sympathetic to [illegible]

Insight: Interview with Dr Dewi Evans 26/4/04

TB: Now Dr Evans you were asked to examine the case of Lucy Crawford back in 2001. What struck you first when you were given access to the medical notes in the Erne Hospital?

Dr Evans: I think the first thing is that the notes were very badly kept and very well organised. Of course it was a great tragedy because the little girl was admitted one evening and had collapsed within a few hours of admission and on looking at the information in some detail it was clear that there were problems of fluid replacement. Her main problem was gastro-enteritis, which demands intravenous fluids in severe cases. There were problems initially in getting the intravenous fluids in, which can happen in young children, but once the fluids had gone in it was clear to me that the wrong fluid was given. And also too much of this fluid was given and this led directly to the brain swelling which ultimately led to her death.

TB: So whenever Lucy was admitted with gastro-enteritis did gastro-enteritis, was this a contributory factor to her death or was it basically that Lucy died as a result of too much fluid being given and the wrong fluid being given?

Dr Evans: Well if the gastro-enteritis had been treated correctly in my opinion she would not have died and so it was the fluids themselves which contributed to her death. If you give fluid that it too dilute, and I know this is very technical, this causes a disturbance in the salt balance within the blood and within the brain and the brain's ability to get the salt balance correct is not very quick so therefore if you give fluid with too little salt too quickly then this leads to a condition where the cells in the brain swell. This of course interferes with the ability of the brain to receive oxygen and this is what ultimately is fatal.

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TB: So when you look at Lucy having being admitted at half past seven and by three am the following morning she had died that must have been quite striking in a healthy 17 month old child.

Dr Evans: Well, it's very exceptional I'm pleased to say. One does lose patients from severe gastro-enteritis and also young children can become ill very very quickly so it's not wholly exceptional for children to admitted to hospital and die within a few hours. I suppose the most common condition which does this is meningitis but our obligation is to evaluate the condition of the child on admission, carry out the appropriate blood test according to need and then prescribe the right treatment. Of course it's essential that everybody knows about the fluids that are given and the other treatment so that isn't any mistake between what you think the patient is getting and what the patient actually is getting. Hospitals are very complex places, there are lots of people working on hospital wards. You're not quite sure what the experience and expertise of all the individuals are so it very important you have accurate documentation of everything that is done.

TB: So if you look at Lucy's history from when she entered the Erne hospital at half past seven and the attempts that were made over 11 times, the mother recorded, to inject with an IV drip. It wasn't until half past ten or eleven o'clock that that went in and by 3.00 she died. What exactly occurred?

Dr Evans: I think what happened was this; clearly the junior doctor had difficulties in getting the intravenous access. Getting intravenous access in young children can be difficult. I think what we tend to advise is if you can't get a line in after two or three attempts that you ask someone with more expertise, more experience. So he should have first of all summoned someone else in at an earlier time. Anyway he eventually did so.

UTV

TB: Three hours later?

Dr Evans: Three hours later. Too long. But he got it right eventually and the line was established. What should have happened then was that you should make a clinical assessment of your patient, make sure the blood pressure is normal, try to assess as well as you can how dehydrated the little girl was then estimate what fluid you needed; first of all to make up the deficit caused by her vomiting and also how much fluid she would need simply to get the blood pressure back to normal and to maintain normal replacement. All this is something which should be carried out quite routinely in any department. Then the first thing they failed to get right was they failed to give an intravenous bolus of fluid which would have the same degree of concentration of salt as you find in blood or plasma and I think that if they'd done that this may well have not happened. What they did do instead was give this very dilute fluid one fifth the salt strength of plasma and give quite a lot of that over the next four hours – more than should have been given, given the little girl only weighed 9 kilos (about 20 lbs) and by giving a lot of dilute fluid very very quickly this caused interference with the concentration of salt in the blood and also the concentration of salt in the water within the brain cells.

TB: So that's what effectively killed her?

