Dr NCA HUNT
BSc, MB BS, MRCPath, DipRCPath (Forensic)
Home Office Accredited Forensic Pathologist

Consultant - Forensic Pathology Services

FPS
Forensic Pathology Services

STATEMENT OF WITNESS

(C J Act 1967 s 9; M C Act 1980, ss 5A(3)(a) and 5B; M C Rules 1981, r 70)

Statement of *Nicholas Charles Alexander HUNT, BSc, MB, BS, MRCPath, DipRCPath (Forensic)*

Age of Witness (Date of Birth) *Over18*

Occupation of Witness *Home Office Pathologist*

Address *Forensic Pathology Services,*

This statement, consisting of 14 page/s signed by me, is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated 25 July 2003

Signed.....

Signature witnessed by.....

TVP/1/0059

DR NICHOLAS HUNT

FPS
Forensic Pathology Services

THIS IS A CONFIDENTIAL REPORT TO THE CORONER AND SHOULD NOT BE DISCLOSED TO A THIRD PARTY WITHOUT HIS PERMISSION

FINAL POST MORTEM REPORT

SC:39 /2003/cb

25th July 2003

Dr David Christopher KELLY – date of birth: 14.05.44

At approximately mid-day on the 18th July 2003, at the request of Thames Valley Police, I attended the scene of a suspicious death near Longworth, Oxfordshire.

I was logged into the outer cordon of the scene at 12.00 hrs.

I approached the inner cordon via a farm track and field. I was logged into this cordon at 12.04 hrs by PC

On arrival I was met by DI Ashleigh Smith, Acting Principal SOCO, Mark Schollar and Senior SOCO, John Sharpley

At this stage I was given brief background information by Mr Schollar, these being that the deceased was believed to be Dr David Christopher Kelly, date of birth: 14.5.44.

I understand that the deceased, a Ministry of Defence adviser, had been reported missing by relatives. He was apparently seen heading for a walk at approximately 15.00 hrs on the 17th July 2003. He was subsequently seen at 15.30 hrs walking northwards. That, I understand, was the last known sighting of him (at this stage).

I understand that he was reported missing sometime between 23.00 hrs and midnight

At approximately 09.15 hrs on the morning of the 18th July 2003, a body was discovered at the relevant location by a search team. Paramedics attended and on the basis of their examination declared that life was extinct at 10.07 hrs.

Scene Video

Prior to entering the scene itself I was shown a digital scene video by SOCO This shows the entrance and the common approach pathway and then the body of the deceased, a middle-aged male, lying fully clothed on his back

Shown on the ground next to him was a knife and a wristwatch.

There was bloodstaining visible over the left arm.

Fact of Death

Having met with the Senior Investigating Officer, DCI Young, I then proceeded to examine the body itself for the purposes of verifying the fact of his death.

The fact of death was confirmed at 12.35 hrs.

There then followed a period of time during which a fingertip search was conducted of the common approach pathway and the arrival of the forensic biologist was awaited

SCENE EXAMINATION

At 14.10 hrs I was logged back into the inner cordon by DC in the company of Roy Green, and John Sharpley.

By the time I returned to the immediate scene a scene tent had been erected over the deceased.

The body was that of a middle-aged, Caucasian man appearing the stated age. He was lying on his back with his head towards his left shoulder. His left, upper arm was in a line with the shoulder, with his elbow flexed, and his left hand pointing down towards his feet. His right upper arm lay at his side with the right elbow flexed and the right fist clenched over the right chest area. His legs were extended out before him with the left hip externally rotated. The right hip was slightly internally rotated.

Clothing

- A green 'Barbour' waxed jacket, which was undone at the zip and the buttons at the front. A mobile telephone, pair of bi-focal spectacles, a key-fob and a total of 3 blister packs of co-proxamol (10 packs) were found in the bellows pocket on the front right panel of the jacket. Only one co-proxamol tablet remained in its blister pack.
- A blue, grey and white-striped shirt; the upper four buttons of which were undone. The shirt had been left slightly open to expose the upper chest area and an ECG electrode pad was visible over the left, upper chest.
- A pair of blue denim jeans, the zip of which was done up. The left leg of the jeans was pulled up to approximately mid-calf level. The right leg was pulled up to just above the ankle.
- A brown leather belt with a white metal buckle which was done up at the waist. On the brown leather belt, over the right hip area, was a 'Virgin Atlantic' Velcro closed pouch. The Velcro was done up although the pouch flap was at something of an angle.
- A pair of beige socks.
- A pair of walking-type boots, brown leather, with the laces done up in double bows.

