

Transcript of the Sheku Bayoh Inquiry

Wednesday, 24 April 2024

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(10.02 am)

LORD BRACADALE: Good morning, Mr Logue. Ms Grahame.

Evidence of JOHN LOGUE (continued)

Examination-in-chief by MS GRAHAME

MS GRAHAME: Thank you very much. Good morning.

A. Good morning.

Q. Yesterday, as we were concluding our discussion at the end of the day, we had turned to paragraph 38 of your response, SBPI 00454.

A. Yes.

Q. And we'd look at the first section of that paragraph, here we are, where it talked about the traditional approach to engaging with families in death investigations and how it has evolved since you joined Crown Office and part of that was the recognition of Article 2 and the need to engage with families and you had just finished your evidence and you were talking about Article 2 is a legal requirement and requires the crown to engage with families but you said:

"I think there probably is still some way for us to go to be as transparent as possible. I think there is still a traditional conservatism about the sharing of information simply because there is a concern that that may somehow put an investigation at risk and I think the

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1 organisation is still working to -- I don't think we've
2 yet reached the point that we will get to in terms of
3 transparency. I think there is still work for us to do
4 on that."

5 And I was interested in your thoughts on the work
6 that you plan to do in relation to engaging with
7 families and how you intend to improve that in the
8 future?

9 A. Yes. I'd be very happy to explain some of that.

10 I think in covering the answer that I gave last night in
11 talking about the Article 2 issue I don't think I
12 probably described very clearly that beyond the
13 Article 2 aspect of this, my personal view is that it is
14 widely accepted now within the organisation that it just
15 simply is the right thing to do. And the challenge
16 facing us is that on a case-by-case basis we will almost
17 in every case have possession of very, very sensitive
18 information and it is sometimes not easy to make a
19 decision based on guidance and experience as to which
20 information should be shared and should not be shared
21 and that is something that we continue to work on.

22 And so in terms of looking ahead to the work that we
23 were doing, one aspect of that at the moment is that we
24 are undertaking a review of what I described yesterday
25 as our Victim Information and Advice Service. So we are

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1 looking at the way in which we provide that service, the
2 underlying principles, as well as some of the more
3 practical procedural elements of how the communication
4 with victims and bereaved relatives take place so it's a
5 wide ranging review.

6 Beyond that, the current Lord Advocate attaches the
7 highest priority to establishing effective communication
8 with victims and bereaved relatives and she has made it
9 clear that, as Lord Advocate, that is a priority for us
10 as prosecution and death investigation service. And so
11 beyond the review programme that I've spoken about, we
12 are generally examining all aspects of our work to find
13 ways in which we can enhance the information we provide,
14 improve the way in which we provide it and ensure that
15 it is as consistent as we possibly can make it in order
16 to give effect to the current Lord Advocate's personal
17 priority.

18 I have to say she demonstrates that on a personal
19 level. I have been with her when she has met with
20 bereaved relatives and she is very clear that as an
21 organisation we should seek to provide as much
22 information as it is possible to do and so she very much
23 leads by example in relation to that and what we're
24 doing as an organisation now is trying to give effect
25 that that as widely and as consistently as possible.

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1 Q. And the review that's underway at the moment, how long
2 do you anticipate that will take?

3 A. That review has reached an important point in the last
4 month or so and we've extended that. We anticipate that
5 will take, I think, at least another year to reach its
6 conclusion. That doesn't stop us to make improvements
7 as we continue. We're not waiting until the end of
8 that.

9 There are other aspects of our work which drive our
10 desire to improve communication with bereaved relatives
11 and victims. Just last week, the Inspectorate of
12 Prosecution published a report in relation to domestic
13 abuse and was critical of our work in the context of
14 domestic abuse and so there will be a body of work now
15 put in place, as a matter of urgency, to accept her
16 recommendations and implement changes to deal with that.

17 A member of the Crown Counsel team is currently
18 undertaking a review of sexual offences and the way in
19 which they're prosecuted and that I have no doubt --
20 although it is not concluded and I have not seen it yet,
21 I have no doubt that will lead to similar
22 recommendations about how we can improve our work to
23 communicate with victims.

24 I suppose the final point I would add is that we
25 know from the information we get from victims or

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1 bereaved relatives, we monitor complaints, for example,
2 we receive correspondence from politicians who speak to
3 the constituents who pass on information on behalf of
4 their constituents and I would say that it is clear to
5 us that victims and bereaved relatives being unhappy
6 with the amount of communication, the way it's
7 communicated is I think the most frequent issue that we
8 face in terms of feedback which we're given about the
9 quality of our work, so that also drives it to be a high
10 priority for us.

11 Q. So you're listening to complaints and comments being
12 made by families, bereaved families, and victims
13 themselves?

14 A. Very much, from a wide range of sources, and although I
15 have spoken about that wide range of work that's
16 underway, I should also say I do see examples of people
17 providing positive feedback as well and complimenting
18 individuals who they have worked with, be they
19 prosecutors or staff who provide the victim information
20 and advice service but it's -- that's not a -- we're not
21 in any way complacent in simply saying we're getting
22 some positive feedback and therefore we're achieving
23 what we want to achieve. It's about learning from that
24 and trying to make that as widespread and consistent as
25 possible.

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1 Q. Thank you. Let's go back to paragraph 38 then. I think
2 we had reached the -- do you see the line that says
3 "judgment about what was needed to meet the family's
4 needs"? I think we had got to that part. It's around
5 halfway down the screen.

6 A. Yes.

7 Q. The next section says:

8 "Although I was not involved in discussions with
9 them or their solicitor, my understanding at the time
10 was that they wanted to instruct their own experts."

11 This relates to Mr Bayoh's family?

12 A. Yes.

13 Q. "This in itself is unusual in death investigations and
14 seemed to me to be a reason to justify a broader
15 approach to the provision of information in a way which
16 would not affect the integrity of the investigation."

17 I'm interested in that part of this paragraph.
18 Obviously you say you weren't directly involved in
19 discussions, but you were aware that they wanted to
20 instruct their own experts and I think earlier in your
21 evidence you did talk about, and we certainly heard
22 other evidence, that Mr Anwar had indicated that they
23 would like to instruct their own expert.

24 You say it's unusual in death investigations. Why
25 is it unusual in death investigations? Do you know why?

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1 A. I think the simplest explanation I can give is that was
2 the first time I think I was ever aware of a bereaved
3 family asking to instruct their own experts, so I was
4 describing it as unusual in that sense. Now, that's not
5 to say that it had never happened before, but I think it
6 was the first time I was ever aware of it. I'm not
7 aware of it since, but, again, it may well have
8 happened, but it was not -- it was not a routine part of
9 every death investigation to, for example, invite
10 bereaved relatives to consider instructing their own
11 experts.

12 Q. Right. And you said:

13 "It seemed to me to be a reason to justify a broader
14 approach to the provision of information."

15 Can you help us understand what you mean by that?

16 A. Yes, my recollection is that in order to assist with
17 that we recognised that we would need to provide, for
18 example, perhaps more detailed information about the
19 postmortem at a much earlier stage than we might
20 otherwise have done. We would routinely in death
21 investigations share information about the postmortem,
22 for example, including a copy of the postmortem report.
23 We would try to do that in as sensitive a way as
24 possible, but it was clear that much more detailed
25 information would need to be provided at an earlier

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1 stage around the forensic examination, postmortem
2 pathology, and I think, I could be wrong, but I think as
3 the investigation progressed that expanded beyond the
4 forensic pathology and forensic evidence to also include
5 expert witness who were required to look at issues of,
6 for example, of police restraint.

