AREAS FOR WITNESS STATEMENT
MR STUART TAYLOR

Please provide your **full name, date of birth, personal or business address.**

Stuart [redacted] Taylor
DoB [redacted]/1982

Police Investigations and Review Commissioner
Hamilton House
Hamilton Business Park
Caird Park
Hamilton
ML3 0QA

Please provide as much detail as you can in relation to each of the following questions. These questions will focus on your role at the Police Investigations and Review Commissioner (PIRC) and your involvement in PIRC's investigation following the death of Mr Bayoh.

Your professional background and experience

1. Please provide a summary of your professional career including the job titles, dates held and a short summary of your duties. Please include details as to any further or higher education you have undertaken.

Prior to commencing my role at the PIRC my career history is as follows:

04/02/2013 – 08/07/2013 Information Officer/Vetting Officer for Disclosure Scotland (Scottish Government)

I analysed information by consulting various electronic criminal record databases to vet people to provide potential employers and voluntary sector organisations with criminal history information on individuals applying for posts.

12/2012 – 01/2013 Admin Assistant (Central Evidence Team) at Ingeus Ltd

I was responsible for gathering evidence relating to clients entering employment. I had to communicate with people from diverse backgrounds and would often have to engage with people who were extremely reluctant to speak to me. There was also a counter-fraud aspect to my role; identifying potential benefit fraud and ensuring that this was passed on to the appropriate authorities.

12/2011 – 12/2012 Residential Child Care Worker for Spark of Genuis Ltd

I worked as part of a team supporting up to six high tariff children/young people, with a variety of complex needs including; neglect, issues related to drug and alcohol misuse, involvement with the criminal justice service, various forms of abuse, mental health problems and learning difficulties. This was in a 24 hour residential setting. A children's home.

04/2007 – 08/2011 Patient Services Coordinator for Bupa Home Healthcare

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I was responsible for coordinating and managing the health care provision of chronically ill NHS patients within their own homes, as opposed to within a hospital setting. This role demanded a considerable amount of cooperation with other stakeholders such as NHS partners, patients and their families.

I completed a Master of Arts (Applied Social Science) at the University of Glasgow in 2004. I completed an HNC in Social Care at Kilmarnock College in 2011

2. Please expand on any professional experience you consider relevant to your role within PIRC. This could include previous employment or training.

I did not have any previous investigatory experience prior to my role within the PIRC. However, I have worked with people from challenging backgrounds in a number of previous jobs which allowed me to gain experience in communicating with people in highly stressful situations, for example when working in a children's residential unit, as a member of the Children's Panel, and when working with chronically ill patients. I also gained experience at working within a multi-agency arena, when working with partners in social work and health, in relation to previous work with vulnerable children. When working as a Residential Childcare Worker within a children's home, I completed a 5 day course in Therapeutic Crisis Intervention (TCI) which involved 'safe-handling' (restraint) of children and young people.

3. Prior to 3 May 2015, what, if any, contact had you had with the following Police Scotland officers: Craig Walker, Alan Paton, Nicole Short, Ashley Tomlinson, Alan Smith, Kayleigh Good, Daniel Gibson, James McDonough and Scott Maxwell?

None that I am aware of.

4. Prior to 3 May 2015, had you had any contact with the Police Scotland officers you encountered in the course of the PIRC investigation? Please include detail as to how and when you met them, and your relationship as at May 2015.

None that I am aware of. If I had it would have been through previous PIRC investigations, but I am not aware of having been involved in any investigations with any officers involved in this incident prior to 3 May 2015.

5. As at 3 May 2015, was there any policy or guidance for PIRC staff who were acquainted with a Police Scotland officer that they encountered in their role, or who was the subject of a PIRC investigation? If so, please can you identify the policy or guidance in question.

I am not aware of specific written guidance relating to PIRC staff being 'acquainted' with Police Scotland officers that they encounter as part of their role at the PIRC, or who is subject of a PIRC investigation. However, I would say that it is accepted practice that if a member of PIRC staff has a relationship with a police officer who is under investigation then they would alert the Lead Investigator to this so that they could decide whether or not it was appropriate for that member of staff to participate in the PIRC investigation. Personally, as a Lead Investigator, I have in a specific case had reason to ask Investigators to alert me to whether or not they had had previous dealings with an individual who was important to an investigation. On this occasion, a couple of PIRC Investigators informed me that they had had previous dealings with the individual and I made the decision, endorsed by my line manager, to exclude these member of staff from the investigation.

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6. Has PIRC ever investigated police officers with whom you were acquainted? What process would be followed if you had a personal or professional relationship with an officer investigated by PIRC?

I am not aware of the PIRC having investigated any police officers that I am acquainted with. I am not acquainted with very many police officers in my personal life, if I am being perfectly frank. I would not think it appropriate for me to investigate a police officer that I had a close relationship with and would indicate this to my line manager and probably Head of Department at the earliest opportunity, should the circumstances ever arise.

