The Sheku Bayoh Public Inquiry

Witness Statement

Dr Gillian Pickering

Taken by [redacted] at [redacted] A&E on Friday 10 December 2021 and on MS Teams on Wednesday 23 February 2022

Witness Details

1. My full name is Dr Gillian [redacted] Pickering. My date of birth is in 1982. I work as a Consultant in Emergency Medicine. My contact details are known to the Inquiry.

2. As a Consultant, I've been working in my current hospital for three and a bit years. As a trainee, I've been here since 2010, so eleven years in total. I was in Victoria Hospital, Kirkcaldy from February 2015 to the beginning of August 2015.

3. As my speciality is in Emergency Medicine, we do training as a higher speciality trainee. In Fife I was what you call a Registrar. In 2015 I was in my second year of being a Registrar so it's called an ST5, speciality training Year 5. I was at Victoria Hospital doing six months of emergency medicine training as part of my overall programme.

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4. In practice, past and present, I have treated patients in cardiac arrest. We could have up to three or four a week or we might not have any in a week. It probably averages out over the year as being one to two a week.

Sheku Bayoh

5. I remember the man who I now know to be Sheku Bayoh attending A&E with a cardiac arrest. He was black. He was a big build guy and he was tall. I had never seen him before. I now know who he is. We would have got his name from the police and logged his details into our computer. Also I remember his name from the news.

6. There are three things that make me remember this patient. I remember thinking at the time that the story given to us in A&E didn't quite make sense. I was told about a knife but I didn't see any knife wounds on him. This stuck in my mind.

7. What also stuck in my mind was that I didn't know what caused the cardiac arrest. He was a young man who suffered a cardiac arrest and died. As a trainee at this point I was interested in what caused this and what, if anything, could've been done differently. No one seemed to know what caused his cardiac arrest. Also the media coverage of his death meant that I was reminded of it afterwards.

8. I have viewed the A&E medical records for Sheku Bayoh (PIRC-01069).

9. My notes are at pages 7 and 10 of the pdf file. I remember recording this in writing on the day. I recognise my handwriting under "*Multidisciplinary Notes*" dated "*3/5/15*" at "*0900*" at page 7. 9am on 3 May 2015 is when I have written the notes. My signature is at the bottom of the notes at page 10. The notes on page 10 would not necessarily be chronological, but that's what happened. I don't remember if I recorded anything on a computer system at Fife but it

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would be just the same as this. It would be verbatim, I would just type up exactly what I had handwritten.

10. I remember the man came into A&E sometime in the middle of my time in Fife on a weekend. My shift was a Friday or Saturday night. From the A&E records at page 7 I see this was in the morning of 3 May 2015.

11. In Fife we did 12 and a half hour shifts. I was 8pm until 8am. We did handover at 8am and that could take until 8:30am. That was my shift on the night of 2 May 2015 to morning of 3 May 2015.

12. In the morning of 3 May 2015 the nurses did their changeover where the night nurses hand over to the day nurses at around 7am. I remember one of the nurses coming in to start her shift. She was plump with gingery, coppery hair, maybe slightly blond. She was short and in her fifties.

13. She turned up slightly flustered and saying that she had seen somebody wielding a knife outside on the corner near the hospital, on a straight bit of road. She said something like the person was wielding a knife and trying flag people down. She said that he looked like he might have been under the influence of drink or drugs.

14. The nurse said something like "I bet that person will come to us". I understood this to mean that in a situation where he gets hit by a car, or collapses, or stabs somebody else or himself with the knife, he will end up in A&E with us. This is something A&E practitioners might think of when we see any odd event.

Admission of Sheku Bayoh to A&E

15. I vividly remember when the man came into A&E. I remember because of what the nurse had said when she came in at the changeover. About 5

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minutes after the nurse told us about the man with the knife, the crash box went off. This is a pre-alert line that an ambulance crew can phone if they're bringing someone they want us to bring to our resuscitation room, we call it resus.