The body was undressed at the scene and relevant tapings and swabs obtained.

Bloodstaining and contamination on clothing

- There was bloodstaining visible over front of the right side of the shirt beneath the left hand, the palm of which was bloodstained.
- There was some bloodstaining over the right groin area and over the tops of both thighs.
- There was a heavier patch of bloodstaining over the right knee area. Also in this area was greenish material.
- There was some bloodstaining over the right elbow region and also over the right shoulder region of the waxed jacket
- There was a patch of light bloodstaining over the inner aspect of the right knee
- There was heavy bloodstaining over the left arm, including that part which was within the jacket at the scene.
- Dirt and bloodstaining over the back of the left elbow
- Bloodstaining over the back of the left elbow

Bloodstaining and contamination on exposed body surfaces

- There was heavy bloodstaining over the left arm, including that part which was inside the jacket sleeve
- Lighter bloodstaining over the back of the fingers and palm of the right hand.
- There was a band of what appeared to be vomitus running from the right corner of the mouth, slightly upwards over the right earlobe tip and then onto the right mastoid area. This appeared to have relatively uniform and parallel sides. Such material was noted around the mouth over both upper and lower lips. Vomitus could also be seen running from the left corner of the mouth and there was a possible patch of vomit staining in proximity to the left shoulder on the ground. There was some vomit staining on the back of the left shoulder area of the waxed jacket and also on the outer aspect of the upper sleeve of that side of the jacket.
- A small blood spot was noted over the right side of the neck, which was sampled at the scene.
- Two further small bloodspots, one just in front of the tragus of the right ear and one over the right cheek were also individually sampled
- The body had also acquired some soiling with dirt from the process of undressing at the scene and from movement into the body bag.

Adjacent scene

Lying adjacent to the left shoulder/upper arm was a 'Barbour' cap with the lining side uppermost. There was blood over the lining and also the peak.

Lying near his left hand, on the grass, was a black resin-strapped wristwatch, presumably a digital watch, lying face down and showing some bloodstaining.

Lying adjacent to this was a white metal 'Sandvik' pruning-type knife, or gardener's knife, with its blade extended from the handle. There was bloodstaining over both the handles and the blade and a pool of blood beneath the knife which was approximately 8-10 by approximately 4 – 5 cms.

Lying propped against some broken branches, to the deceased's left and about 1' from his left elbow was an open bottle of 'Evian' water (500 mls) The top lay close by but further

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away from the deceased. There was some smeared blood over the bottle and over the bottle top

There was bloodstaining and a pool of blood in an area running from the left arm of the deceased for a total distance of in the order of 2'-3'. There was also a patch of possible bloodstaining on the ground near the left hip region

Rigor mortis
At approximately 17 30 hrs following the tapings and swabs I was able to examine the body more fully and I noted that rigor mortis was fully established in all muscle groups.

Rectal Temperature
The rectal thermometer was inserted having first obtained a duplicate set of sexual swabs. The reading was made at 19.15 hrs when the ambient temperature was recorded at 20 8°C. The temperature on the rectal thermometer was 24°C.

Signs of visible injury
Once able to examine the left wrist I noted a total of at least five incised wounds of varying depth running in parallel over the front of the left wrist.

There was no other visible injury to the body at this stage.

