Witness Name: Mary Griffith
Statement No.: 1
Exhibits: 0
Dated: 06.06 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF MARY GRIFFITH

I, Mary Griffith, will say as follows: -

Nursing career and employment at the Countess of Chester Hospital

1. I trained and qualified from Great Ormond Street Children's Hospital in 1975 as a State Registered Nurse (SRN) and Registered Sick Children's Nurse (RSCN). My husband's job took us to Plymouth where I worked as a staff nurse on the children's plastic surgery ward. In 1977 we moved to Chester, where I was a Staff Nurse on the special care baby unit at West Cheshire Hospital. I then got a position as Ward Sister on the children's surgery ward at Chester Royal Infirmary. I left in 1979 **I&S** **I&S** In 2007, I went back to work as a band 5 on the Neonatal Unit (NNU) nurses bank at the Countess of Chester Hospital (COCH). In 2008 I was contracted as a band 5 on the NNU at the countess of Chester hospital, where I worked part time until my retirement in 2016.

2. As a part time band 5 staff member working on the NNU, I was a staff nurse with nursing responsibilities. Day to day, I saw to observations, cares, feeds and any medication ordered for the babies in my care. I helped with the general upkeep of the ward, cleaning equipment and stocking cupboards.

The culture and atmosphere on the NNU at the hospital in 2015-2016

3. I have been asked to describe the quality of the management, supervision and support of the nurses on the NNU between June 2015 and June 2016. I felt well supervised and supported whilst working on the NNU. Other staff members were approachable, and I felt I could discuss any queries or problems with no sense of inhibition.

4. In relation to the relationships between clinicians and managers, nurses, midwives and managers, and medical professionals at the hospital between June 2015 and June 2016, I was not aware of any problems between the stated groups that might have eroded my sense of being supported or prevented me seeking advice.

5. I have been asked if I had any concerns as to the safety of the babies on the NNU from June 2015 to 25 November 2015 (inclusive). I had no concerns and have no memory of discussions specifically about the safety of babies on the NNU during the period quoted.

Child J

6. I was designated nurse for Child J on several occasions prior to 26th of November 2015 and would have had a professional involvement with Child J's parents, encouraging them to help with the care of Child J and teaching any procedures needed, also updating them on the general condition of the baby, all this, during Child J's stay on the NNU.

7. Child J was born prematurely at Chester with gut complications, transferred to Alder Hey Hospital for surgery resulting in stomas. Child J was then returned to Chester NNU for ongoing care. On the night of 26th/ 27th November, a band 4 nurse was Child J"s designated nurse in nursery 4. I was working in nursery 2 and had no knowledge of Child J 's condition prior to hearing the alarm sound, indicating a drop in oxygen saturation. I went to nursery 4 to offer help, but the medical team arrived, so I returned to where I was working in nursery 2. Child J had a further desaturation and was brought to nursery 2 which was high dependency where I took over child J's care just after 5am. Child J could now have more detailed monitoring and closer observation. Child J had yet a further episode of oxygen desaturation at 7:40 am, was resuscitated and given antibiotics and anticonvulsant medication.

8. When child J arrived at nursery 2 the the band 4 nurse and I would have discussed Child J's deteriorations so that I had knowledge of what had occurred while child J was in nursery 4.
9. My shift was due to end at 8am. I was late leaving as I remember staying back to check the medications prescribed to Child J. I had no interaction with Child J's parents or knowledge of who or how deteriorations were explained to them as I was off shift. I had no further involvement with the care of Child J but child J seemed to

respond to treatment given, I would have gathered this information on my next shift. I cannot recall if there was a debrief concerning Child J's deteriorations on 27th November 2015 due to the passage of time, I would expect there would have been a debrief with medical and nursing staff involved. Being employed as a part time member of staff I may well not have been available.

10. I have no memories of any discussions regarding concerns as to the safety of babies on the NNU between 27 November 2015 and 8 April 2016 and neither did I have concerns regarding safety myself.

Child L and Child M

11. I was designated nurse for Child L and Child M on 9th April 2015, this meant I was the nurse in charge of their care including any treatments, feeds, observations and administration of any drugs prescribed. Prior to this day shift on 9th April, I was not involved with the babies or their parents. From looking at nursing notes on shift I knew that Child L and Child M were both in incubators in nursery 1. They were both being treated for jaundice by phototherapy lamps. Both were on regular blood checks for jaundice and blood sugars. Both babies were on tube feeds and observations.

12. Child L"s blood sugar at start of shift was low, so on doctors instructions, the rate of the 10% intravenous drip was increased. Blood sugars remained low, so a bolus was given on the doctor's instruction (a bolus is a single boost of medication). At 16.30 blood sugar was still low so the doctor ordered 12.5% dextrose. This was made up under a sterile procedure on unit. I was doing this procedure and Lucy Letby was my checker. Lucy checked with me that the equipment and fluids used were in date and seals not broken and concentrations and dosages were correct. At this point Child M's alarm went off, Lucy went to Child M and an emergency call was put out. A band 6 nurse took over from me and I went to help with Child M.
13. I did have concerns about Child L's blood sugar levels despite the increasing doses of IV dextrose but know that premature babies have problems regulating their blood sugars, consequently they require close monitoring.

