MAY 25 2004

HENRIETTA CAMBELL INTERVIEW WITH DENZIL M'DANIEL

How did the ....case come to your attention you referred in the first article to June 2001 and you corrected that to 2003 there was a note that I took from the tape of the interview were you previously said you became aware of Lucy's death when Rachel died in 2001.

And I didn't that was a big mistake I mean its not a mistake in its not important in the general issue about what I was trying to portray but it is important where you're coming from and I know that and I mean it was sloppy on my part in the article I had it in brackets to check when did I get informed and I didn't check it you know and the brackets then got removed and .....I mean it is inferred in the debate with UTV but you're going to have to discount that because in the setting that I was I wasn't I hadn't briefed myself on any dates on anything that I had received but I can produce a letter that did alert me to Lucy's death and the issue about .....when the coroner referred it to me and we had the correct date and we did give it to the Irish News and I mean if for any legal purposes any time it has to be produced its there but Denzel that was a mistake on my part I don't know if you've ever made a mistake before but it was a mistake.

So then when you said in the UTV interview about this untoward death untoward event of Lucy's death when Rachel died and the Coroner's office the two cases being presented with eachother.

But not but not at the time of Rachel's death it was in putting those two together when the Coroner was referred about Lucy's death it was when the two .....deaths were put together and the Coroner and you know when he was referred the case by .....and Social Services Council so that its right in that point that when the two deaths were put together and that was following Rachel's death and that was some months afterwards or whenever it was it was only when we put those two together that it was realized there really is an imperative about trying to get out good guidelines to implement them and to monitor them in terms of the replacement and need indeed to be fair to .....Trust it was they who rang me about Rachel's death almost immediately after and said look there is something here that we need to sort out as a region and I think all credit does go .....for that cause it might that we could get moving on that quite quickly.

So really then when Stanley Winter wrote to the Coroner and who informed you that was the first you knew of Lucy Crawford's death.

First I knew of Lucy's death yes.

.....Family

Well no they wouldn't have Denzel you know they wouldn't have informed me there are as we tried to explain as I tried to explain to Fergul McKinney after the interview there are fifteen thousand deaths in Northern Ireland every year and most of those actually take place in hospital most people whether they're old very old or young actually die in hospital a huge percentage of people so about how many of those deaths are then reported

to the crime room about 3 and a half thousand of those deaths would be referred to the Coroner so the Coroner has a full-time the Coroners have a full-time job in questioning and investigating then some of those deaths if even just the Coroners deaths were all reported to me for a further or different examination I couldn't do the job of Chief Medical Officer now I mean what looking at the Coroner and I and also throughout the whole of the UK the looking at methodology of trying to report untoward deaths now I don't know if you now the whole view of the Coroner system following Shipman where the looking at trying to establish maybe exactly what we're thinking about medical examiners who sit with the coroner and look at all of those deaths but we're no where near that that would be a huge resource to put in place.

The thing is though that there is obviously no formal procedure you weren't told this type of Trust but you've just told that you were told by the Trust immediately by the .....about Rachel Ferguson.

Yes, yes the difference there as far as I can.

.....do you feel that the difference is that

Well I think the difference there as far as I can understand is that when Rachel died she was referred to the Royal who the doctors in the Royal said to .....there is a problem here it does need to be sorted out it's a regional issue. So .....then immediately referred it to me there being no one else in the region now.

I believe Lucy was also referred to the Royal.

Lucy was also referred to the Royal but I don't think there was the same sort of oh my goodness there's something here for the region we need to sort out I don't think that sort of realization was there and I don't know I mean it would be interesting to look at why that was.

Are you saying that the Royal didn't pick up on the seriousness of it is that what you're saying.

Well I don't know I mean it would be interesting maybe to go back to the Royal but it was a long time ago.

If there is a pattern here and Rachel was referred to the Royal in 2001 a year after Lucy was referred to the Royal why to you think it took them to 2003 before Lucy's case was referred to the Coroner if they noticed a pattern at the Royal.

I the Lucy's case was not referred to the Coroner and that's all I know you know I haven't gone into the detail of that Denzel as to why or what took place or not but certainly Rachel's death was referred to the Coroner.

Its just that if there was a pattern here as to two deaths within a year one would have thought that there would have been lessons to be learnt it doesn't seem to have been shared with you until it was brought to the Coroner two years later.

