Witness Name: Tracey Gillies
Statement No: NHSL-00088

Dated: 25.02.2026

ELJAMEL INQUIRY WRITTEN STATEMENT OF TRACEY GILLIES

I, Tracey Gillies, will say as follows:

Part A Roles and Responsibilities

1. **Please set out your qualifications. If there is more than one contributor to the statement, please set out the qualifications of each, with a description of which part(s) of the statement each one contributed and why.**

   1.1. My qualifications are MBChB (University of Bristol) 1989, Fellowship of the Royal College of Surgeons (FRCS) 1993.

2. **Please explain your professional/ occupational background, in particular focussing on roles and the responsibilities which you held/ hold relevant to or potentially relevant to the neurosurgical department of Ninewells Hospital or Mr Eljamel. If you wish, you may exhibit a CV/ CVs with your statement.**

   2.1. My current role is as the Executive Medical Director in NHS Lothian, a role I have held since the 1st February 2017. In summary, the role of the Executive Medical Director is to provide professional clinical advice to the NHS Lothian Board and Executive Team, and along with the Executive Nurse Director, to provide professional leadership for a range of professionals, in my case doctors, dentists, psychologists, pharmacists and healthcare scientists, and to oversee the delivery of a number of functions within the Corporate Management Team.

2.2. I was appointed as a Consultant General Surgeon in NHS Lothian in 2004 and left Lothian in 2014 to take up the post of Executive Medical Director in NHS Forth Valley until 2017.

2.3. My only involvement in the provision of neurosurgical services in NHS Tayside (Ninewells Hospital) was the limited review I was asked to undertake in 2018. I have never worked in NHS Tayside, nor in any neurosurgical department in any hospital in the UK and I have never met Mr Eljamel in any setting to the best of my knowledge.

Part B Structures and Key Individuals

3. Please provide an overview as to the role, function and responsibilities of NHSL over the relevant period, in particular with regard to functions of relevance to the provision of neurosurgical care to patients in hospitals under the control of NHSL providing neurosurgical services.

3.1. Within the NHS Lothian area, trusts undertook the delivery of services including neurological services until around 2003/2004. The Western General Hospitals NHS Trust was established in 1993 by SI 1993/2933 which was dissolved in 1999 by SI 1999/1070 and its rights and liabilities transferred to Lothian University Hospitals NHS Trust which was established by SI 1998/2717. This trust was, in turn, dissolved in 2003 by SSI 2003/597 when its rights and liabilities were transferred back to NHS Lothian. Neurosurgical services have been provided by these three bodies at the Western General Hospitals site until the relocation of the services to the Little France site in 2020.

3.2. The concept of NHS Trusts was introduced in the NHS Community Care Act 1990. This gave power to create Trusts, and to devolve functions of Health Boards to Trusts. Trusts were autonomous organisations, with their own Boards reporting to the Scottish Executive (as then called). Health Boards were responsible for commissioning services from Trusts, public health, health promotions, service co-ordinations and strategic planning. The Trusts were responsible for implementing the strategic plans of the Health Board by organising and providing healthcare services, under the direction of Trust Management Team. The Trusts were operationally responsible for the delivery of healthcare services.

3.3. The Trust Chairs and Chief Executives were members of the Health Board and shared collective responsibility for the performance of the local NHS system. As Trusts were separate public bodies, their formal accountability was to Scottish Ministers and Scottish Parliament, rather than to the Health Board. Therefore, the Western General Hospitals NHS Trust and Lothian University Hospitals NHS Trust were each responsible for the operational delivery of neurosurgical care during the time of their existence.

3.4. In 2003, national guidance was issued via the Health Department Letter 2003/11 (HDL 2003/11) [NHSL-00022] with the intention to bring this diverse model of health provisions to an end and replace it with single system of health provision. This resulted in the dissolution of Trusts and staff, property, rights and liabilities transferred back to the Health Board. This essentially created the model of delivery of healthcare similar to what we see today of a Health Board responsible for the strategic planning, governance, performance management, and operational responsibility for the delivery of healthcare.

3.5. From the dissolution of Lothian University Hospitals NHS Trust in 2003, NHS Lothian have provided (and both strategically and operationally been responsible for) inpatient and outpatient services for neurosurgical care from the Western General Hospital and Royal Hospital for Sick Children which included diagnostic, assessment and treatment services. To the best of my knowledge, neurosurgical services were managed in the same way as other acute services through management oversight internally and reported to the Board through the governance subcommittees.