Protective Clothing
During the course of the entire time I spent at the immediate scene I wore a pair of protective overshoes, a hooded white scene suite, a pair of gloves and a mask (the hood of the scene suite was up at all times). My personal dictation machine was also enclosed within a rubber glove during the course of examinations

I was logged out of the inner cordon at 19.19 hrs by DC

I was logged out of the outer cordon at 19.35 hrs

EXHIBITS LIST - SCENE

The following exhibits were handed to SOCO at the scene:

NCH/1	Right nostril swab
NCH/2	Left nostril swab
NCH/3	2x mouth swabs
NCH/4	Right shoe
NCH/5	Left shoe
NCH/6	Right sock
NCH/7	Left sock
NCH/8	Belt
NCH/9	'Virgin Atlantic' pouch from belt (empty)
NCH/10	Jeans – empty pockets
NCH/11	Underpants – 'Jockey'
NCH/12	Control swab and water
NCH/13	Plucked pubic hair
NCH/14	Penile shaft swab – wet and dry
NCH/15	Glans swab – wet and dry
NCH/16	Leaf from left hand

NCH/17	Barbour jacket
NCH/17/1	Mobile phone – Nokia, in front bottom bellows pocket
NCH/17/2	Co-proxamol blister packets – front bottom bellows pocket
NCH/17/3	Renault car key and 1x Yale key-front bottom bellows pocket
NCH/17/4	Glasses – front bottom bellows pocket
NCH/17/5	Flat cap from game pocket
NCH/18	Shirt
NCH/19	Perianal swabs x2
NCH/20	Anal swabs x2
NCH/21	Rectal swabs x2

POST MORTEM EXAMINATION

On the evening of the 18th July 2003 I attended the mortuary at the John Radcliffe Hospital, Oxford in order to undertake a Special post mortem examination on the body of David KELLY

The post mortem examination commenced at 21 20 hrs.

Those persons present were.

DCI Alan Young	SIO
DC Charles Boshell	Exhibits
	CID
Mark Schollar	Acting Principal SOCO
Katie Langford	Senior SOCO
	SOCO
	SOCO
	CID
	HMCO
	Mortuary Technician

Photographs were taken under my direction. I performed the post mortem examination.

Received in a white, signature-sealed bodybag and wrapped in a black, plastic sheet was the body I recognised from the scene. Head and hand bags were in place.

He was of medium build. He weighed 59 kgs, and was approximately 170 cms tall.

He had grey, wavy head hair, shorter at the back and sides with frontal thinning and balding over the crown. The head hair was up to approximately 8 cms over the front of the crown.

He had a full, grey, almost white, beard
He had a moderate amount of truncal body hair

The pubic hair was normal in distribution
The penis was circumcised

The fingernails were trimmed to approximately 0.1 cms
There was heavy dirt soiling but no obvious sign of fresh damage

Scars

- Two vaccination scars over the left, upper arm
- An old, curving scar around the outer aspect of the right elbow.
- There was scars representing possible calluses or treated warts over the inner aspect of the tips of both thumbs

Tattoos

There were no tattoos on the body.

Clothing

Described above.

Signs of Treatment

4 ECG electrode pads; 2 over each side of the upper chest, 2 over each side of the lower chest area.

Post Mortem Changes

- Rigor mortis was still firmly established in all muscle groups.
- The primary pattern of hypostasis was entirely posterior with blanching over mid-back and buttocks.
- Hypostasis was still mobile and shifted anteriorly on turning the body.
- It was noted that hypostasis was generally weakly developed.

SIGNS OF SHARP FORCE INJURY

There was a series of incised wounds of varying depth running across the front of the left wrist and slightly onto the thumb side of that wrist. The complex of wounds extended over 8 cms from side to side and approximately 5 cms from top to bottom.

The largest wound lay towards the elbow end of the complex and was 6 cms in length with a series of notches over the inner, upper edge. There was crushing and maceration of the skin towards the outer edge where there were again a number of notches. This wound penetrated through to the level of the tendons in the flexor compartment and there was some damage to the tendons themselves, although none appear to be completely severed. The ulnar artery had been completely severed and the ulnar nerve had been partially severed. The radial artery was intact as was the radial nerve. The wound was up to approximately 1 – 1.5 cms deep.

At the crease of the wrist there were two deep wounds. The lateral, deeper wound penetrated to the level of the flexor retinaculum (sheath of dense connective tissue around muscle tendons at the front of the wrist) and was approximately 2 5 cms long on the skin surface. The smaller, shallower wound was 2 cms long.

There were multiple, fine, superficial, incisions extending from all of the deeper incisions and the vast majority of the injuries lay in parallel with one another.

