the date of the discovery of the body of Dr Kelly – Lord Falconer of Thoroton, then both Secretary of State for Constitutional Affairs and Lord Chancellor, (in his capacity as Secretary of State for Constitutional Affairs) appointed Lord Hutton, a Lord of Appeal in the ordinary, to chair an *ad hoc* non-statutory judicial inquiry into the circumstances surrounding the death of Dr Kelly (“the Hutton Inquiry”).
3. On 21 July 2003, at the Oxfordshire Coroner’s Court, an inquest was opened by Nicholas G. Gardiner, one of Her Majesty’s Coroners (“the Coroner”), touching the death of Dr Kelly. At this date, the final conclusions of pathologist, Dr Nicholas Hunt, who conducted the post-

mortem on Dr Kelly's body, were not available and so the hearing was adjourned.

4. The Hutton Inquiry opened on 1 August 2003 with the terms of reference "urgently to conduct an investigation into the circumstances surrounding the death of Dr Kelly". Full hearings in the Hutton Inquiry then began on 11 August 2003.
5. On 13 August 2003, Lord Falconer, this time in his capacity as Lord Chancellor, invoked s17A Coroners Act 1988 and the Coroner, finding no exceptional reason to the contrary as required by that statutory provision, adjourned the inquest into Dr Kelly's death pending the outcome of the public inquiry.
6. On 28 January 2004, Lord Hutton formally delivered his report to the Secretary of State for Constitutional Affairs. From the evidence heard by him, Lord Hutton adopted the conclusions of the Home Office pathologist, Dr Nicholas Hunt, following his examination of the scene of the discovery of Dr Kelly's body and subsequent post-mortem: that the cause of Dr Kelly's death was as recorded on the death certificate:

"1(a) Haemorrhage

1(b) Incised wounds to the left wrist.

2 Co-proxamol ingestion and coronary artery atherosclerosis"

Accordingly, the primary cause of death was said to have been the bleeding caused by cuts to Dr Kelly's left wrist, not the ingestion of coproxamol or coronary artery atherosclerosis. A copy of the death certificate can be found at Appendix 1.

7. On 16 March 2004, the Coroner held a further hearing to determine the question under s17a(4) Coroners Act 1988 as to whether there existed any exceptional reason for resuming the inquest following the

conclusions reached by Lord Hutton and approved by the Lord Chancellor. At that hearing, at which only the Ministry of Defence and the Hutton family were represented, the Coroner concluded – in a hearing lasting no more than 15 minutes – that there were no such exceptional reasons and did not resume the inquest.

Central premise:

- a. a failure to pursue available lines of inquiry at the inquiry and the existence now of new evidence means that a full inquest is “*necessary or desirable in the interests of justice*”;
- b. the non-statutory Hutton Inquiry established by the Secretary of State for Constitutional Affairs and commended to the Coroner by the Lord Chancellor (in reality, the same person) as an adequate means to satisfy the requirements of a Coronial inquest under s17A Coroners Act 1988 was not in fact an adequate inquiry;
- c. the conclusions of the Hutton Inquiry, which were accepted by the Coroner without a substantive hearing, were not the result of a “full, frank and fearless” investigation. Had the inquiry been so, much of the evidence now available could have been put before and taken into consideration by Lord Hutton;
- d. the Coroner refused to resume the inquest and rejected relevant evidence following the findings of the Hutton Inquiry despite representations made and evidence submitted to him as to the exceptional reasons why an inquest should in fact be held; and
- e. upon a review of the evidence now available, there was insufficient evidence available to the Hutton Inquiry at the time to reach the conclusion that Dr Kelly had deliberately killed himself and that the primary cause of death was, as recorded on the death certificate:

"1(a) Haemorrhage

1(b) Incised wounds to the left wrist.”

Your memorialist and his colleagues therefore humbly pray that you be pleased to use your discretion under s13 Coroners Act 1988 and thereby make an application to the High Court of Justice to require that a full and proper inquest be held. By the discovery of new facts and evidence, insufficiency of the previous inquiry, rejection of evidence and due to procedural irregularities of a material nature in the inquiry, the Coroner’s proceedings and (potentially) the gathering of the evidence relied upon in the Hutton Inquiry, it is in the interests of justice that the High Court directs a full inquest be held touching the death of Dr David Kelly.

The arguments below are set out as follows:

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Section 1 – Factual background

1. Dr Kelly was an eminent government scientist of exceptional knowledge, skill and experience specialising in biological weapons who was employed by the Ministry of Defence. He was the government’s most senior scientist and weapons inspector and had the highest possible security clearance available (for both the United Kingdom and United States). A copy of this is to be found at Appendix 2. He had also formerly worked as a weapons inspector for the United Nations. In July 2003, Dr Kelly’s name was leaked to the press as the source of a story broadcast by the BBC about the British government’s dossier on weapons of mass destruction in Iraq. On 15 July 2003, Dr Kelly was

summoned to appear before the Parliamentary Foreign Affairs Select Committee which was investigating Britain's path to war with Iraq.

2. On 17 July 2003, Dr Kelly worked at home in Oxfordshire before leaving at around 3pm to go for a walk, as he did on a daily basis. When he had not returned by around midnight, his wife, Mrs Janice Kelly, reported him missing.
3. On the morning of 18 July 2003, Dr Kelly's body was discovered in an area of woodland called Harrowdown Hill around a mile from his home by two members of a search party set up after he had been reported missing.
4. The Home Office pathologist, Dr Hunt, was called to the scene by the Thames Valley Police on the same day, 18 July 2003. Dr Hunt carried out investigations of the scene between 12.10-12.35pm and 2.10-7.19pm. He then conducted a post-mortem examination of Dr Kelly's body at the mortuary at the John Radcliffe Hospital, Oxford, between 9.15pm that evening and 12.15am on the morning of the 19 July 2003.
5. A death certificate in Dr Kelly's name was registered on 18 August 2003 with the primary and secondary causes of death stated as follows:

 "1(a) Haemorrhage
 1(b) Incised wounds to the left wrist.

 2 Co-proxamol ingestion and coronary artery atherosclerosis"
6. Dr Hunt was then called as a witness by Lord Hutton at the Hutton Inquiry and gave evidence on 16 September 2003. A transcript of the evidence provided by Dr Hunt can be found at Appendix 3.