3.6. NHS Lothian's documentation retention policies are 7 years, unless related to maternity. Corporate documentation retention is for 7 years, which means it is difficult to provide information in relation to the exact delivery of neurological services before 2018.

4. Please provide an explanation of the areas related to the care of neurosurgical patients in which NHSL (a) had exclusive responsibility; and (b) had shared competence with other government departments, agencies, public or private bodies over the relevant period. As regards (b) please set out how RCS's responsibilities overlapped or interacted with the responsibilities of those other bodies in that regard.

4.1. Further to the explanation in response to question 3 above, NHS Lothian (and the various trusts prior to its formation in 2003) had responsibility for providing care for neurosurgical patients who were being treated in institutions for which NHS Lothian was responsible. These included the Western General Hospital (main site for adult provision for inpatients and outpatients) and Royal Hospital for Sick Children.

4.2. Where the complexity of care or intervention was greater than NHS Lothian could provide, my understanding is that the patient would be transferred to another institution, i.e. clinical responsibility would be transferred to that other institution rather than shared with NHS Lothian. Another institution would mean another responsible corporate body- for example Great Ormond Street Hospital. In referring to this practice, I mean in a theoretical sense, i.e. if clinicians in NHS Lothian did not have the relevant clinical expertise this would be assessed on a case by case basis and determined by the patient's needs. In a highly specialised area of practice there may be requirements for quaternary level care. Any such individual patient movement would be through the Safe Haven route in conjunction with National Services Division (NSD) part of NHS National Services Scotland (NSS) with information held by Safe Haven [NHSL-00018, NHSL-00019, NHSL-00020, NHSL-00021]. My understanding is limited by my knowledge of the details of service provision across the relevant time periods. Highly specialised services are provided for the Scottish population through NSD, who commission Scottish health boards with the relevant expertise to provide these or who commission a provider in another country, usually England.

4.3. In response to (b), my understanding is that RCS had no responsibility for the direct delivery of care to neurosurgical patients. My understanding is based on the Royal College of Surgeons of England's status as a professional body rather than as an organisation providing direct patient care. Any requirement for further information would need to be addressed to the Royal College of Surgeons.

5. Please provide a high-level overview of the structure of NHSL and a list of key roles within NHSL over the relevant period, insofar as relevant to the neurosurgical service provided by it and matters covered by the Inquiry's Terms of Reference and List of Issues.

5.1. In the time period specified, I do not have detailed knowledge of the structures and roles of NHS Lothian. As far as I am aware (and explained in response to question 3 above), paediatric and adult neurosurgery have been provided on a regional basis by NHS Lothian for most but not all conditions which would be based on individual patient needs or requirements. Care of neurosurgical patients would be on a case by case basis but could include the following associated disciplines of neurology, neuroradiology, interventional neuroradiology, neuro-anaesthesia and critical care within medicine and from professional groups including nurses, allied health professionals, radiographers and physiologists.

5.2. The paediatric epilepsy service has been provided on a nationally commissioned basis for Scotland by NHS Lothian since 2012. This service was not consolidated into a national one before 2012. Interventional neuroradiology weekend out of hours cover is shared between NHS Lothian and NHS Greater Glasgow and Clyde and this has been the case since 2004. Prior to that arrangement, cover was provided by each organisation separately.

6. Please explain how the role of NHSL over the relevant period fitted with the role/ remit of the following key organisations which did or could have had a role in the oversight of aspects of the professional practice of Mr Eljamel:

6.1. General comment - to the best of my knowledge, NHS Lothian had no involvement with these organisations in relation to Mr Eljamel's professional practice.

(a) The Scottish Executive/ Scottish Government;

6.2. NHS Lothian has the same relationship with Scottish Government as the other territorial health boards.

(b) Insofar as relevant to the provision of healthcare over the relevant period, the UK Government;

6.3. I am not aware of any direct relationship between NHS Lothian and the UK Government in the provision of healthcare, other than through the work and output of agencies such as NICE and MHRA or their predecessors.

