The Sheku Bayoh Public Inquiry

Witness Statement

Dr Zoë Smeed

Taken by [redacted] on MS Teams on Monday 4 April 2022

Witness Details

1. My full name is Dr Zoë [redacted] Smeed. My date of birth is in 1982. My contact details are known to the Inquiry.

2. I'm currently working for [redacted] as a Consultant in the Emergency Department (ED), pre-hospital and retrieval medicine.

3. I'm an A&E consultant. The other part of my job is Consultant for the air ambulance. It's the [redacted], so it's both the [redacted] in [redacted] and [redacted] Hospital.

4. My qualifications are MBChB, BSc (Hons), MCEM, RCEM, FIMC and DRTM. I did the BSc in Biomedical Sciences in 2000 and I finished that in 2003. I then went on to my MBChB, which is my medical degree and finished that in 2008. Both degrees were at the University of Aberdeen.

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5. I then went on to do my ED exams. MCEM is our membership exam, and FCEM is our final exam. That's done through the Royal College of Emergency Medicine.

6. The FCEM, which is the Fellowship exam, the Consultant exam for Emergency Medicine, I completed that in 2017.

7. The FIMC, which is the Fellowship exam for PHEM, Pre-Hospital Emergency Medicine, I completed that in 2017 as well. The Diploma in Retrieval Medicine I completed in 2019. I completed these at the Faculty of Pre-hospital Care for the Royal College of Surgeons in Edinburgh.

8. I am also a member of the British Medical Association.

9. By May 2015 I'd completed my membership exam for Emergency Medicine, that was in 2012. I completed my MCEM exam so I was a member of the Royal College of Emergency Medicine but not a fellow. I was still a registrar doing my training.

10. I'm currently a Consultant in Emergency Medicine, Pre-hospital and Retrieval Medicine. The majority of my job is spent working as an A&E Consultant in the Clyde Emergency Departments. As part of my job plan, I also work for the Air Ambulance providing pre-hospital care, which is going out to incidents at the roadside. I also provide retrieval, where we would go and provide critical care to patients on the islands and then bring them back to intensive care or HDU facilities.

11. In May 2015 I was working in the Victoria Hospital in Kirkcaldy. I was still doing my specialty training, so I was a Senior Registrar, but still undergoing my ED training at the time. I was ST5, my fifth year of training. It's 6 years to do ED. I also took a year out to do pre-hospital speciality training, which was August 2015 to August 2016.

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12. In 2015, I was a senior trainee, but I was still undergoing training. As a Registrar, you would have some responsibility in terms of managing the department, seeing patients, but there was always a Consultant there who would have overall oversight of the patients and of managing the department. As a Consultant, you are more unique in your practice, in terms of you have overall responsibility when you're in charge for the department and for the patients you're seeing.

13. As an ST5 I spent all my time doing Emergency Medicine. The first two years of training was ACCS training, which is Acute Care Common Stem. So, of that, you would only do 6 months of emergency medicine. From ST3, so your third year in training, that's when you do your pure ED training.

Previous statement

14. I have read my previous statement to PIRC on 3 June 2015 (PIRC-00259).

15. I remember being asked to give a statement which the patient had consented to. I can only assume there was consent because generally you would always check that the patient has given consent.

16. I don't remember giving the statement. We give lots of police statements in A&E. I just know I was asked to give a statement. I can't remember the details.

17. My memory would definitely be better when I gave the statement to now. I told the police the truth. I told them what PC Nicole Short, the patient, told me, effectively.

18. I don't know if my notes were verbatim or not because I don't really remember. So, generally, everything that I gave in my statement was what

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was either in my notes or what my recollections of what the patient had told me.

19. I have been asked if, in the event that something in my Inquiry statement contradicts what's in my PIRC statement, which should be preferred. It depends what it is. If it's a memory or recollection, it's several years since it happened so it's unlikely that my memory is as accurate now as what it was. However if it's clinical information, I was a trainee when I saw the patient, so my medical knowledge should be better now as a Consultant than then as a Registrar.

20. I can't remember if I signed each page of my statement. I have been shown a handwritten copy of the statement and see my signature at the bottom of each of the pages.

Medical records

21. I have read my notes in PC Nicole Short's medical records and the discharge letter to her GP (PIRC-01160; PIRC-01163).

22. We see a lot of police officers, unfortunately, who attend ED with injuries, so without my notes I won't be able to remember anything that happened. When I look at my notes and my statement it doesn't trigger any memories. I can only say what's in the notes.