16. I can't recall exactly what they said over the crash box but I don't think they said it was a cardiac arrest. I think they said a collapsed male. I can't remember either way.

17. It was maybe 2 or 3 minutes after the call that he came into A&E. I remember because at around 7:30am I would be more aware of the time as I knew I need to hand over soon.

18. If the ambulance crew thinks somebody is sick enough and needs to come to resus, they'll put a call in, what we call a standby. Usually, you get 10 minutes. We got about 2 or 3 minutes for him because he wasn't far away. We all then had to get ready and go to the space that we want them to bring the patient.

19. The patient then came in. He was on a trolley from the ambulance. He had been seen by the ambulance crew and they brought him to resus. He came out the ambulance doors into resus and straight to me. He doesn't go to anywhere else.

20. Resus is a big bed area and I think it had 8 beds. If you're looking down resus he was put in the first right cubicle.

21. I positioned myself at the head end because I'm the senior on at night so I was at the head end. I was the decision-maker in the A&E at this time. I then allocated the juniors to their roles.

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22. Dr Sophie Rollings was a junior doctor I remember her being there. I can't remember the names of all others. So it was me, Rachel Anderson, Sophie Rollings and Surinder Panpher. From my previous statement PIRC-00118 I see that Fiona Gillies was also there, I don't remember Fiona being there but I'm sure the statement is accurate. Dr Rachel Anderson, Dr Surinder Panpher and Dr Fiona Gillies were not present when the patient arrived. They came on at 8am and the patient was already in resus.

23. I thought an ITU consultant came down at some point but I can't remember his name. I see in my previous statement PIRC-00118 on page 2 that I said "*Dr Susan Downie who was also present phoned for anaesthetics and Dr Martin Clark attended at Resus to take over the management of the airway.*" That will be correct, Dr Clark would have been the anaesthetist. I don't remember Susan Downie being there but from reading the statement she obviously was there.

24. There would have been probably another two nurses and I don't think there was any more.

25. I am still vaguely in contact with Sophie Rollings on Facebook. I work with Dr Rachel Anderson and Dr Fiona Gillies in my current role. I'm not in contact with any of the others.

Presenting complaint

26. With the ambulance crew, I was told by one of the paramedics that he was in respiratory arrest and they were bagging him but he had a cardiac output. I spoke to the paramedics in the cubicle in resus. We were waiting for them in resus. Bagging means putting on a mask over the patient's face with a clear plastic air bag, we call an Ambu bag, that we squeeze to push air into the patient's lungs to get oxygen into the patient. This is also called ventilating.

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27. You check for a pulse when they come in and then you check it again every two minutes as part of the algorithm. When he came in his pulse may have been checked by Sophie or one of the nurses. While the paramedics gave the story I was feeling for a pulse. There was no pulse so I told the others he's actually in cardiac arrest and to start CPR. He could have been in respiratory arrest with the crew and that's why they were bagging but he definitely had no pulse when he came into the resus room.

28. I've been shown my previous statement (PIRC-00118) at page 2 where I said "*I had checked his carotid neck artery and had found a pulse.*" I genuinely don't recall that. I do vividly remember us doing CPR very quickly. I suspect I felt it, looked to get the story, and then felt it again and noticed it had gone. If I had felt the pulse then I would've gone on to do other things and we obviously haven't done those.

29. I've been shown my previous statement to PIRC dated 14 May 2015 (PIRC-00118) and on page 2 in the first paragraph I state "*The message related to a young male cardiac arrest.*" Further down page 2 in the first paragraph I state "*At this time when radiod in he was in respiratory arrest but had come over the radio as a cardiac arrest which was wrong as he had a pulse when he came.*"

30. The radio is the same as the crash box. What I said previously must be true. He didn't have the pulse for long, that much I can tell you. My memory is that he was in cardiac arrest, and he was in cardiac arrest very quickly. It was less than a couple of minute and then he was in cardiac arrest. I can't remember who took the call.

