SHEKU BAYOH INQUIRY

Dr Christopher [redacted] Speakman

Witness Statement for the Sheku Bayoh Inquiry

Full Name: Christopher [redacted] Speakman

Year of Birth: 1989

Qualifications and Experience

1. I qualified as a Doctor on 9th July 2013, from the University of Leicester. My qualifications are Bachelor of Medicine, Bachelor of Surgery (MBChB), BMSc (Hons), and I am a Member of the Royal College of Physicians MRCP(UK). I am fully registered with the General Medical Council, with registration number [redacted] In August 2022 I will have been a doctor for 9 years.

2. My experience can be summarised as:

- Completion of Foundation Programme Training in the South-East Scotland Deanery (Edinburgh and surround, August 2013 – August 2015).
- Clinical Development Fellow in Oncology and Neurology in the same region (August 2015 – August 2016)
- Completion of the three year core training programme Acute Care Common Stem - Acute Internal Medicine (ACCS-AIM) in the West of Scotland (Glasgow and surround, August 2016 to August 2019).

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- I took a sabbatical year from August 2019, which was cut short in March 2020 due to the COVID-19 pandemic, wherein I returned to work as a locum medical registrar until August 2020 at Forth Valley Royal Hospital.
- Completion of a one year post as a Senior Clinical Fellow in Acute Medicine at the Glasgow Royal Infirmary (August 2020 – August 2021)
- From August 2021 until the present day, I am a Specialty Trainee (Registrar) in Acute Internal Medicine. I am currently a Specialty Trainee, Year 3 (ST3). I work at the [redacted]

3. In my current role, I perform a variety of duties. On a short 9am to 5pm day my work is predominantly on my base ward, which is a respiratory or COVID-19 ward. I complete daily ward rounds of patients, review unwell patients on my ward, perform procedures and interventions as indicated, provide advice to more junior doctors and doctors outwith my own specialty, and occasionally attend outpatient clinics. Whilst on call, typically a 9am to 10pm or 9pm to 9am shift, the above duties extend across the whole hospital, whilst assessing patients for medical admission to hospital from General Practitioners and the Emergency Department. I also lead the cardiac arrest team, perform emergency reviews of unwell patients, and directly manage admissions to the high dependency unit.

4. In addition to this I am working towards completion of the expected higher level competencies of my training programme (Acute Internal Medicine), and am the joint Chief Registrar foy my hospital, acting as a representative for junior doctors to the Consultant and Managerial teams of the hospital.

5. In 2015, my role and responsibilities were not dissimilar to those listed above, but as a more junior doctor still in my Foundation Training at that point, took less of a leadership role. I would primarily review patients daily on a ward round, attend to necessary tasks relating to their care, and on-call I would be involved in the assessment of patients requiring admission to hospital. In

Signature of witness..... [redacted]

addition, I was a member of the cardiac arrest team and was working towards the expected competencies of a Foundation Doctor.

Statement to the Police Investigation and Review Commissioner

6. Having read my Statement to the Police Investigation and Review Commissioner, I can confirm it is true and accurate to the best of my knowledge, and I signed it as noted, although I cannot see my signature present on the notes provided to me for the purposes of this current written statement.

Events of 10 and 11 May 2015

7. My role on the 10th and 11th May 2015 was to work as a Foundation Year 2 Doctor, assessing patients requiring admission to hospital under the care of General Medicine and performing clinical tasks pertinent to their admission. My nightshift began at 8pm on 10 May and ended at 8am on 11 May.

8. That night I worked with [redacted], a doctor a few years my senior, performing the same tasks as myself. I cannot remember the names of any other colleagues that I worked with on that shift.

9. My memory of what happened on the 10th and 11th May 2015 is very poor, as 7 years of continuous clinical work has elapsed between then and the present day. I have no clear recollection of assessing Nicole Short. I rely on my statement to the Police Investigation and Review Commissioner and my clinical notes in providing this statement.

10. With that in mind, I am not anticipating that there will be any discrepancies between this statement and my statement given to the Police Commissioner, but I am asked which statement should be preferred in the event that there are any apparent discrepancies. The answer is that my statement given to the Police Commissioner should be preferred on the basis that my recollection was clearer closer to the time of the events.

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

Nicole Short's arrival at hospital

11. In reference to the medical records relating to Nicole Short, I can confirm my signature is within the scanned admission documents pertaining to her attendance on 11/5/15. I can make no comment on how this patient presented on arrival to hospital as I was not present for her arrival.

