David [redacted] Green, born [redacted] 1959,

Procurator Fiscals Office

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I have been a Procurator Fiscal for 39 years, I am currently Procurator Fiscal for Homicide and Major Crime in Scotland.

My previous post was Head of the Scottish Fatalities Investigation Unit (SFIU). I had been in that post since 2012, when the unit came into existence. The Scottish Fatalities Investigation Unit is responsible for investigating all sudden, unexpected, unexplained and uncertificated deaths in Scotland. Sub-units of SFIU dealt specifically with deaths in the Health and Safety context (HSD) and with deaths as a result of a Road Traffic collision (RTFIU). As head I had responsibility for all areas of work in SFIU, HSD and RTFIU. Essentially I was responsible for investigating all deaths occurring in Scotland which were not homicidal or suspicious of homicide. Staff in these units were based in Glasgow, Edinburgh, Inverness and Aberdeen. As there was no provision for on call cover for these units it fell to me to provide an out of hours on call service 24/365. Having been a Procurator Fiscal since 1983 I had had exposure and involvement in deaths investigation from my earliest days in the service. I have dealt with innumerable deaths of all description including some hundreds of murders. In the 2000s I had responsibility for the Glasgow deaths unit responsible for all deaths investigations, other than homicide, in Glasgow. I was, however, responsible for the homicides which occurred in my own Division. I was involved in all the deaths in custody which occurred in Glasgow during that time. I had received on the job training since 1983 and other training in the intervening years. More recently I provided training for my deputes, as well as training for members of the medical profession and police officers into aspects of deaths investigation. I have had significant involvement in deaths investigation of all types including deaths in custody.

The Lord Advocate has responsibility for the investigation of all sudden unexpected, unexplained, uncertificated and suspicious deaths occurring in Scotland. In former times the local Procurator Fiscal, as representative of the Lord Advocate would be responsible for all such investigations. More recently the Service has been reorganised with specialist units brought into being with responsibility for specific areas of work such as homicide's (Homicide Unit) and deaths investigation (SFIU). Staff in SFIU would receive reports of deaths from the police, medical practitioners, registrars of death etc and would take all necessary steps to investigate the death such as instructing post-mortem examination, toxicology and any other specialist reports. Instructing the police on investigations to be carried out by them, seeking specialist medical reports, reports from the Health and Safety Executive, AAIB, RAIB etc etc and any other action required. On completion of the investigation the final report would be sent to Crown Office for Crown Counsel instruction on whether or not a Fatal Accident Inquiry should be held. The decision on whether to hold a fatal accident inquiry is entirely a matter for the Lord Advocate.

If during investigations evidence of criminality was uncovered the case would be passed to the relevant unit such as Homicide, Health and Safety Unit or CCAPD.

Before the advent of Police Scotland it was open to the Procurator Fiscal, in consultation with the local Chief Constable to instruct an outside force investigate any death in police custody. When Police Scotland were established it was necessary for the role of the Police Investigations and Review Commissioner (PIRC) to be extended to include an investigative role in order that they could, independently, investigate any death in police custody or following contact with the police.

In advance of Police Scotland coming into being in 2013 and having regard to the enhanced role of the PIRC, meetings had been held involving Crown Office, the Police and PIRC to establish the process for dealing with deaths in custody of the police or following contact with the police in order that all organisations understood their role. I was involved in these discussions along with my then colleague Kate Frame who was the Head of Criminal Complaints Against the

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Police (CCAPD) at Crown Office. The discussions involved all aspects of interaction between ourselves, Police Scotland and PIRC and were not limited simply to deaths investigations. The process that was agreed in a death case was that the Professional Standards Department of Police Scotland would, having been advised of a death in custody or following please contact, would contact myself or my deputy, for me to consider whether PIRC should be instructed to investigate or the investigation would be left with police Scotland. Plainly there might be occasions when colleagues in CCAPD would be required to be involved and I would do that when required. Both pre and post Police Scotland coming into being scenarios were considered and tested with both Police Scotland and PIRC involved. Not all deaths after police contact require to be independently investigated e.g. circumstances in which the contact is fleeting or occurred some time ago. All deaths in police custody require to be independently investigated and PIRC are always instructed to investigate as soon as COPFS are made aware of the death.

