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Criminal Allegations
Against Police Division CAAPD

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DEATH OF SHEKU BAYOH KIRKCALDY 3 MAY 2015

BRIEFING NOTE

Purpose

To detail and timeline the work carried out by CAAPD between 3 May 2015 the date of Mr Bayoh's death and 11 November 2019 when the Victims Right to Review (VRR) process concluded.

Background

On 3 May 2015 Sheku Bayoh died at the Victoria Hospital, Kirkcaldy, shortly after being restrained by police officers in the town's Hayfield Road.

On that date the Police Investigations and Review Commissioner (PIRC) were instructed by the Lord Advocate to carry out an investigation in terms of Section 33A of the Police Public Order and Criminal Justice (Scotland) Act.

The original terms of reference were set out on 3 May 2015 to investigate the interaction between the police and the deceased at the time of his arrest and events thereafter.

On 5 May 2015 the terms of reference were expanded and clarified to include investigation of

(i) *The circumstances leading up the incidents namely Mr Bayoh's movements late on Saturday 2 May and during the early hours of Sunday 3 May prior to the contact with police, including his attendance at* [redacted] *Kirkcaldy and events following his attendance there.*

(ii) The incident in which the police became involved with Mr Bayoh shortly after 7am on 3 May 2015.

The terms of reference were further expanded on two occasions primarily as a result of information and representations made by the deceased's family's solicitors Anwar & Co.

On 12 June 2015 following concerns in relation to the events that occurred after the initial involvement of police offices, PIRC were further directed to investigate:

(i) Allegations by the family that they were provided with misleading and erroneous information concerning the death of Mr Bayoh to family members and a concern as to why they were provided with that information

(ii) Concerns that the initial police investigation and attempts to secure evidence were not thorough meaning that crucial evidence was lost to the enquiry

(iii) There was inappropriate conferring between police officers.

These expanded terms of reference were included following discussion on the scope of the enquiry and in particular the terms of Section 33A of the Police Public Order and Criminal Justice (Scotland) Act 2006. PIRC were instructed to investigate these aspects of the case on the basis that they might disclose evidence that could amount to the commission of a criminal offence, such as criminal neglect of duty or an attempt to pervert the course of justice.

On 2 July 2015 Anwar & Co alleged that a key witness Zahid Saeed had complained about his treatment by police officers during the investigation. PIRC was further directed on the basis that the allegation made appeared to include an allegation of criminal conduct. Accordingly the terms of reference were expanded to include

- *Allegations of criminal conduct by police officers made by Zahid Saeed including assault and abuse at Kirkcaldy Police Station*

Shortly after the death of Sheku Bayoh, the Lord Advocate and Crown Office officials met with Mr Anwar and the deceased's family to set out the direction of the investigation and to provide reassurance that it would be robust and thorough. The family were advised that there would at least be a Fatal Accident Enquiry into the circumstances of Sheku's death. The Lord Advocate (past and

present) have since continued to meet regularly with the family to advise on progress and direction of the investigation.

Anwar & Co have raised a number of concerns both with the Crown and with PIRC. Particular concerns were raised in relation to inter alia investigative techniques and approach, investigative short comings in the early stages, collusion between officers and the detrimental effect on the enquiry from officers failing to provide statements at an early stage.

From the outset the Anwar & Co were on an exceptional basis provided with significant disclosure. This disclosure was provided solely to enable them to instruct their own medical experts. The family were also from the beginning invited by the Crown to provide input to the Crown investigation and did so by e.g. suggesting particular lines of enquiry and providing the details of a number of expert medical witnesses some of who subsequently provided reports to the Crown.

PIRC's final report was submitted to the Procurator Fiscal on 10 August 2016 and considered by senior officials at Crown Office. The case was factually and legally complex in relation to cause of death and the use of force by police officers. Consideration was given to what further work was required to be carried out by the Procurator Fiscal to assist Crown Counsel in determining whether criminal proceedings should be libelled against any individual officer and/or the Police Service of Scotland.

Towards the end of August 2016 the case was allocated to two Senior Procurator Fiscal deputes working under direction and supervision of Les Brown then Head of Criminal Allegations Against the Police Division. A dedicated Advocate Depute (Ashley Edwards QC) was also allocated to the case.

