Office of the Attorney General 6 December 2010
Mr Kevin McGinty
20, Victoria Street
London
SW1H 0NF

Ref: The unnatural death of Dr David Kelly: For the attention of the Attorney General

Dear Mr McGinty,

I should be grateful for your drawing the following to the attention of the Attorney General. Many questions arise from the accounts given in evidence by Dr Hunt, but the three main ones are:-

•a substantial dissonance between the evidence written or said at three different times
•the question of whether there was intent to commit suicide
•the question of whether death occurred without there being any intention of suicide

I set out below three excerpts of evidence, the last being informal and presumably given with the permission of the coroner, Mr Nicholas Gardiner.

ONE

Dr Nicholas Hunt Verbal evidence 16 September 2003 at the Hutton Inquiry

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2 It was noted that he has a significant degree of
3 coronary artery disease and this may have played some
4 small part in the rapidity of death but not the major
5 part in the cause of death.
6 Given the finding of blister packs of Coproxamol
7 tablets within the coat pocket and the vomitus around
8 the ground, it is an entirely reasonable supposition

9 that he may have consumed a quantity of these tablets
10 either on the way to or at the scene itself.
11 Q. What did the toxicology report suggest?
12 A. That he had consumed a significant quantity of the
13 tablets.
14 Q. I am not going to trouble you with the details of the

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15 toxicology report. Was there anything else in addition
16 to the toxicology samples that you noticed?
17 A. (Pause). **Really the only other thing in addition to**
18 that was the coronary artery disease that could have had
19 a part in the rapidity of death in these circumstances.

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TWO

HEART: The aorta showed focal complex plaques particularly in its distal descending portion. There was no aneurysm. The major non-coronary branches were widely patent. The great veins were unremarkable. The pericardium, atria and valves were normal. The right and left coronary arteries were co-dominant. The left and right coronary arteries emerged from a single sinus. Within the mid-portion of the right coronary artery there was almost complete obliteration of the lumen by atheroma. Elsewhere there was 60 –70% stenosis in this vessel. Within the left, anterior descending coronary artery there was up to 70% luminal stenosis by atheroma with one point distally which appeared to have been re-canalised. The circumflex artery and the obtuse marginal branch showed 60 – 70% stenosis focally. There was no definite acute plaque event identified. Slicing the myocardium showed occasional minor flecks of pallor in the posterior wall of the

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left ventricle raising the possibility of previous episodes of ischaemia/infarction, however there was no evidence of territorial infarction. The ventricular chamber dimensions were normal.

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THREE

'A textbook suicide' The pathologist who conducted the autopsy on David Kelly in 2003 breaks his silence to reject the conspiracy theories surrounding the scientist's death

Steven Swinford Sunday Times Published: 22 August 2010

"Crucially, however, there were two other factors in the death of Kelly. During the autopsy, Hunt

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discovered that Kelly was suffering from a severe form of coronary heart disease called

atherosclerosis, although he had been unaware of this.

Two of his main coronary arteries were 70%-80% narrower than normal (Comment diameter or cross sectional area?), creating a significant risk of cardiac arrest. ''If he had dropped dead in the canteen at Porton Down [the government research establishment where he had worked] and you had seen his coronary arteries, you would have had a very good reason to believe that was the only reason he died,'' said Hunt.

His condition greatly reduced the ability of his heart to withstand sudden blood loss, and also made him more susceptible to stress. It also made his heart more vulnerable to a synthetic opiate in the painkiller he had taken, co-proxamol.

The prescription painkiller was withdrawn in 2007 after it emerged that overdoses, either accidental or deliberate, were causing up to 400 deaths a year. It contains dextropropoxyphene, a synthetic opiate that can cause the heart to develop an abnormal rhythm, leading to cardiac arrest."