Dr Evans: Yes, what happened was that the salt sodium level in the blood fell quite quickly. Again it's technical but the initial value was 137 and it fell to 127 in a matter of hours – that's a very significant drop and that undoubtedly contributed to the brain swelling happening.

TB: So what happened was that the child entered the hospital with gastro-enteritis but it was the treatment she received which killed her.

Dr Evans: Effectively, the treatment failed to save her and if she had another form of treatment I think she would have survived. So she was given the wrong treatment.

TB: If you look at the notes that were available to you whenever you carried out your examination of what had occurred back in February 2001 it is quite clear that there was a failure by the staff to identify exactly how a) how much fluid Lucy had lost but then b) to actually decide upon how much fluid she would need and how much they were going to give her.

Dr Evans: Well it seemed that there was no protocol in place for managing a child with gastro-enteritis. That seemed to be the most obvious point and in this particular case there was no evidence that an experienced doctor had written in the notes that Lucy should be treated with the correct fluid in the correct volume in other words the written instruction was not carried out in detail and you really must do this.

TB: Now you looked back at the notes and you found that the following day the hospital had seemed to have rewritten history as you described it. How did it do that?

Dr Evans: Well, by 3.00 in the morning when she collapsed it was clear that they had to transfer her to a larger centre and I think there were queries from the large centre in Belfast about the fluid that Lucy was given and I think it's natural that somebody added to the notes. Again, one of the difficulties that we've all had with this case is working out exactly and accurately what actually was given. Initially I felt that Lucy had not only received too much fluid but had received even more fluid because there was a huge discrepancy in her weight from the time she was initially admitted to the time that she was weighed at post mortem. But I'm not sure whether those weights were accurate so with regard to other information I think that somebody probably got the figures wrong with regard to the hourly fluid rate that she received. It's obvious that she received over 100mls per hour and I think there was a note saying she

received only 30mls per hour. Now again, I've no idea how those figures came into being.

TB: Was somebody trying to cover their tracks?

Dr Evans: I don't think so, not at the time. You see, at the time it wasn't confirmed that she had saeduludima – that was confirmed following post mortem obviously and there would have been some doubt clearly regarding the cause of her collapse initially. It was clearly completely unexpected. What I would have expected of the hospital authorities to do once the cause of death was ascertained was to explore all the avenues, to look to see whether anything could have been done differently, if only to avoid such a tragedy occurring again.

TB: They failed to do that.

Dr Evans: I don't think they did very well. They obtained an independent report from another consultant who said that he could not explain why Lucy had developed brainswelling - saedeludima. Well, fine, but if you get one opinion who admits that he doesn't know what caused it then you have an obligation as hospital authority in my opinion to get an opinion from somewhere else. I mean, we have a well-structured system of specialists within the UK in medical practice and it would not be very hard to get a report from, for example, a paediatric intensivist who would undoubtedly have come to the conclusion that the brain swelling was caused by the inappropriate fluid.

TB: That was critical – the hospital and the trust would seem to be quite happy with an inconclusive report.

Dr Evans: Well, it's up to them to decide how far they scrutinise things. I think that what comes out of this for me is how much better was the coroner's system in that there were four medical people who gave an opinion at the coroner's inquest and all

of us came to the same conclusion and I would think that if the coroner could get these independent opinions, which he did, then the hospital organisation should have done the same three years earlier.

TB: So in your opinion why did the hospitals fail to go after the truth here?

Dr Evans: I think that's a very difficult question if I may say so.

TB: But they didn't go after the truth, that's it, they failed to find out for or on behalf of Lucy's parents what exactly had occurred. I mean, that's blatantly obvious from the review and from the Quinn Report.

Dr Evans: I think that what happened is – I don't think they system of independent scrutiny is as yet sufficiently well developed. I think the system does vary in different parts of the British Isles and we have a more effective system of independent scrutiny now than we had say five years ago, but a lot of this has occurred as a result of so-called scandals such as the death rate in the Bristol cardiac babies, for instance. So therefore change tends to occur only after some sort of tragedy.

