

Transcript of the Sheku Bayoh Inquiry

Wednesday, 17 April 2024

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(10.03 am)

LORD BRACADALE: Ms Grahame.

MS GRAHAME: Good morning, Mr Brown.

A. Good morning, Ms Grahame.

LES BROWN (sworn)

Examination-in-chief by MS GRAHAME

Q. You are Les Brown?

A. Yes.

Q. What age are you?

A. I'm 60.

Q. And you were employed in Crown Office and have been since 1985?

A. Yes.

Q. You joined as a trainee and you've worked your way up to the extent that in November of 2014 you were head of the Criminal Allegations Against the Police Division?

A. Yes.

Q. We've heard that that's called CAAPD?

A. Yes.

Q. Right and you had -- had you been in that unit before you took on the role of head of the unit?

A. No, I had not been in that unit. And historically that role of the investigation of criminal allegations against the police or complaints against the police,

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1 that was dealt with by -- it was on a regional basis
2 within the Crown Office and Procurator Fiscal Service
3 and normally it would be the most senior Procurator
4 Fiscal in the areas who would deal with that, but CAAPD,
5 the Criminal Allegations Against the Police, was a
6 specific unit that was created I think round about 2012,
7 and that was a central unit that was staffed by a number
8 of people and that it would deal with all criminal
9 allegations against on duty officers nationally so that
10 was the history of CAAPD.

11 I was appointed to CAAPD towards the end of 2014
12 and, as I said in my statement, I took over from
13 Kate Frame, who of course became the commissioner at
14 PIRC and I think that Kate Frame was the first head of
15 national CAAPD, if that assists.

16 Q. Kate Frame, and we've had heard from her, she was the
17 first head of CAAPD and then you were appointed from
18 about November 2014, I think, you say in your statement?

19 A. Yes, it was around about that time, yes.

20 Q. Thank you. And that was a new unit then set up in 2012?

21 A. It was a relatively new national unit and, as I said,
22 I had very limited experience prior to that for the
23 reason that those cases tended to be dealt with
24 separately from the rest of the organisation.

25 Q. Thank you. And you stayed there until November 2019,

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- 1 you said in your statement?
- 2 A. Yes.
- 3 Q. When you were appointed as Procurator Fiscal for
4 South Strathclyde?
- 5 A. Yes.
- 6 Q. And is that where you are today?
- 7 A. It is.
- 8 Q. You've mentioned in your statement that the CAAPD
9 department unit would receive PIRC reports; is that
10 right?
- 11 A. It would receive PIRC reports. I am confident that the
12 first PIRC report that I saw was in fact came from that
13 source. But you're absolutely correct, the unit would
14 see reports from PIRC, the other unit within COPFS,
15 within Crown Office Procurator Fiscal Service, that
16 would see PIRC reports would be the Fatalities Unit,
17 SFIU headed by David Green. So they would see reports
18 in respect of sudden deaths and deaths that PIRC were
19 instructed to investigate on behalf of the crown, but we
20 would see in CAAPD reports submitted by PIRC, obviously
21 normally in respect of criminality.
- 22 Q. Right. And we'll come on to that in due course, thank
23 you. Have you watched in the evidence that's been
24 before the Inquiry?
- 25 A. I have haven't watched a huge amount of evidence, but I

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1 have seen some broadcasts in relation to the evidence,
2 yes.

3 Q. On television?

4 A. Yes.

5 Q. Well, you may not be aware that there's a blue folder in
6 front of you and that contains some hard copies of
7 documents that we hope will be of assistance to you --

8 A. Thank you.

9 Q. -- in the course of your evidence. And you should feel
10 free to open that up and use any of the documents, refer
11 to them at any time at all.

12 A. Thank you.

13 Q. As we go through your evidence, there may be particular
14 parts of your statements or your relate responses or
15 documents that I would like you to comment on. They'll
16 come up on the screen in front of you, but you'll always
17 have the blue folder as well.

18 A. Thank you.

19 Q. And, please if there's anything else that you think you
20 would like to refer to or that would help us, please let
21 us know what it is. If we cannot lay our hands on it
22 immediately, we will try and get it over the next break
23 or overnight.

24 A. Thank you.

25 Q. All right. Let's look, first of all, at the request for

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1 a Rule 8 statement which is SBPI00444. And you'll see
2 this has come up on the screen. If we can move down and
3 this is a series of questions which were sent to you by
4 the Inquiry team and you were then asked to consider
5 those questions and prepare responses.

6 A. Yes.

7 Q. And this was the first one that was sent to you and it
8 covers, as we'll see on this page, your role and the
9 experience you had and it goes through a large number of
10 questions.

11 A. Yes.

12 Q. If we look at the very bottom of this document, so it's
13 38 pages long, we don't want to see the docs, but if we
14 can look at the last sort of question, please. We'll
15 see that its contains 194 sort of questions and the last
16 one is:

17 "Please sign and date your statement".

18 A. Yes.

19 Q. And did you follow that process in order to provide the
20 Inquiry with information about your involvement with the
21 investigation into Mr Bayoh's death?

22 A. Yes, I did.

23 Q. Thank you. And if we could look at your response to
24 that which I think is SBPI 00419. Now, this is the
25 response so it's your response to that Rule 8 request

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1 that we've just look at and it's dated 27 November 2023.

2 A. Yes.

3 Q. And if we can look at -- it's 112 pages I think. If we
4 can look at the final page. There we are. We see that
5 you've signed or the copy that you have should have been
6 signed, which you're nodding; is that correct?

7 A. I did sign it.

8 Q. You did sign it.

9 A. It was a process which had to be followed to sign it
10 electronically and I did sign it electronically and
11 submitted it.

12 Q. Thank you, that's fantastic. And the last paragraph
13 says:

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

18 A. Yes.

19 Q. And you understood that when you signed it?

20 A. Yes, I did.

21 Q. Thank you. And you did your best when you replied to
22 this Rule 8 request to give a true and accurate record
23 of your recollections of the events?

24 A. Yes, I did.

25 Q. Thank you. So that was your first response to a Rule 8

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1 request. I may call that your first statement.

2 A. Yes.

3 Q. Just because it's shorter and easier to understand.

4 Then if we can look at the second time the Inquiry got
5 in touch with you, that is SBPI 00437 and this was a
6 second Rule 8 request, and it's -- and if we can go down
7 to the bottom of that page, we'll see that this is the
8 final paragraph there, 28:

9 "Please sign and date your statement."

10 So it's a shorter more focused series of questions?

11 A. Yes.

12 Q. And then your response to that was SBPI 00459, and this
13 is a 12-page response and again we can see at the
14 bottom, the paragraph at the end, there's an area for
15 your signature and am I right we can see it on this one,
16 although it's redacted, it won't be redacted on your
17 copy and your hard copy in your folder, we see you
18 signed it on 9 February this year?

19 A. Yes.

20 Q. And again the same paragraph appears at number 27 on the
21 screen:

22 "I believe the facts stated in this witness
23 statement are true. I understand the statement may form
24 part of the evidence before the Inquiry and be published
25 on the website."

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1 A. Yes.

2 Q. And again, you understood that to be the case when you
3 signed it?

4 A. Yes, I did.

5 Q. And you were trying your best to give a true and
6 accurate record?

7 A. Yes, I was.

8 Q. And then finally, you gave a supplementary statement
9 which is SBPI 00474, and this is really only a page, so
10 if we just go to the bottom, it was an aspect about the
11 statute which applied, just a clarification point
12 really.

13 A. Yes.

14 Q. And again, you've signed that on 4 March, 2024, and the
15 final paragraph we can see is in exactly the same terms
16 as previously and you understood that to be the case
17 when you signed?

18 A. Yes.

19 Q. Thank you. I would like to ask you about, first of
20 all -- before I begin going through your own personal
21 involvement, I would like to show you a document and see
22 whether you were aware of it. It's PIRC 04453. We've
23 heard evidence about this document that it was dated
24 December 2013, so the year prior to you becoming head of
25 CAAPD?

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1 A. Yes.

2 Q. But it was a memorandum of understanding between PIRC
3 and the crown?

4 A. Yes.

5 Q. Now, on the final page of this document, sorry, the
6 final page of the substantive document, not the
7 appendices, if we can move up, please, we'll see it's
8 been signed on behalf of PIRC on 10 December 2013 and on
9 behalf of the Crown Office on 11 December 2013, so it
10 was signed at the end of the year before you started?

11 A. Yes.

12 Q. And if we can go to the top of the document again to the
13 first page. You'll see that it says "Memo of
14 understanding between Crown Office and ..." If we can
15 move down to "PIRC". And we've heard evidence that this
16 was about essentially an agreement, an understanding,
17 between the two organisations?

18 A. Yes.

19 Q. Were you aware of this document when you were head of
20 CAAPD?

21 A. Yes, I was.

22 Q. Thank you. Could we look at this document, and just
23 very briefly look first of all -- we will look at pages
24 3 to 5, so if we can see -- we can start with paragraph
25 4.1. See there it says "Role of Crown Office and

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1 investigations" and it talks about the Crown Office
2 being the sole prosecuting authority.

3 Then if we can move on to page 4. I'm interested in
4 paragraph 4.3 at the top of the page:

5 "Crown Office has responsibility for the
6 investigation of all sudden and suspicious deaths."

7 And then it deals with the role of the PIRC in
8 investigations and if we can look at paragraph 5.5, it
9 says:

10 "PIRC investigations are intended to comply with the
11 five principles of effective investigation outlined by
12 ECHR; namely, independence, adequacy, promptness and, so
13 far as possible, public scrutiny and victim
14 involvement."

15 A. Yes.

16 Q. And that's something you were aware of that there are
17 five obligations in relation to an investigation,
18 independence, adequacy, promptness, so far as reasonably
19 possible -- so far as possible, public scrutiny and then
20 involvement of the victim or the next of kin?

21 A. Yes.

22 Q. That will be a theme that we will continue to turn back
23 to as we go through questions.

24 A. Thank you.

25 Q. Those five obligations. And my understanding is that

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1 those obligations to effectively the crown investigation
2 into sudden deaths, unexplained deaths, and that the
3 investigation in certain circumstances for crown will be
4 crowd by PIRC.

5 A. I consider that that makes it explicit and clear that
6 there is requirement to comply with those principles in
7 respect of the investigation carried out by PIRC. I
8 consider that there is an overriding obligation on the
9 part of the state as a whole, which would include the
10 crown and any subsequent proceedings, to have regard to
11 those principles in that overall investigation, yes.

12 Q. And we've heard evidence that those five obligations
13 apply to the crown and also to PIRC and that's really
14 what you have just been saying?

15 A. Yes.

16 Q. Thank you. And then at the bottom of that page:

17 "Examples where the Crown Office may require an
18 investigation by PIRC ... "

19 Because it's clear that the Crown Office don't
20 always require PIRC to do an investigation?

21 A. Yes.

22 Q. But there are certain circumstances where the PIRC are
23 required to do an investigation?

24 A. Yes.

25 Q. 6.1:

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1 "Decisions as to which cases will be referred to
2 PIRC will be taken by the appropriate prosecutor. Each
3 case will be dealt with on its own facts and
4 circumstances and the following examples of
5 investigations that might be referred to PIRC are for
6 illustrative purposes only and are not intended to be an
7 exhaustive list, nor are they intended to bind the
8 prosecutor's discretion on the facts of any specific
9 case."

10 But they give some examples which are indicative of
11 the type of situation where PIRC might be called upon by
12 the crown to do an investigation?

13 A. Yes.

14 Q. And the first couple of examples we see on that page
15 there are death in police custody. The decision about
16 whether a death falls within the category of "death in
17 police custody" lies with Crown Office.

18 A. Yes.

19 Q. And it may also include a death following direct or
20 indirect contact with the police. So that would be --
21 would that be where a death occurs when the police are
22 there or may be shortly after the police have left?

23 A. Yes. And as that particular paragraph seems to say,
24 typically, where there has been some form of pursuit,
25 some interaction with the police that has been a factor

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1 in relation to the incident, yes.

2 Q. And there's mention to include the use of firearms or
3 other weapons, a road accident directly or indirectly
4 involving police vehicles or any incident where there's
5 an inference that there was police involvement in which
6 it could be inferred there was a direct or indirect
7 causal or contributory link to death?

8 A. Yes.

9 Q. Thank you. And then if we move on to the next page, and
10 if we start looking at section 7:

11 "Protocols for interaction between Crown Office and
12 PIRC during an investigation"

13 And if we see here, 7.3:

14 "In the case of death or serious injury
15 investigations COPFS recognises the importance of
16 allowing the PIRC early access to ensure independence
17 from any police investigation from the outset."

18 A. Yes.

19 Q. And does that go back to the Article 2 requirement for
20 independence in relation to the investigation and in
21 that sense independence from the people that are being
22 investigated?

23 A. Yes, it comes back to that principle and it is the case
24 that the creation of the PIRC was intended to address
25 that when of course a national police force was created

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1 so those were interlinked and clearly the creation of
2 PIRC was concerned with ensuring that independence from
3 the police, yes.

4 Q. We've heard evidence that in the past there were a
5 number of different police forces around Scotland,
6 people have called them "legacy forces", and there was
7 the opportunity at that time if officers were suspected
8 of having done something wrong, say in Fife, another
9 area, another police force from a different area could
10 investigate those allegations, but once it became
11 Police Scotland that caused an issue, it wouldn't be
12 possible, and they set-up PIRC to be independent?

13 A. Yes.

14 Q. That's maybe a bit simplistic, but does that explain it?

15 A. It does and obviously I'm long enough in the service to
16 remember that as an approach that was taken. The
17 question as to whether it was adequately independent is
18 of course not for consideration today, but the principle
19 of independence, I would suggest, in having a different
20 force that was unconnected with the incident, was
21 recognised even in those days, yes.

22 Q. And so that's why PIRC were set-up from 1 April 2013 to
23 be that independent body to investigate any allegations
24 against police officers?

25 A. Yes, and given that specific responsibility, yes.

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1 Q. And it was the crown who would instruct PIRC to or the
2 Chief Constable could refer matters to PIRC himself?

3 A. The Chief Constable could. There is -- I'm pretty
4 confident there is also a discretion on the
5 Commissioner themselves that they can take on an
6 investigation, but certainly those are the typical
7 routes whereby the PIRC would carry out an
8 investigation, yes.

9 Q. Thank you. And then if we look at 7.4:

10 "In the case of a death investigation the police
11 will be required to submit the initial death report by
12 the next working day to the Scottish Fatalities
13 Investigation Unit of Crown Office. The PIRC will
14 submit its full death report into the investigation of
15 the death within timescales determined by Crown Office
16 in each individual case."

17 A. Yes.

18 Q. So in the case of a death investigation, there's an
19 initial death report and that is to be sent from the
20 police to the Scottish Fatalities Investigation Unit,
21 the SFIU. We've heard from David Green in the Inquiry
22 and I think he was the head of SFIU at one time?

23 A. He was. He was the head of SFIU for a number of years
24 and he certainly was head of the SFIU at the time of
25 this investigation.

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- 1 Q. And then at 7.5:
- 2 "In the case of a criminal investigation... "
- 3 So there's a distinction drawn here with the
- 4 previous paragraph.
- 5 A. Yes.
- 6 Q. Earlier one is death investigation, this one is criminal
- 7 investigation.
- 8 "Crown Office CAAP Division will instruct whether
- 9 PIRC shall by way of a full investigation report on the
- 10 agreed template or/and an SPR together with full
- 11 statements and productions and will determine the
- 12 timescales for each individual case."
- 13 A. Yes.
- 14 Q. What's an "SPR"?
- 15 A. It's a standard police report.
- 16 Q. So this is in the situation 7.5 relates to a criminal
- 17 investigation. So it's not at the SFIU referred to
- 18 here, it's CAAPD, and there's a template and an SPR and
- 19 then there's the suggestion full statements and
- 20 productions and timescales to be determined by CAAPD?
- 21 A. Yes.
- 22 Q. And can you explain this distinction that's drawn here
- 23 between 7.4 and deaths investigations involving SFIU and
- 24 7.5 involving criminal investigations involving CAAPD?
- 25 A. Yes. I think it seeks to draw a distinction because, as

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1 I am sure the Inquiry are well aware, there are two
2 routes set out in the legislation whereby PIRC would
3 typically be instructed so they can be instructed in
4 relation to the investigation of a sudden death that
5 will involve the police, but they can also be instructed
6 where the terms of the legislation appear to be
7 applicable and that in relation to the criminality and
8 the wording of that where there is -- I think it is
9 where there is an indication that an officer may have
10 committed an offence, that is the other route.

11 I would say that they are obviously both under the
12 same section and the powers of the crown to instruct
13 derive from that section, that being section 33A of the
14 relevant legislation, and so to some extent they make
15 clear that they are crown-directed or crown-instructed
16 investigations, both of those, to distinguish them from
17 other means by which PIRC may investigate certain
18 circumstances.

19 Q. Thank you. So we've heard evidence that the relevant
20 section is 33A and there are two types of investigation
21 envisaged within that legislation. There's the B1,
22 which is circumstances where the police have been
23 involved?

24 A. Yes.

25 Q. And B2 where there are criminal -- potentially criminal

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- 1 allegations?
- 2 A. Yes, that is the wording and indication. I think that
- 3 is the wording, yes.
- 4 Q. So section 7 reflects that distinction that arises from
- 5 the statute that created?
- 6 A. Yes.
- 7 Q. The investigation in PIRC?
- 8 A. Yes. I would consider that that is the reference in
- 9 those two paragraphs of the memorandum of understanding,
- 10 yes.
- 11 Q. And this section envisages that circumstances will be
- 12 dealt with -- the circumstances type of investigation
- 13 will be dealt with by SFIU, the criminal side will be
- 14 dealt with by CAAPD?
- 15 A. Yes.
- 16 Q. Thank you. Can I turn to your -- I am finished with
- 17 that document, thank you very much.
- 18 There was no reference, however, in that document
- 19 that I could find certainly that refers to specifically
- 20 to Article 14, discrimination?
- 21 A. No.
- 22 Q. No?
- 23 A. Yes.
- 24 Q. Are you aware of any documents akin to that memorandum
- 25 of understanding between crown and PIRC that related

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1 specifically to Article 14?

2 A. I'm not aware of any document that referred to
3 Article 14. I am familiar with Article 14.

4 Q. We'll come on to that later, if I may. So you became
5 head and you were head of CAAPD in May 2015. You have
6 said in your statement -- let's look at that briefly,
7 SBPI 00419, and I'm interested in some of your answers
8 cover a number of pages. It's page 68 that I would like
9 to look at, which is actually your answers to questions
10 108 to 109, and if we can look at paragraph 1 on page
11 68. I think it's the next page. Maybe sometimes the
12 page numbers differ depending whether it's the PDF or
13 the actual document.

14 Can I just check. Can you keep going, please.
15 Thank you. Can I see the top of that page, please, yes.
16 So this may be -- I've called it page 68. It may be
17 page 69 on the PDF, is it? I'm sorry about that.

18 So this is the first paragraph and I'm interested in
19 the final sentence here:

20 "To my knowledge this was the first time CAAPD had
21 been involved in a sudden death investigation. That was
22 normally conducted and overseen by SFIU."

23 Now, we have heard that SFIU were involved in
24 arranging the postmortem which had taken place on 4 May?

25 A. Yes.

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1 Q. And I'm interested in why, if this was being treated as
2 a sudden death and we've heard evidence that it was a B1
3 investigation into the circumstances and that initially
4 Dave Green was the person who contacted PIRC and
5 instructed them to start the investigation, why was
6 CAAPD brought in instead?

7 A. Yes. I'm -- I'm aware that the instruction that was
8 issued by senior colleagues over the course of the
9 weekend and prior to my involvement simply specified the
10 general section and I think I'm correct in saying it did
11 not seek to differentiate between B1 or B2.

12 Q. That's my understanding.

13 A. So that instruction had been issued and I know it was
14 modified or expanded, again prior to my involvement, but
15 still did not distinguish between the two, so SFIU were
16 involved at the initial stages and that was in
17 accordance with normal procedure in relation to being
18 advised of the circumstances of the death of Mr Bayoh
19 and also instructing initial procedures, including the
20 postmortem examination, and that in my experience was
21 very typical.