7. As stated above, on 28 January 2004, Lord Hutton then formally delivered his report to the Lord Chancellor. He concluded that the cause of Dr Kelly's death was suicide by "haemorrhage due to incised wounds of the left wrist" in combination with "coproxamol ingestion and coronary artery atherosclerosis"; that is to say that Dr Kelly bled to death as a result of the injuries to his left wrist.

8. Amid growing suspicions among doctors that the cause of death evidenced by Dr Hunt and provided in his report by Lord Hutton was improbable, we wrote, in December 2009 and on behalf of Dr Frost and his colleagues, to the Coroner to seek disclosure of the medical records and post-mortem documents and photographs relating Dr Kelly's death. In January 2010, the Coroner refused our request for disclosure. He also revealed that, sometime after the conclusion of his inquiry, Lord Hutton had taken the highly unusual step, in secret, of recommending that the records be protected from disclosure or publication for 70 years from the date of the inquiry. Copies of this correspondence are provided at Appendix 4.

9. There followed some media coverage of this surprising revelation and, on 26 January 2010, Lord Hutton himself made a public statement to various news broadcasters that he would advise the Ministry of Justice to disclose the post-mortem report to the doctors. Thereafter, we wrote to the Secretary of State for Justice seeking disclosure of this and additional documentation. The text of Lord Hutton's statement is provided at Appendix 5 and copies of our correspondence with the Ministry of Justice are provided at Appendix 6.

10. Since this time, in The Sunday Times on 22 August 2010 (copy provided at Appendix 7), Dr Hunt has taken the highly irregular step of speaking to the media to provide further, more detailed information relating to the post-mortem examination and condition of Dr Kelly's body than that provided to the Hutton Inquiry in 2003. It is highly irregular for a Home Office pathologist such as Dr Hunt to discuss with

the media his findings after the conclusion of the inquisition into a death – Rule 10 (2) of the Coroners Rules states that “unless authorised by the coroner, the person making a post-mortem examination shall not supply a copy of his report to any person other than the coroner”. Although Dr Hunt has not in fact provided (to your memorialist’s knowledge) a copy of the post-mortem report to any other party, he has ostensibly made these statements on confidential matters without the required permission of the Coroner and in breach of the Home Office Code of practice and performance standards for forensic pathologists.

11. These matters – together with a range of other serious concerns with the sufficiency of the Hutton Inquiry, the apparent irregularity of several elements of the Hutton Inquiry proceedings (including questions over its validity as a form of post-mortem inquisition), the myriad of unanswered and unsatisfactorily answered questions, rejection of evidence by the Coroner and new expert evidence (all of which are treated in detail in Section 4 below) – create serious doubt as to whether sufficient evidence existed at the time of the Hutton Inquiry to enable Lord Hutton legitimately to arrive at the conclusion that Dr Kelly committed suicide or died as a result of the primary cause of death recorded on his death certificate. There is therefore an urgent need for the inquest which the refused – without examining the evidence – refused to resume in March 2004 to be quashed and a new inquest ordered under a new Coroner in order to assess the evidence in full.

Section 2 – Legal principles

12. This memorial requesting that you make an application to the High Court to quash the inquest which should have been resumed despite the invocation of alternative proceedings under s17A Coroners Act 1988 is brought under Section 13 of that Act. We set this out here:-

13. — (1) This section applies where, on an application by or under the authority of the Attorney-General, the

High Court is satisfied as respects a coroner ("the coroner concerned") either—

(a) that he refuses or neglects to hold an inquest which ought to be held; or

(b) where an inquest has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that another inquest should be held.

(2) The High Court may—

(a) order an inquest or, as the case may be, another inquest to be held into the death either—

(i) by the coroner concerned; or

(ii) by the coroner for another district in the same administrative area;

(b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and

(c) where an inquest has been held, quash the inquisition on that inquest.

13. Reference is also made to the recent case of R (on the application of Sutovic) v HM Coroner for Northern District of Greater London: Sutovic v HM Coroner for North London (2006) EWHC 1095 [Admin]. It is submitted that Sutovic is a case within which the principles of s.13 applications are correctly restated by Moses LJ in his judgment.

14. In Sutovic, the Claimant was the mother of a young man who had died in Serbia. The mother of the Claimant was unhappy with the investigations that had occurred in Serbia and with the inquest that had happened in this country. In Sutovic the Claimant successfully petitioned for the inquest to be re-opened. The claim was brought by way of Judicial Review as well as application under s.13.
15. In considering the s.13 claim in Sutovic, Moses LJ made the following observations: “*The factors of central importance are an assessment of the possibility (as opposed to the probability) of a different outcome, the number of shortcomings in the original inquest, and the need to investigate matters raised by new evidence which had not been investigated at the original inquest*” (para 54). Moses LJ also restates the conclusion found in R v West Sussex Coroner, ex parte Edwards [1991] 156 JP 186, that “*a new inquest may be ordered even if there is a high probability that the outcome will be the same.*” (para 54).
16. This statement echoes the findings of Woolf LJ (as he then was) in Re Rapiere [1998] 1 QB 26. Woolf LJ found that, “*in many cases it will be quite impossible to say what will be the effect of the new evidence However, whatever the outcome, it still may be in the interests of justice that their evidence should be explored in public before a jury.*”
20. A review of the authorities also demonstrates that it is not necessary for the new evidence being proffered to have been available at the time of the original inquest. In Re: Fletcher (1992) 156 JP 522 it was held that new expert reports based on evidence available at the time of the initial inquest did constitute new evidence.
17. As set out in s13(1)(b) Coroners Act 1998, the body of new expert evidence now available, the insufficiency of the initial inquiry at the first instance, the irregularity of proceedings, rejection of evidence and refusal of the Coroner to hold a substantive inquest mean that it is in the interests of justice for there to be a full, frank and fearless inquest. It is submitted that, had this evidence been available to the Coroner at

the time of the initial inquisition, had the inquiry made been sufficient and had the proceedings not been tainted with irregularity, there is a strong probability (although that is not the test) that Lord Hutton (and therefore the Coroner) would have recorded a different outcome. This new evidence therefore deserves to be heard.

