Witness Statement Ref. No. 082/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Judith Hill

Title: Miss

Present position and department/employer:

Chief Executive Officer

Northern Ireland Hospice Care

Length of time in post: 3 months approx

Previous position and department/employer in 1995:

Chief Nursing Officer
Department of Health and Social services from September 1995,
previously Regional Director of Nursing South&West Regional Health Authority
\England

Previous position and department/employer in 2000:

Chief Nursing Officer

Department of Health, Social services and Public safety

Previous position and department/employer in 2001:

Chief Nursing Officer

Department of Health, Social services and Public safety

Membership of Professionals Bodies:

Nursing and Midwifery Council
Royal College of Nursing

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) For what period of time were you the Chief Nursing Officer? 9years 6 months September 1995 to end of February 2005

(ii) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?

Through media coverage arising I believe from the coroner's inquest into Lucy Crawford's death. Up to then I was not aware of the other 2 deaths but became aware through subsequent events during 2004.

(iii) Describe in detail the steps you took:
(1) to discover why the children died;
(2) why the DHSSPS was not made aware of the deaths at an earlier stage; and
(3) to ensure that lessons would be learned for the future.

Following the media coverage in relation to Lucy Crawford I spoke informally with Chief Medical Officer as to whether there were any nursing issues to be addressed. She felt the main issues related to medical practice and the handling of the enquiry by the local Health and Social services Trust

However I decided to ask a member of nursing officer team at the DHSSPS to review the education programmes for nurses in relation to IV fluids to ensure hyponatraemia was covered. The response was positive.

Particular areas of interest (Cont'd)

(iv) Give details of your colleagues within the DHSSPS with whom you discussed the steps to be taken in response to the deaths of Adam, Lucy and Raychel to include the reasons why and when they were contacted by you and the outcome of your discussions.

As above
The action related only to Lucy Crawford as I had not been aware of other incidents.
I cannot remember a Departmental Board discussion or corporate decision about what action to be taken until intense media coverage though Board minutes 004-019-236 record I was present when issue of Lucy Crawford's death was raised.
Work was done in DHSSPS to strengthen critical incident reporting mechanisms in summer of I believe 2004 but it could have been earlier. Nursing team contributed professional advice issues to the work.

(v) Explain the role and responsibility of the DHSSPS in the education/training of student nurses and nurses.

DHSSPS commissions pre registration education and in partnership with HPSS Boards and Trusts post-registration education and continuing professional development.
The budget for nursing education is held by the Director of Human Resources who convenes service level agreement meetings with education providers. The nursing officer on the Chief Nursing Officer
. (CNO) team advises and attends meetings. CNO chairs Education Strategy meeting which is a subcommittee of the Central Nursing Advisory Committee which advises DHSSPS on education developments.
DHSSPS is the sponsor Department for the Northern Ireland non departmental bodies who quality assure nursing education on behalf of the UK regulatory body for nursing.

(vi) Give details of any advice given by your Group in respect of changes to the education/teaching of student nurses and nurses in fluid management and record keeping as a result of lessons learned following the deaths of Adam, Lucy and Raychel.

Following the initial check no specific advice was given by the Nursing group about the content of education programmes in relation to fluid management for nurses as the training review was deemed satisfactory.
No specific advice was given by Nursing group on record keeping. Standards for records have been issued to the nursing profession by the regulatory body and the quality assurance processes for education check the standards are taught on programmes.
Work was done in DHSSPS to develop guidance in relation to record management though not specifically record keeping . One of the nursing officers was a member of the group drafting the guidance and contributed her professional advice and expertise.

Particular areas of interest (Cont'd)

(v) Give details of any discussions you had with colleagues both within the DHSSPS and outside in order to provide advice to nursing colleagues in fluid management.

As above I asked a member of the nursing team at DHSSPS to check programmes and report back which was done and we believed the issues were being adequately covered.

(vi) In your role as a member of the Departmental Board, explain what information you received or solicited about the procedures, investigations and events that followed the deaths of Adam, Lucy and Raychel

As Above I spoke with Chief Medical Officer in relation to Lucy Crawford. She mentioned that guidance had been produced earlier following a previous incident. To my knowledge members of DHSSPS nursing team had not been involved in producing that guidance.

As above following media coverage in relation to Lucy Crawford I was present at the Board discussions as minuted 004-019-236 and 004-020-238

(vii) Again in your role as a member of the Departmental Board, explain what steps you took to discover why the children died and to ensure that any lessons would be learned.

Other than above I personally did not take any further steps. Issue was handled I believe by others in DHSSPS.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports

[Please attach additional sheets if more space is required]

Subsequent to Lucy Crawford's death in 2004. I became aware informally of concerns about the nursing team on the ward which was very stressed by the ongoing media coverage leading to sickness and reduced nursing levels The issue was discussed between Permanent Secretary, Chief Medical Officer and Director of secondary care. Medical officer and Children's Nursing adviser from the DHSSPS visited the trust and reported back with some advice regarding leadership for the team and the environment of care to safeguard the care of the children. I rang the Director of Nursing/Acute services of the trust and subsequently wrote outlining a number of issues and offered Children's Nursing adviser support if required. The offer as such was not taken up but the nurse adviser kept in touch informally through her children's nursing network and reported issues were being addressed.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: G E Hill **Dated:** 06/07/05