Witness Name: Veronika Jiraskova
Statement No: 1
Exhibits: VJ01
Dated: 06 September 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF VERONIKA JIRASKOVA

I, Veronika Jiraskova, will say as follows: -

1. My full name is Veronika Jiraskova.

2. I provide this statement in response to a request dated 6 June 2024 under Rule 9 of the Inquiry Rules 2006 ("the Rule 9 Request"). This statement is based on my personal recollection of events and a review of various documents, as referenced in this statement.

3. To assist the Inquiry to the best of my ability, I have addressed each question set out in the Rule 9 Request insofar as I am able to do so at this stage of the process.

Medical Career and employment at the Countess of Chester Hospital (the "hospital")

4. Please see my CV at **Exhibit VJ01.** This provides a short summary of my qualifications and medical career to date. **INQ0107983**

5. In 2015-2016, I was a GP Trainee (SHO) at the hospital. I am unable to recall the exact dates, but I think I worked in the paediatrics team between August 2015 - February 2016. I think I then worked in the Obstetrics / Gynaecology team between February 2016 - August 2016.

6. I then worked in the Geriatric Medicine team. I left the hospital in approximately June 2018 to work in a GP practice. I finished my GP training in April 2020 and have taken on various GP roles since. I am currently employed by the Countess of Chester as a GP working for Hospital at Home, alongside my other roles as per my CV at **Exhibit VJ01.**

The culture and atmosphere of the neonatal unit ("NNU") at the hospital in 2015-2016

7. In 2015 – 2016, I did not have a manager on the NNU as far as I can remember. I had a Clinical Supervisor – this was a female consultant whose name I have forgotten. She was responsible for technically overseeing my progress during my paediatric rotation.

8. In my statement to the police dated 3 July 2021 **[INQ0100870]** I stated:

"[f]rom my own personal view, I found that the unit did not feel like a team that was working in a cohesive way, with some doctors disliking others [and that] I did not enjoy my time on the unit."

9. The team spirit in general did not feel healthy. I can only speculate what impact on quality of work this could have had.

10. I have been asked to describe the relationships between: (i) clinicians and managers; (ii) nurses, midwives and managers; and (iii) medical professionals (doctors, nurses, midwives and others) at the hospital. As a junior doctor, I cannot remember seeing any managers, it was mainly doctors and nurses.

11. As stated above, the relationships were not healthy, people were talking behind one another's back and GP trainees were generally looked down at. There were some exceptions and the longer I was there, the better it felt as I got to know the people. Generally, I found the six months was somewhat traumatising. However, I was also going through personal issues in my life at that point, so my opinion may not be perfectly objective.

12. I do not feel it is fair for me to judge whether the quality of relationships on the NNU affected the quality of the care being given to the babies on the NNU. I spent very little time in the NNU and when I was there, I needed supervision as my competency was very limited. Due to the passage of time, I have forgotten many things. It was not a friendly

environment, and I did not like going there. In terms of how much the atmosphere affected the neonatal care, I do not know.

13. I was at the hospital from September 2015 for six months whilst I undertook my training:

    a. Compared to the other hospitals at which I worked during my training, the Countess of Chester was the worst place in terms of professional relationships I have ever worked in.

    b. In terms of the working relationships at the Countess of Chester compared to the equivalent relationships at the other hospitals I worked at during 2015 and 2016, most places had some degree of issues, but it has never been that bad anywhere else for me.

    c. I have been asked whether I had heard comments or reports on: (i) the quality of care; (ii) the quality of the management, supervision and/or support of doctors; or (iii) the nature of the relationships. These are fairly vague terms and I do not remember discussing these as issues at that time.

Whether suspicions should have been raised earlier and whether Lucy Letby ("Letby") should have been suspended earlier

14. I was not involved in any discussion with any local network of hospitals about adverse incidents and/or deaths of babies.

15. I first realised there was a problem when I moved to Obstetrics / Gynaecology and my Gynaecology colleagues told me that the NNU was closing or restricting taking new patients (I cannot remember exactly) due to increased neonatal mortality on their unit. I was told to keep this secret to not panic the public and expectant mothers.

16. I was not worried about the number of deaths on the NNU as I had no idea that there was an issue with increased neonatal death at the time I was there.

17. At my junior level, I did not get involved with how deaths on the NNU were investigated or when postmortems were requested.

18. I was completely unaware of the suspicions or concerns of others about the conduct of Letby. I found out about the allegations via the media.

Safeguarding of babies in hospitals

19. Safeguarding children training is compulsory training for every doctor.

20. I do not know if my professional body would assist me with safeguarding guidance or advice in the context of suspicion or abuse by a member of staff towards babies. In this situation, I would turn for help from my colleagues and my clinical directors.

21. I did not turn to any professional body for advice in respect of events at the hospital.

Reflections

22. I do not think if the babies had been monitored by CCTV the crimes of Letby could have been prevented, but I think it could help deliver justice. I did not see any concrete evidence of Lucy Letby committing these crimes, which is unsettling. I personally have great doubts that she has committed the crimes that she denies.

23. I do not know whether systems, including security systems relating to the monitoring of access to drugs and babies in NNUs, would have prevented deliberate harm being caused to the babies named on the indictment.

24. I have been asked what recommendations I think this Inquiry should make to keep babies in NNUs safe from any criminal actions of staff. I would review the evidence of the alleged crimes. If the evidence is clear and overwhelming, and the senior doctors were calling on the management to suspend Lucy Letby as it was stated in the press, then management needs to become accountable.

Any other matters

25. There is no other evidence which I am able to give from my knowledge and experience which is of relevance to the work of the Inquiry.

26. I consider my previous police statement to be accurate.

27. I have not given any interviews or otherwise made any public comments about the actions of Letby or the matters of investigation by the Inquiry.

Request for documents

28. I do not have any documents or other information which are potentially relevant to the Inquiry's Terms of Reference.

Statement of Truth

I believe that the facts stated in this witness statement are true to the best of my knowledge and belief. 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 of its truth.

Signed: PD

Dated: 06.09.2024 | 14:41:20 BST