



The Sheku Bayoh Public Inquiry

Witness Statement

Dr Surinder Panpher

**Provided by witness
on Wednesday 16 February 2022**

Witness Details

1. My full name is Dr Surinder [REDACTED] Panpher. My date of birth is in 1978. I work at [REDACTED] My contact details are known to the Inquiry.

Qualifications and experience

2. I qualified as a doctor in 2001.
3. My qualifications are MBChB from University of [REDACTED] (2001) and FRCEM (2012) from the Royal College of Emergency Medicine.
4. I have worked full time as a doctor since 2001. I was a doctor in training from 2001 until 2012. I began specialist training in emergency medicine in 2007. I have been a full time trained specialist of emergency medicine since 2013.
5. My current role is Consultant in Emergency Medicine. I provide care for acutely ill and injured patients in addition to providing emergency medicine

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training for junior doctors. This is the same role as I had in May 2015 and my roles and responsibilities have remained the same.

Statement to PIRC

- 6. I have read the PIRC-00096 statement. This statement is true and accurate. I do not recall if I signed this at the time when it was noted. I have been shown a handwritten copy of my statement. I can confirm my signature is at the bottom of each of the pages.

3 May 2015

- 7. From reading of the PIRC statement, I understand that I was filling a vacant shift on 3rd May 2015. My role was locum consultant in emergency medicine and the shift times were 8am to 5pm.
- 8. From reading the PIRC statement I see that the other doctors present were Dr Gillian Pickering, Dr Martin Clark, Dr Sophie Rollings and Dr Rachel Anderson. The nursing staff present are not named and I do not recall their identities from my memory.
- 9. The date of 3rd May 2015 is at the time of writing over 6 years and 9 months ago and my recollection is poorer now than at the time of the PIRC statement.

Sheku Bayoh's arrival at hospital

- 10. I have read the hospital record PIRC-01069 and confirm that I did not make any of these notes. The were made by Dr Gillian Pickering, Dr Martin Clark and Dr Rachel Anderson. None of the signatures in the notes are mine.
- 11. The patient was treated in the emergency department resuscitation room. This room is specifically used to treat severely ill and injured patients including

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those in cardiac arrest. The room consists of 8 individual cubicles that each have the necessary equipment to perform resuscitation.

12. The A&E notes show that Mr Bayoh arrived by ambulance.

13. From my reading of PIRC-00096, I described Mr Bayoh as male, black, muscular build, appearing late 20s or early 30s and stripped of any identifiable clothing. I did not know or recognise him.

14. I do not recall police being present with this patient.


Assessment and treatment of Sheku Bayoh

15. I became involved after my arrival for the 8am shift. My reading of the PIRC-00096 states that I attended for a handover meeting which occurs at the start of the shift at 8am. This is where I was informed that a patient was currently undergoing active resuscitation in the resuscitation room. My role was to be updated on the situation and ensure the appropriate medical care was being given.

16. From my reading of the PIRC-00096 I was given information by Dr Gillian Pickering who at that time was the Specialty Trainee Year 5 doctor that had been on night shift when Mr Bayoh was brought to hospital. The night shift finishes at 0800hrs and according to the A&E notes Mr Bayoh arrived at hospital at 0744hrs.

17. My assessment of Mr Bayoh was by visual inspection. This includes looking at the information provided by the hospital bedside cardiac monitor and to ensure the essential procedures of resuscitation were being carried out by the medical staff.

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18. My reading of the PIRC-00096 at page 2 states the treatment Mr Bayoh received was cardiopulmonary resuscitation using both the automated mechanical LUCAS thumper machine and also manually, intravenous adrenaline and electrical direct current cardioversion. The A&E notes at page 7 also state the use of intravenous amiodarone and intravenous naloxone. There was no response to these interventions.
19. Advanced Life Support protocol is an internationally recognised guidance created by the Resus Council that is used in all cases of cardiac arrest. It dictates the type of treatment required in every circumstance of cardiac arrest. This operated fully in Mr Bayoh's care.
20. CPR can be administered manually by a healthcare worker physically using their hands to press the centre of the patient's chest, or it can be performed by a LUCAS thumper machine that also compresses the centre of the chest. The airway can be supported by means of tubing placed inside the mouth or with intubation further down into the trachea. A patient will be ventilated by means of compressing a bag of oxygen over the tubing or into the endotracheal tube after intubation. Breaths are provided by the process of ventilation. Chest compressions are administered by pushing the chest at least a third of the height downwards at a rate of 100 compression per minute. Medication in CPR is intended to stimulate the heart and blood vessels to achieve the return of spontaneous circulation, a situation in which the heart beats spontaneously and provides blood supply to the vital organs.
21. From my reading of the A&E records PIRC-01069 I see that an arterial blood gas sample was taken at 0753hrs and again at 0820hrs. The purpose of these tests is to assess for any potentially reversible causes of cardiac arrest that are not already being treated and also to guide the efficacy of the resuscitation attempt. The results are documented in the blood gas machine print outs which are seen on pages 8 and 9 of PIRC-01069. These show that

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there were no potentially reversible causes that were not already being treated and that resuscitation measures were not efficacious.

22. The patient's ethnicity was not a factor in his assessment or treatment.

Restraints

23. I do not recall the patient being restrained at the time of my assessment.

24. In general terms, any person being in handcuffs would have limited access to the veins in the arms used for cannulation.

25. From my reading of the PIRC-00096 the initial lead was taken by Dr Gillian Pickering as she was the most senior doctor present when Mr Bayoh arrived. The lead was passed to me on my arrival. This role was then delegated to Dr Rachel Anderson as I continued with other responsibilities. Dr Rachel Anderson was at that time a Specialty Trainee Year 5 doctor and therefore qualified to be delegated the lead. A position of Specialty Trainee Year 4 and above is the qualification level needed to be team leader.

