Witness Statement Ref. No. | 328/1

NAME OF CHILD: Raychel Ferguson

Name: Philip Gardiner

Title: Dr.

Present position and institution:

Consultant Physician and Rheumatologist: Western Health and Social Care Trust

Previous position and institution:
[As at the time of the child's death]
Consultant Physician/Rheumatologist & Post-Graduate Tutor - Altnagelvin Hospital Health & Social Services Trust ("AHHSST").

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2000 - present]

Educational Appointments:

Postgraduate Clinical Tutor for Altnagelvin hospital (NI Committee for Postgraduate Medical and Dental Education) 1997 – March 2002
'Locum' Postgraduate Clinical Tutor – 2002-2004
Chairman, Postgraduate Clinical Tutors' Committee : 2001-2002

Regional Chair for N. Ireland, British Society of Rheumatology (2011-2014)
Member, Education and Training Committee British Society of Rheumatology (2011-2014)
Member, Council of British Society of Rheumatology (2011-2014)
RCP Specialty Advisor for Rheumatology (service) N. Ireland, (2011-2014)
Member, Specialty Training Committee for Rheumatology (NI)
Member, ARMA (Arthritis and Musculoskeletal alliance) NI regional steering committee 2005—present

Previous:

Lead Clinician Rheumatology, Dermatology and Neurology – Western Trust 2007-2011
Training Program Director for Rheumatology: NICPMDE 2001 - 2007
Regional Specialty Advisor for Training in Rheumatology (N. Ireland), JCHMT/Royal College of Physicians 2002 to 2007
Member, Specialty Advisory Committee for Rheumatology (JCHMT) 2002-2007
Hon. Secretary, Ulster Society for Internal Medicine (2008-2012)
Hospital Dean of Examinations, Royal College of Physicians of Ireland (2008-2013)

Previous Specialist Society Involvement:

British Society for Rheumatology:
National Biologic Therapy Central Registry Planning group 2000-2002

Irish Society for Rheumatology:
Member of ISR council 2005 - 2009.

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

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

Ref:	Date:	

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.

(1) Please provide the following information:

(a) Your qualifications as of 2001 (please also provide a copy of your CV);

MB BCh BAO MD FRCP

(b) Describe your career history;

I trained in Queen's University Belfast and carried out my post-graduate training in N. Ireland and the Northeast of England. I have been a Consultant Physician/Rheumatologist in Altnagelvin hospital since August 1994
I was appointed as QUB educational supervisor for pre-registration house officers 1996-7
I was appointed by the Medical Staff Committee as the Post-graduate Tutor for Altnagelvin hospital in 1997 for a 5 year period to 2002.

I was the regional Training programme director for Rheumatology for NIMDTA/NICPMDE 2001 to 2007 and I am currently the Regional Chair for the British Society for Rheumatology 2011-2014. I was the Royal College of Physicians Regional Speciality Advisor for Rheumatology Training (JCHMT) 2002-2007 and I am currently the Royal College of Physicians Regional Speciality Advisor for Rheumatology (Service) 2011-2014.

(c) Please describe your work commitments at the AHHSST from the date of your appointment;

I have been employed as a full time consultant covering general medicine and rheumatology. At that time I covered clinics in Omagh and Enniskillen as well as having responsibility for Spruce House, a facility for young adults with severe physical disabilities.

(d) What was the role of the Dean of Post Graduate Studies and what were its functions, accountabilities and responsibilities, and was this reduced to writing by 2001? If so please provide a copy of the same.

There was no such post as Dean of Postgraduate Studies at that time.

(e) What was the role of the Post Graduate Clinical Tutor and what were its functions, accountabilities and responsibilities, and was this reduced to writing by 2001? If so please provide a copy of the same?

The role of Postgraduate Tutor had not been specified in writing at the time I was appointed and I did not have any clear list of responsibilities. I did 'work-shadow' Dr Brendan Devlin the previous postgraduate Tutor when I was appointed. I was paid one session's salary to carry out these additional duties. When I stepped down in 2002 after completing my 5 years in post the Postgraduate Tutor's post had become part of NIMDTA/NICPMDE's formal responsibility and a job description was drawn up for my successor according to regional

guidelines. An appointment panel was convened by NIMDTA for that appointment.
I did understand that my role would be to promote and assist in the delivery of postgraduate education across the hospital. I also understood that I had a responsibility to manage the study leave budget for trainees. I assisted in the organisation of induction courses for new doctors and some of the lunchtime postgraduate meetings in medicine. Each specialty had a 'Royal College Tutor' in place that was nominally responsible for facilitating teaching in that specialty. I did not at any stage organise teaching for the surgical or paediatric divisions nor did I have sight of their educational programmes.

