The Sheku Bayoh Public Inquiry

Witness Statement

Professor Jason Payne-James

Taken by [redacted]

Via MS Teams

on Friday 13th January 2023

Witness Details

1. My name is Jason Payne-James. My contact details are known to the Inquiry.

2. I am registered medical practitioner in independent medical practice and a forensic physician and a General Medical Council recognised Specialist in Forensic and Legal Medicine.

Qualifications and experience

3. I am a Bachelor of Medicine and a Bachelor of Surgery. I hold Masters degrees in law and science. I am a Fellow of the Royal College of Surgeons of England, a Fellow of the Royal College of Surgeons of Edinburgh, a Fellow of the Royal College of Physicians, a Fellow of the Faculty of Forensic & Legal Medicine of the

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Royal College of Physicians, and a Fellow of the Chartered Society of Forensic Sciences. I am an Honorary Clinical Professor at Queen Mary University of London, Bart's in London. I'm an independent forensic physician. I was a Forensic Medical Examiner for over 30 years for the Metropolitan Police Service. I am Chair of the Scientific Advisory Committee on the Medical Implications of Less-Lethal Weapons and an external advisor to the National Crime Agency. I'm Lead Medical Examiner at the Norfolk and Norwich Hospital in Norwich.

Professional Background

4. My personal role as a forensic physician includes clinical, academic, research and teaching roles. I have particular interests in deaths in custody and have reviewed, approximately, 100 or more cases over the years. So, my general clinical background in the past, has been, in part, as a forensic physician, working within police stations and working with the police. But, the other aspects of my work relate to research and writing and my academic interests.

5. I'm still in clinical practise. I qualified in 1980. I trained in surgery and then moved into gastroenterology and worked in accident & emergency medicine and other specialties including orthopaedics and general medicine. Around 1990 I left the NHS and since then have worked predominantly but not exclusively in clinical forensic medicine.

6. When I moved into clinical forensic medicine, in essence, I was a Forensic Medical Examiner for the Metropolitan Police Service in London doing regular sessions. Forensic Medical Examiners are not employed by the Metropolitan Police Service but are contracted to provided forensic medical services. Most doctors will be either independent contractors providing services to the police or they will be subcontracted via commercial or, occasionally, by NHS providers who have tendered for the services.

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7. I have been an independent contractor pretty much all my life and remain so. The only employed work I do is as the Lead Medical Examiner, part-time, for Norfolk and Norwich Hospital. I have been in this post since 2019. Over the course of my time working for the Metropolitan Police Service and then occasionally places like Essex Police, I would have seen about 70,000 patients in police custody from 1990 to 2021.

The Term Forensic Physician and the discipline of forensic and legal medicine

8. I have been asked to elaborate on the differences between a forensic physician and a forensic pathologist. A forensic physician deals with the living aspects of forensic medicine. A forensic pathologist's role is generally just simply to determine cause of death from a deceased body. Forensic physicians deal with the living. In the case of someone who is alive and then dies, then both forensic physicians and forensic pathologists should be instructed in looking at the determination of the cause of death. It's often thought that forensic pathologists alone can determine a cause of death. Forensic medicine broadly embraces forensic pathology and forensic medicine. There is overlap in these roles. Forensic pathology is recognized by the General Medical Council as a defined medical speciality; clinical forensic medicine, as of yet, is not recognized as such. But, the process to create a speciality of forensic and legal medicine has been ongoing for a number of years.

9. In the last three or four years in Scotland, a Medical Reviewer system has been established. In England, since 2019 there has been a Medical Examiner system whereby clinicians such as myself are tasked with reviewing and ensuring the accuracy of cause of death and the circumstances or events leading up to that and speaking to the family and the treating doctors. That is the standard policy in all

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acute hospital trusts in England & Wales and is now extending to the community. This will become statutory in 2024.

10. In my role as Lead Medical Examiner, I am responsible for a team that have explored the accuracy of medical certificates of cause of death of over about 10,000 patients in the last three years or so.

11. Terms for 'forensic physician' are interchangeable. The general public, older police officers, older lawyers and older doctors use the term 'police surgeon' or 'divisional surgeon' – somebody who used to go into police stations in order to medically assess. They still do but are now generally referred to as forensic medical examiners. NHS Scotland, I think, is generally responsible for the commissioning of forensic medical examiners in Scotland. Across England & Wales for over 40 police forces, it's a more random system where sometimes doctors, sometimes nurses, sometimes paramedics, may be called in to assess individuals who have been arrested, or detained, or indeed, are complainants of crime.

12. I have been asked how being forensic physician works in terms of medical practise. It can vary. My understanding is that most Forensic Medical Examiners (FMEs) in Scotland have a background of general practice. It sometimes was the case, historically, that you'd have your day job as a GP and then go on call. But now, doctors are normally contracted either through private companies, sometimes through NHS Trusts to provide services to Police Scotland, for example. In the UK, every police service will have its own mode of delivering forensic medical services. In the case of Sheku Bayoh, he wouldn't have been seen by a forensic physician because he died in the street.

