

I, MICHAEL D. INNIS, Medical Practitioner. declare as follows:

1. I am not a party to this action. I am competent to testify as a witness as set forth herein.
2. I am a physician licensed to practice medicine in Australia. I am a pathologist and a hematologist. My qualifications are MBBS (Batchelor of Medicine and Batchelor of Surgery) University of Madras 1942; DTM&H (Diploma of Tropical Medicine and Hygiene) University of Liverpool; FRCPA 1960 (Fellow of the Royal College of Pathology Australasia); FRCPath 1972 (Fellow of the Royal College of Pathology United Kingdom). I have substantial experience in hematology and have had experience in interpreting laboratory results for over 30 years.
3. I trained as a registrar in pathology in England and then specialized in hematology. I was a consultant hematologist in the Princess Alexandra Hospital Brisbane from December 1960 to July 1979. I was responsible for the analysis and interpretation of all hematological problems. From 1979 to 1995 I worked as a consultant in private laboratories and in the Repatriation Hospital Brisbane. I am currently director of "Medisets International" my own company that has a computer program devised and patented by me which can analyze laboratory results. I have been a part time lecturer in Medicine at the University of Queensland and have instructed candidates appearing for Fellowship of the Royal College of Pathologists of Australia.
4. Some of my published medical articles and letters include: (1) Simian virus 40-contaminated polio vaccine and cancer rates. JAMA. (Nov 4, 1998) 280(17):1481-2; (2) Clinical problem solving--the role of expert laboratory systems. Med Inform (Lond). (Jul-Sep 1997) 22(3):251-61; (3) Computerized interpretive reporting in haematology. Med J Aust. (Jan 2, 1989) 150(1):49; (4) Bain BJ, Neill PJ, Scott D, Scott TJ, Innis MD, Automated differential leucocyte counters: an evaluation of the Hemalog D and A comparison with the Hematrak. I. Principles of operation; reproducibility and accuracy on normal blood samples. Pathology (Jan.1980) 12(1):83-100; (5) Letter: Transmission of infectious mononucleosis by blood aerosol? Lancet. (Jun 5 1976) 1(7971):1249; (6) Letter: Nephroblastoma--genetic aspects. Med J Aust. (Aug 17 1974) 2(7):268; (7) Epidemiology of childhood leukaemia in migrant populations. Med J Aust. (Aug 3 1974) 2(5):155-8; (8) Hereditary theory of childhood oncogenesis. Oncology. (1972) 26(5):474-80; (9) Nephroblastoma: possible index cancer of childhood. Med J Aust. (Jan 1 1972) 1(1):18-20; (9) Hartley LC, Morgan TO, Innis MD, Clunie GJ. Splenectomy for anaemia in patients on regular haemodialysis. Lancet. (Dec 18 1971) 2(7738):1343-5;(10)

Murphy KJ, Innis MD, Hepatic disorder and severe bleeding diathesis following nitrofurantoin ingestion. JAMA. (Apr 29 1968) 204(5):396-7.

5. In September 2002, I was asked to review the Kaiser medical records of Phillip Buell, age 2 ½ who allegedly died from a fatal fall in April 1983 that resulted in the second degree murder conviction of Ken Marsh and to give my opinion of whether there was evidence of any coagulopathy (bleeding disorder).

6. Ms. Tracy Emblem, petitioner's attorney sent me the following documents to review: Alvarado Hospital records; Children's Hospital records; Dr. Williams Autopsy; Microscopic findings of Benjamin Landing, MD.; Kaiser out-patient (birth to death) records and hospitalization records; Clearer copies of the Kaiser labs; A summary of blood labs, subject to my independent confirmation and review; Dr. Barbara Wolf's declaration submitted in Superior Court Case No. HC13707; Dr. Paul Wolf's declarations submitted in Superior Court Case No. HC13707; Duke University (94) report; 6/9/96 stain for EB virus report.

7. I do not know the petitioner, petitioner's counsel or anyone in the Buell family. I have received no compensation whatsoever to review the records and have done so on a pro bono basis.

8. Upon reviewing these records, it is my opinion that Phillip's cause of death was cerebral edema and intracranial hemorrhage following a coagulopathy (bleeding disorder) resulting from Hepatitis induced by Infectious Mononucleosis. I base my opinion on the following history of Phillip Buell:

9. Birth to November 1982 History. Phillip was born on July 15, 1980. His date of death was April 24, 1983. He had facial petechia when he was born (M.R. 145). Facial petechia are uncommon but not unheard of in a normal delivery. However, this symptom is suggestive but not proof of a coagulopathy.