7 Q. And having experienced this with the family for
8 Mr Bayoh, has that given you pause to reflect on whether
9 that's something you would roll out on a broader basis
10 to give other families more disclosure?

11 A. It was certainly something that I don't think any of us
12 at the time thought was incorrect or improper in any
13 way. It was simply regarded as being unusual. I can't
14 say that in every single investigation that it would be
15 something that every bereaved relative -- set of
16 bereaved relatives would want to do, but I have no issue
17 in principle with it being done and if there's a way in
18 which we can facilitate that or support it, then I would
19 be very happy to look at that.

20 Q. And do you envisage this being the position, the more
21 expansive disclosure, if you like, only if the family
22 wish to instruct their own experts or would you consider
23 it even if they didn't wish to instruct their own
24 experts?

25 A. I think the answer to that I would rely on the principle

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1 I was trying to describe yesterday that we would try to
2 meet the needs of individual bereaved relatives on a
3 case-by-case basis and that would really be the guiding
4 principle. And so some bereaved relatives may not want
5 as much information. I have experience in other
6 investigations where there was a strong sense that they
7 did not perhaps want immediate contact from the crown in
8 the very early days in the way that Mr Bayoh's family
9 did and I have had experience in some cases where
10 families felt that was intrusive to have that early
11 contact.

12 So I think my own experience tells me that you
13 really have to judge it on a case-by-case basis and try
14 to meet the individual needs of bereaved relatives in
15 each case. The important thing from your point of view
16 would not be to approach that understanding with any
17 preconceptions or limitations.

18 Q. And is that the approach that is taken in Crown Office
19 now, to treat each family as according to their own
20 needs?

21 A. So there are a wide range of death investigations and,
22 as a general principle, that would be -- that is my
23 understanding of how we consider and implement in
24 particular the procedural aspects of Article 2 and there
25 is very detailed guidance which has been prepared in

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1 relation to Article 2 within the SFIU team that we
2 talked about yesterday. So they have prepared guidance
3 on what Article 2 means for death investigations and
4 they have for example different -- difference pieces of
5 guidance for different types of investigations so for
6 example, death investigations involving the death of a
7 child or death investigations involving a death in
8 custody. But I'm confident in saying at the heart of
9 that there is a clear understanding in the team that
10 meeting the needs of the family is an important part of
11 the investigation.

12 Q. And the Article 2 guidance that's been prepared by SFIU,
13 has that been rolled out beyond the four walls of SFIU
14 to other teams such as CAAPD?

15 A. I couldn't say whether it's been shared with CAAPD, but
16 one of the consequences of moving, as I described
17 yesterday, from a model where investigations were
18 carried out in local procurator fiscal's offices and
19 there was a need therefore to have standard guidance
20 that was available to the whole service on every aspect
21 of our work, because anything could arise in any office
22 at any moment.

23 Now that we have dedicated teams, that has changed.
24 I think the nature of our guidance (the guidance is now
25 more specific, in particular for the specialist teams.

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1 They will develop and build their own guidance and part
2 of doing that is cross-checking, for example, with our
3 policy team and with other operational colleagues in the
4 organisation as they do it. So I know, for example, the
5 guidance I looked at in relation to SFIU was on our
6 knowledge bank that you were asking about yesterday and
7 to that extent therefore it's available for anyone in
8 the organisation to find and it can be found by
9 searching in relation to Article 2 or by searching in
10 relation to SFIU. There would be a number of ways in
11 which you can find it so I don't think it's guidance
12 that would be restricted or unavailable to other teams.

13 Q. And when was that guidance prepared?

14 A. The particular guidance I was looking at recently
15 I think was prepared in the last few years, so it's
16 perhaps two or three years old.

17 Q. So after 2015?

18 A. I think so, yes, yes.

19 Q. You've mentioned Article 2, is there similar guidance
20 that's available in relation to Article 14?

21 A. No, there isn't and that's one of the things I'm
22 reflecting on as a result of my involvement in
23 the Inquiry is the extent to which we need to consider
24 other issues, particularly Article 14.

25 What I should say is that very extensive guidance

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1 was introduced by the service with the incorporation of
2 the Convention in 1999. And mandatory training was
3 delivered to all prosecutors, detailed guidance was
4 provided both in hard copy and then ultimately available
5 digitally. That guidance is no longer available on our
6 knowledge bank because I think in developing our
7 knowledge bank and moving to a point where
8 the Convention had been incorporated for such a long
9 time, guidance which was prepared for a number of people
10 who had no previous real understanding of the Convention
11 and had to adapt it to it I think may have been -- it's
12 not available on our knowledge bank and I can't explain
13 why, but I'm making an assumption that in upgrading, as
14 we did a few years ago, a decision was perhaps taken
15 that that guidance from 1999 perhaps was out of date and
16 needed to be removed.

17 But on a general point, guidance on ECHR compliance
18 is available across the organisation. It features in
19 the training for new prosecutors. It features heavily
20 in relation to the work of the appeals unit and so it's
21 more mainstream, I think, rather than having dedicated
22 guidance about the incorporation of the Convention,
23 which was the previous guidance. The reason I'm
24 mentioning that is I would need to check, but I think
25 that may have still been available in 2015 because it

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1 was routinely available to the whole organisation for
2 many years, but would need to double-check on that to be
3 absolutely sure.

4 Q. Right. Thank. Just to be clear, now is there guidance
5 available if someone is seeking guidance, not just on
6 Article 2, but Article 14, would that be available in
7 the knowledge bank?

8 A. So specific guidance in relation to Article 14 in our
9 work I don't think is part of our knowledge bank.
10 Article 14 and legal material is available to
11 prosecutors in the organisation. Every prosecutor has
12 access to the LINETS network which is an online legal
13 database and therefore I would expect prosecutors in the
14 organisation to be able to access research and keep
15 themselves up to date in relation to legal developments
16 through Westlaw, through that portal. So that's another
17 source of information which is available.

18 But specific COPFS guidance in relation to
19 Article 14 I don't think we have that in our guidance at
20 the moment. We do have a large body of guidance in
21 relation to our qualities duties, but I don't think that
22 has a specific section in relation to Article 14 and how
23 that impacts on our operational work.

24 Q. So for a precognoscer, for a depute who is involved in a
25 crown investigation, into the death of someone like

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1 Mr Bayoh, a death in custody, where would they now look
2 to get guidance about how to make sure that
3 investigation was not just Article 2 compliant, but
4 Article 14 compliant?

5 A. Well, I would them to expect to be accessing -- they
6 would be part of the SFIU team and I would expect them
7 to be able to access the specific guidance I referred to
8 earlier. There is more general guidance available. We
9 have other key documents in our guidance and my view is
10 that our ECHR guidance is now mainstream throughout
11 those, rather than stand-alone guidance. So for
12 example, there's a Precognoscer's Handbook which is a
13 source of guidance for case preparers and people
14 carrying out precognitions and I would expect that,
15 therefore, to contain mainstream guidance in relation to
16 Convention duties.

17 Q. In relation to SFIU, will they always now deal with
18 deaths in custody? I think you talked about a specific
19 unit.