13. I have been pointed to the fact that the Forensic Physician who was instructed to attend the police officers in this case also worked as a GP. It's very typical of the kind of portfolio work practices that doctors often do; many salaried GPs work in

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this way. I think the term 'Forensic Medical Examiner' is used in Scotland (rather than Force Medical Examiner) and this would need to be confirmed.

14. I have been asked to elaborate upon the discipline of forensic and legal medicine. The Faculty of Forensic and Legal Medicine of the Royal College of Physicians was established in about 2005/2006. It was founded to promote for the public benefit the advancement and knowledge in the field of forensic and legal medicine and to develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity . It was set up, in part, by the Home Office. It was seed-funded originally by the Home Office. There were various groups of doctors who were not part of any major college system. For example, some coroners in England & Wales were appointedby virtue of their medical qualificationprior to the 2009 Coroners and Justice Act. These doctors had organisation to assist in revalidation and appraisal. A home was needed for them. This was the same for those doctors working in sexual offences medicine in sexual assault referral centres. They did not have a natural home as they focused simply on sexual offence medicine work. The biggest group were people doing general forensic medicine (otherwise known as clinical forensic medicine) as police surgeons or forensic medical examiners, or forensic physicians. These terms are interchangeable, dependent on the title just assigned by a police force.

15. Forensic physician is the appropriate term that should now be used to embrace those dealing with the clinical aspects of forensic medicine which involved predominantly healthcare in custody and the facilitation of forensic aspects of work that the police require. Such work includes harvesting biological specimens, bloods and swabs, intimate swabs, doing intimate searches, assessing a detainee's fitness to detain or to be interviewed and then documenting injury for the purposes of court and then being able to present that evidence to courts, either in written form as statements or as live evidence.

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16. The number of doctors practising in that area of general forensic medicine was probably of the order of several hundred, between 500 and 1,000 people who would be forensic physicians coming from a GP background. But there has been an increasing trend over the years for many doctors to be portfolio working. So, for example, they will be doing one session as a forensic physician but then also doing other roles such as sessional clinics or tribunal work. Since 2019 many doctors are becoming, as part of their role, Medical Examiners, so looking at causes of death. In the last decade or so portfolio working has been seen by many doctors as providing a better qualityof life, I think, in terms of medicine.

Involvement and Experience with deaths following restraint

17. I have previously provided evidence in other public inquiries (the Baha Mousa and Al-Sweady Inquiries). I have dealt with approximately 100 deaths in custody in both prison and in the police setting over the years because I have a particular interest in healthcare in custody, and restraint and the effects of restraint, such as handcuffs, Tasers and irritants sprays.

18. Many deaths in custody are preventable. Drugs, or alcohol intoxication or withdrawal or common factors, and then a small proportion of the cases relate to or may have had some involvement with different types of restraint. In the clinical field we (along with emergency medicine and ambulance practitioners) are the professionals who have most clinical experience of trying to determine when somebody is at risk and when they are not – for example trying to differentiate between those that are just not wanting to be arrested and those whose acute behavioural disturbance is related to some underlying medical condition, which may be drug intoxication, or a mental health crisis. But the clinical expertise is trying to determine whether somebody is safe to be in a detention setting or whether they need immediate medical treatment in an appropriate medical facility. In my view, that is the essence of the role of a forensic physician, to try and ensure the safety of the patient.

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19. I have been asked if I can put a number on the cases of death in custody involving restraint which I have been involved in. It would be impossible to say how many investigations involving restraint I have partaken in. There are commonly cases in which people don't die but are subject to different modes of restraint. Then, you have to consider the types of restraint. Are we talking about simply being placed on the ground, on the back, for example? Are we talking about somebody who's been batoned and sprayed with an irritant spray? Are they using CS or PAVA?

20. I think, for the purposes of Sheku Bayoh's death investigation, it's really important that people are aware of the fact that using the term "restraint" embraces such a wide range of things and to different people. To a police officer, it will mean a different thing than it does to someone like myself who has been dealing with detainees who had been restrained for most of my career. It will mean something different, for example, to a psychiatrist where restraint may be required for medical purposes. The point is, that broad terms mean different things to different people. For me, working in police custody, restraint means what type of restraint has been used and in what context.

21. In the context of deaths in police custody, some of the modes of restraint used are modes which are used in other settings as well. In terms of mental health, one of the biggest issues that faces police and clinicians and, in fact, patients, is trying to differentiate between whether the death occurred in the context of somebody with mental health problems or other medical condition or whether it was somebody who was simply being restrained because they were violent.