TB: The problem with this one is this tragedy had occurred in April 2000 and the Trust involved didn't get to the bottom of it and within 18 months a second child had died only up the road in Derry, under the same board area. That's a double tragedy within an area that really should have identified the problems in the first place.

Dr Evans: It is a double tragedy. I prepared this report in February 2001 which is less than a year after she died. Now if I had enough information to come to a definitive cause for death then that information should have been available to the hospital trust if they'd bothered to get an opinion from an appropriate expert in the field.

TB: And a second life could have been saved.

Dr Evans: Well I can't comment on other cases of course.

TB: The concern is that, I'm sure you're well aware of this - a family looking back at what occurred here and looking back on the failure of the Trust not to employ a specialist, they see cover up, they see the medical profession closing ranks and that it didn't go after what exactly had occurred and it had an obligation on behalf of the family do so, but it failed utterly to do that. Can you understand that in this day and age, in 2004, a family feeling like that?

Dr Evans: Absolutely and this is not an isolated event. I think that within the NHS that decisions regarding investigations of this nature rest with hospital managers by the way and not with hospital consultants – and I'm not trying to pass the buck. But they are the ones who are responsible and of course they are one step removed from the clinical case itself which would make it a little bit less emotional I would have thought so they are the ones who should have got themselves a good, thorough, robust independent report and not just from one individual but from two or three if there was need for that.

TB: Does that hint that the Trust was aware there was a problem but is it a case it depends who you ask to review the case the answer you are going to be given?

Dr Evans: I think that the situation is this: if someone makes a complaint and it answers all the questions and the family is satisfied with all the answers then that's fine. But if the family is not satisfied and say look, you haven't given us all the explanations then I think you have to be honest and say, well, what you really need to do is we'll organise an independent review getting experts from outside of this area. Now you can either do that, and the structure's in place and has been in place for many years. Or, the family can seek their own solicitor, which is what they did in this case, who can find an independent medical expert from another part of the islands.

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TB: What you're really saying is that trusts are incapable of carrying out independent reviews really and it's very difficult in a small area like Northern Ireland, very similar to your South Wales, in that it's incapable of carrying out an independent review. To ask somebody from a hospital within the same board area to carry out a review is hardly independent.

Dr Evans: Yes, I don't think I would ask someone from my own area, it's Northern Ireland, South Wales, similar population, everybody knows everybody else. As far as how much effort a trust or any organisation will take to organise a review on the whole it depends on how much pressure is placed upon them.

TB: That's the reality.

Dr Evans: That's the reality of it. You have to push to get the answers. I'm afraid that's the case.

TB: That's what the worrying thing is here, the hospital obviously knows that something had gone wrong, carried out its own review in the immediate weeks after Lucy's death. The family complained officially in September and at that point the hospital had carried out this review and yet said that a full investigation would take place and then refused to give over the review until the family would come and meet them so that they could explain the review. That's a worrying set of circumstances, it smacks of some sort of arrogance that the Trust was going to feel that the family weren't going to understand the review themselves so that they were going to come in an schmooze them about what exactly had occurred.

Dr Evans: Yes, I think with a situation like this is that patients are at a disadvantage because of course they do not understand medical technicalities and I think that if they're not immediately satisfied the best thing is to get an independent medical expert who is there on their behalf, who is still impartial and may still conclude

though the hospital did everything they could and this was unforeseen, a horrible tragedy but nobody did anything wrong. But the problem the Trust lies still I think in being open and transparent and saying: this is the information, we are prepared to share all the information with you and we will even encourage you that to get an independent review this still doesn't occur in certain cases. Probably I don't know the structure in Northern Ireland as well as I do here but there is probably less information in Northern Ireland than there is on the mainland when it comes to procedure investigating clinical complaints.

TB: Really? That's quite worrying too.

Dr Evans: Well one of the things we have now in Wales and England is an organisation called CHI – Commission for Health Improvement, that has developed. CHI has an independent scrutinising role, which can make recommendations, can walk into the Department and say let's find out how you manage certain patients and certain conditions. Surely that is an organisation that should be available to all the peoples in the UK, I would think.

