In the Family Health Services Appeal Authority case no: 14822

Heard at Harrogate	
On 15 December 2008	

Before

Mr J D Atkinson (Chairman)
Dr E Walsh-Heggie
Mr M Rayner

Between

Dr E Heinzman
(GMC No: 6074341)

Appellant

and

Leeds Primary Care Trust

Respondent

Representation:

For the Appellant: None
For the Respondent: Ms F Morris of Counsel

DECISION AND REASONS

The Appeal

1. This is an appeal by Dr Emily Heinzman against the decision of the respondent issued on 2 September 2008 to remove the appellant from the respondent's performers list under the Health Services Act 1977 (as amended) and associated regulations.

The Proceedings

2. The appellant began her GP training in February 2005 and subsequently worked as a GP registrar in Dr Addlestone's practice from August 2006 to May 2007 and then in Dr Marshman's practice from January 2008. The appellant was accordingly included on the respondent's performers list.

3. By a letter dated 12 May 2008 the appellant was notified of her suspension from the performers list.

4. By a letter dated 2 September 2008 the respondent notified the appellant that her continued inclusion on the performers list was prejudicial to the efficient delivery of NHS primary medical care services. The reasons given for that decision in summary were:

    i. serious deficiencies in the appellant's behaviour and performance with a lack of insight
    ii. repeated pre-meditated fraudulent and inappropriate prescribing

iii. substandard record keeping
iv. deficiencies in the appellant's ability to work professionally with colleagues
v. inability to demonstrate progress with specialist training requirements
vi. lack of honesty and probity

5. By letter dated 17 September 2008 the appellant gave notice of appeal.

6. Appeals to the FHSAA are by way of redetermination.

The Law

7. The relevant law is to be found in the 1977 Health Services Act as amended together with associated regulations. Extracts of the relevant law as set out in National Health Service (Performers Lists) Regulations 2004, as amended may be summarised as follows:

   Regulation 10(3) … a primary care trust may remove a performer from its performers list where …

   10(4)(a) his inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the relevant list perform.

8. In addition, in an efficiency case the respondent may instead of deciding to remove a performer decide to remove the appellant contingently; that is subject to conditions relating to preventing any prejudice to the efficiency of the services in question.

Preliminary Matters

9. The Panel noted that the appellant, although previously represented, was not represented at the hearing. The appellant indicated that she was content to proceed in the absence of a legal representative. The Panel acknowledged that the appellant's lack of legal representation was a matter that needed to be taken into account in ensuring that the hearing was fair and that the appellant was afforded the opportunity to present her case.

10. The Panel accordingly structured the hearing, with appropriate breaks, to enable the appellant to reflect and prepare for the different stages within the hearing. In particular evidence was heard first about the primary facts followed by evidence on the option of the appellant being contingently removed from the list. This determination is accordingly structured to reflect those steps.

The documents and evidence considered

11. The Panel had before it the originating documentation from the appellant numbered A1 and from the respondent numbered to R6.

12. For the hearing the respondent filed a bundle indexed and paginated to 241 the contents of which need not be set out here.

13. For the hearing, the appellant did not file a bundle; however at the hearing she produced the following further documents: letter dated 12 December 2008 from Dr Buller; letter dated 4 December 2008 from C Brogan; urine test results for the period 24 October 2008 to 27 November 2008; and plasma ethanol test dated 15 November 2008; the production of which raised no objection from the respondent.

14. In addition, in the course of the hearing the Panel also received in evidence a letter from the respondent dated 3 September 2008.

Opening Submissions on behalf of the respondent

15. Ms Morris relied on her amended skeleton argument and made further submissions as follows.

16. The respondent came to the view that the appellant's circumstances should be considered under the head of an efficiency case, rather than a suitability case following consultations with NCAS. The range and multiplicity of the matters, including record keeping, safe prescribing, falsifying records, lack of insight and failure to disclose gives rise to issues that are broader than that of suitability.

17. In taking that approach the appellant was afforded the opportunity of arguing for contingent removal, that being an option that would not be available if the matter was to be treated as a suitability case. However the respondent further submitted there were no conditions that could be imposed that were capable of removing any prejudice to the efficiency of delivery of services.