22 CAAPD became involved on my return to work, as it
23 were, after the holiday weekend when, as I said in my
24 statement, I was asked to go through to Crown Office and
25 it was indicated to me that a decision had been taken

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1 that the investigation would be -- would either lie with
2 CAAPD or be overseen by CAAPD at that stage and that was
3 a decision that had already been taken.

4 As regards an explanation as to why that was,
5 I cannot recollect any clear indication other than I
6 consider that it was -- it was considered that there was
7 at least the potential for criminal proceedings at that
8 stage and that it was appropriate that it be overseen by
9 CAAPD at that stage, because it would involve
10 considerations in relation to the actings of the police
11 and possibly further proceedings depending on the
12 results of that investigation. So that is my
13 recollection in relation to that particular decision,
14 but it was a decision that I was advised of and that was
15 the way that matters proceeded at that stage.

16 I'm pretty sure that the Lord Advocate had been
17 I think involved in that decision, because, as I say,
18 that was the decision that had been reached and I was
19 being advised of that decision.

20 Q. The Lord Advocate at that time would have been
21 Frank Mullholland; is that correct?

22 A. Yes, it was.

23 Q. And I think in your statement you talk about being asked
24 to come through to Crown Office to have a meeting with
25 Stephen McGowan?

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1 A. Yes.

2 Q. We've not heard from him yet but we hope to hear from
3 Mr McGowan. He was the fiscal for major crimes and
4 fatalities investigation?

5 A. Yes.

6 Q. Can you explain to people where he was or where you were
7 in relation to his role. You're head of CAAPD at this
8 point?

9 A. I'm head of CAAPD. It's a civil service structure.
10 Stephen McGowan would be senior to myself, he occupied a
11 higher grade and had -- and was operating in that job
12 title. Sometimes I know that the job titles can
13 sometimes be a bit misleading that you're head of
14 something, but then there's somebody else that has got a
15 different job title, but he certainly was senior to
16 myself in effect. I'm pretty sure he was the line
17 manager of David Green and I was further down than
18 David Green at that time.

19 So if that assists, in respect of where
20 Stephen McGowan was, he was senior to David Green who
21 was senior to myself in terms of grade at that time.

22 Q. All right. So Stephen McGowan is above both you and
23 David Green?

24 A. Yes.

25 Q. And David Green as head of SFIU has been involved in the

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1 initial stages --

2 A. Yes.

3 Q. With the death of Mr Bayoh, but then was it at that
4 meeting with Mr McGowan that he said you would be having
5 oversight I think as head of CAAPD?

6 A. I don't know if that was the term that was used, but
7 certainly it was made clear that the investigation was
8 going to rest at that stage with CAAPD rather than with
9 SFIU, the fatalities unit.

10 LORD BRACADALE: Sorry to interrupt.

11 Mr Brown, should I understand then that the head of
12 CAAPD had a lesser grade than the head of the deaths
13 unit.

14 A. Yes.

15 LORD BRACADALE: What was the thinking behind that?

16 A. I can't -- I don't think I can assist your Lordship in
17 respect of that. As I said in my statement, the head of
18 CAAPD when Kate Frame occupied that role was at a higher
19 grade. The -- it had been downgraded, to use a term,
20 after Kate Frame's departure. It had been occupied by a
21 senior civil servant. I was not a senior civil servant
22 when I was appointed, so I know I was the first head of
23 CAAPD to be appointed who was not a senior civil
24 servant.

25 LORD BRACADALE: Thank you.

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1 A. A decision had been made I suppose at an organisational
2 level. That's as far as I can say. I was not involved
3 in those discussions and the decision to downgrade, as
4 it were, had been made prior to my appointment and I was
5 appointed to it on a level transfer.

6 LORD BRACADALE: Thank you.

7 MS GRAHAME: Thank you. Regarding your role, I wondered,
8 and I don't know if this is on the play list, it's
9 something we might have to get later, COPFS 02539, this
10 is a letter written by Stephen McGowan to PIRC, and it's
11 on 5 May 2015. It's not. What we'll do is we'll come
12 back to that after our morning break if I may.

13 So you have that meeting with Stephen McGowan when
14 you come back to work, you go to Crown Office and meet
15 with him, and was it at that meeting that he appointed
16 you to deal with the Sheku Bayoh investigation.

17 A. Yes, I think that would be fair to say, yes.

18 Q. And you've mentioned the Bank Holiday Monday, we have
19 heard that was 4 May, so was this meeting on 5 May, the
20 day you had returned to work, or the day after?

21 A. I cannot be certain, I'm sorry to say. I'm very
22 confident that it would have been Tuesday of that week
23 at the earliest.

24 Q. Right.

25 A. I can't be absolutely certain that it was the Tuesday,

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1 but out of all the days I think it's most likely to have
2 been the Tuesday, although I did go through emails as to
3 whether -- how did I know to go to Crown Office that
4 day, I cannot remember.

5 Q. Well, the letter that Stephen McGowan appears to have
6 written was on 5 May and he sent -- as I say, we'll look
7 at it later -- but he sent it to PIRC and he said:

8 "Les Brown, Head of CAAPD, will be the senior fiscal
9 with oversight of the case and bring as much assistance
10 from Crown Office as required."

11 A. Yes, that would accord with my general recollections
12 then and I think I have seen that piece of
13 correspondence.

14 Q. Your role from that point was to provide oversight and
15 handle the investigation into Mr Bayoh's death?

16 A. Yes, to provide oversight and obviously investigation
17 and the eventual PIRC report was to be submitted to
18 CAAPD. I think I have said in my statement that at that
19 time and in the light of the fact that even at that
20 early stage it was clear that this was going to be a
21 significant and important investigation. I was
22 reassured I suppose that I would be able to draw on the
23 experience of senior colleagues, including
24 Stephen McGowan, in respect of that, but that is
25 correct, yes.

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1 Q. Thank you. And before we go into the steps that you
2 then took, can I ask you some questions about the unit
3 that you were head of?

4 A. Yes.

5 Q. I think in your statement you say you dealt with around
6 50 cases a month, is that -- was that the position in
7 about May 2015?

8 A. I think -- I think it was and there was a -- there was
9 some -- it was a memorandum that I reminded myself of in
10 relation to that. I do think that the overall case load
11 did reduce because I have seen that over recent years it
12 was less than 50, but that would be correct.

13 Q. At around May 2015?

14 A. Yes, and one of the other things that I think I did say
15 in my statement was that there was a backlog of cases
16 that I inherited and clearly dealing with cases within
17 CAAPD, because of the sensitivity of them and the fact
18 that police officers will want them dealt with as
19 quickly as possible, that was a primary source of
20 concern, a significant number of cases that were getting
21 older and in particular some data protection offences
22 that seemed to be building up in respect of that. But,
23 yes, a significant number of cases, around about 50 is
24 the best of my recollection at that time and of course
25 during the course of the initial investigation and

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1 subsequently other large sensitive cases were dealt with
2 by the unit and I had oversight of those as well.

3 Q. The team that you were managing at that time, you have
4 told us that there were two part-time principal deputies?

5 A. Yes.

6 Q. Two part-time deputies and two non-legally qualified case
7 preparers?

8 A. Yes.

9 Q. And plus yourself so was the team -- you were one of
10 seven, you had six staff?

11 A. Yes, although I think at least one of the case preparers
12 was part-time as well.

13 Q. I was going to ask.

14 A. I think they might have been, but certainly the
15 principal deputies -- now the principal deputies are the
16 kind of first line managers within the organisation,
17 they were part-time and they were highly experienced and
18 in fact the unit as a whole, if it assists the Inquiry,
19 was I would term it pretty experienced in that all of
20 them had certainly been there for a lot longer than
21 I had been and some of them had been there for a
22 considerable period of time.

23 Q. So they had experience of working within that unit and
24 experience of criminal allegations against the police
25 investigations?

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- 1 A. Yes, and the processes that the unit was expected to
2 follow, yes.
- 3 Q. Okay. So you had six staff working for you, five of
4 them were part-time?
- 5 A. I think -- I think -- I think that's -- that's right,
6 yes.
- 7 Q. And we've heard the names of three of them,
8 Fiona Carnan, who's given evidence to the Inquiry?
- 9 A. Yes.
- 10 Q. Alisdair MacLeod and Erin Campbell?
- 11 A. Alisdair MacLeod was not a member of CAAPD.
- 12 Q. Right.
- 13 A. Alisdair MacLeod was seconded to this particular
14 investigation, Alisdair MacLeod had come from another
15 part of the organisation. The same applies to
16 Erin Campbell. Erin Campbell was not a full member of
17 CAAPD at any time and, again, was seconded into the
18 Inquiry.
- 19 Q. Were they in addition to the six members of staff that
20 you already had then?
- 21 A. Yes, they were.
- 22 Q. And were they full time?
- 23 A. Yes, yes, they were, but it was later on in the Inquiry,
24 if it would assist the Inquiry as regards dates.
25 I would struggle in respect of the date, but I'm pretty

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1 confident it was, I think, around the time of the
2 submission of the final PIRC report.

3 Q. And what was at the submission of the final PIRC report,
4 when they both were seconded?

5 A. Yes.

6 Q. Right.

7 A. Yes.

8 Q. So in the initial stages at least, prior to the
9 submission of the final PIRC report, they didn't -- they
10 are not told seconded to the team?

11 A. Yes.

12 Q. And they only became involved after -- we've heard the
13 final PIRC report was submitted in August 2016. So that
14 would be sometime after that date Mr MacLeod and
15 Ms Campbell would come on board seconded to your unit?

16 A. I think that is correct. I have seen an email however
17 that suggests that Erin Campbell was there a bit earlier
18 than that so I could be wrong, but what I am confident
19 of is that during the initial stages, and I'm very
20 confident that it was after the submission of the first
21 PIRC report that they became involved. I just can't
22 remember exactly when it was, but I thought it was
23 around about the submission of the second PIRC report.

24 Q. We'll maybe be able to double-check that. So the first
25 PIRC report was the interim report from PIRC, and the

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1 final report. The interim report came in August 2015,
2 and the final report came in August 2016. Does that
3 help you further?

4 A. Yes, it does and that is -- I know that that's when they
5 came in. I know that it's been referred to as the
6 interim PIRC report, and there is reference in some of
7 the documentation. To the best of my recollection it
8 was not at that time submitted as an interim report but
9 became one because of further work that was instructed
10 and, for what it's worth, it wasn't titled "interim
11 report", but it became an interim report. That's
12 correct and that's why it's referred to as the interim
13 report.

14 Q. All right. Thank you.

15 Was Fiona Carnan always part of the CAAPD unit?

16 A. Yes, Fiona Carnan was but for the -- Fiona Carnan only
17 became involved in the Inquiry into Mr Bayoh's case
18 later, much later on in the process and after the
19 involvement of Alisdair MacLeod, but she was there all
20 the time.

21 Q. Thank you. In relation to Mr MacLeod and Ms Campbell,
22 as they were seconded to your unit, what experience did
23 they have of investigations in relation to police
24 officers before being seconded?

25 A. I know that they were brought in or I suspect they were

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1 brought into the team because of their -- because of
2 their experience in investigating significant and
3 challenging cases. That's the first thing that I would
4 say.

5 I know that Alisdair MacLeod had had experience,
6 direct experience, and had involvement in a case that
7 did involve police officers and, to the best of my
8 recollection, it was quite a high profile case that
9 involved allegations of police officers misleading
10 authorities, but that wasn't a CAAPD case for the simple
11 fact that it concerned off -- I understand it concerned
12 off duty police officers and CAAPD only dealt with on
13 duty-allegations, but he brought that experience.

14 As regards Erin Campbell, Erin Campbell was, like
15 Alisdair MacLeod, regarded as a very competent
16 investigator and I can't recollect any specific case
17 that she would have been involved in that involved the
18 police, but that was part of the skill set that I think
19 was under consideration when they were seconded to the
20 team.

21 Q. And were they seconded because of the existing level of
22 the work -- the workload that the existing team were
23 covering, that you needed additional staff to come in?

24 A. I think my recollection in relation to that was that it
25 was clear that at the crown were going to have to

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1 undertake significant enquiries, those were going to be
2 detailed and probably time consuming and were important
3 and that in effect this was at the crown moving after
4 the submission of the PIRC investigation towards the
5 decisions that the crown were going to have to take and
6 I am confident that there was a recognition that
7 secondment and additional resources was required in
8 order to achieve that and that certainly was what I was
9 keen to secure, that there would be those who had that
10 skill set who were going to be dealing with this
11 particular case in itself.

12 Q. Did they work exclusively on the Sheku Bayoh

13 investigation when they did come into the team?

14 A. Yes, they certainly were not -- they certainly were not
15 given any other CAAPD work.

16 Q. Right.

17 A. No, they were a resource to assist in the preparation of
18 the case of Mr Bayoh.

19 Q. We've heard evidence from witness from PIRC who said
20 that -- we asked them questions about their workload and
21 the number of investigations they had and they've
22 mentioned that there was the M9 crash in relation to
23 Yuill and Bell and that occurred in roughly around July
24 and they've explained, those witness, about the impact
25 of that significant investigation on their resources and

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1 the workload and I wonder, you have mentioned other
2 significant investigations, did that incident have an
3 impact on the workload of your team?

4 A. Yes, it did. As I said in my statement, the M9 tragedy
5 was reported and dealt with by CAAPD and that was dealt
6 with by an existing member of CAAPD with some assistance
7 from a case investigator so to that extent that
8 particular investigation was dealt with within existing
9 resources.

10 Q. So that was absorbed into the existing workforce, the
11 team?

12 A. Yes, I would say it was.

13 Q. And was that one of the principal deposes or one of the
14 deposes?

15 A. It was actually one of the deposes with assistance from
16 myself and the principal deposes, yes.

17 Q. But again someone who was remained part-time at that
18 stage?

19 A. Yes.

20 Q. Right. I think in your statement SBPI 00419 -- perhaps
21 if we could look at page 3, which is one of the answer
22 4. So page 3 and it's -- here we are:

23 "Prior to becoming involved in this case I had no
24 experience of investigating deaths following police
25 contact or in police custody, nor any cases where race

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1 was a factor."

2 So you didn't have any experience of cases where
3 race may have been a possible factor and was that in
4 relation to simply police contact or police custody
5 cases or any type of case?

6 A. It was in relation to police contact cases or
7 significant investigations where race was a factor.

8 I think I have said later on in my statement that as
9 part of my general duties at one stage in my career as a
10 district Procurator Fiscal I was aware of cases that had
11 a race element in my own jurisdiction and there was a
12 process within the organisation as a whole for
13 monitoring those and ensuring compliance with policy so
14 I had dealings with those, but in relation to
15 significant investigations and in particular deaths
16 investigations or deaths with the police -- following
17 police contact, I had no experience of that.

18 Q. I think in fairness to you, question 173, which I think
19 is page 104, you do say so -- that's question 173, page
20 104:

21 "I have no previous experience of racism being a
22 factor to investigate in an investigation relating to a
23 death in custody or death during or following police
24 contact or the actions of on-duty police officers."

25 A. Yes.

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1 Q. Do you know -- I have asked you about Mr MacLeod and
2 Ms Campbell, do you know of the team -- your core team,
3 if I can call them that -- what experience they had of
4 handling an investigation which involved consideration
5 of the factor of race? What experience did your core
6 team have of that?

7 A. I'm not aware of what experience they had.

8 Q. Right. Looking back now, do you think that was a
9 disadvantage? You've talked about Mr MacLeod and
10 Ms Campbell and the limited experience that perhaps they
11 had in relation to that. You're not aware of others.
12 Do you think you're conscious of an absence of
13 experience in relation to race investigations?

14 A. I don't recollect that being part of the discussions at
15 the time that they were seconded into the unit. What I
16 certainly valued -- I first of all valued the fact that
17 there were some additional resources coming and also, as
18 I have already said, they were -- they were resources
19 with considerable investigative experience and, to use
20 the term, a proven track record of carrying out
21 sensitive investigations very efficiently and very
22 diligently and very effectively and that was a -- you
23 know, I think that was a consideration in the selection
24 of them, although I don't recollect being involved in
25 actually selecting them, but that was a consideration

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1 that I had.

2 Q. If you had had the option to select who was to join the
3 team, for the purposes of being part of the
4 investigation in relation to Mr Bayoh, is race a factor,
5 experience of race investigations something you would
6 have look forward?

7 A. I think it would be important to either have had
8 experience of race or to be able to demonstrate that you
9 could acquire and did acquire those kind of -- those
10 kind of skills and have that -- have that experience,
11 yes.

12 Q. Thank you. Looking back now at the team you had at your
13 disposal, do you think a team with more experience in
14 race investigations might have proved to be of
15 assistance and of benefit?

16 A. I think -- I think it would always be of benefit if --
17 if members of the team had a particular skill set that
18 was relevant and I certainly regard those kind of skills
19 as being relevant to this -- to this particular
20 investigation.

21 Q. In relation to the investigation into the death of
22 Mr Bayoh, who we know was a black man, would those
23 skills have been of benefit? Looking back now, do you
24 think that might have been of benefit?

25 A. I think -- I think it could have been of benefit, yes.

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1 Q. Right. Thank you. Now, you're going to be here for the
2 remainder of this week and your involvement which is
3 clear from your statements as the head of CAAPD spans
4 four and a half or more years. To make things a little
5 bit easier for people to follow what you're telling us,
6 I would like to break this period down into three phases
7 or periods and I will focus my questions on each period
8 in chronological order?

9 A. Thank you.

10 Q. So period 1 will be the period that we've touched on
11 from 3 May when Mr Bayoh died up to what we've heard was
12 called an interim PIRC report, so that first PIRC
13 report, which I understand was sent to Crown Office on
14 7 August 2015. So it will be that period between
15 May 2015 and August 2015?

16 A. Yes.

17 Q. That's period 1.

18 A. Yes.

19 Q. Period 2 will be from the first PIRC report or the
20 interim report, which is 7 August 2015, up until the
21 final or second PIRC report and that's as I -- as we've
22 heard 10 August 2016, so it's roughly a year's period
23 between 7 August 2015 and 10 August 2016. So period 2
24 will be that year between the two PIRC reports.

25 A. Yes.

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1 Q. And period 3 will cover the period from the final or
2 second PIRC report on 10 August 2016 up until
3 August 2018 when we've heard that there was a decision
4 taken by Crown Counsel in relation to proceedings?

5 A. Yes.

6 Q. And I won't be going into that decision as part of the
7 Inquiry, but that period between August 2016 and
8 August 2018, which is a two-year period, I will be
9 exploring as period 3?

10 A. Yes.

11 Q. Now, there might be other little miscellaneous things
12 that I have to add in, but largely that will be the
13 structure of my questioning over the next three days.

14 A. Thank you.

15 Q. And I will remind you about those dates as we go
16 through.

17 A. Thank you.

18 Q. So let's start with period 1, which we've already
19 touched upon, and that's from his death up until the
20 first PIRC report or the interim PIRC report, whatever
21 we call it. And we have heard, just to put this into
22 context, Mr Bayoh died at 09.04 on Sunday, 3 May. It
23 was a Bank Holiday weekend.

24 A. Yes.

25 Q. We've heard evidence from David Green at SFIU that he

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1 contacted PIRC at approximately 9.35 in the morning and
2 asked them to investigate the death and he asked them to
3 investigate the circumstances of the death, but
4 primarily at that stage they were to look at the events
5 in Hayfield Road and the events after the cause of
6 death. The police at that stage were to continue to
7 look into the events leading up to Mr Bayoh's arrival at
8 Hayfield Road.

9 And we have then heard that there was no formal
10 letter of instruction that day. The first letter of
11 instruction from the crown came on 5 May, which I think
12 was probably around about the day that you came back to
13 work, sent to PIRC and instructed them at that stage to
14 take over the entire investigation, both the events
15 leading up to Hayfield Road, the events at Hayfield Road
16 and the cause of death.

17 A. Yes.

18 Q. And I think we do now have that letter on the play list,
19 COPFS 02539, and this is a letter written to
20 Irene Scullion, head of investigations, it's dated
21 5 May 2015 and if we look at the top you'll see that the
22 heading is:

23 "Crown Office. Mr Stephen McGowan, Procurator
24 Fiscal, Major Crime & Fatalities Investigation."

