David Green Second Statement

David [redacted] Green, DoB [redacted].1959

c/o COPFS

I am now retired after 40 years in COPFS. I retired as Procurator Fiscal Head of Homicide & Major Crime on 5th August 2023.

I have been asked to provide a further statement with specific questions being asked of me. The following are my answers to the questions as numbered.

1. I had been a Fiscal for over 30 years at the time of Mr Bayoh's death. I had investigated numerous murders, I was responsible for the Glasgow Deaths Unit for 7 years in the 2000's and had been head of the Scottish Fatalities Investigation Unit (SFIU) since 2012. I consider I had considerable experience of family liaison in deaths cases. As Procurators Fiscal we speak of family liaison as a police/PIRC matter once responsibility passes to COPFS we refer to it as Victim Information and Advice (VIA).

   I certainly had experience of race being a factor in a number of cases e.g. a murder of an asylum seeker in Glasgow where the motivation appeared to be racist. I have considerable experience of dealing with deaths in the Jewish and Muslim communities. I have also dealt with deaths from the Chinese community as well as individuals from across Europe. I cannot, at this remove, recall specific deaths in any detail but can advise that in what might be described as "Coronial Deaths" or Cause of Death Investigations I have sought to accommodate cultural and religious requirements e.g. in those of the Jewish Faith by seeking, if possible, to avoid invasive autopsy. In those of the Muslem Faith by seeking to expedite the post mortem process. Such steps are routine in SFIU.

That said, in cases where the autopsy is for a criminal justice purpose i.e. where homicide or criminality is suspected such accommodations are not often possible as the interests of justice are paramount.

PIRC

2. I agree that this document properly reflects my involvement.

3. While only Mr McGowan can answer why he initially drafted a letter stating I would be the Senior Fiscal in charge, I think it likely that this was drafted before a decision was taken to instruct CCAPD to lead the investigation. Normally such investigations are led by SFIU. I was not involved in this decision. Prior to being made aware of this instruction I assumed the investigation would be led by SFIU.

4. I believe the content of Mr Logue's letter is accurate so far as I am aware, with these caveats vis a) I had instructed PIRC to investigate the circumstances of Mr Bayoh's death in terms of S33A(b)(ii) of the 2006 Act, verbally and in an email. I advised that I would send a formal instruction on Tuesday 5th May. On the evening of Monday 4th May I became aware that Mr Logue had concluded that PIRC should investigate in terms of S33A(b)(i). That was his decision. At the time of my original instruction I did not consider that I had any indication that a person serving with the police may have committed an offence. I am unaware if Mr Logues instruction had been delivered in writing to PIRC at that point. This was out of my hands. b) I know that Keith Harrower and a colleague from PIRC had met the family on 3rd May. I do not know if PIRC FLO's were involved albeit Mr Harrower's colleague may have been in that role. I know PIRC intended to visit the family again on 4th May but do not know if that occurred. I cannot comment on the statement that PIRC "were confident that a relationship could be established"

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5. I did not necessarily expect PIRC to seek advice. It was possible that matters might arise which they would wish to discuss. This of course occurred when they sought my advice/direction on when the autopsy would take place.

6. I am of the view that COPFS should advise PIRC in much the same way as we provide advice to Police Scotland i.e. on matters pertinent to the investigation but not on operational matters. Ms Kate Frame, then the PIRC commissioner had been a PF for many years and on leaving was the same grade as myself. I anticipated they would seek advice from her.

7. Operational decisions are e.g. who to deploy, when and where, how to investigate, whom to interview and in what order. In short all the usual decisions in any investigation. I would only anticipate their seeking advice if something exceptional arose.

8. I can only comment on the instruction to PIRC on 3rd May. All other instructions post date my involvement and thus are outwith my knowledge.

   On 3rd May I instructed PIRC to investigate in terms of S33 A(b)(ii) the circumstances of Mr Bayoh's death from the time that the police were first contacted by members of the public concerned by his behaviour till he was pronounced dead. I also instructed that the police should investigate earlier incidents and alleged drug taking as at that time they did not appear directly related and in truth I had concerns about the PIRC's ability to staff a potentially large enquiry given that are a small organisation.

9. I agree with Mr Ablett's statement. Having instructed a number of PIRC investigations I had not supervised them on a day-to-day basis. There were discussions in some cases and in practical terms there was no difference between an investigation by police

or PIRC. In my view the point is moot in that the Commissioner has a duty to investigate and must comply, where directed by the prosecutor. Such direction or directions are thus lawful instructions as provided by S 41A (i) (a).