(2) Who bore ultimate responsibility for the provision of education and training in Altnagelvin Hospital in 2001?

Ultimately the Postgraduate Dean in NIMDTA and the Chief Executive of Altnagelvin shared responsibility for postgraduate education. At that time the funding to organize postgraduate teaching in Altnagelvin hospital was at a very low level, so the provision of postgraduate teaching was based largely on good will and professionalism.
The delivery of postgraduate education in the hospital was a shared responsibility between the postgraduate tutor and consultants who were college tutors and/or educational supervisors for their trainees. Each consultant was allocated a group of medical trainees to supervise. 'Royal College tutors' were appointed by the relevant Royal College e.g. Royal College of Physicians or Royal College of Surgeons but these roles were ill defined and were carried out on a voluntary basis over and above normal duties. One of the problems at that time was that these posts were not subject to any job description and doctors were not given any additional teaching time in their timetable. There was no formal job planning in 2001. In most cases there were no published educational curricula in 2001 (apart from the specialty training programmes). In many specialties there was a lack of clarity or detail around the curriculum for teaching, so even for enthusiastic College Tutors there was a great deal of variation in what was actually covered as part of the teaching. In some specialties the bulk of training was delivered by consultants who were not the nominal 'College Tutor'. The posts were recognized by the Trust in that the College tutors were on the Education and Training committees and handled communication between their training body and the Trust e.g. in relation to Specialty Advisory Committee (SAC) visits.

(3) Please describe the system and structure for the provision of education and training at Altnagelvin Hospital at or prior to 2001.

All clinical consultants were expected in their employment contract to provide education for the medical students and medical postgraduate trainees attached to their wards. The historical system of trainee education had been based on an 'apprenticeship' model where the trainer would decide what knowledge to impart to the trainee. It was understood that they had special responsibility for **teaching the senior trainees or registrars,** and the JCHMT had pioneered the way in formalizing the curriculum for this senior group of trainees in the late 1980s. These changes were implemented in Altnagelvin hospital and training posts here gained official approval by the relevant training bodies (Specialty Advisory Committees or SACs).
The teaching of **pre-registration house officers was under the control of QUB,** and at the time I took on responsibility for teaching them in 1996 we were getting some guidance about how to design and deliver a curricular programme of education.
An associate GP Tutor had been appointed with responsibility for 'in-hospital' education of GP orientated SHOs and protected time was allocated to allow this teaching to take place. A strong GP training programme was in place in Altnagelvin hospital in 2001 and this was organised by **Dr Paddy McEvoy,** a senior GP. About 8 SHO posts in the hospital were recognized as GP training posts.

The group of 'senior house officers' in 'general medicine' were not in any of these categories and were known in educational circles as the 'lost tribe' as their career path and teaching curriculum was completely ill defined.
As Postgraduate Tutor I was expected to help organize the teaching programme over and above my full time job as a clinician. I had the help of one secretary and had the help of a finance officer to help distribute a small allocation of study leave money for each trainee. The postgraduate tutor was initially nominally responsible for the work of the undergraduate tutor, but in later years QUB directly supervised that individual and the teaching programme.
The postgraduate tutor did not have any authority over or responsibility for the work of the college tutors. As Postgraduate Tutor I was **answerable to Stella Burnside, Chief Executive, Altnagelvin Hospital and Dr Jack McCluggage, the postgraduate Dean at NIMDTA.** I helped to organize the educational inspection visits organized by NIMDTA and some of the Royal Colleges. At these visits NIMDTA officials would question trainees and then speak to all of the trainers and college tutors. The relevant college tutor would have been responsible for organizing and supervising Royal College visits in their specialty. QUB also organized an annual review of PRHO teaching. The reports and recommendations from these visits would be discussed with the Chief Executive and discussed at our **hospital 'Medical Education Committee meeting'** comprised of the Postgraduate tutor, The Undergraduate (QUB) Tutor (Dr Frank O'Connor), the PRHO supervisor, the Specialty College Tutors, and the GP tutor.