Now .....with Rachel and that was referred not the pattern Rachel's death was referred to me immediately and we began to take steps and then when Lucy's death I can put that scheme of things Lucy's death then referred to me by the Coroner to say here's another case which I got uncovered and in essence that makes it really important that guidelines properly in place implemented monitored.

So the guidelines that there is a view that in 2002 was really just based on Rachel's death.

That was the first spark of danger lets see if we need guidelines in place you know.

But not in Lucy's death.

But not in Lucy's death.

Could you just clarify another thing for me from the article were you say in some incidences the fluid that was used in Lucy's case in specifically Lucy's case this in some incidences these children may put some children at risk. Can you just clarify for me do you mean that there was something .....about Lucy's or about there could be in certain children that there was something .....

Okay nobody really knows Denzel and I mean this is .....and you keeping up to date with the debate that's raging in the

.....do you think that that may be a possibility

Well I don't know I can't say because I not an expert I have to know a little bit about everything but there is still a debate about proper fluid replacement and there's still I think a hard search to find how people crude recognize early those children that might be at risk of responding in this dangerous way developing hyper-nutria which may go on to be fatal.

I think its fairly clear from opinion including Dr Ted Sunder that there isn't any ..... response.

Well if you read all of the literature on it what I

This is Dr Sunder's literature

I know and I know Ted and I know what he said and I'm meeting him and I don't know him personally but I've read all that he has said and I've been reading it availably together with all the.....

.....in the Lucy Crawford case.

Yes, yes.

Is there anything in there you know is .....in this Lucy's case.

Well look at the data and what we you know from the data and the biggest study I think of response to fluid replacement is Mariam can help sight me for it sight it for me was the study and across general hospitals and this was some time ago when the fluids we're talking that Lucy got were in general use and I tried to write down the figures earlier. Mariam its one in three hundred of children who were getting those fluids would develop hyper-nutria one in three hundred and 10% of those one in three hundred 10% of those would go on to have a fatal reaction now that data was gathered across many district general hospitals the issue for Anne is that I don't know I could check how many children are actually referred to them each year it may not be as many as three hundred but you would expect

This is a really crucial point for me a really crucial point for me in that one of the things that you said to Fergul you know and I understand what you're saying with the dynamics of the interview and so on but one of the things you said was the reality in those two events was the abnormal reaction which is seen in very few children.

I was basing that statement on what we had ran from a large study of children reported widely in the journals about the incidents of hyper-nutria being one in three hundred of which 10% of those one in each ten of those one in three hundred will go on to die and saying that in using those fluids that has been the risk it's a very small risk but it is one but any death of a child is one that we should make absolute effort to ensure doesn't happen so it may be a rare event that you get hyper-nutria but you cannot allow even one death so therefore we need to change what we do in Northern Ireland and that's why we went on to produce the guidelines. The fluids that have been used

Sorry I keep coming back to the .....motion because Dr Sunder said it wasn't the Coroner's report which is very clear that it wasn't the family have been through hell anyway they're especially annoyed at the notion that there was something in Lucy's makeup that may have led to her death well it was in fact it the fluid it was the management of fluid are you sticking to your position that there may have been something .....about Lucy that may have led death.

Well the point I was trying to make and it was very clumsily made I absolutely agree Denzel but the point I was trying to make is that hyper-nutria is reported as being very rare incidence that would be one in every three thousand children receiving those fluids hyper-nutria has been reported as being a fatal thing now in Northern Ireland context that is very rare and the problem for us is that there has been nothing in the medical literature that would say who that one in three thousand would be and that was the point I was trying to make.

Well in this particular case we know which one it was it was …..the other point that I would like to make is that in your article you refer to the fluid you don't refer anywhere to the management of the fluid.

Yes, yes.

I mean would you happy with the management of the fluid.

Well what we have done in our guidelines is to say that you have to be careful and you have to monitor the fluid levels and the electrolyte levels in the patient in which the fluid is being replaced I think it was clear from what I'm reading in the Coroner's report I haven't got access to the medical notes but I think that anybody reading those reports would say and agree with the Coroner that the management of the fluids could have been much, much better and that it was inadequate that was the summary.

Slight understatement.

