1. Once a case was identified as a Homicide Unit case, my duties included:

   (i) marking cases for prosecution (ii) attending forensic strategy meetings, which were multi-disciplinary meetings usually involving the police, a pathologist and forensic scientists, where the issues which might be discussed could include the current progress of a case, other potential lines of investigation and family liaison (iii) monitoring organ retention and seeking Crown Counsel's instructions in relation to the release of deceased bodies (iv) liaising with defence agents in relation to defence post mortems (v) reading documentation submitted by the police prior to case allocation (vi) instructing the police to make further enquiries (vii) sending requests for scientific analyses of evidential items to the Scottish Police Authority, the independent body which provides forensic services to COPFS (viii) notifying the Crown Office High Court Unit of cases and agreeing target reporting dates (ix) allocating cases to case preparers or the unit's depute procurator fiscal, with detailed instructions and guidance; very occasionally I allocated a case to myself (x) monitoring the progress of precognitions during the case preparation process, providing ongoing advice to case preparers (xi) ensuring that COPFS met their duties of disclosure to the defence (xii) reading the precognition in advance of the case being reported to Crown Office to ensure that all lines of enquiry had been followed and that all relevant evidence had been secured, including any expert witness evidence or evidence which might undermine the Crown case or exculpate the accused (xiii) certifying that the quality of cases met departmental standards (xiv) monitoring adherence to target reporting dates (xv) ensuring that all Crown Counsel instructions, often referred to as post-indictment issues, were complied with up until the conclusion of proceedings.

2. I liaised with the depute procurator fiscal in the Scottish Fatalities Investigation Unit (SFIU) for the East of Scotland. The SFIU was the department within COPFS which received reports of deaths occurring in Scotland, including deaths

which were sudden, suspicious, accidental or unexplained. The Homicide Unit and SFIU shared a mutual interest in a number of cases, such as deaths which might be suspicious and where homicide had not been ruled out. I met with the SFIU (East) depute on a monthly basis when we would discuss each case on the mutual interest list and identify whether the Homicide Unit or the SFIU had the lead. Our discussions would determine which team was responsible for the management of the case. We might decide to transfer the management of a case from one unit to another, most commonly from the Homicide Unit to the SFIU where an investigation had determined that there were no suspicious circumstances.

3. I was responsible for staff management, dealing with issues such as performance management and the completion of annual reports, ill health and attendance management, and the flexi-time system.

4. In have been asked to specify training I had completed relevant to my role in the investigation. As I have stated, I did not take part in the CAAPD investigation. My role was limited to attending at Edinburgh City Mortuary on 4 May 2015 for the post mortem. However, more generally speaking, as far as my role as an SLM is concerned, as a depute procurator fiscal in the Solemn Unit at Paisley, I had discussed the management of the unit and the preparation of cases with the SLM on a regular basis and had substituted for the SLM when she was on leave or otherwise absent. By the time of the post mortem in 2015 I had gained a significant amount of experience in preparing and prosecuting solemn cases at sheriff and jury and High Court level. I had been an advocate depute for six years between 2004 and 2010 and had led evidence from pathologists in High Court trials. I had held SLM posts between 2010 and 2014. A significant amount of my training had been practical in-post training allowing me to develop the skills and competencies necessary for solemn case

management. I do remember that I participated in a training course on the management and preparation of complex cases around 1998 although I no longer remember the details of the training provided.

5. With regard to post mortem training, I do not recall any specific training other than the guidance referred to below concerning religious and cultural death practices. I had represented the interests of an accused person at my first defence post mortem in around 1990. I was present at a number of Crown post mortems when I was a depute procurator fiscal between 1993 and 2000. I attended post mortems after joining the Homicide Unit and would have been responsible for doing so until I left. I was present at a number of post mortems although I cannot say how many post mortems I would have been present at throughout my COPFS career. I have been asked how often I am required to attend post mortems. My current duties do not require my presence at post mortems.

6. Turning to my experience of family liaison, as an advocate depute I had considerable contact with VIA and would meet with complainers or next-of-kin regularly. After joining the Homicide Unit I would have discussed family liaison with senior investigation officers (SIOs) in charge of the police investigation, and with FLOs, particularly at forensic management meetings. I remember meeting one family at the handover stage. I was not involved in family liaison in any deaths cases where race was a factor.

