

Freedom of Information Act 2000 (Section 50)

Decision Notice

Date: 7 September 2010

Public Authority: South Central Ambulance NHS Trust
Address: Unit 7 and 8
Talisman Road
Bicester
Oxfordshire
OX26 6HR

Summary

The complainant requested considerable information from the public authority concerning the death of Dr David Kelly in 2003. He requested information including internal communications and minutes within the Trust. The public authority said that it held no relevant recorded information. It confirmed its position in its internal review. The Commissioner has carefully considered this case and has determined that on the balance of probabilities no recorded information was held by the public authority at the date of the request. However, he has found a procedural breach of section 10(1). He requires no remedial steps to be taken.

The Commissioner's Role

1. The Commissioner's duty is to decide whether a request for information made to a public authority has been dealt with in accordance with the requirements of Part 1 of the Freedom of Information Act 2000 (the "Act"). This Notice sets out his decision.

Background

2. South Central Ambulance NHS Trust (the 'Trust') was established on the 1 July 2006 following the merger of four ambulance trusts in the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire. It

is a public authority by virtue of paragraph 40 of Schedule One of the Act.

3. The Commissioner believes it is useful to have an understanding of the events that led up to the public authority's involvement with Dr David Kelly and the events that preceded it that indicated that information may be held. Dr Kelly was an expert in biological warfare. He was a former UN weapons inspector. In 1991 he led the first biological weapons inspection meeting in Iraq.
4. On 17 July 2003 Dr Kelly was reported missing by his family.
5. On 18 July 2003 at 9:40 a call is made to Oxfordshire Ambulance Trust. At 9:55 the paramedics David Ian Bartlett and Vanessa Elizabeth Hunt went to the scene. They were employees of Oxfordshire Ambulance Trust. At 10:07 the patient was pronounced dead by the paramedics.
6. Later the same day, Lord Hutton was appointed to conduct an independent judicial inquiry by Lord Falconer, the Secretary of State for Constitutional Affairs (and then Lord Chancellor). The terms of reference of it were to "urgently to conduct an investigation into the circumstances surrounding the death of Dr Kelly." This inquiry led to the production of the 'Hutton Report'.
7. On 2 September 2003 both paramedics gave their evidence to the Hutton Inquiry. They remained employees of Oxfordshire Ambulance Trust. The Commissioner has considered the transcripts of this oral evidence.¹ He also notes that there is no information in the Hutton Report about the paramedics apart from the facts stated in paragraph 5 above.
8. On 12 December 2004 a newspaper article narrated by the paramedics appeared in the Observer newspaper². The article explained:

'Dave Bartlett and Vanessa Hunt sought permission from their employer, Oxfordshire Ambulance Trust, before agreeing to be interviewed. They spoke as individuals and not as representatives of the trust.'

¹ The transcript can be found at:
<http://www.the-hutton-inquiry.org.uk/content/transcripts/hearing-trans27.htm>

² The article can be found at:
<http://www.globalresearch.ca/index.php?context=va&aid=303>

The Request

9. On 25 July 2009 the complainant requested the following information in accordance with section 1(1) of the Act [the Commissioner has added the emboldened numbers to distinguish between the requests]:

'As you will see my request relates to the death of Doctor David Kelly in 2003. The documentation I seek may date from that period or it may have been generated since. Just to clarify I am interested in receiving all material even if it was generated by the now defunct Oxfordshire Ambulance Trust.

1. *Any communications (including emails) between the Trust and staff members Dave Bartlett and Vanessa Hunt which in anyway [sic *any way] touches upon the circumstances surrounding the death of Doctor David Kelly and the ongoing speculation about his death. The communications could have been generated at the time of the death or could have been generated more recently. I am interested in those communications irrespective of whether the two individuals still work for the organisation. Please feel free to redact their names and addresses from any individual correspondence.*
- 2**[1]** *Any communication (including emails) between the Trust and any other member of staff which touches upon the circumstances surrounding the death of Doctor David Kelly and the ongoing speculation about the death.*
- 2**[2]** *Any minutes of any meeting of the Trust which in any way touches upon the circumstances surrounding the death of Doctor David Kelly and the ongoing speculation. These meetings could have taken place at the time or they may have happened more recently.*
3. *Has the Trust (or its predecessor) carried out its own inquiries into the death of Doctor David Kelly. If so can it please provide all documentation generated by this inquiry.*
4. *Any correspondence between the Trust and any coroner and or coroner's court and or coroner's court official which in any way relates to the death of Doctor David Kelly and or the ongoing speculation about the death and or the failure to hold an inquest into the death.*