18. Although aware that, in this context, the application they are making is to yourself as Attorney-General rather than to the police or to the Coroner, Dr Frost and his colleagues, as medical professionals, are particularly sensitive to the common law duty incumbent on every citizen to report any information likely to lead to an inquest. As stated by Dame Janet Smith at page 520 paragraph 19.126 of the Third Report of the Shipman Inquiry:

“At present, all citizens are under a common law duty to report to the police or coroner any information likely to lead to an inquest. The existence of this duty is not well known, although everyone knows that they should report suspicions of crime to the police. I recommend that the Coroner Service should seek to educate the public about the functions of the Service and, at the same time, encourage members of the public to report any concerns about a death”.

19. The Attorney-General will note that the common law duty refers to a duty to report the information which might lead to an inquest to the Coroner or the police. However, given the fact that the Coroner himself has already seen fit not to resume the inquest despite the exceptional reasons provided by Dr Frost and his colleagues as to why it should be resumed (of which more below) and to reject any further calls for the resumption of his inquest; and that Thames Valley police concluded, at a very early stage, that Dr Kelly's death did not warrant a full murder investigation, the doctors take the view that the reporting (again) of their concerns to these bodies would prove futile and so humbly direct their report to you by way of this memorial.

20. Dr Frost and his colleagues therefore consider it their legal and ethical duty to provide you with this memorial, the more so due to their qualifications and positions as medical professionals with the highest expertise on the matters of central concern to the medical issues to be addressed in this memorial. In putting forward this memorial, the doctors consider of great significance the recommendation made by Dame Smith at page 520 paragraph 19.128 of the Third Report of the Shipman Inquiry that:

“In my view, there should be a statutory duty on any qualified or responsible person to report to the Coroner Service any concern relating to the cause or circumstances of a death of which s/he becomes aware in the course of his/her duties. In the class of 'qualified' persons, I include doctors, nurses, midwives and paramedics. In the class of 'responsible' persons, I include hospital and hospice managers, registrars, care home owners and managers, police officers, firefighters, funeral directors, embalmers and mortuary technicians. The duty upon such a person should be to report to a coroner or coroner's investigator, as soon as practicable, any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect”.

The individual and collective expertise of Dr Frost and his colleagues places each in Dame Smith's class of 'qualified' persons and it is their submission that the information contained in this memorial and appendices constitutes information which “might amount to evidence of crime, malpractice or neglect”.

Section 3 – Evidence before the Hutton Inquiry and the Coroner

21. A full transcript of the Hutton Inquiry hearings is available at http://www.the-hutton-inquiry.org.uk/content/hearing_trans.htm – however, for present purposes, only the transcript of the evidence given to the inquiry by Dr Hunt is included with this Memorial (at Appendix 3).

22. In summary, Dr Hunt reported and concluded as follows:

- a. he examined the body and the scene from 12.10pm – 12.35pm and from 2.10pm – 7.19pm on 18 July 2003;
- b. he found three blister packs with a combined capacity of 30 tablets of coproxamol in Dr Kelly's jacket pocket which contained only one tablet;
- c. there was some bloodstaining over the trousers and in particular over the right knee; the heaviest staining was over the left arm, including within the jacket; the most obvious area of bloodstaining was around the left wrist, where it was relatively heavy; there was an area of bloodstaining to his left side running across the undergrowth and the soil over an area of 2 to 3 feet in length maximum;
- d. there was a Sandvig gardening knife whose blade and handle was stained with blood next to Dr Kelly's left side;
- e. he took a rectal body temperature reading of 24 Celsius at 7.15pm on 18 July 2003 and concluded that, using a particular technique of estimating time of death on the basis of rectal temperature, Dr Kelly must have died between 4.15pm on 17 July and 1.15am on 18 July;
- f. he then examined the body in the mortuary at the John Radcliffe hospital between 9.20pm on 18 July 2003 to 12.15am on 19 July 2003;
- g. there was a series of cuts of varying depths over the front of the left wrist, the largest and deepest of which had severed the ulnar artery;
- h. there were no signs of defensive injuries;

- i. unbeknownst to Dr Kelly, he had atherosclerosis (coronary artery disease) but there were no signs that he had suffered a heart attack;
- j. there was “no great volume” of tablet material in the stomach but toxicology showed that dextropropoxyphene, an opiate type drug, and Paracetamol were present in his blood and stomach contents;
- k. that Dr Kelly’s spectacles were on the ground next to the body; that the relatively passive distribution of blood; that the neat way a water bottle and its top were placed; that there was little sign of trampling of the undergrowth; and that the location was a “very pleasant and private spot” all indicated that this was an act of self-harm;
- l. that Dr Kelly died as a result of haemorrhage as a result of the incised wounds on his left wrist hastened by the presence of dextropropoxyphene in his blood and underlying coronary artery disease;
- m. that there was no pathological evidence to indicate third party involvement in Dr Kelly’s death.

Section 4 – Evidence and concerns arising after the Hutton Inquiry and failure to resume the “inquest”

23. Over the six and more years since the conclusion of the Hutton Inquiry, Dr Frost and his colleagues have identified several questions under the relevant legal heads in s13(1)(b) Coroners Act 1988 which, in the interests of justice, require that an inquest now be held into Dr Kelly’s death.

Irregularities of proceedings

24. It is your memorialist’s contention that the investigation into the death of Dr Kelly was flawed in a number of fundamental ways.

The roles of Lord Falconer of Thoroton

25. In the first instance, attention is drawn to the role played in the investigative process by Lord Falconer of Thoroton. As previously indicated, Lord Falconer, at the relevant time and throughout the period between July 2003 and the end of March 2004, fulfilled two roles within government: he was both Secretary of State for Constitutional Affairs and Lord Chancellor.
26. On 18 July 2003, in his position as Secretary of State for Constitutional Affairs, Lord Falconer announced his decision that a public inquiry would be held into the circumstances surrounding Dr Kelly's death. The inquiry ordered by the Secretary of State for Constitutional Affairs and to be conducted by Lord Hutton (and whose parameters and powers were laid down by the same Secretary of State) was not a public inquiry called under the Public Inquiries Act 1921. It was an *ad hoc* non-statutory judicial inquiry ordered under the inherent powers of the Secretary of State. It was therefore able only to address those matters which Lord Hutton deemed fell within the very limited range of the terms of reference provided to him and lacked the statutory powers available to the chair of public inquiries established under the Public Inquiries Act 1921.
27. Astonishingly, Lord Hutton, the judge charged with chairing the inquiry, had never sat as a Coroner or had any judicial involvement in Coronial proceedings and had conducted only one previous, minor public inquiry.
28. Following the commissioning of the Hutton Inquiry by Lord Falconer in his role of Secretary of State for Constitutional Affairs, Lord Falconer then (in his role as Lord Chancellor) stepped in to the proceedings commenced by the Coroner on 21 July 2003 to invoke his powers under s17A Coroners Act 1988 to ensure that the Coroner's inquest was adjourned pending the outcome of the inquiry. As such, the Coroner's jurisdiction to investigate, in the normal way, this unexplained and unnatural death was ousted by Lord Falconer through

