

**SHEKU
BAYOH
INQUIRY**

The Sheku Bayoh Public Inquiry

Witness Statement

Dr Gillian Norrie

**Taken by [REDACTED] by MS Teams
on Tuesday 22 March 2022**

Witness Details

1. My full name is Gillian [REDACTED] Norrie. My date of birth is in 1971. My contact details are known to the Inquiry.
2. I graduated with a BSc in statistics from Strathclyde University in 1994, and graduated with an MBChB from Aberdeen University in 2008. I have a postgraduate Diploma in Sexual Health, the DFSRH; I think it might have been 2013, but I can't recall. I also have the postgraduate qualification of MRCPGP – that's the GP membership. That was in 2015.
3. In 2008 I came to Edinburgh to do my foundation medical training. That's a two-year programme. I was on the academic programme in Edinburgh. After that, so that would have been 2010, I began my GP training, again in Edinburgh. So, during that training I would have had many training posts, which is normal in postgraduate medical training, in various hospitals in Edinburgh, covering many specialisms, including general practice. That would be until I qualified in January 2015.

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4. In May 2015 I was working part time as a forensic medical examiner. That was my role whereby I was involved in this incident. Also I worked part time as a locum in Edinburgh, a GP.

The role of the forensic medical examiner

5. I have been asked about my role and responsibilities as a forensic medical examiner. To be honest, it's some time ago now. I haven't done that role since 2017, so you have to appreciate that it's quite some years since I've been there, about five years almost, four and a half years. I worked there for three years, from, I think it was September 2014 or something until November 2017, on a part-time basis as a forensic medical examiner for NHS Lothian. So that was part time, out of hours, so it would be evenings that I worked.
6. Generally I would be on call from something like, about 5.30, 6 o'clock or something to 8 or 9 the next day. Sometimes I worked weekends. That was very rarely. So for me to be working that Sunday morning was unusual, but occasionally I did do some weekend work.
7. In my role, I would be the first port of call for police if there was an incident with, generally, sexual assault, victims of sexual assault. It would be forensic examinations of those victims, obtaining samples and so on. You'd meet the officer, get some background from them about what's happened, why they've asked you to do this. You get some information and then you go and see the victim and then speak to the victim and get an idea from them what's happened.
8. The reason I'm asking that is not because I'm a police officer, it's because I would like to know how they've been assaulted and how that best informs what my expectations would be on examination so that I don't miss things. I

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need to know a little bit about what exactly the assault involved so that I can best direct my examination. I would always take some history about it and then do a physical.

9. A lot of the work's sexual assault, but not all, so you might get called to a physical assault, a domestic incident, for instance, and be asked to examine the patient and document injuries. Then the police would follow up with photographs.
10. Occasionally I may have been asked to examine an accused and to take samples from them too, and some of the work was custody work as well, but a lot of that is done by nursing staff, so if there was any medical issues for those in custody then occasionally I'd be called in to deal with that.
11. I have been asked about the role of forensic medical examiner involved in relation to examining police officers. That was very unusual in my experience, so much so that when I was contacted to do that by the coordinating nurse, I said, "Is this something that forensic examiners do? I've never been asked to do this before," and I called the clinical lead, [REDACTED] to discuss it with her, because I was uncertain as to doing this activity, because I'd never been involved with police before in that aspect of the work. She said as well it was slightly odd but she felt that it was something that I should do, so she suggested that I go along and undertake the examinations. This was the only time in the whole 3 years I was there part time that I have ever been asked to do that. Speaking to colleagues, I don't think it's something that we do often. It's often custody work with individuals who are in custody or victims and the alleged perpetrators of crime as well, but never officers.
12. I have been asked if I know who would usually examine police officers for evidential purposes in relation to injuries sustained by them in the course of their duties. I have no idea. I can't comment. It might be some other forensic

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medical examiners have been asked to do that, but that certainly wasn't a role that I had ever been involved in before. To my recollection, it's not really part of the job spec. I have been asked whether within, for example, NHS Lothian, some forensic medical examiners would do what I did and others would only deal with police officers. The answer is no – we all do the same thing.

Documents provided by the Inquiry

13. I have read my previous statement to PIRC dated 3 June 2015 (PIRC-00282) and my previous statement to PIRC dated 22 January 2018 (PIRC-00283). I have read medical notes, reports and records relating to the officers I saw on 3 May 2015 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
14. I think I am happy with the notes. I think generally all the notes are mine and it is my signature at the bottom. They are a true and accurate record of what happened at the examination. I told PIRC the truth in my two interviews and the two statements are an accurate record of what I told them apart from a few points.
15. I have read my PIRC statement dated 22 January 2018 (PIRC-00283) at the bottom of page 2: "*At the history that she provided prior to my examination concerning this contained in was provided to her by a colleague.*" I don't know what that sentence means. Obviously I speak to individuals. That's all part of the examination. We don't just bring a patient in and physically examine them. We have to speak to them and obviously gain information, gain the history and then sometimes that helps you direct your examination. I have been asked if I would adopt this part of the statement. No, that's not something that I would have intended to say. I don't know why it was written like that. It

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doesn't make sense. How would I know it was provided to her by a colleague?