25 And if we look down the letter refers to Mr Bayoh

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1 and, as you've pointed out, it refers to section 33A of
2 the 2006 Act.

3 A. Yes.

4 Q. And it's a form -- to formally confirm the request made
5 on 3rd, which was two days prior, that PIRC carry out an
6 investigation into the circumstances surrounding the
7 death of Mr Bayoh. And then it specifies the
8 circumstances leading up to the incident and then the
9 incident itself. And at the end it says:

10 "My colleague Les Brown, head of the Criminal
11 Allegations Against the Police Division, will be the
12 senior fiscal with oversight of this case and will bring
13 in such assistance from Crown Office as required."

14 And if we carry on to the bottom, we will that
15 there's a signature from Mr McGowan. So that was the
16 first formal letter of instruction. Were you given a
17 copy of this?

18 A. Yes, I think I was.

19 Q. Thank you. And thinking about this period of time,
20 we're calling period 1, I would like to ask you
21 questions around the sort of five procedural obligations
22 under an Article 2 investigation and the first thing
23 I would like to ask you about is independence.

24 A. Yes.

25 Q. We're focusing on this period of time when you've become

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1 involved, you're head of CAAPD and I want to ask you
2 some questions all related to the issue of independence,
3 which we know is important under Article 2.

4 So I would like to ask you about the independence of
5 PIRC from Crown Office or what the relationship is
6 between PIRC and Crown Office. Could we look at
7 SBPI 00419, and I'm interested in answer 14 on page 9.
8 So it's page 9 and it's an answer 14. Here we are:

9 "I do not consider that the Act envisages that
10 Crown Office are responsible for the supervision of PIRC
11 in relation to their day-to-day investigations as this
12 would call into question the role and operational
13 independence of the Commissioner. The fundamental
14 relationship between crown and PIRC is set out in the
15 Act and provides that the Commissioner must comply with
16 a lawful instruction issued by the appropriate
17 prosecutor under section 33A, but I do not consider that
18 this provision envisages supervision of PIRC in relation
19 to the discharge of their function and responsibilities.
20 Essentially my view is that Crown Office can direct the
21 PIRC to investigate in a similar way that it does with
22 the police, but does not seek to prescribe how to
23 achieve this, nor does it micromanage investigations."

24 Now, I'm interested in this paragraph. We've heard
25 from a number of witness who talk about this

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1 relationship between PIRC and the crown and I'm
2 interested in your perspective.

3 We know that PIRC were only set-up on 1 April 2013
4 and we have heard evidence about how this investigation
5 into the death of Mr Bayoh was a significant
6 investigation and can you explain to the Chair how you
7 saw the relationship with PIRC. You've mentioned it as
8 being akin to the -- with the police but can you help us
9 understand.

10 A. Of course or I'll try.

11 Q. Thank you.

12 A. I do think I say at one point in my statement that I
13 considered that at this stage the relationship was
14 relatively undeveloped and that to some extent is my
15 perspective at this stage. I'm also bringing to bear
16 experience over the whole of my time in CAAPD and I
17 think I probably was reflecting that in that particular
18 answer. I consider that the crown has obviously got
19 responsibility for instructing the PIRC to carry out an
20 effective investigation. But I consider that the PIRC
21 has I would term it a wide operational discretion as to
22 how to carry that out.

23 One of the terms that I do remember Frank Mulholland
24 using was that his expectation was that PIRC would
25 follow the evidence and I took it that he clearly meant

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1 in respect of that the PIRC didn't need to go constantly
2 going back to the crown to ask for authority, should we
3 look at this? Should we look at that? I considered
4 that PIRC did have a degree of independence and
5 operational responsibility and statutory responsibility
6 to carry out an effective investigation, whatever that
7 might mean in relation to the particular facts and
8 circumstances of any investigation that they were
9 required to carry out and for that reason when I say
10 that I didn't consider that it was for the crown to
11 micromanage an investigation, that it would not normally
12 be for the crown to instruct how the PIRC should carry
13 out its investigations, especially at an early stage in
14 the investigation.

15 As the Inquiry will be well aware and I suspect you
16 will want to explore this, that somewhat changed
17 following the submission of the first or the interim
18 report where detailed instructions were given, but in
19 respect of the general instruction that was given to
20 PIRC to investigate the tragic death of Mr Bayoh, that
21 is why I do not consider that it is the role of the
22 crown to micromanage the investigation or to supervise
23 each and every one action that the PIRC takes and, in
24 generality, I think it is for the crown to instruct the
25 PIRC to investigate and that the PIRC has a discretion

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1 as to how to carry that out, clearly looking to the
2 principles of Article 2, and in particular to carry out
3 an effective investigation.

4 Q. Was it your view that you were really giving PIRC free
5 reign to use their experience as investigators to, as
6 you say the Lord Advocate put it, to follow the evidence
7 and carry out their own investigation?

8 A. I don't know that I personally would use the term "free
9 reign", but I do consider that the PIRC required to
10 address what is it that we need to investigate here and
11 I know there was a general instruction in respect of it,
12 but it was implicit in that, I consider, that it would
13 have to be effective and it would have to examine the
14 most obvious things that were relevant to that
15 investigation, including, just to take as a generality,
16 the use of force and the circumstances of that. Now,
17 that was not specified in the instruction to PIRC, but
18 I think it would be inconceivable that that could not
19 form part of the consideration of an effective
20 investigation.

21 Clearly, independence was a relevant factor and that
22 means, to my mind, that the investigation must analyse
23 and consider what is important and come to some form of
24 conclusion as to where the investigation is going and
25 also that at the early stage of the investigation,

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1 especially of this type of potentially complex and very
2 sensitive investigation, the situation is relatively
3 fluid. And so when I say to draw on their investigative
4 expertise, the PIRC's investigative expertise to my mind
5 does draw on the kind of skill set that the police bring
6 to an investigation and the reason that I mention the
7 police is that technically the crown will not be
8 involved in micromanaging a police investigation but
9 will rely on the investigative skills that the police
10 have to prepare and submit a report which was then for
11 the crown to consider as part of their responsibilities
12 and, if necessary, to instruct it further inquiries to
13 direct on the areas that further Inquiry is required,
14 but not typically in my experience to prescribe how to
15 go about doing that.

16 Q. Thank you. We've heard evidence, obviously Mr McGowan
17 in his letter said you would provide assistance from
18 Crown Office. Perhaps we would look at and, again, I'm
19 not sure if this is on the play list, but Billy Little's
20 statement to the Inquiry, SBPI 00421. No. We can come
21 back to that.

22 But to summarise we may have heard some evidence
23 from witnesses from PIRC who said they had higher
24 expectations of Crown Office, that Crown Office would
25 raise issues that had been -- they had identified as

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1 being significant and they would raise those issues with
2 PIRC. Did you see that as part of your role to raise
3 issues and send them to PIRC?

4 A. To some extent I did and I responded to PIRC, I was in
5 communication with PIRC, to direct them to areas and I'm
6 sure the Inquiry is -- has a number of pieces of
7 correspondence where I have directed PIRC as to areas
8 that they require to explore. Those were intended to
9 reflect, to quite a significant extent, concerns that
10 had been expressed by the Bayoh family.

11 As the Inquiry will be aware, I was involved in
12 meetings with the Bayoh family from an early stage and I
13 think I have said in my statement that I was aware of
14 the profound effect that the death of Sheku Bayoh had
15 had upon them.

16 And so when I was communicating with PIRC, I would
17 on a number of occasions communicate the concerns of the
18 family as to areas of the investigation that they
19 considered were important and that was one of what I
20 thought was one of the appropriate actions that I could
21 take. Having said all of that, that came from the fact
22 that the crown were meeting with the family and in
23 regular dialogue with their solicitor, even from the
24 early stages, but I would suggest that that doesn't
25 absolve the PIRC from engaging and listening to the

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1 family's concerns as well, but I do think a dynamic
2 developed during the course of this Inquiry whereby the
3 crown was relaying the concerns of family and asking
4 that that either be incorporated into the PIRC's general
5 investigation or directing them to specific areas that
6 required investigation.

7 Q. Thank you. Could we look at page 5 and this is in
8 response to question 9. There we are. And you say here
9 I think slightly further down, keep going, please -- no,
10 go back up. I'm looking for a section that says:

11 "It was important not to police any limitation or
12 restriction on the scope."

13 Here it is. It's just below halfway down that page.
14 About halfway:

15 "The approach recognised that it was important not
16 to place any limitation or restriction on the scope of
17 the investigation at an early stage in the process. The
18 crucial fact was that this was a crown directed
19 investigation to distinguish it from other PIRC
20 investigations, including requests by SPA or
21 Chief Constable to investigate serious incidents or
22 where the Commissioner considers it to be in the public
23 interest."

24 So you felt at that stage it was important not to
25 place limitations or restrictions on the scope of the

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1 investigation and was that what you were saying earlier
2 that you were not providing a very strict framework in
3 which the PIRC investigation was to be carried out?

4 A. Yes, certainly not at an early stage and I was mindful
5 of the fact that although I was not involved in the
6 letters of instruction, I don't recollect being
7 consulted or drafting it, it was already done by the
8 time I became involved, clearly, as I have said, this
9 was a general direction to investigate the circumstances
10 that was at a very -- it was at an early stage I would
11 say because it occurred -- same day PIRC were involved
12 as the incident and that I think was consistent. A
13 general direction -- I appreciate this will be a matter
14 for the Inquiry as to whether a general direction was
15 appropriate, but my colleagues obviously considered it
16 was appropriate and I was mindful of that and I
17 considered that it gave PIRC considerable scope to
18 employ their investigative skills and to, I suppose,
19 consider, reflect and refine on those as -- as
20 information and evidence was gathered and assessed.

21 Q. And I think later in your statement you say you saw your
22 role as providing PIRC with advice and assistance as
23 required?

24 A. Yes, and I think my general approach, I think my general
25 approach to work is to try to assist in the effective

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1 investigation and I would see that as my role in
2 relation to PIRC. There are questions later on that I
3 won't approach at the moment where it talked about
4 operating responsibilities and I do consider that there
5 are operational responsibilities, but in general I think
6 it's unhelpful to refuse to engage in respect of it. So
7 if I was asked for a view, I consider that I would try
8 to be as helpful as possible, but recognising also that
9 it was sometimes not for the crown to give assurances to
10 PIRC or to give authority to PIRC to approach things in
11 a certain way or to obtain evidence. That would not, I
12 consider, be for the crown to do in normal
13 circumstances, but I would, as I say, attempt to be as
14 helpful as possible if PIRC did have questions and I
15 would either consider those myself or in most cases
16 would share those with others, other senior colleagues,
17 and we would take a view in respect of that and when
18 crown counsel became involved, that generally was my
19 approach as well.

20 Q. So at this stage in the early stages of this
21 investigation, you have told us how you had limited
22 involvement with PIRC at that time or in terms of your
23 experience of PIRC it was limited at that time. This
24 was the first PIRC report ultimately that CAAPD had
25 obtained. You've mentioned in your statement and you've

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1 mentioned today about the experience of PIRC and their
2 investigators. How satisfied were you at that stage
3 that the PIRC investigators were experienced and
4 sufficiently experienced to undertake an investigation
5 into the death of Mr Bayoh or was that an assumption
6 that you made?

7 A. I saw no reason to question their skill set at that
8 stage and to some extent autumn this was clearly going
9 to be a demanding investigation, it was this type of
10 investigation that PIRC was created for in my view.

11 Q. Were any other issues raised with you by PIRC
12 questioning whether they had the skill set to
13 investigate the death of Mr Bayoh, any concerns raised
14 with you?

15 A. No, I don't recollect any, and also, as I said at one
16 point in my statement, and I don't know how relevant
17 this is, but at that time, PIRC, and the Commissioner in
18 particular, were in active dialogue with the crown and
19 the Lord Advocate looking to extend the range of cases
20 that they considered should be referred to PIRC as a
21 primary investigator and those included cases of some
22 complexity and sensitivity, in particular allegations of
23 a sexual nature, but that was -- you know, I mention
24 that because of the general background so as opposed to
25 any suggestion that PIRC didn't possess sufficient

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1 skills that PIRC were looking to expand the range of
2 investigations which they considered they should handle
3 and by implication considered that they should be
4 handling.

5 Q. We've also heard evidence about the resources available
6 to PIRC at that time and this is prior to the M9 events.
7 Were any issues raised with you about pressure of
8 resourcing the investigation into Mr Bayoh's death?

9 A. No, I don't recollect any -- any exchanges or
10 information being conveyed in that respect.

11 Q. Could we look at page 21 of your first statement and
12 this is in response to question 34. It's page 21 that
13 I'm interested in. Here we are. Can we look at the
14 next paragraph, please. There's a section that talks
15 about -- you'll see it towards the bottom of this page:

16 "Both myself and others in Crown Office were in a
17 position to lend assistance and advice to PIRC where
18 required or requested but care had to be taken at an
19 early stage in the investigation not to risk usurping
20 the role of the Commissioner as independent investigator
21 who will be reporting to the crown."

22 I'm interested in this use of "usurping the role of
23 the Commissioner". Can you explain what you meant by
24 that?

25 A. I think what I meant in relation to that was

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1 the Commissioner had a role, and I consider had an
2 important role, in respect of the conduct of an
3 investigation that was being carried out by the PIRC and
4 that my expectation and I think the expectation of
5 others would be that senior people, if not
6 the Commissioner, but the Commissioner, you know, had
7 experience in relation to these types of investigation,
8 would bring their investigative and professional skills
9 and that rather than the crown issue a list of detailed
10 instructions at that stage, that it was appropriate to
11 allow PIRC to carry out the investigations as they saw
12 fit and to submit a report to the crown and thereafter
13 for the crown to assess whether they could proceed on
14 the basis of that report or whether further
15 investigations were required.

16 So when I say "usurping", I think I'm referring in
17 particular to the stage prior to the submission of a
18 report by the crown where I do consider that
19 the Commissioner and other senior investigators have an
20 important role to play and can also bring a skill set
21 which is different to the skill set which I hope that
22 the crown can bring to the -- to the investigation.

23 Q. Would it be fair to describe the relationship as you
24 understood it as to be one at arm's length or that the
25 crown were taking a light touch in relation to

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1 instructing PIRC?

2 A. Well, if the PIRC had asked for advice in relation to a
3 particular aspect, then I think that I'm confident the
4 crown would have responded, they would not have said no,
5 this is -- this is not for us. We would have responded
6 in hopefully a constructive and a helpful way, but I
7 don't recollect any correspondence or exchanges to that
8 extent prior to the submission of the first report.

9 Q. So prior to submission of the first report do you
10 remember anyone from PIRC asking you to provide more
11 direction in relation to how the investigation should be
12 conducted?

13 A. I don't recollect in relation to the -- how the -- the
14 investigation should be constructed. I do recollect and
15 I have seen some -- some general inquiries or looking
16 for reassurance in respect of an approach that was to be
17 taken. I recollect an approach in respect of some of
18 the material that had been gathered, in particular a
19 mobile phone. That was -- to my recollection that was
20 the level of approach that was requested.

21 There were however meetings at -- well, there were
22 meetings at Crown Office and I can recollect that there
23 were meetings that involved the Lord Advocate and that
24 the Commissioner was present in respect of those so
25 there was -- there was discussion at that level, but I

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1 don't recollect any direct approach to me asking for
2 specific direction I don't think.

3 Q. Later in your Inquiry statement you say that after the
4 first report from PIRC, and we will come on to that
5 period later, but you took a more directive approach.
6 That was a phrase you used in your statement.

7 A. Yes, it is.

8 Q. But so is it correct to think you did not take a
9 "directive approach" in this first period to the PIRC
10 investigation.

11 A. I used the term "directive" because what I did at that
12 stage was I -- that I was involved in carrying out --
13 along with others, but very much myself -- in carrying
14 out a review of the PIRC report an analysis of what I
15 requested required to be done. I shared that with other
16 senior colleagues and I did share that with the
17 Lord Advocate, and there was quite intensive discussion
18 at that stage as to what still required to be done in
19 order to progress the investigation and I used the term
20 "directive" because clearly, and the Inquiry will be
21 aware of this, there was more detailed and directive
22 instruction given as to the areas that required to be
23 further explored and that is --

24 Q. We'll come on to that later, but that's not the approach
25 you took initially.

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1 A. I wasn't asked, as I recollect, for any specific
2 direction and the PIRC were clearly preparing the report
3 and I know that they were waiting on the submission of
4 statements, but when they received the statements in
5 June there was an expectation that the PIRC would be
6 reporting in fairly short course the results of their
7 investigation and that they did so, because it was
8 August when the crown received that report.

9 Q. Looking back now, do you think there would have been
10 some benefit in the crown taking a more directive
11 approach in that first period between May 2015 and
12 August 2015?

13 A. I think that there was -- there was potentially scope
14 for doing that, that the overall strategy on approach,
15 that would have given an opportunity for input at
16 that -- at that stage in respect of the overall strategy
17 and approach and, with hindsight, clearly the overall
18 strategy and approach was of importance in respect of
19 this -- in respect of this case.

20 But it is difficult to do that in isolation before
21 one actually sees the results of the Inquiry and that is
22 why I do come back to the point that you're only seeing
23 the results of the Inquiry when the report is submitted.

24 Q. And so would you have had concerns to come back to the
25 issue of independence if you had been given -- been

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1 taking a more directive approach at that period between
2 May and August 2015? If you had taken a more directive
3 approach during that first period between May and
4 August 2015, would that have then given you cause for
5 concern in relation to the issue of independence?

6 A. I'm sorry. Do you mean the independence of the PIRC?

7 Q. Yes.

8 A. Well, I consider that the independence of the
9 investigation as a whole is the important thing and
10 therefore if the crown were in a position to lend
11 assistance, I think that that would be something that
12 would have been -- if we had been approached, that would
13 have been done, but I wouldn't have concerns about
14 interfering with the -- with the independence of the
15 PIRC, because I consider that the obligation on the PIRC
16 was to be independent and it was the same obligation on
17 the crown to be independent to some extent we were
18 working for the same ends. We both had an interest in
19 ensuring that the investigation was effective.

20 Q. Okay. Thank you very much.

21 Would that be an appropriate moment?

22 LORD BRACADALE: We'll take a 20-minute.

23 (11.34 am)

24 (A short break)

25 LORD BRACADALE: Ms Grahame.

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1 MS GRAHAME: Thank you. We've heard evidence about the
2 postmortem which took place on 4 May 2015 and so this is
3 the day before you became -- had the meeting with
4 Mr McGowan and started providing oversight. We've heard
5 that Bernie Ablett, who was a fiscal, was present.

6 A. Yes.

7 Q. The crown we've heard organised the postmortem,
8 I understand through the SFIU, the Scottish Fatalities
9 Unit?

10 A. Yes.

11 Q. In addition, PIRC -- people from PIRC were present,
12 investigators, and at that time PIRC -- in terms the
13 instruction from crown, PIRC were in charge of
14 investigating the cause of death?

15 A. Yes.

16 Q. The police were still in charge of investigating events
17 leading up to Mr Bayoh's arrival at Hayfield Road, but
18 that didn't involve the cause of death which was the
19 PIRC part. We've also heard evidence that neither PIRC
20 nor Mr Ablett for the crown expressed any concerns about
21 the police being present at the postmortem.

22 Now, we've obviously been talking about the period
23 1, talking about this early stage. We are talking about
24 Article 2 and the independence requirement in terms of
25 Article 2. I'm interested in your views about the

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1 presence of police -- members of Police Scotland
2 officers at the postmortem which was being carried out
3 at that time. So the presence of the police at the
4 postmortem?

5 A. Yes.

6 Q. Do you have any concerns about that?

7 A. Yes, I would. Going back to Article 2, Article 2,
8 amongst other things, in respect of independence
9 requires no organisational or hierarchical connection
10 between the investigators and those being investigated.

11 I think that there is a risk, a potential risk, in
12 relation to how that would square with those who the
13 organisation, which is itself being potentially
14 investigated and its members are being potentially
15 investigated, being present during the early stages of
16 an investigation where important information that
17 relates to obviously the cause of death, but how that
18 might relate to the -- how that cause of death came
19 about, that there is a risk that that would be
20 compromised, that independence would be compromised.