Within a couple of months of his birth, Phillip developed a paroxysmal cough with vomiting thought to be due to Chlamydia pneumonia. An X-Ray of his lungs found bilateral upper lobe and left lower lobe pneumonia. Erythromycin was prescribed and a month or so later he developed a rash on his face thought to be an allergic reaction. He also developed an eye infection. At about 17 months of age, Phillip again developed bronchitis and was said to be coughing day and night. Amoxicillin and Phenergan were prescribed. He had a cough and ear ache and was again prescribed

Amoxicillin.

10. On 11/15/82, Phillip bumped the back of his head and developed a cephalhaematoma (collection of blood on the scalp) and according to his mother "went downhill after that." On 12/26/82, Phillip's mother complained the patient was having easy bruising. She also complained that his abdomen was hurting (2455) for a couple weeks before the 1/5/83 Kaiser hospitalization and that he had vomited bile (2405)(2406). The cephalohamatoma and bruising are highly suggestive of a coagulation disturbance.

11. It is important to record these minor injuries in view of what they were later to be interpreted as suspected child abuse. On 1/5/83, a child abuse report to that effect was filed by Dr T.F Cashmore, a Kaiser physician.

12. In reviewing the patient's Kaiser records in Superior Court Case No. HC13707, Dr. Barbara Wolfe, on 6/22/95, declared: ".there is no evidence of pre-existing natural disease in this child, which would cause unusual or excessive bleeding at the time he died." It is my opinion that Dr. Barbara Wolfe evidently does not regard a cephalhematoma as evidence of a pre-existing bleeding disorder. However, when one considers the relatively minor incident which caused it (he bumped into a wall) one has to consider a coagulopathy in the differential diagnosis.

13. On 1/5/83, three months before his death, the mother observed Phillip to be pale, clammy and poorly responsive and took him to the local hospital. He had been complaining of having a stomach-ache for 2 weeks prior to this episode. Infectious Mononucleosis is a cause of Hepatitis and Hepatitis causes abdominal pain.

14. Phillip's pulse rate was 165/mt and Blood Pressure 110/70. The scalp hematoma was again noted and abrasions behind the neck and scattered ecchymoses (a hemorrhagic, non elevated, irregularly formed discolored area of the skin cause by the seepage of blood beneath the epidermis) over the periumbilical area were recorded. Phillip's 1/5/83 Kaiser hospitalization record documents "scattered ecchymosis" (2406); another (76) documents 4 small abraded areas near umbilicus and describes the upper two as "ecchymosis." Ecchymosis is also noted on the right side of the patient's neck in three areas. Petechia (tiny red spots on the skin caused by a small amount of escaping blood) are noted on the patient's lower right abdomen (2406). These are bleeding symptoms. Ecchymosis and petechia are the skin findings in patients with a coagulopathy whatever the cause. A defect of the

capillary vasculature may also cause petechia.

15. The above symptoms are evidence that Phillip was bleeding into the skin and into the scalp.

16. Phillip's laboratory tests on admission showed:

| | | |
|---------------------|-------------|---------------|
| Hemoglobin | 9.7 | g/dl |
| WCC | 38,000 | 10^9 /L |
| Differential Count. | Neutrophils | 77 |
| Lymphocytes | 20, | Eosinophils 3 |
| Platelets | 794,000 | 10^9 /L |

17. The next day on 1/6/83, Phillip's Hemoglobin had fallen to 8.7 g/dl, the WCC to 21,000 with a differential count of Neutrophils 81, Lymphocytes 12, Band forms 2, Monocytes 5. A few spherocytes (a erythrocyte which is spheroid in shape but more fragile, occurring in certain hemolytic anemias) and slight basophilic stippling was seen on the blood film and the test for Infectious Mononucleosis was reported to be positive.