16. At the top of page 2: "*At the time I conducted the examination of the officers I was a Force Medical Examiner (FME) I no longer carry out that role as of November 2015. I am now working as a locum general practitioner covering all of Edinburgh.*" That's wrong, I stopped working there in 2017, two years later. It's just a typo. Just to be correct. When you do locum general practice you're not on call for the whole of Edinburgh. I work in a few practices in Edinburgh. I'm a GP who's self-employed. I'm a senior GP. I'm fully qualified and I work for NHS Lothian on a self-employed basis usually at two or three regular practices in Edinburgh.
17. At the bottom of page 2, "*amnesia*" is a strange term. It's not something that I would generally write. I would usually say, "She didn't appear to be confused given the fact that she was orientated in time, place and person," but maybe I did say amnesia, maybe the police specifically asked me that. I'm happy to leave that.

Instructions

18. It was always by phone call that you get called. If you're on call, you'll have a call that comes in to say that there's a job, and to coordinate that work. It's essential to do that. When I was on call that day, I think generally it's just one FME covering a large area, so I would have been on call for all the way down to the Borders, West Lothian, Edinburgh City, and it must have been Fife as well actually. Yes, so it's a big area. There's only usually one, maybe two doctors at that time who were on call, and I think there was another person. I think maybe they were involved in something else. So, , there's a big area that you're responsible for. That's coordinated by the forensic nurse at St

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Leonard's. They receive the request and then they get in touch with you to allocate the work. So yes, I would have had a phone call about that.

3 May 2015

19. 3 May 2015 was 7 years ago, so I can't say I have a perfect recall, but yeah, I remember it. I was on call on the Sunday. I received a call from the coordinator, I think the forensic nurse from St Leonard's, to ask me to go along and examine police officers in Kirkcaldy where there had been a death in custody.
20. I was given information at that stage, I think by the nurse, about who had contacted the service, Inspector Jane Combe, and what had happened. So they had told me that the police had been called that morning to an incident that happened in custody following a disturbance where a man was seen brandishing a knife, and the officers had used a CS spray and had restrained this individual. Then he had apparently had a cardiac arrest, or some such fatal event, and then sadly died that morning.
21. It was very unusual for me to be asked to go along and examine police, so I said I'm not sure that's something that I should be doing and I want to check with my boss, so I phoned the clinical lead and asked her about it, and she said, "Yeah, I'm not sure. It does sound quite unusual but I would go along. There's going to be a PIRC inquiry. You need to just go along and do it." So then I made my way across to Kirkcaldy.
22. I think the traffic was quite bad. It took a while. I think there were issues with the bridge, so going across there. I can't tell you who I met with. There was lots of police. I think they were waiting around in a common room or something. I was shown into a room where I could examine them.

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23. There was a nurse with me. Sadly, I haven't documented her presence, but I think there was a nurse there who helped just with blood pressure and taking some clinical observations to speed up the process, because it was going to be quite lengthy. I then started to see the officers and conduct the examinations. There wasn't a specific order. I think I probably asked, "Well, who should I see?" and they just said, "Oh, just let them in." There wasn't a list, it wasn't done alphabetically or by seniority, as far as I can recall.
24. They just came in one at a time and I spoke to them a bit about making sure they were okay, what happened to them. I don't need specific details, that's not my role, but just specifics about what their role was in the incident, to try and tailor the examination and be as accurate as I could, and then take some medical history from them and do the examinations.
25. Then I think after that, I can't recall exactly the timeline, I was again asked by an officer, a detective, I think, to examine another individual who had been with the deceased earlier on in the early hours, I think. I haven't seen those notes that I compiled since then. They'll be with Orchard Clinic. I was asked to examine him and I think take some swabs or something. Then I went home.
26. I had all the written notes and then the next day, so that it was still fresh in my mind, I generally do the dictation as quick as possible. I dictated all of those cases, dropped it off with the secretary at the Orchard Clinic. It was typed up and then checked by me a few days later, whenever the secretary had done the dictation. That was it.
27. I have been asked whether, when Jane Combe contacted me, I was to be involved on a welfare basis or a forensic basis. I can't say. I think probably in my previous statement on 22 January 2019 one part is not entirely accurate

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at page 2: *"PI Combe I think provided me with the history of the incident involving the officers."* If I was being pedantic, I contacted the forensic nurse who then informed me, so I don't think I did speak with her directly. I was asked to go along and examine the officers, document any injuries and that was it. Clearly as a doctor, if I had any concerns, if I thought that they were at risk, from a sort of mental health perspective, then I would have actioned that. That's a given in what we do, but basically the task that I was tasked was to go along and examine these officers and document injuries.

