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Our ref: 1030118.0001/PJT/PJTT
Your ref:

15 February 2019

NHS England
Legal Team
4W08 4th Floor
Quarry House
Leeds
LS2 7UE

VERY URGENT

Letter before claim pursuant to the judicial review pre-action protocol

Dear Sirs

We have been instructed by Mr Jeremy (known as Paul) Thomas-Peter of [redacted] to commence proceedings against you for judicial review.

This letter is formal notice of such commencement as required by the pre-action protocol in judicial review proceedings. **The proposed claimant is terminally ill and anticipates that without appropriate treatment as recommended by his Consultant Oncologist he will deteriorate into critical illness within 3 months, with a life-expectancy of only days or weeks beyond that point. As such we request that you give this matter your most urgent and serious consideration.**

1. Proposed claim for judicial review

Mr Thomas-Peter challenges the decision communicated in a letter dated 8 January 2019 to refuse his consultant oncologist's request for funding for specified treatment to treat his metastatic squamous cell carcinoma.

2. The Claimant

Mr Paul Thomas-Peter of [redacted] (hereinafter referred to as "The Claimant"), DOB [redacted].

3. The Defendants

i. NHS England, Legal Team, 4W08 4th Floor, Quarry House, Leeds LS2 7UE.
ii. The Right Hon Matt Hancock MP, Secretary of State for Health and Social Care, Richmond House, 79 Whitehall, London SW1A 2ND

4. The details of the Claimant's legal advisers dealing with this claim

Peter Todd (Partner)
Hodge Jones & Allen Solicitors, 180 North Gower Street, London NW1 2NB
Ref: 1030118.0001/PJT/PJTT

5. The details of the matter being challenged

Your decision of 8 January 2019 not to accede to the Claimant's Consultant Oncologist's Individual Funding Request (IFR) for combined immunochemotherapy comprising ipilimumab (50mg) and pembrolizumab (100mg) ('the requested treatment') to treat the Claimant's metastastic squamous cell carcinoma.

6. The details of any Interested Parties

N/A.

7. The issue

Background

The Claimant is a [redacted]-year old former member of the Armed Forces who is terminally ill with metastastic squamous cell carcinoma, a form of skin cancer. Without the treatment recommended by his Consultant Oncologist his life-expectancy is limited. Despite the efficacy of the proposed treatment not being in doubt, and despite the relatively modest cost of the proposed treatment, the consultant's request for funding of that treatment has been refused. That refusal is apparently on the basis that if the Claimant were to be given the requested treatment a larger group of patients who may benefit from the same treatment may have to be given it.

In 2006 the Claimant developed a growth on his right temple. He was told informally by a doctor and a pharmacist that this was a fungal infection and the growth did not give him any discomfort so he did not seek further medical attention until 2010 when he went to his GP. The Claimant's GP confirmed the growth was a fungal infection. In December 2013 the Claimant felt unwell and consulted another GP, who was concerned by the growth and referred the Claimant to a specialist. The specialist diagnosed the Claimant with cutaneous squamous cell cancer (cSCC) of the skin.

The Claimant underwent a local excision and graft to remove the growth from his right temple in January 2014. However soon after this the Claimant developed lumps on his right ear and biopsy carried out in April 2014 confirmed that the Claimant's cancer had metastasised. This is a rare occurrence in cSCC.

However in August 2014 the Claimant was found to have recurrence of the cancer in his lymph nodes. He underwent a parotidectomy and partial neck dissection to the right side of his neck.

From September to November 2014 the Claimant underwent daily radiotherapy and adjuvant chemotherapy (firstly with cisplatin, then with carboplatin). Both the cisplatin and the carboplatin made the Claimant extremely nauseous and unwell but made very little difference to the progression of the cancer.

In April 2015 a CT scan showed mediastinal lymphadenopathy and a PET-CT scan showed active mediastinal and hilar lymphadenopathy, with no evidence of another primary source. An endobronchial ultrasound and biopsy confirmed the presence of metastatic cSCC.

In May 2015 the Claimant was declared terminally ill with no treatment options and given between 3 and 18 months to live.

In October 2016 the cancer had progressed, with scans showing a new lung nodule, adrenal lesion and subcutaneous lesions. The Claimant decided not to have more chemotherapy because of how sick the first round had made him with little effect on his cancer. He commenced anti-metabolic therapy but discontinued this after 3 weeks because he experienced serious side effects.

