The Sheku Bayoh Public Inquiry

Witness Statement

DCS Patrick Campbell

Taken by [redacted] at [redacted], Glasgow on 10, 11 and 17 November and 14 December 2022 in Edinburgh

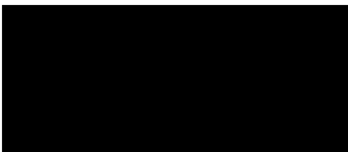
Witness details

1. My full name is Patrick [redacted] Campbell. My date of birth is in 1971. My contact details are known to the Inquiry.

2. I am a Detective Chief Superintendent (DCS) within the Specialist Crime Division of Police Scotland. I have been a DCS for five years. That role was temporarily interrupted when I was made a temporary Assistant Chief Constable (ACC) for 13 months during that five year period. I subsequently reverted to DCS. Prior to that I was a Detective Superintendent (DSU) and that was my role in May of 2015. I was DSU for local policing covering Lothians and Scottish Borders with in Scotland. I was in charge of all major and local crime within that Divisional Area.

3. By 3 May I had been there for about two and a half years. I went there around January 2013. The incident happened on 3 May 2015.

Previous statements



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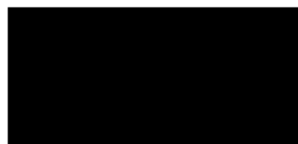
4. I provided a response to a Rule 8 request by the Inquiry dated 16 May 2022 (SBPI-00134).

5. I prepared my own statement on 19 May 2015 (PS00288). That statement was an operational statement. I prepared a handwritten statement which would have gone to the Home Office Large Major Enquiry System ("Holmes") incident room of the Inquiry (led by PIRC and supported by the Major Investigation Team (MIT) of Police Scotland). That was the initial statement. As soon as the investigation moves to a Holmes platform it will automatically generate a number of actions requesting statements. One action it will generate is for all officers involved in the early stages of the investigation to provide a statement. An action came to myself to provide a statement. That was a standard process. I prepared that statement myself and I wrote a true and accurate account to the best of my recollection at the time.

6. I also provided seven statements to PIRC (PIRC-00211 dated 19 June 2015; PIRC-00212 dated 3 July 2015; PIRC-00213 dated 6 July 2015; PIRC-00214 dated 7 July 2015; PIRC-00215 dated 8 July 2015; PIRC-00216 dated 15 July 2015; PIRC-00217 dated 12 January 2018). Extensive statements were given to the PIRC over a period of time – and over a number of dates as the statements were detailed and lengthy. The DSUs are set up over the areas and have oversight of all crime and all public protection matters; so it's a naturally busy position. To take a week out of your diary is difficult when you have got other incidents and critical incidents to oversee. That is the reason why a number of statements were given to the PIRC. It was not ideal as you would rather provide a statement in its entirety as soon as reasonably practicable. However due to the nature of the post, and competing operational demands, it was difficult to achieve that.



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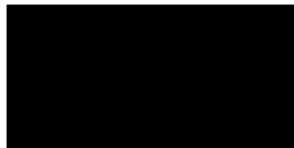
7. I gave the PIRC a true and accurate account to my best recollection at the time. I believe I was asked to read over and sign my statements.

8. I have been asked about the background to my statement dated 12 January 2018. It looks like a point arising from a previous statement, regarding clarification of a point made by DSI Keith Harrower from the PIRC. In the statement I clarified that certain information I had given previously came from another officer. The other point to clarify was that Keith Harrower said the conversation took place at 10:22 hrs.

9. The normal process for a death in custody would be for the DSU covering the relevant part of the country to be deployed. I was the on-call DSU covering crime within the east of the country that morning. Police Scotland, to this day, is split between east, west and north. As on-call DSU, I would be on duty for seven days and consider matters across the east of the country. That was why I was appointed Senior Investigating Officer (SIO) for the death of Sheku Bayoh.

10. While carrying out 'on-call' duties on a daily basis, I would normally contact the on-call Detective Chief Superintendent (DCS), who, on this occasion, was DCS Lesley Boal. Lesley would have strategic oversight for all criminal matters within Police Scotland for a 24-hour period. Every morning between 07:00 hrs and 07:45 hrs, whist on-call, I would call the DCS and provide her with an operational and crime update regarding all serious crime in the east of the country over that 24 hour period – or incidents likely to cause media coverage or reputational risk. The DCS would thereafter take all the crime updates from across the country to the daily Assistant Chief Constable (ACC) and also to the Monday morning Organisational Review meeting (ORM) chaired by the Chief Constable.



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11. The call I made to her at 07:45 hrs was to provide her with a crime update. She called me back at 08:15 hrs to make me aware of the incident in Kirkcaldy. There is a discrepancy in one of my statements about when I had been notified by Lesley but, as I say, the first call to her was for the initial crime update and it was at 08:15 hrs that she made me aware of the incident in Kirkcaldy.

12. The second clarification relates to the call I took from Keith Harrower. When I checked back via my daybook I noted that the call was made from Keith to me at 10:20 hrs. Therefore, the discrepancy in one of my statements is that I stated that it was 10:00 hrs I took the call from Keith, but in fact it was around 10:20 hrs.

13. My memory of the incident and my actions and response was naturally better back when I gave my statements than it is now. Naturally it would be better because of the passage of time. In hindsight, my earlier statements did not explore in as much detail some of the thoughts, actions and activities I carried out and considered at the time of the incident, particularly around Post Incident Management.

Training

14. There is no specific training within Police Scotland for the rank of DSU, or when you are appointed as a DSU. At that rank/level it is mainly particular specialisms that you would identify and request to receive further training or professional development in relevant areas. This could be areas such as Disaster Victim Identification (DVI) or Counter Terrorism SIO. For example, I had an interest in the operational deployment of Firearms Officers and in 2018 I was trained by the College of Policing as a Strategic Firearms Commander. You can opt to train in many s specialist areas. However, the expectation by the time you reach the rank of DSU is that you have the requisite experience

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and knowledge for that rank, and can competently take on the role of SIO for any aspect of Major Crime Investigation.

15. The SIO training course facilitated by the Scottish Police College (SPC) is normally attended before you attain the rank of DSU, normally at DI or DCI level. Before that there are various levels of training that you would undertake – again, rank and role dependent – such as initial detective training and advanced detective training. I was also trained in a number of other specialist areas, as detailed on my training schedule.

16. Before joining the police, I obtained a Bachelor of Arts degree (BA) in Management Studies at Glasgow Caledonian University, and, while I was with Strathclyde Police, I was also awarded a Diploma in Forensic Medicine at Glasgow University. This was prior to May 2015. It was a part-time course and took place two evenings a week for a period of 12 months.

17. I have seven pages of SCOPE records which detail, extensively, the training which I have undertaken throughout my service. I have brought a printout of the records with me to this meeting to assist with an explanation of the nature and extent of that training.

18. I have Officer Safety Training (OST) recertification in June 2015. Before that I was recertified in 2012. I am not sure why. I am conscious of the fact we retake the recertification. There is senior officer recertification which is a more condensed version of the two to three day course. I do not know how accurate Scope is. I think it was annual as far as I can recollect.

19. For certification, I would get probably either the staff officer telling me that it was due or you would have someone informing you within the department. Or, you might get an email from the officer safety training team saying that

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recertification was due and offering dates. On a number of occasions this was carried out within the Scottish Crime Campus in Gartcosh.

20. STR in my Scope record refers to the legacy days at Strathclyde. They were the host force who dealt with the training before we became one national police force. On my record the FTC is the Force Training Centre and the SPC is the Scottish Police College. The Force training was at Jackton in South Lanarkshire; and the national training was at the SPC in Tulliallan.

21. Delivery of the SIO training is at the SPC. I think it is a two week course now. There is input from specialist areas of expertise: experienced police officers, advocates, defence solicitors, staff from pathology and guest speakers from across the United Kingdom who have managed sensitive investigations. It is principally about the pragmatic aspects of running an investigation and the expectations and standards to be applied, and is taught through a mixture of classroom lessons and role-playing various training scenarios.

22. SPC has what is called a "Hydra" suite. You would be given the role of SIO, and, a situation would be presented on the screen, to which you would state what you considered to be the best course of action. You would have your team around you and, through the course of the event, you would get various "feeds" coming in round about, and you would require to consider whether to change that course of action. This was an effective way of putting policy and procedure into practice in a safe, but realistic, classroom environment.

23. To acquire the specialisation of SIO. there are various "snap tests" and exams throughout the course. There is also continual assessment, where you have to reach and maintain a particular level to be successful in the course.

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24. The Initial Investigating Officer (IIO) is simply a role within the post incident procedures (PIP) SOP. It is a categorisation of what I would deem to be the SIO in the investigation aspect of the PIP process. The difference is, because of the PIP process and the fact that the investigation will move to the PIRC, the IIO is more of a temporary role, where you manage the integrity of the process until the PIRC come in and take over the entirety of the investigation. You are basically running the investigation under the guidance of the PIRC who are normally remote at that stage. Your role as SIO is under PIRC until they have physically arrived. Ordinarily, the SIO label or appointment is given to someone who will see the investigation through to its completion – including court proceedings. The IIO is temporary until that is handed over to PIRC.

25. The whole aspect of PIP is UK-wide: it is not particular to Scotland. It is based on the College of Policing guidance, as is, for example, all firearms training in the UK. I am a strategic firearms commander, and there are the same processes, procedures and responses, should it be London, Glasgow, or anywhere else in the UK.

26. In legacy days within Strathclyde, and across all Scottish Forces, there used to be an annual SIO conference for DC to DSU/DCS ranks that you would be expected to attend. That stopped when we became a national force in 2013, and, thereafter, it was delivered in a different format - mainly a one-day event at the Scottish Police College and was categorised as Continuous Professional Development (CPD). There is a also a UK-wide SIO conference run by NPCC/College of Policing. This normally takes place over a three-day period. These conferences are excellent and are normally built around a particular theme. The day normally consists of teaching around case studies, new or emerging technologies/techniques and various workshops. I have always found them to be really worthwhile. The Scottish conference used to be annual - normally held in the SPC over a one-day period - but, as I recall it, there has

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not been one for a few years now, not helped perhaps, by the effects of the pandemic.

27. I was not trained as a Post Incident Manager (PIM) but I had a general awareness of the process. While I was aware there was a SOP for it, I did not receive any formal training in respect of the PIM's role in PIP.

28. There was nothing about investigating the actions of police officers under the SIO training that I can recall. I have never had any difficulty with investigating police officers. If a police officer - whether on or off-duty - is involved in any incident or crime you would treat them the same as any member of the public; trying to ensure complete transparency, and that the investigation was managed competently and fairly at all times.

29. In 2015, Police Scotland was in its infancy. As I recall it, the first PIP SOP was in March 2013 and was in existence for two years, before being refreshed in 2015. I am unaware of any significant deployment and use of the PIP process across either legacy forces or Police Scotland between 2013 and 2015. The PIP process was designed and developed for the operational response to the discharge of a firearm by a police officer causing death or serious injury. The emphasis was on traditional firearm discharge. I am also aware that this was extended to include death or serious injury following police contact (non-firearm) sometime later (2017). My understanding was that this incident was the first deployment of the PIP process in Scotland following a non-traditional firearm discharge incident, which had resulted in death following police contact. The definition states 'conventional weapon or less lethal weapon' and therefore this may cover the discharge of PAVA/CS which is categorised as a Section 5 firearm under the Firearms Act 1968 (1988 as amended).

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30. In 2015, there was no specific or general training to officers across Police Scotland in the PIP process that I am aware of, and only recently has Police Scotland issued an Officer Aide Memoire and Guidance (November 2022) around PIP. In 2015, Police Scotland was still in the process of merging a significant number of legacy force SOPs which led to disparate processes across a number of legacy forces during the initial emergence of the Police Scotland. I personally had an awareness of the process; mainly due to the use of the procedures in England and Wales but also due to previous deployments within Force Crime Policy Departments throughout my service. This was through general reading and awareness of how PIP was utilised. As regards specific training, I had not received anything regarding this prior to May 2015.

31. I had training on family liaison protocols with family members of deceased persons following homicides or incidents of unexplained death. It would happen throughout all the detective training which I took part in, from initial detective training all the way through to the SIO course. This covered some of the challenges that often transpired with such sensitive deployments. The Family Liaison Officer (FLO) is a distinct and unique role, often crucial to the success of any major investigation. One of the early actions of any SIO is to deploy family liaison officers as soon as reasonably practicable, to the next kin of the deceased. This is standard process. From my personal experience, the FLOs play a crucial role.

32. I was not trained as a FLO – it is a specialist role. I was aware of the role, its remit and the benefit that the family liaison officer was to any major investigation. As a SIO I would identify and deploy FLOs. There is a FLO coordinator in Scotland and we would look at who was available. The Major Investigation Team would have their own cadre of FLOs. If the matter was likely to move to an inquiry by the Major Investigation Team, there would be

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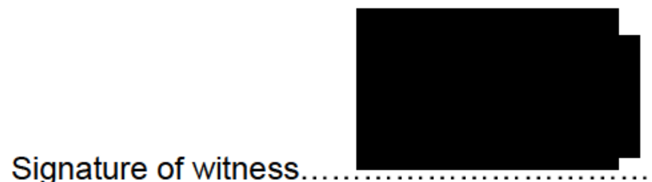
an early suggestion by myself as SIO that we would utilise FLOs from the MIT. That would allow a degree of continuity.

33. The role of the FLO is to provide a close link to the family, providing them with necessary information about the investigation. It is a dual role and also seen as an investigative aspect regarding information that the family may hold that may assist in any subsequent enquiry. It may include taking statements from family members; for example, seeking initial information regarding the movements of the deceased or relevant aspects of his/her background, such as medical information.

34. I completed a training course with the title “Ethnic Awareness” on 3 January 1998. This training took place at the Jackton Training Centre. I cannot really remember the details of that course, but it was based on the guiding principles at Strathclyde Police around fairness, integrity and respect; in particular the aspect of promoting an organisational culture of treating everyone with dignity and respect. Over the last 25 years there have been various inputs regarding ethnic awareness and integrity.

35. I completed a training course with the title “Race Relations” on 1 March 1998 (It looks as if it has been a set of courses within the force that we were required to attend), a training course with the title “Equality and Diversity – Non Supervisory Personnel”, and another with the title “Equal Opportunities Awareness Stage 2” on 18 and 19 March 2002. These were, and still are, standard refresher courses that would be held either annually or biannually. The content would change throughout the course due to legislative changes and the like. I cannot remember much of the content of these courses.

36. I completed a training course with the title “Values and Ethics Briefing” on 30 November 2014. This was taught over one day. What I can recall about this is



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that in 2013 we were the first force in the UK to introduce a code of ethics. It was centred on fairness, integrity, respect and human rights. I think that was the initial course which explained what that actually meant. That was a standard course for all officers and police staff across the country.

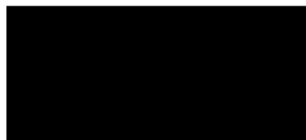
37. My Scope record shows that I attended a Values and Ethics Briefing including the "WDF". This is a reference to the Women's Development Forum.

38. I obtained certification in "Specialism in Project Management – Pride (STR)" in 17 May 2007 having completed a course called "Pride Project Management" between 14 and 17 May 2007.

39. One of the specialisms in Police Scotland is Project Management. It was to do with the ability to structurally run projects and programmes of work introduced to Police Scotland. It is a recognised standard you have to obtain to run programmes of work, such as the use of technological or other processes. You obtained that qualification over a week and it was the industry-standard, not just for police but over the whole public sector. We were developing a national homicide database at this time - a national database of all historic homicides; taking from them the best practice, and learning from poor practice too.

40. Police Scotland was trying to develop a database system that allowed SIOs and other members of staff to have immediate access. For example, Pride Project Management allowed you to develop an appropriate structure and framework for its introduction to the force, and to ensure ECHR compliance etc. I think that is why I went on it, because the introduction of the national homicide database was of particular interest to me.

41. On my record, "LPD" may well stand for Leadership and Personal Development, though I may be wrong about this. I think that "SLPD" is the



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Scottish Leadership Development Programme. It was for the development of senior leadership. I was expected to go on this course.

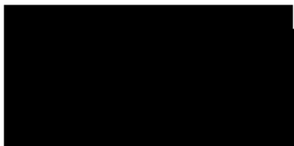
42. Training in CS/PAVA deployment and record-keeping was part of OST training. The whole aspect of PAVA, deployment, escalation, the aftermath of recording and storing, seizure of discharged PAVA and medical consequences was all part of OST.

43. On 1 March 1998, I completed a course relating to "CS incapacitant". That might have been when it was introduced. It was a stand-alone course because of the very nature of what you were using. After that it was a matter of recertification.

44. I completed another course on 6 July 2001 at FTC, also called "CS Incapacitant". I do not remember this. I thought we had only done one course on this, as a stand-alone course, and that thereafter it was incorporated within officer safety training.

45. I also had fast-strap training on 26 October 2009. There was nothing relevant in the training to the actions or decision-making in May 2015.

46. Lessons learned from other jurisdictions are always a crucial part of training; for example, issues with positional asphyxia. The SIO course was being continually developed because of changes not just in Scotland but across the UK. I found it a really interesting course. It incorporated first aid, sepsis and resuscitation amongst other things. The OST recertification courses were interesting and there were changes quite regularly across UK policing that were incorporated into your next "requal".



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47. For experiences arising from significant incidents - such as the Stephen Lawrence, Habib Ullah, Sean Rigg and Christopher Alder cases - as well as other incidents that were relevant to equality, diversity and race, there were significant inputs into the equality and diversity and OST courses over the years, in terms of identifying potential shortcomings and good practice. None of these courses "stood still", they were constantly evolving. My impression is that the findings from the various inquiries and reviews are still filtering through into law enforcement. For example, the findings of institutional racism following the MacPherson Public Inquiry, led to significant internal review across all UK law enforcement agencies.

48. I completed "Crime TRNG – Media Training" in 27 November 2009. This was part of the SIO course. It was a full day set aside in for media training. From recollection the course was delivered by external consultants. It was an excellent course because it was not just about how to deliver media input, but also covered how you were interviewed by the press. The practicalities were really brought home to you. Of course, a great deal of that comes from experience and it becomes second nature the more you get involved.

49. The DCS for Local Policing would look after all eight DSUs in the territorial policing area. The DCS was my immediate line manager at that particular time. I would enrol on courses either at my request, or following a suggestion from my line manager. I would complete all the required courses in the rank of DSU. There were more external courses particularly .

50. Around 2018, I became interested in firearms command and I went on to be trained as a strategic firearms commander. That was outside the remit of crime and more to do with specialist response. I would have had a discussion with my line manager about the training - whether I was suitable and if there was space available.

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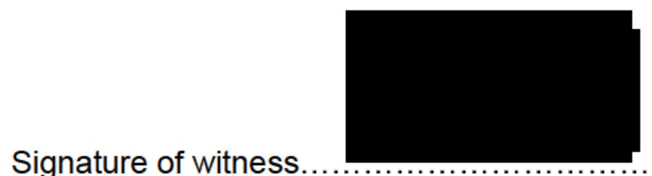
51. I was a line manager for others. I had oversight and command of the CID, and public protection officers within that divisional area – so that was from DCs through to DCIs and the officers within that crime area. I was also part of the divisional command team, ensuring that the criminal investigation pillars - and all aspects of public protection - were fit for purpose. This included training and other aspects of professional development of the staff.

52. If there were any changes or alterations to policy or procedures across the Force, or new SOPs being introduced, you would normally get a force memorandum which would direct you to the particular SOP and the relevant policy. This was mainly highlighted on Police Scotland's intranet. Other than being sent an email, it was your own personal responsibility to read it and review if there were any significant changes.

53. The reading of memoranda and SOPs is not monitored. There are some aspects that require mandatory online training, though that is more in recent years. In general there were hundreds of the old SOPs going back to 2015. It was your own responsibility to read them. You also had the awareness that you had the capability to refer to the SOP while dealing with any unusual or challenging incident. So, if you had any concerns or were looking to clarify anything you could refer to the SOP. Again, there was no register kept of who read what.

54. Police officers are made aware of training and reading materials on Police Scotland's intranet site. There is a "people and development" site. On that, there is access to training and associated material. This is now managed via an online training platform named 'Moodle'.

Experience



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55. I had completed 27 years police service by September of 2022, and for almost 25 of those years I have been on the criminal investigation side - initially with Strathclyde Police and now Police Scotland.

56. I have experience of deaths in custody which goes back to my days with Strathclyde Police, although the definition has moved on from the days of the legacy forces. Investigation of deaths which had occurred within 48 hours of recent police contact was really extended. There was a lot of flexibility with the timespan; for example, uniformed officers picking up a drunk male, taking him home, and days later finding him dead within his home address after choking on vomit - that would be deemed to be a death following recent police contact. I have also been involved in various death in custody cases. One occurred in [redacted], where a foot pursuit resulted in a male falling and, during his apprehension, suffering a cardiac arrest and dying A further one [redacted] [redacted], involved the restraint of an intoxicated male who had been found to be unresponsive within the rear of the Police vehicle. The death of Mr Bayoh is certainly not the norm, but the police response has come on from where it was fifteen to twenty years ago. The response is less dictated by timescales and now more by circumstances. The introduction of PIRC in 2013 has also brought with it independent oversight for incidents such as deaths in custody.