the use of his powers in his dual roles. The use of these powers to oust the Coroner's jurisdiction was then compounded upon the conclusion of the Hutton Inquiry when, again under the s17A Coroners Act 1988 procedure, Lord Falconer (as Lord Chancellor) declared himself satisfied with the conclusions reached by Lord Hutton, thus requiring the Coroner to find "exceptional reason" not to resume his inquest. The memorialist contends that this use by one individual of the powers of two positions within the governmental executive represents a fundamental irregularity in the proceedings by which Dr Kelly's death was investigated, through the exclusion of the statutory powers available to a public inquiry under the Public Inquiries Act 1921 and the Coroner's powers under the Coroners Act 1988 and the Coroners Rules 1984.

The application of s17A Coroners Act

29. Furthermore, the memorialist calls into question the propriety of the invocation of s17A Coroners Act 1988 by the Lord Chancellor in this instance. It is submitted that the parliamentary purpose in enacting this provision was to enable the Lord Chancellor, in particular cases of public importance, to intervene and to ensure that, in the public interest, an investigation is carried out into a death (or deaths) which goes beyond the remit of the Coronial jurisdiction but which still allows that "the death in question is likely to be investigated adequately by a judicial inquiry set up to inquire into the wider events in which the death occurred" (see extract from Hansard at Appendix 8).

30. The provision had previously been invoked in inquiries, for example, into the Ladbroke Grove rail crash and the Shipman inquiry. Each of these had been cases involving multiple deaths and each was a statutory public inquiry under the Public Inquiries Act 1921. However, in establishing the public inquiry on an *ad hoc* non-statutory basis rather than under the auspices of the Public Inquiries Act 1921, Lord Falconer, as Secretary of State for Constitutional Affairs, instigated a lesser inquiry than would have been carried out had an inquest or

statutory inquiry been held: the Hutton Inquiry was manifestly relatively powerless and lacking investigative bite when compared to its statutory equivalent or Coronial proceedings. It is particularly to be noted that, although the terms of reference set down by Lord Falconer required Lord Hutton "to conduct an investigation into the circumstances surrounding the death of Dr Kelly", no provision was made in the terms of reference for a proper investigation into the cause of death, a question which would have been fundamental to Coronial proceedings yet was manifestly lacking from the instructions to the Hutton Inquiry.

31. Additionally, Lord Hutton, whilst a serving judge at the time of his appointment and during the period he was taking evidence. However, he then retired on 11 January 2004 before reporting as a former judge on 28 January 2004. It must therefore be asked whether the requirements of s17A Coroners Act 1988 – which require a judicial inquiry – have been fulfilled, given that, at the conclusion of the judicial inquiry called by Lord Falconer, Lord Hutton – the judicial chair of the inquiry – was no longer a serving judge.

32. The *ad hoc*, non-statutory Hutton Inquiry was therefore an inappropriate investigative vehicle for Lord Falconer, Lord Chancellor to adopt for use under s17A Coroners Act 1988 and did not, as required, represent an adequate alternative form of investigation into the death to Coronial proceedings. It is therefore submitted that a full, open inquest under the Coroners Act 1988 must now be held.

Inadequacies of proceedings in the Hutton Inquiry

33. Moreover, as the Hutton Inquiry was very hastily called and conducted, and no full inquest ever held, the proceedings lacked the formal preparatory proceedings which would certainly have followed had the matter been heard in the Coroners Courts, as should have been the case. Such pre-inquest proceedings (and, in particular, pre-inquest reviews) are essential, amongst other matters, in establishing the

involvement of properly interested persons, defining the scope, depth and breadth of the inquest investigation and whether or not it would be appropriate for the Coroner to empanel a jury. The lack of these pre-inquest proceedings, the exclusion of potentially properly interested persons from the normal Coronial processes by the exclusion of the Coroner's jurisdiction and the fact of the terms of reference being set down by the Secretary of State, all point to a highly irregular set of proceedings leading to an inevitably insufficient inquiry.

34. The exclusion of the Coronial jurisdiction by the Secretary of State and his decision to call a public inquiry outside the auspices of the Public Inquiries Act 1921 also had the effect of meaning that witnesses did not provide their evidence under oath and therefore on pain of contempt of court. s11 (2) Coroners Act 1988 states:

“The coroner shall, at the first sitting of the inquest, examine on oath concerning the death all persons who tender evidence as to the facts of the death and all persons having knowledge of those facts whom he considers it expedient to examine.”

This irregular feature of the procedure adopted in the Hutton Inquiry again undermines the integrity of the evidence presented to Lord Hutton and inherently therefore the conclusions he reaches, giving rise to a requirement of a full inquest into the circumstances and causes of Dr Kelly's death with the benefit of the usual rules of evidence in the Coroners Courts.

35. Moreover, the fact of the inapplicability of the Coroners Court also had the fundamental impact of denying to Lord Hutton the power to compel witnesses available to Coroners in normal inquest proceedings. As such, Lord Hutton was prevented from examining witnesses – including Dr Kelly's dentist, who was not called despite it being reported that Dr Kelly's dental records went missing from her practice very shortly after

his death and then reappeared days later) and Superintendent Young, head of the Thames Valley Police's investigative team – and thus from drawing out potentially vital evidence as to the extent and nature of the police investigation into Dr Kelly's death.

