The Sheku Bayoh Public Inquiry

Witness Statement

Alan Finlayson

Taken by [redacted] by telephone
On Thursday 20 December 2021 and 14 February 2022

Witness Details

1. My full name is Alan Finlayson. My date of birth is in 1973. I work at [redacted].

2. I work with [redacted]. I broke my back in July 2021 so I'm doing various other things and can't work on the road at the moment. I'm still officially an ambulance paramedic I'm just not doing the job at the moment.

3. I hold a IHCD Ambulance Paramedic qualification. At the time of the incident regarding Sheku Bayoh I was an ambulance paramedic. I joined SAS in around December 1995.

4. I started as an ambulance technician. The difference is that paramedics are a bit more advanced, for example they can provide intravenous access to the patient and a few other paramedic skills. You've a wider range of drugs to use.

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5. I also did a university degree in my own time. It was a BSc in Health Studies at the University of the West of Scotland. I graduated in 2014. I did 6 modules. One was Pain Management, another was Diabetic Management. There was a compulsory module in Critical Research Appraisal. I did Leadership, another called Teaching & Professional Practice, and I did Ethics as well.

Glenrothes Ambulance Station

6. I can't remember the date of the incident. It was maybe April or May, at least three years ago. It was definitely the weekend. I can't remember if it was Saturday or Sunday.

7. I was day shift on that particular day at Glenrothes. It must have been a 7 o'clock start that day because I've operational reasons why I think that was the case.

8. I was working with another paramedic that day called David Taylor. I call him Dave. There is a division of duties, one person is the attendant and the driver. I was the driver that morning. The attendant would be the person to ask questions about what happened, get information on the patient, that sort of thing. The driver tends to control the vehicle, get things ready, get bits of kit. We're both paramedics but we tend to have a division of duty so we're not doing the same thing and not getting in each other's way. There's a sort of blanket rule which we try to split the driving sort of 50/50.

Call to attend the incident

9. At approximately 8 o'clock or maybe shortly after we got the call to the incident.

10. I'm not sure if it was a verbal message that we got from our control or if it was like a text message. This system of communication has changed over the

years. But the message, regardless, came through. The wording of it was something like "police officer injured, person with knife" or vice versa. It might've said "attacker with knife". There was no further details.

11. It instantly it gave me the impression that a police officer had been stabbed or wounded with a weapon. Initially, that was the kind of thing that I thought we were going to.

12. I don't know where the information for this call came from. I would assume the police may have called them. I don't know what's the chain of communication from the scene.

13. We don't always necessarily get, shall I say, factual information. Generally, sometimes, information's confused. Control can't always make out what people are saying. Also everything has to go through a certain code and has to fit in the box when they send it to us. The information can sometimes be a bit vague, confusing, misleading sometimes and even downright wrong.

14. The bottom line is, they've only got a few seconds to get the ambulance moving so they've got a time pressure as well to just pass that information as they get it. Sometimes information from the scene changes.

15. The information comes from our ambulance control centre which is based in Norseman House at South Queensferry. Any calls that come in from the public, the police, GPs, whatever, are coordinated at that centre and they are dispatched to us.

16. If you phone 999, one person at a call-handler desk picks up the phone call and they put all the information on the call into a computer. Someone else at a different desk, the dispatcher desk, sees that coming onto the computer and then they dispatch an appropriate ambulance.

Signature of witness.[redacted].....

17. Nowadays we hardly ever speak to a person at control. Everything is done by text message and I can't remember back then whether it was a radio call or whether it was the current text message system.

18. We have little airwave radios that give a snapshot of the message. There's a little LCD display on them that the text of the job comes through, so we can see straight away. We just get a snapshot on our radios.

19. There's a sort of terminal in the front of the ambulance with has our GPS, our satellite navigation, all the greater job details.

Leaving Glenrothes Ambulance Station

20. I was driving the ambulance and we left the ambulance station in Glenrothes. The incident was giving us a location in Kirkcaldy. That is about 5 or 6 miles from the station.

21. Now, I can't remember specifically where the first location was that we were given. We were given three different locations for this so it might kind of highlight some confusion at some point prior to us getting there, but it didn't actually affect our response time.

22. We were given a location in Kirkcaldy. I think that first location was somewhere near where eventually we did go to get the patient, but en route there must've been some confusion somewhere along the line. We were given a second location, I can't remember where, but somewhere far out, further away in Kirkcaldy, like the other end of town. I think it was somewhere down near the esplanade or Dysart end of Kirkcaldy.

23. I became concerned that now we didn't know where we were actually going, so asked my colleague Dave to basically get onto to control and confirm the location.

