



The Sheku Bayoh Public Inquiry

Witness Statement

Dr Sophie Rollings

**Taken [REDACTED] on MS Teams
on Monday 10 January 2022**

Witness Details

1. My full name is Dr Sophie [REDACTED] Rollings. My date of birth is in 1984. My contact details are known to the Inquiry.
2. I qualified as a doctor in 2012. I went to [REDACTED] to do two foundation years in [REDACTED]. In core training we do four-month placements at the hospitals and in registrar training we do six-month placements.
3. On the 2nd and 3rd of May 2015 I was 9 months into my registrar training. I started in August 2014. My placement was at Victoria Hospital, Kirkcaldy for one year. I was doing an A&E job in emergency medicine called a Clinical Fellow post. It's a one-year standalone post.
4. Then I changed speciality to anaesthetics. I started anaesthetics training in 2016 in [REDACTED]. I then lived in [REDACTED] in 2018 before returning and entering my registrar anaesthetics training in [REDACTED] in 2020.

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5. I'm now an Anaesthetic Registrar in a hospital in [REDACTED] At the minute I'm in cardiothoracics, which is a speciality placement block. As anaesthetic regs, we deal with emergencies that come into A&E and we deal with anaesthetising patients for elective and emergency theatre cases. We do pre-assessing and optimising patients for surgery. We cover obstetrics, epidurals and spinals for elective and emergency work. We also do some intensive care as part of our training.
6. I've read the statement I gave to PIRC on 21 May 2015 (PIRC-00206) and the A&E medical records (PIRC-01069).

Victoria Hospital A&E

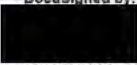
7. I can't remember all the doctors who I worked with on 3 May 2015. Dr Gillian Pickering and I were paired up. We did every single shift together. I remember Dr Martin Clark came in on the morning of the 3rd for a day shift. From my statement at page 1 I see my colleagues were also Dr Susan Downie and Dr [REDACTED] I don't remember [REDACTED] and Susan being there. From my statement at page 2 I remember the names of nurses Ovens and Jacqui James. Also in my statement at page 3 I see that Dr Surinder Panpher, Dr Rachel Anderson and Dr Fiona Gillies also came in for the day shift and were in resus.
8. I can remember some of what happened on the morning of the 3rd May because it sticks vividly in my head. I was doing a night shift. This is 8pm to 8:30am.
9. Towards the end of the shift one of the day nurses came in and said she'd seen a guy running around with a machete in Kirkcaldy. She said she was

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worried because she was at the traffic lights and couldn't lock the passenger door, obviously because the guy had a machete.

10. In my statement to PIRC the machete is not mentioned. I definitely would've said that at the time to PIRC as well. I remember this moment vividly. She came in and said either a knife or a machete. I remember she was scared because she wasn't able to lock the passenger door.
11. I know her name from my statement at page 2: "*Linda Lambert*". She's an A&E nurse.
12. A few moments later we had the standby call, which is the call the ambulance can make direct to the A&E department to say there is something very urgent. I think in this case it was cardiac arrest. I don't remember who answered the call. They would tell you the condition of the patient and how far away they are, normally. I don't remember the specifics of the call this case.
13. I remember exactly what cubicle we were in and the general setup. I remember because I was working there for a year. The resus area at Victoria Hospital has about 6 or 7 beds going up, 3 or 4 on each side. These cubicles are all individually equipped and separated by curtains around the sides and the front.
14. He was in Resus 1 which is a cubicle with slightly more equipment than you'd find in the other ones. This is for acutely unwell patients. It had all the monitoring in the corner, a trolley either side of the bed which had all your cannulation equipment, and it's got airway equipment at the back wall. It might have had the transport ventilator in there but I can't remember.

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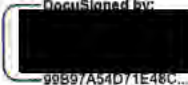
15. When the call comes in we go straight to Resus 1 to make sure all the equipment was there and ready to go. The equipment was IV access and oxygen availability. That is to take the bloods and get the oxygen ready to put on the patient. This would be for any majors patient not only a cardiac arrest.

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16. Next thing I know it was him who was being wheeled in by the paramedics and the nurse who said she'd seen this guy with the machete said "oh, that's him".
17. I can remember something in the air that irritated the back of the nose. It was a prickly feeling. I can't remember if it made my eyes water. Retrospectively I was told it was probably pepper spray but I don't know myself.
18. I can remember exactly what he looked like. I didn't know who he was at the time but I now know him to be Sheku Bayoh. He was a big guy, well-built. He had handcuffs on. He was wearing a white t-shirt. He was unconscious.
19. I don't remember leg restraints now but I know I mentioned them in my statement at page 2: "*...he was handcuffed with the hands at waist level and his legs were strapped also as a restraint.*" I do remember the handcuffs.