Well it was disastrous for Lucy dreadful absolutely dreadful there's no doubt about that but what it did mean was that we were adamant in our correspondence with the Health Service that we have to be extremely careful monitor carefully ……and carefully register what's happening with fluid replacement it's a big lesson from Lucy's death.

I'll come back to the point that you haven't issued or addressed how you speak about the particular fluid you haven't addressed the management of that fluid do you back what …….Trust did what the hospital did on that particular occasion.

What I back and absolutely without any exception is the Coroner's report and what he said that you know in a way is the duty.

You haven't addressed the management of the fluid in this article.

Well no I haven't

You spoke specifically about the fluid which I'd maybe like to come back to but …….Trust's handling of the management of the fluid too much fluid you haven't…… addressed it I mean could you clear it up for me now.

As I've said Denzel I haven't got the medical notes the Coroner has referred them to the GMC the case to the GMC all I have to go on is the Coroner's report which was sent to me and I agree with his conclusions absolutely I mean let there be no mistake about that you know now its not my job to go and investigate what happened.

That's the difficulty that I have and which I refer to in my original piece in the Irish News on the one hand you say you back the Coroner 100% but you're ……when you talk about ……reaction the possibility of it …..when you say that you can't talk about the management of the fluid when the Coroner clearly says

that there was fundamental errors in the management of the fluid so where do you stand on those particular points if they back the Coroner on one side do you not you're appearing to be only you're certainly giving the perceptive of attracting the back.

I'm absolutely agreeing with the Coroner and I absolutely agree with what the Coroner with what the Coroner has done which has been to refer that to the GMC for a proper conclusion on the medical care that's the job of the GMC the Coroner recognized that it was not his job I recognize it as not my job to do that. That does need to be done by the proper body the GMC I mean I'll have to wait on what those conclusions are and that's the proper place for the Coroner to refer that to so that's where the proper interrogation of that lies and it doesn't lie with me nor would I want to ever cut across what is properly the role of the GMC in doing that.

Just so that we are absolutely certain you're not ruling out the possibility that there was a ……..reaction in Lucy's case and you're not commenting on the fluid management …….trust.

Now don't misquote me and I'll try not to get myself confused what I'm saying about hyper-nutria in general cause I have to talk in general and not about Lucy because my job to look at public health and it would be other people's jobs to interrogate as the Coroner has done Lucy's death the GMC will do that but what I'm saying is that we now have in the past four years two children who died of hyper-nutria now its written up and recorded in the medical journals that a death from hyper-nutria is a rare occurrence one in three thousand post operative children in a number of DGH's and we can get to that article and develop it but we don't want one to happen again in Northern Ireland there rare ……..are the word to use because it infers as you say that maybe it was because of some genetic makeup of Lucy we don't know that yet we don't know what makes certain youngsters at risk ten children given the same fluids same volumes children look at a like and one of them to develop hyper-nutria what makes them do that I don't know that yet it maybe that Ted Sumner knows who that might be and if so together with the other international experts that I've called together to look at this then we can help to reduce the risk even further that's proper risk management done across the population in Northern Ireland now I mean you are interrogating …..that's proper and right for you to do that but my job is to say are there issues here with the home of the childhood population of Northern Ireland that we need to be aware of how can we prevent a next death from hyper-nutria of any cause whether wrong fluid right fluid not enough fluid too much fluid or even fluids given orally cause we know that they can cause hyper-nutria that's my job Denzil now I know that you're anxious to find other answers and in a way we need to make sure you're clear about who the right people are to give those answers and the Minister is going to meet with me and she'll answer the questions which are properly for her but I'm not trying to ……I'm just trying to tell you what I feel in my heart as needed to be done coming out of those two deaths.

Yeah I think the difficulty is though that we have to learn lessons from individual cases as well and I think because we don't know the full circumstances after four

years of Lucy's death how can we possibly learn all the lessons but just again I don't want to put words in your mouth but I just want to clarify something you said it is possible then that you have ten children .....but it is possible.

.....That was in a hypothetical case of ten children it might be three hundred children in the DGA

.....

Well its what happens in a district general hospital the same fluids given over the past thirty years have been the hypo tonic solution that Lucy and Rachel got now from the evidence that we have here and you have to look at the population sizes to begin to infer therefore what is that meaning for our population because you know the one case tells you something but it doesn't there's a danger in generalizing always from the one case. What I'm saying is that in a district general hospital with those same practices that we've had using the same fluids it would appear looking at large numbers of patients that out of three hundred children one of them will go on to get hyper-nutria and we want to know why that is but more importantly we want to put measures in place to prevent that happening.

