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Hallmann R37

MG11(T)

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 6 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: S HALLMANN Date: 01/02/2006

I am Shirley Sandra HALLMANN and I live at an address known to Hampshire Police.

I am employed as a Grade E Nurse at Jubilee House, Cosham, Hampshire.

I trained at St Mary's Hospital, Portsmouth between 1968 and 1971, qualifying as a State Registered Nurse, (SRN) and my number is 439846. Between 1971 and 1972 I extended my training to midwifery in Edinburgh, Scotland, qualifying as a State Certified Midwife, (SCM), and my registration number is Code A

I returned to St Mary's, Portsmouth, Hants until 1973 when I emigrated to the United States of America, working for a year in intensive care in Forth Worth.

Between 1976 and 1980 I was employed in the State of Iowa working in obstetrics and minor surgery.

I returned to Britain in 1980 and was employed at St Mary's Hospital, Portsmouth, Hants on the medical ward as a Staff Nurse, working night shift going on for a year as a Midwife at Blackbrook.

As a result of a back injury I was not employed between 1982 and 1988.

I restarted work in 1988 as a Staff Nurse in the Eye Dept at the Queen Alexandra Hospital, Cosham, Hants for a period of six months, returning to St Mary's where I worked in

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gynaecology.

Between 1991 and 1996 I was employed as a Staff Nurse at the Royal South Hants Hospital, Southampton during which time I worked in acute medicine.

Between 1996 and 1998 I worked in patient rehabilitation in Moorgreen Hospital, Southampton.

In January 1998 I commenced work as an F Grade Staff Nurse at the Gosport War Memorial Hospital, Gosport, Hants .

In 2000 I started work as an E grade nurse at Jubilee House, Cosham, working in palliative and continuing care.

Whilst I was employed as a Grade F Staff Nurse at GWMH I was Deputy Manager of Dryad Ward, my then line manager being Gill HAMBLIN. When Gill HAMBLIN was on duty I would revert to the responsibilities of a E grade nurse. As such I would have care of the patients in an oversee role.

As Deputy Manager I would have responsibility of the ward when the manager was not there. The role of Deputy Manager requires an F Grade.

Gill HAMBLIN did not want me as a Deputy and did not make me feel welcome. There was tension between us because of this. On one occasion when she was off sick I spoke with Barbara ROBINSON , then Hospital Manager who said she also had problems with Gill.

Whilst working on the ward I had concerns. I did not feel that the patients always had a chance to see if alternative medication would work for them before the decision to start a syringe driver was made. I expressed my concerns to Gill HAMBLIN and on one occasion to Dr BARTON . Before this I had mentioned my misgivings to other members of staff, Freda SHAW , Lyn BARRETT and Sharon RING (E Grade) as well as Barbara ROBINSON. They all felt the same way as to how some patients were put on to Diamorphine, an opiate, and Midazolam , a

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sedative drug.

I am aware of the Analgesic Ladder. This is a method whereby you assess the pain level of a patient. The process is set by using the lowest amount and least powerful drug, increased on a scale until the patient is comfortable. This is set by the Doctor, in this case Dr BARTON.

I remember one patient, a lady who came to us from another hospital with a fractured femur. She was elderly and complained of pain in her leg. I recall that she occupied a single room next to the psychiatric ward. Dr BARTON put this lady straight on to Diamorphine. This is not usual. I cannot remember if the drug was administered by injection or syringe driver. Dr REID came in one day to do a ward round, which he did monthly, shortly after the lady was admitted to our ward and said she was with us for rehabilitation. She complained about the pain in her leg. Dr REID got her onto a walking frame and she walked with the assistance of this. He took her off Diamorphine straight away. The lady was discharged some months later to a nursing home.

I wrote my concerns privately at home and have given the Police my personal papers. I also spoke to my mother, Joan McILROY at the time. I felt if I went over the appropriate channels at work I would be discredited.

When I asked Gill HAMBLIN why we were going on to syringe drivers directly, she never gave me a satisfactory answer.

On another occasion when I asked her she replied, "I hope when you die, you die in pain". She told me that Dr BARTON was upset with me. I went to Dr BARTON and apologised if I had offended her in any way. She replied, "It's not that. You don't understand what we do here".

I had been trained in the use of syringe drivers when I worked in the acute trust in Southampton Royal South Hants Hospital.

I was certified to administer drugs intravenously but there was no need for this on Dryad Ward,

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GWMH. Syringe drivers are subcutaneous, i.e. under the skin.

A syringe driver is a battery driven device to which a syringe is placed, having been loaded with the drugs as per the doctor's instructions to enable a mean level of comfort for the patient. The plunger regulates the administration of drugs over a twenty four hour period. It is placed in an area where the patient is least likely to remove it by movement of the body or by other means. This may be the abdomen, upper chest or back.

