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2 March 2011

Our ref: JS/HLE/FTP/Kelly

PRIVATE AND CONFIDENTIAL
FOR addressee ONLY
Dr Mike Durkin
[redacted]

General Medical Council

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SPECIAL DELIVERY

Dear Dr Durkin

Instructions for Expert Opinion
General Medical Council v Dr James Kelly

Thank you for agreeing to give an expert opinion in relation to the actions taken by Dr James Kelly, Geriatrician and Medical Director of the Sperrin and Lakeland Health and Social Care Trust, Northern Ireland ("the Trust") following the death of LC, a patient at Erne Hospital, Enniskillen, Northern Ireland in April 2000.

The GMC will of course pay your reasonable fees and expenses for producing this report. I confirm that you advised me by email dated 28 February 2011 that your rate for a written review of materials, current evidence enquiry and written report is £180.00 per hour. Once you have had an opportunity to review these instructions, I should be grateful if you would contact me to indicate your total estimated fees and expenses for this work. **Please do not commence work on the report until your estimated fees have been agreed.**

As confirmed to you in our telephone conversation on 21 February 2011, I require the report as a matter of urgency. You confirmed that you would be able to prepare a report within 14 days of receiving the instructions. I should be grateful if you would deliver your report to me by no later than Monday 21 March 2011. Should you anticipate any difficulty with this deadline, please let me know as soon as possible.

Purpose of these instructions

I act on behalf of the General Medical Council ("GMC"), which is investigating a complaint, which has been made in relation to Dr Kelly.

This case has been listed to be heard by a Fitness to Practise Panel between 28 November to 16 December 2011 at the GMC's offices in Manchester. The question the Fitness to Practise panel will consider is whether, if the facts alleged against Dr Kelly are proved, his fitness to practise is impaired to a degree that would justify

action on his registration. In assessing impairment, the Panel will need to consider how far below an acceptable standard of practice the doctor fell.

You may be required to give evidence at the hearing, and for this purpose I would be grateful if you could keep the first 2-3 days of the hearing available.

It has been held by the courts that clinical negligence, such as would give rise to civil liability for damages, would not normally be sufficient to indicate impaired fitness to practice, although it may be a factor towards establishing this; rather, it is necessary to establish whether the doctor's actions have fallen **seriously** below the appropriate standard.

You should be guided by the GMC's published Guidance "Good Medical Practice 2000" and any other relevant guidance in considering the appropriate standards to be applied. If you do make reference to any other guidance/documents please provide a copy to me as an appendix to your report. As you will appreciate, the question of whether the doctor's fitness to practise is actually impaired will be a matter for the Fitness to Practise Panel alone. You should therefore not express any opinion on this or whether the actions or failings you identify amount to misconduct.

In this letter, I have set out some instructions to enable you to provide your opinion on whether the doctor's actions and treatment fell short of what could be expected of a reasonably competent Medical Director and, if so, in what ways and to what extent.

Conflict of interest

You have indicated that you feel there is no conflict of interest which would prevent you from preparing a report for the GMC. If, on review of the papers, you are unsure as to whether there may be a conflict of interest or feel that there is a conflict of interest which may prevent you from providing an independent expert report, I should be grateful if you would contact me to discuss this. For example, a conflict of interest may arise if you know either the doctor under investigation or the complainant or one of the key personnel at the referring body personally or on a close professional basis or if you have previously given an opinion on any of the issues on which the GMC is instructing you to prepare this report. If you are in any doubt as to whether a conflict of interest may exist, please contact me to discuss.

Materials

With this letter, I am enclosing the following documents:

1. Letter of instruction from Mr Fee to Dr Quinn dated 21 April 2000.
2. Copy of the documents that Dr Quinn was provided with by Mr Fee.
   a. Anonymised hospital records of Lucy Crawford
   b. Summary post mortem report dated 17 April 2000
   c. Final post mortem report dated 12 June 2000
3. Report by Dr Quinn dated 22 June 2000

4. Report by Moira Stewart dated 26 April 2001

5. Good Medical Practice (2006)

Should you identify any additional documents or type of documents that you may need to see (for example, x-rays or scans that have not been included with your instructions), please let me know and I shall make enquiries as to their existence and/or availability.

Additionally, should you feel that you would benefit from a report from an expert in a different discipline in order to assist you to complete your report, please inform me of this so that this can be considered and a suitable expert instructed, if necessary.

Background

1. On 12 April 2000, LC was admitted to Erne Hospital. After collapsing she was transferred to Royal Belfast Hospital for Sick Children ("the Hospital").

