The Sheku Bayoh Public Inquiry

Witness Statement

Dr Katherine Mitchell

Taken by [redacted] by MS Teams
on Wednesday 16 March 2022

Witness details and professional background

1. My full name is Katherine [redacted] Mitchell. I was born in 1980. My contact details are known to the Inquiry.

2. I work in a hospital in Scotland. I qualified as a doctor in July 2005. I hold a MBChB, which is my degree qualification, and I'm also a member of the Royal College of Emergency Medicine. The MRCEM is a three-part examination process and I passed the final examination in November 2016.

3. My involvement with the Royal College is I have rights to vote in some of the elections and access to certain materials online, mainly for the purposes of education. So, there's no formal involvement with any procedures within all panels or committees within the Royal College.

4. I'm currently a Specialist Trainee Year 5 in Emergency Medicine. I work in the Accident and Emergency department and cover a range of different shifts. I work day shifts, evening shifts, and overnight shifts. And within that, I'm providing care to the patients that come into the department with a range of physical and mental health problems. So providing immediate care and

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investigation, then referring on to appropriate specialties if required or discharging the patient back to the care of their GP.

5. From 2005, I worked for 2 years as a foundation doctor and 16 months in ophthalmology (including 6 months of maternity leave). It's a branch of medicine that specialises in eye disease.

6. After a 4 year break I returned to clinical medicine in 2012 and refreshed my foundation competencies. Because of the break I had had, I wasn't eligible to apply for specialist training at that point without refreshing those competencies. And that was the way that I chose to do it.

7. On 3 May 2015 I was an FY2, which is a Foundation Year 2 doctor. FY2 posts are the second year of a foundation programme which doctors complete after graduation. Upon completion of the foundation programme doctors may then apply for core or specialist training.

8. I moved to Victoria Hospital, Kirkcaldy in April 2015. I have been asked what A&E experience I had prior to April 2015. After I qualified I worked for 4 months in the previous Fife A&E department as part of a Foundation Programme, this was between April 2007 and August 2007. Historically it was on two sites and then moved to the one site that it now occupies in the Victoria Hospital, and I believe there's a Minor Injuries Unit in Dunfermline now. So I had spent 4 months working between the Dunfermline A&E and the Victoria Hospital A&E when they were on two sites prior to taking the career break.

9. In the August of 2015 I started my Emergency Medicine specialist training. I have worked in A&E, anaesthetics, intensive care and general medicine as part of my training.

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10. My role and responsibilities in my FY2 post in 2015 was to assess and manage the patients coming into the Accident and Emergency department. But with significantly more supervision than I would have in my current role. So either discussing the patients that you had seen with a more senior colleague, if you had uncertainties at all, and we were encouraged to do that fairly routinely. Or, if you were managing a more complex patient in the department, then probably being directly supervised or having a more senior member of staff present with you during the assessment.

PIRC statement

11. I have read my previous statement to PIRC (PIRC-00294). I gave a true account to PIRC to the best of my recollection and using my notes. Having read it, it doesn't really bring back anything in my memory that I could add on top of what is already written down, unfortunately.

12. I would have thought my memory would be better when I gave the statement than it is now. I have been asked if, in the event that there is a contradiction between what is in my Inquiry statement and what is in my PIRC statement, which statement should be preferred. I'm not an expert, but I would imagine that recollections given closer to the time are more likely to be accurate. So using the initial information in my PIRC statement seems to me to make more sense than using information provided now.

13. In my statement on page 3 I state "*punches to head*" are written in the A&E notes, but this should be "*punches to back head*".

3 May 2015

14. On 3 May 2015 I was working a day shift, 8am to 8pm. As I drove to work, I had to be diverted from my usual route because there were police vans and

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police incident tape en route in Kirkcaldy. I arrived at work and was aware of an ongoing resuscitation attempt in the department.

15. In my statement I note that Dr Rachel Anderson was working with me that day. There's a lot of staff that worked within that department and I can't remember who else was on shift that morning.

16. Rachel was one of the more senior doctors in the department, but I can't remember what her official role would've been at that point. As one of the more senior doctors, she would have been available for me to ask questions to. Now, as to who had the overall responsibility for the department at that time? I wouldn't be able to tell you who that was.

PC Nicole Short

17. PC Nicole Short attended A&E on 3 May 2015. I think I can remember in the consultation that she was still in uniform when I met her. I think she was blonde and seemed to be of reasonably slim or normal build. And I think I remember the cubicle in which the consultation took place. It was in the minors area of A&E and, if I remember correctly, she had colleagues – I don't remember if it was one or two – with her during the consultation.