Towards the upper end of the injury complex there were at least four criss-crossing, superficial incisions varying in depth between just cutting the epidermis to just entering the fat. These varied in length between approximately 2 5 and 3 cms. They were all crossed by a number of fine incisions, some orientated obliquely across the wrist. The impression given was of multiple, so-called 'tentative' or 'hesitation' marks.

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There was also a series of at least three, minor, superficial incisions running in parallel on the inner aspect of the junction of the left wrist crease with the left hypothenar eminence (bulge of tissue at the base of the little finger on the palm of the hand). These were each approximately 1 2 cms in length.

There was extensive reddening around the whole injury complex indicating that they had been inflicted whilst the victim was alive.

OTHER SIGNS OF INJURY/MARKS UPON THE BODY

Head and Neck

1 On the left parietal scalp at a point approximately 8 cms above and 1 cm behind the top of the left ear was a series of three, superficial abrasions covering a total area of 1 2 x 0.5 cms. The largest component lying posterior and 0.5 by up to 0.3 cms

2. Lying at a point approximately 5 cms behind the top of the left ear, at a similar level to the above-described injury, was an area of irregular abrasion extending in total over 2 5 x 2.5 cms in a rather discontinuous fashion. The longest component being 2.5 x 0 4 cms and linear.

3 Over the left side of the back of the vertex, at a point approximately 10 cms above and 8 cms behind the top of the left ear, was a 0 2 cm abrasion.

Trunk

There were a number of so-called Campbell de Morgan spots over the trunk and a small group of post mortem 'abrasions' over the upper chest suggestive of insect activity, but no definite evidence of injury noted on external inspection.

Right Upper Limb

No sign of sharp force or other injury to this part of the body.

Left Upper Limb

No sign of additional injury to this area of the body.

Left Lower Limb

An area of reddish discolouration, probably irregular hypostasis, over the side of upper part of the left calf/shin. This area extended over 3 by up to 1.9 cms but was not confirmed to be bruising on subcutaneous dissection.

A minor red lesion of uncertain origin on the back of the mid-part of the left calf

Right Lower Limb

A tiny red lesion of uncertain origin on the inner aspect of the right, mid thigh and measuring less than 0 1 cms in maximum dimension

Minor reddened lesion with a light serum crust, of uncertain origin, over the inner aspect of the right knee, less than 0.1 cms in maximum dimension

Punctate, reddened lesion, 01 cms across on the outer aspect of the left, upper thigh

INTERNAL EXAMINATION

SCALP: There was no evidence of scalp bruising. The scalp was stripped to the level of the nape of the neck posteriorly.

SKULL: The skull was of normal thickness. The dura was stripped and there was no skull fracture.

BRAIN: The meninges and dural sinuses were unremarkable. The external and cut-surface appearance of the brain was normal. The vertebrobasilar system and Circle of Willis showed only minimal focal atheroma. There was no aneurysm and no intracranial haemorrhage.

FACE: The facial soft tissues were dissected to the level of the bone and there was no evidence of soft tissue or bony injury.

MOUTH: There was a small abrasion consistent with contact against the teeth or biting of the lips on the lower lip in the midline. This was approximately 0.6 x 0.3 cms. There was no significant vital reaction. There was no other injury to the lining of the mouth. The teeth were natural and uninjured. There was some evidence of previous dental work. The tongue was unbitten

NECK: The neck structures were formally dissected in situ following full vascular drainage. There was no bruising in the strap muscles. The hyoid bone and thyroid cartilages were intact. The cervical spine was intact. The vascular structures of the neck showed only minimal focal atheroma.

CHEST: The pleura were stripped. The ribs were flayed and there was no evidence of old or fresh rib fractures. The pleural cavities were unremarkable.

LUNGS: The tracheobronchial tree was normal. The lungs were normally inflated and showed a degree of posterior hypostasis, but no other definite abnormality. In particular there was no evidence of infection, infarction, tumour or pulmonary embolus.