18. The present proceedings before the Panel were being conducted in parallel with two other matters. First, the appellant remained on police bail whilst investigations continued into fraudulent prescribing. Her case was awaiting consideration of charges which were expected to be formulated within 2 to 3 weeks. Second, the GMC had imposed conditions on her registration in July 2008 and an interim order was set to be reviewed in January 2009. The January 2009 GMC review hearing could look substantively at the issues and would be able to take into account matters that had arisen since the making of the interim order.

19. Turning to the allegations and evidence, the primary facts showed a wide range of concerns. The appellant, over a period of about 18 months, had prescribed a variety of drugs, using a range of methods, for individuals who were not her patients, such drugs being used for herself and a friend CW together with others, for recreational purposes. Some of the prescribing had been undertaken when the appellant was on sick leave. The appellant had thereby exposed individuals to risk in circumstances for which she had no clinical responsibility and was unaware of what other drugs they were taking.

20. The appellant had failed to keep proper records and created false entries in patients' records. The appellant had made false representations to the prescription pricing authority by stating that certain prescriptions were subject to a fee exemption when they were not.

21. The appellant in the course of such prescribing had concealed her own identity with a view to misleading others.

22. The appellant had misled a range of professionals, in the course of inquiries into her actions, as well as at a PCT disciplinary panel convened to consider her suspension and the GMC interim orders panel of July 2008.

23. The appellant had engaged in such activities that were outside any governance framework and outside the limits of her competence. By her actions she had also demonstrated that she was unable to make appropriate judgments about her own fitness to practise.

24. The appellant had taken cocaine and had allowed her private residence to be used for such a purpose, despite denying such use to those professionals who were advising her about her health and welfare and at times when she was subject to inquiries by the police. The appellant has continued to use cocaine up until mid September 2008, despite the conditions imposed on her by the GMC in July 2008 and assurances offered about abstinence.

Evidence on behalf of the respondent as to inefficiency

25. The appellant in correspondence indicated that she did not dispute the primary evidence relied on by the respondent. Accordingly, at the hearing only Dr Riley, Director of Primary Care for the respondent attended to give oral evidence. He adopted as evidence in chief his statements dated 6 August 2008 and 21 November 2008. It is not necessary to set out the contents of those statements here. At the hearing the appellant confirmed that she did not dispute the primary facts as set out within those statements.

26. Dr Riley was also asked about the new evidence produced by the appellant at the hearing, including the various blood and urine tests showing negative results for a range of drugs and plasma ethanol levels at less than 10mg/dL and that she had last taken cocaine in mid September 2008. Dr Riley's replies may be summarized as follows. The appellant's use of alcohol was a concern and he would be looking for the appellant to be abstaining from alcohol. The appellant's use of cocaine in September 2008 showed that appellant had given inconsistent evidence about her drug usage. Concerns remained about the appellant demonstrating abstinence from drug usage. It was accepted that the tests showed that there had been a lack of use in the 2 months prior to the hearing; however cocaine is a drug that tends to be used sporadically and single test samples are not reliable.

27. The respondent also relied on the statements of Mr T Jamieson, Head of Medicines Governance for the respondent dated 8 August 2008; and the letters of Dr S McMain, Associate Postgraduate Dean (General Practice) at the Yorkshire and Humber postgraduate deanery, dated 2 June 2008 and 7 August 2008. At the hearing the appellant also confirmed that she did not dispute the primary facts as set out in those documents.

Oral evidence on behalf of the appellant as to inefficiency

28. The appellant did not prepare a statement for the hearing. She was content to confirm her acceptance of the accuracy of the allegations and evidence against her and to refer to the additional evidence that she had brought on the day of the hearing. Her oral evidence was directly primarily to developments since September 2008 and the viability of conditions that could be put in place which would allow removal on a contingent basis. Her further oral evidences is therefore summarised at a later point in this determination.

The Panel's findings of fact

29. Given the approach taken by the parties to the primary facts as noted above the Panel finds as follows.

30. The appellant applied for GP specialty training in 2004. She began training in general practice with Dr Addlestone in August 2006. By March 2007 the appellant's progress in training was seen as unsatisfactory in that she had failed to pass any components of the requisite 4 summative assessments. In May 2007 the appellant re-sat and failed the multiple choice component of her assessments.

31. The appellant whilst in employment at Dr Addlestone's practice wrote three prescriptions for her friend CW in the period March to April 2007, including one prescription for 200 codeine tablets. At all material times CW was not the appellant's patient, but a person with whom she had a personal relationship.