Signature of witness... [redacted] .....

24. We were driving down the A92 south from Glenrothes to Kirkcaldy. The changes in the location didn't mean we had to divert anywhere or change direction. So it didn't affect our time in any way.

25. The location was then confirmed as Hayfield Road. That is the location of where we did get the patient. I don't remember how long it took but it would be 7-10 minutes, off-hand.

Arrival at Hayfield Road

26. We went down Overton Road and entered Hayfield Road from that end and travelled along the length, east to west, past the hospital until we came to this individual, which was at the far end. On the satellite map of Kirkcaldy (SBPI-00009) the place where we entered Hayfield Road is marked with a "1".

27. We arrived there to find a police presence in the area. There were a lot of police officers around the area. There were police vehicles.

28. From the windscreen I could see there was a patient lying on the ground. Police were performing basic life support on the patient. One police officer was performing chest compressions on the patient.

29. I can't remember much about the police officer who was performing chest compressions. He was male and was wearing a police uniform. I can't describe anything about him or what the uniform looked like.

Sheku Bayoh

30. The patient was lying on my left-hand side as I was driving, partly on the pavement and partly just off of the road. His back was on the ground. His

head was perpendicular to the direction of the pavement, towards the hedge. His feet were actually on the edge of the road or on the road.

31. My first impression of the scene was being surprised that it weren't a police officer that were lying on the ground. That was the first thing that kind of caught me.

32. We were within sight of Victoria Hospital when we stopped. We were a matter of two metres or a metre from the patient. On the satellite map of Hayfield Road (SBPI-00008) the place where I stopped the ambulance is marked with a "2" and the place where the patient was lying is marked with a "3".

Attending to the patient

33. I parked there, my colleague Dave went to the patient first. He left out the passenger door. Dave took the bag and the oxygen.

34. I was shortly behind him. I can't remember if he or I brought the defibrillator. I had to park the vehicle, put the handbrake on and things like that. I went out the driver's door and started attending to the patient.

35. To my recollection the weather was dry at this point. I'm going to say dry and sort of sunny.

36. The patient was unconscious. He was wearing a light grey t-shirt. I'm almost positive he had jeans on but I can't remember if they were blue or black.

37. The patient was handcuffed across his front. I don't remember what they looked like. I assumed the ones with the black bit in the middle but I'm not sure. He was 'cuffed at the wrists. The arms were angled down from the shoulders and they met in the middle of the body somewhere around about

his groin or waist. I can't remember the angle of the shoulders but I suppose they'd be up a little bit.

38. I don't remember his legs or if they were restrained at all.

Cardiac arrest

39. I think we identified quite early on, if not straight away, that it was pretty serious. Cardiopulmonary resuscitation (CPR) was either ongoing at the point or that we basically continued that in conjunction with the police helping.

40. My colleague Dave confirmed that the patient was indeed in cardiac arrest. It's quite a serious condition. He confirmed that the patient wasn't breathing and there was no pulse.

41. That is the first step anyone would do in that situation, regardless of what's going on 'round about. It's possible to think people are in cardiac arrest when they're not, so sometimes we do see patients and actually they're breathing.

42. When a patient's in cardiac arrest there's two things we need to do: we need chest compressions, which the police were doing; and we need to potentially manage an airway, which means making sure that air can get in and out.

43. We do the chest compressions with our hands. Nowadays we do have some mechanical things that are for the whole of Fife, that's in a team leader's car. They can go out and back up crews nowadays. Chest compressions make the heart pump so that we can circulate the blood volume.

Airway

44. It is the paramedics' job to ensure the airway. Anybody can do chest compressions but the paramedics' skill is to manage an airway. Dave went to the head end of the body and ensured the airway.

45. The airway is the area between your mouth and your lungs, basically the whole anatomical system for getting air from the atmosphere into your body to exchange the gases and so on.

46. There's a number of things that can happen to an airway. What we need to ensure is that the airway is open so that the air can get from the atmosphere to the lungs. There's usually seven different things we can do to manage an airway, and that's all individually patient-specific, depending on what we find at any given time.

47. There's a thing called an airway ladder. We do the simplest thing that gets that airway open; and that might just be lifting the head a little bit, or it may just be moving the patient in a different position. It escalates, so if that doesn't work, we go up the next step of the ladder and so on. That goes all the way up to putting tubes down people's throats and things like that. There's all these different steps in between.

48. We don't do mouth-to-mouth with a patient, this is to prevent infection. We have a silicon rubber facemask-shaped thing that goes over the patient's mouth and nose. It's shaped anatomically to fit the mouth and nose. It's attach a rubber silicon bag which you squeeze. The air in the bag basically goes into the patient's mouth and nose and into their lungs. That's called ventilating. We can further attach that to an oxygen cylinder to provide oxygen.