A report was submitted to Crown Counsel on 16 May 2018, 22 months after receipt of the final PIRC Report. On 13th June a Supplementary Report was submitted to Crown Counsel in respect of the analysis of evidence and recommendations about Health and Safety Act and Corporate Homicide. [redacted]

This decision was intimated to the family by the Lord Advocate at a meeting in Crown office on 3 October 2018. The reasons, discussed at the meeting, were confirmed to the family by the DCA in a letter dated 4 October 2018. In her

letter the DCA advised the family of their right to review the Crown's decision under the Crown's Victims right to Review Procedures (VRR).

Mr Bayoh's family through their legal representative submitted a VRR application on 1 February 2019. The initial application was supplemented by subsequent correspondence up to 13 June 2019. Additional representations were made during the review process and it was appropriate for all the issues raised by the family to be fully addressed. The review raised a number of complex issues some of which required further investigation by the Crown and this had a bearing on the time taken to complete the review.

[redacted]

Crown Investigation

The Crown investigation was primarily focussed on the actions of the police officers involved in restraining the deceased, the restraint techniques used and whether they were justified and proportionate in the circumstances. Further the Crown sought to establish as precisely as possible the cause and mechanism of death.

The precognoscers wished to establish if there was any evidence of criminality on the part of the material police officers either individually or collectively or by the Police Service of Scotland. The offences under consideration were:

Assault

Culpable homicide

Corporate homicide – in terms of section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007

Contravention of section 3(1) of the Health and Safety at Work Act 1974

Attempt to Pervert the Course of justice

It was decided at the outset to precognosce all the civilian witnesses who viewed the restraint process along with the ambulance personnel who attended the locus. Precognition was necessary to ensure the Crown had a precise factual background before consulting expert witnesses. The Crown were also mindful of the criticisms being made in regard to PIRC's statement taking. Witness precognitions are discussed further below.

The work carried out by the precognition team is detailed below.

In September 2016 the precognoscers started by familiarising themselves with the 4 volumes of the PIRC Reports, witness statements and available CCTV.

Statements

PIRC submitted almost 400 witness statements to the Crown which were reviewed by the precognoscers. During this process a very detailed summary of each witness statement was prepared. Although a time consuming exercise, this allowed precognoscers and later Crown Counsel to electronically cross reference witness accounts and search for key words. This witness table was particularly useful in comparing and contrasting the accounts of the officers involved in restraining the deceased.

All the statements obtained from the material officers were also examined and compared to transcripts of airwave messages. This was to establish if there had been any deliberate attempt to mislead PIRC investigators about what they knew about the incident at a certain time e.g. whilst on route to Hayfield Road, perhaps with a view to justifying the level of force later used. An example where an officer might have appeared to be misleading PIRC was found within PC Walker's statement. In his statement PC Walker said he was made aware by an airwave message that 'the weapon had been described as a sword and the male appeared to be under the influence of a substance and attacking passing cars…' The precognoscers' examinations of the airwave transcripts showed no such information was passed to officers on route to Hayfield Road. The content of officers' statements was addressed in the Report to Crown Counsel

PIRC had not compared the material officers' statements with the airwave transcripts and it was one of the necessary steps taken by the team to establish whether or not any of the material officers had attempted to pervert the course of justice.

Accuracy of Statements

During the precognition process (discussed below) an issue was identified in relation to the accuracy of the statements submitted by PIRC. This came to light during the precognition of Ashley Wyse. At page 60 of Volume 1 of the PIRC Report Wyse was attributed as stating '*The deceased was lying on his back and that it looked like one of the police officers was using a baton on the deceased's upper chest, towards his throat, to hold him down'* Wyse provided PIRC with two statements neither of which contained the above information. Enquiries with PIRC confirmed that the original version and Clue2 version both contained the reference but the paragraph had been omitted in error when the statement had been copied as it fell between two pages.

On 24 October 2016 PIRC were asked to provide an assurance that all statements submitted to the Crown had been checked for accuracy and that

there were no similar omissions. On 26 October 2016 Mr McSporran at PIRC confirmed all statements had been checked and were in order.

At the beginning of March 2017 there was further concern PIRC had not proof read statements despite Mr McSporran's earlier assurances. This followed comparison of Wyse's manuscript statement and typed statement which revealed a number of typos and inaccuracies between the two.

