

**RESTRICTED**

Form MG11(T)

Page 1 of 5

**WITNESS STATEMENT**

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: HALLMANN, SHIRLEY SANDRA

Age if under 18: OVER 18 (if over 18 insert 'over 18') Occupation: STAFF NURSE

This statement (consisting of 7 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: Shirley Hallmann

Date: 28/07/2003

I am the above named person and I live at the address overleaf. I qualified as a State Registered Nurse in 1971 and as a Midwife 1972. I have worked in the USA for seven years as a Nurse and in various hospitals in Portsmouth and Southampton since 1989.

In January 1998 I went to work at the Gosport War Memorial Hospital as a Senior Staff Nurse, a Grade F. This was a promotion for me and the first time I had worked on a long term care ward for the elderly. I had previously worked on an elderly rehab ward at Moorgreen Hospital. I was used to working with elderly people.

The only ward I worked on at the GWMH was Dryad Ward. The Ward Sister was Sister HAMBLIN and our Medical Assistant was Dr. BARTON. Dr. LORD was the Consultant until she was replaced by Dr. REID.

As the Senior Staff Nurse I would run the ward when Gill HAMBLIN was not about. I was also meant to be second in command of the ward however, things did not work out. I found out early on that Gill HAMBLIN did not want a deputy and was against having an 'F' Grade. This meant I was given very little responsibility from the outset.

When I first arrived at Dryad Ward I was impressed with the level of general patient care. The patients were well cared for, they were always clean, including hair and nails, the Ward was clean and nurses gave great attention to making sure that the patients ate properly. This was due to the way Gill HAMBLIN ran the ward. She was an excellent nurse with regards to general patient care, she ensured that staff under her kept up those standards. She was very much an old

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Signature Witnessed by:

2004(1)

**RESTRICTED**

Continuation of Statement of: HALLMANN, SHIRLEY SANDRA

Form MG11(T)(CONT)

Page 2 of 5

fashioned Sister like the matrons of years ago, her word was law.

Against this she was not a person who could be approached or questioned. I knew that Gill had been at of the hospital a long time and she seemed stuck in a time gone by. It was therefore extremely difficult to introduce new ideas and methods.

I had not been at the hospital very long when I began having concerns about the use of syringe drivers . A syringe driver was meant to give pain management over a 24 hr period.

Syringe drivers were for the terminally ill who were in a lot of pain and or distress. On Dryad Ward we would use Diamorphine and Medazolan in the driver. After these drugs were prescribed and the syringe driver used I never saw anyone come off the driver alive.

There were times when it was appropriate to use Diamorphine and or Medazolan and as a Nurse on an elder care ward you accept some people are going to die. I thought it was important when people died that they do so in comfort without pain or distress. I wish to make it quite clear that I am not anti the syringe driver, my concern is that at the GWMH the drivers were used too early before other methods of pain control had been tried.

As soon as a patient came into Dryad Ward Dr. BARTON would speak with the patient and then write up their regular medication. She would also authorise the use of a syringe driver as and when it was required. She is the only Doctor I have known to do this. It meant the authority was in place and the decision whether to use a driver or not was now with the trained nurses. In reality this meant Gill HAMBLIN. Gill HAMBLIN was not in the practice of consulting with other staff to find out if a patient was in pain. Her management style was autocratic, but I think she made her judgements in the belief that she knew all the relevant information and what was best for the patient.

Gill HAMBLIN and Dr. BARTON were very close. When Dr. BARTON did her early morning rounds she was accompanied by Gill HAMBLIN. A lot of the decisions about patient care were made between Gill HAMBLIN and Dr. BARTON during these early morning rounds. In my

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**RESTRICTED**

Continuation of Statement of: HALLMANN, SHIRLEY SANDRA

Form MG11(T)(CONT)  
Page 3 of 5

opinion Dr. BARTON was very trusting of Gill HAMBLIN. Dr. BARTON would not question Gill HAMBLIN'S views.