12. I attended the patient after she had already arrived in Assessment Unit One (AU1), the primary assessment area for patients referred to General Medicine by A&E and General Practitioners.

13. I cannot recall at what time Nicole Short arrived, nor at what time my assessment began on 11/5/15, but can confirm my assessment was completed at 0330hrs as this is indicated in the clinical notes.

14. I can see that the clinical nursing notes written by [redacted] document Nicole Short's arrival to be 2230hrs on 10th May 2015, and that she continued to await review by a doctor at 0130hrs on 11th May 2015.

15. I can only describe Nicole Short as documented in the medical case notes. I do not remember her sufficiently that I could identify her in the present day.

16. The records indicate that she was awake, dressed in pyjamas, and appeared [redacted] I did not recognise or know Nicole Short. I cannot recall whether I was aware of the death of Sheku Bayoh at the time of assessing Nicole Short. If I was aware of it, I did not make any connection with the history given by Nicole Short. If I had been made aware of the connection, I think it is highly likely I would have noted it in the records.

17. I do not recall if anybody was with the patient at the time of my assessment, and no further detail relating to this is recorded within the case notes. I do

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

note however that relatives were documented as present with the patient at 2230hrs within the clinical nursing notes.

18. The section of notes entitled 'Presenting Complaint' and 'History of Presenting Complaint' are a summary of why Nicole Short attended the hospital that evening. I have summarised in the records the sequence of events leading to the attendance on 11/5/15 as reported to me at that time by Nicole Short, followed by a description of her reported symptoms. This includes the answers to specific questions querying a base of skull fracture (i.e. the presence of "CSF Otorrhoea / Rhinorrhoea"). Subsequently, her past medical history is documented, followed by my examination findings which include her "General Appearance", followed by summaries of a focussed cardiovascular, respiratory, abdominal and neurological examination as guided by the patient's history of presenting complaint.

Assessment of Nicole Short

19. I was the doctor providing the initial medical assessment to Nicole Short on her arrival to hospital. My role was to take a clinical history of the presenting problem, perform a relevant clinical examination, formulate a differential diagnosis, and formulate and action a plan of investigation and management of the identified problems.

20. The records that would have been available to me at the time indicate that Nicole Short had attended both her own General Practitioner and the Emergency Department in the days prior to her presentation to hospital on the 10th May 2015. I cannot recall, nor do I have access to the case notes that relate to the date, time, participants or outcome of these encounters. The patient had been assessed by [redacted] on the 10th May 2015 at 2116hrs, and the outcome of this encounter was a referral to AU1 at the Victoria Hospital, Kirkaldy. I do not know if any treatment was commenced at this point, although this directly led to my involvement with the patient in the early hours of 11th May 2015.

Signature of witness..... [redacted]

21. I can see from the clinical notes that the patient told me that she was a police officer, and had been violently assaulted during the apprehension of a suspect, and that she had been punched to the back of the head, leading to her collapse, following which she had been stamped on whilst on the ground.

22. The notes indicate that the patient told me that she had attended the Emergency Department following the incident, and subsequently her own GP, had been diagnosed with concussion and provided with painkillers.

23. The records indicate that the patient described to me a one-week history of intermittent nausea, vertigo, visual blurring and double vision, alongside some [redacted] The records indicate that the patient also described some sensory disturbance on the right side of the face and with a facial droop, also on the right, which had been pointed out by friends that evening, and prompted her to attend the Out of Hours General Practitioner. The records indicate that the patient denied any symptoms suggestive of cerebro-spinal fluid leaking from the skull, and described some neck stiffness that had abated by the time of assessment. As with all patients that I assess, I would have provided Nicole Short with the necessary time to relay her story and describe her symptoms to me.

24. As previously mentioned, the only information that I had been provided about the patient was the referral letter from [redacted] on 10th May 2015, recounting the same history of presenting complaint that I elicited that morning.

25. I documented that the patient was ordinarily fit and well, which indicates to me that I was not made aware of any other relevant medical history. Had I reviewed any relevant clinical information pertaining to Nicole Short, I would have documented this as part of my assessment.

Signature of witness..... [redacted]

26. I did not detect any injuries on examination. My assessment of the patient was performed at the bedside, and I have documented that my impression was that she appeared well, but [redacted] She was fully alert and oriented, with normal vital signs as recorded in the clinical nursing notes. I do not recall, nor is it documented within the clinical notes or PIRC, any discussion regarding injuries to their back or torso, and this is something I would have documented and examined in more detail had this information been conveyed to me.