31. I see in the A&E records at page 7 I've written *"In resus initially -> ventilated by a C-circuit -> pulse lost within two mins"*. I just don't remember him having a pulse initially but that will be true and accurate.

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32. I would have got the story of what happened to the patient from the paramedics, not the police.

33. I don't remember being told about pepper spray. I see in my notes in the A&E records I've written something about pepper spray at page 7: "*Pepper gas used…*". That will be what I was told at the time. I don't remember if I was told this by the police or one of the paramedics. I suspect it was one of the paramedics, I would only speak to the police if I want more information.

34. The rest of what I've written here as "*PC*" which means "presenting complaint" is what I've been told by the paramedics. I don't recall fully what I've been told but what I've written will be what they have verbalised to me. I've clearly been told the patient was found by the police with a knife and aggressive and attacked a police officer. Pepper gas was used and he was uncooperative and somehow he's been hit on the back of his head.

Assessment of the patient

35. As soon as a patient is handed over to me, I will start to reassess the patient from the beginning. We have a system, A, B, C, D, E. It's a very easy system for A&E doctors. Each letter is as follows: airway, breathing, circulation, disability, environment. We work our way through that from A to E.

36. I remember seeing a mark on his head but can't remember where. From the A&E records at page 10 I see that this was a mark above his left eyebrow. This is noted to be: "*Head – left forehead abrasion*". That will be correct.

37. My first impression was seeing a man who has been put in handcuffs by the police. I don't know why he was arrested or if he had been put in handcuffs for his own safety. His hands were handcuffed at the front, which is a bit unusual for me because I'm used to seeing them at the back if a person is handcuffed in A&E.

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38. The handcuffs are circular, two circle holes for the hands with a bit in the middle. There was a hole for a key to open them. They were normal silver metal handcuffs.

39. I didn't intubate him. I think I tried and then we phoned for anaesthetics or intensive care, whoever came down. I think they did intubate him and then I stepped back to run the arrest.

40. In the A&E records at page 10 I've written "*Intubated by anaesthetics (Con M Clark) -> 8.0 ETT -> c bougie*". That is Consultant Martin Clark. The size of the endotracheal tube (ETT) is 8mm in diameter. The note also says we used this with a bougie which is a plastic stick that you can put in through the cords and to feed the tube. So we couldn't just put the tube in straight away, we had to use a bougie to feed the tube in.

41. I've been shown my previous statement (PIRC-00118) at the top of the third paragraph of page 2 I state: "*I wanted to secure the airway so I looked via a laryngoscope to see if I could get a tube into his airway so I put in a -1- gel to allow me to ventilate better.*" This should be an "i-gel". It's a trade name. It's a plastic tubing that sits above the epiglottis but it doesn't go into the trachea. It doesn't go in and take over the airway but it sits there and allows us to give better oxygenation in a way.

LUCAS Machine

42. I've not recollection if he was on a LUCAS. I speculate that we probably did put one on but I just can't fully remember.

43. The AutoPulse or the LUCAS machine is for automatic CPR. Both of these machines are also called a Thumper in medical slang. We don't say that in

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front of the patients. Rather than us having to do CPR manually, it frees us up and it stops us getting exhausted from doing chest compressions.

44. A curved board goes behind the patient's back, a band goes across the chest and a big sucker device hits onto the chest. A suction thing makes contact with the chest and sucking onto the chest. It's loud and you can hear it from nearby. The patient's arms are moved out of the way.

45. It should connect in the middle of your breastbone, probably about 2 or 3 inches down from what we call the sternal notch, between the two collarbones. It's over the heart so you're wanting to do manual compressions of the heart. We use the machine to compress the chest and squeeze the heart so it's doing its job pumping blood.

46. It beats at probably 100 beats per minute. If we do manual CPR it's a bit different. We do 30 compressions and then two breaths, then 30 compressions and two breaths. So you do five cycles of that in two minutes before you stop and do a pulse check. Two breaths is two squeezes of the bag of air to oxygenate them. It's difficult to equate the LUCAS to manual CPR.