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Comments

a. In ONE there is a 'significant degree of coronary artery disease'. In TWO (the PM report dated 25 July 2003 and published by all media outlets 22 October 2010) and THREE (statements as reported by Mr Steven Swinsford of the Times) severe disease is reported. Eg 'Within the mid-portion of the right coronary there was almost complete obliteration of the lumen by atheroma (derivation – Latin: porridge)

b. ' ..and this may have played some small part in the rapidity of death but not the major part in the cause of death.' (The rapidity of death was not proven I believe.) It 'may have played some small part .....' but in THREE ''If he had dropped dead in the canteen at Porton Down [the government research establishment where he had worked] and you had seen his coronary arteries, you would have had a very good reason to believe that was the only reason he died,'' said Hunt.'
The evidence recorded in the post-mortem report of 25 July preceded the verbal evidence given at the Hutton Inquiry 22 days later.

c. '17 A. (Pause). Really the only other thing in addition to that (tablets implied) was the coronary artery disease that could have had a part in the rapidity of death in these circumstances.' The conditional is noted.

d. A short letter by myself which was published in December 2003 included:-

"The picture fits more with 'a cry for help' (later editing -as seen in **survivors** in A&E departments)'. Although Dr Kelly was not a 'medical' doctor, he was well versed in what I have termed 'the biology of death".

He was acting director at Porton Down for 10 years I believe. Non-recovery experiments on mammals such as sheep and primates would have required that they were finally 'put to sleep'. He would have known the methods employed and known in particular that intravenous potassium chloride was a sure and instant way to die. I believe it is a preposterous proposition that this highly intelligent man intended to take his life by cutting his wrist with a most unsuitable and possibly

blunt blade, and by swallowing co-proxamol tablets. If both these acts were self-inflicted, it is 4 highly unlikely they were done with the intention of selbsmordt.

I add that, as an orthopaedic and trauma surgeon, I am familiar with those who have sadly attempted suicide by taking tablets along with cutting the wrists. I saw them before repair of their nerves and tendons on the ward and when they were taken to theatre for my repair of those structures. I saw them in the ward afterwards and in follow-up in the clinics. There were not dozens of such patients.

Among these above questions that will be answered in a new inquest are the following. It is posed by the first paragraph of the transcript below – letter from Nicholas Gardiner.

''The preliminary cause of death given at the opening of the inquest no longer represents the

view of the Pathologist and evidence from him would need to be given to correct and update the evidence already received."

It is supposed the letter was written 6 August 2003, the day Dr David Kelly was buried.
1.Which part of the PM report of 25 July by Dr Hunt 'no longer' represented his view by 6 August?
2.'Preliminary' – the unsigned death certificate gives no hint it was such.
3.'…. evidence from him would need to be given to correct and update the evidence already received."
It is understood the inquest was re-opened on about 13 August. It is possible there was no public notice of that re-opening but, in any event, what do the transcripts show as to the correction and updating of the previously recorded evidence?
4.No other post-mortem report by Dr Hunt has been placed in the public forum other than that of 25 July. Does one exist and if it does why was that 'corrected and updated' one not published instead ?

A letter from Nicholas Gardiner, Oxfordshire Coroner, and sent in early August to the Department of Constitutional Affairs (Transcription)

''The preliminary cause of death given at the opening of the inquest no longer represents the view of the Pathologist and evidence from him would need to be given to correct and update the evidence already received.

As you will know, a coroner has power to compel the attendance of witnesses. There are no such powers attached to a Public Inquiry. If I do adjourn under Section 17(1), I would be unable to resume, if at all, until after the Public Inquiry has been concluded and thus would not be in position to assist Lord Hutton, should any assistance be needed in that respect.

In matters of this sort, I need to be scrupulous in following the provisions of the Coroner's Rules, and I have in mind in particular Rule 16 (Adjournements in a Formal Manner) and Rule 19 (Obligation to Notify Family).''

Coroner's Offices Level 1 John Radcliffe Hospital

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The proper path in this case should have been an inquest hearing taken to completion before any inquiry into the 'circumstances surrounding'. The

precipitate instruction by Lord Falconer has lead to the worst of dogs dinners, to quote a phrase from Churchill. Just the points above show that what has taken place is worse than a travesty. It must be put right.

Yours sincerely

David Halpin MB BS FRCS

CC to Frances Swaine of Leigh Day, Mr Duncan Parrish PPS to Mr Grieve, and colleagues