Kirkcaldy Police Station

28. I have been asked to describe the common room that I mentioned. There was an area within the Kirkcaldy Police Station. I think I went up a corridor or something and turned right. You walked in, there's like a big space. I'm not sure if there's a pool table, so they all kind of congregated. Maybe not all, but there was a collection of officers, people to be examined were there. I was led into a room that was quite near, where the nurse was, or where the nurse eventually came. I can't remember if she was there.
29. I was briefly in the common room. I didn't sit down. I think I may have been introduced to the senior officer who was leading the thing. I think he'd come down from somewhere – Dundee, Aberdeen or something. Come in from somewhere in the north-east. It wasn't a lengthy discussion. I think he might have been there; he might have come into the other room. I didn't sit down, I didn't observe them in terms of what the officers were doing. I think, people might have been playing pool, but I might be wrong at that. I can't put my hand on my heart and say that exactly was what was going on, but it was just an area where they were and I think they'd been there for a while.
30. I have been asked if it was the officers I would go on to examine who were all congregating together in this common room. That's my recollection. I have

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been asked if I also met the senior officer to whom I referred in the common room. I can't remember. I have a feeling it was in the clinical examination space but I couldn't be certain. I have been asked what the purpose of me going into the common room was. I think you had to walk through, or maybe I just saw them through the door. I think it was just proximity. As I say, it was a long time ago, but they were in that space.

Personnel

31. The nurse who was with me was female; I can't remember her name and I had never worked with her before. I think she was someone from Fife. I don't really cover that area. It's generally Edinburgh I was working.
32. In the notes, the handwriting's different on the name and the date, I think she said she would do that. She was writing down their details just to make the thing quicker, doing some writing, their names, date of birth, address and so on at the top. I think she was helping by taking clinical observations, so blood pressure, oxygen saturations, things like that, just to speed it up. I can't remember if she was present for all of the examinations. I really don't know, but I do remember there was someone there helping just with a wee bit of the admin, and they were doing some blood pressure and things for a while.
33. I have been asked if I have ever seen this nurse again in my work. No idea. I should have documented it. I should have got her name and put it on the report. That's something I've missed. I don't even know who it was. I don't recall. I've never seen her since or before.

Examining the officers

34. I did not have any other contact with the officers other than in the examination room. I wouldn't have measured them. I don't think there was scales and

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things in there. I mean it was a room that had been set up. It wasn't really, truly, a clinical room. It didn't have a couch. It was just a place that we'd been put in. It had good light and things, which was ideal – it was a bright space that you could have a surface examination. I would just have taken their word for it asking what's your weight and height. So it's not absolutely accurate in that respect. I have been asked if I brought a bag and equipment such as a stethoscope with me, and if I remember using it. I did.

PC Nicole Short

35. I can't remember how long I spent with PC Nicole Short. I'd have to look on my notes. I don't know if I've put times on for everyone. I actually think I worked late. I was only on call for a certain time so I was being efficient, so I may have missed the times in and out, and there was such a lot of examinations.

Forensic examination records

36. I have been shown my notes relating to Nicole Short in a Forensic Examination Record document (PIRC-01301). I have been referred to page 3 where I wrote "15:45" at "*Time of Examination*" and "16:10" at "*Examination End Time*". I see I was with Nicole Short for 25 minutes.
37. I have been asked if I can recall anything that might not normally be included in the notes. I can't recall anything different. As I say, it was such a long time ago. Part of the reason why I do the dictation very quickly after I see a patient, or an individual, is just to make sure that I do document what's gone on. But no, I don't recall anything else of any significance.
38. I think she was small, a sort of petite, dark colour hair, I think. I had never seen her before in my life. I have been asked if I remember anything about

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her manner or demeanour. No, nothing different than what I'd have documented. Nothing specific.

39. I would say it might have been useful for me to have said when I dictated my notes that she had already been seen in the A&E. For me, that's a reassuring thing, as a doctor, because otherwise there may have additional concerns that need more thorough equipment, fundoscopy and things like that, which are present at and are best to do in a more clinical setting like A&E. However, things can obviously evolve. I may have mentioned that when I dictated it, which I didn't, so that might have been more useful information to have put in, but, as I say, I didn't think it was that important.
40. I have been referred to page 3 of my notes on Nicole Short: "*Officer Requesting – INSPECTOR JANE COMBE – Reason for Examination – Assault in line of duty*". It's probably better to have written that the reason for examination was "Documentation of injuries" and possibly, "obtained while working".