5. *All internal documentation (including emails) held by the Trust's press office which in any way relates to the death of Doctor David Kelly and the ongoing speculation about his death. This material could have been generated at the time of Doctor Kelly's death or more recently.'*
10. On 22 September 2009 the public authority issued a response. It apologised for the delay. It explained that it did not hold relevant recorded information in this case. This was because it did not enter into correspondence with any party regarding the incident and has not found any paperwork or electronic correspondence about it. It explained that the ambulance personnel attended the inquest, but those notes are held by the coroner and not the public authority.
11. It also clarified that its role was only to deliver emergency medical care and it would not be unusual for it not to hold such information. It explained that it had no role in speculation on causes of incidents or the circumstances around them. Finally, it said that it had very limited interaction with the media regarding the incident and has no records of media coverage.
12. On 22 September 2009 the complainant requested an internal review. He explained that he did not believe that no information was held and that he was dissatisfied with the delay and the lack of explanation about it.
13. On 29 September 2009 the public authority communicated the results of its internal review. It apologised for the delay which it explained was due to it failing to process the request as a FOI request.
14. In relation to the search for information it explained that it had examined its records and was unable to find information or records about Dr David Kelly's death. It explained that the information was historic and predates the formation of the Trust. It explained that many of the previous management staff were no longer employed by it.
15. It explained that the only information that would typically be held by the ambulance trust would be a Patient Report Form which related to the clinical assessment and treatments undertaken by the attending ambulance staff. It said even if it located this form it would not be eligible for release. It explained that it held no records of the evidence provided by the ambulance staff at the inquest.

16. It then dealt with each request individually.
 1. No recorded information held.
 - 2[1]. No recorded information held.
 - 2[2]. No knowledge of any meetings. No recorded information held.
 3. No investigation was conducted. No recorded information held.
 4. It is understood that witness statements were supplied by the former Trust, but this information belonged to the Coroner. No recorded information held.
 5. No recorded information held. It is likely that the press enquiries would have been coordinated by Thames Valley Police.

The Investigation

Scope of the case

17. On 11 December 2009 the complainant contacted the Commissioner to complain about the way his request for information had been handled. The complainant specifically asked the Commissioner to consider the following points:
 - He did not accept that no relevant recorded information was held in this case.
 - He was dissatisfied with the public authority's delay in dealing with his information request.
18. On 4 February 2010 the complainant agreed with the Commissioner that the scope of this case will be:
 - To determine on the balance of probabilities whether the public authority holds any relevant recorded information for the six requests dated 25 July 2009.
 - To consider section 10(1) in respect to the failure to provide a response within 20 working days.

19. The complainant also raised other issues that are not addressed in this Notice because they are not requirements of Part 1 of the Act. For clarity, the Commissioner can only consider information rights issues.

Chronology

20. On 29 January 2010 the Commissioner emailed the complainant. He asked the complainant to confirm that he agreed with the scope of his investigation and to present any further evidence that he wished the Commissioner to consider about why information may be held in this case.
21. On 4 February 2010 the complainant responded to the email. He explained that he was content with the scope of the case and that he considered that information was held because he believed that when the ambulance crew who found Doctor Kelly's body expressed their concerns about his death in public they did so with the support of the Trust (and/or its predecessor). He considered that this meant that there were strong grounds for believing there must be paperwork for at least this aspect of the complaint.
22. On 10 February 2010 the Commissioner made detailed enquiries to the public authority. He asked it to explain why it believed there was no recorded information for the events mentioned in paragraphs 5, 7 and 8 above. He asked detailed questions about the searches conducted, its records management, what it holds for its business purposes and what advice and assistance that it had provided. They were answered on 9 March 2010.
23. Between 18 March 2010 and 31 March 2010 the Commissioner made further enquiries of the public authority and received responses to them.

Analysis

Substantive Procedural Matters

Is relevant recorded information held for any of the six requests?

24. The Commissioner is limited to considering whether or not recorded information exists at the time of the request for information. This is the only information that a public authority is obliged to provide. This is made clear in section 1(4) of the Act. The date of the request is 25 July 2009 in this case.