57. Before 3 May 2015 I did not have any experience in the investigation of police officers. This would normally be the role of the Professional Standards Department or the Anti-Corruption Unit. I had however been involved in a number of investigations where off-duty police officers had witnessed a significant incident and were witnesses. The police officers involved in such incidents are key witnesses, until the evidence suggest otherwise, and are not being investigated.

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58. As with any member of the public, police officers, whether on or off duty, are detailed as witnesses at that time until suspicion falls upon them. It is all about keeping that open mind in the initial stages until there is evidence or intelligence or witness statements that suggest that they fall into the suspect bracket.

59. Race was not a factor in any of these investigations that I can recall. I would just like to elaborate on the experience I have had in dealing with culturally diverse communities within this country. Over the 27-year period, I had a lot of experience in North Glasgow dealing with the impact of asylum seekers being housed within the Barlanark and Balornock areas. Thereafter I worked in South Glasgow and Govanhill: one of the most culturally diverse communities in Scotland. I policed that and managed a lot of the incidents in both those areas over a number of years. This was not something new and, while there was nothing that caused me specific concern as such, I did become more aware of cultural issues from my own experience.

When I got the initial call, I just kept an open mind around what had occurred and began to consider the wider implications; and thought that this would likely move towards being declared a critical incident. It is important to highlight that the national threat Level to the Police within the UK at the time of this incident **was 'Severe' and that an attack on Police was 'highly likely'**. There had been significant terrorism-related incidents earlier that year in Europe. I therefore anticipated that due to the circumstances of the incident, it might gain significant media interest as well as impact on the local community, particularly on minority groups. I had a wider appreciation and open-mindedness about what I was going to face at Kirkcaldy police office before I became actively involved there. Was this an incident triggered by ideology, or was this an

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incident simply involving the arrest of an individual and that this individual was black.

60. I spent around three years in crime policy and strategy, developing policies and strategies within the crime portfolio at Strathclyde police when I was a DI and a DS. I was aware of many of the responses and protocols when we moved over from legacy forces to Police Scotland. We transferred a number of those SOPs as such and policies over from legacy forces. We unified them as one for Police Scotland. These were things such as the PIP SOP. Although it does not really refer to criminal investigations as such, I was aware of the contents because of some of the background policy work I had carried out.

Notebook and daybook

61. I have a police notebook and that was seized by the PIRC. It is not something that I would complete on a day to day basis detailing my response to an incident as such. This is mainly due to the fact that, for the type and nature of incidents I am involved in, I have to write quite a bit. Because of the size of a notebook it would be filled quickly.

62. The CID daybooks in Scotland were called different things throughout the country. In Strathclyde it was called it a daybook and you basically detailed your responses, thoughts and actions. I don't think I had any entries other than the dates in my police notebook. It was not something that we regularly completed. If you went back to uniform or a response job you would use your notebook, or PDA as it is now called. Otherwise you would use your daybook. If you dealt with something serious you would take your daybook and detail the analysis of the incident and the response in that.

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63. My daybook detailed things such as calls and other details taken in that period. That would be more what I would utilise as a notebook instead of a normal police notebook. Detailed investigations tend to require writing than what a uniformed officer would put in a notebook.

64. The daybooks are more around your own personal responsibility. I have got all my daybooks going back a number of years. You would always keep them because you would never know how to account for what occurred going back a number of years.

65. There was an issue with a police issue notebook. It is your personal responsibility to manage that and record, retain and secure the book. It is certainly not something you would discard once it is complete. Guidance on best practice can be found in the relevant Police Scotland SOP.

Media

66. I have been following the inquiry. I have seen some of the evidence; mainly out of interest to see the format and structure of the evidence. I don't think my recollection of events has been affected by anything I've seen in the media. I think I've seen part of Amanda Givan's evidence. I cannot recall any of the officers as such. I think I have seen a couple on catch-up on the website but could not give details of the officers involved.

Role on 3 May 2015

67. The DSU in any investigation is more likely to be the SIO. Various ranks could be appointed SIO, but in homicide investigations it is mainly from DI level and above – that is certainly my experience over the over the past 25 years. As

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SIO you would be expected to lead the investigations and there was nothing unusual in me being appointed as SIO.

68. The overarching remit is to strategically lead on the criminal investigation. Because of the fact it is declared a critical incident - and also a major incident - the Gold group structure was initiated by ACC Ruaraidh Nicolson. That provided a strategic framework to manage the incident.

69. The SIO covers the criminal investigation. The whole aspect of community impact, partnership engagement, and the media, is encompassed in the Gold strategy by the ACC. I appointed a Deputy SIO who was DCI Stuart Houston. I would put in place the initial investigative strategy in response to the incident. The strategy related to scene identification, identification of witnesses and suspects, forensic strategy, analytical support, intelligence support, family liaison strategy, appointment of FLOs and inclusion of the family, any impact assessment in the community, among other things. These are all parts of the process and my thinking in response to this incident.

70. A lot of this is a pretty natural response to any investigation

71. I have been asked if we had understood we were investigating a suspicious death. That is not the case – we are taught to start with the worst-case scenario. This is to ensure nothing is evidentially or forensically lost because what is in place is how you would deal with the most serious incident. The protocols and processes are the same for all of them.

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72. Circumstances required extra investigation, scene investigation, witnesses to be located and a family liaison strategy to be developed. This is the same for any death. Any unexplained death would be treated potentially as a homicide until it had been investigated. Part of our training was to treat that scene the same way as we would in any potential homicide investigation.

73. ACC Ruaraidh Nicolson was in charge of the overall Police Scotland response. We always have an on-call ACC who has oversight over policing in Scotland after normal business hours across Police Scotland. The ACC chairs the daily strategic morning meeting. The information I would give Lesley Boal around incidents of note, she would raise (if relevant) at this forum. I became aware that this had been categorised as a critical incident when the strategic meeting had finished. Lesley explained to me that they were going to put in place a Gold command structure within Kirkcaldy police office. That is a familiar process and structure for any major or critical incident.

74. The group structure incorporates Gold, Silver and Bronze roles. For any critical incident or major incident there is always a Gold group command structure in place. I was Bronze lead for the investigation, that is an allocated role for the SIO.

75. Silver commander was Chief Supt Gary McEwan, the divisional commander. There were a number of different Bronze leads: for example, for media or community. It very much depends on the nature of the incident. It would be quite normal for me to be appointed Bronze and to update at the respective Gold groups. Garry declared a critical incident at 0910 hrs.

76. After the appointment, Lesley contacted me at 0815 hrs and briefed me with details that a black male with a knife had been arrested by Police Scotland

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officers and during restraint he had thereafter become unconscious. I use the term “likely to prove” in my statement. It is a Police term that we use to describe the deteriorating and critical condition of a subject. It indicates that Mr Bayoh was very poorly and may not recover. Lesley asked me to get more information at that stage about what was transpiring in Kirkcaldy.

77. I had already called Colin Robson who was the on-call DI for the Fife area. Colin relayed to me the fact that Mr Bayoh was in hospital and his condition was giving cause for concern at that stage. He gave me some brief details of the incident, that the man had become unwell and had been taken to Victoria Hospital. I spoke to Colin Robson about personnel, crime scene management and asked whether we had sufficient resources at that stage. I informed Colin that I was going to start making my way from Livingston to Kirkcaldy. I contacted Lesley Boal back and I said I would travel through to Kirkcaldy and take command of the investigation at this stage.

78. I got into the car at about 08:30 hrs that morning and drove to the Kirkcaldy office. I spoke to a number of people on the way through, including Craig Blackhall, the on-call PSD representative. I made Craig aware of the incident and that there could be a potential death following police contact or death in custody. There is a standard process for informing Crown and the PIRC around the nature of what is developing in respect of such incidents. This is carried out initially via the on-call PSD Officer. I phoned Craig and he informed me he would spoke to the Fatalities Unit in Crown Office and that they were the direct link into notification into PIRC. I spoke to a number of different on-call officers within CID to do with bringing in sufficient resources to deal with the aftermath at that stage.

79. Resources were one of my main considerations. On Sunday morning you tend to have fewer resources to call upon across Police Scotland. I began to contact

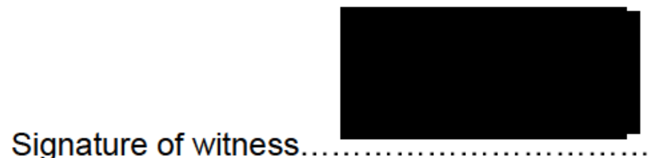
Signature of witness................................

a number of individuals from surrounding Divisions as well as the MIT to ensure we had sufficient resources to manage incident and investigation. When I looked at the officers on duty in Fife itself, it was very limited from a CID perspective. There was a need to look at other areas. I looked at and contacted officers within Lothians, South Lanarkshire, among others, and ensured resources would attend for a briefing as soon as possible.

80. I am aware that a Deputy Post Incident Manager was appointed. There was a female appointed to assist Conrad Trickett. Her name escapes me for now. She was not trained in PIM. The PIP for this was in its infancy at that stage. I am aware of the post but that is far more structured now because of the wider awareness of the role of the PIM.

81. I have been referred to the PIM log (PS00387 at page 13) – "*PIM Support – Insp Jane Combe*". She will be the one who was appointed the Deputy.

82. PIP is a distinct set of procedures and protocols that was initially developed to manage situations where there has been a discharge of a weapon by the police, and which has resulted in death or serious injury. The PIP process ensures that there is balance between the welfare needs of the officers with the needs of the enquiry. A death following police contact, post incident management or post incident deployment as it was initially called, was first developed by ACPO/Centrex in England and Wales, and thereafter extended and rolled out to policing in Scotland. This is not just initiated following death by a firearm by the police, but has now been extended to encompass any contact or any serious injury to an individual. The initiation and decision to stand up of the PIP process was made by ACC Nicolson. It must be made by a strategic (or executive) officer. From speaking to DCS Boal, this matter was discussed at the morning ACC Strategic meeting, which Lesley Boal attended.



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CI Conrad Trickett, the appointed PIM, was also on duty at that time. I believe he was at the morning executive meeting on an unrelated matter.

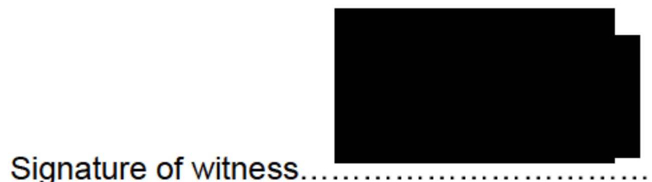
83. The PIM role is distinct from that of SIO, or IIO as it's known in the PIP process. The IIO/SIO would be me, but the PIM was CI Conrad Trickett. His role was to balance the welfare needs of the individuals who are defined as key witnesses, with the needs of the investigation. My role within that is a role that is appointed by the ACC and I would liaise with Conrad regarding the various aspects of the process and protocols surrounding that.

84. The PIP is a four-stage process. Conrad would manage that four-stage process and would speak to me on anything at all that he required clarity on. The IIO was simply to do with the investigation itself. With the notification from Crown that the PIRC were coming to take this on, my role at that stage was to manage the investigation until such a time that a competent handover would be made to PIRC in its entirely. I would liaise with the appointed officer from PIRC, Keith Harrower. It was clear to me what our roles were when I was told that this would be a PIRC-led investigation supported by Police Scotland.

85. The IIO and SIO are ultimately similar in nature and role – there is no distinction within the SOPs. The IIO would be the initial senior officer for the investigation. Within the PIP process my title simply changes from SIO to IIO. The role mirrors that of an SIO. Due to the defined protocols and the instruction by COPFS to PIRC, I was simply managing the investigation until such a time as PIRC were able and had the capacity to take on the investigation.

PIRC's role

86. The Crown directed PIRC to lead on the investigation into the death of Mr Bayoh, supported by Police Scotland. That is what I was informed by Craig



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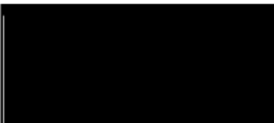
Blackhall at the time. Blackhall informed me that Dave Green from the Crown Office was going to speak to the on-call PIRC and contact me directly. At 09:35 hrs that morning I was made aware that ownership of the case was going to move from Police Scotland to the PIRC. Due to the nature of the incident, I did expect that from the early stages even before it was confirmed by Craig.

87. PIRC came online not long after Police Scotland in 2013. I would suggest this was probably their first major deployment in response to a live-time major investigation and critical incident. I had dealings with PIRC prior to this. That was telephone calls and clarity on deaths in custody or deaths in police contact. We were normally directed remotely by PIRC to deal with enquiries and thereafter we reported back to them. In respect of a physical deployment of PIRC, that was the first time I was involved with them where they were dealing with a live-time incident.

88. I did give to the key witnesses, the subject officers, a briefing about PIRC's role. From a CID perspective we were well aware of what PIRC's role was. Sometimes it is quite challenging being a SIO in an investigation led remotely by PIRC when the initial circumstances are moving quickly. I liaised with Keith Harrower to ensure that PIRC were informed, and that the actions we were taking at that time were in line with his strategies.

89. PIRC's role never changed in any way. It was always a PIRC-led investigation. Between 3 and 4 May 2015 there was no dubiety at all. PIRC were supported by Police Scotland, and we brought Holmes in to manage the investigation. A lot of the personnel involved within Holmes and detailing the processes and systems were Police Scotland officers. The lead sat with PIRC early on that day. For the first four hours or so that was done remotely until they attended at Kirkcaldy. There was a clear communication channel between myself and Keith Harrower from PIRC.



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90. I am not sure if the Firearms PIP SOP was used. I would imagine that if it was used it would be used by the PIM. I believe it was Conrad Trickett's first deployment as PIM. He explained to me that this was his first every deployment when he arrived at the Kirkcaldy office. The first time I was made aware of it was 10:00 hrs or 10:05 hrs - I got a call from Lesley Boal after the morning meeting with the ACC and she informed me that CI Trickett had been appointed PIM and was attending. The PIP had been activated and CI Trickett was deployed. Lesley told me he would be attending at Kirkcaldy Police Office and undertaking all that the role entails.

91. I knew from my general awareness of what PIP involved. I had a knowledge of the stages that were involved in that process. But that was through my own personal reading. I had no training so it was general awareness of the balance of the welfare and wellbeing of officers, and the investigation. The in-depth mechanics and workings of it I was not trained, so I was reliant on the PIM for that. I was reliant on him doing it. I was the IIO. I was quite clear on what my role was. The remit of the PIM was to manage the post incident management process. It was the Gold commander ACC Nicolson who activated the process and put that in place. I was just a part of the process as the IIO. I was aware that I needed close liaison with Conrad Trickett in order to deal with any crossover.

92. Conrad had oversight of the whole PIP process as the PIM. That is the overall objective of balancing the welfare of the officers, with the needs of the investigation. It was clear from the deployment of the PIM that the officers were key police witnesses because of the process that was put in place around PIP.

93. In my briefing to the officers on 3 May, I spoke to Conrad prior to delivering it to ensure he was okay with it. I was aware that it was not part of the PIP

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process, but thought it was necessary to give the officers, who were clearly distressed, an update in respect of the investigation. Conrad did not think there was anything wrong with it.

94. The pertinent and relevant aspect of the crossover in this case was the personal account of the officers and what that entailed: explaining where you were, your honestly held belief of what occurred and what use of force was required. Those are the three stages of the process and they were relevant to my role of IIO in the investigation.

95. Through the course of the morning of 3 May we were investigating the movements of Mr Bayoh and why he ended up being at Hayfield Road and thereafter being confronted, restrained and arrested by police officers. By late morning on the 3 May 2015, I had established a clear account of his movements from leaving his home address to his presence on Hayfield Road. The gap in my knowledge was that I was not aware of exactly what had occurred with the key police witnesses when they came into contact with Mr Bayoh on Hayfield Road. In the absence of eyewitness testimony at this stage, what were the actions, and the use of force, of the individual officers involved, while restraining and arresting Mr Bayoh. That was the gap that I had identified and I believed that it was operationally critical to the investigation. This was why I was keen to seek the submission of their Personal Initial Account and/or operational statements. This is the aspect that crosses over with my role and that of the PIM more than any other.

96. If the officers were suspects or are suspected of criminality or misconduct offences - they would be excluded from the PIP process. The officers concerned were involved in the engagement with Mr Bayoh. There was nothing to suggest anything criminal had occurred. As the name suggests they were Key Police Witnesses. If there was any evidence of potential of misconduct or

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criminal activity then that could change. Their welfare and wellbeing would be a concern throughout.

97. That part of the PIP process sits with Conrad. I explained in the briefing that there was requirement for Operational Statements/Personal Initial Accounts (Stage 3 of PIP). I told Conrad Trickett the requirement and the need for them to account for their actions and in particular their use of force. It sits with Conrad however it's important for me in my investigation. With PIP activated, it is the remit of the PIM to obtain this, not the IIO.

98. It was clear from early on and confirmed by Keith Harrower at 10:20 hrs that they were witnesses and they were treated accordingly. I briefed the officers concerned of the nature of the investigation and how this was now going to progress. I informed them I was treating them as witnesses and Keith agreed with that. He was remote and was not fully aware of the circumstances of what was developing in respect of the reluctance of the officers to provide an account of their movements and actions. We agreed that on the information we had at that stage they were all to be treated as witnesses. In the course of the morning I spoke to Dave Green at the Crown Office and he again highlighted the fact that they were to be treated as witnesses.

99. It was a PIRC-led investigation, so it was Keith Harrower who decided if they were witnesses or suspects. My discussions with Keith concerned the various strategies which I had put in place and what I had discovered at that stage around the circumstances leading to the death of Mr Bayoh. I was able to confirm from my perspective on the basis of the information and intelligence which I had, that the Police Officers concerned were nothing more than witnesses and Keith agreed.

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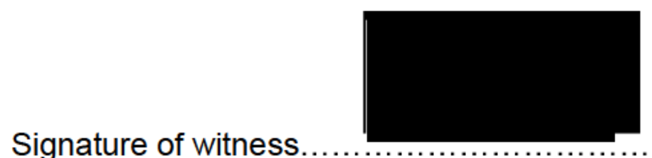
100. Keith was making decisions based on the information I gave him at that time, as well as his discussions with COPFS. He had to take cognisance of the briefing, and, his awareness of the facts that had been established before deciding the status of the individual officers involved. He completely agreed with my assessment that the officers concerned were essential witnesses and not suspects based on what had been established, and he reiterated that in subsequent phone calls over the course of the morning.

101. It was also a Crown-led investigation and the Crown has a significant involvement in any investigation; so it would be normal protocol to inform them. That is pretty standard in all death investigations - to have that early liaison with Crown. However, with deaths following police contact, the significant difference is that, under the legislation, COPFS has a duty to ask the PIRC to investigate.

102. It was a challenging situation because we had a delay in the PIRC attending, and taking over a quite significant critical incident which was developing at real pace. Keith had indicated, during some early conversations, joint deployments around CSMs, FLOs and other critical roles – between PIRC staff and Police Scotland officers - however this could not be put in place until they had physically attended at Kirkcaldy. It was something I had not experienced prior to this.

103. What that did involve was a number of phone calls to and from Keith Harrower. Before they (PIRC) arrived there was already a significant amount of work that had been progressed. It became clear what we were dealing with at that stage. Because of PIRC being in its infancy, the relationship between PIRC and Police Scotland being quite new, there were various challenges, such as: the joint deployment of CSMs, FLOs, H2H coordinators, the mechanics of how this would work and the capacity of PIRC to support the various strategies that had



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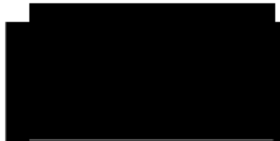
been put in place. I knew Keith from Strathclyde Police so that did help because we did have that established relationship.

Initial understanding of the incident

104. It was treated as an unexplained death investigation at that stage. There is always a possibility that there could be evidence of criminal activity, and you have to keep an open mind at all times, and make your decisions on what information and intelligence you have at any given time. If there was reasonable cause to suspect criminality in respect of any individual, then you can move from dealing with them as witness to suspect very quickly. However, there was nothing to suggest any criminality or misconduct around the actions of the key police witnesses to this incident at this time.

105. It became quite clear in the morning of the 3 May 2015, that there were five loci. That was part of that conversation I had with Keith during the course of the morning. Mr Bayoh was watching a boxing match at a friend's house and thereafter went back to his home address. Once we had the recollection of significant witnesses such as Collette Bell and others, the movements and timeline from the previous evening became quite clear. There were no significant gaps in my knowledge regarding how he ended up on Hayfield Rd engaging with the police officers.

106. At that stage I was unaware of what happened with the officers themselves when they confronted and restrained Mr Bayoh other than what I got from Colin Robson, the DI at the scene. All I knew was that he had been restrained, CS/PAVA had been discharged and there had been baton strikes to Mr Bayoh. Regarding the restraint and arrest of Mr Bayoh, what actually had occurred and what officers did, was still very unclear. There was a clear identified gap of what had actually occurred at the scene. In respect of the location of the



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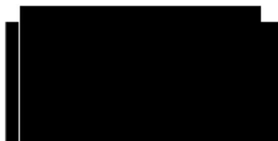
officers prior to my arrival at Kirkcaldy Police Office, I was informed by DI Robson that the officers concerned had been placed within the canteen area and that their wellbeing was being looked after.