History

41. I have been referred to page 3 of my notes on Nicole Short: "*History: Called to incident 07:15am. 'Black man chasing cars'. When arrived 2 colleagues spraying. Nicole's colleague sprayed then Nicole took batton out but ran away as was chased. She was hit on head with fists, fell forward to hands on ground, then back stamped on. Colleague arrived and took to van. To -> A+E => Check up -> observe and analgesia. INCIDENT: INDIVIDUAL RESTRAINED AND DIED.*" The signature at the bottom is mine.
42. The history's from the patient, so it's the patient who gives me that history, that's what she told me. I have been asked if I would ever get that from anyone else. No, not unless they were present. And I would have said

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collateral history obtained. This is taken to best direct the examination. My role is not there to ascertain finer details. It's just really to aid with the clinical examination.

43. I have been asked why I have put in inverted commas at the entry that reads "*Black man chasing cars*". Because that's something that Nicole Short said. It must have been. I can't remember what she said, but that's generally what quotation marks mean.
44. "*When arrived, two colleagues spraying*" is not in quotation marks because I was possibly paraphrasing at that point. I'm not sure. I think they were called to the incident, the police, by whatever, however that happens, I have no idea. Possibly a member of the public, I don't know, but they were called to an incident and told that a black man was chasing cars. So that's what she was told. I think the quotes are someone told them black man was chasing cars. So all the rest of it's what she said: when she arrived, two colleagues were then spraying CS spray.
45. I took the notes as she's saying it to me in the examination, given how badly it's written.
46. "*Nicole's colleagues sprayed then Nicole took batton out but ran away as was chased.*" I think what she's told me is that she obviously went to help a colleague. She took her baton out and then ran away and then he's chased after her. I think that's what she said. I have been asked if Nicole Short told me any more about how that happened, for example why she ran away. No. Presumably because she was scared but that's my assumption. I don't know.
47. "*She was hit on head with fists, fell forward to hands on ground*". I think she fell down. She said she was hit on the back and she fell onto her knees and her hands, down on all fours would be a better description, I think is what

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she's saying. And then her back was stamped on, because I obviously wanted to know where she was sore, what had happened.

48. "*Back stamped on*", I have been asked if Nicole Short told me this. Presumably, yeah, that's what's written. I mean just that she receives an impact on her back, but I couldn't say if it was a repeated stamping or anything like that. It's not really my role to try and iron out the finer details of the event. It's really just to direct my examination. I want to know, you know, where she might be injured to see what way she'd been hurt. Of course you have to be thorough and look everywhere.
49. I have been asked whether I can remember Nicole Short saying anything about being on all fours, or if that is my understanding of what happened. I'm giving my understanding of what that means but yeah, that's how I've described it, fell forward onto hands and ground. I mean it's quite hard to put your hand down on the ground without falling down on your legs as well, but it's not impossible. I think what she was saying was she went down on all fours. I think that's quite evident from the examination. I think she may have had a few abrasions and things in those areas, which would tie up.
50. "*Colleague arrived and took to van*". It looks like the colleagues helped her to the van. They took her, assisted her to the van, to safety.
51. "*A+E*" means accident and emergency. They've said, "Observation and analgesics," so that just means observe how things go: if you become unwell, get back in touch or see your GP, but they were happy to discharge her under observation – apparently and to take pain relief if she was sore.
52. I've been told this second-hand obviously. I haven't spoken to the A&E. This is an account that I've been given from Nicole. No one else has given me this other than her. I have been asked whether I would have had access to Nicole

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Short's records at this stage. Absolutely not. I don't know who she saw in A&E, when she went, obviously what time whatever, it's obviously after 07.15, but I don't have any other information.

53. *"INCIDENT: INDIVIDUAL RESTRAINED AND DIED"*. It's a significant thing that happened. A death in custody is just terrible. That's what the incident was but I'm not sure why I've written it. Maybe just because it is significant, a significant event that happened. It is definitely my handwriting. I can't see me going back, unless I just tidied stuff up at the end, but it wouldn't have been retrospectively the next day or anything like that I don't think.
54. I have been asked if I may have written it on before I saw each of the officers as note at the bottom of the page. Not at all. It's a strange place to put it. I'd probably put it right at the top if it was something that I was setting out for each person. But it's not because I don't think she's then saying, "Oh yeah, and actually he then died." I think that was known at the outset. I was told that: there's a death in custody, please go and examine the police officers. That was what I was called about.

Examination of PC Nicole Short

55. Sometimes you could give the Glasgow Coma Scale but that's not something that routinely we would do for observations unless there was concerns about her neurological status.
56. A fundoscopy is looking into the back of the eye with an ophthalmoscope, a special piece of equipment, which I do have. It's very difficult to do, certainly in bright light, and it was a very bright room, without dilated pupils and things. I look into the back of the eye to see if there is any evidence of any raised intracranial pressure, things like that. The health of the eye as well, but in terms of neurology, looking to see if there's any pressure in the head. So you

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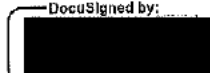
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could get that if you'd been hit in the head. You could have raised intracranial pressure, if you had a bleed on the brain. I knew that this patient had been seen already in the A&E for a head injury. She had told me that. That had been done earlier. There'd been no change in her clinical status that gave me any concern. She didn't appear confused, so I wasn't worried about not doing the fundoscopy.

