Witness Statement Ref. No. 139/2

NAME OF CHILD: Claire Roberts

Name: Roger Stevenson

Title: Dr

Present position and institution:

Previous position and institution:
[As at the time of the child's death]

First term Paediatric SHO, as part of the 2yr RVH Medical Rotation / Training Scheme

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since your Witness Statement dated 6th January 2012]

Previous Statements, Depositions and Reports:
[Identify by date and title all those since your Witness Statement dated 6th January 2012]

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	**Date:**	
WS-139-1	06.01.2012	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

QUERIES ARISING OUT OF YOUR INITIAL WITNESS STATEMENT

With reference to your Witness Statement dated 6th January 2012, please provide clarification and/or further information in respect of the following:

(1) Answer to Question 2 at p.2

"I recall that the medical team consisted of the Consultants attached to Allen Ward, a Paediatric Registrar and I think 2-3 SHOs. One of these SHO had more experience and was training especially in Paediatrics..."

(a) State to the best of your recollection the identity of the other 2 SHOs on the medical team attached to Allen Ward on 22nd October 1996

I am unable to recall the exact identity of the other 2 SHOs. To the best of my recollection it may have been a Dr Liz Dalzell and a Dr Cloadagh Brennan but I am not entirely certain of these 2 names.

(b) State to the best of your recollection the identity of the SHO who *"had more experience and was training especially in Paediatrics"* at that time.

It would have been the above named doctors.

(2) Answer to Question 3 (c) at p.3

"... I was on duty during the day of the 22nd, within normal working hours..."

(a) State to the best of your recollection what were the *"normal working hours"* during the day at that time.

To the best of my recollection normal working hours were from 08.30 to 17.30

(3) Answer to Question 8 at p.5

"The ward round was conducted by Dr. Sands on the morning of the 22nd... A member of the nursing team was, as I recall, also present..."

(a) Identify the *"member of the nursing team [who] was...also present..."* by name and position.

I am unable to recall any of the names and positions of the nurses present that morning.

(4) Answers to Question 9(a) & (b) at p.5

"(a)...I documented the results of those bloods outside their normal parameters, in the notes and this was likely to have been noted at the time of the ward round..."

"(b)...I am unable to recall if these results were conveyed orally during the ward round or if Dr. Sands read these results for himself."

(a) State whether or not it was or was likely to have been *"noted at the time of the ward round"* that the blood results recorded at Ref: 090-022-052 by Dr. Volprech related to a blood sample taken upon admission on 21st October 1996, and not to any sample taken on the morning of 22nd October 1996.

It was likely that the blood results recorded were those that related to the sample taken upon admission.

(b) State whether you made Dr Sands aware that those blood results related to a blood sample taken upon admission on 21st October 1996, and not to any sample taken on the morning of 22nd October 1996.

I am unable to recall if I made Dr Sands aware that these blood results related to the sample taken at admission.

(c) In particular state whether Dr. Sands was, or was likely to have been, aware that those blood results related to a blood sample taken upon admission on 21st October 1996, and not to any sample taken on the morning of 22nd October 1996.

It was likely that he was aware of these results were from the sample taken on admission as it was unlikely that any further samples would have been taken to the ward round that morning.

(5) Answer to Question 17 at p.9

"I am unable to recall if I did consider carrying out... a blood test for electrolytes. I am unable to recall if I did discuss with Dr. Sands the need to repeat a blood test for electrolytes. Any considerations were likely to have been made at the time of the ward round that day with Dr Sands."

(a) State to the best of your recollection whether or not there was any ward round discussion relating to carrying out a further blood test for electrolytes and/or full blood count on 22nd October 1996. If so, describe that discussion to the best of your recollection.

I unable to recall if there was any discussion about carrying out a further blood test.

(b) State whether any request was made for a repeat electrolytes test for Claire either during the ward round or later on 22nd October 1996. If so, state who made this request, when it was made and when the sample was to be taken from Claire for that test.

I am unable to recall if a request for a repeat electrolyte test for Claire was made either during the ward round or later. I am unable to explain why not.

(c) State whether a repeat electrolytes test for Claire was planned either during the ward round or later on 22nd October 1996. If so, state when it was planned to carry out this test and where this was recorded.

