Witness Name: Dermot Kennedy

Statement No.: WITN3363001

Exhibits: WITN3363002-03

Dated: 3/11/20

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF DR DERMOT KENNEDY**

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I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 28th June 2019.

I, Dr Dermot Kennedy will say as follows: -

**Section 1: Introduction**

1. **Please set out your name, address, date of birth and professional qualifications.**

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

2. **Please set out the positions you have held as an infectious disease consultant, the organisations in which you held these positions and your role and responsibilities in these positions.**

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 GRO-B during his last HIV illness in 1992 in ward 8, Ruchill Hospital [RH], Glasgow. I had reviewed GRO-B and his twin brother at RHSC Hospital, Yorkhill for 6 months before then by request of Dr Brenda Gibson OBE.

I use clinical abbreviations throughout and for ease of reference I set them out here:-

- AIDS = Acquired Immune Deficiency Syndrome;
- AZT= Zidovudine or azidothymidine [HIV anti-viral drug]
- CD4 =CD4 Immune Lymphocytic Cell;
- CSF = Cerebrospinal Fluid
- EM = electron microscopy
- GRI = Glasgow Royal Infirmary
- HIV = Human Immunodeficiency Virus;
- HCV = Hepatitis C Virus;
- ID = Specialty of Infectious and Tropical Diseases
- LP = lumbar puncture
- MIBE = measles inclusion body encephalitis
- PCP = Pneumocystis Carinii pneumonitis;
- PM = Post mortem.
- RHSC = Royal Hospital for Sick Children, Yorkhill
- RH = Ruchill Hospital
- SH = Stobhill hospital
- SGH = Southern General Hospital [now the Queen Elizabeth University Hospital]

3. **Please set out your membership, past or present, of any committees or groups relevant to the Inquiry's Terms of Reference which can be found on the Inquiry's website at www.infectedbloodinquiry.org.uk .**

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

**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.

**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: Criticisms of** GRO-B

4. **The 3 criticisms under Rule 9 are: In paragraph 46 of his statement, Mr** GRO-B **states that [1] `you came to speak with him at the bedside of his son the night before he passed away. He states that you had come to ask whether a post-mortem could be performed on his son. He further states that [2] he asked you not to ask this to his wife** GRO-B **. He further states that [3] he was not informed of the results from the post-mortem until a chance meeting took place some six months later`. Please comment on this.**

I will respond here to the 3 criticisms Mr GRO-B makes in his written statement. These are the only criticisms I am formally asked to reply to by the Inquiry. First, I wish to express my commiserations to Mr and Mrs GRO-B over the loss and traumas their family have undergone. I have read carefully both statements of Mr and Mrs GRO-B , along with the transcript of his oral evidence on 11th July 2019. I note that the Rule 9 request pre-dated this oral evidence. Also, several other criticisms and deprecations are made in both his written and oral statements. I haven`t responded to these as I have not been asked to. However, I want to state that I cannot agree with the validity of these 8 other criticisms. If the Inquiry asks me to respond to these I will certainly do so.

To address these criticisms, I will first outline GRO-B medical problems in 1992, and then the circumstances of his PM. I will also describe two signally important scientific issues: the implications of a PM for his identical twin; and the PM complexities of, and thus delay in, the diagnosis of his fatal measles encephalitis. The first is relevant to criticisms 1 and 2 since GRO-B, who were under my care, had HIV infection. The 2nd is pertinent to criticism 3 about delay in reporting back. I will submit copies of pathology reports and correspondence discovered in the files of the University Dept. of Neuropathology at the Queen Elizabeth University Hospital [formerly SGH], Glasgow.

**Medical summary:** Both twins had severe Haemophilia A, HIV and HCV infection - GRO-B`s disease being 3-4 years ahead of his twin. Its progression resulted in absent puberty, growth stunting, `always ill`; and a low CD4 immune count. He started HIV drug AZT in 1988; but didn`t tolerate it; thus viral resistance. In 1990 developed AIDS [as PCP]. At my 1st review in 1991- a frail, wasted teenager. Admitted x2 in 1992; but died in GRO-B with encephalitis, confirmed by scans, an HIV neurologist, and normal CSF at LP. Multiple anti-infective therapies failed; no pathogen identified. Convulsions and coma preceded death. GRO-B signed the PM permission form - allowing tissue sampling. It was all of 28 months after the PM that the diagnosis of measles encephalitis was finally confirmed.

