

STATEMENT GIVEN ON WEDNESDAY 17 JANUARY 2024

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1. At the time of the investigation, I was a member of the Crown Counsel team. I held the position of Assistant Principal Crown Counsel. In August 2016, following a request from Alex Prentice KC, who was at that time the Principal Crown Counsel, I was appointed the allocated Advocate Depute for the investigation. One of the duties of Crown Counsel is to assess and issue instructions in cases that may potentially proceed in the High Court. In large and complex cases an allocated Advocate Depute is often appointed at an early stage to provide high-level advice and direction and interim Crown Counsel's instructions (CCI) when required. I became an Advocate in 2008 and in 2011 I was appointed a Senior Advocate Depute. In 2015 I accepted the post of Assistant Principal Crown Counsel. In 2019 I was appointed Deputy Principal Crown Counsel and in February of 2022 Principal Crown Counsel. As Assistant Principal Crown Counsel, part of my role was deputising for the then Deputy Principal Crown Counsel and Principal Crown Counsel. My duties included conducting the most complex and sensitive High Court trials, preparing and presenting cases for the Appeal Court, providing CCI in particularly sensitive matters and Crown Counsel management. I am providing this statement nearly six years after issuing my CCI in this case. I have not had the opportunity of reviewing all the papers available to me at the time of my involvement as my papers are with the inquiry. There are many details of the investigation that I am afraid I do not now recall. In the six years since issuing CCI in the investigation I have been extensively involved in numerous high profile , lengthy and complex cases as well as dealing with the everyday business of the High Court .The volume of material that I have reviewed over that period makes the retention and recall of details in individual cases difficult .
2. In August 2016 I was allocated to the investigation by the Principal Crown Counsel.
3. As the head of the system of criminal prosecution and investigations of deaths in Scotland the Lord Advocate has responsibility for the investigation of all sudden, suspicious and unexplained deaths. The purpose of a death investigation is to eliminate the risk of undetected homicide, to irradicate dangers to life and the health and safety of the public, to allay public anxiety, to assist in the maintenance of accurate statistics.

The investigation of deaths advances a number of public interests. These include:

(a) The medical cause or causes of any death should be accurately identified and recorded. In any death where a medical practitioner is unable to certify the cause of death, the death will be reported to the Procurator Fiscal for further investigation.

(b) Where a death has occurred as a result of circumstances which could reasonably have been avoided, those circumstances can be identified and if possible, lessons learned with a view to avoiding similar deaths in the future.

(c) Where an individual has died at the hands of the state or whilst in the custody of the state the circumstances of that death should be investigated independently as part of the state's arrangements for securing respect for the right to life, protected by Article 2 of the European Convention of Human Rights.

The system for investigation of deaths for which the Lord Advocate is responsible is accordingly concerned with the investigation of all sudden, suspicious and unexplained deaths. This is identified in the Scotland Act 1998 separately from the prosecution of crime as one of the two core functions retained by the Lord Advocate. The deaths which are investigated include all those which fall into the categories above including: homicides and potential homicides; deaths attributable to road traffic accidents; accidents at work; suicides; deaths by drowning or as a result of fire or explosion; sudden infant deaths; unexplained deaths in the health care setting; and deaths due to an infectious disease which imposes an acute and serious public health risk, including food poisoning and legionnaires disease.

4. Prior to being appointed the allocated Advocate Depute, I had eight years' experience of dealing with cases investigated by Scottish Fatalities Investigation Unit and Complaints Against the Police Department in COPFS. For five of those years I was a member of the Senior Crown Counsel team. I took silk in September 2016. I do not recall race being a particular feature in any of the cases I was involved in, except in the Appeal Court where I was involved in cases which included debate on the law surrounding the inclusion, in charges, of racial aggravations.
5. As a member of the Crown Counsel team I was experienced in meeting and communicating with next of kin. In the prosecution of homicides I would meet next of kin at regular intervals before trial and thereafter at

important points during the trial. I do not recall race being a particular issue in any of the cases I have prosecuted.