I am able to recall if a repeat electrolyte test for Claire was planned either during the ward round or later. I am unable to explain why not.

(d) State where a request for blood tests for electrolytes and/or full blood count would usually have been noted/recorded in October 1996, and by whom this request would usually have been recorded. In particular state whether this request would usually have been recorded in:

(i) the clinical notes

It would have been my practice to document a request or plan, had it been made, to undertake blood tests for a patient in the clinical notes.

(ii) the nursing notes

I am unable to state if a request would have been included in the nursing notes.

(iii) on a separate piece of paper

I am unable to recall if the request was put on a separate piece of paper.

(iv) in the ward round diary or

I am unable to recall if a ward round diary was used.

(v) in a book as 'work to do'.

I am unable to recall if a book as "work to do" was used.

If so, explain when and by whom this would be done and whether it was done in Claire's case.

(e) Explain whether or not further blood tests for electrolytes and/or full blood count would likely have been discussed and/or requested at Claire's ward round.

I am unable to recall if discussions/requests for further blood tests at Claire's ward round took place.

(f) State when further blood tests for electrolytes and/or full blood count would normally/likely have been carried out when a paediatric patient had been admitted on the previous evening and those blood tests were carried out on admission, particularly if the serum sodium concentration and white cell count results were abnormal and there was no definitive or definite diagnosis on the ward round.

To the best of my recollection, further blood tests that were required or requested on a ward round would normally have been taken that morning following the ward round.

(g) If the ward round discussion resulted in a decision/plan/request to carry out those blood tests again on 22nd October 1996, state:

(i) How soon after the ward round and/or when would the sample for those blood tests likely/normally have been taken and by whom

To the best of my recollection, normally blood tests were taken by the SHO that morning after the ward round.

(ii) Who would have been responsible for ensuring/checking that blood samples were taken in accordance with any such plan/decision/request, transported to the laboratory and obtaining/checking the results thereof.

The responsibility would have been with the person taken the blood sample, to label the sample tube and appropriate labelled form, which was then placed in a basket for collection by the hospital porters to be taken to the appropriate lab. To the best of my recollection, test results were then taken back to the ward, via internal mail system, to the ward later that day, usually in the afternoon.

(iii) The reasons why a blood sample was not taken until approximately 21.30 on 22nd October 1996.

I am unable to give reasons why a blood sample was not taken until 21.30 on the 22nd October 1996.

(h) State at what times any additional intravenous cannulas (that is other than the cannula sited on admission) were sited on 22nd October 1996, and identify who sited any cannula/s on 22nd October 1996 and identify the note thereof.

I am unable to recall at what time and by whom any additional intravenous cannula/s were sited.

(i) In particular state whether you sited the cannula in the afternoon of 22nd October 1996 to enable the intravenous infusion of midazolam to be administered to Claire at 16.30 as recorded in the Fluid Balance and IV Prescription Sheet (Ref: 090-038-135). If you cannot recall this specifically, state whether you would normally/likely have been responsible for siting a cannula as SHO on duty on Allen ward.

I am unable to recall if I sited the cannula in the afternoon of 22nd October 1996. To the best of my recollection if would normally be the responsibility of the SHO on duty on Allen ward to do this though there may have been nurses trained in this procedure. I am unable to recall if that was the case on Allen Ward.

(j) Identify the person/s by name and job titles who would normally have sited any cannula in Claire's case.

I am unable to recall other people by name and job title that would normally have sited any cannula in Claire's case other than the Doctors.

(k) Identify the person/s by name and job title who would have been responsible for obtaining a blood sample from Claire to carry out blood tests on electrolytes and full blood count during the day on 22nd October 1996.

It would have been the responsibility of the SHOs on duty that day to normally take a blood sample.

(l) Explain whether, before ending your duty on 22nd October 1996, you checked that a blood sample had been taken from Claire for testing electrolytes and full blood count, and what the results of those tests were, and explain the reasons for your answer.

I am unable to recall whether I checked that a blood sample had been taken from Claire or its results as it was possible that no request was given to me to do these test following on from the ward round or Dr Webb's visits that afternoon of the 22nd October.

(m) If the request/decision for further blood tests on electrolytes and/or full blood count was made after the ward round on 22nd October 1996, state whether that decision/request/plan would likely/normally be noted and recorded in any document, and if so, identify that document and identify who would have been responsible for making that note/record.

