SHEKU BAYOH INQUIRY

TRANSCRIPT OF THE INQUIRY

Thursday, 9 June 2022

(10.00 am)

LORD BRACADALE: Good morning. Before we start this morning I just want to say that you will note that neither of the assessors is here today, but I think as I explained at the beginning of the hearing, if they're not present here, they're following the proceedings using the broadcast and the live transcript and then they keep in touch with me.

Now, Ms Grahame, who is the first witness today?

MS GRAHAME: The first witness today is Dr Katherine Mitchell.

LORD BRACADALE: Good morning, Dr Mitchell.

A. Good morning.

LORD BRACADALE: You're going to be asked questions, but before that, I ask you to take the oath. So would you raise your hand, please?

DR KATHERINE MITCHELL (sworn)

LORD BRACADALE: Ms Grahame.

MS GRAHAME: Dr Mitchell is going to be taken by Ms Thomson.

LORD BRACADALE: Ms Thomson, yes.

Ms Thomson.

Questions from MS THOMSON

MS THOMSON: Good morning, doctor.

A. Good morning.

Q. Is your full name Katherine Mitchell?

A. It's Katherine Frances Michelle.

Q. And how old are you, Dr Mitchell?

A. So, I was born in 1980. I'm 42, I think, no? Yes.

Q. Give or take.

A. 42 this year.

Q. 42 on your next birthday?

A. Yes.

Q. Grand. And what are your professional qualifications?

A. So I graduated with an MBChB and that was in 2005 from the University of Dundee, and since then I have gained the MRCEM, which is a qualification in emergency medicine issued by the Royal College of Emergency Medicine, it's a three-part examination.

Q. All right. You mentioned the MBChB; is that a medical degree?

A. Yes.

Q. From a university?
A. Yes, a Bachelor of Medicine and Surgery.
Q. And the MRCEM, what does that stand for?
A. That's a Member of the Royal College of Emergency Medicine.
Q. And you explained that was a three-part examination?
A. Yes.
Q. Am I right to understand that in your current role you are a specialist trainee, year 5, in emergency medicine?
A. That's correct, yes.
Q. Should we understand then that your specialism is emergency medicine?
A. Yes.
Q. If I can take you back to May of 2015, at that time you were working within the A&E department at the Victoria Hospital in Kirkcaldy?
A. Yes.
Q. And I understand that at that point in your career, you were what's called a foundation year 2?
A. Yes.
Q. Can you explain, please, what that actually means?

A. So with the current structure of medical training, after you graduate you work in a foundation programme for two years, so I had initially graduated in 2005 and worked in a foundation programme at that point until 2007 and then as -- I worked in ophthalmology after that. I then had a break while my children were small and returned back into practice, regained those foundation competencies over a course of three years part-time, and then was eligible to apply for specialist training, which I have undertaken since 2012. Does that help to answer the question?

Q. It does, it does. Foundation year might not mean very much to me or to others who are listening to the proceedings, so I thought it would be helpful to ask you to explain, so I think we have a clear idea now of your career progression from university through to 2015 and where you are today, and I think I'm right to understand too that your specialism now certainly is in accident and emergency medicine.

A. Yes.

Q. I'm going to be asking you some questions about

a patient who you saw in the A&E department at the Victoria on 3 May 2015, a constable Nicole Short, who had been assaulted at work.

Before I ask you any questions, I want to make sure that you've got everything that you need to give your best evidence to hand and there's a folder in front of you, doctor. If you open that up --

A. Yes.

Q. -- you should find within it a copy of the statement that you gave to the Inquiry team. That's got reference 115 on it.

A. Yes.

Q. And it's a statement that you gave to a member of the Inquiry team on 16 March of this year, do you see that?

A. Yes.

Q. If we could have that on the screen, please, page 15, paragraph 79. I will just take you to the end of the statement. It concludes with the words:

"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."

Do you see that?

A. I do.

Q. And beneath it, do you see your signature?

A. So it was explained that it was an electronic signature and I was to sign it electronically, which I did.

Q. Grand. And have you in fact signed every page electronically?

A. I believe so, yes.

Q. You will see that on the version that's popped up on the screen your signature has been redacted; the hard copy in front of you bears your electronic signature.

A. That's correct.

Q. And also the date, 16 May of 2022.

A. Yes.

Q. Also in the folder there should be a statement that you gave to the PIRC, that's the Police Independent Review Commissioner, on 17 June of 2015. That's got reference 294. So the statement was given on 17 June 2015 to a DSI Miles who was accompanied by a trainee from the PIRC and you gave that statement at the A&E department.

Do you recall giving that statement?

A. I think I do, yes.

Q. And when you spoke to the PIRC, would you have done your best to tell the truth and give a complete and accurate account of the events of 3 May?

A. I would have done.

Q. If we can flick back to your Inquiry statement momentarily, please, at paragraph 11, please. When you gave your statement to the Inquiry you were referred back to your earlier statement given to the PIRC and you said:

"I have read my previous statement ... I gave a true account to PIRC to the best of my recollection and using my notes."

Would those be the accident and emergency notes?

A. Yes.

Q. You don't have a separate note?

A. I don't have any separate notes, no.

Q. "Having read it doesn't really bring back anything in my memory that I could add on top of what is already written down unfortunately."

And if we scroll down to paragraph 12 please:

"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 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."

So you have been clear that if there is any discrepancy between your Inquiry statement and your PIRC statement, we should prefer the PIRC statement because it was given closer in time to the events of May 2015.

A. I think so, yes.

Q. Grand. Also within the folder there should be the Accident and Emergency notes for Constable Short. They are PIRC 1158. Perhaps if we could look at the second page very briefly, Ms Drury, and scroll down just a little further, just so that we can see your name

there, "Name of doctor"?
A. Yes.
Q. "Mitchell FY2", that's foundation year 2, I assume?
A. Correct.
Q. "Time seen 8.20", and, sorry, if we scroll up just a little bit so that we can see that Constable Short's name also features, top right-hand corner, I think. And we see these are the notes that relate to Nicole Short.

Now, we don't need to scroll further through the document on the screen but if you could perhaps cast your eye through those notes and confirm that they are written in your hand?
A. Yes, they are.
Q. So these are the notes that you took on 3 May 2015?
A. Yes.
Q. Can I ask whether you wrote these notes during the consultation with Nicole Short or did you write them up later on?
A. I can't remember exactly, but because working in the emergency department in Fife, you can take paper notes rather than typed notes, what I would usually have done

I think would be to take the card into the cubicle with me and probably write some of the history whilst I was speaking to a patient, and then examine them, but probably write-up the examination sitting outside of the cubicle after I had finished.

Q. So it would be your practice then to do a combination of taking the history and writing that up at the time, carrying out the examination and then writing up the rest of your notes retrospectively?

A. Yes, yes.

Q. Would they have been written up within a short time of seeing the patient?

A. So I would always try and write my notes up certainly on the same day and I would imagine that they were probably completed within quite a short time of seeing her.

Q. May we take it that the notes are true and accurate?

A. They would have been accurate to the best of my knowledge, yes.

Q. And insofar as you have agreed that your memory was perhaps better in May 2015 than it is today --

A. Yes.

Q. -- should we prefer what is written in the notes, if it should come to pass that there might be any discrepancies between the notes and statements that you have given subsequently?

A. I think so. They would have been the first things that I wrote down, followed by the PIRC statement, followed by the statement given to the Inquiry, so if there is any discrepancy -- as I say, I'm not an expert but I would imagine what was written down first is probably the most accurate.

Q. Because they were closest in time to your examination of this patient?

A. Exactly.

Q. So they were written up in all likelihood partly during the consultation and partly later that day, whereas your PIRC statement was given more than a month later on 17 June --

A. Yes.

Q. -- and your Inquiry statement was given some seven years after the event.

We can take that down from the screen for now, thank

you, Ms Drury.

So I'm going to ask you some questions about Constable Nicole Short. Do you recall that patient at all?

A. A very vague recollection only of the consultation. As I have said in the statement that I gave, I think she was quite slim build, I think she may have had blonde hair and I do remember examining her, but all the details I would have to refer to what I have written down previously.

Q. You must see a lot of patients in A&E?

A. We do.

Q. Can we look then at the medical notes at page 3 and we will begin with the history. So we see again the notes are dated 3 May. They're dated 8.10. The cover sheet was dated 8.20.

A. I wonder if some of the clocks in the department and the computer screens had slightly different times --

Q. I see.

A. -- so I can't explain why one is 8.20 and one is 8.10 but that's a potential explanation.

Q. But can we take it that the clock that was to hand when you took the history said 8.10 on it?
A. I can't remember exactly.
Q. All right. "Mitchell FY2", again that's yourself. And the first six lines or so give a history of the incident. Can I ask you just to read out that history, the first six lines or thereby?
A. Starting with:

"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 [the] police van."

Q. Grand. At the very beginning there's a circle with a cross and 29. What does that mean?
A. So that would refer to the age of the patient and the fact that she is female.
Q. That's the female gender sign, is that right?
A. Mm-hm.
Q. Is it your practice to take the history from the

patient?
A. If I'm able to, it would be my practice to take a history from the patient, yes.
Q. In what circumstances might that not be possible?
A. So if a patient is unconscious then they wouldn't be able to give you a history and you might be able to collect information from other people, or if somebody is very confused you might get information from other people with their consent, if it's necessary and practical to gain that.
Q. Can you recall whether on this occasion the history came from Constable Short or from someone else?
A. I can't recall, but I can't see any reason why it would have come from somebody else.
Q. And if we look at the history, it includes the words "Remembers falling and putting arms out to save herself"?
A. Yes.
Q. Does that tend to suggest that she has shared her recollection of the events with you?
A. That's how I would interpret that, yes.

Q. Doctor, from a medical perspective, why is it important for you to take a history from a patient?
A. So a history starts to give you information about why the person has presented to you. It gives you information about what their presenting complaint is, what symptoms they're suffering, and it often helps you to work out the reason for those symptoms and to focus your examination and then any subsequent investigations that are necessary as well.
Q. So it's an information-gathering exercise essentially for you?
A. Yes.
Q. And in taking a history from the patient, would you be keen to elicit from them what has happened?
A. Yes.
Q. And any injuries that they're aware of?
A. Yes.
Q. And any body parts that might be sore?
A. Yes.
Q. Now, in the notes -- and you have the hard copy before you, please cast your eye over that if it would be

helpful -- there's no mention of back pain or pain in Constable Short's right-hand side. If she had complained of pain in her back or side when you took the history, would you have made a note of that?

A. I can't see any reason why I wouldn't have made a note of it.

Q. Would it have been important to you if she had made a complaint of back pain or side pain?

A. It would have been, because then it would have alerted you to the fact that there was potentially an injury affecting her right-hand side, or her back.

Q. Nicole Short has now given evidence and she described experiencing a searing pain in her right-hand side after the assault. If she had complained of a searing pain in her right-hand side when you examined her, would you have made a note of that?

A. I don't see any reason why I wouldn't have done.

Q. And again, would that have been important information from your perspective?

A. Yes.

Q. I would like to ask you some questions now about your

examination of Constable Short and if we could perhaps go back to your Inquiry statement for a moment, please, and again the relevant paragraph will pop up on the screen. Paragraph 77, please.

We can ignore the first sentence for now but it records that:

"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."

So should we understand that in a case such as this where there is a complaint of an assault, you will carry out what's known as a top-to-toe examination?

A. Yes, and then sort of focusing on areas where there are particular interests, so the patient had given a history of a head injury, so part of my examination would have focused on whether that head injury was likely to be

significant in terms of requiring further investigation, but I think if I look at my examination, I have also examined her chest and her tummy to try and elicit whether there were any injuries in those areas of the body as well.

Q. So was your examination limited to the head, the chest and the tummy, or did you carry out a top-to-toe examination?

A. So as part of the assessment for a head injury you are looking at how the nervous system is working so that also includes looking at the patient's face and examining their face and whether there are any what we would call cranial nerve injuries or deficits and also their arms and legs to make sure that the muscle groups and the sensation in all four limbs are working correctly as well. I think --

Q. All right -- sorry, carry on.

A. Thank you. I think I have also mentioned that she had some abrasions over her elbows and knees, so had looked at her hands to see if there was any signs of injury there as well.

Q. So were there any parts of the body that weren't examined as part of your top-to-toe examination?
A. I don't think so, looking at the notes.
Q. Why is a top-to-toe examination important where there's a history of assault?
A. With any sort of trauma there can be what we would sometimes term a distracting injury, so an injury which is maybe more severe and more focused on by the patient and maybe the clinician initially, but if there has been trauma, then it's important to establish whether there are any other injuries that have not been apparent initially.
Q. So could a distracting injury potentially mask something of equal importance that's going on that --
A. Yes, but is maybe presenting a little bit more subtly.
Q. I see. Does the top-to-toe examination, or rather on this occasion, did the top-to-toe examination involve an examination of the torso?
A. So I have written within my notes that there was no injury -- obvious injury to her chest and noted that percussion was resonant throughout, so that would have

involved tapping on her chest to see whether the lung fields were resonant. I have then written "vesicular breath sounds throughout" which would have involved listening to the patient's chest and therefore examining her torso.

Q. Now, if we can look at paragraph 50 of your Inquiry statement, please. You give a description of what is meant by the chest from your perspective as a doctor and you say:

"The 'chest' is describing from the bottom of your neck down to the bottom of your rib cage ... 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."

So when you say you carried out an examination of the chest, are you examining the front of the body, the back of the body or both?

A. So I can't remember the specifics of this consultation unfortunately, but you would be examining both the front

and the back usually.

Q. That would be your normal practice?

A. Yes.

Q. And can you think of any reason why you would have deviated from your normal practice in this consultation?

A. No.

Q. When you examine the chest, do you do that on top of the patient's clothes or do they require to undress?

A. So it does depend a little bit on the situation. I know that this patient had people with her when I saw her and you're obviously aiming to carry out as thorough examination as possible, whilst maintaining the patient's dignity. I can't remember when whether I examined -- asked her to take off her upper clothes or not on this occasion.

Q. Are there any aspects of a chest examination that would require you to look at or touch the patient's skin beneath their clothing?

A. So, I have written -- can I just go back to my notes?

Q. Please do.

A. So I have written that she had no chest pain and that

there was no obvious injury to the chest. As I said, I can't remember whether that was directly looking at her skin or not. Had she described chest pain, or had I elicited any tenderness when I was examining her by tapping on her chest or listening to her chest then I would imagine that I would have asked her to take her clothes off so I could look at the skin and see if there was any bruising or marks there.

Q. Now, we know that on the day in question, Constable Short was wearing a protective vest --

A. Right.

Q. -- as part of her uniform. Do you recall her wearing a protective vest?

A. Not during the consultation, no.

Q. All right. And if she had been, would you have asked her to take that off?

A. I don't know the equipment exactly, but I would imagine it would be very difficult to listen to a person's chest through a large vest, so if she was still wearing it, I probably would have asked her to take it off.

Q. I can perhaps help you with that, doctor. I think we

have a demonstration vest in the hearing space. And if Ms Drury can perhaps pass it to you so you can feel the weight of it and the thickness of it.

A. Thank you.

Q. Would you have been able to carry out an examination of the chest on top of that vest?

A. I would have thought not, no.

Q. So if she had been wearing that when she came into your consultation room, would you have asked her to remove it?

A. I would have imagined so, yes.

Q. Thank you. You can perhaps give that back to Ms Drury.

Returning to your Inquiry statement, if we could scroll up just a little bit, please, to paragraph 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."

You mention there pressing and in your evidence you spoke about tapping; are they one and the same thing?

A. So I talk in the statement -- in the notes about percussion, which is a particular part of the chest examination. You place your hand on the patient's chest and tab like this (indicating) and you're trying to elicit whether there is a sound of sort of hollowness to indicate that there is air within the lungs, or whether there is the sound of dullness which might indicate fluid within the lungs, and in the case of trauma, that might be blood, or whether there is a sound of what we would term hyperresonance which would indicate that there's too much air within the chest cavity and a potential pneumothorax, where air has come within the pleuritic space rather than the lung itself and therefore potentially compressing the lung.

Q. So you demonstrated there what you would do when tapping or percussion. You put one hand on the patient's chest --

A. Yes.

Q. -- and it was a knocking gesture that you made?

A. Then just knocking on your knuckle to try and elicit how air is moving within the chest cavity.

Q. Would you do that to the front of the chest, the back, or both?
A. Often just the back, but sometimes the front as well, and I can't remember whether it was the front and the back in this case.
Q. But it certainly would have included the back?
A. Yes.
Q. Returning to your statement at paragraph 49, you explain that your 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 Constable 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."

So when you describe there pressing on the chest, is that the same as the percussion or the tapping that you have demonstrated?
A. No, that would be more just pressing to see whether there was tenderness over any of the ribs.
Q. I see. So the tapping or the percussion is to do with the lungs essentially?

A. Yes.
Q. And looking to identify whether there were any problems with the lungs, but the pressing is to identify areas of tenderness?
A. Yes.
Q. So again, when you said that you would press, you made a gesture against your body. Can you do that again and explain how you would press the chest?
A. So just pressing gently over the chest wall itself and seeing if a patient is finding that uncomfortable or not. Unfortunately, I have not specifically referenced that in my notes, so I can't say whether I did that on this occasion or not.
Q. Would that be your practice?
A. Practice varies depending on the situation, and if she hadn't complained of chest pain then I can't say I would have necessarily done that. If she had complained of chest pain I would have done, or am likely to have done. As I say, I don't want to say anything that's not correct.
Q. So your usual practice if there had been a complaint of

chest pain certainly would be to press in the way that you have described, and you have said that the chest includes the front of the body and the back. If there had been any complaint of back pain, would you have carried out a similar examination?

A. Yes, and if I can just go back to my notes again -- I have written that she had no C-spine, so cervical spine tenderness, but I have not documented whether or not she had back pain.

Q. All right. And if there had been a complaint of back pain, is that something that you would have noted?

A. Yes. Well, I can't see any reason why I wouldn't have done.

Q. So you can't assist us, relying on your memory seven years after the event, as to whether you pressed to check for tenderness, but you are quite clear that at the very least, you would have tapped the back of her chest or her back, essentially, to check for any issue with the lungs and that tapping that you demonstrated, do you do that at a particular place on the back, or is it all over the back?

A. So I would usually do that in three places on each side, so in the upper part of the chest on the left, so when I say "chest", the back of the chest, so the upper part on the left and the right, then the middle on the left and the right, and the base on the left and the right.

Q. And in your experience, where a person that has sustained an injury to the back of the chest or to their back, can that tapping, albeit you are looking -- your interest is in checking their lungs -- can that process of tapping elicit tenderness where there is an injury?

A. I would imagine if you're placing your hand and then tapping over it, if there is tenderness you may elicit it at that point, but you're not pressing in, so you might not.

Q. The tapping that you would have carried out on Constable Short's back, would that have been on the skin or on top of her clothes, or can't you say?

A. I'm afraid I can't remember.

Q. If you had, at any time, seen her skin and noticed a visible injury, would you have made a note of that?

A. Again, I can't see any reason why I wouldn't have noted

that.

Q. If you had noted any bruising or redness, would you have noted that?

A. Again, I don't see any reason why I wouldn't, and in the areas where I had noted redness, such as on her right ear, I have documented that in the notes.

