POLICE SERVICE OF NORTHERN IRELAND

Police Identification Mark RH108

SUMMARY OF TAPE RECORDED INTERVIEW

TAPE REF NO:

BDV 71/05

Master Tape Seal Number(s):

T88911A

PERSON INTERVIEWED: DR JAMES FRANCIS KELLY

ADDRESS: C/O ERNE HOSPITAL, ENNISKILLEN

DOB: [redacted]

PLACE OF INTERVIEW: GROSVENOR ROAD PSNI

DATE OF INTERVIEW: 06/04/2005

TIME COMMENCED: 1628 HOURS TIME TERMINATED: 1641 HOURS

INTERVIEWING OFFICERS:

1 D/SERGEANT CROSS, CARE UNIT, ENNISKILLEN PSNI
2 D/CONSTABLE HALL, CARE UNIT, PSNI, ENNISKILLEN
3

OTHER PERSON(S) PRESENT:

1 [redacted] solicitor
2
3

MADE BY: D/CONSTABLE HALL

Tape Number and Tape Times:

D/Sgt Cross: It's still the 6th of April 2005 and it is 1627, same four people are present as we continue the interview and if I could remind you Doctor that the caution still applies and also if I could ask you to confirm that there were no questions asked in relation to these matters between tapes?

Mr Kelly: I can confirm that D/S Cross.

D/Sgt Cross: Doctor if I could just ask you to finish where you had commenced.

Mr Kelly: I believe that adding to notes days after the event is inappropriate. I'm happy and if I was asked for advice I'd be happy for a doctor to keep a record outside of the notes so that at a later stage if it became an issue they could produce that as a contemporaneous record. The point you make in terms of adding with it clearly dated and timed and signed, I don't think there is anything in the sense of wrong legally.

D/Sgt Cross: Yes.

Mr Kelly: But I'm not aware, that would need to be tested by others, that's a legal matter, but I wouldn't be advising it, I would be advising against it.

D/Sgt Cross: Right, when Doctor Malik was discussing that issue with you and you were discussing it with him, was there any suggestion that what Doctor O'Donohoe was in fact inviting him to do was to make a record that would be later misleading?

Mr Kelly: Can I, can I just clarify are you asking me was there any suggestion that Doctor Malik or do I think that was Doctor Malik's understanding?

D/Sgt Cross: Yes broadly speaking, was Doctor Malik being invited?

Mr Kelly: I felt that Doctor Malik was making it very clear to me that he did not feel that.

D/Sgt Cross: Yeah.

Mr Kelly: That he was not being encouraged to alter notes, but he's offered the notes if he wanted to add any additional commentary.

D/Sgt Cross: Uh huh.

Mr Kelly: That's the way I interpreted, I started the interview wondering exactly as you described because of Doctor Asghar's letter and comments.

D/Sgt Cross: Hm hm.

Mr Kelly: And so therefore I was trying to deal with that issue and clarify in my own mind and to my satisfaction that there wasn't an attempt here.

D/Sgt Cross: Yes. Doctor the last thing I want to discuss with you would be the matters in relation to the Coroner... You obviously had it in your mind that this may well go to the Coroner because you had suggested that a copy of notes should be secured. Now in the

event it didn't go to the Coroner for a number of years... Do you know why there wasn't an Inquest contrary, it would appear, to your expectation?

Mr Kelly: I had full expectations there would be an Inquest. I cannot see any situation given the circumstances of this death when it would not have been referred to the Coroner. It is the responsibility and the duty of the doctors at the facility where the patient or child in this case dies to report such matters to the Coroner. I would have had full expectations, it was my complete understanding at the time that the Coroner was aware of this case and his information would have been supported provided the Coroner would have been supported by the post-mortem, that was my full understanding and some years later as we were going through the litigation I even asked CSA or I was involved in a conversation with CSA in relation to surprise there hasn't been an Inquest to date.

D/Sgt Cross: Hm hm. Do you recall a discussion with Mr Mills in which the Coroner was discussed as a possibility and indeed the possibility of a criminal investigation if the Coroner took a certain view?

Mr Kelly: Which again reflects my complete belief that this had been referred by the clinicians in the Royal to the Coroner and that there would be an Inquest.

D/Sgt Cross: Hm hm... If I could just take you back, I missed the significance of one comment you made... did you feel the post-mortem report pushed for an Inquest or not?

Mr Kelly: I have, I mean it's total speculation on that, I would have thought that would have been additional information supplied to the Coroner.

D/Sgt Cross: Yes.

Solicitor: This is a decision for the Coroner to take upon a view of the post-mortem.

Mr Kelly: I mean in other words what I'm suggesting, what I'm saying to you, is that I would have had an expectation that if a post-mortem had been performed in this case that that would also have been shared with the Coroner, not just reporting the case.

D/Sgt Cross: Hm hm. You see in the event it wasn't, but what you've already said if there's a fault there, it's with the people in Belfast?

Mr Kelly: Correct...

D/Sgt Cross: You did say that earlier.

Mr Kelly: I don't know how to answer that.

Solicitor: If it was a fault ...

Mr Kelly: I said the expectation would be that this would be reported and has always been my understanding and in all other cases that I'm aware of that's what happens.

D/Sgt Cross: Yeah. You see the Coroner's Act is broader that that, whatever practice is amongst hospitals, and I accept what you're saying, that the Erne may rightly feel that this is a matter for the Royal to address with the Coroner, but the actual legislation is very very broad and it basically says anyone, eh ... now it does specify medical practitioners and other types of people, undertakers, etc, that anyone who has information that is relevant to the death of a person... has an ongoing obligation to refer that to the Coroner and that would go as far as the family and the family's solicitor and the like of Dewi Evans and so, I'm not trying to say that you should have, as opposed to all of these other people, everybody did have an obligation. Can I ask, Doctor, wherever you part or party to a discussion in which the lack of an Inquest was discussed and there was a discussion taken not to tell the Coroner anything further?

