Witness Name: Paul Desmond
Statement No.: WITN0479044
Dated: 25th February 2025

INFECTED BLOOD INQUIRY

FOURTH WRITTEN STATEMENT OF PAUL DESMOND

I provide this fourth statement following my first, second, and third statement, in response to a request under Rule 9 of the Inquiry Rules 2006 dated 14th January 2025.

I, Paul Desmond, will say as follows:

Introduction

1. My name is Paul Desmond. My date of birth is GRO-C and my address is known to the Inquiry.

2. I have been the CEO of the Hepatitis B Positive Trust (www.hepbpositive.or.uk) for more than 15 years. We also offered key evidence to the Inquiry and IBCA at www.thetruthabouthepc.org.uk and on our you tube channel.

3. My first witness statement to the Inquiry, dated 11th December 2018, provided details of how my own infection with the hepatitis C (HCV) virus was left forgotten on my medical file for 25 years until I spotted it. Further research into how this happened provided me with shocking clarity as to how the "cover

up" and spread of misinformation in the UK nearly killed me and jeopardised my recovery.

4. My second statement, dated 11th July 2019, provided the Inquiry with details of some of the experiences I have had whilst running a national helpline to assist victims of viral hepatitis, together with some of my interactions with various charities, organisations, NHS agencies and politicians.

5. My third statement to the Inquiry, provided information about the circumstances in which I authored a book called, "When Spin Kills".

1. **Please describe the nature of the work which you and your colleagues within the Hepatitis B Positive Trust have been undertaking, in relation to the question of compensation, since the publication of the Inquiry's report in May 2024.**

6. The Hepatitis B Positive Trust is registered under Charity Number: 1152985. We run the National Hepatitis Helpline dealing with callers 365 days a year. We also campaign for access to care and proper guideline usage. We also do detailed patient research into transmission of hepatitis B (HBV). We have been registered as a charity since 2013 and since then we have recommended more than 500,000 vaccinations and helped many thousands of callers to our helpline.

7. As part of the activities of the Hepatitis B Positive Trust, around 2-3 times per month, we travel with our exhibition stand which is placed in supermarkets and public and NHS venues. We have been doing this for 12 years now.

8. Over the years, we have received many pages of patient medical notes and records on their infected blood cases so that we can consider and understand them and advise individuals on the source of and progression of their HBV infections.

9. We take many calls/contacts from thousands of individuals who have been infected with HBV through healthcare and through contaminated blood.

10. We have developed a toolkit of medical abbreviations that we use when we are looking at patient's cases, searching for evidence of the type of infection they have received, the source of that infection, and the date of their infection. We primarily help, on average, around 1,000 new patients per month. Of these 1000 patients, the majority have acquired HBV infection from healthcare settings directly or indirectly either in the UK or abroad. Patients who contact our helpline are 90% from UK. On social media, they come from all over the world. Some will have arrived in the UK with HBV from healthcare abroad. Some will have been infected with contaminated blood in the UK.

11. We have been helping to assess infected blood cases since 2005. We also provide patient education and counselling to infected blood victims and their families.

12. Due to the increased volume of calls to our helpline since May 2024, we have established a new Facebook group, which has new members joining every day. We expect it to continue to grow in size. We also have a dedicated 0800 helpline.

13. Since May 2024, we have noted an increase in calls from infected individuals who have previously been turned down by the Infected Blood Support Schemes and are now considering and helping making claims for compensation to IBCA. We appear to have developed a reputation for being able to help patients to understand their medical notes and records.

14. Most callers to our helpline feel that they have no faith in the IBCA ever providing compensation to victims of HBV. We reassure them to try. Some feel that the obvious lack of understanding of HBV has affected the bandings of the scheme. For example, acute HBV infection, which has a high mortality rate, and has killed many people, will be incredibly difficult for patients to prove. In my experience from looking at the notes and records of hundreds of

HBV patients, there was a tremendous resistance in the NHS to note acute HBV infection in a patient's death certificates. 0.5 to 1% of those infected with HBV will die in the acute stage (known as going fulminant). Some are saved, but many are not. In these cases, their death certificates will often say that they died of 'acute liver failure'. This means that where the individual has died from acute HBV infection through contaminated blood, there is a risk their families will never be compensated.