20 A. Yes, as time has passed, having created a specialist
21 team called SFIU, we have learned that actually within
22 that broad specialism of death investigations there has
23 been a need to create an even more specialist team, so
24 we now have a dedicated team that deals with deaths in
25 custody and that's part of the later stage SFIU team but

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- 1 they focus on deaths in custody.
- 2 Q. And they've recently prepared Article 2 guidance that's
3 available to that team in SFIU?
- 4 A. Within SFIU there is a version of the Article 2 guidance
5 which relates to deaths in custody, yes.
- 6 Q. And in relation to Article 14, I think a moment ago you
7 said you were reflecting on whether that should perhaps
8 also be included?
- 9 A. Yes, that's correct.
- 10 Q. Right, thank you. Going back to paragraph 38, you then
11 turn to agreeing with Mr McSporran. We've heard he was
12 the lead investigator with PIRC:
- 13 "... to the extent this made the coordination with
14 family liaison between different organisations more
15 important and potentially more challenging."
- 16 And I'm interested in any thoughts or reflection you
17 had. We've heard there were Police Scotland's FLOs,
18 there were PIRC FLOs. You told us yesterday about
19 Crown Office and VIAS. Can you talk about the sort of
20 the challenges and how those challenges have been
21 addressed?
- 22 A. Yes. They -- what I've described at the beginning of
23 that paragraph and what you asked me about yesterday as
24 the traditional approach, you might describe that as
25 being a linear approach to an investigation where one

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1 organisation is taking the lead with the contact with
2 the family at a particular time because it relates to
3 that stage of investigation.

4 In the circumstances I've described to you a few
5 moments ago where we, for example, see the need to
6 provide more detailed information direct to a family,
7 then that brings us into direct contact in this case
8 with the solicitor acting on behalf of the family and so
9 therefore you have the family and and their solicitor
10 engaging with different organisations and that's what I
11 meant what I said it makes the coordination more
12 important. That places a responsibility on all of the
13 organisations who are in contact with the family to
14 coordinate that and to understand what each other is
15 doing and to make sure that we are not creating a
16 situation where we're causing any confusion for the
17 family and that's what my reference to potentially more
18 challenging is describing.

19 In terms of what we have done about that, the answer
20 to that is simply good working relationships right from
21 the very beginning and clarity about the purpose of each
22 person's role and the -- who will be engaging with the
23 family and sharing that information.

24 Q. So from what you've said, you place some emphasis on
25 coordination between different organisations. It's --

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1 to understand, it's not your position that it should be
2 the responsibility of someone else?

3 A. No, I think it would be very difficult, for example --
4 if we take what I've described in relation to the early
5 days of this investigation, it would be very difficult
6 if we felt the right thing to do was to share detailed
7 information about postmortem or our arrangements on
8 instructing experts. It would be very difficult, I
9 think, for us to pass that to another organisation and
10 then expect them to pass it on to the family. That
11 introduces scope for misunderstandings,
12 miscommunications, passing information through another
13 party. So I think the better course of action is for
14 the relevant organisation to conduct its own
15 communication but to bear in mind that responsibility of
16 coordination and clarity.

17 Q. Thank you. And then moving on, if we could move up
18 the page, we see:

19 "Race was a factor in the investigation in my view
20 only to the extent that it was known and understood that
21 the developing understanding of institutional racism and
22 previous examples of failures to meet the needs of
23 members ethnic minority communities in investigations in
24 Scotland and in the UK meant that it was an important
25 objective of that investigation to maintain the

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1 confidence of Mr Bayoh's family in its thoroughness and
2 independence. Meeting their needs as individuals was a
3 justifiable basis of doing things differently."

4 I wonder if you could expand on that part of
5 paragraph 38. Was your view that race was limited to
6 the significance of engaging with the family to maintain
7 their confidence?

8 A. I think from the point of view of our engagement with
9 the family that that was where there was an intersection
10 between the question of race and that communication with
11 the family. I think it was also going to be a critical
12 element of the investigation to understand the
13 circumstances in which Mr Bayoh died and whether race
14 was a factor in those.

15 So I think there was another element that I don't
16 think -- I think my answer to this paragraph is really
17 focused on communication with the family, but I think
18 there's a broader element to race and I'm simply here
19 trying to describe the impact of that on the confidence
20 of Mr Bayoh's family in the investigation.

21 Q. So the Chair is not to understand this part of your
22 statement as saying race is excluded from any other
23 consideration, but simply that it's relevant in relation
24 to engagement with the family and their confidence?

25 A. Yes, of course, yes, absolutely.

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1 Q. Thank you. And can you explain to us what your
2 understanding was of the significance of race to the
3 investigation as a whole, not just specifically in
4 relation to your dealings with the family?

5 A. I can only do that in relation to my early involvement
6 in the first few days at a point when it was not clear
7 what had happened, but given the circumstances, it was
8 obvious to me when I was first advised that a black man
9 had died early in the hours of Sunday morning in the
10 course of being restrained by a number of police
11 officers. It was clear to me that this was an
12 investigation which would need to carefully consider the
13 element of race in what had happened.

14 I don't remember the details but I have a -- I have
15 a memory that as I was being told about this, and I
16 can't remember -- as I said yesterday, I can't remember.
17 I think I was called to update me that this had
18 happened. I have a clear memory that I immediately was
19 thinking of there had been a recent incident in the
20 United States where a young black man had been shot
21 I think and killed by police officers and I mention that
22 because the issue of the confidence of minority ethnic
23 communities in policing was a high profile international
24 issue and therefore that was an important piece of
25 context in understanding the nature of the investigation

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1 that we were dealing with, but also, as I have already
2 spoken about this morning, how that would impact on the
3 confidence of Mr Bayoh's family in the investigation.

4 Q. And you talk about the international context and the
5 importance of understanding that on 3 May 2015. When
6 did you become aware that in fact it was an issue of
7 concern for Mr Bayoh's family?

8 A. So I think in some of the documents you showed me
9 yesterday I think I refer to being aware I think perhaps
10 in the update I provided to the Lord Advocate on the
11 Tuesday morning. I think I had been advised that the --
12 there were difficulties in establishing effective
13 communication with the families because the families did
14 not -- I'm generalising here -- my impression was they
15 had -- they did not trust the police.

16 Mr Bayoh had died at a point where he was being
17 restrained by the police and that distrust of the police
18 seemed to me to extend to others in positions of
19 authority who had responsibility for the investigation.
20 So that was my general understanding within those first
21 few days.

22 Q. And you say the Tuesday, would that be Tuesday, 5th?

23 A. Yes. I think that was the email that you showed me
24 yesterday sent on about half past 8 on the morning of
25 Tuesday, 5th.

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1 Q. Yes, that's correct.

2 Can I ask you about some other evidence that we've
3 heard. We've heard about the approach to race that was
4 taken in -- specifically in relation to the
5 investigation into Mr Bayoh's death and we've heard from
6 Les Brown who was the head of CAAPD in this regard.

7 Now, I don't have it on the play list for today so
8 it won't come on to the screen, but I asked for a hard
9 copy of a statement from Les Brown to be put in your
10 folder and it's SBPI 00419 for those listening behind
11 me, but I'm going to read something out to you and it's
12 about what we heard from Les Brown about an incremental
13 strategy that was adopted and I would like to then ask
14 you for some comments on that.

15 So you'll see paragraph 105 of the statement which
16 is probably on page 2 of the hard copy in front of you:

17 "A key element of the incremental strategy approved
18 by the Lord Advocate was to separate out and resolve the
19 issue of potential criminality and to get to a point
20 where Crown Counsel could take a decision in this regard
21 with the necessary confidence, thus permitting the
22 investigation to move forward to other areas in
23 anticipation of an Inquiry whose forum had yet to be
24 determined. It had been hoped initially that the
25 necessary further inquiries could be completed

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1 relatively quickly."