The fluid that you refer to and you talk here about it being in common use for thirty years and you also refer to the condition of hyper-nutria not widely recognized among health professionals across the UK at the time of Lucy's death but in fact it has been written about widely for a long number of years.

It started to be written up in the Journals going back many years reporting one or two cases here and there and because the evidence of the experts is what's important here you do need to refer to what's recently written which gathers together all the evidence over the years and begins to put that in place and unravel a picture now the most recent and probably the most comprehensive essay or debate on hyper-nutria was just about two or three weeks ago in the archives of .....I don't know if you've seen that one yet but that's the one that you could turn to which gives you a full expression of the debate around hyper-nutria I'm not an expert Denzel you know I have to know a little bit about everything but if you want to know more and updates what was said by Ted Sumner it updates what was said by Dr Evans in recent inquests it is update debate around hyper-nutria and if you need a copy of that we can get it to you.

So this supercedes Ted Sumner.

Well its expands on the debate and it says there is no black and white here and we need more research what it does is it sets out the case on one side and the case on the other and again I would say the conclusions are what we put in our guidelines which are really about being careful being watchful and monitoring what's happening to each child and if you don't know what you're doing or what's going wrong call in the experts now as you probably are aware the guidelines that we put in place are ahead of many places in the UK and indeed have been commended by them but we will continue to update those in

the light of the new debate and in the light of what a number of international experts will be telling us in the next few weeks as we continue to review the guidelines.

And do those experts include Dr Sumner.

Well I would regard Dr Sumner as very much an expert in .....intensive care and rightly that was why.

You haven't actually met him yet.

No, no but I intend to because I think he will provide quite a valuable judgment of what our guidelines are about and how we might begin to apply them even further.

Why do you think after three years that someone from .....hasn't called in Ted Sumner before now after three years three years on from Rachel Ferguson's death he was able to at Rachel's inquest to prepare some of the papers that have been written about hyper-nutria as far back as 1998 and in fact his .....this has been written about at great length by ....in 1992 and articles have been written about as far back as

When we first sat down with a small group convened by CMO to draft the guidelines we did actually contact and speak to Dr Sumner unfortunately we didn't have the opportunity to meet him but I had a conversation with him and several correspondence by email so he did have an input into the guidance and was a very valuable individual in doing so and combined with our own .....and intensive care specialists locally I think all contributed very valuably.

Is it right that you Mariam spearheaded the work around the guidelines you spoke to Ted Sumner .

Yes and got quite a lot of input in what his practice was and what he would like to see .....and what the best practice so his input along with many others from different specialties including laboratory medicine intensive care .....all played a valuable role.

So the response then to make it right is that I don't know Ted Sumner I intend to meet him very soon and I've never spoken to him but thankfully Dr .....Senior Medical Officer did involve him I wasn't aware of that.

It was quite a while ago we sorted out that kind of expertise because we recognized his role and .....

I suppose if we're all you said previously in a previous interview my job as Chief Medical Officer is to look at issues for the population of Northern Ireland to make sure we learn from untoward events.

Yes.

There don't seem to be too many lessons learnt from Lucy's untoward event.

Well what there is guidelines Denzel which are commended by Ted Sumner.

I think you said previously in an interview that the guidelines weren't based on Lucy's death.

But they are relevant to as we now know aren't they.

But there are serious issues about the fluid management that haven't been addressed.

Well we'll give you a copy of the guidelines I don't know if you've ever seen them.

Oh yes I have.

Okay so have a look at that and it is quite clear about the ensuring close management of fluid replacement so it is relevant to Lucy's death its also relevant to the death in the UK some months ago in a major ……unit headed by a very highly esteemed international expert a death the same as Lucy's and the one or two deaths that do happen each year which are hyper-nutria throughout the UK it is relevant to all of those deaths it is relevant those guidelines I've said that had they been in place in early 2000 well I said it about Rachel Ferguson's death on the BBC because I do mix up the two the two I mean they're both very emotional and very emotive stories and I do mix up the two but had those guidelines been in place then it might have been that Lucy and Rachel might not have died but.