10 In my view my initial instruction was sufficient for PIRC to attend at Kirkcaldy and begin investigating, securing evidence etc. The instruction could not be more detailed due to the paucity of information at the time and the need for PIRC to deploy from the Glasgow area to Fife. The instruction could be (and was) altered and amplified as evidence emerged and the situation changed.

11 I agree with the account of my involvement.

12 I can only comment on my instruction given on 3rd May which is correct, but I wish to make it clear that my instruction on behalf of the Lord Advocate was in terms of S 33A(b)(ii) of the 2006 Act

13 These emails post date my involvement in this matter. I have no knowledge of the issues and do not feel I can comment. I can however advise that I have no knowledge of any agreement between PIRC and Police Scotland such as is suggested.

14 I was aware of the MOU having been involved in drafting the document. I respect of my instruction of 3rd May the only matter which required further action was to agree a date for submission of a full death report from PIRC. Clearly date setting could only take place once PIRC had a sense of the scale of the investigation and the likely time of completion. I expected to have that discussion in due course. Given my instruction was in terms of S33A(b)(ii). I plainly did not envisage this beig reported by SPR at that moment in time. I cannot comment on others expectations after 5th May.

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15 I can confirm that meetings did take place between 2013-2015 but at this remove do not recall what was discussed. I am retired and have no access to any COPFS systems or documentation.

16 .At the time that Mr Bayoh's death was reported I was advised that he had been involved in an altercation with a friend and that there may be a drugs background. As previously explained I instructed Police Scotland to investigate these earlier matters which would include the possible misuse of drugs and the supply of drugs to him. Given that the cause of death was unknown issues of culpable homicide were at that time premature.
Police Scotland have all the skills and experience to investigate such matters and given the apparent separation of time and place of the events which led to Mr Bayoh's death I took the view the police should investigate these issues. As I previously indicated I was also concerned not to overwhelm PIRCs limited resources. There was no departure from normal practice. I had split investigations on previous occasions.

17. I was unaware of any evidence regarding drugs until I was asked to review document PIRC-0001.

18. COPFS has a duty to engage with and provide information to nearest relatives in death investigations in accordance with the Family Liaison Charter that said, the timing and manner of that engagement differs depending on the nature of that investigation.

In a non-suspicious deaths investigation the death is reported to SFIU by the police, medical practitioner or other and SFIU staff would then contact nearest relatives regarding the need for and date of any autopsy, body release, further enquiry etc.

In a suspicious death or homicide case or other death potentially to court proceedings the process is different. Police Family Liaison officers (FLO's) or if PIRC instructed their FLO's, take responsibility for initial

liaison with nearest relatives. COPFS only become involved and take over such liaison after an FLO/COPFS handover which takes place once the investigation is complete or substantially so and/or an accused has appeared in custody. Plainly neither event had occurred during my involvement thus I had no contact with the Bayoh family.

19. As explained above COPFS has a duty to keep nearest relatives informed from the time of handover to conclusion. Plainly this includes the time spent on precognition. I was not involved in such matters in this case and cannot comment further.

20. As I have explained above the Procurator Fiscal is, as provided in the Family Liaison charter, responsible for appropriate communication with nearest relatives but this obligation arises at different points depending on the nature of the investigation.

This presentation relates to cause of death investigations not criminal justice investigations – see para 18 for what happens in a criminal justice case.

21. I advised Mr Brown that the cause of death could be amended by the Sherrif as part of an FAI as a reminder to him and for no other purpose. I advised against opening up that discussion with Mr Anwar as I felt it was premature and would potentially lead to further correspondence from him given his request for additional information to be inserted into the Medical Certificate of cause of death (MCCD) and in any event he should, as a lawyer with involvement in FAIs be aware of this.

While I cannot speak for my colleagues, I was always of the view that there would be an FAI. This death occurred in police custody and thus an FAI was mandatory. It was for this reason that I instructed a two-doctor autopsy.

22. This is not my letter. It is on note paper which identifies me as head of SFIU but I did not send it and have no knowledge of it. It is a standard letter sent out by SFIU to advise nearest relatives of a change to the cause of death on the MCCD. It was sent out by my SFIU East staff. I cannot comment further.

23. When pathologists conclude that an MCCD requires to be amended, usually at the time they produce their final Post Mortem report, the amended certificate is sent by them to National Records. The pathologists advise SFIU (or homicide in a murder case) and the procurator fiscal, in turn advises the relatives of the change in order that they can obtain an amended MCCD. It is clear that Mr Brown sent a copy of an identical letter to Mr Anwar and explained it was a standard SFIU letter. It maybe that SFIU sent an identical letter to other nearest relatives.