32. In May 2007 the appellant went on sick leave from Dr Addlestone's practice until December 2007. Over that period of time she wrote 5 prescriptions for CW, 3 of which were for codeine, 2 for kapake. The appellant also wrote a private prescription for codeine for a person, AW; and on 10 January 2008 wrote a further codeine prescription for CW.

33. Following the appellants change in employment and her move to the Oulton practice from January 2008 to 3 April 2008, the appellant wrote 6 prescriptions for CW for codeine, dihydrocodeine, tamazepam or diazepam. One of the prescriptions was written using her former employer's prescription pad.

34. In addition, the appellant reprinted a prescription on 12 February 2008 in the name of patient SS for 200 codeine tablets and signed the reverse of the form herself; the appellant also wrote and signed the reverse of prescriptions for JH and AW.

35. In addition, in the same period the appellant printed and then deleted from the records a prescription for codeine in the name of patient SS.

36. The prescriptions noted above did not come to the attention of the investigating authorities until Mr Jamieson conducted inquiries following the events of 16 April 2008.

37. On 9 April 2008 the appellant recorded that she undertook a home visit to a patient PS. PS's medical record did not show that a prescription had been issued on that visit.

38. On 10 April 2008 the respondent was notified that the appellant had presented a prescription for codeine in the name of PS.

39. On 11 April 2008 the practice manager attempted to obtain an explanation from the appellant whilst she was conducting her morning surgery. The appellant was found to have fallen asleep during morning surgery. On 16 April 2008 the appellant said that she had obtained the codeine in PS's name for her friend CW.

40. On 18 April 2008 the appellant gave an undertaking to the respondent not to repeat any fraudulent or improper prescribing. The appellant was asked whether or not she had written any other improper prescriptions besides the prescription of 9 April 2008 in PS's name. In reply the appellant failed to disclose the items prescribed in the period from March 2007 to 3 April 2008, as set out above.

41. On 21 April 2008 the appellant wrote and attempted to collect a prescription for codeine in the name of JH using a prescription from her previous employers pad.

42. On 7 May 2008 the appellant was assessed by Dr Mellors, a consultant in occupational medicine, in the course of which the appellant denied using inappropriate medication or recreational drugs. Dr Mellors was of the view that the appellant was fit for work.

43. On 9 May 2008 the appellant was suspended by the respondent following an oral hearing. In the course of the hearing the appellant falsely denied that she had been involved in more than the two prescription incidents of 10 April 2008 and 21 April 2008. In the course of the hearing the appellant also falsely claimed to have posted a sick note on 3 May 2008.

44. On 9 May 2008 the respondent was also advised that the police had begun making inquiries.

45. On 2 June 2008 the appellant was arrested for questioning, in the course of which the she tested positive for cocaine.

46. On 5 June 2008 the appellant told the respondent that she was not aware of her being involved in improper prescribing save for the incidents of the 9 and 21 April 2008.

47. On 9 June the appellant falsely stated to the respondent that the positive cocaine test undertaken by the appellant was a result of using a prescribed mouthwash.

48. On 20 June 2008 the appellant provided an incomplete list of her misprescribing, identifying approximately 12 occasions compared to 17 prescriptions identified in subsequent inquiries.

49. On 7 July 2008 the appellant falsely repeated her claim to Dr Mellors that she was not involved in misusing drugs.

50. Following a hearing on 25 July 2008 at which the appellant was legally represented, the GMC imposed conditions on the appellants registration, with a review date of January 2009. In the course of the hearing the appellant failed to disclose her prescribing using the names of SS and PS.

51. On 2 August 2008 the appellant admitted using cocaine and using codeine daily.

52. On 5 August 2008 Mr Jamieson produced a report, substantively repeated in his statement of 8 August 2008, showing the result of his inquiries and the extent and method of the appellant's misuse of prescriptions.

53. On 2 September 2008 the respondent held the hearing which decided that the appellant be removed from the list.

54. At the hearing before the FHSAA the appellant admitted that when she was ill she had used cocaine up to twice a week and that the last occasion she had used cocaine was in September 2008.