2 So this was described as an incremental strategy and
3 during his evidence, Les Brown explained to the Chair,
4 who asked him to give a little more information about
5 this concept of an incremental approach, and he said:

6 "If we had moved on post that decision, the
7 criminality decision, we would be looking at the wider
8 issues that could be explored at a fatal accident
9 inquiry and I was of the view that that could include
10 factors such as race and exploration with the officers
11 with their considerations so wider than that, so
12 anything relevant to a fatal accident inquiry.

13 "In essence what we were doing here was trying to
14 reach as quickly as possible a stage where Crown Counsel
15 were able to exclude or otherwise criminality and then
16 allow the wider investigation to move forward in
17 relation to issues that were considered relevant to a
18 fatal accident inquiry."

19 And on further questioning he explained that the
20 further issues that would be looked at later would be
21 race issues.

22 So this incremental approach or this incremental
23 strategy appeared to be very much focusing primarily on
24 criminality and we've heard from Fiona Carnan, the
25 precognoscer, that her approach to the analysis was to

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1 seek to identify criminality and the plan was that once
2 a decision had been taken by Crown Counsel on that issue
3 that later, at some point further down the road, then
4 issue of race would be looked at.

5 I'm interested in any thoughts that you have in
6 terms of policy or otherwise where that type of
7 incremental strategy, which separates out criminality
8 and leaves race to a later stage, is something that you
9 are aware of being adopted in Crown Office?

10 A. My -- so in terms of -- in terms of policy as you
11 describe it, my view of the normal approach in an
12 investigation which is complex like this and raises a
13 number of questions is that there is a need to progress
14 through the investigation in a way which deals with each
15 of the individual elements, but my own experience of
16 those is not -- I don't -- this is the first time I've
17 seen the reference to "an incremental strategy".
18 That's -- but I can offer you an interpretation of what
19 I think that is from my own experience, but I can't
20 speak from how it was done in relation to this
21 particular investigation.

22 But what I would expect to happen is that an
23 investigation would identify a number of issues which
24 needed to be considered and I said yesterday that it was
25 clear, I think, to all of us who were involved in those

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1 initial days that the question of criminality was an
2 immediate or was an obvious issue which would need to be
3 explored in the investigation and, in simple terms, was
4 an immediate priority. There may be wider issues which
5 relate to broader learning which could come out of a
6 fatal accident inquiry or an inquiry of this nature, but
7 the priority would be to reach a decision on the
8 criminal aspects as quickly as possible.

9 I would not expect that that would mean that those
10 individual elements would be isolated off from each
11 other and dealt with one at a time. The investigation
12 I would expect would have an understanding of all of
13 them, and be trying to make progress on all of them at
14 the same time as perhaps identifying particular
15 priorities, so I'm not -- I'm not aware of an
16 investigation where we would take a compartmentalised
17 approach and say, well, we're only going to look at this
18 and we're not going to look at anything else until we've
19 finished look at this. I think our approach as much as
20 possible is to progress the whole investigation.

21 One of the challenges we've found in recent years
22 has been that with creating the specialist units we may
23 find ourselves with an investigation perhaps where more
24 than one team is involved and therefore there needs to
25 be coordination. We have learned that it -- you may

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1 need to progress parallel investigations in two separate
2 teams at the same time, rather than allowing one team to
3 reach a conclusion before the other team then takes
4 over. That just simply builds in delay into the
5 process. So for example you wouldn't -- you wouldn't
6 want a team looking at a criminal investigation and no
7 one else dealing with the broader aspects that I've
8 referred to until that team had finished. You would try
9 to make -- make sure that there was sharing of
10 information and progress on all aspects at the same
11 time.

12 Q. So in terms of the approach that you're describing,
13 there's not a compartmentalisation where one thing is
14 dealt with and then a delay until a second thing is
15 dealt with but there is progress made -- a continuous
16 progress on every aspect?

17 A. Yes.

18 Q. So they're working -- I think the word you said was
19 they're working in parallel?

20 A. Yes.

21 Q. And in terms of two units, are they communicating with
22 each other to see if perhaps one team have discovered
23 something of assistance or useful and the other team
24 find out about it as well?

25 A. Yes, I would expect the teams to be in touch with each

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1 other, to be sharing information and to be assisting
2 each other so for example to illustrate we may have a
3 case where our health and safety team is investigating
4 it as a potential criminal matter because it appears to
5 relate to health and safety legislation and the other --
6 there may also be a broader death investigation which we
7 expect to lead to an FAI in due course. And so because
8 of those different elements of specialisations we may
9 have the same broad investigation, different aspects of
10 it dealt with by two different teams, but because they
11 sit in two different teams that doesn't prevent us a
12 single organisation doing all we can to make sure they
13 work together.

14 Q. So you're getting the benefit of this specialisation but
15 also ensuring that nothing is missed by either team?

16 A. Exactly, and that's -- that can be a challenge
17 sometimes, but that's the priority in -- in relying on a
18 strategy of specialisation.

19 Q. And in terms of thinking back to the five procedural
20 obligations under Article 2, you mentioned delay and
21 there will be a desire to avoid delay, for things to be
22 done as quickly as they can be. Does that also avoid
23 deferring or delaying looking at something that can be
24 significant?

25 A. Indeed, yes, that's correct.

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1 Q. And allows both sides of the investigation to proceed at
2 a reasonable pace?

3 A. That's correct.

4 Q. Thank you. Thank you very much. Can I ask you now
5 about some further paragraphs that you've given us in
6 your statement and the first of these is 104. You've
7 talked about your experience dealing with complaints of
8 criminal allegations against the police, but you can't
9 remember if racism was a factor in any of those
10 investigations or in any death investigations for which
11 you were responsible.

12 I think I may have touched on this yesterday
13 actually. On reflection, can you think of any actual
14 cases that you've dealt with where race was a factor and
15 looking primarily at criminal allegations against the
16 police?

17 A. Not in the context of criminal allegations of the
18 police. Overnight I reflected and I do remember, at the
19 point where I became the Procurator Fiscal in the east
20 of Scotland, and I was based in Edinburgh, there was a
21 homicide case in Edinburgh at the time where a young man
22 had been killed in Edinburgh and he was the member of a
23 minority ethnic community and had been killed as a
24 result of violence in the street, but that case did
25 not -- although there were issues there of confidence

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1 amongst the minority ethnic community in the
2 investigation, it was not a case that involved an
3 allegation of criminality on the part of the police.

4 Q. Was that Mr San?

5 A. Yes, that's correct.

6 Q. We've heard some evidence in the past about that
7 situation and that was a -- race was a factor in
8 relation to that?

9 A. So at the point where I became Procurator Fiscal for the
10 east of Scotland, I could be wrong, but I think the
11 High Court case may have concluded by that stage or was
12 just about to take place, so I took up post just at the
13 point where the case was coming to trial or had reached
14 a conclusion. I'm afraid my memory of it isn't
15 significant, but I do remember concerns on the part of
16 his family and in the wider community about the issue of
17 racial violence in Edinburgh.

18 Q. All right. Thank you. Can we look at paragraph 106.
19 We've obviously considered -- sorry, I should have said
20 105:

21 "Mr Bayoh's race was a factor to the extent that
22 COPFS had learned from its experience in the early 2000s
23 of the mistakes which were made in the investigation and
24 prosecutions connected to the death of Surjit Singh
25 Chhokar."

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1 And I think we briefly mentioned that yesterday, so
2 you have an awareness of Chhokar and you've said that
3 Crown Office learned from mistakes made in relation to
4 that case?

5 A. Yes.

6 Q. "Two reviews had been carried out and lessons had been
7 learned which led to a strong corporate commitment to
8 promoting equality, diversity and inclusion in all
9 aspects of our work, including our operational
10 activities."