TB: When you looked at the Quinn Report, what struck you about it?

Dr Evans: Well I only saw the Quinn Report recently and in his report he says that he knew that the child from the post mortem had saedeludima but he couldn't comment on how this had happened, he didn't come to any conclusion regarding the cause of the brain swelling. Now all of us have a different level of expertise. If he didn't know I would respect that and accept that and if I received a report of that nature, and I was the hospital manager, I would then get a second report from someone with a more specialist expertise in the management of very sick children, for example, paediatric intensivist. I would probably have spoken to the doctor first of all to ask if he would

like to elaborate on those aspects of medical care where he didn't feel he qualified to comment on.

TB: It was quite clear that Quinn failed to identify exactly what occurred in the hospital and what had occurred, what had happened to Lucy.

Dr Evans: Well I think he failed to recognise the significance of giving too much fluid which was too dilute, although the evidence was there, from the differences in the blood tests carried out on Lucy when she came into hospital and the blood tests carried out a few hours later so the evidence was there. But again this was quite this is quite a specialist field and it may well be that, let's be frank, saedeludima is still a pretty rare condition in children so it may well be that no individual consultant had seen more than one or two cases in a lifetime.

TB: So what do you think Quinn should have done?

Dr Evans: He should have advised the Trust to get a second report from another medical specialist looking specifically at cause or causes of saedeludima in Lucy's case.

TB: So in your opinion not only did the hospital fail Lucy on the night of her treatment but they also failed in the investigation to discover what had occurred.

Dr Evans: The hospital trust had a duty of care to investigate thoroughly. Once they had one report that failed to come up with the answers, and I don't criticise that, then they should have got themselves more reports and in my experience of dealing with clinical complaints on a regular basis it is not unusual for solicitors or other organisations to seek four or five reports from individuals with different levels of expertise in different fields before coming to a conclusion. So there is nothing unusual about getting reports from several people. In fact it's the norm in complicated cases which obviously Lucy's case was.

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TB: And yet that didn't occur?

Dr Evans: No. And I think that is something one should criticise the Trust for. They failed to pursue the case robustly enough.

TB: And how important is that?

Dr Evans: It's very important because hospitals don't belong to the managers, hospitals belong to the people and it's very important that local people have trust in their own hospitals and in their own health organisation. We all know that people die in hospital and most of the time they die from their illnesses. They don't die because people get something wrong. But if there a query, of course people are far more emotional when it comes to the death of children which is understandable, I think that there is an obligation there to investigate far more thoroughly and I think this is something they failed to do in this particular case.

TB: This is a statement, if we just want to look at statement 1, and read it and give me your opinion.

Dr Evans: There is a statement here: the reality of this event, it is something you do not see in very few children. Saedulidima is rare but it's not caused by an idiosyncratic response, that is unforeseen.

TB: Lucy didn't have anything in her physiology that made her more susceptible to this. It was the treatment she received.

Dr Evans: No, she didn't. Any child with gastro-enteritis of this age who received this kind of treatment would have been at risk of Saedulidima may not have developed Saedulidima but would have been at risk of Saedulidima. So therefore it is the treatment that drives the patient to develop the Saedulidima.

TB: Is the statement right or wrong?

Dr Evans: This statement is wrong.

TB: Would it therefore worry you that it was made by the Chief Medical Officer for Northern Ireland?

Dr Evans: Well yes you do. Clearly the Chief Medical Officer may not be a practising clinician and may have no experience of children's medicine at all but it is incorrect.

TB: That statement was made following the inquest into Lucy Crawford and following the death of another child and yet Henrietta Campbell was still maintaining that this was something to do with the physiology of Lucy Crawford.

Dr Evans: No, that's not true. This event was caused by the fact that she was a young child who had gastro-enteritis and whose fluid replacement was incorrect.