It would normally be my practice to note any such request as part of ongoing treatment plan, which would have been documented in the clinical notes.

(6) Answer to Question 19 at p.10

"I think that this was Dr. Steen."

(a) State the basis for your belief that Dr. Steen was responsible for Claire's care on 22nd October 1996.

To the best of my recollection, this was based on hearing the next morning that Claire had died in PICU and I knew that Dr Steen was the duty Consultant for Allen Ward at that time.

(b) State whether any other members of the paediatric medical team or nursing team shared that belief, and if so, identify those persons.

To the best of my recollection this was shared by Dr Sands and the nursing team. I am unable to recall the identity of the nursing team who shared this belief.

(7) Answer to Question 20(c) at p.11

"I recall Dr Sands and another SHO were present on this ward round and to my knowledge nurses were also present. I am unable to remember who the other Doctor was or nurses were."

(a) State to the best of your recollection whether the SHO *"present on this ward round"* was male or female.

To the best of my recollection I think the SHO was female but I am not entirely certain of this.

(b) For your assistance, the other SHOs known to be on duty on 22nd October 1996 include Dr. Neil Stewart and Dr. Joanne Hughes. State to the best of your recollection whether the SHO *"present on this ward round"* was either of those SHOs.

I am unable to recall if it was either of these two doctors.

(8) Answer to Question 22(e)(i) at p. 12

"I am unable to recall if consideration was made about carrying out another electrolyte test, possibly due to the Sodium result falling just out of the range of the normal parameters."

(a) State to the best of your recollection whether these blood test results would normally/likely have caused you any concern at all, and if so, the nature of and reasons for your concern. If not, explain why not.

To the best of my recollection, these results may not have caused me concern as they just fell out of the range of normal based on my level of paediatric experience at that time and the possibility that there were other clinical conditions to explain Claire's clinical state at that time.

(9) Answer to Question 24(a) at p.12

"This [intravenous fluid prescription] was written up [by] me."

(a) You have not adequately answered Question 24. Please state who determined the prescription and rate of administration of fluids. In particular, state whether it was you, another SHO or a more senior clinician e.g. Dr Sands.

This was a continuation of the prescription and rate of administration of fluids that had already been determined by Dr Volprech at the time of Claire's admission as per Ref 090- 038-134

(10) Answer to Question 24(g) at p.13

"I am unable to recall if monitoring was discussed on the ward round in relation to Claire's serum sodium concentration."

(a) State to the best of your recollection whether monitoring of Claire's serum sodium concentration would likely/normally have been discussed on the ward round given the serum sodium concentration result of 132mmol/L on admission on 21st October 1996.

I am unable to recall if it was likely that monitoring would have been discussed on the ward round based on the results given and my level of paediatric experience at that time.

(11) Answer to Question 25(b) at p.14

"This was likely to have been taken from the conclusions or possible alternative diagnoses made at the morning ward round by Dr Sands."

(a) Identify who made the conclusions and/or possible alternative diagnoses on the ward round with Claire on 22nd October 1996.

Dr Sands, which I documented as "non fitting status" in the clinical notes, see Ref 090-022-053. Dr Sands then added Encephaliitis and Encephalopathy.

(b) State whether an electroencephalogram (EEG) or MRI scan was discussed at the ward round, and if so, describe the nature and outcome of the discussion and explain the reasons why this was not recorded in the ward round note.

I am unable to recall if this was discussed on the ward round.

(c) If you cannot recall this specifically, state whether an EEG or MRI scan would normally/likely be discussed at the ward round when a paediatric patient is diagnosed with "*[n]on-fitting status*" (Ref: 090-022-053).

It could be possible to discuss further investigations on a ward round in this clinical scenario but whether it was normal or likely to be discussed in all such cases I would not have had the experience in paediatrics at that time to say.

(12) Answer to Question 25(c)(iii) at p. 14

"I am unable to recall if these specific diagnoses were considered and/or discussed at the time of the ward round or whether were part of a diagnosis by another person."

(a) If encephalitis was considered and/or discussed on the ward round as a possible cause or complicating factor, explain why your ward round note does not refer to encephalitis.