22. I've been involved in all kinds of restraint deaths and all kinds of deaths in custody. These may include deaths from drug overdose, deaths from alcohol intoxication and may include deaths from alcohol withdrawal. The whole gamut of cases. I suspect there's only two or three forensic physicians who have looked at as many custody deaths as I have in the context of detention and restraint. I only

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know of a handful of others working from the same background as myself and with the same clinical forensic medicine experience.

23. I may be instructed by a range of bodies and organisations, for example, PIRC, the Independent Office for Police Conduct (previously the Independent Police Complaints Commission) and the Prison & Probation Ombudsman. I may be instructed by the General Medical Council to look at the actions of healthcare professionals who were involved in the care of somebody. I may be instructed on behalf of the police who are looking at the actions of police officers or the actions of healthcare professionals. I may be instructed on behalf of families.

24. In my various roles I may be aware or be involved in providing opinions on how someone dies in custody. I have given written and live evidence in such cases in coroner's court, for regulatory bodies and in criminal trials in the UK and internationally,

25. Every custody death is a tragedy and needs appropriate medical review. For example, there was a recent death in Essex, Braintree. It's a similar case where a Taser was deployed. Similarly, a man jumped off Chelsea Bridge. Inevitably, there will be concerns about somebody's prior mental health, their current mental health or whether or not they were or weren't intoxicated with drugs, whether or not they were CS or PAVA sprayed. These are just the bread and butter of the death investigation of people who sadly died following or during contact with the police.

PIRC Letter of Instruction – Effects of nandrolone, MDMA and alpha-PVP

26. I received a letter of instruction from PIRC (PIRC-03434(a), PIRC-03434(b)) and was instructed to look at the effects of drugs that were taken, the incapacitant sprays, the effect of the restraint and then to look at the effect of those in

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combination. Additionally, whether the cuffs and the leg restraints could have contributed to any positional asphyxia.

27. In paragraph 856 of my report (PIRC-02529(a)) I discuss about the physiological effect of the drugs, specifically, the effects of nandrolone, the MDMA and the alpha-PVP. In my report, I mention that it would be appropriate for cardiac pathology to review the heart in light of the history of drug use and anabolic steroid use.

28. The purpose for this is that it's a common issue within deaths in custody that many people have already got a pre-existing heart disease and it may be used as either a defence or actually used as a cause of death if there are abnormalities present. Having said that, having a normal cardiac status, I don't know if Mary Sheppard says this, but it doesn't stop you from having a cardiac arrythmia as a result of, for example, some of those drugs present. I'm not a toxicologist. But, in terms of a clinician, our interest in particular is; what are the risks of having taken a particular type of drugs. Of course, if you mix them, there is an increased risk that you may have precipitated a fatal cardiac arrhythmia, which can be present in the absence of structural abnormality of the heart.

Use of CS and PAVA

29. In my report, I comment on the use of CS and PAVA. In my opinion, the lack of effect makes it unlikely that either together or in isolation the PAVA or the CS were significantly implicated in Sheku Bayoh's death.

30. SACMILL (of which I am Chair) which has oversight of less-lethal weapons. One current issue is that under all international conventions CS and PAVA are considered to be less-lethal weapons and thus there should be oversight by SACMILL. SACMILL and the Committee on Toxicity have expressed the view that SACMILL should have oversight for CS and PAVA use. However for a variety of

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reasons CS and PAVA use by police is exempt from SACMILL oversight in the UK. The amount of information on the clinical aspects of the effects of PAVA and of CS are limited. There are very few studies that have actually looked at the direct effects, but the conclusion that I have come to in Sheku Bayoh's case is that it is unlikely CS and PAVA contributed to his death. The seeming absence of effect would, I think, lead one to suggest that it is unlikely that it had a direct effect on Sheku Bayoh's death. PAVA and CS are different compounds. There's much less data, there's much less structured research, peer-reviewed research on PAVA than there is on CS spray and it's a real knowledge gap that probably needs to be filled, but at the moment the Government seem reluctant to alter the status of CS and PAVA in terms of oversight.

Asphyxia

31. In paragraph 858 of my report (PIRC-02529(a)), I comment on asphyxia and the physiological effect of the physical restraint of the deceased in the circumstances of his arrest.

32. I have been asked who I believe is best placed to speak to the physiological effect of a restraint. You'll get everybody such as a cardiologist, a respiratory physician, an ITU person, a forensic physician, Emergency Department, everybody will have a view. In my view, you have to look at this in very simplistic terms.

33. I was involved in the Jimmy Mubenga case, which had to do with restraint, who died when he was being returned via an airplane. People drill down into biochemical aspects of what is happening and there are, since 2015, a number of studies that say, for example, in prone restraint, putting somebody facedown on the ground, does that impair their ability to breathe? And the answer is that if you're taking normal subjects and you're testing them then the answer is "seemingly not," but that's never the case when people are being restrained in the context of the police.