57. I've done a cranial nerve examination. So looked at the pupils, how they're moving tested all the other cranial nerves in the head. There's 12. It's a very quick examination. Feeling for sensation. I look at the various different nerves, getting her to open her mouth and things.
58. "*Chest*" is just shorthand for examining her respiratory system. That's really looking at the lungs, listening to the lungs. I'm just saying that it's clear, there's no crackles or there's no reduced air entry which might indicate things like collapsed lung, so that's a normal respiratory examination.
59. "CVS", that's the cardiovascular system. That was just the heart sounds are normal. There's no evidence of murmur. Her abdomen was soft and non-tender. There was no masses there, so no lumps anywhere, but again a normal examination of the abdomen.
60. You can't examine the chest over clothes. You wouldn't be able to hear properly. I mean I don't remember specifically but I can't do a respiratory examination through clothes. I would have lifted her top and listened to her chest.
61. That part of the examination, the chest and abdomen and so on, that's a basic physical examination. That's not a documentation of injuries. So, firstly, I'm just checking the abdomen and it doesn't look like it's firm. I'm checking if it's

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hard, there's something bleeding there, anything to worry about – that's why I'm doing that. But it's not specifically to look for injuries.

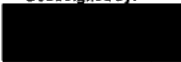
62. That's the next part where I would document the injuries. I would look at those areas. I'd do a surface examination thereafter, to make sure there aren't any, but if there was any that I've seen when I've examined her tummy then I would have documented them below. I wouldn't put it in that part.
63. I'd look for injuries after, but, I would need to listen to her back anyway to do her chest examination, so if there were injuries I would see them. Then I would specifically look for it in the next part as well. This is to better document the examination, because it's going to confuse things. I have to have a systematic approach. I want to get the physical out of the way and then do the injuries next.
64. I have been referred to the entries in the medical records (PIRC-01301) at page 4:

Injuries

Right knee: (1) 1cm x 1cm abrasion } patella
circular red colour
(2) 1cm x 1cm abrasion
circular red colour

Left knee (3) 3cm horizontal x 2cm vertical
Red circular abrasion injury, 1cm superior to tibial tub

Left hand (4) hypothenar eminence 1cm
circular blistering bruise
erythema and tenderness
-> continued

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(5) -> tender (R) occipital area and

(6) R mastoid no injuries noted but tender on palpation

(7) tender (R) cervical spine, no injuries seen.

65. My signature is at the bottom of the notes on page 5.
66. On the right knee it's just a little scratch, like a graze, an abrasion from blunt force trauma. After that it says "*patella*", so that's the kneecap.
67. On the left knee, tibial tuberosity is the location of the injury. I'm saying that there is an injury and where it exactly is. I'm saying on the left knee there's another abrasion injury and it's about a centimetre above or superior to the tibial tuberosity. It's just a kind of landmark, to mark where things are on the anatomy.
68. On the left hand, the hypothenar is a part of the palm of your hand, just above your wrist, below the pinkie. I think it's more like a bruise rather than an abrasion. I think the skin's not really traumatised but it's kind of a bit discoloured. It's got a bruising and a little bit swollen. It's red. It's kind of a reddish bruise and it's tender. So, again, consistent with putting your hand down on the ground. I have been asked if I have said it's reddish because I have written "*erythema*" next. Yes. Tenderness means when I'm palpating it, it feels a bit sore.
69. "*Tender right occipital area*" means it's tender at the back of her head, more on the right side and then just around the right mastoid. I think in my notes I've numbered 5 the kind of right back of the head area and then number 6 is just the mastoid process.

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70. Anything right or left described anatomically is the patient's side, never the examiner's. The mastoid is a bone behind the ear. It's just a part of the skull. You can kind of feel it. It's slightly roundish. I'm obviously looking for injuries and there's none, no visible injuries, but then I'm touching, so I'm pressing on her and asking her, "Does it hurt?" and she's saying it's a bit tender.
71. "*Tender right cervical spine, no injuries seen.*" means there's no physical injuries present but it is tender when I'm pressing on it. That means that at that point in time there's nothing to be seen, although acknowledging that it's sore. That doesn't mean that there won't be injuries. So it might be that injuries do evolve, or they did evolve. It might be that some bruising did come up, but there certainly wasn't any when I saw her. It's quite early so it's impossible to say whether or not it would remain like that, I think at this stage.
72. The cervical spine is your neck. The spine goes from the cervical area all the way down, thoracic, lumbar, sacral, so it runs all the way down, but just on the right side of her neck at the back, it's tender, all the way up there to behind ear and into the back of her head. I have been asked how far down the tenderness goes down. I haven't documented. The entire cervical spine runs for seven vertebrae, but I haven't said it runs all the way down. So all the neck to where her back, thoracic spine begins, but it's just tender at the neck. Take it that most of her neck's tender on that side.
73. The vertebrae are just the little bones at the top of your spine that connect up to your skull, so they're just small. Obviously they change in size as they go down the back, all the way to your bottom, but they're just seven little square bones at the top of the neck. The neck's part of the spine, so it's just the neck, but in medical speak. Just the right of her neck is tender.