In December 2016 a CT scan showed significant disease progression with tumours in the Claimant's lungs, spine, left adrenal gland, retroperitoneal and mesenteric areas.

In January 2017 the Claimant underwent single fraction radiotherapy to the metastasis on his spine. He received a second opinion at the Royal Marsden Hospital from Dr James Larkin, who recommended platinum-based chemotherapy, despite the limited effect the first round had had on the progression of the Claimant's cancer.

The Claimant researched his condition and found that there was treatment available in other areas of the world that had had real success in fighting metastasised cSCC.

The Claimant then consulted Dr Nolting, at the Hallwang Clinic in Germany. A PET-CT scan taken in March 2017 at the Hallwang Clinic showed extensive disease, involving subcutaneous, intramuscular lesions, nearly all lymph node sites, adrenal metastases, brain metastases in his right and left frontal lobes, pericardial infiltration with pericardial effusion and detection of at least one definite CNS metastasis.

In March 2017 the Claimant went to the Hallwang Clinic and received combined immunochemotherapy comprising ipilimumab (50mg), pembrolizumab (100mg) cyclophosphamide 50mg 5 days per week, capecitabine 1000mg bd daily, anti-tumour vaccination and IV infusions of vitamin C, selenium, zinc, alpha lipoic acid and glutathione.

The Claimant had an impressive clinical and radiological response to this treatment; after 4 cycles of immunotherapy the Claimant was almost completely clear of cancer. A CT scan taken in May 2017 showed a massive tumour reduction at all sites, with no significant toxicity.

In July 2017 a repeat PET-CT scan showed the cancer was active in the Claimant's mediastinum and supraclavicular fossae (although it was much improved compared with the PET-CT scan prior to treatment at the Hallwang Clinic in Germany).

The Claimant then sought the opinion of Professor [redacted] a Consultant Medical Oncologist at Southampton Hospital and a specialist in immunotherapy. Professor [redacted] considered that the ipilimumab and pembrolizumab were by far the most likely active components of the prior treatment, and recommended the Claimant have ongoing immunotherapy. Professor Ottensmeier considered this an appropriate course of treatment in view of the Claimant's excellent prior response, absence of toxicity and the ongoing biologically active disease on the PET-CT scan.

In view of this recommendation and the Claimant's excellent response to the immunotherapy carried out in Germany, the Claimant's Consultant Clinical Oncologist, Dr [redacted] submitted an Individual Funding Request (IFR) in September 2017.

While the IFR was being considered, the Claimant received 4 further cycles of immunotherapy, which was delivered by Professor [redacted] in Southampton between September and December 2017. A PET-CT scan demonstrated that he had had another excellent response.

The IFR was supported at a local level and put forward to NHS England (NHSE). On 17 October 2017 NHSE sent the Claimant a letter saying his IFR would not go to a national panel because he did not meet the clinical exceptionality criteria. It said that the Claimant was representative of a group of patients who have a similar condition and are at the same stage of that condition and who could potentially all request the same treatment.

The Claimant's Consultant Oncologist could not understand why NHSE had made this decision.

On 3 November 2017 the Claimant wrote to the IFR Screening Group asking for an explanation as to how they had reached this conclusion. On 29 November 2017 a representative from the IFR Screening Group responded telling the Claimant that his Oncologist should be able to explain the decision, but since he could not on this occasion, advising Dr [redacted] to write to them direct instead.

Accordingly Dr [redacted] wrote to the IFR Screening Group on 18 December 2017. The IFR Screening Group failed to answer his letter.

In June 2018 a further PET-CT scan showed that the Claimant's cancer had progressed again in both of his adrenal glands, bowel and lymph nodes.

The Claimant wrote to the IFR Screening Group again on 13 September 2018 asking that they reply to his Oncologist within 14 days regarding their decision to refuse funding for the requested treatment. On 27 September 2018 the Claimant received a letter from a Ms Carol Brooke-Read stating that the Claimant's letter had been forwarded to the IFR Senior Manager who would reply to him 'in due course'.

In November 2018 Dr [redacted] submitted another Individual Funding Request.