7. I am asked to describe what training I had completed in relation to equality and diversity issues. In around 1999/2000 I had completed a training course on racial and cultural awareness which was the first set of COPFS-wide training events following the reports by Dr. Raj Jandoo into liaison arrangements between the police, COPFS and the family of the deceased Surjit Singh Chhokar, and by Sir William McPherson following the murder of Stephen Lawrence. I have been asked to describe the content of any course. I recall topics such as (i) treating all

those involved in the criminal justice process fairly regardless of their race (ii) how cross cultural communications and misunderstandings could lead to difficulties in court (for example the amount eye contact made by a witness might be determined by their cultural background rather than whether they were telling the truth) (iii) the religious and cultural death practices of the main faith communities in Scotland (iv) s.50A of the Criminal Law Consolidation (Scotland) Act 1995, the statutory offences of racially aggravated harassment and racially aggravated behaviour and the statutory racial aggravation (v) that racial motivation was to be taken into account when marking a case and deciding whether proceedings should be instituted, and further that there was a rebuttable presumption in favour of prosecution (vi) that race should be a factor to consider throughout the life of a case (vii) pleas should not be negotiated which removed racial motivation from the case where there was admissible evidence of such (viii) that it was vital that complainers, witnesses and next-of-kin receive communications in their first language.

8. If any of the above was not covered by the training then such guidance was available as reference material, in hard copy and on the COPFS intranet, including policy guidance on race matters contained in Crown Office circulars, the COPFS Book of Regulations and the Lord Advocate's 2002 Guidelines to Chief Constables addressing (i) the investigation and reporting of racist crime, (ii) the assessment of language needs and cultural sensitivities and (iii) death reports and associated crime reports.

9. I had not been involved in the investigation of cases involving suspicious or unexplained deaths, deaths in police custody or deaths during or following police contact where racism was a factor.

10. I have been asked whether, in my experience, COPFS routinely considered race when dealing with a death in custody or death during or following police

contact. I cannot comment on the specific types of case mentioned because I have not been involved in the preparation of such cases. However, given the training and guidance referred to above, regular courses on race and diversity provided by the COPFS training college, the drive by the department to ensure that all staff were trained in race and diversity, and the supervision of staff by managers, I would expect that, in the majority of cases, COPFS staff would identify any racial aspects when dealing with cases, whether a case involved death in custody, death during or following police contact, or any other scenario where race was an issue.

11. Turning now to events prior to the post mortem, I have attempted to recall anything of Sunday 3 May 2015 in order to assist the Inquiry. However, as a result of the eight-year gap between then and now I have no memory of that Sunday, whether relating to any professional duties or my private life.

12. I have been referred to document COPFS-02903 which contains emails sent by senior members of COPFS staff on 3 May 2015. I do not feature as a recipient and I have no recollection of seeing these emails at any stage prior to the Inquiry allowing me access to them on 7 August 2023. One email was sent by SFIU head David Green at 3.46pm on 3 May 2015. In the email David Green confirmed that a post mortem had been fixed for the following day and that I would cover for COPFS' interest. I have been asked when David Green contacted me, and what was discussed. I simply have no memory of David Green contacting me. One reason for that might be that he did so and I now have no recollection of it. Alternatively David Green could have contacted my senior line manager Nicola Patrick and she, in turn, could have contacted me to instruct me that I was to arrange a post mortem and attend at the mortuary the following day.

13. I was present at the post mortem on 4 May 2015. By that time the Police Investigations and Review Commissioner (the PIRC) were taking over, or had

taken over, from the police in the investigation of the case. There were both PIRC investigators and police officers present at the post mortem.

14. I have been asked to explain what the duty of the procurator fiscal is in relation to deaths. It is the duty of the procurator fiscal to make initial enquiry into all reported deaths, and to further investigate all sudden, suspicious, accidental, unexpected and unexplained deaths and allegations of homicide.

15. A death investigation can take many forms depending on the circumstances of the case. At one end of the spectrum would be deaths reported by a doctor where the death was due to natural causes and the doctor was prepared to issue a death certificate. At the other would be deaths with clear evidence of homicide. The level of investigation is a matter for the procurator fiscal to determine.

16. I have been asked to explain what the role of the procurator fiscal is in attending post mortems. The purpose of a post mortem is to detect the cause of death by carrying out a full examination of the deceased and to recover any evidence or samples which might assist in determining the cause of death. In some cases the cause of death cannot be determined immediately by the pathologists and further enquiries are necessary. The procurator fiscal is present at the post mortem to ensure that all evidence is secured which could assist in establishing the cause of death.

