Strictly Private and Confidential
Mr James Stables
General Medical Council
3 Hardman Street
Manchester M3 3AW

Our ref: RMcM/EH/M389
Your ref: JS/HLE/Kelly

14th April 2011

Dear Sir,

Re: MPS Member – Dr J F Kelly

We write further to your letter dated 24th March 2011 (plus enclosures) and apologise for the slight delay in responding to your correspondence on which we would comment as follows.

1. We have only been provided with pages numbered pages 1 – 22 (inclusive), 46 – 57 (inclusive), 155 – 158 (inclusive) and 170 – 237 (inclusive) of the enclosures sent to Dr Durkin. We would be grateful if you would forward the further pages for our consideration.

Letter of instruction

2. Background (page 3; numbered paragraph 5): you have informed Dr Durkin that the "final post mortem" report at Tab 2c was provided to Dr Quinn on or around 21st June 2000. From the enclosures sent to Dr Durkin (as enclosed with your letter to us) it is not clear as to which version of the Post Mortem Report you are referring to. For the avoidance of any doubt, the Post Mortem Report dated 17th April 2000/13th June 2000 (copy attached) (Tab 17 our enclosed Bundle) (pages 171 – 179 (inclusive) of Dr Durkin's Bundle) was the version provided to Dr Quinn by Mr Fee at the meeting on or around 21st June 2000. The version of the Post Mortem Report dated 6th November 2003 (that refers to hyponatraemia being one of two pathological processes that could have caused LC's cerebral oedema) (Tab 48 of our enclosed Bundle) (pages 46 – 57 (inclusive) of Dr Durkin's bundle) was not provided to Dr Quinn on 21st June 2000 (it coming into existence 3 ½ years later) and, indeed, Dr Kelly had not seen this version until he received the GMC's correspondence (please see paragraph 5c of our correspondence to the GMC dated 1st July 2010). Given the, in our view, significantly different emphasis in the two Post Mortem Reports, we consider that is it is essential that this matter is brought to Dr Durkin's attention;
3. Background (page 3; numbered paragraph 5): Dr Kelly had believed that the Post Mortem Report dated 17th April 2000/13th June 2000 (but which appears to have been prepared by Dr M D O'Hara on 17th April 2000) (Tab 17 our enclosed Bundle) (pages 171 – 179 (inclusive) of Dr Durkin's Bundle) prepared by the "Northern Ireland Perinatal/Paediatric Pathology Service, Department of Pathology, Royal Group of Hospitals HSS Trust" would have been forwarded to the Coroner's Office by

the Royal Belfast Hospital for Sick Children. The responsibility for liaising with the Coroner would have lain with the clinicians at the Hospital where the Deceased died, however, at all times, Dr Kelly believed that an Inquest would take place. It is of note that the November 2003 version of the Post Mortem Report (Tab 48 of our enclosed Bundle) (pages 46 – 57 (inclusive) of Dr Durkin's bundle) appears to have been prepared at the request of HM Coroner at the "Institute of Pathology, Grosvenor Road".

4. Background (page 3; numbered paragraphs 3, 4 and 5): Dr Kelly, at the request of the Chief Executive (Mr Hugh Mills) and the Review Team (Mr Fee and Mr Anderson), and in his capacity as Medical Director, met with Dr Murray Quinn on 21st June 2000 (Tab 18 of our enclosed Bundle) along with Mr E Fee to discuss his findings. Dr Kelly also attended the meeting to clarify if there were any urgent concerns in terms of Dr O'Donohoe's practice that required immediate action. Dr Kelly was **not** involved in choosing or instructing Dr Quinn to prepare a report;
5. Background (page 3; numbered paragraph 6): Clearly there are a significant number of other individuals/information contained within the report of Dr Moira Stewart forwarded to Dr Durkin that the GMC may wish to redact;
6. Background (page 3; numbered paragraph 6): It is essential that Dr Durkin is made aware that Dr Stewart's report was prepared following Dr Kelly's suggestion to the then Chief Executive and then subsequent request to the Royal College of Paediatrics and Child Health for an external review to comment on performance issues relevant to Dr O'Donohoe's practice. Dr Kelly ensured that LC's case was included in this review, which we say is evidence of good governance;
7. Background (page 3; numbered paragraph 6): In fairness to Dr Kelly, we consider that Dr Durkin ought to be asked whether, or not, Dr Kelly's view that Dr Stewart's report (which raises biochemical abnormality as a possible cause of a seizure like episode and subsequent deterioration as well as other possible causes for LC's death) was not definite in terms of the role hyponatraemia played in LC's death, was an acceptable position to adopt;
8. Background (page 3; numbered paragraph 6): Dr Kelly's evidence will be that when Dr Stewart's report became available, LC's family had issued legal proceedings. Dr Kelly was advised by the Trust's legal advisors that Dr Stewart's report should not be shared with LC's family due to the ongoing legal action. Dr Kelly challenged this view, however, he was prevented from sharing this report with LC's family by the Trust's legal advisors until the claim for damages was concluded. The Review Team (of which Dr Kelly **did not** form part) had stated in their conclusions, and in subsequent correspondence, that it was their intention to meet with LC's family and share the findings. It was not intended that Dr Kelly, as Medical Director, would be part of any such meeting. In fairness to Dr Kelly, we consider that Dr Durkin should be asked to comment on whether, if such evidence is accepted, Dr Kelly's actions were of an acceptable standard;
9. Background (page 4; numbered paragraphs 7 & 8): It is important that it is made clear to Dr Durkin that RF's death occurred at a different Health & Social Services Trust from that in which Dr Kelly was Medical Director;
10. Background (page 4; numbered paragraph 8): Dr Kelly and the Sperrin Lakeland HSS Trust (his employer) had no knowledge or input into the circumstances of/investigation in relation to RF's death (which, as above occurred at a different Hospital Trust); and
11. Background: The Coroners' Service for Northern Ireland underwent significant changes in mid 2006. We attach a copy of some background information as regards