55. The appellant has been a patient of Dr Buller consultant psychiatrist since December 2006 with a period when she was discharged from his care between January and August 2007. Dr Buller in the past had recommended counselling which the appellant chose not to pursue. The appellant has been referred to an addiction therapist who has seen the appellant on 6 occasions between 8 September 2008 and 27 November 2008. Over that period of time routine blood tests have not shown any positive findings.

The respondents evidence on contingent removal

56. Dr Riley in his adopted statements of 6 August 2008 and 21 November 2008 set out the respondents evidence as to why there were no conditions that could be imposed that would remove any prejudice to the efficiency of the services to be provided. In summary those statements indicate that given that the appellant had engaged in sub standard conduct across multiple areas of practice, that some of aspects of the appellant's practice were very significantly below the expected standard and had taken so many forms, it was not possible to find a logistically practical or re-inforceable set of conditions that would meet the relevant requirements.

57. Dr Riley's further oral evidence on this aspect of the appeal may be summarized as follows. The supervisory requirements that would be necessary to monitor the appellant's practice are very different from the monitoring requirements of a senior house officer in a hospital setting. Such a doctor would not be on the performers list. Such a doctor may undertake a 12 week placement within a GP practice, but this would largely comprise sitting in and observing. The doctor would not be expected to work autonomously, unlike a GP registrar on a 12 month placement.

58. The respondent is not aware of any concerns relating to the appellant prior to 2006. To the extent that the appellant had a mental health condition and was involved in substance abuse, such matters do not always result in a loss of insight. Some people may recognize that they are depressed. Some drug users may make efforts to cover up their use.

59. Even if the concerns about the appellant's health and drug use could be met, the available evidence did not show that the appellant's performance would be adequate. The appellant's performance as a practitioner gave cause for concern, which had become apparent in a primary care setting where there were expectations of a practitioner acting autonomously within the community, undertaking home visits and prescribing. The governance frameworks involved and the pressure of work together with the temptation to abuse are different in such circumstances.

60. The evidence does not show that the raft of the respondent's concerns have been met. The respondent's view is not that the appellant may never become a GP, but that she had not displayed the requirements to show that she should remain on the list. There are other areas within medicine where a practitioner is not required to prescribe. In order to return to practise the appellant would need to show adequacy in relation to insight, prescribing, record keeping, and honesty.

The appellant's evidence and submissions on contingent removal

61. The appellant gave further oral evidence which may be summarised as follows. Things started to wrong for her following her GP placement. There were difficulties in her personal life.

62. The appellant accepts that the respondent had accurately described her behaviour, but at that time the appellant had been in denial about her substance misuse. It was accepted that this had made matters worse but the appellant is now making progress. The appellant had been unable to take steps at an earlier stage because of the fear of the stigma attached to making such an admission. The appellant at the time did not know who to turn to for help.

63. As to the allegations relating to the fraudulent prescriptions, the appellant had no insight at the time. She did not realize that there were up to 30 items. It was accepted that she had made big mistakes, but removal from the list now would amount to her being stigmatized for her mental health condition. The appellant was now tackling her condition, she was compliant with her medication, had attended her out-patient appointments and had a supportive network.

64. The appellant had taken steps to really address her condition since August 2008. Her drinking was now at a social level at weekends on the advice of her counsellor. Her addiction to drugs had started at the end of 2006 when her relationship broke up. The appellant is following the guidance of her psychotherapist, her GP, Dr Buller and Ms Brogan, the substance misuse worker.

65. The appellant is willing to follow any re-entry procedure put forward by the PCT. The prescribing issues that had been identified were fuelled by her addiction. The appellant is now free from that addiction.

66. The appellant no longer moves in the same social circles as when she was taking drugs and now associates with people who are not interested in such matters.

67. It is accepted that there is no medical or expert evidence to support the appellant's contention that she is now free from addiction. The appellant began seeing Ms Brogan as a result of the conditions imposed by the GMC. Ms Brogan stressed the importance of being honest which is why the appellant now agrees that she has not used cocaine since September 2008. The appellant was never physically addicted to cocaine. She first started using it in 2006, in order to numb her feelings rather than for recreational use. The appellant was addicted to codeine. The cocaine use had been intermittent but when she was off sick the appellant had used it up to twice per week.

68. The appellant did not find working in a primary care particularly stressful. Her work in hospital had been more so. The appellant enjoyed working as a GP and wished to pursue that career.