21 Q. Thank you. And then we've also heard evidence that at
22 the conclusion of the postmortem that the then lead
23 investigator from PIRC discussed with one of the
24 pathologists about the cause of death. It was an early
25 stage at that point, but in particular discussed whether

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1 blunt force trauma had caused the death -- blunt force
2 trauma to the head.

3 And we've heard, and I'm summarising here, we've
4 heard a number of witnesses in relation to this, that
5 information that blunt force trauma to the head had not
6 been the cause of death was later shared with the
7 officers who had attended Hayfield Road and at that
8 stage those officers had not yet given statements. They
9 had yet completed use of force or use of spray forms.
10 There was no paperwork had been completed at a point.

11 And I'm interested -- we've also heard that the lead
12 investigator authorised that sharing of information from
13 the pathologist for the purpose of getting statements
14 from the officers. We've also heard that the permission
15 was not sought from the crown or consent was not sought
16 from the crown to share that information. Do you have
17 any concerns about that?

18 A. I think I was asked about that in my statement. I would
19 have concerns for the same reasons, as I explained in my
20 previous answer, that there would be a risk that the
21 provision of information could affect the approach to
22 the giving of statements and in particular the
23 information contained in those statements.

24 Q. And again, thinking about Article 2 and independence,
25 was that a concern with that sharing of information from

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1 the pathologist through PIRC authorising the sharing
2 with the officers?

3 A. Yes. I think there is always great care has to be taken
4 in the sharing of any evidential information during
5 the -- during the whole of an Inquiry, but particularly
6 in the early stages where it has the potential to affect
7 critical stages of it and one critical stage would
8 clearly be the provision of statements, the accuracy of
9 those, and whether they have been affected by any
10 information that has been provided where it shouldn't
11 have been provided, if I can put it like that.

12 Q. We've also heard that information regarding the
13 postmortem was shared with those officers prior to -- or
14 we've heard evidence to this effect that it was shared
15 with the officers prior to being shared with the family;
16 do you have any concerns in relation to that?

17 A. Well, I would have concerns from a number of respects.
18 First of all, I consider that those who are bereaved are
19 entitled to learn of significant information in advance
20 of -- in advance of others. I think that type of
21 information has to be conveyed sensitively and that
22 clearly the -- that has got the potential to affect the
23 way that the family consider that they are being
24 treated. It would affect, I would suspect, the way that
25 they would view the fairness of the procedure, and

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1 affect the overall confidence that they should have and
2 are entitled to have in the independence of the
3 investigation.

4 So I would have concerns from a number of respects,
5 including a basic human response that that certainly
6 does not sit right and that they would be well entitled
7 to feel upset and let down in respect of that.

8 Q. Thank you. Sticking with the independence issue,
9 I would like to ask you some questions about other
10 evidence that we've heard, that PIRC itself, the
11 organisation, was resourced by a large number of former
12 police officers, particularly from -- in relation to
13 this investigation from the Strathclyde area. Do you
14 have any concerns about independence in light of that,
15 that PIRC carrying out an independent investigation for
16 the crown in relation to the death of Mr Bayoh yet was
17 populated by a large number of former officers?

18 A. I think that's probably quite a difficult thing to
19 assess. What I would say is that -- I would think
20 personally that there has to be a recognition as to a
21 potential conflict and that at an organisational level
22 there would have to be processes, procedures, in place,
23 and that the organisation at an organisational level
24 would require to address that.

25 Having said that, I think I do recognise that where

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1 one requires a specific skill set, and in particular an
2 investigative skill set, and I think in relation to
3 what -- if you're investigating the police, on one
4 review the best people to investigate the police are
5 those who have experience of policing, but I do think
6 that there would require to be a much wider
7 consideration as to how that can be dealt with and
8 assessed at an organisational level through the mix of
9 stuff, through the checks and I suppose checks and
10 balances within the organisation, organisational values,
11 quite a wide range of things, but I do think it would
12 have to be a consideration.

13 Q. I think in your statement, and I won't go to the section
14 at the moment, but you were referred to an email from
15 Mr McGowan which was dated 12 May 2015 where concerns
16 were expressed about PIRC requesting statements from
17 officers who had been involved in the incident through
18 Police Scotland, so the PIRC were requesting statements
19 from the individual officers but through Police
20 Scotland. We've heard evidence that they didn't provide
21 statements until the 4 June, a later date. Can you
22 share any concerns that you had with this part of the
23 process that PIRC are asking Police Scotland to get
24 statements from the officers?

25 A. Well, I -- I think I said in my statement that I did

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1 have concerns as regards that approach because my view
2 is that it gives the impression and it would be an
3 unfortunate impression and I think a very mistaken
4 impression where you are trying to -- it's important
5 that you assess your independence that in some way you
6 require to go through the organisation which in effect
7 is being investigated in order to obtain essential
8 information for your investigation. It introduces an
9 unnecessary layer but I would suggest a very undesirable
10 layer in respect of that, because I consider that it
11 implies that the organisation -- the police have some
12 measure of control over the way that such information is
13 provided.

14 Q. In your experience, what would your preference have been
15 in relation to PIRC making requests for statements from
16 the individual officers?

17 A. Well, I -- from my perspective, and I think also from
18 Stephen McGowan's, his concern was that going through
19 the officers created that impression and that in order
20 to assert independence -- sorry -- to assert
21 independence there requires to be an approach directly
22 to the officers. They're the ones who are being asked
23 to give statements and that there doesn't require to be
24 any organisational filter applied to that.

25 And even if the officer said, which was anticipated

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1 at the time of that email because I did look at that
2 email when I was preparing my statement, the statement
3 would probably be "I am not providing a statement", at
4 least it would be a statement to that effect that was
5 provided directly to the PIRC investigators.

6 Q. I would like to ask you about another situation that
7 we've looked at and you comment on. This was at a later
8 period, so I'm slightly moving out of period 1 and this
9 is a minute in around November 2017 and you say there
10 was a sense of frustration in your approach that PIRC
11 inquiries were being conducted by making requests to
12 Police Scotland for documentation regarding training,
13 and standard operating procedures. So this is later.

14 But they were being referred for approval to senior
15 officers from Police Scotland. Was this an ongoing
16 issue that you had concerns with about PIRC going
17 through Police Scotland to seek advice -- seek
18 information that was relevant to their investigation?

19 A. Well, it was -- it was -- it was the same issue, it was
20 the same common theme, and I do remember pointing this
21 out to I think it was law officers that I considered it
22 was frustrating that that seemed to be another example
23 of going through the organisation and the officer in
24 those circumstances, to the best of my recollection, had
25 said something like I'm seeking permission to provide

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1 information, so getting authority to provide
2 information, whereas I considered that that was -- that
3 was something that shouldn't be happening because PIRC
4 have got a statutory -- a statutory responsibility and
5 have a number of -- have a number of avenues open to
6 them to obtain information directly so, yes.

7 Q. Did you point this out to PIRC?

8 A. I don't recollect that this was ever specifically
9 highlighted to PIRC. In relation to the provision of
10 statements, the focus at that time was actually to
11 secure the statements rather than ask PIRC to obtain
12 statements that would effectively say "I'm not providing
13 a statement" so that was the focus at that time.

14 The purpose of my memorandum to the law officers was
15 to point out my -- as I say, the sense of frustration
16 and that this was an example. I have no knowledge as to
17 whether anybody else pointed this out to PIRC at a later
18 stage. It was something that perhaps could have been
19 included in any review of the case, but I'm not aware as
20 to whether it was pointed out at an organisational
21 level.

22 Q. I'm interested in whether and to what extent you think
23 PIRC had the authority to go, first of all, direct to
24 the individual officers and ask statements. Do you
25 consider there to be any particular authority that was

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- 1 required or particular instruction required that gave
2 them the authority to do that?
- 3 A. The legislation provides that the PIRC have the -- have
4 the authority in a crown-directed investigation of a
5 constable and applying that, applying that similar
6 consideration, they have the authority to approach and
7 obtain information from witness directly rather than
8 going through the organisation. I don't know what the
9 motivation was in respect of it, whether it was
10 deferential or otherwise, but I considered that it was
11 worth -- that it had the potential to create an
12 impression that PIRC in some way, shape or form had to
13 go through the organisation which it was in effect
14 actively engaged in investigating.
- 15 Q. And was it your view at that time that police were
16 witnesses and not suspects?
- 17 A. Yes.
- 18 Q. And then in relation to the PIRC authority or power to
19 obtain standard operating procedures or SOPs, did you
20 consider that PIRC had the authority to seek the SOPs
21 and go direct to whatever department retained those?
- 22 A. Yes, I did.
- 23 Q. And was that on the same basis as you have just
24 explained?
- 25 A. Yes.

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1 Q. Can I move on. Still dealing with this first period and
2 still dealing with the issue of independence -- no, but
3 moving on from independence to the second procedural
4 obligation under Article 2, which is adequacy, and I
5 would likely to ask questions around that procedural
6 obligation.

7 So we've heard that the investigation on behalf of
8 the crown begins with the instruction to PIRC. They're
9 an independent body. And are they -- they're carrying
10 out the investigation on -- ultimately on behalf of the
11 crown, on instruction --

12 A. Yes.

13 Q. -- of the crown. You've talked about the instruction
14 being under section 33A. There was no distinction drawn
15 initially between B1, investigation into the
16 circumstances, and B2, more criminal focused?

17 A. Yes.

18 Q. As far as you were concerned, I'm interested in whether
19 you feel that made a difference to PIRC, because we've
20 heard two different answers on this. So
21 the Commissioner, Kate Frame, said she didn't think it
22 made much difference to PIRC the fact that B1 or B2
23 distinction hadn't been made in that letter of
24 instruction, but the lead investigator on 3 May, who was
25 Mr Keith Harrower, said that those were two very

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1 different referrals requiring a different response and a
2 different legal framework.

3 Now, it may be in relation to that response that he
4 saw these two differently or it's possible that he was
5 referring to crown-led and Chief Constable directed?

6 A. Yes.

7 Q. But as far as you're concerned, whatever the Chair makes
8 of the different answers, did you see there being a big
9 different in terms of the PIRC investigation?

10 A. To state the obvious, it's under the same section. I
11 know there are different subsections, but it's under the
12 same section. They are both crown-directed and the
13 powers of the PIRC are the same in any crown -- as I
14 understand it, in any crown-directed investigation.

15 The potential for criminality, I considered that
16 that was well-recognised throughout the PIRC from the
17 early stages that although clearly the assessment was
18 that the police should be treated as witnesses and were
19 treated and were advised they were being treated as
20 witnesses, in any investigation, there is the potential
21 for the focus of that investigation and the direction of
22 that investigation to change and I do mention that and
23 specifically in respect of PIRC powers.

24 The PIRC are used to, I would suggest, the status
25 changing, not so much in respect of section 33A but if

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1 we go back to the memorandum of understanding, where the
2 PIRC have a statutory responsibility to deal with and
3 review complaints handling, and those are complaints
4 about the conduct of the police that are assessed as not
5 amounting to criminality, there is a clear understanding
6 on the part of the PIRC that -- that if they come across
7 information that suggests that a crime may have been
8 committed, they immediately refer that to the crown.

9 And in my experience, as a head of CAAPD, that
10 happened on numerous occasions. So PIRC were used to
11 the status of investigations changing and it requires a
12 constant, I would suggest, assessment of information to
13 consider whether the status of the investigation has
14 changed by the provision of information and that could
15 have potentially happened in any -- in this case or in
16 any case depending on what information comes out.

17 Q. Thank you. I would like to look now at a letter you
18 wrote on 11 May 2015. So it's COPFS 02833A. You'll see
19 this is a letter from the Criminal Allegations Against
20 the Police Division to Kate Frame, PIRC, on 11 May 2015.
21 And if we look to the bottom, we'll see that this is
22 written by you. There you are, the head of CAAPD.

23 A. Yes.

24 Q. And if we can go to the beginning. Now, it's my
25 understanding this is the first letter that you actually

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1 wrote to PIRC. You can tell me if that's wrong but --
2 so you refer to the ongoing investigation.

3 You say a letter was received by Crown Office from
4 the solicitor acting for the family of the deceased and
5 there was mention there that they had instructed
6 Professor Busutil regarding inquiries and then you say
7 in paragraph 2:

8 "I have been able to advise the solicitors that no
9 police casualty surgeon was in attendance, no
10 photographs were taken of the body of the deceased at
11 the scene of death by the authorities. However, I would
12 highlight the following questions that have been raised
13 by the solicitor in order that these can be covered in
14 your investigations and so that there can be ongoing
15 discussions with the crown regarding appropriate
16 disclosure."

17 I think at that time, there had been a request for
18 disclosure from the family through their solicitor,
19 partly in relation to their instruction of
20 Professor Busutil, who was a pathologist.

21 A. Yes.

22 Q. And was this one of the types of letter you mentioned
23 earlier before the break where concerns raised by the
24 family were shared by you with PIRC?

25 A. Yes.

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1 Q. And if we can look at these bulletpoints. I will read
2 them short, but there's a number of points raised: a
3 request for a detailed narrative of events immediately
4 preceding the death, past medical history of the
5 deceased should be fully looked into, particularly
6 with -- there's mention there of sickle cell disease and
7 a history -- any history of mental health problems
8 should be looked at, recovery of tablets is mentioned,
9 observation that the deceased collapsed in the course of
10 being arrested, handcuffed, leg restraints, and a query
11 as to why this was necessary, how many officers were
12 involved and what procedures were used to enable
13 restraint. An observation that he was actively
14 resuscitated on-site and in hospital. There were
15 various puncture marks from needles and a query raised
16 in relation to how good the resuscitation was. Whether
17 anything removed from inside his mouth when he was being
18 resuscitated and observing damage. And then in respect
19 of the autopsy examination a number of separate points
20 raised there. Observation of petechial hemorrhaging in
21 the eyes suggestive of asphyxia. Observation there was
22 no evidence of upper airway luminal obstruction.
23 Raising issues of constriction of his neck. Observing
24 that there was evidence of a terminal physical struggle,
25 abrasions to his mouth and querying whether the level of

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1 restraint by the officers was justified and commenting
2 on restraint and impact of that.

3 So these were all issues that had been raised by the
4 family. Was this in relation to a meeting with the
5 family that the crown had already had or you had been
6 involved in or was it through correspondence?

7 A. I'm sorry. I can't remember.

8 Q. All right. We'll come on to meetings with the family at
9 a later time. Now, you have said that -- at the bottom
10 there you wanted to ensure that PIRC were sighted on
11 these issues as the Inquiry proceeded and was this an
12 example of you alerting PIRC to the family's concerns.

13 A. Yes, it --

14 Q. Were no other letters from you saying we want you to
15 look at or we're instructing you to look at these
16 various aspects that are raised here?

17 A. To the best of my recollection, this was an example of
18 me reflecting back concerns of the family. Looking to
19 the date of the letter, I am pretty sure this was at the
20 stage that the Inquiry, and I make reference to that,
21 had instructed their own expert. So to some extent I
22 think the purpose of this letter was twofold. It was to
23 get clarification of certain factual matters that
24 presumably Professor Busutil or certain of the family
25 and their solicitor requested would assist

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1 Professor Busutil in their inquiries on behalf of the
2 family, but also, as I suppose I put it at the end, I
3 wanted to sight PIRC on these concerns so that they were
4 aware of them and so they could give appropriate
5 consideration to these issues at that early stage of
6 their Inquiry.

7 Q. If there is a perception that to some extent the family
8 were providing more direction to PIRC than the crown in
9 relation to issues that were of concern to them, would
10 you have any comment to make about that? Were you
11 concerned that the family were giving more direction to
12 PIRC or comment to PIRC than the crown were?

13 A. I think it's entirely understandable that when the
14 investigation was with PIRC that there would be issues
15 being raised by the family, either directly or through
16 their solicitor, with PIRC as regards issues that they
17 wished investigated, but what I do recollect obviously
18 is that a significant amount of concerns were being
19 expressed by the crown and that tended to result in
20 sighting the PIRC of those or on occasions for
21 directions to investigate those areas on behalf of the
22 family.

23 Q. And these were on behalf of the family?

24 A. On behalf of the family having regard to the obligation
25 to involve the family, but also to ensure that PIRC were

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1 in a position to so far as possible answer concerns that
2 the family had that were requested appropriate and were
3 relevant to the investigation.

4 Q. Thank you. I would like to move on to -- we've heard
5 evidence about a forensic strategy meeting and that took
6 place on 12 May 2015 and there are minutes for that
7 meeting, which we can have on the screen, where you are
8 specifically named, if I'm right in thinking, and I
9 think you say in your statement you attended that
10 forensic strategy meeting?

11 A. I did.

12 Q. And you say that you had very limited involvement in the
13 instruction of forensic tests and analysis. You say at
14 one point in your statement:

15 "I had no experience of receiving SOCO statements in
16 PIRC directed investigations."

17 So can you explain what you meant by that, you had
18 no experience of receiving statements?

19 A. I think I was asked a specific question.

20 Q. Right.

21 A. In my -- in my request for a statement as regards SOCO
22 statements and that -- I was asked about the provision
23 of those types of statements, typically scenes of crime
24 statements, and I simply have no experience of receiving
25 those directly. In police cases they normally go to the

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1 police and, you know, in a PIRC-directed investigation I
2 don't recollect ever being engaged with that at all. So
3 that's why I put it that way, but I recollect I think I
4 was specifically asked about those.

5 Q. Let's have the minutes on the screen, please, PIRC
6 04161. We have look at the these before, but we'll put
7 them up.

8 And you see this is minutes for that meeting, 2.40,
9 Tuesday, 12 May and a number of people are present,
10 I think it was chaired by John McSporran, who we've
11 heard at that time was a senior investigator with PIRC
12 and was the lead investigator ultimately with the
13 investigation in relation to Mr Bayoh. And Mr Little
14 was also present and then we also see "COPFS Les Brown,
15 head of CAAPD".

16 I think you're mentioned specifically at the minutes
17 relating to agenda items 4 and 7. So 4 it says that you
18 spoke briefly about the role of Crown Office in respect
19 of the investigation of deaths and the tasking of PIRC
20 to undertake an independent investigation and report
21 their findings to Crown Office.

22 And then at 7 you were mentioned and you made a
23 request in relation to a personal radio that had been
24 taken from PC Craig Walker which appeared to have a
25 bloodstain on it, submitted for examination and you

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1 asked for the examination to establish if the blood
2 could be identified as contact or spray in nature and
3 DNA profile would also be required.

4 If we can go back to the -- near the top of that,
5 and we'll look at the introduction. So we see that --
6 we see the introduction:

7 "Number 2. Welcome and purpose. John McSporrان
8 opened the meeting and thanked everyone for attending.
9 He outlined that the purpose of the meeting was to
10 discuss and agree the prioritisation of the forensic
11 examination of productions seized during the PIRC
12 investigation into the death in police custody of
13 Mr Bayoh on 3 May."

14 We've heard evidence that there were a number of
15 areas covered in this meeting and I'm interested
16 primarily in two of those areas and the first relates to
17 the knife that was found at Hayfield Road some distance
18 away from where Mr Bayoh first had contact with the
19 police. Do you remember the discussion at this meeting
20 about the purpose of forensic examination of the knife?
21 Do you remember anything about that?

22 A. I'm sorry, I don't.

23 Q. You don't. Was there any other explanation given by
24 Mr McSporrان or anyone else on behalf of PIRC as to what
25 they were trying to achieve by examining the knife?

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1 A. I am struggling to remember any detail of that
2 discussion at all in relation to that. I would think
3 that it might have been the case that they were looking
4 to see whether there was any link to that knife that you
5 could prove a link to the incident and where the knife
6 had been obtained from.

7 Q. Right. And then the other thing I'm interested in, and
8 you have been asked about this in your statement, is
9 Nicole Short's vest or body armour?

10 A. Yes.

11 Q. And I think you say in your statement you weren't
12 involved in the direction to the SPA in relation to any
13 fingerprint examination of her vest and you were not
14 aware that this might hinder further examination?