17. However the procurator fiscal does not look over the shoulder of the lead pathologist conducting the examination, and would not direct the pathologist on how they should go about examining the body of the deceased. The way in which the examination and dissection is carried out is a matter for the clinical judgement and skill of the pathologists.

18. The procurator fiscal acts in the public interest. The procurator fiscal does not attend at a post mortem on behalf of the family, although in death investigations the public interest includes the interests of the family. In Mr Bayoh's case I expected that the family would want to know what had caused his death. The post mortem had the potential for providing answers at least as far as the mechanism of death was concerned

19. Before the examination begins the procurator fiscal should confirm that the police, or in this case the PIRC, have advised the pathologists of the circumstances surrounding the death. Often the information would be provided to the pathologists during a briefing at the mortuary. If a police sudden death report is available then a copy of the report would be made available to the pathologists.

20. The procurator fiscal should ensure that the deceased's medical records are available prior to the post mortem (i) if the records can be recovered prior to the commencement of the post mortem and (ii) if the pathologists consider that the medical records are necessary. It is a matter for the pathologists to decide whether they require to see the records.

21. In this case, document COPFS-02895 confirms that DS Robert More of the MIT emailed me at 11.33am on 4 May 2015 seeking written authorisation to take possession of Mr Bayoh's medical records. I note that I replied at 11.41am with the authorisation sought. I would have done so in terms of the duty of the procurator fiscal at common law to fully investigate the circumstances surrounding the death of Mr Bayoh. It would have been, at least for the short duration of my involvement, my responsibility to provide the police with authorisation to recover the records. The medical records might contain information of assistance to the pathologists in determining why Mr Bayoh died.

22. An essential fact requiring proof at any future proceedings would be the identification of the deceased. At the post mortem the procurator fiscal must ensure that the deceased has been formally identified. My experience was that deceased persons were usually visually identified by family members, although other persons who knew the deceased sufficiently well in life could also make an identification. Other means of identification include identification by fingerprints, dental or medical records, comparing the deceased person with photographs of the deceased in life and DNA comparison.

23. In this case I was advised that Mr Bayoh's family did not wish to engage in the identification process. I have been asked if I had any other experience of family members not wanting to identify the deceased. I cannot think of any specific examples of cases where a family had taken that line. If a family decided that they did not want to travel to the mortuary to identify the deceased then that would be their decision and their wishes would be respected.

24. There could be cases where it would not be possible to invite family members to take part in a formal identification. The physical condition of the deceased's body might be such as to rule out visual identification.

25. The procurator fiscal should instruct that all necessary samples are taken at the post mortem and that labels attached to the samples have been signed by the pathologists and the production officers before the removal of the samples from the mortuary to the forensic laboratory.

26. If the pathologists considered it necessary to have the deceased's brain forensically examined then the procurator fiscal would sign an organ retention form at the conclusion of the examination and before the brain is sent to a neuropathologist.

27. At the earliest stages of death investigations family liaison would be the responsibility of FLOs deployed by the police or the PIRC. Their duties would include (i) obtaining details of the deceased, the deceased's family members and nearest relative or next-of-kin, including details of any religious or cultural aspects (ii) explaining legal procedures to the family (iii) providing the family with information regarding what bereavement or emotional counselling or practical advice might be available to them from support agencies (iv) advising the family of the arrangements for the post mortem (v) discussing whether any of the bereaved relatives wished to view the deceased and/or engage in the identification procedure prior to the post mortem (vi) arranging transportation to allow the family to travel to the mortuary, and (iv) keeping the family advised of the progress of the investigation.

28. It is the responsibility of FLOs to share details of the family with the SIO and COPFS in advance of the post mortem.

29. Family liaison would be handed over from the FLOs to VIA at an appropriate stage. The handover would take place at a handover meeting chaired by the SIO in charge of the case, and would often be held at a COPFS office, with the family, the SIO, the FLOs and a VIA officer present. The timing of the handover meeting would vary. It would often take place shortly after an accused had appeared in court, or after the deceased's funeral.

30. I have been asked about the role of VIA. VIA is a specialist service within COPFS which is dedicated to assisting victims of crime, next-of-kin and witnesses. In the context of a death investigation, and following a handover from the FLOs to VIA, the VIA officer is the single point of contact for the family. The VIA officer is responsible for keeping the family up-to-date with the progress of the case, as well as providing general information about the

criminal justice system. The method of contact, the frequency of contact and the level of detail of information would be agreed between the VIA officer and the family. The VIA officer would advise the family of support services which might be available to them.