It may have been that after further thought either during the ward round or just after it finished, Dr Sands wished to document other possible working diagnoses in Claire's notes such as encephalitis

(b) If encephalopathy was discussed on the ward round, explain why your ward round note does not refer to encephalopathy.

It may have been that after further thought either during the ward round or just after it finished, Dr Sands wished to document other possible working diagnoses in Claire's notes such as encephalopathy

(13) Answer to Question 25(i) at p. 15

"I recall that Dr Sands went to seek further opinion in light of the possible diagnoses as considered/documented on the ward round. I was left on the ward to continue with the other daily duties that arose in relation to the other patients admitted/present on the ward on that day."

(a) State whether you had any discussion with Dr. Sands after he spoke to Dr. Webb, and if so, state when and where you had these discussions, the nature thereof, identify who was present and where this discussion was recorded.

To the best of my recollection, I think that Dr Sands returned to the ward to inform me that he had spoken to Dr Webb and that Dr Webb was going to review Claire's case. I believe that this was a verbal communication and not therefore documented. I am unable to recall if anyone else was present.

(14) Answer to Question 27(d) at p.17

"My understanding was that Dr. Webb's role was to give a neurological opinion in relation to Claire whilst she was a patient in Allen Ward."

(a) You have not adequately answered question 27(d) (iii). Please state the basis for your understanding.

This was based on the verbal discussion as I have alluded to in the above answer. I took this to mean that Dr Webb was giving a second opinion as he was a Paediatric Neurologist in light of the working diagnoses following on from the ward round.

(b) State if Dr. Webb had a registrar and SHO allocated to the Neurology department as part of the neurology service.

(i) On 22nd October 1996, identify Dr. Webb's neurology

- registrar
- SHO.

I am unable to comment on the staffing allocated to the Neurology department at that time or identify who the registrar or SHO were.

(ii) State if Dr Webb's neurology

- registrar
- SHO.

liaised with you at any time during your treatment of Claire and if so, state when this happened, what was discussed and what happened as a result.

To the best of my recollection, the only contact was with Dr Webb.

(15) Answer to Question 30(g)(iii) at p.20

"I am unable to recall the actual dose administrated but believe that it was likely to have been the 12mg but I am aware that I cannot say for certain."

(a) Explain why you *"believe that it was likely to have been the 12mg"* as opposed to 120mg.

I accept I cannot be certain the exact dose I gave, other than give the opinion that if 120mg of Midazolam had been given as a single dose that would have had a profound effect on a child, which would have been obvious at the time of administration.

(16) Answer to Question 32(b) at p. 22

" I recall that Dr Sands and I were present on the ward the time of Dr Webb's 3rd attendance. I do not recall if I was present at his third examination and other discussions regarding further treatment for Claire's condition."

(a) State whether Dr. Sands was present at Dr. Webb's 3rd attendance and examination of Claire recorded at 17.00 in the medical notes.

I am unable to recall if Dr Sands was present at the attendance of Dr Webb and his examination of Claire.

(b) Describe the *"other discussions regarding further treatment for Claire's condition"*, when and where these discussions took place and who was involved in those discussions.

To the best of my recollection, Dr Webb passed on to Dr Sands, his thoughts on Claire's condition and his advice on further treatment following on from his 3rd review and examination. This may have been a verbal discussion following Dr Webb's attendance and examination.

(c) State whether any note or record was made arising from or relating to these discussions, and if so, identify that note or record. If not, explain why not. If you do not recall whether a note or record was made, state to the best of your recollection whether a note or record would normally/likely have been made, and if so, state where.

To the best of my recollection this appears to have been documented by Dr Webb in the clinical notes. Ref 090-022-055

(17) Answer to Question 34(d) at p. 25

"...Any review was likely to have taken place at a time after I had left the hospital that evening."

(a) State to the best of your recollection at what time you "*left the hospital that evening.*"

I am unable to recall exactly what time I left that evening.

(b) If you are unable to recall specifically the time at which you left, state to the best of your recollection at what time you would normally/likely have left the hospital when on duty during "normal working hours" [your answer to Question 3 on p. 3].