15. In the Facebook group I recently set up, I have two members whose family member died immediately from liver failure, having received the HBV infected blood.

16. There are comments in the group from lots of people infected with HBV, and those whose family members have passed away, having been infected. There is a general message of confusion and lack of understanding about if, and when, they will ever be able to apply for compensation.

17. It is no wonder that they are confused about this, because there has been no direct messaging from the IBCA in relation to victims of HBV and no numbers to call or individuals to regularly inform and relate to them.

18. If the Hepatitis B Positive Trust had been involved in establishing the framework and the bandings for the new scheme, this type of issue could have been identified and rectified early on.

19. Likewise, if the hepatology experts and agencies who supported the Inquiry had been involved in establishing the framework and the bandings for the new scheme, then issues specific to HBV could have been identified and understood early on.

20. Unfortunately, this did not happen, and instead, lawyers, individuals and teams who knew rather less about infected blood, and even less about HBV infection, were tasked with setting up the scheme with zero input from us.

21. Despite our years of experience working with and supporting victims of HBV, the Hepatitis B Positive Trust has been rather excluded from any structured daily involvement with the IBCA or access to its staffing process.

22. As a result, I believe that IBCA are ill-informed regarding HBV and the number of individuals infected by healthcare in the UK.

23. For example, it is clear from the new scheme that it has not been properly understood or recognised that acute HBV is a major long-term issue. For instance, the 50% of elders who will go on to get various forms of cancer have serious possible consequences arising from a previous acute HBV infection. Those needing to access chemotherapy for cancer can face deadly reactivation issues, caused by the infection. There is a list of 20 drugs that are known to reactive acute HBV in patients who are previously cleared of it. For example, in elderly people who suffer from arthritis and rheumatism, all need steroid treatments for these conditions which can often reactivate acute HBV.

24. It is therefore my view that some oversight and assistance is required in respect of HBV in order for IBCA to properly assist these patients with accessing compensation.

2. **What, if any, external support or assistance has been, or is, available to you and your colleagues in undertaking the work described above?**

25. It has been my experience in running the Hepatitis B Positive Trust, that there is no support or assistance available to me and the charity externally. We run the charity based purely on donations.

26. Our mission at the Hepatitis B Positive Trust, is to end the terrible silence about the UK's booming epidemic of HBV infections and the lack of testing and vaccinations for all those at risk. We also aim to draw people together who have HBV, to give them a bigger collective voice to exact better services and enable them to support one another. We also aim to promote

interventions designed to prevent HBV infections and deaths, via the universal vaccination of children and the safe testing of the 20 million adults in the UK at high risk of infection. We also aim to promote the welfare of people with HBV infection and its related complications by educating people living with HBV, the health professionals who care for them, the general public, and by facilitating supported networking between patients, their families and friends.

27. We have a deep concern at the moment, that in attempting to establish a system of rules for compensation, less informed and uneducated individuals have adopted the same parameters for HBV as they have for HCV, when both conditions affect an individual and progress in very different ways, causing very different impacts, both acutely and over time.

28. Through my work with the Hepatitis B Positive Trust, years of experience have taught us to learn directly from each individual case and having done so, we are able to better understand categories of risk, progression and impact.

29. Since November 2024, I have been in contact with James Quinault (Cabinet Office) and have attended meetings with his good self and Minister Symonds of the All-Party Parliamentary Group (APPG) when HBV is concerned, most recently on 4th Dec 2024.

30. I have attempted to express to Mr. Quinault that there are lots of victims of contaminated blood, who suffer either with acute, cleared or chronic HBV and the IBCA needs to better understand HBV infection.

31. I don't believe that these conversations have been fed back to the IBCA in depth and across its departments as they have not contacted me.

3. **Please describe the involvement of people infected and affected in the decision-making regarding compensation (whether by Government or IBCA or both) as you and your colleagues within the Hepatitis B Trust have experienced it.**

32. The lived experience of the patients who contact us is that they are watching the plans being made for the new compensation scheme from a distance. They are experiencing the strange sensation of people being hired to work for IBCA, and plans being made for them as victims of HBV, with absolutely no engagement with them, and no time-line as to when any of this will happen.

33. Not all of those who contact us were involved in the Infected Blood Inquiry, and they don't have legal teams to help them to understand what is going on.