49. I cannot remember if we were ventilating the patient from the beginning. That is what we would normally do so I can't think of any reason why we wouldn't

have. David was working on that end to start off so his statement will be more accurate in that regard.

Respiratory arrest and cardiac arrest

50. The difference between respiratory arrest and cardiac arrest is that cardiac arrest means the heart's not working, whereas respiratory arrest it's just that the lungs aren't. You're not physically breathing, but the heart's still got some kind of output.

51. If the patient was in respiratory arrest then it's possible that we got some output back from the CPR.

52. The difference in treatment of a respiratory arrest is that we only ventilate the patient, we don't do chest compressions in a broad sense. We might still do chest compressions in some cases depending on the patient's heart rate and other variations.

Condition of the patient

53. I don't recall seeing any injuries on the patient. That doesn't mean there wasn't, I just don't recall seeing anything.

54. I didn't notice anything like police spray.

55. I can't remember if I spoke to anyone about what was going on. It is a part of our job to find out what happened or if anyone else is hurt, especially given the circumstances.

56. I'm not sure whether myself or Dave that asked about the injured police officer or whether we did ask that. I remember the police mentioning or alluding to

the fact that a female police officer had been taken to the hospital already in one of their own vans or cars or something.

57. I can't remember if we either had gotten a message that another crew were either coming to back us up or whether we asked for another crew. We were told there was another crew coming from Leven. I knew there was another crew at Glenrothes that had just started, that was why I knew the time of day that we started that, because the second crew started at 8 o'clock. I thought they would've been sent then but never mind.

58. There was no response from the patient and we didn't notice any improvement in his condition.

Moving patient

59. The patient was in cardiac arrest and we were out on the street. It's not a very dignified place to be performing any work on someone and with the hospital just a mere 100/200 metres or so along the road I kind of felt that was the best place to get the patient for definitive care with all the proper medical specialties, there's half a dozen people to do the same job as myself and David and they can do it much more effectively, and also given we were so close to it.

60. Another reason I wanted to go to the hospital was one of the police officers had intimated that the gentleman had been on the ground and other police officers had been on top of him trying to restrain him. I can't remember the specifics but it was enough to give me an indication that significant weight had perhaps been on the patient.

61. I don't know if the patient was running and was jumped or rugby tackled by police, or if the patient was already on the ground and someone jumped on him. To me, these make a difference in potential outcomes. The impression I

got was that whilst the patient had been there, there had been an officer or perhaps several officers lying on him to try and pin them down while they restrained him.

62. I can't remember which police officer told me this. It might have been the guy that was doing the CPR but I couldn't tell you what he looked like.

63. I had a worry that perhaps it wasn't necessarily in itself an airway problem, perhaps also a chest problem. Various chest problem can cause cardiac arrests as well. I wondered if it may be something like that we're dealing with. We potentially have a secondary condition as well as the primary cardiac arrest.

64. I made the suggestion to go to hospital but I don't know if it was a one-person decision or if Dave and I discussed it.

65. While maintaining CPR we got the patient onto our stretcher into the ambulance. David and the police or perhaps David himself by this point maintained the work they're doing on the airway and on the chest compressions.

66. I got the kit out the ambulance, the stretcher. There was enough police presence there to help us just to physically lift the patient onto the trolley. We kept going with CPR, obviously apart from that second or two when we're lifting.

67. Once the patient's on the trolley, we continue with the work that we're doing, the CPR. We pushed the trolley into the ambulance, the distance was a matter of a couple of metres.

Signature of witness... [redacted] .....

Patient inside the ambulance

68. Then in the ambulance, in this case both David and I could go in the back because one of the police offered to drive the ambulance for us. Both of us could go in the back and keep going with CPR to the hospital.

69. The officer who drove us to the hospital was a different officer from the one who was doing CPR, that's about all I can tell you. He was male and I'm sure he was younger than the one doing CPR on the street.

70. We notified the hospital we were coming in. We phoned ahead.

71. I can't remember if the police were travelling with us. It can't physically remember seeing one. I think it was just Dave and I who were doing CPR.

Restraints

72. The restraints were still on the patient when we drove to the hospital. In hindsight it probably wasn't our smartest move. At the time it wasn't affecting anything we were doing. Just as or just shortly after we started moving, one of us, me or Dave, said "Should we maybe have got these handcuffs off?".

73. At the time we were happy that the CPR we were doing was good CPR in spite of the handcuffs. They weren't affecting us in any way, and that's why we made a decision to just go to the hospital.