Restraints and CPR

47. The police don't usually say anything to us unless we ask them a question. I remember the police officer saying, "Do you want me to take the 'cuffs off?" when he saw us starting CPR. He looked quite shocked, like he didn't know what was going on. His eyebrows were raised and his eyes were wide. He was short with dark brown hair. I don't know his name. The police didn't say anything else to me throughout the morning.

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48. I remember I was asked if I wanted them to take the handcuffs off. There can sometimes be debate with police about taking these off in A&E. In this case the police didn't dispute with me at all and took them off.

49. Handcuffs would hinder CPR because if somebody small like me was standing over him on a stool doing CPR and his arm is in the way then my hand might not get full contact with the chest. You're doing compressions on the centre of the chest over the middle and over the sternum. If the hands are over the body, and they're a big person who has got big hands, you might not get your full hand in over the area you need to compress. Whereas if you've got things away from the chest, you've got full exposure and you're able to get proper, decent compressions. It doesn't stop you doing CPR completely but it can hinder it.

50. I have been shown my previous statement to PIRC on 15 June 2015 (PIRC-00119). On page 2 I said "*The male was lying on his back and was handcuffed. He did have a large chest and his arms were positioned lower on his stomach. This would not have impeded in any way attempts to perform CPR as this requires work on the sternum.*"

51. I think what I was saying in the statement was that they wouldn't have impeded CPR because they were off straight away. Had they stayed on then they would've been in the way. The CPR would not have been as good. If his hands were down towards his stomach then his upper arms would've been across the chest a bit and impeded CPR.

52. It would be very difficult to get IV access in the arms if the arms were 'cuffed. It's very difficult to get into that area. We usually go for the anterior cubital fossa, on the inside of your arm where the elbow bends. We usually go there in resus because the back of the hand is usually very shut down. If the person's in cardiac arrest, they're going to down in their extremities first, so

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the veins are not going to be easy to see. You want access quickly so you can start giving drugs.

53. I don't remember if he had leg restraints. If the legs are done then often they have a spit net and other things on as well because their behaviour's been wild and so on. I don't think he did but I would be lying if I said yes or no to that.

54. The leg restraints made no difference to what we were doing. The only thing we would want is to get access to the legs to check there's no injury. Also if we're struggling to get access up in the elbow for something in called an interosseous needle, which is putting a needle into the bone to be able to give drugs through the bone marrow, we would need access to the legs. That wasn't the case for this patient.

Fractured Ribs

55. You would expect to fracture some ribs from CPR and using the LUCAS. If you're doing proper CPR at the right pressure, you will usually crack ribs.

56. The ribs that would break are usually from rib 4 to 8. You've got rib 1 at the top and then you count down the chest. You've got 10 that are attached and then you've got 2 floating so you've got 12 in total. 4 to 8 are in the middle at the front.

57. It would not be common for rib 1 to fracture in the course of chest compressions. In CPR you're talking ribs 4, 5, 6 and further down. To break up at rib 1 you have to press higher up at the top. It's not inconceivable because you can't say in medicine that anything is absolute, apart from death. Realistically you can't say breaking rib 1 in CPR is not a possibility.

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58. I cannot recall ever seeing rib 1 break in CPR. If you've got an osteoporotic elderly person you could break further up just because of the impact, but I think it's less likely.

59. There are two reasons why positioning a LUCAS incorrectly would not be likely to break rib 1. The first is it's quite hard to get the LUCAS up to there because you've got a bit on the machine that goes around the back and has to click in around the body. This would prevent it being located high enough to break rib 1. Secondly I would be saying to the nurses if it was too high or too low when they are putting it on. There are quite a few people who'd be in a room who have enough experience of a LUCAS to know whether it's in the right place.

Diagnosis

60. For the assessment of cardiac arrest, there's a list of things that you would think about when someone comes in. He came in unconscious with not really any hint of what has caused him to arrest. I had a list of things in my head to think about.