It would normally or likely to have been around 17.30

(18) Answer to Question 34(e) at p. 25

"The plan of care was to monitor Claire in light of the treatments suggested and started as per Dr Webb, with review and reassessment by the nursing team and on call medical team as required."

(a) State when/at what time was next review and reassessment of Claire was planned to occur after Dr. Webb's attendance at 17.00 on 22nd October 1996. If you do not recall specifically, then state to the best of your recollection when/at what time was the next review and assessment of Claire likely/normally planned to occur.

I am unable to recall or state to the best of my recollection whether a time was advised or planned for next review.

(19) Answer to Question 35(d) at p.26

"I am unable to recall the identity of whom I handed over to, this may have been Dr Stewart as per Ref 090-022-056, who appears to have been the on-call Medical SHO for the 22nd Oct. I am not able recall the level and inform them of any patients, problems or tasks which they needed to know about. nature of the handover other than it was my usual practice to speak with the on-call SHO at my"

(a) This answer appears to have words missing and to be incomplete. Please provide a complete answer.

My apologies for this, this is a typographical error on my part. It should be as following

"I am unable to recall the identity of whom I handed over to, this may have been Dr Stewart as per Ref 090-022-056, who appears to have been the on-call Medical SHO for the 22nd Oct. I am not able recall the nature of the handover other than it was my usual

practice to speak with the on-call SHO at my level and inform them of any patients, problems or tasks which they needed to know about"

(20) Answer to Question 37(d) at p.27

"I was aware that nursing staff were undertaking hourly CNS observations following Dr Webb's 1st assessment and request that this was started."

(a) State whether you read the CNS observation chart (Ref: 090-039-137) on 22nd October 1996, and if so, state when. If not, state the reasons why not. If you do not recall specifically, then state to the best of your recollection whether you would likely/normally have read or checked this chart whilst on duty, and if so, when would you normally/likely have done so. If you would not normally/likely have read or checked this chart whilst on duty, explain the reasons why not.

I am unable to recall if I read the CNS observation chart on the 22nd October 1996. It would have been my experience that normally this was undertaken by nursing staff and if there were any changes then this would have been brought to the attention of the doctor.

(21) Answer to Question 37(e) at p. 27

"A Glasgow Coma Score of <8 is considered severe... I would feel a score of less than 8 indicates the onset of coma."

(a) State whether you were aware of Claire's Glasgow Coma Score of < 8 at 15.00. 16.00, 17.00 and 18.00 on 22nd October 1996, and if so, state what action you took in relation to those scores. If not, explain the reasons why not.

To the best of my recollection, I was not aware of this and I am unable to given any explanation why not.

(b) If you do not recall this specifically, then state to the best of your recollection whether you would likely/normally have been aware of a patient's Glasgow Coma Scores whilst on duty, and if so, how would you normally/likely have become aware of these scores, and what would you likely/normally have done if you had known of them. If you were not likely/normally aware of the Scores, explain why not.

In my experience at that time, if a patient's Glasgow Coma Score had changed, from what it had been, that would have been brought to the attention of medical staff. It may have been that as there had been no change, that this was not therefore passed to me for my attention.

(22) Answer to Question 37(f) at p. 27

"I would have had to discuss this with a more experienced Paediatrician at the stage of my seniority and experience, who would then discuss this with the staff of the PICU."

(a) State at what Glasgow Coma Score you would normally/likely have spoken *"a more experienced Paediatrician"* about a patient, whether to raise a concern or to discuss the possibility of admission to PICU, and state the reasons why.

If the Glasgow Coma Score had decreased then the reason for this change would have to be determined and it would have been likely that I would have sought the advice of a more experienced doctor.

(23) Answer to Question 38 at p. 27

"I do not recall if I was informed of the GCS by the nursing staff. This may have been noted and discussed with Dr Webb at the time by the nurses."

(a) You have not adequately answered Question 38. State whether you considered contacting Dr. Steen, Dr. Webb or Dr. Sands on 22nd October 1996 in relation to Claire's GCS and deteriorating condition, and if not, why not, and if so, what exactly was discussed, what they did about it and what the response was.

To the best of my recollection, I am unable to recall if I did or did not consider contacting Dr Steen, Dr Webb or Dr Sands. I am unable to explain why I did not do so on the 22nd October other than in the knowledge that Dr Webb was to review Claire later that afternoon to review the response to the treatments which he advised.