15 A. Yes.

16 Q. We've heard about the order in which certain tests are
17 carried out.

18 A. Yes.

19 Q. We've heard evidence that when fingerprint testing is
20 carried out a particular substance is used which is dark
21 and can cause the appearance of material to alter. And
22 we've also heard evidence that on Nicole Short's vest
23 there was a mark sort of described as possibly being a
24 footprint or a footmark and that was to be analysed.

25 Do you recall any part of the discussion at this

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1 forensic strategy meeting in relation to Nicole Short's
2 vest about whether fingerprint examination and testing
3 was required in the circumstances?

4 A. No, I don't recall any discussion in respect of that.

5 Q. Do you remember if there was any consideration given or
6 advice given by the forensic scientists about the order
7 of fingerprint testing in relation to the vest and
8 whether it should be done at a later stage primarily?

9 A. No, I don't recollect any discussion in respect of that.

10 I obviously -- in preparing my statement I realised why
11 the Inquiry is interested in this and thinking back,
12 I would think if there had been discussion that had
13 indicated or made clear that the order of the
14 examinations could affect whether another type of
15 examination could have been carried out that I would
16 have remembered that and that I, you know, there might
17 have been expected to have been some discussion as to,
18 you know, whether that was right, whether it was
19 appropriate and to some extent, which was the more
20 important, if you had to choose between one or the
21 other.

22 Q. We certainly saw in the welcome/purpose section that the
23 purpose of the meeting was to discuss and agree the
24 prioritisation of the forensic examination of
25 productions, but you don't remember any specific

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1 discussion about prioritising fingerprint evidence on
2 Nicole Short's vest?

3 A. No.

4 Q. From the perspective of the crown, could you see any
5 benefit in fingerprint examination of the vest worn by
6 Nicole Short at Hayfield Road?

7 A. Well, it would depend obviously on the result of that
8 and to some extent, you know, the more information that
9 you potentially have you can factor that into your
10 investigation.

11 Q. Right. Was there any discussion about the order of
12 tests?

13 A. No, I don't recollect any discussion about the order of
14 tests and, in particular, whether it would affect the
15 ability to undertake further tests.

16 Q. Was there any discussion about a possible stamp having
17 taken place at that time and that a stamp in relation to
18 Nicole Short who was wearing the vest?

19 A. I thought about that, because obviously that -- a stamp
20 during the incident was -- is of interest to the
21 Inquiry. I don't -- I don't recollect any mention of
22 that at that meeting. Having said that, there must have
23 been some reason to suggest that type of examination of
24 the vest.

25 Q. Right. And was any consideration or any part of the

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- 1 discussion at the meeting about the possibilities of
2 soil analysis by forensic experts in relation to the
3 vest and in particular a mark on the vest?
- 4 A. I don't recollect any and I -- I don't think there was.
5 So my answer to that is I do not recollect any
6 discussion about potentially carrying that out.
- 7 Q. In terms of the crown rule, and you were present at this
8 meeting, can you explain to the Chair what your -- what
9 the purpose of your presence at this meeting was?
- 10 A. I think it was expected that my presence was, first of
11 all, to be involved in this process as the head of
12 CAAPD. I think in addition to that, to ensure that no
13 obvious investigative -- investigative approaches were
14 not being considered and also I think to have some
15 input, because clearly I did have some input in respect
16 of whether it would be possible to examine whether it
17 was dropped blood or spray blood because that might be
18 of assistance in indicating what was going on at the
19 time that that was taking place.
- 20 Q. Had you been -- so this is 12 May. Had you been briefed
21 by PIRC as to where they were in terms of their
22 investigation into the circumstances that had taken
23 place at Hayfield Road?
- 24 A. I don't recollect a formal briefing. I know that there
25 were briefing documents that were circulated and shared,

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1 but I don't recollect being briefed by PIRC as regards
2 what stage they were at in their investigation at this
3 point or any detailed discussion.

4 Q. To what extent did that lack of a briefing limit your
5 ability to contribute to this forensic strategy meeting
6 in relation to what they were going to do and what tests
7 there were to be carried out and the order of those
8 tests?

9 A. I think my attendance and my contribution was limited to
10 hearing what was being considered and clearly I made a
11 brief contribution in explaining what the role of the
12 crown was and suggesting something that I thought you
13 might be of assistance.

14 Q. Had you been given a briefing by PIRC at that point,
15 would it have been possible for you to have given a more
16 effective contribution at that meeting?

17 A. I think that might have been the case. It might have.

18 Q. Right. Can I look at another document, please. This is
19 minutes from a meeting on 14 May 2015. COPFS 04609.
20 Now, these are handwritten minutes, we have heard
21 evidence about these, it's dated 14 May, 2015, you can
22 see at the top right-hand corner, and we have heard that
23 these are -- were prepared by a Lindsey Miller. Now, we
24 have not heard yet from Lindsey Miller. It was a
25 meeting with the PIRC between the Lord Advocate. You

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1 see the initials on the top left.

2 A. Yes.

3 Q. Lord Advocate, Kate Frame and John Mitchell, who both
4 are from PIRC, Kate Frame was the Commissioner, and then
5 yourself, Les Brown; do you remember this meeting?

6 A. Yes, I think I do.

7 Q. Thank you. Now, these are obviously minutes taken by
8 Lindsey Miller, but at this stage there's no police
9 statements been obtained by PIRC.

10 A. Yes.

11 Q. No operation statements, not as witnesses, no forms
12 completed, no notebooks to assist.

13 So this is prior to them actually giving their
14 statements on 4 June and we've heard evidence that
15 during the meeting the Lord Advocate talked about it
16 being a disgrace there were no statements. Do you see
17 the first line there? And they should be suspended and
18 Mr Mitchell had not disagreed with that approach.

19 And as we go down the page, there's a comment I'm
20 interested in your view on and it relates to interview
21 under caution. So we'll have to keep going down. Stop,
22 please. Do you see just above the middle of the screen
23 the initials "JM", that's John Mitchell on the left,
24 just below the line that's coming down this, and it
25 says:

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1 "May need to detain and interview under caution."

2 Do you see that?

3 A. Yes.

4 Q. This is a carbon copy of the Duggan scenario. I am
5 interested in your thoughts at that time about the
6 status of the police, because obviously interviewing
7 someone under caution they've moved from witness to
8 suspect, as I understand it?

9 A. Yes.

10 Q. And we've heard evidence the police were treated as
11 witnesses?

12 A. Yes.

13 Q. Certainly up until this point. Did you have a different
14 view about the status of the police at this stage when
15 this meeting was taking place?

16 A. No, I didn't, I -- I knew that that they were being
17 treated as witnesses, that they had apparently been
18 advised that they were being treated as witnesses.
19 Everybody at that meeting was aware of that and I was in
20 agreement on the information that I had that that they
21 would be -- they should be treated as witnesses.

22 There was an ongoing investigation into what had
23 happened and you might be asking me further questions in
24 respect of this, but I have obviously given answers in
25 respect of the status of the police and I have given

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1 that some thought and I have reflected in my experience
2 as well. But in answer to your question, I knew that
3 they were being treated as witnesses and that was
4 something that I was in agreement with, was comfortable
5 with at that stage, because that would maximise the
6 chances -- the opportunity at that stage to obtain the
7 information that the investigation needed.

8 Q. You do indeed in your statement say the decision to
9 treat officers as witnesses was made prior to me
10 becoming involved?

11 A. Yes.

12 Q. And you agreed with that assessment and saw no reason to
13 interfere it -- interfere with it?

14 A. Yes.

15 Q. I think we have also heard evidence that the status of
16 the officers was something that was being kept under
17 review and it could change depending on the
18 investigation and the outcome of that investigation and
19 information and evidence that was obtained by PIRC?

20 A. Yes.

21 Q. Was there anything on 14 May that you were aware of that
22 caused you to think that their status had changed from
23 witness to suspect?

24 A. No.

25 Q. When John Mitchell proposed interviewing under caution,

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1 what was your view on that?

2 A. I have to say I don't have a detailed recollection of
3 that meeting. I don't think I provided any notes that I
4 had taken. It looks like as if Lindsey Miller --

5 Q. These are Lindsey Miller's minutes.

6 A. -- was the note-taker, but in reading through it, and I
7 read through it before I provided my statement, my
8 recollection was that various options were being
9 discussed and considered because some of the comments
10 would appear maybe to be contradictory.

11 But if you move to detain and to interview under
12 caution, you're immediately -- you're immediately giving
13 the officers the right to remain silent, whereas the
14 focus of the Inquiry at this stage was to try to obtain
15 the statements and that there was -- that the statements
16 should be provided because the officers were witnesses
17 at that time. And as I recollect it the Lord Advocate
18 was in agreement that they should be -- that they should
19 be witnesses and treated as witnesses for various
20 reasons and that at the end of all of this, although he
21 clearly was frustrated and, you know, Lindsey Miller has
22 noted -- I can almost hear him saying it's a disgrace he
23 considered -- I had better not speak for the
24 Lord Advocate -- but he was frustrated because of the
25 effect it was having on the investigation and that he

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1 considered that there was no reason for them not to
2 provide statements and indeed he wrote to the
3 Chief Constable to that effect and that ultimately was
4 the avenue that was pursued in order to try to secure
5 the provision of statements by the officers.

6 But as I say, I come back to the point that if you
7 move to change the status and to detain, you will
8 immediately give the right to the officers to remain
9 silent, whereas the focus of the investigation at that
10 point, and I think subsequently, was that they should be
11 providing statements.

12 Q. And in relation to the Lord Advocate, you said he wrote
13 to the Chief Constable to -- about the fact the officers
14 hadn't given statements.

15 Now, earlier when we were talking about PIRC going
16 through Police Scotland to obtain statements, you said
17 you didn't know if that was deferential. What about the
18 Lord Advocate himself writing to the Chief Constable
19 about the failure of the officers to give statements; do
20 you have any comments about that?

21 A. I think I'm risking speaking for the Lord Advocate.
22 What I would say is that that I obviously knew that the
23 Lord Advocate had written. The Lord Advocate was
24 I think approaching the Chief Constable as the head of
25 Police Scotland to point out at an organisational level

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1 the effect that this was having upon the conduct of this
2 investigation and to some extent it had been the subject
3 of comment. So as I say, I don't want to speak for the
4 Lord Advocate, but he obviously felt it was appropriate
5 at an organisational level and I would suggest that's
6 different from the PIRC approaching officers or
7 approaching senior officers in order to obtain
8 permission. The focus of this was to point out to the
9 Chief Constable I think as the head of Police Scotland
10 what the Lord Advocate's perspective on this situation
11 was.

12 Q. Thank you. Can we move on to the next page, please, so
13 page 2 of these minutes, and you'll see, if we can move
14 down the page, there's a reference to Baltimore that I'm
15 interested in picking up. Here we are. So towards the
16 bottom of the screen we can see there that there's a
17 reference attributed to the Lord Advocate on the left;
18 do you see "LA"?

19 A. Yes.

20 Q. They're keen to avoid another Baltimore?

21 A. I'm sorry. I had better find the correct --

22 Q. If we look at the screen as it appears, at the very top
23 it's Kate Frame.

24 A. Yes.

25 Q. Then "JM" John Mitchell.

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- 1 A. Yes.
- 2 Q. Then "LA", Lord Advocate.
- 3 A. Yes.
- 4 Q. And there's two lines noted by Lindsey Miller in the
5 minutes.
- 6 A. Yes.
- 7 Q. And at the very end it says they are keen to avoid
8 another Baltimore.
- 9 A. Yes.
- 10 Q. What was your understanding of that reference?
- 11 A. Well, looking at the passage in its totality, if you
12 just give me a second I'll just read that. Yes, there's
13 obviously reference to previous discussions, there's
14 mention of the Cabinet, there's mention of AA that I
15 think probably is Mr Anwar and it clearly has been
16 previous discussions.
- 17 I think from recollection it's a reference to a
18 situation in America where there had been actions by the
19 police that had caused -- well, at the very least
20 considerable unrest in relation to it and that that was
21 something and as I recollect it was a situation whereby
22 the police were viewed as behaving in a way that was
23 towards -- I think there was -- there was an element of
24 brutality and I think racial tensions, if I'm right.
- 25 Q. Thank you. And at that time, at that meeting, were you

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1 and others at the meeting aware that there was a concern
2 about racial tensions, because the police had been
3 involved with Mr Bayoh and he had died and he was a
4 black man?

5 A. Yes.

6 Q. And we've heard that the incident in Baltimore had
7 happened the month prior to the death of Mr Bayoh?

8 A. Yes.

9 Q. And were you aware that the family had expressed
10 concerns about whether the death of Mr Bayoh was
11 racially motivated at this stage?

12 A. I can't recollect anything specific and I'm obviously
13 looking back to that date and what did I know before,
14 but I'm pretty clear that the whole circumstances where
15 we had a situation where a black man had died following
16 restraint, interactions with multiple police officers, a
17 good deal of media attention by that stage and comment
18 to some extent issued and an immediate instruction to
19 the PIRC and an investigation that was ongoing and here
20 we're seeing discussions with Cabinet, apparently with
21 Mr Anwar, involvement by a law officer who was clearly
22 very much engaged and actively engaged at this stage,
23 that was one of the main issues. And it was -- I would
24 suggest it was clearly an issue at that stage.

25 Q. Thank you. I'm conscious of the time. Would that be

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1 ...?

2 LORD BRACADALE: We'll stop for lunch and sit at 2 o'clock.

3 (1.00 pm)

4 (Luncheon adjournment)

5 MS GRAHAME: I would like to move on to 4 June, if I may.

6 There's a bottle of water, just feel free to help

7 yourself. It can get quite warm in here in the

8 afternoon.

9 A. Thank you.

10 Q. So I'm going to move on to 4 June and that was the date
11 that the officers gave statements to PIRC. I don't know
12 if you were aware of that in advance but that's the date
13 that statements were taken from the officers?

14 A. Yes.

15 Q. We've heard evidence that there was some discussion on
16 2 June, an agreement that the officers would provide
17 statements, and we've heard that arrangements were made
18 within PIRC and that for a number of the officers they
19 gathered them together at the police college on 4 June,
20 each was interviewed by two people from PIRC?

21 A. Yes.

22 Q. That did not apply in relation to PC Paton or
23 Nicole Short, they were dealt with at separate
24 addresses, but the others were present at the police
25 college and those statements were all taken on the one

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1 day. And we heard some evidence from Mr McSporran, who
2 was the lead investigator at the time, about the
3 arrangements that had been put in place to take those
4 statements. And we have also heard evidence that a
5 witness interview strategy was prepared. There had
6 been -- the strategy had not contained any specific
7 questions about race and the strategy had not contained
8 any specific questions about justifications on use of
9 force.

10 We've heard a number of witnesses talk about the use
11 of force with police officers is lawful or can be lawful
12 in the course of their duties, but in order to be
13 lawful, it has to be justified, and that relates to
14 whether it was reasonable, necessary, proportionate.

15 A. Yes.

16 Q. It has to be the minimum force used to achieve their
17 legitimate aims.

18 A. Yes.

19 Q. And they have to have either tried less forceful options
20 and failed or consider those to have been inappropriate
21 in the circumstances?

22 A. Yes.

23 Q. But the witness interview strategy didn't go into the
24 justification in any meaningful way.

25 Hearing that now about the approach to the interview

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1 of the police officers on 4 June, which was around over
2 a month after Mr Bayoh had died, do you have any
3 concerns about the absence of a witness interview
4 strategy that contained questions about race?

5 A. Yes, I would have concerns about that.

6 Q. Tell us what those would be?

7 A. I consider that when an investigating authority is
8 looking to ascertain the circumstances of an incident,
9 especially an incident such as we were dealing with
10 here, where there were concerns about the impact of race
11 from a variety of points of view, but at its most basic
12 when one considered the overall circumstances that
13 occurred on 3 May that it would be -- it would be
14 important, and very important, to explore issues of race
15 in your investigative strategy when you were seeking to
16 get an account from the officers, but also to examine
17 not only what they did, but clearly that would be
18 extremely important, but why they did it and what their
19 perceptions were in their attendance and whether race
20 played a factor in that.

21 Q. And equally, in relation to hearing that there was no
22 specific questions directed to justification and the
23 points I've mentioned, preclusion, absolute minimum
24 force used, whether it was reasonable, whether it was
25 necessary, whether it was proportionate, in the absence

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1 of those types of questions in a witness interview
2 strategy, would you have concerns about their absence?

3 A. Yes, I would and --

4 Q. Why?

5 A. My reason for saying that is to some extent the same
6 kind of considerations, but when one is looking to
7 examine the actions of police officers, especially where
8 force has been used and it has resulted -- sorry -- I'll
9 choose my words differently -- someone has died after
10 that interaction, I would suggest it's absolutely
11 critical to explore what the officers did, what
12 techniques they employed, but also, I think equally
13 importantly, to explore with them why they did that and
14 what their justification and mindset was at that time,
15 so look like looking to assess what their perception of
16 the incident was and that -- that would be separate from
17 what the actuality was because perception can be
18 important.

19 Q. Thank you. I would like you to look at a briefing note.
20 We have heard evidence about this. Now, this was
21 prepared after you left your role as head of CAAPD.

22 A. Yes.

23 Q. But it's a comment on things that were happening during
24 the time you were head of CAAPD. Could we look at the
25 briefing note prepared by Alisdair McLeod, COPFS 02126A.

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1 And you'll see that it was prepared by Alisdair McLeod
2 who was in CAAPD and at that time it was sent to the
3 then head of CAAPD, Justin Farrell.

4 A. Yes.

5 Q. Did he take over from you?

6 A. Yes, he did.

7 Q. And you'll see at the beginning the purpose of this note
8 is in relation to detailing and time lining the work
9 carried out between 3 May 2015, which was the date of
10 Mr Bayoh's death, and November 2019, which was a later
11 period of time relating to the VRR.

12 I'm interested at this stage, we'll come back to
13 this later, but at this stage I'm interested in one
14 aspect of the content of this document and it relates to
15 page 6 and it's towards the bottom of that page and it's
16 a chapter entitled "rib fracture". And just -- I don't
17 know if you've ever seen this document. I'll go through
18 it with you. And this says:

19 "During the analysis of the statements [that's the
20 police statements] it was noted that three of the
21 officers involved in the restraint had made reference to
22 hearing the deceased fracturing a rib during the
23 administration of CPR.

24 "The deceased's ribs appeared to be intact at the
25 postmortem on 4 May [that's the date the postmortem was

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1 carried out]. However, a fracture to his left first rib
2 was discovered following a further examination by
3 pathologists on 29 May 2015."

4 A. Yes.

5 Q. We've heard evidence from Dr Shearer that a subsequent
6 further investigation allowed them to discover this
7 fracture. That same day, Mr Brown, that's you as I
8 understand it, advised Anwar & Company and PIRC about
9 the deceased's rib fracture?

10 A. Yes.

11 Q. And was that -- is that correct, that you --

12 A. Yes.

13 Q. -- on that day advised Mr Anwar, or perhaps someone from
14 his firm, and you also advised PIRC that a rib fracture
15 had been discovered by the pathologist?

16 A. Yes, it was Mr Anwar I'm pretty sure.

17 Q. Right.

18 A. Yes.

19 Q. Thank you. And that was the same day as the pathologist
20 discovered the rib fracture?

21 A. Yes.

22 Q. And then in his statement dated 4 June, 2015, so this is
23 a few days later, PC Walker told PIRC he heard the sound
24 of a rib cracking when he was carrying out CPR:

25 "At this time PC Walker handed over an undated

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1 pre-prepared statement to PIRC."

2 We've heard from PC Walker that he had prepared a
3 statement himself in the early stages after the events
4 and handed that to PIRC on the day --

5 A. Yes.

6 Q. -- he gave his PIRC statement, 4 June. Notably, in this
7 statement PC Walker made no reference to hearing a rib
8 crack during CPR. So there was a situation where his
9 pre-prepared statement had no reference to the rib
10 cracking.

11 A. Yes.

12 Q. But on 34 June, when he's giving his statement to PIRC
13 at Police College he made reference to it.

14 A. Yes.

15 Q. Then if we can move on to the next page:

16 "Two other officers, PCs Paton and Tomlinson, also
17 made reference in their PIRC statements dated 4
18 June 2015 to the deceased's rib fracturing during CPR.
19 Within the PIRC report medical experts instructed by
20 PIRC put forward various scenarios as to how it could
21 have occurred."