In recognition of the fragmented nature of postgraduate education in the hospital, shortly after my appointment in 1997 I wrote to the clinical directors and specialty advisors to ask them to confirm who was the nominated college tutor for their department and who else was actively involved in teaching. I also asked for a copy of the current departmental educational programme. I asked them 'what type of teaching would you like the Tutor to focus on for 'general teaching'. I asked them when their department had last been visited by the SAC or Specialist Advisory Committee of JCHMT. I asked them if a core curriculum had been issued by their college and if this was being used in planning the educational programme. I also asked about use of log books and appraisals. I asked them to keep me informed of developments in their specialty and alerted them to the educational issues faced by the SHO group in particular. In 1997 I also wrote to Dr Heather Dunn, then Clinical Director for Medicine to update her on new teaching arrangements for SHOs including the specific use of the RCP core curriculum for teaching SHOs under Dr Moles, then RCP Tutor for Medicine. One of my first moves as Postgraduate Tutor had been to ensure that all new trainee doctors arriving in the hospital would have resuscitation training as well as a formal induction programme. These developments were discussed at the Medical Education Committee.

(4) Please describe the systems in place to ensure that the education and training provided in Altnagelvin Hospital in 2001 were up to date?

The educational structures in our hospital were similar to those in operation throughout N. Ireland, and the role of the Postgraduate Tutor was similar to other hospitals. The Deanery determined the way that postgraduate education was organized at that time and changes to formal training programmes under JCHMT were implemented immediately across the UK. We were among the first hospitals in NI to initiate curricular teaching for PRHOs under advice from QUB. Our junior doctor handbook was shared with other hospitals by the Postgraduate Dean as an example of best practice and around that time I was appointed as Chair of the Postgraduate Tutor's committee. Our GP training programme had probably the best success rate in NI in the MRCGP exams. Reports from education visits and trainee educational feedback reviews often praised the quality of training and educational supervision. The provision of up to date postgraduate education in the surgical department had been enhanced by the arrival of new consultants such as Mr Robert Gilliland, Mr Stephen Dace and Mr Paul Neilly.

(5) **Please state whether fluid management was taught at Altnagelvin Hospital at or prior to 2001 and if so please provide details of the same?**

In 1996 I set up an educational teaching programme for pre-registration house officers under advice from QUB and I can recall having arranged for a consultant in anaesthetics to teach them about fluid balance every year. This tutorial was arranged to take place close to the start of their educational year. I believe Dr Moohan may have been responsible for the PRHO teaching programme in 2001. I can also recall having organised an annual teaching session on electrolyte disturbances as part of the main post-graduate teaching programme. I did not have any direct knowledge of the content of the educational sessions delivered to trainees in paediatrics or surgery at that time.

(6) **Please describe the nature of any links which may have existed between the AHHSST, the RBHSC and the wider medical community with respect to:**

(a) **Information sharing;**
I am not aware of any specific links, but specialty colleagues do tend to share medical issues within their own networks. These issues are sometimes raised at regional medical meetings such as royal college education days or the 'Ulster Society for Internal Medicine'. The Postgraduate Tutors forum was also a place where Tutors could share important issues relating to education but these usually related to the organization of teaching rather than its specific content.

(b) **Coordination of education, training and medical updates;**
The Royal College of Physicians of London and Edinburgh organized regional training days in NI for consultants and senior trainees. Similar training/update days were organized by most of the Royal Colleges. Altnagelvin hospital provided study leave for consultants to attend these and other meetings. Most doctors try to keep up to date with general journals such as the BMJ or Lancet and their own specialty journal. I made a strong case for the Trust to pay for 'UpToDate' software to help doctors get accurate and detailed up to date information. I am not certain what year this came into use. I also involved the library staff in showing medical trainees how to access medical information online.

(c) **Communication between clinicians and academic staff.**
We do not have any academic departments in this hospital. Most consultants would have some links with academic colleagues and most would attend conferences at least twice a year to keep up with the latest advances.