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34. So the difficulties for experts is that we are giving an opinion which is often determined on facts based on evidence which is not purely medical or scientific, and that's a problem for everybody. I've had to take into account what seems to have happened. I've had to take on the function, as it were, of a court to determine what happened. To me, what seems to have happened is that a number of police officers, one of them, if I recall rightly, heavy in weight, were on top of Mr Bayoh.

35. I have been informed that there is evidence to say that one of the police officers who was lying across his body weighed 25 stone. This broad statement brings up a huge number of other issues. Number one, what was Sheku Bayoh's habitus? I'm advised he was of muscular build, normal BMI and weighed 12st 10lbs. Facedown, if somebody was simply lying on him, would that compromise his breathing? Well, if he wasn't too big, he wasn't massive, then, in my view probably not. The question then you've got to look at is, just in isolation, a 25 stone man lying on top of him, is that going to impair him? Well, it might. Is there any way of assessing that? No.

36. The fractured first rib is only likely to have been caused with some form of severe blunt force I do think that a 25 stone man falling on top of somebody could have caused a first rib fracture. If there's that degree of force then it would, perhaps only momentarily, create a situation in which Sheku Bayoh went into cardiorespiratory arrest. This is where this crossover between pathologists and living forensic physicians and other doctors would be. The first rib fracture, in my view, is highly unlikely to have been caused by cardiopulmonary resuscitation. First rib fractures, according to new, more recent studies on isolated traumatic first rib fractures are generally associated with a substantial degree of force.

37. I recall a recent case of an American football player who had a cardio-respiratory arrest following a direct impact when two people ran into each other. There's a condition called commotio cordis, where the heart can suddenly stop because the

point at which the impact occurs coincides with the electrophysiological changes in the heart and it precipitates the heart stopping.

38. Simply laying on Sheku is unlikely to have caused death, unless he was forcing himself down on him. Falling down in force on top of him could have done that.

Cardiorespiratory arrest and the ongoing restraint/struggle

39. I have been asked to comment on forensic pathologists' comments on the fact that the restraint cannot be considered on its own, that it has to be considered in association with the struggle against the restraint. This is about the biochemical changes that can occur which are undoubted. For example, a 25 stone police officer laying on top of Mr Bayoh is unlikely to cause a problem. However, the evidence that I had was that it was more than one officer, including a 25 stone man.

40. We also don't know whether he was brought to the ground suddenly. I am trying to explore the factors that would have posed an influence. Had he been struggling? We haven't taken into account the effect of drugs eithers. But the struggling is the exhaustion, the change in body biochemistry does have the potential to result in a cardiorespiratory arrest as well. So it all goes to a cardiorespiratory arrest, what can contribute to it. The balance is, certainly in England and Wales coronial terms, what did more than "minimally, trivially or negligently contribute". I'm advised the test in Scotland is whether it was a material contribution, was the contribution more than de minimis and you have a number of factors here. So, probably you can take out the CS and PAVA spray because there was no apparent effect. Can you take out compression of some kind, holding him to the ground so he can't take adequate breaths in and out? You can't exclude that, in my view. What about the effects of severe struggling, fighting against people? Again, biochemically you can't take that out.

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41. Another factor to be taken into account is the leg restraints and arm restraints. That becomes another added factor as physical resistance against these restraints can increase the risk of metabolic derangement that could result in cardiorespiratory arrest

42. I have been directed to Dr Nat Cary's report (COPFS-00196) dated 23 October 2015. Dr Cary's comments on Sheku Bayoh's struggling:

> *"… considered from struggling. As is commonly the case in acute behavioural disturbances, the deceased displayed remarkable strength and stamina. Ongoing restraint and struggling in these circumstances is very likely to lead to significant metabolic disturbances with early breakdown of muscle releasing potassium which can participate cardiac dysrhythmias and the development of metabolic acidosis."*

43. I have been asked if I agree with the above statement. These are very broad points that I don't think anyone would dispute but, more importantly, you can't say that that wasn't the case. A question for Dr Cary might be "Is it possible that a 25 stone man dropping directly on top of a prone man could cause a commotio cordis resulting in cardiac arrest?" And I suspect he'd say, "Well, I don't think you can exclude that." I think that's the difficulty we all have. We know the complexity of a case like Sheku Bayoh's. I'm speculating, but he would have been anxious, he may have been frightened, he'd have been struggling, he'd have been fighting, there's all kinds of metabolic changes, the sort of fight or flight things that we all experience. When you're struggling it changes your body, and I use the term very broadly, your 'body biochemistry', because looking at the detail, for example, of the creatine kinase and things like that it doesn't show exactly what happened at the time that he was arrested. It's not like somebody arresting in hospital where you may have just taken blood results that you can look and analyse. It's pure speculation.