34. Patients feel that they are not being given the opportunity to be involved in what is being planned for them and are never seeing or hearing their ideas being acknowledged or incorporated into the scheme, or any road map of what is being designed. The mood amongst HBV victims is despair and rage, and many have died since the Infected Blood Inquiry commenced having seen no recognition and no justice.

35. HBV victims feel that they are once again being forgotten and that the focus is, as usual, on those who are already receiving financial support, having been infected with HCV or HIV. The exclusion of victims of HBV from infected blood support schemes is an injustice that is now being perpetuated by IBCA. The failure to prioritise these patients means that many more of them will pass away prior to ever seeing any kind of justice for what happened to them.

36. It is difficult to understand how those living infected with HBV could not be prioritised over the groups of people who have already received hundreds of thousands of pounds in compensation as interim payments. The least that IBCA could have done is provide a timeline for when these individuals (or their families) can start to apply for compensation and especially harvest as an independent list all infected at some point with HBV. Even now, does such a list exist? At the moment, the mood is one of uncertainty, where nobody knows whether or not they should invest money and time in obtaining probate documents, and obtaining medical records and recording painful statements, if it will be years before any action can be taken to obtain compensation.

37. Victims of HBV feel like the loudest voices are of the same campaign groups, every single time there is an engagement exercise, and HBV is pushed out of sight and out of mind. As a result, no-one knows how to get in touch with IBCA or how to be engaged or involved.

38. We are very grateful that since October 2024, we have been included in 3 or 4 meetings with the Cabinet Office on Zoom and that Emma has contacted us three times. However, we regret the void of communication after meeting John Glen at Whitehall in February 2024. It is unfortunate that job creations have not been clearly revealed and in-depth relationships with key IBCA functionaries are not in place.

4. **Please describe the principal concerns (if any) which you and your colleagues within the Hepatitis B Trust have, in relation to the involvement of people infected and affected in the decision-making regarding compensation (whether by Government or IBCA or both).**

39. It was our expectation that there would be representatives in the IBCA that potential applicants could phone up, talk to, and maybe they would have the ability to meet patients in some way and talk to them about their concerns. This is not the case.

40. I am concerned about the level of training at IBCA in respect of HBV infection. The individuals working for IBCA may have the best intentions but at the moment, they are uneducated as to HBV and unable to communicate directly with HBV victims. This is unacceptable and creates a gap between those infected with HCV and HIV and those infected with HBV. This has been a cause of distress and trauma for HBV victims, which has been compounded by the IBCA, rather than remedied, following the outcome of the Inquiry.

41. The information that we have received through our helpline, has suggested the need for a 'go to manual' to assist IBCA assessors to read and understand patient's medical records and notes in respect of HBV and HCV infections. It is essential for any claims assessors to be able to understand

and recognise the signs of HBV and HCV infection in a patient's notes where it is not expressly stated (which was often the case at the time).

42. It is of real concern to me that IBCA staff are likely unaware of the different ways in which individuals became infected with HBV and HCV through contaminated blood. For example, we can sometimes see on a patient's medical records, where an expectant mother has become anaemic, most anaemic pregnant women would be given blood given pre-birth. She would be treated with a blood transfusion, and in many cases, the transfusion would not be recorded as such, because it was such a standard practice. Anyone looking at medical records in a case like this, without the necessary level of experience to understand medical practices at the time, may conclude that there is no evidence of infection. Yet, we know, from the Infected Blood Inquiry, that many mums were infected through childbirth and through transfusions received during childbirth. Mums were also infected through anti-D injections that they received during and after childbirth.

43. In addition, many patients were infected with HBV through dialysis. Children could be infected where they needed to be in incubators after their birth, most incubator babies had mini transfusions of platelets. Many common procedures at the time would expose the patient to a high risk of infection. Those who have had transplants and needed multiple blood products would have an even higher risk of exposure to infection.

44. Whoever is making decisions about HBV infection, would need to have the relevant experience of recognising in a patient's notes where they have received a postpartum blood transfusion, platelets, a mini transfusion, an IV drip, plasma, or a clotting agent. They would also need to be able to recognise HBV symptomology, such as where the patient is recorded as being tired, yellow, jaundiced, raised enzymes, high ALT results, or other signs of impact on liver function.