The real point that I am making though is to learn lessons from an untoward death that untoward death has to be properly investigated it hasn't been properly investigated it wasn't properly investigated by the Sperrin Lakeland Trust who didn't even inform you about it.

I don't know if you're aware of all the work that's gone on in the last two or three years throughout the UK in trying well out of Shipman

Sorry specifically to learn from an untoward death it has to be investigated properly do you feel that the Sperrin Lakeland Trust investigated that death properly.

Okay I expect that to be looked at by the GMC because they are responsible not only for how they will be responsible for investigating not only how and why Lucy died and what went wrong but also the papers were reported to them about how it was investigated by the processes that the Trust put in place the GMC I expect to tell us or inform us whether or not in the medical examination of Lucy's death whether or not that was appropriate and up to standard.

But you know quite apart from the medical aspect the investigation that the Sperrin Lakeland Trust should have been done properly to enable you to do your job properly it wasn't.

The

Do you have faith in their investigation.

I can't

……..

I can't answer that for its not for me to answer Denzel.

Its crucial for you to be able to learn from untoward events you have to be able to say to the Health Trust was that investigated properly.

Yeah and what I'm saying.

Four years on we haven't had any answers from the Sperrin Lakeland Trust.

And what I'm saying is that there has been no proper formalized process in place there has been no proper formalized approach in place today for the investigation of untoward deaths we now recognize that throughout the UK not just me but throughout the UK we know that we have to begin to have a process in place which will allow us early warning on issues such as this there are bits and pieces

So there is no investigation procedure in untoward deaths.

Each Trust would be responsible for the investigation

I understand what you're saying that there is no formal reporting for such so they wouldn't have to report it to you which I find quite strange but if there is no procedure fine but the Trust must have a procedure to investigate the deaths.

Well yes and you have to approach the Trust

And do you have faith in the Sperrin Lakeland Trust.

Well each death will have a different method of investigate and interrogation that's a question which I have not looked at because its not my job to look at it.

But you must be able to say sorry but I keep coming back to this if you're going to learn from an untoward death which is an issue for the whole population not just the Crawford family there must be a proper investigation procedure in place in the

Sperrin Lakeland Trust in this case there doesn't seem that there was do you have faith in their investigation.

Well its quite clear that there was no process for the reporting of Lucy's death to me nor indeed the outcome of any investigation now whether or not the CMO is the right person to refer that to but even throughout the UK in England Scotland or Wales we have not yet a proper procedure in place for doing that we're striving to do that and I think that we've learnt the lessons from Lucy's death that if such a process where in place and could properly be put in place then we could hopefully take by the action that would prevent deaths.

In my opinion Lucy's death wasn't investigated properly at all would you support I have already called in my own newspaper I have already called for a independent enquiry cause I believe that is the only thing that will restore confidence in the Health Service in Fermanagh would you support that at all.

Denzel I actually prefer to wait until the GMC looks at it cause I feel that they are the proper people to tell us whether or not there was medical negligence or irresponsibility now I know that you have a right to take your view on that now on what you've seen but I will actually want to hear what the GMC have said because I think that they are properly

And will the GMC look at the investigation procedure.

Well within the whole context of what was done about medical care that will arise.

It will arise.

Yes.

So the GMC will look at the investigation process.

The Coroner and I think I'm right in saying this the Coroner has referred all his papers and conclusions to the GMC so it is comprehensive and conclusive.

But not as I understand it look at the investigation.

Well the issue around how it was established and within the medical network within the Western Board that clinical network which is .....and Erin those papers have all gone to the GMC and will be looked at.

You've written to the Crawford family you know that they were very unhappy at the tone of your letter.

Well I knew that almost anything that I would write would hurt.

You could have offered a meeting you could have said I would like to meet you.

I have offered a meeting. Oh no come on Denzel come on now you can't play that.

.....

Can we read you the letter and tell me if I have

Would you like to meet the family

I would love to meet the family and I'll tell you why, because having been forced through the media to talk about Lucy I feel that I would want to meet them because there can be nothing worse than hearing this middle aged woman rabbiting on and I really feel that they have been hard done by.

.....You said you would be prepared to meet them if they thought if they thought

I would be very happy to meet them I didn't say I would be prepared to meet at least if I did that's not like me. Now please be fair with me here Denzel please.

If it would be helpful to you I would be very happy to meet you. It doesn't indicate any desire by you which you should have felt.