107. There was a lot being done – such as house-to-house enquiries and key witnesses being traced. I actioned two officers to look at CCTV opportunities in the area. There was a number of eye witnesses who came in at that particular stage. I was aware in the morning there was a concerned call to the police from Collette Bell that she could not find her partner and the house was in a state of disarray. That call was linked to Sheku. Collette Bell was a significant witness, as well as Zahid Saeed because of his association with Sheku leading up to the incident at Hayfield Road. We were looking to complete the timeline and looking at opportunities to understand what happened.

108. I briefed DCS Lesley Boal. I knew she was on her way to Kirkcaldy and I spoke to Lesley at that time. She was my line manager that day. She was discussing this with me, and offered advice and thoughts on how we could progress it; something that was quite normal. Regarding the status of the officers as witnesses, Lesley totally agreed with that as well.

109. At the early stages, we were investigating the movement of Sheku Bayoh in the lead up to the incident on Hayfield Rd. We were looking at his address, Martyn Dick's address, and where Mr Bayoh may have had a knife on Hayfield Rd. The actions of the police officers were part of that wider assessment and the investigation that would follow. At that early stage it is essential that you keep an open mind around what you are dealing with. The actions of the police officers concerned was an essential part of the investigation, however I did not set out to investigate and to focus on the actions of the police officers



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concerned as, from the information I had a that stage, the police officers were key witnesses and not suspects.

110. I can only base my investigative strategy and decision making on what I know at the time. We keep an open mind about the investigation.

111. I have been referred to a copy of my redacted daybook (PS18269) at page 3:
"* *Kirkcaldy – MITs*
2x officers approached – male in street – walking wounded
CPR – DSU – on call"

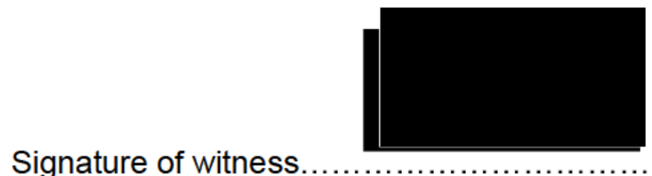
112. I would come on duty at 0630 hrs and do a phone call among the eastern divisions. This is an update on what's been happening.

113. The information I had was that there was an injury to an officer. I recall that she who was the "walking wounded". CPR was ongoing on Sheku. Lesley suggested as I was on call DSU and I should attend Kirkcaldy around that time.

114. MITs was when I was on call speaking to Lesley Boal on the initial call. They were looking at what resources and she suggested the MIT.

115. That was the initial notification of it. It was not until I called Lesley Boal back round about 08:30hrs I was beginning to head towards Kirkcaldy.

116. At that stage I wasn't aware if Lesley Boal was coming. It wasn't until 10:00 hrs that the Gold command structure was going to be put in place. ACC Nicolson and Lesley were attending. A Gold meeting was scheduled for 11:30 hrs at Kirkcaldy



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117. I have been referred to my daybook (PS18269) at page 4: "*Federation Rep – Called out – Amanda Givan (Fed)*
<-> 0910 – critical incident Gold Group __1130 …__ "

118. My recollection of noting this down at Kirkcaldy Office at 09:15/09:20hrs. I had spoken to Garry McEwan who said this was a critical incident, he had declared it. Myself and Colin Robson were sitting down considering priorities and fast-track actions.

119. The underlined word in brackets is "member". That's because I was going to be a member of the Gold group.

120. After that I was focused on identifying resources to assist the investigation.

121. I have been referred to my daybook (PS18269) at page 4: "*D/I Colin Robson*".

122. The notes in my daybook on the rest of page 4 were written in the first meeting with Colin Robson and prior to the first Gold meeting. That is all the same meeting with Colin Robson. Just me and Colin Robson, no one else. We located the areas. Hendry Road – across from that was to take a statement from "Harry K". There were calls about Sheku with a knife. We had a number of Storm incidents, command and control, highlighting the lead up to this incident. There was number of calls from various locations and we were looking at priorities in respect of that.

123. I have been referred to my daybook (PS18269) at page 4:-
"*(1) __Hendry Road__, Kirkcaldy*
__0714hrs__ – African looking male chasing comps cars
Jumping in front off cars – stopping them

Signature of witness................................

(2) <u>Hayfield Road</u>, Kirkcaldy

<u>0715hrs</u> – *Blk male in poss off large knife*

white t-shirt, no jkt, 9 inch knife

male subdued – Asp strike / CS Spray

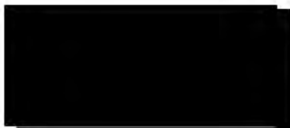
Hayfield – Victoria Hospital

124. "Comps" cars means complainers' cars. 07:14 hrs which makes me think this is taken from Storm incidents log. Colin Robson and I sat through and identified timing. That timing is exact and I've noted that down at that stage. "Poss" is possession. "Jkt" means jacket. "Asp" strike means baton strikes.

125. Colin is reading the Storm log and I am writing it down. It's probably a more condensed version. "TST" is take statement, shorthand from incident room procedures. We would not write "take statement" every time. So I am already identifying relevant witnesses to take statements from.

126. I stated in my PIRC statement (PIRC-00217 at page 2) the following: "*I have been informed that within these notes DSI Harrower has recorded having a conversation with myself at 1022 hours and that I said "male ran towards officer with a knife". I recall stating that to DSI Harrower. Colin Robson was the on-call Detective Inspector that day and he provided me with numerous updates. It was Colin Robson who mentioned during one of the updates that Sheku Bayoh had ran towards the officers with a knife.*"

127. There was a male in possession of a knife and the knife was recovered nearby in the grass area. Colin had actioned for that to be seized. Regarding the timeline and sequence of events at Hayfield Road, the initial information was that he had possession of a knife and had moved towards the officers concerned. I now know that this to be inaccurate.



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128. In reality, it did not make a difference to the investigation or the status of the officers if Mr Bayoh was holding the knife or not. The calls coming from the public corroborated that he had been in possession of a knife and 'chasing cars'. When the officers confronted Sheku Bayoh on Hayfield Road, the understanding to this day is that he had recent possession of a knife. Looking back, he had recent possession although now we know he didn't have possession of it at the time he was restrained by the officers. The officers who responded did not know if he had it or not.

129. The timeline is tight with the calls coming in. It is quite clear I have detailed that at 07:14hrs he has jumped in front of cars and the male has been subdued. We were aware he had possession and I knew the knife was recovered in the grass nearby. It was becoming evident that he did have possession of a knife a short time prior to the confrontation with the police officers.

130. I have been referred to my daybook (PS18269) at page 5: "*1020hrs – Call from D/I Keith Harrower – PIRC*
Call from David Green – therefore circumstances of Des of investigation "

131. It may be Keith Harrower has highlighted during my call with him that he has spoken to David Green. I spoke to David Green twice over the course of the first day.

132. Keith indicated it was 1022 hrs but I just rounded it here to 1020hrs. He was previously a DI with Strathclyde but was now a DSI with PIRC. Keith informed me he had been instructed by COPFS to lead on the investigation on behalf of PIRC.

133. I spoke to David Green twice. The first time was late morning/early afternoon and the second was to discuss the postmortem following reluctance by the

Signature of witness.................................

family of Mr Bayoh to attend the mortuary for identification protocols. I do not imagine I was speaking to Keith Harrower at the same time. I think Keith is indicating he has had a call from David Green.

134. I have been shown the PIM Log (PS00387). I have seen the PIM log before today from the disclosure. I have had a chance to read through all of it. I had not seen it prior to the Public Inquiry disclosing it. Conrad Trickett was keeping this. I knew he was keeping a log but I didn't know it was this document.

135. The PIP was in its infancy within Police Scotland. The PIM log is detailed as an ACPO/IPCC document. Obviously we had not rebranded it by then, thus it was the ACPO Policy Log.

136. I have been shown the PIM Log at page 2: "*Date 3/5/15. Time 0955. Stage 1 Sit rep as known to the PIM: Reports male machete in street. Police attend, male strikes one with machete. Other officers use CS and arrest. Use batons restrain. Collapses. CPR commenced by officers -> ambulance -> hospital. PLE 0906. Declared critical incident. PIM Informed of Incident By – ACC.*"

137. I recall being informed it was a knife. I daresay a machete was mentioned in the morning. The initial report as a knife from Lesley Boal and then confirmed by Colin Robson. I can't recall the word machete being used by Lesley or Colin. I branded it a knife at the Gold group not a machete. My understanding was not that a machete was used by the male on an officer at any point.

Incident at Hayfield Road

138. My role was to lead on the investigation which developed following the incident at Hayfield Rd. I was only dealing with the aftermath of what had occurred. I had no role in the police response to the calls from the public of a male with a

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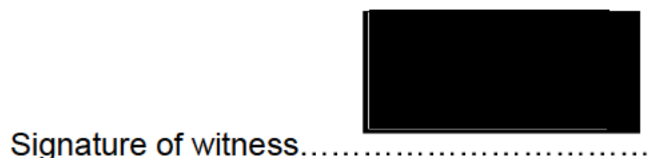
knife. Justification was a significant element in my investigation. We were to consider whether the use of force was legal, necessary or proportionate. That was a wider consideration at that stage. We were only going to get that in the course of the investigation and through the submission of operational statements. It was therefore a significant element.

When I took the investigation on there was nothing to indicate that the force used by the police officers was disproportionate or that anything criminal had occurred. It was about keeping an open mind and being open and transparent. You are always looking at the possible action and conduct of all persons that come into an investigation and examining intent which may indicate some aspect of criminality. You can only base your judgment and decision making on what evidence, information and intelligence you have at the material time. There was nothing to indicate that there was any excessive force by any of the officers concerned at the time.

139. As stated previously, at the early stages of the investigation, there was a significant knowledge gap around what exactly had occurred at Hayfield Road and how Mr Bayoh had become hospitalised and unfortunately died.

140. From the information that I had at that time, Sheku Bayoh was in possession of a knife a very short time prior to the altercation with the police on Hayfield Rd. The actions and use of force from what I had established, from an early stage, led me to conclude that the force used would be necessary and proportionate to restrain Sheku and there was nothing else to the contrary based on the information that I had.

141. The agreement with Keith was that without any further information at that stage they were to be treated as witnesses.



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142. Based on the information I had at the time, we had established the movements of Sheku. Witness statements suggested he had been under the influence of alcohol and/or drugs of some sort. We knew that there had been an argument with Zahid Saeed, an altercation between him and Sheku and that he had left his home address. This was coming from independent witnesses.

143. That thereafter took us to the calls coming in from the public, mainly motorists, about a male with a knife jumping in front of cars, the restraint, and Sheku eventually being brought to the ground and arrested. Nothing at this stage raised suspicion of the officers for criminal or misconduct proceedings against any of them.

144. Collette Bell called the Police around 08:30 hrs or 8:35 hrs and had been concerned about her partner Mr Bayoh – as she had returned home and found it insecure and signs of a disturbance within. We thereafter conveyed Collette Bell to Kirkcaldy Office where a statement was noted from her. Collette made us aware of conversations throughout the previous evening with Mr Bayoh. Collette had also contacted Zahid Saeed via telephone and Mr Saeed had told her about Sheku's behaviour and actions. Collette Bell had informed the investigation team of her discussion with Mr Saeed. A short time later we got Mr Saeed from his home address and he also attended at Kirkcaldy Police Office, and from the disclosure from Mr Saeed – we could establish more clearly the movements of Sheku, and, that the argument with Mr Saeed - which would appear to be extremely out of character for Mr Bayoh - had appeared to be the trigger for him attending at Hayfield Road.

145. Sheku Bayoh being a black male had no impact on my decision making. Absolutely not. It would not have mattered, as I would have come to the same conclusion no matter what race, colour or ethnicity of the individual involved - that they were witnesses from the information that I had.

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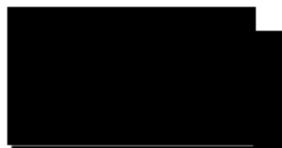
146. I had spoken to DI Colin Robson on the way to Kirkcaldy Police Office when driving through. The initial priority at the scene was to secure it. This would be with cordons to make sure nobody entered and to leave everything *in situ*. I was looking for identification of a CSM to ensure we had integrity of Hayfield Road secured and no issues around its integrity. Integrity relates to scrutiny that could come afterwards, when I might have to confirm that there was no aspect of cross contamination or access to the scene and that we could deploy the specialists into that scene and capture all evidential data.

147. I cannot recall who was in charge but I know we had the scene secured. I think Colin Robson had initial oversight of the scene. There were limited CID resources in place at the time, as they were basically engaged with the hospital itself and securing the remains of Sheku. The scene would have been secured by uniform officers with crime scene entry logs. The oversight would have been DI Colin Robson who was in charge of the investigation prior to my arrival.

148. The Area Control Room (ACR) had no impact on the subsequent investigation from my perspective. The Storm logs have entries by the ACR that I could see. These logs showed the calls that came in and how the actions resulted. There was a number of actions that came from that. Regarding the actions of the ACR prior to the restraint, I had no involvement. I did have an interest regarding the Storm logs. That was of interest and that led to additional statements from the significant witnesses.

149. We would look at every aspect of it, including the advice and guidance of the ACR to the officers. The immediate fast track actions at the early stages is something I'd be aware of. The significance of this at that particular time was down on the list of priorities. We would come across it because of the audio recording and the directions that were provided.



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150. It is normal for CID to be deployed to the hospital in the course of a response to a potential fatality to secure the remains and also to seize any aspect of medical intrusion or intervention in an attempt to save the life of the deceased. Clothing that was seized could be also secured. Colin Robson had that well in hand. One of the CID officers was with Sheku in the ambulance when he was taken to the hospital.

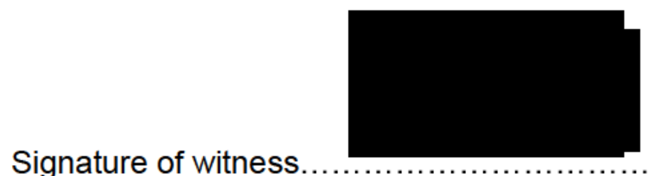
151. I was not aware of the scene entry log, however it is a normal occurrence. Responsibility would be with Colin Robson and then the CSM deployed to the scene who would take responsibility surrounding that.

Status of the response officers

152. The officers were witnesses and that did not change.

153. Overall, my responsibility was to ensure that their uniform and equipment was seized and that their accounts were provided. I spoke to the officers around 11:30 hrs that morning and I explained the requirements placed on them.

154. The requirements were for them to provide operational statements or via the PIM, their 'Personal Initial Accounts' and also the requirement to seize their clothing and footwear. We would do that under sterile and controlled conditions. Even at that early stage we would move towards a structured systematic approach that would be done by two officers overseen by DCI Stuart Houston brought over from Edinburgh to manage and coordinate all identified scenes linked to the investigation. He was Overall Scene Coordinator and would coordinate the management and forensic recovery from all scenes assisted by individual Crime Scene Managers and Production Officers for each



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independent scene. This also included the seizure and recovery of the clothing and equipment of the subject officers.

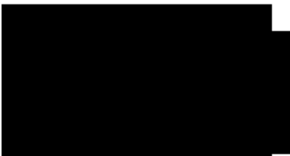
155. “Subject officers” is a police term - these are officers who are significant to the investigation or key police witnesses under the PIP process.

156. I asked Stuart to develop a forensic strategy for the recovery, we talked through it and I was happy with it. Keith Harrower was involved in that discussion. We had a forensic meeting with the PIRC. Lesley Boal was also present. Next, we put in place the process for the recovery and capture of the equipment as well as clothing and footwear. Thereafter there was to be a medical examination of all key police witnesses prior to them going off duty.

157. There had also been seizure of items from the locus due to inclement weather prior to my arrival.

158. I have been referred to Keith Harrower’s statement (PIRC-00007) at page 2: “*About 1022 hours that morning I contacted Detective Superintendent Patrick CAMPBELL by telephone and he provided me with a summary of the incident from the Police Scotland perspective. At this time he stated that he believed there were seven police officers involved in the incident and the officer safety equipment worn by them was being taken possession of. He also stated that Police Scotland Federation Representatives were in attendance at the office. I confirmed at this time that the status of the police officers was witnesses.*”

159. I can recall speaking to Keith about this matter, and I informed him that we were going to seize all Officer Safety Equipment, as well as clothing and footwear from all the Key Police Witnesses. This would be carried out under sterile and controlled conditions under the direction of a dedicated CSM and Production Officers not involved in the original incident, to ensure integrity. The



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statement from Keith indicates that we had already taken possession which was not the case. I think this may be just the way that this has been written by Keith. After the second Gold group we went into a Forensic Strategy Meeting where all identified scenes, as well as the forensic strategy proposed to manage the scenes, was discussed. Keith as well as other representatives from PIRC were present at this meeting and there were no concerns raised around any aspect of the Forensic Strategy by anyone from PIRC.

160. "Equipment" is batons, handcuffs, PAVA and CS spray. It does not mention clothing and footwear in the statement, although this was an essential element of what we were looking to recover from the officers.

161. I have been referred to Keith Harrower's statement (PIRC-00007) at page 3: "*About 1240 hours that morning I again contacted Detective Superintendent CAMPBELL by telephone. During this call I asked him to confirm that the police officers footwear was being taken and I also confirmed again that the status of the police officers was witnesses.*"

162. I do not know why he is claiming that he confirmed the officers' status again – I do not think this was the case as it was very clear in both my and Keith's approach that the officers were witnesses – nothing had changed since the earlier phone call. I genuinely do not recall him saying this again and I am not sure why he would. He is simply repeating what he and I already knew. I actually do remember that phone call. I do not remember what was said about the footwear – it was something I had discussed earlier on with Keith and also was something that was part of the forensic strategy and recovery from the officers involved in the arrest. It was really essential that we seized footwear and clothing. By the time Keith called me at 12:40hrs – all of this was in progress by Police Scotland.

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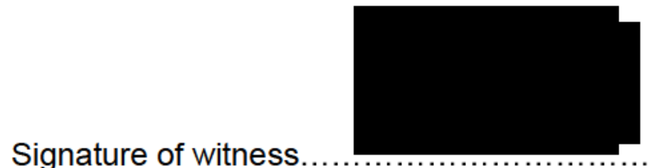
163. There was a gap in our knowledge about who used force and why, which is not unusual when dealing with incidents involving a number of people – particularly at an early stage. We would normally seize footwear, clothing and anything else they were carrying – from officers or witnesses who have maybe been present at a crime scene and may require to be eliminated forensically from the investigation as the enquiry progresses. Regarding the incident on 3 May 2015, the seizure of clothing and footwear was carried out with the consent of the officers concerned. We ensured they had clothing to decant into. I explained the reason for it: to ensure integrity and transparency of the investigation. This was nothing out of the ordinary, just a normal action in respect of any complex investigation.

164. I have been referred to Keith Harrower's statement (PIRC-00007) at page 5: "*About 1515 hours myself and the other PIRC investigators had a meeting with the police witness Detective Chief Inspector Stuart HOUSTON, Scene Management Coordinator… At some point during this meeting Detective Superintendent CAMPBELL entered the office and he informed me that the police officers involved in the incident had been advised by the Police Federation representative not to provide witness statements. At this point I asked Detective Superintendent CAMPBELL to inform the Scottish Police Federation representative that I would be willing to meet with them to clarify the officers status as witnesses. No subsequent meeting took place with them.*"

165. I can recall the conversation. There had been an earlier conversation with myself and Keith when it became clear that initial advice from the Federation representative was not to provide statements at this time prior to seeking legal advice. In respect of Keith's request to speak to the officers – I can't recall this. I do not know why I would ask the representative whether the officers would like to speak to him. He could easily go downstairs and speak to the officers himself if he desired. I cannot recall him asking me this question. It was up to



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him to go and speak to the officers if he deemed it appropriate and something that he wanted to do – he was, after all, in charge of the investigation.

Management of the response officers

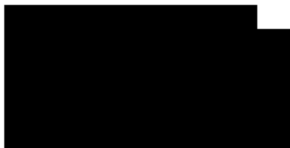
166. I did not know the officers previously and had no dealings with them at all.

167. Nicole Short was still in the hospital at the time when I arrived at Kirkcaldy Police Office. The remaining officers were in the canteen. They were requested to attend there by Inspector Stephen Kay. The direction for all officers from Inspector Kay was that they should return to the canteen and be there for a hot debrief to ensure everyone was safe and that wellbeing was in place. When I arrived they had already been there for a period of time together.

168. They had been involved in a traumatic incident. The officers involved had Police service ranging from one to 29 years. They were all still upset and traumatised by what had occurred. When I spoke to them Mr Bayoh had, by that time, unfortunately passed away. That brought further concerns to the officers. It was a really traumatic incident. Inspector Kay, I believe, was there to provide some information on what was to happen next.

169. The officers had been involved within the scene at Hayfield Road. They had been together there, together in vehicles returning to Kirkcaldy Office. The aspect of coming back to the canteen area in the office was from Inspector Kay's perspective, I believe, well-intended - ensuring that there was concern for their health and wellbeing and welfare.

170. The forensic aspect of it at that time probably was not that significant to Inspector Kay, it was more about welfare for him, than forensic capture. By the time I arrived, because they had been together for that time, the necessity



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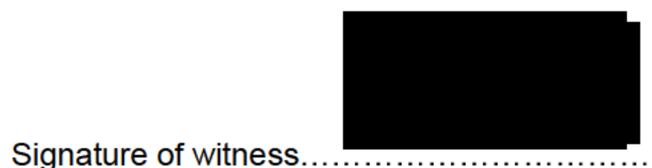
around immediate forensic capture was not as significant as making sure it was done right. It was a challenging environment because the officers had been put together prior to my arrival.