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74. You can have a look at the neck. You can feel it. You don't even need to really move the clothes much. It's just "lift your hair up". If there's a t-shirt or a top, just push it back slightly, get the entire length of the neck.

Injuries to back or ribcage

75. I have been asked if there are any notes of tenderness of the back or the ribcage. There are none at all. I don't document all negative findings. There's nothing in the shoulder, there's nothing in the loin. You're documenting injuries. That's where the injuries are felt or seen. I have been asked to comment on the position that I was seeing a patient who whose back was said to have been stamped on and I have not made any notes about any injuries relating to that. My feeling on that is because there's none. I've documented the injuries that I have found.
76. I can't say with absolute certainty, but my feeling is that I would have felt around all those areas, especially given the fact that she told me that she was stamped on in her back. That's the whole reason why I'm asking that history. I'm not a police officer, I'm not taking the history because it's my job to find out the rights and wrongs of that. The reason is I want to know what her involvement was in the incident to best direct my examination. I have to assume that I have felt all of her areas. I'm just documenting the positives that I've found.
77. I have been asked if it would be unusual for me not to examine the back and the rib cage. Yes. I've already examined her chest, which includes the back. I have been asked how sure I can be on the basis of my notes and memory that I examined Nicole Short's back and ribcage. It was 7 years ago, but my assumption is that I have done that. It's highly likely, but I can't with 100% certainty say that that was done.

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78. Obviously I've looked at it, so that's part of the examination, to document there was no physical injuries there, because I've looked at that when I examined her chest and listened on her back with a stethoscope, especially because she told me she was sore at the neck, and there's not been anything to see. Did I feel down? I suspect I have but I can't absolutely say with 100% certainty. It would be unusual to then stop and not feel down the rest of the area, because that's where it was sore, but I think it's highly unlikely that you'd just stop at the bottom of the neck then. You'd keep going to see where else is sore. But there isn't negatives written in those findings.

Forensic Medical Report on Nicole Short

79. I have been referred to a forensic medical report relating to Nicole Short (PIRC-01310). This is just the thing that I then dictated after examining her, when I got back the next day. You need to have a typed official examination record. I have been asked if I have dictated this from my notes the day after I examined Nicole Short. That's right.
80. I have been referred to page 3 of the report: "...on the instructions of Chief Inspector Conrad Trickett..." I have been asked if he was the senior officer I referred to earlier in my statement as being present on my arrival at Kirkcaldy Police Station. I think so.
81. I met this person, I met Conrad Trickett when I arrived. He must have been the guy who was there, the senior man, but he didn't give me the history. We didn't go through it. The history was given when it was phoned in, to my colleague, to request the examinations, and that came from Jane Combe to my knowledge. On page 3, "*History from Inspector Jane Combe*" is what she told my colleague.

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82. I have been referred to page 3 of the report: *Incident details given by PC Nicole Short...She reported that she approached but ran away as she felt threatened by this individual who proceeded to chase after her, shouting expletives.*" It has been highlighted to me that this entry is not in my notes and I have been asked if I included it here because I remembered Nicole Short saying it. That's right. Definitely. I mean I'm not going to document every single word of what people say. There was a lot to get through that afternoon. That would have been her telling me in my memory about what happened. I haven't written every word down on that handwritten note. I acknowledge that.
83. I have been referred to my report at page 3: *"Her back was then stamped on, she thinks several times. Her colleagues arrived and helped her to the police van, to safety and then proceeded to restrain the individual."* I have been asked whether Nicole Short told me that during my examination of her. Yes, absolutely. I had no other involvement with any of these officers after their examination.
84. I have been referred to my report at page 4: *"...she was composed and behave appropriately throughout"*. She'd had a head injury, so I have concerns and have to think when I'm looking and speaking to an individual: are they displaying any signs that would lead me to be concerned about them, and that can obviously manifest by speech, how people are, how people behave. People often have had received a head injury and are behaving quite erratically, where that's been missed and terrible things happen. So her behaviour was appropriate. Her manner would have been appropriate, how she spoke would have been appropriate. It didn't indicate to me that I had any concerns about her neurological status. That's what I'm saying there.
85. I have been referred to page 4 of my report: *"A full body surface examination was conducted and the following injuries were documented:"*. I have been

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asked if I would have specifically dictated the words "*full body surface examination*" or if those are a style used in such reports. I will have dictated this. It's pretty standard to write that, so it's just looking all over for injuries, head to toe. Essentially the surface examination is looking at the skin and documenting injuries, or feeling the skin. If there's an injury, feeling for tenderness. You're looking at the surface. You're listening with your stethoscope. I have been asked if that's what happened in my examination of Nicole Short. Yes.