22 And I think this was an issue that the crown did go
23 on to investigate --

24 A. Yes.

25 Q. -- at a later stage in the hope that they would provide

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1 some clarity about when the fracture had occurred and
2 the significance of the fracture?

3 A. Yes.

4 Q. "The crown carried out extensive further independent
5 inquiries in relation to the deceased's rib fracture.
6 Although the rib fracture did not lead to Mr Bayoh's
7 death, the precognosers recognised that it's very
8 existence may have illustrated the force and mechanism
9 of restraint used by the officers. To that end in
10 February 2017, the crown instructed
11 Professor Anthony Freemont, an osteoarticular
12 pathologist at the University of Manchester. In his
13 report, dated 20 July 2017, Professor Freemont concluded
14 ..."

15 And he came to some conclusions about the rib
16 fracture I don't need to go into.

17 A. Yes.

18 Q. Moving on:

19 "The precognoscers found of interest that the
20 information about the rib fracture, which was only made
21 known to PIRC on 29 May 2015, was somehow potentially
22 being explained away by three of the officers when they
23 provided statements on 4 June 2015. After careful
24 consideration of all the evidence, there was
25 insufficient evidence to make any more of it, other than

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1 to say it was suspicious and potentially called into
2 question the integrity of the PIRC investigate at that
3 point."

4 I'm interested -- it then moves on to another
5 chapter. I'm interested in your recollection of the
6 discussion around this rib fracture. Obviously, the
7 timing was of significance to CAAPD at that moment. The
8 rib fracture was discovered on 29 May and on 4 June
9 three police officers are commenting on it in their
10 statements that they're giving to PIRC.

11 A. Yes.

12 Q. Can you tell us a little bit about the concerns that you
13 had about this element of the PIRC investigation?

14 A. Yes. Can I say right at the start that I recollect the
15 discovery of the rib fracture and it might be of
16 assistance to the Inquiry if I say a little bit about
17 that. Obviously, this was some time after the initial
18 postmortem examination and the body of Mr Bayoh had not
19 been released at that point and the family and Mr Anwar
20 had been kept up to date in relation to that and in the
21 background there were inquiries by the family as well
22 that were ongoing, but the fact that the body had not
23 been released for that time was a matter of concern and
24 I do recollect, and I think I said in my statement, the
25 Lord Advocate took a particular concern in respect of

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1 that as well. So there was -- there was -- there was an
2 anxiety to get the body released as quickly as possible,
3 but subject to all necessary and appropriate inquiries
4 being carried out.

5 Now, my recollection in relation to the discovery of
6 the rib fracture was that it was indicated that there
7 was a further scan or procedure that could be carried
8 out, but my recollection is that there was an indication
9 that that was unlikely to reveal anything because of the
10 extent of tests that had been carried out up until that
11 point so that information was -- was there at that time.
12 I recollect asking that that be done, because I took the
13 view that it was another -- it was another legitimate
14 part of the investigation and that even although the
15 consensus of opinion was that it was unlikely to reveal
16 anything, I was of the view that it should still be
17 carried out. I did discuss it briefly with Dave Green
18 to my recollection as well. So it was carried out, but
19 I have to say in the expectation that it wouldn't or it
20 was unlikely to reveal anything further.

21 It wasn't -- even although the scan was carried out,
22 and I have also said something in my statement about
23 that I took some steps to try to ensure that that
24 procedure was carried out that so far as possible
25 respected Mr Bayoh's dignity in respect of the movement

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1 of the body and I did make inquiries with the
2 pathologist as to how that could be carried out, but the
3 procedure was carried out, the further scan, and there
4 was an exchange of emails with the pathologist where
5 they indicated that something had been found, but until
6 they fully considered them, and I think also viewed the
7 body, that it could have been what was termed a
8 postmortem artefact, namely something that had not
9 occurred at the time of the incident.

10 However, it was further investigated on that day and
11 the information came in that day that you have referred
12 me to that a rib fracture had been discovered, a rib
13 fracture in a specific area, and that was the
14 information that was available at that time so I
15 became -- I was made aware of that and, as you've
16 indicated, I took steps to advise a limited number of
17 people at that time. I know that David Green was aware.
18 I know that I advised the Lord Advocate of it
19 immediately. I also took steps to advise Mr Anwar and
20 PIRC were advised of it that day as well. So that is
21 the background to the discovery of the rib fracture and,
22 as I say, I mention all of that, because it was quite a
23 late process and it was to some extent in my
24 recollection unexpected that it was found.

25 In relation to this particular passage that was

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1 written by Mr MacLeod --

2 Q. Mr MacLeod.

3 A. -- yes, I have seen this before, although not in this
4 format. This was intended as a record of the work that
5 the crown carried out so I have seen it and I was aware
6 of this issue at the time. It had been noted I think by
7 Mr MacLeod at a later date that there was this omission
8 in the earlier statement provided by the officer and
9 also the fact that it had been -- it had been mentioned
10 after the discovery of the information. And I think
11 that the Inquiry team as a whole considered it, I would
12 say, puzzling that the description, which was quite a
13 detailed description, including hearing a sound that was
14 attributed to a rib fracture, was being mentioned in
15 those circumstances and Crown Counsel were made aware of
16 it as well and law officers were made aware of it as
17 well for the reason that it was considered that it would
18 be worthy of some investigation as to whether, and this
19 was a hypothesis, whether there was the possibility that
20 police officers had become aware of this by some
21 improper provision of information and that's what I said
22 in my statement in respect it.

23 So that was part of the reasons for the further
24 investigations.

25 Q. In terms of your specific concerns in relation to the

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1 PIRC investigation, and you talk about improper methods
2 of police becoming aware, was this a concern that that
3 improper method had been some sort of disclosure by PIRC
4 or PIRC investigators to the officers at some stage
5 during the process of their statement taking?

6 A. I said "provision of information". Clearly it would be
7 speculation as to whether that had happened, that was
8 the first hypothesis, and as to who. If that were to be
9 at the case, that was a matter of speculation, but it is
10 mentioned there because it did result in further
11 investigation and inquiry because of the timing and
12 because of the provision of that information at that
13 point where it had not been mentioned in a previous
14 statement.

15 As I said in my statement, it was fully explored and
16 Crown Counsel did not consider that it was a matter that
17 it could be taken merited further action at that stage
18 but it was -- it informed further investigations by the
19 crown to explore the timing and the reasoning for that.

20 Q. And those further investigations would have taken time
21 of themselves?

22 A. They did take some time indeed.

23 Q. Thank you. I would like to move on to look at the cause
24 of death. I would like to begin by asking you some
25 questions about the framework in which cause of death is

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1 considered by the crown?

2 A. Yes.

3 Q. And then we'll move on to the postmortem report. I will
4 put some propositions to you and you can tell me if you
5 agree with them. Let me just find the right page.

6 When the crown are looking at cause of death, they
7 will be looking at whether there is a single cause of
8 death or perhaps a number of causes?

9 A. Yes.

10 Q. And those causes would be said by lawyers to have
11 materially contributed to death?

12 A. Yes.

13 Q. I think Dr Shearer gave evidence that a single stab
14 wound to the heart will be the cause of death, a sort of
15 straightforward one cause and that would go in her
16 report. But there are other examples, other causes of
17 death, which could be she described as multifactorial;
18 you agree with that?

19 A. Yes, that would be the term I could use, yes.

20 Q. And that would be where there are maybe one or more,
21 two, three, four, multiple potential causes which have
22 all contributed to the individual's death?

23 A. Yes.

24 Q. And there will be another phrase that you will
25 understand, a Latin phrase, de minimis and we have asked

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1 a number of people about that and as I understand it,
2 and you can tell me if you agree, de minimis is
3 something that is completely trivial, or insignificant
4 or not important in any way, it can be dismissed
5 effectively?

6 A. No consequence I agree with that.

7 Q. Of no consequence and that's a concept that you will as
8 a lawyer understand.

9 A. Yes, I hope so.

10 Q. And if something is trivial, of no consequence,
11 insignificant, it can be dismissed and pushed out of
12 consideration in relation to cause of death?

13 A. Yes.

14 Q. So where lawyers talk about something being de minimis
15 it means it didn't play any part in the death, would you
16 accept that?

17 A. It didn't play a significant part and I suppose can be
18 discounted that would be.

19 Q. It doesn't play any significant part, it can be
20 discounted, so it's trivial?

21 A. Yes.

22 Q. Thank you. And my understanding of the legal position
23 is that -- and this will be a matter for legal
24 submission. If anyone disagrees with me they can
25 address this matter in the future.

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- 1 A. The same applies to me as well.
- 2 Q. But there's a well-known case amongst lawyers called
3 Bonnington Casting v Wardlaw where there was a claim of
4 an employee who sustained an injury which was caused by
5 exposure to dust and some of that dust was completely
6 the fault of his employer. So there was a wrong there
7 that was attributable to the employer.
- 8 A. Yes.
- 9 Q. But there was other dust and that was nobody's fault or
10 certainly not the employer's fault, so there were two
11 types of dust and the dust caused him an injury.
- 12 A. Yes.
- 13 Q. And the court looked at that situation where there's
14 more than one possibly contributing factor: one is a
15 wrong it's a fault and one isn't.
- 16 A. Yes.
- 17 Q. And it was not possible in that case scientifically to
18 prove which one caused the injury?
- 19 A. Yes.
- 20 Q. They could never -- the medical science wasn't at a
21 stage where they could say it was this dust and not that
22 dust or vice versa?
- 23 A. Yes.
- 24 Q. And the court said the person claiming compensation
25 didn't need to prove that fault caused if it was enough

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1 that he could show that it materially contributed to his
2 injury?

3 A. Yes.

4 Q. So if the pursuer could show that the faulty dust
5 materially contributed, that was enough for him to win
6 his case?

7 A. Yes.

8 Q. In terms of causation in Scotland, it's a sole cause or
9 material contribution. That's the sort of test.

10 A. Yes.

11 Q. A contribution to a harm which is more than de minimis
12 will be material?

13 A. Yes.

14 Q. So if it's more substantial, more than the de minimis
15 side, which is just trivial and you put aside, then it's
16 considered material and that could be a material
17 contribution?

18 A. Yes.

19 Q. And that's enough for the pursuer in that case to win
20 his case?

21 A. Yes.

22 Q. And then that legally evolution of causation was
23 developed in a case called McGhee v National Coal Board.
24 You'll remember that from university and beyond.

25 A. I do.

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1 Q. Where there is an injury caused by two or more factors
2 operating together, one of those, there's a breach of
3 duty or a wrong or a fault and one isn't and it's
4 impossible to ascertain the proportion in which either
5 factor was effective in cause of death and in the
6 injury, then all the person has to prove is that the
7 faulty contribution was a substantial cause of injury.

8 And to make life a little bit easier for you, I have
9 also given you a case called Johnstone v HMA, which is a
10 Scottish criminal case. There's a copy of that on your
11 table.

12 A. Yes.

13 Q. It's a case from 2009 from the Appeal Court and it was
14 an authority at that time in 2015. It remains in the
15 bench book today actually.

16 A. Yes.

17 Q. It's not necessary for a death to have only one cause
18 and this was a murder actually. Can we look at page 247
19 and is I'll read it out, I'll tell you what this says.
20 There's reference to an English case, Court of Appeal
21 case, and a decision by Lord Justice Beldam. I am going
22 to read this out to you.

23 Do you see it at the top of page 247?

24 A. Yes, I do.

25 Q. "It's not the function of the jury to evaluate competing

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1 causes or to choose which is the dominant, provided they
2 are satisfied that the defendant's acts can fairly be
3 said to have made a significant contribution to the
4 victim's death."

5 A. Yes.

6 Q. "And we think the word 'significant' conveys the
7 necessary substance of a contribution made to the death
8 which is more than negligible."

9 Do you see that?

10 A. Yes, I do.

11 Q. And then further down at paragraph 56, so halfway down
12 that page, the Scottish Court of Appeal said:

13 "This English decision which we have cited are
14 consistent with the approach to the law of causation
15 adopted in [a Scottish case that they're mentioning]."

16 Then towards the middle of that paragraph, top of
17 that paragraph, the court said:

18 "In the present context, the law's requirement that
19 the wrongful act of the accused should have materially
20 contributed to the death of the deceased is not in
21 doubt."

22 A. Yes.

23 Q. So it's all about material contribution.

24 A. Yes.

25 Q. And then if we look at the next page, and this is

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1 paragraph 57, halfway through and beginning with the
2 words "the only criticism"; do you see that, paragraph
3 57?

4 A. Yes.

5 Q. Halfway down the page, 248?

6 A. Yes, I see it sorry, yes.

7 Q. "The only criticism which might be made of these
8 direction ..."

9 It's talking about the directions the trial judge
10 gave:

11 "... is that the judge did not specify that the
12 contribution to death must be material or significant."

13 A. Yes.

14 Q. So if a contribution to death is material?

15 A. Yes.

16 Q. It's not de minimis?

17 A. Yes.

18 Q. And if it's material, it's significant?

19 A. Yes.

20 Q. Would you agree with that? Thank you.

21 Let us look, please, at the final postmortem report.
22 It's PIRC 01445 and I am interested in the page 17,
23 which is page 18 on the PDF. And this is the final
24 postmortem report from 18 June?

25 A. Yes.

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1 Q. Can we look at the sort of middle -- below the middle
2 and it gives us the cause of death here and it says:
3 "Sudden death in a man intoxicated by MDMA (ecstasy)
4 and alpha-PVP whilst being restrained."

5 Do you see that?

6 A. Yes.

7 Q. And if we can go back, I would like to look at the
8 preceding paragraphs and I would like to start look at:

9 "Taking everything into consideration, death here
10 was sudden in nature. In summary, there was no evidence
11 of gross or histological natural disease that would
12 account for death."

13 We have heard evidence there was no natural illness
14 that would have accounted for the sudden death of
15 Mr Bayoh?

16 A. Yes.

17 Q. "Toxicology revealed MDMA and alpha-PVP and these drugs
18 could potentially have caused sudden death at any time
19 due to a fatal cardiac arrhythmia."

20 My understanding is that these types of drugs could
21 cause you to drop down dead at any stage?

22 A. Yes.

23 Q. "That said, it is recognised that restraint in itself
24 can be a cause or contributing factor in some deaths,
25 and given the circumstances in that this man was

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1 restrained at the time of his respiratory arrest and
2 postmortem examination showed petechial hemorrhages,
3 that may represent a degree of asphyxia and it cannot be
4 completely excluded that restraint has also had a role
5 to play in death here."

6 A. Yes.

7 Q. I would like to go through this. That is a long
8 sentence. I would like to go through it.

9 So the drugs themselves could have caused sudden
10 death at any time. You have agreed with that, and then
11 it says:

12 "Restraint in itself can be a cause of death."

13 So restraint can cause death of itself?

14 A. Yes.

15 Q. And it can also be a contributing factor?

16 A. Yes.

17 Q. Restraint in itself could be the sole cause or it could
18 be a contributing cause, a contributing factor?

19 A. Yes.

20 Q. And it says here:

21 "At the time, given the circumstances, in that this
22 man was restrained at the time of his respiratory arrest
23 and postmortem examination showed petechial hemorrhages
24 that may represent a degree of asphyxia... "

25 A. Yes.

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- 1 Q. "It cannot be completely excluded that restraint has
2 also had a role to play in death here."
- 3 So the pathologist is noting that at the time, in
4 the circumstances of this case, he was restrained at the
5 time of his respiratory arrest?
- 6 A. Yes.
- 7 Q. And restraint cannot be completely excluded, so it
8 cannot be completely excluded as de minimis or trivial
9 or insignificant or of no consequence; do you follow?
- 10 A. Yes.
- 11 Q. Do you agree with that?
- 12 A. I -- I -- I -- what I take is that the pathologists are
13 making it absolutely clear that it cannot be completely
14 excluded that restraint has also played a role in the
15 death here, yes.
- 16 Q. And if it's not being excluded --
- 17 A. Yes.
- 18 Q. -- then it is a factor contributing to death?
- 19 A. It's a factor that has to be considered, yes, as to
20 cause of -- as contributing to the cause of death.
- 21 Q. As contributing to the cause of death.
- 22 A. Yes.
- 23 Q. And if it's a factor contributing to the cause of death,
24 which is being included as -- by the pathologists as a
25 factor contributing to cause of death, that must be a

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1 material contribution to death?

2 A. Yes.

3 Q. Thank you, and then it says:

4 "overall it is not possible to be sure what has been
5 the most significant factor in death here and as such
6 the cause of death is best regarded as being sudden
7 death in a man intoxicated by MDMA and alpha-PVP whilst
8 being restrained."

9 Now, as we've also heard evidence and as I
10 understand it, it would never be possible for a
11 pathologist to say the alpha-PVP was 50 per cent the
12 cause of death and the ecstasy was 20 per cent the cause
13 of death and the restraint was 30?

14 A. Yes.

15 Q. They cannot provide those sorts of numerical exactitudes
16 in terms of a cause of death?

17 A. Yes.

18 Q. That's just not possible, but what is possible is for
19 them to identify the material factors and what
20 contributes materially to the cause of death?

21 A. Yes.

22 Q. And they have done that here?

23 A. Yes.

24 Q. Thank you. We have heard evidence from a number of
25 witnesses, but before I turn to that, I would like to

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1 ask you what was your understanding of the role that
2 restraint played in the cause of Mr Bayoh's death?

3 A. Clearly the passages in the -- I'm sorry. Could we keep
4 up the --

5 Q. Oh, yes. Do you want the final postmortem report kept
6 up?

7 A. Yes, thank you.

8 Q. It was page 1718.

9 A. Sorry. Just when we got to it, just the conclusion that
10 we were referring to.

11 Q. Here we are.

12 A. Thank you. That's it there. Just a little bit further,
13 thank you. Thank you very much.

14 Q. If we can have the actual cause of death on the screen
15 I think. Is that or were you wanting the --

16 A. Absolutely. Thank you. Thank you very much. Thank
17 you.

18 Q. I think that's everything on the screen.

19 A. Yes, that was seen by me, considered by me, considered
20 by the -- I was going to call it the investigative team,
21 and also considered by the Lord Advocate at the time and
22 was considered carefully. Reference to restraint is
23 obviously there. It is in the cause of death.

24 Now, the cause of death at that stage, what I
25 recollect in relation to that was that it was considered

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1 what's sometimes called a narrative cause of death in
2 that there are a number of factors multifactorial in
3 relation to this, but that restraint was one of those
4 factors. And what I do recollect, and I think I
5 referred to this in my statement, was that the
6 Lord Advocate, and I was in agreement with this, he was
7 keen to try to separate out, so far as possible, whether
8 it was possible -- sorry I'll rephrase that. He was
9 keen to see whether it was possible to separate out the
10 extent to which each of those factors had played a part.
11 So all of those, whether it was the extent of the drugs
12 or the extent of restraint and also and associated with
13 that, as I recollect it, exploring whether the -- how
14 the cause of death could relate to the actions on the
15 police at the time of the incident and, in particular,
16 whether the deterioration in Mr Bayoh was likely to be
17 sudden and without apparent warning or gradual. And
18 that the Lord Advocate was clear that he wanted further
19 expert opinions sought on doing that.

20 Although I don't want to speak, you know, for
21 Mr Anwar here, I do I think recollect some
22 correspondence where he also considered it important to
23 try to separate out the various elements in the cause of
24 death, including obviously restraint and pointing that
25 out. So that was the focus of the start of the further

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1 investigations in respect of this, because it was, as I
2 say, a narrative cause of death. There were factors in
3 relation to that that further -- further opinion or the
4 seeking of further opinion appeared to be of assistance
5 in determining the way the investigation was going to go
6 and also with particular reference to the actions of the
7 police, what they did at the relevant time.

8 And so that is -- that is my recollection in respect
9 of the cause of death and the explanation that was very
10 fairly stated by two -- I would say two very
11 well-respected pathologists. It wasn't as if anybody
12 was, certainly on the crown side, seeking to revise or
13 discredit that opinion because the report fairly states
14 a number of factors and, as they put it, it cannot be
15 completely excluded that restraint has also had a part
16 to play in the death here and that the petechial
17 hemorrhaging may have been an indicator, may have been
18 an indicator.