171. I was aware there were identified locations across the country as PIM suites but a PIM suite could also be spontaneous location. Conrad Trickett decided that the canteen was the PIM suite. I was guided by the trained PIM and I was more than happy to concur with that.

172. I had not been trained in the PIM process but in a designated PIM suite there are ready made stocks of pre-prepared boxes of literature, signage for the doors and information for the officers. It is a ready-made incident box. The door signs say "no entry". Layout of relevant PIM suite includes where the officers should be placed, where they should be warned about conferral and where their body armour should be paced. The boxes are for the PIM to control.

173. It began as a PIM suite when we were concerned about what was going to happen there between them. To me it was about making sure it was being adhered to. The suite was identified to balance the welfare and needs of the officers and the investigation was going to be realised.

174. In a statement I gave to PIRC there is a point about the separation of officers and how I did not really see that point. It probably does not accurately detail my thought processes about the issue. I am conscious that the officers should not be separated unless there is a requirement for them to be separated. There was a consideration about whether it was necessary, whether it was safe to do so in the context of this traumatic incident, and whether it was practicable. The Firearms PIP SOP (paras 8.8, 10.3 and 19.4) details that unless circumstances dictate otherwise, they should not be separated.



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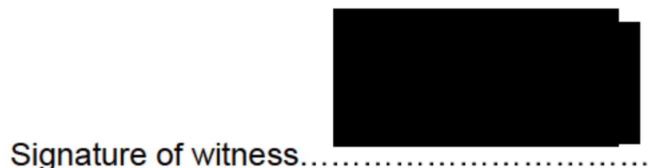
175. I had seen the SOP before and I was aware of it on the day. I was aware of the fact that they should not be separated. I did not read it on the day but it was a document we had in the initial incident room. We did have access to the document. We obviously had Conrad who was the PIM who was familiar with it.

176. It was not a firearms incident. As I said earlier, the process and guidance in England & Wales had been extended to include incidents not involving a firearm which had led to death or serious injury. Because PIP is a UK wide Policing process it was a consideration in the early stages by the ACC that it could be easily replicated by the PIP for this process. Although it was not a firearms discharge by the police, the requirements and the stages of the process still work very well with death or serious injury caused by police contact in any way.

177. Even the aspect of the CS/PAVA spray may be considered a firearm under the Firearms Act. It's a Section 5 firearm under the legislation, although it is not seen as a traditional discharge of a firearm by the Police.

178. Utilising PIP procedure and protocols was the decision of the ACC. It could only be an executive officer. My understanding was it was a decision that was made by ACC Ruaraidh Nicolson. I found that out from Lesley Boal. When I spoke to Lesley at 10:00 hrs that is when she told me the PIP process had been initiated by the ACC. That decision had been made. The proposal was that Gary McEwan said it had fallen under a firearms PIP, and that PIP should be activated.

179. In line with that there was no circumstance indicating the requirement to separate the officers. There was not anything to indicate anything criminal or



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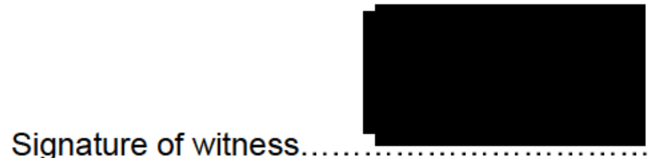
misconduct and there were significant control measures to ensure they did not confer. That was confirmed by Garry McEwan and Colin Robson.

180. I was aware that Inspector Kay, DI Robson as well as one of the Sergeants highlighted to the officers at various times, that they should not confer. The guidance is extremely clear - unless circumstances dictate otherwise, they should not be separated. There was nothing to suggest that the non-conferral direction was not being compiled with. The more updated Police Scotland SOP is along those lines, so that should not change.

181. Separation of the officers was a consideration and again you are looking at integrity, transparency, the whole aspect for non-conferral to ensure that the process is dealt with without any concern about the integrity of what occurred. There was significant discussion and consideration about that. We had to balance the welfare and wellbeing needs of the officers with the requirements and needs of the investigation, to ensure that the balance was in place. That was central to everything we discussed around the aspects of separation. There was a lot of discussion around it. I don't think my statement to PIRC highlights the detailed consideration and discussion around this matter. It was not just whether it was justifiable, it was to keep the officers together and ensure their wellbeing and welfare was paramount.

182. We had suitable control measures to ensure no conferring took place. A Federation representative was present. Some of the senior management were present with Inspector Kay and his staff. Garry McEwan, the commander, was in the building and his CI Nicky Shepherd was ensuring there was that integrity and, that the wellbeing and welfare of the officers was maintained. A number of them made the officers aware that they must not confer. Conrad would read out the aide memoire which also which makes it very clear around non-



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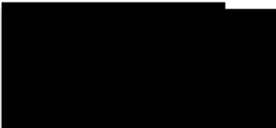
conferral. The officers were aware that there was no place for conferral. When I briefed the officers I made it very clear they must not discuss the incident.

183. Amanda Givan was there for wellbeing and welfare support. She was aware that the officers should not confer and should not discuss the incident. She is an experienced officer as well. Amanda, with her presence in the PIM suite, and with her awareness and knowledge, was ensuring that there should not be any conferral at all.

184. The Federation representatives should be there to provide support and guidance – with their priority being around the wellbeing of the officers, whether that is facilitating legal guidance and direction or the timescale for providing statements. They consider whether medical assistance is required and make sure officers fed and watered as required. This ensures that they are catered for not just physically, but also that the procedural requirements that are expected of the subject officers are followed,

185. The only caveat is that today, PIP is far more fluid and process-driven than it was in 2015. It was in its infancy in Police Scotland in 2015. Conrad did his best to explain and Amanda did as well. These were officers involved in a traumatic event. The ins and outs of the PIP process would be challenging to explain to the officers as they had no awareness or training in PIP. When I say "fluid" I mean we are far more aware of the mechanics and framework when PIP is declared and what actions and activity fall into place. Aide memoires are now provided to officers in PS so they know what PIP means. There has also been recent national guidance around it in Police Scotland. That enhances the awareness and knowledge of all the officers involved. Where we were in 2015 to where we are now, in terms of the overall awareness of officers across Police Scotland is "night and day". Cadres of PIM, who have that knowledge,



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are available, so that everyone knows what is required and the various stages of the process. This was not the case in 2015.

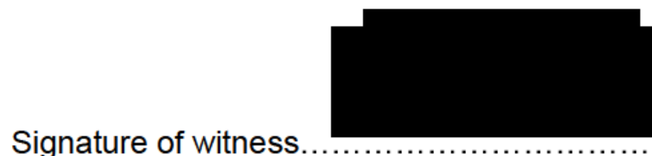
186. I was aware that PC Nicole Short was not with them. I was informed by Colin or Garry that she was in the hospital. She was there in the subsequent briefing. Nicole Short was already there when I was introduced to the officers.

187. There was discussion around separating the officers between me and Keith Harrower, Lesley Boal, Colin Robson and I think Garry McEwan as well on my arrival.

188. Thinking on it now, my immediate thoughts were to separate but once we had that wider feeling and seeing what the SOP stipulated I believed I took the right action at that stage. The initial consideration is whether there was benefit in separating the officers at this early stage, mainly whether that would enhance the integrity of the initial investigation and whether it safe, necessary and practicable.

189. For safety, we knew there was no suggestion of criminality. Once I looked at the wider considerations around it I believed there was enough to ensure that there was no conferral. Within the office I was quite happy we had the safeguards around that.

190. I did not brief them on the use of their mobile phones but I recall they were given advice about that. They were encouraged to contact family. The information within the community was that an officer had, potentially, been stabbed so they were encouraged to ensure that their family knew they were safe and well. The aspect of non-conferral should entail the use of mobile phones and messaging around that. That was all taking place on, and subsequent to, my arrival, when they were all made strictly aware of this issue.



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191. I believe the forensic recovery was done in a really structured manner. We maintained the integrity of what was seized and how it was seized. The forensic physician was there also to carry out health check of the officers prior to them going off duty.

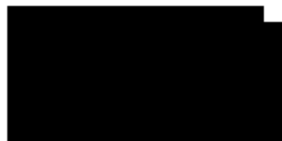
CCTV

192. I had been to Kirkcaldy Police Office on a number of occasions, mainly managing on-call incidents. I was there previously, dealing with a homicide and also a child death. I have not operationally worked out of the office however. I was not aware the CCTV outside at the back of the office was not working.

193. The normal process for assessing and documenting PC Nicole Short's injuries is that she would have been examined by the Doctor within A&E who would detail her injuries and treatment. She was also examined by the Forensic physician at Kirkcaldy prior to going off duty. Again, Nicole's injuries would be detailed within the Doctor's report. I think she was photographed a number of days later. The bruising does not normally come out until later.

Forensic Medical Examiner

194. I use the term "Forensic Medical Examiner" (FME). This term can cause a bit of confusion. In Strathclyde they were called "police casualty surgeons". They are called out to ensure the welfare and wellbeing of the officers following an assault incident, as well as managing the medical concerns of prisoners within custody suites. A request is made that the officer attends hospital or goes to their GP within 24 or 48 hours if their condition deteriorates (this depends on which legacy force is involved). We discussed with the Forensic Physician at



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the Forensic Strategy Meeting that there would be a quick check-up with the FME and that all officers would be given the support they needed.

195. If an officer feels they were assaulted, or punched, the FME would detail this information. The FME would carry out the necessary examination to see if there was any injury or requirement for any additional treatment. In general it was a general wellbeing and welfare check-up.

196. I have been asked to comment on Dr Norrie's evidence to the Inquiry at the hearing on 9 June 2022 to the extent that she said she had not been asked to examine police officers in her FME capacity, that it was very unusual and that she was not sure it was something she should be doing; so she first checked with her boss who agreed that it was quite unusual but that she should go along with it.

197. I do not know who Dr Gillian Norrie is. I know from previous serious crime incidents that the FME can examine police officers. I did not know it was Dr Norrie on the day. I have not seen her evidence to the Inquiry. As I recall it, it was normal practice to ask them to do this if it is was deemed necessary. I would suggest that for any police officer, whether arrested, assaulted by someone in police custody, or assaulted in general, the normal action is to attend A&E or to be seen by an FME. Especially if it was a head injury. We would discuss their physical and mental wellbeing when they had that health check and so they were given that extra additional support.

Amanda Givan's evidence

198. I remember seeing PC Amanda Givan on 3 May 2015. When I arrived at about 09:15 hrs I went directly to Garry McEwan in the divisional commander's room

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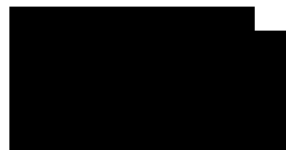
and had a very quick 5/10 minute conversation with him, asking where the staff were and what resources were available.

199. Colin directed me to one of the CID rooms in the office and I based myself there. Colin and I developed the various strategies around the investigation. While there, my first interaction with Amanda was in the room when she introduced herself. I was aware a federation representative was in attendance, and I acknowledged her; however we were dealing with the immediate aftermath of a critical incident and identifying fast-track actions. I therefore informed Amanda that I would speak to her later.

200. The next time I saw her was within the canteen area around 11:30hrs that morning. I do not know if I have seen all the evidence provided by Amanda but I have seen some of it.

201. I have been referred to PC Amanda Givan's evidence to the Inquiry at the hearing on 14 June 2022: "*Yes -- well, when I say there was no one -- there was no one in control of the canteen area, which I would have expected if you had brought a number of police officers back to sit together, I would have expected someone to be there, even just to check on their welfare and make sure they were okay… It was all a bit chaotic and I just generally got the impression that I was in the way and I absolutely didn't want to be slowing anything down or hampering their investigation, so I -- but I left my business card, I told them that my intention was to go back downstairs and make sure the cops were okay… I suppose telling him that I was going down to look after them, or to remain with them, I was hoping that he would send along someone from Police Scotland that would do that job. It's absolutely their responsibility, so I was hoping that that would be the case.*



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202. I remember the business card. That was around 10:15 hrs in the morning. We were identifying the initial actions. I wouldn't say it was chaotic: it was fast moving. There were resources being deployed around the place. We had Colette Bell in at that stage.

203. The control of the canteen area was by various supervisory officers including Nicky Shepherd, Stephen Kay, and the on-duty Sergeant. Amanda Givan was also present and late morning the PIM (Conrad Trickett) arrived. The officers were not told not to sit down and not move about, or not to have any general discussion. They were told not to discuss the actual incident. As I saw it, there was suitable control measures in place. I don't know what Amanda was referring to when she said there was no control. We were balancing the needs of the individuals with the needs of the investigation. We were waiting for the arrival of the PIM.

204. From my perspective, it was unusual for the federation representative to attend and introduce herself to the SIO. That is not a normal occurrence, however this was not a normal incident. In any investigation of a death or a homicide you would not have a Federation representative introducing herself. I think that's perhaps why I looked at her quite strangely, as I wasn't sure how she was aware of the incident and who had requested her attendance. I think it's unusual to have a federation representative sitting in an office with officers who were relevant to the investigation without being requested by the PIM or other Senior Officer.

205. She was there as a Federation representative - to give advice and guidance to the officers, however I would say her role would also be to have wider consideration for their welfare and wellbeing. She was also a serving police officer. From my perspective, the person from Police Scotland allocated to manage their welfare and wellbeing was the PIM Conrad Trickett – he was the

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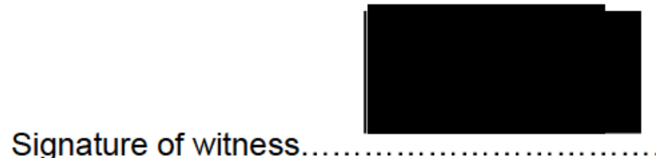
one to manage the process and take the lead on who was coming along to support the officers. It looks like Amanda wanted this to happen instantaneously and was maybe frustrated by how long things were taking to be put in place.

206. Amanda was there as a Police Scotland officer and as a Federation representative. Her responsibility as well to ensure that their wellbeing and welfare was considered.

207. I have been referred to a further section of PC Givan's evidence to the Inquiry at the hearing on 14 June 2022: "*I asked about post-incident procedures, given the nature of what we were -- what the police were dealing with, and he said he would get -- he would get back to me… When I asked -- when I asked if that was a consideration, you know, I got a kind of -- not a startled look, but, you know, the impression I got was that was the first of him considering that that might be suitable. Q. Who gave that you startled look? A. Superintendent Campbell.*"

208. I had only been informed 15 minutes before that that the PIM process had been initiated. My thought was: how was Amanda aware that this had been activated? Without going into detail, I acknowledged to her it had been considered. As I said, I had only been made aware 15 minutes previously. Because of the fast-moving nature of the actions and the nature of the incident itself I did not think it appropriate to discuss that with Amanda.

209. It was not my remit to initiate the PIM process, I was informed by Lesley Boal in the phone-call that morning that it had been initiated. It was not my decision – this decision was taken by the ACC. I was aware Conrad Trickett was attending. That was not due to any action that I had given. It is not for the SIO or the IIO to initiate the post incident procedures.



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Completion of paperwork

210. Inspector Kay was overseeing the officers' welfare and wellbeing at that time. Amanda Givan was also giving additional support. Nicky Shepherd was also present as well as Garry McEwan. They came in and out. There was a senior management team that was looking after the officers concerned at that time. That welfare aspect extends to them preparing and providing their paperwork – the officers' statements, notebooks, use of force and spray forms. They also have a personal responsibility to complete that paperwork. The officers are very familiar with the process for any use of force and discharge of CS or PAVA. That would be supervised by their immediate supervisor.

211. The Immediate supervisor was a Sergeant. Inspector Kay was their Inspector. On any normal shift in Police Scotland you would have Constables with immediate line management with a Sergeant and looking after the shift that day would be an Inspector. Supervisors and supervisor control is done in groups: the dayshift, backshift and nightshift. Inspector Kay was overseeing that. They have oversight of all the incidents ongoing within their particular divisional area. Further up, you have the area commander. Garry McEwan who was the Divisional Commander would have strategic oversight of the incident from a Divisional perspective.

212. I had no line management responsibility with regard to the officers completing their paperwork. As IIO/SIO I would not be involved in the normal operational process for completing the relevant documentation. At that operational level, it would be the sole responsibility of their line management team to ensure that it was in order and had been completed in the appropriate manner.

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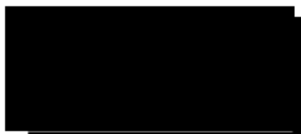
213. We would obtain that paperwork in the course of the investigation. The natural flow for all relevant paperwork would eventually come to the incident room. But that would not be within the first three or four hours of dealing with a critical incident.

214. An "injury on duty" form and other various forms would be completed by the officers. The expectation would be that they would filter through to the relevant incident room. The supervision of this would sit with line management and I did not see that as an urgent requirement I had at that time. Other matters in the investigation were more pressing, and more paramount, to myself.

215. As IIO/SIO my initial strategy and priority were about crime scenes, witness strategy, timeline for movements of deceased, community impact, , resource implications, and otherwise taking the investigation forward. Use of force forms and other relevant paperwork was, understandably, important. When you are running a very dynamic investigation, it's something that would be delegated to a line management team for completion by the relevant officers.

216. The officers' accounts would normally be obtained by a request for operational statements. As an experienced SIO in the normal course of events you would obtain operational statements from all officers before they go off duty. There is usually a requirement to re-interview the officers because that initial capture, trauma and response to the incident sometimes requires more clarity, and an expansion on what is in their statement. For any normal incident, I would make it clear to the officers they would require to provide operational statements prior to the termination of their duty.

217. I was almost an agent for the PIRC in requesting the statements. From 09:00 hrs to the time PIRC arrived at 13:35 hrs, I was in constant contact with Keith Harrower and we discussed this requirement at some length. The officers were



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key police witnesses, and nothing at all hinted at them going into the “suspect” bracket. We discussed that in detail. The information we were passing to officers was agreed with both Keith Harrower and David Green. Before I spoke to officers, I had spoken to Keith on a number of occasions.

218. I explained to the officers that it was a PIRC-led investigation and that Mr Bayoh had passed away. I included in this that they required to provide operational statements. Keith and I we were in complete agreement that we would require operational statements from them.

219. When I addressed the officers there were no concerns relayed to me. That may be because they completely understood everything. It was pretty short because, I was going into a Gold group meeting. But it could have been due to the effects of trauma that they did not ask anything: they may not have fully understood. But, I considered that I had made it very clear that there was a need for operational statements.

220. My position was that they were key police witnesses. It was clear when I addressed them that their status was that of witnesses and we would require from them, before going off duty, operational statements. That Stage 3 PIP process of personal initial accounts would also encompass their involvement, and provide the information that was missing at that time, in the absence of full operational statements. The request for an operational statement would be required prior to completing the tour of duty that day, similar to their Personal Initial Accounts under the PIP Process.

221. Stage 3 of the process rested with the PIM. Obtaining their accounts sat with Conrad. That would have filled some of the gaps that were present that day. It would be within his remit to complete the four stages of the PIP process.

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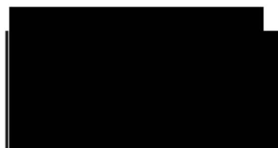
222. The PIP process is about the balance of the welfare of the officers with the needs of the investigation. The provision of accounts of incidents assists the IIO because of the contribution that initial account gives in Stage 3 of the process. If we had obtained that initial account it would have filled in some gaps about what had happened.

223. With hindsight it is easy to say this was a normal course of events. But the PIP process was in its infancy in Police Scotland. There was difficulty about what this entailed and expectations about what the officers concerned were required to provide. Looking through the lens of 2022, the processes are more fluid now with a greater understanding of what PIP involves. Back then it was harder to know about personal accounts - it was almost uncharted territory at that stage. By "More fluid", I mean there is now a better understanding among all officers; for example, the existence of PIM suites, what is initiated, and what is put in place as soon as one is declared. The organisational learning is far more structured now, which ultimately influences the development of immersive training and exercising.

224. I have been shown the PIM log (PS00387) at pages 13 and 14: "*1340 … Take external clothing. No need to take statements at this time... 1341 D Supt Pat Campbell speaks to officers… No operational statements at this time. DCI Houston*"

225. There is an issue with this. The time is said to be 13:40 hrs which is, in my recollection, inaccurate. 13:35 hrs was the time of the arrival of PIRC at Kirkcaldy office. I immediately went into a briefing with Keith Harrower and his team around 13:35/40 hrs. I would not have spoken to Conrad at this time. I had already spoken to Amanda Givan. That time is almost five to six hours into Police Scotland's response to the incident. I was not introduced to Conrad as



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a PIM at this time. It is clear I could not have been in two places at the one time.

226. All I can think of, is that Conrad's log was completed sometime later and there has been a discrepancy with his recollection and that is why the time is detailed there.

227. "No need to take statements" – I am not sure why that is detailed at 13:40 hrs and 13:41 hrs. A number of items are accurate, and there was no suspicion directed at the officers. I did discuss this with Conrad. At this time we were still looking for operational statements. It was later that afternoon that the officers were pretty adamant that they were not going to give statements before taking legal advice.

228. The log does not appear to detail the stages of the PIP process that should have been adhered to. As for the context of what has been written on pages 13 and 14, it is maybe for Conrad to provide an explanation of that.