61. The first thought is trauma because I could see there was a mark on his head. My thought was, to explain this as simply as I can, whether he had enough trauma on his brain causing pressure on his breathing and heart control centres, causing cardiac arrest.

62. I checked for trauma. The patient's head was the only site that I could see any injury. There was no other obvious trauma that we could see externally. This means checking for swelling or broken bones that could cause a loss of blood volume. There was no deformity that may have also caused this.

63. I then thought he may have taken drugs and ended up putting himself into an arrhythmia. Drugs can cause you to have seizures and potentially go into

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cardiac arrest if you're hypoxic for too long. Hypoxic means not getting enough oxygen.

64. If you have a seizure for too long a period of time, you cannot get enough oxygen to your brain. You have respiratory arrest and then a cardiac arrest. Drugs can cause your heart to go into different rhythms. It can then cause you to arrest as well.

65. I wondered if he might have taken an opioid overdose, heroin or a variation of heroin, and therefore I gave him a drug called naloxone to try and reverse that. That didn't really do anything. I don't remember how many times I gave it.

66. I've been shown my previous statement (PIRC-00118). At the top of page 3 in the first paragraph I stated: "*I may add when he first came in he was given Naloxone which would reverse any opioid he had taken such as methadone/heroin.*" I probably gave it more than once. In the A&E records at page 7 I see I've written "- *given naloxone 3.4 mg iv*". He's had quite a bit of naloxone from me. I must've tried quite a bit to see if it would help. "*iv*" means intravenously.

67. Often in these situations I give it more than once because it doesn't always work straight away and we're doing his circulation with CPR so it's going to be slow to effect the body compared to when the person is alive. There's not really any other drugs that I can give somebody in cardiac arrest to help with any possible drug overdose.

68. There are no blood checks for what the patient might have taken in that situation. The only thing we might do is if we can look up his notes and see if there's a past history of it. If there's a past history of it, then I'm more likely to know what drugs he usually uses and that gives me a bit more information on

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what I can potentially give him. If he is known to be a drug user I might've thought about blood borne diseases.

69. It wasn't difficult to get the patient IV. This means intravenous access. I don't recall that being an issue. The junior did get it fairly quickly. If somebody is a regular drug user and injects drugs regularly, their veins are not good and they'll often have marks on their groin and elsewhere from where they inject. There will also be marks on their knuckles and nothing in the back of their hands to use for IV access.

70. He didn't have that. I do not recall him having anything that made me think he was a regular IV drug user and we got his cannula in quite quickly.

71. In the A&E records at page 7 I've written: "*CPR commenced – iv access (R*) DH 16G*". This means we had IV access in the right dorsum hand, so he must have had good veins in the back of his hand. The DH16G is the size of the cannula. That's a grey cannula and quite big.

72. In the same page of the A&E records I've written "- *bloods*" which just means we've taken a blood sample from him. In the A&E records at page 10 I've written: "*(Rt) femoral A-line by Dr R Anderson (ST5) ABG x2*". This means a right femoral arterial line was put in by Rachel Anderson and she's taken two arterial blood gas samples.

73. Alcohol might cause cardiac arrest but not in this case. It can knock you unconscious and you might vomit, aspirate and then go into a cardiac arrest but that didn't look like that. He had no evidence of vomit that I could see so he may have had alcohol on board but I don't think that would have been the reason he arrested.

74. Another possible cause I considered was an underlying medical problem like cardiomyopathy, which is an enlarged heart. The patient may or may not

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know about this. The heart can go into dysarrthmias that sometimes people don't know until something bad happens.

75. Ultimately I don't know what caused the patient's cardiac arrest. My gut feeling at the end of the arrest was this is most likely to have been drug related. I knew no history of his background so if he has no history of drug use then I would think it wouldn't be drug related, but obviously I didn't know that at the time. I have to go with what's in front of me.