19 So all of these factors required to be in the
20 opinion of the Lord Advocate and the investigative team
21 to be further explored. I think it's also fair to
22 comment that one of the drugs in particular, alpha-PVP,
23 was relatively unknown at that time and that it was
24 considered that some expert opinion on the effects of
25 those drugs as regards both behaviors, or potential

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1 behaviors, as well as the effect on the body was --
2 merited further consideration.

3 But I should also add that in respect of the
4 causation in relation to -- in relation to the
5 consideration by Crown Counsel, it was always expected
6 that the consideration of proceedings in criminality
7 should accept that the de minimis test was met and that
8 restraint had played a part in death. They made that
9 assumption. Clearly that would, if ever there had been
10 proceedings, that would required to be proved to the
11 requisite standard, but Crown Counsel specifically
12 accepted that as a given and in fact they referred to
13 the case of Johnstone that you've kindly put in front of
14 me and which I was aware of because it was referred to
15 by Crown Counsel.

16 Q. All right. There was a lot in that answer. Let me go
17 over some of the points.

18 A. I am sorry.

19 Q. No, not at all. The respected pathologist you were
20 referring to were Dr Shearer and Dr Bouhaidar who had
21 prepared this postmortem?

22 A. Yes.

23 Q. And you said it was always accepted that the de minimis
24 test had been met so that restraint played a -- had a
25 material contribution?

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1 A. Well, I should maybe rephrase that that when it came to
2 the decision-making it was -- Crown Counsel proceeded on
3 the basis that the causation test had been met.

4 Q. So in terms of the view that the causation test had been
5 met that restraint played a part in the death of
6 Mr Bayoh, and that the crown could lead evidence at
7 least that that was the case, why was it necessary to
8 separate out the various factors?

9 A. I think as one of the primary reasons for that was to
10 have opinion on that as it related to the behaviour of
11 the police officers and, as I said earlier, as to
12 whether the deterioration in the condition of the
13 Mr Bayoh was likely to be sudden or otherwise as that
14 related to the actions of the police officers so far as
15 they were discovered during the course of the
16 investigation.

17 Q. I wonder if you can explain that a little further,
18 because obviously the cause of death is given as "sudden
19 death". So it's recognised that his death was sudden in
20 that sense. So why was there a need to look for further
21 evidence to show that it was a sudden death?

22 A. Well, for the reason that it would be -- it was
23 considered important to relate it to the behaviour of
24 the -- of the police officers, and also the -- to relate
25 it to the behaviour of the police officers and the

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1 actions of the police officers involved in the
2 restraint, involved in the restraint process, so that,
3 you know -- for instance, to give an example, were the
4 police aware that his condition was deteriorating but
5 continued with the restraint beyond that point?

6 Q. That's not the question that a pathologist is going to
7 be able to help you with, or any medical expert, were
8 the police aware that his condition was deteriorating,
9 they will not be able to give assistance in relation to
10 awareness of the officers. And what -- you would accept
11 that?

12 A. Yes. Well, a pathologist can't comment on what the
13 police knew or -- at the time, but the crown would be
14 able to compare that evidence with the other evidence
15 that was available to set out the actions of the police
16 officers.

17 Q. And certainly the cause of death says "sudden death
18 whilst being restrained" so it recognises that whilst he
19 was restrained his death occurred?

20 A. Yes, indeed. But there is also the consideration as to
21 what restraint means and "restraint" to many people
22 means something that is done to somebody, typically in
23 this case it would be the actions of the police
24 officers, but in the wider sense restraint is also, as
25 I think some of the other pathologists commented,

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1 struggling against restraint as well. So that has got
2 to be a factor as well in relation to restraint, so
3 restraint to that extent is an event.

4 Q. I think we'll come on to the struggle part. I think
5 Dr Carey recognised that when he did a report that the
6 struggle against restraint either by officers or with
7 leg restraints or handcuffs could -- could be a
8 significant part of the consequences for Mr Bayoh.

9 But in relation to the restraint itself, the crown
10 would have needed to look at the timeline of events and
11 look at what was happening and we've heard evidence
12 certainly that he became unconscious at the point he was
13 being restrained and so to what extent was that
14 distinction required by the crown to pinpoint exactly
15 when he became unconscious?

16 A. My own view was that that was relevant in considering
17 whether the actions of the police officers in all the
18 circumstances could be considered criminal and whether
19 the restraint constituted a crime and the actions of the
20 police officers during the course of that could
21 constitute a crime.

22 Q. Right. I'm interested in -- we've obviously talked
23 before and we've heard other evidence about how use of
24 force such as restraint can be lawful, but it must be
25 justified to be lawful and there are various factors

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1 that have to be considered if it's justified, so
2 whether -- is it reasonable, is it necessary, is it
3 proportionate, was it the minimum force necessary to be
4 used in the circumstances, were there less forceful
5 options open to the officers.

6 None of those factors require, as I understand it,
7 the crown to consider what the pathologist is saying.
8 Those factors could be looked at -- in terms of seeking
9 a justification that would come from the officers,
10 rather than from a pathologist?

11 A. Yes.

12 Q. So why if you've said whether the restraint was
13 criminal, why would it matter? Surely it would be more
14 significant to look at what the officers were saying in
15 terms of justification, instead of looking at what the
16 pathologist could help you with?

17 A. Yes. The crown has to consider and the decision that
18 Crown Counsel ultimately had to make was whether the
19 behaviour of the officers in all the circumstances and
20 taking into account all of the relevant factors,
21 including the assessment of risk, whether that could
22 constitute a crime and obviously there were further
23 investigations and expert opinions sought in respect of
24 the behaviour of the officers and that was the focus of
25 the further investigations and that was one of the main

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1 considerations by Crown Counsel in assessing whether
2 criminality could be established, but as I say, they
3 were -- they made the assumption and proceeded on the
4 basis that causation was not going to be an issue and
5 rather looked at the whole circumstances and the expert
6 evidence in relation to the behaviour of the officers
7 that was obtained from the restraint expert.

8 Q. If the justification for a use of force is absent,
9 completely, or if it does not cover all of the
10 individual elements of the use of force by an officer,
11 would you take it from that, in the absence of
12 justification or without a complete justification, that
13 the use of force is excessive? Is that not sufficient
14 for the purposes of the crown?

15 A. In order to consider whether there was a crime, in these
16 particular circumstances, my understanding and belief is
17 that there is -- there is a mental element in the crime
18 and to constitute a crime of say assault there has to be
19 an intention to do harm and that whilst all of these
20 elements will be relevant considerations, the crown
21 still has to satisfy itself, Crown Counsel would still
22 have to satisfy themselves, that there was evidence from
23 which it could be reasonably be inferred that there was
24 intention to do harm in all the circumstances.

25 So all of these elements are considerations and

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1 I know the restraint expert looked at those, but there
2 still is the concept in the police world of excessive
3 force where that is a complaint of excessive force but
4 it is accepted that it does not constitute an assault in
5 all the circumstances. In order to constitute an
6 assault, as I say, there are various elements and there
7 has to be, from the case law as I understand it, an
8 element of intention to do harm, an element of bad --
9 bad intent.

10 Q. And this is not something that you could exclusively
11 look at the intentions of the officers in relation to,
12 you needed support of the pathologist to assist with
13 that assessment, did you?

14 A. Well, potentially the pathologist would have assisted
15 and that was at the consensus of the team and that
16 certainly was the view of the Lord Advocate who was
17 clear that he should wished further medical expert
18 opinions sought of the various elements of the cause of
19 death.

20 Q. Was this aspect necessary for the crown's purposes?

21 A. The -- are you referring to the further --

22 Q. Seeing if there was any further assistance, medical
23 assistance available that could help with your
24 assessment of intent?

25 A. It would -- it would assist or potentially assist in

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1 separating out the various causes and the extent to
2 which, in the light of the fact that the original
3 pathologist said it cannot be completely excluded,
4 whether a further opinion could be sought in relation to
5 clarifying that.

6 Q. Whether it could be excluded?

7 A. The extent to which restraint had -- had contributed to
8 death.

9 Q. Right. If you could give me a moment, please. I'm
10 conscious --

11 LORD BRACADALE: Will we take a break at that point, a
12 15-minute break.

13 (2.57 pm)

14 (A short break)

15 LORD BRACADALE: Ms Grahame.

16 MS GRAHAME: Thank you. I just wanted to take a step back
17 for a moment and check which period of time we're
18 talking about, obviously I'm interested in the first
19 period of time, and we're talking specifically about the
20 postmortem, the final postmortem report, and that
21 arrived on 18 June, 2015. And you've said in your
22 statement and we know from evidence that the dedicated
23 advocate depute in the crown investigation was
24 Ashley Edwards then QC now KC.

25 A. Yes.

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- 1 Q. And I'm interested in when was she appointed to assist
2 CAAPD in relation to Mr Bayoh's death?
- 3 A. It was at the time of the submission of the final PIRC
4 report, to the best of my recollection, round about that
5 put.
- 6 Q. So round about August 2016?
- 7 A. Yes.
- 8 Q. So any comments that you are making in relation to
9 Ashley Edwards taking a view on whether the test for
10 causation had been met or -- I think you said she gave
11 you the Johnstone case herself -- are they in relation
12 to that latter period?
- 13 A. Yes.
- 14 Q. Post August 2016?
- 15 A. Yes.
- 16 Q. Thank you. Well, we will maybe come back to that at
17 that stage.
- 18 So at the stage the final postmortem report has been
19 made available to you and you've sent that on to PIRC,
20 you've emailed it to PIRC for them to consider, you had
21 not had any discussions with Ashley Edwards at that
22 time?
- 23 A. No, but as I said, I'm confident that the Lord Advocate
24 was cited in the final postmortem report, not Ashley.
- 25 Q. Right. So insofar as I understood your evidence before

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1 the afternoon break where you talked about the causation
2 test having been met or a given it's a restraint is a
3 material contribution to the death of Mr Bayoh, and
4 you've talked about wishing to embark on further
5 inquiries in relation to whether those inquiries with
6 medical experts may assist the crown in considering
7 intention or matter of state of mind of the officers?

8 A. Actions -- I would say actions of the officers, their
9 behaviours.

10 Q. Their behaviours?

11 A. Yes.

12 Q. Nothing to do with their state of mind at that point?

13 A. Not -- I think mainly in relation to their behaviours.
14 Mention of petechial hemorrhaging, to what extent was
15 that consistent with, for instance, asphyxiation in the
16 sense of crushing or compression of during the incident
17 and also, as I say, in assisting -- potentially
18 assisting the actions of the officers in relation to
19 criminality as to whether their behaviours met the test
20 for a crime such as assault or culpable homicide and
21 the -- whether there was any assistance to be obtained
22 in respect of the medical evidence as to whether the
23 deterioration in Mr Bayoh was likely to be sudden or
24 otherwise in that should -- was there evidence that the
25 officers should have realised that he was in

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1 difficulties and behaved accordingly or otherwise, that
2 those kind of considerations when it refers to
3 restraint, but also what was being done during the
4 restraint and what were the medical consequences of
5 that.

6 Q. What may have been open to officers to be observed
7 during that period of the restraint which may have
8 implicated their -- had consequences for their own
9 actions?

10 A. Yes. And what could the medical assistant -- what could
11 the medical evidence assist with in relation to what the
12 likely action of the officers were. For instance, was
13 there evidence of officers piling on top of him and
14 remaining in that position for long periods of time
15 whereby the medical evidence was consistent with those
16 kind of actions or otherwise and that's why I refer to
17 was his deterioration likely to be sudden or otherwise.

18 Q. Thank you. So you've received the final postmortem
19 report. You've told us that you were aware of
20 Johnstone, the decision Johnstone in relation to
21 material contribution. Did you read the final
22 postmortem report when it came in?

23 A. I would -- yes, I was aware of the final postmortem
24 report. I think I probably should say that I think
25 I was aware of Johnstone at a later stage when all of

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1 the evidence was being considered. I didn't
2 particularly Johnstone at that point.

3 Q. In terms of the postmortem report that we're talking
4 about, was it clear to you from the point at which you
5 read it that restraint had been a material contribution
6 to death?

7 A. It was clear to me that restraint required to be
8 considered and that restraint was specifically mentioned
9 in the sense that it could not at that stage in the
10 opinion of those pathologist be -- I think the phrase
11 was completely excluded.

12 Q. In terms of the opinion of two respected pathologists,
13 Dr Shearer and Dr Bouhaidar, it was a material
14 contribution to death?

15 A. It was mentioned in the cause of death, in the terms of
16 restraint and of course restraint I have suggested
17 means -- can mean different things to different people,
18 but it would be the actions of the officers that you
19 would have to consider, what did they actually do in
20 restraining Mr Bayoh, so their actions in restraining
21 him.

22 Q. Yes, but there was no suggestion it wasn't the officers
23 who restrained him?

24 A. Not at all, no.

25 Q. No. So the officers or a number of officers have

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1 restrained him. By 18 June when the report comes in you
2 have the police officer's statements, they were
3 available on 4 June, so you know the identity of the
4 officers who were involved in the restraint and you know
5 that restraint is now specifically mentioned as part of
6 cause of death?

7 A. Yes.

8 Q. And you understand the concept of material contribution?

9 A. I do. In respect of the statements, I know the
10 statements were apparently obtained at that time,
11 I don't have a recollection that they were submitted at
12 that point.

13 Q. So perhaps you didn't have copies of the officers'
14 statements when the postmortem report came in?

15 A. Possibly, yes.

16 Q. Do you remember?

17 A. I don't remember. No, I don't remember reviewing them.

18 Q. Had you had --

19 A. I was awaiting the PIRC report.

20 Q. You were waiting for the PIRC report?

21 A. Yes.

22 Q. Had you had any sort of briefing from PIRC about the
23 contents of the officer's statements at that stage?

24 A. I don't recollect a briefing, no.

25 Q. And so you forwarded the postmortem report to PIRC.

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1 There's an email in the papers sent to the Inquiry where
2 you've forwarded that by email to PIRC and was it --
3 what were your expectations of PIRC in relation to what
4 they would do with the postmortem report?

5 A. Well, I expected that it would be factored into their
6 eventual report. It was clearly evidence that required
7 to be considered.

8 Q. Right. And we've heard evidence that in relation to
9 this period, so we're talking after the postmortem
10 report in 18 June and before the first PIRC report is
11 sent to Crown Office, that during that period between
12 June and August there was a process entered into whereby
13 the crown asked PIRC to start identifying experts and
14 giving -- obtaining CVs of experts and providing those
15 to the crown, is that -- do you remember that?

16 A. I think that that would have been triggered by the
17 arrival of the postmortem report and the consideration
18 of the report by the crown and in particular by the
19 Lord Advocate. That would -- that probably would fit,
20 yes.

21 Q. Did you have a role to play in relation to speaking to
22 PIRC or instructing them in that process, the process
23 whereby they would start to identify suitable experts?

24 A. I don't recollect playing a direct role in that
25 personally. My understanding and -- is that there

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1 were -- there were consultations. As I said, the
2 Lord Advocate was engaged in that and, as I recollect
3 it, PIRC and the Commissioner indicated that they would
4 prepare -- they would prepare a submission in respect of
5 those experts whom they had identified for the approval
6 of the Lord Advocate and that that was the way that that
7 was being approached.

8 Q. Let's look at your statement, please. I'm interested in
9 question 131 to 132 or the answers to questions 131 to
10 132 and I think it's PDF page 80. You've got it.
11 That's perfect.

12 "The Lord Advocate had clearly indicated at an early
13 stage of the PIRC investigation that the instruction of
14 further experts was necessary to explore the cause and
15 mechanism of death."

16 When you say there "at an early stage of the PIRC
17 investigation", would this have been after the final
18 report had been obtained?

19 A. Yes, I think so, yes.

20 Q. "It was necessary to explore the cause and mechanism of
21 death and to clarify the significance of the role that
22 drugs and restraint played in the death and the extent
23 to which they interacted."

24 It appears there that the Lord Advocate wanted
25 further investigation in relation to the cause of death,

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1 was that your understanding of the Lord Advocate's
2 wishes at that time?

3 A. I have said cause and mechanism and I am referring to
4 the interaction, because we obviously had a cause of
5 death, we had a cause of death at that stage, but to
6 separate out the elements.

7 Q. Right. Thank you.

8 "It was also important that the cause and mechanism
9 of death were not considered in isolation but that
10 proper consideration was applied to how they related to
11 the accounts given by eye witnesses and police."

12 Is that partly what you were saying earlier a moment
13 ago?

14 A. Yes.

15 Q. "With a particular focus on whether the deterioration in
16 the condition of Mr Bayoh was likely to have occurred
17 suddenly and without warning or otherwise."

18 Again, what you have been talking about?

19 A. Yes.

20 Q. "I suggested specific questions in relation to the
21 significance of the continued application of handcuffs
22 and leg restraints and whether that could have affected
23 resuscitation efforts."

24 And is this the latter part of restraint, still part
25 of restraint with the handcuffs and leg restraints, but

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1 not necessarily involving multiple officers --

2 A. Yes.

3 Q. -- engaging in a physical restraint?

4 A. Yes, it was -- it was a particular concern of mine to
5 explore that because there was evidence that after he
6 became unresponsive, after Mr Bayoh became unresponsive,
7 that the handcuffs were being continued to be applied
8 and that was something that I considered was worthy of
9 an investigation as to why that was, but also as to
10 whether it could have affected resuscitation efforts.
11 That was something I considered should have been
12 explored.

13 Q. And then carry on, please. If we can move down the
14 page:

15 "The rationale behind instruction of experts was to
16 bring expertise in relation to potentially significant
17 areas of specialisms that could bring clarity in
18 relation to these critical questions. For my part,
19 I was aware that the Lord Advocate had taken a personal
20 interest in the selection of experts with and expressed
21 desire to use the experts from the international
22 community. The identification of experts was informed
23 by two key considerations: do they appear to possess the
24 necessary skills, qualifications and experience to
25 comment on a particular issue and does it appear that

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1 expert opinion on that particular issue will be of
2 material assistance to the decision-maker or the court
3 in determining a crucial issue?

4 "For the crown it is an overriding and important
5 principle that the identification of experts must be
6 carried out independently. Expert witness will also
7 have an overriding duty to report their opinions in a
8 balanced and professional manner. To fulfil the
9 requirement of independence an expert must not be
10 instructed with a view to obtaining a predetermined view
11 or to advance a particular theory. The instruction of
12 an expert is the beginning of a process rather than an
13 end."

14 So this -- if we move to the top of where we were,
15 page 80, please. So the Lord Advocate has expressed an
16 interest in further exploring the cause and mechanism of
17 death, there's a number of elements that are of interest
18 to the crown and, as I understand it, that was then --
19 PIRC were then asked to identify certain experts.

20 I'm interested in why the PIRC were asked to do that
21 and why Crown Office didn't do that?

- 22 A. As I said, the Commissioner was involved and indicated
23 to the crown and to the Lord Advocate that she would
24 prepare a briefing on experts that they had identified.
25 It was a PIRC investigation, that is to state the

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1 obvious, but it was a PIRC investigation and the
2 investigation was still resting with the PIRC at that
3 point. Certainly the Lord Advocate considered that it
4 was appropriate to ask the PIRC to identify experts and
5 I don't recollect that there was any indication from the
6 PIRC that they would have difficulty in doing that.

7 It's -- in my experience it's not entirely -- it's
8 not without precedent that an investigating authority
9 would identify an expert. There are occasions where the
10 police will do that typically where they are preparing a
11 case for submission to the crown. The process in this
12 particular case, as the Inquiry will be aware, is that
13 the PIRC, and I think the Commissioner herself, to some
14 extent reviewed the recommendation and then submitted
15 the proposed expert to the crown which was forwarded for
16 consideration along with a CV and according to those
17 considerations there was approval given to seeking an
18 expert report from that person.

19 Q. Which person are you specifically --

20 A. Sorry. From the experts I should have said, from the
21 experts, yes.

22 Q. You've said it was not without precedent. We've heard
23 evidence that the investigators with PIRC and in
24 particular Mr McSporran, the lead investigator, did have
25 experience of seeking expert opinion in relation to

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1 forensic matters, no experience or less experience in
2 relation to instructing medical experts in relation to
3 issues of causation.