74. By the time we thought about it, the police officer that was driving the ambulance didn't have the keys with him or something. I don't know if just one set of keys matches one handcuffs, I don't know how these things work, but I think the officer that was there just didn't have the keys to unlock them.

75. I think that's why we decided not to take them off. They weren't affecting us and we would just deal with it at the hospital. They weren't available to unlock them.

76. I think when we thought the 'cuffs were on that was when we were looking for a vein. There was a bit of a discussion between Dave and I in the ambulance about either trying to get a vein or should we get a vein. We saw we couldn't because the 'cuffs are on.

Cannula

77. There's a couple of reasons why we would look for a vein in a patient. We look for a vein to insert a cannula, it's like a needle thing that goes in. Through that cannula, we could give certain medications, or we could attach a drip to it. This is a route of getting medicine in.

78. The medicine varies depending on what the patient's presenting with. I can't remember what rhythm he was in. We can give adrenaline in a cardiac arrest. Atropine's been taken away. The other one we can give is amiodarone. I don't think he would have got amiodarone because I don't think he had the right rhythm. If we thought he'd had, say, a heroin overdose, we could've given naloxone. A lot of our drugs go intravenous.

79. There was no suggestion of drugs being involved in the patient's condition.

Drive to hospital

80. I don't know how long it took us to get to hospital but I think around 5 minutes.

81. I think the police officer went the wrong way to the hospital. I would've just turned around either in a U-turn or went around the roundabout and straight along the road but he went a different way. I'm sure he turned left and went

down Hendry Road. He did a square rather than just a U-turn. It was unplanned and took a bit longer than I'd anticipated.

Arrival at hospital

82. At Victoria Hospital A&E we had notified them we were coming in so they were all waiting for us. David and I continued with CPR while we were moving him out the ambulance. I'm not sure from if it was a lift or ramp or whatever because I'm not sure what ambulance we had on the day.

83. We spoke to a nurse to say this is the patient and to know where is the appropriate bay. David did the verbal handover.

84. Resuscitation continued right into the hospital, into the resuscitation (resus) area at A&E. The resus area has something like eight beds, but maybe only two of them are properly equipped with full resuscitation equipment. We went into one of them.

85. The doctors and staff are all waiting for us. There's a doctor, there's an anaesthetist, there's three or four nurses. There's half a dozen people, easily. We go into the hospital, slide the patient over onto the hospital bed and then the hospital staff take over.

86. The police were there in the hospital at the time we arrived. There was the driver that drove us in. I don't know if the police followed. They may have gone the shorter way. I can't remember any of them. There were three or four maybe in uniform.

87. David would probably have completed the paperwork and taken it back to hand it over to nursing staff. I can't remember if we went back in or if I was with him or not.

Signature of witness..... [redacted] .....

88. We complete a Patient Report Form for every patient. That would have been David that done that. The attendant does the paperwork and the driver gets the equipment cleaned and wiped down, replaces things and fixes things that are broken.

Miscellaneous

89. When it was announced that it was going to a public inquiry somebody from I think the Ambulance Service said they were going to help me and support me and help us with all the legal, technical stuff. I think he asked for a statement. I was asked questions the incident and given help. I'm not sure if it was a full statement or just bits that required clarification.

90. My manager set up a meeting. It was over the phone. I don't know if he was a lawyer. I don't remember their names and I don't have any emails or letters from them.

91. I deliberately avoided reading anything about this incident in the media. There's been programmes on the television I think. I've avoided that. It's been on the news that there's a public inquiry and things like that.

92. I know of one of the issues in the early days was the claim that he was carrying a knife. That's what started the whole thing off in the first place. As far as I can remember there wasn't a knife found. I can't remember if there was ever a knife found. I think I heard this from Dave who read it in the news. I said "Dave, don't tell me, I don't wanna know".

Patient Report Form

93. I've now read the Patient Report Form (PRF) that was filled out by David (PIRC-01068). I noticed that the time at the top is when David would've filled out the form, at 8:37am.

94. We don't use these forms anymore, it's been quite a few years since we've used this particular type. I haven't read them before and I don't normally read a PRF once we've put them in the system. Partly because there's not enough time to do so. Partly because with the new system as soon as we put it in the system every time you press the "save" button it vanishes into the ether. So we don't go back in. There's also data protection and stuff so I don't go back and read the records.

95. Having read the PRF it hasn't helped my memory at all. It made me think I must have been at a different job from David. I'm just wondering how bad is my memory. The PRF was done at the time. The more I read it the more I'm thinking I don't remember these things happening. For example the leg restraints, I have no memory of leg restraints.