31. I have been asked if VIA was used during the investigation of the case. I am unable to say. That would have been a matter for CAAPD.

32. I have been asked what experience I had in dealing with the PIRC prior to 4 May 2015. My first contact with PIRC investigators was on 4 May 2015. I have been asked what the normal practice was for COPFS staff communicating decisions and instructions to the PIRC or advising the PIRC on their investigations. I cannot say because I was not involved in the investigation of any other cases where the PIRC was involved.

33. I am asked what my understanding of the PIRC's role was in the investigation of this case. At the time of the post mortem I understood that PIRC investigators were in the process of taking over from the police and that they would carry out an independent investigation into the circumstances surrounding the death of Mr Bayoh.

34. I have been asked whether the PIRC was directed to investigate the death in terms of s.33A (b) (i) or in terms of s. 33A (b) (ii) of the Police, Public Order and Criminal Justice (Scotland) Act 2006. I was not the COPFS legal member of staff who directed the PIRC to carry out an investigation. I understand from Inquiry papers that David Green did so. I have no experience of COPFS liaison with the PIRC in terms of s.33A (b) (i) or s.33A (b) (ii) and cannot comment on whether there would be any difference between investigations carried out under paragraph (i) and those carried out in terms of paragraph (ii).

35. I was not aware whether the PIRC's instructions were changed or were expanded upon during my involvement with the case on 4 May 2015.

36. I have been asked whether COPFS supervised or directed the PIRC. Again, because I have no experience of COPFS liaison with the PIRC, I cannot say. In terms of S.33A of the Police, Public Order and Criminal Justice (Scotland) Act 2006 it is a duty of the Commissioner to carry out an investigation where directed to do so by the appropriate prosecutor. The provision is silent as to whether the prosecutor has the authority to supervise the PIRC in its day-to-day investigations. By contrast, the terms of s.17 of the Police (Scotland) Act 1967 make the police subordinate to the prosecutor: "…in relation to the investigation of offences the chief constable shall comply with such lawful instructions as he may receive from the appropriate prosecutor." I cannot comment as to whether this makes a practical difference.

37. I am sure that I would have discussed Mr Bayoh's death with Nicola Patrick at the Procurator Fiscal's Office, Edinburgh on the morning of 4 May 2015 although I cannot remember doing so. I do recall that another homicide case had been reported to me during the night of Thursday 30 April 2015 following a stabbing in Dunfermline. The suspect had been arrested and was due to appear in court on a charge of murder on 4 May 2015, the same day as Mr. Bayoh's post mortem. I had discussed the circumstances of the other case with the SIO and had planned to mark the case during the morning of 4 May 2015 once the police report had been received. I would have attended at a post mortem of the deceased on either Friday 1 May 2015 or Saturday 2 May 2015, although I have no memory of it. I am confident that I would have arranged for a forensic strategy meeting to be held to discuss the other case at some point during the week commencing 4 May 2015, although, again, I have no recollection of attending any meeting.

38. I cannot recollect what information had been provided to me by Nicola Patrick about Mr Bayoh's death. At the commencement of the post mortem I am fairly confident that I would have been aware of a description of events similar to the description contained within the email sent by Stephen McGowan to the Private Office at 1.24pm on 3 May 2015 contained in document COPFS-02903.

39. I attended at the mortuary shortly after midday on 4 May 2023. My recollection is that I was to contact Nicola Patrick at the conclusion of the examination to let her know whether the pathologists had identified a cause of death.

40. I am referred to document COPFS-02398 (b) and I have been asked why I did not complete certain sections of the form. This is not a COPFS form. This is a form used by the pathologists and would have been completed by Dr BouHaidar during the post mortem. There may be additional entries by Dr. Shearer.

41. Prior to attending at the post mortem I had not been involved in investigations concerning deaths in police custody, or deaths during or following police contact.

42. I have been referred to document PIRC-04173 at page 22 which describes that the family were not engaging with the PIRC and that they would not be in attendance at the mortuary to carry out an identification of Mr Bayoh. Whilst a bereaved family should be offered the opportunity of seeing and spending time with a deceased relative I had been advised that the family of Mr Bayoh did not wish to do so. I also had been advised that Mr Bayoh's identification would be confirmed by way of fingerprints. I suspect that I would have been provided with this information before I arrived at the mortuary. I understand from document PIRC-04148 that David Green had been advised on 4 May 2015 that the family would not attend and that he had provided instructions in relation

to other means of identification. It may be that this information was cascaded down to me prior to my leaving for the post mortem.