36. The lack of applicability of the rules of evidence of the Coroners Court also had the consequence that the evidence provided by witnesses was not tested in the normal way through cross-examination by the representatives of other properly interested persons to the proceedings. Evidence was accepted, with minor clarifications only, at face value and without challenge, just one flaw in the procedural framework of the Hutton Inquiry which had the consequence of rendering the inquiry insufficient in its breadth, reach and thoroughness.
37. A significant instance of the failure to cross-examine, leaving important evidence untested, is to be found in Lord Hutton's treatment of Dr Kelly's alleged ingestion of coproxamol prior to his death. It was assumed that, as Mrs Kelly had been prescribed coproxamol, the empty blister packs of these tablets found in Dr Kelly's jacket pocket must have belonged to her. However, this was never established adequately at the inquiry. It was not established whether Mrs Kelly would normally have had such a number of tablets, whether she had recently obtained a repeat prescription or when and from where the tablets had been dispensed.
38. More significantly, however, the evidence of the toxicologist, Dr Alex Allan, as to the ingestion and the levels of Paracetamol and dextropropoxyphene in Dr Kelly's blood after death were not subjected to scrutiny. The blood concentrations detected in Dr Allan's report indicate a level above the therapeutic but below the toxic range. However, he finds that the residue of only 1/5 of a tablet was found in Dr Kelly's stomach. The timing of the tests is unknown, as is the time of death. Both are essential in reaching any conclusions as to the levels

in Dr Kelly's blood at the time of his death and therefore his intention or otherwise to kill himself, clearly of fundamental significance in reaching a verdict of suicide. However, Dr Allan was not pressed on such matters, nor did Lord Hutton look into them in any alternative manner, leaving a significant gap in the forensic analysis which would be necessary to enable Lord Hutton safely to arrive at the conclusion he did. That such is the case was demonstrated clearly when, in September 2004, the British Medical Journal forensic experts remarked that the level of Paracetamol and dextropropoxyphene in Dr Kelly's blood should not have been taken as an accurate indicator of the amount allegedly ingested. Dr Frost and his colleagues highlighted this in a letter to The Guardian newspaper on 28 September 2004, a copy of which is included at Appendix 9 to this memorial.

39. A further fundamental element which stood to be proved on the basis of the evidence before Lord Hutton at the inquiry in order to reach the conclusion that Dr Kelly had killed himself is the specific intent to do so. Lord Hutton satisfied himself of this on the basis of the evidence of Professor Hawton at the inquiry. However, in so doing, he failed properly to engage with the possibility that Dr Kelly had not in fact intended to kill himself. It is a fundamental tenet of the recording of a verdict of suicide in Coronial proceedings to prove beyond a reasonable doubt "intent to die". It is the memorialist's position that, on the basis before Lord Hutton and in light of his failure to press Professor Hawton on this point, that the requisite intent was not apparent in Dr Kelly's actions prior to the discovery of his body: he had made plans to see his daughter on the evening of 17 July 2003 and had not put his affairs in order. Further uncertainty is cast on the question of intent to die by the unanswered questions, highlighted above, in relation to the number of tablets of coproxamol allegedly taken by Dr Kelly and the levels of Paracetamol and dextropropoxyphene in his blood according to the toxicology reports.

40. Moreover, recent letters from expert psychiatrists Professor Colin Pritchard and Dr Phillip Timms have since highlighted respectively the apparent lack of intent and moreover the very unusual mode of alleged suicide apparent in this case: the cutting of one wrist. Copies of these letters are attached at Appendix 10 and 11.

41. It is the memorialist's position that – given this failure properly to engage with the question – the finding of “intent to die” could not have been reached on the evidence available to Lord Hutton and so the verdict of suicide cannot be deemed to be safe.

The death certificate

42. Since the conclusion of the Hutton Inquiry and the closure of the Coronial proceedings, it has become known that the final death certificate in relation to Dr Kelly's death was registered on 18 August 2003. This is despite the fact that the cause and circumstances of Dr Kelly's death, the subject of the Hutton Inquiry, had scarcely started hearing evidence and Dr Hunt, the Home Office pathologist who carried out the post-mortem, had yet to provide his evidence to Lord Hutton. Accordingly, it appears that the cause of death, which Lord Hutton was purportedly trying to establish through his inquiry, had been “established” - in private - and registered long before his findings were published in January 2004. Additionally, it appears that this death certificate was registered without notification to the inquiry or to the public: no mention of its existence or registration was made during the inquiry proceedings, nor was it presented in evidence.

43. Moreover, the death certificate which was registered was highly irregular. The proper form of the death certificate is set out at Form 22 of Schedule 4 to the Coroners Rules 1984. It requires that the following matters be found (as relevant):

“(1) Name of the deceased (if known):

(2) Injury or disease causing death:

- (3) Time, place and circumstances at or in which injury was sustained
- (4) Conclusion of the jury/coroner”.

The death certificate completed in respect of Dr Kelly’s death, and found at Appendix 1, clearly fails to record such information.

- 44. The place of death, required under (2) above, is not identified. In cases where the place of death cannot be ascertained, it is normal practice for the Coroner to make a statement on the death certificate to this effect. There is no such statement on Dr Kelly’s death certificate.
- 45. An inquest is said to have taken place on 14 August 2003. However, although the inquest had been opened and then adjourned by the Coroner, no inquest had yet been concluded and no verdict or findings as to the circumstances of Dr Kelly’s death reached or made.
- 46. The certificate itself is not signed by a Coroner or a doctor as required.
- 47. The date of death is given as 18 July 2003, despite the fact, detailed below, that this is far from being clear, given the inexplicable and considerable delay in taking the rectal body temperature.
- 48. For these reasons, the regularity of the death certificate is highly questionable.

Irregularities in the Coronial proceedings

- 49. As indicated above, the Lord Chancellor stepped in, on 13 August 2003 and after the Coroner had opened proceedings in the Coroners Court on 21 July 2003, to request that the Coroner’s proceedings be adjourned under s17A Coroners Act 1988 pending the outcome of the Hutton Inquiry. Not finding any exceptional reason to refuse such a request, the Coroner properly adjourned the inquest. However, the memorialist understands that, despite having adjourned his inquest

and thereby surrendered jurisdiction to investigate, the Coroner was then invited a meeting with the Department for Constitutional Affairs at which he asked for permission to take further evidence from Dr Hunt in private before recording a cause of death. If true, this represents a clear attempt by the Coroner to resume his investigation once adjourned under s17A Coroners Act 1988. That such a resumption was attempted and that evidence may then have been taken in private – and was not then revealed by the Coroner on the resumption of the inquest on 16 March 2004 – represents a significant irregularity in the proceedings which casts doubt over the integrity of the decision of the Coroner not to resume the inquest and thus requiring that a full, frank and open inquest be held.

