1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to his death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.
2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.
2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. CURRICULUM VITAE

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EDUCATION	Leighton Park School, Reading, Berks.	1969-1973
	St John's College, Cambridge University.	1974-1977
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DEGREES AND QUALIFICATIONS

BA, Cambridge University	1977
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MB BChir, Cambridge University	1980
MA, Cambridge University	1981
MRCP (UK)	1983
Accreditation in General (internal) Medicine and Geriatric Medicine	1989
FRCP	1994
MBA (Distinction) University of Hull.	1997
Certificate in Teaching	2001
NHS/INSEAD Clinical strategists program	2003

SPECIALIST SOCIETIES

British Geriatrics Society

British Society of Gastroenterology

British Association of Medical Managers

PRESENT POST

Dean Director of Postgraduate Medical and Dental Education Kent, Surrey and Sussex Deanery.	2004-present
Consultant Physician (Geriatric Medicine) Queen Marys Hospital, Sidcup, Kent.	1987-present
Associate member General Medical Council	2002-present

PREVIOUS POSTS

Associate Dean. London Deanery.	2004
Medical Director (part time) Queen Mary's Hospital	1997-2003
Operations Manager (part time) Queen Marys Hospital, Sidcup, Kent	1996-1997
Senior Registrar in General and Geriatric Medicine Guy's Hospital London and St Helen's Hospital	

Hastings.	1985-1987
Registrar in General Medicine and Gastroenterology	
St Thomas' Hospital, London.	1984-1985
Registrar in General Medicine	
Medway Hospital, Gillingham, Kent	1983-1984
SHO rotation in General Medicine	
Kent & Canterbury Hospital, Canterbury	1982-1983
SHO in General Medicine	
Kent & Sussex Hospital, Tunbridge Wells	1981-1982
House Physician, St Thomas' Hospital	1981
House Surgeon, St Mary's Portsmouth	1980

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The Organisation of Stroke Care. Physicians and managers working together to develop services. Professional training and clinical governance in geriatric medicine. All at Argentinean Gerontological Society 50th Anniversary meeting. Nov 2001

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Leslie Pittock.

[2] Full set of medical records of Leslie Pittock on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[6] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

5 CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence)

5.1. Mr Leslie Pittock had a very long history of depression as clearly set out in a summary (13). In 1959 he had reactive depression, it occurred again in 1967. In 1979 he had agitation and in 1988 agitated depression.

5.2. He had a further long admission with agitated depression in 1992 (8) complicated by an episode of cellulitis (30). This culminated in an admission to long-term residential care in January 1993 (34). He had further admissions to hospital under the care of the psychiatric team including June 1993 (37) when some impaired cognition was noted. In 1995 there was a home visit for further psychiatric problems (42).

5.3. In 1995 (44) there was a change in behaviour; loss of weight and increased frailty was noted. He was falling at the residential home. He was expressing grief, frustrations and aggression. At this time his psychiatric medications included Diazepam, Temazepam, Thioridazine, Sertraline, Lithium, and Codanthrusate for constipation. His other problems were hypothyroidism and Parkinsonism with a tremor. (Note: this was not Parkinson's disease but tremor, rigidity and akinesia which occurs similar to Parkinson's disease but as a result of long-term anti-psychotic medication).

5.4. On 29th November 1995 he was admitted under the psychiatrist Dr Banks (46) to Gosport War Memorial Elderly Mental Health beds. His mental test score was documented at 8/10 (50). He was discharged back to residential home on 24th October (46) with a continued diagnosis of depression (56). However, his very poor mobility and shuffling gate was noted (57).

5.5. On 13th December 1995 he was re-admitted (62) to mental health beds at the Gosport War Memorial under Dr Banks stating "everything is horrible". He was verbally aggressive to the staff and was not mobilising and staying in bed all day. He felt hopeless and suicidal. (62).

5.6. On 22nd December, diarrhoea started and he also had chest symptoms. It was thought he had a chest infection, and was treated with Erythromycin (64). On 27th December he was "chesty, not himself", and his bowels were causing concern. The physiotherapist noted that he had signs in his chest (65). A second course of a different antibiotic (Cephalosporin) was prescribed (81). The nursing

cardex documents that he started becoming faecally incontinent on 20th December and then had further episodes of diarrhoea (140). It is also noted that by 1st January (147) he was drowsy with very poor fluid intake.