Q. And if we turn to the notes, please, at page 3, a little bit further down the page, please, Ms Drury, you have recorded:

"No chest pain. No obvious injury to [the] chest. [The] percussion resonant throughout."

That's the tapping that you have described:

"Vesicular breath sounds throughout."

What does that mean?

A. So that's listening with a stethoscope to the patient's chest, again, usually the back and the front and you're listening to see how air is moving through the lungs to determine whether that is equal on both sides. If it was unequal, then it might suggest an injury to one side of the chest and whether that air is moving in a normal or vesicular way, or whether there are any added sounds

to the breathing, such as crackles or crepitations, or possibly wheeze as you might hear in an asthmatic patient.

Q. When you used the stethoscope, is that on the skin or on top of the clothes?

A. Again, I can't remember exactly in this case.

Q. Doctor, can you assist me with this: where is the kidney area on the body?

A. So I would say the kidney area is about here (indicating).

Q. You are indicating -- you have put your hand on --

A. Just below my rib cage --

Q. -- below the rib cage --

A. -- and on the back.

Q. Just above the waist?

A. Yes.

Q. Between the bottom of the rib cage and the waist?

A. And the top of your pelvis.

Q. And the top of the pelvis.

I want to ask you some questions now about loss of consciousness and I want to begin by asking you how you

would assess for loss of consciousness. In a patient who is now conscious but how would you confirm or rule out a history of loss of consciousness?

A. I would ask the patient what they remember about the events and if they can give me a full history of exactly what has happened with no breaks or gaps in their memory, then that would indicate that they haven't lost consciousness. If they have a piece of the recollection that is not clear to them, then that might suggest that they have lost consciousness, or indeed, if they just say "I can't remember what happened after this point", then that could indicate that they lost consciousness at that point as well.

Q. All right. If we look at page 5 of the medical notes, please, sorry, just the top of that page, please. This is a continuation of your notes and it begins:

"GCS ... 15/15."

What does that mean?

A. So that's the Glasgow Coma Scale and it is scored out of 15 points, and 15 out of 15 means that the patient is alert and orientated, their eyes are open spontaneously,

that their speech is not confused and that they are able to obey commands or follow instructions that you give.

Q. And what's "PEARL"?

A. So that is an abbreviation used in respect of an examination of a patient's pupils indicating that each pupil is reactive to light.

Q. You then explain:

"No cranial nerve deficits identified."

What's the relevance of that?

A. So your cranial nerves are the nerves that supply your head and your face. We carry out an examination which includes asking about changes to vision, looking at how the eyes are moving, looking at how the muscles of the face are working, very crudely testing a patient's hearing by making a quiet noise in each ear, asking about sort of speech -- well, observing speech and asking whether they have noticed any sort of asymmetry or difficulty swallowing, any changes to the function of their face.

Q. And you recorded:

"No cranial nerve deficits identified. No double

vision."

A. That's correct.

Q. "No --"

Is CSF cerebral spinal fluid?

A. Correct, yes.

Q. From the -- would that be nose and ears?

A. Yes.

Q. And what does the absence of cerebral spinal fluid tell you?

A. So you're looking for whether there is CSF coming from a patient's ears or nose because it can fit with a base of skull fracture, so a more serious head injury.

Q. So if it was present, it would be a red flag for something more serious?

A. (Nods).

Q. "No blood in the ears".

What might blood in the ears indicate?

A. Again, it could be an indication of a base of skull fracture.

Q. "No batties sign", what's that?

A. Sorry, my writing is not very good there. So no battle

sign.

Q. Battle sign.

A. Battle sign refers to bruising behind each ear, and again is a sign of a base of skull fracture.

Q. So this is a lady who has given a history of having been struck to the head and you are looking to rule out the possibility of a more serious head injury, is that correct?

A. That's correct.

Q. And finally "No C-spine tenderness"?

A. So that would likely have involved pressing on the bones of her neck to make sure that there was no tenderness there.

Q. Returning to consciousness, if we can go to your Inquiry statement, please, at paragraph 32, you say:

"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."

And you said earlier in your evidence that you would

be looking for any breaks in the history of events. Were there any breaks or missing parts in the history that Constable Short was able to give to you?

A. So looking back at my notes, I didn't find that there were any breaks in that history. She was able to describe -- well, I have written that she described what had happened prior to the event in the fact that she had been chased and that she remembered the fall itself and putting her arms out to save herself, and then that she curled up in a ball and was then lifted by one of her colleagues, so I didn't find any breaks in the history when I discussed that with her.

Q. Returning to your Inquiry statement, at paragraph 33, you say:

"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.

"If a patient can recollect all of the events then it would be normal practice to assume that they hadn't lost consciousness because they can describe everything that happened. If a patient can't recall 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's important in terms of your clinical decision-making, but also whether there is a lengthy period of amnesia or memory loss before the incident which wasn't demonstrated to me in this case."

What is the significance of a period of amnesia in the 30-minute period leading up to a head injury?

A. So that's one of the situations where we would carry out a CT scan of a patient's head after a head injury, so there's a number of different indications that are published in guidelines and if a patient can't remember the 30 minutes before a head injury, I believe there's an association with more serious injury and therefore the suggestion in the guidelines is that you would be

sensible to carry out a CT of the patient's head.

Q. So it would be an indication for further investigation?

A. That's right, yes.

Q. In paragraph 35 of your Inquiry statement -- you were taken to your PIRC statement where you had recorded:

"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."

And you say that if that's what you said a month or two after, that would be an accurate version of events. So should we understand that as far as you were concerned you were able to discount the possibility of loss of consciousness here?

A. That's correct.

Q. Can you look, please, at page 6 of the medical notes. I think on the screen it might be upside down. No, just my copy that's upside down. It appears to say LC, would that be loss of consciousness?

A. Yes.

Q. "Punches to back head". Do you recognise that handwriting?

A. I'm afraid I don't.
Q. So it is not your handwriting?
A. It's not mine.
Q. Can you assist us as to whose handwriting it may have been?
A. My only suggestion would be it could have been the triage nurse, if the patient was taken to triage prior to being seen by myself, which would have been the usual practice within the department, they may have written that there, but I don't know.
Q. But as far as you were concerned, loss of consciousness is something that you considered and you felt able to eliminate?
A. That's correct.
Q. If Constable Short had lost consciousness at about 7.20 am, what impact, if any, would that have had on her presentation when you saw her about an hour later?
A. So it's difficult to say, but I would imagine that if she had lost consciousness at that point, she wouldn't have been able to tell me what had happened in the events leading up to her presentation, or certainly the

events around that time. I don't know what events were taking place at exactly that time, but if she had lost consciousness, I would have expected there to be a gap in the recollection that she gave me.

Q. Is it possible to suffer from concussion without having lost consciousness?

A. So after an injury to the head you can get a -- without losing consciousness, you can have symptoms such as feeling a little bit sick, maybe feeling a little bit unsteady, finding that your memory is not as good or you're very tired, and I believe those would be symptoms of concussion, so I think yes, you could have symptoms of concussion without loss of consciousness.

Q. So if we were to hear that Constable Short was subsequently diagnosed with post-concussion syndrome, that wouldn't undermine your assessment at the time that she hadn't suffered a loss of consciousness?

A. I think you would have to ask a medical expert about that.

Q. If we can return to the medical notes, page 4 of the notes, please, and the bottom of that page, please,

Ms Drury, so having conducted your -- taken the history and conducted the examination of the patient, you have recorded your impression which was:

"Head injury. No neurological deficit identified. No bony injury identified."

And the plan:

"Discharge with head injury advice. Advised to stay with someone today overnight."

A. That's right.

Q. Is that standard advice for a patient who may have suffered a head injury?

A. Yes, yes. So after a head injury we're trying to ascertain whether there is any evidence of a serious head injury that would require further investigation or observation at the time, but there is recognition that some of these symptoms can develop after a consultation and therefore we advise patients to stay with someone for 24 hours after a head injury, and to represent should certain symptoms occur, or if they have further concerns.

Q. Doctor, I want to return to your consultation with

Constable Short and I asked you lots of questions about what she was wearing, whether she undressed and perhaps unsurprisingly, seven years down the line you don't recall. I am, however, reminded that when Constable Short gave evidence on 24 May to this Inquiry she said:

"I was given a gown to put on, a hospital gown to put on."

Now, tell me about hospital gowns. When a patient is asked to put on a hospital gown would the expectation be that they take off their day clothes and just wear the gown?

A. I think so, yes.

Q. And what's the purpose of a patient putting on a hospital gown?

A. It would potentially make your examination more -- easier because -- so it's a little bit like at the hairdresser when you're asked to put a gown on over your front and the back is open, so it could make your examination easier.

Q. So the back of the gown is open?

A. Usually, yes.
Q. And if the back of the gown were open, then you would be able to see the back of the chest more easily?
A. Yes.
Q. And if Constable Short had been wearing a gown that was open at the back, can you comment on whether it would have been more or less likely that your examination would have been performed on the skin?
A. I suppose it's probably more likely, but I can't -- I honestly can't remember those details.
Q. You can't remember, all right. I want to move on to ask you about another issue now, doctor. There is evidence before the Chair that the man who assaulted Nicole Short stamped on her back. Now, she does not recall this but was told about it after she returned to the police station following her visit to A&E.

Two police officers have given evidence that they saw the man stamp on her back. A civilian eye-witness to the incident says it did not happen. So you will appreciate it's a contentious issue and the Chair to the Inquiry will require to make a finding in due course as

to whether the man stamped on Constable Short; if he did, where on her body, how many times and with what degree of force. And it may assist the Chair to know what the medical evidence tells us and, as you may be aware, you were the first doctor to examine her after the assault.

I would like to give you descriptions of the stamp, the descriptions that have been provided by the two officers who say that it happened, and it may be that we can bring these up on the screen, if not I will read them out. Ms Drury, do we have PIRC 263, which is Constable Tomlinson's statement? If we could go to page 3, paragraph 3, please.

(Pause).

If we can scroll down. I'm sorry, it appears I must have the wrong page reference, but not to worry, I will simply read out what I had hoped this would say:

"He stomped on her back with his foot with a great deal of force. He put his full body weight into the stomp and used his arms to gain leverage. After he did this she went back to the floor and never moved.

I thought he had killed her. He stomped on her back again with the same force and she wasn't moving."

So that's the description provided by Constable Tomlinson in his statement to the PIRC and I would like to give you a similar description provided by Constable Walker, and again, I will just read this out, but this is from a statement he gave to the Inquiry:

"PC Short was lying face down in the prone position on the road. Sheku Bayoh was standing at right angles to her. I saw him with his right leg in a high raised position. He had his arms raised up at right angles to his body and brought his right foot down in a full force stamp down onto her lower back, the kidney area."

So those were the descriptions given by the officers and when they gave their evidence, they were asked to demonstrate the stamp, and I'm going to ask you to watch their demonstrations because the evidence was of course recorded, so if we could perhaps watch Constable Tomlinson's demonstration first.

(Video played)

And now Constable Walker's demonstration.

(Video played)

Okay, so you have heard the verbal descriptions and you have seen the demonstrations that were given in evidence. Now, doctor, I'm going to ask you some questions about that, and if you feel that these questions take you out of your field of expertise, then please just tell me, but would you have expected a stamp or stamps as demonstrated there to have caused injury?

A. I think you probably are taking me a little bit out of my field of expertise for a proceeding such as this and maybe a sort of forensic expert might be more appropriate to provide a more definitive answer, but on the first page of my medical notes I have written that the patient's abdomen was SNT which is soft and non-tender and that there was no obvious abdominal injury and no abdominal pain. That would have involved pressing on the front of the patient's tummy, putting one hand underneath and then sort of squeezing the kidney area between two hands to see if it elicited any tenderness.

Q. Squeezing the kidney area?
A. So, the flank, yes.
Q. And had there been any tenderness would you have made a record of that?
A. I don't see any reason why I wouldn't have done.
MS THOMSON: All right. Can you bear with me a second please.
(Pause).
Thank you, doctor. I have no further questions for you.
Thank you, sir.
LORD BRACADALE: Thank you. Are there any Rule 9 applications for this witness? Ms Mitchell.
Dr Mitchell, would you mind going back to the witness room while I hear a submission?
A. Of course.
(Pause).
LORD BRACADALE: Yes, Ms Mitchell.
Application by MS MITCHELL
MS MITCHELL: Just one issue, in the Inquiry statement given by Nicole Short at paragraphs 23 and 24, she indicates

that she told the doctor, that being Dr Mitchell -- sorry, I should say for the record, that's Inquiry statement of Nicole Short, it's number 41, at paragraphs 23 and 24. At paragraph 23, the last sentence, it says -- when she was being examined by Dr Mitchell:

"I told the doctor at the time I knew I wasn't speaking normally but she discounted that for some reason."

And then at 24:

"I do remember telling Dr Mitchell that I felt I wasn't speaking right and her replying that I sounded all right to her."

Now, we have also heard evidence given by this witness that in terms of the Glasgow Coma Scale, one of the things that she assesses is speech and what I would like to know from this witness was if Nicole Short mentioned to her that she was not speaking normally, would this have been important, would she have written it down, would this have been significant and what further steps might she have taken.

(Pause).

Ruling

LORD BRACADALE: Yes, very well. I will allow you to ask that. If you can rearrange the seats.

Thank you. Can we have the witness back, please.

DR KATHERINE MITCHELL (continued)

Questions from MS MITCHELL

LORD BRACADALE: Dr Mitchell, Ms Mitchell who is the senior counsel for the Bayoh family has a question for you.

A. Hello, good morning.

MS MITCHELL: Good morning. Just one issue that I want to ask you about, and that is you have explained to us this morning as part of the Glasgow Coma Scale one of the things that you assess is speech. Can you explain to us what that is, what you carry out?

A. So really just through talking to the patient to make sure that their speech is orientated, that they can describe events, that they don't appear to be confused in any way, or indeed, that that speech has got a sort of unusual or slurred quality to it. My notes indicate that when I examined the patient she was not confused

and that her speech was normal.
Q. If Nicole Short mentioned to you that she wasn't speaking normally, would that have been clinically significant to you?
A. So I don't see any reason why I wouldn't have noted that down and it may have then been a reason to carry out further investigation.
Q. Why would it have been significant?
A. So if she felt her speech was abnormal, then it may have indicated an underlying brain injury which might require a CT scan, or it could have indicated an injury to another part of the body that's involved in conducting your speech, such as your face and your mouth, your lips or your tongue.
Q. Can you imagine would there be any circumstance if Nicole Short said to you that she wasn't speaking normally, you saying that -- your saying that Nicole Short sounded all right to you and not writing that down?
A. I can't remember the exact details of the conversation, but I can't imagine why I wouldn't have noted down if

she felt her speech wasn't normal.

MS MITCHELL: And you may have taken further steps if that were so?

A. Possibly, yes.

LORD BRACADALE: Thank you, Ms Mitchell.

Dr Mitchell, thank you very much for coming to give evidence to the Inquiry.

The Inquiry is going to adjourn in a moment and then you will be free to go.

Now, the next witness, Ms Grahame, is going to give evidence remotely?

MS GRAHAME: That's correct, yes.

LORD BRACADALE: So what we will do I think is adjourn for 20 minutes and take an early break in order to make the arrangements for the witness to give evidence remotely.

MS GRAHAME: Thank you.

(10.58 am)

(Short Break)

(11.24 am)

LORD BRACADALE: Now, Ms Grahame, who is the next witness?

MS GRAHAME: The next witness is Dr Gillian Norrie and she

is joining us remotely, so we can now see her on the screen.

LORD BRACADALE: Good morning, Dr Norrie. Can you see and hear me?

Dr Norrie?

I will try again. Dr Norrie, can you hear me?

A. Yes, I can hear you now.

LORD BRACADALE: Thank you. And can you see me?

A. Yes, I can.

LORD BRACADALE: That's fine, thank you. Good morning, you're going to give your evidence, as we know, remotely. You will be asked questions by Ms Grahame who is the Senior Counsel to the Inquiry.

Before that, I wonder if you could say the words of the affirmation after me.

DR GILLIAN NORRIE (affirmed)

LORD BRACADALE: Now, the next face that you will see is Ms Grahame and she will ask you the questions.

A. Okay.

LORD BRACADALE: Ms Grahame.

Questions from MS GRAHAME

MS GRAHAME: Thank you.

Good morning, Dr Norrie. I'm Angela Grahame.

A. Good morning.

Q. Your name is Gillian Norrie, is that correct?

A. It is.

Q. What age are you, Dr Norrie?

A. 50.

Q. And we have all of your contact details, so I'm not going to ask you to repeat that.

A. Okay.

Q. I'm going to be asking you about 3 May 2015, and you are here to help the Inquiry today because on 3 May 2015, as I understand it, you were working as a forensic medical examiner at Kirkcaldy Police Office, and that was a role that you had been doing since September 2014; is that correct?

A. That's correct.

Q. And could you explain to the people listening what a forensic medical examiner does?

A. Okay. So a forensic medical examiner is an independent doctor who assists the police. Usually it's to aid

gaining forensic evidence, so if there has been a situation where a case may go to court then I am involved in examining either victims or accused to document injuries and obtain forensic sampling.

Q. You have told us in your statement to the Inquiry that you did many sexual assault allegations and you were commonly involved in that type of work.

A. Yes. That is the most common reason that I was called, while working as an FME. However, sometimes you were called to road traffic accidents to assess fitness to drive and take samples for toxicology, or occasionally you may be called to assist an individual in custody who became unwell, who had complex medical needs, but yes, sexual assault was a big part of the job.

Q. Thank you. Now, there are three statements I would like to refer to, first of all. Now, I don't know -- as you are remote, you may not have hard copies. Do you have those hard copies? You do, I hope.

A. I think I might have two.

Q. Well, let me go through them --

A. I do have a folder, yes, I have a folder of information.

Q. Excellent, that's excellent news. Well, the first statement I would like to refer you to is one dated 3 June 2015 and this was given at 14.35 hours. Now, we will see that here on the screen. You may also see it on your screen, but you should have the hard copy of that as well.

A. Yes, I have that.

Q. Perfect. So this is a statement that you gave to PIRC on 3 June 2015 at 14.35 and it was taken by DC Gilzean and DC Muir at St Leonards Police Station in Edinburgh. Is that the one that you have?

A. It is.

Q. And am I right in saying that you gave that statement on that day and that you would have -- it would have been read over to you, or you would have had a chance to look through it and then maybe sign it?

A. Yes, that's correct.

Q. And you could have confirmed you were happy with it, or you could have said you wanted to make changes.

A. Yes.

Q. Thank you. And were you doing your best at that time to

give a true and accurate account of what you had done on 3 May 2015?

A. I was.

Q. And was your statement at that time given to the best of your memory?

A. It was.

Q. So if there's any differences between subsequent statements, or your evidence to the Chair today, should the Chair prefer this statement?

A. Yes.

Q. And then the second statement I would like you to look at please is dated 22 January 2018, so this was nearly three years after the events, again, given at St Leonards Police Station by Investigator Neil Robertson. Do you see that one?

A. Yes, I have that.

Q. And I know that you have some comments to make about this statement and I will come to those shortly and we will deal with that during the course of your evidence.

A. Okay.

Q. And then the third thing I would like you to have a look

at is a statement you gave to the Inquiry, so SBPI 88, and that's dated 22 March this year. Do you have that?

A. Yes, I have that.

Q. And again, you have signed that?

A. Yes, I have.

Q. And if we look at paragraph 110, so that's on the last page, it says:

"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."