HEART: The aorta showed focal complex plaques particularly in its distal descending portion. There was no aneurysm. The major non-coronary branches were widely patent. The great veins were unremarkable. The pericardium, atria and valves were normal. The right and left coronary arteries were co-dominant. The left and right coronary arteries emerged from a single sinus. Within the mid-portion of the right coronary artery there was almost complete obliteration of the lumen by atheroma. Elsewhere there was 60 -70% stenosis in this vessel. Within the left, anterior descending coronary artery there was up to 70% luminal stenosis by atheroma with one point distally which appeared to have been re-canalised. The circumflex artery and the obtuse marginal branch showed 60 – 70% stenosis focally. There was no definite acute plaque event identified. Slicing the myocardium showed occasional minor flecks of pallor in the posterior wall of the

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left ventricle raising the possibility of previous episodes of ischaemia/infarction, however there was no evidence of territorial infarction. The ventricular chamber dimensions were normal.

OESOPHAGUS: Healthy and uninjured.

STOMACH: The stomach contained a moderate amount of dark-coloured fluid without definite tablet residue visible macroscopically although there were some remnants of food, including possible tomato skins. There was no intrinsic abnormality.

INTESTINES: The mesenteries were normal with no evidence of injury. There was no evidence of peritonitis. The small and large intestines were normal. The appendix was present and appeared healthy.

LIVER: The liver showed slight pallor in keeping with blood loss but there was no focal abnormality. There was no macroscopic evidence of significant fibrosis. The gall bladder contained a moderate amount of relatively thin bile. There were no stones. The extrahepatic biliary tree was normal. The vascular structures of the porta hepatis were normal.

KIDNEYS: The renal capsules stripped with ease to reveal smooth-surfaced kidneys showing slight cortical pallor in keeping with blood loss but no other abnormality. The pelves were not dilated. The ureters were of normal calibre.

BLADDER: The bladder contained a moderate volume of pale yellow urine. It was not cloudy. The balder wall and mucosa appeared normal.

GENERATIVE ORGANS: The penis and scrotum were uninjured. The testes were dissected and inspected directly. They showed no evidence of injury or natural disease. The prostate gland showed slight nodular enlargement. It did not appear to be cancerous.

SPLEEN: The spleen had a normal external and cut-surface appearance. It was uninjured. There was no significant lymphadenopathy.

ENDOCRINE ORGANS: The pituitary, parathyroid, thyroid, pancreas and adrenal glands appeared normal.

OTHER ORGANS: Subcutaneous dissection of the upper limbs revealed no additional area of injury.
Subcutaneous dissection of left, lower limb revealed a small area of bruising over the outer part of the upper end of the left shin, just below the knee, measuring approximately 1 cm in maximum dimension.
Subcutaneous dissection of the right, lower limb revealed two areas of bruising, just below the level of the right knee on the inner aspect of the upper part of the shin, the uppermost 1 cm in maximum dimension and the lower 1.5 cms in maximum dimension.

Subcutaneous dissection of the back revealed two small bruises each approximately 1 cm in maximum dimension, over the lower part of the left side of the chest in the mid- axillary line.
Muscular dissection of the lower back showed a small area of haemorrhage in the upper part of the para-lumbar muscles on the right, lower chest area.

ORGAN WEIGHTS:

Brain	1621 gms
R Lung	368 gms
L Lung	475 gms
Heart	412 gms
Liver	136 gms
Pancreas	139 gms
Spleen	92 gms
R Kidney	159 gms
L Kidney	166 gms

Post mortem concluded at 00 15 hrs on Saturday 19th July 2003.

EXHIBITS LIST – MORTUARY

The following exhibits were handed to DC BOSHELL at the mortuary:

NCH/22	Plastic bag from head
NCH/23	Comb head hair
NCH/24	Right hand bag
NCH/25	Plucked head hair
NCH/26	Pulled head hair (drugs)
NCH/27	Combings – beard
NCH/28	plucked beard hair
NCH/29	Left hand nail clippings
NCH/30	Right hand nail clippings
NCH/31	Scissors used for nail clippings
NCH/32	Electrode pads
NCH/33	Swab – vomit – RHS face
NCH/34	Swab – vomit – LHS face
NCH/35	Wet and dry swab of apparent bloodstain to RHS of face
NCH/36	Wet and dry swabs – right cheek
NCH/37	Body bag
NCH/38	Black plastic sheet
NCH/39	Jar of preserved urine
NCH/40	Container of urine
NCH/41	Container of bile
NCH/42	Container of bile (preserved)
NCH/43	Heart blood
NCH/44	Blood fluoride oxalate
NCH/45	Blood EDTA
NCH/46	Blood EDTA
NCH/47	Plain blood
NCH/48	Left lung

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Exhibits – mortuary Contd.