Between 2013 and 2019 I instructed numerous PIRC investigations. I know I instructed the vast majority of such investigations, only if I were on leave would someone else do this. I am afraid I do not hold any records in this regard but PIRC may do so.

My involvement in the investigation into Mr Bayoh's death was as follows:-

On Sunday 3rd May 2015 I received a telephone call from the on call senior officer at Professional Standards, Police Scotland. I cannot now recall who this was. I was advised that an incident, resulting in a death in custody had occurred in Kirkcaldy. I was advised that at about 07.15 hours police had received calls from the public alerting them to a black male, stripped to the waist, brandishing a knife and approaching members of the public in cars. My recollection was that he was said to have banged the knife on the roof of a car being driven by a nurse on her way to work. I was advised that officers had been detailed to search for this male and that 4 police vehicles containing 7 officers had located the man. On approaching him he had run at the officers and a struggle ensued.

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I was advised that he had struck a female officer had but that this was not with a knife. I was told that PAVA spray had been used but that this had no effect. That the man had been struck with batons and that during the restraint handcuffs and leg restraints had been utilised.

I was told that during this the male had collapsed and that CPR had been commenced by police officers and continued by ambulance personnel who were called to the scene. The man, who was named as Sheku Bayoh, was conveyed to the Victoria Infirmary, Kirkcaldy where he received treatment but despite the efforts of medical personnel he had succumbed.

I informed the officer that I intended to refer the matter to PIRC who would take over the investigation. I was also advised that it appeared Mr Bayoh had been watching a boxing match earlier in the morning with friends and that there had been some sort of altercation between them. I instructed that Police Scotland could carry on investigating this earlier incident but that the circumstances leading up to his death were to be investigated by PIRC.

I then tried to contact the PIRC on call number, my recollection is that the call went to voice mail and I asked to be called back. I then called my colleague Stephen McGowan and made him aware of the circumstances as I understood them, that I was referring the matter to PIRC and would also take steps to arrange a 2 Doctor post-mortem. I was concerned that the Crown Agent, Law Officers and other colleagues be made aware of this as I anticipated media interest in what was obviously a high-profile incident.

At about 09.30 I made contact with Keith Harrower, Senior Investigator at PIRC who was on call. I made him aware of the circumstances and instructed that PIRC should investigate the incident from the point of the reports coming into the police about his behaviour till his being confirmed dead at the hospital. That the police would investigate the matters that occurred elsewhere, earlier that morning as they did not appear connected and that I would arrange a 2 Doctor post-mortem. I confirmed that the body was at the Victoria Infirmary and would be transferred to Edinburgh City Mortuary for examination. I also advised that all

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officers involved were either at or on their way to Kirkcaldy police office where a post incident management process would take place.

I next called back the officer from Police Professional Standards advising him of Keith Harrower's identity and contact details and confirmed my instructions. I was advised senior officers were aware and that a handover to PIRC would be facilitated.

I then followed up these calls with emails sent to Police Professional Standards, PIRC and colleagues in Crown Office. This is normal practice. These emails set out the background and my instructions to PIRC which were to investigate the circumstances of the death as stated above, in terms of the Police, Public Order and Criminal Justice Act 2006 Section 33A (ii) namely to investigate, on behalf of COPFS, the circumstances of this death involving a person serving with the police which the Procurator Fiscal is required to investigate. I did not instruct an investigation in terms of Section 33A (i) which relates to an investigation "*in which there is an indication that a person serving with the police may have committed and offence*" as at that point I had no evidence which might have given such an indication.

It should be noted that the instruction to PIRC could be modified at any time and in this case was modified to S33A (i) either on 4th or 5th May by which time I was no longer involved in this matter.