27. I performed an examination of the patient's cardiovascular, respiratory, abdomen and musculoskeletal symptoms during which I would have felt the patient's pulse, assessed her hydration status, and listened to her heart and lungs. This was followed by an examination of her abdomen, which would have involved palpation of the abdomen, looking for tenderness, swelling or enlargement of any abdominal organs. The records confirm that these examinations revealed no abnormality.

28. Although the Inquiry has not specifically asked about my assessment of the patient's neurological system, I can see from the records that I determined that Nicole Short's symptoms were predominantly neurological in nature, so I conducted a thorough neurological examination, focussing on the cranial nerves with the history of head injury in combination with the presenting complaints. Here I elicited several clinical signs, including tenderness to touch over the right mastoid process (the smooth bony prominence behind the right ear). I also detected a subtle right sided facial droop and reduced sensation of the right side of the face. I also detected a very slight weakness on the right-hand side. The records indicate that I did not detect any restriction of motion of the patient's cervical spine, nor any signs of haematoma of the scalp.

29. I am not able to provide an opinion on the consistency of any positive or negative clinical information or examination findings with the background

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

information given to the Inquiry relating to the preceding events. I possess no training, skills nor qualifications in forensics.

30. No treatment was indicated nor required, although paracetamol was prescribed in the event it was needed for analgesia. No specific advice was provided to the patient. The plan was to arrange a CT scan. I left the patient, where I found them, at their bedspace in AU1, their condition unchanged from the start of my assessment.

CT Scan

31. I am asked about CT scans. I do not have any particular expertise in CT scanning, but can assist by providing an overview of what a CT scan is and what information it provides. A CT (Computed Tomography) scan is an imaging modality used in various clinical settings that uses Xrays to build up a two dimensional, cross-sectional image or 'slice' of a targeted area. Body tissues have different densities, and therefore absorb different amounts of Xrays. Denser tissues (e.g. bone) will absorb more xrays, and less dense tissues (e.g. air-filled lung) will absorb fewer xrays, which is detected by the CT scanner. Depending on how much the xrays are absorbed by the tissues, they will appear black ("very few xrays absorbed"), white ("many/all xrays absorbed") or grey ("some xrays absorbed"). As such most body tissues will appear some shade of grey relative to how much they absorb xrays. As a body part is passed through the large ring-shaped scanner, multiple images or "slices" are taken, allowing a 3D representation of the body part to be digitally created. As such, CT scans are often used in clinical practice to help detect or define abnormalities such as, but not limited to, bleeding, fractures, infections and abscesses, cancers, and inflamed organs.

32. I would refer any patient who had suffered a head injury for a CT scan of their head who complained of, or had identified on examination, any of the following – ongoing headache, nausea or vomiting, confusion, speech disturbance, coma or transient loss of consciousness, neurological deficit

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

(such as weakness or numbness of a body part), seizures, papilloedema (swelling of the optic disc detected on ophthalmic examination), a history of intracranial bleeds, a history of being on a blood thinning drug or congenital or acquired bleeding disorders (such as haemophilia, or cirrhosis of the liver for instance). This list is by no means fully exhaustive but would generally be reasonable indications to refer a patient for a CT Scan of the head.

33. I referred Nicole Short for a CT Scan of the head because she complained of ongoing neurological symptoms (as defined by reduced facial sensation and subtle right sided facial droop) following a reported head trauma, and I wanted to rule out an intracranial bleed or skull fracture.

34. This scan was reported by the Radiologist, [redacted] as normal, and as such no specific intervention or further investigation was felt to be required, with her symptoms explained as a concussion.

Miscellaneous

35. I am asked a number of additional questions under the heading "miscellaneous", which I will address below.

36. I am asked if I remember the interview in which I gave my PIRC statement, and the approach of the investigators and what questions were asked. I remember little of the interview from my PIRC statement with regard to the investigators and their approach. I recall that I was asked a number of questions relating to my assessment of Nicole Short, and the content of this interview is explicitly documented within my statement from that interview.

37. I am asked if I am still in contact with any of the doctors and nurses who treated Nicole Short and whether I have discussed this with any of them. I am not in contact with any other healthcare professional who was potentially involved in this case.

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

38. I am asked whether I have read or seen anything about this case in the media and whether I am influenced by anything I have seen or heard. I have not kept up with press reporting in relation to this case since its occurrence. I have not made an active effort to view information relating to the case since being asked to provide this statement. I didn't think there would be any benefit in doing so. It wouldn't influence my statement in any way because I am relying entirely on the records and a previous statement to provide a factual account.

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.

May 10, 2022 | 2:15 PM BST
Date.....Signature of witness.....[redacted]