Restraints on the patient

20. His arms were handcuffed at the front and his hands were down about waist level. I can't remember how far apart his wrists were. If a patient's arrested we would need the hands free for the person because they're getting IV access and things like that. It wouldn't necessarily alarm me that the patient was coming in in handcuffs but obviously we need them off to treat the patient.

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21. By having his arms at his waist it's not impeding us doing CPR. You'd want the arm over the side of the bed so you could physically get the IV access in. Also generally you would want the patient freed up to do a full examination of any patient.
22. If I was doing IV access I would hang a patient's arm down by the side of the bed and I would kneel on the floor and that helps gravity let the blood go to the hand and it helps with your position. It's hard to lean over a patient and put a cannula if their arm's across the chest.
23. In anaesthetics now I would normally put the cannula in the back of the hand. In A&E quite often the hand can be difficult and there's a bigger vein in the arm so they sometimes put them in the arms. Essentially you find the best vein.
24. In my statement at page 2 I said: "*Gillian Pickering had requested that the restraints and cuffs be taken off right away.*" I can't remember this now but it would be fairly routine.
25. There were some police there with him. I can picture one of them because he had a long coat on at the time. I think he had dark hair and a beige coat on. Like a rain mac. In my statement at page 2 I said "*I remember one policeman coming in with him. He was in uniform.*" I can't remember if this was a different officer.
26. We got a handover from the paramedic team and then started our own assessment.



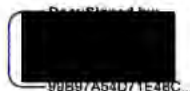
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Initial assessment

- 27. Normally, in a resus situation, one doctor would take the lead have an overall picture of what's happening and make sure that certain steps are done. In practice, there's normally more than one person doing something. Someone might be assessing the airway and, at the same time, someone else might be then checking for a pulse, taking bloods. Someone else might also be listening to the chest at the same time.
- 28. With any acutely unwell patient the first thing isn't to necessarily diagnose what's wrong. We have to fix the things that are going to stabilise the patient, which are always going to be airway, breathing and circulation. Regardless of what is the cause, that's always the first things you would do.
- 29. In my statement to the police on page 2 I said that "*Gillian (Pickering) had taken the 'lead'...*". She was the most senior doctor at the time. Normally, there's no point in everyone battling over what to do. One person, normally this tends to be the most senior person there, would say what we're going to do. You generally take the lead from the most senior doctor.
- 30. It wouldn't just be down to her to decide what approaches to take to stabilise the patient. We all have a say. Everyone did what they knew they had to do, for example I just took the bloods without being asked.

Blood testing

- 31. We take bloods routinely in any acutely unwell patient. We check to see any abnormalities in the blood that would cause whatever condition they're coming in with. You do this as soon as you possibly could.



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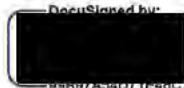
32. The bloods are essentially routine. You look at the full blood count that would show signs of infection. You would look at Us and Es to see if there's an electrolyte abnormality that might cause cardiac arrest or anything like that.
33. I don't remember what happened to the bloods. I must've put them on the side, which is quite a normal thing. In an acute situation like that a nurse that's outside would come in, take them and then do a time-consuming request on the computer to test them.
34. Someone else would do the administrative part of putting labels on and sending them off. They would be sent to the lab not long after they were taken.

Administering fluids

35. We gave the fluids at the same time as we took the bloods. All these things tend to be done concurrently. We wouldn't necessarily withhold any treatment before we've got the bloods. Having given treatment it wouldn't necessarily change anything in the bloods that we were looking at.
36. The patient was given a bag of fluid. This is just normal sodium chloride or Hartmann's, which is an isotonic fluid. It's pretty standard for any patient to be given a bolus of fluid. If they are hypovolemic that would help with that situation. It also helps get the blood pressure up which then increases the cardiac output if they've got one.

Assessment of the patient

37. We do an A, B, C, D, E assessment. Quite often in an emergency situation all over these steps are being done at the same time.