96. Having seen the PRF on page 2 I see that the date of the incident was 3 May 2015. Name and age are unknown because we didn't know who the patient was at the time. "Call received" and "call passed" means when the call was received by the Ambulance Service and when the call was passed to a crew. It's when we first become aware of it.

97. I don't know why "call received", "call passed", "crew mobile" and "crew at scene" is all at 7:33am. If a call is received and deemed to be life threatening the ambulance is dispatched almost immediately. It might be a keying error. The buttons are in the driver's cab. There's a laptop-like thing in the front that you use to record this. It's got a satnav and everything on it. Also touchscreen buttons for "crew mobile", "crew at scene" and that sort of thing.

98. The records show we were at the scene for 9 minutes. I'm not sure if that's right. When the police officer was driving the vehicle I don't know if he was using the buttons or not. I don't know if the "left scene" button was pressed

when we left. I don't remember if we shouted to the officer from the back to press the button.

99. It's possible the times of leaving the scene at 7:42am and patient at hospital at 7:44am could be right. We were only literally a few hundred metres along the road.

100. "AVPU" stands for "alert", "voice", "pain" and "unresponsive". It's a hierarchical quick assessment method to see how alert they are and check their level of consciousness. It's loosely based on the Glasgow Coma Score (GCS).

101. "Airway treatment OPA" means using an oropharyngeal airway. It's a plastic tube thing that we stick into someone's mouth to kind of dislodge their tongue from falling to the back of their throat. It's shaped anatomically to do that. It allows the passage of air.

102. Under "Treatment options" David has put "BVM and resuscitation". BVM is an abbreviation for "bag valve mask". I described that as a "bag and mask" previously. Resuscitation to me would not mean chest compressions, that would only mean the breathing part, ventilation.

103. Under circulation it shows "pulse rate – none" and "most peripheral pulse found – Carotid". I can't explain it. To me if you've found a carotid pulse then you must have a pulse rate so I can't explain that one. This part of the PRF is the "Primary Survey" so this is what you find straightaway. It's just a wee error. Maybe it's meant to be that we had no pulse to start off with but then found a carotid pulse.

104. "AMPDS" is an abbreviation for the codes the Scottish Ambulance Services use. You hear this kind of thing on American TV programmes all the time. A Code 1 is abdominal pain and Code 9 is a cardiac arrest, for example. The number then has subcodes depending on whether the person's breathing or

not breathing. That's where all your E's and zeroes come in. It goes Code 1 to about 30.

105. Both cardiac arrest and cardiac/respiratory arrest have the same code. I don't know why both of them have the same code. To me they should have a different code.

106. The GCS is nil but that doesn't make sense. It should be 3, which means there was nil eye opening, nil verbal response and nil motor response. It might just be the old system we were using. Under "Vital Signs" GCS is noted as 3 which is correct.

107. At the bottom of page 2 under "Vital Signs" it shows he had no pulse at 7:33am, his pulse came back at 7:41am and it might have stabilised by 7:44am. "Irrlrr" means it's an irregularly irregular heart rate. You can get regularly and irregularly irregular heart rates. Irregularly irregular means a pulse that follows no set pattern at all. A regularly irregular heart rate might beat, miss a beat, then beat again.

108. "Sinus tachy" means sinus tachycardia which basically means a really fast heart rate. "BPM" means beats per minute. The heart rate is 159 beats per minute. Depending on what sort of books or research you read, I think the kind of ballpark normal is somewhere between 60 and 100.

Previous statements

109. When I gave my statement to PIRC it was nearer the time and my memory was better then than it is now. I told the police the truth. I read over and signed the statement. I also remember giving a statement to the Crown Office. I told them the truth and my memory would be better then than it is now. If there is a contradiction between this statement and either of my previous statements then the previous statement should be preferred.

Signature of witness.....[redacted].....

110. In my PIRC interview things didn't start off very well. Technically we're not supposed to print off the PRF because of data protection. Because David had done it PIRC were quite uppity with me. They said my colleague had done it so why couldn't I do it. I felt under duress. They'd come from Glasgow or wherever to come and see me and I'm saying to them I don't have the PRF and we're not supposed to have a copy of it. They were really quite snippy and quite arrogant about the whole thing. It really didn't start off well that meeting. There was a lot of bad feeling. I was under duress to provide evidence from a statement that technically I shouldn't even have had in my hand at that time. I don't think I was as helpful to them because of the way they spoke to me and what they were asking me to do. They should have went through appropriate channels to get the PRF. It should be recorded on secure channels.

111. I believe the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

Signature of witness... [redacted] ..... Date... 29/05/2022