TB: This is obviously very worrying to the family that the Chief Medical Officer has said that. Is it worrying to you as a specialist?

Dr Evans: Well I would hope that the Chief Medical Officer would have spoken to the appropriate medical paediatric experts first before getting a statement out. I would not expect the Chief Medical Officer to know everything about clinical matters in all fields of medicine. For any Chief Medical Officer relies on the information from the relevant specialist. It definitely concerns me a bit.

TB: This is a case of high public awareness and interest obviously and given many of the things you've just said to me of the importance of the trust to investigate it properly the concern is, and one of the reasons that we're here is that the Chief Medical Officer seems to still be suggesting four years after Lucy's death following a rigorous coroner's inquest that it was the physiology that was the problem and this is the concern.

Dr Evans: I think the Coroner handled this tragedy superbly. The investigation was very robust, very thorough. I think it was an excellent example of the role of a

coroner in investigating a death of this kind. I would advise that the Chief Medical Officer should read all the statements made by various people in the inquest.

TB: The problem is there have been words said in public that this is a case of hypotraemia, it's very rare, we didn't know very much about it in the year 2000. Dr Saunder stated quite categorically that this has been around for many years and fluid therapy has been around for many years, in fact he said first year medical students would learn this. So why in the year 2000 in you opinion do we have such a drastic event of the death of a child over something so simple?

Dr Evans: I think that we have been in many departments, not ours, giving this dilute fluid, this fifth normalcy one in children's departments for decades and it's relatively recently, in the last few years, that the text books are prepared to say use stronger solutions. For instance text books published in 1998 said we can use fifth normalcy so therefore it just sums up how medical progress progresses. This fluid has been around a long time. I think if it had not been given excessively I think Lucy would not have experienced ihyponatraemia. I think the problem was too much was given of the fluid that was the inappropriate fluid as well. But I think we have to carry the responsibility for this and I think that the management of fluid replacement in children is far better recognised now than it was a few years ago.

TB: You've never used the solution 0.8?

Dr Evans: No we don't use the 5th normalcy.

TB: Why is that?

Dr Evans: If you use dilute solution in children 24 hours or more, maybe 12 hours or more, the salt level in the blood falls. If the fluid replacement is relatively gradual there is no harm but I've always found it more sensible to use fluid that contains more salt, what we call half normal saline and of course if you're dealing with children who

are acutely ill one would give a bolus solution of fluid that contains even more salt, which contains 0.9 % sodium chloride which contains the same isotonic value as plasma.

TB: Would you look at statement 2. Is that accurate?

Dr Evans: I'm quite sympathetic to the statement, I have to admit. Whether you like it or not brain swelling is rare and also until fairly recently many children's departments have been using this dilute saline solution in treating children. Usually you get away with it if you don't use too much of it. I think I would our views have firmed up over the last few years against using these dilute fluids and I think we are far more aware of the risks of dilution of dilute sodium that we were a few years ago. It's not the dilute sodium that's the problem it's the fact that can be linked with Saliludima as in Lucy's case.

TB: The fact is here that here that the Chief Medical Officer is talking about abnormal reaction but it wasn't the abnormal reaction in the child, was it not?

Dr Evans: No this wasn't an abnormal reaction. An abnormal reaction occurs if you hear of a tragedy sometimes when someone dies of a bee sting. They get what you call an idiosyncratic response. Lucy did not experience an idiosyncratic response. She was ill on admission because of the gastro-enteritis and she received inappropriate fluid and as a result of that her body's physiology which was inherently normal reacted in this way, it led to the low sodium value in the blood and that caused associative brain swelling.

TB: So it wasn't an abnormal reaction. She got too much fluid.

Dr Evans: She had too much fluid of the wrong fluid. It wasn't an abnormal reaction though.

TB: So that's inaccurate.

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Dr Evans: It is incorrect.

TB: Why 21 years ago did you say that I'll never use 0.5.