On 8 January 2019 Lucy Devapal, IFR Case Manager, wrote to Dr [redacted] on behalf of the IFR Screening Group ('the Screening Group'). The letter stated that the Claimant's IFR was considered by the Screening Group on 21 December 2018 and that it had been concluded the request should not be forwarded to the IFR Panel for consideration. The rationale for the decision was given in an IFR Screening Group Pre-Panel Screening Document ('PPSD') enclosed with the letter.

<u>The Relevant Criteria</u>

The IFR Commissioning Policy states that the following criteria must be satisfied for NHSE to provide funding in response to an IFR:

- *There is evidence that the patient presents with **exceptional clinical circumstances**, that is:*
    - *There is an NHSE clinical commissioning policy, NICE Technology Appraisal…*[not applicable to this Claimant's case]

      OR

- *There is **not** a relevant NHS England clinical commissioning policy, NICE Technology Appraisal (TA) guidance or Highly Specialised Technology (HST) Appraisal guidance in place for the management of the patient's condition or combination of conditions, and **the patient's clinical presentation is so unusual that they could not be considered to be part of a defined group of patients in the same or similar clinical circumstances** for whom a service development should be undertaken.*

AND

- *There is a basis for considering that the requested treatment is likely to be **clinically effective** for this individual patient;*

AND

- *It is considered that the requested treatment is likely to be **a good use of NHS resources**.*[1]

(emphasis added)

The meaning of 'exceptional' clinical circumstances has been clarified by the court. In *R (on the application of S (a child by her father M) v NHS England* [2016] EWHC 1395 (Admin) Collins J said in paragraph 12 of his judgment :-

> "The policy considers what is meant by exceptionality. I do not propose to burden this judgment with the four pages which deal with this. I shall summarise. It starts by stating that 'very few patients have clinical circumstances which are exceptional so as to justify funding for that patient which is not available for other patients'. Thus the approach to exceptionality must be to require considerably more than a failure of usual treatment. But it must be borne in mind that **exceptional is not the same as unique** and that there should not be an approach that denies that any but an extreme case is regarded as exceptional. **In its ordinary meaning, exceptional can mean no more than a case which does not meet what is normal**. (emphasis added)"

The Decision

The PPSD gives the following reasons for refusing the Claimant's IFR:

- *'This patient belongs to a larger group of patients with metastatic squamous cell carcinoma of the skin who have failed to respond, progressed or are intolerant of standard therapy.*

- *There is no clinical evidence that this patient is likely to benefit more from this combination than anyone else in this larger group.*

- *The Screening Group noted the patient's improvement, however, other patients in similar clinical circumstances may not have had that opportunity to access the treatment or self-fund and this does not demonstrate grounds for exceptionality.*

[1] Specialised Commissioning Team, *Commissioning Policy: Individual Funding Requests,* version 2 (17 November 2017), p.6.

- *Having self-funded treatment does not mean the NHS must continue funding.'*

The PPSD concludes that all of the above reasons means there is '*insufficient evidence demonstrating that an arguable case for clinical exceptionality had been made*. *The Screening Group agreed there was no clinical evidence to suggest this patient is so unusual that they could not be considered to be part of a defined group of patients in the same or similar circumstances for whom a service development should be undertaken.'*

There is no dispute as to the likely clinical effectiveness of the requested treatment for the Claimant, or that prolonging the Claimant's life using this treatment would be a good use of NHS resources. The refusal is based on the conclusion that the Claimant did not present with exceptional clinical circumstances.

Grounds for Review

The Defendant's decision is irrational at common law and incompatible with the Claimant's rights under Article 2 of the European Human Rights Convention ('the Convention').

The Right to Life: Article 2 and the Common Law

The common law has long-recognised the sanctity of human life. As Lord Bingham (then Sir Thomas Bingham MR) said in *Airedale NHS Trust v Bland* [1993[AC 789, 808, "*a profound respect for the sanctity of human life is embedded in our law and moral philosophy*". This principle was discussed by Brooke LJ in *In re A (Children)(Conjoined Twins: Surgical Separation)* [2001] Fam 147. Having referred to representations from the Archbishop of Westminster, in particular the Archbishop's submission that "human life is sacred, that is inviolable, so that one should never aim to cause an innocent's person's death by act or omission", Brooke LJ said that "*there can (also) be no doubt that it was these principles, shared as they were by the other founders of the Council of Europe 50 years ago, which underlay the formulation of article 2 of the European Convention on Human Rights*."