On 15 March 2017 Mr Brown wrote to Anwar & Co and advised that Ashley Wyse's statement (referred to as Witness S) had been disclosed incomplete due to an administrative error. On same date the DCA Mr McGowan advised the PIRC Commissioner by letter that Wyse's incomplete witness statement had previously been disclosed to the deceased's family and expert witnesses. Reassurance was sought from the Commissioner that all typed statements had been proof read and compared with the original handwritten versions for accuracy.

On 28 April 2017 the Commissioner advised the Crown by letter that a manual check of all the remaining statements had been completed with each statement having been proof read and compared against the original handwritten version for accuracy. It is now clear the statement checking exercise had not been completed at the time of the Commissioner's letter. On 14 June 2017 Deputy Senior Investigator William Little advised the Crown by letter that the statement comparison process had now been completed and enclosed a disc containing 21 statements where omissions had been identified and rectified.

The initial failure to provide accurate statements caused significant extra work to be carried out by the precognoscers. The amended statements required to be sent to all the expert witnesses who were asked to confirm if anything contained within amended their opinion. None of the experts wished to amend their opinions. Statement folders previously prepared for Crown counsel also had to be recalled to have statements removed and replaced with correct version.

<u>Rib Fracture</u>

During the analysis of the statements it was noted that three of the officers involved in the restraint had made reference to hearing the deceased fracturing a rib during the administration of CPR.

The deceased's ribs appeared to be intact at the post mortem on 4 May 2015 however a fracture to his left first rib was discovered following a further examination by pathologists on 29 May 2015. That same day Mr Brown advised Anwar & Co and PIRC about the deceased's rib fracture.

In his statement dated 4 June 2015 PC Walker told PIRC he heard the sound of a rib cracking when he was a carrying out CPR. At this time PC Walker handed over an undated pre-prepared statement to PIRC. Notably, in this statement PC Walker made no reference to hearing a rib crack during CPR.

Two other officers, PCs Paton and Tomlinson also made reference in their PIRC statements dated 4 June 2015 to the deceased's rib fracturing during CPR.

Within the PIRC Report, Medical Experts instructed by PIRC put forward various scenarios as to how it could have occurred.

The Crown carried out extensive further independent enquiries in relation to the deceased's rib fracture. Although the rib fracture did not lead to Mr Bayoh's death the precognoscers recognised that its very existence may have illustrated the force and mechanism of restraint used by the officers. To that end in February 2017 the Crown instructed Professor Anthony Freemont, an osteo-articular pathologist at the University of Manchester. In his report dated 3 July 2017 Professor Freemont concluded inter alia that the rib fracture occurred in life, prior to contact with the police and was unlikely to have been caused during CPR. His timeline and conclusions are discussed more fully below in relation to the medical evidence.

The precognoscers found it of interest that the information about the rib fracture which was only made known to PIRC on 29th May 2015 was somehow potentially being explained away by three of the officers when they provided statements on 4th June 2015. After careful consideration of all the evidence there was insufficient evidence to make any more of it other than to say it was suspicious, and potentially called into question the integrity of the PIRC investigation at that point.

CCTV and Timeline

The precognoscers spent a number of weeks reviewing and analysing CCTV footage recovered by PIRC. The principal CCTV footage was obtained from a camera situated in the car park of Gallagher's Public House at the junction of Hendry Road and Hayfield Road. It was analysed alongside a timeline produced by PIRC which was found to contain inaccuracies.

Although the footage is of poor quality, by contrasting with the accounts of material witnesses, airwave messages, and calls to Police Scotland the precognoscers were able to produce a detailed timeline of events for Crown Counsel. The timeline allowed the precognoscers to pinpoint with confidence important markers in the incident such as the arrival times of police vehicles, the duration of the restraint process and the moment officers realised the deceased was in medical difficulty.

Precognitions

The precognoscers were tasked with precognoscing all eye witnesses to the restraint process along with ambulance personnel. A total of 16 witnesses were

identified for precognition. Precognitions started at the beginning of October 2016 and all except one (Sean Mullen discussed below) were completed by 23 November 2016.