69. The appellant accepted that she had not been completely honest at the GMC hearing. The appellant had been involved in a social network which she did not know how to get out of. The appellant had not taken cocaine in the period 30 May 2008 to 21 July 2008. In the period from 25 July 2008 to September 2008 the appellant had taken cocaine. She did not know why she had done so, despite having been given a second chance.

Decision and Reasons

70. In the light of all the evidence and submissions, and in the light of the findings above, the Panel finds that the appellant shall be removed from the performers list for the reasons set out below.

71. The facts show that the appellant's continued inclusion on the performers list would be prejudicial to the efficiency of the provision services. The prejudice to the provision of services arises in a number of forms. From a patients perspective, the appellant's behaviour has resulted in the creation of inaccurate and false entries in their medical records by the appellant abusing the system in a variety of ways, such as creating computer generated prescriptions, duplicating prescriptions, and canceling prescriptions.

72. The appellant by providing drugs for the use of others outside an acceptable governance framework has also created unacceptable risks for the health of those individuals given that the appellant would not be aware of what other drugs they were taking and that those individual's GPs would also be unaware of the drugs which the appellant had supplied to their patients. Further, the appellant's behaviour, ranging from falling asleep in surgery, mis-prescribing, misusing drugs and using street drugs is likely to undermine patients confidence in the ability of the NHS to provide a satisfactory service.

73. In addition to those matters identified from the patients perspective the appellant's behaviour also gives rise to prejudice in the provision of services from the respondent's particular perspective as a provider of medical services. Thus the amount of public resource devoted to dealing with this appellant's performance and behaviour are substantially greater than the resources rightly devoted to the supervisory regime inherent in the training of any other GP registrar who is performing within acceptable norms.

74. The appellants behaviour also results in prejudice to the efficiency in the provision of services from the appellant's own personal perspective. The appellant's behaviour shows a lack of judgment and insight in a number of respects, ranging from her own misuse of drugs, her inability to recognise the times at which she is not able to perform at a satisfactory professional level and the misleading of her colleagues who have attempted to assist her.

75. In considering whether or not there are conditions which may be placed on the appellant's continued inclusion with a view to removing any prejudice to the provision of services, the Panel is aware of the need for such conditions to be able to meet all the concerns arising from the facts as found.

76. The appellant submitted that the main issue she needed to address was her addiction to drugs, and codeine in particular. In evidence she said that she was now free from such an addiction, that her alcohol intake had been appropriately limited, that she had not taken cocaine since September 2008 and that she had the support of a number of professionals.

77. The Panel finds that the appellant's own account of the degree of success that she has achieved in dealing with her drug misuse is unlikely to be reliable. The appellant on a

number of occasions has been asked to give a full account of her use of drugs and has not only failed to give a full account, but engaged in repeated behaviour very shortly after being questioned about such matters. For example and not exhaustively, at a meeting on 18 April 2008 the appellant was asked about the prescription concerning PS (arising from the events of 10 April 2008) and at that meeting said that there were no other untoward prescriptions and that she would not repeat any mis-prescribing; however 3 days later on 21 April 2008 the appellant was discovered fraudulently attempting to obtain codeine in the name of JH. The appellant also told Dr Mellors the occupation health assessor on two occasions that she was not misusing drugs, when clearly she was misusing drugs. Perhaps most strikingly, the appellant became the subject of an interim order by the GMC in July 2008 with conditions relating to her use of drugs, yet continued to use cocaine until September 2008.

78. There are other similar instances in which the appellant has sought to deny or minimise her drug taking and behaviour, and in such circumstances the Panel attaches little weight to the appellant's assertion that she is now free from addiction. In considering the extent to which such a claim is supported by medical evidence or expert opinion the Panel has weighed the evidence from Dr Buller, consultant psychiatrist and Ms Brogan, together with test results of the blood and urine samples. The Panel finds that the evidence does not support the appellant's claim to be addiction free for the following reasons.

79. The report of Dr Buller dated 12 December 2008 provides background history and the appellant's treatment package which does not relate to her drug use. It does not express an opinion on the progress or otherwise of the appellant's drug addiction.