(c) Healthcare Improvement Scotland and its predecessor organisations;

6.4. NHS Lothian has had a relationship with HIS since 2011 (previously QIS) on a corporate body to corporate body basis relating to standards in the delivery of healthcare.

(d) NHS Education for Scotland and its predecessor organisations;

6.5. NHS Lothian has a relationship with NES and its predecessor organisations on a corporate body to corporate body basis relating to the standards of undergraduate and postgraduate medical education, where NHS Lothian is the Local Educational Provider and NES has oversight of the standards.

(e) The Department for Medical Education;

6.6. Scotland does not have a Department for Medical Education.

(f) The University of Dundee;

6.7. NHS Lothian has no formal relationship with the University of Dundee as far as I am aware. NHS Lothian conducted a search and has not identified any agreements between NHS Lothian and the University of Dundee. Individual employees of NHS Lothian may have acted in an individual capacity, for example as an examiner for undergraduate or higher degrees and as far as I am aware this is not monitored by NHS Lothian.

(g) The Royal College of Surgeons;

6.8. NHS Lothian has no formal relationship with the Royal College of Surgeons, although individual employees of NHS Lothian may undertake professional work or make contributions based on their individual skills and knowledge, with the support of NHS Lothian. Examples of this would include postgraduate examinations, contributions to the committee work of the college or as an elected officer. Such commitments would be requested and managed at a local departmental level and not collated centrally.

(h) The Royal College of Surgeons (Edinburgh);

6.9. NHS Lothian has no formal relationship with the Royal College of Surgeons (Edinburgh) although individual employees of NHS Lothian may undertake professional work or make contributions based on their individual skills and knowledge, with the support of NHS Lothian. Examples of this would include postgraduate examinations, contributions to the committee work of the college or as an elected officer. Such commitments would be requested and managed at a local departmental level and not collated centrally

(i) Other Royal Colleges which may have had a role or a possible role in relation to the practice of neurosurgery within NHS Tayside over the relevant period;

6.10. As above. Such commitments would be requested and managed at a local departmental level and not collated centrally.

(j) The General Medical Council;

6.11. The General Medical Council is the regulator of all individual doctors employed within NHS Lothian. The Responsible Officer role was introduced in 2012 by The Medical Profession (Responsible Officers) Regulations 2010. In Scotland the Responsible Officer role is part of the duties of the Executive Medical Director further details of which are outlined in paragraph 7.4 below. For the period in question therefore (2012 until 2015) this was the Executive Medical Director, Dr David Farquharson. I am the current Responsible Officer. The duties of the role are set out by the General Medical Council and there have been no changes since 2012.

(k) The British Medical Association;

6.12. NHS Lothian interacts with the British Medical Association as the main trade union representing doctors through the Local Negotiation Committee and supports work in partnership. This would include the right of an employee to be accompanied by their trade union representative in any investigatory process.

(l) The Health and Safety Executive; and

6.13. NHS Lothian works within the statutory regulation of the Health and Safety Executive

(m) Any other bodies which held a remit relevant to matters falling with the Inquiry's Terms of Reference.

6.14. Although not a statutory body, the Managed Service Network for Neurosurgery with Scotland was established on behalf of the Chief Executives in 2009 and incorporated as national service in 2014 [NHSL-00011]. It provides standards for neurosurgical care and audits outcomes, producing an annual report [NHSL-00010]. Documents related to its establishment and function have been provided to the Inquiry.

7. Please explain the main principles of policies and systems operated within NHSL, including how and these evolved over the relevant period, insofar as they were relevant or potentially relevant to the care of neurosurgical patients, relating to:

(a) Appointments of consultants over the relevant period, including but not limited to the process by which consultants' professional qualifications and competence were verified (ToR 1);

7.1. NHS Lothian systems and policies in relation to the appointment of consultants were and are in line with the Scottish Office and Scottish Executive Health department circulars of 1996 and 2003 which set out the requirements for an Advisory Appointments Committee. The circulars have been provided to the Inquiry. [NHSL-00007]. The following documents have been provided to the Inquiry for background information [NHSL-00023 to NHSL-00041].