5.7. On 2nd January 1996 Dr Lord, consultant geriatrician was asked to see (66) and on 3rd January he was noted to be clinically deteriorating with poor food intake (66), albumin of 27 (67). An abdominal x-ray on 27th December describes possible "pseudo-obstruction" (116). This is a condition when the large bowel fails to work and starts to dilate, usually in patients who have multiple illnesses including Parkinsonism, electrolyte imbalance, infections, antibiotics and other drugs. Prognosis is often poor and depends on resolving the underlying causes.

5.8. On 4th January 1996 Mr Pittock is seen by Dr Lord, Consultant Geriatrician who noted severe depression, total dependency, catheterisation, lateral hip pressure sores and hypoproteinaemia. (67) He states that the patient should be moved to a long-stay bed at the Gosport War Memorial Hospital and that his residential home place should be given up as he was unlikely to return. On 5th January he is transferred to Dryad Ward for "long-term care" (151). Dr Lord also states (5M) "Mrs Pittock is aware of the poor prognosis".

5.9. Medical notes after transfer (13M and 15M). On 5th January a basic summary of the transfer is recorded, on the 9th January increasing anxiety and agitation is noted and the possibility of needing opiods is raised. The nurses cardex on 9th said that he is sweaty and has "generalised pain" (25M). On 10th January a medical decision is recorded "for TLC". In the medical discussion (13M) with the wife also apparently agrees "for TLC". I am not sure of the signature of 10th January in the medical notes (13M). The nursing cardex records they commenced Oramorph and that Mrs Pittock is aware of the poor outcome (25M).

5.10. The 15th January the nursing notes document that a syringe driver has been commenced (25M) and by the evening the patient is unresponsive (26M). However on 16th January there is some agitation when being attended to and Haloperidol is added to the syringe driver (26M). On the 17th the patient remains tense and agitated,(27M) the nursing cardex states that Dr Barton attended, reviewed and altered the dosage of medication. The syringe driver is removed at 15.30 hours and the notes say "two drivers" (27M).

5.11. The next medical note is on 18th January, eight days after previous note on 10th January. This states further deterioration, subcut

analgesia continues....... try Nozinan. On 20th January the nursing notes state that Dr Briggs was contacted regarding the drug regime and there was a verbal order to double the Nozinan and omit the Haloperidol (28M). This is confirmed in the medical notes on 20th January (15M). The medical notes on 21st January state "much more settled", respiratory rate of 6 per minute, not distressed and on 24th January the date of death is verified by Staff Nurse Martin in the medical notes (15M).

Note: Nozinan is a major tranquilliser similar to Chlorpromazine but more sedating. It is usually used for patients with schizophrenia and because of its sedation is not usually used in the elderly, though it is not completely contraindicated. Used subcutaneously in palliative care for nausea and vomiting at a dose of 25 – 200 mgs for 24 hours although British National Formulary, 39 Page 14, states that 5 – 25 mgs for 24 hours can be effective for nausea and vomiting with less sedation.

5.12. **Drug Chart Analysis:**

On 5th January at transfer (16M), Mr Pittock is written up for the standard drugs that he was on in the mental health ward including his Sertraline and Lithium (for his depression) Diazepam (for his agitation) Thyroxine for his hypothyroidism. The drug chart also had Diamorphine 40 – 80 mgs subcut in 24 hours, Hyoscine 200 – 400 micrograms subcut in 24 hours and Midazolam 20 – 40 mgs subcut in 24 hours. Midazolam 80 mg subcut in 24 hours written up but not dated and never prescribed. (18M)

5.13. On 10th January, Oramorph 10 mgs per 5 mls is written up for 2.5 mls four hourly and prescribed on the evening of 10th and the morning of the 11th. On the 11th Oramorph 10 mgs per 5 mls is written up to be given 2 mls 4 hourly 4 times a day with 5 mls to be given last thing at night. This is then given regularly between 11th and up to early morning on 15th January. This is a total daily dose of 26 mgs of morphine (19M).

