WITNESS STATEMENT

Agency Ref :S067
PF Ref :

Surname : CLARK Other or previous surname :

Forenames : Martin DoB : [redacted]/1972 Age : 43

Occupation : Anaesthetist Other Occupation : MBCHB FRCA(Fellow Royal College Anaesthetists)

Police Station : Years Service :

Disclosable address :

Post Code:

This statement was taken :

Date and time : 12th of May 2015 13.20

By : EDWARD MILES
Place : Within A&E Victoria Hospital, Kirkcaldy

In the presence of :

I have/the witness signed/refused to sign this and all other pages

It was/not read over to the witness and was/not recorded on Audio tape and/or Video tape

States :

I am employed by NHS Fife in Consultant Anaesthetics and Intensive care working from Victoria Hospital and have worked within NHS Fife for the last 7 years in this capacity.

On the 3rd May 2015 I was the anaesthetic resident working nightshift and was called at approximately 830am to attend at A+E. My timing may be incorrect but I was called on the on call phone.

I arrived at A+E within about 1 minute. A patient a black male, muscly, naked chest was being ventilated by a laryngeal mask airway which is a tube which sits above the larynx and it ventilates the patient keeping the airway open. I then decided that this

wasn't ideal and I decided to intubate the patient. This was inline stabilisation and put a E.T. tube into his trachea. This is a grade 3 view, intubation and requires bougie (plastic stick bent at one end to allow you to get to the trachea). The position of the tube was confirmed with caprography (a CO2 detection if there is any in the lungs). Air entry was bilateral and equal suggesting the tube was in the trachea in the correct position. The patient was reasonably easy to ventilate (so it was reasonably easy to squeeze the bag). He was put onto the ventilator which was okay with the pressures (ventilator pressures) and was delivering the desired ideal volumes which was 500/600ml of oxygen.

Various members of staff were carrying out CPR and they were switching in and out as they got tired. CPR was producing a good pulse in the groin so an A+E doctor inserted an arterial line into the femural artery. This provided a good blood pressure reading. The blood pressure was anything from 140 systolic to about 70 systolic with chest compressions. Basically CPR continued as per protocol with adrenalin given when appropriate. The protocol essentially means that CPR is chest compressions, oxygenate the patient and give adrenalin regularly and consider drugs such as amiodarone, an anti arrthymic which may help the patient come out of VF (ventricular fibrilation). During this period there were numerous personnel present including the A+E registrar (Dr G Pickering) who was running the arrest pretty well. We (the doctors) considered reversable causes the 4H and 4T, Hypovolaemia, Hypoxia, Hypohyperthermia, Hypo/hyperkalaemia + tension/tamponade, thromboembolism and toxins. We wouldn't do an x-ray then which would have meant stopping CPR so I did an ultrasound of the heart and lungs and another anaesthetist was in charge of the head end (taking over the role - I think it may be David who was dayshift).

The images that I took are on the ultrasound machine as cardiac arrest. Its in 2 segments as the patient had been scanned several times. The scans showed minimal cardiac contractility (not moving). The movement on the last scan showed none or absolutely minimal but essentially none. I scanned the lungs which showed a bilateral sliding lung sign which means the lungs are against the chest wall and suggests against a significant numothorax but doesnt absolutely rule it out but confirms ventilation is occurring. At some point we went on to the THUMPER which is a pneumatic machine that does chest compressions. At that point the ventilation started to struggle as the compressions were interfering with the delivery of breaths. We then reverted back to manual 'bagging' (squeezing the bag). Basically there was a general feeling to stop. I was uncomfortable intially whilst in the PEA pulseless electrical activity with very slight cardiac movement on echo. We continued on until we were in an agonal/asystolic rythym and essentially no cardiac contractibility on the echo. The images are saved. So there is a video of his heart and lungs just moving/not moving - heart not moving. I agreed at this point, that is when the heart was not moving that we should stop. The A+E doctors I'm guessing pronounced life extinct. Despite very well run C.P.R the patient continued to deteriorate so after CPR of about 1 hour 14 minutes which included the THUMPER we decided to stop. We checked to see that there was no other injuries. He had about 3 litres of intravenous fluid which would combat any blood loss. There was no further involvement from me other than to write up my notes which I did on the A+E form. I have been shown a copy of the A+E Form and signed a documentary production backing sheet. The only change to this statement would be that the THUMPER when initially applied was a

little bit low and was immediately readjusted to the correct position higher up on his chest. This is an accurate version of events.

Signed : (Witness)

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WITNESS STATEMENT

CONFIDENTIAL MATERIAL - NOT TO BE DISCLOSED

Surname : CLARK Forenames: Martin
Alias/known as :

Place of birth : [redacted] Age : over 18

Telephone : [redacted]
Home address : [redacted]

Post code : [redacted]

Telephone :
Business address :

Post Code :

Mobile : [redacted]
Email :
Fax/Pager :
Other :

Dates when unavailable in next 12 months :

Other Confidential Material :