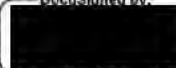
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- 38. A is for "Airway". You would always check the airway to make it sure it's clear and that the person's not going to be choking or have anything that's going to stop them breathing, and that the head is in a position where they're not obstructing the airway.
- 39. "Breathing" is an assessment of their breathing. Are they breathing? If they are, what does it sound like? You would listen to their chest. Do they have air entry both sides? Is it adequate? Things like that.
- 40. C is for "Circulation". This is blood. You would check for a pulse. You would check their blood pressure if they had a pulse, and it also is at the point where you would take bloods. You would take a set of bloods off. You get IV access, and you would most likely give some fluid.
- 41. D is for "Disability". You would look for any signs of injury. You would assess their Glasgow Coma Score or GCS, which is their conscious level. You would check their blood sugar to make sure it's not a low blood sugar that's causing whatever they've come in with.
- 42. Then E, is for "Exposure", and "Everything else", we call it. You would expose the patient to make sure there's nothing obviously wrong, and then "Everything else" is to check the blood sugar and anything else. Are they bleeding? Anything like that.

Patient's condition

- 43. He had no apparent injuries on his body. His torso and arms were completely exposed and I don't remember seeing anything. On his head an abrasion was documented in the records at page 10: "Head -> left forehead abrasion".

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It vaguely rings a bell but if you asked me where on the head I couldn't tell you.

- 44. I think he had a pulse when he came in because I don't think CPR was ongoing. I see in the A&E notes at page 7 he had a pulse: "*In resus initially -> ventilated by C-circuit -> pulse lost within 2 mins*". I see from my statement at page 2 that I took bloods and put the cannula in: "*I got access into his right arm or hand, that is IV access, and obtained bloods.*" You can still do this if he's got a pulse but it would've made it more difficult. I don't remember if he had a pulse specifically but know it from the notes.
- 45. If he's got a pulse that means his heart is beating and generating sufficient cardiac output that he would generate a pulse. If he has a pulse but isn't breathing then I would think that is a respiratory arrest. You wouldn't do CPR because he's got a cardiac output.
- 46. CPR is cardiopulmonary resuscitation. This is chest compressions. If somebody has no pulse then you would start it. It is essentially chest compressions. If they collapse and they're not breathing, even with a slightly thready pulse, you would probably start CPR if they're not breathing, depending on the clinical circumstances. If you've got a pulse you can detect at the wrist then you've got cardiac output and you wouldn't do CPR.
- 47. I can't remember if the patient's pulse was thready or not. I'm not sure if I was the person that assessed the pulse.
- 48. A respiratory arrest is if you can't see any signs of breathing. You might still have a pulse, but you might have stopped breathing from some other reason. Normally, in that instance, if you've stopped breathing, there's going to be a period of time when then your heart probably is going to stop afterwards.



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Diagnosing cardiac arrest and respiratory arrest

- 49. A cardiac arrest is when your heart has essentially stopped beating, and that is, stopped providing an output. There might still be some movement in the heart, and there might still be some electrical activity on the monitor, but it is not beating in a way that produces a cardiac output. Therefore it is not life sustaining.

- 50. The causes of respiratory arrest are quite often an obstructed airway. Opiates, things like morphine, heroin, things like that, can stop you breathing. Quite often people are in respiratory arrest secondary to drugs and toxins. Otherwise there are lots of other reasons why people stop breathing.

- 51. In this case I don't know if he wasn't breathing secondary to the fact he was unconscious. If you're unconscious then you would obstruct your airway. In medicine, a GCS of less than 8 essentially means you're unconscious.

- 52. This patient had a GCS of less than 8. If you're unconscious then your airway is at risk of becoming obstructed by your tongue going back into your airway. The soft tissues of your airway don't sustain themselves. There's no reflexes so they will occlude your airway and you won't be able to breathe.

Treating respiratory arrest and cardiac arrest

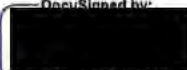
- 53. To treat a respiratory arrest, if they're not breathing, you would open up their airway. That involves manoeuvres with their head. You'd lift their chin, tilt their head back, open the mouth, make sure there's nothing in the mouth that was stopping them breathing.