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44. The post-mortem biochemistry is subject to huge variation. So, nowadays, I don't think there's ever much difference between our broad views. In simplistic terms for courts and juries, does struggle alter your body biochemistry that has the potential for precipitating problems like cardiac arrythmias? I think most clinicians and pathologists would have to say yes. It comes to a matter of degree of what does the court determine? It's more helpful, often, for a court to have determined matters of fact and then for them to say to he experts "Right, we are accepting this is what happened, now what do you think are the most relevant contributors to Sheku Bayoh's death? What can be excluded and what can't?"

45. In my report (PIRC-02529(a)), I talk about the role of the restraint and the weight of the officers on his upper torso. I also talk about the injuries to Sheku's lips. Those may have possibly occurred when Sheku had been facedown on the ground.

The significance of Sheku Bayoh's physical build and the drugs in his system

46. I have been asked to consider Sheku Bayoh's physical build in terms of his struggle and restraint. Sheku Bayoh was of muscly build, and may have continued to struggle for longer due to his strength.

47. His body habitus may have contributed. Somebody who is very muscled with big deltoids, big pectoral muscles and, in particular, a big latissimus dorsi, when they are restrained, it may affect their ability to breathe in and out as deeply as they might. So, body habitus could have influence on the ability to breathe.

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48. There's also the perception that because someone is bigger they will inevitably fight more. I don't think that that's necessarily the case. The fact that he's muscly and strong and has had drugs does not make it a certainty that he would have fought more, that's not necessarily the case. But it may have happened.

49. Does the fact that he might have taken drugs mean that he was inevitably going to fight harder than somebody else who hadn't? Perhaps yes, perhaps not. The effects of drugs may have just tired him out because drugs, and particularly stimulant-type drugs, tend to exhaust people.

Excited Delirium / Acute Behavioural Disturbance

50. What used to be called excited delirium syndrome is part of acute behavioural disturbance. In the last year, there's been a substantial review of medical terminology. I'm one of the people who believe that you can use the term "excited delirium syndrome" in the living situation because it implies somebody who needs immediate medical help. They're fighting very aggressively, they may feel hot, they've stripped off and they seem out of control. They're people who need immediate help. They shouldn't be further restrained unless absolutely necessary and they shouldn't go into custody. Now, because of a huge number of issues with which I have huge sympathy for, and particularly when you look at the events in the United States in the last couple of years, there have been concerns of excited delirium being used as terms as causes of death, which it's not. It is simply a constellation of symptoms. There have been a number of publications this year where people have stepped back from using excited delirium as a cause of death. I'm in complete support of that. And that approach has recently been supported by the National Association of Medical Examiners in the USA.

51. As a clinician working with law enforcement professionals, mainly in the UK but also elsewhere, law-enforcement and healthcare professionals need some means

of determining whether this is somebody who just simply doesn't want to be arrested and is fighting off the police or this is somebody who is struggling due to mental health issues. It may be because of the effects of drugs, but they need immediate medical help, that's why we use this term. But there's also been a step back from the Royal College of Psychiatrists, and the Faculty of Forensic and Legal Medicine not to use that term.

52. Excited Delirium is an area that I'm specifically interested in. This Physicians for Human Rights Report in the United States produced a report *Excited delirium and deaths in police custody: the deadly impact of a baseless diagnosis* (WIT-00035) that said excited delirium should not be used, in essence, because it has racist overtones. And that has been actually broadly supported by the medical establishment. Part of that report explored the links of contacts of individuals with bodies, for example TASER (now Axon Enterprise) that might have a vested interest in using the term excited delirium. Just for the avoidance of doubt, I have no links of any kind commercial entity which influences my opinion. Mine is based on my clinical experience and my review of available data. But that, again, is something that I think needs to be taken into account.

53. There is an issue that excited delirium syndrome and excited delirium are not considered part of the disease statistical manual, the International Classification of Diseases. I, amongst others, still think it has validity as a term to assist in the management of living patients. Because there are a number of features of this, whatever we call it, excited delirium syndrome, that are quite well-defined and have been defined in peer-reviewed medical studies. However, coming back to it, there is no evidence, in my view, that Sheku Bayoh had excited delirium syndrome. Because if he had, I would have expected the police officers to recognise it and get him immediate medical help.

54. I'm aware that a position statement has been issued from the Royal College of Psychiatrists, recommending that the term excited delirium is not used and that

'acute behavioural disturbance' was used as an alternative. Acute behavioural disturbance embraces a wide variety of things and, in fact, the Royal College of Physicians, which is just one of many organisations that have commented on this matter. I think that for political and appropriate reasons there's been a wind-back from the use of excited delirium syndrome and although, as a clinical practitioner, I believe it has validity, as somebody who is involved in both direction and standard setting, I don't believe it should be used currently. Having said that, I am sure that the debate about whether and when the term may be used to save lives is not over.