**PM process:** the tortuous nature of this is critical to the 3rd complaint. The PM was at a distant [Stobhill] hospital. Two subsidiary, but not core, causes of death were: an acute bronchopneumonia and a bleeding duodenal ulcer. These had already been diagnosed ante-mortem. They were recorded in the interim September 21 PM report but since they were already, I believe, known to the GRO-B these were not further communicated to them. We awaited the definitive diagnosis [which unfortunately would take a further 28 months]. The appearance of [uncut] brain was normal; so it was sent by the pathologist to academic neuropathologists in the SGH for EM review. After 7 months, though there was still no definitive diagnosis, the consensus of opinions had opted for measles. In January 1995 two Belfast specialists, with special techniques, finally confirmed a measles encephalitis.

**Timing of PM findings:** It is worthwhile specifying the timelines of the findings here:-

| Date | Where | Result | Report |
|---|---|---|---|
| 4/9/92 | PM at SH | nil [bar the 2y causes as above] | interim1 on 21/9/92 |
| 9/92 | opinions – SGH*<br><br>[*opinions from experts in 4 cities = consensus, but not unanimous, for measles] | `consensus` is ? measles | interim 2 on 22/3/93 |
| 1/95 | 2 labs in Belfast^<br>[^using new techniques of immunocytochemistry and in-situ-hybridization] | definitively measles | final report on 5/1/95 |

**Implications of identical twins:** our concern for GRO-B `s twin was due to their genetic identicality. Was genetics critical to [a] the rapid rate of his HIV progression, and [b] the form of his fatal illness? Could their different disease dynamics be simply due to different times of their HIV infection? Was GRO-B 's virus more virulent? Did co-factors, such as HCV or other silent infections, accelerate disease? If the twin`s immunodeficiency reached a similar stage, might he develop this fatal encephalitis? Was it treatable [despite multiple empirical therapies, had we missed one?]. Was it preventable? These issues could only now be resolved by a PM; an unusual but very cogent reason to seek one. GRO-B `s twin would soon be at risk of AIDS, and perhaps also the added risk of this fatal illness? We needed a strategy to anticipate it, and hopefully to avert it. We had first to know its nature!

**Measles encephalitis – a difficult PM diagnosis**: this only became fully apparent with the unexpected discovery in March 2020 of GRO-B `s PM reports in their specialist files in the SGH Pathology Dept. [duplicates of those in his clinical notes]. That it took 28 further months to reach a definitive diagnosis, through specialists in 4 cities with their unique techniques, testifies to the complexity of this diagnostic puzzle. The initial [March1993] consensus, though not a unanimous view, was of a paramyxovirus diagnosis, based on the EM features. Of this group`s 7 viruses, only measles and mumps can - rarely - cause encephalitis. The diagnosis of measles was thus speculative. The breakthrough came in

Belfast in late 1994 when Glasgow heard of 2 state-of-the-art, new techniques there: in-situ-hybridization and immuno-cytochemistry. The Belfast reports confirmed the detection of widespread measles virus in GRO-B `s brain. It was only issued in Jan 1995 which was 28 months after the PM.

In 1993, I should not have been surprised at this measles diagnosis. I had written an article [Kennedy DH, `Measles`, Practitioner 1990; 234:895-900] 3 years before GRO-B `s death in which I state: "measles is now the major viral threat to immunocompromised children...[it] presents classically [with rash] or atypically. [with] convulsions. [it] heralds a delayed, but ultimately fatal, encephalitis." In1990 there was no treatment for this; and in 2020 there is still no treatment. We now know of 3 types of measles encephalitis: Measles Inclusion Body Encephalitis [MIBE] afflicts only the immunocompromised. It`s likely that GRO-B had this variant. It is - 100% - fatal and there remains no treatment.

**The three criticisms:** Responding now to these formal criticisms:-

**1st criticism: `Pressure` and bad timing regarding a PM [Mr GRO-B 's Witness Statement: p18 para 46]** Mr GRO-B 's account of being broached about a PM before GRO-B 's death is correct. However, I believe we would have approached him – diffidently - but given the evidently fraught circumstances, with care and empathy. Our timing relates to the following: [a] most importantly, the PM findings might be of potential medical significance to GRO-B 's twin [b] HIV+ve remains had also to be rendered safe without undue delay due to the risks of release of infectious fluid. This often contained, apart from HIV, many other pathogens [due to the state of advanced immunodeficiency]. Protocol required remains to be made safe promptly, despite any family debate over a PM. [c] unable to predict the time of death precisely, especially if near a weekend, I aimed to raise in advance a delicate, indeed embarrassing, issue myself. I didn`t want to delegate this after death to an unknown doctor. [d] I repeated this after GRO-B 's death hoping that Mr GRO-B would see the potential importance of a PM for his other son. I don`t think I unduly pressured him but, nevertheless, I do regret if this did upset him. I believe I was motivated by the best of intentions in an issue of undue medical importance to his family.