Consideration was given to whether the Crown could simply rely on the statements obtained by PIRC but this was not considered appropriate given the nature of the decision Crown counsel was being asked to make. The Crown were also mindful of Mr Anwar's criticism of PIRC's approach to statement taking, and particularly his observation that similar distinct phraseology was used by a number of independent witnesses.

Consideration was also given to whether it was possible to precognosce witnesses of fact and experts witnesses concurrently but it was decided it was essential have a precise factual background available prior to consultation with experts.

The precognoscers took an 'old fashioned' approach to these precognitions. This allowed witnesses to describe events in their own words which were noted verbatim. Questioning was limited to clarification to ascertain if there was any merit in Mr Anwar's comments regarding the civilian witnesses statements.

Although PIRC made reference in their report to Sean Mullen and his passenger Danny Robinson it is respectfully submitted they did not fully recognise their significance. Both PIRC statements were relatively short and did not reflect the time they were at the locus. Mullen and Robinson arrived at the scene at the same time as Police Vehicle 1 and watched events unfold for a total of 1 minute 41 seconds from four different positions on the roadway. The precognoscers did considerable work to establish Mullen and Robinson's line of sight from each position. This information was thereafter inserted into the SPA composite disc discussed below.

Mullen failed to attend for precognition on a number of occasions, despite being personally served with a citation by PIRC and being spoken to personally by the precognoscers. He was eventually precognosced on 20 December 2017. At precognition the Crown were able to establish further important detail from Mullen. In particular he spoke to the deceased attempting to kick PC Short whilst she was on the ground, a fact not contained in his PIRC statement. [redacted]

Ashley Wyse Snapchat

PIRC retrieved four Snapchat videos from Ashley Wyse's mobile telephone. Although PIRC produced a detailed timeline detailing the content of each clip

they did not try to establish the timings of the clips and therefore did not recognise their significance.

By mapping the arrival times of police vehicles the precognoscers were able to establish that the first snapchat clip occurred at some point between 07:21:47 hours and 07:22.27 hours, significant as the restraint process started at 07:21:08 hours.

Following a request by the Crown in November 2017 PIRC evidenced timings for the Snapchat clips which were then inserted alongside the Gallaghers CCTV footage in the SPA Composite disc. In relation to the first clip which is of most significance PIRC managed to narrow the timescale to a period between 07:22:09 and 07:22:25 (16 seconds) by finding the relevant point in the Gallagher's footage.

Having identified the timing of the CCTV the footage was again compared with the accounts in the statements of the officers present at that time.

From the Composite disc containing both the Gallagher's CCTV and the Snapchat 1 Clip precognoscers were able to establish that 1 minute, 1 second into the restraint only one police officer was lying either beside or on top of the now deceased . None of the other officers present were on top of the deceased and there was no "pile up".

Identifying the timing of the Snapchat clip 1 was an important piece of work carried out by the precognition team. It allowed a brief glimpse of the methods of restraint being used at that time. This enabled the precognoscers to ask the OST Expert for his opinion on the actions of the police officers at that particular time.

Medical Evidence

The cause of death recorded in the final PM Report recorded a combination of possible contributory factors which required to be further explored by the precognoscers.

Dr William Lawler

On 3 April 2017 the Crown instructed Dr Lawler a former Home Office Pathologist to act as an independent reviewing pathologist. His role was to review the various reports, particularly the reports dealing with the cause of death and provide opinion on the methodology and approach adopted.

Dr Lawler produced his first report on 22 May 2017. Following receipt of reports by Professor Freemont and Professor Eddleston he was requested to also consider these reports and produce a supplementary report. Dr Lawler produced

his 2nd report on 13 August 2017. Dr Lawler produced further reports on 13 March 2018(body images) and 21 May 2018 (pulse activity).

Professor Anthony Freemont

On 15 February 2017 the Crown made initial contact with Professor Freemont at Central Manchester University with a view to obtaining an opinion on the significance of the deceased's rib injury and particularly whether the fracture could have occurred during the administration of CPR.

A letter of instruction along with an expert witness package was sent to Professor Freemont on 16 March. The letter and expert witness package was only forwarded to Professor Freemont once PIRC confirmed the accuracy of witness statements.