25. When investigating cases involving a disagreement as to whether or not any further information is in fact held by a public authority, the Commissioner has been guided by the approach adopted by the Information Tribunal in the case of *Linda Bromley & Others and Information Commissioner v Environment Agency* (EA/2006/0072). In this case the Tribunal indicated that the test for establishing whether information was held by a public authority was not one of certainty, but rather the balance of probabilities.
26. He has also been assisted by the Tribunal's explanation of the application of the 'balance of probabilities' test in the same case. It explained that to determine whether information is held requires a consideration of a number of factors including the quality of the public authority's final analysis of the request, scope of the search it made on the basis of that analysis and the rigour and efficiency with which the search was then conducted. It also requires considering, where appropriate, any other reasons offered by the public authority to explain why the information is not held.
27. The standard of proof has been recently confirmed by the Tribunal decision of *Innes v Information Commissioner* (EA/2009/0046). It stated at paragraph 41 that:

" This Tribunal is not prepared to introduce any kind of sliding scale in terms of the standard of proof beyond the balance of probabilities. The House of Lords and other senior courts in recent decisions have confirmed the importance of maintaining the core principle -- in civil proceedings -- that the correct test is the balance of probabilities. It is only in relation to Asylum and childcare and child safety issues that there is any kind of variation."

28. The Commissioner will apply this standard of proof to this case.
29. Each of the six requests is asking for different sorts of information that would require different searches to be conducted. The Commissioner has decided therefore to consider each in turn:

1. Communications between the two paramedics and the Trust about the circumstances of Dr Kelly's death.

30. The Commissioner notes that this request has broad parameters in time. It applies to all such communications from 18 July 2003 to the date of the request 25 July 2009.

31. When assessing the quality of the public authority's reading of the request he believes that it is reasonable to read it as the public authority has done so; that is:
 - It must be between either of the two paramedics and anyone else in the Trust.
 - It must contain information about the circumstances of Dr Kelly's death.
32. The Commissioner has also read the request as both parties have done to also embrace information generated at the scene by the paramedics for the Trust.
33. The public authority explained that it would have expected to have had a Patient Report Form (a PRF). This paper form is required for its business purposes. It explained that this form would only include clinical assessment information about Dr Kelly and would not contain any other information. It explained that this form had been mislaid.
34. It explained that the information was usually digitised and held electronically by date in its PRF archives. It explained that it only holds records from 2003 in digital format in its Clinical Order Reporting System. However, having checked its system for all the entries on the date of the incident, and the dates one day either side to ensure it was not misfiled³, it could not find the relevant PRF form. It has conducted these searches twice. It was supposed to keep this form for ten years in line with its document 'Life Cycle Policy'. The Commissioner has checked what this form would contain and is satisfied that it would only contain clinical assessment information.
35. The public authority has also explained that the personnel files of the paramedics have also been checked and no information has been found about Dr Kelly.
36. The Commissioner was also interested in how the public authority dealt with the Hutton Inquiry and whether it was possible that there are communications in respect to it that may be embraced by the request.
37. The public authority explained that the two paramedics received personal letters addressed to them at Ablington Ambulance station requesting their attendance at the Hutton Inquiry. It stated that it held no record of the Trust itself being contacted. The Commissioner has viewed the transcripts carefully and is of the view that the emphasis is

³ 17, 18 and 19 July 2003.

on the visual evidence of the paramedics themselves and not the Trust itself.