45. Years of experience have taught me how to recognise the signs of HBV infection in a patient's notes and records, when it is not expressly recorded. I

don't know how it can be expected that non-medical case workers for IBCA will be able to recognise infection in this way.

46. I have sent e-mails to IBCA raising these issues, but they have not engaged. I would be happy to deliver training to IBCA across 5 or 6 core areas. I have made this clear, but my offer has been ignored.

47. Attention needs to be paid to the psycho-social journey of victims of HBV. For example, women with acute HBV would have been advised never to have children because of their infection.

48. Attention needs to be paid to the effect of HBV on cognitive ability and performance.

49. These factors should figure in compensation guidelines, had they been implemented and designed by an individual with experience of HBV infection. That has not happened and is a source of frustration to all HBV victims.

50. There is a need for counselling education modules for psychological and health support for newly hired staff at ICBA so that they can communicate with victims without traumatising them further.

51. There is a need for IBCA to produce a contact list, so that HBV victims know who to call with questions about potential claims.

52. There is a need for an expert in HBV infection to devise and implement training to IBCA caseworkers and assessors.

53. There is a need for the production of a user guide or manual to guide HBV, HCV and HIV victims through the IBCA application process.

54. The view of patients who did participate in the Inquiry, is that they are confused as to why their own legal representatives with years and years of experience in understanding their HBV infections, have not been permitted to

participate in the establishment of the compensation schemes. This is what Sir Brian intended, but IBCA has excluded lawyers with a vast amount of experience from the plans for the compensation scheme. Patients feel that it is a waste of all of the years of experience of the legal teams representing Core Participants in the Infected Blood Inquiry, to not trust them to use that experience to assist with the establishment of the scheme and the setting of compensation bandings.

55. There is a need for compensation to be able to evolve to match the evolving understanding of morbidity as a result of HBV infection.

56. There is a need for IBCA to produce a definitive guide to what medical records and notes would be adequate to confirm a transfusion record. It is important to understand that sometimes when a transfusion occurs, it is not noted as such, due to its normality and/or frequency. What will IBCA accept as evidence of a transfusion?

57. There is a need for IBCA to clarify what they will accept as evidence of the transmission of HBV from contaminated blood.

58. From the scheme as it stands, it appears that there is a lack of understanding that there are 20 non-liver related ailments attendant to HBV infection. HBV does not just affect the liver the same way as HCV.

59. There is a need for the IBCA caseworkers to actually understand the transfusion industry. For example, do they understand the usage of IV immunoglobulin, plasma, red blood, equipment, clotting factors and platelets? With 2.5 million units of transfusion blood distributed annually, do IBCA caseworkers have any understanding of the distribution map of the industry to patients and the likelihood of infection? They will need to know this if they are determining the likelihood of infection of any patient who has incomplete and unclear records, or where their records are unobtainable.

60. There is a need for the extensive list of known abbreviations for transfusion, transmission and morbidity so that IBCA caseworkers recognise these when looking at patient's records and notes. We sent a list setting this out to IBCA on 15th August 2024. We received no confirmation that it would be acknowledged or included in the assessment of claims for the scheme.

61. IBCA needs to have an extensive list of maximum order and blood scheduling, and the patient conditions known to be transfused, for example, an underweight baby, an anaemic mother (and their abbreviations). Again, we emailed a list to IBCA on 15th August 2024 but received no acknowledgement that the data would be included or how to work together to structure its inclusion to assist claims assessment.

62. IBCA needs to ask the right questions of scheme applicants in order to establish the impact on the victim. For example, if a mother is affected with acute HBV and forgoes having children as a result of that infection, where does her compensation fit in the scheme?

63. What will happen to the patients who had chronic HBV infections that fall into the 0.7% who have achieved clearance for several years followed by reactivation? How will their damages be calculated?

64. IBCA claims assessors need to be aware that HBV is often explained as 100 times more infectious than HIV and therefore the impact on both infected and affected victims can be much wider.

65. There needs to be clarity provided by IBCA as to the weight given to patient testimony in cases where a patient's notes or records are no longer available. Over 20 years you get a feel for when a story rings true and, more recently, we note a similar 'rings false' feeling since compensation is being offered. How deep is assessor awareness of this issue?

66. There needs to be clarity provided by IBCA as to the weight given to actual physical scars and evidence of surgery in the relevant period for patients with no complete records or notes.