#### The Police Investigations and Review Commissioner (PIRC)

6. I had no direct communication with PIRC, either before or after becoming involved in the investigation. My involvement with PIRC before being appointed to the investigation extended only to the marking of certain cases involving criminal allegations against the police, which Crown Counsel regularly provide CCI. My involvement after being appointed to the investigation was on an indirect basis only and involved agreement with the investigating team as to what further investigations required to be carried out by PIRC.
7. I have no direct involvement with instructing PIRC, although, as outlined above, I was involved in some decision making with regard to further enquiries. Some of those further enquiries required work to be carried out by PIRC.

#### Police Officers' status

8. It is normally the role of the investigating body/reporting agency to distinguish and make decisions on whether a person is to be treated as a witness or a suspect. If suspicion is crystallising on a particular witness then a caution requires to be administered prior to obtaining any further information from that person. It follows that if a witness is a potential accused the Crown would not involve the witness in the precognition process. The Crown's role depends on the individual investigation and the stage that that investigation has reached.
9. During this investigation I kept an open mind about the status of all those involved. From recollection there was a point toward the end of the investigation (November or December 2017) where it was discussed that officers not directly involved in the restraint might be precognosed. I do not recall if there was a final decision made regarding this discussion.
10. I have read my email to Mr Brown dated 3 June 2018. (Document 04530, document 19 in my bundle). I reported with my draft CCI to the Lord Advocate on 1 June 2018. This was partial CCI and dealt with the cases against the individual officers. I forwarded my second draft CCI to the Lord Advocate on 19 June 2018. This dealt with the health and safety aspects of the case. I sent a further supplementary draft CCI to the Lord Advocate on 22 August following my consultation with one of the experts. I issued my CCI on 26 August 2018. By the time of this e-mail I had completed all of my reading and research, including all the consultations with all but one of the experts. In advance of issuing my final CCI we were looking at potential next steps. I am not sure about

the paragraph that is specifically being asked about. [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] from the e-mail I understand that concerns whether there should be a Fatal Accident Inquiry or whether the circumstances may be better aired in the form of a Public Inquiry.

The investigation looked at all potential criminality. That meant that we were looking at all those involved in the restraint/post-incident actions and the Police Service of Scotland as a whole.

11. The death in Police custody was thoroughly investigated in line with the Lord Advocate's core obligations as outlined above. The death itself was the starting point and the evidence of risk in health and safety terms. The nature and circumstances of the death in itself meant that a full investigation was merited and indeed required. In order to make a decision on criminality a complete knowledge of the facts and circumstances were required.

#### Ingathering of evidence and analysis

12. The role of COPFS is in line with the Lord Advocate's role in the systems of criminal prosecution and investigation of deaths all as outlined above.
13. I was provided with two PIRC reports and the expert reports that had been instructed by PIRC I do not recall if I had any further documents at the point of instruction. In September 2016, I met with the case preparation team (at that time Erin Campbell and Alastair MacLeod), two Deputy Crown Agents (Lindsey Miller and Stephen McGowan) and the head of CAAPD (Leslie Brown). At that meeting an outline investigative strategy was agreed; in particular, the civilian witnesses who required to be precognosed were identified.
14. The initial picture raised the possibility that there was criminality involved. For my part, I approached the matter looking for criminality. As an Advocate Depute experienced in criminal advocacy I looked at all possible admissibles of evidence and how those admissibles could be strengthened, supported, evaluated and corroborated. The investigation team explored and examined every potential source of evidence. A fuller understanding of the circumstances of Mr Bayoh's death could only be achieved after the detailed exploration and subsequent legal analysis.
15. I have read my page 3 of my Notebook 2. I am not sure if it was just Mr Nelson's account that was being discussed at that time. I also wanted to explore what the witness Ashley Wise could see from the window/windows. In addition I wanted to explore the number of other witnesses' sightlines. When I wrote the abbreviation "recon," I presume I was thinking about a reconstruction to assess and review all available sightlines. Because of the differing recollections of witnesses and

sometimes how those recollections changed over time, I wanted in so far as possible to establish fixed reference points as a cross-check to either support or challenge the witness' evidence.

16. Race was looked at as part of the investigation with particular emphasis on the previous disciplinary record of the restraint officers. Race did not really feature in the examination of the actual restraint or the medical evidence except with regard to the prevalence of the genes associated with sickle cell anaemia in the Afro-Caribbean population.