5.14. Diamorphine 80 – 120 mgs subcut in 24 hours is written up on 11th January "as required" as is Hyoscine 200 – 400 micrograms in 24 hours, Midazolam 40 – 80 mgs in 24 hours. 80 mgs of Diamorphine together with 60 mgs of Midazolam are then started by syringe driver on the morning of the 15th January and re-started on both the mornings of the 16th and 17th January. (18M). On 16th January Haloperidol 5 mgs – 10 mgs subcutaneous for 24 hours is written up, prescribed over 24 hours on both 16th and 17th. I am not clear if this

was mixed in the other syringe driver or was the "second pump" referred to in the nursing cardex. (20M and 27M)

Diamorphine 120 mgs subcut in 24 hours is then prescribed on 18th January, together with Hyoscine 600 mgs subcut in 24 hours. The drug charts (20M) show this starting on the morning of 17th January and at 08.30 hours. If this correct there may have been up to three syringe drivers running, one with Diamorphine 80 mgs, one with Diamorphine 120 mgs in and one with the Haloperidol. The reason for this confusion needs clarification.

The subsequent drug charts all appear to be missing for the final 6 days, however the nursing notes (27M, 28M and 29) suggest that there was a fairly constant prescription of 120 mgs of Diamorphine 24 hours, Midazolam 80 mgs 24 hours, Hyoscine 1200 mgs, Haloperidol 20 mgs and Nozinan 50 mgs. On the 20th there was no Haloperidol and the Nozinan was increased 100 mgs a day. This is still the prescription on 23rd January (27M).

6 TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1 This section will consider if there are any actions so serious they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Mr Leslie Pittock. Also if the actions or omissions by the medical team, nursing staff or attendant GP's contributed to the demise of Mr Pittock, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

I will also consider whether Mr Leslie Pittock received the proper standard of care and treatment from the medical and nursing staff including identifying any actions or omissions by the medical team, nursing team or attendant GP's that contributed to the demise of Mr Leslie Pittock.

6.2 In particular I will discuss a) whether Mr Pittock had become terminally ill and if so whether symptomatic treatment was appropriate and b) whether the treatment provided was then appropriate.

6.3 Mr Pittock has an unfortunate long history of depression, which had become more difficult and complex to manage and increasingly distressing in terms of his agitation related to his depressive symptomatology.

6.4 He had many treatments including high level drug treatment over many years and many episodes of electro convulsive treatment (ECT).

6.5 The complex and unresolved psychiatric problem led to a requirement to move to a residential accommodation in 1993. However he had further relapses and problems in 1995. A change occurred by September 1995 where the residential home was now noticing weight loss, increasing frailty and falls. Although a subsequent admission only came to the conclusion that he was depressed I have no doubt that his terminal decline was starting from that time.

6.6 By October 1995 he had extremely poor mobility and a shuffling gate. When re-admitted in December is aggressive, essentially immobile and extremely mentally distressed alongside his increasing physical frailty.

6.7 It is impossible in retrospect to be absolutely certain what was causing his physical as well as his mental decline. It may be that he was now developing cerebrovascular disease on top of his long standing drug induced Parkinsonism together with his persistent and profound depression agitation. It is not an uncommon situation for people with long standing mental and attendant physical problems, to enter a period of rapid decline without a single new diagnosis becoming apparent.

6.8 His deterioration is complicated by a probable chest infection (64, 81), which does not respond particularly well to appropriate antibiotic and physiotherapy treatment. He also has bowel complications attendant on all his other medical and drug treatment (116).

6.9 Dr Banks, psychiatric service asked Dr Lord, Consultant Geriatrician, to see the patient on 2nd January and he is actually seen on 4th January 1996. Dr Lord describes a very seriously ill gentleman. His comments that a long-stay bed will be found at the Gosport War Memorial and that he is unlike to return to his residential bed, reflect the fact that it was probably in his mind that this gentleman was probably terminally ill.

6.10 Mr Pittock is then transferred to Dryad Ward and is apparently seen by Dr Barton. A short summary of his problems is written in the notes but no physical examination, if undertaken, is documented.

It is normal clinical practice when accepting a patient to a new inpatient environment to undertake and record a basic physical examination. This will form a baseline for future management and a clinical record for other members of staff. The lack of a record of any examination, if undertaken, would be poor clinical practice.

6.11 It remains clear from the nursing record that he remains extremely frail with very little oral intake on 7th January (25M). When seen again by Dr Barton on 9th, there is the first note suggesting that Opiates may be an appropriate response to his physical and mental condition.