18. I don't have any other specific recollections about the handover that morning or anything else, and would have to rely on my notes and previous statement for more information about my interaction with Nicole Short, and any other patient subsequent to that.

19. I didn't know this patient personally, and to my recollection not professionally.

20. The standard practice would be for patients to be triaged by a triage nurse prior to their medical assessment. So, that interaction may have preceded my consultation with her.

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21. I put at the top of my notes the time 8:10. I can't remember, but that is probably when I saw PC Short. And at the bottom it looks like I discussed the plan with Rachel at 9:40. I don't remember how much of that time was spent with PC Short. I did speak with her and then examine her, which is probably more than 10 minutes' work.

22. I can't remember any more specifics of the actual conversation that we had. I wouldn't be able to give any more information other than what's written on the notes that I've made.

23. I have read PC Short's A&E medical records (PIRC-01158). I recognise my handwriting on pages 5 and 6. I have signed the bottom of page 6. These are my notes.

24. Reading from page 5 of my notes, "*08.10*" is when I probably started seeing PC Short. "*FY2*" is my grade.

25. She had also had some observations taken.

PC Nicole Short's history

26. I have recorded the history in my notes on page 5:-

> *Police officer*
> *Chased by member of the public this morning, sustained blows to the back of the head. Remembers falling and putting arms out to save herself. Curled up into a ball and was then lifted by one of colleagues and told to sit in police van.*
>
> *No vomit since incident.*
> *Now has occipital headache.*

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27. And I think my normal practice would be to gain the history that had led to a person coming to A&E from the patient themselves, rather than from a third party. So it's unlikely that that information was given to me by anyone else other than PC Short. But 7 years down the line, I can't remember the exact interactions of the consultation and whether information was provided by different people.

28. I have been referred to my previous statement at page 2: "*The patient Nicole Short was in the Minors area and she described to me as having been chased by a member of the public… She said that she remembered falling to the ground… She said she had been from there lifted up by one of her colleagues…*". I have no reason to believe that this information is incorrect or that the information was provided by anyone other than PC Short.

29. I think it's very difficult to write down absolutely everything a patient says, providing a transcript of a consultation would be a very lengthy thing to do. So, when I'm speaking to a patient, there are particular pieces of information that I am trying to clarify that are going to be important to my decision-making as a doctor to look after them to the best of my ability. Therefore, what is then written in the notes may be condensed. It will be a condensed description of the events and trying to include the things that are going to be most important medically.

30. So, as an example, the fact that she hadn't vomited since the incident is important, because if somebody has vomited a certain number of times, then you would consider further investigation, such as a CT head scan. That's why that particular sentence was included in my initial description.

31. I have been asked if she had told me that she was stamped on, stomped on and/or kicked when she was on the ground, when she was curled up into a ball, is that something that I would include in my notes. If I had been told that

information at the time, I don't see any reason why I would have omitted that information from my notes because it would've been another part of the history that may have then been important in determining what injuries she was likely to have sustained.

32. One of the parts of my assessment would be, can the patient talk to you and describe what has happened in a coherent way and she did that. That's confirmed in my notes by the fact that I've written she was GCS 15, so alert and orientated.

33. If she had been hazy in her recollection, it's likely I would have written that down. If there was a bit that she couldn't remember, that would have been clinically significant so it's likely I would have written it down. If she had a hazy or incomplete recollection of events, then I would have been likely to conclude that she may or did have a loss of consciousness. And looking at my notes, I felt that she hadn't lost consciousness.

34. If a patient can recollect all of the events, then it would be normal practice then to assume that they hadn't lost consciousness because they can describe everything that happened to you. If a patient can't re-call the 30 minutes before a head injury this would be a reason to carry out a CT scan of their head. So it's not necessarily the loss of consciousness that is important in terms of your clinical decision making, but also whether there's a lengthy period of amnesia or memory loss before the incident, which wasn't demonstrated to me in this case.

35. In my previous statement to PIRC at page 3 I have written: "*During my examinations of Nicole Short I was able to discount the loss of consciousness by her ability to recall of the events pre and post event.*" If that's in the statement that I gave just a month or two after I've seen her then that's what I would say is the most accurate version of events.

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36. I can't remember exactly what the triage note from the nurse was. There is further information in somebody else's handwriting on the back page of the medical notes. On page 7 of PC Short's medical records someone else has written what looks like: "*? LOC Punches to back head*". I don't know if that was written by the triage nurse or whether that was written by somebody else.

37. "LOC" means a loss of consciousness. The question mark means that there may or may not have been a loss of consciousness.