NCH/49	Contents of stomach
NCH/50	Liver
NCH/51	Deep muscle tissue
NCH/52	Vitreous humour (preserved)
NCH/53	Vitreous humour

TOXICOLOGY

At the time of completing this report, I have been provided with the following verbal information by Dr Alexander ALLAN, a forensic toxicologist from Forensic Alliance Limited.

- The blood sample contains the drug dextropropoxyphene at a concentration of 1.0 micrograms per millilitre.
- The blood sample contains the drug paracetamol at a concentration of 97 micrograms per millilitre.
- Paracetamol is present in the stomach contents.
- No alcohol has been detected.
- The results of the analysis for volatile chemicals is still pending.

In addition, I have been provided with a copy of the formal statement of Dr ALLAN dated 21st July 2003 and given the laboratory reference FAL-05969-03

A range of therapeutic and non therapeutic drugs were looked for as detailed in the statement. In addition, the blood has been analysed for the presence of volatile chemicals.

The levels of dextropropoxyphene and paracetamol in the blood were confirmed as above.

Acetone was found in the urine but no other volatile chemical was detected.

HISTOLOGY

A total of 15 Haematoxylin and Eosin stained sections have been examined.

The sections of the brain show mild widening of the pericellular and perivascular spaces in keeping with a mild degree of terminal brain swelling. There are no features of infarction (stroke), haemorrhage, inflammatory disorder or tumour. The meninges are normal.

The sections of the heart show no evidence of old or recent infarction. There are no inflammatory changes in the heart muscle. The connective tissue component (interstitium) is within normal limits.

The lungs show small areas of collapse and minimal, focal oedema (fluid collection). There is no evidence of significant fibrosis (scarring) and no microscopic evidence of infection, infarction, tumour or pulmonary embolus.

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The liver shows mild large droplet fatty change. The architecture and portal tracts are normal. A few groups of lymphocytes are noted in lobules but are not associated with liver cell destruction.

The kidney shows typical post mortem changes but otherwise unremarkable glomeruli, tubules, interstitium and vessels.

The spleen and adrenal gland show no significant pathological abnormality.

TIME OF DEATH ESTIMATION

The following estimate offered of the likely post mortem interval is based upon the temperatures recorded at the scene and computed with the aid of Henssge's nomogram as described in: Henssge, Knight, Krompecher, Madea and Nokes. The Estimation of the Time of Death in the Early Post mortem interval; 2nd Edition, Arnold, London, 2002.

Using the standard nomogram, the estimate obtained is that death is likely to have occurred some 18-27 hours prior to taking the rectal temperature at 19.15 hours on Friday 18th July.

This gives a time range of between 16.15 hours on 17th July and 01.15 hours on 18th July during which death is likely to have occurred.

CONCLUSIONS

1. The deceased was an apparently adequately nourished, man in whom there is no evidence of natural disease that could of itself have caused death directly at the macroscopic (naked-eye) level.

2. He has evidence of a significant incised wound to the left wrist, in the depths of which his left ulnar artery has been completely severed. This is in the context of multiple incised wounds grouped over the front of his left wrist and of varying length and depth.

3. The arterial injury has resulted in the loss of a significant volume of blood as noted at the scene.

4. The complex of incised wounds over the left wrist are entirely consistent with having been inflicted by a bladed weapon; the most likely candidate for which would be a knife.

5. The knife present at the scene would be a suitable candidate for causing such injuries.

6. The orientation and arrangement of the wounds over the left wrist are typical of self-inflicted injury. Also typical of this is the presence of small so-called 'tentative' or 'hesitation' marks.

7. The fact that the watch appears to have been removed whilst blood was already flowing suggests that it has been removed deliberately in order to facilitate access to the wrist. The removal of the watch in this way and indeed the removal of the spectacles are features pointing towards this being an act of self-harm.