43. I have been asked whether there were any problems in commencing the post mortem as a result of the medical records and the sudden death report being unavailable. The post mortem may have commenced slightly later than planned whilst an unsuccessful attempt was made to locate Mr Bayoh's medical records. However the pathologists did not express any concern about carrying out the examination without the medical records. I don't see anything unusual in that. I note in Dr Shearer's statement, document SBPI-00304, that in perhaps 70 per cent of cases she may not have the medical records, or indeed need them. I do not recall the pathologists being concerned by the absence of the police report either. They were briefed by the PIRC before the post mortem. Ultimately it would be a matter for the pathologists to decide what information they required before beginning the examination.

44. My recollection is that PIRC investigators had completed their briefing of the pathologists around the time I arrived at the mortuary. I recall viewing the post mortem from the viewing gallery which was separated from the examination room by plate glass. When other witnesses refer to matters arising during the examination I would have been present in the gallery area at the time.

45. I do not recall hearing a conversation about ritual washing. I was not advised that the family wished access to Mr Bayoh's body to wash it prior to the post mortem. If such a request had been made then it could have been discussed with the pathologists and the SIO to determine whether the washing might, in any way, compromise the integrity of the post mortem or the collection of samples.

46. I do remember that Dr Shearer spoke to me during the post mortem when she explained that, as a result of Mr Bayoh's black skin, bruising would be less

apparent if the examination was restricted to the outer surface, and that it was necessary to look at the underside of the skin for signs of injury. I have a clear recollection of seeing Dr. Shearer demonstrating this to me from the other side of the plate glass.

47. I do recall that the matter of cultural aspects was raised with me by Dr. Shearer. I cannot remember how the concern was expressed and I do not remember the terms "cultural issues" or "culture" being used. The issue was clearly a religious issue because it related to Mr Bayoh being a Muslim. It arose in the context of a discussion about obtaining a sample of plucked hair from Mr Bayoh. I was aware that Muslim families suffering a bereavement would have two main concerns, firstly that the deceased's body should be buried as soon as possible, although in this case delay was inevitable given the need for a full enquiry into the cause of death, and secondly that there should be no desecration of the body, although I understood that a post mortem would be tolerated where an examination was necessary to establish the cause of death.

48. I have been asked whether I was involved in discussing or otherwise considering COPFS' obligations under Articles 2 and 14 of the ECHR in respect of Sheku Bayoh and his family. I was not involved in any such discussions.

49. Articles 9.1 and 9.2 of the ECHR were relevant at the post mortem stage. In terms of Article 9.1 everyone has the right to freedom of thought, conscience and religion and this would include, for example, the right to hold a religious conviction that a deceased's body should not be desecrated by having a hair sample taken from it. However in terms of Article 9.2 authorities can interfere with the right to manifest a religious belief provided that the interference is lawful, appropriate and no more than is necessary to protect public safety, public order, health or morals, or for the rights and freedoms of other people. The duty of the procurator fiscal to establish the cause of Mr Bayoh's death

would constitute a qualification in terms of Article 9.2. Dr Shearer advised that a hair sample could be analysed to confirm whether or not there was any evidence of chronic drug abuse which might have played a part in Mr Bayoh's death. I relied on the judgement of the pathologists that the removal of a hair sample might assist in determining the cause of death. Dr Shearer advised that a small sample could be removed from the rear of Mr. Bayoh's neck. I recall seeing Dr Shearer taking the small sample from the nape of the neck. The taking of the sample was lawful, appropriate and no more than was necessary as part of the investigation into Mr. Bayoh's death. My decision at the post mortem was that the invasive interference with the deceased's body by the removal of a hair sample to assist in determining the cause of death took precedence over any religious concern raised during the post mortem.

50. I note from the email I sent to Nicola Patrick that the brain had a cloudy surface. I do not remember this detail. However I would have obtained this information during a discussion with the pathologists immediately following on from the post mortem. The pathologists appear to have suggested that this might have been caused by degeneration of the brain, although this anomaly is usually seen in the elderly and not in someone of Mr Bayoh's age. The pathologists suggested as an alternative explanation that the cloudy appearance might be as a result of ingested drugs. The pathologists assessed that the brain should be retained and examined by a neuropathologist.