Article 2 ECHR contains the most fundamental of human rights and provides both substantive and procedural rights. As is well-established these rights must be practical and effective.

In the present case the Claimant will die without the treatment his consultant says he should have. The refusal to fund this treatment is a breach of the Claimant's fundamental right to life. Furthermore the procedural arrangements by which the funding has been refused is contrary to the procedural obligations contained in Article 2 in that it fails to have any regard to the fact that the consequences of the decision will shorten the Claimant's life.

Not only is this failure a breach of Article 2 and the common law right to life it is also a breach of the common law requirement to ensure that the decision-maker has regard to all relevant considerations and asks itself the correct questions before making its decisions, *Secretary of State for Education and Science v Tameside MBC* [1977] AC 1014 per Lord Diplock. This common-law procedural obligation was clearly breached in this case given that the decision-makers never addressed their minds to the life-threatening consequences of its decision.

Furthermore, the substantive decision not to provide the treatment requested by the Claimant's consultant in the IFR was itself unreasonable. In a case such as this where the consequences of the decision are so profound there needs to be a 'searching review of the primary decision-makers review of the evidence' and the court will adopt an approach that amounts "in substance to a

requirement of proportionality, although less structured than under the Human Rights Act 1998', *Pham v Home Secretary* [2015] 1 WLR 1591 per Lord Reed (also see Lord Mance in *Kennedy v Charity Commission* [2015] AC455 at [51]). The deicsoin to refuse to fund the treatment recommended by the Claimant's consultant was clearly not proportionate when the Claimant's life is balanced against the possible funding of similar treatment for a disputed number of other patients.

In addition to the above we consider that your decision is fundamentally flawed for the further reasons set out below.

The Patient Group

- *'This patient belongs to a larger group of patients with metastatic squamous cell carcinoma of the skin who have failed to respond, progressed or are intolerant of standard therapy.'*

The patient group has been incorrectly defined with regards the Defendant's own criteria.

The larger patient group in question is all patients with squamous cell carcinoma of the skin. Where there is no clinical commissioning policy or NICE appraisal guidance in place with regards a particular treatment, the IFR commissioning policy does not require the stage of the disease or the level of response to standard treatment to be taken into account when defining the relevant patient group. The Defendant has defined the group too narrowly and in doing so has not followed its own policy.

The Defendant's definition of the patient group is also based on incorrect information and is inherently contradictory. The PPSD states at box 16:

'It is not clear which group of patients this refers to, as squamous cell carcinoma is more common and metastatic disease is also common.

The Screening Group agreed that the submitted evidence suggested significantly higher numbers than stated in the application. The Ribero et al (2017) paper states 5% of all cutaneous squamous cell carcinomas will metastasise, suggesting a group size of around 250 patients.'

This is incorrect and contradictory. Metastasis of cSCC is not common; in fact it is rare. Even by the Defendant's own measure, a 5% metastasis rate is by definition not 'common'. A group size of 250 patients within a UK population of over 60 million people cannot conceivably be deemed 'common'. The Defendant's reasoning on this point is utterly irrational.

In addition the Ribero et al (2017) paper has been incorrectly cited. The paper in fact states that 5% of cSCC cases 'will become locally advanced, recur **or** metastasize'[2] (emphasis added). This means that the cases that metastasise are a subgroup within the 5% estimated by Ribero, so the number that metastasise is significantly less than 5%. Although the Ribero et al (2017) paper does not quantify the percentage of cases that specifically metastasise, other published literature estimates the number to be as low as 2%.[3]

[2] Ribero et al, 'Drug therapy of advanced cutaneous squamous cell carcinoma: is there any evidence?' *Current Opinion Oncology* 2017; 29: 129-35, p.130.
[3] NHS National Institute for Health Research, 'Cemiplimab for advanced cutaneous squamous cell carcinoma – first line' NIHRIO (HSRIC) ID: 12662 p.3. http://www.io.nihr.ac.uk/wp-content/uploads/migrated_new/12662-Cemiplimab-for-advanced-cSCC.pdf [Accessed 12 February 2019]

There is also no data provided regarding how many patients whose cSCC has metastasised have failed to respond to, progressed in spite of, or are intolerant of, standard therapy. Indeed by definition many of these patients will have died. As such there is no evidence to support the Defendant's estimation of a patient group size of 250 people; this number has been produced on an irrational basis.