Dr Evans: As a young doctor I've always had a large part of my practice relate to management of diabetes and management of new born babies and you simply realise that if you give dilite fluids then the sodium value falls. So I thought let's give a solution that contains more salt and I've just always done it. I have to emphasise I didn't change my practice as a result of experience of experiencing Salaeidima in a patient of mine many many years ago.

TB: If you transferred a child from here to a specialist hospital in Cardiff, do you sent the notes with the child or do you send them later?

Dr Evans: It varies. Usually nowadays one copies the notes and hangs on to the originals here just in they get lost.

TB: Given that the pathologist was unable to identify that she had died of hyponatraemia, is that because the notes were not there that he wasn't able to identify exactly what had occurred in the Erne?

Dr Evans: How do you mean?

TB: When the Royal Victoria Hospital carried out a localised postmortem by the pathologist he does not mention hyponatraemia.

Dr Evans: I'm not sure whether he would have known about the change in Lucy's blood salt level from the time of admission to the time of collapse.

TB: So that would explain that - he wasn't aware because it wasn't on the notes?

Dr Evans: I've no idea

TB: When you look at the notes is easy to come to the conclusion Quinn did or is it only because you are a specialist you are able to identify exactly what had occurred?

Dr Evans: Once the results of the post mortem are available and once you've got time to look at the results of the investigations and if still in doubt you can check the medical text books then you should be able to come to a conclusion.

TB: What lessons should be learnt? You've covered a number of cases and another hyponatraemia case in Northern Ireland.

DR Evans: I've dealt with two cases fairly close together and other case the child survived without any long term effects. That was a case where the child simply received far too great a volume of fluid. She had a kidney complaint which meant she was unable to excrete fluid effectively and therefore she developed significant fluid overload case and collapsed as a result. In that particular case one is talking of a teenage child who is admitted to an adult which of course is something one would try to avoid.

TB: The concern is you've dealt with a couple of cases in Northern Ireland there have been others where children have either died or been seriously injured as result of improper fluid management and yet here in 2004 the Chief Medical Officer seems to be unaware exactly what is the problem?.

Dr Evans: Well I know that in 2003 Northern Ireland they published a very good robust document advising on the dangers of hyponatraemia and advising on an effective way of treating it and I think that if it's any consolation that is probably something that came out of these two or three cases.

TB: Should that really not have been fluid management, not hyponatraemia because its about the fluid management, not the hyponatraemia.

Dr Evans: It is.

TB: Isn't that the point?

UTV

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Dr Evans: I think that with fluid management is that in the management of young children we as a profession have not always been sufficiently robust and obsessive in ensuring that children are weighted accurately and receive very accurate amount of fluid and that the whole of this is monitored on a very careful basis.

TB: So in fact we really need a paper telling doctors about fluid management, is that the important thing here?

Dr Evans: Yes, there is a document available known as APLS document which relates to children and actually spells out how to deal with fluid replacement therapy in children in a very straightforward way. The third edition was published fairly recently and the information in the third edition is not exactly same as the information in the second edition. So therefore I think it shows that we are constantly prepared to learn, learning sometimes from tragedies like this.

TB: So whenever the Chief Medical Officer made a great deal of the hyponatraemia and published charts that were put up in hospitals really did that not miss the point in that Lucy died and subsequently Rachel Ferguson died as a result of the mismanagement of fluids.

Dr Evans: The deaths were due to the failure of fluid management yes.

TB: Not to do with hyponatraemia. Hyponatraemia was the effect, the cause was fluid management.

Dr Evans: Yes, the problem was caused by giving this dilute fluid and too much of it.

TB: Should she not have attacked that and made it the focus of the concern?

Dr Evans: I think what she should do, I can't speak for the Chief Medical Officer is to look at the systems in use in all the children's hospitals in Northern Ireland and ensure that they follow the guidelines that were published there last year.

UTV

TB: When you called to give evidence in reports on this sorts of cases in various parts of the UK is it distressing when you see the failures that happen in Lucy's case and the subsequent failures of the management to identify and deal with the issues properly?