I merely confirmed that this was the normal procedure and the reasons for sending out the letter, given this was my area of expertise, much as I advised Mr Brown the MCCD could be altered at the end of the FAI. Mr Brown was in charge of this investigation, and it is for him to explain as I have no knowledge.

24. VIA are responsible for updating nearest relatives once the case has been transferred to COPFS from the FLOs.

I have no knowledge of this as my responsibility ceased after 5th May. Thus, I cannot comment.

25. Given I had instructed an investigation in terms of S33A(b)(ii) it is clear that I had not determined any officer was a suspect. The cause of death was not known and might have been from a natural cause. The position could have changed at any time in accordance with the evidence. On occasion in homicide cases, I have discussed with the police if an individual should become a suspect in a murder case. I have

never encountered this in a death in custody and cannot comment further.

Plainly if a person is a suspect their status changes giving rise to protections such as the right to consult a lawyer and interviews under caution etc.

26. I would have anticipated that PIRC would have obtained statements and COPFS having no role.

27. I had no involvement in obtaining statements from officers and cannot comment.

28. I have only on very rare occasions attended the scene of a death in custody and on these occasions usually with a pathologist to supervise body recovery. I saw no reason to go to Kirkcaldy and no purpose in my doing so. I anticipated PIRC would supervise the PIM process. It would not be appropriate for me to be there. I cannot see what benefit might have been gained from my attendance.

I requested assistance from Mr Ablett the depute on call for homicide in East Scotland, to cover the autopsy. The reason for this is that it was standard practice, as directed by Lord Advocates over many years that the fiscal attend any homicide or suspicious of homicide post mortem to ensure all aspects were covered, all samples taken, all labels signed and to get an instant read out from the Forensic Pathologists at the conclusion of the autopsy. This to inform further inquiries.

I was supposed to be on a public holiday on the 4th of May hence my request that he cover this as the postmortem was in Edinburgh and they were not on holiday.

This was standard and normal practice.

29. These two matters are entirely distinct. The light aircraft crash involved two pilots. I was advised that there was significant disruption to the bodies and a need for a Disaster Victim Identification (DVI) approach to identifying the remains. As someone with significant experience in this field I concluded I should attend with a specialist police team. Despite it being a public holiday, I attended at the scene. There were a number of distinct benefits in my attendance including my pressing upon a forensic pathologist the need for her to attend the locus to assist. I do not feel it appropriate to say more about this matter given the sensitivities for the families involved.

30. That Sunday I did not have access to a computer to produce formal instruction on letter headed paper. PIRC were made aware on 3rd May that this would not be sent until 5th May due to the 4th May being a Public Holiday in Glasgow. I sent PIRC an email by phone on 3rd May giving my instructions and the parameters of the investigation. At this time this was standard procedure during the out of normal working hours period.

I was of the view that Mr Ablett, a Principal Depute, from East Homicide was not the correct person to meet ACC Nicolson. Mr Ablett would have had no further involvement in his case and in any event colleagues such as Stephen McGowan and John Logue were already involved.

I do not think a fiscal attending at Kirkcaldy would have provided any meaningful assistance or added any value to the investigation. Anything that required COPFS input could be achieved by telephone and emails.

So far as I am aware neither PIRC or Police Scotland sought any instructions or assistance during 4th May and in any event Messrs McGowan and Logue were involved and able to deal with matters. They were aware that I had deployed to Perthshire.

31. I was made aware CCAPD were to lead in this case. Les Brown had been instructed by Stephen McGowan; he then knew as much as I did. We did discuss and I offered any assistance I could give.

32. The role of the Procurator Fiscal at any autopsy in the case of any death in custody, where criminality may have occured is identical to that in a case of homicide. To ensure the pathologists are aware of the circumstances as known; to ensure all relevant productions are taken and labelled; to have any relevant productions shown to the Forensic Pathologists at the conclusion of the autopsy; to instruct any further enquiry as informed by the autopsy and to obtain a briefing from the Forensic Pathologists on their findings and cause of death. Also to ensure that in cases where identification was uncertain to ensure that appropriate steps were in place to appropriate actions are being taken to identify the deceased. I would not ordinarily expect a Procurator Fiscal to attend an autopsy following a death involving police contact.