76. I had to think about all these possible causes because it was not a clear story of what happened before the patient came into A&E.

Race and sickle cell

77. Sheku Bayoh being a black man had no impact on the assessment or treatment. However the only thought I might have considered is that sickle cell could be a cause. Sickle cell is a hereditary disease that is in some black people.

78. It's when the blood cells have a sickle shape to them. You can either carry the gene with the sickle cell trait or you have sickle cell itself. It basically means that the body doesn't always carry oxygen as well as it could and, therefore, you can have crises. These crises can be bone crises because you've got occlusions because of the sickle cell sticking or you can have chest crises.

79. For it to apply in this case, Sheku Bayoh would need to have been unwell medically beforehand. He would need to have had a different presentation to what was reported to us. It would be a slow deterioration in his health. You would need something like chest pains for a time and become more unwell before going into cardiac arrest. It doesn't fit with this situation.

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80. I might have thought of sickle cell at the time but I don't know. I might have thought about it but it didn't fit the picture so it wouldn't have acted on it because he needed the cardiac arrest treatment. Sickle cell treatment wouldn't have helped him at that time. He was getting what he needed: oxygen and fluid. We had to get his heart restarted and then consider other treatments.

Treatment

81. It's only from reading my notes in the A&E records that I'm remembering anything to do with what happened with the running of the arrest because it's hard to remember all these things and, from my notes, he obviously went into a rhythm that we could shock him, so we did that.

82. For treatment we follow an algorithm. There are certain drugs we give, and when the patient was in ventricular fibrillation we apply electric shock. VF means there is no pulse but the heart has a rhythm that can get an electric shock.

83. Our cardiac arrest algorithm is CPR for two minutes and then do a rhythm check. This is repeated. Each time you do a rhythm check, you're looking to see, first of all, if there's a pulse, so if you got what we call return of spontaneous circulation, or you're looking to see what the rhythm is on our machine. We had pads on his chest so we're looking to see what the rhythm might be.

84. On three occasions his rhythm was VF. We then gave three shocks so we're looking at the rhythm and we're also looking for whether it's a shockable rhythm or not.

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85. We gave him certain drugs to try and stabilise the rhythm. After the third shock, you give a drug called amiodarone and you also give adrenaline at that point. This is to try to stabilise the heart rhythm.

86. In the A&E records at page 7 I've written: "- *fluids 500ml NaCl 0.9%*" means sodium chloride. "-> *total of 18mg*" means we've given 18mg of adrenaline throughout the time that we were doing CPR.

87. For treatment, I went down the trauma route, couldn't find anything. I went down the drug potential route. Nothing seemed to do anything.

88. We're looking to see if there's a pulse or any signs of life and then, while we're doing CPR, shocking and waiting for those two-minute checks, we're also going through something called the four Hs and the four Ts.

Reversible Causes of Cardiac Arrest

89. We have what's called "reversible causes" in cardiac arrest. To check and treat these causes we've got what we call the four Hs and the four Ts. If we identify one or more of the four Hs or four Ts we can possibly reverse the cause of the cardiac arrest and stabilise the patient.

90. The four Ts begin with tamponade, when there's blood in the pericardial sac, so the sac around the heart if there's been trauma to the heart and you can get blood compressing stopping the heart from being able to beat. Toxins, that can be intentional drug overdoses, accidental drug overdoses, recreational drugs, medication, anything like that. This can be illegal or prescription drugs.

91. The next T is thrombus, for example a massive pulmonary embolism, blood clot, on their lungs that's causing pressure on the heart causing them to go into an arrest, or a massive heart attack from a blood clot in the arteries that feed the heart muscle.

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92. The final T is tension haemothorax, so that's when the lung has collapsed on one side and is pushing over and you need to decompress it. I don't recall looking in my notes in the A&E records that we did that. I think we had good air entry on both sides when we were bagging him. I don't recall decompressing his chest.