11 Can you explain to us in relation to lessons learned
12 how that was implemented across the wider organisation?

13 A. Yes. I'll perhaps start by just explaining that my
14 recollection of the Chhokar case is from the perspective
15 of someone who had been in the organisation for a number
16 of years by that point. I was not directly involved in
17 the cases, but I therefore was very aware, as I think
18 everyone in the organisation was, of this very high
19 profile case and the reviews and the reviews -- there
20 were two reviews as I remember.

21 One looked at the manner in which the case had been
22 prosecuted and one considered the question of how the
23 organisation had treated Mr Chhokar's family and the
24 Lord Advocate at the time, Colin Boyd, personally led a
25 very significant piece of work across the organisation

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1 to make sure that the lessons from those reviews were
2 understood by all staff, because some of the messages
3 were very difficult to hear. As a member of staff in
4 the organisation, it was a very difficult time to hear
5 what had happened, to understand the consequences for
6 Mr Chhokar's family and to reflect on how you as an
7 individual and the organisation had worked in a way that
8 produced that outcome for his family and so it was
9 direct and individual for all of us.

10 My memory of it is it consisted in training and
11 issues equalities which I think we talked about
12 yesterday. The principal lesson I've always taken away
13 from it was the learning point that if you treat
14 everyone the same then you are not meeting people's
15 needs and you are not therefore -- by treating everyone
16 the same you create circumstances where people cannot
17 partake or cannot understand and their needs will not be
18 met by the investigation. And so that's been the
19 principal lesson I think that I have taken away from
20 that over a number of years.

21 It's still a case which is talked about in the
22 organisation. In my position I have spoken about the
23 importance of that case and the reviews which followed
24 to new staff who joined the organisation, because in our
25 induction training to this day we include an element of

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1 awareness raising of the importance of equality to the
2 work that we do that the -- how it is embedded into the
3 framework of the organisation.

4 As time progressed beyond the Chhokar investigation,
5 we also then adopted wider lessons, for example, from
6 the equalities legislation which was passed by the
7 UK Government and the Equalities Act and so a number of
8 that -- that has led to -- there are a number of
9 structural elements to this. So we have -- we have an
10 equalities board in the organisation which oversees the
11 work that we continue to do to this day. We have a
12 senior equalities champion who is responsible for
13 ensuring that there is an understanding -- the lessons
14 that we learned and the understanding in response to the
15 Chhokar reviews continue to be relevant and known about
16 within the organisation.

17 Q. Thank you. Following on it says:

18 "Speaking for my own personal decisions and actions,
19 I was conscious that black, Asian and ethnic minority
20 individuals may not have had confidence in the criminal
21 justice system because of previous mistakes, such as in
22 the Chhokar investigation."

23 I think that's what you mentioned earlier. You were
24 aware that there might be issues with the Bayoh family
25 not having confidence in the criminal justice system,

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1 for example.

2 A. Yes, and I think the other element I would add to that
3 on reflection is that their own personal lived
4 experience, prior to any involvement with the crown, may
5 also have caused them to have a lack of confidence in
6 authority and beyond their own individual experience, it
7 is frequent to see media reporting, for example, of
8 issues involving discrimination, be it individual or
9 constitutional, across the UK as well and so it
10 continues to be a high profile issue and something that
11 everyone is aware of.

12 Q. Thank you.

13 "It was therefore important that our engagement with
14 the Bayoh family should focus on building and
15 maintaining their confidence in the independence and
16 thoroughness of our investigation. I cannot recall a
17 particular decision in which this was a factor which led
18 me to a particular conclusion or action, but I was aware
19 of it throughout my involvement in the early stages of
20 the investigation."

21 So it was something that you were conscious of at
22 that time?

23 A. That's correct.

24 Q. But as I think you said yesterday, you were involved
25 between 3 and 7 May in this matter?

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1 A. Yes.

2 Q. Can we move on to 106:

3 "My view as described in my previous answer is that
4 COPFS had happened great progress since the early
5 2000s in learning and changing to reflect a better
6 understanding of equality, diversity and inclusion. My
7 experience was that any case in which the deceased was
8 not white would involve consideration of the factors
9 learned from the Chhokar inquiries."

10 And you have already told us about those factors.
11 Was it your expectation that all members of staff in
12 Crown Office would be in the same position as you and
13 remember learnt lessons from Chhokar and be able to
14 implement those lessons in their daily work?

15 A. So I think I can answer that question in relation to the
16 group of people with whom I was working in the early
17 days of this investigation and we were all at a
18 relatively senior position in the organisation with a
19 large amount of experience and I think I'm right in
20 saying that all of us were members of the organisation
21 at the time of the Chhokar case and I have no doubt that
22 all of us carried that with us and remembered the key
23 lessons from that.

24 The challenge in the organisation as time has moved
25 on has been to ensure that people joining the

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1 organisation understand our values, understand the
2 importance of equality and understand something of the
3 history of where we've come from and why we give this
4 priority.

5 Q. And in terms of the people you were working with at that
6 stage, can you tell us their names?

7 A. Yes, so I would start with the Lord Advocate, who was
8 Frank Mulholland at the time. He wasn't directly
9 involved in those first few days. I had detailed
10 discussions with Stephen McGowan. I don't remember
11 having personal discussions with Les Brown or with
12 David Green, but I was in email contact in particular
13 with David Green and there were others that -- I think
14 Bernard Ablett attended the postmortem on the Monday.

15 I don't remember if I had any particular discussions
16 with Lindsey Miller in those first few days, because I'm
17 not sure that in her role she had any direct involvement
18 in the investigation at that time. Most of them my
19 I think was with Stephen McGowan. I think I also would
20 of -- I can't remember whether I did it by email or had
21 a discussion, but I would have also briefed the crown
22 agent at the time, who was Catherine Dyer.

23 Q. Thank you. Can I go back, we can still see it on the
24 screen, to you say:

25 "It was important our engagement with the Bayoh

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1 family should focus on building and maintaining their
2 confidence in the investigation."

3 Can you explain to us how -- what your expectations
4 were and how you envisaged that building and maintaining
5 of confidence to be achieved?

6 A. It can be very challenging in general terms. You are in
7 contact with people who are suffering a bereavement and
8 dealing with the consequences of that and you are
9 therefore on top of that having to communicate with them
10 in relation to an official investigation, so it can be
11 very, very challenging and there is no simple,
12 I think -- there is no simple way that can be applied as
13 a template to every single case.

14 It to my mind is about trying to assess and
15 understand the right time to open the communication.
16 It's about the way in which the communication takes
17 place. My view is it should be as much personal as
18 possible. It's not the sort of relationship I think you
19 can just build up through documented communication.
20 There may be a need for some formality and some people
21 may prefer information to be given in writing, but my
22 working assumption would be that as much of the attempt
23 to build confidence should be done on a personal basis.

24 In some cases, families have legal representatives
25 and that introduces a different element into the

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1 relationship and they prefer contact to come through
2 their legal representative and so you therefore rely on
3 the professional relationship between yourself and any
4 lawyer acting on their behalf. So it can be done in a
5 number of different ways.

6 I should also say in relation to my description of
7 doing this and meeting the needs of the families that
8 can be your objective, but it's not something that --
9 you can do your very best to achieve it, but it's not
10 that you can guarantee. We could -- it is possible we
11 could do everything and there may be an aspect of a
12 death that someone feels they just simply -- they remain
13 unsatisfied with the investigation for some reason. I'm
14 talking in general terms here, not about in particular
15 investigation.