229. At 11:30 hrs he had a meeting with the officers. Conrad was speaking to the officers when I went in the room and he introduced me to them. 11:30 hrs is accurate in that Conrad introduced me, and then I interjected to give them an update on where the investigation was. Some of the areas he has detailed there, such as FME, cross contamination, food, clothing, legal advice, would have been discussed by myself and Conrad. 11:30 hrs is accurate and that is when the address to the other officers took place.

230. In the right-hand channel, it looks Conrad has identified the ownership of the various actions that came about. Where he has written "With SIO", Conrad may have identified areas where I had the oversight and governance. The areas such as 'clothing being seized', statements, were with Jane/SIO.

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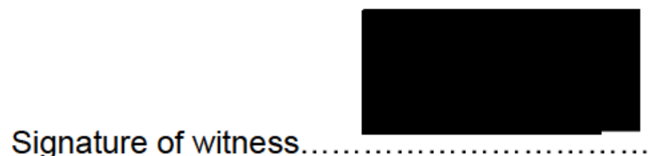
Finishing time, I think "with SIO", was when it was likely that they could return home.

231. In relation to the time they could return home, we were looking for the forensic recovery of the equipment in terms of the forensic strategy and looking after their welfare and wellbeing. They would be remaining in the canteen area at all times. We were trying to do all that as quickly as we could. They were coming to me asking when this would occur. Amanda Givan also had a role in that as well.

232. I have been shown the PIM log at page 14: "*1341 D Supt Pat Campbell speaks to officers. Provides initial circumstances of enquiry to date. No suspicion on part of any officer.*"

233. During my brief to the officers involved, I explained that the investigation was fast moving. I explained the direction of COPFS, that ownership of the investigation rested with PIRC supported by Police Scotland. They (PIRC) on their arrival would give further requirements around what they required. The update I provided was brief in that I confirmed that My Bayoh had passed away and the death was now being treated as a death in custody. I also explained their status as witnesses, checked on their welfare, and explained to them the requirement for operational statements and the seizure, with their consent, of the OST equipment, uniform and footwear, prior to them concluding their duty. I also explained that ACC Nicolson had initiated the PIP Procedures which CI Trickett would explain more about.

234. There is no mechanism for me to compel officers to provide statements or Personal Initial Accounts. There was no suspicion at all from the information that I had obtained at this time. They were key witnesses and it was about them providing operational statements/personal initial accounts.



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235. I explained to Amanda Givan that as IIO it was operationally critical to obtain a version of events about the actions of the officers and their use of force. I explained to her that I was still going to request operational statements. Amanda advised officers that, until they had legal advice, they should not provide statements at that stage and it became clear, as the day progressed, that we were not going to obtain either operational statements or a version via their Personal Initial Accounts from the officers through the PIP process. That was before my first briefing to the officers at about 11:30 hrs. My understanding was that Conrad was also present at that stage. I had just spoken to Conrad and their legal status was that of witnesses.

236. To the best of my recollection, use of force and spray forms were electronic back then. The completion of these would be the responsibility of officers in collaboration with line management. They would produce the forms for comment and would be sent through for force training. That would be requested by the incident room. The operational statements would be different. They would come straight to my team. It was a manual incident room at that time and we would process any actions coming from them. That did not occur but the statements would be the only aspect that would come through to the incident room on day one. There was also a delay with the submission of their forms.

237. We would not normally seize police notebooks in the initial stages. Your police notebook is a personal responsibility to complete as you have been trained to do prior to completion of your duty. I think aspects of notebooks are relevant in most incidents particularly verbatim accounts by an injured party or complainer. It is something we would look at but in the normal course of events it is more something the officer would look at prior to completing operational

Signature of witness.................................

statements. Normally it's a reference point for them during completion of their operational statement.

238. Normal practice for confirming a person's status as witness or suspect is through verbal communication. We would confirm their status is that of a witness by telling them that this is the case. If they fell into the suspect bracket, again we would inform them that this was the case and thereafter consider the use of the relevant legislation to progress matters. I informed them that they were key police witnesses and there was nothing to suspect any criminality. They would not have been requested to participate in the PIP process if they were anything other than witnesses. That was verbally given by myself and I was seeking to reassure them. They were obviously very nervous and it was extremely traumatic for them.

239. I have been asked whether the officers could have their status provided to them in writing, and the extent to which this would be normal practice. This is not normal practice and not something that I have come across. If they had been detained on suspicion under what was Section 14 of CPSA 1995, there would be relevant paperwork for the Police to complete regarding their status as suspects, but this was not the case.

240. On the other hand, for a witness, you would take a statement and make it clear to them why you are taking it. It is not the normal course of events to confirm witness status in writing. We would normally speak to them, ask for a witness statement, and we would explain that it may be used in the course of proceedings.

241. I had no involvement in following up with the officers for their statements. I completed my involvement on 4 May. There was a Gold group on the morning

Signature of witness.................................

of 4 May where there was a more significant handover to PIRC and MIT in the office. “Holmes” was set up and established to manage the incident.

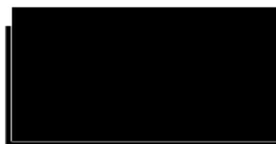
242. I believe there was a discussion at that meeting about the requirement for operational statements, but that was handed over to PIRC and DCI Keith Hardie, who took on my role in the MIT.

243. As I understand it, the SPF’s role is to provide advice and guidance in relation to welfare and wellbeing and not with regard to officers completing paperwork.

244. I was aware of requests from PIRC for the officers’ statements in the days following 3 May 2015. It was discussed early on in the investigation on 3 May, and it was discussed during Gold groups. PIRC and myself were “on the same page” about requesting operational statements. These officers were key witnesses and not suspects, so they could provide statements. As for Amanda’s position around the advice, I accepted that. I understood that was the advice of the Federation. There was no conflict around that. Her advice was given with the best of intentions and based on her experience, and I am not suggesting that she was wrong. We were both there doing a different and difficult role around that incident. I understood that and I wanted to make the best of it that I could at that stage.

Memoranda on statements from subject officers

245. I have been referred to two memoranda dated 26 March 2015 (PS10953; PS10954). I had seen these prior to 3 May 2015. They would be issued through the Police Scotland intranet and published. You are regularly sent memos – the great majority are simply published on the Police Scotland intranet, however some of the more important ones would be sent to the officers’



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mailboxes as attachments. There was a personal responsibility to go in and read them. They would go to all ranks.

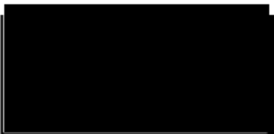
246. As a senior officer, there was a duty to ensure that your officers and staff had awareness of them. The two memos in particular were important as they highlighted a change in protocol when officers were dealing with an incident when there was an on-duty criminal complaint against an officer. I briefed all my officers about the issues that may arise and the need for awareness of it.

247. I have been referred to the memoranda of DCC Neil Richardson (PS10953) at **page 1**: "*Direction has been provided to PSD from the Crown Office and Procurator Fiscal Service (COPFS) to the effect that the practice of obtaining statements from officers' subject to 'on duty' criminal complaints must cease with immediate effect.*"

248. I had seen this. I thought the first memo did not really explain wider considerations, not just the officers on-duty, but also the officers responding to an incident. When I first read this memo I thought it would cause confusion. A second memo being sent the same day is extremely unusual. I believe the second one was issued as the initial memo did not fully explain processes to be adopted when dealing with on-duty criminal complaints.

249. I carried both memos in my daybook because of how significant they were in terms of the requirements for on-duty officers, their status, and how they should be treated. The aspect of not being asked for operational statements is also in that bracket.

250. It is okay to put out memos to the service but they may require further interpretation and discussion with line management and a better degree of awareness. I was not the only one who needed more by way of explanation



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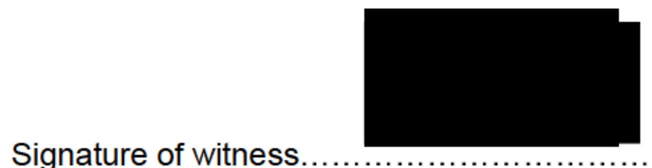
from DCC Richardson. I think that is why the second memo went out with more detail which, as I say, was unusual.

251. I had printed both memos and kept them in my daybook for reference purposes. This was not the only guidance I would carry with me – I would also have on call contact numbers, protocols for dealing with deaths in custody, child death investigation protocols, and other relevant documents for managing significant incidents. I kept both of these memos because they were significant.

252. The first one did not adequately explain what the criteria were and how to respond to such an incident. At that time, Police Scotland was still in its infancy and we were still merging a number of legacy-force SOPS. We had legacy computer systems that did not "speak" to each other, which was really challenging - particularly when on-call and you had to respond to incidents in various parts of the country. In 2015 we would ask for operational statements from all officers concerned. That had been normal procedure for a manual incident room or a Holmes-based incident room. The memo refers to the case of *HMA v Cadder* and is worded in such a manner that it directs all officers that the practice must cease immediately.

253. At paragraph 4 there is reference to an officer's operational statement being given in cases where they are accused of criminality. That is the area in which, I thought, you have to treat every incident individually and look at the status of each officer and whether there is any cause to suspect. Paragraph 4 states that if they do submit a statement then we can use it. The second memo is more useful for officers and their line management.

254. In respect of the relevance to 3 May 2015, this was not applicable or relevant. This is because the officers were witnesses or "key police witnesses" under the PIP Process. It was clear that they did not fall within the bracket of criminal



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conduct or on-duty criminal complaints about their activity - particularly around their use of force.

255. I have been referred to the memorandum from Ch Supt Eleanor Mitchell (PS10954) at page 1: "*One such area, which raised significant debate, was the obtaining of operational statements from on-duty Subject Officers with the status 'under investigation for a criminal allegation'. This status can only be reached either through assertion of criminality by a complainer or based on evidence gathered and always concludes with a submission in report format to the Criminal Allegations Against the Police Department (CAAPD).* "

256. The "significant debate" related to the inconsistencies surrounding the direction about the legal status of officers. Providing operational statements was not in line with the rights of officers accused of criminal conduct. The memo was attempting to bring together the correct procedures and protocols and to bring clarity to the systems around it. There is nothing to suggest this applied to the officers in this matter.

257. It is further stated on page 1: "*The decision in simplistic terms is the gathering of evidence, and in turn the aforementioned operational statements to the point of submission to CAAPD can be considered no different than gathering a statement from any suspect in a criminal investigation; and this facet is an operational matter for Police Scotland.*"

258. This basically means that any officer suspected of on duty criminal conduct has the same rights as any member of the public – i.e. the rights of suspects. Police officers were to be treated no differently, whether on or off-duty.

259. The "facet" refers to the operational implementation of the guidance and Police Scotland were to disseminate memos across the force memos, and they would

Signature of witness.................................

be in a SOP. That is how it would normally be distributed to the officers concerned.

260. I have been referred to page 2 of Ch Supt Mitchell's memorandum: "*In reaching a decision on, whether a Subject Officer under criminal investigation should be asked to submit an operational statement or not, it is incumbent upon Police Scotland that consideration is given to the ethical themes around:*
   - *Fairness to all involved including the Subject Officer*
   - *Differential in the threshold for reporting a police officer v member of the public to Crown Office & Procurator Fiscal Service (COPFS)*
   - *Accepting the differential between police officer v member of the public and understanding that both can conclude through criminal proceedings*
   - *Independent assessment on the case presented against the police officer through CAAPD*
   - *Evidential value the operational statement would bring to the enquiry*
   - *Opportunity for confusion and impact to the investigation over what can be acted upon as evidence if a version of events is produced within a Subject Officer's operational statement.*

261. I had the memo with me in the course of the morning. I read through it in the course of the morning to follow these considerations. The memo is long and goes into detail. When this came out I read it in detail and put it out to my teams because of its significance. I was therefore familiar with it.

262. I recall speaking to my colleagues and asking if they were familiar with it. It was one of the most important and significant memos. The officers on the day did not fall within the category of officers subject to on-duty criminal allegation. They had not been near that threshold from the statements and intelligence we had at that time.

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263. Both the memos were considered when considering their status. There was nothing at all to indicate there had been any on-duty criminal activity. At that stage it was necessary, proportionate and perfectly legal to request their operational statements. Although the memos were something I had referred to, as I say, the officers did not fall within that bracket.

264. Craig Blackhall was the on-duty PSD representative and I also spoke to him over the course of the morning regarding what happened and the status of the officers.

Liaison with family and friends

265. Family Liaison and interaction with next of kin and family members is normally reserved for specially trained Family Liaison Officers (FLOs). I identified at the initial stages how significant and crucial this was and identified the development of a FLO Strategy and the identification and deployment of FLO's was a high priority action for me. The identification of the deceased is paramount and, thereafter, the identification of the next of kin. I was not actually involved in that process of identification of the FLOs as I delegated this to Colin Robson and Keith Hardie in the MIT. Between Keith and Colin they were tasked to identify suitably qualified FLOs to attend.

266. The outcome was that two FLOs had been initially identified and Colin was contacting them to attend at Kirkcaldy for briefing. Colin had identified them from neighbouring divisions. Keith Harrower had indicated to me that he was not able to deploy PIRC FLOs until Monday 4 May – I am not sure why this was – however it left a significant gap on the Sunday and, due to the critical nature of the deployment, the resourcing of this matter fell to Police Scotland. The difficulty was in finding, at extremely short notice, suitably trained officers

Signature of witness................................

particularly at the weekend when there are reduced resources across the country, particularly FLOs. It sounds simple and straightforward, but it is not.

267. There was a delay in them attending initially. Colin had updated me and at that time I was concerned there was a delay. I was concerned about the length of time we were taking to speak to the family. The information around the incident at Hayfield Road was already in the community and was also beginning to hit the media.

268. I spoke to DCS Lesley Boal early that afternoon - before the second Gold group meeting to explain we were having difficulties in identifying trained FLOs and the officers we had identified were attending from distance. Lesley and I both agreed that we had to identify officers as soon as possible. I did not want the family to find out from a third party. We agreed that we would identify two Detective officers who were not trained FLOs but who were involved in the investigation; to get them to stop what they were doing, and attend directly to inform the family of the death of My Bayoh. I was directing this to be done via Colin Robson to the identified officers.

269. Because the investigation was moving to PIRC, supported by Police Scotland MIT, we also needed MIT FLOs, to ensure continuity and consistency with the deployment. Again, DCI Keith Hardie was assisting with this aspect.

270. There was also an administrative error on the STORM computer system that suggested there were Divisional FLOs on duty who were not in fact on duty. This was explained to me by Colin Robson.

271. Because of the delay with the identification and attendance of the FLOs in the early afternoon, I asked two of the enquiry DCs to attend and deliver the death message to the family. That was through consultation with Keith Harrower who

Signature of witness..................................

was being kept updated on it. Keith had identified in early discussion that he could not get two FLOs from PIRC on 3 May and that it would only be on 4 May. That left a significant gap because we needed FLOs going to the family ASAP. The decision was then made to get Police Scotland FLO trained officers to be deployed and engage with the family.

272. The DCs delivered the death message to the family. My understanding was that there was a number of family members within the family home when the message was delivered. I believe that included Collette Bell. Colin Robson was overseeing this deployment – and was keeping me informed around this deployment, as I was preparing for the Gold group meeting at 14:40 hrs. Colin fed back that the family were suspicious of what had occurred – due to the information already in the community, and I believe that there was suspicion that officers were keeping information from them. I did not find this surprising in the circumstances and expected the engagement with the family to be challenging. With hindsight, it may have been more appropriate for PIRC to deploy FLO's independently to the family – however they were not available.

273. The message provided to the family would be very simple, with limited information provided to them at this time. This was not to be obstructive – but based on the limited information we had available at that time – particularly around the restraint and arrest of Mr Bayoh at Hayfield Road. Naturally the family would be asking questions that the officers did not have the information to answer. I was informed by Colin that Collette Bell was present and it was only natural that she would have informed the family at that stage of what she believed had happened – as she had been interviewed earlier that day by the Police. The momentum of the enquiry was moving at pace and media interest was significant at this time.

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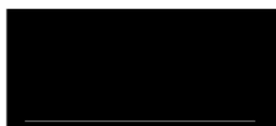
274. At around 15:00 hrs I was within the Gold group meeting chaired by ACC Nicolson. From recollection, I believed that Colin received a text message or call from the Detectives who had delivered the death message to the family. Colin had indicated for me to step out of the meeting briefly. I stepped out of the Gold meeting and Colin made me aware that the family were looking for further information at that time. Colin wanted to know whether there was anything more that we could inform them at this time.

275. I indicated towards DCS Lesley Boal and the two of us stepped outside and we put together an extended form of words. I ran this through Keith Harrower, and the PIRC were happy with the wording. I passed this through to Colin Robson, who relayed it to the officers concerned.

276. Thereafter I heard back from Colin Robson after delivering that. It was no great surprise: we knew there was still anger and concern about what had occurred. The feedback was that the information we had provided had not really filled the gap in what the family were looking for. It was extremely difficult at that stage with what we knew at that time and you have to be very conscious of what you say. It seems sterile and almost cold, and it is unfortunate that the death message appears like that.

277. That information came back to myself, Lesley Boal and Ruaraidh Nicolson the ACC. Because of the feedback, following the conclusion of the 14:40 hrs Gold group meeting we discussed the relationship between Police Scotland and the family. Garry McEwan said that he knew that one of the family members was part of a local independent advisory group. It also came back that one of the family members had asked to speak to Garry. There was discussion about whether it would be beneficial for Garry to go and speak to the family to see if he could answer any further questions. ACC Nicolson agreed that that would



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be beneficial and directed Garry to attend at the family unit, and to identify the early issues that had been built up within the family.

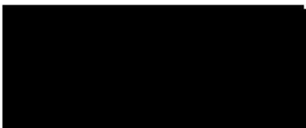
278. The forensic meeting was directly after that. It probably lasted an hour to ninety minutes.

279. I understood that the family had anger and concern relating to the nature of the incident. This was completely understandable. The information which came back from the family via the officers and from CS Garry McEwan, was that Mr Bayoh was unconscious during his arrest. That information did not come from the Police. The information the family had, was that the police were involved in the death of their loved one, so you can well understand the anger directed at Police Scotland.

280. It was also discussed that there was a delay with the MIT FLOs, one was off duty and we were calling them back on duty. We spoke with Keith Harrower about whether there was potential to bring out the PIRC FLOs.

281. Collette Bell was in the office from about 10:15 hrs onwards. That was a normal course of events, particularly since she had phoned us. The officer who attended to speak to Collette observed that it was clear there had been a disturbance within her home address. We also traced Zahid Saeed and he was conveyed to Kirkcaldy police office for the purpose of providing a statement. It was not to make them feel insecure or nervous, but to take them away from a location that may be linked to the investigation.

282. Initially – prior to speaking to Collette - we were not sure who was the next of kin of Mr Bayoh. It was not until we interviewed Collette that we identified that Kadi Johnson was the sister of Sheku and was, in fact, the next of kin. It was only through that discussion that we were aware of this.



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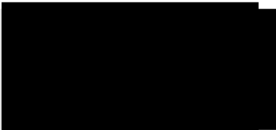
283. Next of kin is sometimes a partner, but if it's a partner and they are not married they are less likely to be next of kin, although we were aware they had been in a relationship for a number of years. Although she was able to give a lot of background, it is usually a close family relative that is identified. It is important to get the next of kin correct as this can cause significant issues with future engagement with the family if this is not correctly. It is also crucial to get that message to the family at the earliest possible time.

284. Keith Harrower was present when ACC Nicolson actioned Garry McEwan to attend with the family. Keith Harrower thought it was appropriate for Garry to attend and answer some questions from the family before MIT and PIRC FLOs were deployed. I believed that it was appropriate for Garry to attend as a senior officer and because of his already established relationship with one of the family members.

285. It is unusual for a Silver commander or a senior officer to personally attend with the next of kin. We would normally try to deploy FLOs immediately but it is not always easy. You are calling people out who are off duty. There is sometimes a delay with it. Sometimes you deploy people who are not trained FLOs because the delay is becoming significant. It is not the first time it has happened to me. Either way it is not normal for senior officers to attend, but it was carried out in this case with the best of intentions.

286. The initial intention was for a joint deployment of a Police Scotland FLO and a PIRC FLO – if a PIRC FLO was available. If the PIRC considered it would be more beneficial to be two PIRC FLOs then it would be more beneficial to leave the Police Scotland FLOs totally detached from it.

287. FLOs are part of an investigation team. They are integral to engagement with the family and support the family. They provide information around progression



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of the investigation to the family unit. Also FLOs obtain information from the family that's pertinent to the investigation so they can feed that back into the investigation itself. It may well include taking statements from the family.

288. It is, unfortunately, quite a common occurrence for police officers in their daily duty to deliver death messages. Uniformed officers often deliver death messages. I had done that for a number of years as a uniformed officer as well as a Detective. In this case, because of the circumstances of the death of Mr Bayoh, the fact that it has been declared a critical incident, and the need for having extended engagement with the family, you would naturally consider deployment of FLOs.

289. FLOs can answer questions but they might not be aware of SIO/IIO information that is relevant to the investigation and which may be sensitive. There may be information at that stage that you may not want to be placed in the public domain. There may be areas that still need to be clarified and corroborated. Their role is to provide enough information to answer their questions of the family, without providing information that is sensitive or still being established or corroborated.