Then although we can't see your actual signature, we can see it has been redacted on the screen, but it was dated 10 May this year.

A. Yes, that's right.

Q. And so you have -- in giving this statement, you have done your best again to give a true and accurate record of your involvement in these events.

A. That's correct.

Q. Thank you very much.

Well, first of all, I would like to look at the

Inquiry Statement, which is on the screen, but you have your copy and if there's anything I'm not referring to you want to mention, please just let us know and we can get that put on the screen as well.

A. Okay.

Q. So you have told us about your role in May 2015 as an FME. Can I ask you to look at paragraph 11 first of all of your Inquiry statement.

A. Okay.

Q. And you have said here that it was unusual for you to be asked to become involved with the police, and you hadn't been asked to do that previously.

A. Yes.

Q. Sorry, examining police officers, I should say.

A. Yes.

Q. And then can we look at paragraph 21 as well and you say:

"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'."

And you made your way across to Kirkcaldy. So you weren't based in Kirkcaldy at that time?

A. No, so it's -- there are only two doctors on call at any time when I was working there in the forensic service, and we shared the workload. Generally I covered Edinburgh and down towards borders area. However, sometimes I did go across to Fife, if needs be, so I can only assume that the job was allocated to me because the other doctor on call was already engaged in other work, so it could sometimes happen that I went across to Fife.

Q. Thank you. So you would be on call and you would receive a call and you would then travel to the relevant police office to conduct whatever --

A. Yes.

Q. -- was required.

A. Yes, or a sexual assault, I'm sure you know, we would do an examination -- if, for instance, it was a sexual

assault, they didn't take place in police stations, they had -- there was an independent clinical area that they were done (inaudible overspeaking) --

Q. They were done in --

A. -- police stations.

Q. -- a separate suite?

A. Yes.

Q. And prior to giving this Inquiry statement that we could see on the screen here, I understand that the Inquiry team sent you copies of medical records to allow you to look at them, relating to officers that you examined that day, is that correct?

A. Yes, that was done via an internet, electronic viewing of that, yes.

Q. And you have detailed that in paragraph 13 of your statement?

A. That's correct.

Q. Thank you. And then if we could look at paragraphs 31 and 32, you say that you were accompanied by a nurse, a female nurse, and you don't remember her name but she assisted you during your examination of the officers.

A. That's my recollection. It was a long time ago, but there was a forensic nurse present at some stage. I'm not sure if she stayed for the duration, but at some point there was someone assisting me.

Q. Thank you. And you have also said at paragraph 32 that she wrote down some details to speed up the process: names, dates of birth and addresses and so some of the writing in the notes is hers in relation to the preliminary details, but the rest of the writing in the notes is yours?

A. That's right.

Q. Thank you. And then can we look at paragraph 14, please, and you say having looked at them you were happy with the notes. You think generally all of them are yours with your signature at the bottom. They are a true and accurate record of what happened at the examination and you also told the PIRC -- told PIRC the truth in your two interviews, and that's your position to the Inquiry, that the record --

A. That's correct.

Q. Thank you. Now, subject to a few points that you have

mentioned and detailed in your Inquiry statement, that remains the position?

A. It does, yes.

Q. But let me just look at the areas where you weren't as comfortable and I think there are four areas and I would like the Chair to be made aware of those, so that he gets a complete picture of your understanding, so if we look first of all at paragraph 15. Now, this relates to the -- this is the second statement that you gave, the one on 22 January 2018, which was nearly three years later after these events, and you have said in that:

"... at the bottom of page 2 [of that statement, it is quoted in paragraph 15]: '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 doesn't make sense. How would I know it was provided to her by a colleague."

And so you have clearly explained your view on that passage within that statement to PIRC on 22 January, is that correct?

A. Yes.

Q. Because the sentence doesn't really read as if it makes sense?

A. No. Yes, it's quite ambiguous, it's not clear. I can't follow what was said. It doesn't make a lot of sense to me.

Q. But when you examined any officer, you would come in and you would speak to them and you talk about directing your examination; what do you mean by that?

A. It's very helpful to get some background from a patient, so that you can better focus on where potential injuries may be. However, that's not to say that you would only look at that area. You have to do -- adopt a very

systematic approach and look everywhere, but it is very helpful to have some background, so that if I do find an injury it makes me think about "Does that tie up with what happened? How did they obtain that injury?" Obviously individuals can have obtained injuries prior to events, have sort of older injuries as well sometimes, so it can just make it a bit more focused, if I know some background.

Q. Is it fair to say that you want to be thorough --

A. Yes.

Q. -- but you also want to focus on any immediate concerns that the patient themselves have?

A. That's correct.

Q. Thank you. Could we look at paragraph 16. We have that on the screen at the moment and we're still reviewing your PIRC statement of 22 January 2018:

"At the top of page 2: 'At the time I conducted the examination of the officers I was a Force Medical Examiner ... 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."

So again, that's a mistake in that statement and you wish that to be corrected.

A. Yes.

Q. Thank you. And can we move on to paragraph 17 and it says:

"At the bottom of page 2 [that's the PIRC statement] 'amnesia' is a strange term. It's not something 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."

So I just wanted to ask you about this. When you

were giving your statement to PIRC in January 2018 was it in response to questions that were being asked by the officers or the investigators?

A. Yes. I mean all of this is quite some time ago, but yes.

Q. So is it possible that it was the police, as you say, specifically asked you about amnesia, rather than a word that you volunteered?

A. Yes.

Q. Right. "Happy to leave that", but subject to that slight caveat?

A. Uh-huh, I would agree.

Q. And then finally paragraph 27, please:

"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 [I think we're talking about a statement on 22 January 2018] one part is not entire accurate 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."

Now, can I just be clear: we've got the nurse who accompanied you in the examinations and we've got PI Jane Combe who is a female inspector. When you say "I contacted the forensic nurse who then informed me so I don't think I did speak with her directly", who are you talking about speaking with directly?

A. DI Combe. I didn't actually speak with her directly. That information was given to me second-hand by the coordinating nurse for the forensic service who was allocating the job.

Q. Right. So there was a nurse who made the call to you to allocate the work to you?

A. That's right.

Q. And that's who you spoke with?

A. That's correct.

Q. And you didn't ever actually speak to DI -- Police Inspector Combe?

A. No. I had no interaction with her directly.

Q. So whatever information is there, it didn't come from

Jane Combe?

A. No, that was -- that was given second-hand to me.

Q. Thank you. So you have talked to us about receiving the phone call. Could you look at paragraph 18, please. You tell the Chair there that you received the phone call, you accepted the work and you have also told us a nurse was with you and I think in another paragraph you say there was no specific order in which you were asked to examine the police officers at Kirkcaldy Police Office.

A. Sorry, is that paragraph 18 or page 18?

Q. Paragraph 18. I will refer to paragraphs.

A. Okay.

Q. And we will have the paragraphs come up on the screen. It makes it easier for us to see things.

A. Yes.

Q. And then there's also paragraph 23 and you talk about the nurse.

A. That's right. That was a nurse that was present in the police station at Kirkcaldy when I arrived.

Q. Yes, that's lovely. And then can I ask you to look at

paragraph 26 and you say there:

"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."

And is that your -- was your normal practice in May 2015 regarding preparation of the notes?

A. Yes. It's always a good idea to do the dictation, the formal report as soon as possible. I wouldn't leave it a long time between examinations and compiling the formal report. So yes, that's the normal process for me.

Q. So you have talked about written notes and you have talked about dictation. Can you explain the sequence of events when you are preparing these notes?

A. So I take the written notes at the time of the examination. They're documenting history and examination findings and --

Q. Are those the handwritten notes?
A. They're handwritten. But a formal report is compiled thereafter and that's what I'm talking about with the dictation of my findings from the written notes.
Q. Thank you. Could we look at paragraph 35 please and 36, and you will see that paragraph 35 -- I'm going to be asking you questions about PC Nicole Short, not all of the examinations you conducted.
A. Okay.
Q. And you say you:

"... 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."

Having reflected on that now, do you have any sense of how long you spent with PC Nicole Short?
A. I think it was 25 minutes because when I actually was allowed to view my written notes, the times are

documented.

Q. So you were -- you had actually taken the time to document the times in and out?

A. Yes.

Q. And then can we look at paragraph 36, please. Do we see that you have also been shown your notes and there was a forensic examination record prepared and you have given us the times there.

A. Yes.

Q. I would like to --

A. That's correct.

Q. -- look at PIRC 01301, please, and we will look at the start of this, page 3 I think. This is it. And you will see there that this is headed up the "Forensic examination record" for Nicole Short, born 1986, and the date of examination is 3 May 2015, and the time of examination is 15.45 at Kirkcaldy, and it ends at 16.10.

A. Yes.

Q. Were those the entries that you said the nurse completed, or is that your handwriting?

A. I think that's my -- can I have a quick look again?

I think it's my handwriting.

Q. Right. And then can we go further down the page, please. It says:

"Officer requesting: Inspector Jane Combe.

"Reason for examination: assault in line of duty."

And is this all your handwriting?

A. It is.

Q. And we see that the word "History" appears and it says:

"Called to incident 7.15 am 'Black man chasing cars'."

That's put in apostrophes:

"When arrived 2 colleagues spraying."

Then does it say:

"Nicole's colleague sprayed then Nicole took baton 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 ..."

I can't read the next word, sorry.

A. I can't see it. You would have to put it on the screen for me. I don't have it in the folder.

Q. Right. Anyway, it says "something" to van?

A. "Took to van I think".
Q. "... took to van to safety."
And then:
"To A&E to check up, observe and analgesia."
And then you have put in capital letters:
"Incident: individual restrained and died."
So that was a history. Who provided that history at that time?
A. Nicole Short.
Q. Right. And it says there then "Back stamped on", so there's a mention of her back having been stamped on. Do you see that in your writing?
A. I can't view it. You have to put it up for me. Thanks.
Q. Oh, right. Do you not have a hard copy --
A. I don't have that. I don't have any of my actual original medical notes in the folder.
Q. That's absolutely fine. I can read things out.
Now, as we move on to page 4, so if we can move down the screen please -- keep going, please. Then there's a -- on page 4 you have detailed the injuries. Are these the injuries that you noted at the time during

your examination?

A. They are.

Q. Right. And can we -- I won't go through those in detail. There's no mention of back there, so it says right knee, left knee and left hand, all right?

A. Mm-hm.

Q. And then if we can look at page 5 it reads:

"Tender [right] occipital area and [right] mastoid no injuries noted but tender on palpation."

And then:

"Tender [right] cervical spine, no injuries seen."

A. Yes.

Q. And then there's a GMC number at the bottom?

A. Yes, that's my registration.

Q. That was your registration. So there was no reference in those notes of your examination of an injury having been noted by you to her back?

A. That's correct.

Q. Right. And does that mean that you didn't see or find an injury to her back?

A. Yes.

Q. And can you tell us how your examination was conducted please? What's your normal practice?
A. Normal practice is to take some vital signs, some observations, so blood pressure, temperature, things like that, heart rate, obviously obtain consent first and then conduct a general physical examination which would entail, you know, checking their understanding, their neurological status, certainly if there was a head injury, listening to their chest, listening to their heart and lungs, feeling their abdomen, and then in terms of the injuries, what we do is a very systematic approach, so we start from the head and work down to the feet and looking at the surface area and documenting any injuries that are found.
Q. We have heard the phrase that doctors do a top-to-toe examination. Is that what you're describing when you say the head to the feet?
A. That's right.
Q. And can you confirm if you examined Nicole Short's back?
A. I did.
Q. Did you examine it as far as her lower back into her

kidney area?

A. Yes, I did, as I say, a top-to-toe examination, so I worked systematically down from the head to the bottom of her body to her feet.

Q. Had you found any injury, bruising, marks, discomfort, tenderness, is that something that you would have noted?

A. Yes.

Q. If PC Short had complained of pain in a particular area of her body, including her back, or to her right side, is that something that you would have noted?

A. It is. That was the purpose of my being there, to document the injuries, so yes.

Q. Thank you. Can I ask you to look again at your Inquiry statement, paragraph 55, and you were asked about your examination of PC Short and you say:

"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."

What do you mean when you say "concerns about her neurological status"?

A. If I was worried about her -- how she was neurologically, so if she was presenting after being hit in the head in a way that gave concern, so such as behaviourally, if she was irritable, or inappropriate, disinhibited, or she was drowsy, things like that would obviously prompt me more to look at the GCS, to document the GCS, but her GCS was 15, it was 15 out of 15, there was no concern about her neurological status when I saw her. I do recall that.

Q. Thank you. I'm correct in understanding that 15 out of 15 is normal?

A. That's correct.

Q. If you had seen any changes in her speech or the way she was speaking, is that something you would have noticed or noted?

A. Absolutely.

Q. Were there any signs at that stage, when you saw her, that she had suffered a loss of consciousness?

A. I mean that's a very difficult one to answer. I'm not sure I could really say one way or another. Sometimes individuals can lose consciousness and then be fully

conscious when you see them, so there's nothing really subsequently that would be obvious to correlate both of those things, but I can say that I didn't have concerns about her neurologically when I saw her. I couldn't say with certainty she had had an episode of loss of consciousness, if that makes sense.

Q. Yes. There was nothing at that time that you noted that gave you any cause for concern?

A. There was nothing.

Q. Thank you. Can we look at paragraph 58, please. You have been asked about her chest and you say this:

"... 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."

A. It is, yes.

Q. And when you check someone's lungs, are you checking the front of their chest or the back of the chest or both?

A. Both of those things.

Q. Right. So what people such as myself would commonly call your back, you're actually looking at her back?
A. Yes, it's often referred to as chest examination when you're listening in the back, listening to the lung fields, yes.
Q. Thank you. And would you please look at paragraph 60. You say:

"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."

And is that your recollection of what you did that day?
A. Yes, it is.
Q. So could you see her skin at that point?
A. Absolutely.
Q. And again, if you had noted any marks or injuries, or tenderness or discomfort, is that something you would have noted?
A. It is, but it's better to do the physical examination

first and then be more thorough to then do the actual head to toe documentation of injury afterwards, so yes, I may have listened to her chest and be listening to the breath sounds and things like that, if she would have said "That hurts, I'm comfortable there", I would be aware of it, but that would be unusual to combine both, you would usually split it up, to do a physical examination, as I said, and then document injuries afterwards.

Q. So physical and injuries, you look externally and listen are internally as part of your examination?

A. Yes, so you do a physical examination, as I said, sort of with your stethoscope and feeling for things in the lung and the chest and the abdomen, whatever you're doing, but then I would do a separate systematic approach to the documentation of the injuries thereafter. Otherwise it becomes messy, it's difficult to make good notes if you try and combine both.

Q. Thank you. Can we look at the paragraph just above, number 59. It says:

"'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 were no masses there, so no lumps anywhere, but again a normal examination of the abdomen."

Can you explain exactly what you mean when you say abdomen?

A. An abdominal examination is looking at -- examining the area below the diaphragm, so below the chest down to the pubic area, so, you know, you're feeling it, making sure that it feels normal, feels soft and listening with your stethoscope as well, so it's just doing the routine abdominal examination.

Q. Thank you. Does that include your sides as well, what I would consider my left side or my right side, or is it only at the front?

A. I don't -- I think if you're referring to feeling into the kidney area there I don't think I specifically examined her kidney. I can't say one way or another. It doesn't always.

Q. And would you have asked her to lift or remove her clothing in order to complete this examination?

A. Yes.
Q. Thank you. Could we look at paragraph 63. You say:
"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."
So does that mean the top-to-toe examination and then look for specific injuries if there's a complaint of those?
A. So as per -- the top-to-toe examination is the physical examination. You're looking at the surface area of the skin and documenting the injuries as you go.
Q. Thank you. Can we look at paragraph 64, please. You will see that the medical records 01301 are actually listed here by you, so you have in your Inquiry statement a record of what is contained in the report. Do you see that?

A. Yes.
Q. Right. And then you continue to discuss those injuries up to paragraph 74, so you will have the copy, hard copy of your Inquiry statement and we could maybe go through those just to look at those briefly.
A. Mm-hm.
Q. So if we could scroll through to paragraph 74. Can I just say, are you content that those paragraphs 64 to 74 contain what you want to say about those entries about the injuries?
A. Yes.
Q. Thank you. Can we look at paragraph 75. You have been specifically asked about injuries to the back or rib cage and 75 says:

"I have been asked if there are any notes of tenderness of the back or the rib cage. 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 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."

So can I just be clear: you are looking for injuries and if you see any, you document them in your notes?

A. That's correct.

Q. And you are also listening to the patient, so if they complain of pain or discomfort or having been injured in a particular area, you also note that?

A. Yes, so I'm looking and I'm feeling for tenderness.

Q. And if you find that tenderness, you are going to note that down in your records?

A. That's correct.

Q. And even if you didn't find it, if someone complained of it, if the patient complained of it, you would also note that down?

A. I would. If I can just clarify that, although we get the background history to help better direct the examination, I'm still doing a thorough examination because an individual might not be aware they have

actually been hurt in a certain place. Sometimes that just becomes evident a bit later on, so I'm feeling -- I'm examining thoroughly and feeling down the back to make sure that there are no areas of injury.

Q. Thank you. So you're not just relying on the patient, you're also checking that independently yourself?

A. Absolutely.

Q. And in this particular record and in this particular examination of PC Short, there were no injuries noted in relation to her back, or her abdomen, or her -- in that general area.

A. That's correct. At that time, when I saw her there was nothing to document in terms of injuries in those areas.

Q. Thank you. Then paragraph 76 you say:

"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."

And is that your feeling today?

A. It is.

Q. Right. So you're there to do your job and the reason for taking the history and doing the examination is to note any injuries that she may have sustained that day?

A. Absolutely. I mean that's my role, that's why I was there, so yes.

Q. Thank you. Then can we look please at -- for completeness -- PIRC 01310, and if we can look at the first page and do you recognise this, can you see that on the screen, it's a forensic medical report on PC Short, Nicole Short?

A. Yes. I don't have that in the folder but I can look at it on the screen.

Q. Thank you. It's really just to confirm that this is the report that you described --

A. That's right.

Q. -- dictating, at least the next day or within a few days.
A. That's correct. That's the report.
Q. And I think in your statement, at paragraph 79, you say it was dictated, or it may have been dictated on 7 May and we see at the top of the screen that the date given is 7 May?
A. Okay, that may be the date it was typed.
Q. And can that differ from the day that you have dictated it?
A. Yes.
Q. And why would -- could you explain why?
A. I'm not entirely sure if it that's the secretary's date when she did it, or that's the date that I dictated it, because clearly I have seen the patient before that on the original handwritten notes. I think that's the date that the secretary types it.
Q. And can there be a number of days between you dictating it and giving the tape to your secretary for transcription?
A. Yes, theoretically that's possible, but, as I say,

I think the dates do correlate very closely to one another: the date it was typed and the date that I saw the patient, but yes, it's up to the FME when they do their dictation, but as I said earlier, I like to get it done while it's all fresh in my memory.

Q. But in any event, it's based on your recollection, your memory and your notes taken at the time?

A. Yes. It's basically the notes that you're dictating.

Q. Thank you. Can I ask you to go back to your Inquiry statement, please, paragraph 80, and we will just get that on the screen now. You say you 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."