It was my intention to follow up these instructions with formal letters on Tuesday 5th May on my return to the office but by then the matter had been taken out of my hands so I did not do so.

My expectation was that PIRC would, as soon as possible, deploy to Kirkcaldy and take over the investigation. I fully expected that they would oversee the PIM process and in effect deal with all aspects of the case, reporting for instructions/advice as and when appropriate.

I then spent some considerable time making arrangements for the transfer of the body to Edinburgh, for 2 Forensic Pathologists to conduct the examination and that a Quasar examination would be utilised in advance of the PM. As 4th

May was a public holiday in Glasgow I also arranged that an experienced colleague from the Edinburgh office, Bernard Ablett, on call for homicides in East Scotland, would attend the PM.

I was updated on developments during the day by Detective Superintendent Campbell and DSI Harrower namely that PIRC were in attendance and crime scene examination was ongoing. I remained content, at that stage, that the police could investigate the earlier matters. I kept Crown Office colleagues abreast of all developments. Emails were sent by Blackberry and I have no access to them though others might have them in received items.

Late afternoon/evening I was made aware of [redacted] Calls were made and received about this throughout the evening and it became clear that [redacted] to this incident would be required and that I would need to attend the scene.

Late that night, about 23.30 I think, I was advised by PIRC that the family had indicated they would not attend the mortuary to identify Mr Bayoh. I instructed that the post-mortem should proceed as arranged. My reasons for this were that in my view it was essential to ascertain the cause of Mr Bayoh's death as soon as possible. There were many possible causes, I thought the most likely would be postural asphyxia with cardio/pulmonary arrest but there were other possibilities such as a drug related cause or a natural cause due to a medical condition. I had been made aware at some point that Mr Bayoh had consumed drugs and that there were no bleeding injuries found at the hospital. In my opinion it was necessary in the public interest for the post-mortem to proceed to inform the nature and direction of the investigation. All arrangements were in place and his identity could be confirmed at a later stage. The body could be identified by PIRC staff.

I understood that PIRC would approach the family again the following morning to see if they had changed their mind and would identify.

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I left [redacted] at about 06.00 hours on 4th May and travelled to [redacted] I returned home, perhaps about 19.00 hours. During that time I had no contact or calls in relation to Mr Bayoh's death and it follows that I issued no instructions.

My last involvement was on 5th May when I received a call from the Lord Advocate seeking information and a subsequent call from him regarding the neuro pathology examination of Mr Bayoh's brain. I made enquiry on his behalf and updated him. This was my last substantive involvement in this death as I was then advised by Stephen McGowan that the investigation was transferred to CCAPD and thus out of the remit of SFIU. I did act as a post box for reports etc coming in from pathology and toxicology but passed on all matters to my colleague Les Brown then Head of CCAPD.

I consider the above explanation of my involvement answers a significant number of the questions asked of me, what follows are my answers in respect of questions not covered:-

8. I cannot recall any case in which race was a specific factor. There may have been deaths where the deceased was not Caucasian. I have always investigated all cases regardless of race, creed, or colour.

9. I have attended all mandatory training over the years. An understanding of the different attitudes to death, post-mortem examination and funerary practices is essential in SFIU.

10. I made no reference to any materials in my dealings with Mr Bayoh's death. It was dealt with in exactly the same manner as any other death in custody.

14. As stated I gave instructions that the investigation was to be handed over to PIRC. I received the usual assurances that the police would facilitate this. This was normal practice and I had no reason to doubt that this would not happen in the same way as it had on previous occasions. Given my limited involvement in the matter I am unaware if my expectations were met.

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15. While there is no requirement to take notes I did so but cannot locate them now. That said, the contents of my notes were conveyed to colleagues by email briefings sent by me at the time.

16. See above.

18. I gave no specific instructions to police or PIRC as regards police post incident management (PIM). My expectation was that PIRC would oversee this as had been agreed and exercised previously. I had also been involved along with senior officials from PIRC in providing inputs to training for senior police officers on this subject. Given that no issues had been experienced in other earlier cases I saw no need to do so.