(b) Broad systems of clinical governance, in place over the relevant period and how they evolved, including corporate governance, professional governance and whistleblowing (ToR 3);

7.2. Clinical governance, both conceptually and in demonstration has changed significantly between 1995 and 2015. It is generally taken to have developed in the

late 1990s. Arrangements in NHS Lothian have evolved over the time period between 1995 and 2015, but at the latter part of that period included regular reporting to board committees, both the Healthcare Governance committee and then an Acute Hospitals committee (which existed between 2014 and 2019). Reporting included both updates on management actions and annual reporting of adverse events, medicines management and the Hospital Transfusion committee as examples. The following documents have been provided to the Inquiry for background information [NHSL-00075 to NHSL-00085].

7.3. Protection of whistleblowers came in in 1999 from the Public Interest Disclosure Act 1998 with the further developments in Scotland as detailed below:
2011 – PIN Whistleblowing Policy
2015 – appointment of Whistleblowing Champions
2015 – INWO was created
2021 – INWO National Whistleblowing standards (delayed due to Covid)
NHS Lothian endeavours to work in line with the expected policies and standards.

The following documents have been provided to the Inquiry for background information [NHSL-00042].

7.4. Professional governance (of doctors) changed with the introduction of the Medical Profession (Responsible Officer) Regulations in 2010. NHS Lothian works to deliver care in line with the expected standards and reports on these to board sub-committees on a regular basis. Each designated body has a Responsible Officer and in the NHS in Scotland that has been the Executive Medical Director as per the Board's governance structure since 2003/4. The Executive Medical Director for 2003-2009 was Professor Charles Swainson, then Dr David Farquharson until 2017. I am not aware of the position between 1995 to 2003. The role of the Responsible Officer is to be accountable for the oversight of all doctors connected to that Designated Body, both for the provision of appraisal and recommendations to the GMC for relicensing (referred to as revalidation) and for the investigation and action of any concerns raised about a doctor's practice. [NHSL-00014, NHSL-00015, NHSL-00016, NHSL-00017]

(c) Broad systems and rules about work patterns within the NHS, balancing work between the NHS and the private sector (ToR 2/ 3) and about supervision/ training of junior colleagues (ToR 2);

7.5. NHS Lothian uses job planning guidance, an internal document agreed in partnership with the BMA and our main academic partner, University of Edinburgh, which has been available to NHS Lothian staff since 2013 and is updated regularly. It sets out expectations about time in private practice (which should be identified in job plans if it happens regularly) and to specify time for educational supervision. Job planning was introduced as part of the new consultant contact in 2004. The formal job planning framework was only developed in 2013 and I cannot recall what formal documentation supported these arrangements prior to 2013. The following documents have been provided to the Inquiry for background information [NHSL-00086 and NHSL-00087].

7(d) Medical research (ToR 2);

7.6. NHS Lothian's Research and Development function is run, in the main, in close conjunction with the University of Edinburgh through the Accord office. Details of the mechanisms followed and changes over time are set out in the document provided to the Inquiry. [NHSL-00008]. This document was prepared by NHS Lothian's Research and Development Associate Director and is dated 2021. The document explicitly sets out the development of research and development structures in the relevant time period.

7(e) Complaints and feedback systems within NHSL (ToRs 4 and 5);

7.7. I have been provided with additional information by NHS Lothian's Head of Patient Experience (Ms Jeannette Morrison), which is in line with my own understanding. "*All staff are encouraged to deal with complaints and these should be investigated and responded to (where possible) within 20 working days. The NHS Lothian Complaints Policy, sets out roles and responsibilities for all staff who are involved in complaints handling, encourages team to learn from complaints and the policy also offers advocacy services to support people to make complaints. DATIX is the complaints document management system. The NHS Lothian Complaints Team offered a "single point of contact" to make it easier for the public to contact the organisation and this could be either in writing, face to face or by telephone. "*

7.8. The changes in policy and approach over time [NHSL-00005] and the Complaints Policy (2011) [NHSL-00004] have been provided to the Inquiry. The following documents have been provided to the Inquiry for background information [NHSL-00066 to NHSL-00074].

7(f) Internal and external information sharing systems, candour, including with professional bodies and the GMC (ToRs 7 and 13);

7.9. NHS Lothian would expect to share relevant information with other organisations and regulators as required. The number of organisations can vary dependant on the relevant issue but an example of who NHS Lothian would share information with can be seen in the case of public protection where NHS Lothian would share information with relevant local authorities and Police Scotland. The following documents have been provided to the Inquiry for background information [NHSL-00053 to NHSL-00065].