DR Evans: I certainly feel it concentrates the mind and I think it helps my own department's clinical practice that one see the things can go wrong terribly. You have to be impartial, you have distance yourself from the human emotion and the human tragedy otherwise you can't practice medicine with other children.

TB: Finally, how do you categorise what went wrong with Lucy and subsequent management of the investigation into her death.

DR Evans: I think there was a failure to ensure that there were the best protocols available. That could have been accessible to anybody. There was initially a technical failure, a failure to give the intravenous access and I think that there was a failure to document information from an experienced doctor carefully, accurately, objectively, spelling out in detail what fluid Lucy should have received and over what period of time. So therefore there was a failure of basic application of clinical practice.

TB: And what about the management?

Dr Evans: Once the cause of death was ascertained then the Trust managers had a duty of care to the family to investigate the cause of death very thoroughly indeed which should have meant if necessary getting reports from three or four medical experts across the British Isles so that they could find out if there were any avoidable factors in order to prevent his happening again. They failed to do that, the relied on one report only, they should have obtained more.

TB That's a lot of failures.

UTV

Dr Evans: It's a lot of failures and I think one's experience of when things go wrong in hospitals it's usually due to a number of errors when one or two errors may not make a difference when you add them all up together you end up with the difference between life and death. And this is what happened here.

TB: what do you think about the failure of the hospital to ask the chief witnesses and their view of what went wrong.

DR Evans: What do you mean by chief witnesses?

TB: The people who were by the bedside watching what had occurred, the Crawfords themselves. What do you think about the failure of the hospital to actually engage with family on their views of what had occurred……They never asked the family for their opinions…is that not a failure on behalf of the hospital?

Dr Evans: Well we have an open door policy so that if parents want to come and talk to us following the event of a death then we will talk to them.

TB: Should they not be included in this review – the family's evidence. You have only been able to reach the conclusions as a result of ranging the depositions from the mother.

Dr Evans: Well that and the contemporaneous clinical record and the results of the post mortem. The way one deals with complaints of this nature is that you would interview the medical staff involved in Lucy's care at the time of her death, speak to the family as well and following those interviews seek an independent opinion. That is what I would do and this is what we have done. Now I've not seen any statement from any of the nursing staff. That is what Trust management should do.

TB: And they didn't?

Dr Evans: Well you'd need to check on this because I can't claim that I've seen every document relating to Lucy's death.

TB: But it is quite striking that in the days and the weeks afterwards that they did not seem to be open to asking the family to come in and give them a statement of exactly what they had witnessed on the night. Not a complaint, but because they have a piece of the jigsaw do they not?

Dr Evans: they do

TB: They know the child better than anyone.

DR Evans: Didn't the parents write a letter of complaint to the hospital.

TB: Not until six months after the death. What they immediately did was say to the hospital, what went wrong? At the meeting the doctor didn't bring the notes, so he could say, I don't know what went wrong.

Dr Evans: I didn't know that.

TB: So when the family left they said, he didn't know what went wrong, we must find out what went wrong. But the hospital showed immediately afterwards no inclination to discover… is that not a damning indictment of the procedures immediately following an untoward incident.

Dr Evans: If you have a death of this nature you should inform the coroner. In this case I don't know when the coroner was informed of Lucy's death but it should have been done straight away presumably the death would have been notified to the Belfast coroner because that's where she died. What hospital organisations do, whether you like it or not, is that unless someone says we want more information there may well not be an investigation in to what happened.

TB: So no learning was made from the incident.

Dr Evans: Well this sort of case should be presented in the departmental meeting and the medical profession has a good system of networking where we present all the difficult and complicated cases to our colleagues in the scientific meetings so we have those options available to us. We have the scrutiny of being accountable in law to a coroner quite rightly so information does come out as a result of those procedures, but I don't know whether the parents made a formal request or complaint saying we are not satisfied with the care Lucy received, and we are making a formal complaint, and we want all the answers. What they did was speak to their local solicitor which is a perfectly appropriate thing for them to do.