38. The public authority explained that it managed this situation through the staff's Operational Manager driving them to and from the Inquiry providing moral support in accordance with its procedures where staff are required to be interviewed or are to give evidence. The public authority explained that it would not have expected there to be recorded information held about this issue and has checked that there is nothing held.
39. The Commissioner was also interested in how permission was given for the paramedics to provide the interview that was outlined in paragraph 8 above and whether there was relevant correspondence that would be caught by this request in respect to the giving of this permission. The public authority explained that it had interviewed the relevant parties and confirmed that the permission was provided orally and there was no recorded information generated within the public authority in respect to it.
40. The public authority also explained that there was a subsequent interview on television. This comprised of a televised interview with the paramedics presenting their personal opinion. It explained that whilst this interview took place on the public authority's property it was not involved itself at all in the interview process.
41. The Commissioner has considered whether he believes that the paramedics' views reflected the views of the Trust as an entity. He is satisfied that the paramedics' views are the views expressed by themselves as individuals. This is consistent throughout all the material that he has considered.
42. The Commissioner also asked what further enquiries were made by the public authority. It explained that it had checked its position with the Chief Executive of the former Trust, its Operations Manager and through detailed interviews with the paramedics themselves.
43. The Commissioner has also considered how the files were transferred between organisations during the merger of the Trusts and the public authority's confidentiality policy. He does not believe that there is anything that would indicate that relevant recorded information would be held by the public authority in the circumstances of this case.
44. The Commissioner has concluded that on the balance of probabilities there is no relevant recorded information held by the public authority in respect to this request for information. He is satisfied that the

searches conducted by the public authority are sufficient and that the reasoning provided is persuasive.

2(1) Communications between staff members of the Trust about the circumstances of Dr Kelly's death.

45. The wording of this request is clear and it has the same time parameters as in 1 above.
46. As above, the Commissioner was also interested in how permission was given for the paramedics to provide the interview previously been mentioned in paragraph 8 and 40 above and whether there was relevant correspondence that would be caught by this request in respect to it. It was explained that the permissions was provided directly from the former chief executive to the paramedics orally and that there was no recorded information in relation to it. In addition there were no intermediaries between which information may have been generated.
47. The Commissioner notes that the Police, the Coroner and the Hutton Inquiry were all tasked with investigating the circumstances of the death of Dr Kelly. The public authority had no organisational reason to provide further information about Dr Kelly's death or to communicate in respect to it. Its only role was to deliver emergency medical care to patients. The Commissioner is satisfied that this is the case.
48. The Commissioner has also taken into account the searches that were conducted as discussed for point 1 above.
49. The Commissioner has concluded that on the balance of probabilities there is no relevant recorded information held by the public authority in respect to this request for information. He is satisfied that the searches conducted by the public authority are sufficient and that the reasoning provided is persuasive.

2(2) Minutes of meetings of the Trust that any way touch on the circumstances of Dr Kelly's death and the speculation around it.

50. This request also has the same time parameters as in 1 and 2(1) above.
51. The Commissioner acknowledges that as the individuals were called to the Hutton Inquiry it may be reasonable to assume that the public authority would have held a meeting to consider its position in relation to a national event. The public authority has however confirmed that such a meeting did not occur.

52. The Commissioner asked why the public authority was sure that no such recorded information was held. It explained that there were a number of staff who had been at the public authority for the whole of the relevant time period and that they had been asked whether any such meetings took place. This included the Chief Executive, the Operating Manager and two paramedics.
 53. The public authority has explained that the personnel files of the two paramedics have also been checked and no information has been found about Dr Kelly.
 54. The public authority explained that it was aware that the Police conducted interviews with the paramedics. However, it did not have copies of these interviews. It explained that the Police drafted handwritten transcripts of the interviews and kept them. It explained that it did not keep copies of statements given to external agencies.
 55. The Commissioner has carefully considered the context of the public authority's position in this matter. The public authority's role is to provide an ambulance service and to deliver emergency medical care. It must focus on doing what it is responsible for and not to make judgments on public matters for which the police, the Coroner and the judicial inquiry were responsible. The Commissioner does not believe there was any business reason for the public authority to hold meetings about this matter despite the level of public interest in this matter.
 56. The Commissioner is satisfied that these arguments are persuasive and that on the balance of probabilities there is no recorded information about any meeting held by the public authority or its predecessors that touches on the circumstances of the death.
3. *Documentation of any inquiry conducted by the Trust or its predecessors.*
57. The public authority has stated that neither it nor its predecessors conducted an inquiry into the death of Dr Kelly.
 58. It explained that its role was to provide an ambulance service and not to conduct inquiries into deaths which is the role of the police. It would not have any business need to conduct such an inquiry.
 59. It also explained that it has ensured that it has not conducted any such investigation by asking the staff who were working for it at that time. They confirmed that no such inquiry was conducted.

