

# The 'Unnatural' Death of Dr Kelly: The Forensic Pathology - The Subversion of Due Process Continues

## Part three

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Andrew Watt ended his article with the post-mortem examination being carried out by Dr Nicholas Hunt on the evening the body was found 18 July 2003. It was the penetrating smell of Lysol, lights and stainless steel in the mortuary of the John Radcliffe Infirmary Oxford, as well as the remains of a fit husband and father. Nine police officers were in attendance, the most senior being Detective Chief Inspector Alan Young who was in charge of the investigation. He was at the scene on Harrowdown Hill where the unidentified body was found by Louise Holmes. In spite of his lead position in the inquiry into a missing person, and then a suspicious death, he was neither called to the Hutton Inquiry which started sitting 13 days later, nor did he submit a statement to it (1). There is no obvious explanation for the presence of nine police officers at this very morbid autopsy given that the police had sprayed the word 'suicide' about earlier that day. The size of the squad would surely have fitted better if murder was foremost in the minds of the investigating authorities.

The examination finished just after midnight. Dr Hunt wrote up his report of his findings at the scene and of his post mortem examination the next day, the 19th of July. He would have come to preliminary conclusions as to the cause of death and been helped in that by the early findings of Dr Allan the toxicologist. That first report has never been published; it was not referred to by Dr Hunt when he gave evidence at the Hutton Inquiry (2) The only report, and that is entitled Final Post Mortem Report - 25th July 2003, was published in October 2010, by the Ministry of Justice. The only original copy of this in existence is a very poor 'scan'. An OCR and tidied version of this is here (3). That the findings in the first report have never been made public was one among three important concerns brought by this author to the General Medical Council in 2011, established by the Medical Act of 1858. (4) This will be discussed later but suffice to say they were dismissed.

Dr Nicholas Gardiner, HM Coroner for Oxfordshire, opened an inquest as the law demands for all violent, unnatural or unexplained deaths on the 21st July. It is surprising that transcripts of coronial hearings are seldom made. The hearing would have been attended by Dr Hunt, the coroner's officer and the police. It would have been adjourned until more evidence had flowed in. However, it can be inferred that the cause of death had been given by Dr Hunt. (5 )

Whilst this mouse of an inquest moved ever so quietly, an elephant had been trampling the undergrowth for the three previous days, starting at Harrowdown Hill. Within three hours of the body being found, my Lord Hutton had been engaged to chair an ad hoc inquiry, by my

Lord Falconer as Dr Watt has already described. Miles Goslett recently reported in the Mail that Hutton had confirmed in a letter to Norman Baker MP that he had been asked to meet Lord Chancellor Falconer in his Lord's office around noon of the 18th July and that he agreed to serve.(6) At that point the subject, David Christopher Kelly CMG DSc had not been identified and no cause of death had been established. This fixer was a friend of Blair's when they were in chambers studying law! He had assisted his friend the PM in bolstering the claim that there was a legal basis for a massive bombardment and invasion of Iraq rather than it being a supreme war crime as defined at Nuremberg.

It is salutary to consider that it took six and half years for the Chilcot Inquiry into the Iraq 'War' to be set up in which over one million Iraqi humans died, at least two million were maimed by customary calculation and four million were made refugees in Syria and Jordan. It took the New Labour high command, the sofa cabinet, just three hours after the death of just one man to set up Hutton with the clear intention of containing the inquiry and ensuring safe conclusions. The instruction given to Hutton was to '...urgently to conduct an investigation into the circumstances surrounding the death of Dr Kelly'. 'Urgently' can be interpreted as 'nail this promptly', 'consider' as 'without especial accuracy' and 'circumstances' as equalling the 'media furore' which obviously drove Kelly to an inevitable suicide. It was not who the deceased was, and how, when and where he died which are the plain duties of a coroner. It was the 'circumstances'; and if anything showed the mind and the motives of this most evil cabal, that word is the nub.

The words of the two conversations (6) between Falconer in Westminster and his pal Blair on wing to Tokyo in the hour after noon that day have not, of course, been revealed. That it was to do with an awkward corpse in a wood it is fair to assume. After all, it was a central topic at the press conference in Tokyo where blood, or other medium, drained from Blair's face with 'Have you got blood on your hands Mr Blair' from a Daily Mail journalist. The obvious answer was that he had the blood of thousands upon thousands of people on his hands whereas the European only had one white man in mind at that moment.

Correspondence by Ms Albon of Falconer's other office (he was also the Secretary of State in the Department of Constitutional Affairs - Mikado style) with the Oxfordshire coroner has a dictatorial ring to it. It was recognised he had to reconvene his inquest in law but this mouse then had to be silent until the elephant had trumpeted the findings. All this was engineered by the mechanism of Section 17a of the 1988 Coroner's Act. It had been applied for multiple deaths of common cause - Shipman, the Ladbroke rail crash and the sinking of the trawler Gaul. It had at its root - efficiency in investigation, thoughtfulness towards loved ones and verdict as to the common cause. There was no justification for invocation of Section 17a on top of this ad hoc inquiry other than to shackle the coroner and thus to subvert due process. With a few 'phone calls Falconer had made certain with this ad hoc 'judicial' inquiry that there would be no evidence under oath, no ability to subpoena witnesses, no cross examination and no ability to call a jury. The last thing he wanted was twelve good women/men and true.

The coup de grace for the mouse was this Section 17a. There was a further hearing on the 14th of August at which an extraordinary death certificate was conjured up and registered four days later. The hearing was not publicised and again there was no transcript or reportage. This officer of the Crown whose authority and duties stretched back to the 13th Century had been made into a small creature by power and cunning. "The use of these powers to oust the Coroner's jurisdiction ..." is how Frances Swaine of Leigh Day & Co put it

an excellent memorandum to the Attorney General in October 2010. (7) (Leigh Day were initially instructed by Dr Frost; they did a large amount of excellent work without charge.)