4 May 2015

23. I didn't remember seeing the patient until I saw my notes again. It was a long time ago. I didn't really know the ins and outs. It's not something I recall. I don't think I was aware that the police officer was involved in the incident involving Sheku Bayoh, I only know what she disclosed to me, which is what is written in my statement.

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24. On 4 May 2015 I was working a 2pm to 2am shift. I was working as a Registrar. There's always a Consultant in-hours on shift who's more senior than you. Out of hours, there's a Consultant available from home who could come in if needed or could provide advice if needed. There were other Registrars on that day but we would be about the same level. Others from ST3 to ST6. I can't remember who else was on shift that day.

25. I see from my statement that the patient attended A&E at 15:40 that day. That is on the front of her patient card. That time is put in by the receptionist at the front desk where they'd book in.

26. I have been asked where in the A&E at Victoria Hospital I would see my patients. It would depend on what they come in with. So it would be in resus if they're critically unwell, potentially. There's a majors area and there's a minors area, and occasionally you may see them in different areas, depending on space and capacity. But I can't honestly remember where I saw her.

27. In the medical records on the front page it says she was referred from NHS 24 as the "Source of referral". I'm assuming she called NHS 24 who advised her to attend A&E.

28. I don't remember what the patient looked like. I wouldn't normally write about the patient's general appearance in my notes.

29. From reading the notes it looks like she'd re-attended. So, she'd been to the department before. As a Registrar, you would see your own patients straight off, and occasionally if one of the more junior members of medical staff asked you to review a patient, you would sometimes review them, but it looks like I saw her straight off. I don't know who saw her the first time she presented.

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30. When I saw the patient I can't remember whether I had or whether I hadn't read the previous notes. Sometimes it takes a while for them to be put on the system. Usually all the medical notes for the ED attendances would then go on the computer system, but sometimes there's a lag and a delay. So, I may or may not have had that information but I'm not sure.

31. In the history I wrote that the patient had been seen in ED and "DC", which means discharged. I can't remember if that is what she told me or what I read from the system. I'm assuming it's what she told me.

32. I'm not sure what time she was discharged, but reading my notes and reading what she presented with, I can't imagine from the time of me initially seeing her to the time of her being discharged it being a long period. The only thing is potentially if I got called away to go see a critically unwell patient or something like that, she might've been in the department longer.

33. I have been referred to my PIRC statement at page 2: "*I saw this patient who provided her personal details to me and presented as a police officer who had been chased the previous day (3.12.15)...*". That should be 3 May 2015. She was assaulted the day before I saw her.

History

34. I have been referred to my PIRC statement at page 2: "*She said she had received a blow to her head (back of head) and her back had been stamped on.*" I probably wouldn't describe it like that but sometimes, when the police take a statement, they summarise what you say. They don't write down word for word what you say. So I don't know if it's how the police officers described what I've said, or if I've said what I thought she said. I would prefer to refer to both the statement and my notes.

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35. I have been referred to the medical records (PIRC-01160) at page 5: "*Blows to the back of her head, back and stamped upon her back.*"

36. What's written in the medical notes is more likely to be accurate than the statement because they were written at the time. She will have told me that she received multiple blows to the back of the head. I assume this note means she also received blows to her back.

37. I have been referred to my PIRC statement at page 2: "*She informed me that she wasn't sure if she had lost consciousness… She had mild headaches which was resolved with analgesia. There had been no vomiting or nausea, but she felt intermittently lightheaded. She reported no medical history, allergies or current medication.*"

38. That's basically the history I'd received from the patient. Generally, it's what the patient said. I don't know whose exact wording it is, whether it's the patient herself or whether it's the person who's summarised in the statement.

39. [redacted]

40. I have been referred to the medical records at page 2: "*Presenting Complaint: HEAD INJ / FURTHER COMPLAINT*". That would be completed by the receptionist and not me.

41. I have been referred to the medical records at page 5: "*Chased by member of the public @ work yesterday and sustained alleged assault.*" I wrote "alleged" mostly because we were advised to do that in medical school. Because you're not there, you don't know that she has been assaulted. I'd pretty much always put "alleged" in.