I have been asked what is meant by the term, named nurse. This is the nurse who is named on the patient's notes who is responsible for that patient's case. On Dryad Ward 'lip service' was paid to this. In effect if HAMBLIN or the doctor was on they would decide what would be done with the patient, e.g. if they could get up or have to stay in bed etc. The carers on the ward would answer to a patients minor needs and make sure they were kept comfortable; the more serious issues were undertaken by the named nurse.

In other hospitals I had worked in the Grade E Nurse would go round the patients with the doctor on the rounds. On Dryad Ward the rounds were conducted Monday to Friday. Dr BARTON would come in about 0720 hrs then HAMBLIN would come in about 0730 hrs and they would do the rounds. If HAMBLIN was off then I or another Staff Nurse would deputise for HAMBLIN. This was not normal practice.

The rounds were a brief walk around when the patients were spoken to (if capable) regarding their problems.

Any entries in the patient's notes were done at the time however, if it was very busy they would be completed by the end of the shift in order to complete handover to the next shift.

I worked 0730-1615 hrs or 1200-2030 hrs with a half hour break on the latter shift.

There term ANC means all nursing care and is used

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The term TLC of course means tender loving care and was used

The term "I am happy for staff to verify death" was used

I have been asked to detail my involvement in the care and treatment of Geoffrey PACKMAN , from memory and referral to his medical notes (Exhibit Reference BJC/34) I can state that on page 55 of the notes dated 1/9/99 at 1350, I have written,

"No breath sounds
No heart rate auscultated
No radial pulse felt
Pupils fixed and dilated
RIP. Death verified"
I have signed that entry S HALLMANN.

I have further written,

"Son notified. Rev M SHERWIN to notify Mrs PACKMAN"
I have signed that entry S HALLMANN.

This entry refers to the death of Mr PACKMAN. Death can be verified by a trained nurse.

On page 62 of the notes dated 23/8/99 which is a summary of significant events form, I have written,

"Admitted from Anne Ward following an episode of immobility and sacral sores. Catheterised. On profile bed, hoist only.

Mrs PACKMAN is awaiting a decision re = Mastectomy at QAH tomorrow". I have signed this entry S HALLMANN.

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This entry is an admission summary and indicates that I was the nurse who admitted the patient. I was not the named nurse for this patient however at that time I was an F grade nurse.

Also on page 62 of the notes, at 1900 hours on 26/8/99 I have written,

"Dr BARTON here. For Oramorph 4 hourly. Wife seen by Dr BARTON, explained Mr PACKMAN's condition and medication used"
I have signed this entry S HALLMANN.

I can cross refer this entry to one at page 172 of the notes which is a prescription chart for the patient.

This shows an entry for Oramorph 10mgs in 5 mls. The dose which has been written up by Dr BARTON which I can identify through her signature and writing shows a variable dose every 4 hours. The route is shown as oral and 10mgs were given on 27th, August 1999 at 0600 hrs, 1000hrs, 1400 hrs, 1800 hrs also given by me and 20mgs at 2200 hrs. The dose was always increased at night so that the patient could have a good nights sleep, without disturbance. 10mgs were also given on 28/8/99 at 0600hrs, 1000 hrs, 1400 hrs given by me, 1800 hrs given by me and 20mgs at 2200hrs. On 29/8/99 10mgs was given at 0600 hrs, 1000 hrs, 1400 hrs given by me, and 1800 hrs and 20mgs given at 2200. The only dose given on 26/8/99 was at 2200 hrs when 20 mgs was given. On 30/8/99 10mgs was given at 0600 and 1000 hrs only.

I also cross reference this to the Dryad Ward Controlled Drugs Record Book (Exhibit Reference JP/CDRB/24) pages 54, 55 and 59.

On page 64 of the notes which is a summary of significant events, dated 1/9/99 I have written,

"Dr REID here". The rest of the entry that follows has been crossed through with ERROR initialled by me as SH (Mr PACKMAN off ward. To discuss discharge plans with Mrs PACKMAN, OT and Physio signed by me S HALLMANN)

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I have further written,

"To continue" signed by me S HALLMANN.

Also on pages 64 and 65 of the notes, dated 3/9/99 at 1350 I have written,

"Mr PACKMAN examined:-

No breath sounds

Pupils fixed and dilated

No heart rate auscultated

No radial pulse felt

RIP Dr Notified

Rev Margaret SHERWIN will notify Mrs PACKMAN of husbands death

Son notified. Unable to contact daughter or brother" I have signed this entry S. HALLMANN.

On page 63 of the notes which is a summary of significant events dated 28/8/99, I have written,

"Remains very poorly- No appetite has refused all food. Wife visited- Very distressed as she is having surgery this coming week- QA Thurs." I have signed this entry S HALLMANN.

I do remember this man, he had dreadful pressure sores. I believe he had been stuck on the toilet and the sores were in the shape of the toilet seat. The sores were yellow and pussy. It was extremely difficult to dress these sores which were the worst I have ever seen.