#### Expert witnesses

17. I had no involvement in the instruction of the experts by PIRC. By the time I was appointed as allocated Advocate Depute to the investigation, PIRC had already provided the Crown with both its interim and final reports. With regard to the experts subsequently instructed by the Crown, I participated in discussions as to which experts were required to further the investigation's knowledge of the circumstances and the processes involved in Mr Bayoh's death. In some cases, I reviewed the expert's CV and advised on suitability. I had no direct involvement in the preparation of the letters of instruction although on some occasions I was provided with the draft letters and given the opportunity to revise. The opportunity to revise also included the opportunity to extend or restrict the information and documentation provided to the experts.
18. I have read the notes of the consultation with Dr Anthony Bleetman dates 9 May 2018 (document 05627 – document number 7 in my bundle). This is a record of the consultation I had with him on 9 May 2018. I consulted with all the main experts. The purpose of consulting with all the main experts was for me to make sure I had a full understanding of all the issues before I made any decisions on criminality. At all these consultations I directed the questioning of the experts and therefore all the matters that were discussed assisted in furthering my understanding of the circumstances.
19. I have read the email from Mr Les Brown to Prof Sebastian Lucas dated 29 May 2018 (02468 – document 4 in my bundle) This was sent in the months immediately before I issued CCI. I was copied into the e-mail as the decision to go back to the expert has previously been discussed with me. The reason this was necessary was the report from Dr Soilleux on sickle cell traits. The investigation was requesting that Professor Lucas examine the histology slides in light of the findings of Dr Soilleux.
20. I have read the note of the consultation with Dr Kerryanne Shearer dated 4 June 2018 (document 04194(a) – document 15 in my bundle). My consultation with Dr Kerryanne Shearer took place on 4 June 2018As with my consultations with the other experts, I led at this consultation and the

whole purpose was to clarify and increase my understanding of the information that the witness was able to provide. All the questions were targeted towards this aim.

21. I have read my notebook at pages 11 and 13 (05199 – document 9 in my bundle). Page 13 appears to be a continuation of a list started on page 11. It looks like a to-do list. From the expert reports it can be seen that Dr Karch has a contrary view to all the other cardiovascular experts. This can be seen from item number 10 where I have asked that Dr Lawler be asked about Dr Karch's findings. This was a process that we went through with all the other relevant experts.

22. I was not aware of any issues relating to Dr Karch, or if I was, I do not now recall. I do not think I was aware of Mr Bayoh's family's views of Dr Karch nor any media statements attributed to Dr Karch. If I was aware of any of those issues at the time of the investigation, I certainly do not recall any such issues as the time of giving this statement. I am not aware if either of the relevant Lord Advocates held views with regard to Dr Karch. The only information I used to assist my understanding of Dr Karch's opinion was the opinions of the other experts in the investigation.

#### The Health and Safety Executive (HSE)

23. Prior to my involvement in the investigation I do not recall any particular involvement with HSE beyond marking general health and safety cases that required CCI. In my subsequent roles, particularly relating to investigations conducted by the custody deaths unit (CDU) I have had more extensive involvement with HSE.

24. I am not sure I can say what, if any, difference it would have made for HSE to have become involved in the investigation. All I can say is that, in the investigation, all potential health and safety offences were fully examined.

25. [REDACTED]

#### Family liaison

26. I do not recall any involvement in liaising with Mr Bayoh's family prior to issuing CCI. I am aware that Mr Bayoh's family had been given access to a range of documents prior to my involvement. The investigation that was ongoing when I was appointed allocated Advocate Depute was an investigation into criminality. As such, during the time of my

involvement, up to the point of issuing CCI, the normal and accepted disclosure rules applied and were followed.

27. [REDACTED]

28. [REDACTED]

29. [REDACTED]

30. I have a full understanding of the role of VIA with regard to both death and criminal investigations. In this case as far as I can recall it was the request of Mr Bayoh's family that contact with them should be made through their solicitor. I do not recall at what stage that request was made.