Other apparent irregularities

50. It is widely known that, during his investigations, Lord Hutton visited Mrs Kelly at home. It is presumed that this was to take her evidence as to the circumstances of Dr Kelly's death and the days leading up to it. Whilst this is not proscribed by the Coroner's Rules and cannot be impugned as being an irregularity in itself, it is a measure adopted only in exceptional circumstances by a Coroner. However, it would be imperative that a Coroner undertaking any such visit would then, in the interests of justice and transparency, provide details of that evidence in open Court. Following this meeting, Lord Hutton made no mention and provided no detail as to the content of the statement taken from Mrs Kelly. As nothing is known of the substance or content of the meeting held by Lord Hutton with Mrs Kelly, it is not possible to say definitively whether any evidence was taken in this meeting (although it is hard to imagine that it was not) and thus not possible to say definitively whether any irregularity therefore exists. However, Mrs Kelly's evidence as to Dr Kelly's state of mind in the days leading up to his death would, on any view, be considered vital to a Coroner and, if any was taken, it was absolutely contrary to the interests of justice if Lord Hutton then failed to share its content with what was a public inquiry.

The 70 year recommendation

51. As previously indicated, it has emerged that, at some time after the conclusion of his inquiry, Lord Hutton made a recommendation, in private, the existence of which did not become known to the public until January 2010, requiring that the materials relating to Dr Kelly's death and, in particular, the post-mortem photographs, reports and medical notes should not be disclosed to the public until 70 years after the conclusion of the inquiry (that is, until 2074). This was a highly unusual recommendation and not a power available to the Coroner under either the Coroners Act 1988 or the Coroners Rules 1984. Its intended effect, according to Lord Hutton, was to protect the Kelly family from further upset which might be caused by those who might have wished further to investigate Dr Kelly's death. However, its actual effect has been that of 'suppressing' from the public domain vital raw material information in relation to Dr Kelly's cause of death and thus preventing any such independent investigation. This secret recommendation for secrecy and lack of transparency is highly irregular and would have been impossible in the context of Coronial proceedings. It was only possible by virtue of the fact that the Hutton Inquiry was an inquiry called out of the inherent power of the Secretary of State for Constitutional Affairs rather than the usual, inquisitorial Coronial proceedings or the much more unusual statutory public inquiry under the Public Inquiries Act 1921 investigation, both of which are creatures of statute and thus governed by strict statutory rules.

Insufficiency of inquiry

The reach of the Hutton Inquiry

52. The Hutton Inquiry was said by Lord Falconer (as Lord Chancellor) to be adequate to satisfy the requirements of a Coronial investigation into the death of Dr Kelly. Indeed, the public was led to believe by Lord Falconer that the powers and reach of the Hutton Inquiry would go beyond those powers available to Coroners under the statute and the Coroners Rules in order to lay bare the facts and circumstances of Dr

Kelly's death. However, in assessing this statement against the facts available, it is apparent that this has not been proved to be the case and in fact serious doubts remain over whether key elements of the duties of a Coroner were indeed fulfilled – and therefore whether an adequate inquiry was actually conducted – into Dr Kelly's death.

53. The Coroner's duties at an inquest are set out at Rule 36 Coroners Rules 1984:

“(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely–

- (a) who the deceased was;
- (b) how, when and where he came by his death;
- (c) the particulars for the time being required by the Registration Acts to be registered.”

The information therefore required can be summarised as:

- 1) the identity of the deceased;
- 2) the place the deceased came by his death;
- 3) the time of death;
- 4) the cause of death;
- 5) a verdict as to by what means the deceased came by his death.

54. In reviewing the findings of the Hutton Inquiry: the place of Dr Kelly's death is not stated; the time of Dr Kelly's death is recorded in very broad terms and in reliance on evidence which itself is tainted or at the very least rendered less accurate than it could have been by unexplained – and inexplicable – delay on the part of Dr Hunt; a cause of death is recorded but, as set out by this memorial, this is now subject to grave doubts, as is the “verdict” recorded by Lord Hutton of suicide. As such, it cannot be said that the requirements of the Coronial process detailed above have been met, nor the Coroner's

statutory duties fulfilled, by Lord Hutton's Inquiry at the behest of the Secretary of State.

55. Moreover, it is evident, from the transcripts of the Hutton Inquiry available at the hyperlink included above under section 2, that the time spent addressing the medical evidence in the proceedings was disproportionately insignificant in comparison with that spent on the incidents leading up to Dr Kelly's death. Including time given over to taking evidence from the toxicologist, Dr Alex Allan, approximately half of one day out of 24 full days of hearings was taken up by medical evidence. As illustrated above, in relation to the levels of Paracetamol and dextropropoxyphene present in Dr Kelly's blood after death, the manifest failure to engage sufficiently with or to test in any way the medical evidence provided by Drs Hunt and Allan represents a significant shortcoming in the adequacy of the investigation carried out by Lord Hutton. The proper consideration and testing of medical and toxicology evidence put forward in suspicious cases such as that of Dr Kelly is central to the Coroner's investigations but in Lord Hutton's investigations, the scrutiny to which it was subjected was unacceptably limp.

56. It is further your memorialist's case that vital witnesses who would have been in a position to provide valuable evidence to the Hutton Inquiry were not called and that the investigative function of the inquiry, said by Lord Falconer to be intended to be farther reaching than would be possible under the Coroners Act 1988, in fact fell far short of being an adequate or sufficient inquiry into the circumstances surrounding Dr Kelly's death.

57. It is therefore submitted that the conclusions reached by the Hutton Inquiry as to the cause of Dr Kelly's death cannot be considered safe and that a full Coronial inquest is essential.

The pathologist's examination of the scene and post-mortem examination

58. In his evidence to the Hutton Inquiry, Dr Hunt stated that he carried out the rectal body temperature measurement at 7.15pm on 18 July 2003. It is remarkable that this was some 7 hours after he was first given access to the location where Dr Kelly's body was found (12.10pm) and some 5 hours after he was given access to conduct a full examination of the scene (at 2.10pm). This delay in taking the body's rectal temperature was not challenged by Lord Hutton. The significance of this failure to seek an explanation for this delay lies in the fact that, as the body cools after death, the longer the delay in taking the rectal body temperature, the wider the time-window within which death may have occurred becomes, meaning that the accurate assessment of a time of death becomes more and more difficult as time passes. A body temperature reading taken several hours earlier would have enabled a more accurate time of death to have been ascertained, yet this was not done and the failure to do so went unchallenged at the hearings.