(7) **Please include details of any contractual arrangements entered into with respect to the provision of education and training at the AHHSST.**

As above - I was appointed as Postgraduate Tutor March 1997-March 2002. That is all I am aware of.

(8) **Prior to June 2001, did the AHHSST have any system whereby lessons learned from serious untoward/adverse incidents in the Altnagelvin Hospital could be incorporated into the education and training provided?**
Nothing formal.

(9) **How did the AHHSST satisfy itself that the educational needs of medical staff were met?**
Presumably on the basis of satisfactory annual reports from QUB, NIMDTA and the JCHMT visits to confirm that a good standard of training was being provided for PRHOs, Registrars, and SHOs respectively. The use of study leave budgets was also a documented, and a detailed record of each trainee's attendance at postgraduate meetings was kept. Documentation of the trainees' induction programmes, curricular teaching and appraisal for trainees were all in place by 2001 as advised by NIMDTA and JCHMT. Each year NIMDTA carried out RITA assessments in training for registrars - these were attended by external visitors from JCHMT. Any negative comments on the quality of training would be followed up. I think that the online questionnaire for trainees came at a later stage than 2001.

(10) **In 2001 did the AHHSST provide any education and training to its staff in respect of the following (and if so please describe):**

(a) **Intravenous fluid prescription and administration in post-operative children;**
I recall that practical aspects of giving intravenous fluids was covered in the PRHO mandatory teaching programme, but the teaching within medicine at SHO/Registrar level was geared more toward the management of hyponatraemia and hypokalaemia.

(b) **Post-operative nausea and vomiting;**
I am not aware of specific teaching in this area.

(c) **Monitoring and recording of fluid balance;**
I am not aware of specific teaching in this area apart from the PRHO session.

(d) **Electrolyte replacement and testing;**
I am sure that there was a session on electrolyte imbalance for SHO/Registars in the medical programme

(e) **Adverse Clinical Incident Investigation;**
As far as I can recall, the expectation that incidents should be reported to the clinical director was normal at that time.

(f) **Clinical record keeping;**
Guidance was issued in the Junior Doctor's Handbook to ensure good practice in clinical record keeping. This was covered in the general induction for all trainees.

(g) **Communication between clinicians;**
I am not aware of any specific teaching or training in this area apart from 'Teaching the Teachers'.

(h) **Communication with next of kin?**
There were sessions on 'communicating bad news' by the palliative care consultant Dr Garvey.

If the AHHSST did provide any such education and training to its staff please state:

(i) **Whether it was modelled on or informed by any published guidance, and if so please identify this guidance;**
I cannot recall the specific details.

(ii) **How the AHHSST satisfied itself that such education and training was being complied**

with?

This education was delivered on a published programme, attendance records were kept. Informal feedback from trainees on the teaching programme was sought at the end of every year, and modifications were made where necessary. At that time (2001) there was little or no supervision of the education programmes within individual departments.

(11) **Please describe your role and responsibility for:**

(a) **Clinical protocol/policy monitoring;**
None (in my role as Postgraduate Tutor).

(b) **The adoption of protocol/policy on clinical practice into the educational system as a result of NCEPOD, NICE, CREST, GMC, UKCC and other relevant bodies.**
None (in my role as Postgraduate Tutor). I did facilitate meetings e.g. the launch of the CREST guidelines on osteoporosis.

(12) **Please describe the steps taken to teach and disseminate recommendations deriving from external sources including the following:**

(a) **The Royal Colleges;**
This would have come under the role of the college tutor at that time.

(b) **UK Central Council for Nursing, Midwifery and Health Visiting;**
Any urgent recommendations would have been sent by the Dean to the Postgraduate tutors in each hospital. I did not receive any recommendations during my 5 years in the role.

(c) **Department of Health;**
I am not aware of any specific recommendations during that period.

(d) **Audit Commission;**
I am not aware of any specific recommendations during that period.

(e) **National Confidential Enquiry into Peri-Operative Deaths;**
I am not aware of any specific recommendations during that period.

(f) **General Medical Council;**
I am not aware of any specific recommendations during that period.

(g) **British National Formulary**
I am not aware of any specific recommendations during that period.