Evidence of Benefit

- *'There is no clinical evidence that this patient is likely to benefit more from this combination than anyone else in this larger group.'*

This is obviously incorrect. The Defendant has failed to consider the highly relevant evidence submitted by the Claimant's Consultant Oncologist. Upon commencing therapy at the Hallwang Clinic, the Claimant's body was riddled with tumours; he had subcutaneous, intramuscular lesions, tumours at nearly all lymph node sites, in his adrenal glands, in his brain at the right and left frontal lobes, pericardial infiltration with pericardial effusion and at least one definite CNS metastasis. There is no doubt that the Claimant was close to death. Yet after finishing his first course of immunotherapy, the Claimant was nearly completely clear of cancer.

In the IFR at Section 9 Dr [redacted] described the Claimant as having an *'excellent clinical response'* to the first course of immunotherapy in Germany, which caused '*substantial disease regression at all sites'* and left his condition *'much improved'.* He said that the PET-CT taken after the second course of immunotherapy in England showed '*maintenance of excellent response'*. In Section 16b Dr [redacted] describes the Claimant as having had an '*exceptional response both clinically and imaging'*.

Similarly at Section 9 it is recorded that Professor [redacted], a Consultant Medical Oncologist who is also a specialist in immunotherapy, recommended the Claimant have ongoing immunotherapy '*in view of good response and ongoing biologically active disease'*.

Dr [redacted] further states at Section 16b that: *'In view of his excellent prior response to well tolerated combination immunotherapy coupled with long duration of response, rechallenging with ipilimumab/pembrolizumab offers a good chance of benefit'* and that compared to other patients at a similar stage of the condition '*he can be expected to be much more likely to respond to further immunotherapy on the basis of his excellent previous durable response*.'

As such there is an abundance of clinical evidence, supported by highly specialist Consultant Oncologists, that the Claimant's response to the immunotherapy was considerably better than that which could be expected from other patients at the same stage of the disease. The Defendant failed to take these highly relevant factors into account and give them appropriate weight when considering the Claimant's clinical exceptionality.

- *'The Screening Group noted the patient's improvement, however, other patients in similar clinical circumstances may not have had that opportunity to access the treatment or self-fund and this does not demonstrate grounds for exceptionality.'*

The implication of this statement is that because other patients may not have been able to access the treatment requested, the Claimant cannot know whether he is likely to benefit more from the treatment than the other patients in the group. This is entirely supposition. The Defendant has no data regarding the response of patients who have not had access to the treatment. In contrast, the Claimant has clinical and radiological evidence supported by multiple Consultants that his response was excellent and beyond what could have been expected from other patients in his position.

- *'There was no evidence supplied with the application to support the use of the combination of drugs requested. It was also noted that the patient received a number of other interventions alongside ipilimumab and pembrolizumab. These other interventions may have been wholly or partly responsible for changes seen in the patient and not the requested combination.'*

As above, there was plenty of evidence supplied with the application to support the use of this combination of drugs in this Claimant's case; any suggestion otherwise represents a failure to take this evidence into account and is irrational.

It is not disputed that the Claimant's treatment at the Hallwang Clinic contained drugs in addition to pembrolizumab and ipilimumab. However, as Dr [redacted] submitted in the IFR application, Professor [redacted], who is a Consultant Medical Oncologist and a specialist in immunotherapy, considered that the pembrolizumab and ipilimumab were '*by far the most likely active components of the prior treatment*'. Hence he recommended the requested treatment. In suggesting that the other interventions may have been 'wholly or partly responsible' for the Claimant's response to the requested treatment, the Defendant disregarded the highly relevant evidence put before it by a specialist in the field, whilst providing absolutely no evidence to the contrary. The Defendant's reasoning on this point has no evidential basis and again fails to take into account evidence that is highly relevant; as such it is entirely irrational.

Other irrelevant factors taken into account

- *'Having self-funded treatment does not mean the NHS must continue funding.'*

This principle (stated at Principle 15 of the Commissioning Policy Ethical Framework) is not relevant to the Claimant's case. The Claimant is not asking for the continuation of any treatment. The Claimant requested a stand-alone treatment of 4 cycles of immunotherapy as recommended by his treating Consultants. The fact that he has self-funded complete cycles of this treatment on previous occasions is only relevant in that is has generated evidence that helps to establish his exceptional clinical circumstances. No treatment was left unfinished and as such he is not requesting that the NHS fund any continuing treatment.