So earlier in your statement you mention arriving at Kirkcaldy Police Office and meeting with a senior officer --

A. Yes.

Q. -- and in the report we have just looked at you mention the name Conrad Trickett.
A. Mm-hm.
Q. Can you tell us when you arrived at Kirkcaldy Police Office how you were briefed on what your job was to be that day and who did that: was it Chief Inspector Trickett?
A. To be perfectly honest with you it was such a long time ago and obviously I may not have documented the whole process of actually getting out of my car and getting into the station and who met me and so on. My recollection is that I arrived and was met by someone -- an officer and taken through to the area where I was to conduct the examinations and then the senior officer, who I think was Chief Inspector Conrad Trickett -- I have obviously got his name -- just basically it was an introduction and a sort of "Thanks for coming", but I don't think I got any background from him.
Q. All right, thank you.
A. I don't think that's documented and I don't recall getting any more information from him, other than just

acknowledging I had arrived and thanking me for coming.

Q. Thank you. Can we look at paragraph 84 of your Inquiry statement. You say:

"I have been referred to my report at page 4 ..."

That's the report we just looked at, and you are referring to Nicole Short and you say:

"'... she was composed and behaved 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."

And that's something that you comment on in the report that we just looked at?

A. Yes, absolutely. I mean she -- there was -- obviously I had been told that she had been hit on the head, she had gone to the A&E with a head injury, so that's something that -- it's important when I'm examining that individual to bear in mind.

Q. And you're looking out for that?

A. I am.

Q. Thank you. Can we look at paragraph 87, please. You say:

"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."

Now, you say that you are qualified to comment on bruising that can evolve over time and I would be very interested if you could share some of -- share an explanation of how bruising evolves over time.

A. So what bruising is is bleeding after trauma to the tissue, there will be bleeding beneath that area, sort

of capillaries will leak and blood will leak out, that's often why an area can become red after an impact and that can take some time to develop, so it might not be evident immediately. Sometimes it evolves over sort of one or two days and will actually develop into a bruise. Just -- what I wanted to be clear about really when I was asked specifically about that is that there were no injuries at the time of seeing Nicole Short in terms of bruising to her back, but that's not to say that she couldn't go on to develop bruises.

Q. Can you explain what causes a bruise to happen, to occur?

A. A force applied to the -- an impact of force applied to the tissue will cause bleeding under the tissue and into the skin and cause a bruise to develop, so it's blood that will leak out, and when it bruises, it's the blood that's changing colour as the particles are being reabsorbed, so that can take some time, but as I say, I'm not an expert. I was asked could I comment on the bruise and I feel I could, but I'm not an expert in that.

Q. No, no, that's sufficient for our purposes, thank you.

Had you -- can I ask you to comment on paragraphs 88 and 89, please. This relates to loss of consciousness in Nicole Short and you say -- you were asked whether you can remember if there was anything to suggest a loss or potential loss of consciousness and you say you 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."

So you were aware at that time she had been to the A&E, they had assessed her for a head injury and discharged her. We understand they discharged her with advice in relation to a head injury?

A. A device? I didn't know about that. But she had told me in the background, as is documented in my written

notes, that she went to the A&E and they had said that she should be observed but she wasn't admitted to my knowledge.

Q. And be observed, does that mean by a member of her friends or family?

A. That's generally the case when an individual has had a head injury and is discharged from the A&E, they usually make sure there's someone at home with them.

Q. And so that is the advice that was given by them and that's normal if you are suspected of having had a head injury?

A. Oh, I'm sorry, I thought you said they gave her a device; they gave her some advice, yes, that's completely normal, absolutely.

Q. Sorry, it must just be the connection maybe wasn't quite as good there.

A. Yes.

Q. No device was given at any time as far as I'm aware. Thank you for clarifying that.

Can we look at the next paragraph, please, paragraph 89, and then you say:

"... 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."

So as you note there, neurological symptoms can evolve and things can change over time, but when you saw her at 3.45 on 3 May 2015 you did not have any concerns?

A. No concerns.

Q. No concerns. And if you had had concerns, you would have sent her straight back to A&E?

A. Absolutely.

Q. Thank you. I would like to ask you some further questions in relation to another report, please. So look at paragraph 25 of your Inquiry statement first of all, and do we then see that:

"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."

So this was a separate individual, a non-police officer, that you were also asked to examine?

A. Yes.

Q. Can we look --

A. Yes.

Q. -- please at PIRC 01319 and I think page 3 again will probably be the start. Do we see that this relates -- this is a report by you dated -- it says dictated on

4 May and it is dated 8 May.
A. Yes.
Q. And it's in relation to Zahid Saeed, born 1983. Is that correct?
A. Yes, I can see that, yes.
Q. And we can see that --
A. Can I just say, going back to what we said before, sorry, I haven't seen these formal reports for quite some time, but in the top right-hand corner there, there is a date where it is dictated and --
Q. I just noticed that.
A. -- in that other statement we were talking about before.
Q. I just noticed that.
A. So that's just to clarify on that.
Q. I have just put a red star round that bit myself. Let's go back to PIRC 01310 for the moment and see if we can solve that mystery. Ah, so indeed -- I should have asked for the screen to be further down. We can see on this one, 01310, it is dictated on the 4th. So it gives date of examination, 3 May, dictated on 4 May, as you indicated earlier, and then typed -- presumably 7 May is

the date it was typed.

A. Yes, so that's the secretary's date, as I have said.

Q. So this report which was prepared on Nicole Short was dictated the day after the examination.

A. Yes. It looks like it.

Q. Thank you. Let's go back to PIRC 01319, please, and if we could just go up -- thank you. It says:

"Background information from DC Simon Telford."

So will this have been the senior officer, detective, or the officer, Simon Telford --

A. Yes.

Q. -- who asked you to carry out this examination?

A. Yes, that must be the name of the detective that we alluded to earlier.

Q. Thank you. Can we just read that passage please, if we come down the screen slightly:

"The victim Zahid was watching a boxing match last night with the deceased, Sheku Bayoh. They apparently had a few drinks of alcohol. They had an argument and Zahid parted company with Mr Bayoh, however he later returned to Mr Bayoh's house. At that point Zahid Saeed

reported that Mr Bayoh attacked him and hit him over the head about five times. He ran away but was chased and Mr Bayoh hit him with a whirly-gig outside in the garden. Zahid Saeed went to the A&E in Kirkcaldy at midday for a review."

And is that the background information that you received from DC Telford at that time?

A. Yes.

Q. Thank you. Now, in fairness, we have an Inquiry statement from Zahid Saeed which is SBPI 71 and I will just very briefly show you paragraph 20, and this is a signed statement from Zahid Saeed and paragraph 20 makes it clear that he -- he is talking about his friend, Sheku Bayoh, and it says, fourth line down:

"He did throw the washing line pole but it missed me. I said 'Shek, this is not you'. I was shouting that as him. I was shouting 'stop' and 'what are you doing?'"

So thank you, that's fine. If we can go back to PIRC 0139, please. So you have been given the information from DC Telford that it was a whirly-gig.

The up-to-date information that the Inquiry has appears to be that it was a washing line pole. I don't know if it that will make any difference at all?

A. I don't know. I mean I don't really know what a whirly-gig is. I think it is some sort of laundry device, you know, for washing -- for gardens, that moves round, but that -- I was given that information so that's something I was told.

Q. Thank you. Do we see that the examination was commenced at 18.30 hours, half past 6? We should have the report back on the screen.

A. Yes.

Q. And Zahid Saeed had:

"... poor eye contact, his speech was normal but quiet. He was orientated in time, place and person."

We may have heard that phrase mentioned previously with other people. What does it mean "orientated in time, place and person"?

A. It's a useful phrase to indicate if there's any concern about confusion. It means that he can give you his name, he knows who he is, he knows where he is, what

time it is. He is not confused.

Q. Thank you. Then can we go on to page 4, please, and here you have noted again:

"A full body surface examination was conducted and the following injuries were noted."

And you have listed six injuries that were noted there by you as a result of your examination.

A. Okay.

Q. Then we see "Opinion":

"A bruise is caused by blunt force trauma such as a knock, blow or pressure on the skin. It will change colour over a passage of time. It can cause swelling. There was [no] evidence of swelling and tenderness in this gentleman's scalp which are not showing signs of bruising as yet but obviously this could change over time."

I think that's consistent with what you have already told us about bruising and how the colour changes and things change over time?

A. Yes. I think you might have read out there was no evidence of swelling; it says there was evidence of

swelling.

Q. Oh, sorry, sorry, that will be my mistake:

"There was evidence of swelling and tenderness in this gentleman's scalp which are not showing signs of bruising as yet but obviously this could change over time."

Thank you. Sorry, I misread that.

A. No, that's okay, just to clarify.

Q. And:

"Similarly the swollen area on his face (the maxilla area) may well change and become more discoloured over a period of time and develop into an obvious bruise as the days progress."

And is that days as in more than one day?

A. Yes, I mean it can take a couple of days, one or two days for bruising to really develop and it can take obviously quite a bit longer for it to fully resolve.

Q. Thank you. And do you see:

"Again this is consistent with trauma. I informed DS Telford of my findings."

And then you mention that forensic samples were

taken at the request of CID and you talk about the various samples that were taken by you during your examination.

A. Yes.

Q. And then can we just move up, and you then give some general advice about management and then you have signed that on 1 June 2015.

Can I go back to the injuries briefly and ask you one or two questions, on page 4, sorry. Thank you, that's lovely. You talk about the:

"Right maxilla 2cm swelling, tender on palpation, normal colour.

"Top lip internal ... laceration..."

And then you mention "Right of frenulum"; where is the frenulum?

A. It's a little tag of tissue of skin beneath the lip in the mid-line.

Q. Top lip?

A. Top lip, underneath there is a small piece of tissue there connecting the actual lip to the gum.

Q. Thank you. And then there was mention of an injury to

the hand, I think.

A. Mm-hm.

Q. Can you explain to us:

"Left hand dorsal aspect a 4 cm linear abrasion in the vertical plane. 3 cm superior to the third posterior metacarpophalangeal joint."

A. (Inaudible) joint.

Q. And that's number 5. Can you point out on your own hand where that abrasion was apparent?

A. Was it the right-hand it said?

Q. It says left hand dorsal aspect?

A. Left. So it is the back of the hand (indicating), sort of just down from the knuckle there.

Q. Thank you.

A. A few centimetres down and running vertically.

Q. Thank you very much. And then can we go back to your Inquiry statement please and paragraph 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."

And so you couldn't find any injuries on his knuckles which would be indicative of punching or fighting, using his hands?

A. Mm-hm.

Q. Is that correct?

A. Yes, that's -- I mean, again, this was a long time ago, but that's what's documented in the report.

Q. And the injury on the hand you have said it's possible that that could have been a defensive injury?

A. Yes.

Q. Thank you.

A. I mean, I was asked about that specifically and it could be.

Q. Do you know -- can you explain to the people listening

what a defensive injury is?

A. When you're trying to protect yourself, so if you put your arm up over your head as you're being hit, you're defending yourself.

Q. And if you're then struck --

A. Yes.

Q. -- thank you. And then can we look at paragraph 99 please:

"I have been asked whether there was anything about the fact that Zahid Saeed had been hit, potentially in the head, with the whirly-gig, that would me 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."

So again, is this entirely in line with what you have already told us today?

A. Yes, I think all I'm saying there is I was asked specifically about, you know, how accurate his account was and in terms of police evidence and it's not really my role, as I was trying to just clarify. My position there was to assess him from a medical perspective.

Q. So your focus was about the patient and his --

A. Yes.

Q. -- medical issues.

A. It was.

Q. And then can we look at paragraphs 100, 101 and 102, and you were asked about your involvement with PIRC and that relates to giving your statements to PIRC.

A. Yes.

Q. And you have said that -- can we move the screen down

please and you were working at St Columba's Hospice in Edinburgh at the time when PIRC contacted you. This would be in 2018?

A. Yes.

Q. And you were working there and you say at 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."

And then at 102 you go on to say:

"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."

And then you go on to say at 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 had been hit? It wasn't her recollection?'"

This is in relation to Nicole Short:

"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."

And really I just wanted you to feel that you had an opportunity today to say anything more about the PIRC

statement that you would like to in relation to these concerns that you have expressed here.

A. No, I mean it perhaps looks like it has put it quite strongly there and it's certainly not a complaint, but I didn't really see the point or the need for them to come to my work at that stage to do this -- take this additional -- this additional statement several years later and I wasn't really sure of the point of it. As I say, I was just trying to clarify that, what my role was and that hadn't changed: it was to examine and assess the patient from a medical perspective, but not really -- it's not really a role for me to then doubt what they say and I felt that there was suggestion of that in the questioning.

Q. Sorry, I couldn't hear that last part of your answer.

A. I just felt like there was some element of that, when they took the statement, they were specifically focusing on that, so it just was slightly unusual I felt. I didn't understand the point of that additional statement and that interview.

MS GRAHAME: Thank you very much. Could you just give me

one moment please, Dr Norrie.

(Pause).

(Video feed cut out)

LORD BRACADALE: Dr Norrie, can you see me now and hear me again?

A. Yes, I can.

LORD BRACADALE: Yes, thank you. Thank you very much for giving evidence to the Inquiry. I'm about to adjourn for arrangements for the next witness to be made and then somebody will deal with you and bring your link to a close. Thank you very much.

A. Thank you.

LORD BRACADALE: I will adjourn briefly.

(12.38 pm)

(Short Break)

(12.46 pm)

LORD BRACADALE: Ms Grahame, who is the next witness?

MS GRAHAME: The next witness is Mr Ian Anderson.

LORD BRACADALE: Good afternoon, Dr Anderson. Are you going to take the oath?

A. Yes.

LORD BRACADALE: Just raise your right hand and say the words after me.

DR IAN ANDERSON (sworn)

LORD BRACADALE: Ms Grahame.

Questions from MS GRAHAME

MS GRAHAME: Thank you.

Good afternoon, Mr Anderson.

A. Good afternoon.

Q. You are Ian Anderson?

A. Yes.

Q. And what age are you?

A. 71.

Q. And I understand you retired in 2011?

A. No, I retired from the NHS in 2011 but I have been working since in private practice.

Q. So continuing your work as an expert witness in relation to --

A. In medical legal work, yes.

Q. Medical legal work. And you were a consultant in accident and emergency from 1984?

A. Yes.

Q. And you have an expertise in the initial assessment of head injuries and on the mechanism of injury?
A. Yes.
Q. And you were for a while the President of the Royal College of Physicians and Surgeons in Glasgow?
A. Yes.
Q. And you're here today to help the Inquiry because you examined Nicole Short on 21 May 2015 and that was on the instruction of her solicitor, Peter Watson, and he invited you to give an opinion on the injuries sustained by Nicole Short and her then clinical situation, is that right?
A. Yes.
Q. And in that regard, you have told us that that was to look for residual physical injuries and any effects of those injuries on her activities of daily living?
A. And employment, yes.
Q. And employment, thank you.

Now, I want to make sure that you have everything you might need today in front of you, so that you're comfortable. So do you see the black folder in front of

you?

A. Yes.

Q. Now, there should be, I think, your Inquiry statement there, that's SBPI 00077. Now, you have a hard copy, but when I ask for specific paragraphs maybe I will refer you to them, it will also come up on the screen right in front of you, but when I do that, it might just be the one paragraph that you can see, so if you wish at any time to look through other parts of your Inquiry statement, please feel free to do so.

A. Thank you.

Q. And you can just let me know which paragraphs you would like to refer to.

A. Yes.

Q. And then in addition, you should have a copy of your medical report on Nicole Short as well?

A. Yes.

Q. So I want -- you have hard copies of those and you -- feel free just to look at them at any time?

A. Thank you.

Q. So let's look first of all then at your Inquiry

statement and that's 77, and you will see it's on the screen, it says, "Dr Ian Anderson", and it was taken over FaceTime on Tuesday 29 March of this year and that was someone from the Inquiry team who was in touch with you and was able to take your statement through the use of technology. I think we were maybe still -- maybe not quite in lockdown, but there were a lot of restrictions still on the go in March, is that right?

A. Yes, yes.

Q. And then can we look at the final paragraph, please, which I think is 44. We will get that on the screen and it says:

"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."

And in the knowledge of that, you have then signed your Inquiry statement on every page and I think that may have been done electronically as well, or -- but you have a hard copy and I only have the redacted copy in front of me.

A. Yes, it was signed physically by me actually, in the presence of one of the Inquiry staff.
Q. Thank you. Well, that's excellent.
A. I'm afraid I'm of an age where I have a healthy disrespect for technology.
Q. I'm exactly the same, but I'm trying to work my way round that.

So the signature -- we don't see that on the screen, but you have your copy and know that you signed it?

A. Yes.
Q. And we see that that was on 6 May 2022.
A. Yes.
Q. Thank you. And you were doing your best when you gave this statement to the Inquiry to be truthful and to be as accurate as you could be?
A. Given that it had been some considerable number of years before I had compiled the report, yes.
Q. You're not the first witness to have said that, so it's seven years since you actually looked at, or examined Nicole Short.
A. Yes.

Q. So there may be parts of your statement where you rightly say your recollection is not as clear now as it would have been at the time?
A. I could tell you that now, yes.
Q. Thank you. That's very helpful, thank you.
Then can we look at PIRC 01405, so this is the medical report that you prepared on Nicole Short and we can see that on the screen and then if we can look to the first page, it was prepared on 21 May 2015 and that's your name, Mr Anderson, and you have given the fact that you are a fellow of various royal colleges.
A. Yes.
Q. Emergency Medicine and others. Do you want to tell us about your membership of various royal colleges?
A. Well, that's at the beginning of the report and I really don't want to bang the drum about what I did when I was a younger man.
Q. That's very modest of you, but let's look at that for the moment and just -- we can see -- so for the assistance of the Chair when he comes to consider this at a later time, he can see that you have listed various

royal colleges that you are a member of and as I understand it, when you're made a fellow, that's a more significant status than just being a member?

A. Yes. It's also more expensive.

Q. I'm sure that's true. Thank you.

So when we look at this medical report, it was prepared on the instruction of Peter Watson who is a solicitor and it was on behalf of Nicole Short.

A. Yes.

Q. And she was the patient. And can we look at the last paragraph of the last page, first of all. And we will come back to this, but I just wanted to highlight this paragraph that you have put in your report and you say:

"I confirm that insofar as the facts stated in my report are within my knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion."

And so is it fair to say you are proceeding on the basis that these facts are true and you say that "Insofar as the facts stated are within my knowledge,

I have made clear which they are", and "I believe them to be true", and I think that's the nub of it, isn't it, Mr Anderson: it's the facts that you had in May 2015, you have noted them in your report, but -- and I think on paragraph 13 of your Inquiry statement you say that's still a correct statement. You can have a look at that.

A. Yes.

Q. So your opinion is based on the facts from 2015 and that was the facts that were based on medical records that you had been sent in relation to Nicole Short?

A. Yes.

Q. And a history that you took from Nicole Short?

A. Yes.

Q. And information that was provided to you by her solicitor that was available to the solicitor then?

A. Yes.

Q. And that was 21 May 2015?

A. Yes.

Q. And am I right in thinking, Mr Anderson, that that paragraph is there in your medical opinion because if the facts change, then your opinion may also change?