80. Ms Brogan is the relevant professional dealing with the appellant's use of codeine, cocaine and alcohol. Ms Brogan is part of the Leeds Community Drug partnership. The Panel is unaware of her professional standing or experience. In a report dated 4 December 2008 Ms Brogan sets out only limited information, relating for example to dates of her one hourly meetings with the appellant on 6 occasions, negative blood tests and brief comments on the appellant's reporting of wanting to make progress. On any view this report cannot be seen as a comprehensive assessment of the appellant's addiction to drugs. Accordingly, the Panel finds that there is insufficient evidence to show that the appellant is free from addiction as claimed.

81. It therefore follows that in considering the possibility of contingent removal the viability of any conditions must be considered within the context of the appellant not being free from addiction. In order for conditions to be viable they must be capable of removing the prejudice to services that not only arise from the appellant being treated for addiction, but also capable of removing the prejudice arising from the other elements of her behaviour.

82. Accordingly, the various elements that conditions would need to address are as follows: the appellant's drug addiction and treatment; the appellant's willingness and ability to resort to various relatively sophisticated methods in improperly obtaining prescriptions and covering her tracks; the need for the appellant to engage in meaningful training moving towards autonomous prescribing; and the need to complete training within a reasonable timescale. The Panel in coming to its view have considered not only the range of possible individual conditions but also the cumulative effect of such measures in determining viability of the measures as a whole**.**

83. The Panel is of the view that it is not possible to adequately frame conditions that would meet the prejudice arising from the appellant's drug addiction. Not only is there an insufficiency of information as to the appellant's past drug use, the Panel has only limited information about the progress made to date, and the prognosis. The Panel is therefore not able to identify concrete measures that might be put in place to ensure compliance and provide for adequate reduction in the risk of mis-prescribing and drug misuse. In this respect the Panel's views accord with those of Dr Riley, at paragraph 39 of his statement of 6 August 2008, that there

would be real difficulties in establishing a drug testing regime where the appellant would be working in the community, with means of accessing prescriptions; and without an understanding of the rehabilitative context.

84. In addition to drug screening and reports on progress on matters of addiction, there would need to be a range of measures that enabled the appellant's prescribing to monitored, both in the context of her addiction and her understanding of the prescribing systems which enables her to take steps to try and avoid creating an audit trail. There are a number of logistical difficulties in identifying a suitable regime to meet these requirements. The appellant, as a trainee GP, does not issue prescriptions in her own name and uses a pad that is the name of her supervisor, rather than her own name. The supervisory regime required to monitor all prescriptions would be manifestly overburdensome. A system of spot checks or review would need to be devised and resourced; with an acknowledgement of the risks of fallibility involved in such a regime.

85. A further difficulty in framing a suitable regime is that the appellant is still in training. In particular, it is an essential part of GP training that the trainee move from a relatively highly supervised regime to a clinical governance regime within which the practitioner acts autonomously. There are obvious tensions between moving from a high degree of supervision to appropriate professional autonomy as a practitioner where, as with this appellant, the trainee is subject to the superadded requirements of drug screening, an addiction treatment programme, and monitoring of prescribing to prevent misuse of drugs. In addition, the Panel also take account of the fact that the appellant has failed her summative assessments and will be further behind in her training because of the significant periods of sick leave.

86. The Panel finds: looking at the totality of the conditions that would need to be put in place; the inherent difficult in identifying suitable regimes given this appellants drug misuse; the range of issues to be addressed; and the logistical difficulties arising from the conditions singly and cumulatively; that there is no set of viable conditions that could be imposed with a view to removing any prejudice to the efficiency of provision of primary care services in this case.

Summary

87. The Panel directs that Dr Heinzman be removed for the Leeds Primary Care Trust's lists of medical performers because her continued inclusion would be prejudicial to the efficiency of the performance of primary care medical services

National Disqualification

88. Ms Morris in her skeleton argument and orally before the Panel submitted that the appellant should be made subject to a national disqualification. The Panel noted that the FHSAA had not entered such an application into its record.

89. The Panel considered that in the event of the appellant's appeal on removal being dismissed, it would exercise its own powers under regulation 18A of the Performers Regulations 2008 to consider whether or not to impose a national disqualification at a further hearing.

90. Accordingly, in the light of the above determination, the Panel directs that there be a further hearing, as previously and provisionally listed on the 20 January 2009, to determine whether or not the FHSAA should impose a national disqualification on the appellant.

Signed Date

Mr J D Atkinson, Chairman