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42. I have been referred to the medical records at page 5: "*? LOC at time.*" "LOC" means loss of consciousness. I would have asked her if she lost consciousness. I've put that to her and she's unsure. It's a routine question you would ask a patient with a head injury: "Did you lose consciousness?". It would help you decide how severe their head injury may or may not be and whether or not you would need to scan them.

Examination

43. I have been referred to my statement at page 2: "*On examination her chest was clear, good air entry, heart sounds normal, abdominal exam was normal.*" It would be a routine examination. How you conduct this examination is always the same. Without looking at my notes I would be uncertain of the exam findings.

44. I have been referred to the medical records at page 5: "*OE Chest clear good AE HS 1+11+0 Abdo SNT BS ✓*". "AE" means air entry. "HS" means heart sounds. 1+11+0 is a normal heart beat. I listen to the heart with a stethoscope. You can do a stethoscope over clothes but it's possibly more accurate underneath. Routinely I would listen under clothes, but you don't always listen under clothes. I guess it depends on patient's comfort, where you're examining them. "Abdo SNT BS" means abdomen is soft non-tender and "BS ✓" means bowel sounds present. Examining the abdomen can be over clothes or underneath. I don't remember if I did my examination under this patient's clothes or not.

45. The notes show she is GCS15, and then it is a normal breakdown. She is orientated to where she is, what time it is and who she is.

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46. I have been referred to the medical records at page 5: "*No nausea / vomiting. Mild headaches, resolved with analgesia and "all over body pain", intermittent lightheaded episodes.*" She's probably told me that she'd had some headaches and they've got better with painkillers. I assume she used the words "all over body pain" because they're in the commas.

47. So all over body pain is generally you're just sore everywhere, which would be typical if you'd been assaulted. As part of the assessment, when you're testing power, coordination, movement of her arms and legs. If she had any significant injuries there, she may not be walking, she may not be able to do some of those movements. So you would identify and you would probably ask, "Is there anywhere specifically where you're sore?", and then you would focus on those points in the examination.

48. I listened to her chest. I can't tell you from memory if I looked at her chest and ribcage. Commonly, I would feel down the chest wall as well, and that's what I would normally do. I can't tell you because I've not written in my notes whether I did that or not, but I probably did, but I can't say for 100%.

49. How I've presented my findings is how you would routinely write your chest/cardiovascular/abdo exam in medical notes. So I think if I'd have noticed that she was sore, I probably would have documented it. I guess you can sometimes be distracted or called upon for an urgent matter so there's potential you may miss recording it. But, if I haven't documented it, it's more likely to be negative than a positive.

50. I have been asked if, having been given the history that she has had blows to the back of the head and back, stamped upon her back and now complaining of all over body pain, would I do anything to follow up with that. You would feel all down her spine, which I did, and I suspect I also felt down her paraspinal muscles as well. And, as we said, if I didn't find anything, I may not have documented that because it wouldn't be routine to necessarily write all the

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negatives. You would usually look and feel in the examination, I can't say for definite because I can't honestly remember seeing her.

51. If you see somebody who's assaulted not just to their head, then you would examine them elsewhere. If it was purely just a head injury, then you may just do the neurological exam. You focus your examination based on what you were told and on each situation.

52. In examinations, you don't really know what's happened. We're not really forensically trained. So if she said to me she was stamped on the back, you may find something, you may not find something. Sometimes with time, like with muscle aches and pains, symptoms can start later or if you've got other injuries or other symptoms, that may mask pain in certain areas. Similarly for example, rib fractures and things, you don't always see them at the time of injury. You may see them or suspect them later. So sometimes, similarly with bruising, it might not necessarily appear immediately after the event, but might appear later. But we're not forensically trained, so basically, if she said to me she was stamped on her back and I didn't find anything, I wouldn't say anything back to her.

Injuries

53. I have been referred to my statement at page 2: "*My impression was she had a mild head injury, post-concussion syndrome, no indication for CT scan. Soft tissue injuries and acute stress reaction.*" Post-concussion syndrome is, after you have a head injury, you can get symptoms of concussion. So you can have mild headaches, nausea, light-headedness. That's normal after a head injury.

54. A CT scan takes formal pictures of your brain to see, after a head injury, if there's any blood or bruising on the brain. We've got set criteria as to when we would consider doing a scan and she didn't meet those criteria. So she didn't need one.