Examination of PC Nicole Short

38. Depending on the information that you get from a patient and whether they're presenting as well or unwell would determine then which examinations you might do.

39. So she had described the blows to the back of her head, indicating a head injury. So part of my examination focused on looking for signs of a more serious head injury. But she had also described falling and putting her arms out and being on the ground, which would've probably been the prompt for examining things like her chest and her tummy to see if there were signs of injuries in those parts of the body as well.

Head examination

40. Checking for cranial nerve deficits is really looking for signs of dysfunction within the face, including whether the patient has got double vision, and I've noted that she didn't.

41. So, that is looking at the patient's face to see if there is obvious asymmetry asking about or examining their vision and their eye movements; see whether the eyes are moving together in, up down to the left and right, and at the sort of four points of the square as well; asking whether they have any double

vision when they're moving their eyes; checking the sensation on your face is the same in three different zones and equal on each side; asking the patient to close their eyes tightly and make sure that the muscles that close your eyes are working correctly and equally on both sides; asking them usually to purse their lips and make sure that the muscles that you use when you're closing your mouth are working the same and equally on both sides, sometimes puffing out their cheeks to check those muscles as well; usually roughly testing someone's hearing by using a very quiet noise to see if they can hear that normally; and assessing their speech, asking them to stick their tongue out to see that their tongue is working normally; asking them to shrug their shoulders and turn their head to each side to check some of the neck muscles.

42. Having written in the notes "*No cranial nerve deficits identified*" I would assume I had done those checks.

43. Then looking in her ears to see if there's any blood or any clear CSF fluid.

44. Then no Battle's sign. Battle's sign is associated with a particular type of skull fracture called a "base of skull fracture" and it refers to bruising behind both ears.

Chest examination

45. I can't remember the absolute specifics, but usual practise would be to look at the chest and to see whether the person's breathing was laboured or not, and then to listen and ensure the lungs sounded as if they were working well and filling normally, and that the amount of air moving on each side of the chest was the same.

46. She had some observations taken including oxygen saturation. Now, that was at 8:20, it says in the notes on page 2. I don't know if that is my writing or not.

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47. I have been referred to my notes in PC Short's records on page 5: "*(B) – No chest pain*". I can't remember whether that was her telling me that she wasn't experiencing chest pain or whether that was the result of having then pressed on her chest to examine it.

48. My usual practice would be to press and see whether there was actual chest tenderness when you were pressing over the chest wall itself. But again, without having specifically written "No chest tenderness", I can't tell you whether that was what I did at the time or not.

49. Usual practice would be to look at the chest and to press on it. Then to listen to the chest as well. I may have asked PC Short's colleagues to leave or asked her if she was happy for me to continue with the examination with her colleagues present. I can't remember the detail of the examination.

50. The "chest" is describing from the bottom of your neck down to the bottom of your rib cage. I suppose your ribs are coming down lower on each side than they do in the middle, and they are providing some protection to your upper abdominal organs. This would include your lungs. Listening to a patient's chest/breath sounds would usually include listening at both the front and back.

51. I have been asked if there is anything I would expect to see on the chest before bruising would develop. I'm not a forensic expert so, in terms of injury patterns, that information would probably need to be from somebody else.

PC Nicole Short's injuries

52. I have no recollection of PC Short's injuries. I have to refer to my notes.

53. I found that she had abrasions over both her elbows and her knees, and an abrasion with some swelling over the palmar aspect of her left hand. And I've

written that it's her hypothenar eminence, which is the area of soft tissue on the palm side of the hand on the other side from the thumb. It is muscles and fatty tissue.

54. I've written on page 6 that there was "*No bony tenderness*". So, I hadn't elicited any signs of an injury to the bone or a fracture. I've also written that there was some erythema, which is redness, on her right pinna, which is the visible part of the ear.

55. To be honest, looking at the notes, I would say it's not clear what "*No bony tenderness*" and "*No bony injury identified*" on page 6 relates to, whether it is just the left hand or also the elbows and knees. If I had found bony tenderness over any of those places, then I would have noted it and organised x-rays, so it's probably reasonable to conclude that it refers to all of those areas. "*No bony tenderness*", in terms of my usual practice, would be more likely to relate to areas such as the arms or legs or over your ribs.

56. If I had noticed erythema on the head, I would have noted it. In a patient who's got a lot of hair on their head, erythema, reddening of the skin, could be difficult to identify. You would be more likely to identify something that you could feel, such as a lump. And there's no indication in my notes that I felt any lumps on her head. I can't remember examining her head for lumps but it is and was my usual practice to do so.