2. On 13 April 2000 patient LC was declared dead. An opinion is <u>not</u> required with regards to the treatment that LC received at either Erne Hospital or the Hospital.

3. On 14 April 2000, Dr Kelly, Medical Director advised Mr Mills, the Chief Executive and Mr Eugene Fee, the Director of Acute Hospital Services at the Trust of the death of LC. Dr Kelly asked Mr Fee to instigate a full clinical review of LC's death at Erne Hospital. Mr Fee agreed to jointly coordinate the review with Dr Anderson, the Clinical Director of the Women and Children's Directorate at the Trust.

4. On or around 21 April 2000, as part of the review Mr Fee enquired whether Dr Quinn, a Consultant Paediatrician at Altnagelvin Hospitals Trust would be prepared to comment on the circumstances surrounding the death of LC and her treatment at the Hospital. Dr Quinn agreed to the request and Mr Fee provided Dr Quinn with a formal letter of instruction enclosing a summary of LC's hospital records. A copy of these documents is shown at tabs 1 and 2.

5. On or around 21 June 2000, Dr Quinn met with Mr Fee and Dr Kelly to provide verbal feedback following his review of LC's notes.. Dr Quinn was provided with a copy of the final post mortem report relating to LC. A copy of the final post mortem report is shown at tab 2c. At that meeting Dr Quinn verbally agreed to provide a written report detailing some of the main issues discussed. A copy of Dr Quinn's signed report dated 22 June 2000 is shown at tab 3 ("the Report").

6. The Royal College of Paediatrics and Child Health commissioned a report by Moira Stewart, a College Representative to prepare a report on the management of four clinical cases presented to Tyrone County Hospital and Erne Hospital, Enniskillen. On 26 April 2001 Dr Kelly received a copy of the report prepared by Dr Moira Stewart. A copy of Dr Stewart's report is shown at tab 4.

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7. On 10 June 2001, RF died at the Hospital in similar circumstances to LC. An opinion is not required with regards to the treatment that RF received at the Hospital.

8. The GMC received a letter from Mr and Mrs Ferguson ("the Complainants") dated 6 November 2004 in which they made complaints about 7 doctors including Dr Kelly. The complaint related to the death of their daughter on 10 June 2001. The Complainants also alleged that subsequent investigations that were undertaken by the Trust failed to reveal the truth about RF's death.

9. On the 17 February 2004 an inquest into the death of LC was held.

10. Ulster television produced a television programme "When Hospitals Kill" which was broadcast in 2004. During the course of the TV programme "When Hospitals Kill", Dr Q was confronted on camera by the reporter with the allegation that he was not "independent". Dr Quinn admitted on camera that he was "sweet-talked" into providing the summary that he did. A copy of the transcript is shown at tab 4.

11. It subsequently transpired that the treatment and death of RF and others was to be examined as part of a Public Inquiry into Hyponatraemia-related Deaths led by John O'Hara QC in Northern Ireland. The Public Inquiry was set up in December 2004 and was also to examine the related deaths of two other children of which LC was one.

12. The Public Inquiry was placed on hold when the Police Service of Northern Ireland commenced a criminal investigation into the children's deaths. On 12 December 2005 the Complainants were informed that the GMC, in accordance with its then standard policy, would await the conclusion of the criminal case and the publication of the Public Inquiry report before taking any substantive action under its fitness to practise procedures.

13. In early 2008 the police confirmed that no criminal charges were to be brought against any doctor in relation to their investigation. Following the police decision, the Public Inquiry was reactivated but is currently again suspended pending a decision by the Minister of Health in Northern Ireland as to whether it should progress.

14. In view of the fact that there is no indication as to whether or not the Public Inquiry will progress in the near future a decision has now been made to progress the GMC investigation notwithstanding that the public enquiry is still ongoing.

Issues to address

Please consider the following;

1. Should Dr Kelly have notified the Coroner that LC had not died of natural causes?;
2. Should Dr Kelly should have made enquiries to see if Dr Quinn had previously had interaction with the Trust?
3. If enquiries had revealed that Dr Quinn had previously had interaction with the Trust, would Dr Quinn be considered an independent expert for the purposes of writing the report?;
4. Whether Dr Kelly failed to identify that Dr Quinn's Report was flawed a) because the report failed to identify that hyponatraemia as a probable or possible cause of LC's death or b) for any other reason;
5. Whether Dr Kelly acted appropriately by not disclosing a copy of the report by Moira Stewart received on 26 April 2001 to a) LC's family and b) the Coroner;
6. Whether Dr Kelly failed to adequately investigate LC's death;
7. Whether Dr Kelly should have taken any further action on receipt of the report;
8. If Dr Kelly had dealt with the investigation differently, could this have led to RF receiving a more appropriate treatment plan;

In addition to the above, please also consider the following: -

a. Whether the actions taken by Dr Kelly fell below that expected of a reasonably competent Medical Director ;

b. If so, the ways and extent to which such conduct fell below the required standard and, in particular, whether the conduct fell **seriously** below the standard of a reasonably competent Medical Director; and

c. Any other issues which, in your opinion, are relevant to this case and which I have not raised in the above questions.