60. It has also checked the personnel files of the staff to ensure that there were no investigations into the crew's action. This confirmed that there had been no such investigation.
61. The Commissioner is satisfied that these arguments are persuasive and that on the balance of probabilities there is no recorded information about any inquiry conducted by the public authority or its predecessors.
4. *Correspondence between the Trust and the Coroner (or Coroner's court or official) about Dr Kelly's death, the speculation about it or the failure to hold an inquest.*
62. The time period where there is most likely to be recorded information for this request is between the date of the death 18 July 2003 and the end of the Coroner's inquest on 16 March 2004. The Coroner in this case was Mr Nicholas Gardner.
63. It may help to clarify the Coroner's role. He is responsible for investigating any death reported to him and must hold an inquest where he is not sure that the death was caused by natural causes [Section 8 of the Coroner's Act 1988]. In this case the Coroner opened an inquest as he believed that the death was caused by an 'incised wound' to the left wrist.
64. On 21 July 2003, the inquest was opened at Oxfordshire Coroner's Court. The legislation provides that unless there are 'exceptional reasons' the inquiry must be adjourned when the coroner is informed by the then Lord Chancellor that a judicial inquiry was being undertaken [Section 17A(1) of the Coroner's Act 1988 as amended]. As in paragraph 6 above the then Lord Chancellor informed the public that a judicial inquiry was being undertaken. In accordance with the legislation the inquiry was therefore adjourned on the first day to allow the Hutton Inquiry to proceed.
65. Section 17A(4) of the Coroner's Act 1988 only allows for the adjourned inquiry to be resumed where there are 'exceptional reasons' to do so. On 16 March 2004, the Coroner confirmed that there were no 'exceptional reasons' for the inquest to be resumed in this case and it would therefore be closed. He explained that this was so because it included a detailed pathologist's report and its verdict of how Dr Kelly died was accepted by his family. He went on to state that he had considered all the evidence before coming to the conclusion that there were no 'exceptional reasons' in this case.

66. From the above, the Commissioner believes that it is reasonable to look for relevant information between 18 July 2003 and 16 March 2004 in respect to this request. However, he has also checked whether any other information was held at the date of the request 25 July 2009.
67. The public authority has explained that, as an organisation that provides emergency medical care, it had no reason to address the Coroner about the cause of Dr Kelly's death. Further the Coroner had no need to address it about the death as the information that it could contribute was already known.
68. It explained in its internal review that it understood that written witness statements were provided by the paramedics to the Coroner at the time of the inquest. However, it had not kept copies. It stated that the statements would be the property of the Coroner.
69. After the Commissioner made detailed enquiries it became apparent that the public authority had confused the Hutton Inquiry for the Coroner's inquest. It explained that it thought at the time that the two were synonymous.
70. It conducted further enquiries by talking to the paramedics involved and confirmed that it had never received separate documents from the Coroner. In addition its staff never made further statements to the Coroner himself. The only letters that the public authority had knowledge of were those that personally invited the paramedics to appear before the Hutton Inquiry.
71. It explained that it held no recorded information that related to this matter. For the avoidance of doubt, it explained it also held no recorded information about the Hutton Inquiry.
72. It explained that it had checked the personnel records of the staff and asked all the relevant individuals within it whether any information was held by the public authority. It explained that these searches did not find any recorded information.
73. It explained that had it held information it would have been kept in line with its confidentiality policy. The Commissioner has checked the policy and does not believe there is anything in it which would indicate that information would be held by it.
74. The Commissioner is satisfied that the searches that have been conducted are reasonable and that on the balance of probabilities that there is no recorded information held by the Trust that was exchanged with the Coroner.

5. *All internal documentation held by the Trust's press office that in any way relates to Dr Kelly's death or the ongoing speculation about it.*
75. This request also has the same time parameters as in 1, 2(1) and 2(2) above.
76. The public authority explained that it (and its predecessor) had issued no written press statements. The Commissioner has checked online and can find no records of any press statements at all. He has also been presented with no evidence of any statements by the complainant.
77. The public authority also explained that it had ensured that the former Communications Manager of the Oxfordshire Ambulance Trust had been contacted on its behalf and he has confirmed that no press briefings or statements were given by it.
78. The Commissioner enquired how the Trust and its predecessor coordinated its media handling. He was told that both the Trust and its predecessor coordinated its own.
79. The public authority explained that it had also carefully checked the manual press and media information files that were held by its predecessor to confirm that there is no information still held in respect of its press office.
80. The Commissioner made enquiries concerning the public authority's comments about Thames Valley Police coordinating its media policy. He asked whether there was a relevant agreement or anything that may be relevant information about how it handled the press coverage in this instance.
81. It confirmed that it did not have a written agreement. However, it explained that it was common practice in the case of sudden death for the Police to coordinate press coverage in order to avoid the possibility of it prejudicing ongoing investigations. It stated that its response was attempting to assist the complainant by pointing him to the relevant public authority that may hold press statements about the incident.
82. It also explained that the majority of the press enquiries received by the public authority are telephone enquiries. It explained that these were not recorded. It explained that they would only ever contain very general information, in order for it to adequately protect patient confidentiality, unless the patient provides consent for a more detailed response to be issued.