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54. You would certainly be putting oxygen on the face and taking over their breathing for them. Oxygen would be from a bag and mask on the mouth. This is a sealed plastic mask over the mouth and a bag to squeeze to push the air into the patient.
55. I don't remember if he had this on when he arrived but it would be incredibly unlikely that any patient wheeled in by a paramedic wouldn't have oxygen on their face.
56. If someone's not breathing, and particularly with a cardiac arrest, then you would put some sort of airway into their mouth. It sits just at the back of the throat above the larynx, we call it an i-gel or a laryngeal mask. You would either put one of them in or you would actually want a definitive airway, which means an endotracheal tube (ET), which goes into the airway and sits below the vocal cords. From my statement at page 2 I see that this is what we did with the patient: *"In this situation the anaesthetist would do the intubation and I'm not sure if Gillan (Dr Pickering) had intubated the man, that is insert the ET tube. ... Another anaesthetist (unknown) came down and was at the head end, making sure the tubes were in and oxygen levels were okay."*
57. Quite often, medics will have little masks they can put over the patient's face to do mouth-to-mouth. But more often than not now you wouldn't be advised to do it because of communicable disease and I certainly wouldn't want to do it. There's not really any situation in hospital where you would do mouth-to-mouth in 2015 or now.
58. With the bag and mask you've got a seal over the airway and a means of getting the air in so there's no reason to do mouth-to-mouth.

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- 59. If you can't see any physical signs that would stop them from breathing in respiratory arrest, you would then probably go on to start CPR. You would have to think of other reasons and be thinking of the causes. Normally, if someone isn't breathing and it's not a case of just opening up the airway then you probably would go on to start CPR.

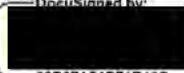
- 60. Treating respiratory arrest is different to cardiac arrest. In a short period of time you're not going to know what's caused the respiratory arrest. It's not unusual for someone that's in respiratory arrest to go into cardiac arrest. In the time in respiratory arrest you might have supported the breathing but they're still going to go into cardiac arrest.

Reversible causes of cardiac arrest

- 61. In treating cardiac arrest you also think of reversible causes. They're called the four Hs and the four Ts. Whilst you're resuscitating your patient with CPR, these are things that you would go through systematically to rule out any of those causes that you could then potentially reverse. This is with the aim of stopping the cardiac arrest. You can have more than one of them going on at once.

- 62. This is programmed into us, any doctor and probably some nurses as well. We would all be thinking of the four Hs and four Ts. Quite often the team leader would stand back and go through each out loud. I don't remember if that happened in this case.

- 63. The four Hs would be firstly "hypothermia" - is the patient hypothermic? "Hypovolemic", do they not have enough circulation volume? Normally that's from some sort of bleeding.

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- 64. "Hyper-" or "hypokalaemia", that is something you would assess from their blood: is their potassium really high or low? Either could cause a cardiac arrest. "Hypoxia", which is low oxygen levels, which could be secondary to not breathing.


- 65. Your four Ts would be a "tension pneumothorax", which would come from trauma, but you assess that when you're assessing breathing because you wouldn't hear air entry if there's a tension pneumothorax.

- 66. "Thrombus", which is essentially blood clots anywhere, normally in the heart. "Toxins", any drugs that might cause cardiac arrest. "Tamponade", which is when you get fluid around your heart, again, normally from trauma, that would stop it beating effectively.

Advanced life support algorithm

- 67. We didn't find a pulse and diagnosed cardiac arrest. At that point we immediately started CPR, which is chest compressions. There's an advanced life support algorithm that everyone goes by. You do CPR for two minutes. Then you pull CPR and you check what the heart rhythm is or you check a pulse. If there is a pulse, assess the heart rhythm on the monitor. If he doesn't have a pulse you would see on the monitor what rhythm his heart is in and immediately start CPR again. That is absolutely routine.

- 68. This two-minute repeat cycle went on for the whole time the patient was in resus. We took it in turns to do the CPR chest compressions. When I was doing it I remember thinking it is more difficult because he was such a big, muscular guy. I could still do CPR but in somebody that's strong and muscular you've got to use more force.

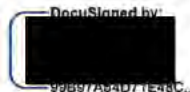
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69. Every two minutes someone would shout out that it's two minutes and ask for a "pulse check" or a "rhythm check". Everyone would pause. One person would go and try and feel a pulse either at the wrist or normally at the neck. Then you would go to see if there's any electrical activity on the monitor.
70. I have read in my statement at page 2: *"Most of the time the man/deceased was in PEA, (pulseless electrical activity), where you can see some of activity in the cardiac monitor (electrical monitor) so then CPR is continued as this is a non-shockable rhythm."*
71. To explain this, in advanced life support there are two stems to the algorithm. There are non-shockable rhythms and shockable rhythms. With a non-shockable rhythm you wouldn't shock them because it's not going to reverse the underlying issue, it's not going to help.
72. Shockable rhythms basically means your heart is in an abnormal rhythm and you can shock them out of it. This is if the heart is not beating correctly, it's fibrillating. It basically means the wall's flapping in and out. It doesn't generate a pulse but you can shock the heart and then the electrical activity would generate a pulse.
73. PEA is pulseless electrical activity, which means there is electrical activity of the heart but it's not generating a pulse.