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8 Other features at the scene which would tend to support this impression include the relatively passive distribution of blood, the neat way in which the water bottle and its top were placed, the lack of obvious signs of trampling of the undergrowth or damage to clothing. The location of death is also of interest in this respect as it is clearly a very pleasant yet relatively private spot of the type that is sometimes chosen by people intent upon self-harm.

9. Many of the injuries over the left wrist show evidence of a well-developed vital reaction suggesting that they have been inflicted over a reasonable period of time (minutes rather than seconds or hours) before death.

10 There is a total lack of classical 'defence' wounds against a sharp weapon attack. Such wounds are typically seen in the palmar aspect of the hands or over the outer aspect of the forearms.

11. It is noted that he has a significant degree of coronary artery disease and this may have played some small part in the rapidity of death but not the major part in the cause of death.

12 Given the finding of blister packs of co-proxamol tablets within the coat pocket and the vomitus around the mouth and floor, it is an entirely reasonable supposition that he may have consumed a quantity of these tablets either on the way to or at the scene itself.

13 The toxicology result indicates that prior to his death he had consumed a significant quantity of these tablets. The active ingredients of co-proxamol are paracetamol and dextropropoxyphene. The absolute levels of paracetamol and dextropropoxyphene in the blood are not particularly high and may not ordinarily have caused death in their own right. In this particular case however, even these levels may be relevant as one must consider that dextropropoxyphene may cause death by its actions upon the heart leading to abnormalities of heart rhythm. Such abnormalities of heart rhythm are made all the more easy to induce if there is hypotension (low blood pressure) as the result of bleeding and underlying narrowing of the coronary arteries. In this case, both the latter factors would be operant.

14 Dextropropoxyphene is an opioid drug which is relatively rapidly absorbed into the blood following ingestion. It has an analgesic effect and hence would be expected to deaden the perception of pain due to injury, particularly when taken in the sort of amount seen here which is above the normal therapeutic range.

15 In addition to the usual toxicology samples I had also provided police with one of the lungs of the deceased should the question of him being over powered by an assailant using a volatile chemical such as chloroform be raised. Given the lack of volatile chemicals detected in the blood, I am satisfied that this may be re-united with the body for burial.

16 The minor injury to the inner aspect of the lip is not associated with bruising nor damage to teeth and does not appear to have any well-developed vital reaction. This sort of injury may be caused if the tissues of the mouth are bitten.

17. The minor abrasions over the head are entirely consistent with scraping against rough undergrowth such as the small twigs, branches and stones which were present at the scene

18. The minor reddened lesions on the lower limbs are typical of areas of minor hair follicle irritation.

19. I have undertaken subcutaneous dissection of the arms and the legs and there is no positive evidence of restraint-type injury.

20. There is no positive pathological evidence that this man has been subjected to a sustained, violent assault prior to his death.

21. There is no positive pathological evidence to indicate that he has been subjected to compression of the neck such as by manual strangulation, ligature strangulation or the use of an arm hold.

22. There is no evidence from the post mortem or my observations at the scene to indicate that the deceased had been dragged or otherwise transported to the location at which his body was found.

23. In accordance with current Home Office guidelines I have retained small samples of major organs for histological analysis. The minor findings in the lungs and the brain are in keeping with the cause of death. The finding of mild fatty change in the liver is not relevant in terms of causing death. Such changes may be seen in a number of settings such as diabetes, sustained alcohol consumption, fasting, etc.

24. The pathological investigation into the cause of death is now complete and I have no further need for Dr Kelly's body to be retained.

25. In summary, it is my opinion that the main factor involved in bringing about the death of David Kelly is the bleeding from the incised wounds to his left wrist. Had this not occurred he may well not have died at this time. Furthermore, on the balance of probabilities, it is likely that the ingestion of an excess number of co-proxamol tablets coupled with apparently clinically silent coronary artery disease would both have played a part in bringing about death more certainly and more rapidly than would have otherwise been the case. Therefore I give as the cause of death:

1a. Haemorrhage
1b. Incised Wounds to the Left Wrist

2. Co-proxamol ingestion and coronary artery atherosclerosis

Dr Nicholas Charles Alexander HUNT
BSc, MB, BS, MRCPath, DipRCPath (Forensic)
Home Office Accredited Forensic Pathologist
Consultant – Forensic Pathology Services