The precognoscers specifically asked him to consider:

a) The mechanism of the fracture and whether it was more likely to have been caused by the process of restraint or the use of an external 'thumper' for CPR

b) The force required to cause a fracture of this type

c) If the fracture could have been caused during CPR and the likelihood the fracturing would have been audible

On 30 March Professor Freemont requested to have sight of samples obtained from the deceased at post mortem and arrangements were put in place for him to examine them on 27 April.

Professor Freemont submitted a report on 2 May 2017. However on 8 May he emailed the precognoscers stating he had been thinking 'long and hard' about the case and requested further information. Following consultations with Dr Kerryanne Shearer the information requested was provided to Professor Freemont on 17 May.

On 5 June Professor Freemont requested some special stains to be prepared and submitted to him in Manchester for examination. He carried out his examinations on 21 June and produced his report on 3 July 2017. He concluded all the evidence pointed to the deceased having sustained an isolated left 1st rib fracture in life. In terms of aging relative to the time of death, it occurred definitely within 24 hours of, probably within 6 hours of, and almost certainly no less than 2 hours before death. It was improbable that the fracture was caused by CPR. Due to the anatomical relationships of the 1st rib, whilst a direct blow could have caused the injury, it was unlikely in the absence of fractures of other adjacent bones. The most plausible cause of the fracture was an indirect injury such as falling on an outstretched arm or a blow to or fall onto the shoulder.

Professor Freemont was unable to explain the sound reported by officers during CPR but did not believe it was caused by the 1st left rib fracturing.

Professor Michael Eddleston

On 26 April 2017 the Crown instructed Michael Eddleston, Professor of Clinical Toxicology, University of Edinburgh to comment on the behavioural impact of the drugs taken by the deceased. In particular he was asked to provide an opinion on the individual and any synergistic effects of MDMA and Alpha PVP on the brain. More particularly the Crown sought to establish what effects the levels and combination of these two drugs may have had on the deceased's mood, cognitive ability and behaviour. Professor Eddleston produced his report on 2 June 2017.

Professor Eddleston concluded the deceased had been suffering from 'drug – induced psychosis' which he further described as 'stimulant or sympathomimetic drug-induced psychosis.

Professor Eddleston also raised the question of whether the PSOS Use of Force Standard Operating Procedure (SOP) in place at the time of the deceased's death adequately covered the situation in which officers found themselves in. His concerns are set out in detail in his report but essentially he was critical that the SOP made no link between the guidance for mental health conditions and the guidance for persons suffering from drug induced psychosis.

Following Professor Eddleston's concerns in August 2017 PIRC were asked to carry out inquiries to establish the provenance and medical governance informing the relevant sections of the SOP. Additionally the precognoscers wished to satisfy themselves that current officers were receiving adequate guidance on mental health conditions including drug induced psychosis. Through extensive enquiries PIRC established that the OST training as at 3 May 2015 was based on the Probationer Training Safety Manual which included a module on excited delirium. The Use of Force SOP was not referred to during training.

Sickle Cell

In her initial report dated 14 August 2016 submitted to PIRC Dr Soilleux noted some red blood cells with abnormal perhaps sickling morphology on some of the histology slides. Whilst not suggesting sickle cell disease was solely responsible for death she suggested genetic testing for sickle cell anaemia and related abnormalities.

Following his review of the medical evidence on 22 May 2017 Dr Lawler also suggested that it would be worthwhile checking if the deceased had one of the haemoglobinopathies specifically sickle cell disease.

On 3 October 2017 it was confirmed the deceased was a carrier for sickle cell trait. The pathologists advised this had no relevance to cause of death but it would require to be disclosed to the deceased's family. However, at consultation with the Crown on 30 January 2018 Dr Lawler recommended further opinion be sought from a haematologist.

At the beginning of February 2018 the Crown contacted a number of haematologists from around Scotland but due to the complexities of the case none were willing to provide an opinion.

On 16 March 2018 Mr Brown consulted with Dr Soilleux who confirmed her earlier opinion the deceased being a carrier of sickle cell may well have been a factor in his death.

On 6 April 2018 the Crown contacted the Sickle Cell Society and obtained a list of Sickle Cell Centres and experts. A number of specialists in Scotland were approached none of whom felt in a position to assist given the complexities of the case.

Dr Soilleux produced a second report on 10 May 2018. She also suggested the Crown make contact with haematologist Tim Littlewood at Oxford University hospitals who in turn suggested the Crown speak to Professor David Rees at King's College Hospital in London.