86. I have been referred to page 4 of my report: "Head...2. *Tenderness over the right trapezius muscle. No bony tenderness of the cervical spine, no bruises or abrasions noted.*" That's in the neck. It's another part going down the neck. I think that's just better describing the right cervical spine to the trapezius in the neck. The bony tenderness would be the actual vertebrae I was talking about in the middle. It's the muscles around to the right that are tender.
87. I am qualified to comment on bruising that can evolve over time. I have been asked what I would say about potential bruising in a person whose back has been stamped on, possibly several times. I'm not an expert in that. I don't feel I can comment on that. But certainly I haven't documented any tenderness there.
88. I have been asked whether I can remember if there was anything in my assessment that is not in my notes to suggest a loss or potential loss of consciousness in Nicole Short. I can't comment on that. Certainly if someone's been unconscious, you're not always going to find something a couple of hours later. She did go to the A&E. She was taken to the A&E because of a head injury, or she was taken there to be looked at because there was concern. And she'd been seen in the right place, in the emergency department, who look at these injuries and injuries all the time and had no concerns about her.

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89. But sometimes neurological symptoms can evolve. I'm not an expert on this. Sometimes things can evolve over time. There was nothing that I had concern about at that time. If I had, then I would have directed her to the A&E. I would have managed her appropriately. You do that all the time as a GP. If anyone's got any problem with a loss of consciousness, they go straight to the A&E. I'm not going to manage it, as a GP. I'm not going to manage it in a police station. She'd be in the A&E and she had gone to the A&E, but I think, my understanding from what she said the A&E said, she just had the observation. When I saw her, the second doctor on the scene, again I didn't have clinical concern at that time, but things can evolve.

Zahid Saeed

90. I think from reading the statements that were sent by the Inquiry, Zahid Saeed was the individual that I was asked to look at. We were told that he had spent some time with the deceased earlier on, in the early hours of the morning or something.
91. I remember being asked to examine him vaguely. I don't remember anything about it, any outcomes, but I remember that I was asked to do that at the station. I think that was at the station, to my recollection. It's 7 years ago. It's a long time. I see a lot of patients in that time, but I think so. I think that I was asked probably just at the very end of seeing all those officers, asked to do another examination as I was leaving.
92. I have been asked if I remember Zahid Saeed's account of what happened and if I remember his injuries. Not really. I think I was asked to take swabs of his hands. I think that's the forensic evidence I took, and then I think they told me that he had been in a house or something together earlier in the morning, and that the deceased had left, but no, I don't remember the ins and outs of it.

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93. I have been referred to my report on Zahid Saeed (PIRC-01319). I signed page 5. On page 3 I wrote: "*He ran away but was chased and Mr Bayoh hit him with a whirly-gig outside in the garden.*" A whirly-gig is one of those things you put your washing on. I think he must have said that's what it was. Not a word that I use. I think it's one of those things that you put laundry on, outside in the garden, that can move round.
94. His injuries included a cut lip. The bit in the middle's the frenulum, so the little tag attachment to the gum, if you lift your lip, then it's just right of that, because inside, internal, he's just got a little cut there.
95. The "*post-auricular area*" is behind your ear, probably not quite the mastoid. It's just behind the right ear, it's a bit swollen, so it's not red but it's a bit swollen and a bit tender.
96. I have been referred to my report at page 4: "*Left hand dorsal aspect a 4cm linear abrasion in the vertical plane 3cm superior to the third posterior metacarpophalangeal joint*". What I'm saying is that on the back of the left hand there's a line of 4cm that was just kind of like a graze, an abrasion, in the vertical plane, 3cm above the third, the middle finger. So the knuckle, the third metacarpal phalangeal joint, we call it the MCP joint, so there's like a scratch, an abrasion, like blunt force trauma injury which is kind of red and in a line in that area. That sounds like what I'm describing there. It seems like what I'm saying is that it's above the knuckle and it goes to a vertical line, a 4cm kind of line, sort of scrape. It's not quite actually on the MCP joint. It's not like the knuckle itself is swollen or has an abrasion. It's kind of just coming just above it, and it's actually 3cm above it, so it's in the middle of the hand, the back of the hand.

