Press Release from the Inquiry into Hyponatraemia-related Deaths

Commencement of full public hearings

Date issued: 17th February 2012

The Inquiry into Hyponatraemia-related Deaths will open its public hearings at **10am** on **Monday, 20th February** in Banbridge Courthouse, Banbridge.

The Inquiry is examining the deaths of three children – Adam Strain, Raychel Ferguson and Claire Roberts. It is also investigating events following the death of Lucy Crawford and specific issues arising from the treatment of Conor Mitchell.

Proceedings will begin at 10am with opening remarks by the Inquiry's Chairman, John O'Hara QC. This will be followed by an opening address from Senior Counsel to the Inquiry, Monye Anyadike-Danes QC, which will set out the structure of the Inquiry and the main issues to be considered. Legal representatives for the main interested parties to the Inquiry will then be given an opportunity to make opening addresses if they wish.

The public hearings are scheduled to run until the end of November 2012. The Inquiry Chairman hopes to complete his report and present it to the Minister for Health by the summer of 2013. It is intended that the public hearings will focus on each case in question in chronological order, commencing with that of Adam Strain.

The Inquiry was established by the then Minister for Health in Northern Ireland, Angela Smith, in November 2004. It was suspended in 2005 in order to allow the PSNI to undertake investigations related to the three cases which the Inquiry was initially examining.

In 2008, the police indicated that their investigations were complete and the Public Prosecution Service directed that there would be no prosecutions. As a result, the Inquiry announced the resumption of its work at a Progress Hearing on 30th May 2008. The terms of reference were revised in November 2008.

The Inquiry oral hearings are open to the public. Details of them will be posted regularly on the Inquiry's website (www.ihrdni.org), and a full transcript of each day's proceedings will be available on the website the following day.

Please see information overleaf in the editors' notes.

Editors' notes:

1. The public hearings, commencing at 10am on 20th February, are public hearings and the media are welcome to attend. However, filming, photography and audio-recording will not be permitted in the Inquiry Chamber. Banbridge Courthouse is on Victoria Street, Banbridge, BT32 3DH.

2. The current schedule for the Inquiry's full public hearings is available at: http://www.ihrdni.org/inquiry_hearing_schedule_-_18-10-11.pdf

3. The Inquiry Chairman is John O'Hara QC.

4. The Inquiry is examining the deaths of three children – Adam Strain, Claire Roberts and Raychel Ferguson. It is also investigating events following the death of Lucy Crawford and specific issues arising from the treatment of Conor Mitchell.

    - Adam Strain died at the age of 4 years in the Royal Belfast Hospital for Sick Children on the 28th of November 1995;
    - Claire Roberts died at the age of 9 years on the 23rd of October 1996 at the Royal Belfast Hospital for Sick Children;
    - Lucy Crawford died at the age of 17 months in the Royal Belfast Hospital for Sick Children on 14th April 2000, after having been initially treated at the Erne Hospital, Enniskillen;
    - Raychel Ferguson died at the age of 9 years in the Royal Belfast Hospital for Sick Children on the 10th of June 2001, after having been initially treated in Altnagelvin Hospital;
    - Conor Mitchell died at the age of 15 years in the Royal Belfast Hospital for Sick Children on 12th May 2003, after having been initially treated at Craigavon Area Hospital.

5. The Inquiry's terms of reference are as follows:

    - to hold an Inquiry into the events surrounding and following the deaths of Adam Strain and Raychel Ferguson, with particular reference to:
        i. the care and treatment of Adam Strain 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 and Raychel Ferguson;
        iii. the communications with and explanations given to the respective families and others by the relevant authorities;
    - to report on the areas specifically identified above and, at the Chairman's discretion, examine and report on any other matters which arise in connection with the Inquiry;
    - to make such recommendations to the Department of Health, Social Services and Public Safety as the Chairman considers necessary and appropriate.

6. The Inquiry Chairman announced, in May 2008, his decision to include the death of Claire Roberts and investigation of specific issues arising from the treatment of Conor Mitchell. The Inquiry's investigation of issues involved in Conor's treatment will include an investigation into record-keeping with reference to the DHSSPS Guidelines on Hyponatraemia that had been issued by the time of his treatment, and their focus on proper fluid management. The Inquiry will also examine whether the fact that Conor was admitted to an adult ward rather than a children's ward was relevant to the issue of whether the Guidelines were adhered to.

7. Following the amendment of the Inquiry's Terms of Reference by the then Minister for Health in November 2008, to exclude any inquiry into the events surrounding and following the death of Lucy Crawford in 2000, the Chairman considered how the Terms of Reference would be interpreted in their new form. After consultation the Chairman decided:

> ".... the terms still permit and indeed require an investigation into the events which followed 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. This reflects the contention that had the circumstances of Lucy's death been identified correctly, and had lessons been learned from the way in which fluids were administered to her, defective fluid management would not have occurred so soon afterwards (only 14 months later) in Altnagelvin, a hospital within the same Western Health and Social Services Board area."

8. Further information, including details of the Inquiry's interpretation of its Terms of Reference, and additional matters being investigated by the Inquiry are available on the Inquiry's website at: www.ihrdni.org

9. Any media enquiries should be directed to the Inquiry's Press Officer, Liz Fawcett, on 028 9020 0811 or 0771 943 5662. Liz can also be contacted by E-mail at: liz@lizfawcettconsulting.com