51. It was usual to consider the involvement of drugs as a possible explanation in a death investigation. This would be the case irrespective of the racial, cultural or religious background of the deceased.

52. I am referred to document WIT-02250 which contains two forms, the post mortem request form and the organ retention form. These are distinct forms and do not form two sections of one form.

53. It is suggested to me that the post mortem and organ retention form has missing fields. The organ retention form does not have missing fields. The other form, the post mortem request form, was used as a formal request to the pathologists to carry out a post mortem. The form would be emailed to the pathologists after arrangements had been made by telephone. The form has sufficient details to allow the pathologists to marry up the request with their case file. The field relating to the mortuary location could have been completed although the venue would have been agreed during the telephone discussion. The form was not used for any other purpose, there was no necessity to complete the other fields, and that is why the other fields are not populated.

54. I have been asked why the organ retention form was signed on different dates. The explanation is that the brain was not examined by the neuropathologist Professor Colin Smith on the same day as the post mortem. His place of work was elsewhere. I signed the form at the mortuary on 4 May 2015 at 6.16pm and this authorised the mortuary to send the brain to Professor Smith's laboratory. The form was signed by Professor Smith once the brain was in his possession. Once the brain had been returned from Professor Smith to the mortuary a mortuary technician signed the form. The Homicide Unit depute procurator fiscal Faith Miller confirmed that the brain had been returned to the body and signed the form on 14 May 2015. This information amounted to an audit trail of the whereabouts of the brain and ultimately provided confirmation that the brain had been reunited with the deceased's body. This was standard practice in all cases where the brain and/or other organs were retained.

55. I have been referred to William Little's statement PIRC-00370 where he states that Dr Shearer was instructed to obtain swabs from Mr Bayoh's nose and mouth following a discussion with me. I do not remember this. However it would appear from Inquiry documents that tapings had been taken from Mr

Bayoh's nose and mouth at the Victoria Hospital in Kirkcaldy to capture PAVA or CS Spray residue. The results might confirm that the sprays had been deployed by the police against Mr Bayoh. I would have sought advice from the pathologists, and it would appear that the pathologists suggested that it would be more effective to use wet and dry swabs to capture any residue. On the basis of their recommendation I would have instructed that wet and dry swabs should be used to take samples from the area of Mr Bayoh's nose and mouth. I have been asked whether this would be standard practice. I had not been involved in any other case where PAVA or CS spray had been used on a deceased person prior to death and I cannot comment on whether this particular method of attempting to capture spray residue would be standard practice. I am not a forensic scientist or pathologist. However I would expect that a cotton wool swab, particularly a wet swab, would pick up residue more effectively than tape.

56. I have been referred to Dr BouHaidar's statement to the Inquiry SBPI-00318, at paragraphs 49 and 50. Dr BouHaidar states that the procurator fiscal would inform the family that the brain had been retained. I have been asked whether I advised the family of the details of the post mortem examination. I did not attempt to make contact with the family immediately after the post mortem to advise them of the post mortem or to provide them with information about organ retention. I had not been tasked with the duty of family liaison. At that stage the FLOs deployed by the PIRC were responsible for keeping the family updated. Their first task would be to speak with the family to develop a communication strategy agreeing (i) what information the family would want to be told (ii) how much detail they would want to hear e.g. did they want to hear details of the post mortem examination (iii) would the family expect regular updates, or would they wish to be contacted only when there was something significant to tell them (iv) which family member would be the

primary point of contact. The effect of losing a loved one can be devastating for a family. Hearing details about the post mortem examination could be extremely upsetting. The retention of the brain would very likely cause further distress, even in circumstances where it was necessary to retain the brain for examination. The FLOs would require to deal with the issue of communicating details of the post mortem examination and organ retention sensitively, and communication with the family could only be in accordance with the family's wishes.

57. I signed the organ retention form and would have discussed the post mortem findings with the pathologists. It would appear that I returned to the Procurator Fiscal's Office where I instructed SPA Forensics to carry out an analysis of samples obtained during the post mortem for drugs and steroids. The results could assist the pathologists in determining the cause or causes of death.

58. I have been asked what the usual practice would be as far as the PIRC instructing SPA Forensics is concerned. I have not been involved in an investigation involving the PIRC and cannot answer this question.