(24) Answer to Question 38(a) at p. 28

"I am unable to state the threshold for calling a consultant in RBHSC in October 1996, as we would normally have spoken with a more experienced SHO or the registrar of the ward or the registrar on call if there were concerns. They in turn may have contacted the consultant. There would have been a hierarchical process if any concerns about a particular patient."

(a) State whether you contacted or considered contacting *"a more experienced SHO or the registrar of the ward or the registrar on call"* on 22nd October 1996 in relation to Claire. If so, identify by name or position whom you contacted, the reasons why and identify any document in which this contact would have been or was recorded. If you did not contact or consider contacting any of the above persons, explain why not.

To the best of my recollection, I am unable to recall if I did or did not consider contacting another more experience SHO or Registrar.

(b) If you do not recall this specifically, then state to the best of your recollection whether you would likely/normally have contacted or considered contacting *"a more experienced SHO or the registrar of the ward or the registrar on call"* in relation to a patient in Claire's condition and state the reasons why.

It would have been likely that I would have considered contacting another SHO or Registrar in relation to a patient in Claire's condition, as a that time I would have been inexperienced in paediatric neurological cases and needed the advice of others.

(25) Answer to Question 38(c) at p.28

"I am unable to recall the times but I am able to recall that he was present around the ward during the morning and then later in the afternoon after completing other possible commitments such as an Outpatient clinic and/or his teaching responsibilities."

(a) State at what time(s)

(i) an outpatient clinic

(ii) teaching responsibilities

would normally/likely finish.

I am unable to state the times when an outpatient clinic and teaching responsibilities would have finished. This is not within my knowledge.

(26) Answer to Question 40 at p. 28

"I believed Claire was under Dr Steen, as the named consultant between her admission and up to the time of my leaving the ward at the end of shift. I am unable to recall if there had been a formal transfer of responsibilities to Dr Webb or that he was providing advice in managing Claire's condition."

(a) State to the best of your recollection at what time you left *"the ward at the end of shift"*.

17.30

(b) State precisely how *"a formal transfer of responsibilities"* of a paediatric patient's care from the paediatric medical team to the paediatric neurology team was carried out at that time.

"a formal transfer of responsibilities" is a phrase that I have used to answer this question rather than an actual written formal protocol. In my experience transfer to care between consultants was usually a verbal agreement between two consultants transferring over who had ongoing responsibility for that patient's care. It may have been discussed with the family and it may have been documented in the clinical notes as well as the nursing notes, to ensure continuity of care.

(c) State whether any transfer of responsibilities from Dr Steen to Dr Webb, whether formal or informal, would normally/likely have been recorded in any document/note, and if so, identify that document/note and the normal/likely author thereof. If this would not normally/likely have been recorded in any document/note, explain why not.

It would be likely to have been recorded but I am unable to explain why this was not done on this occasion.

(d) Explain how you would normally/likely have learned of any transfer of responsibilities e.g. from Dr. Steen to Dr. Webb.

The SHO would have normally been informed verbally.

(e) Explain how and when the other members of the medical team and the nursing staff would normally/likely have learned of any transfer of responsibilities e.g. from Dr. Steen to Dr. Webb.

It would be my understanding that this was passed on verbally.

(f) Explain how and when the patient and/or their family would normally/likely have learned of any transfer of responsibilities e.g. from Dr. Steen to Dr. Webb.

It would normally be my experience that this would have been discussed with the patient and family with a more senior doctor than my experience at that time, and an explanation given why another consultant was taking over their care.

(27) Answer to Question 48 (a) at p.30

"I am unable to recall if I had any communications with Dr Steen in relation to Claire for the period of time I was on duty i.e. the 22nd Oct. I am unable to recall if Dr Steen attended and examined Claire during the above period of time."

(a) If Dr Steen had attended or examined Claire at any time prior to 04.00 on 23rd October 1996, state whether that attendance and examination would normally/likely be recorded in the medical notes and the nursing notes.

It would be likely that this would have been documented in the medical and nursing notes in my experience.

(28) Provide any further points and comments that you wish to make, together with any documents

I have no further comments to add.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: T.R Steen **(Dr TR Stevenson)** **Dated: 20th June 2012**