Crown Counsel Mr Brown consulted with Professor Rees in London on 8 May 2018 and he suggested contact be made with Professor Sebastian Lucas at St Thomas Hospital. Professor Lucas subsequently submitted a report to the Crown on 18 June which confirmed his earlier oral opinion that sickle cell trait contributed to the cause of death.

<u>Body Mapping</u>

On 7 February 2018 the precognoscers met and consulted with Andy Mason SPA Forensic Services at the Scottish Crime Campus. Later that day Mr Mason produced 3d Body Mapping images detailing possible positions of the deceased based on the accounts of eye witnesses and the material officers.

The images captured on 7 February 2018 did not fully capture the body position envisaged by Crown Counsel and the precognoscer and Crown Counsel met with Mr Mason on 9 February 2018. Following this meeting Mr Mason produced further 3D Body images on 16 February 2018.

On 27 February 2018 the Crown sent the 3D Body Positions multimedia disc to Dr Lawler for his consideration and to confirm if any of the images caused him to alter his views already stated in his reports and at consultation. After reviewing the images Dr Lawler produced a third report dated 13 March 2018.

OST Expert

The Crown encountered considerable difficulty in identifying a suitable OST Expert. A number of enquiries were made in England and Northern Ireland. In December 2017 the Metropolitan police College in Hendon was approached for assistance. Unable to put forward one of their own officers to assist they provided details of a known and trusted former training officer Martin Graves, now operating as an OST expert in the private sector.

Mr Graves was contacted on 19 December 2017 and initially provided with general non-specific details about the case. The following day Mr Graves forwarded his CV and confirmed he would be in a position to start reviewing the materials and be in a position to provide a report from mid-January 2018. Following Crown Counsel's agreement Mr Graves was formally asked to provide a report on 22 December 2017.

Mr Graves was contacted by telephone on 8 January 2018 and provided with specific details about the case.

A detailed letter of instruction and pen drive was couriered to Mr Grave's business address on 24 January 2018. The letter of instruction referred to a report delivery date of mid-February which had been discussed previously.

The original materials provided to Mr Graves in January included documentation in relation to the training delivered to the material officers. On 21 February 2018 Mr Graves was advised by email that PIRC had carried out further enquiries in relation to the nature and content of officer training and a further letter of instruction and materials was being prepared.

On 22 February 2018 Mr Graves advised the Crown that he had not been able to devote time to preparing his report [redacted]

A second letter of instruction and materials was couriered to Mr Graves on 24 February 2018 and he was asked if he would be in a position to deliver his report by 19 March 2018 as precognoscers were aiming to submit their report to Crown Counsel on 23 March 2018. On 7 March 2018 Mr Graves confirmed his report would be completed and available prior to going on annual leave on 22 March 2018.

On 16 March 2018 Mr Graves advised the Crown that he was unable to play a number of titles on the SPA Multimedia Presentation disc. The disc was originally provided to Mr Graves along with the first letter of instruction on 24 January and it would appear he only attempted to view it for the first time on 16 March. A further multimedia disc was couriered to Mr Graves on 16 March 2018.

Further on 16 March 2018 the precognoscers made arrangements with Mr Graves to discuss his emerging conclusions over the telephone on 21 March

2018. This was with a view to finalising the report to Crown Counsel by 23rd March 2018. Although the consultation with Mr Graves was very useful he advised the Crown that his report would not be completed until 6 April 2018. As a result it was decided not to submit a report to Crown Office until Mr Graves report was received and assessed and ongoing sickle cell investigations progressed.

On 5 April 2018 Mr Graves advised the Crown that he required further time to complete his report given the complex nature of the questions contained in the letter of instruction.

The OST Report was received on 14 April 2018. It was examined in detail and was found to contain a number of typing and dictation errors. A number of points re factual accuracy were also raised with Mr Graves. After consideration of the points raised by the Crown Mr Graves initial report was treated as a draft and he submitted his final report on 29 April 2018.

Mr Graves was precognosced by the precognoscers at Paisley PF office on 11 May 2018.

Airwave System

The precognoscers carried out detailed analysis of the messages transmitted on Police Scotland's airwave system. As stated earlier this was principally to establish what information was available to the officers whilst en route to the locus. Following an instruction by the precognoscers PIRC also established information could not have been communicated to officers by any other means other than through the recorded channels.

