Press Release

The Inquiry into Hyponatraemia-related Deaths

Issued 30th January 2018

For immediate use

The report of the Inquiry into Hyponatraemia related Deaths will be published on 31st January 2018

The Chairman, Sir John O'Hara will deliver a statement at 12 noon at the Crowne Plaza Hotel, 117 Milltown Road, Shaw's Bridge, Belfast BT8 7XP

NOTES TO EDITORS

Arrangements for 31 January 2017

1. The launch event to publish the Inquiry report will take place at 12 noon on Wednesday 31st January 2017 in the Crowne Plaza Hotel, 117 Milltown Road, Shaws Bridge, Belfast BT8 7XP

2. Members of the media are being permitted on the morning of publication, prior to the commencement of the Chairman's statement to have advance sight of the report under strictly controlled conditions and will be required to sign a Declaration.

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GENERAL BACKGROUND

1. The Inquiry into Hyponatraemia-related Deaths was established under the Health and Personal Social Services (Northern Ireland) Order 1972, by virtue of the powers conferred on the Department by Article 54 and Schedule 8 and it continues pursuant to the Inquiries Act 2005.

2. It was established in November 2004 by the then Minister for Health in Northern Ireland, Angela Smith MP. Her decision was made against the background of concern and publicity about the treatment in local hospitals of three children who had died in circumstances where hyponatraemia had caused or was a major factor in their deaths.

3. Hyponatraemia is a condition in which the concentration of sodium in the blood falls below safe levels. It can result from excessive sodium losses, caused for example by vomiting, or can arise in a number of different ways. One variant is dilutional hyponatraemia in which excess fluid in the system reduces sodium levels by dilution. The less sodium in the excess fluid, the greater the dilution. Excess fluid can be introduced by excessive intravenous infusion or can result from excess water retention, or a combination of both.

4. The original Terms of Reference for the Inquiry as published by Angela Smith (then Minister with responsibility for the Department of Health, Social Services and Public Safety) on 1st November 2004 were told an Inquiry into 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.

iii. The communications with and explanations given to, the respective families and others by the relevant authorities. The original terms of reference are available on the Inquiry website:-

http://www.ihrdni.org/terms_of_reference.htm#terms_of_reference-Anchor

5. The work of the Inquiry was stayed in 2005 to permit investigations by the Police Service of Northern Ireland ('PSNI'). Ultimately, the Public Prosecutions Service for Northern Ireland determined that there should be no criminal prosecutions and therefore the way was clear for the Inquiry to resume its work.

6. At a progress hearing on 30th May 2008 the Chairman announced that the work of the Inquiry was to be expanded to include the case of Claire Roberts and certain aspects surrounding the death of Conor Mitchell.

7. In May 2008 Mr & Mrs. Crawford requested that the Minister withdraw Lucy's case from the scope of the Inquiry. Following consultation, the Chairman decided that the terms of reference still required investigation into the aftermath of Lucy's death such as the failure to identify the correct cause of death and the alleged Sperrin Lakeland cover up because they contributed, arguably, to the death of Raychel in Altnagelvin. The terms of reference were revised by the Minister in November 2008 to reflect this change and are also available on the Inquiry website:-

   http://www.ihrdni.org/terms_of_reference.htm#rev_terms_of_reference

8. During the course of its investigations the Inquiry received 538 witness statements and more than 12,634 documents. The Inquiry heard evidence from 179 witnesses over 148 days of public hearings during which were held at the Courthouse in Banbridge.

All media requests for information should be directed to the

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