93. I have been shown my previous statement (PIRC-00118). At page 3 I stated: "*There was some discussion and Rachel may have suggested putting IV canulation to decompress the chest. Both Dr Clark and I disagreed as the patient had no chest trauma and this would have given him a collapsed lung which would have given him more problems. This stage of the proceedings occurred from memory at about 0830am.*" I remember I said this and the anaesthetist agreed with me. They did an ultrasound of the lungs and the lungs were both moving. I still agree that decompressing the chest would not have done anything. I don't recall arguing about it in any way. It's a sensible suggestion made by that doctor, but we knew both his lungs were working and we didn't have any obvious sign of trauma on his chest so you could potentially get yourself into more trouble by doing this. This suggestion occurred in the middle of the resus efforts at 8:30am.

94. After checking the four Ts we check the four Hs. Firstly hypoxia, this is the patient not getting enough oxygen even though we are using the bag valve mask. Hypothermia is if they have been lying out in the cold or been submerged in water. So if they've got a temperature that's like -32 then we have to keep warming them up until they're a sensible temperature.

95. Next is hypovolemia, so they've not got enough circulating blood volume because they've bled somewhere or they're septic and the distribution of the fluid in their body is not correct. Finally hyperkalaemia, this is if their potassium is too high, and that can be from kidneys that don't work properly,

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sepsis, from drugs, or for lots of other reasons. This can cause the patient's heart to go into arrhythmia and cardiac arrest.

Arrival of colleagues

96. At this point, Dr Surinder Panpher and Dr Rachel Anderson arrived. This was around the time of the nurses' handover, which is about 7:30am. They both started their shift at 8am. I told them what was going on and we then continued what we were doing. Surinder was the Consultant on shift and Rachel was another Registrar on the day shift. I must have given Surinder a summary of what was going on.

97. Having looked again at my notes in the A&E records at page 7 the patient was in VF at some point and we shocked him but it didn't do anything. I stated "*3 episodes of VF rhythm*". We continued to do what we would do normally in the algorithm. The patient's heart then went into a non-shockable rhythm so we kept doing only CPR and giving him adrenaline every second cycle.

98. I did also have the Intensive Care Consultant down at this point and they were at the head end so I then shifted to the feet end because that's where I remember talking to Surinder.

99. I would have given a summary of what had happened and what we had done so far and where we were with the patient. He is a Consultant and I wasn't at the time so he's senior to me.

100. At this point we discussed if it was drug related or trauma causing him to go into an arrest. Rachel suggested rolling him to see if there's any injury on his back. There was nothing on the back of his head. We couldn't find any sign of trauma. A trauma can be anything from a minor to major injury.

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101. I think they also did an echo, an ultrasound of his heart to check if there was any movement. In the A&E records at page 10 I've written "*Echo -> by M Clark -> minimal RV movement -> viewed 3x throughout CPR 1°*". Echo is an ultrasound of the heart. There is minimal right ventricular movement of the heart. Dr Clark has looked three times at the heart on separate occasions.

Blood test

102. Following the four Hs and four Ts, we can checked the patient's blood gas. Sheku Bayoh's test is in the A&E records. It comes out of a machine like a receipt and it's basically a list of numbers.

103. It's called venous blood gas because it gives us the oxygen and the CO2, among other things. It's called this for the information we're looking for, not the test itself. We do arterial blood gases and we do venous blood gases.

104. In this case we would have done a venous one because we would have done it when we put in the cannula and we'd have taken some blood off and run it through our machine very quickly because blood tests take a bit of time and we won't get that back for at least 30 to 40 minutes, whereas a blood gas I can put through a machine and get some immediate information that's useful to me.

105. The information I want to know is what's his Hb, that's his haemoglobin. If it's low I would need to give this guy blood. I see from the A&E records that his was 131. That's totally fine.

106. I also want to know how much acidosis is in his blood system from the arrest and how much of it will be reversible because you can get an idea of what his

prognosis is going to be. I work on hydrogen irons. A lot of other people work on pH. It's what you get used to working on in your department. His hydrogen irons were 213. That is not compatible with life. His acidosis was very bad.