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97. I have been asked for my opinion on whether Zahid Saeed's injuries match his account of what had happened in the incident. He's obviously received some trauma to the face, so he could have been hit. That would marry up. He could get injuries from another incident, but if he was hit over the head, he could have some of the injuries that were there. Often you get injuries with the knuckles from punching and fighting but that's one at the back of the hand. I'm not sure how he's got that. I have been asked if that could have been a defensive injury. It's possible.
98. I have been asked if I can remember Zahid Saeed's demeanour when I was examining him, or how he was behaving or acting. No, I don't remember. Other than saying that his behaviour was appropriate.
99. I have been asked whether there was anything about the fact that Zahid Saeed had been hit, potentially in the head, with the whirligig, that would make you think I had to be a bit careful about his account or how he was feeling, because he might have suffered a head injury. He'd been to the A&E as well. He went to the A&E first. He'd been seen by the experts before I saw him in terms of who should look at his injuries. I don't really feel it's my role. I mean I'm not taking a police statement, so, I didn't have concerns about his neurological status when I saw him, in terms of from a medical perspective. My feeling is all about safety and patient safety. If I had concerns, I would send him back to the A&E, but he told me he had been to the A&E. His account helps better direct my examination, but I should still examine everything for completeness anyway. So that's not really something that is part of my role.

PIRC

100. That statement was taken – I remember because they came to a job I was doing while I was working as a specialty doctor in palliative care at St

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Columba's Hospice in Edinburgh. They contacted there while I was still a locum GP. I was doing additional work, hospice work, and they came there and took it while I was at work. It was handwritten, they wrote it.

101. I did feel the PIRC interview was quite confrontational, if I'm being honest. They were not quite suggesting answers, but it was possibly slightly intimidating. I was under caution, but that's maybe putting it too strongly. I mean I was quite surprised with the line of questioning. It's not really my role to be cross-examining patients. I'm there in a capacity to do a forensic examination and to assess a patient's wellbeing, physically and mentally. It's not for me to cross-examine patients.
102. So if I get an account and I have no other suspicion that there's any other concerns regarding their consciousness or neurological status, then I will document it. It's not for me then to say, "Are you sure nobody's told you that?" So it was slightly unusual of PIRC to expect that. It's not really for me to then cross-examine a patient, because essentially they're patients of mine at that stage and I'm making sure they're physically well, being a forensic physician. It's not for me then to doubt what they say. I have to document what they say, to help better direct the care given and the examination that I perform, to do as good a job as I can, as a forensic physician.
103. I was a little bit surprised about the PIRC line of questioning about, "Well, would you have behaved differently if you had known that she didn't actually recall that, that someone actually told her that she'd been hit? It wasn't her recollection?" No, it's obvious that, everyone's treated the same regardless. It's not defined on the history they give me. It can just help. I was slightly surprised at the line of questioning.
104. I have been asked whether it make a difference to my examination if a patient has no recollection of something happening but have been told by someone

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else that it happened. This is collateral history. People have losses of consciousness all the time, such as epileptic seizures and things like that, that they don't necessarily remember the events, and we always have to get witness accounts. It helps, but I don't think it was relevant for me to necessarily go into that level of detail with Nicole at that stage, given I had the reassurance she'd already been seen in A&E and that I had no concerns about her medically when I assessed her.

105. Of course it's helpful to get their accounts, as I say, because it can better direct your examination, but it shouldn't be this sole examination. You have to examine thoroughly everything.

Media

106. I have seen Sheku Bayoh's death in the news, but I haven't been following it that thoroughly. I think at the beginning, yeah, I was sort of noting it, because I had a connection, but I haven't been closely following it. I knew there was a Public Inquiry. I haven't necessarily been avidly following anything. I don't follow anything on social media connected to it or anything like that, no.

107. I have been asked whether, from what I have seen in the news and social media, I know about any disputed evidence surrounding Nicole Short. Because I'm not sure how reliable a lot of the stuff is that's written, I don't read a great deal into it. I think I do know that if I'm being completely honest. The family and stuff have said that the deceased didn't do a lot of stuff like physically assault Nicole Short and that's being contested by Nicole or the officers. So I know that there's discrepancies there, is what I would say, but I think that's the basis of the dispute, that perhaps she didn't receive injuries and she thinks she did. I think that's what I know has happened. I don't follow it closely.

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108. I have been asked if I have read, seen or heard anything that might have influenced my evidence. No, not in the slightest, because it was done immediately before any of this was disputed, so it's all documented and written, so what was there was there. Nothing's changed since, and what I've given today is just an account of what I said.

109. I have been asked if on the basis of what I have seen I have any comments on the way the medical evidence in this matter has been reported. No, I don't have any comments. I don't actually know anything about it. I honestly haven't got a clue, so no, I have no comments to make.

110. 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.

May 10, 2022 | 3:52 PM BST

Date..... Signature of Witness

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