290. After obtaining the details of next of kin from Colette Bell, the delay was with the deployment of FLOs.

291. I have been told DS Graeme Dursley states that the following death message was given to the family: "*Following an incident this morning, in the Hayfield Road area of Kirkcaldy, officers from Police Scotland have been attempting to arrest Sheku Bayoh, during which time he became unconscious, conveyed to hospital by Scottish Ambulance Service and despite best efforts by medical staff died shortly after 9am this morning.*"

Signature of witness.................................

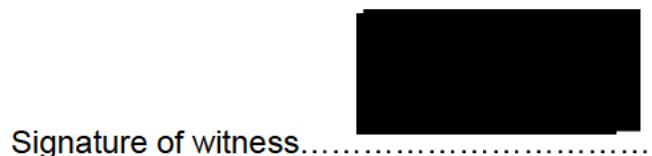
292. Following consultation with DCS Boal, I provided DS Dursley with a form of words to provide additional information to the family. This form of words was in addition to the initial death message.

293. I have been told Collette Bell was given the death message at Kirkcaldy Police Station and a statement was taken from her immediately afterwards. I do not know about Collette Bell's statement. I was aware she was in the station. At 10:15 hrs onwards, two DCs were interviewing her relating to the call made about her concern for Sheku Bayoh. She was an essential or critical witness and that is why she was brought to the office; to get an understanding after she had informed us about the disturbance at her home. I did not instruct anybody to give her any information.

294. I am now aware of the information they gave her but was not aware at the time. I agree with it now. It was obvious to Collette that it was Sheku who was the deceased. It was not until after the officers briefed Colin Robson that I was told. It was also necessary for identification purposes too, as Collette had assisted with this matter. I am not sure, but I think it was possibly Colin Robson who had actioned it - to get her from her home address and bring her back to the office.

295. I do not know what happened after that. The decision was made, perhaps on 4 May, that we would just deploy PIRC FLOs. Having Police Scotland representation as a FLO in hindsight was not the best thing to do. PIRC was independent of Police Scotland and that was picked up on at the Gold group meeting on 4 May.

296. In hindsight, on the Police Scotland side, when the family were aware of the altercation on Hayfield Road it may have been more beneficial for PIRC FLOs to have been deployed to deliver the death message. PIRC did not have



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resources on 4 May to deploy, so we had to deploy Police Scotland FLOs because we could not wait for the following day to pull the resources together.

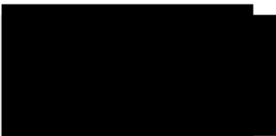
Media engagement

297. When I was driving from Livingston to Kirkcaldy there was a news broadcast that an officer was stabbed in Kirkcaldy. I knew this to be inaccurate and I contacted the on-call media rep, Kate Findlay, to ask her to withdraw the statement from Radio Forth, not just for the community impact but the impact on the officer's family. The injury to the officer was not serious because Colin Robson was with the officer at the hospital and I knew there was no serious injury. I knew she had been assaulted but not with a knife.

298. I heard the broadcast on Radio Forth at 8:30 hrs or on the news at 09:00 hrs. My recollection of what I had heard was that a police officer had been stabbed. There was no injury or significant injury and no knife used. I called Kate Findlay the on-call "comms". She was unaware of where this had come from. It had not come out of Police Scotland.

299. I was not aware of the source of the news then. I am potentially aware of that now. From subsequent investigation and the media releases at the time, work was done from the PIRC about where that information came from. I am aware of the contents of their investigation. They clarified that Police Scotland had no involvement at all in that information. I have become aware of that just recently in the documentation that has been disclosed by the Inquiry.

300. Myself, Inspector Kay and Kate Findlay had agreed a holding statement around 09:30 hrs that we would put out: that police were dealing with an incident at Hayfield Road. Late in the morning, Lesley, Ruaraidh and I had looked at pulling together a more pro-active media statement. Having checked



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with PIRC and Crown, that was declined and we were to have no further involvement and nothing else went out. It was an "if-asked" statement.

301. I have been referred to my previous statement dated 19 June 2015 (PIRC-00211) at page 3: "*I was at this time preparing to leave Livingston and drive to Kirkcaldy, therefore, I made contact with Detective Chief Superintendent Boal via my Police issue telephone and provided her with a verbal update of what had been briefed to me by Detective Inspector Robson. She informed me at this time that she had provided a brief to ACC Ruaraidh Nicolson and that 'on call Policing Standards Department (PSD),' Superintendent Craig Blackhall had been briefed, this was to ensure that if the injured male did prove that there was an immediate referral to 'Crown.*"

302. The term "injured male did prove" basically means - "if he had died". The expression is a shortening of "prove fatal". "LPE" is life pronounced extinct. "Immediate referral to Crown" is the immediate briefing to the Scottish Fatalities Unit at the Crown Office. There would have been a referral anyway because of the police contact. The PSD would decide whether to refer to Crown Office.

303. "Serious injury" is a pretty flexible term. A serious assault is any assault to permanent disfigurement, impairment or to serious injury. It would ordinarily be for PSD to make that assessment. I would, and still do, err on the side of caution. I would report to PSD on this as a matter of course.

304. I have been referred to the PIM log at page 16: "*1930. Press release handed over by Press Officer – Kate. Shown to Scott Maxwell, James McDonough. Federation representative.*"

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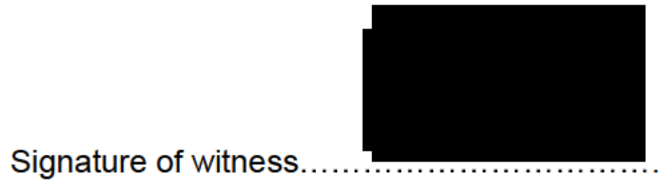
305. I was not aware of this. It was not a press release issued by Police Scotland. It was quite clear by late morning that we were not putting out anything at all. Any press release from PIRC we were made aware of. They did not tell me about anything being shown to Scott Maxwell or Scott McDonough. All I can think is that it is a PIRC press release. I made the Federation representative and officers aware of its content.

Gold Group meeting 3 May 2015 at 11:30am

306. I remember attending them. The Gold group is structured as a strategic group that considers more than just the investigation side. There was significant media interest in the incident and it also had significant impact on the local community and their trust and confidence in Police Scotland. My role in that would be to update the Chair and the rest of the Group's membership about the investigation and then there would be inputs from individual members appointed in respect of areas such as community engagement, media relations, engagement with relevant partners and areas such as equality and diversity. It's relevant to the Gold commander for insight how this incident is managed and how this is progressing. It also provides him with the information required to brief the Chief Constable and the executive team.

307. It is more of a high level update, a synopsis about where the investigation is at that time. We would not go into detail about sensitive matters because of the wider membership of the group. If there were challenges then we would raise them as well. We would not go into detail; for example, we traced Collette Bell and here is what her statement says. If the Gold commander required more information then it would be a more private discussion off-table.

308. I have been asked if the information I received at the Gold meetings would affect the investigation. On occasions it would, but not for this investigation. It



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is good to hear about media interest, where it sits, and the strategy that is in place around media engagement. We were getting updates on community impact and people gathering on the street (perhaps people in a demonstration). You get a feel for areas of conflict, such as the reluctance by officers to provide operational statements and some of the challenges around CCTV capture etc. It is beneficial to get inputs from the key stakeholders but it did not bear on my investigative strategy for this incident.

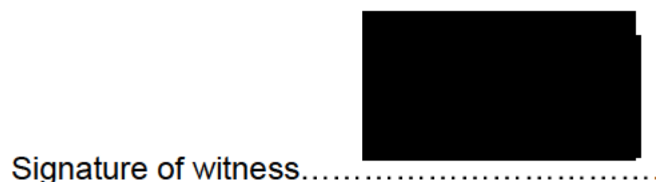
309. I have read the Gold Group Meeting Minutes for 3 May 2015 at 11:30hrs (PS06491).

310. At the start of the next Gold group, they would produce the minutes and ask if there was any information to add or errors to fix. The minutes would be handed out, along with the agenda and the Gold strategy. So you would normally have the minutes from the previous meeting to hand.

311. I think Colin Robson compiled the first set of minutes but I am not sure who compiled the other ones.

312. I have been asked how the Gold strategy affects the investigation. It is, essentially, an overarching high level strategy about returning the community and Police Scotland to business as usual. It is standard for all investigations to have this structure. I believe that Garry McEwan had pulled this strategy together. It is about supporting the community, and returning the community to normality.

313. I have been asked what it means to ensure the integrity, interest and reputation of Police Scotland. This is usually part of the Gold strategy - the last point is about the interest and reputation of the organisation being maintained. It is about being honest, transparent and adhering to the code of ethics and the



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national decision-making model. That is how we try to be open, transparent and fair.

314. I have been asked if ensuring the integrity, interest and reputation of Police Scotland would be maintained by finding no fault on the part of any police officer. Although the immediate reputation of Police Scotland would be harmed if the officers were accused of criminal conduct, the long-term reputation would be maintained with an honest and transparent investigation and leaving no stone. I had no difficulty with this term of reference.

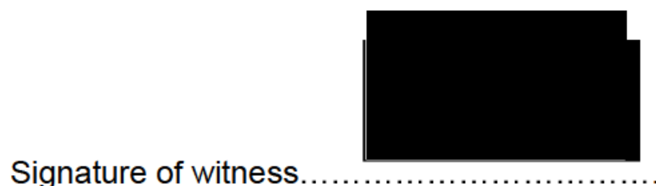
315. Nobody in the meeting raised a difficulty with that point. The person reading over the minutes would normally ask if there was any difficulty with the Gold strategy. That is always discussed in the initial stages.

316. The factual update by DI Robson was because I was late to the Gold group. The factual update would normally be by the SIO/IIO. Because I had been absent it was given by Colin Robson. Although I cannot remember precisely, I recall coming in about five minutes after it started. I think it started at 11:35 hrs.

317. I am unsure if the Gold strategy was read out exactly. I would read it out verbatim. Nobody raised anything in the course of the meeting with the Gold strategy. Colin provided the update and either I did not hear it or I came in later after he had finished.

318. I cannot recall if I saw the minutes. It is normal that the minutes would be available at the next meeting. I cannot recall if I had an opportunity to see DI Robson's factual update.

319. The status of the officers was updated by myself and DCS Lesley Boal. The Federation representative had offered the officers advice. I briefed that there



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was an early indication that the advice from the Federation was that they should not provide operational statements until they had received legal advice. There was a general discussion. I know that Garry and Ruaraidh both spoke about it.

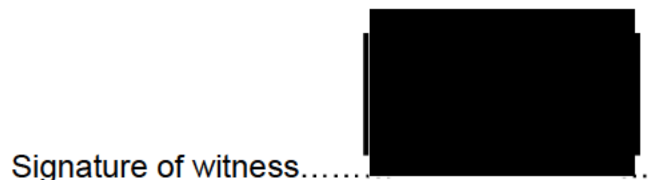
320. There was not much detail. I know it was subject to discussion at the 14:40 hrs meeting. I explained to the group that I had spoken with Keith Harrower and David Green and that it was clear they were all witnesses. I cannot recall any definitive action around this.

321. I would have started it with the timeline and the rest would be DCS Lesley Boal. It would be myself dealing with it, supported by Lesley.

322. Colin's update is almost a preamble surrounding the investigation. Thereafter the process about the death of Mr Bayoh and the investigation would be outlined by me. A lot of this would come from my daybook and from the notes I had taken at the time. It was a dynamic investigation. Not all of it would be in the daybook, just the main points about significant areas.

323. Race was not a factor at all. There was discussion, not about race in particular, but if there was any aspect of the incident that might be terror-related or linked to counterterrorism. That would be pretty normal for any incident regardless of race. We would ensure there was not anything at all that was linked to terrorism. If there had been such a link, the necessary intelligence checks with security partners would be carried out.

324. I have been referred to the minute at page 2: "*3. Investigative process – (DCS Boal/Det Supt Campbell) … Priority actions – Statements from Martin Dick/Saeed Zaheed/independent witness speaking to male with knife*".



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325. There were more priority actions than these three witnesses. There were at least three separate calls from the public about Sheku Bayoh's behaviour. Collette Bell was a significant witness. Martyn Dick and his partner were involved in Sheku Bayoh's movements. That is just a snapshot of some of the relevant witnesses. The "independent witnesses" are the three who were in cars who were called in on 999 and who spoke to Sheku Bayoh carrying a knife.

326. With regard to priority actions: there were 5 *loci* to secure and possibly search, CCTV capture, house to house, PF liaison, intelligence with CT. These were all priority actions that were considered. The priority actions should be all bullet-pointed. They are all essential to any successful investigation. The identification of the deceased and notification of the family is also paramount in your mind. Thereafter, locations were secured and forensic integrity maintained. Early capture of CCTV was required. Initial witness statements should be taken. These are all essential and high priority. I would identify them and then allocate them.

327. The *loci* needed to be identified and then secured. That is just to secure integrity. Uniformed officers stand by at the locations. It is police jargon - the way you'd speak at these meetings. You would ensure a scene entry log was in place, to enable proper forensic examination and to protect against forensic cross-contamination issues developing. We would not discuss the legal basis for the loci to be secured at this meeting.

328. Securing *loci* was my responsibility. The legal basis for them to be secured is because they are an integral part of the investigation. There is a common law power to seize and secure property and evidence in respect of major investigations. In 2015, there were different opinions across the law enforcement agencies, and also COPFS, about whether a search warrant was

Signature of witness................................

necessary for the examination of crime scenes and *loci* of major crime investigations. Presently, we tend to go down the search warrant route for all property that we search. At the time however, it was at the discretion of the on-call PF whether you would require a search warrant for a location linked to an incident as such. You would always seek direction from COPFS.

329. The normal course in homicides throughout the years is to secure the property, forensically search it, and secure the evidence. This was based on common law powers. On some occasions COPFS directed that there was a requirement for a search warrant. It depended on who you spoke to at COPFS. It has changed now in that you err on the side of caution, and issuing search warrants is now the norm.

330. I have been referred to my daybook (PS18269) at page 4: "*(iv) <u>Unidentified</u> male who is associate of decs – who is this and is the person injured*"

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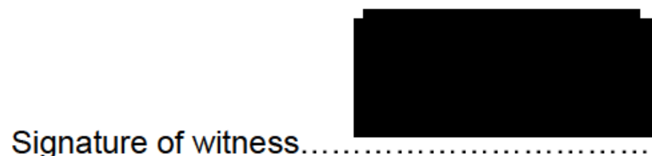
331. This is an associate of Mr Bayoh, called Zahid Saeed. We were investigating how he was connected to Mr Bayoh and what the altercation was between himself and Mr Bayoh.

332. I think this information came from Colin Robson, but initially from Collette Bell. She had received a call from Zahid Saeed saying he had been assaulted by Mr Bayoh. It was important that we found out if he was safe and well.

333. I have been referred to the Gold meeting minutes at page 2: "*3. Investigative process – (DCS Boal/Det Supt Campbell)… CT considerations – Raised by ACC and to be reviewed by NIB.*"

334. Ruaraidh's background is that he was involved in the CT aspects of criminal investigations at the legacy Strathclyde force. He had in-depth knowledge of



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terrorism incidents and how they were managed. The threat level was raised to severe – indicating that an attack on police was highly likely. Again, it would be natural in considering the CT perspective for wider intelligence checks to be carried out internally and with external partners. It would be natural to ask this. I see Ruaraidh has raised that but, race apart, it would be normal research we would do. I cannot recall who spoke about it first in the meeting.

335. I have been told there is a daybook entry by DI Colin Robson (PS18495) stating at page 2: "*CT Consideration / Motivation / Threat level / Severe*".

336. That is the threat level. Colin prepared the minutes for the meeting, and that is where he has the link to counter terrorism.

Gold Group meeting 3 May 2015 at 14:40

337. I have read the Gold Group Meeting Minutes for 3 May 2015 at 14:40 hrs (PS07268).

338. I am unsure if I saw those minutes again at 20:15 hrs. I have seen them before but I am not sure now if it is from the Inquiry's disclosure or at the time in 2015.

339. I have been asked if I know PS Paula Warrender. I know the name.

340. It is a standard agenda for the Gold groups. I provided the update on the investigation process. The numbers in the minutes corresponded to the agenda items. There was nothing much different from the last meeting. They had fixed this meeting at the last meeting. Three to four hours further down the line you fix another meeting to ensure things are moving along as they should be.

Signature of witness..................................

341. I do not remember any discussion about the change in the terms of reference, regarding removal of the point about ensuring the reputation of Police Scotland. The note looks like it says "integrity of investigation" but I cannot recall that.

342. The factual update was from Colin Robson again. Colin was referring to the call cards and Storm incident reports from the motorists. The facts he highlighted were that there had been an alleged assault on Zahid Saeed by the Mr Bayoh at his home address.

343. This was the first time the PIRC attended the Gold group and I had met the PIRC prior to the Gold group. There was nothing we were unaware of that was going to be raised at the Gold group.

344. I have been shown handwritten notes and have been told these are PS Warrender's notes from the meeting (PS06514). I have been told she has written the following at page 1: "*Factual update DI Robson… All calls linked, units attended – STAY SAFE RISK ASSESSMENT*".

345. I don't remember that being explained. I know what it is. At that time a "stay safe" warning would normally be given by the ACR. I cannot recall it being discussed.

346. I have been told in PS Paul Warrender's handwritten notes from the meeting (PS06514 at page 2) she has written the following: "*Male – went for female. On ground kicked to head.*".

347. I do not remember that being said. It indicates an assault on the officer. It would have been discussed. I was not sure what had been involved. I knew it was a physical assault but I was unsure about the extent of it. We knew she had

Signature of witness…………………………

sustained some sort of injury, but it was not as serious as had been broadcasted on the public radio, where it was said was that an officer had been stabbed.

348. I have been told in PS Paula Warrender's handwritten notes from the meeting (PS06514 at page 2) she has written the following: "- *during struggle he lost control of knife*".

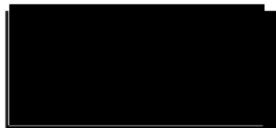
349. I do not remember that being said. That was not my understanding. We were not sure at that time. We knew the knife had been recovered nearby on an area of grassland. The gap I identified in my own knowledge surrounded the the coming together of the officers with Sheku Bayoh.

350. I have been referred to the Gold Group Meeting Minutes at page 2: "*Seizure of productions, Staff have been advised by Federation staff not to provide any statements.*"

351. I had raised that issue again. There was a discussion. It was said: "why not give statements, they are clearly witnesses?". They were clearly not willing to prepare statements until they had received legal advice. The Gold commander, myself, Colin, Garry, as well as the PIRC, were all in agreement they were to provide statements.

352. There was nervousness on the part of the officers, whether due to trauma or because the cause of death was still unknown. And, they were advised that they should receive legal advice.

353. Keith Harrower was on the same page as everyone. It was clear from very early on until circumstances dictated otherwise that the officers were witnesses and there should be no issue with them providing statements.



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354. The factual update had no impact on the discussion. It had been discussed all morning with Keith Harrower. There was nothing to suggest there was reasonable cause to suspect they were anything other than witnesses. Keith Harrower agreed with that. The Gold group reiterated that they were key police witnesses and nothing more.

355. I have been referred to the Gold Group Meeting Minutes at page 3: *"CCTV Strategy – TSU also called out re presence of CCTV in police vehicle which attended at locus (update police vehicle CCTV seized has not been working since March 2015, seized regardless,"*

356. The CCTV was potentially operational but the Technical Support Unit said it was not. The wider consideration was: why was that the case? While that was not an immediate concern, it was something we would want to pick up: that we had CCTV not working in some of our police vehicles. I cannot remember if anyone said anything about this at the meeting.

357. I have been referred to the Gold Group Meeting Minutes: *"…update PF Fatalities David Green has been notified and he has made Nicki Patrick and Steven McGowan aware, neither have attended and David Green awaiting update)"*

358. I spoke to Dave Green twice on that day. There is reference to Stephen McGowan,who was working very closely to the Lord Advocate at that time. Nicki Patrick was the Senior PF Depute in charge of homicide. That was the relevance of the notification to both of those individuals. I cannot recall either if my update related to their attendance or whether they were asked to attend. It was not the norm for the PF to attend but, again, it would not be unusual. The on-call PF for homicide would normally attend the initial forensic strategy

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meeting following a homicide or suspicious death. The invite in respect of the Gold Group would be from the Gold commander not from myself.

The incident was being managed on the Crown side by the SFIU. It looks as if Dave Green, quite rightly, had informed the homicide fiscal and Stephen McGowan (who was the link to the Lord Advocate' Office).

359. On the PSD side Craig Blackhall certainly was informed. Myself and Craig Blackhall had contact with David Green. Ruaraidh Nicolson knew him quite well. Liaison with the Crown would be by myself and Keith Harrower, throughout the day.

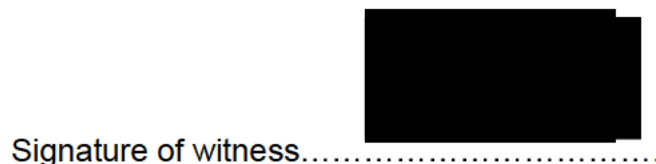
360. I have been referred to the Gold Group Meeting Minutes: *"4. Review of policy/decision log – (All)*

Discussed – 1 policy decision recorded. 0910hrs 3/5/15 C.Supt McEwan declared the matter a critical incident."

361. This is not my policy log. Normally with minutes there is a running action log or policy log of any decisions made and policies outstanding. There should be an ancillary action log. It shows the actions generated but not what the actions were. There would normally be a running action log but I have not seen that in any documentation.