33. My involvement was to contact the on call Forensic Pathologist for NHS Lothian. To ascertain the availability of the mortuary and the Forensic Pathologist. To advise the Forensic Pathologist of the circumstances as I understood them and make arrangements for the time and place of the examination. In this case I also requested Quasar examinations after discussion with Dr Shearer. I advised the Police and PIRC of the arrangements.

This was entirely normal practice.

34. I asked Mr Ablett who was the on-call Procurator Fiscal for East Federation Homicide to cover the autopsy as it was taking place in his area and I was supposed to be on public holiday on the 4th of May. What I meant and I believed I conveyed to colleagues was that he would ensure the matters detailed in para 32 above were attended to.

35. At this remove I cannot recall who told me the name Sheku Baukou nor do I recall when I became aware that the correct name was Bayoh. It is not unusual at the start of such an investigation for there to be

uncertainty or lack of clarity about a deceased name, date of birth etc. Not infrequently autopsies are carried out on “unknown male/female” before identity is established. Sometimes individuals are identified by nickname. Not infrequently there is confusion over “Mac” or “Mc”.

I expected that the PIRC investigation would provide the correct details and these would be confirmed by visual identification, fingerprints, DNA or a combination of these.

Plainly it is essential to properly identify an individual regardless of their ethnicity.

36. It is absolutely standard practice to instruct a two doctor post-mortem (with full toxicology if the circumstances suggest it). It was obvious to me from the outset that this was a death in custody and thus a mandatory FAI hence the requirement for a two-doctor post-mortem. I had not ruled out potential criminality. This was a “criminal justice” post-mortem and “corroboration” was essential. A one doctor post-mortem would not have been appropriate. This was entirely normal practice.

37. SFIU are the single point of contact for arranging post-mortems and releasing bodies this is to avoid confusion and error. As a result, I had involvement as a “postbox” to ensure instructions were issued in a timeous.

I would say this, when instructing the autopsy, I anticipated that COPFS would have been able to carry out all procedures and release Mr Bayohs body by either the 6th or 7th of May.

While I am unaware of the detail it is clear that Mr Anwar requested additional investigations and at one time seemed to wish a second post-mortem. These matters resulted in delay.

I was only involved in ensuring the transfer of the body from Edinburgh city mortuary to the Royal Infirmary of Edinburgh for the purpose of X-Ray/CT scanning and its return.

38. It appears that Mr Anwar asked for radiological investigations. The request was not made to me but to Mr Brown. Mr Brown and Mr Anwar are better able to answer this as I was not involved. As I have previously stated my hope and intention was that Mr Bayohs body would have been released not later than 8th May.

39. As far as I am aware our autopsy investigations were complete as at 5th May. I believe that radiological examinations were undertaken at the request of the Crown instructed Forensic Pathologists but am unaware of the date of this. It was certainly early on in May.

I do not know how the family of Mr Bayoh were advised of body release.

40. I regret the use of the word “defence” in this context. I used it to differentiate it from a Crown instructed autopsy, this was common usage. I have never experienced a situation where a family have instructed their own post-mortem other than after the body had been released. I should not have used this word and should have instead used the phrase “family instructed”. I regret this.

I at no time, then or now, have considered the police officers to be victims of the incident.

41. I have no knowledge of this and cannot comment other than to say that had there been an unequivocal finding that Mr Bayoh had been the victim of an assault leading to his death, any police officer(s) charged as a result would have had the right to have a defence post-mortem.

42. I think it appropriate to set out my position in regard to the autopsy that will answer these questions.

I am aware that it is best practice to conduct an autopsy as soon as possible. I was a member of the group that produced the first iteration of the Code of Practice and Standards for Forensic Pathologists in Scotland. I chaired the multi-agency group who promulgated the second edition of the Code. I led for COPFS in matters relating to Forensic Pathology.

I was also conscious that mortuary space and the availability of Forensic Pathologists is a significant limiting factor in our ability to progress such examinations. As such I was content that the examination could proceed on 4th May.

I was made aware during 3rd May that there were no obvious signs of injury to Mr Bayoh, as such the cause or causes of his death were entirely unknown. It was possible that he had died of an entirely natural cause either related or unrelated to the incident involving the police. It was also possible that his death may have been drug related, I had been made aware he took drugs and anabolic steroids were mentioned as he was a body builder. It was, of course, also possible he had died as a consequence of police actions, perhaps of asphyxiation.

As such there was a clear imperative to know why he had died, this being the foundation stone for subsequent investigations, in what was a “criminal justice investigation”.