7(g) Rules and practices relating to clinical supervision, suspension, dismissal and removal of the name of a neurosurgeon from the GMC medical register (ToRs 8 to 11);

7.10. Policies regarding the investigation and disciplinary action against a doctor are set out in the NHS Circular (1990) 8 with amendments in PCS (1990) 32. NHS Lothian follows the circular and acts in accordance with NHS Scotland policies. The circulars are available from the Scottish Government as the authors of the policies.

7.11. Removal of a neurosurgeon from the GMC medical register is a GMC matter.

7(h) Investigations undertaken into the professional practice of consultants in the NHS in Scotland over the relevant period, such as those covered by ToR 12;

7.12. Policies regarding the investigation and disciplinary action against a doctor are set out in the NHS Circular (1990) 8 with amendments in NHS Circular (1990) 32. NHS Lothian follows the circular and acts in accordance with NHS Scotland policies. The circulars are available from the Scottish Government as the authors of the policies.

7(i) The creation and maintenance of effective document management systems within NHSL over the relevant period and subsequently (ToR 14); or

7.13. NHS Lothian manages records in line with the relevant policies produced by the Scottish Government including Scottish Government's Code of Practice for Records Management. The following documents have been provided to the Inquiry for background information [NHSL-00043 to NHSL-00052].

7(j) Any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues.

7.14. I have no further matters to add at this time.

8. What policies and systems were operated by NHSL over the relevant period relating to the assessment of the following:

8(a)Neurosurgeons' technical surgical skills;

8.1. I am not aware of a policy to assess Neurosurgeons' technical surgical skills in NHS Lothian between 1995 and 2015. During this time period, the systems in place within all areas of surgical practice were principally local morbidity and mortality meetings. A clearer organisational approach to these meetings in NHS Lothian was not developed before 2015. The Scottish Audit of Surgical Mortality ran from 1994 to 2015 and included neurosurgery. NHS Lothian participated in this. ISD Scotland now Public Health Scotland manged the Scottish Audit of Surgical Mortality and are better placed to provide further information to the Inquiry.

NHS Lothian currently works as part of the Neurosurgical MSN who audit outcomes against agreed standards [NHSL-00009]. The Neurosurgical MSN is better placed to provide information to the Inquiry on their role, functions and responsibilities.

8(b) Neurosurgeons' patient care, including communication with patients; or

8.2.I am not aware of a policy to assess Neurosurgeons' patient care including communication with patients in NHS Lothian between 1995 and 2015. Neurosurgeons in NHS Lothian used patient satisfaction questionnaires in line with the expectations of the GMC for all doctors for revalidation purposes from 2012 onwards. Before that, a

questionnaire developed by the MSN from 2009 was used for outpatients. Neurosurgical MSN may be able to provide this information to the Inquiry.

8(c) Neurosurgeons' workload management, including his commitment to private practice.

8.3 I am not aware of a policy to assess Neurosurgeons' workload management including their commitment to private practice in NHS Lothian between 1995 and 2015. There was a policy introduced in 2012 to remind all clinical colleagues about the expectations regarding private practice [NHSL-00013]. I am not aware of anyone within NHS Lothian who would be able to provide any further information on this question.

Part C - the 2018 report by NHS Lothian into actions relating to Mr Eljamel

The remit of the 2018 report

9. By whom was the 2018 report ordered?

9.1. The report was commissioned by Malcom Wright and Annie Ingram (the then NHS Tayside Chief Executive and depute Chief Executive respectively). I was approached by them following a meeting in September 2018 and asked to review how NHS Tayside had learnt from the concerns. The request was to me as a current Medical Director without any expectation of the involvement of any other reviewer. [NHSL-00003]. The emphasis in the conversation was on the approach taken by NHS Tayside and whether there were any opportunities to improve that. There was no instructions provided to me beyond the Terms of Reference dated 19 November 2018

10. What information and/ or concern had led to the 2018 report being ordered?

10.1. Those details were not shared with me, but I understood it to be a consideration of how NHS Tayside could consider ways to improve the organisational approach and response to serious concerns about the practice of an individual (Mr Eljamel) and their impact on patients and other staff. The documents provided to me are listed in the Report [NHSL-00012]. My knowledge at the time of the verbal request was limited to the information already in the public domain and the only documents I

have had access to were those provided by NHS Tayside which were the documents detailed on page 1 and 2 of my Report [NHSL-00012].