362. There should be an action log. It is a running log that sits nicely with the minutes. It will include matters outstanding from the last meeting. You would run through the actions and, whoever was asked by the Chair, would run through any outstanding actions.

363. On page 3 it says "*Action raised to put in place a strategy to obtain all CCTV available*". That would normally form part of the running action log. Tasks



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identified and ownership given. You would feed back at the subsequent meeting. I am not sure how this was managed at the time because I was not involved in the minutes.

364. The minute-taker would be responsible for the action log. The action log may have been incorporated into the minutes. The action log would sit with the Gold commander and the person taking the minutes. Whether or not this has been done, I am not sure.

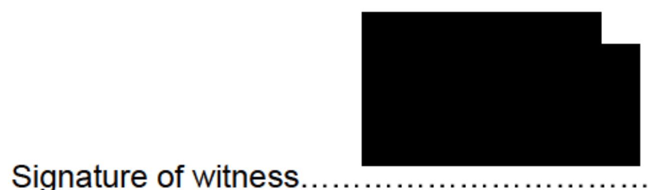
365. I cannot recall saying much around these issues myself. I have already stated how they affect the investigation.

366. Anything to do with the media is significant and integral to the investigation. You can put out things such as a witness appeal. I have got a real interest in that as SIO. The update on media at the Gold group is there for that purpose. That whole purpose of the media strategy is with Crown and with PIRC. I had no input on this myself.

Gold group meeting 3 May 2015 at 20:15

367. I can recall it being a shorter meeting. There was a factual update from me. I think I'm giving the factual update that the Gold commander wanted a quick run through. I said I would run through the factual update and the investigative process to cut it short and condense what we were discussing.

368. I gave an update on crime scenes, progress of examination of the scenes, and anything of significant evidential value recovered. I explained when we would stand down and the release the scenes back to their owners.



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369. We updated on handover to PIRC FLOs from Police Scotland to PIRC. That is on page 3.

370. The seizure and transfer of a deceased to the city mortuary is under my remit, under direction of the Crown; thereafter everything to do with the post mortem is within the remit of the Crown. Pathological examination is also with them.

371. The intention was for me to hand over the SIO/IIO-side of things from a Police Scotland perspective to DCI Keith Hardie and the MIT, and this was done after that meeting. Police Scotland were handing the investigation over, in its entirety, to PIRC. They had Gold group around the table discussing where we were with it. It was under direction of PIRC but that physical handover was actually the following day. The post mortem and Gold group actions would be for PIRC. The discussion between myself and Keith Harrower was around that.

372. It was going to the MIT in Police Scotland. Keith Hardie had MIT lead for Police Scotland. He was going to work alongside PIRC in the subsequent investigation. It went to MIT because of the capacity that the MIT had was more than I had. I am attending the on-call function as on call Detective Superintendent. The normal course of events, even today, is that the on-call manages the first ten or twelve hours hours, and then it goes to the MIT. If it going to be more protracted, or long term, we have a cadre of officers in the MIT to take it on.

373. The decision-maker for this was Ruaraidh Nicolson. The complete handover was not after the 20:15 hrs meeting - it was the following day after post mortem examination had taken place. When I came back for the Gold group we had a further meeting regarding the post-mortem and communications to the family and the officers involved in that. I think Keith Harrower was on annual leave and he handed over to Billy Little. Billy took on Keith's role on 4 May. Billy had

Signature of witness.................................

attended the post mortem examination and phoned me after that to have a meeting. It was 20:00 hrs on 4 May that we met to go to through the priority actions that were still ongoing.

Forensic Strategy

374. I was the owner of the forensic strategy. I actioned the development of the forensic strategy. That would entail the various *loci* across the investigation and the seizure of clothing and equipment of the key police witnesses.

375. Because of the development of the significant number of locations relevant to the death and the unusual aspect of the seizure of equipment and footwear, I brought in Stuart Houston from Edinburgh as Scene Coordinator, to oversee the processes in place across the various *loci* and ensure their integrity. He was on-call, and an experienced investigator

376. I had the agreement of PIRC for this and they also concurred with what we were putting in place around the forensic strategy.

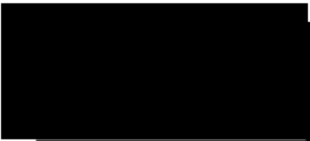
Forensic Strategy Meeting

377. I have read the Forensic Strategy Agenda (PS17896) and the Forensic Strategy Document (PS01298).

378. My Rule 8 statement covers the forensic strategy meeting (SBPI-00134).

Searches of property

379. Strategic direction about relevant *loci* sits with myself as SIO. The relevant locations become apparent. We were aware of Hendry Road and Hayfield



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Road. Collette Bell's address was also Mr Bayoh's address. Saeed's car was relevant, as was the home address of Martin Dick. In any investigation involving a number of relevant loci, the priority is to ensure their integrity. If a locus is not relevant we can stand it down. All the locations have to be secured and stood-by with locus protection officers. The best practice is to secure them as soon as possible.

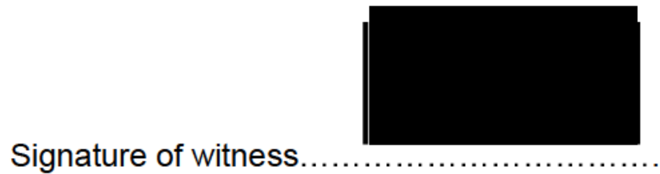
380. When we have secured it and controlled a locus, no-one has access until we are in a position to release it back to the owner, once we have been able to fully consider its relevance.

381. Ultimate decision-making in this regard was mine. The information came up from Collette Bell's statement. With regard to Collette Bell's address, from her statement what appeared to have happened was a disturbance in the kitchen, and a potential altercation. As the day progressed we had Zahid's recollection about Martyn Dick's house, and that too became relevant. At Martyn Dick's house my direction was to secure it to see if there was anything that required to be searched. It is always better to secure and seize what you can and to deploy CSMs to see what relevance they have.

382. Garry McEwan would have known the *loci* from the Gold Group. I would have given an overview of what the property was and its significance so he would have been aware of this

Hayfield Road recovery of evidence

383. I endorsed that Hayfield Road should continue to be secured. It was a significant scene. Colin had already secured and seized that and put cordons in place. I agreed with what he had done with that. There were no issues with that being scene one of the crime scenes.



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384. I was aware of issues from a briefing from Colin Robson. He said that officers' safety equipment was seized from this location due to heavy rain at the time The knife was also seized from a grass area nearby. It is unusual for a DC to photograph a knife with a mobile phone, but I could understand why this took place. This had taken place prior to my involvement.

385. Full protection measures were in place. When we knew that the condition of Sheku was giving cause for concern there was no way we were going to stand them down and there was a need for a longer term strategy for what was required at that scene. That is detailed within the forensic strategy document.

386. I was aware that batons were seized at the scene and there were other items that had been discarded and left in *situ* at that time. The action in the forensic strategy was for forensic seizure. The CSM could consider further. I do not know about a forensic tent at Hayfield Road.

387. These aspects were all delegated to Stuart Houston. We never handed back the Hayfield Road locus - we had control of that at all times.

388. I remember the officers' safety equipment and a police radio at the location. I do not recall being told about the significance of any police radios.

389. The normal practice is for forensic capture of everything at the scene in situ as it is open to the elements at this time and moisture can impact on DNA and fingerprints. If the weather was poor you would get it covered in some sort of manner, such as by a Crime Scene tent. I do not think Colin knew how significant this incident was going to be at the outset, or realised the significance and benefit of leaving everything in situ. I aware from him when I asked him about the knife that we had seized it and he said it was starting to

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rain heavily. I think he did it with the best of intentions. Normally we would photograph it in situ and then seize it. Ensuring there was documentation and labelling was the normal process for forensic submission. There was a risk of forensic loss because it was not done that way. I had no control over this because I was not there at this point.

390. I do not know when it was that we stood down Hayfield Road. We had that scene for a significant period of time, either into the evening of 3 May, or the following morning.

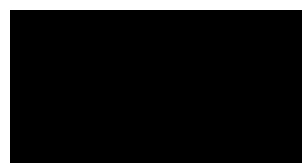
Collette Bell's address

391. Collette Bell's house was seized on my instruction. This was after the call at 8:30hrs and her concern for her partner Sheku Bayoh, that she had found him to be missing and also from the briefing regarding the lead up to the altercation in this incident.

392. Officers were dispatched to Collette and the feedback was that there was a disturbance in the kitchen and it appeared that something had occurred there. The feedback was coming through Colin Robson.

Martyn Dick and Kirsty MacLeod's address

393. Martyn Dick and Kirsty MacLeod's address was relevant to the investigation. We knew Sheku Bayoh had been in Martyn Dick's house in the early morning. He attended with Mr Saeed to watch a boxing match. We know there had been a disagreement with Mr Bayoh and Mr Saeed in that property. It was a relevant scene so it was secured. We needed to make a timeline of the movements of Sheku Bayoh from the previous evening to Hayfield Road. It was a relevant



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scene and we would secure that and have an examination by a crime scene manager. That is detailed within the forensic strategy document.

394. The legal basis to seize was the consent of the householder. We explained why we required to secure it at that time. As our awareness, the relevance of it was less than we first thought. We were aware Sheku Bayoh had been there and it was subject to a search, but was not as relevant in terms of the investigation.

395. All the scenes were secured under common law powers being linked to the death of Sheku Bayoh. That time in 2015 that was normal direction from an SIO, to secure under common law, speak to the PF about necessity for any search warrants. It was under common law and the consent of Martyn Dick.

396. I do not know where Martyn and Kirsty went - I believe it was to a family member or a friend. We reassured them that we would return it to them as soon as reasonably practicable.

397. I am not aware of DNA swabs from them. That would have been done under the direction of DCI Stuart Houston. The forensic strategy would be for Stuart to put into practice. I would not be surprised if we took their DNA for elimination purposes. I would expect it to be done for the forensic strategy. It would be with the consent of the occupiers and we would explain why we would be doing that.

398. I am not aware of anything being seized at the address. Herbal matter and grinders does not ring any bells for me. If that was the case, it would be managed under the direction of Stuart Houston in respect of any investigations and proceedings surrounding that. I do not recall anything else. I delegated the

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management of the various locations to Stuart Houston and the CSMs who took on that role.

Zahid Saeed's address

399. The main relevance for Zahid Saeed's address was a disagreement and alternation between Zahid and Sheku Bayoh, first in Martyn Dick's address and then in Sheku Bayoh's home address. There appeared to be an alleged assault. Zahid made off [redacted] to his home address. The car was also relevant as was the initial assessment of Zahid's home address, mainly because we were unaware of what had occurred between Sheku and Zahid: had there been a fight, was Sheku Bayoh assaulted by Zahid?

400. The relevance of the car and the home address was unknown at that stage. This is normal for this stage of the investigation. We would seize what we could initially and we would maintain the integrity of the scene..

401. I do not know who the occupiers were at Zahid's house. That would be delegated to Stuart Houston to manage. The various scenes would have a CSM for different locations, production officers and identification officers to do photographs, 360 degree photographs and so forth. That would be delegated to the Crime Scene Coordinator who Stuart Houston was at that time. Stuart Houston was also responsible for returning the property to the occupiers as well.

Sheku Bayoh's body

402. Sheku Bayoh's body was conveyed to Victoria Hospital in Kirkcaldy. He succumbed in the resuscitation room there. Very early on I was aware that Detectives were there in the hospital and the possibility that Sheku Bayoh

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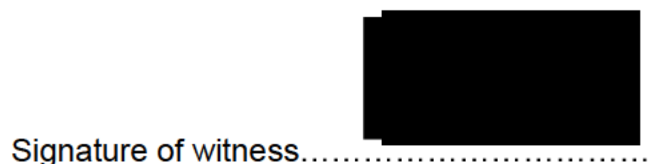
would pass away. This is normal for any unexplained death. Colin Robson informed me that officers had been in the ambulance with Mr Bayoh. The notification of death that Colin Robson gave me was that he had passed away. We ensured that we had secured the remains of Mr Bayoh. This was about the integrity of the remains and ensuring the seizure of the clothing. We needed to be aware of the surgical intervention that took place and would ensure we could properly transmit the remains to the city mortuary.

403. The whole aspect of repatriation and the religious aspects were discussed at the forensic strategy meeting. We also discussed consultation with the Foreign and Commonwealth Office and the embassy or consulate representing the interests of Sierra Leone nationals. At this initial stage we were unsure if the body would need to be repatriated. It was general conversation around that, and the religious aspect as well - that wider awareness of the diversity side of things. We knew from speaking to Colette that Mr Bayoh was a Muslim so we also had to consider the requirements and considerations of his religion. Further consideration was given about the family unit as such, and how to engage with them.

404. It would be for Crown Office to give us instruction on repatriation. It is something we would report to them around the requirements or wishes of next of kin or the family. It would be for Crown Office to provide that strategic direction.

405. The body of Mr Bayoh was removed from the resuscitation area into a side room. We secured it by a posting uniformed officer outside the door. We had two detectives outside the door taking details of the staff who had treated him in the resus area. Once that was done there was less to do at that time. I was content that we had secured the remains of Mr Bayoh at the time.



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406. I discussed with Colin Robson the necessity of securing the remains. I explained that if there had been a blood transfusion at the time, it was a basic requirement for detectives to obtain the pre-transfusion sample. I would not need to instruct Colin Robson in every detail to secure that. I would make sure that any witnesses, samples, clothing and any CCTV would be looked at in order to support the investigation. Even areas such as searching the ambulance: did we need to do anything about the ambulance that took him there? These are standard processes we undertake for any unexplained death as a matter of course.

407. I had very little involvement in the identification of Sheku Bayoh. Colin Robson oversaw that aspect with the staff under his control. It was crucial that we identified Mr Bayoh as soon as possible and identify an FLO to inform the family of the death.

408. Normally at the point of identification we would deploy FLOs to the next of kin once ID is obtained as a matter of course. Normal action in respect of this is once we have no doubt that this deceased. It is important that we get that right, and that we ensure we have identified the deceased and who the next of kin is. It is important to establish who the next of kin is and that the death message is delivered to a single point of contact.

409. It would have been a Police Scotland FLO that was deployed. I did discuss it with Keith Harrower at that time. He explained that it was unlikely that PIRC would be able to have a FLO available until the next day. The fact is we had to deploy FLOs as soon as possible. PIRC could no- resource that so it fell to Police Scotland to deploy.

410. The was a delay in the deployment of FLOs. I actioned Colin Robson and a DCI in the MIT to identify suitable FLOs to deploy. The problem was there was

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no-one on duty in the immediate area who were trained as FLOs. The normal course of events would be to deploy them from the division and from the MIT. The MIT would take on the investigation and it was always going to be helpful to have FLO from the MIT.

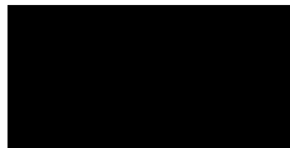
411. When I tasked Colin Robson, the problem was that they identified a FLO from Dundee or Perth and it would appear that the details of who was deployable from the Storm system, our command and control suite, was inaccurate in that we believed the individual was on duty at the time but they were not. There was a delay in identifying the FLO and they had to come from Dundee.

412. In hindsight, could we do it quicker? - yes - was there a delay? – yes, there was. DCS Lesley Boal and I identified two detectives within the area who were involved in the initial stages of the investigation and we asked them to attend and speak to the family. I made the direction throughout consultation with Lesley Boal that the delay was too significant to delay further, and with the best of intentions we deployed two DCs to deliver the death message without delay to the family.

413. One of the pillars of the investigation, is the deployment of FLOs. They are an integral part of the investigative team. They are trained investigators. It about providing information to the family but also taking information from them as well.

4 May 2015

414. On 4 May 2015 I was still the IIO/SIO for Police Scotland, and I was still on-call as well. I briefed the Chief Constable and the Force Executive at around 09:00 hrs on the progress of the investigation. Thereafter I attended at Kirkcaldy police office. Any other significant incidents were still coming to me



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as an on-call. Any unexplained deaths, I was being made aware of. I was not leading on them as such; I was just being made aware and providing advice. My focus after providing the update was to attend at Kirkcaldy police office to carry on the investigation and move towards a more significant handover to PIRC and the MIT.

415. I have been shown the minutes for the Gold group meeting at 12:30 hrs on 4 May 2015 (PS03161).

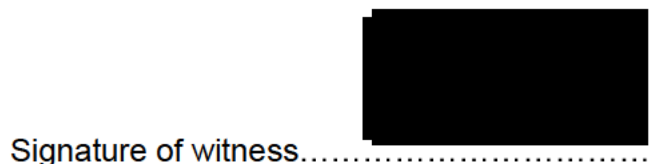
416. I was present for this meeting.

417. I have been referred to page 1: "*Officers were dispatched from Kirkcaldy and on arrival were faced with deceased to engage them physically, assaulting a female officer and fighting with others.*"

418. It was Colin Robson who provided the information. It is a standard update in respect of Gold group - headlines about the incident itself and the subsequent main points of the investigation. These are short, sharp updates and are to assist not just the Gold commander, but also any individual who had come into the Gold group for the first time that day. We were by that time more aware of how the investigation was progressing.

419. I have been referred to page 1: "*Family seem to have disengaged with Police.*" Page 2: "*Family seem to have disengaged with Police – decision made for C/Supt McEwan and Supt Milton to visit and re-engage.*"

420. That was not part of my update. Chief Supt McEwan had been actioned by ACC Nicolson the previous evening to engage with the family. It was really due to the fact that during the evening it appeared to the officers that the family had disengaged with the police at an early stage. Chief Supt McEwan had



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knowledge of the family and that meant that he may be able to go and answer some of the difficult questions the family were asking at that stage.

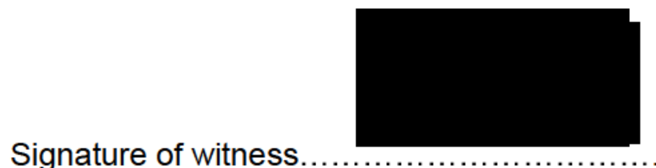
421. I provided the update regarding the family disengaging. Family liaison was my remit but I was not dealing with the deployment of Garry McEwan. The decision to deploy Garry McEwan and Nicola Shepherd was made on the 3 May by the ACC. It was an unusual deployment as such, it does not happen in the majority of investigations. The Gold commander took the decision because he thought it would assist with the ongoing relationship with the family.

422. Family liaison and strategy was driven by myself and PIRC but this was additional support from the Gold commander to Garry McEwan and Nicky Shepherd.

423. The outcome was that the family probably got more questions than answers. It was done with the best of intentions. The only update I was getting about this was from the Gold group and the relationship with the family was challenging. The challenge was due to the lack of information that we could provide to the family at that time. We did not know much more than we were telling them. They were asking, quite naturally as any family of a deceased would, questions we were unable to answer.

424. I am not sure if the PIRC FLOs were deployed. I know that Keith Harrower engaged with the family on the evening of 3 May. The direction was not to deploy Police Scotland FLOs but to deploy PIRC FLOs. That was agreed between myself, PIRC and ACC Nicolson.

425. I have been asked if I was aware of any Police Scotland FLOs attending at Kirkcaldy and being briefed. They may have been: things were moving quickly. I did speak to Keith Hardie about attendance of MIT FLOs.



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426. I have been referred to page 2: *"MIT tasked with tracking the movements of the deceased from Arran Crescent, Kirkcaldy to locus of death."*

427. I am not sure that is accurate. We had already established the movements of the deceased. It was probably a more detailed review of his movements from 2 May until 3 May, so that we had not missed something or investigative opportunities. We were keeping an open mind to the investigation and we had an idea of the witness statements that had been obtained, and we may have needed a more detailed review of what we might have overlooked. The decision was that it would be a PIRC led investigation supported by MIT because of availability of MIT resources in Police Scotland.

428. Keith Harrower was present at the Gold group so it would have been something PIRC was aware of it. It was PIRC-led, supported by the MIT. That strategic oversight is by PIRC at all times.

429. I have been referred to page 2: "*TASK – Advice to be gained from PIRC regarding the disclosure of the PM results to the Officers involved in the incident. Supervisor to be identified to carry this disclosure out*"

430. This relates back into the welfare and wellbeing of the officers. They were key police witnesses. They were, from my engagement with them on 3 May - and from feedback from the Gold group - extremely traumatised by what had occurred and they had questions about the cause of death.

431. What further information there might have been from the post mortem examination came up in the Gold group. As the post mortem results came in there was a further meeting at 20:00 hrs, or thereabouts, between myself and representatives from PIRC. Billy Little was the senior investigator at that time.

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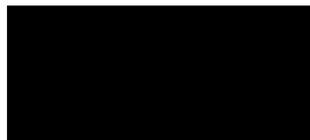
We agreed a form of words with Billy around what we could inform the key police witnesses. It was more about welfare, wellbeing, and to be open and transparent with the officers involved in it.

432. That is something that would ordinarily be done. As well as the family being visited to inform them of the cause of death, the key police witnesses would be informed about the outcome of the post mortem.

433. I have been asked if it is normal in deaths cases to disclose the cause of death to witnesses. Not particularly - we would not tell witnesses generally the PM results. The decision was made in consultation in PIRC that we would provide some words to them. The advice was that it was competent to do so and my focus was on welfare and wellbeing - being open and transparent in what we could give them.