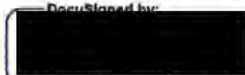
Respiratory arrest and cardiac arrest

26. A respiratory arrest occurs when a patient stops breathing but still has a pulse. A cardiac arrest occurs when a patient is not breathing and has no pulse.

27. There are multiple conditions that can cause respiratory arrest. Examples include blockage of the airways, decreased effort of breathing or weakness of the chest muscles responsible for breathing. The signs of respiratory arrest is that the person will not be breathing, will be unconscious and will have a change of colour to the face and hands. It is treated by removing the cause of the condition and by supporting the breathing through the process of

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ventilation with oxygen. The cause of respiratory arrest in Mr Bayoh was not apparent.

28. There are multiple conditions that can cause cardiac arrest. Examples include coronary artery disease, abnormal blood circulation, insufficient oxygen supply, abnormal body temperature and abnormalities to the blood chemistry. The signs of cardiac arrest is that the patient will not be breathing or have a pulse, will be unconscious and will have a change of colour to the face and hands. Cardiac arrest is treated according to the ALS protocol with chest compressions, ventilation, intravenous drugs and if indicated with direct current cardioversion. The cause for cardiac arrest was not apparent in this case.

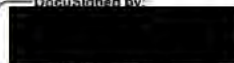
29. Respiratory arrest may not require chest compressions if the heart is still beating effectively. Respiratory arrest can progress to cardiac arrest if the cause can not be removed. The consequences of treating respiratory arrest with CPR would result in providing additional assistance to the heart that is not required, but this would not be expected to result in harm or worse outcome.

Specific tests and treatment

30. From my reading of the PIRC-00096 at page 2 I see that Dr Martin Clark performed a bedside ultrasound of Mr Bayoh's heart and abdomen. He found flickering movements of the heart that were not associated with a pulse. He stated that the abdominal ultrasound was normal.

31. From my reading of the PIRC-00096 at page 2 I see that there were 3 occasions that Mr Bayoh received electrical direct current cardioversion. I do not have record of the exact time but this was during the resuscitation attempt. The reason electrical cardioversion was delivered is that this is the action that the ALS protocol dictates is required for the type of heart monitor appearance that Mr Bayoh was displaying.

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32. From my reading of the A&E record at page 7 I see that he was given intravenous adrenaline and intravenous amiodarone which were both given as per the ALS protocol. He was also given intravenous naloxone which was administered as a trial to reverse the potential that an undisclosed opiate drug toxicity might be contributing to the cardiac arrest.

LUCAS machine


33. A thumper machine is also known as a LUCAS device. It is used in cardiac arrest to provide chest compressions mechanically instead of being delivered manually by healthcare staff. It works by having a soft circular plunger placed over the centre of the chest which compresses the chest at a rate of 100 per minute. I do not know what pressure is delivered.

34. From my reading of the PIRC-00096 at page 2 the LUCAS machine was initially used but was discontinued due to being unable to gain satisfactory positioning. A satisfactory position needs to be achieved quickly so that chest compressions are not interrupted. Whilst it is possible to readjust positioning in most cases, if it is predicted this will interrupt CPR for too long healthcare workers will convert to manual compressions are used so that CPR is not delayed, It is not recorded how long it was used for on Mr Bayoh.

Fractured ribs

35. Breaking of a patient's ribs during CPR is a common occurrence in both manual compression and compression by machine. This occurs in both circumstances when the positioning is correct. Incorrect positioning does not increase the likelihood of fracture.

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- 36. I am not aware if any colleagues fractured ribs. From my reading of the PIRC-00096, I did not perform CPR so I could not have fractured any of Mr Bayoh's ribs myself.
- 37. The first rib is located higher to the centre of the chest so is not in the location where compressions are occurring. In my personal experience and practice I have not been aware of fractures occurring in the first rib area in the patients I have personally resuscitated.
- 38. The LUCAS device should be placed in the centre of the chest, below the first rib. From my reading of the PIRC-00096 at page 2 the machine was placed too low on the chest therefore further away from the first rib than is correct.
- 39. I do not recall if a chest X-ray was carried out. From my reading of the A&E notes there is no mention of a chest X-ray being performed. Patients undergoing active resuscitation are not able to have a chest X-ray as the resuscitation attempt cannot be stopped to allow the X-ray to be taken.

Life pronounced extinct

- 40. From my reading of the A&E record at page 10, it states that the decision to pronounce life extinct was a "*team agreement*" but the notes do not specify objectively who made the decision. The notes at page 11 state the decision was made because there was "*no movement on echo of the heart*" and "*no movement on A line trace*".
- 41. It is not recorded who called the time of death. I do not know the cause of death.
- 42. The resuscitation effort was performed in accordance with ALS protocols. The events after death are not documented.

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43. From my reading of the A&E record at page 13 Mr Bayoh arrived at hospital at 0744hrs and at page 10 and 11 life was pronounced extinct at 0904hrs.

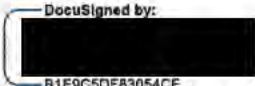
Miscellaneous

44. I do not recall the interview in which I gave the PIRC statement.

45. Dr Pickering and Dr Anderson no longer work in NHS Fife and I do not have contact with them. Dr Martin Clark [REDACTED] and I occasionally see him in a professional capacity. I do not recall if we discussed the case at the time. I do not recall the identity of the nursing staff involved. I have not had any recent discussions about this case with any doctors or nurses.

46. I am aware there was a television documentary regarding Mr Bayoh. I have not been influenced by anything I have seen or heard. I do not recall how the medical aspects of the case were publicly reported.

47. 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 April 14, 2022 | 1:54 PM CVT