21. I was advised that Mr Bayoh was black at the outset. I immediately apprehended that whatever the facts and circumstances, yet to be established, this was very likely to be a very high-profile matter and that questions of race would inevitably arise. The fact that the deceased was black made no difference to the decisions and actions that I took.

23. See above.

24. I was not aware of any media coverage. I don't use social media. I expected the police to conduct a community impact assessment as they do in all homicides. I expected that would be shared with PIRC. This had no influence on my actions or decision making.

25. This was a death in custody. As such PIRC had to be instructed to carry out the investigation. A 2 Doctor post-mortem was necessary. A Fatal Accident Inquiry is mandatory in a death in custody. As such the accuracy or otherwise of the information given to me was irrelevant. I instructed PIRC to investigate to obtain an accurate account of what happened to inform decisions on future actions and for a future FAI. This was standard practice.

26. I was advised that PIRC were on site and that a crime scene examination was taking place. I was advised that Mr Bayoh had been consuming drugs of some sort earlier in the morning. I advised colleagues of this information but at

this remove I don't recall if this came from Keith Harrower or DSU Patrick Campbell.

27. A suspicious death is one where there is suspicion of possible criminal involvement of another/others in the death. The death is treated as a potential murder with 2 Dr PM, crime scene management and full forensics. A non-suspicious death is any other death and can include uncertificated natural deaths as well as suicides and other types of death. These cases are investigated by a one Doctor PM and may include limited other investigations such as toxicology. All cases are approached on their own facts and circumstances.

28. A death in custody is a mandatory FAI at the very least. As such all such cases are treated as if they are suspicious. No assumptions are made.

29. The death was being treated as a death in custody as explained above.

30. The role of Professional Standards was, on being made aware of the matter to advise the Procurator Fiscal. To convey the Fiscals instructions to senior officers and other officers involved in investigating the death. To facilitate a handover to PIRC if they were instructed to investigate. As previously stated I was not infrequently made aware of deaths where there has been minimal or historical contact with the police and a PIRC referral was not required.

31. I had no liaison with Professional Standards regarding PIM. I expected that PIRC would take control or at least oversight of this. I know nothing of anything they may have done.

32. – 34. In instructing PIRC in terms of S33A (ii) I made no judgement on officers being suspects or witnesses. In term of the PIM protocol, I expected they would give an early statement setting out their "honestly held belief " as to the circumstances. If anything arose that caused PIRC to consider that officers should be treated as suspects, then mechanisms were available for them to advise the Fiscal of this and the direction would have changed to 33A (i) and the officer(s) advised they were now being treated/questioned as a suspect. None of this happened during my limited involvement in this case. I gave no instructions on this. I cannot assist further with this line of questioning other than to advise

that my colleague John Logue instructed that PIRC should take over responsibility from Police Scotland for investigation of the earlier events that morning and amended the terms of the referral to 33A(i).

35. -40. I had no involvement in any of these matters and thus either cannot comment or do not think it appropriate for me to comment.

41. – 44. I had no involvement in any of these matters and cannot comment further.

45. The role of COPFS in family liaison begins at the point of handover from the FLO's assigned to the family. In the greatest majority of cases these are police FLO's but in a small number of cases they will be from PIRC. In most cases a FLO/ Victim Information and Advice (VIA) handover takes place shortly after an individual has been charged and appeared in court. VIA staff are part of COPFS. In certain cases where a prosecution will not take place the handover happens at a suitable point after the case has been reported to us. Such cases might be where no action is contemplated or possible or an FAI is in contemplation.

46. I took no decisions in this regard.

47. COPFS has a duty of care to nearest relatives as well as a duty to keep them informed of progress in such cases. These duties arise at the points outlined above and continue throughout the life of the case. Contact with and information provision can be by face-to-face meetings, Teams meetings, telephone calls, email or letter, dependent on the wishes of the nearest relatives. Frequency of contact is also a matter of agreement with them. These duties and responsibilities had not come into play during my short involvement with this death.