6.12 It is my view that this gentleman by this stage had come to the end point of a series of mental and physical conditions and that his problems were now irreversible. He was in considerable mental distress and had physical symptoms partly related to that and partly related to other medical problems. In my view he was dying and terminal care with a symptomatic approach was appropriate.

6.13 On the 10th Oramorph was started. Oramorph and Diamorph are particularly used for pain in terminal care. The nursing notes document that he had some pain; but most of his problems appeared to be restlessness, agitation and mental distress. However, despite the lack of serious pain, morphine like drugs are widely used and believed to be useful drugs in supporting patients in the terminal phase of the restlessness and distress that surrounds dying. I would not criticise the use of Oramorph in conjunction with his other psychiatric medication at this stage.

6.14 The decision that he was now terminally ill and for symptomatic relief appears to have been made appropriately with both the family and the ward staff and there was no disagreement with this decision.

This is indicated in the medical notes by the comment "poor TLC" (13M) together with the statement that it was discussed with the wife "for TLC" (note TLC= tender loving care). Beyond the statement in the medical notes that the patient was "for TLC" there is no specific justification given for the Oramorph in particular to be started. The notes are at best very thin and sparse and good medical practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and, if necessary, an appropriate examination"...... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the

information given to patients and any drugs or other treatments provided". The lack of information in the written notes, as documented in this report, represents poor clinical practice to the standards set by the General Medical Council.

The Drug Chart analysis (para. 5.12) described Diamorphine, Hyoscine and Midazolam all written up to be prescribed with a dosage range. This is quite common clinical practice, the aim of which is to allow the nursing team to have some flexibility in the management of a patient needing symptom control at the end of their life without having to call a doctor to change the drug charts every time a change in dosage is needed to maintain adequate palliation. However, there seems no rationale for writing up the dose of Midazolam at 80 mgs separate from the prescription above for 40 – 80 mgs.

6.15 The dose of Oramorph given from the early morning of 15th January was 26 mgs of morphine a day (see paragraph 1.14) (19M). On the 15th a syringe driver is started containing 80 mgs Diamorphine and 60 mgs of Midazolam. If a straight conversion is being given from Morphine to Diamorphine then you normally halve the dose i.e. 26 mgs of Oramorphine might be replaced by 13 mgs of Diamorphine (Wessex protocol). If you are increasing the dose because of breakthrough agitational pain then it would be normal to increase by 50% each day, some clinicians might increase by 100%. This would suggest that the maximum dose of Diamorphine to replace the stopped Oramorphine might be up to a maximum of 30 mgs of Diamorphine in 24 hours. Starting 80 mgs of Diamorphine is approximately three times of the dose that could conventionally be argued for.

As individuals response to Morphine or Diamorphine can be extremely difficult to predict, this is why clinicians will usually start with a low dose, then increase, with regular and close review to assess the patients response and to find a balance between pain, symptom relief and excessive doses. The main side effects of excessive dosage would be depression of respiration and consciousness. No justification is provided in the notes for starting at approximately 3 times the dose that could be conventionally argued for.

I believe the dose of Oramorph originally prescribed between 11th and 15th January was appropriate, however, no justification is given within the notes for originally writing up the higher than usual doses of Diamorphine and Midazolam on 11th January, the same time as the Oramorph was started, nor indeed is any rationale

made in the medical or nursing notes, the decision to commence the syringe driver on the 15th January. This lack of medical documentation is poor clinical practice.

Where clinicians significantly deviate from standard clinical practice, it is poor clinical practice not to document that decision clearly. It is very unwise from a medico legal perspective.

6.16 Midazolam was also started at a dose of 60 mgs per 24 hours. The main reason for using this is terminal restlessness and it is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours for this purpose. Although 60 mgs is within current guidance, many believe that elderly patients need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270). This would again suggest that the patient was being given a higher dose of Midazolam then would usually be required for symptom relief. Where clinicians significantly deviate from standard clinical practice, it is poor clinical practice not to document that decision clearly. It is very unwise from a medico legal perspective.