(h) **DHSSPSNI;**
Each consultant would normally have received direct communication from the DHSSPSNI and would have been responsible for implementing the guidance. In some rare cases such as new legislation relating to child health, specific training courses were put in place for all doctors to attend. To my knowledge, dissemination has never been via the Postgraduate Tutors.

(i) **HPSS;**
I am not aware of any specific recommendations during that period.

(j) **Paediatric Intensive Care Society;**
I am not aware of any specific recommendations during that period.

(k) **Management Executive.**
I am not aware of any specific recommendations during that period

(13) **Please state whether you served on the Hospital Executive or Hospital Management team?**
No

(14) **Was there any system of independent external scrutiny in place to review the educational programme in the AHHSST, and if so please detail the same?**
Queen's University Befast (QUB) – At least one visit annually to confirm that a good standard of training was being provided to PRHOs according to QUB guidance.
NIMDTA – At least one visit annually to confirm that a good standard of training was being provided to SHOs and GP trainees. Trainees and trainers interviewed, report directly to Stella Burnside Chief Executive. Recommendations made.
JCHMT – occasional visits by SAC representatives in every specialty to confirm that a good standard of training was being provided for Registrars and Senior Registars in specialty training.

(15) **Please advise whether you liaised with:**

(a) **Doctors from other teaching hospitals charged with education;**
Yes - the handbook for junior doctors that I had developed was shared by the Postgraduate Dean with other Postgraduate Tutors in NI as an example of good practice.

(b) **Representatives from medical schools in Northern Ireland?**
Yes - in the design and delivery of the PRHO curriculum over which they had responsibility. I was also involved in the running and delivery of undergraduate exams (Final MB).

(16) **Please detail those opportunities available in 2000-2001 to Deans of Post Graduate Studies/ Post Graduate Clinical Tutors from across Northern Ireland to meet and exchange information of professional relevance by way of managed network or otherwise.**
We had meetings once or twice a year as a committee of postgraduate tutors. I attended these meetings regularly and at one point chaired the committee. Dr McCluggage the Postgraduate Dean was at all of these meetings. We were encouraged to point out areas in which education could be improved and I personally was very critical at that time of the meager budget assigned to training of postgraduate trainees across NI. I sat on a committee to get the study leave payment up to a level equal to other hospitals in NI. However, these committees dealt with general issues not specific protocols etc.

(17) **With respect to the Critical Incident Review meeting held on 12th June 2001 please confirm;**

(a) **Whether you had any involvement with this process;**
No

(b) **Whether you were made aware of any shortcomings and deficiencies were identified by the Review;**
Not during my time as Postgraduate Tutor

(c) **When and how you first become aware that the RBHSC had discontinued the use of Solution 18;**
I cannot recall ever having been told this before 2001.

(d) **What steps, if any, were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?**
None, as far as I am aware.

(18) **In relation to the Critical incident Review Meeting please confirm whether any consideration was given to the competence and training needs of those who cared for Raychel?**
As far as I can recall, I was not made aware of the critical incident review meeting or the recommendations that arose from the review.

(19) **In relation to the statement made to the PSNI on 14th March 2006 by Dr. Nesbitt that he** *"spoke to Dr. Chisakuta, a Consultant in Paediatric Anaesthesia and Intensive Care in the RBHSC about their use of No.18 solution in post-operative surgical children and he informed me that they had been using precisely the same regime as Altnagelvin Hospital but had changed from No.18 solution six months previously because of concerns about the possibility of low sodium levels. This was also the position in Tyrone County Hospital"* **(Ref: 095-010-040) please state:**

(a) **Whether you became aware that the RBHSC and Tyrone County Hospital had changed from the use of Solution 18, and if so how and when;**
I was not aware of this during my time as Postgraduate Tutor.

(b) **Whether this been communicated to you through any other channel prior to June 2001;**
No

(c) **If you became aware of it, what steps you took to understand this decision?**
Not applicable

(20) *"On 14 January 2002 the CMO visited Altnagelvin in connection with another matter. I arranged for her to meet with Dr. Nesbitt to view a Powerpoint presentation on hyponatraemia. Dr. Nesbitt had prepared this presentation himself and had previously shown it to me. I found it very helpful in understanding the complex subject of hyponatraemia (021-054-117 up to 021-054-133)"* **(Ref: WS-143/1 p.11). In relation to this please confirm whether you were involved in the preparation or use of this presentation?**

No – to my knowledge I was not aware of that visit and I do not recall having seen the presentation at that meeting with the CMO. I do remember attending a postgraduate meeting on hyponatraemia around that time but I do not recall any details.