48. I had no involvement in this.

49. As mentioned above I was made aware about 23.30 on 3rd May that PIRC had received a "frosty reception" from the family who were declining to attend the mortuary to identify Mr Bayoh. Other than that I had no knowledge or involvement.

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50. COPFS have the lead role in any media engagement. Police Scotland should "run past" us anything they wish to put out and we may instruct amendments. They do not do this in non-case related matters. There is no interaction between COPFS and the Scottish Police Federation.

51. I had no involvement in this.

52.- 56. I was not involved in any Gold group meetings and have no knowledge of such meetings taking place. I would observe that COPFS sometimes are invited and do attend such meetings following major incidents or in certain high-profile homicides. These instances are case specific.

57.-60. I was not involved in any way in issues relating to forensic examination and as such do not feel that I can comment.

61.-67. I have no knowledge or involvement in securing and searching property in this case and as such cannot answer these questions.

68. When a death is reported to the Procurator Fiscal the body comes under his/her control. Decisions on post-mortem examination are entirely matters for the Fiscal including the nature and extent of the examination and any other examinations such as toxicology. The police are normally involved in securing the body and transferring the body to the mortuary. They have a contract to do this and the body may be accompanied by police officers. They are also, in 2 Doctor cases, present to seize productions.

69. I do not know what involvement the police had in the post-mortem other than that a police officer corroborated a PIRC investigator in identifying the deceased to the Pathologists. I would be unsurprised if the police were present to assist with seizing productions and conveying samples to laboratory's etc but always under the direction and control of PIRC.

70. I recall a discussion with DSU Patrick Campbell regarding the family refusing to attend the mortuary to identify Mr Bayoh. I believe I had a similar discussion with Keith Harrower. The content of that discussion and my decision and reasons for so deciding are set out earlier.

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71. We understand repatriation to refer to a body leaving Scotland for burial or cremation elsewhere in the world. In which case a "Furth of Scotland" certificate is required in any Fiscal case before the body can be transported out of Scotland. This is done as soon as the examinations are complete and the body released from the mortuary. I am not aware if Mr Bayoh's body was transported out of Scotland but if so I was not involved. If on the other hand the question is about the release of the body back to the family after examination, I was involved in seeking the earliest examination possible, as set out above and in transmitting instructions seeking to expedite release after examination. I should explain that while the investigation had transferred to CCAPD all instructions to and results from Pathologists, Toxicologists etc are routed through SFIU as is the body release. The mortuary will not accept such instructions from elsewhere hence this being routed through myself and my unit. In homicide cases police FLO's will advise the family that the body has been released. I don't know what happened in this case but would not expect the police to be involved.

72. As part of the post-mortem process the Fiscal must ensure that the deceased is properly identified. Often that is by visual identification by friends or relatives but other means such as fingerprints, DNA and odontology can be used. It is a matter for the Fiscal to decide the means of identification dependent on the circumstances of the death and the condition of the body. There are international standards for this (Europol). A body is not released until identification is certain.

73. Mr Bayoh was named as the deceased in my earliest contact with the police. It appeared that his identity was not in doubt. That said some identification required to be made to the Pathologists hence my instruction that he be identified by those who dealt with his body at the Victoria Infirmary. Such an approach is not uncommon in deaths investigations with identification confirmed by other means at a later stage.

74. As indicated I had no involvement in Police Scotland's post incident management.

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75. Mr Bayoh's race had no impact on my decisions or actions other than to cause my early alert to Crown Office colleagues, as explained earlier.

76. I would not do anything differently.

77. I have no such experience.

78. Race is/was always a relevant factor, both then and now. Potentially as a possible motivation for the conduct leading to the death but certainly as it may be perceived by nearest relatives, the media or the general public as being racially motivated. From my perspective this has not changed.

" I believe the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website."

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