434. I have been asked if there were any concerns with providing the cause of death prior to the officers giving their accounts. There are no issues or concerns with this. We would ask PIRC if it was deemed an appropriate thing to do. For welfare and wellbeing we were being open and transparent. They were witnesses not suspects. They had not provided a version of events and we deemed this to be in support of their welfare and wellbeing. If PIRC had said that this was not to occur then we would not have done so.

435. I have been asked if considerations of the officers' wellbeing and welfare conflicted with the interests of the investigation. No, it was a balance, particularly with the post incident protocol in place. Was I looking for operational statements, and what occurred with use of force, yes I was, it was a gap in the investigation. I had to balance that with the wellbeing and welfare of the officers. Their status was as key police witnesses.



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436. Part of normal post incident management and them being key police witnesses means that we balance the their needs with the needs of the investigation.

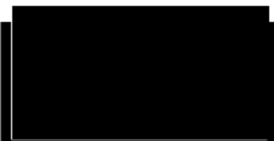
437. I have been referred to **page 2**: "*TASK – Media (Lucy Adamson) to be made aware of the PM results*".

438. I am not sure who Lucy Adamson is. I was not sure if she was PIRC, Crown or Police. I was not involved in it. The media-side sat with the PIRC. ACC Nicolson pulled together a media release to be put on the 3 May. I had sight of the media release from Kate Finlay. That had been given to the PIRC to go out, but they said they did not want the media release to go out after consultation with the Crown. The update that we got out was that no media was to go out. I stepped back from the media at that time.

439. If something is high profile as this, or a homicide, we would normally make the media aware of the fact that a post mortem examination had taken place. We would not go into detail about blunt force trauma, toxicology, and that sort of thing. We would make them aware of the post mortem at that time and that the family had been made aware. We would keep it very sterile as we would be sensitive to the concerns of the family.

440. I have been referred to the minutes: "*5. Community issues – (Safer Communities/CI Shepherd) TASK – Identify a command structure for potential change in community opinions i.e. potential marches or demonstrations… 8. Resources – (CI Shepherd)… TASK – Confirm resourcing is in place for the next 3 days in regards to any change in social media or community tension.*"

441. This would be with Nicola Shepherd.



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442. I have been shown the PIM log at page 17: "*13:00 Discussion with Supt McKenzie regarding provision of statements. Reference SOP section 10. Email to Supt Campbell / McKenzie / CI Shepherd / Amanda Givan (Federation representative) to inform.*"

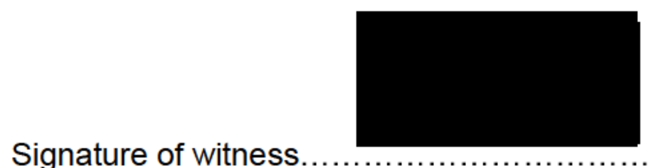
443. This is around a requirement for the officers to provide statements at Stage 3 of PIP regarding "honestly held belief" and the use of force. That was not provided by them. However, it is detailed as a requirement under the SOP. This was because they were seeking legal advice and had not provided this to Conrad. The next stage was the provision of full witness statements. Stage 4 was the provision of statements after the conclusion of 48 hours and, thereafter, within seven days to PIRC. He was giving an update as to where that was at this time. John McKenzie was the Superintendent for Professional Standards (PSD). Conrad Trickett was dealing with the officers and he was updating me in this entry.

5 May 2015

444. On 5 May 2015 I was not focused on the Sheku Bayoh investigation. The handover to the MIT was on Tuesday morning (5 May 2015) at 08:50 hrs. That was from myself to Keith Hardie as Police Scotland SIO at that time.

445. I was to handover the policy file in its entirety to Keith Hardie. He knew what we were going to do. The 3rd and 4th were extremely busy, nonstop, so the handover could not be earlier. That was the first time we could have the opportunity to sit down with a coffee and do a handover as such.

446. I have been shown the PIM log at pages 17 and 18: "*Tuesday 5 May… Spoke with Jane Combe (am/pm) She updated me that cause of death was advised*



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last night pending toxicology and did not result from blunt trauma. Officers had been told last night."

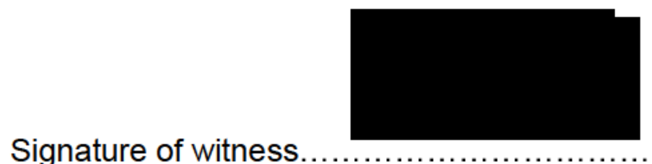
447. What we told the officers is what came back from the pathologists. The information was from Keith Hardie at the post mortem, as well as Billy Little. The exact content of the wording was from the pathologist. The pathologist has said about the blunt force trauma. Keith Hardie had phoned me from the mortuary with the cause of death and what had been established. If it had been blunt force trauma we would have told the officers the same thing. We would give them an accurate interpretation of the post mortem examination.

448. What came out of the post mortem was that blunt force trauma had not caused death. That is sometimes all we can get from a post mortem examination. It would be the decision of PIRC. The meeting was to establish what we would release to the officers and the families. Ultimately, as I say, this decision lay with the PIRC.

6 May 2015

449. I had no involvement on 6 May 2015.

450. I was aware of an ex-partner and child on the days I was involved. I think Collette told us that while she was at the office. The death message would go to the next of kin and there would normally be a family update on the death. If there was a requirement for Police Scotland to become involved and speak to the next of kin we would facilitate that. We would do that with partners in that international arena also, if the family member resided outwith the UK. We were lead by the next of kin on what to do and, if they required any further assistance with transmission of the death message elsewhere, then we would do that.



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SIO Management Policy File

451. I have read the SIO Management Policy File (PS17854).

452. The management policy file is there to record strategic and tactical decisions. This is relevant to detail because it records where we were with this incident and how it is playing out. Sometimes you record too much and sometimes too little. It is the prerogative of the SIO.

453. It is difficult to record in the policy file when things are occurring. You are not sure of the relevance at the outset. Normally, a record is made as soon as reasonably practicable afterwards. I know a number of the times will seem a bit out in the updates, that is because the updates are provided in the policy file only when you have a chance to detail them, not in 'live time' - because that is what would be detailed in my daybook. I would then transfer the strategic and tactical decisions from my daybook to the Policy File when I had an opportunity.

454. It is difficult to detail the answers and decisions verbatim. You are dealing with a live incident – where decisions and actions are initially detailed in daybook and transferred to the policy file. I am sure there will be times and dates that might be incorrect because of the lateness of when I am writing this, potentially in the early hours of the morning.

455. I have been referred to page 10: "*Diversity considerations Gill Boulton*". I was detailing the appointment of the various officers and their roles in this entry. I think Gill Boulton was the CI or Inspector at the time. That role is to look at all Equality and Diversity considerations resulting from this critical incident, looking at a wide range of aspects: do we need an independent advisory group; who are the relevant community members, leaders; to provide us with

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directions around race issues or wider diversity considerations. Gill was tasked with this – I think by Garry McEwan or the ACC.

456. It was crucial that this was in place even before the Gold group to ensure we looked at that wider aspect of the incident and how it would impact not just on the local community but across the country. The potential media output that would come from the death of a black male, following his arrest by police officers, in the climate of the time, and following the deaths of other black males while in custody in other parts of the UK was significant.

457. I have been referred to page 13: "*Deployment of 2x DC's to deliver death message to confirm next of kin – sister Kadi Jonson… Delay in FLO deployment due to location that FLOs were travelling from – Cri – Decision made with DCS Boal to deploy 2 x DCs to deliver death message to prevent any further unnecessary delay*".

458. Keith Harrower was aware of that. It was a Police Scotland FLO deployment. That was before the second Gold group and Keith Harrower was aware there was a delay with the deployment of Police Scotland FLOs. Keith Harrower explained there could not be a PIRC FLO till the next day. So there was an initial lack of engagement with the family.

459. I have been referred to page 14: "*Due to request for further information from next of kin decision made to provide form of word including incident including P Scotland officer. Wording profile to DCS Boal and provided to Ds Graeme for transfer to officers at locus.*
To provide next of kin and family with further information regarding death off Sheku Bayoh."

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460. That's correct but it should be DS Graeme Dursley. I think I forgot his name when I was writing this. I think this was during the Gold meeting. I think I was called out of the Gold meeting to provide that information. Colin Robson received a telephone call and I was called out.

461. I have been referred to page 18: "*Decision to look at alternative method of identification follow on decisions by family off deceased not to attend identification at P.M.*
Identification from COPFS (David Green) around necessity to run PM to establish cause of f death. Suggested ID verification fingerprints… and also by … in alternative at hospital on 3/5/15

462. These were issues with the family around their willingness to participate in the identification of Sheku Bayoh. The alternative would be fingerprints and the other was the officers at the hospital on the day in question.

463. That was a conversation the previous evening on 3 May 2015, not 09:00 hrs on 4 May 2015. I spoke to David Green a number of times on the 3 May about the family's unwillingness to attend to identify Sheku Bayoh prior to the PM taking place. The family had initial resistance to attending so there was a lot of discussion between myself and David Green about what else could be utilised. We could use officer priors to, and after, the death, and fingerprints. That is what we were looking at as we moved together post mortem on the 4th.

464. As SIO I would be involved in the initial engagement, the scope of the investigation and around the post mortem arrangements. As SIO I would normally attend the post mortem. Keith Hardie was taking over so it was beneficial for him to attend. I would stand back from that. As SIO you are involved in the discussions with Crown around preparation for post mortem.

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465. As for the family's resistance, I think there were the obvious barriers that had been built up in respect of what they perceived had occurred around the death of Mr Bayoh. I discussed the issues we had with the deployment of FLOs, and Garry McEwan attempting to provide more information. There was clear resistance in that that they suspected Police Scotland officers were involved in the death of their family member.

466. I recall that there was a request that the post mortem was delayed for family members travelling from England to attend. I think this came from Garry McEwan and his engagement with the family. It was discussed in a Gold group. That decision is with the Crown Office. They arrange the availability of the pathologists. There was no flexibility around moving the post mortem. We had next of kin and family informed, that there was not any requirement to delay it to allow the family to attend because the post mortem was going to take place on the grounds that the Crown had directed it.

467. I do not think this contributed to the family's decision not to engage in the identification. The barriers were already in place to be honest. It was clear there was that disengagement on the 3 May. Extensive efforts were made to engage with the family however the perception in the local community of what happened, supported by the media coverage was becoming more significant and led to a challenging relationship between Police Scotland and the family. The family were disengaged and were seeking legal advice and direction at that time.

468. I have been referred to page 19: "*To speak personally to all involved uniformed officers and make them aware off scope of investigation and request to seek clothing + footwear.*

To provide transparency + integrity in investigation."

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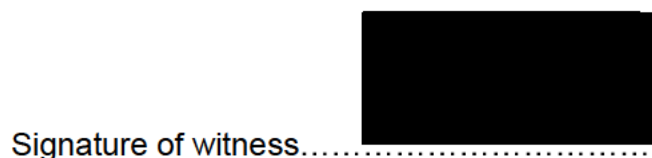
469. This should be the 3 May, not 4 May. This was my initial discussion with the officers. It is meant to be 13:00 not 1500 hrs. There was no requirement to speak to the officers, I did that to provide an update, they were extremely traumatised by what occurred. There was no requirement under the processes or procedures for me to speak to them.

470. I have been referred to page 23: "*Agreed form of words with PIRC agreed "Following post mortem exam off Sheku Bayoh cause of death has been detained as "unascertained pending toxicology" There is no evidence of any blunt force trauma injury which would have been a contributing factor to Mr Bayoh's death"*
NB: The brain has been seized for further examination."

471. This update was to be given to the family and the officers. The words were agreed with PIRC but the part about the brain being retained was left out. Evidence of petechial haemorrhaging, no fractures: I left that out because it is a more concise statement. The main part of it was that the cause of death is unascertained pending toxicology.

472. What PIRC and I were trying to provide was a concise update from the pathologist of what their findings were. They did not go into any detail of petechial haemorrhaging. It was a concise statement. I know what petechial haemorrhaging is but I am unsure of whether the officers would know.

473. Petechial haemorrhaging is the blood vessels becoming inflamed, bursting, caused by a number of things, restraint, health condition or various other conditions. At that early stage it was not appropriate that we provide them with information such as this. That is what we got from the pathology. Ultimately the decision of what we informed them was for PIRC to decide.



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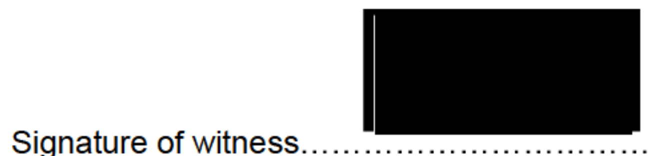
474. We can only explain and give the officers what is given by the independent pathologists. That is all we can do with the family and the officers concerns. That rests with the PIRC - to endorse what information is transmitted. That could have been withdrawn. What I deemed to be relevant was an overview of the findings of the post mortem.

475. I have been referred to the rationale for providing this update at page 23: "*Reason: To ensure no mixed messages to family and officers is passed. To ensure consistency.*"

476. I have been asked why officer welfare and wellbeing is not given as the reason. That was obvious, we would provide an update of the post mortem. It did link in for them as witnesses to this incident. References to mixed messages and consistency was about the message to the family that would go to the community and it would go to the officers. There was a single voice and there was a single form of words that would not cause conflict. We were to ensure that the family were also informed with what we were told by the pathologist. That is despite the examination of the brain and so on - that would be consistent with any unexplained death.

477. I have been asked if the family raised any concerns about this update. No, that was dealt with by the PIRC on 4 May. I was not aware of any requirements or requests. The arrangements with the family were in place and Keith Harrower spoke with the family on 4 May and it was a decision by PIRC to manage the family and the arrangements of the post mortem examination. Keith Harrower also spoke with family on the evening of 3 May.



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478. I have been referred to page 25: "*Chief Supt Gary McEwan briefed via telephone ref enquiry to date and cause of death. Chief Supt McEwan to pass agreed form off words to officers concerned.*

Local commander to pass information to the officers involved in incident."

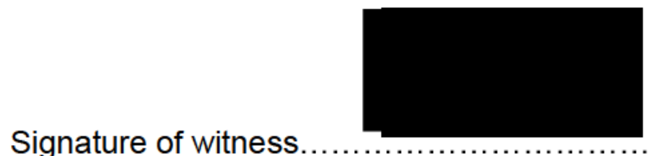
479. This was to be done by Garry because they were Garry's officers. Ruaraidh and Garry thought it would be better for him to deliver the update. Ruaraidh agreed and I did not have any issue with it. Garry had personal knowledge of the officers.

480. I have been referred to page 26: "*Small piece of cannabis resin recovered – will be progressed by division*
Agreement with PIRC to release property in question."

481. The cannabis was not really relevant. I would just pass that back to the division. I believe it was just a personal quantity, a small amount. We were retaining it, but it was not being managed as part of this investigation. It was still subject to examination. It was a case of a separate investigative strand that would be progressed by local officers.

482. I have been asked if potential cannabis resin found at an address Sheku Bayoh had visited would be of interest to the investigation into his death. From the information we had it would appear it was more the tablets that Sheku Bayoh had taken that were relevant. I was informed it was a piece of cannabis resin and it was quite clear it was cannabis. It was clear it would be seized. There was nothing else of evidential value at the property, so we could return the property to them.

483. I have been referred to page 27: *"Potential MDA offences by deceased*



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X potential requirement for Full forensic deployment"

484. MDA is Misuse of Drugs Act 1971. This is more relevant to this property, as a precursor to what had occurred. Zahid said the deceased took a clear bag of tablets from I think his sock area and proceeded to take a number of them. There was an altercation and the tablets were on the floor.

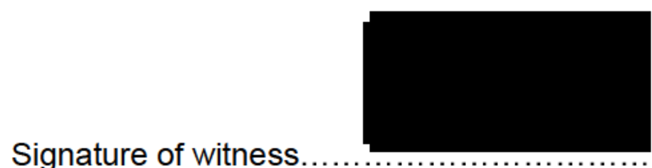
485. This would be an offence of possession of drugs under Section 5(2) of the MDA 1971. We still had to examine the recovered tablets. What we could gather from Zahid his behaviour had changed when he took them.

486. The consideration was that this may have been a contributory factor to his death - the fact he had taken controlled substances. "MDA offences" is more of a police shorthand, he had been under the influence of some sort of controlled substance but we were not sure what it was.

487. I have been asked if it is normal to investigate potential MDA offences of deceased persons. If it is linked to the incident and it subsequently leads to his death it is something we would look at, yes. We would not investigate somebody being concerned in the supply of a controlled substance after they had died. We would investigate whether the controlled substance which was taken was a contributory factor to the death of the individual – this is normally only known after toxicology is established. It was about his behaviour and conduct in the lead up to his death which, from the investigation, was completely out of character.

Race

488. I have been asked to what extent Sheku Bayoh's race was a factor in my actions and decisions in this enquiry. None whatsoever. I have never made



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any decisions throughout my service, and also in my personal life, based on someone's race or ethnicity, or religion. The wider post mortem considerations and the management of the remains of Sheku, that was not to do with race as such but more to do with his religion. Nothing I did, and no decisions I made, were influenced negatively in anyway by race. It was positive that we had an understanding of family concerns in areas surrounding that issue. In the time I was involved in the investigation, race was never a factor in my outlook, decision-making or in any of the investigative strategies which I put in place. I had, and have, no negative preconceptions regarding race. I would say that I am anti-racist. Racism from my personal perspective is utterly deplorable and has no place either in policing or in society at large.

489. There were wider considerations around our understanding of our diverse communities across Scotland. This comes through engagement with them, and also through knowledge, education, and awareness of what the expectations are of particular groups, individuals and society would expect in a modern Scotland.

490. During the response to the death of Sheku Bayoh, there was genuine concern about how his race may negatively affect the perception by the public of the police response and his death. This also extended to the impact on, and perception of, the multi-cultural and diverse communities across Scotland and the community impact that may present itself.

491. This incident also took place in a climate where there had been a number of well publicised deaths of black males in custody – particularly in England and the USA - where restraint had been a potential contributory factor. We also had a different threat level regarding international terrorism at that time, the recent murder of Lee Rigby in 2013, and with the threat level raised to severe, indicating an attack on police officers was highly likely.

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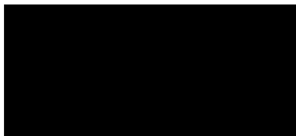
492. The threat level in the UK was sitting at severe, following terrorist attacks across Europe and threats to police officers in the UK. Police direction and memos towards the tail-end of 2015 in respect of a threats from terrorist organisations were available. It was something that myself and the Gold commander were aware of and the potential consequence in the community across Kirkcaldy and Scotland.

493. It was the perception that could possibly be taken from the incident in Kirkcaldy that it could be seen as some perhaps related to a terrorist activity or incident - but we knew it was not. We were conscious of that because of the precursor incidents, and we had a significant threat to law enforcement in Europe at that time. These were things that were of no relevance, but we wanted the public to be aware that it was not a terror related incident.

494. The aspect of any person dying in police custody is always traumatic for the family of the deceased person. It is also of concern to the police officers involved and indeed to all police officers. Thankfully such incidents are rare. The fact that Sheku Bayoh died while in police custody – regardless of his colour, nationality, or ethnic origin - was a significant concern to myself and to the senior management team in Police Scotland. A great deal of this was dealt with through the Gold group in the diversity strategy.

495. From the investigative side of things, in respect of filling in some of the gaps in the investigation that existed, by early on 3 May we were keeping an open mind but we had significant evidence how Sheku Bayoh had got from where he was the previous evening, to Hayfield Road.

496. In respect of learning from the incident, the significant gap for me, was the officers concerned not providing statements at the initial stages. There was a



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gap in respect of the use of force and who did what in the arrest of Mr Bayoh. I believe the requirement for this information at an early stage is operationally critical to any SIO, and the lack of provision of such statements or the submission of their Personal Initial Accounts impacts on the public's perception that officers are refusing to cooperate and thereafter suspicion falls on policing that something untoward has occurred. The introduction of the PIP Process at the initial stages is intended to balance the needs and wellbeing of the officers – with the requirements of the investigation. The PIP process did not significantly assist the investigation during the initial days – providing very little support – so I am not convinced that it addressed that 'balance'. I believe this matter could have been resolved far quicker and it would have resulted in greater information being provided to the family, and also to the investigation team – rather than waiting weeks for the submission of statements from the officers involved. From an investigative perspective, if they had been able to provide that initial information, even after legal advice had been provided, and if we had information at that early stage regarding the restraint and whether the force used was legal, proportionate and necessary, it may have filled that gap with the family and the community as to what had occurred.

497. If it was a black man or a man of any race or colour, it would not make a difference to me on how I led the investigation during the initial response. The challenge around this was confusion with the officers about what they had been told about not providing statements and seeking legal advice, and their lack of knowledge and awareness around the PIP Process. Perhaps that prevented the investigation from moving as quickly as possible in the early stages.

498. I cannot recall any examples of discrimination, racist jokes or comments during my service, which is not to say that it does not happen, just that I have not personally witnessed it. I have been involved in a number of investigations

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involving black and minority groups (including the re-investigation of the Surjit Singh Chhokar case). At the time, I was not aware of any racist views held by specific police officers, including those said to be held by an officer involved in this incident. This was the first time I had been in contact with these officers.

499. Although there is relevant documentation that I have not yet seen, I believe to the best of my knowledge, that 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.

1 February 2023

Date………………… Signature of witness……………………………………......