(21) **In relation to the following statement:** *"The problem in the Children's Ward seemed to be even if Hartmann's was prescribed, it was changed to No.18 by default"* **(Ref: 021-057-137) please state:**

(a) **Whether the Post Graduate Deanery took any steps to review this practice;**
I am not aware of any specific instructions in this regard.

(b) **The education and training provided before 2001 in respect of the administration of intravenous fluids in Ward 6;**
I am not aware of the specific details of the education delivered in ward 6 at that time.

(c) **Whether you were aware of any disagreement with regards to the suggested regime change (with regards to the use of Solution 18?**
As far as I can recall I was not consulted about the specific recommendations.

(22) **In relation to the Memorandum signed by Dr. Nesbitt on 2nd May 2003 (Ref: 021-044-091) and the *"uncertainty regarding the management of surgical paediatric patients"* please state:**

(a) **Whether you were aware of this uncertainty;**
No I was not.

(b) **Whether the Post Graduate Deanery took any steps to review any disagreement of approach between the surgical and paediatric specialty teams?**
To my knowledge this did not arise as an issue in any of the Deanery visits that I was involved with.

(23) **Prior to June 2001, please state whether the AHHSST had established:**

(a) **Education and Training Committees;**
our **hospital 'Medical Education Committee meeting'** comprised of the Postgraduate tutor, The Undergraduate (QUB) Tutor (Dr Frank O'Connor), the PRHO supervisor, the Specialty College Tutors, and the GP associate tutor,.

(b) **Education and Training programmes to respond to issues arising out of the Clinical Effectiveness and Risk Management Committees;**
I do not recall any.

(c) **Appraisal and revalidation procedures for medical staff as proposed by the GMC;**
Appraisal/RITA assessments took place for specialist trainees. At that time it was not required by the GMC for other doctors.

(d) **The Hospital Quality Improvement Programme Committee;**
I am not aware if any such committee existed at that time.

(e) **Inter-professional partnerships with the Universities/medical schools/other academic institutions;**
Yes – see above description of relationship with QUB and JCHMT. The Dean also sat on COPMED, a national group of postgraduate Deans. I sat on the regional Postgraduate Tutors committee – led by the PG Dean Dr McCluggage.

(f) **Inter-hospital collaboration in respect of learning medical lessons;**
I am not aware if any such arrangements existed at that time.

(g) **A multi-disciplinary Research Committee;**
I am not aware if any such committee existed at that time.

(h) **Systems to develop Care Pathways;**
I am not aware that any such systems existed at that time.

(i) **Systems for the monitoring of Patient Charter standards;**
I am not aware that any such systems existed at that time.

(j) **Systems for ensuring the conduct of quality assessments;**
There was a clinical audit committee (multidisciplinary) of which I had been an active member. This existed in parallel to the medical audit committee which had oversight of medical audit. There was an audit department to assist with these audits.

(k) **Staff appraisal systems;**

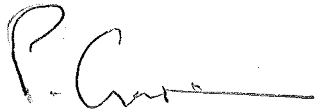
Regular appraisal for trainees was introduced in 1997 and was taking place regularly by 2001. Compliance was checked annually by NIMDTA and JCHMT. This did not extend to involve other groups.

(l) **Arrangements for learning from Clinical Effectiveness Conferences and research seminars?**
Not specifically. All consultants were responsible for maintaining their own education through the study leave CPD system, and all specialist trainees had a list of essential and recommended training courses they had to attend during their training. Funds were provided from the study leave budget to facilitate this. Doctors were able to share their learning in the postgraduate meetings at lunchtime or meetings after hours. I set up a journal club forum and invited consultants to suggest important papers to be discussed.

If so please describe the same.

(24) **Please provide such additional comment as you think relevant. It would be of very considerable assistance if you could attach such documentation as you may hold which relates to procedures, strategies, policies or other issues of relevance.**

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

Signed: 

Dated: 21 . 8 . 13