By applying Principle 15 to the question of exceptionality rather than the ethical issue it was designed to deal with, the Defendant is effectively penalising the Claimant for having paid for the treatment courses that have both established his clinical exceptionality and kept him alive to date. This is unfair, an incorrect application of the Defendant's policy and is another irrelevant factor the Defendant took into account when making its decision.

The Claimant meets the criteria for clinical exceptionality

As stated above, the correct patient group is patients who have cSCC. As above, only 2-5% of cases of cSCC metastasise, making the Claimant's clinical presentation by definition 'beyond what is normal'. The Claimant is also much younger than most patients with cSCC, which makes him even more unusual.

Even compared to those patients whose cSCC has metastasised, the Claimant is clinically exceptional. The median overall survival rate for these patients is less than 2 years,[4] and the 5

[4] NHS National Institute for Health Research, 'Cemiplimab for advanced cutaneous squamous cell carcinoma – first line' NIHRIO (HSRIC) ID: 12662 p.3. http://www.io.nihr.ac.uk/wp-content/uploads/migrated_new/12662-Cemiplimab-for-advanced-cSCC.pdf [Accessed 12 February 2019]

year survival rate is 11%.[5] The Claimant has now survived 5 years from when his cancer metastasised, so he is highly unusual even amongst this patient group. Furthermore, a proportion of the 11% that survive for 5 years must by definition have responded to standard treatment, so for the Claimant to have survived this long without responding to standard treatment makes him extremely unusual.

In addition, the Claimant has strong evidence that he has an exceptionally good response to the treatment requested. The unusually good response to the treatment, coupled with the strength of the evidence in support and his unusually long survival period, makes him far beyond what is considered normal and therefore clinically exceptional. Indeed his Consultant Oncologist described him as 'unique', even though as Collins J made clear in *R (on the application of S (a child by her father M)) v NHS England*, a person's clinical presentation does not need to be unique in order to be deemed exceptional.

Cost-Effectiveness

It should be noted that the cost of the requested treatment, at £31,154.40 is relatively inexpensive. Taking into account the cost saving to the NHS if the requested treatment were to replace another round of chemotherapy for the Claimant, and the fact that the treatment will prolong the Claimant's life, the treatment can easily be considered cost-effective.

8. The details of the action that the Defendant is expected to take

Without the requested treatment it is certain that the Claimant will die. He is already beginning to deteriorate and approximately 3 months to live. Accordingly you are requested to review your decision as a matter of the utmost urgency and confirm that the treatment requested by the Claimant's consultant will be funded.

9. ADR proposals

The Claimant is willing to consider any reasonable form of ADR proposed providing that they are sufficiently speedy and effective. .

10. The details of any information sought

The cost to the NHS of the platinum-based chemotherapy that he has been offered (despite its extremely limited effect on his cancer).

11. The details of any documents that are considered relevant and necessary

Please disclose any documentation that details the basis on which the Claimant's IFR dated November 2018 was refused.

12. The address for reply and service of court documents

As per 4 above.

[5] Toll A, Margalef P, Masferrer E, *et al*. 'Active nuclear IKK correlates with metastatic risk in cutaneous squamous cell carcinoma' *Arch Dermatol Res* 2015; 207:721-729; Brunner M, Veness MJ, Ch'ng S, *et al.* 'Distant metastases from cutaneous squamous cell carcinoma: analysis of AJCC stage IV', *Head Neck* 2013; 35:72-75, cited in Ribero et al, 'Drug therapy of advanced cutaneous squamous cell carcinoma: is there any evidence?' *Current Opinion Oncology* 2017; 29: 129-35, p.130.

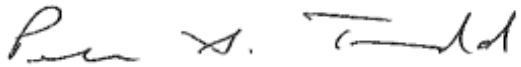
13. Proposed reply date

We request a response within 7 days ie close of business on 22 February 2019. Unless you take the action sought above we intend to issue proceedings against you without further notice. Should that prove necessary we shall be seeking an urgent hearing of the matter and will seek an order that you pay our client's costs.

In the event of non-compliance with the pre-action protocol we reserve the right to refer that to the court and seek appropriate sanctions.

We look forward to hearing from you by return.

Yours sincerely



Peter Todd
For Hodge Jones & Allen Solicitors