18. Other Laboratory Tests carried out were:

| | | |
|--|-----------|----------------|
| Alkaline Phosphatase | 52 U/L | Control 9 - 35 |
| Aspartate Aminotransferase (AST, SGOT) | 33 U/L | Control 9 -30 |
| VCA antibody titre | 1/300 | |
| EA antibody titre | 1/30 | |
| Infectious Mononucleosis Test | Positive. | |

19. While these tests provide clear evidence that Infectious Mononucleosis is, and has been, present for some time, and has caused Hepatitis, it is regrettable that, in view of the presence of bruising and hemorrhage into the scalp, no attempt was made to perform definitive tests to establish or rule out a coagulopathy (bleeding disorder). The tests that should have been done at this stage were:

- Bleeding Time
- Prothrombin time
- Activated Partial Thromboplastin Time
- Thrombin Time
- Fibrinogen estimation
- D -dimer test

These tests should have been supplemented by further tests of Hepatic Function since there is evidence of Hepatic involvement.

Alanine Aminotransferase
Albumin
Bilirubin
Gamma Glutamyl Transferase
Lactic Dehydrogenase

20. These tests are absolutely imperative in the investigation of a child who is bruising easily and has a visible haematoma on the scalp. Only by knowing the exact cause of the bleeding can one administer the appropriate treatment. Among the suggested mandatory investigations of hemorrhage in infants is a Coagulation screen. This mandatory requirement was ignored. Had these tests been carried I have little doubt that the tragedy, which followed, could have been averted. In my experience, with over 30 years interpreting laboratory results, Infectious Mononucleosis causing hepatic failure and a reduction of the coagulation factors can be surmised from the evidence presented above. The coagulation studies performed prior to his fatal illness were inadequate when investigating the cause of bruising and bleeding in a child.

21. The 1/5/83 spleen study reports state the patient's spleen scan was suggestive of a subscapular hematoma (2517) (a swelling of blood which occurs in an organ or tissue resulting from ruptured blood vessels). It also states "increased bone marrow uptake of the tracer" and "nonspecific reticuloendothelial cell activity" consider "chronic anemia." The presence of "spherocytes" in the blood is evidence that a hemolytic anemia due to infectious mononucleosis was a complication and this is sufficient to account for the increase in bone marrow activity.

22. Phillip had a low hemoglobin. There are two reasons for a sudden fall in the level of hemoglobin. 1. Hemorrhage 2. Hemolysis. The Kaiser doctors thought of and looked for hemorrhage but did not find it. The reason is because the fall in Phillip's hemoglobin level was due to hemolysis which is common in infectious mononucleosis and is evidenced by the presence of spherocytes in the blood film.

23. On 1/25/83 Phillip was referred to a Kaiser hematologist for evaluation. (2413) The request for a hematology consult is extremely significant as the clinicians themselves must have considered the possibility of a coagulopathy causing Phillip's bruising and medical symptoms. However the timing of their request was inappropriate as they had already given Phillip a blood transfusion which negated any prospect of finding a bleeding disorder. Dr Chadwick was later to state that the Hematologist had found no abnormality,

but none was to be expected after Phillip had received a blood transfusion.

24. On 2/10/83 the patient had a spleen scan follow-up study that states:

"This

is top limits of normal in size with somewhat increased tracer uptake (2418). It also states, "this appearance and change raises the distinct possibility of a superior and laterally placed hematoma either intrinsic or extrinsic to the spleen." Phillip's spleen was still enlarged as it invariably is in infectious mononucleosis.

25. The ruptured spleen was ruled out at autopsy and there was no intra-abdominal fibrosis as one would expect. If the bleed had occurred into the intestine it would have been seen in the stool. It is highly probable that the drop in the level of hemoglobin was part of the hemolytic process which can occur in Infectious Mononucleosis.

26. Phillip's coagulopathy symptoms (bruising and bleeding) are documented in his medical records. On 2/10/83, the patient had an unexplained spontaneous nose and gum bleed. The patient's medical record also describes purpura (2417) (spots caused by tiny hemorrhages that invade the tissues). Purpura is typical in patients with coagulation disturbances or bleeding disorders.

27. On 3/25/83 Phillip's medical record again notes new ecchymosis after minor trauma, suggesting a coagulation disturbance (2437). On 3/31/83, a petechial rash was seen on Phillip's abdomen and chest which again is a very strong indication of a coagulation disturbance (2436). The records also note that Phillip continued to complain of abdominal pain and vomiting. (2438.) Another patient record documents that Phillip was "pale" and his abdomen was hard (2437). Ecchymoses appearing after minor trauma is strong evidence for a coagulation disturbance. The abdominal pain is very likely attributable to Hepatitis associated with Infectious Mononucleosis. His paleness is due to the anemia, partly hemolytic in origin, as a complication of Infectious Mononucleosis.