I was firmly of the view that the autopsy should take place as soon as possible. It was essential in the interests of justice and for that matter in the wider public interest as well as the interests of his family and the police officers involved that the cause of death be ascertained as soon as possible.

It is not necessary to have a body identified before autopsy, indeed in some deaths such identification is not possible. Alternative means such as other persons who know the deceased as well as nonvisual methods, finger prints, DNA and odontology are available and are frequently used in such cases as DVI deaths.

In some cases, the identity of the deceased is unknown at the time of the autopsy and part of the purpose is to assist in the identification of the deceased.

I ensured that the family were advised of the time and place of the autopsy and that they were asked if they would attend and identify him. There was no obligation on them to do so.

I was advised that the family were not willing to attend the mortuary and that they were waiting for “elders” to travel from, I believe, London. Moreover, I was advised that the family would consider this request once they arrived.

Thus, there was no time frame for this to occur nor any certainty that the family would ever attend to identify the body.

In the face of this uncertainty and the necessity, in my view, of conducting the autopsy as soon as possible I decided it should go ahead as arranged.

I would refer to the final page of PRC 03694 which confirms the information I was given.

As it turned out he was identified by his fingerprints.

The decision to go ahead with the autopsy on 4th May was not an arbitrary one, rather one taken in light of the circumstances, and I believe it was the correct decision.

43. My presentation in 2013 was in relation to examinations carried out by SFIU for a non-criminal justice purpose i.e. what would in England be “Coronial Examinations”.

Death’s investigations in a criminal enquiry are different as the interests of justice and the wider public interest are paramount. See Paragraph 42.

44. Treating doctors, often in A&E, occasionally ask for this information for audit purposes. Given the very high profile of this death, I considered it inappropriate to provide any information other than the MCCD (a public document) particularly as the post-mortem had not revealed anything that would have been assistance to the audit process. I was concerned about security of this information.

45/46/47 As indicated above my instruction was that PIRC should investigate in terms of S33A(b)(ii). At that point in time the cause of Mr Bayohs death was completely unknown. He might, conceivably, have died from a natural cause such as cardiac arrest. He might have died as a result of drugs intoxication. He might have died from the effects of restraint potentially in combination with any of the above.

Until the position was clarified the officers were witnesses. I was only involved in this on 3rd May and made it clear to Keith Harrower and Pat Campbell that was my view, that said their status could change at any time as evidence became available. Had their status changed to suspects, legal protections would have come into play but not during the time I was involved.

This did not happen during the period I was involved.

48/49 These are matters that are outwith the scope of my involvement and I cannot comment.

50 On the morning of Tuesday 5th May I received a telephone call from Lord Mulholland the then Lord Advocate. He asked for a briefing about the circumstances of this case as he was due to attend a cabinet meeting, I believe at Bute House. I told him all I knew about the circumstances and the post-mortem results.

Perhaps two hours later I received a further call from the Lord Advocate who instructed me that Amer Anwar was to be given " his choice of

Neuropathologist" and this person would carry out the examination of Mr Bayohs brain. I thought this highly unusual, it was something that had not happened before in my thirty years of service. The fact is that the Crown had in place contracts for neuropathological examinations with Dr Colin Smith being contracted for this case. I expressed my surprise and confirmed that Dr (now Professor) Smith held this contract. I was instructed that Mr Anwar would advise who should do this. I then contacted Dr Shearer to make her aware of this and put a hold on Neuropathological examination, she in turn advised me that Dr Smith had attended early that morning and had already completed the examination as he was travelling to a medical conference that day.

I in turn made the Lord Advocate and others aware of this.

51. COPFS 04924 sets out the position. The Lord Advocate wished to accommodate Mr Anwar by having the neuropathology done independently of the Crown.This is not procedure. I set out the position and the independence of medical staff involved and confirmed that blocks and slides of brain tissue would be available for others to examine.

Given the Lord Advocates direction, as above, and how far the process had progressed it was plainly not possible for me to obtemper the Lord Advocates instruction.

52. The written instructions for autopsy, neuropathology and toxicology are issued on SFIU notepaper. While I instructed all three when arranging the post-mortem, I issued no further instructions. These are responses coming in regarding these instructions and my passing them on to Mr Brown. The chains make it clear that when a question arose I referred it to Mr Brown to deal with directly (email 18/5).

53. Dr Smith had carried out the neuropathological examination on the 6th May and he then went abroad. I was not aware if he was still abroad

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or had returned nor if he was aware of the significant media attention on this death. Clearly, we were all under pressure to get results and progress the investigation. See Crown Office 04924 where on 6th May Stephen McGowan asks when Dr Smiths report will be available and advises that the Lord Advocate is seeking it “asap”.