On the occasions I undertook rounds with Dr. BARTON, I would say a patient did not need a driver. Dr. BARTON would question me and say she would try another method of pain control but she would possibly use a syringe driver later. I recall on one occasion after I had done a round with Dr. BARTON and we had not used a driver on a patient, seeing that patient on a driver the following day. This was after Gill HAMBLIN had done a round with Dr. BARTON. I asked Gill why the patient was on the driver and she simply replied, "Because". I did not feel that this was a satisfactory answer.

I am unable to recall any names of patients who went on drivers who in my opinion other forms of pain management should have been tried before. As time passed my professional relationship with Gill HAMBLIN deteriorated. Gill would ignore me and slam things down in front of me. She would do this in front of other staff. We didn't talk and this was not good for the ward in general. Dr. BARTON remained civil and kept a very professional attitude.

In 1999 Gill HAMBLIN had four months off sick. During this time I ran the ward. I introduced several new measures including clinical supervision, regular assessments for the staff, investors in people and for the potential for student nurses to join us. I would listen to staff about concerns and or problems. Although I have no evidence to prove this I believe that on the ward the use of syringe drivers was less common.

Gill HAMBLIN returned to work and things went from bad to worse between us. I had gained access to Gill's desk and had found some money that had been donated to the ward. This was not a case of theft, just poor management by Gill. However, she was cross with me because I had been in the desk. Not long after Gill had returned I was sent to the QA Hospital to help with the Staff crisis. I was asked and agreed to do this.

When I returned to the GWMH, Barbara ROBINSON told me I had upset Dr. BARTON, but I was not say anything to Dr. BARTON. Nor would Barbara give a reason as to why I had upset

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Continuation of Statement of: HALLMANN, SHIRLEY SANDRA

Form MG11(T)(CONT)  
Page 4 of 5

Dr. BARTON. I spoke to Dr. BARTON and said, "I believe I have upset you and I am sorry if I have". I didn't know what I was saying sorry for but I thought it provoke some discussion. Dr. BARTON said, "It's not that, but you just don't understand what we do here". I took this to mean the syringe drivers.

A post was available at the QA on a lower grade than the one I held at the GWMH. It seemed to me that both Gill HAMBLIN and Dr. BARTON were putting me under pressure to take this post. In the end I made a complaint about both of them on the basis of harassment. Gill would not speak to me after this. However, Dr. BARTON remained professional at all times.

The complaint process is well documented and I hold papers that relate to it. This can be produced if required. The upshot was that I left the hospital on a lower grade.

With regard to the use of syringe drivers I have spent the last three years working at Jubilee House where we deal with palliative care issues. In my opinion patients at GWMH were put on syringe drivers too early and on too high a dose of either Diamorphine or Medazolan.

A practice was in place at the GWMH, which was there because of Gill HAMBLIN and Dr. BARTON to put patients on syringe drivers. I believe both women believed they were doing the best for each and every patient. I do not believe that they ever intended to harm or kill any patient.

In my opinion Dr. BARTON was responsible for the high dosages given to the patients. Her actions were ill thought out and could have lead to the premature death of a patient. Other GP's in Dr. BARTON's did not prescribe such large doses. I do believe that other medical staff should have mentioned what was happening. I shared my concerns with other 'E' grades at the ward who said it had been going on so long it was useless to argue. I also spoke with Barbara ROBINSON the Hospital Manager and briefly told me of my concerns. Barbara said they were aware and they were being dealt with.

I have never spoken with the Police about the GWMH prior to today. I became aware of the

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Continuation of Statement of: HALLMANN, SHIRLEY SANDRA

Form MG11(T)(CONT)

Page 5 of 5

investigation via the local press. I did speak with CHI and expressed my concerns. I am aware that Dr. BARTON told management that I worked to my own agenda and that changes to treatment routines particularly relating to opiate administration would happen on shifts when I was not working.

I left the GWMH in September 2000. I wish I had expressed my concerns earlier but I did not feel I had the expertise to question a Sister and a Doctor.

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