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55. I can't explain the exact 2015 guidelines without looking them up, but things you'd have been looking for or you'd be worried about is if the patient had a persistent severe headache which didn't get better with analgesia, if she got significant amnesia from the event, significant loss of consciousness, if she was overtly confused but not anxious, but more confused in terms of not knowing where she is, her conscious level is not appropriate, or if she'd got persistent vomiting. So there's lots of different criteria to when you would think about scanning or not scanning, and you would use the guidelines to decide whether you needed to scan someone or not.

56. There were none of those things that made me think that a CT scan was indicated. So the problem with the scanners, as with anything, there's a risk. You're giving patients unnecessary radiation by putting them through a test they don't need. So, for her, she didn't give any indications that I felt at that time that she needed a CT scan.

57. I have been asked if, seeing my notes again today and with 7 additional years of emergency medicine experience, would I have done anything differently. I don't think I would've CT'd her, reading my notes.

58. I have been referred to the medical records at page 5: "*Mild soft tissue facial swelling right.*" I haven't actually written which part of the face. I can just say that on the right-hand side of her face she had some facial swelling.

59. I have been referred to the medical records at page 5: "*No bony tenderness to facial bones or TMJ*". That's your temporomandibular joint, so it's more your jaw bones.

60. I have been referred to the medical records at page 5: "*No C-spine tenderness FROM neck mild R paraspinal tenderness*". "FROM" means full range of movement. She's moving her neck normally. She had no tenderness

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over the bones in her neck, she had some mild tenderness to her right paraspinal muscles at her neck, which are more muscular, and she was able to fully move her neck. So you do that if you're worried about looking for a fracture with the neck. I test tenderness by feeling down the spinal bones and checking if it is sore.

61. I have been referred to the medical records at page 5: "*No TLS spine tenderness / bruising*". This means she has no thoracic, lumbar or sacral spine tenderness or bruising.

62. The next part of the notes is checking plantars, basically checking the nerves in the foot by tickling the bottom of the feet. It's not very pleasant. I would get her to take her shoes and socks off for this. Power, reflexes, sensation, coordination all normal.

63. I have been referred to the medical records at page 5: "*Imp Minor head injury – no indication to CT – post concussion syndrome – Soft tissue injury*". "Imp" is my impression. So effectively I don't think she's got a fracture anywhere.

Treatment

64. I have been referred to the medical records at page 6: "*Plan – DC with cocodamol + ibuprofen + head injury advice*". Usually you would give verbal and written advice. I advised her if things aren't getting better or if things change, then come back and either come back to ED or see your GP. It's the routine, normal way of writing that.

65. I have been referred to my notes at page 4. I have prescribed this patient co-codamol and ibuprofen. Co-codamol is a mixture of codeine and paracetamol. It's two drugs together, so it's slightly stronger than paracetamol. I would prescribe it if the patient is not getting relief with paracetamol. You can buy lower strength co-codamol over the counter. I've prescribed her the higher

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strength co-codamol. We would typically prescribe the higher strength, I don't think we had the lower dose available in the department. Drugs might cure some of your pain not all of it.

66. It might have been possible I discussed the management plan with one of the Consultants or the fact that I was giving a police statement to one of the Consultants. I'm not sure. If that happened, you would commonly note it, but you might not always note it. If you've discussed it with a Consultant and they've agreed that your management plan is accurate and they would have done what you plan to do, then I might not necessarily note it.

Miscellaneous

67. I can't recall knowing that this patient was related to the incident involving Sheku Bayoh. I guess, unfortunately, it's a small hospital and commonly we would do a handover of shifts, so I guess I may have been aware that a patient was brought in, a young guy who sadly passed away from a cardiac arrest, but I don't think I necessarily knew the two things were related. I don't remember PIRC telling me in the interview that they were connected. When I got the information in the letter from the Public Inquiry's office that's when I was aware that I was involved somehow.

68. I was aware the case was being investigated years ago and I know it recently hit the BBC news website, and part of that was I just recognised his name with the Inquiry details. So I know it was released on the BBC news website a few days ago. In 2015 I was not following it on local media or social media. I think I was aware it was happening but I wasn't purposely following it.

69. I don't think I knew the connection between my patient and Sheku Bayoh. I think when I was contact by the Inquiry, I assumed it was someone connected, so potentially someone who'd been potentially a police officer in the incident. I don't know if that's from a guess or from a recollection of being

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told, I don't know. Just when it came through, I think I wondered, "Oh, I wonder if that was the police officer that had been assaulted".

70. 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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May 17, 2022 | 4:52 PM BST

Date of Signature.....