I would be happy and I mean happy please Denzel be fair to me.

The family are taking it worse.

Yes, I know that nothing I would say would in anyway help the family now I'm asking you as an individual does that not imply to you and I mean

Are you asking me for my personal opinion.

No, no I'm not.

.....I think it could have been written better.

Well of course it could everybody writes could be written better. Well

You could have written a desire to meet them it doesn't indicate any desire to meet them.

Denzel

It indicates if you want a meeting I will meet you.

Do you know why I said that I mean a letter from me I'm going to come down and meet you I mean how awful would that have been they have to feel have to feel that they would want to meet me otherwise I mean what could be worse.

Just a token

I think the fact that its them that offered the meeting indicates same as happy to meet them and puts obviously the Crawford family in a very difficult time the opportunity to either except or not except a meeting but I think as the CMO writing to them and offering them that meeting shows that there is willingness in the CMO to meet with them.

You have to be fair to me Denzel and not drive this as a further ……I'll tell you I actually in my life I try to be honest open fair and caring and to have this misrepresented and to have what I said picked over the bones of it the very bread I can't cope with that.

The letter at the moment as far as I'm concerned isn't an issue I'm just telling you what the family's perception was.

And you said it in the Irish News so you know.

It wasn't the Irish News, I didn't refer to your letter in fact my references to yourself in the Irish News were minimal.

I know.

Put it on paper and I'll go back through the literature because obviously what you want is to get to the root of what the ……medical issues are around fluid replacement and hyper-nutria. Denzel I have to admit that I am not an expert in this and don't try to set me up as someone as trying to be so on all of these issues when an absolute imperative exists around the detail and the expert view you can't come to me to have it here in my head what I can do is get you the references or refer you to the experts who can do that you can't ask of me what I'm not and I'm a public health doctor I'm not ……intensive and that's why picking over the bones of what I say diverts the issue about how we properly ensure that fluid replacement is as it should be cause when I want that to happen I go to the experts.

Well certainly you know the main criticism in my area would be directed towards the Sperrin Lakeland Trust I might as well be perfectly frank with you and the point that I made earlier is that for you to be able to do your job properly as in advising the population of Northern Ireland the Sperrin Lakeland Trust failed near enough because it didn't investigate they didn't inform you to begin with I don't think you've said anything today that would lead me to believe that they have been in contact with you even yet. Secondly they did not investigate this death properly and still have not, so how can we learn lessons from an untoward death that hasn't been properly investigated in fact they haven't investigated at all.

Okay the Minister will in her interview with you will tell you what procedures are being put in place throughout the UK and particularly the procedures that are being put in place here in Northern Ireland to make sure that issues such as Lucy's death might be dealt with at an earlier stage I fully admit and have done that four years ago they were imperfect and not at all comprehensive and what we need is a system which allows proper reporting which can be systematically then analyzed and teased out so that the important issues emerge I have to admit that over the past four years for me attention has been focused on stopping three thousand people down each year early because they smoke thousands more dying early because they're not getting access to a proper diet and many more dying early because of all the other vague lifestyle issues that are of concern so for me in terms of priorities its saving the three thousand who die from smoking which always has to be top of the list somebody has to look after them but we do also need a way of picking out the one or two deaths which actually are important and which mean that you can put proper systems in place but those are two separate issues one focusing on the individual the other focusing on population public health saving thousands and that is my job now that's not to say that the other job is a lesser one but we do need to get that right and that's what we're engaged in.

I think I am conscious at times as well but there are two elements for me one is the reporting obviously that lack of system you need the untoward death to be reported to you to take action also you need information about that untoward death which a proper investigation would uncover there was no proper investigation in this case.

And I would fully expect that guidelines on how to properly investigate untoward events will be part and parcel of what is being done throughout the UK to make this better all of it coming out of Bristol and Shipman all of those things are trying to say earning are also relevant to the Lucy's death the Rachel's death.

You appear there again I don't want to misquote you appear there to be suggesting to me that you are not happy with the Sperrin Lakeland Trust investigation in this case.

No what I'm saying is we have not had proper guidelines which are up to date which are in place for the proper and thorough investigation of untoward incidents by deaths and that's a rec with will need to be taken forward we our role in the department is development of strategy and policy so a strategy and a policy on proper investigation is what we need to do.