57. GCS 15 implies that she was alert and orientated. The PEARL (pupils equal and reactive to light) abbreviation refers to checking pupils to make sure they're reactive to light and my notes indicate that they were.

58. She didn't have any tenderness over her cervical spine. I didn't elicit any sign of a neck injury at all.

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59. The next part of the examination, it's just really documenting that both arms and both legs were moving as I would expect them to. If I had found abnormalities with different parts of that examination it may have prompted us to carry out further investigation. For example weakness on one side of the body might indicate a more severe head injury and the need for a CT head scan. There are guidelines to help clinicians determine which patients should have a CT of their head after a head injury.

60. If there had been a facial droop, then that might have indicated a sort of neurological disturbance. And then we would have probably discussed requesting a CT head for the patient.

61. So, from my history and examination, I didn't elicit anything that meant that PC Short required a CT scan of her head. And it suggested clinically a more minor and less concerning head injury.

62. I have been asked if in my subsequent years of Emergency Medicine practice I would take a different view today if I was placed in the same position. I'm not sure, based on what I've read from my notes, that I would have made any different conclusions or done anything else in relation to that sort of assessment and the discharge advice that I gave her.

63. In my notes at page 6 I have written: "*0940 Above discussed with Dr R Anderson, agrees with plan.*" I think it would have been my usual practice to discuss cases with a senior doctor prior to the patient leaving the department. Any appropriate changes or additions could be addressed before they left the emergency department rather than doing that retrospectively.

64. I can't see anything else that I had noted as a positive injury or sign of injury.

65. I would interpret the word "contusion" as meaning a bruise. If I had identified any bruising, contusions or tenderness on this patient's chest I would've

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added this to my notes. I don't see any reason why I wouldn't have added those things in if I had observed them at the time.

Advice and treatment

66. From my notes, it's not clear whether it was verbal or written head injury advice that she was given, but it would be a standard sort of discharge advice after a head injury to advise someone to stay with somebody for 24 hours. That was standard practice.

67. This is in case any symptoms develop that require you to be reassessed or to have further medical assessment. And the reason that we ask people to stay with somebody rather than look out for that themselves after a head injury is because, if you were to have a seizure or to become more confused, then you might require that other person to contact the medical help rather than being in a position to do it yourself.

68. I suppose it's what we would call safety netting. When we discharge a patient, we try to point out important changes in their condition that might require them to seek further medical attention. And often with head injuries, that advice is written down on a pre-printed sheets of paper and given to the patient.

69. Nothing was prescribed for the patient. But a part of the standard head injury advice would be to take simple painkillers for that, something like paracetamol and/or ibuprofen. But if you are requiring stronger painkillers than just those two, that you would seek further medical advice. Again, that's part of the standard head injury advice. And exactly what I said to her when she was discharged, I couldn't tell you.

70. I wasn't in A&E when she returned. I think I might have been aware of her repeat attendance. I can't remember exactly what it involved.

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71. By coincidence, professionally, Dr Rachel Anderson and I still work in the same department. I have been asked if I have had any discussions about this patient with her. No. Until I reread my PIRC statement this morning, I had forgotten that Dr Anderson had any involvement in the case.

Media

72. I have read a little bit of the media. I think it was through the BBC website and I've also had a look at the Inquiry website when I first received a letter from the Inquiry. I had a look at the website and then tried to find out a little bit about what had happened between the events of 2015 and the current situation.

73. I think apart from that, I'd maybe read a newspaper article a little bit closer to the time. But those are the only times I've really followed it very closely.

74. I don't think I saw headlines about the initial incident but I'm not 100% sure.

75. I don't think there's anything that I've read which I could say I felt was reported inaccurately.

76. I have been asked if I have been influenced at all by anything I've read in the media. I hope not. I am aware that there are some inconsistencies between some of the evidence that was submitted at the first inquiry, and I'm aware of the reported conflict as to whether former PC Short sustained injury, was it described by somebody as stomping on her chest? Or not? And that there is conflicting evidence around that.

77. So I had assumed that that would be one of the things that the Inquiry wanted to ask about in more detail. And all I can state is my recollection and my notes as I've written them, my recollection to the best of my knowledge, and what would have been generally taken to be my examination of a patient who had

presented after a history of an assault; which would generally be that sort of top-to-toe examination to try and establish whether there were any injuries that were not initially obvious either to the patient or the clinician.

78. I don't think I can expand on that any more than I have done. I assume it's probably a fairly crucial part of my statement to the Inquiry but, with the time interval, I can't reliably give the Inquiry any more information than that which I've already supplied, unfortunately.

79. 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.

Signature of witness..... [redacted] ..... Date..... May 16, 2022 | 4:12 PM BST