Should this case eventually proceed to a fitness to practise hearing, it may assist you to know that the question that the Fitness to Practise Panel will be considering is whether, if the facts alleged against Dr Kelly are proved, his fitness to practise is impaired to a degree that would justify action on his registration. In assessing impairment, the Panel will need to consider how far below an acceptable standard of practice the doctor fell.

It has been held by the courts that clinical negligence, such as would give rise to civil liability for damages, would not normally be sufficient to indicate impaired fitness to practice, although it may be a factor towards establishing this; rather, it is necessary to establish whether the doctor's actions have fallen **seriously** below the appropriate standard.

You should be guided by the GMC's published Guidance "Good Medical Practice 2006" and any other relevant guidance in considering the appropriate standards to be applied. If you do make reference to any other guidance/documents please provide a copy to me as an appendix to your report. As you will appreciate, the question of whether the doctor's fitness to practise is actually impaired will be a matter for the Fitness to Practise Panel alone. You should therefore not express any opinion on this or whether the actions or failings you identify amount to misconduct.

Evidential issues

When you are considering this matter I would be grateful if you could outline your own experience in this area. Should you feel the need to see any further documents or notes then please let me know and I shall do my best to obtain them for you.

Your observations must be based on the evidence which you have before you and you should not seek to resolve any disputes in relation to factual issues.

Layout of your report

The GMC has formulated a suggested standard layout for expert reports which you may find it helpful to follow. The suggested layout (by reference to key headings), and the format for a statement of truth, which should be incorporated within your report, are set out in Annex 1 to these instructions.

Duties of an expert

Although I am sure you are aware of the rules concerning experts and their duty to the Fitness to Practise Panel, the considerations you need to have in mind when preparing your report are summarised in Annex 2. Please read this document carefully. The checklist at Annex 3 should be completed and signed and returned with the report.

Instructions and written questions

Although the oral and written instructions you receive from me are not privileged, they will not be disclosed to the other side (and you will not be questioned about them) unless there are reasonable grounds to consider that your report does not include an accurate or complete summary of all the material instructions. The summary should refer to the facts and instructions given to you which are material to the opinions expressed in your report or on which those opinions are based.

Although it is unlikely in GMC matters, after your report has been served on the doctor under investigation, you may receive a list of questions from the doctor's representatives which should be limited to those necessary for the purpose of clarifying your report. I should be grateful if you would inform me if this happens before responding to any such request in case I have not received a copy of the questions.

In addition, there may be occasions when the GMC could be required to disclose these instructions and/your report to a third party pursuant to its obligations under the Data Protection Act or the Freedom of Information Act. If this possibility arises,

we will contact you and endeavour, so far as we are able to, to take your views on disclosure into account when determining whether to disclose.

Hearing

As mentioned above, this case has been listed to be heard before a Fitness to Practise Panel between 28 November to 16 December 2011. Should you be required to give evidence before the Fitness to Practise Panel, you will be contacted in advance of the hearing to check your dates of availability and/or to attend any pre-hearing conferences with Counsel should this be necessary.

If any aspect of my instructions is unclear or if I can assist further then please do not hesitate to contact me.

I look forward to receiving your report together with a signed copy of annex 3 in due course and thank you for your assistance in this matter.

As mentioned above you will appreciate that, should the matter proceed to a formal hearing, it is likely to be necessary for you to give evidence before the Fitness to Practise Panel. If this should happen, you will be contacted in advance of the hearing to check your dates of availability and/or to attend any pre-hearing conferences with Counsel should this be necessary.

If any aspect of my instructions is unclear or if I can assist further then please do not hesitate to contact me.

I look forward to receiving your report together with a signed copy of annex 3 in due course and thank you for your assistance in this matter.

Yours sincerely,

Hannah Eldridge
Solicitor
Direct Dial [redacted]
Direct Fax [redacted]
Email heldridge[redacted]