A. Yes.
Q. And you would like the Chair presumably to know that if there are different facts available to the Chair, or new information, some of that may be significant to you and to the opinion that you formed then?
A. Yes.
Q. Thank you. Now, it will not surprise you to know that as this Inquiry has significantly more information at our disposal today than you had on 21 May 2015?
A. Yes.
Q. It's a long period of time. And can I also confirm that when you prepared your report in May 2015, you did not have anything from any other police officers: no statements or precognitions or anything like that?
A. Not that I can remember, no.
Q. And that may be because they did not give statements to PIRC until 4 June, which was actually after you examined --
A. Yes.
Q. -- Nicole Short, so none of that information was available to you at the time.

A. That's correct.
Q. So your report here, you did not take account of any of that, and even since your Inquiry statement that we looked at a moment ago which was taken in March and signed by you in March of this year, even since then we have taken a number of very detailed statements from eye-witnesses and other witnesses and we have also taken many hours of oral evidence from witnesses during the hearings, and none of that would have been available to you at the time.
A. That's correct.
Q. So none of that would have been available to you, it wasn't available to your patient, Ms Short, it wasn't available to your instructing solicitor, Mr Watson.

And today I would like to give you an opportunity to consider some of that new information and if you feel that that is significant to you in your opinion, I would very much like you to tell the Chair because it's important that he understands completely what your views are.
A. Okay, I understand.

Q. Are you happy to go on that basis?
A. Well, I understand.
Q. Thank you, that's great.

So the other thing, in fairness to you, Mr Anderson, I would just like to explain at the outset is that we have another consultant who is coming later, after your evidence, and he is also going to hopefully assist the Chair, and he was Mr Rudy Crawford and he was an accredited specialist in A&E medicine and surgery and he retired from the NHS in 2016, after more than 37 years in clinical medical practice, and he was 26 years as a consultant at Glasgow Royal Infirmary?

A. Yes, I know Mr Crawford as a colleague. I don't need any introduction about his background.
Q. I did suspect that you may have.
A. It's a small church, as you might imagine, and I was president of what now is the Royal College of Emergency Medicine of which he is a fellow so ...
Q. So you do know him, you know of him?
A. Yes, I do.
Q. Thank you. Now, I will come to this later when we're

discussing this, but he had prepared a report for the Crown in August 2019. It was a desktop report regarding injuries to PC Nicole Short, and he has now given an Inquiry statement from May, 12 May, and I will be able to refer you to this later, but I just want you to know this before we start. So he gave a statement in May, after you had given your statement, and some of the information we have been able to provide has now resulted in him changing his opinion, so I will -- but I will let you see that as well, so you know. I'm not trying to hide anything from you.

A. I wouldn't think you would anyway.

Q. No, I'm not doing that.

So let's just very briefly go back to your medical report please, PIRC 1405, and you have already told us that page 2 details your appointments, and just in the last couple of minutes, can I ask you, you have been an expert or a skilled witness giving evidence to courts for many years I imagine?

A. Yes.

Q. And will that be in criminal cases as well as civil

cases?
A. Yes, both in England and in Scotland.
Q. So throughout the UK really?
A. Yes.
Q. And how many reports have you prepared over those years; are you able to give us any sort of indication?
A. I suppose they would be in their thousands now, yes.
Q. And have you prepared many reports for police officers?
A. Some years ago I did; latterly very few.
Q. Thank you. And would that be both if they were maybe defending criminal allegations, but also if they were pursuing their own civil claims or --
A. Yes.
Q. -- that type of thing?
A. That's right.
Q. So a variety of different scenarios. And equally, you will have given various reports to non-police officers over the years?
A. Yes.
MS GRAHAME: Would that be an appropriate moment?
LORD BRACADALE: Would that be a convenient point? We will

stop for lunch and sit at 2 o'clock.

(1.01 pm)

(The luncheon adjournment)

(2.00 pm)

LORD BRACADALE: Yes, Ms Grahame.

MS GRAHAME: Welcome back, Mr Anderson. I would like to move on to look at your medical report, if we may, and that's PIRC 01405. And that should come up on the screen.

The first thing I would like to do is just to go straight to your opinion and that's on pages 8 and 9 of the report, so towards the end. Just keep going, please. We will see a section that says "Opinion". Thank you. I think I'm using the pages of the report rather than the PDF, that will be the explanation.

Now, it is very neatly and simply expressed and set out, so if you don't mind, I will read that out so that everyone can hear what we're talking about:

"Nicole Short was a 29-year-old police officer who suffered injuries consistent with having been caused in a violent assault whilst on duty on the morning of

3 May 2015.

"She suffered a blunt head injury and contusions to the back of the right side of her scalp and over her right external ear.

"She suffered an associated neck sprain injury.

"She suffered contusions to the right side of her torso, particularly over her lower right rib cage, consistent with having been caused by blunt injury.

"She suffered abrasions and soft tissue injuries over her knees and elbows, consistent with having been caused when she fell to the ground after being struck over the head.

"She attended hospital on 3 and 4 May 2015 and on neither occasion was the standard of initial assessment and clinical management adequate given the mechanism of injury recently sustained.

"It was not until 10 May 2015 that she underwent appropriate imaging of her head and neck, despite her having suffered a period of post-traumatic amnesia in the aftermath of her head injury and also given ongoing post-concussional symptoms following her assault.

"She suffered some right sided facial weakness and which, on the balance of probabilities, has been the result of local injury to the main nerve supply to the muscles over the right side of the face as it exits through the base of the skull."

And then over on to page 9:

"The injury at that site would be entirely consistent with having been caused by a blunt injury.

"When I reviewed her on 21 May 2015, some 18 days following her assault, she clearly was continuing to suffer genuine and troublesome concussional symptoms together with slowly resolving right sided facial weakness and, on the balance of probabilities, some resolving focal neurological signs of weakness affecting her right upper limb.

"She is likely to suffer from post [I think that's concussional] symptoms for some six months or so following her assault. Her facial weakness will gradually ease over the course of some three months following her assault and during that time her upper limb symptoms will gradually settle."

And then if we just look to the end of the page, that's just your signature at the bottom.

A. Yes.

Q. Now, there's one area I'm particularly interested in so I would like to go back to page 8, please, and it is the paragraph towards -- this is page 8 of your report. Just stop there, please. It's the paragraph that begins "She suffered contusions". So it's around about the centre of the screen.

A. Yes.

Q. "She suffered contusions to the right side of her torso, particularly over her lower right rib cage, consistent with having been caused by blunt injury."

Now, first of all, can you point out to the Chair the right side of your torso, particularly in the area of the lower right rib cage so that he knows exactly what area we're talking about?

A. It would be that area (indicating), my Lord.

Q. So that's just on your right side, just under your rib cage -- your bones?

A. Just at the lower border of the rib cage, between that

and the upper surface of the abdomen.

Q. Thank you. And you have talked about contusions; can you tell us what a contusion is?

A. Really soft tissue injuries. That means there's no open wound, no penetrating wound and it's -- usually it would be the soft tissue injuries below the level of the skin, or even the coverings of the muscles between the ribs.

Q. So no visible bruising or discolouration?

A. Not by the time I saw her, no.

Q. Thank you. Then you talk about it being consistent with having been caused by blunt injury. What do you mean by blunt injury? What did you have in mind at that time?

A. It could have been caused by a blow, or indeed by a fall against their torso at the same time as she fell forwards. I couldn't be specific about it because the findings were not major. We're not dealing here with an individual who had had a very serious injury to her chest involving multiple rib fractures, at more than one level of the rib, and a high probability of damage to the underlying lung with or without a collection of blood between the chest wall and the lung, or

a collection of air, and the clinical terms would be either a haemothorax or a pneumothorax.

Q. So is it fair to say that the contusions are at the lower end of severity?

A. Yes.

Q. And actually in paragraph 32 of your Inquiry statement, if we can have that on the screen, you do say specifically:

"There was no external bruising on [her] rib cage. If there had been, I would have put it down. Contusions are soft tissue injuries which involve no breach of the overlying service surface."

So that's nothing damaged on the skin itself?

A. Yes. It doesn't get away from the fact it can be a painful injury because the enervation, the nerve supply to the underlying muscles, and indeed the external surface of the lung can give rise to quite marked symptoms of pain, particularly when moving. Anybody who has suffered pleurisy, for instance, which involves inflammation of the covering of the lung really gets very severe pain.

Q. So people can still experience pain, even though there's no external or obvious visible signs?
A. Yes, yes.
Q. Can I look again -- sorry to go back -- to your report. You have told us how you interviewed Nicole Short and I think if we start on page 3, please, of the report, that may be 4 of the PDF. Yes, that's the page, thank you.

So you interviewed Nicole Short and I think that's your normal practice, to speak to the patient before you prepare your opinion?
A. Yes.
Q. And you have said that she -- you will see just the second last paragraph on the screen:

"At hospital she gave an account of being struck over the back of her head and remembered falling to the ground but had a hazy recollection of following events."

Then on page -- can we look over to page 5, you also talk about -- thank you. If you could go up, please. Sorry, go down again. Thank you. You talk about -- I have not got the right number here, page number here.

4 May, she phoned NHS 24 at 14.33 and was referred back to A&E at Victoria Hospital. That may be on the previous page, sorry. Can we go back one. There it is.

This is where my lack of a hard copy is a disadvantage, Mr Anderson. So we see there the reference there:

"She contacted the NHS 24 helpline at 14.33 hours on 4 May 2015 and was subsequently referred back to [A&E at] Victoria Hospital ... [and] she attended there at 15.40 hours on 4 May ..."

And you say at the bottom there:

"At that time she was noted to be suffering from a subjective feeling of light headedness and was noted to have some right sided facial swelling."

When you use the word "subjective", could you explain to people what you mean?

A. Just what the individual would describe without any objectivity about it. I mean you can't really have any objectivity about light headedness, it's a symptom.

Q. And is that the same with pain? Everyone's experience of pain is personal to them?

A. Yes.
Q. And:
"She complained of generalised pain in her limbs and torso."
A. Yes.
Q. Right. So there was a complaint -- was this a complaint at the A&E department of Victoria Hospital --
A. Yes.
Q. -- of generalised pain in her limbs and torso at that time and that was on 4 May 2015. You have noted that presumably from her records?
A. Yes.
Q. Thank you. And then you have talked about a hazy recollection, and can we look at page 5 again, please.
A. Yes.
Q. I think there's -- something has gone wrong with my page numbering here, but I think you were aware at the time that she had been wearing a protective vest that had been provided. We have heard them called stab-proof or --
A. Yes.

Q. -- yes, vests at the time. And then can we look at page 6, please. And you see paragraph 2, she had pain in her neck and over her torso in addition to an ongoing headache. So again, reference to her torso?

A. Yes.

Q. And so there's reference to pain and there's reference to -- on page 7 I think we're going to look at you say there was no residual bruising noted on either side of her rib cage, and localised tenderness was noted on the -- can we just keep going moving down, please:

"No residual bruising was noted on either side of her rib cage but localised tenderness was noted over the outer aspect of the right side of her lower rib cage."

And then:

"Auscultation of her chest using a stethoscope revealed normal breath sounds."

I would like to ask you just a little more about that paragraph.

A. Yes.

Q. So again, you note that there's no bruising on either side of her rib cage, so you have checked that to see,

but you noticed localised tenderness over the outer aspect of the right side of her lower rib cage. Is that the area that you pointed out earlier?

A. Yes.

Q. So there's a complaint of pain from Ms Short, and then you have noticed localised tenderness, that's tenderness in that area?

A. Yes.

Q. And then you talk about auscultation of her chest using a stethoscope. Can you explain what that means?

A. Yes, anybody with a likely history of blunt force injury over the chest who complains of symptoms of pain (a) you've got to look at it, so you've got to see it, you've got to feel it, and you've got to listen to it and the reason you've got to listen to it is you've got to make sure that the normal sounds of the lung are audible through the stethoscope, without which you have a concern that there may be something covering the lung and in case of trauma it's usually blood or fluid, or in fact that the lung is not inflated to the extent that the breath sounds can be conducted to the outside of the

chest, so this is old fashioned Osler-type medicine where you look, feel -- in fact before you look, you listen, so you listen to the patient, you look at the patient, you feel the patient, and then you do all the other things which modern medicine is infatuated with, like scans and all the rest of it, which my junior colleagues now love to do, but they're not terribly good at looking, listening or feeling.

Q. But often the old school methods are the best and most reliable?

A. Well, they are, but they're not taught terribly well at medical school now I'm afraid and they're not adopted routinely in clinical practice which they should be.

Q. But certainly in terms of your examination of Nicole Short, you were listening to her chest?

A. So if somebody was to put me on the spot and say: did this lady have a haemothorax or a pneumothorax underlying this chest, I would have said to you, no. To be absolutely sure in the early days of her injury you would have had to do a x-ray of her chest. Now, I have no recollection of whether a chest x-ray was performed

or not because I haven't noted that in my records.

Q. No, that's fine.

Can I ask maybe a simple question: when you say that you're listening to the chest, obviously as a lay person you think your chest is at the front, you're not thinking about your back.

A. Yes.

Q. But we have heard some evidence that if you're listening to someone's chest, you're actually using the stethoscope on their back, is that the --

A. Well, you should really use it on the front, the back and the side.

Q. So everywhere?

A. Yes.

Q. And that's your normal practice, is it?

A. Yes.

Q. Thank you. And that's what you would have done with Nicole Short?

A. Yes.

Q. And to listen properly, does that mean that you have to, or the patient has to remove their clothing so that you

can actually contact -- have contact between the stethoscope and their skin?

A. Yes.

Q. And is that what you do?

A. That's what I do, but in fact, I was a patient recently and the doctor who looked after me listened to my chest through my shirt.

Q. Is that right?

A. Which I didn't think was very clever, to say the least.

Q. You would think he would be trying his best with somebody of your experience?

A. Well, it was a lady, so I had to be polite and not pull her up on that.

Q. Well, I won't hear anything bad about women doctors!

A. I'm a great supporter of them normally.

Q. Good, good. Can I ask you is pain -- we have heard that Nicole Short made a complaint of pain and your report says localised tenderness in that area. Is there a difference in your mind between pain and localised tenderness, or are they just two sides of the same coin?

A. Really two sides, yes. They're usually associated.

Q. Thank you. So on the basis of your report there's nothing visible on the skin, Nicole Short had a contusion and localised tenderness to her right lower rib cage, and that was consistent with a blunt injury and you have told us what that was.

Now, the Chair has been hearing evidence obviously about what happened at Hayfield Road on 3 May 2015 and the Chair has heard evidence that Nicole Short may have been stamped on and he has also heard evidence that she wasn't stamped on, so you will understand that's quite contentious.

A. Yes.

Q. And it will be a matter for the Chair to make a decision on that, but one of the things that may assist him in reaching a decision is to hear what medical evidence is available to either support that, that a stamp happened, or contrary to that, and that's why I want to ask you some questions about this.

Now, I realise that that isn't information you had available to you when you prepared this report. I can say first of all to you Nicole Short has given evidence

before this Inquiry to say she doesn't remember that happening as she lay on the ground. She remembers being curled up on her right-hand side, so lying on her right-hand side in the sort of foetal position. But colleagues of hers have told her she was stamped on. So that's how that information is known to Nicole Short; it wasn't information known to her at an earlier stage prior to speaking to her colleagues, and she doesn't remember that happening.

Can I ask you to look at paragraphs 36, 37 and 38 of your Inquiry statement, please. So it is 36 -- we will start with 36. And you were asked to what extent these contusions -- that's the contusion that you have noted in your report:

"... were consistent with the following account of the incident ..."

And this is quoted to you:

"... 'a man stomped on her back with his foot with a great deal of force. He put his full body weight into the stomp and used his arms to gain leverage'."

And I think you weren't clear yourself at that stage

about what a stomp is, and I will help -- I will hopefully be able to help you with that -- and then 37, you weren't sure about the word "stomp" and you talk about recognising a direct blow caused by a kick or a knee, I'm not entirely sure, and then you said at 38:

"I have been asked to what extent the localise pain in the rib cage ... is consistent with a man kicking PC Short hard in the rib cage with the sole of his foot. It is consistent with a blunt force injury, which could be a kick, or it could be a fall. The localised tenderness is consistent with a hard kick."

Now, as I said to you earlier, you did not have any statements from police officers at the time that you prepared your report on Nicole Short and I can confirm that a stomp, we have heard evidence, is actually a stamp, just to be clear on that.

A. Yes, I thought that was the case.

Q. But I would like to show you something because we have also heard that PC Short was wearing a vest and I wonder if you could just see that vest. So when this happened -- yes, it is the demo -- it's the

demonstration vest. So you can touch it, you can feel it, you can feel the weight of it and -- you have probably seen that sort of vest, Mr Anderson --

A. Yes.

Q. -- with your experience for officers.

So I'm going to read out some of the descriptions that have been given of this stamp, and then I'm going to ask you to look at some footage and then I will ask you questions about it, but let me first of all have on the screen PIRC 263 and this is the page 3, paragraph 3. So this is a statement given by a police officer Tomlinson on 4 June 2015, so after you had seen Nicole Short, and I'm going to read out a part of that. This is in relation to Mr Bayoh. Thank you, that's the paragraph "He ran past me", so -- and you will see:

"She fell to ground face down ..."

That's line 4, do you see that?

A. Yes.

Q. "... when he punched her and she tried to protect her head and push herself up with her hands at the same time. I ran over to assist her, but before I got there,

he stomped on her back with his foot with a great deal of force. He put his full body weight into the stomp and used his arms to gain leverage. After he did this she went back to the floor and never moved."

So I'm now going to ask Ms Drury to play a very short clip which actually is part of the evidence of PC Tomlinson where he demonstrates what he meant by that, and then if you watch the small monitor when that's played -- we can play it more than once if it would help. Right, let's play that, please, Ms Drury.

(Video played)

Would you like to see that again, Mr Anderson?

A. No, no, thank you.

Q. You're happy with that, right. Then the other thing -- so that's two stamps, that's PC Tomlinson. The other evidence that the Chair has heard -- and again, you did not have this before -- this comes from SBPI 00039 please, so this is an Inquiry statement from a PC Walker, another police officer at Hayfield Road that day, and I'm interested in paragraph 47, and you will see that by this -- do you see the second line:

"By this time PC Short was lying face down in the prone position on the road, close to the south pavement. Sheku Bayoh was on the opposite side of PC Short to me, standing at right angles to her and facing towards me. I had a clear and unobstructed view of him and saw him with his right leg in a high raised position. He had his arms raised up at right angles to his body and brought his right foot down in a full force stamp down onto her lower back, the kidney area."

And again, I would like us to watch a small clip of the evidence that the Chair has heard from PC Walker, and this will be demonstrating the stamp. So he has said it was at her lower back in the kidney area, but this is his demonstration of that stamp. If we could watch that.

(Video played)

Would you like to see that again?

A. No.

Q. Thank you. We can just take that off the screen.

So as we sit here today, we now have the benefit of these statements and those demonstrations. They were

not available to you at the time, either when you saw Nicole Short or actually when you completed your Inquiry statement, but we do have that available today. Now, I appreciate that you have just seen that for the first time, but can I ask you some questions about what you have seen?

A. Yes.

Q. That will be very helpful. So can we look first of all at paragraph 39 of your Inquiry statement, and you said -- so this is given before you saw anything that I just showed you:

"I have been asked how long it would take to develop visible injuries to the torso in these circumstances. That'd happen pretty soon. Certainly in the hours and by the day following an injury you would expect to see something. If she'd had bruising at the site of blunt force trauma, it would be visible, certainly by the next day, certainly by the time she had been seen several times in the hospital, if anybody had looked at them. If she'd had blunt force injury at that site, they would have seen bruising."