16 I would always want to understand that view and to
17 see if there is anything I could do about it, but
18 sometimes, unfortunately, there are cases, death
19 investigations in particular, where there may be nothing
20 more that we can do as part of our investigation, but
21 the bereaved relatives remain dissatisfied with the
22 outcome of the investigation as a whole.

23 Q. And would part of building and maintaining confidence
24 also include listening to the family and having regard
25 to issues that are of concern to them?

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1 A. Very much so, and I think that's -- an example of that
2 is what we talked about earlier this morning about the
3 provision of information. In this particular case,
4 there was a desire to instruct separate experts. It
5 seemed to me they did not want to rely on any experts
6 that the crown instructed, so that was an example
7 I think of the sort of listening and taking account of
8 that you've described.

9 Q. And would it also include, as you said, the family's
10 concerns about race and racial motivation, whether that
11 was a factor in the death? Is that the type of thing
12 you would want to have regard to as part of building and
13 maintaining the confidence of the family?

14 A. Yes.

15 Q. Thank you. First of all, can we look at COPFS 04923 and
16 this is an email that you sent to Les Brown on 6 May
17 2015. So COPFS 04923. And just to go towards the
18 bottom, if we can see where it starts, sometimes these
19 are quite complicated getting to the bottom of the
20 thread.

21 So you'll see initially there's an email from
22 Irene Scullion, who we have heard is from PIRC, to
23 Les Brown, head of CAAPD, regarding a query and talking
24 about productions. Then if we can move up, he
25 acknowledges that, and then Irene Scullion sends an

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1 email on 6 May 2015; do you see that?

2 A. Yes.

3 Q. She sends this to Les Brown:

4 "See attached press release for your consideration.
5 This is in response to a request from the media in
6 particular The Scotsman and a request if Crown Office is
7 content with this."

8 Moving up, a response from Les Brown on the same day
9 sent to the private secretary of the Lord Advocate and
10 you were cc'd into this email:

11 "Please see attached draft press release prepared by
12 PIRC for approval."

13 And Les Brown says:

14 "I would prefer that it simply specifies that
15 further forensic examination is being undertaken in an
16 attempt to ascertain the cause of death and that there
17 is ongoing liaison with COPFS and that the family of the
18 deceased are being fully informed on the progress of the
19 investigation."

20 And then if we can see the response to that. This
21 comes from you:

22 "Les, can you call me? I have a couple of questions
23 about contact with the family."

24 And if we can move up, you'll see this is your email
25 on the same day to Les Brown, various people copied in,

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1 and you say:

2 "Les, I've dropped the Lord Advocate out of this
3 just now. I would like to make some changes to the PIRC
4 line so that it reads as follows."

5 And then in a different font:

6 "Inquiries by the PIRC continue into the
7 circumstances leading to the death of Mr Bayoh on 3 May.
8 The postmortem examination has been carried out and
9 further specialist forensic examination continues in
10 order to identify the cause of his death.

11 "A meeting was held with the family and their
12 solicitor today and they have been updated with the
13 progress of the investigation. Liaison with the family
14 will continue. PIRC investigators are continuing with
15 house-to-house investigations in Hayfield Road.

16 "The response for information from the local
17 community has been heartening, but it is important that
18 anyone else with information about the incident which
19 occurred ... contact PIRC investigators."

20 And then if we can move back down to see the end of
21 that:

22 "Les, can you call me, I have a couple of questions
23 about contact with the family."

24 And if we can to the response from Stephen McGowan,
25 "call to AA fine". That will be Aamar Anwar?

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- 1 A. That's correct.
- 2 Q. And then if we can look to the top, please, email from
3 you to Stephen McGowan on 6 May 2015:
- 4 "Great, well done. He knows we are playing it
5 straight."
- 6 So that seems to be a reference to Mr Anwar --
- 7 A. Yes.
- 8 Q. -- and the call or the conversation that Mr McGowan has
9 had with Mr Anwar. Can I ask about the use of that
10 phrase "he knows we are playing it straight"; can you
11 expand on what you meant then?
- 12 A. Yes, I was asked about that in my statement and I
13 just -- I can't quite find the answer now, but I think
14 what I was trying to convey there was --
- 15 Q. It could be paragraph 69. Would it help if we put that
16 on the screen paragraph 69?
- 17 A. Yes, that's correct.
- 18 Q. I think you said you didn't recall the conversation at
19 that stage and I'm wondering if you have had an
20 opportunity to reflect on it. This is where you were
21 asked to comment on the email.
- 22 A. Yes, so I'm afraid I still don't recall any of the
23 detail about the phone call and if there was a phone
24 call, I was certainly asking Les Brown to call me to
25 discuss what was going to be said. But the particular

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1 terms that I've used there was in a sense I think my
2 view at that stage that the issues we've just spoken
3 about in terms of being able to build and maintain
4 confidence that from my understanding, and as I've said
5 I hadn't had any direct conversations with Mr Anwar
6 myself, from my understanding it appeared to me the
7 reference to the call being fine was an indication that
8 Mr Anwar understood that we were doing our best to
9 assist him in his responsibilities as solicitor for the
10 family and that there would be hopefully no question of
11 any distrust which the families might have towards
12 authority in general, as I have described it, that they
13 would see that we were doing our best to operate an
14 independent and thorough investigation.

15 Q. Right. And did you see that as an important aspect of
16 your engagement with the family to have a good working
17 relationship with Mr Anwar?

18 A. I did, and I was reflecting back to Stephen McGowan that
19 I thought that that was a positive outcome to the phone
20 call.

21 Q. Thank you. Can we look at paragraph 58 of your
22 statement since we have it on the screen, and this is
23 something noted about language. I think it's towards
24 the bottom. You'll see "I intervened to point out to
25 the officials"; do you see that?

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1 A. Yes, I do.

2 Q. "To point out to the officials who were involved in this
3 issue that the word 'Imam' appeared to me to be a
4 mistake, perhaps a spelling error on the part of the
5 author. My understanding of the Islamic faith was and
6 is limited, but I understood an Imam to be a faith
7 leader in a community and Imam to refer to an aspect of
8 the Islamic faith. On that basis, I wanted to ensure
9 that the error was acted upon by officials to ensure
10 that the Lord Advocate was aware of it and that it did
11 not feature in any subsequent communications."

12 Do you understand the importance of accurate
13 language?

14 A. I do and that was why I was making this point. I did
15 not want the what I regarded as spelling mistake to be
16 perpetrated or repeated by anyone and it came in the
17 context, I think if I remember correctly, that the
18 Lord Advocate was seeking to personally have a meeting,
19 if I remember correctly, brokered through our set-up by
20 with the assistance of a local MSP in the area and the
21 Lord Advocate was offering or responding to a suggestion
22 that he could have a meeting with members of the local
23 community, community representatives, and I had spotted
24 that there was what appeared to me on the face of it to
25 be a spelling mistake and I was concerned that that

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1 might, if it wasn't picked up, could be repeated in any
2 media communication or anything that was said by someone
3 else who would be supporting the Lord Advocate and that
4 that -- it would be a mistake and that would be very
5 unfortunate and could damage the confidence building I
6 described.

7 So although on one view it was a small point for me
8 to be pointing a spelling error in an email, I regarded
9 it as important that it should be corrected.

10 Q. And in light of what you said earlier about it's
11 important to deal with individuals and address their
12 specific needs and not to make assumptions that may not
13 meet their needs, can I ask, was it checked with
14 Mr Bayoh's family whether making contact with a
15 religious leader would be something that they would have
16 found helpful?