Hence, I wanted the report expedited and wanted Dr Smith to understand why. This was not normal practice.

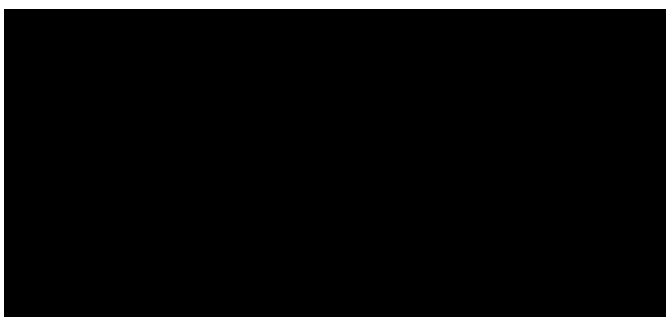
54. As can be seen from Para 52 I referred these matters to Mr Brown as the person in charge of this investigation. He had no reason to involve me in this.

55. This relates to PIRC finding Caffeine in capsules labelled Testosterone at Mr Bayohs home and advises that the lead Forensic Pathologist and Toxicologists have discussed and agreed to test Mr Bayohs blood for Caffeine. Given their agreement, had I dissented, it is very likely I would have been criticised.

Caffeine would never normally be tested for and in this regard this investigation was different but was advised by experts.

56. I first became aware of this when provided with materials by the Inquiry. I know nothing of this.

57/58. SFIU as the unit investigating deaths maintained information relating to individuals of proven expertise in areas of medicine. As such we could advise on potential expert witnesses. I do recall advising that Prof. Shepherd might be an appropriate person to approach for a Cardiac opinion. I do not recall Dr Soilleaux at all. I gave no other advice.



It is entirely normal to seek assistance across COPFS. Homicide and HSU would routinely ask if we were aware of an expert in a particular field. All SFIU would do is provide the name and contact details.

59-62. I had previous experience of HSE investigations. At the time of my involvement in this matter it would not have been appropriate to involve them given that the cause of death was unknown. I am unable to answer these questions given I was only involved for the first two and a half days and knew nothing of the investigation thereafter.

63. [redacted]

64/65. I was not involved in any such discussions and cannot comment further.

66. The Crown are responsible for all media releases in such a situation. All potential press releases by Police Scotland or PIRC are considered for approval by senior prosecutors and Crown Office media before release.

67. I was not following the media to any extent at all. I was emphatically not influenced by the media. I am not aware of colleagues being influenced by the media and cannot image that they would be. We are well used to media reporting of our cases but are not influenced by this.

68/69. I was involved in a brief discussion with PIRC who wished to put out a brief statement confirming that they had been instructed to investigate M Bayohs death. I agreed this was appropriate and advised it should be cleared with Crown Office media. Mr McGowan dealt with these aspects I was not involved in any way.

70. I was entirely unaware of this until now. I therefore cannot comment further.

71. I had no knowledge of this and cannot comment further.

72. I am not aware of the Scottish Police Federation having any role. I am not aware of anything they may have said or released and cannot comment further.

73-75. I was until now, unaware of these matters and thus have no knowledge of them.

76. COPFS has always considered race in any such case in so far as it may have an impact on funerary rites or explain the motivation for what occurred.

77. I understood that Mr Bayoh was Muslim though I don't recall from whom I received that information or when. I certainly considered it as a possibility hence my concern to ensure, so far as possible, that the post-mortem process proceeded as expeditiously as possible in order that his remains be released to his family at the earliest point.

78. It is always imperative to proceed with such investigations as expediently as possible. In that respect this investigation was no different

from any other. It was a criminal justice investigation; the interests of justice and the wider public interest demanded it be so. The only difference was that I was conscious that the family, for religious reasons, would wish the body returned as quickly as possible and I sought to assist in that.

79. I was aware of training and reference materials. I delivered some of this training and wrote a great deal of the guidance. I did not require to make use of these. I was only involved in post incident management in instructing PIRC.

80. In so far as I was involved I felt I had been sufficiently trained.

81. I cannot answer for Police Scotland. I have no idea why they were asking these questions or why Mr Bayoh's name is incorrectly spelt. That said, I was obviously asked for my views as Head of SFIU and dealt with such matters routinely. I did not see why we could not answer directly but Mr Browns answer is accurate. I cannot speculate on why these questions were not answered directly.

82. "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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