INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

LIST OF ISSUES

1. The Inquiry will examine the events surrounding and following the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson, with particular reference to:

   (i) The care and treatment of Adam Strain, Lucy Crawford and Raychel Ferguson, especially in relation to the management of fluid balance and the choice and administration of intravenous fluids in each case;

   (ii) The actions of the Statutory Authorities, other organisations and responsible individuals concerned in the procedures, investigations and events which followed the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson;

   (ii) The communications with and explanations given to the respective families and others by the relevant authorities.

2. The Inquiry will consider what teaching/training has been given during the last 20 years in fluid management and/or hyponatraemia to:

   (a) medical students;
   (b) doctors;
   (c) student nurses;
   (d) nurses;

at Queens University Belfast and other relevant institutions. To what extent has this teaching/training been similar to or different from the equivalent teaching and training outside Northern Ireland?

3. The Inquiry will consider whether changes to teaching/training in fluid management and/or hyponatraemia in Northern Ireland since the deaths of Adam Strain, Lucy Crawford and Raychel Ferguson are sufficient to minimise the risk of further deaths from hyponatraemia in children.

4. What procedures, if any, had been in place during the last 20 years to ensure that information and lessons which emerge from Coroner's Inquests are disseminated within:

(a) The hospital concerned;
(b) The Health Service in Northern Ireland;
(c) Beyond Northern Ireland?

In relation to the issues referred to above, the Inquiry will consider what are the respective roles, if any, of:

(a) The hospital involved;
(b) The Area Board;
(c) The Chief Medical Officer;
(d) The Department.

5. The Inquiry will consider how many deaths there have been in Northern Ireland during the last 20 years in which hyponatraemia/fluid management was:

(a) The primary cause of death;

(b) The secondary cause of death.

6. The Inquiry will consider how the deaths referred to above are broken down in terms of:

(a) Hospitals;
(b) Age of patients;
(c) Date of death.

7. With reference to point 5 and 6 above, the Inquiry will consider whether such figures are in keeping with equivalent figures outside Northern Ireland, by reference to:

(a) Equivalent figures for the rest of the United Kingdom;
(b) Equivalent figures with other European Countries.

8. The Inquiry will consider whether, regardless of its findings in relation to point 7, is there any extent to which such deaths are avoidable.

9. The Inquiry will consider the guidelines introduced in Northern Ireland in March 2002 on "Prevention of Hyponatraemia in Children". The Inquiry will consider whether the same were:

(a) Appropriate at that time;
(b) Whether they are still appropriate;
(c) Could/should they have been introduced earlier, eg after the death of Adam Strain in 1995.

10. The Inquiry will consider whether the said guidelines introduced in 2002 have been followed and it will also inquire into the whether a sufficient mechanism exists for ensuring that they are followed.

11. The Inquiry will consider what procedures, if any, have been in place during the last 20 years for the reporting of untoward deaths in hospitals in Northern Ireland:

    (a) By the hospital concerned to the Department of Health;
    (b) By the hospital concerned to other hospitals so that lessons may be learned.

12. The Inquiry will consider what procedures are in place within the Department of Health, Social Services and Public Safety for the monitoring of untoward deaths in hospitals in Northern Ireland and the dissemination of information/lessons learned from such deaths:

    (a) To hospitals in Northern Ireland;
    (b) To the Health Service in Northern Ireland;
    (c) Beyond Northern Ireland.

13. The Inquiry will consider the extent to which the need for improvements in record keeping and improvements in communication with the families of ill patients as highlighted at the inquests of Adam Strain, Lucy Crawford and Raychel Ferguson have been recognised and addressed within the Health Service in Northern Ireland.