The nursing notes documented anxiety, agitation and generalised pain for which the Midazolam and the strong opioids (Oramorph and Diamorphine) were started. Midazolam is often used for the restlessness of terminal care and although Oramorphine and Diamorphine are usually used for severe pain, in clinical practice it is often used as well for the severe restlessness of terminal care. One study of patients on a long stay ward (Wilson J.A et.al. Palliative Medicine 1987:149-153) found that 56% of terminally ill patients on a long-stay ward receive opioid analgesia. Hyoscine is also prescribed in terminal care to deal with excess secretions which can be distressing for both patient and carers. I believe this was appropriately prescribed and given.

6.17 Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. Based on the evidence suggesting unusually high dosage of these medications being used I have considered whether there was evidence in the notes of any drug complications, in particular whether giving three times the normal starting dose for both Diamorphine and Midazolam together caused excessive sedation or other side effects might be considered gross negligence or an unlawful act. I was only able to find two pieces of evidence. The first was a statement in the nursing notes (26M) that by the evening that the syringe driver was started, the patient was unresponsive. The aim of palliative

care is to provide symptom relief not possible over sedation leading to unconsciousness. However, this did not continue and Mr Pittock was noted to be more alert and agitated again on the 16th.

Secondly on the 21st January (15M) a respiratory rate of 6 per minute is noted suggesting some possible respiratory depression.

6.18 A further drug, Nozinan, a sedating major tranquilliser is added to the drug regime, 50 mgs a day on the 18th January and increased to 100 mgs a day on the 20th January. Though this is within the therapeutic range in palliative care, 25 – 200 mgs a day when it is used for nausea and vomiting, the BNF advises 5 – 20 mgs a day and that the drug should be used with care in the elderly because of sedation.

The rationale for starting Nozinan appears to be the fact that the patient had become unsettled on Haloperidol (a different sort of major tranquilliser) and Nozinan is more sedating that Haloperidol. A verbal order to increase the dose of Nozinan from 50 to 100 mgs is documented in the medical notes (M15). This suggests that the 100 mgs was not actually written up within the Drug Charts, which if true, would be poor clinical practice. The absence of the drug charts makes this harder to determine.

6.19 The prediction of how long a terminally ill patient would live is virtually impossible and even palliative care experts show enormous variation (Higginson I.J. and Constantini M. Accuracy of Prognosis Estimates by 4 Palliative Care Teams: A prospective cohort study. BMC Palliative Care 2002 1:21). The combination of the high doses of Diamorphine, the high doses of Midazolam and the high doses of Nozinan are in my view likely to have caused excessive sedation beyond the need the symptom control in this dying man. In my view the medication is likely, but not beyond reasonable doubt, to have shortened life. However, I would have expected this to have been by no more than hours to a few days had a lower dose of all, or indeed any, of the drugs been used instead.

7. OPINION

7.1 Mr Leslie Pittock was an extremely ill, frail and dependent gentleman on his admission to Gosport War Memorial Hospital and was at the end point of a chronic disease process of depression and drug related side effects that had gone back for very many years.

7.2 The major problem in assessing Mr Pittock's care is the lack of documentation. Good Medical practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on history and symptoms and if necessary an appropriate examination".... "In providing care you must keep clear accurate legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drugs or other treatments prescribed". The major gaps in the written notes, the lack of evidence of appropriate examinations, use of unusual drug regimes without adequate documentation in the medical notes, changes in prescription without proper documentation, all represent poor clinical practice clinical practice to the standards set by the General Medical Council. However, by itself, these do not prove that the medical or nursing care provided to Mr Pittock was sub-optimal, negligent or criminally culpable.

7.3 In my view the drug management as Gosport was sub-optimal. There was no written justification at any stage for the high doses of Diamorphine and Midazolam written up in the drug charts and subsequently prescribed to Mr Pittock. The notes and the drug charts leave confusion as to whether at one stage there may have been three syringe drivers being used. The dose of Nozinan may have been prescribed by verbal prescription and not written up in the drug chart. Combinations of the higher than standard doses of Diamorphine and Midazolam, together with the Nozinan were very likely to have caused excessive sedation and may have shortened his life by a short period of time, that in my view would have been no more than hours to days. However, this was a dying man, the family appeared to have been appropriately involved and the patient did eventually die without distress on 24th January. While his care is sub-optimal I cannot prove it beyond reasonable doubt to be negligent or criminally culpable.

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129

9. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature:______________________________ Date: ______________