Witness Name: Dr Dermot Kennedy
Statement No.: WITN3363004
Exhibits: None
Dated: 28 January 2022

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF DR DERMOT KENNEDY**

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I provide this statement in response to the request under Rule 9 of the Inquiry Rules 2006 dated 2 November 2021.

I, Dermot Kennedy, will say as follows: -

## Section 1: Introduction

1. My name is Dr Dermot Kennedy.
   My address is GRO-C.
   My date of birth is GRO-C 1944.

2. I am a retired Infectious Diseases consultant physician [1978-2006] in Glasgow but beforehand I worked in ID as registrar and lecturer from 1970. Including locums and volunteer work in Africa after 2006, I have had 30 years of clinical care of HIV patients. This includes W2239's late son during his last HIV illness in 1992 in ward 8, Ruchill Hospital [RH], Glasgow. I had reviewed the patient and his twin brother at RHSC Hospital, Yorkhill for 6 months before then by request of Dr Brenda Gibson OBE.

3. I was a member of multiple HIV groups, both local [chair -2] or national. These included:-

3.1. **Committee or working groups**: 7 government [4 London, 3 Edinburgh], 2 Medical Research council committees; all relating to the clinical care, prevention, science or epidemiology of HIV.

3.2. **Scientific committees** - membership of 10 in total including 5 as session chair; principally the `International Congress on Drug Therapy in HIV Infection` held 2 yearly 1992 – 2010.

**Section 2: Response to Criticism by W2239**

4. I have read W2239's 2nd and 3rd statements of August 2021 [WITN2239012 and WITN2239013]. I believe these mainly repeat complaints made in July 2018, perhaps with slight variations in wording. I believe I responded to these complaints in detail in my previous statement of November 2020. I would however like to provide this additional statement by way of further response to W2239's criticisms.

5. I have identified 9 issues of significant complaint or dissatisfaction expressed in W2239's two further statements, both of August 2021. I refer to them sequentially below with my responses underneath. They begin with quotes from W2239's text linked to the page and paragraph number. I don`t identify any specific complaints in WITN2239013 other than what, I think, are mainly general ones.

6. **Extent of Post Mortem [PM]**

"*I was unaware as to the nature and extent of the post mortem*" – [WITN2239012, page 1, para 5].

6.1. After 29 years, I am confident about what I did not say [namely that a post mortem (PM) would be limited to obtaining cerebrospinal fluid (CSF) alone], whilst I may not recall the exact words of what I did say, Dr McMenamin may. I would emphasise that the signed PM permission form states clearly

"I…[W2239] hereby consent to the examination of the body of [my son…] and to the removal of tissue, if required, for the treatment of other patients or for medical education and research". W2239 signed this. I believe its meaning is quite clear, if lacking in full and precise anatomical detail and techniques, which many lay people might find too explicit.

6.2. A highly unusual aspect here is that `treatment of other patients` did actually involve in this case another family member.

**7. Destination of referred specimens:**

7.1. W2239 writes *`[samples of my late son's body parts]….had been circulated amongst various medical schools, individual researchers..`* [WITN2239012; page 1. Paragraph 5].

7.2. When seeking PM consent, I was unaware of, nor alerted before the PM to, the prospect of specimens being despatched to `outside` experts. I did not, in particular, anticipate that the brain in its entirety would be sent to the Southern General Hospital [SGH], though it would seem probable that some tissue specimens might be. I did not further anticipate the forwarding of specimens by SGH to expert specialists outside of Glasgow. This is not, in any way, a criticism of such; quite the opposite. Given the possible preventive value of establishing a clear diagnosis, I would have hoped that outside expertise and innovative technology be recruited to help establish a diagnosis– which is, indeed, what happened when the 5th laboratory- in Belfast -was finally involved. To assist clarity I feel I would describe the referral destinations differently from W2239. My understanding is that these individuals would be experts in the field of encephalitis, who using their special expertise/experience might help establish an important diagnosis.

7.3. At that time, it was not standard practice for families to be told what was going to happen to the specimens taken at Post-Mortem, not least because gross examination might suggest an unexpected diagnosis which would need confirmation. Practice may have changed but I am not aware.

