WITNESS STATEMENT

Criminal Procedure Rules, r27.2; Criminal Justice Act 1967, s.9; Magistrates' Courts Act 1980, s.5b

Statement of: GRIFFITHS, YVONNE

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

This statement (consisting of 3 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 in it anything which I know to be false, or do not believe to be true.

Signature: Y GRIFFITHS Date: 11/06/2019

Tick if witness evidence is visually recorded ☐ (*supply witness details on rear*)

I am the above named person and I reside at the address overleaf.

Further to the previous statements that I gave in relation to the investigation in to the Neonatal Unit at the Countess of Chester Hospital I would like to add the following:

On Tuesday 11th June 2011 DC Booth conducted a witness interview with me and asked me whether I recall a policy or decision not to give the same nurse a poorly/ very poorly baby for more than one night as this would put the nurse under too much pressure/ stress. Historically we have always liked to allocate the same nurse to the same baby over two long days or three night shifts for continuity.

Usually the shift leader on the shift before decides who is allocated to which baby. So for example, the shift leader on days would decide which nurse to allocate to which baby on the night shift that night. Obviously the nurse would have to hold the right qualifications for the acuity of the baby. The most poorly babies in ITU would be allocated to a Band 6 Nurse where ever possible. If this was not possible a Band 5 nurse who was trained in Qualification in Speciality (QIS) would be allocated the baby. This was previously known as the ITU course.

If the Ward Manager at the time, Eirian Powell, or I felt a nurse had a particular bad run, i.e. a particularly demanding/ poorly baby we might decide that nurse should be given a lighter work load i.e. a less demanding baby. In those circumstances we would mention it to the team leader that the nurse may need a break and that they should be allocated a different baby.

Usually Eirian and I did not know or review which nurse was allocated to which babies. This was a job for the Team leader to sort out.

In October 2015 I think the medical staff had already raised questions / had suspicions in relation to Lucy Letby's involvement in the collapse and or death of a number of babies in the Neonatal Unit. Doctor Brearey in particular had expressed concerns. I however did not have any concerns about Lucy at that stage and as far as I know nor did the other nurses.

I cannot remember having a specific conversation with Nurse T in relation to whether Lucy should be allocated to baby, Child I, for a third night shift on 14th October 2015.

I have looked at the staff rota for that day/ night and can confirm that Nurse T was on a long day, I was working a late and Lucy was due to work her third night that evening.

I have also looked at Child I medical records on the Badger system. On 12th October Child I Child I was in one of the outer nurseries. She was demanding and tolerating 4 hourly feeds. She was a baby that had been extremely premature. During the early hours of the morning on 13th October 2015 Child I was in one of the Special Care Nurseries and was being looked after by Irrelevant & Sensitive in a normal cot. I&S was a brand new, junior nurse. During the early hours on 13th October 2015 I&S went on her break and she asked Lucy to keep an eye on Child I during this time.

At approximately 03:20 on 13th October 2015 Nurse Lucy Letby found Child I to be pale and her aponea alarm had not sounded. Child I was given Neopuff and it was noted that at 3:30 she had no heart rate. Child I did not have an IV line at the time. Child I was given adrenaline and later a blood transfusion. Due to the fact that she had deteriorated her level of care was upgraded to High Dependency so she was then given to Lucy Letby to look after.

On the night shift of 13th October in to 14th October 2015 Lucy was the allocated nurse for Child I again. Child I had been moved to Nursery one by this time. Lucy was more than capable and fully trained in looking after babies in ITU. She was very competent, meticulous and always attended any necessary training or study days. She was not as experienced as the Band six nurses but she ticked all the boxes. At 05:00hrs on 14th October 2015 Child I had a desaturation and gradually declined. She was intubated at 07:00hrs and resussitation was commenced. Child I recovered but remained intubated.

I think that during 14th October 2015 Doctor Brearley may have commented to me not to give Lucy Child I again for a third night. I cannot remember any specific conversation or decision in relation to this, I am just speculating regarding anything Dr Brearey said. I think he was suspicious of her as she had been present when several babies had collapsed.

I think I agreed that I would tell the team leader not to allocate Child I to Lucy for the third night. I did not personally suspect that Lucy had caused any baby to collapse or come to harm but I thought at least she