Crown Precognition

31. Once the reporting agency has made a report to COPFS, COPFS initiates an investigation. The results of that investigation are either included in a full Crown precognition or a report to Crown Counsel for instruction depending on the type of case. The role of Crown Counsel in the precognition process is varied and dependant on the nature and complexity of the case. In essence the role of CC pre reporting for CCI is to provide direction, when necessary, to ensure that the investigation report (precognition) has explored all relevant areas and provides all necessary documentation to allow CC to make a fully informed decision on criminality. At this stage CC is not involved in analysing or interpreting the information to be included in the precognition. In this case this was a pre-petition precognition. I was allocated to the case some months after the PIRC had reported to COPFS. The investigation/precognition process was already underway. As indicated above, I met with the investigation team and various other officials in September 2016. My input into the process was as outlined above. ( high level advice and direction )
32. The decisions in regard to the form of the Crown precognition were largely made by the investigating team, which included senior legal personnel. As the investigation proceeded, I continued to provide high-level advice and direction as outlined above. If there were areas that I wanted to be further investigated then I was able to discuss this with the investigation team. I had no involvement with the actual drafting of the final precognition.
33. I have read page 9 of my Notebook 2 (Document 05199/document 9 in my bundle) Number 2 on my to-do list says "point to point messages are now confirmed – changes position in narrative". The word is "changes" as opposed to "change." What I think this means is that at this point I had already seen parts of a narrative (possibly a chronology of events) or it had been discussed with me and I was aware that this changed the position. I am not entirely sure, but I think this was something to do with one of the experts who disagreed with the way the airwaves messages tied in with the CCTV evidence. I have a tick against this so it was obviously discussed with the investigation team. I think this is also what is being discussed at 4 and 5 on the same page.
34. I have read page 10 of my Notebook 2 )Document 05199/document 9 in my bundle) The investigation was reaching its final stages and I wanted to be able to make my decision and issue CCI as soon as possible. There were a number of things I required in order to be able to do this. I was trying to set a timetable with regard to consultations with experts and to do that I needed a full set of papers which included the narrative and analysis. This is because I needed a full understanding of everything we had in order to maximise the value of consulting with the experts. I don't recall if the timescale was adhered to but I was



happy I had everything I needed prior to embarking on the consultations.

35. I do not think that race was a particular focus in the Crown precognition, aside from those areas mentioned above. It was however a fact that Mr Bayoh was of Afro-Caribbean descent and was therefore one of the matters I took into account when assessing the reasonableness of the officers' decision-making process.

#### Lord Advocate

36. I have outlined the core roles of the Lord Advocate above. As I understand the history of the case there were two Lord Advocates in post during the course of the investigation. The first Lord Advocate was in post until 1 June 2016: this was prior to my involvement in the investigation and my knowledge of his involvement is limited beyond an awareness that he had met with the family and/or the agent who was acting on behalf of the family. The second Lord Advocate was already in post by the time that I was appointed the allocated Advocate Depute. The Lord Advocate was briefed at intervals with regard to the progress of the investigation but not specifically the detail. It was decided that it would be the Lord Advocate that was briefed and not the Solicitor General and that would allow the Solicitor General to be the Law Officer who could deal with any potential review of the ultimate decision. It was also agreed that once my CCI was drafted it would go to the Lord Advocate for review/approval. It was my understanding that during this process the Lord Advocate would have access to the full precognition together with the foundation documents .

37. At intervals I updated the Lord Advocate with regard to the stage that the investigation had reached, but there was no discussion with regard to the in-depth details or my ongoing analysis of the emerging information.

38. My recollection is that I only met the family on 3 October 2018, that this was after I had issued CCI and it was arranged specifically to discuss that CCI. If I have met the family on earlier occasions this will be documented in the case papers. I was aware that there were earlier meetings with the Lord Advocate of the day and COPFS but I do not recall being present at any of the earlier meetings.

39. That is entirely dependent on the Lord Advocate and how they approach the post and the duties of the Lord Advocate.

40. I was only involved with one Lord Advocate during the course of the investigation and his involvement was entirely consistent with his approach to other similar investigations.

41. I have read my emails with Stephen McGowan dated 7 February 2017 (document 04515/document 3 in my bundle). – In this e-mail a meeting to be held on 8 February 2017 is being discussed. I do not have a copy of the minute that is referred to in the e-mail so I do not know why the meeting was being held nor do I recall the content of the minute.

Investigation into the purported leak to the Mail on Sunday of the decision not to prosecute.

42. My recollection is that I issued CCI on 26 August 2018 (although I had made staged decisions as outlined above) and I do not recall the Mail on Sunday newspaper article nor any discussions around the publishing of the article.