the Administrative Redesign/Modernisation of the Coroners' Service in Northern Ireland. LC's death occurred at the Royal Belfast Hospital for Sick Children (part of the legacy Royal Group of Hospitals and Dental Hospital HSS Trust) and, therefore, the Paediatricians at this hospital (rather than the referring Erne Hospital, where Dr Kelly was Medical Director) would be responsible for referring LC's death to the Coroner for Greater Belfast. Had LC died at the Erne Hospital, Dr Kelly would have, in accordance with practice at the time, liaised with the Coroner for Fermanagh and Omagh. Dr Kelly understood that a Post Mortem was being performed, which he believed was a Coroner's Post Mortem rather than a Hospital Post Mortem, which was actually being performed. From the outset, when he requested a copy of LC's notes to be retained, Dr Kelly fully expected that an Inquest would be held. We understand that discussions did take place between clinicians at the Royal Belfast Hospital for Sick Children and the Coroner for Greater Belfast. Whilst he accepts that he, or members of the review team, could have telephoned the Coroner for Greater Belfast or the Royal Belfast Hospital for Sick Children to ascertain the position of events, Dr Kelly was never appraised that a Death Certificate had been issued or that the Coroner was not aware that a Post Mortem had been performed within 24 hours of death. Dr Kelly would have anticipated that the Pathologist's report prepared by Dr M D O'Hara dated 17th April 2000/13th June 2000 (copy attached) (Tab 17 our enclosed Bundle) (pages 171 – 179 (inclusive) of Dr Durkin's Bundle) would have been sent to the Coroner for Greater Belfast by those at the Royal Belfast Hospital for Sick Children. It would not, in our experience, have been unexpected at that time (or even now for that matter) for an Inquest to take place a number of years after a patient's death. A Letter of Claim in respect of a civil claim for damages being brought by LC's parents was sent to the legacy Sperrin Lakeland HSS Trust in April 2001 and a Writ of Summons commencing a civil claim for damages being issued on 15th June 2001. Upon receipt of the Letter of Claim, the handling of the litigation and the Coroner's Inquest fell to be dealt with by the Trust's legal advisors. On two occasions, Dr Kelly enquired of the Trust's legal advisors as to the progress of the Inquest. Dr Kelly was informed that delays in the Inquest process were not unusual. Dr Kelly submits that had he been informed that an Inquest was not planned, he or one of the members of the Review Team would have contacted the Coroner's Office. With the benefit of hindsight, Dr Kelly wishes that he had contacted the Coroner for Greater Belfast to enquire as to the progress of an Inquest that he believed was always going to take place.

Issues raised by Dr Durkin

As regards the issues raised by Dr Durkin, we would comment as follows (adopting your lettering):

a. Job Description: Please attached 'Background CV/Job description' which we consider ought to be sent to Dr Durkin, together with Dr Kelly's Job Description (as initially enclosed with our letter to the GMC dated 1st July 2010) (further copy attached; Tab 9 of our enclosed Bundle);
b. Management structure: We are only able to provide a copy of the initial Trust Management Structure (Tab 10 of our enclosed Bundle) enclosed with a letter to Dr Kelly dated 25th November 1996. We do not believe that this document was updated in advance or during Dr Kelly's period as Medical Director;