Arrival of colleagues

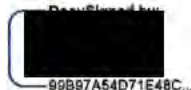
74. Dr Clark arrived after the patient was in resus. He is an intensive care consultant. In these situations, where a patient is in cardiac arrest, they're going to need to be intubated, which is when you put a tube in the airway. That is normally done by anaesthetics. Once the patient has been intubated

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they then need to go to intensive care. This is something I would do in my current role as an anaesthetic registrar.

- 75. When Dr Clark came in he was doing an ultrasound of his heart with an ultrasound machine. An ultrasound machine shows an echo of the heart on a monitor. It's reasonably routine if somebody like that's gone into cardiac arrest to have a look to see if the heart's actually beating or what it's doing and to see if there is any abnormality.
- 76. This would be looking for what the heart generally looks like in that situation. You can also assess for any fluid round the heart. This is cardiac tamponade, one of your Ts. Essentially you would look at the heart and see what it's doing. You would look to see if there's any movement and if there's any abnormality in the way it's beating.
- 77. There are four valves in the heart. There's two valves between each atrium and the ventricle. One in the pulmonary vessels and one in the aorta, your outflow tracks. You would tend to look at the valves and you would look at the muscle as well to see what it was doing.
- 78. Dr Clarke would've been the only one making the call on the echo. I don't remember this specifically but if there's just a bit of a flicker then the heart's not doing its job properly. It wouldn't be a reassuring sign. A tiny amount of movement wouldn't generate a cardiac output.
- 79. The femoral line in the right groin inserted by Rachel was used to assess blood pressure, but we can also use it then later down the line for taking blood samples.



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Race and sickle cell disease

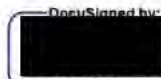
- 80. There's nothing about the patient being black that we have to consider when assessing or treating him. The only thing that I know now from my anaesthetic training is that with anyone of black ethnic origin you would always think of sickle cell disease. That's more the minutiae of anaesthetics training than generally a patient coming into A&E.

- 81. Sickle cell disease, essentially, is when you have like an abnormal haemoglobin chain in your red blood cells. It means in certain situations your red blood cells can sickle, which means they change shape and they can cause small blood clots in your vasculature.

- 82. It is much, much more prevalent in black, Afro-Caribbean, patients. If you've got someone with Afro-Caribbean origin coming, you would think: do they have sickle cell disease? Not necessarily in a patient coming in cardiac arrest, just generally. If we were in an exam now, you would be expected to ask: do they have sickle cell disease?

- 83. The condition's not reversible. If someone has a "sickle cell crisis", if someone's acutely unwell, secondary to their sickle cell disease, then you would do symptomatic treatment. I've personally never seen it in practice, it's not particularly common. You would see it down south where there's a larger black population. We don't see it as much in the north or Scotland.

- 84. I don't think this wouldn't have been widely known in 2015, but I was very junior so it wouldn't have been something that would ever have been at the forefront of my mind. It's more related to anaesthetics. I wouldn't have thought of this at the time.

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- 85. Looking back now, sickle cell disease seems unlikely in the patient's state. Sickling crises are normally precipitated by infection, acute illness, dehydration and fasting. Looking at this, I would think that is unlikely in his state at the time.


- 86. My comments on sickle cell disease are not at all related to this case. I haven't made these comments in reference to Mr Bayoh's case.

Drugs administered

- 87. The patient was given adrenaline. I don't know if I was the one that gave him adrenaline. Because I did the IV access it doesn't necessarily mean I had to be the person to give the adrenaline.

- 88. Amiodarone would often be given to a patient. I remember explaining this when I got interviewed by the police. It's fairly routine in cardiac arrest. I don't remember giving it to the patient but I remember explaining to the police why we would give it. If a patient's in ventricular fibrillation and it's still refractory to shocking the patient, you sometimes try some amiodarone because it's an anti-arrhythmic and sometimes this can help fix the abnormal rhythm.