A letter that Mr Gardiner wrote 6th of August to Ms Albon includes "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."

(5 - section ONE). This was brushed aside in a letter from lawyers acting for Dr Hunt who were reacting to this long letter from the author to the GMC listing his concerns about Dr Hunt's performance.(5) Whether his opinion had been changed or not, there was an absolute professional and legal requirement on him to reveal his initial report with its conclusions and his train of thought.

This principle has been tested in the case of Dr Kenneth Shorrocks who is currently suspended for unknown reason from the Home Office list of forensic pathologists which was last updated 15th May 2013. This extract from (5 - section ONE) - "He was charged with serious professional misconduct by the General Medical Council on eight counts I believe. He had produced a second post-mortem report on a hospital patient which was indicative of negligence by the surgeon without any reference to his first report which had exonerated the surgeon.'

The surgeon was charged with manslaughter but was cleared. He complained to the Home Office whose Scientific Standards Committee of the Policy Advisory Board opined that he had not 'maintained the standards required' and simply issued advice, its interest ending in July 2004. The surgeon then complained to the General Medical Council. Mr Vernon Coaker, Minister of State at the Home Office, said in a letter to the author 22 November 2008 "The GMC had been considering the complaint for, I believe, many months (prior to July 2005) and had, similarly, taken no steps to restrict Dr Shorrocks's practice."

Of the greatest importance is the fact that he was called from Sheffield to examine the remains of Jean Charles de Menezes who had been shot with six hollow point bullets in the head as he sat in a 'tube' carriage 22nd July 2005. Sheffield is 150 miles from London which has at least 8 forensic pathologists available. The call to attend a headless Jean Charles was in spite of the fact that a charge of serious professional misconduct was hanging over him; the first hearing by the GMC Fitness to Practice Panel was only six weeks after the killing of Jean Charles. There had been several adjournments of the GMC hearings of this charge which was first heard 5th of September 2005. The nine page summary of the final hearing 19 February 2007 found him guilty of serious professional misconduct. (8 -HALPIN website)

This author wrote to five relevant authorities before the 22nd September 2008 inquest at the Oval, Kennington about this most improper instruction given to Dr Shorrocks to take this case in the summer of 2005. There were no replies from any one of the five; this included the Public Solicitor to the inquiry and Justice4Jean. Dr Shorrocks's evidence would be central at this inquest and would include the position and identity of each bullet prior to ballistic studies, and would thus indicate which weapon and which agent had injured Jean Charles beyond recognition IF the evidence had not been contaminated. The Independent Police Complaints Commission does not have a reputation for being just but it did not take possession of the scene until 48 hours had elapsed.

The final hearing of five altogether took place on the 5th of February 2007. The GMC panel

found him guilty of the charge of serious professional misconduct. It found his actions “unprofessional, inconsistent, unreasonable, not based upon the medical and pathological information and likely to bring the medical profession into disrepute”.

Two professors of forensic pathology advised the panel:-

Vanezis – ‘He further stated that if a pathologist had reason to change his conclusions or opinion, an explanation should be given as to why he has deemed this necessary.’

Pounder – ‘ Dr Shorrock had a duty to make reference to the existence of the first report. In addition, the second report should have given the reasons for his change of view.

Many had written in support of Dr Kenneth Shorrock. He was simply issued with a reprimand.

The reader has two forensic pathologists in examine.

One was lecturing at the Police Staff College, Bramshill, Hampshire when he was called to a corpse on Harrowdown Hill which was all about a supreme war crime.

The other was called from Sheffield to a most high profile unlawful killing at Southwell Tube Station, London.

Should the second have been on gardening leave until the GMC had considered the serious charge against him? Or did Jean Charles not deserve the best within our law?

Should the first not have fully revealed the first post mortem report he wrote up on Dr Kelly on the 19th of July? It is certain there was a FIRST report and Lord Hutton referred to it in his introduction. Were the opinions as to the causes of death different in important ways between the 19th of July and the FINAL Post Mortem Report of the 25th of July. It is clear the Coroner thought so. That this gross defect slipped through is typical of much that happened at Hutton. His professional and legal duty was made completely clear later in the case of Dr Shorrock.

We move on next to the Hutton Inquiry and its many defects.

Notes

1. <http://chilcotscheatingus.blogspot.co.uk/2010/11/death-of-david-kelly-operation-mason.html>
2. <http://webarchive.nationalarchives.gov.uk/20090128221550/>, <http://www.the-hutton-inquiry.org.uk/content/transcripts/hearing-trans33.htm>
3. [http://wikispooks.com/wiki/Document:David\\_Kelly\\_Post-Mortem\\_Report](http://wikispooks.com/wiki/Document:David_Kelly_Post-Mortem_Report)
4. [https://en.wikipedia.org/wiki/General\\_Medical\\_Council](https://en.wikipedia.org/wiki/General_Medical_Council)
5. <http://dhalpin.infoaction.org.uk/23-articles/dr-david-kelly/144-letter-to-ms-c-f-floyd-investigation-officer-general-medical-council>
6. <http://www.dailymail.co.uk/news/article-2362659/Revealed-How-Blair-fixer-picked-judge-David-Kelly-Inquiry-just-hours-weapons-inspectors-suicide.html>
7. <http://www.dailymail.co.uk/news/article-1337661/David-Kelly-report.html>
8. <http://dhalpin.infoaction.org.uk/23-articles/dr-david-kelly/146-shorrock-gmc>

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