59. Since the conclusion of the Hutton Inquiry, Freedom of Information Act requests - made by MP Norman Baker in 2007 - have shown that the knife with which Dr Kelly is alleged to have used to cut his wrist showed no sign of Dr Kelly's own - or indeed any - fingerprints. This is despite there being no evidence that Dr Kelly had been wearing gloves prior to or during his alleged attempts to cut his wrist nor were any gloves discovered at the scene. This was a curious point which would have been apparent to Lord Hutton at the time of his inquiry had proper investigation been made and one absolutely relevant to establishing whether Dr Kelly did indeed cut his left wrist in the way concluded by Lord Hutton.

60. Dr Hunt's post-mortem led him to conclude that Dr Kelly died between 4.15pm on 17 July 2003 and 1.15am on 18 July 2003. However, information obtained from Thames Valley police by a Mr Garrick Alder under an Freedom of Information Act request has indicated that a police helicopter equipped with thermal-imaging technology flew over the exact spot where Dr Kelly was assumed by Lord Hutton to have

killed himself at 2.50am on 18 July 2003 without detecting his body. Although Assistant Chief Constable Michael Page gave evidence to the Hutton Inquiry indicating that a helicopter using thermal-imaging technology had been deployed in the search, Lord Hutton did not delve any further to establish the search routes of the helicopter or to question why the thermal-imaging had apparently failed to detect Dr Kelly's body which, at 2.50am, would have been substantially closer to the normal body temperature of 37 degrees Celsius than the 24 degrees Celsius recorded at 7.15pm the same day.

Rejection of evidence and refusal by the Coroner to resume the inquest

61. Upon considering and examining Lord Hutton's findings, published on 28 January 2010, Dr Frost and his colleagues very quickly came to the view (for the reasons set out in the report of Dr Frost et al at Appendix 12) that it would have been highly improbable for Dr Kelly to have died from the injuries said to have been the cause of his death by haemorrhage. As such, Dr Frost and several colleagues wrote on several occasions and as matters of urgency to the Coroner, Mr Gardiner, to express grave concerns at the conclusions reached by Lord Hutton and to present their professional view as to why the conclusions were incorrect and unsafe. A copy of this letter together with copies of other relevant letters, to which the Coroner did not reply, are attached at Appendix 13.

62. Dr Frost then wrote again to the Coroner in conjunction with 5 other medical professionals expert in the relevant areas to present their agreed view that the conclusions reached as to Dr Kelly's cause of death and therefore the conclusions of the Hutton Inquiry should not be accepted and that exceptional reasons existed as to why the Coroner should hold a full inquest into the death. Again, no response was received. A copy of this letter is enclosed at Appendix 14.

63. Thereafter, on 16 March 2004, as already illustrated, Mr Gardiner held a further hearing at which he expressed the view that he was "happy"

with the conclusions reached by Lord Hutton's report and that therefore he saw no exceptional reasons, as required by s17A(4) Coroners Act 1988, to resume the inquest and thus concluded that he would not do so.

64. The Coroner's refusal to respond to the letters of Dr Frost and his fellow medical experts and his apparent refusal to consider the evidence they put before him in deciding whether or not exceptional reasons existed which dictated that he should resume the inquest constitutes a rejection of relevant and persuasive evidence which may have made a material and substantive difference to the outcome of the Coronial proceedings, had they been properly considered by the Coroner in the exercise of his duty under s17A. If, indeed, he did consider the letters sent by Dr Frost and his colleagues, the Coroner made no mention of this in his hearing. Dr Frost and his colleagues also take the view that the Coroner's declarations had the effect of giving the impression to the public that Lord Hutton's conclusions were of the same quality as might be reached by the Coroner himself.

65. Perhaps most alarming, in this context, is the interview given by the Coroner to the Mail on Sunday in excess of two weeks prior to the hearing at which he concluded his inquest in which he stated that he was seeking "closure" to this matter, apparently indicating that he had already reached the view that there were no exceptional reasons for continuing his inquest despite not having heard the parties at the hearing and the continuing representations of the doctors as to the fact that the cause of death recorded and the conclusions of the Hutton Inquiry were unsafe.

New evidence

66. Since the conclusion of the Hutton Inquiry, Dr Frost and a number of eminent medical professional colleagues have maintained fundamental doubts as to the findings of the Hutton Inquiry and, in particular, the medical conclusions reached by the pathologist, Dr Hunt. A copy of

their medical report, signed by all, can be found at Appendix 12. They conclude, in broad terms, that it would be highly improbable for Dr Kelly to have died as a result of the pathological factors given by Dr Hunt as the cause of death. They say, therefore, that the findings of Lord Hutton are, therefore, at the very least unsafe.

67. Additionally, and significantly, Dr Hunt has, on 22 August 2010, come forward in The Sunday Times to provide further information relating to his examination of the scene at which Dr Kelly's body was found and his post-mortem examination which is inconsistent with and goes beyond that he provided in evidence to the Hutton Inquiry. Not only is this highly irregular, it also confirms Dr Frost's concerns – shared by his colleagues – that the Hutton Inquiry did not go as far as would have a Coroner's inquest in examining, testing and exhausting the evidence provided by the witnesses he called.

68. In his evidence to the Hutton Inquiry, Dr Hunt stated that there was:

“bloodstaining on the clothes [...] including in the sleeve of the Barbour jacket on the left. [...] There was some staining [...] over the left arm. That was the heaviest staining, really, including within the sleeve of the jacket. [...] The most obvious staining was around the left wrist. [...] There was an area of bloodstaining to his left side running across the undergrowth and the soil and I estimated it was over an area of 2 to 3 feet maximum in length”.

However, in an interview given to the Sunday Times on 22 August 2010, Dr Hunt is reported as saying that, “in actual fact there were big, thick clots of blood inside the sleeve, which came down over the wrist, and a lot of blood soaked into the ground”. The later evidence would appear to be inconsistent with that provided to the inquiry, as his descriptions indicate that there was in fact a large quantity of blood around and on Dr Kelly's body. It also goes further in suggesting that

“a lot of blood” had “soaked into the ground”, that “[DC Coe and the paramedics] might not have seen it, but it was there and I noted it in my report”. No evidence as to this was provided by Dr Hunt at the Hutton Inquiry, nor has the post-mortem report yet been made public.