By comparing PIRC prepared transcripts with CCTV footage the precognoscers were able to establish a crucial message passed at 07:20:49 hours had been attributed by PIRC to the wrong officer (PC Smith) as he had not yet arrived at the locus. PIRC were requested to carry out further investigations and it was established that the message was most likely passed by PC Paton who had pressed his emergency button at this time.

SPA Composite Disc

The precognoscers and PIRC attended a number of meetings with Frank Brown at SPA Forensic Services at Gartcosh with a view to SPA producing a multi - media presentation to assist Crown Counsel's decision making. In December 2017 the Forensic Services Section of the SPA produced a composite disc containing various pieces of electronically recorded information. It includes a Timeline containing maps providing locations and chronology of the early morning events prior to police arrival. It also includes a separate link to the

various pieces of CCTV footage and a map showing the positions of both witnesses and civilian and police vehicles. The disc also contains audio recordings of emergency calls and airwave recordings. Additionally there are 360 degree panoramic views of the locus from various locations on Hayfield Road.

CCTV, audio and snapchat footage was also synchronized and combined to produce a chronology of events. From this the precognoscers were able to establish the exact period of restraint. A stop-clock was inserted in the right hand side of the screen which starts when the deceased was taken to the ground and stops at 4 minutes 2 seconds when PC Smith called for an ambulance.

Health and Safety at Work Act 1974

The precognoscers also considered whether there was any evidence to consider a breach of section 3 (1) of the Health and Safety at Work Act 1974 by the Chief Constable of Police Scotland or any individual officer.

The precognoscers considered that Police Scotland could have breached the Act if the training delivered to officers in relation to the method of restraint and recognising individuals with drug induced psychosis was deficient.

As stated earlier Professor Eddleston questioned whether the Use of Force SOP in place at the material time was fit for purpose. He was critical that the SOP made no link between the guidance for mental health conditions and guidance for excited delirium.

Through further extensive enquiries directed by the precognoscers PIRC established that police officer safety training was based on the Probationer Training OST Manual and a PowerPoint presentation which contained detailed information on excited delirium. The SOP did not form part of the training. The training officers who delivered OST training latterly to the officers involved in the restraint all confirmed officers would have been reminded of the issues of excited delirium and positional asphyxia during their OST refresher training.

Following these further enquiries the Crown were in a position to put their findings to OST Expert Martin Graves who overall was unable to point to any obvious and significant gap in the materials which would justify a section 3 charge being libelled.

Media Reference re Eye Witness not followed up by PIRC

On 24 May 2018 the precognoscers identified a newspaper article whereby an apparent eye witness claimed they had spoken to police at the time but had never been revisited.

The precognoscers prepared a list of witnesses who resided in Hayfield Road and a list of witnesses who viewed the restraint process. PIRC were asked to do a similar exercise after which the lists were compared and matched up.

To rule out the possibility that someone had provided relevant information or an eye witness account to police or PIRC which had not been properly followed up, PIRC carried out a full manual check of all the House to House Forms.

Following this exercise the Crown satisfied themselves all relevant witnesses had been identified during the investigation process and the selection of witnesses to be precognosced was sound.

Consultations

Mr Brown and Crown Counsel together and individually carried out a number of consultations with expert witnesses prior and post submission of the Report on 16 May 2018:

Dr William Lawler (Reviewing Pathologist) 30 January 2018

Dr Liz Soilleux (Sickle Cell) 16 March 2018

Professor David Rees 8 May 2018

[redacted]

Dr Anthony Bleetman 9 May 2018

Dr Kerryanne Shearer (Pathologist) 4 June 2018

Martin Graves (OST) 20 August 2018

Access to CCTV Footage

A BBC Scotland 'Disclosure' programme broadcast on BBC1 on 17 December 2018 featured CCTV footage from Gallagher's Public House and mobile telephone footage taken by Ashley Wyse a resident in Hayfield Road. Both pieces of footage were initially seized by Police Scotland and provided to PIRC shortly after the incident. The programme also highlighted extracts from redacted statements and one particular document the PIM log. It is unknown how the BBC managed to obtain this footage and documentation.