55. I have been writing a chapter about excited delirium. If we look at the peer-reviewed medical literature at the moment there are more recent publications that are using and consider the term excited delirium appropriate. I am involved in what is called a Delphi study, which is looking across a broad range of practitioners, which will not be published probably until next year or so. The study is looking at how the terms ABD, excited delirium, et cetera, should be used. Whatever the status that the Chair decides excited delirium/acute behavioural disturbance has at the moment, I would say that it has been, particularly in the last two years, changing, and it is going to continue to evolve. It is not a definitive one. In particular, the Physicians for Human Rights Report which was then referred to in a Lancet editorial *End the use of "excited delirium" as a cause of death in police custody*[1](WIT-00040). It is important and it should be considered, it is just one consensus opinion and there are many other consensus opinions and they are continually being revised and reviewed.

56. I have been asked to confirm my understanding on the sort of causes and presentation of excited delirium/acute behavioural disturbance. Acute behaviour disturbance historically embraced excited delirium. I've expressed my views that I think the term is useful. I think one has to be very aware of and ensure that whenever anybody is stating something, confirm whether they are talking from a

[1] The Lancet, V.399 March 12 2022

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personal point of view or from the accepted consensus. Often, that may differ a little bit.

57. I work on a number of publications. I'm one of the co-authors of the Faculty of Forensic and Legal Medicine Acute Behavioural Disturbance guidelines on management in police custody (SBPI-00275). We've moved away from excited delirium so that term should not generally be used However, there are a number of things, for example, people stripping off, being hot to the touch, so tactile hypothermia, not being able to vocalise properly, sort of grunting, making noises, being attracted to glass and mirrors and breaking them. Those are the kind of features to look for. Possibly the best work in terms of the studies are probably Christine Hall's from Canada. But there are a number of studies that identify what those key identifying factors are. Just because somebody has some of those factors doesn't mean that it's necessarily excited delirium.

58. There have been a number of inquests over the years that have actually concluded that excited delirium was the cause of death, which I don't think is necessarily right. However, I've also been involved in many cases clinically where officers who have been trained in recognising excited delirium, often junior officers because it became more recognised, had identified somebody and said, "Look, this person has got excited delirium, he needs to go to hospital." But acute behavioural disturbance is much broader than that. So it can just be people not wanting to be arrested and then you have to consider numerous, differential diagnoses. Is it acute intoxication from drugs? Is it an acute psychosis? Is it a combination of both? But there are ways of narrowing it down but I would like, from a personal point of view, to consider that in the clinical setting, in the living setting, I don't think it should be used as a cause of death, but in the living setting it should be used as a means of identifying somebody who specifically needs immediate medical care. It may include cooling, it may include sedation, but they need to be in a setting where there are immediate resuscitation facilities.

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59. I have been asked on my view on whether excited delirium can be a cause of death. The prevailing international consensus is that excited delirium or excited delirium syndrome should not be used as a cause of death. When the term is used then excited delirium is the manifestation of a range of conditions that can ultimately result in death but is in itself not the cause of death.

60. I think it is important that experts who have given evidence on excited delirium ensure that they are reflecting on what the current medical opinion is and that they are currently involved in that work. I'm just making a general comment. I'm just saying what the broad principle is. I've explained very clearly how the consensus view is, I am part of that consensus, but speaking as an individual I still think that this story about what excited delirium is and whether or not it has some utility in terms of safe management of living people, I think we haven't come to the end of that story yet.

61. When considering experts' reports, including mine, keep in mind that I'm not a toxicologist. I'm aware of the toxicology and the effects of the, as it were, the pharmacology of many drugs. I will comment on toxicology broadly, but I would defer to a toxicologist were we asked the same question on a matter of toxicology.

62. My view is that the speciality best to qualify the mental state of Sheku Bayoh at the time would be a mixture of forensic physician and Emergency Department because we see acute intoxication and we see people are acutely behaviourally disturbed. In my view, psychiatrists tend to do it in a more confined environment where perhaps somebody's mental health diagnosis is known, not always. But our role as forensic physicians and those working, perhaps, general practitioners in the emergency department and are seeing people whose behaviour is, in broad terms, odd; and they're perhaps being disruptive or whatever, our role is to try and identify what's causing that, whether we're forensic physicians or emergency department or paramedics or those working in the Ambulance Services or anybody in primary care who may encounter those people.

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63. With my report, you are looking at a report that is 8 years old. There have been further published studies on, for example, Alpha–PVP and first rib fractures. Additionally, the Royal College of Emergency Medicine criteria for acute behaviour disturbance/excited delirium have also changed. Clearly, the Inquiry has to consider is what was the available evidence at that time or what is it now.

De-escalation and Use of Force

64. I have been referred to my report (PIRC-02529(a)). At paragraph 793, I state:

> *"In subjects who do not respond to verbal calming and de-escalation techniques, physical control measures are necessary before medical assessment and intervention can be initiated and medical staff protected."*

65. Generally in use of force, police will try and de-escalate everything. I can't comment on how trained Police Scotland was at that time. My medical opinion in 2015 was that the recommended approach to people in excited delirium would be to calm and de-escalate.