69. Dr Hunt continued by saying that he had looked “at every millimetre of skin [...] for any puncture marks and so forth, any sign of skulduggery – between the fingers, the toes, under the nose, behind the ears, here, there and everywhere – to see if you can find something that’s out of kilter. There was nothing”. However, it is your memorialist’s position that, although there was a reported ‘absence of evidence’ of any foul play (particularly in the context of any needlemarks), this ‘absence of evidence’ does not constitute ‘evidence of absence’ and that, accordingly, proper Coronial assessment of the evidence provided by Dr Hunt and all the relevant witnesses is essential in carrying out an adequate inquiry.

70. Finally, Dr Hunt also provided additional evidence in relation to the alleged narrowing of Dr Kelly’s coronary arteries to that he had provided to the Hutton Inquiry. In The Sunday Times article of 22 August 2010, Dr Hunt provides information that two of Dr Kelly’s main coronary arteries were 70-80% narrower than normal, creating a significant risk of cardiac arrest. “If he had dropped dead in the canteen at Porton Down and you had seen his coronary arteries, you would have had a very good reason to believe that was the only reason he died”. His condition is said by Dr Hunt to have greatly reduced the ability of his heart to withstand sudden blood loss and also made him more susceptible to stress. The weight placed by Dr Hunt on the coronary artery disease in more recent information he has provided is in stark contrast to the evidence he gave to Lord Hutton in which he indicated that this “may have played some small part in the rapidity of death but [was] not the major part in the cause of death”.

71. It is your memorialist's view that this sudden provision of fresh evidence by Dr Hunt reflects an anxiety on the pathologist's part that the evidence provided to the Hutton Inquiry in relation to the scene of the discovery of Dr Kelly's body and in his examination of Dr Kelly's body was insufficient to support the conclusion he had reached as to the cause of death.

72. Further fresh evidence has also been provided by David Bartlett, the ambulance technician who arrived at the scene shortly after the discovery of Dr Kelly's body. In an interview with The Mail on Sunday on 12 September 2010 (which can be found at Appendix 15), Mr Bartlett stated that, on arriving at the scene, he noted that Dr Kelly's "left sleeve was rolled up and you could see a wound with some dried blood around it". This is in direct contradiction to the evidence provided by Dr Hunt to The Sunday Times on 22 August 2010, in which he stated that "there were big, thick clots of blood inside the sleeve, *which came down over the wrist*" (emphasis added). This is an important contradiction in evidence which was, again, not explored by Lord Hutton in the inquiry and which raises questions both as to the accuracy of the evidence provided by witnesses and also to the sufficiency of the inquiry itself.

73. Mr Bartlett then continued in The Mail on Sunday that, when he arrived at the scene, Dr Kelly "was lying flat out some distance from the tree. He definitely wasn't leaning against it. [...] When I was there the body was far enough away from the tree for someone to get behind it. I know that because I stood there when we were using the electrodes to check his heart. Later I learned that the dog team said they had found him propped up against the tree. He wasn't when we got there. If the earlier witnesses are saying that, then the body has obviously been moved". The "earlier witnesses" referred to by Mr Bartlett are the searchers who discovered Dr Kelly's body, Louise Holmes and Paul Chapman, who each gave evidence to the Hutton inquiry that Dr Kelly's body had been found propped up against a tree.

74. DC Graham Coe, one of the group of Thames Valley police officers first to arrive at the scene, has also, in September 2010, provided further information as to the evidence he had provided to the Hutton Inquiry. In evidence at to the Hutton Inquiry, DC Coe was clear in stating that, on the morning of the discover of Dr Kelly's body, he was accompanied only a single colleague, DC Colin Shields. However, in an interview with the Daily Mail reported on 9 August 2010, DC Coe, now retired, explains that there had been a trainee police officer present with he and DC Shields. Although it is not clear as to whether this new evidence in itself is of a material nature, it again goes to the point that the questioning to which Lord Hutton subjected witnesses was less than thorough and reflects the palpable insufficiency of the initial inquiry. A copy of this article can be found at Appendix 16.

75. This new evidence, together with the expert opinion provide by Dr Frost and his colleagues, raises significant new questions as to the volume and distribution of blood at the scene, whether the scene of the discovery of Dr Kelly's body had been disturbed prior to the arrival of scene examiners and, once more, the sufficiency of Lord Hutton's initial inquiry.

Section 5 - Conclusions

76. In *Bloom v HM Assistant Coroner for North London*, Tuckey LJ said:

“In considering this provision [s13] it is not necessary to show that a new inquest would reach a different verdict, only that it might do so. Even if a different verdict is not, in fact, reached by a different coroner, this would not negate the request for a second inquest under s13 Coroner Act 1988 (see *Re Rapier* [1988] QB 26)”.

77. It is submitted, in light of the procedural deficiencies and insufficiency of the investigation of the Hutton Inquiry, the rejection of evidence by the Coroner on the Lord Chancellor's communication to him of the findings of the Hutton Inquiry and the compelling new evidence provided in the form of the expert view of Dr Frost and his colleagues, and for all the reasons expounded above, that the conclusions reached by Lord Hutton and adopted by the Coroner are not safe.

78. Moreover, for all the above failings and reasons – and in particular the Coroner's gross failure to hold a substantive inquest into Dr Kelly's death, as required by s8(1) Coroners Act 1988 – it is submitted that the United Kingdom government has not, as yet, fulfilled its investigative duties under Article 2 of the European Convention on Human Rights.

79. Dr Frost and his colleagues take the view that, in light of the information presented in this memorial, compelling grounds exist for the holding of a new inquest in order to reach accurate and empirical conclusions as to the death of Dr Kelly. In the words of Christopher Clarke QC, Counsel to the Inquiry for the Saville Inquiry, "the tribunal's task is to discover, as far as humanly possible in the circumstances, the truth: not the truth as people see it; not the truth as people would like it to be; but the truth, pure and simple, however complex, painful or unacceptable to whomsoever that truth may be. The truth has a light of its own".

80. It is consequently submitted that it is necessary and desirable in the interests of justice for there to be a fresh, full inquest into Dr Kelly's death before a different Coroner. The memorialist therefore humbly requests that the Attorney-General exercise his power under s13 Coroners Act 1988 to apply to the High Court to seek an order to quash the inquest held by Coroner Nicholas Gardiner in 2003-4 and to order a new inquest into Dr Kelly's death.

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Dr Stephen Frost
September 2010