59. I then sent my email to Nicola Patrick at 07.23pm on 4 May 2015. I advised that the cause of death was unascertained pending further investigation. I copied the email to my immediate line manager Band G procurator fiscal depute Fiona Cameron, and to the Procurator Fiscal for the East of Scotland, who, at that time, was the late John Dunn. I have been asked why I did not copy David Green into the email. I am unsure and needless to say it would have been an easy thing to do. I suspect that I had not been in direct contact with David Green and, having said to Nicola Patrick that I would report back to her following the post mortem, that was what I did.

60. I am asked why I used the phrase "almost complete degloving". In context, I stated that there was "almost complete degloving of the deceased's skin to allow the pathologists to examine the underside for bruising." I used that description to emphasise that Dr Shearer had conducted a detailed external examination of Mr Bayoh's body by separating what appeared from the viewing gallery to be significant sections of the skin from the layers underneath to look for any sign of injury, and to assure Nicola Patrick that, at least to my medically untrained eye, a most careful external examination had been carried out.

61. I am asked why I did not advise Nicola Patrick of the retention of the brain, why I did not mention cultural or religious sensitivities, and why I did not advise Nicola Patrick about the reluctance of the family to attend at the post mortem. I am also asked whether it was normal to include information, such as the information referred to in these questions, in a post mortem update. The primary aim of my email was to report back to advise that the cause of death was unascertained. My message was not intended to constitute a full report of every aspect of the post mortem. I am sure that I thought that COPFS knew of the disengagement of the family and the requirement to have Mr Bayoh identified by fingerprints. I had not issued the fingerprint instruction. Another legal member of staff would have done so in the knowledge that there was an issue. I am asked where this information might be found. The family's engagement and other aspects of the case might be noted in the minutes of forensic strategy meetings and included in PIRC FLO statements. Details of the post mortem examination and samples taken would be detailed in the post mortem report.

62. I would have taken handwritten notes on an A4 pad at the mortuary. I would not have retained the original handwritten notes once I had typed up the email to Nicola Patrick. The data contained within the email would have constituted a copy of the notes taken by me at the post mortem. I am unaware of any COPFS

requirement existing in 2015 to retain my handwritten notes once they were typed up in the email, and I am unaware of any COPFS form which I should have completed for internal record-keeping.

63. I am asked why I requested to be present at any meeting with Ruaraidh Nicolson. My view must have been that if there was to be a discussion about the case, and if the case was to be allocated to the Homicide Unit, then it might be helpful for me to be there. It would be normal for me to be present at discussions with the police about Homicide Unit cases. I do not remember being at any meeting with Ruaraidh Nicolson or indeed any other meetings once the CAAPD had assumed ownership of the case.

64. I was unaware that David Green and John Logue were communicating with one another shortly after I had sent the email to Nicola Patrick. Their emails are contained within document COPFS-03876 and refer to not having heard from me. I do not remember seeing the emails prior to the Inquiry allowing me access to them on 7 August 2023.

65. At some point around 7.30pm on 4 May 2015 I would have left work to travel home, a journey which usually took between two and a half and three hours. When I arrived home I would have seen Nicola Patrick's email sent at 21:46 advising that she had forwarded my email to David Green. In order to clarify whether I should be reporting to Nicola Patrick or to David Green, I sent the email to David Green at 22:22:57 asking whether SFIU or homicide had the lead. I am asked what the significance of this would have been. At the time I would have had in mind that whichever team had the lead would have been responsible for the preparation and reporting of the case. I am asked if David Green responded to my email. I have no memory of receiving a response from David Green although that might simply be because, as a result of the passage of time, I do not remember his email, rather than because he did not respond.

66. In hindsight I realise that the case would have been destined for preparation by the CAAPD, the specialist division within COPFS responsible for investigation allegations against on-duty police officers, and that my involvement was, to all intents and purposes, limited to having been present at the post mortem.

67. I have been asked whether I considered how the manner in which the post mortem had been carried out might affect the viewing of the body by the family. It would be quite normal for bereaved family members to want to see their loved one. Despite the invasive nature of the post mortem I understood that the body would remain capable of being viewed. The task of presenting the deceased for viewing by the family would be one for either the mortuary staff or the funeral directors. If the family wished to view the body after the post mortem then mortuary staff or the funeral directors would be able to prepare and dress the body so that it would be in a suitable condition for viewing.