And I suppose my first question is if the Chair accepts the evidence of those officers that Nicole Short was stamped, as they demonstrated, with that level of force onto the back, lower back of Nicole Short, perhaps in her kidney area, would you have expected there to be some visible signs of that on her body?

A. Yes.

Q. You would.

A. Yes.

Q. What sort of visible signs would you expect?

A. I think she would have had -- if somebody had had -- if I could use the Glasgow parlance -- a kicking, and as you might imagine, I was involved in a lot of such cases during my NHS clinical career, the first thing a patient complains about is exquisite pain at the impact site, such that they have real difficulty even standing straight up, so you can actually see a patient who has had a kicking, being extremely uncomfortable and then of course if the clothing is removed, then you can see external evidence of bruising, scuff marks -- although that would be mitigated by the fact that she has been

wearing a protective vest. I have to say, the police vest is designed to prevent penetrating trauma, not to mitigate blunt trauma, but it will indirectly do so because it's a heavy, thick piece of kit, so you wouldn't expect scuff marks particularly, but you would still expect to see quite marked localised tenderness and developing bruising.

I'm relying on my colleagues who had three or four times the opportunity to assess Nicole at the hospital. I cannot believe that they wouldn't have been directed to looking and listening and feeling her chest in such circumstances as was demonstrated.

Q. So if that had -- if that level of force and that type of stamp had occurred, you would expect that to be something that would be drawn to the doctors' attention?

A. I mean, Nicole is a small lady, she is 5 foot 2 inches, and she is only 7.5 stone in weight. She is a very small target area for anybody stamping on her loin or chest wall.

Q. And we have heard that Mr Bayoh was 5 foot 10 in height and 12 stone 10 and --

A. He is not a huge man at that, but even so, he is a youngish male and she is a very lightly built lady.
Q. Thank you. And is that the sort of thing that we have seen that would cause pain to somebody?
A. Oh, yes.
Q. Yes. And if the person was conscious at the time that that was happening, that's something that would be recognisable, they would be aware of that?
A. It may be, but in the circumstances which were described to me, with somebody with a blunt head injury and obviously concussed, it may not have been at the front of their mind. This is an individual who, from my sort of assessment, was fearful for her life, she thought she was going to die, and in these circumstances one can excuse them not for being entirely accurate about the whole list of their signs and symptoms of injury.
Q. Thank you. And certainly if the person was unconscious at the time they wouldn't have been aware of what was happening?
A. Well, even impaired conscious level rather than loss of consciousness.

Q. Impaired. But as that consciousness returned to more normal levels, would you expect them to be able to experience that pain?
A. Oh, yes.
Q. At that stage?
A. Yes.
Q. So maybe in the hours or the days that followed, that would be something that would be obvious?
A. Yes.
Q. And would you have expected someone to be able to experience tenderness or discomfort in that area?
A. Yes.
Q. Even after the initial moment?
A. Yes.
Q. And you would have expected bruising to develop?
A. Yes.
Q. Over what timescale would you expect the bruising to develop?
A. I would have thought by the following day or so the bruising would have developed and usually would have set -- I would have expect the bruising to have settled

by the time I saw this lady, which was some several --
Q. You were on 21 May, so 18 days after.
A. Yes, I would expect the bruising to have subsided.
Q. So you wouldn't expect to have seen anything by the time you saw her?
A. No, but I would not have been surprised if the patient still complained of symptoms, albeit --
Q. If that had happened?
A. Yes. There's other indirect things of course which I may bring up, with your permission.
Q. Yes, please do.
A. If somebody has a kick over the loin, what can happen -- the kidney lies very low below --
Q. Could you point out the kidney area specifically.
A. Yes, just run a hand over that area (indicating).
Q. Just over that area?
A. One of the first things one would do in the presence of blunt force trauma to that particular part of the torso would be to, if possible, test the urine, because you could well pick up very small traces of blood in the urine which is common after blunt trauma in that area,

and that would be a part of the initial assessment in an emergency department.

Q. I should be clear, the statement I read out from PC Walker which mentioned the kidney area was not available on 21 May when you --

A. No.

Q. -- saw her, that was actually part of his Inquiry statement. Can I ask you a little bit more about the vest. What sort of protection do you think the vest would have given to PC Short in terms of protection from any blunt injury?

A. Because it's extra thickness over her torso, one could have thought it would give some form of protection but again, I have to come back, the vest is colloquially called a stab vest. It wasn't designed to mitigate against blunt trauma, it was designed to prevent someone getting penetrating trauma, particularly in Scotland from a knife, not very effective with a gunshot, but mercifully that's not a problem in civilian practice yet in Scotland.

Q. Yes, thank goodness.

Can I ask you to look at paragraph 29 of your Inquiry statement, please. You say here:

"I think, to clarify how she was struck ..."

Do you have that?

A. Yes.

Q. "... it might be more appropriate to look at the records compiled following her initial and subsequent attendances at hospital, because these were in the hours and days after the incident. That would be a lot easier to clarify. But I saw this lady two or three weeks after the incident."

So I think to assist the Chair should he pay particular regard to the examinations and evidence about the examinations in the days after 3 May?

A. Yes. The findings on initial assessment and clinical management in the emergency departments on her earlier attendances would be something that you would be well advised to look at closely.

Q. Thank you. So if there was nothing in those records in the days after --

A. Well, there's two explanations for that, let me

interrupt. One is it was never done, and that happens. I'm not trying to be critical of colleagues, but it happens. While the other is it was assessed and not recorded, or it was assessed and it wasn't there. These are all three explanations for that.

Q. And that's something that the Chair should consider in relation to those other doctors?

A. Yes, you will probably have read in my statement that I wasn't overly impressed with the standard of initial assessment and management of this lady until I think it was the 10th that she appeared in a medical unit by goodness rather than a trauma unit and it was only then that she was properly assessed in the way of scanning. By that time, Nicole's problems were related to her blunt head injury, not to her chest injury, and even when I assessed her, I didn't pay a huge amount of attention to her residual chest symptoms which were relatively minor, but obviously I wasn't provided with the information that you have described to me, and in many ways that's an advantage because her continuing problems when I saw her were related to her blunt head

injury and I thought they were genuine and I thought they were very significant.

Q. And I'm not going to be asking you too many questions about that, but certainly it does appear that in terms of the importance and the significant injury, it related to her head --

A. Yes.

Q. -- rather than anything else.

A. But it shouldn't have taken until 10 May before somebody scanned her.

Q. In relation to her head?

A. Yes.

Q. Can I ask you about some other possible causes of -- you told us about the localised tenderness and I just want to -- we have heard other evidence as well and I would like to just ask for your comments if you can help us.

Can I ask you about the possibility that perhaps the level of the stamp was less than the force that's been demonstrated by the officers; could that have mitigated the impact and resulted in no bruising, or very little?

A. It could have.

Q. And --
A. Injury is dependent on force, as you know, and if it was less force, there would be less injury.
Q. Thank you. And then we have heard from Nicole Short herself -- she has given evidence to the Inquiry -- that she was curled up in a ball, as you knew, but she has described it as the foetal position on her right side, and that's the side where you found the localised tenderness. Now, in her evidence she said that she had a sore body, her side, and at her hips:

"My utility belt had also dug into my hips so my hips were sore. I do not recall strikes to my body whilst I was lying on the ground."

And I asked her to clarify that and she said she felt that her spray and her baton were in the area of her hips. You will know the police wear a utility belt?
A. Yes.
Q. And it was her hip area on both sides and she said yes and confirmed that that was causing her hips to be sore.

Now, is that the sort of thing that could have caused the localised tenderness --

A. Yes.
Q. -- that you --
A. Yes.
Q. Yes. That could have been on the 21st, that could have been the cause?
A. Yes.
Q. And we have heard some very little evidence but there was also a suggestion, so I'm going to put it to you, that a witness gave evidence that he didn't know whether one of the other officers could have stood on her, he didn't know about that. That wouldn't account for the localised tenderness?
A. I can't imagine anybody standing on her but, you know, these things I suppose could happen but no.
Q. And then she has also given evidence and we have heard evidence of her falling on the ground, hands forward in quite a dynamic movement where perhaps her feet were lifted off the ground, and is that the sort of fall that could cause or result in the localised tenderness that you describe?
A. She may have racked her chest wall, in colloquial terms,

by twisting at the time of her fall, that could have caused it.

Q. Could have caused the --

A. But you know, I have to come back again, when I assessed this lady, I had no major concerns about residual chest symptoms or signs, but I still had continuing discomfiture about the sequelae of her blunt head injury.

Q. Thank you. That's very helpful. So really it was the head injury that was of concern then, not the torso or the contusions?

A. No, no --

Q. They were minor?

A. -- no, these were not part of my concerns.

Q. Thank you. I did say previously that I would mention Dr Crawford to you, although I think you have been very helpful so far, it may not be necessary, but in fairness to you, if we could have Dr Crawford's statement, SBPI 117, and if we can look at paragraph 24, and I'm wondering if you agree with Dr Crawford on this. He has done a desk report on Nicole Short in 2019:

"There certainly wasn't any evidence of serious injuries caused by stamping. From my point of view, stamping is a very dangerous and potentially lethal injury mechanism, it can cause very serious life changing injuries. I've seen people with this. Stamping to the head or body, people have died as a result of that. It's potentially life threatening. It's fair to say, in my opinion, there is no evidence of serious injuries or gross injuries consistent with a serious of life-threatening stamping injury."

Do you agree with that?

A. Yes, I do.

Q. Yes. Thank you. Paragraph 25, please:

"Nicole Short has no recollection of it. It's possible that this could be explained by amnesia. Given the description of the stamping, I would have thought there would have been evidence of it, such as fractured ribs or significant blunt force injury or pattern bruising."

Do you --

A. I think we already discussed that.

Q. I think you agree with that as well?
A. Yes, I do, yes.
Q. That's good, thank you. Now, the only other thing I'm interested in really is in relation to loss of consciousness, and I know that you have an expertise in head injuries, so I would like --
A. Only in the initial assessment and management of them, I'm not a neurosurgeon, but I see more head injuries than neurosurgeons see because neurosurgeons only see a fraction of head injuries after we have cured them in the emergency department.
Q. Well, I'm very interested in loss of consciousness and I'm hoping you will be able to help me with this.

So in your report -- I won't take you back to it on the screen, but you talk about concussion and post-concussional syndrome and post-traumatic amnesia and you have very fairly explained that that was something of much interest to you at the time.

Can you be conscious and still sustain concussion?
A. Well, the medical term of concussion is a diffuse injury to the brain, without any abnormities shown on a scan

and that would be contusions to the brain surface, or bruising to the brain surface, collections of blood within the substance of the brain, or below, or outwith the coverings of the brain. Now, these are all focal injuries.

Concussion is a diffuse injury of the brain -- poorly understood, to be honest, because it doesn't really show up in a scan. If you hit me over the head with a bottle and then put me in a scanner and I'm a bit confused before I get angry about it, the scan will be normal, but the brain is not normal, so the -- almost certainly the electrical connections within the brain are dysfunctional as a result of that diffuse injury and that's what we loosely call concussion now, but it doesn't show up in a scan and indeed, it didn't show up in this lady's scan either, mercifully, three weeks after her injury, or two weeks after her injury.

Q. Does that concussion necessarily involve a loss of consciousness at any point?

A. Not necessarily, but usually, albeit it could be very brief indeed, so if you speak to a patient who has been

concussed, they may have a period of post-traumatic amnesia which may be very, very limited and by that I mean minutes, or indeed it could be, you know, half an hour or whatever, but the duration of post-traumatic amnesia is strongly related to the severity of the head -- of the brain injury, so if you have somebody coming in who can't remember much about it, that usually should be a pointer to the fact they have had a significant brain injury and that's why nowadays we have a low threshold of scanning people.

When I was a boy, it was all done with bits of paper and fingers moving and all the rest of it. You look back on it, it was crazy. You weren't detecting anything at all and now you just put them in a scanner and you get a picture of the brain. Fantastic if you do it; if you don't do it, you're still at sea.

Q. Thank you. And when you talk -- you used the word amnesia.

A. Yes.

Q. And you have talked about post-traumatic amnesia, it may be minutes or it may be half an hour. Is that the same

as you talked about the hazy recollection?

A. Yes. The hazy recollection would be the colloquial term for what I understand as post-traumatic amnesia, whether it be very mild, moderate or severe.

Q. All right, thank you. If the Chair was looking for reliable indicators of a loss of consciousness, what sort of things would he be looking for in the evidence, if anything?

A. Very difficult. You would have to go back to the patient and ask them what was their first recollection after the incident. It sounds very crude, but it's probably the only way you can work it out, I'm afraid. If Ms Short had no recollection at all of the incident up until in time that she was pulled off the ground and either escorted or taken to the police vehicle or indeed back to the station, that would be a very significant degree of post-traumatic amnesia.

My impression from talking to her was that the degree of post-traumatic amnesia she had was relatively brief.

Q. We have heard from Nicole Short and we have looked at

her previous statements given over a period of time and she has a recollection of being -- of having a blow to the back of her head --

A. Yes.

Q. -- falling with her hands out, curling up to protect herself into a foetal position on her right-hand side, putting her hands behind her head at the bun where she had her hair, and she remembers being pulled up by a colleague and going over to a van. So there don't appear to be any immediate and obvious gaps in that --

A. Yes.

Q. -- narration. Is there anything that -- but she doesn't remember any blows that came and the Chair will want to try and decide what happened during that period. Is there anything he should look out for?

A. Well, she had residual signs of injury to her head when I saw her because she was tender over the back of her ear and over the back of her scalp.

Q. You are pointing to your right-hand side?

A. Yes, to the right-hand side. So I'm in little doubt that she did sustain a blow to the head and I don't

think that was caused by a fall.

Q. All right. And you're sure it was her right-hand side that was the issue?

A. Well, my memory doesn't stretch to seven years, but I think it was the right side, I recorded in my notes, yes.

Q. Thank you. And we may have heard evidence that her Glasgow Coma Scale when she went to hospital after the incident was 15.

A. Yes.

Q. Which is normal, I think.

A. Yes.

Q. And that the -- we may also have heard evidence from Dr Mitchell who was the A&E doctor when she went, and again, none of this would have been available to you, we have just heard from Dr Mitchell actually, that there was nothing that she was noting, or nothing that she was aware of that indicated a loss of consciousness. There's no cranial nerve deficits, no double vision --

A. These are terribly crude clinical notes. If you get a -- any individual comes in who is involved in blunt

force trauma now with any suggestion of brief post-traumatic amnesia or whatever, or in layman's terms if somebody's not right, you stick them in a scanner now and that's the only way you can go to bed and sleep safely that night, otherwise you don't know what you're dealing with.

There is a lot of indication from previous research on patients who talk and die, and this is due -- work done by Professor Jeanette in Glasgow, in days well before the scanners were uniformly adopted and patients who talk and die usually have one underlying pathology and it's called an extradural haematoma and it's the typical thing of somebody who has had a rugby injury as well, who has been kicked in the head, gets up, dusts himself down, runs around the park, goes into the changing room and dies, because it's the interval of time between the mechanism of injury, the collection of blood clot inside the head, raised intracranial pressure, failure of perfusion of the brain by oxygenated blood and they die. Tragic, because if you can relieve the pressure in the brain, they live

normally because there's nothing wrong with the substance of the brain, it's pressure, and that's why nowadays young doctors are all taught to have a very low threshold of scanning people, particularly when you have some worries about the account of the mechanism of injury, whether it has been witnessed or not, so that's the way you deal with the head injuries in the modern world.

Q. So for someone who attends hospital with a head injury, even where they've got a Glasgow Coma Scale of 15 and they appear to be normal and there's no apparent post-traumatic amnesia and there's no suggestion that they're not right, would you expect that person to have to have a scan nowadays?

A. Well, nowadays, probably, yes, for the reasons I described about the patients who talk and die.

Q. But in 2015?

A. I retired in 2011 from the NHS. If Ms Short had come into my emergency department prior to my retiral and I had been on the floor with a junior doctor I would have turned round and said "Are you going to scan this

lady or not?" Now, I wasn't a martinet in clinical practice, but the answer I would have hoped to get from a junior colleague is with "Yes". So, you know, scanning somebody's head now is what you and I remember as getting an x-ray of, you know, a sore ankle. It should be very low threshold. It's cheap, it's cheerful and it's readily available in most hospitals 24/7 now.

MS GRAHAME: All right, thank you.

Could you just give me one moment, please.

(Pause).

Thank you so much, Mr Anderson. I have completed my questioning today.

A. Okay, thank you.

MS GRAHAME: Thank you very much.

LORD BRACADALE: Are there any Rule 9 applications? No. Well, thank you very much, Mr Anderson, for coming and giving evidence to the Inquiry. I'm going to rise briefly so that the next witness can be introduced and you will then be free to go.

A. Thank you.

(2.50 pm)

(Short Break)

(2.55 pm)

LORD BRACADALE: Now, Ms Grahame, who is the next witness?

MS GRAHAME: The next witness is Dr Rudy Crawford and he will be taken by my learned junior.

LORD BRACADALE: Thank you.

Good afternoon, Dr Crawford. I think you will take the affirmation, will you?

A. Yes, my Lord.

DR RUDY CRAWFORD (affirmed)

Questions from MS THOMSON

LORD BRACADALE: Ms Thomson.

MS MCCALL: Thank you.

Good afternoon, doctor. Is your full name Rudy Crawford?

A. Yes.

Q. May I ask how old you?

A. 73.

Q. And I believe that you are a consultant in accident and emergency medicine and surgery?

A. Yes, retired.

Q. Retired. I will take you to your qualifications and your experience shortly but before I do that, I want to check that you've got everything that you need to give your evidence today in front of you. There's a black folder there. Can I ask you to open that up and within it you should find a number of documents. Firstly, a statement that you gave to the Inquiry, it's SBPI 117, on 12 May of this year.

A. Yes.

Q. Do you have that before you?

A. Yes.

Q. You will see it will come up on the screen in front of us as well and I wonder, Ms Drury, if we can go to paragraph 58 at the end of the statement. Do we see that your statement concludes with the words:

"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."

A. Yes.

Q. You have then gone on to sign the statement. It might

have been a docu signature, I think, on 16 May of this year, is that correct?

A. That's correct.

Q. You will see that we have blanked out your signature on the version that is available for public viewing, but I think the signature should be on the hard copy before you.

A. That is correct.

Q. Also within the folder there should be a report that you prepared on injuries suffered by Nicole Short and that's COPFS 85.

A. Yes.

Q. This is a report that was instructed by the Crown Office and Procurator Fiscal Service we see, and the report is dated 16 August 2019.

A. That's correct.

Q. If it would assist you at any point to have regard to those documents, then you are welcome to do so. If there are any particular paragraphs I want to draw to your attention, perhaps because I want to ask you some further questions, then they will appear on the screen

in front of us.

I said that we would return to your qualifications and experience and they cover some 11 paragraphs of your Inquiry statement. Your statement is already evidence before the Inquiry, so we perhaps don't need to go through those paragraphs one by one, but I have attempted to extract what seemed to me to be the key qualifications, and I understand that you retired from the NHS, as you have mentioned in 2016, after some 37 years in clinical practice, 26 of which were as a consultant at Glasgow Royal Infirmary, is that correct?