67. There must be an agreed timespan over which IBCA will investigate a patient's records. Clarity must be provided as to the extent of investigation carried out by IBCA. Will caseworkers look at GP notes, hospital notes and patient accounts? Will they all be given equal weight? If contradictory, will one override the others? If so, which one?

68. Victims of HBV infection deserve some clarity as to the order of priority for dealing with claims made by individuals infected with HBV. Will they all be invited to apply to IBCA at the same time, or will they need to wait to be individually told to apply? If the latter is correct, is IBCA aware of all the new enrolments that will happen once the gateway is open to HBV patients? How does IBCA intend to manage that?

69. Given the cognitive impact on chronic HBV sufferers and the senior moment states of many victims, will additional support be provided by IBCA for those who are mentally or physically disabled to be able to apply to the scheme and navigate the process of doing so?

70. There will be patients like myself, who went from having de-compensated cirrhosis 20 years ago, to having a perfect liver at this stage. Where do these patients fit in the current compensation scheme?

71. It is a source of frustration for HBV victims that the priority of ICBA is those already receiving financial support from the Infected Blood Support Schemes and those who have already received interim payments. All of the people in the existing schemes have been audited and supported for years now. Why does IBCA need so much more time to pay this group of people, who have already been prioritised over all other victims of contaminated blood? For those who were infected with HBV, they are the only group of infected people

who have suffered catastrophic health impacts individually and have not yet received a penny. This group of individuals must be made a priority by IBCA.

72. It would be possible for IBCA to come up with an interim payment for those infected with HBV so that they could have some money now and then later on, have their claims determined fully. No consideration has been paid to this, even though it has been requested repeatedly by victims.

73. I am still seriously concerned that there is an ongoing epidemic of HBV in the UK. The latest statistics show that 73% of people attending an Accident and Emergency Department have never been tested for HBV or HCV. Most of the 1000 plus new HCV infections found in A&E are in the age range of 50-80. Many relate that no-one has ever told these individuals anything about contaminated blood, they tend to keep their infections a secret, even if they know about it, due to the stigma.

74. Following on from the Inquiry, it is not clear that any action is going to be taken by the Government in order to educate the general public about the ease of transmission of HCV and HBV and the availability of compensation for those who were infected through contaminated blood. What outreach for the newly diagnosed is planned? Some of these will be infected blood cases.

75. Also, at the moment, we have numerous individuals coming into the UK every week, infected with HBV. If we are not educating the public, and testing new arrivals, this will produce a pandemic of HBV infections.

76. Since the Inquiry, I have also noticed that charities and agencies who do not have any experience in treating or talking to HBV victims, are now talking about HBV in connection with the compensation scheme, and they are way behind in their understanding of HBV and the up to date progress that has been made in the last two decades.

77. As far as I can see, there are no HBV experts involved in IBCA. That means that there is nobody working in the IBCA who understands the virus and the co-morbidities of the virus.

78. For example, those infected with HBV and hepatitis D would die much quicker than those singularly infected.

79. I have become quietly exhausted with agencies that think that they know about HBV and when they talk about it, are actually making the stigma worse, due to their ignorance.

80. Is IBCA aware that HBV infected blood residue is up to 100 times more infectious than HIV on medical equipment for surgery and injections? Many catch HBV from healthcare via this route, far more than from just blood products. WHO estimates reused contaminated infected blood equipment has infected towards a billion people, yes a billion, and therefore many HBV NHS deaths and infections will be from this route.

5. **Please describe the impact upon you and your colleagues within the Hepatitis B Trust of the matters set out in 1-4 above.**

81. I have carried out years of unpaid hard work on behalf of victims of HBV. I have written books, answered phone calls, worked tirelessly with my legal team, produced websites and endlessly campaigned to try and find and inform and educate the hundreds of thousands of individuals potentially infected with HBV and HCV and HIV through healthcare in the UK. Most of all, watching victims of HBV infected blood die without any money, with myself having failed them, really hurts.

82. It was extremely disappointing for me, having worked in this field, dealing directly with patients for over a decade, that the Infected Blood Inquiry decided not to call me to give evidence on behalf of the HBV and HCV victims I have assisted.

83. Now I am seeing this play out all over again, in the IBCA's refusal to acknowledge and respond to the issues I am raising with them.