66. I have been asked whether that approach would be in a clinical setting or would it be the approach the police would take. I think it's a common sense approach. I don't think there's a defined approach trained in particular. What I'm trying to convey is that you use the minimum level of force or persuasion. You don't go in and immediately Taser someone and stick them on the ground and put their hands behind their backs. You take a controlled approach, which is what broadly police use of force has always been about. You use the minimal appropriate force. I'm relating it to a medical approach. You need to look at the predominant symptoms. Is somebody very agitated? Is their heart rate very high? Do they need some form

of sedation? Are they hot? One of the problems with what I would have previously referred to as excited delirium syndrome is that they are hyperpyrexial. One of the key things is that they are hot to touch. If they are hot to touch there is a risk that they have a temperature, because of drugs or whatever. If their core body temperature is high, if you have a high body temperature as it progresses there is a risk of seizure and if there is a risk of seizure there is a risk of death. The treatment for that is to reduce the temperature. So, they would, for example, need to be cooled.

67. I have been asked why is calming and de-escalation the approach in these situations. In a way it's a common sense thing. If you just say to somebody, "Shut up and sit down and stop creating a fuss," and that de-escalates the situation, well, that's better than Tasering somebody or spraying them with irritant spray, which may occasionally aggravate the situation. So, you're trying to use the least interventional approach to calm and settle the situation and that's the best option for not only the individual but for any members of the public around and any police officers as well, or enforcement officers.

68. Saying "Shut up and sit down" is just an example. You can use other de-escalating and more calming statements like "Come on, settle down. Have a seat down there". Verbal calming and de-escalation is used in the ordinary sense of the word. There's nothing specifically medical about it.

Clinical Experience with treating patients with Excited Delirium

69. I have been asked whether I have any direct clinical experience of managing or treating patients suffering from excited delirium (taking into account previous comments about the usage of the term). Yes, I have. So, most likely what somebody as a police surgeon or a forensic physician would do is have somebody who's been brought in struggling and fighting arrested from out in the street and

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the police ask you to assess them. You go in, they may be sweating profusely, they're not responding to questions or they're very agitated, they're hitting the walls, things like that, and at times like that you may say, "Right, okay, I believe, for a variety of reasons, because of the factors that you've talked about in the background and why this person's been arrested, I believe this is excited delirium. They need to go to the hospital." So we will call an ambulance. If necessary, they will go with a police escort and, if necessary, they may need restraining. They may need restraints. So how often does that happen? I suppose it would happen, I don't know, two or three times a year in my clinical practice as a doctor working in police custody.

70. I think in the United States there is a generalised belief that whatever this excited delirium was, if somebody exhibited all the features, they would inevitably die. For those who work in emergency medicine or in clinical forensic medicine, we know that's not the case. If people are able to be calmed down, if they've been able to cool down and if they're taken away from whatever is agitating them, then they will survive. So, I suspect that the majority of what has previously been known as excited delirium cases and, to some extent, still are in certain clinical settings, in some emergency settings, and some forensic physician settings, many may be self-resolving as the effects of drugs, for example, settle down. In the same way as taking large amounts of crack cocaine, for the majority of people, they will be agitated for a while, their behaviour will be acutely disturbed and then, as the effects wear off, they'll settle. However, for a small proportion, unpredictable number and unpredictable in terms of each individual patient, some will go on to become hyperpyrexial with excess temperature and they will develop and continue being acutely behaviourally disturbed, which some of us would have called excited delirium syndrome until proven otherwise.

71. On page 71 of my report (PIRC-02529(a)), on paragraph 798, I state:

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> *"There seems to be little doubt about the occurrence of acidosis in these situations but whether or not epinephrine or norepinephrine are contributors is not clear.*

In paragraph 799, I state:

> *"… physical control methods employed should be chosen to minimise the time spent struggling, while safely achieving safe and rapid physical control."*

Excited Delirium Workshop Panel Card

72. On page 71 of my report (PIRC-02529(a)), I talk about the Excited Delirium Workshop Panel card. That's predominantly for law enforcement and that was just a workshop I think we did in 2011, it was multi-disciplinary. The workshop panel took place in the US. However, it was multi-national event albeit it was based at Penn State University in the US. Interestingly, from the PHR, the Physician for Human Rights report makes reference to this and says that a number of the participants were, I think they felt, not disclosing their conflicts of interest. I would somewhat dispute that because I think it was a very broad consensus group. But I still think that the card that was produced as a result of this to try and identify what you should do and when you should do it and what you should do, I think is very useful.

73. It took place because there were concerns about the diagnosis and whether or not it should be used and also the concerns about the amount of methamphetamine and other stimulants used, it's a terrific problem in the US in particular. So, they just happened to be the ones who convened this meeting. It was the US Department of Justice, I think.