8. **Repeat of Request for PM Permission**

"The doctors approached us only 16 hours after our son's death, to discuss with us both the possibility of proceeding with a post- mortem and this was completely ignoring my instructions just prior to my son's death "not to broach this subject ever again"" [WITN2339012; page 2, paragraph 6}.

**8.1. With the exception of this case** I do not believe I have ever repeated a request for PM permission before or, indeed, asked for one in advance of a death. This case was unique- unique in circumstance and motive, with the desire to preserve the life of the identical twin. I have discussed this at length in my first response in 2020. I would add that this new disease was a complex and enigmatic one, presenting so many unknowns to clinicians who were often baffled about how the disease process might unfold. This case had a unique distinction in that infection also affected an identical twin, and here manifestations might `run true`. I know of at least one textbook on the topic of infectious diseases in twins - helpful in clinical decision making - but too early in respect of the new disease of AIDS. In care, our strategic aim was, in part, to devise means by which we might avoid or ameliorate new complications which might possibly emerge. By 1992, the 8th year of my experience of caring for patients with AIDS, we increasingly used prophylaxis against several AIDS conditions. Unusually - as an identical twin - he provided a unique opportunity to possibly avert a repeat of his brother`s fatal illness. This depended entirely on establishing the, as yet unknown, cause of death. This is why we wanted to identify this condition. We believed identification critically required a fully comprehensive PM examination.

9. **Reassurance about non-removal of Body Parts**

"reassured by Dr Kennedy that body parts including the brain were not going to be removed" [WITN2239012; page 2; para 7].

9.1. This discussion did not happen as W2239 reports. Emphatically we did not assure him about non-removal of body parts, or that only a lumbar puncture [LP] investigation alone would be done at PM.

Reassurance:

9.2. I believe most doctors would regard a request to a pathologist to limit investigation to an LP alone as unorthodox, indeed incongruous.

Let me further develop the reasons I gave previously:-

a. CSF had already been obtained by LP 5 days before death and then analysed by the most comprehensive means available. It yielded nothing, though not unusual in encephalitis. Notionally, it would have yielded even less after death given post-mortem processes.

b. It did not require a post-mortem examination to obtain CSF after death. Ward staff could have repeated an LP on site shortly after death. If rigor mortis had developed later, I could have undertaken a `special` cisternal puncture myself.

c. I could never confidently assure W2239 that `parts` would not be `removed`. This was beyond my decision-making. It rightly belonged to the pathologist as part of their designated professional role. Also, pathology was now based in a distant hospital, and further, due to clinical duties, I was unable to attend. Further, an LP is a procedure that young doctors acquire skills to perform; skills that can readily be lost and one that pathologists would never subsequently perform, thus perhaps loosing their competency to undertake an LP.

10. **Removal of Brain and consent form**

"Dr Mcmenamin and Dr Kennedy explained they wanted to take samples of spinal fluid [CSF]. We were reassured ...body parts including the brain were not going to be removed. [Looking] at the consent form I signed on 2nd December 1992...no-where does it, contradict my understanding, of what we fully understood and agreed to at the time." [WITN2239012; page 2, para 7].

10.1. **Removal of Brain**: There are 2 possible different meanings here to the word `remove`: remove from the skull or remove the brain to another location.

I did not know, or suspect in advance, what in fact did happen – the transfer of the brain in its entirety to the University Department of Neuropathology at the SGH. In retrospect I understand why, in a special case of encephalitis it was felt best to do this; but I don`t believe, looking back, I anticipated it then or had foreknowledge of it.

10.1.1. I did anticipate that the brain would be removed from the skull – to be re-positioned later - which routinely happened in every PM case, not just in cases of encephalitis of a puzzling new disease. I anticipated that very thin sections from different parts of the brain would be removed for microscopic, microbiological and pathological study. This would require various cuts in the brain. As it so happened this turned out to happen in SGH and not in Stobhill Hospital. I am quite certain I did not assure W2239 that the brain would not be removed from the skull. There was otherwise no point in having a PM, since we could not establish a diagnosis without examination, by multiple methods, of deep areas inside the brain and that meant removal from the skull.