84. HBV victims consistently find themselves being pushed aside with the focus being on those infected with HCV and HIV.

6. **Please describe the impact you perceive for the decision-making regarding compensation (by Government, IBCA or both) to be having on people infected and affected and why.**

85. Individuals infected with HBV feel excluded from decisions being made in respect of the setting up of the compensation scheme. They feel that their lawyers and agencies have been excluded from that process, even though their lawyers have an excellent understanding of HBV infection and progression, and want to support staff working for the IBCA.

86. They feel that they were promised an 'arms' length body', who would deal with the setting up of the compensation scheme and instead, the whole operation is run by the Cabinet Office and Civil Servants who they do not talk to often enough to deeply trust.

87. HBV victims feel that even though this time, for the first time, they have been told that they can be compensated for their infections, they are still finding that they are not being prioritised and that the focus of the compensation scheme is on those who have already received ongoing financial support and interim payments in respect of their infections.

88. Victims infected with HBV have never received any financial support or compensation yet are being put at the back of the queue in the new scheme, thus compounding the injustice, rather than taking opportunity to remedy it. They are eavesdropping on HCV and HIV patient messaging to try to guess what may happen to them for a year now.

7. **Are there any particular steps or measures which you consider could be taken by Government, IBCA or both to alleviate any detrimental impact upon you, the Hepatitis B Trust and/or the infected and affected communities? If so, please set them out.**

89. First of all, the IBCA should be completely independent of the government and should have independent oversight.

90. It is my view that if victims of HBV, and the Hepatitis B Positive Trust was introduced to, and allowed to get to know staff at the IBCA, and be allowed to be involved with working together with them to create a better understanding and informed approach to dealing with HBV cases, this would help HBV victims to feel that they are being heard, and would alleviate concerns about the level of understanding of HBV in the IBCA.

91. IBCA need to understand that what is on offer in respect of compensation to HBV victims does not reflect their lived experience. IBCA needs further training so that they can understand the distinct characteristics of this condition and the impact that those distinct characteristics might have on the progression of the virus and the life of the infected individual.

92. The approach of IBCA to the staffing of the compensation scheme, has been a missed opportunity. Those who have worked for years and been involved in the Infected Blood Inquiry and have familiarised themselves with all of the documents arising from that Inquiry, including all of the relevant NICE guidelines in respect of HIV, HCV and HBV, and facts of contaminated blood, should have been approached and hired to operate the IBCA. IBCA has employed inexperienced, often new to issue people to work with victims who have already been traumatised on multiple occasions because of the approaches of inexperienced and ill-informed people without hiring or engaging with long term agencies with 20 years hands on experience keen to help.

93. IBCA is possibly duplicating a "111" type arrangement with questions and answers being offered and given over the phone or online with less scope for nuance or individual testimony.

94. The concern of HBV victims is the reduction of their very complex and differing experiences with HBV, to a set of codes, to be entered into a system by an individual who knows little of their suffering.

95. I have asked Nick Symonds and James Quinault for engagement on a number of issues to try to remedy the gaps in IBCA's communications with us and audit deeper files of 'go to' shared knowledge. All I want is to be included in discussions regarding HBV. In my view, the establishment of the IBCA, with the pushing out of many of the experienced individuals who worked on the Infected Blood Inquiry, is a mistake and a waste of expertise and experience.

96. I am due to attend a meeting with the IBCA on 13th March 2025. I am hoping to be able to engage with IBCA. The experience of most of the patients I represent and the campaign groups they belong to, is that the engagement sessions conducted by IBCA over Zoom have not resulted in any real listening that creates working groups and work streams to get any real change or adaptation to the compensation schemes.

97. HBV victims are accustomed to being ignored and the establishment of the IBCA could have been used as an opportunity to remedy this injustice and assist those patients. It is a real shame that this hasn't happened, but it is not too late to do something about it.

98. Finally, there is a concern with many cases having been deeply assessed for 35 years now, has full attention been paid to the minor or zero assessment needs of 90% of those already so assessed? If the bulk of compensation is due when HCV, HBV or HIV is known to be transmitted via NHS care, is there no fast track click to forward? Must IBCA start from scratch when it comes to cases that are well known to the Inquiry? The speed at which claims can be assessed is crucial to HBV victims.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed ____GRO-C____________________

Dated __________26 02 2025___________________