107. There's too much acid in the blood and it wrecks the kidneys. It doesn't allow the cells to work properly so it causes damage to the cells. They will break down. It will knock out your normal regulatory systems because there's too much acid there. So it just doesn't let the body work the way it should.

108. I don't know what caused this acidosis. Cardiac arrest causes more acids to be built by the body the longer you're in an arrest, so part of this will be because he was in cardiac arrest. He may have had an element of it from whatever happened pre- him arresting. I don't know what that would be. He's not pumping his own blood. We're doing it for him with chest compressions and we're not as effectual as his own body doing it. So his body will build up acid.

109. Another thing on that blood test would be his lactate and it's 18 and that's very high. Usually, people are 0 to 2 at the most so 18 is high and I think I remember when we repeated it later on it was too high to be recorded. It was over 20. Generally, people who have that kind of high lactate have a very poor prognosis for survival.

110. People who have seizures will have high lactate but that will come down over time but people who are septic or in cardiac arrest and have a lactate of 18, that would tell me that their prognosis is going to be quite bad. It doesn't mean you stop but it means that you're thinking the prognosis is poor. Basically, oxygen is not getting to where it needs to go in this state.

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Time of death

111. I see from the A&E records at page 10 that we pronounced life extinct (PLE) at 9:06am and Sheku Bayoh came into A&E around 7:30am so I know we were with him for around an hour and a half.

112. Near the time of the PLE, nothing seemed to be working. There was nothing reversible on his gas. A Consultant Anaesthetist or ITU Consultant and an A&E Consultant were in the room at this point so I am not in charge as they are senior to me.

113. The patient was in a serious condition. I thought we should call it. Surinder agreed. My reasons for this were that the patient had been down for nearly an hour and a half and there was nothing reversible that was working. He wasn't going back into a shockable rhythm so we couldn't shock him to restart his heart. We gave him all the drugs we could. His acidosis and lactate were climbing. I thought we had a dead patient and we weren't going to be able to restart his heart.

114. The anaesthetist did not agree. He said the patient was young so we should keep going for a bit longer. I didn't agree but the Consultants were senior to me so I deferred to them. So we kept going for a bit longer, maybe twenty minutes longer or so. We continued CPR chest compressions.

115. Then we all agreed we had to stop because we were getting no return of circulation. It was over an hour and a half that we were doing all this to him and we were getting no signs of life. He was dead, so we stopped it just after 9am.

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116. PLE should be a unanimous decision. In practice I ask everyone if they are in agreement that there's nothing more we can do. If a junior doctor makes a suggestion we can discuss it and if it would be beneficial then we would try it. Usually everyone is in agreement.

117. I think I called the time of death at first. I think I called the time of death and then I got told by one of the Consultants, "Actually, I'm not happy to stop," so then we continued and then I don't think I called the second time. I think I let someone else do it. The PLE of 9:04am is only 5 or 10 minutes after I had first called the time of death.

118. When we all decided to stop, I went away and wrote notes. I knew that this was going to need to be investigated because it was an unexplained death and the police are present. I knew to leave the body well alone. It was moved to the viewing room with everything still intact for the police. A policeman stayed with the body.

Media

119. I haven't read a lot in the media because I decided to avoid it.

120. It wasn't until a few months or a year afterwards that I started seeing Sheku Bayoh in the news. What I've seen is that every so often the family would be saying something about not being happy with the inquiry.

121. I also saw in the news that his death was not drug-related. My own view is based on what I saw at the time when he was with us in A&E.

122. I saw there was a police investigation and then the family were calling for an independent inquiry. I presumed someone might get in touch with me at that point.

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PIRC

123. I remember giving two statements to PIRC. I told PIRC the truth and my memory would be better then than it is now. I read over my statements and signed them. If there is an inconsistency, my previous statements should be preferred, aside from the point about whether the handcuffs hindered CPR.

124. I believe the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

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