Signature of Witness …… [redacted]

74. I have been directed to a list in the panel card that says:

> *"Subjects can demonstrate some or all of the indicators below in law enforcement settings."*

And :

> *"… extremely aggressive or violent behaviour, the constant or near constant physical activity, does not respond to police presence, attracted to/destructive of glass or reflective…"*

That includes anything that reflects, including metal.

> *"… attracted to bright lights, signs, naked, inadequately clothed, attempted self-cooling or hot to the touch, rapid breathing, profuse sweating, keening(?), insensitive to/extremely tolerant of pain, excessive strength and does not tire despite heavy exertion."*

Conclusions on whether Sheku Bayoh had excited delirium

75. In my report (PIRC-02529(a)), I refer to these aforementioned symptoms at paragraph 853:

> *"If the excited delirium syndrome indicators are used only extremely aggressive or violent behaviour and possibly insensitive to/extremely tolerant of pain and excessive strength appear to be present."*

I go on to say:

"I do not consider that his condition, as described at the time of police contact, represented excited delirium syndrome."

76. What led me to the conclusion that excited delirium wasn't present in the case of Sheku Bayoh was that he wasn't described as being hot to the touch. He wasn't stripping off and naked. He hadn't been going at glass. I can't remember whether he was vocalising or not, but it's the absence of all the other factors. That is the reason why I came to that conclusion.

77. So unless there's any evidence that other factors were present, but my reading of the information that I got, no such information was given.

78. I have been pointed to the fact that Sheku Bayoh had been wearing trousers and a short sleeved t-shirt on the day. I have been informed that the weather on that day was approximately 6 degrees and that the weather was overcast with some rain. The average windspeed was 29 to 30 miles an hour at the time. Having considered that, I don't consider he was inadequately clothed for the weather. If you look around high streets outside pubs and clubs in winter people are often scantily clad. Some people may say "He must have been freezing". Well, he may have been, but I don't think that it necessarily fits the criteria. If people have had stimulants they feel warm, but I don't think that it fits the criteria for excited delirium, so that's why I haven't included it.

79. I have been informed that Sheku Bayoh was not responding to the police when they arrived and were shouting commands at him. The first response they received was when they sprayed him with CS spray and he wiped it from his face and laughed and then started to walk towards the officers. I don't think that it's a particularly unusual thing. It's seems about 10% of exposures have no significant effect, When it comes to excited delirium indicators, the more you have the more you can say that the syndrome is present. But, it's not definitive, it's not quantitative.

Signature of Witness ..... [redacted]

It's more qualitative. From my reading of the events described and my encounters with previous arrests, this behaviour is not out of the norm.

80. I have been asked if there is a minimum number of excited delirium indicators that one would expect to be present from the list that has been provided in paragraph 77 of this statement, in order to make a diagnosis. There is not a minimum number as it's not a validated list. There are many things that would point towards a diagnosis. Then, depending on your overall view of where that person is, then you can move it forward. From the point of view of a law enforcement professional, I would expect them to sort of take a more rigid view and try and look at all of those things and see whether they're all there and if they're not, they'll probably seek for assistance from medical experts, which is expected.

81. I have been asked whether there's any consideration on the fact that Sheku Bayoh'sbehaviours on the scene may have been out of character in comparison to how he normally behaves. When people are being arrested, their behaviour is often out of character. When I'm trying to determine, I look at it after the event and I tend to err on the side of, normally, the police should have picked this up or they could have picked this up and I don't believe there's anything they could have done. 99 per cent of times when arrests happen people aren't aware of any pre-morbid conditions or what that person's state is. Sometimes there is information, perhaps from families or friends, but frequently there isn't. Most of the time there isn't. So the police are having to make an assessment or a forensic physician is having to make an assessment on what they see there at the time.

Respiratory Sleep Clinic Records and CT Scans

82. In my report (PIRC-02529(a)), I mention that the deceased was examined at the Respiratory Sleep Clinic. At paragraph 441, I ask *"have the Respiratory Sleep Clinic records been obtained?"*. I have had no communication since the

submission of the report as far as I know. Had I been given additional information I would have amended my report if appropriate.

83. In my report (PIRC-02529(a)) at paragraph 527 I discuss the report of the post mortem CT scan which states that *"there is a well-defined linear lucency in the medial, posterior aspect of the left 1st rib*". I comment there that I have not seen these CT scans. I can confirm that no one has shown me those CT scans subsequently.

84. I do not feel particularly disadvantaged in any way from not having seen those CT scans. I am happy to read them, and for the purposes of a death in custody case, I would say you need a consultant radiologist to look at those.

85. If you are looking at a body post-mortem, MRI, to determine the cause of death, that's specialised. But again, radiologists are probably the people the first go-to people, and some forensic pathologists may be able to do it.

86. 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 8, 2023 | 9:11 AM PDT

Date ……..

Signature of Witness …… [redacted]