28. I disagree with the statement of Barbara Wolf, M.D. that was submitted in San Diego Superior Court Case No. HC 13701. On page 3, paragraph 4A, she offers a medical opinion that Phillip was "a normal healthy child" and on page 4, paragraph 4B she states "there is no evidence of any pre-existing natural disease in this child." Phillip was not a normal healthy child prior to his death. I strongly disagree with her opinion that there was no evidence of disease and her opinion about DIC

(disseminated intravascular coagulation). Her other conclusion about Phillip's mononucleosis on page 4, paragraph 4B "The positive mononucleosis spot tests seen in that time frame were likely simply false positive tests," is not supported by the medical records and Dr. Paul Wolfe's laboratory tests. Phillip had positive mononucleosis tests on 1/5/83, 2/10/83 and 3/4/83. (2451) (2414)(2416) (2435). I have no doubt and agree that Dr. Paul Wolfe is correct in his diagnosis of Infectious Mononucleosis.

29. Terminal Illness History. The child was brought to the hospital by ambulance with a history of having fallen backwards off a couch and struck his head on a raised brick hearth, breaking an ash tray as he fell to the floor. Phillip sustained lacerated neck and scalp wounds. A seizure was observed by Mr. Marsh. Paramedics were called when the child became unconscious and he was found to have fixed dilated pupils and was apneic and needed assisted ventilation. Apnea is a cause of the hypoxic-ischemic changes and cerebral edema seen at necropsy. Proof that this child was apneic is provided by the Paramedic's report that assisted ventilation was required.

30. In the Alvarado Hospital, Phillip's temperature was 95 degrees F, his pulse rate 84/mt. The child's blood was collected for a Full Blood Count, Prothrombin Time and Partial Thromboplastin Time. IV Mannitol was administered, followed by a blood transfusion while he was being transferred to The Children's Hospital.

31. The laboratory test (2253) on 4/27/83 demonstrates:

Blood Gases

pH 7.63

PCO 17

PO2 500

Comment Severe Alkalemia

32. Phillip's complete blood count (2250) (after blood transfusion) was:

Hemoglobin 13.0 g/dl

WCC 28,000 10^9 /L

Platelets 174,000 10^9 /L

The smear shows increased band forms (21%) and burr cells.

33. His coagulation screen (2250) shows:

Prothrombin Time 15.5 secs Control 11.4 Ratio 1.4

PTT 29 secs Control 24 0 41

secs

34. It was noted that the occipital haematoma had steadily increased in size during the transport from one hospital to the next. Several bruises were noted on the child's body and retinal hemorrhages were recorded. In view of the increased Prothrombin Time, not fully corrected by the blood transfusion, these were to be expected. Illustrating the fact that trivial injuries may cause severe intracranial lesions is the case of an infant who slipped and fell injuring his occiput on the ground covered by a thin mattress. Loss of conscious followed by a seizure ensued and an urgent CT brain scan showed a subdural hemorrhage. The fall was regarded as trivial yet the result was catastrophic.

35. Phillip died shortly after admission to the Children's Hospital and a post-mortem examination confirmed the clinical findings. A skeletal survey showed healing fracture of the base first metacarpal and soft tissue swelling over the cranial vault. (2242) What the Radiologist is calling a "fracture" is most probably a callus which is the result of a subperiosteal bleed occurring in children with any coagulopathy and is further evidence of a coagulopathy in this instance..

36. The cause of death, certified by Roger A. Williams, M.D. was stated to be "cardiorespiratory failure, acute due to encephalomalacia, hypoxic, cerebral edema, subdural hematoma, left, large, and hemorrhage, midbrain and pons due to injuries, head."