68. I have been referred to document PS00812 and advised that reference is made in the document to a briefing said to have occurred at 1000 hours on 4 May 2015 chaired by Det Supt Campbell. The briefing which the question refers to occurred at 0915 hours on 5 May 2015. I have no recollection of being present at that meeting and the minutes do not record that I was there. The minutes of the meeting state the following: "At present from Bernard Ablett advises that our terms of reference should be to investigate the police contact with the deceased." I did not brief the PIRC officers at the post mortem on their terms of reference. When I emailed Nicola Patrick I advised: "the PIRC are looking for Terms of Reference from COPFS." I would not have told Nicola Patrick that PIRC officers were looking for terms of reference if I had already directed them on their terms of reference.

69. Inquiry document COPFS-03876 also contains emails between Irene Scullion of the PIRC, John Logue of Crown Office and David Green discussing the PIRC's terms of reference. Irene Scullion's email to John Logue sent at 16.52 on 4 May 2015 attached a PIRC internal briefing paper. The briefing paper had been prepared in the early hours of 4 May 2015. Having received Irene Scullion's email John Logue 's reaction was to forward the email to Stephen McGowan and David Green stating "Irene explained that the PIRC investigation was focused on the police contact on the street; having read this I think is too narrow and will need to be expanded…"

70. It would appear that the PIRC had focused on the locus at Hayfield Road from at least the early hours of 4 May 2015, many hours prior to any discussion I had with PIRC officers at the mortuary

71. Further, I note from page 3 of the statement of John Ferguson in document PIRC 00363 that he was present at a meeting on 3 May 2015 and had been told that, after consultation with SFIU Head David Green, the PIRC would be dealing only with the scenes at Hayfield Road and the Victoria Hospital. I assume that the Victoria Hospital would be in focus for as long as Mr Bayoh's body remained there, and until police officers or the PIRC ensured that there was no other evidence there which might be relevant to the investigation. Once the body had been removed to the mortuary the focus would have been on the Hayfield Road location.

72. This focus on Hayfield Road seems to have been embedded in the PIRC thinking from a stage earlier than my involvement. I may have mentioned the focus during informal discussions at the post mortem. It is possible that there is room for misinterpretation, and that, if I mentioned the current focus at the time of the post mortem, then that could have been construed as a formal direction.

However I would not have issued formal directions to the PIRC at the post mortem.

73. On Wednesday 6 May 2015 I emailed Les Brown, the head of CAAPD, forwarding the email I had sent to DS More on 4 May 2015 authorising DS More to recover the deceased's medical records. By that time, two days after the post mortem, I would have known that the CAAPD had ownership of the case.

74. I may have had the case as a "bring-up" in my diary for 28 May 2015 to check that the brain had been returned to the body. I completed a note at the foot of the post mortem request form that my involvement had been limited to attending at the post mortem and that the case was now being investigated by the PIRC. The completion of the note on 28 May 2015 ended my involvement with the case until I received the Rule 8 request from the Inquiry on 7 August 2023.

75. I have been asked to cover various other areas. My responses are as follows:
    - I had no involvement with the Health and Safety Executive, nor was I aware of COPFS requesting their involvement.
    - I did not follow the media reporting of this case, although I would have seen reports in the media. I was not influenced by media coverage.
    - I had no involvement with COPFS media engagement
    - I know nothing of any discussions relating to the SPF or their representatives' media engagement.
    - I did not see the report in the Sun newspaper of 1 November 2015.
    - I am unaware of any alleged leak referred to. No one investigating any leak has spoken to me.
    - I was not aware of any investigation being carried out on behalf of the SPF.

- I have no information in relation to the COPFS investigation and I cannot say whether the investigation was unduly lengthy. I cannot comment on whether anything could have been done to reduce the length of time of the investigation. My own experience in High Court cases was that it would take longer to prepare cases where expert reports were required.
- I would have become aware of a public inquiry only once it had been announced in the media. I did not do anything in light of this.
- I had no role in sharing the findings of any COPFS or PIRC investigation with Police Scotland. I did not make any findings because I was not involved in the investigation.
- I do not know what the CAAPD or PIRC findings were. I cannot offer a view on whether Police Scotland should have been made aware of the findings.

76. In conclusion, the reason for holding the post mortem was to determine the cause of Mr. Bayoh's death. I consider that the decisions made by me on 4 May 2015 were consistent with normal practice.

77. 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 may be published on the Inquiry's website.

Signed:

Date: 15 September 2023