Tape Number and Tape Times:

Mr Kelly: No, I was not involved in any such discussions. If at the time the Royal had rung me, they didn't, but if they had rung me and said we don't know whether to refer this to the Coroner I would have advised them to refer to the Coroner.

D/Sgt Cross: You see what did happen Doctor Kelly is, Doctor Hanrahan did refer it to the Coroner at the time.

Mr Kelly: And that was my understanding of this, that it was referred to the Coroner.

D/Sgt Cross: But the Coroner's Office, the information given to the Coroner was that the child died broadly speaking of natural causes and therefore a decision was taken not to have an Inquest. And therefore there was no Inquest, but the Coroner of course is strongly of the opinion now that he should never have been told it was natural causes and there should always have been an Inquest and he feels the was not given the relevant information on which to make that decision.

Mr Kelly: I can't comment.

D/Sgt Cross: I appreciate that.

Mr Kelly: I am, I remain surprised, I remain personally surprised that the conversation led to a conclusion that she died of natural causes.

D/Sgt Cross: Hm hm.

Mr Kelly: What you're describing there that's the first time I have ever heard that D/S Cross, that phrase.

D/Sgt Cross: Right. Well you probably have never seen the document, but the, if I just show, I will show it to you since we've gone down this route, but it's unfair to ask you to comment on it. There is the initial medical certificate of death. This is produced on the 4th of fifth basically at the family's request because they need something for the Registrar and the child has died of cerebral oedema, dehydration and gastroenteritis and I would have to say you know that fairly closely follows the post-mortem report, the provisional anatomical summary, that's undated, there are two of those, but that broadly speaking is what that summary says and that's where Doctor Dara O'Donoghue, advised by Doctor Hanrahan, eh wrote that.

Mr Kelly: My only comment, I haven't seen it before, a slight comment that does not reflect the death of natural causes. Cerebral Oedema is not natural causes.

Solicitor: And of course that was completed by someone ...

Mr Kelly: I appreciate that, I have no knowledge of it, I've never seen it before, I cannot comment really any further.

D/Sgt Cross: Well yeah, be that as it may for whatever reason the decision was taken out of your hands entirely or out of the hands of everyone in the Erne, a decision was taken elsewhere that there wouldn't be an Inquest, however if further information came to you later that indicated that there's more to this death than in fact was realised at the time there would be an obligation on the Erne to tell the Coroner that so that the Coroner may review his decision not to have an Inquest.

Mr Kelly: If I think, what you're describing is relevant if the Coroner, the Pathologist, the Paediatrician or any of the teams involved in Belfast had rung and said to me we've done that Lucy has died of natural causes, I would have intervened.

D/Sgt Cross: Hm hm.

Mr Kelly: Before I even had got additional information, I would regard that as my responsibility.

D/Sgt Cross: Hm hm.

Mr Kelly: But I believed right through this that there was going to be an Inquest. I cannot consider the possibilities of there not being an Inquest in that death.

D/Sgt Cross: Hm hm do you recall then Doctor ever being told there isn't going to be an Inquest?

Mr Kelly: I don't recall specifically I think I in the litigation side of things there was surprise there hadn't been an Inquest and would that interfere with you know the delayed Inquest would that interfere with the process of settling the litigation. So there was comments at that meeting, I don't recall what exactly the wording but there wasn't, I was not told the Coroner said there will be no Inquest.

D/Sgt Cross: You see really that decision would have been taken I would say in May 2000 it was an early decision, a very early decision. But you weren't told that at the time then because clearly at the meetings thereafter ...

Mr Kelly: Most definitely not D/S Cross.

D/Sgt Cross: Yeah hm hm. Since we are discussing, I'm not inviting your comment, but to think to be fair so that everybody knows what we are talking about, this is what the Coroner has recorded in his ledger. Now Mr Leckey hasn't recorded this personally. This is page 460 of the Coroner's file, the Inquest file from his office. This is from Doctor Hanrahan, now what happens is that Doctor Hanrahan phones reports initially. He is told to go to a Pathologist, Doctor Curtis is consulted, although he made no record and there is no recollection of it. And whenever Doctor Curtis confirmed there was no reason for an Inquest then the Coroner agreed and

basically wrote it off and what we have there is a death on the 14th of April, it's gastroenteritis, dehydrated, brain swelling, admitted to the Erne two days ago, transferred to the Royal, spoke to Doctor Curtis and there's a death certificate and basically it's gastroenteritis, that's what killed the child and therefore that is natural causes broadly speaking. That's how that thought process appears to have gone on. I'm only telling you that for your information, I'm not asking you to comment.

Mr Kelly: I don't think I should be commenting at all.

D/Sgt Cross: No I don't think you should.

Mr Kelly: I go back to what I said earlier.

D/Sgt Cross: I accept that. But the summary, because we have a duty here to investigate compliance with the Coroner's Act to summarise your position, you were not part to a decision to keep anything from the Coroner?

Mr Kelly: Not at all.

D/Sgt Cross: Or to give the Coroner information that was incorrect?

Mr Kelly: Not at all.

D/Sgt Cross: Doctor is there anything you want to say?

Mr Kelly: No, thank you for the courtesy and the way you have conducted the interview. I appreciate that.

PACE 21 served and interview ended at 1641 hours