17 A. I don't remember whether there was any discussion with
18 the family through Mr Anwar or -- I can't help you with
19 that, I'm sorry.

20 Q. Right.

21 A. I just remember that it was -- I don't even know
22 actually whether the meeting took place or not. I
23 just -- this email exchange was about the possibility of
24 a meeting that was about to happen, so I would need to
25 either check records or you would need to speak to

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- 1 anyone who was there.
- 2 Q. Would it have been your expectation that that's
3 something that would have been checked with the family
4 or through Mr Anwar in relation to whether this would be
5 something the family would wish?
- 6 A. I think it would be -- it would be important to share
7 with the family that any wider attempt at addressing
8 wider community concerns, I think it would be helpful
9 and proper to share with the family that that would be
10 done.
- 11 Q. Thank you. Can I ask you finally about COPFS 05061,
12 which is an email dated 26 May, and I think you were
13 asked about this in answer -- your answer is at 54, but
14 if we go through this I'll -- I think this is -- no,
15 this is -- this is the one that we've just discussed.
16 Sorry, I don't need to go back over that. Could you
17 give me just one moment, please?
- 18 A. Of course.
- 19 Q. Thank you. Sorry, one last thing, to go back to
20 something that you have already spoken about, and that
21 relates to the incremental approach.
- 22 A. Yes.
- 23 Q. If the plan was that CAAPD and the head of CAAPD
24 Les Brown would have oversight of the investigation into
25 Mr Bayoh's death and if their intention was to focus

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1 primarily on criminality, what unit or department or
2 organised people in Crown Office would take forward
3 issues of race if that was to be progressed at the same
4 time, would that be SFIU or would it be someone else?

5 A. The -- to the extent that Mr Brown's team was
6 considering the question of criminality, the wider
7 issues of the investigation, all the aspects of the
8 investigation would have been with SFIU.

9 Q. All right. Thank you very much. I have no further
10 questions for this witness.

11 LORD BRACADALE: Thank you. Are there any rule 9
12 applications? Ms Mitchell. Mr Logue, would you make
13 withdrawing to the witness room, please, for a moment
14 while I hear a submission. Yes, Ms Mitchell.

15 Submissions by MS MITCHELL

16 MS MITCHELL: Just two issues, my Lord. One is the question
17 that was asked of the same witness yesterday: Is there
18 any review process to see whether or not the crown
19 complied with their duties as a public body at the time
20 of the death of Mr Bayoh? Again this witness explained
21 that he would expect people to keep up to date with the
22 law, to know it and to understand it, but it's just to
23 see whether or not there was an audit process and
24 whether or not he would consider that that would be a
25 thing the public body should do in these circumstances.

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1 The next issue is about the leaks in Crown Office.
2 The witness gave evidence yesterday as to where he
3 thought leaks or otherwise not leaks may have come from
4 and what I would like to put to this witness is that
5 over the past few years there have been a number of
6 leaks within Crown Office including, and I simply look
7 at a public document the BBC website, a Crown Office
8 employee was found guilty of breaching the Official
9 Secrets Act on 5 September 2014 in respect of I think it
10 was nine breaches of the Data Protection Act and perhaps
11 more recently also that --

12 LORD BRACADALE: Can I just check what you're saying here.

13 You said he was found guilty of breaching the Official
14 Secrets Act?

15 MS MITCHELL: Yes.

16 LORD BRACADALE: And that's separate from issues of data
17 protection, is it?

18 MS MITCHELL: Well, what I am reading from the -- I'm
19 reading from a website, if the Inquiry will allow me a
20 minute. The article reports that a Crown Office
21 employee has been found guilty of breaching the Official
22 Secrets Act and Data Protection Act by leaking
23 information about court cases and that person was found
24 guilty at Edinburgh Sheriff Court. I can name the
25 person but it doesn't seem relevant for the purposes.

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1 It is just highlighting that there have been breaches of
2 data protection and Crown Office employees giving
3 information albeit it doesn't actually identify who the
4 information exactly was given to.

5 LORD BRACADALE: Did the witness not say yesterday that in
6 fact he had experience of where employees had been
7 prosecuted and that he cited that as an example of how
8 they did seek to investigate and prosecute people if
9 they had material to do so?

10 MS MITCHELL: Yes, my Lord, but my question is: What
11 practices and procedures are put in place to ensure that
12 that doesn't happen? What appeared yesterday, my Lord,
13 was that if such a leak were to occur they would simply
14 check with the official -- the official routes that they
15 could, ie with telephones and computers, they wouldn't
16 go as far as taking statements unless they were
17 satisfied that something required them to do and even in
18 the circumstances that we have in this case, that didn't
19 meet whatever test it was to require them to do that so
20 the question is, what is there in Crown Office about
21 that that might give people guidance other than the fact
22 of course they shouldn't be breaking the law. Are there
23 any -- you know, are there any practices or procedures
24 around working out how one goes about those
25 investigations and what the test is to be?

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1 LORD BRACADALE: What was lacking in his evidence yesterday
2 that you would be filling in?

3 MS MITCHELL: Simply to ascertain whether or not there were
4 or are any practices or procedures that can be
5 implemented. It seemed that it was simply an ad hoc
6 approach that was taken to the internal investigation of
7 this matter. And the test as to when one moved from
8 interrogating the electronic items, which they were
9 allowed to, to asking people whether or not they had
10 been involved in giving any information to anybody
11 didn't seem to exist, it was just decided that it was
12 insufficient for the purposes but I wasn't able to
13 identify what the test was. Given the circumstances of
14 this case we have only a limited number of people
15 knowing about the offence -- knowing about the decision
16 itself, the timing of the decision, the detail supplied
17 about the Lord Advocate's decision-making process, ie
18 the two factors which were cited.

19 LORD BRACADALE: I would like to adjourn to consider the
20 submissions.

21 (11.16 am)

22 (A short break)

23 (11.41 am)

24 LORD BRACADALE: I shall allow Ms Mitchell to ask questions
25 on her first matter, but not on the second matter

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1 relating to leaks. I don't think that would assist
2 further. So we can have the witness back, please.

3 Mr Logue, Ms Mitchell, senior counsel for the
4 families of Sheku Bayoh, has a matter to ask you about.

5 A. Thank you.

6 Questions by MS MITCHELL

7 MS MITCHELL: Just one issue I would like to ask you about
8 and that's in relation to Article 2 and Article 14 and
9 you have explained to us as a body how Crown Office
10 tried to integrate human rights into its learning
11 processes and you would expect people to know and
12 understand these basic human rights and you said you
13 would expect people to keep up to date with perhaps
14 cases or law in that regard.

15 What I would like to ask you is at an institutional
16 level, was there anybody in charge of assessing or
17 auditing whether or not the crown was complying with its
18 duties as a body in respect of Article 2 and 14?

19 A. We complete a review in terms of all of our equalities
20 duties, which would include Convention rights
21 compliance, but specifically tailored towards the
22 Equalities Act and that's published every two years.
23 I don't think -- I don't think within that there is
24 specific focus on Article 2 and Article 14. I think it
25 is broadly framed in terms of the Equalities Act and the

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1 range of duties that applied to us, but I can't think of
2 anything else that we have that would match the
3 description that you're looking for.

4 Q. You spoke about learning lessons and you spoke about the
5 Chhokar Inquiry. Would having such a process in place,
6 a review of the crown's duties under that, on an ongoing
7 basis, on an annual basis, would something like that
8 assist in ascertaining whether or not the crown was
9 complying as a body and whether or not there would be
10 lessons to be learned going forward in respect of
11 whether or not it was complying with its duties?