11. What was the remit of the 2018 report? Was its remit adequate to meet the concerns which had prompted the review being commissioned?

11.1. An email outlining the internal communication within NHS Tayside and a Terms of reference from Ms Ingram have been shared with the Inquiry. [NHSL-00006] My understanding was that the remit was not to reconsider assessment of clinical practice or decisions made, but to consider what lessons NHS Tayside had learnt. The inference of the internal email provided is that there was a desire to demonstrate organisational learning and I therefore concentrated on that aspect. The remit was limited and there was no prompt or request from NHS Tayside for a more extensive process or team. I fully acknowledge and accept the that the review I produced was limited in its extent and product.

Conduct of the review/ investigation

12. What were the main findings, conclusions and recommendations of the 2018 report and what was the reasoning behind them?

12.1. I provided my report to NHS Tayside on 8th April 2019. [NHSL-00002] The findings, conclusions and recommendations are as set out in my report [NHSL-00012]. The key points of the review were the need for more clarity about actions taken, including the restriction of Mr Eljamel's clinical practice and the practical details that followed from this, and the need for a greater support structure in patient facing communications of any type.

12.2. However, I would add that the findings, conclusions and recommendations were hampered by the absence through illness of the NHS Tayside Medical Director. Therefore, it was not possible to understand the processes and decisions made, most specifically regarding the practice of Mr Eljamel once concerns were established and any discussions with the GMC without the opportunity to discuss or question him.

12.3. Additionally, in speaking to individuals within Tayside, it was very evident that there remained considerable distress about actions taken or not taken to the discernible impact onto individuals' health still some time later.

13. What materials/ information was provided to NHS Lothian to inform the 2018 report? To what extent were these reviews or investigations into the professional practice of Mr Eljamel undermined by a lack of available documents or reasonably accurate written information?

13.1. A list of the materials provided to me by NHS Tayside are set out in the report [NHSL-00012].

13.2. My remit [Terms of Reference [NHSL-00003] was not to consider the limitations of previous investigations or reviews into Mr Eljamel's practice, but to consider what NHS Tayside had done in response to them. Therefore, I did not examine the details of the documents that were considered in the previous investigations or reviews, either their extent or accuracy. From my brief I took this to mean the support and structures around the complaints process, not the individual content or mechanisms of investigation of each complaint.

14. How and by whom (along with Ms Gillies) was the 2018 review conducted?

14.1. The review was conducted by me by reviewing the materials provided, visiting NHS Tayside and speaking to the individuals listed in the report. I then wrote the report and the covering letter. I can confirm no one else contributed to the report.

15. Was evidence from/ the point of view of former patients of Mr Eljamel or their relatives taken into account in the 2018 review? If not, why not?

15.1. No, as this was not within the scope of what was requested by NHS Tayside [NHSL-00003].

16. To what extent was the 2018 review undermined by a lack of available documents or reasonably accurate written information? If it was, what difference would adequate records of what happened have altered the outcomes of the 2018 review?

16.1. The documents were provided for the review and the main area where missing written information may have added clarity to the remit of the review (rather than the overall processes as part of NHS Tayside's review) were those in relation to the decision not to investigate Mr Eljamel formally and not to oppose voluntary erasure from the GMC. I could not say whether the provision of this information would have altered my findings.

Outcome of the 2018 review

17. What involvement did NHSL have in the implementation of the recommendations contained within the 2018 report?

17.1. NHS Lothian had no involvement in the implementation of any recommendations from the report. At a personal level, the insights gained into how an organisation handled very significant concerns about the practice of an individual clinician have influenced my own practice within NHS Lothian.

18. To what extent is NHSL aware of whether/ how the recommendations made in the NHSL report in 2018 actioned/ implemented by NHS Tayside?

18.1. NHS Lothian has no knowledge of any actions taken by NHS Tayside to implement the recommendations included in the report.

19. Is NHSL aware of what communication of the remit, methodology and findings of the 2018 review took place with patients or their representatives?

19.1. NHS Lothian is not aware what communication of the remit, methodology and findings of the report took place with patients or their representatives.

Statement of Truth

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

Signed 

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Date……27.02.2026……