- 89. We administered naloxone. This is a drug that would reverse the effects of opiates, things like morphine, heroin or codeine, if they'd taken an overdose. Any of those opiates can stop you breathing. If you give naloxone, that almost immediately can reverse it. In a patient, even if you didn't know that they'd taken those drugs, if they weren't breathing, and you thought it could be secondary to this, you would just give naloxone.

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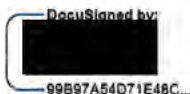
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LUCAS machine

- 90. A LUCAS machine is also called a Thumper. It's not its official name. It gives mechanical chest compressions to the patient. I can vaguely remember we used it and it was low down on the patient. We wouldn't have continued with it on the wrong place. We would've just taken over doing manual CPR. I remember we were doing CPR manually for a long time. I don't remember what happened with the Thumper.
- 91. The LUCAS would normally be around 100 to 120 chest compressions per minute. This is the same number of chest compressions we would give manually in CPR.
- 92. I've not used the LUCAS very often. It's probably used more in A&E but I'm not an A&E doctor anymore. In my year in A&E I saw it a few times but not very often. The reason is often when patients come in cardiac arrest, they're severely unwell or very old and frail and there's nothing we can do to reverse it. So there's no point putting a LUCAS on a patient if this isn't survivable.
- 93. I don't know who put on the LUCAS to the patient. I wouldn't think I would put it on because I wouldn't have been that experienced. It has a flat plastic bit that goes round the back and then a bit that connects over the top of the patient in an arch. In the middle of the arch there's a bit that comes down in the middle of the chest. I can't remember what it is but it's something heavy that comes down to compress the chest.

Time of death

- 94. We were in resus with the patient for a long time. For someone in cardiac arrest, doing CPR for over an hour is a long time.



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95. It gets to the stage if you're quite far into cardiac arrest and at no point has there been a cardiac output, there's little else you can do to stop the cardiac arrest. There's nothing immediately reversible. You take over the breathing of a patient when they're in cardiac arrest and you're doing resuscitation.
96. After half an hour, there's, anecdotally, a reasonably strong chance that they're going to have a hypoxic brain injury that is unlikely to be survivable. You'd be assessing if we should stop at that point. It was discussed.
97. Dr Clark said this patient was a young, fit guy so we should continue. He has potentially got a better chance of recovery because of his age and health.
98. I remember going beyond the end of my shift. There was a team ongoing so I didn't want to just walk out and leave. The patient was in resus for over an hour.
99. In any CPR situation if it's becoming apparent that this is likely to be futile, and there was nothing more as a team we can see that you could do, then we would always put it to the team for everyone to agree that we should stop.
100. I remember thinking "What's happened?" because I couldn't see any obvious signs of what might have caused this. I don't know why the patient wasn't breathing when he came in and I don't know why he went into cardiac arrest. He could have gone into cardiac arrest because he was in respiratory arrest but I don't know.

Signature of witness.....




PIRC

- 101. I remember giving my statement to two PIRC investigators at the A&E Department of Victoria Hospital. I signed the statement. What I put in my statement is accurate, I told the police the truth and my memory was better at the time than what it is now.
- 102. With the PIRC statement the grammar and the way it's written is not the way I would normally speak. It's not natural.

Media

- 103. I'm not on social media much and I didn't see anything about this case.
- 104. I'm not still in contact with the other doctors I was working with in Kirkcaldy. I did send a message to Gillian Pickering to ask her if she had been contacted by the Inquiry. Gillian said yes and that I needed to speak to you. I'm friends with some of the other doctors on Facebook but that's about it.
- 105. In the media, I remember one occasion fairly vividly, it was quite a long time afterwards. I think it was a headline in the Daily Mirror. I just happened to be in the queue in Sainsbury's in [REDACTED] and the Daily Mirror was on the side. I was standing next to it and I saw the front page.
- 106. They'd drawn a picture of a patient with all these boxes and arrows pointing to his body. They said he had broken ribs and he had abrasions all over his body. I just remember thinking: "That's not even remotely true."
- 107. He may have had broken ribs, I don't know, but broken ribs in the context of CPR is totally, totally normal. I remember thinking to a layperson broken ribs

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Signature of witness.....

would make them think "oh my goodness" but to a doctor you'd think yes, he had CPR for an hour, he's bound to have broken ribs.

108. They pointed out abrasions all over his body which I thought were not true, they weren't there. I know he potentially had one on his head. I just remember thinking that I was so angry at the paper. I was thinking it was just rubbish.

109. 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.....  Date..... 4/11/2022