83. The Commissioner is satisfied that the searches that have been conducted are reasonable and he accepts the public authority's reasoning around the press handling of Dr Kelly's death. He is satisfied on the balance of probabilities that there is no recorded information about Dr Kelly's death (or speculation around it) held by the public authority's press office.

Procedural Requirements

84. Section 10(1) (full copy in the attached legal annex) provides that a response must be issued that accords with section 1(1) within 20 working days of receipt of the request.
85. In this case the public authority took more than 20 working days to issue a response that accorded with section 1(1)(a) [to deny that relevant recorded information was held in this case] and the Commissioner confirms that this was a breach of section 10(1).
86. The Commissioner notes that the public authority has apologised to the complainant and the Commissioner about this procedural breach.

The Decision

87. The Commissioner's decision is that the public authority dealt with the following elements of the request in accordance with the requirements of the Act:
- *It correctly denied that it held any relevant recorded information in respect to all six requests that it received on 25 July 2009.*
88. However, the Commissioner has also decided that the following elements of the request were not dealt with in accordance with the Act:
- *It failed to deny that it held relevant recorded information in 20 working days and therefore breached section 10(1).*

Steps Required

89. The Commissioner requires no steps to be taken.

Right of Appeal

90. Either party has the right to appeal against this Decision Notice to the First-tier Tribunal (Information Rights). Information about the appeals process may be obtained from:

First-tier Tribunal (Information Rights)
GRC & GRP Tribunals,
PO Box 9300,
Arnhem House,
31, Waterloo Way,
LEICESTER,
LE1 8DJ

Tel: 0845 600 0877

Fax: 0116 249 4253

Email: informationtribunal@tribunals.gsi.gov.uk.

Website: www.informationtribunal.gov.uk

If you wish to appeal against a decision notice, you can obtain information on how to appeal along with the relevant forms from the Information Tribunal website.

Any Notice of Appeal should be served on the Tribunal within 28 calendar days of the date on which this Decision Notice is sent.

Dated the 7th day of September 2010

Signed

**Pamela Clements
Group Manager**

**Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF**

Legal Annex

The Freedom of Information Act 2000

Section 1 - General right of access to information held by public authorities

(1) Any person making a request for information to a public authority is entitled—

(a) to be informed in writing by the public authority whether it holds information of the description specified in the request, and

(b) if that is the case, to have that information communicated to him.

(2) Subsection (1) has effect subject to the following provisions of this section and to the provisions of sections 2, 9, 12 and 14.

(3) Where a public authority—

(a) reasonably requires further information in order to identify and locate the information requested, and

(b) has informed the applicant of that requirement,

the authority is not obliged to comply with subsection (1) unless it is supplied with that further information.

...

Section 10 - Time for compliance with request

(1) Subject to subsections (2) and (3), a public authority must comply with section 1(1) promptly and in any event not later than the twentieth working day following the date of receipt.

(2) Where the authority has given a fees notice to the applicant and the fee is paid in accordance with section 9(2), the working days in the period beginning with the day on which the fees notice is given to the applicant and ending with the day on which the fee is received by the authority are to be disregarded in calculating for the purposes of subsection (1) the twentieth working day following the date of receipt.

(3) If, and to the extent that—

(a) section 1(1)(a) would not apply if the condition in section 2(1)(b) were satisfied, or

(b) section 1(1)(b) would not apply if the condition in section 2(2)(b) were satisfied,

the public authority need not comply with section 1(1)(a) or (b) until such time as is reasonable in the circumstances; but this subsection does not affect the time by which any notice under section 17(1) must be given.

...