c. Clinical Governance Structure: Although the statutory arrangements for Clinical and Social Care Governance (CSCG) did not officially begin in Northern Ireland until 2003, in preparation, Dr Kelly established the preliminary Clinical Governance Structures (Tab 11 of our enclosed Bundle) and began training in 2000/2001. Dr Kelly and the Director of Corporate Affairs drafted "A Strategy for Ensuring Quality; Clinical and Social Care Governance – A Guide for Staff" (Tab 12 of our enclosed Bundle). We also attach a copy of the DHSSPS Circular, Governance in the HPSS dated April 2003, (Tab 14 of our enclosed Bundle) which puts Clinical Governance in Northern Ireland into context. We consider that Dr Durkin ought to be advised of the above and provided with this documentation and also provided with the 1st CSCG Annual Report (Tab 13 of our enclosed Bundle) (with which Dr Kelly, as Medical Director, was centrally involved);
d. Minutes of Senior Management Team (SMT)/Board: We are not currently aware of any minutes of meetings at which LC's death was discussed either at SMT or Board level. Our understanding is that it would not have been routine for individual clinical incidents to be discussed at Trust Board level. As Medical Director, Dr Kelly did, however, have regular meetings with Mr Hugh Mills, the then Chief Executive, when issues relating to LC's death/the Paediatric Department were discussed. We understand that Mr Mills prepared agendas and made notes of these meetings, which we understand took place on 4th May 2000, 25th July 2000, 9th October 2000, 1st December 2000, 26th January 2001, 26th February 2001, 26th March 2001, 23rd May 2001, 27th June 2001, 24th July 2001, 21st August 2001, 25th September 2001, 3rd December 2001, 2nd July 2002, 20th September 2002, 19th November 2002, 16th December 2002, 13th February 2003, 14th April 2003, 8th May 2003, 12th June 2003, 14th August 2003 and 11th September 2003. Should it be required, such minutes/agendas ought to be requested of the legacy Trust/Mr Mills;
e. Notes of Action: Please see attached 'Actions Taken by Dr Kelly', which we consider ought to be sent to Dr Durkin. At Tabs 16 to 49 of our enclosed Bundle, we have included various correspondence/documentation that Dr Kelly holds detailing some of the steps that he took during this period. Dr Durkin should be made aware that Dr Kelly was, as Medical Director, centrally involved in dealing with issues regarding complaints and issues of performance in respect of Dr O'Donohoe. To assist Dr Durkin, we consider that the GMC ought to forward Dr Kelly's statement that he provided to the PSNI when he voluntarily attended for interview on 6th April 2005 to Dr Durkin (Tab 50 of our enclosed Bundle).

Additionally, we have included (Tabs 1 to Tab 49 of our enclosed Bundle) the following enclosed publications in an attempt to put into context the state of knowledge of the medical profession in Great Britain and Northern Ireland on this issue at that time and subsequently:

(a) Lesson of the week: 'Acute hyponatraemia in children admitted to hospital: retrospective analysis of factors contributing to its development and resolution' Halberthal, Halperin and Bohn; BMJ 2001; 322: 780-2 (distributed by Dr Kelly to All Consultant Paediatricians & Staff Grades at Erne Hospital on 21st June 2001) (Tab 33);
(b) 'Prevention of Hyponatraemia in Children'; 25th March 2002 letter from Dr Henrietta Campbell, Chief Medical Officer (Tab 1 and 2);
(c) CMO's Update 21 (April 2002) (Tab 3)

(d) Editorial: Prevention of hyponatraemia in children receiving fluid therapy'; Dr J G Jenkins, Dr B Taylor and Dr M McCarthy; The Ulster Medical Journal, Volume 72, No.2, pp 69-72, November 2003 (Tab 4);

(e) 'Pediatrics; Official Journal of the American Academy of Pediatrics – Acute Hyponatraemia Related to Intravenous Fluid Administration in Hospitalized Children: An Observational Study' Hoorn, Geary, Robb, Halperin and Bohn: Pediatrics 2004; 113; 1279-1284 (Tab 5);

(f) 'What routine intravenous maintenance fluids should be used? An introduction to the debate' N P Mann, 'Pouring salt on troubled waters – The case for isotonic parenteral maintenance solution' D Taylor, A Durward and 'Rubbing Salt in the wound – The case against isotonic parenteral maintenance solution' M Hatherill; Arch Dis Child 2004; 89; 411-4 (Tab 6);

(g) 'Paediatrics: Doctors ignore advice on IV fluids in children'; Hospital Doctor; page 11; 27th October 2005 (Tab 7); and

(h) NPSA: Patient Safety Alert: 'Reducing the risk of hyponatraemia when administering intravenous infusions to children'; NPSA/2007/22 (Tab 8).

We consider that Dr Durkin ought to be provided with a copy of this correspondence and all the enclosures to assist him in the preparation of his report. Dr Kelly is keen to assist the GMC in their investigation and, of course, should you require any further information, please do not hesitate to contact us.

Yours faithfully,

Carson McDowell
roger.mcmillan[redacted]
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