12 A. I think because we have sought to mainstream both our
13 general equalities duties and also we have sought, as
14 far as we can, to make sure that Convention compliance
15 is embedded into all of our operational work, rather
16 than have one person review whether the entire
17 organisation with the complexity and the range of people
18 and the volume of work is complying with particular
19 Convention rights, I think we would rely on the leaders
20 in the individual parts of the organisation to identify
21 from the case work that they have control over whether
22 or not they were seeing any indications that there were
23 issues to do with Convention compliance. And that could
24 come through their own supervision of their teams and
25 the case work, it could come through comment from the

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1 Appeal Court, for example, in relation to any particular
2 case or it could come through supervision from our
3 inspectorate, or broader political interest in the
4 organisation. So I think -- I think because we've
5 mainstreamed our responsibilities, I think that's the
6 way we've chosen to deal with this, rather than ask one
7 individual to do the exercise that you're describing, if
8 that helps.

9 Q. Really what I'm asking more about is whether or not
10 there is any ability for outsiders or someone in
11 Crown Office themselves to assure themselves that
12 particular rights, particularly these rights that we're
13 talking about, but even in more general human rights,
14 are being complied with by the Crown Office?

15 A. Yes, I think I see the point and I think we rely in
16 terms of external assurance primarily on the work of the
17 inspectorate. Now, of the top of my head I can't -- the
18 inspectorate has been in existence in one form or
19 another for almost 20 years and, in fact, I think the
20 existence of the inspectorate, if I remember correctly,
21 was a specific recommendation from the Jandoo Inquiry.
22 That's why we set up an independent inspectorate which
23 was eventually legislated for. So I think that's the
24 primary method by which we would rely on external
25 assurance that we are performing our work effectively

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1 and complying with any obligations.

2 Q. And would it assist then if we take up your example of
3 asking the heads of all groups to provide, for example,
4 an assurance or documentation or an end of year document
5 to say here are the issues that have arisen in relation
6 to these things and put them forward for learning
7 purposes?

8 What I'm really thinking about is it shouldn't take
9 inquiries for the crown to reflect upon whether or not
10 it's obtempered its duties properly. So going forward
11 would there be a way of an institution having a more
12 reflective process to allow reflexion on how work has
13 been done, how it can be done better and to maintain an
14 institutional knowledge bank and history so that people
15 move or go different places you still have that
16 available to you?

17 A. Yes, no, I understand the point. I think -- I would
18 hope that it's not an organisation that waits for an
19 inquiry such as this in order to reflect and learn.
20 I think the process I have tried to describe whereby we
21 make sure that every senior leader has responsibility
22 for the effectiveness of their teams that requires
23 leaders to reflect on issues such as equality.

24 So, for example, we have a range of activities
25 across the organisation that maintain a very high

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1 profile of equalities priorities work. So I would
2 expect leaders therefore to be conscious of that as a
3 priority and Convention compliance, although I'm talking
4 equalities work, Convention compliance, particularly in
5 relation to Article 14, is I think part of that. And so
6 I think we would very happily consider anything else
7 that anyone would suggest that we can do to improve how
8 we do that beyond the mainstreaming that I have
9 described.

10 I would have a reluctance, and I've always had a
11 reluctance, to rely on something that involves -- and I
12 don't mean this to be critical in any way of the
13 suggestion, but something that relies on filling out a
14 particular form at a particular point of the year and
15 gathering forms together just simply to provide a record
16 of -- in my own experience is that's less than effective
17 in terms of building up the sort of assurance that
18 you're looking for in your question.

19 I think it's much more effective I think to make
20 sure that it's understood on a day-to-day basis that
21 managers have the responsibility. They're understood --
22 they're trusted by the organisation to act on anything
23 they see and to deal with it accordingly.

24 Q. Just one last question on that. So would you think that
25 it would be helpful if managers are acting in that way

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1 for there to be some way that they were able to record
2 their views on these issues so that there could be
3 reflection upon them, for example?

4 A. I can certainly have -- I'm certainly very happy to
5 think about that as a proposal and the best way of doing
6 that but --

7 Q. Just --

8 A. If I understand the question, what you're asking about
9 is how does the organisation gather information to show
10 that this has been done and what the lessons have been
11 learned and I think I'm happy to take that on board as
12 something else to reflect about in the way that I
13 mentioned this morning that I thought perhaps specific
14 guidance in relation to Article 14 might be something we
15 need to think about.

16 MS MITCHELL: No further questions.

17 Questions by LORD BRACADALE

18 LORD BRACADALE: Mr Logue, I wonder if you could help me in
19 relation to the last answer that you gave to Ms Grahame.
20 She asked if the plan was that CAAPD and the head of
21 CAAPD Les Brown would have oversight into the
22 investigation of Mr Bayoh's death and if their intention
23 was to focus primarily on criminality, what unit or
24 department or organised people in Crown Office would
25 take forward issues of race, if that was to be

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1 progressed at the same time? Would that be the SFIU or
2 would it be somebody else? And you said:

3 "To the extent that Mr Brown's team was considering
4 the criminality, all the wider aspects of the
5 investigation would have been with the SFIU."

6 Now, my understanding of the evidence of Mr Brown
7 was that was not the case, that was not happening, and
8 that the approach was that they would concentrate on
9 criminality and then come back after that, after a
10 decision was made, on the question of prosecution and
11 look at what he described as wider aspects in relation
12 to an FAI, including the issue of race.

13 Do I take it that you were not aware then that that
14 was the approach that was being taken?

15 A. No, because I was not involved in the investigation at
16 that stage and so I'm afraid I was offering a view
17 that -- what was a general view on what might happen in
18 terms of structuring the investigation, but I can see
19 that I spoke this morning about sometimes there is
20 challenge in having specialist teams that you have to
21 guard against the risk of an investigation becoming
22 fractured by being divided between different teams and
23 it may be in this case that a decision was taken to
24 avoid that that it was better that Mr Brown's team would
25 continue with the investigation.

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1 LORD BRACADALE: In relation specifically to the issue of
2 race, would you agree that in the circumstances of this
3 case the issue of race might have a bearing on the
4 question of criminality.

5 A. I would agree that you could not consider the question
6 of criminality without considering the question of race.

7 LORD BRACADALE: Yes. So to that end, would you be
8 expecting CAAPD to be investigating the issue of race as
9 part of their exercise of investigating criminality?

10 A. Insofar as it was relevant to the question that they
11 were dealing with. If they were dealing with it in a --
12 I talked earlier about the number of different issues in
13 that case. If they were dealing with the question of
14 criminality, I would expect them to consider the
15 question of race at that stage. There are other broader
16 questions of race, as it seems to me looking out from
17 the inside of the investigation, that would need to be
18 considered at a -- in looking at different issues in the
19 investigation but, yes, race was an issue that would
20 need to be considered at the criminal stage.

21 LORD BRACADALE: You would have to look at race in order to
22 ascertain whether there was any evidence that did have a
23 bearing on criminality relating to race.

24 A. Yes.

25 LORD BRACADALE: And would you see that as part of a

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1 thorough investigation of the kind that you referred to
2 earlier?

3 A. Yes.

4 LORD BRACADALE: And that a thorough investigation of that
5 kind would in turn inspire confidence in a family?

6 A. That would be the hope, yes.

7 LORD BRACADALE: Thank you. And thank you very much,
8 Mr Logue, for coming to give evidence to the Inquiry.
9 I'm very grateful for your time. I'm going to adjourn
10 now and you'll be free to go.

11 A. Thank you.

12 (The hearing was adjourned to 10.00 am on Thursday, 25 April

13 2024)

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