43. I do not think I had a role and I do not recall any involvement in the investigation within COPFS into the source of the information in the Mail on Sunday's article .

44. The investigation had already concluded and I suspect I was engaged in proofreading the final CCI. I do not recall any discussion about the article or potential liaison with Mr Bayoh's family.

[REDACTED]

[REDACTED]  
[REDACTED]

46. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Learning from other investigations

47. My awareness of investigations by the police and/or the CPS into race in England and Wales came only from what was reported in the news and in the press. I was aware, therefore, that this issue had been the focus for some investigations into suspicious deaths and police conduct in general. Every case that you participate in adds to your background knowledge and experience always adds to your learning and assists in your approach in any future investigations. They did not change my approach which is always to make sure that all avenues have been explored.

48. I was interested in the experiences of the CPS and I wanted to make sure that I had not missed anything in our approach to the investigation. I was aware that the CPS had more experience in this type of investigation and I wanted to tap into that experience.

49. [REDACTED]

50. [REDACTED]

51. [REDACTED]

52. [REDACTED]

53. I did not approach or consult with any other person in relation to how the Investigation was proceeding and for ensuring no avenues of investigation had been missed. As the investigation progressed, the instruction of additional experts and the resulting consultations were as a result of the desire to further investigate particular areas.

Race

54. I do not recall race being a factor in any previous death in custody in which I was involved. It may be that race had been a factor in some of the cases in which I issued CCI, but I do not recall any particular case.

55. Beyond the circumstances mentioned above I employed the same level of forensic analysis that I would bring to any case to which I was involved.

56. Every case is dealt with on its own facts and circumstances.

### Training

57. By 2016 I had been an Advocate Depute for eight years. I was experienced in dealing with large and complex cases including death investigations, both prior to reporting to Crown Counsel and following instructions to proceed. I was experienced in preparing and presenting large and complex cases to juries.

58. I had completed all the annual training courses together with eight two-day residential cases.

59. By 2016 I think I had completed at least two separate training modules covering equality and diversity issues.

60. I do not remember making use of any particular materials during the course of the investigation.

61. In my role as Advocate Depute I hope I am constantly learning from all the investigations and cases in which I am involved. I try to put this learning and experience to use in current and future investigations.

### Records

62. There is no requirement for me to take contemporaneous notes or any other record of my involvement in an investigation.

63. All e-mails I receive with regard to an investigation are retained. I also retain any formal CCI which I have issued. I had available to me a full set of papers and this forms part of my record keeping. I understand my papers have been retained by the Inquiry. My record keeping in this investigation was consistent with my normal practice.

### Miscellaneous

64. In my experience this was a lengthy investigation. It was lengthy because of the range and depth of the issues which were explored together with an extensive number of expert witnesses from a full range of disciplines. There was also significant work required with regard to collating and presenting technical evidence. This was all done with the ultimate aim of clearly presenting the evidence to a jury. Visual evidence was also looked at in detail particularly with regard to all possible methods of enhancement. .

65. Once I had issued CCI with regard to criminality, the investigation was at the stage where a decision required to be made with regard to the next steps. At this stage this was a binary decision: FAI or public inquiry.

66. I do not think that it can be said that the investigation deviated from the normal practice. At the outset I was aware of the information that was in the public domain and the way that that information was being interpreted and presented. I was aware of and alight to the sensitivities in this case . Race was a factor that was considered along with all the other evidence and circumstances in the case as outlined above.

67. As I outlined above I hope I learn from my involvement in every case and there are always improvements to be made . In the last few years I have been involved in the setting up of the custody death unit and in the training and allocation of Advocate Deputes to this unit . My involvement in recent high profile health and safety prosecutions/ deaths in custody (M9 ,YOI Polmont suicides) have all assisted in expanding my knowledge base.

68. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] The first part of the e-mail – paragraphs A-D - deals with issues that could be explored in an inquiry. These issues all covered the investigation prior to the matter being reported to Crown Office. That sets in context the paragraph that has been referred to in this question. My concern had been with the way the matter had been dealt with prior to reporting to COPFS which contributed greatly to the Crown's ability to decide the issue of criminality in a timeous manner.

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



Ashley Edwards KC, 18 January 2024