37. In my opinion, Phillip suffered from a disease and this was not properly taken into consideration in determining the child's cause of death. Phillip was born with Chlamydia pneumonia. Although one does not have the results of Chlamydia IgM and IgG antibodies to prove it the fact that he also had an eye infection on 8/20/80 is sufficient clinical evidence to make the diagnosis virtually certain. He also had an EB- virus infection causing Infectious Mononucleosis, as evidenced by the serology findings and the histological and immunological findings of Dr Paul Wolfe in 1994 and 1996. As a result of this infection he developed Hepatitis as shown by the elevation of the SGOT and the Alkaline Phosphatase levels in his blood. Hepatitis is a well known symptom of Infectious Mononucleosis. Further proof of Hepatitis is the report of Dr. B.H. Landing in 1983 which states: "The number of circulating myeloid cells in the sinusoids, many showing nuclear hypersegmentation and fragmentation, is high"

38. As a result of the Hepatitis some of the coagulation factors and Vitamin K can reasonably be assumed to be qualitatively and quantitatively inadequate making the child susceptible to easy bruising and bleeding.

That Phillip bled easily is evidenced by several instances of bruising in the record and by the fact that he developed a haematoma on his scalp after bumping into a wall. His mother and grandmother also remarked on how easily he bruised.

39. I strongly disagree with Dr. Barbara Wolfe's statement in her 1995 declaration that she could find no support for these claims in the records of the Kaiser Hospital. As I have pointed out the relevant important tests were not done. It is regrettable that this evidence of easy bruising and unusual internal bleeding was not adequately investigated early in Phillip's life. It was only when he was close to death, and only after a blood transfusion, that the Prothrombin Time and Partial Thromboplastin Time were ascertained and the former found to be abnormal as it invariably is in Hepatitis. His continued complaints of abdominal pain and vomiting for months are also signs of Hepatitis. (2242)(2400)(2455)(2573)[(2415) 2/7/83 "daily vomiting"; (2433) 2/23/83 "vomits every few days"; (2436) 3/3/83 "has continued to vomit regularly" seen for abdominal pain; (2437) 3/25/83 ecchymosis and abdomen hard; (2438) 3/31/83 "abdominal pain and vomiting," petechiae.

40. Dr. Barbara Wolfe suggests following his head injury Phillip developed the bleeding disorder Disseminated Intravascular Coagulation (DIC) i.e, she attributes the bleeding disorder to the injury. She partly bases her argument on the presence of "burr cells" seen on examination of a blood slide. However, the commonest cause of burr cells is a laboratory artifact and elevated blood pH. Phillip had a blood pH of 7.63. I have not seen any higher in my experience. Furthermore, I have never personally seen DIC with a normal or elevated Platelet count as was the case here. I very much doubt that Dr. Barbara Wolfe has seen one either, and I do not believe that a diagnosis of DIC is valid. Classically, the platelet count is reduced in DIC.

41. From my review of the record, I strongly believe Phillip died from Cerebral Edema and Intracranial Hemorrhage following a Coagulopathy (bleeding disorder) resulting from Infectious Mononucleosis induced Hepatitis. However, since testing was minimal, other coagulation disorders such as a defect of platelets or Vitamin C deficiency cannot be ruled out with certainty but there is no doubt in my mind that Phillip had Infectious Mononucleosis when he died.

42. In my opinion, Phillip had a bleeding disorder prior to his fall and death. It was the cause of his hemorrhage and was due to Infectious Mononucleosis affecting his liver to the extent of interfering with the

normal production of the factors necessary for normal coagulation. His low hemoglobin values were from the Infectious Mononucleosis that causes hemolysis which made the blood transfusions necessary.

43. I understand that blood samples were drawn by technicians at Phillip's autopsy but destroyed without testing. While normally, the six blood tests that I have described would not be done as a standard post-mortem procedure, in this case, where there was evidence of a blood disorder, and bruising, the post-mortem tests should have been done in an attempt to rule in or out disease and a coagulopathy. The value of post-mortem blood tests, except toxicology, are dubious. However, I believe in this case an attempt should have been done to establish whether a coagulopathy or liver disorder was present.

44. I have reviewed Exhibit 13, Dr. Chadwick's 5/17/83 summary of medical records review. I find the summary lacking and misleading in several instances.

A. Phillip did not have "mild pneumonia" shortly after his birth. (1939) He was born with Chlamydia pneumonia which affected both lungs and persisted for several weeks. (2265) I would not call that "mild".

B. Phillip was not "doing well" at 2 months, did not have "minor" illnesses and did not "continue to do well thereafter." (1939) Phillip had a recurrent eye discharge, almost certainly indicating persisting Chlamydia infection, facial rash, cough, fever, stuffy nose, rash on arms, sleep disturbance, folliculitis, keratosis pilaris, "tiny lumps," ear infections, continuous vomiting and various forms of antibiotic and anti-allergic therapy recorded on pages 2372-2398 of the Kaiser medical records that cannot be construed as "doing well."