10.2. **Meaning of consent form:** W2239 states that he has again been `looking at the consent form…nowhere does it contradict my understanding of what we fully understood and agreed to..`

10.2.1. I think the consent form is clear in its meaning – and indeed focuses on this very word `removal` - and as it states `of tissue`. Had there been agreement not to `remove` the brain – a scientifically valueless and thus highly improbable situation – then I`m sure the word `removal` would have been scored out, and an explanatory note added to the form. Dr McMenamin is a very meticulous doctor, but this would have been instinctive to a clinician anyway in completing a legal form.

## 11. Delay in transmitting the diagnosis

"When collecting medication some 6 months later .. I had a chance meeting with Dr McMenamin. Dr McMenamin explained the post-mortem results and

he also mentioned that a measles infection...." [WITN2239012; page 2; para 8].

11.1. I addressed this matter in some detail in my previous statement of November 2020 (at pages 4-7). However, I`ll summarise briefly the methods and the time frame for the complex unfolding of the eventual diagnosis, which proved completely unexpected.

11.2. The diagnosis of measles encephalitis took 28 months to establish, requiring referral of a thinly sliced brain specimen to Belfast for 2 new techniques then available there. Before that, 4 other labs, using electron microscopy, could not reach a consensus, but the majority favoured infection with one of a group of 7 viruses - which included measles and mumps. We were informed of the interim diagnosis of possible measles [or related] virus about 22/3/93 which seems to be very close to the date of W2239`s chance encounter in Ward 8. He was then informed of the [then provisional] diagnosis. There was no delay in forwarding this tentative diagnosis to him.

12. **Why records destroyed?**

"I have not had a satisfactory explanation as to why it was thought [the medical records] destroyed" [WITN2239012; page 2; para 10].

12.1. I am not able to comment on this criticism. It is properly a matter for Greater Glasgow Health Board.

13. **Lack of Informed Consent**

"In summary we had not been given informed consent to the post mortem" [WITN2239012; Page 3; paragraph 11].

13.1. **Consent**: W2239 and W2240 both gave consent. W2239 signed the permission form [see 10 above]. W2240 stated in her submission that both parents agreed to a PM [WITN2240001, p7, para 38] "...myself and my

husband said we did want a post-mortem just in case anything happened with [her surviving son] in case it could help him" She mentioned nothing here about limiting the PM to an LP or making any complaint about the nature of the PM.

13.2. **Informed**: W2239 makes reference to the concept of `informed` in WITN2239012. I recognise –in general – the problems of this term when seeking PM permission from any relative. How specific and technical should you be with bereaved relatives? There was always a real danger of distressing people further, and at their most vulnerable, by over-exact, if not ghoulish, detail. These precise aspects were often left unasked unless further pursued by relatives. If questioned on the nature of any procedures, I would always answer truthfully. The information I gave to W2239 and W2240 on this occasion was consistent with my usual practice. It was also, I believe, the standard practice amongst clinicians at the time.

## 14. Deliberately Misleading bereaved Parents

"we were purposely misled, kept in the dark" [WITN2239012; Page 3, para 11].

14.1. I think to lie and trick grieving, bereaved parents is behaviour that is appalling and unconscionable. Given all that, to do so for the simple purpose of deceit over PM permission, is bizarre in the extreme. This is not how I behave or, I believe, am recognised to behave by other staff. Further, I think it likely that it would amount to serious malpractice with referral to the GMC and possible erasure. In respect of Dr McMenamin, I believe staff and his patients would reject the idea that he was capable of such a charade. I regard him as one of the hardest working, patient-orientated middle grade doctors I have ever worked with in 30 years. The theory implies a pre-planned conspiracy by both myself and Dr McMenamin, which did not happen. This death was not the end of my contact, given the infected twin. There might be multiple occasions when the subject would re-surface, including on-going contacts with other health care staff.

## 15. W2239`s 3rd Statement of August 2021 [WITN2239013]

15.1. Having reviewed this I don`t think there are any significant new complaints or expressions of dissatisfaction which have not been raised in the first two, and which I feel I have answered.

**Section 3: Other Issues**

**16.** I would like to express my sincere condolences to W2239's family on the passing of W2240.

**Statement of Truth**

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 28 January 2022