Press Release from the Inquiry into Hyponatraemia-related Deaths

Revised schedule for public hearings

Date issued: 19th October 2011

The Chairman of the Inquiry into Hyponatraemia-related Deaths has announced that the Inquiry's first public hearing will now be held on 20th February, 2012. The Inquiry's initial full public hearing had been scheduled to take place on 7th November, 2011.

The Inquiry's Chairman, John O'Hara QC, commented:

"We greatly regret this delay, and offer our sincere apologies to the families and other parties involved in the Inquiry.

"We appreciate that the revised timetable will be a disappointment perhaps especially to those families who are anxious for the public hearings to proceed as soon as possible.

"However, new information about the first case we are investigating – that of Adam Strain – has come to light very recently and requires further examination.

"Chronologically, Adam's death is the earliest of those we are investigating and it is vital that we get the facts right in his case, if each of the cases we are examining is to be dealt with properly.

"I am determined that this Inquiry will be robust and thorough and believe that a relatively short delay, while regrettable, is essential if the Inquiry is to do its job properly."

The Chairman is now seeking authority from the Department of Health, Social Services and Public Safety on a revised completion date.

Editors' notes:

1. Adam Strain died at the age of 4 years in the Royal Belfast Hospital for Sick Children on the 28th of November 1995.

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

3. The Inquiry was established in November 2004 by the then Minister for Health in Northern Ireland, Angela Smith MP.

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

    1. 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;

    2. 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
    3. to make such recommendations to the Department of Health, Social Services and Public Safety as the Chairman considers necessary and appropriate.

5. With regard to point 2 above, the inquiry is now investigating the deaths of the following children:

    - Adam Strain, who died at the age of 4 years in the Royal Belfast Hospital for Sick Children on the 28th of November 1995;
    - Raychel Ferguson who died at the age of 10 years on the 10th of June 2001, again in the Royal, after having been treated in Altnagelvin Hospital;
    - Claire Roberts, who died at the age of 9 years on the 23rd of October 1996 at the Royal Belfast Hospital for Sick Children.

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 the issue of the treatment of children on adult wards.

7. Following the amendment of the Inquiry's Terms of Reference by the 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