4 In relation to the -- you say it's not without
5 precedent. The precedent that you are thinking of or
6 precedents you're thinking of, were they in relation to
7 medical -- the instruction of medical experts?

8 A. Any kind of expert I suppose I was thinking of in
9 relation to that comment, but as an organisation, PIRC
10 had a range of I suppose experience and skills, and
11 that -- I do come back to the point that
12 the Commissioner was asked, and I think in dialogue with
13 the Lord Advocate in relation to the instruction of
14 experts, and there wasn't any indication that this was
15 considered either too difficult or inappropriate, the --
16 it was the Commissioner involved, rather than I thought
17 John McSporrان.

18 Q. Were there any other concerns expressed by anyone on
19 behalf of the PIRC as to the ability of the
20 investigators to identify and instruct medical experts
21 in relation to matters pertaining to cause of death?

22 A. Not that I recollect, no.

23 Q. Did you personally have any concerns about leaving that
24 matter to PIRC investigators?

25 A. I didn't have any concerns in respect of that because of

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1 the additional factors in relation to this, namely that
2 they weren't instructing the experts without reference
3 to the crown, they were simply identifying those and
4 forwarding information, including CVs and the expert's
5 track record, as it were, to be able to speak to the
6 things that were considered to be of assistance in the
7 investigation.

8 Q. Given the subtleties in relation to the questions you
9 were interested in hearing from the experts about, so
10 you had the cause of death in the final postmortem
11 report, but you were interested in what further
12 assistance be gleaned from other expert evidence in
13 relation to medical matters, causation, use of
14 restraints, did you have any concerns about whether PIRC
15 understood the purpose that these further medical
16 experts were being sought for?

17 A. No, I don't recollect having -- having those concerns,
18 and as I recollect, the process was quite interactive
19 with PIRC where once the Lord Advocate or anybody else
20 was satisfied that it was appropriate to seek an opinion
21 that there was dialogue in consultation about the
22 instructions and the areas that required to be set out.

23 Q. We have heard evidence from Mr McSporran in relation to
24 a policy log that he prepared at the time where he noted
25 an entry:

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1 "PIRC are to identify medical experts who can
2 provide opinion on cause of death, including the effects
3 of drugs, restraint, medical or drug misuse history of
4 deceased and present CVs to Crown Office so they can
5 select experts whose opinions can be sought. The reason
6 is to attempt to establish the exact cause of death."

7 And you're raising your eyebrows there.

8 A. Sorry.

9 Q. Do you feel that that is an accurate reflection,
10 establishing an exact cause of death, of your intentions
11 in looking for experts who could help?

12 A. I would have thought it was clear and it was clear to me
13 that the purpose was to separate out the various factors
14 that had been mentioned by the original pathologist.

15 It is my recollection, and there's some support from
16 that I think in some emails, that at the time that the
17 initial experts were being considered that PIRC were
18 very content to try to identify experts in relation to
19 the field of drugs. To some extent I think there were
20 some consultation or interaction in America whereby some
21 experts could be identified, but that the crown would
22 try to identify experts in relation to asphyxiation and
23 there are emails and I can recollect seeing that the
24 crown team and myself as part of the crown team would
25 make efforts to identify somebody with particular

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1 expertise in relation to asphyxiation in the sense of
2 any crushing or restriction by mechanical means and I do
3 recollect approaching one particular pathologist who
4 appeared to possess the relevant expertise.

5 They couldn't take it on, but they suggested a
6 couple of others, one of whom was Nat Carey and,
7 obviously, Nat Carey couldn't because he had already
8 being instructed by the family, but he did make another
9 suggestion and that was a pathologist who at a later
10 time was the reviewing pathologist in respect of that
11 pathologist had experience of the Hillsborough disaster
12 and that came through crown enquiries and through
13 enquiries with pathologists who appeared to be in a
14 position to comment in relation to that.

15 Q. And that would be Dr Lawler and we will talk about him
16 in relation to the slightly later period, but coming
17 back again to this period between the postmortem, final
18 postmortem report coming in, and August when you got
19 your first PIRC report, during that period when PIRC
20 were seeking to identify experts and to share CVs with
21 the crown, were you aware of PIRC having been instructed
22 to do that type of work prior to the Sheku Bayoh
23 Inquiry?

24 A. No, I wasn't and I'm not aware of any case where they
25 would have so to that extent this was -- this was new,

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1 was a new approach, but it was obviously following upon,
2 you know, the appointment of the Commissioner with
3 experience within the crown over a number of years so,
4 you know, that may have been a factor in the way that
5 that approach was made between the various officials and
6 law officers.

7 Q. Because Kate Frame had been in Crown Office before she
8 became Commissioner?

9 A. Yes, and I appreciate that she was performing a
10 different role there and you can't just simply say, oh,
11 well, you know it better than some sort of -- you have
12 had more experience, but that could have been a
13 consideration in the approaches that were made and in
14 particular the apparent discussions between the
15 Lord Advocate and the Commissioner in respect of the
16 instruction of the experts. But I suggest that, you
17 know, it's important to bear in mind, as I have said,
18 that they weren't doing it in isolation, they were doing
19 it to some extent in consultation with the crown and
20 then later on at least some form -- some consultation
21 with the family.

22 Q. Why did the crown not simply wait until they had the
23 first report and then proceeded to look for suitable
24 experts once they had the chance to properly consider
25 the evidence that was available and consider the

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1 postmortem report?

2 A. My recollection is that the Lord Advocate saw medical
3 evidence and further exploration of the cause of death
4 as critical.

5 Q. But as I understand the position, until you got the
6 first PIRC report in the August, you were not fully
7 appraised of the factual background when you were
8 looking at the postmortem report?

9 A. Yes.

10 Q. Did that hinder your ability to determine what the
11 critical issues were that you would need further
12 assistance upon?

13 A. I don't think it hindered the ability because the focus
14 was on the terms of the principal, the original
15 postmortem report, the nature of the cause of death with
16 which was multifactorial and the comments by the
17 pathologist about being uncertain as to the extent to
18 which each played a role and the extent to which they
19 interacted, because, as I think you have said during the
20 start of this series of questioning, there was the
21 possibility that one factor was the sole cause of death
22 depending on one interpretation of the explanation
23 provided by the pathologist, drugs were important, but
24 overall the narrative cause of death included all of the
25 factors which did of course mention restraint so it was

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- 1 separating out all of those.
- 2 Q. Are you suggesting that the pathologists were saying in
3 the final postmortem report that one factor could have
4 been the sole cause of death?
- 5 A. No, perhaps that's -- I don't have the report in front
6 of me. I don't want to go that far, but there was the
7 phraseology "not possible to completely exclude" and to
8 that extent that seemed to invite some further
9 explanation and exploration.
- 10 Q. And did you speak to Dr Shearer about that phrase?
- 11 A. I personally didn't speak to her, no.
- 12 Q. And --
- 13 A. But there were subsequent consultations with Dr Shearer
14 at a later stage, including consultations with
15 Crown Counsel.
- 16 Q. Well, we'll look at those at that later phase, rather
17 than mixing them all together, but at this stage you
18 have the final postmortem report, you do not yet have
19 the PIRC report, but you are determining what may be of
20 material assistance to the crown?
- 21 A. Yes.
- 22 Q. Without the benefit of knowing the full circumstances?
- 23 A. Well, prior to the arrival of the PIRC report, which
24 clearly would be of assistance, but even prior to that
25 the Lord Advocate, as I recollect it, was clear that

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1 further investigations in relation to the cause of death
2 were necessary and were appropriate.

3 Q. In terms of identifying where you could get some
4 assistance, was that not going to be made more
5 difficulty because you didn't know all the factual
6 circumstances because you didn't have the PIRC report
7 yet?

8 A. I don't know that it would be made more difficult. It
9 allowed some progression in respect of that and clearly
10 when the experts were instructed information that had
11 been obtained by the PIRC was put before the experts, so
12 it wasn't, I would suggest, premature in that respect.

13 Q. What were your expectations of PIRC in terms of
14 identifying the appropriate experts to help the crown?

15 A. The expectation I think was that they were in a position
16 to put forward experts as suggestions with accompanying
17 materials that would allow the crown to either approve
18 the instruction of those experts or otherwise.

19 Q. Did you have any concerns that PIRC may not be in the
20 best position to identify those experts compared to
21 experienced crown practitioners?

22 A. I didn't have those concerns because of the -- because
23 of the approval process.

24 Q. Did you instruct PIRC to look into questions of the
25 independence of experts, possible bias, possible

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1 complaints, or was that something that was going to be
2 done by crown at a later date?

3 A. I don't recollect any specific instruction although
4 I would suggest that it would -- in relation to the
5 instruction of any expert by an investigating authority
6 that experts should approach the consideration of the
7 questions entirely independently and, as I think I said
8 in my statement, that the function of that and it's a
9 very onerous responsibility but it certainly is -- have
10 regard to it, the requirement not to try to seek an
11 opinion before an instruction is given, but rather to
12 approach those who appear to possess the necessary
13 expertise and take it from that point, but at all times
14 accepting that once the opinion is received that the
15 crown -- neither the crown nor anybody else is obliged
16 to accept it and will also seek to test out that opinion
17 with reference to others and that was always considered
18 to be an element in the part of that process of
19 instructing experts.

20 Q. And in terms of identifying any possible conflicts of
21 interest, was it your expectation that PIRC would flush
22 those out or the crown would flush those out?

23 A. Sorry, you've referred to conflicts of interest, what --

24 Q. When you're instructing an independent expert --

25 A. Yes.

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- 1 Q. -- you want to make sure that there's no conflicts of
2 interest?
- 3 A. Yes.
- 4 Q. That might impact on their independence, their ability
5 to be impartial and not biased or prejudiced about any
6 particular view?
- 7 A. Yes.
- 8 Q. And in terms of flushing out whether there are any
9 potential conflicts, did you see that as being the role
10 of PIRC when they were identifying suitable experts or
11 did you see that as something that the crown would flush
12 out prior to their instruction?
- 13 A. I saw it as part of the process of the selection of
14 experts that there was an expectation there shouldn't be
15 a concern that their independence was in some way
16 compromised, but there was also an obligation on the
17 experts themselves to ensure that they provide an
18 opinion that is independent and that that is part of the
19 process of instructing an expert.
- 20 Q. And as part of that process, where you are considering
21 possible conflicts or issues that may arise that impact
22 on independence, was that part of the process going to
23 be done by PIRC or by the crown?
- 24 A. I think if there was -- my own view on that is that if
25 there was a concern that that is something that the PIRC

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1 would identify, I think it's fair to say that the PIRC
2 knew that experts should be instructed on the basis that
3 they would be in a position to provide an opinion that
4 was of assistance in respect of the questions that were
5 going to be asked of them.

6 Q. You expected the PIRC to be able to identify the
7 questions that would be asked and that would help them
8 identify the right expert?

9 A. Well, the questions were submitted to the crown, as I
10 recollect, for amendment or otherwise, so that process
11 was incorporated into the --

12 Q. So the PIRC --

13 A. -- instruction.

14 Q. -- drafted the questions they thought that the crown
15 might want to ask and the crown then had a chance to
16 review that?

17 A. Yes, where the PIRC -- yes, where the -- where the --
18 where they drafted the questions. I am not clear that
19 that happened in every case as to whether the crown
20 assisted in drafting questions. What I do recollect is
21 that I instructed that a question be inserted in
22 relation to the application of handcuffs, so to that
23 extent I inserted a question.

24 Q. Right. Do you remember revising any questions that may
25 be didn't quite match the crown's expectations?

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- 1 A. I don't have any specific recollection of revising a
2 question, no.
- 3 Q. Was that part of your role in having oversight or was
4 that task given to one of your staff?
- 5 A. No, I would look at them, but I think I -- there
6 probably would be the case that I would -- I would ask
7 for comment from other senior colleagues in respect of
8 them, but, no, I didn't delegate that to anybody else.
- 9 Q. And who were these senior colleagues that you asked for
10 comment?
- 11 A. Principally it would be Stephen McGowan and
12 Lindsey Miller, probably later on in the Inquiry.
13 Lindsey Miller and Stephen McGowan.
- 14 Q. Did they both check over the PIRC questions as drafted
15 by PIRC that were going to be sent to experts?
- 16 A. I couldn't say in respect of each that either Stephen or
17 Lindsey did.
- 18 Q. Okay. And as part of this process, was it left in the
19 hands of PIRC that they would form a view regarding
20 whether the expert was independent and could give an
21 opinion that was not biased in any way and was
22 impartial?
- 23 A. I regarded that as part of the process when
24 the Commissioner made a recommendation to the
25 Lord Advocate in respect of the experts that they had

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1 identified that they considered would be of assistance,
2 yes.

3 Q. Did you think that that was clear to PIRC that you
4 expected that they would check that these were experts
5 who could give an independent opinion?

6 A. I would be surprised if they weren't aware of the
7 importance of selecting appropriate experts that were --
8 that wouldn't be readily criticised from whatever
9 particular point of view.

10 Q. So your expectation was that PIRC would consider that as
11 part of the process?

12 A. I certainly didn't expect that PIRC or the Commissioner
13 would be recommending experts to the Lord Advocate that
14 they considered were either compromised or unsuitable,
15 yes.

16 Q. Did you assure yourself that none of the experts put
17 forward by PIRC were and did you reassure yourself that
18 they were independent and they weren't compromised in
19 some way?

20 A. What I did and what I think others would do would be
21 they would look over the materials that were submitted
22 by PIRC, they would look over the CV, and they would
23 look at the history and the experience that the expert
24 had and look at things like, you know, academic
25 publications that they contributed to, memberships of

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1 society, but also whether they had given evidence
2 elsewhere in respect of -- in respect of matters which
3 were relevant to the particular issue that they were
4 going to be asked about.

5 Q. Now, not all CVs will mention possible conflicts or
6 issues where they have given evidence before, was that
7 something you expected PIRC to look into before they
8 submitted an expert and recommended it to Lord Advocate
9 or was that a task that you carried out yourself?

10 A. I looked and considered the CVs of those experts who
11 were instructed at the initial -- the initial stages
12 shortly following the first PIRC report, as did others.
13 I think for all other experts that the CVs were shared
14 with the family. That's my recollection that some of
15 the others -- certainly some of the others were shared
16 with the family and there was a request for input in
17 relation to those because, as the Inquiry will be aware,
18 there was some disquiet and concern about some of the
19 experts that had been identified.

20 Q. We'll come on to some concerns. But in terms of the --
21 this process that -- that was entered into between PIRC
22 and crown about the -- identifying the experts and
23 obtaining their CVs, was it the task of PIRC to consider
24 things like conflicts or independence or was it going to
25 be the task of the crown or are you now saying it was

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- 1 actually left to the family to raise issues?
- 2 A. I don't want to suggest it was up to the family to raise
3 issues, but that process was undertaken. The
4 responsibility would rest at all times I think with the
5 investigative agency, but in relation to those initial
6 experts, I would say that the -- that it would be --
7 that it was not considered conceivable that the PIRC
8 would put forward experts that would be likely to be
9 compromised and, to that extent, the fact
10 that the Commissioner was suggesting experts at that
11 stage to the Lord Advocate and to others was something
12 that -- was something that was relied upon.
- 13 Q. Right. Did you, as this process was entered into, say
14 to PIRC, or anyone from PIRC, "I want you to check that
15 there were no conflicts with any of the experts that
16 you're sending to the Lord Advocate"?
- 17 A. I don't recollect any such specific direction to PIRC.
18 That is not something that I do recollect.
- 19 Q. And do you remember saying to PIRC or anyone from PIRC,
20 "I want you to check that none of the experts you
21 recommend to the Lord Advocate have been criticised by
22 sheriffs or judges or judges down south, magistrates in
23 any cases"?
- 24 A. No, there was no specific direction to that extent, no.
- 25 Q. Did you expect PIRC to do that check?

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- 1 A. I expected that -- I -- I expected that PIRC would not
2 put forward any experts with whom there was a -- there
3 was a cloud hanging over them or that were likely to
4 attract significant criticism.
- 5 Q. And do you have any thoughts about how you expected PIRC
6 to do that, to see whether there were any clouds hanging
7 over any -- any of the experts they were trying to
8 identify?
- 9 A. That might be quite a challenging thing to do at the
10 stage of instruction because you -- in the selection of
11 an expert you are relying on the fact that to some
12 extent they are experts, they put themselves forwards as
13 experts, there can be consultation with a book of
14 experts and all that will do is set out who claims
15 expertise in those areas, but that's a different
16 consideration. Unless there was -- there was something
17 overt and somebody had been discredited and that that
18 was something that was -- that was obvious, then that
19 might not be an easy -- an easy task to undertake.
- 20 Q. We have heard evidence that the PIRC approached bodies
21 such as the College of Policing to look at whether there
22 were experts or lists of experts, suitable experts, who
23 they could maybe identify. Is that the type of approach
24 that Crown Office staff would have taken if they were
25 looking for experts?

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1 A. From my experience the crown would adopt a similar
2 approach in relation to the identification of an expert.
3 If you're completely at a loss as to how -- as to
4 what -- how to identify an expert, you would go to a
5 directory of experts and start the process from that.

6 Having said that, in relation to this particular
7 case, the crown expert, Professor Freemont, that expert
8 was identified because of previous experience in a case
9 so that was another avenue whereby you could identify an
10 expert. As I recollect it at least, I think it was
11 Professor Mary Sheppard who was approached. My
12 recollection was that she was suggested by Dave Green in
13 relation to that. In relation to Professor Eddleston,
14 I think that he had been involved in some crown inquiry
15 before and was approached because he appeared to possess
16 expertise.

17 As I say, one of the critical is do they appear to
18 possess the necessary expertise to comment on the issues
19 that you want to ask them about and that is -- to some
20 extent that is your first consideration in relation to
21 the instruction of an expert.

22 Q. Certainly in terms of Crown Office and the ability of
23 staff within Crown Office to identify a suitable expert,
24 you could rely on the head of SFIU, you could rely on
25 prosecutors who had maybe taken evidence from good

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1 experts, you could rely on the staff in Crown Office who
2 have built up a body of experience of instructing
3 experts, testing them out at trials and such like?

4 A. Yes.

5 Q. Obviously PIRC are not in the position of the
6 legally-qualified members of staff in Crown Office. Did
7 you think that they would have equal access to advice
8 and assistance in relation to instructing an expert?

9 A. Well, as I've said earlier on, in hindsight and looking
10 back, there was never any suggestion by PIRC that they
11 were struggling or would have difficulty in doing that.
12 That didn't surprise me because of the range of
13 experience and in particular experience that
14 the Commissioner had had in our organisation and also in
15 relation to investigating criminal allegations against
16 the police. So I have to say that that wasn't really a
17 consideration that PIRC were not in a position to do
18 that and, as I say, my recollection is that they did
19 undertake that and engaged with senior people at
20 Crown Office in doing that and in producing suggestions
21 and a briefing in relation to experts.

22 Q. Given we have heard that PIRC had limited experience in
23 instructing medical experts and we've also heard
24 evidence they didn't have any training in instructing
25 experts and given they may not have been in as good a

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1 position as Crown Office staff were in identify experts,
2 looking back now with hindsight, which is a wonderful
3 thing, do you think that perhaps it would have been
4 better if crown had taken on the role of instructing --
5 of identifying experts itself or have provided more
6 guidance in support to PIRC investigators in that task?

7 A. I think with hindsight there is a benefit in including
8 as many considerations in respect of that as possible.
9 That would be difficult to gainsay. There is also --
10 I think in learning from this particular experience
11 there is also advantage in including the -- the family
12 or the solicitor representing the family of the deceased
13 in relation to those. That's not to suggest that
14 they've got a veto or a right not to approve, but
15 whether there is any comment. Because in relation to
16 some aspects, and I'm talking quite generally, there can
17 be, you know, some academics that disagree very strongly
18 with other academics on whatever -- in whatever field,
19 but that includes the medical field, and that's not to
20 say that one is inexpert. It is just that they do
21 disagree in respect of that and I think that the more
22 information you might have in relation to that is of
23 benefit so that would be my comment in respect of that.

24 Q. Right, thank you.

25 I'm conscious of the time. Would that be an

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