A. That's correct.

Q. And that was as a consultant in emergency medicine and surgery?

A. Correct.

Q. Going back a little in time, your career began with a Bachelor of Science honours degree in pure science and that was specialising in pathology, and then you studied for the MBChB, which in lay terms is a medical degree, is that right?

A. Yes.
Q. You are a fellow of the Royal College of Surgeons and a fellow of the Royal College of Emergency Medicine?
A. Yes.
Q. I want to ask you one or two questions about your time as a consultant at Glasgow Royal Infirmary, and I wonder if we might go to paragraph 7 of your statement. You explain that:

"The Emergency Department of Glasgow Royal Infirmary is very busy and at that time ..."

That time being the time that you were there?
A. Yes.
Q. "... treated around 90,000 patients a year with high levels of deprivation, violence and drug and alcohol related problems."

Your clinical responsibilities:

"... included the assessment, diagnosis and treatment of undifferentiated patients presenting with acute illness or injury and the resuscitation of critically ill or injured patients. These included cardiac arrest, head injuries and multiple trauma.

I had particular experience of managing injuries due to violence, including penetrating injuries such as stabbings."

At paragraph 9 you also explain that you have particular experience of managing head and chest injuries and you provided a service for their in-patient management and outpatient management and follow up of head injuries, and if I might also take you to paragraph 11 where you explain that when Strathclyde Police as then was:

"... set up the violence reduction unit to establish a different approach to violence [you] collaborated with them as [you] had been concerned for some time about the high levels of injuries due to violence that [you] were treating in the Emergency Department. Penetrating injuries due to stabbings were a particular problem at that time and the rate of such injuries in the population was the highest in Western Europe and had been for many years. Much of this was gang-related and due to social factors, including poverty, deprivation alcohol and drug misuse."

So you talk there about your medical involvement in violence reduction and your experience of dealing with violent assaults, in particular stabbings, and I wondered whether, in your time as a consultant in accident and emergency, you had built up experience of treating, assessing and managing stamping injuries?

A. Well, yes. Over the years I have treated, assessed and managed a number of cases of stamping injuries and I have dealt with cases, including some that have resulted in fatality or life-changing injuries.

Q. Thank you. Returning to your statement, can we look briefly at paragraph 8, please, where you explain that you have extensive experience of medical legal work spanning 30 years:

"... providing independent expert reports for personal injury, criminal injury and clinical medical negligence [cases] in both civil and criminal cases."

You have given evidence in court including murder trials and fatal accident inquiries?

A. That's correct.

Q. So, Mr Crawford, that was my attempt to extract your key

qualifications and experience from your extensive resumé in your statement, but if there is anything of particular relevance to the matters we will be talking about today that I have failed to draw attention to, then please do bring that to my notice now.

A. No, I think that should cover it.

Q. Grand. I would like now to ask you questions about the report that you prepared, and I wonder if we can begin by looking at your report, paragraph 1.2. And this is a summary -- sorry, paragraph 1, it's at the very beginning of the report, on page 3 if that assists, Ms Drury. So 1.1 and then a little further down, 1.2. There we are, thank you.

So here you set out a summary of the instructions that you received from the Crown Office and you say:

"I have been instructed by the Crown Office and Procurator Fiscal Service to prepare a report commenting on the injuries sustained by PC Short on 3 May 2015 and particularly to comment on:

"(a) whether the injuries are consistent with PC Short being assaulted in the manner described in the

various accounts.

"(b) whether the injuries are consistent with her being stamped on in the manner described.

"(c) whether the injuries are consistent with her being propelled through the air and landing in the manner described.

"(d) whether there is anything in the injuries noted that casts doubt upon the accounts provided of the [incident]."

Now, in your Inquiry statement you explain that you no longer have a copy of your letter of instruction, but it would be your practice to copy the instruction verbatim into your report. You might change the tense, but otherwise, it would be word-for-word the instruction that you received?

A. Correct.

Q. Your report is dated 16 August of 2019; do you recall when the report was instructed?

A. It was 2019, earlier in the year, but I can't remember exactly when during that period of time, but the report did involve a considerable amount of time and work to

produce, so that date was the date that I completed the report.

Q. But it was some time in 2019?

A. It was 2019.

Q. Were you advised why the report was being instructed in 2019, some four years after the incident?

A. I can't remember exactly, but I knew it was due to an investigation into the death of Mr Bayoh that had occurred in 2015.

Q. Now, we may hear evidence that the Crown did not raise criminal proceedings against any of the officers involved in the restraint of Mr Bayoh, and that that decision was intimated to Mr Bayoh's family in October of 2018, and we may also hear evidence that Mr Bayoh's family sought a review of that decision and that in November 2019, the officers were advised that no proceedings were to be taken against them at that time on the basis of the information then available and so it would appear to be the case that the Crown instructed you to prepare this report after their initial decision to take no proceedings, but before the review of that

decision was complete.

Were you aware of that fact?

A. Not that I recall.

Q. Now, Mr Crawford, this is what we might call a desktop report. Am I right to understand that you didn't examine Ms Short?

A. That's correct. I did not see her, I did not examine her. My report is based on the documents that I have listed and the methodology that I have described in the report.

Q. Yes, I see, so you didn't examine her and you didn't see her so you wouldn't have taken a history from her either?

A. That's correct.

Q. And did that lack of opportunity to examine her or take a history from her hinder you in any way?

A. I suspect that the lack of an examination probably didn't hinder me in any way, but I suppose with the benefit of hindsight, being able to take a detailed history myself may have -- would have been beneficial.

Q. As you said, your opinion is based on various documents

that were provided to you and they're listed in your report and they included statements from Constable Short, as she then was, Constable Tomlinson, Constable Paton, Constable Walker and an eye-witness Kevin Nelson. You were also provided with Nicole Short's medical records and statements from the various documents who examined her.

I want to ask you, Mr Crawford, whether it was clear to you, either from your instructions from the Crown Office or simply from your reading of the material that was made available to you that whether Nicole Short was stamped on was a matter of some controversy?

A. I think I was aware that that was an issue of contention, you know, in general terms. As I said, I cannot remember specifically when I became aware. I'm aware now that it is a controversial or -- issue. I am not sure how much I was aware of it at the time that I was instructed.

If I could just double check what I have written to confirm ...

(Pause).

I was specifically asked in the instructions to address the question whether the injuries were consistent with her being stamped on in the manner described, so to that extent I was aware that that was a specific issue that I had to address.

Q. I see, and I think you have highlighted there the instruction that we see at 1.2(a):

"Whether the injuries are consistent with PC Short being assaulted in the manner described in the various accounts."

But was it clear to you, either from the instructions you received or from reading the papers, that the various accounts referred to were in fact in conflict, at least insofar as they related to the stamp?

A. I certainly wasn't aware of it in terms of reading newspapers. I don't remember much, if anything, in the media at the time that it happened or prior to me being instructed, but I was aware that this was an issue that I had to address. I can't say that I was aware -- I'm not sure if I was aware that it was a particularly contentious issue at that time, but my feeling is that

I was aware that it was an issue.

Q. All right. And the questions asked of you don't appear to distinguish between the various accounts. They ask whether the injuries are consistent with Constable Short being assaulted in the manner described in the various accounts, but they don't appear to distinguish between or separate out those various accounts.

A. No, they didn't in the instructions.

Q. And perhaps for that reason, you similarly don't distinguish between them or separate them out in the opinion that you go on to offer.

And the questions that you were given by Crown Office don't appear, at least expressly, to have asked you to consider whether the medical evidence was more supportive of one account over another.

A. No, I wasn't asked that.

Q. Now, you reviewed Constable Short's medical records in some detail and your summary of her medical history extends to some six or seven pages of your report. Now, I don't intend for us to go through that in any detail at all, however, you provide a very succinct summary in

chapter 13 of your report, which is on page 23. It's under the heading "Comments", and I wonder whether I might ask you simply to read out chapter 13 before we go on to discuss your opinion.

A. Okay. Well, chapter 13, "Comments", paragraph 1, it starts:

"Unfortunately, it was not possible to clearly identify the precise injury mechanisms from examination of the CCTV footage. Reliance has been placed therefore on the events described in the various statements, the available medical records and the documents supplied.

"When she attended the Emergency Department shortly after the incident her main complaint was an injury to the head. The doctor noted that she had sustained blows to the back of the head from an assailant who chased her. She had an occipital headache. The doctor's examination was unremarkable apart from finding abrasions on both elbows, knees and left hand. She had no obvious symptoms or signs of a chest or back injury and she was discharged with routine head injury advice.

"When she was examined later that day by Dr Gillian

Norrie it was noted that the assailant had stamped on her back. Her physical injuries were documented and she was noted also to have tenderness in the right Occiput, Mastoid process and the right side of the neck.

"When she attended hospital for the second time the following day she reported further symptoms of 'all over body pain' but her main concern was intermittent light-headedness ... she had mild facial swelling on the right side and tenderness of the spinal muscles on the right side of her back."

I have to say there's a little bit redacted there which I cannot recall what that was:

"The doctor concluded that she was suffering from a minor head injury with post-concussion syndrome, soft tissue injuries ..."

And I'm not sure what the last bit says.

Q. It is something that's not relevant for our purposes.

A. Something that's not relevant for your purposes, okay.

"Her symptoms continued and she eventually underwent CT scan of the head and neck which was unremarkable."

Q. Thank you. That's a very succinct summary of an

extensive volume of medical records.

I wonder if we can now look at your opinion and it is chapter 14, the heading is "Specific questions", where you repeat the four questions that you were asked by the Crown Office and then go on to answer them, so I wonder if we might look at these in turn. The first question of course was whether the injuries are consistent with PC Short being assaulted in the manner described in the various accounts and you say:

"There are several descriptions in the various statements, medical records and opinion by Lord Woolman ..."

Can I pause there just to say that I understand that opinion contained an extract from an affidavit that had been prepared by Nicole Short, is that right?

A. Yes, that's right, and I included that because it was a description of the mechanism of injury in more detail that I thought was relevant because what I was doing in these situations was looking at the history, looking at the mechanism of injury and trying to form opinions based on the injuries observed on those issues and

that's why that was included there because there was some more detail in that that hadn't been clear in previous accounts.

Q. I see, that's helpful. So you say:

"There are several descriptions in the various statements, medical records and opinion by Lord Woolman of the alleged assault of PC Short by the assailant. In my opinion, the injuries identified and the claimant's symptoms overall were consistent with being assaulted in the manner described in the various accounts."

I want to ask a question about that and it's this: when you say that the injuries were consistent with her being assaulted in the manner described in the various accounts, what did you mean by that, and in particular what did you mean by "the manner described in the various accounts"?

A. On the documents -- both on the -- based on the hospital records, based on the accounts of the various witnesses, including PC Short, the other police officers and the -- all the accounts that describe the incident, it was based on those.

Q. Would it be accurate then to say that you looked at the evidence in the round --

A. Yes.

Q. -- and offered a view as to whether the injuries were consistent with that evidence seen in the round?

A. Both in the round, but also I was looking for specific descriptions that would either be supportive or not supportive of a particular mechanism or of a particular injury. The -- I think I will just leave that at that point.

Q. Very well. Let's move on to the second question "Whether the injuries are consistent with her being stamped on in the manner described":

"In my opinion the injuries were consistent with her being stamped on in the manner described. It is of note that the claimant had no recollection at the time or subsequently of being stamped on and there were no specific injuries related to that cause documented on her initial attendance at the emergency department on the morning of the incident. In my view, however, if she had been stamped on several times she could have

sustained a concussive head injury with a brief loss of consciousness at that point that would result in a brief retrograde and anterograde post-traumatic amnesia and she would have no recollection of this event.

"In my view, on the balance of probabilities, this would explain the minor concussive head injury rather than the initial blows to the back of the head, of which the claimant had a full recollection, which would not be consistent with causing a concussive head injury. In my opinion, the complaint of all over body pain the following day would also be consistent with this account, as well as the effects of extreme physical exertion in a 'fight or flight' situation. By that time she also had evidence of swelling and bruising on the right side of the face that was not evident on her initial hospital attendance immediately after the incident or during Dr Norrie's examination later that same day."

So a few questions, if I may, in relation to that particular conclusion. You acknowledge that Constable Short had and indeed has no recollection of

being stamped on.

A. Yes.

Q. And you also acknowledge that there were:

"... no specific injuries related to that cause documented in her accident and emergency notes."

What did you mean by that, "related to that cause"?

A. There was no specific information in the accident and emergency records documented at the time of either a history that she had been stamped on, or of symptoms complained of that would indicate an injury to the chest or back area that -- to suggest that she had been stamped on, and that's what I mean -- so it wasn't documented. That -- I would have to say that that doesn't necessarily mean that she didn't report some of these things, or all of these things, it just means that the doctor who examined her at the time has not recorded or documented any of these symptoms.

Q. I see. So there was no recorded history of a stamp, there was no recorded injury suggestive of a stamp, and there was no record of any symptoms that might have been suggestive of a stamp?

A. Correct.

Q. And you say it doesn't mean that these things weren't said, it could mean that they weren't written down. Now, we heard evidence this morning from the doctor at the accident and emergency department who first saw Nicole Short, and it is of course a matter for the Chair what to make of that evidence, but she gave very clear evidence that if any complaint had been made of pain on the back or the side, tenderness, or of injury, any complaint would have been noted, she could think of no reason why she wouldn't have included that, it would have been relevant information for her purposes, it would have been recorded in the notes. And similarly during the head-to-toe examination, if there had been any redness, bruising, tenderness, injury, anything of that sort noted, it would also have been recorded.

So it's a matter for the Chair what to make of that, but that evidence is before the Inquiry.

You say that if Ms Short had been stamped on several times she could have sustained a concussive head injury with brief loss of consciousness resulting in amnesia.

Was it your understanding that she had been stamped on her head?

A. No, not necessarily. Ms Short, or former PC Short, at no time through any of the documents that I was provided with said that she was stamped on, that she has any recollection of being stamped on, so the issue there was had she sustained a concussive head injury and how and this is where having a detailed history and a detailed mechanism of injury that would be of interest to me as a doctor, but other people might not necessarily see it as particularly important and record. So I -- the information was a bit vague and there was a bit of a gap in some areas, so I could not exclude the possibility that she had received a stamping injury to her head or whether it was to another part of the body, but I have to say that you can get a concussive head injury from a blunt force injury to either the head, the face, the neck, or the body, if sufficient force is applied to cause the head to move in such a way as to cause a concussive head injury, so that could happen if she had been stamped on in the head, or if she had been

stamped on elsewhere in the body, but with sufficient force to cause an injury to the head that would result in concussion. So ...

Q. That's very clear. Thank you.

Returning to your opinion, questions (c):

"Whether the injuries are consistent with her being propelled through the air and landing in the manner described.

"In my opinion, the injuries were entirely consistent with her being propelled through the air and landing in the manner described. In my view, the soft tissue injuries on both elbows, knees and left hand strongly support the description given."

I don't have any questions for you in relation to that conclusion. And for completeness, the final question was:

"Whether there is anything in the injuries noted that casts doubt upon the accounts provided of the incident."

And you say:

"I could not find anything in the injuries or

symptoms noted that was inconsistent with or cast doubt upon the accounts given of the incident."

After addressing those very specific questions you go on to offer an opinion, which again is in very short compass, and I wonder if I could simply invite you to read out your opinion. Again, there are some redactions, some matters that are not relevant for our purposes have been removed.

A. Okay:

"In my opinion, this woman sustained a minor head injury and muscular skeletal soft tissue injuries in the course of her duties as a police officer when she responded to an incident involving a member of the public.

"In my opinion, from a medical point of view, the physical injuries sustained were not serious or life-threatening.

"In my opinion, however ... the incident during which she was in fear for her life and was convinced that she would be killed ..."

Sorry, that doesn't read quite as well as it should:

"However, I am unable to comment further as this is outwith my area of expertise and an opinion would be required from a suitably qualified expert in clinical psychology or psychiatry.

"In my opinion, the injuries identified were consistent with the mechanisms of injury described in the various accounts of how they were sustained."

Q. Thank you, Mr Crawford. So can we take it that your report accurately sets out your opinion on the basis of the information that was made available to you in 2019?

A. That is correct.

Q. Now, information is available to the Inquiry that was not available to the Crown in 2019 and therefore could not have been available to you at the time that you prepared your report and that information includes statements that have been taken by the Inquiry team and evidence given on oath in the Inquiry hearing from a number of witnesses in recent weeks and they include Constables Walker, Tomlinson and Short, and the eye-witness, Kevin Nelson.

I can advise that whether Mr Bayoh stamped on

Nicole Short remains contentious and the Chair to our Inquiry will need to determine whether she was stamped on at all and if so, where on the body, how many times and with what degree of force.

I want to tell you a little about the evidence that the Inquiry has heard before asking you questions about stamps and asking whether the new information changes your opinion or has any bearing on the opinion that you expressed in 2019.

We have conducted an analysis of police Airwaves and CCTV footage and footage from mobile telephones against a real time clock and that has confirmed that from the moment that the police van in which Constable Short was travelling stopped at the scene to an Airwave message "Officer injured PC Short" is 23 seconds, okay? And in that time we have heard evidence that she and Constable Tomlinson got out of the van, Constable Tomlinson shouted instructions to Mr Bayoh, sprayed him with CS spray, Constable Short swung her baton at him, she ran away and was pursued and was struck to the head and fell to the ground. Within a further 10 seconds

Mr Bayoh had been taken to the ground by the police officers in attendance. I don't think any of that is in dispute. I will be corrected if I'm wrong.

And so if she was stamped on, the stamp also happened within that timeframe and the purpose of me saying that is to make clear that on any view this could not have been a lengthy or prolonged assault; it happened very quickly.

I should also make you aware, and I think the PIRC -- sorry, the Crown Office told you about this, that Constable Short was wearing a protective vest at the time and we have a demonstration vest in the hearing room today. I'm sure you have seen many of these in your years of practice.

A. Yes. I also examined clothing and equipment at the request -- and it included the protective vest so I'm familiar with that.

Q. That's right. I think I'm right in saying that the yellow or the hi-vis vest had been bagged --

A. Yes.

Q. -- forensically bagged, but you were able to handle the

body armour beneath it?

A. Yes, that's correct I --

Q. Now -- sorry.

A. Yes, it was in a bag, it had been covered with chemicals and I wasn't able to take it out or examine it in detail, but I could see it within the bag.

Q. Yes. But you were able to handle the black vest?

A. The other equipment, yes.

Q. We have one here. If you would find it helpful to hold it, to touch it, to feel the weight of it, please do so.

A. No, it's okay, I'm fine.

Q. It may be you feel you have seen many in the course of your career.

A. Thank you.

Q. Returning to the evidence, Mr Crawford, Nicole Short said in her evidence that to this day she has no recollection of being stamped on and her evidence was that after being struck to the back of the head and landing on the ground, she curled up on her right-hand side in the foetal position and she was later told about the stamp by colleagues on her return to the police

station after she had been to A&E.

Kevin Nelson said in his evidence that the stamp did not happen and that before he left his window to go outside, Mr Bayoh had moved away from Nicole Short and had been tackled by a police officer in what he described as a bear hug.