The precognoscers were tasked with compiling a list of everybody who had been provided access to the CCTV footage. In addition to COPFS and PIRC 16 people were identified but it was not possible to identify who had provided the materials to the BBC.

Review Process

A VRR application was submitted on 1 February 2019. The initial application was supplemented by subsequent correspondence up to 13 June 2019.

The review was carried out by Principal Crown Counsel. As part of his review he also consulted with the OST Expert Martin Graves on 28 June 2019.

The VRR was concluded on 11 November 2019.

A number of issues required to be addressed by the precognoscers during the VRR process:

Kirkcaldy Police Office CCTV

In February 2019 further enquiries were carried out by the Crown in relation to CCTV footage seized from Kirkcaldy Police office in the aftermath of the incident. This followed a letter of 8 February 2019 from Anwar and Co further to the VRR in which he expressed concerns about the thoroughness of PIRC's examination of the CCTV. The letter expressed concern at the absence of any footage from both the canteen and back door of Kirkcaldy Police Office. It was further suggested that the examination of the footage was inadequate and that a number of cameras within the office that could have contained relevant footage had not been considered. This may have affected the Lord Advocate's decision not to prosecute.

PIRC advised the Crown no cameras were present within the canteen or the back door to Kirkcaldy Police office. PIRC confirmed they had viewed all footage contained on all 16 cameras within Kirkcaldy Police office. Each camera contained approximately 18 hours footage albeit the cameras were motion sensitive and did not record unless activated. PIRC only produced transcripts for 5 of the cameras as the other 11 cameras covered cells and contained nothing of evidential value.

The precognoscers viewed all the footage from the 5 cameras comparing same to the transcripts prepared by PIRC. The transcripts were found to be accurate and completed to a high standard. The PIRC examination of the CCTV proved to be both reasonable and proportionate.

PC Short

In a further letter dated 25th March 2019 further to the VRR Application, Anwar & Co contended that CCTV footage from Gallagher's Pub 'showed that contrary to the police version of events there had been no contact between Mr Bayoh and Nicole Short and no repeated stamping and kicking by Mr Bayoh.'

As this was a major focus of the VRR Application, the precognoscers on the instructions of the Reviewing AD obtained a report from former Rudy Crawford a Consultant in Emergency Medicine. After examining PC Short's medical records, statements and CCTV footage Mr Crawford found nothing in the medical evidence that was inconsistent with or cast doubt upon the accounts given.

[redacted]

Conclusion

It is anticipated that the length of time taken by PIRC and the Crown to investigate the circumstances surrounding the death of Mr Bayoh may become subject to future scrutiny.

Mr Bayoh died on 3 May 2015. PIRC submitted their final report to Crown Office on 10 August 2016 and the precognoscers submitted a report to Crown Counsel on 16 May 2018. Crown Counsel issued instructions on 26 August 2018 and the decision not to prosecute was conveyed to the family on 3 October 2018.

The whole investigation therefore took 3 years and 3 months to complete.

It is respectfully submitted after receipt of the PIRC Report the Crown had to take forward a number of important enquiries. The enquiries were necessary before any assessment of criminal liability of Police Scotland or individual police officers.

The enquires related to establishing:

1. The precise factual background of the incident;

As has hopefully been demonstrated the precognoscers spent a very significant period of time in the earlier part of the investigation trying to establish exactly what happened in Hayfield Road that morning. This involved careful examination of all the available evidence including witness accounts, airwave transcripts and CCTV. Following this the SPA were able to produce a multi- media disc which synchronised CCTV, Airwave Audio and Snapchat footage and also a Body Mapping disc portraying various positions described by the witnesses.

From this the precognoscers were able to provide expert witnesses with a better factual basis of events at Hayfield Road.

2. The cause and mechanism of death.

Given the significance of the medical evidence in this case the Crown was required to instruct a number of expert witnesses and was at their mercy with regard to timescales. Mr Grave's final report was certainly received later than expected and did undoubtedly put back the reporting date by a short period. On the other hand the precognoscers were careful to allow experts appropriate time to complete their investigations.

Receipt of expert reports often led to further enquiries and the precognoscers continuously referred back to witness statements, CCTV and airwave transcripts etc. And as can be seen particularly with Dr Lawler the precognoscers often required to seek further opinion once new evidence became available.

[redacted]

[redacted]