14. In the run up to Child M's deterioration on 9 April 2016, Child M was being nursed in incubator receiving phototherapy for jaundice. Child M was on regular feeds and observations. At 12.15, I noticed Child M had a distended abdomen and increased work of breathing. I was sent to lunch at 12.30 and care taken over by another staff

nurse. She got aspirate from nasogastric tube so Child M was put nil by mouth and 10% intravenous drip rate increased. Child M settled at this time. Whilst seeing to Child L, as described above in my statement, Child M's alarm sounded and an emergency call put out. Child M was resuscitated and put on ventilator and care taken over by Lucy Letby. I have no record of the time this was.

15. I cannot remember if I had any discussions about the deterioration of Child M or Child L on 9 April shift. I was not involved in speaking with the parents during resuscitation, other members of staff were with them, I was part of the resuscitation team. I cannot recall any interactions with Child M and Child L's parents. I had no further care of Child L and Child M but believe they both recovered and went home. I have no knowledge if there was a debrief about Child L or Child M as I only worked part time. I expect there would have been a debrief.
16. I've been asked to consider to what extent did I consider Child M's deterioration to be unexpected. Premature babies for a variety of reasons can have difficulties maintaining their blod sugar and need close observation and support I considered Child M to have been a victim of this vulnerability.

Child O, Child P and Child R

17. I have been asked to provide an account of my involvement into the care of Child P and R. I never looked after any of these babies prior to 24 June 2016 or after this time. I cannot recall what the mood on the NNU was at the start of the shift, due to the passage of time. I didn't have any interactions with the parents of Child O, P and R. There would have been a debrief about Child P's death, but I cannot recall if there was one due to the passage of time.

Child Q

18. I have been asked to provide an account of my involvement into the care of Child Q. I was not the designated nurse for Child Q on 25 June but was working in the same nursery (nursery 2 high dependency) on 25th June 2016, 7:30am to 8pm. Due to the passage of time, I cannot recall what the mood on the NNU was at the start of the shift on 25th June 2016. I had looked after Child Q previously, before 25th June 2016, when I saw to Child Q's care and observations. I updated Child Q's parents on his condition and encouraged them to help with Child Q's care.

19. On 25th June 2016, Child Q was being nursed in an incubator, designated to nurse Lucy Letby. I cannot recall Child Q's condition. I would have had a general handover but not a specific handover regarding Child Q as I was not the designated nurse. I don't have a written record of the contents of the general handover.

20. Lucy Letby was seeing and caring for Child Q in an incubator. Our babies' incubators were at right angles and I was standing at right angles and had my back to Lucy, I was caring for another baby for whom I was the designated nurse. We were in the high dependency unit (nursery 2), so the nursery was not left without a member of staff present. Lucy left to see to a baby in nursery 1, I remained in the high dependency unit finishing off my baby's feed. Child Q's alarm sounded I turned round and I saw that baby Q needed help. I called the shift leader to help, made my baby safe and went to help with Child Q. Doctors arrived and I returned to the care of the baby in my charge. I cannot recall if I discussed Child Q's deterioration with anyone on 25th June shift. Child Q's parents were spoken to by the doctors, I had no interaction with the parents at this time. I was not Child Q's designated nurse so had no in-depth knowledge of baby Q's condition to consider if it was expected or unexpected. There would have been discussion between members of medical and nursing staff to debrief Child Q's deterioration but I have no memory of a debrief.

21. I cannot remember any concerns that I had from after 26 June 2016 about the NNU other than the NNU being extremely busy with more admissions than usual, many of them very sick babies.

Concerns or suspicions

22. I have been asked if I was given any training on how to report concerns about fellow members of staff. I had regular annual training days, ongoing equipment, policies and procedure training. I would have been aware of how to report concerns about fellow members of staff. I knew that concerns should be reported to the unit manager. I had no concerns or suspicions about the conduct of Lucy Letby while working on NNU. I did not know of any concerns until she was removed from clinical duties on the unit. There was no formal debrief about this, but we would have known as members of staff talked amongst themselves. All staff on NNU were concerned about the number

of deaths on the unit. but regarded this as being the consequence of the gravity of the babies' conditions and the increased number of admissions.

Reflections

23. I do not think there are any steps that could have been taken to identify earlier that any harm was being done to babies on the NNU with the resources in place. I have no expertise in the field of CCTV surveillance but can see it as a threat to patient privacy. I have been asked what recommendations I think the Inquiry should make to keep babies in NNU's safe from any criminal actions of staff. I think to increase staff numbers everywhere. During the period 2015 to 2016 on the NNU at COCH there was a lot of overtime worked, and shifts finishing very late.

24. I have no other documents relevant to the Inquiry and all my previous statements are correct to my knowledge and require no alterations.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: PD

Dated: 06.06.2024.