Constables Tomlinson and Walker both said in their evidence that Mr Bayoh stamped on Nicole Short's back. So that, in very short compass, is the evidence before the Inquiry and you will appreciate that this matter remains contentious, and so I would like to explore with you what the medical evidence tells us as this may assist the Chair in reaching a view as to whether or not Mr Bayoh stamped on Nicole Short, and if so where and with what degree of force.

So I would like to begin this chapter of your evidence by asking you some questions about stamping in general, and I noted when I asked you questions at the outset about your time working with Strathclyde Police and your time in A&E dealing with stamping injuries, you mentioned that you had indeed seen life-threatening and

fatal injuries as a result of --

A. Yes.

Q. -- stamps, and I wanted to ask you just how dangerous is it to stamp on someone's body?

A. Well, it's -- we place a lot of emphasis on mechanisms of injury, or mechanism of injury, and mechanisms of injury -- some mechanisms of injury are more dangerous than others, and are at risk of causing life-threatening or fatal injuries, you know, they are potentially lethal mechanism of injury.

That doesn't mean that it's inevitable, or it will happen in every case. For example, stabbings. Stabbing is a lethal -- potentially lethal mechanism of injury and it's highly dangerous and, you know, minor differences in how a stabbing occurs can make all the difference between a fatal injury and a non-fatal injury.

Similarly, stamping. Stamping is more dangerous in my experience than kicking because of the forces involved because injuries occur in patterns, patterns of injury are dependent on the mechanism, and also the

energy forces involved which are transferred to the body and the greater the degree of energy that's transferred to the body, the greater the tissue damage that occurs and this goes back -- and I will not go into -- into simple laws of physics, Newton's laws about conservations of energy.

So these are the kind of things that we consider in dealing with injuries, so stamping injuries are potentially very serious or fatal. I mean I can give you an example or two, but it's mainly because of the energy forces that are involved in it and the potential for, you know, that transfer of energy to the body that can cause rupture of organs, damage to vessels, extensive bleeding and death.

Q. So what sort of injuries could be caused by stamping on a person's body, in particular, stamping on their back? You mentioned rupture to organs?

A. Yes.

Q. What other injuries might be caused?

A. Well, stamping in the back, for instance -- excuse me, I'm a bit dry and hoarse. Stamping on the back,

for instance, it depends where on the back the stamp occurs because people think of the back as the back but from a medical point of view, the back also includes the chest, which includes internal organs inside the chest but also the rib cage also provides a degree of protection to organs in the abdomen which when you breathe out rise up and are effectively in the chest, but separated by the diaphragm muscle.

So the injuries to these organs can occur depending on -- so if you are in full expiration, for example, your liver will be right up -- halfway up inside your chest effectively. You've got your kidneys at the back, you've got organs at the back like your pancreas, you've got major blood vessels at the back, and you've also got these things at the front. Also in the back of the left side you've got the spleen and these are very vascular organs, and if you get damage to the lower ribs, for example, in these areas, then you can get damage to these organs with torrential bleeding.

I saw -- many years ago I saw a woman of 29 who was stamped on on her right lower chest which completely

burst her liver and she bled to death on the operating table, you know, and it was shattered right in the centre of the liver, split into pieces with a stamping injury and you could also see the impression of the heel of a shoe on the body, where that injury was applied.

So that's the kind of injury that can happen if sufficient force is applied. That's just one example.

Q. That's helpful. You did say that it may depend where on the person's back, because the back is quite a large area.

A. It is.

Q. Let's take, for example, the kidney area.

A. Well, again, you know, people talk about the right lower back, but the right lower back can also be the right lower chest. The kidney area -- you know, is also in the right lumbar area posteriorly.

Q. You're pointing to this part of your back; is that where you would find the kidneys?

A. Yes, but they lie at the back of the abdominal wall so they're nearer the back than the front, but the kidneys also move up and down with breathing, so they can be

higher up in the chest or lower down a bit, just as the liver can and the spleen can and the other abdominal organs.

And it is -- and I have not specifically mentioned it in my report, but obviously because I was coming here today I have re-read my report, I have re-read the statements that I was provided with, and there are various places where Ms Short did complain of being unable to breathe so -- and also of right-sided pain and on one of her examinations she was tender in the right paraspinal muscles and to me that would be consistent with having received a blow in that area where she was unable to breathe because of an injury to there, possibly having been winded or an injury causing pain that was restricting breathing.

Q. Before we go any further, her evidence, as I recall it, was that she was very upset, distressed, distraught in the immediate aftermath of this incident, and we heard from another lady officer who arrived at the scene immediately afterwards and went to comfort her, and if memory serves me well she was described as almost

hyperventilating, struggling to breathe, struggling to get her words out, and I'm wondering if that's the sort of description that you're alluding to having re-read some of the statements, whether that presentation would necessarily be attributable to an injury to the chest, or whether it might be on account of the fear and terror associated with the experience that she had just had?

A. Well, I couldn't exclude that as a possibility because, you know -- because you can -- you have mentioned hyperventilation; hyperventilation is a specific, you know, thing that can occur in association with what used to be called panic attacks. I can't exclude that, but she did, in some of the accounts, did seem to have pain in the right side of her body and so -- I accept what you're saying: there could be other causes.

Q. Could be other causes and on the theme of other causes and this pain on the right side of her body, I wonder if I can ask you to look at another couple of pieces of demonstration equipment that we have. Again, you will have seen these before, but the utility belt and the CS spray holder.

Certainly we heard evidence from Constable Short that on the day in question, she was wearing a utility belt of that type, and it had, amongst other things, a CS spray canister which you will see in front of you and if you handle that, you will appreciate that it's made from solid plastic.

A. Yes.

Q. It's hard, it's not a soft item.

Her evidence, as I mentioned to you earlier, was that having been struck to the head and fallen to the ground, she curled up into the foetal position on her right-hand side and she gave evidence that she had pain in her hips afterwards, and a number of witnesses spoke to her holding onto her right-hand side and she said in her evidence that her utility belt had dug into her hips and her hips were sore and that she was aware of her spray and her baton, and she thought that was perhaps what was causing her hips to be sore on both sides, and I'm just wondering, before we go on any further to discuss the stamp, whether again the references that you have alluded to, having re-read the statements that were

provided to you in 2019, that refer to a pain in the right-hand side, might have been caused by falling to the ground and then lying on her utility belt and CS spray can?

A. That's certainly a possibility.

Q. I was asking you questions about how dangerous it is to stamp on someone and I wonder if I can take you to a couple of paragraphs within your Inquiry statement please. Firstly paragraph 24, where you say:

"There certainly wasn't any evidence of serious injuries caused by stamping."

And this is by reference to Nicole Short's medical records:

"From my point of view ..."

Sorry, I beg your pardon, do you have that in front of you? It is also on the screen if that assists?

A. Yes, I see it on the screen.

Q. I will let you catch up.

A. That's fine, thank you.

Q. Do you have that?

A. Yes.

Q. "There certainly wasn't any evidence of serious injuries caused by stamping. From my point of view, stamping is a very dangerous and potentially lethal injury mechanism, it can cause very serious life-changing injuries. I've seen people with this. Stamping to the head or body, people have died as a result of that. It's potentially life-threatening. It's fair to say, in my opinion, there is no evidence of serious injuries or gross injuries consistent with a serious or life-threatening stamping injury."

So in that paragraph you tell us a little bit about how dangerous stamping can be and you have said the same in your evidence today, but you also say that having reviewed Nicole Short's medical records you didn't find any records to suggest she had suffered injuries of that sort.

In paragraph 25 you say:

"Nicole Short has no recollection of it. It's possible that this could be explained by amnesia. Given the description of the stamping, I would have thought there would have been evidence of it, such as fractured

ribs or significant blunt force injury or pattern bruising."

So my purpose at the moment at this point in taking you to this paragraph is to identify another potential consequence of stamping and here you make reference to fractured ribs as well as blunt force injury, so as well as damage to the internal organs, there could be the breaking of bones?

A. Well, yes, there can be, but there may not be, it all depends on the severity and the effectiveness of the stamp.

Q. The severity and the effectiveness?

A. Yes.

Q. And finally on paragraph 30 -- and again my focus just now is to identify the potential causes of a severe and effective stamp, you make reference to fracturing ribs, damaging the lungs and causing internal bleeding, none of which were in evidence in this case.

What I would like to do now, Mr Crawford, is take you to two descriptions of the stamp. You will be aware from what I have told you already, and indeed from your

instructions back in 2019, that two officers, Constables Tomlinson and Constable Walker, speak to Nicole Short being stamped on by Mr Bayoh, and so firstly I wonder if I can take you to Constable Tomlinson's statement, this is PIRC 263 at page 3, paragraph 3. This, I think, you have seen before. There we are. So it is the paragraph at the bottom of the page about halfway down:

"I ran over to assist her, but before I got there, he stomped on her back with his foot with a great deal of force. He put his full body weight into the stomp and used his arms to gain leverage. After he did this she went back to the floor and never moved. I thought he had killed her. He stomped on her back again with the same force and she wasn't moving."

So I think you have seen that description before. There's another description I would like to show you and this is in SBPI 39. This is from Constable Walker in a statement he provided to the Inquiry. It's at paragraph 47, please. At the bottom part of that paragraph:

"I had a clear and unobstructed view of him and saw

him with his right leg in a high raised position. He had his arms raised up at right angles to his body and brought his right foot down in a full force stamp down onto her lower back, the kidney area."

Now, Mr Crawford, both of these witnesses have given evidence before the Inquiry and they were both asked to demonstrate the stamp, and because these proceedings are being recorded I'm in a position to show you the footage of them demonstrating the stamp, so I wonder if we can watch Constable Tomlinson first.

(Video played)

So that was Constable Tomlinson. And Constable Walker, please.

(Video played)

Thank you. Would you like to see that again? Would that be helpful?

A. No, no, that's fine, thank you.

Q. You said earlier that the damage done by a stamp will depend on its severity and its effectiveness. You have seen a stamp demonstrated by two officers; how severe and effective were the stamps demonstrated?

A. Well, my first impression is obviously they're stamping against a hard surface that is unable to give, there's no give or movement in that. Stamping on a body is different because bodies are elastic of varying degrees and that helps to absorb energy and reduce the effectiveness. You might think I'm arguing against what I said earlier, but I'm not.

Also in the circumstances where one is wearing protective body armour and other clothing, and also I had an opportunity to examine the footwear that Mr Bayoh was wearing at the time, which -- I can't remember specifically at the time, but they were soft, essentially soft-looking and kind of feeling shoes with thick, relatively soft soles, in other words it wasn't hard leather and a hard heel like the kind I'm wearing on my foot just now, and like the kind of footwear they were wearing. So all of these things have a capacity for deformation and absorption of energy and it slows down the forces that are being applied to the body. The same thing happens in vehicle crashes where, for example, cars are designed to have crumple zones that

absorb energy that's being transferred so that it takes up that -- dissipates the energy so that it's not all applied to the body, so to speak.

So I have also seen CCTV footage in various cases in the past where people have been beaten, kicked or stamped on, and where, despite it looking very severe, they have not sustained serious or life-threatening injuries. They have sustained injuries, but not the severe kind that's likely to threaten life.

So there are a lot of variables in these things and I would be prepared to accept that's what they saw, but I would also be prepared to accept that in this case it did not result any major injuries from a medical point of view because there are other kind of variables that might influence that. Not every case of stamping results in life-threatening injuries.

Q. I think you will appreciate that ultimately determining what they saw will be a matter for the Chair.

A. Yes, of course.

Q. But I wonder if you can help us in terms of what light the medical evidence might cast on their evidence, and

on the circumstances of this stamp, and I hear all that you say, and there clearly are limitations to performing a demonstration on a hard floor here. However, I wonder -- you have heard the descriptions and you have seen the demonstrations. Stamps performed in the way that they were, what sort of injuries might you expect them to cause?

A. Again, it depends where it is applied to the body. I have made reference to things like pattern bruising, for example. Pattern bruising often gives an indication -- gives an indication of the severity of the forces that are involved where you get pattern imprints on the surface of the body or the skin as a result of these types of injuries. For example, I have seen almost like a traumatic tattoo of the name of a shoe, you know, of a trainer imprinted on somebody's head where they have been stamped on on the forehead, or you can see patterns of the footwear or patterns of the clothing and these are always warning signs of the potential for serious injury because that takes quite a lot of energy to do that.

But in this case there was none of that, but, you know, that could easily be explained by, as I said, the type of footwear, the protective clothing, other clothing that was on. She did not sustain a serious injury. I do not think you can say because she didn't sustain a serious injury that it didn't occur, just purely on that basis alone, so -- but -- sorry, does that answer your question?

Q. It does and I certainly didn't mean to put it to you that because of the absence of injuries she could not have been stamped on; I'm simply looking to explore with you what the medical evidence or the absence of medical evidence tells us about the circumstances?

A. Well, as a doctor, you know, that would be my response to this. It's a very dramatic demonstration, but there are limitations in terms of the modelling, as to how much that would reflect real life, so the -- but -- and again, as a doctor, the history is very, very important, ie the history is the description of the events, or of -- and of the symptoms and signs that a patient has, whether it's for a medical disease or condition, or

whether it is for an injury. You know, there is a -- it's axiomatic in medicine that doctors are taught: listen to the patient, they're telling you the diagnosis. In other words, the descriptions that patients give you of their medical history and of their symptoms can often lead to a diagnosis without even examining a patient. That's where medical conditions are concerned.

In terms of injuries, that history translates into mechanism of injury. The more specific detail you can have on the exact mechanism of injury, the better you are able to anticipate the types of injuries that are likely to occur, and it is fair to say in this case there are gaps. There are gaps in Ms Short's recollection of things, there are gaps in the statements that for me as a doctor I would be wanting more information.

For example, if you take Ms Short's statement where she describes what -- you know, this blow to the back of the head and her falling to the ground, what she describes is falling towards the ground. She doesn't

say "I remember striking the ground", or "I hit the ground and I did this ..." you know, she remembers going towards the ground and putting her hands out to protect herself. She doesn't say anywhere that I have seen that she remembers actually landing on the ground.

Her next memory is of being curled on the ground, or curling up she said, and -- but it wasn't clear to me whether she meant in that statement the physical act of curling up, or that she was curled up, and when you're taking a history, that attention to detail is very important, especially when you're looking at head injuries and trying to assess the severity of the injury and the amnesia. You need to know what the last clear recollection the patient has and then you need to know the next clear memory that signals the return of continuous memory after the injury has occurred and that helps you, again, assess the head injury, and as a doctor you have to specifically question the patient in detail about these things --

Q. I see.

A. -- in order to be able to get that accurately, and in

a lot of these statements, and even in some of the records, that level of detail isn't quite there, but the impression I get from what was in that statement is she gives a clear period of time -- or a clear description where she doesn't actually remember hitting the ground, she doesn't actually remember -- she remembers either curling or being curled up on the ground but there was a gap in-between and I would presume she was lying on the ground when she hit it and what happened between that period she was on the ground and the period when she was curled up and then she goes on to describe trying to get back up off the ground after she has been injured.

So, you know, from a head injury point of view that I was looking at specifically, you know, there is a gap there.

Q. Okay, well, we will perhaps return to that, Mr Crawford, for now. Sorry, bear with me just a moment.

(Pause).

I think, Mr Crawford, she has in fact given further detail in her evidence which may fill that gap. She

describes being hit and then knocked flying, as she puts it, she says "for want of a better phrase", and then hitting the ground and then:

"The next thing I remember is curling up into a ball and grabbing the bun at the back of my head and trying to protect my head and I was on my right-hand side on the ground."

So she appears to give an account of hitting the ground.

A. Can I ask when that was? What account this was? How long after the incident?

Q. Two weeks ago. This was in her evidence under oath to the Inquiry.

A. Oh, two weeks ago. Okay, right, that's seven years later then. That's not what she said at the time, in her statement taken at the time and at the time there is a gap there. I'm not sure how reliable that would be seven years after the event.

Q. Well, it doesn't matter, again that is a matter for the Chair.

A. No, personally as a doctor, from assessing a head

injury, that's how I would view that. I fully accept that's for the Chair to decide.

Q. And I appreciate that perhaps if you had examined this lady and taken a history, you would have specifically looked to ascertain whether she had a recollection of landing on the ground.

A. Correct.

Q. And it may or may not be the case that those examining her in the early stages asked that question or sought to elicit that detail.

A. Correct, correct.

Q. But I can advise you that in her evidence before this Inquiry under oath she said that:

"The next thing -- it kind of jumps because I remember being hit and then knocked flying and then hitting the ground."

So her evidence before these proceedings is that she recalls hitting the ground, so that would appear, on the face of it I think, to fill that gap.

A. Are you asking me to express an opinion on that?

Q. No, I'm not asking for an opinion on that, no.

LORD BRACADALE: (Mic turned off).

MS THOMSON: I would agree, sir.

I would like to move on from that and return to the question of the stamp. The limitations of modelling aside, you have also heard the two descriptions provided. One was to the effect that Mr Bayoh put his full body weight into the stamp using his arms to gain leverage and the other to the effect that the stamp was full force down onto her lower back, the kidney area, so with those demonstrations, and more particularly those descriptions in mind, might you have expected injuries to result?

A. I do recollect that she had tenderness over the right paraspinal muscles, which is the area you're describing, but she definitely did not have other more serious injuries, either visible external injuries or symptoms that she described to suggest that she had injuries in that area, but she was tender in that area. I think that must have been during the examination later that day that Dr Norrie did. I may -- I would have to consult the records, but I think that was where that was

noted. It was just that a stamp in the back -- that would be consistent with a stamp in the back, as opposed to something injuring her on her side.

Q. Well, the Chair has heard from both Dr Mitchell and Dr Norrie and it's a matter for him to make what he will of their evidence, but if I were to advise you that neither Dr Mitchell nor Dr Norrie made any record, or has any recollection of there being any complaint of injury to the torso, anywhere on the torso --

A. Yes, yes, yes.

Q. -- neither noted any bruising, or redness, or tenderness, would you accept that perhaps --

A. Well, maybe --

Q. Let me finish, please.

A. Yes, sorry.

Q. Would you accept that perhaps your recollection -- because you have clearly sought to refresh your memory by looking through records.

A. Yes, I did.

Q. That perhaps your recollection of the findings on that particular day is a little out.

A. No, I accept that it may not have been Dr Norrie, I accept that my recollection is -- but there was a definite report of an injury, or tenderness on examination in that area by one of the medical staff, but I fully accept that it is up to the Chair of this Inquiry to determine the significance of these things and I accept what you say, yes.

Q. Okay.

A. She did not have serious injuries.

MS THOMSON: Sir, I'm conscious of the time. I would anticipate being perhaps another 15 minutes with this witness and I'm entirely in your hands as to whether to continue this evening --

LORD BRACADALE: There is also the possibility of Rule 9 applications. Might there be, without committing yourselves? There might be Rule 9 applications. Well, in that case, I don't think we should continue, if this is a suitable break point.

MS THOMSON: It is.

LORD BRACADALE: Very well. Can you return tomorrow morning, Dr Crawford?

A. Tomorrow, Friday. Yes, my Lord.

LORD BRACADALE: Okay, 10 o'clock tomorrow morning then.

I will adjourn now until tomorrow morning.

(4.00 pm)

(The Inquiry adjourned until 10.00 am on Friday,
10 June 2022)

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TRANSCRIPT OF THE INQUIRY