**2nd criticism – PM request repeated to Mrs GRO-B :** Mrs GRO-B presence at the repeated appeal just after GRO-B 's death was hardly avoidable given, I believe, the health-driven motive to repeat this request. However, I also felt that she had a right of

consultation in this decision, as his other parent, and given her constant OP attendance and devoted concern for her boys. I would add that in her statement Mrs GRO-B neither comments nor corroborates the criticisms of her husband. She states that both parents agreed to a PM; "myself and my husband said we did want a post-mortem just in case anything happened with [GRO-B's brother] in case it could help him" [Mrs GRO-B Witness Statement p7 para 38]. I further note [Mrs GRO-B Witness Statement -p9 para 47] "I believe that the boys were given all treatment they could have had at that time" and she was "unaware of any treatment...not given". She makes no personal criticism of staff. There is not much I would disagree with her account.

**3rd criticism – delay in communicating PM results:** The only delay here was due to the sheer complexity of determining the diagnosis, and not through any neglect or concealment by us. There were 3 stages to this process as highlighted in [8] above: a] the pathological recognition of the diagnosis; b] its reporting to the clinicians; c] our onward transmission to the parents [I will combine b] +c]]. Thus: a] the diagnosis, not of encephalitis, but of the viral infection triggering it, proved extremely difficult to confirm until 28 months after the PM. The reasons, I believe, relate both to his HIV status and to the use of PM fixative; b] /c] there was no point in communicating the September 1992 report, which contained no new information. The March 1993 one did have the unexpected, albeit speculative, diagnosis of measles. This was received just before Mr GRO-B encountered Dr McMenamin in ward 8 and he was then informed of the tentative finding. As it was, I probably intended to tell Mrs GRO-B myself at his twin`s next OP clinic - by taking her aside. The point is that this diagnosis was passed to the parents at a time virtually the same as when we received it. I do not remember if I ever was sent the final report 21 months later [it confirmed what I provisionally knew]. I realise I was 4th point in a chain of communication. I can honestly assure Mr GRO-B that there was no delay in informing him. Any delay related to diagnostic and technical issues.

**Section 3: Other Issues**

Again, I express condolences to the GRO-B family on their loss. Sadly, measles encephalitis, once established, was both untreatable and rapidly fatal. Whilst it may be of little consolation, it may help yet to reflect that since there was then only a 1 year, or at best 2-year survival, from a 1st AIDS episode, GRO-B was able to survive longer, and by

and large living outside of hospital, when compared to many other prolongedly hospitalised HIV patients at that time.

Our core reason for seeking a PM was determined by the ongoing care and protection of GRO-B 's brother. Given the hopeless prognosis of measles encephalitis, once established, it might be felt that he was probably doomed if exposed and thereby infected by this highly contagious virus especially in the circumstance of a similar degree of immunodeficiency to GRO-B . However, there were some limited measures available to avert such an outcome, including possibly protecting him with anti-measles immunoglobulin which I seem to remember was available then.

I hope Mr GRO-B can believe the explanations I provide for his 3 criticisms and realises that there was no dark, ulterior motive to our actions. My hope is that he might also now reflect on his 8 other complaints. However, I have studied these carefully and can provide a robust explanation for all of them. In truth I am perplexed as to why it has taken 27 years for me to be aware of any discontent, and seemingly of a grave degree too. I am gratified that Mrs GRO-B , whom I had somewhat more contact with, makes little criticism of our unit and none whatsoever of GRO-B 's care. However, Mr GRO-B does criticise the unit especially ward 8. This rather saddens me given my, I believe justified, pride in the quality of care it provided and the dedication of its hand-picked staff. I seem to remember that some of its senior staff, moved by their grief, invited Mr and Mrs GRO-B to dinner. I also believe one of the staff's seaside caravan was offered to the family for a break. Certainly, other patients were impressed enough to privately propose the unit for a Royal visit which occurred just before GRO-B 's 1st admission; and 5 years after his death they successfully nominated our unit for the competition 'Best HIV unit outside of London' - which we won.

I am indebted to the Inquiry for allowing me to respond to this, and apologise for any delay which was due to both family and personal illness.

**Statement of Truth**

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

Signed GRO-C

Dated 3-11-20

**Table of exhibits:**

| Date | Notes/ Description | Exhibit number |
|---|---|---|
| | Curriculum vitae | WITN3363002 |
| | Post Mortem Report of GRO-B GRO-B | WITN3363003 |