C. Around mid-November 1982, Phillip began demonstrating early symptoms of his final illness which started with a Cephalohamatome and vomiting. (2399) Dr. Chadwick claims these are symptoms of child abuse and ignores the possibility of a coagulopathy. The Kaiser record states: "Head injury Fell 2 days ago Cephalohametoma." A cephalohematoma is a swelling of the subcutaneous tissues containing blood on the head. The mother said the injury was not from a fall but from Phillip bumping his head on a wall. The cause of the hematoma should have been investigated by doing coagulation studies - especially because Phillip began vomiting,(a sign which should alert one to the possibility of a cerebral lesion) and bruised easily (2455) (2455). When he was hospitalized on 1/5/83, the child displayed

numerous bruises.

D. Dr. Chadwick describes the hemorrhagic symptoms "superficial abrasions and contusions" over Phillip's abdomen. (1939) As explained, Ecchymosis and Petechia are symptoms of a blood disorder and should suggest a coagulopathy including platelet defects and malabsorption of essential nutritional factors such as vitamins C and K both of which are necessary to control bleeding. The fact that Phillip lost weight (002518) provides evidence that these nutritional factors must be considered. .

E. Dr. Chadwick's statement that "a thorough evaluation for pathological easy bruising was negative" is clearly not the case. (1942) A Hematological consultation was requested after a blood transfusion had been given and it is therefore unlikely that any defect of coagulation would be found. A thorough investigation of the coagulation system was negated by the blood transfusion. The Kaiser investigations into Phillip's medical symptoms of disease prior to his death were INADEQUATE. Blood tests during Phillip's hospitalization showed a low hemoglobin level of 9.7 g/dl, WCC 38,000 $\times 10^9/L$, Platelets 794,000 $\times 10^9/L$ Mono spot Test Positive, VCA 1/300 and EA 1/10 and spherocytes were seen on the blood film. Since a sudden drop in hemoglobin may be due to either a hemorrhage or to hemolysis, and Dr. Chadwick was unable to find evidence of a hemorrhage, he should have turned his attention to Hemolysis. He ignored the evidence of Infectious Mononucleosis (IM) which causes hemolytic anaemia and would seem the obvious cause of the fall in Phillip's hemoglobin. Since it also causes Hepatitis it could well explain the bruising on Phillip. Tests to establish the function of the platelets were not done nor was there any estimation of the level of Vitamin C in the blood. These are essential before making a diagnosis of "non-accidental injury"

F Phillip had positive mononucleosis tests on 1/5/83, 2/10/83 and 3/4/83. (2451) (2414)(2416) (2435). Dr Chadwick's surmise that Phillip may have had "some other cause of internal blood loss" to account for the anaemia ignores the essential cause of all Phillip's problems INFECTIOUS MONONUCLEOSIS.

G Phillip's symptoms should have been investigated by instituting coagulation studies immediately the cephalohamertoma was discovered on 17th November 1982(002399). About this time he was also noted to have an increase in tests of Liver Function SGOT, Alk Phos (2506) and since Hepatitis is a very likely cause of his abdominal pain and his vomiting and his bruises MORE THOROUGH LIVER FUNCTION TESTS SHOULD HAVE BEEN DONE.

H. Dr. Chadwick's summary (1939) ignores critical medical hemalogical symptoms and is not a comprehensive picture of this child's medical condition. Dr. Chadwick's summary ignores the two liver function tests which were abnormal and Phillip's elevated platelet count (794,000) (2490) (2404) which can be a feature of liver disease.

45. Dr. Chadwick's report states that his medical record review is "annotated to interpret the significance of various findings with respect to the question 'was Phillip Buell a victim of non-accidental injury and did he die as a result of non-accidental injury?'" (1939). I find his "annotations" completely leave out Phillip's coagulopathy symptoms to support the theory of "non-accidental injury." Phillip was not a victim of "battered child syndrome." (1943) He was suffering from longstanding Infectious Mononucleosis and died as the result of a coagulopathy induced by it.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at __WURTULLA Queensland Australia on October 2nd, 2002.

By: MICHAEL INNIS, Medical Practitioner