As I have never worked for the police I do not have previous working/professional relationships with police officers. A number of PIRC staff are retired officers and will have had previous working and even personal relationships with serving police officers. If a PIRC member of staff had a significant personal relationship or previous professional relationship with a police officer or member of police staff that was subject to investigation by the PIRC, I would expect that they would alert the PIRC Lead Investigator and possible Head of Department to this, so that a decision could be made, on a case-by-case basis, on whether or not it is appropriate for that PIRC member of staff to be involved in the investigation into that police officer or member of police staff. I would expect the impartiality and integrity of the investigation to be given due consideration.

The Police Investigations and Review Commissioner

7. What was your position at PIRC on 3 May 2015? What were your duties and responsibilities in this position?

I was a Trainee Investigator, nearing the end of my 2 year traineeship (due around July 2015). By this point in my traineeship my duties were pretty much equivalent to an Investigator's, in that I would be expected to note witness statements, seize evidence and perform tasks allocated to me, such as listening to telephone calls of Airwave radio transmissions and provide a written transcript etc. We almost always worked in pairs, so I would normally be working with an experienced investigator. For the most part, I would have worked alongside my 'mentor' investigator, Ross Stewart. He was part of my team and I was 'buddied up' with Ross for much of my 2 year traineeship so that I could learn from him and so that he could provide guidance and corrective advice in respect of my practice. I also worked alongside other experienced investigators and learned from their approach and advice too. I reported to DSI William Little who was my line manager. I would say that I was performing most of the standard tasks of an investigator, although perhaps under a higher degree of supervision. At this time, I was also expected to participate in the 'on-call rota' which meant that every few weeks I would be 'on-call' with the rest of my team for any out-of-hours incidents that were deemed to require an immediate PIRC response (turn out).

8. How were trainee investigator vacancies advertised? Were any restrictions placed on the persons who could apply for those positions? Was there any requirement that applicants not have a background in the police?

It is around 10 years since I applied for the post at the PIRC so in all honesty I really couldn't say with any degree of accuracy. That said, my general recollection is that I saw the post advertised via the s1jobs.com website and downloaded the relevant documents from that. Again, my best recollection is that there was no bar on people with non-police backgrounds applying, and it possibly even stated that previous police experience was not a pre-requisite for the post. As I had no police or investigatory background at that time, it is unlikely that I

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would have applied for the post if there was an indication that a police background was required, or even preferred.

I would have looked at the job profile and any competencies and felt that I could meet the requirements, so applied. I must have believed I had a lot of the 'soft skills' and experience required for the role as advertised, otherwise I would not have applied.

9. Who was your line manager or supervisor? Please provide details as to how you were supervised by them. Did you have an annual appraisal? If so, were notes taken?

My line manager at the time was then Deputy Senior Investigator (DSI) William Little. DSI Little retired from the PIRC recently, having been promoted to Senior Investigator in the intervening years. I spoke with DSI Little every day and it would be him who would allocated me 'Actions' to complete for whichever investigation I was working on. I regularly worked with Investigator (Inv) Ross Stewart who was my 'mentor' as I was still a trainee, however I would also regularly work with other colleagues and could be instructed to perform 'Actions' or tasks by other supervisors from time to time.

DSI Little would provide supervision in a number of ways. When briefing about any tasks that I was required to undertake, he would ensure that I was confident that I knew what was expected of me and had the necessary resources or support to fulfil any task given. He would look for updates on tasks to ensure that things were progressing as planned. He may ask to review 'interview plans' or provide guidance for interview plans for any significant witness statements. I believe he also conversed with Inv Ross Stewart in respect of my progress as a trainee.

We did have annual appraisals and a 6 monthly (half way) meeting in respect of this. I believe this would have been recorded, it certainly is nowadays, with a formal appraisal process. In respect of my traineeship, there was a trainee 'portfolio' that was completed and discussed between myself and then DSI Little. I believe that then DSI Little would also have reviewed some of the statements I noted and checked some productions I seized, to ensure that I was completing these tasks to the required standard.

10. Between May 2015 - August 2016, do you feel that there was adequate resourcing for PIRC to comply with its statutory obligations in terms of:

(a) Funding;

I had, and still have, little to no knowledge of what funding the PIRC had during this period, so I do not feel that I am in a position to provide an answer to this.

(b) Staffing numbers;

It would be fair to say that the PIRC was still quite a small organisation during this time period, for example compared with now. It would also be fair to say that the investigation into the death or Mr Bayoh was by far the largest investigation the PIRC had undertaken up until that point. Shortly after the commencement of the investigation into Mr Bayoh's death, the PIRC also undertook a large investigation into the deaths of [redacted] and [redacted] on the A9, which ran in tandem with the investigation into the death of Mr Bayoh. This was a very busy period at the PIRC. However, I was not aware at any point, of the investigation failing to progress due to a lack of staff. I was, however, not involved in the management of

the investigation and was only a trainee, so am not necessarily in the best position to answer this question.

It has always been my understanding, whilst working at the PIRC, that although our investigations must be independent from the policing body we are investigating, there would always be a reliance on there being a constructive working relationship between the PIRC and that policing body. This is the only way that an organisation the size of the PIRC are able to conduct large scale investigations. The PIRC direct the investigation and are the decision-makers, even if every single task carried out may not necessarily be carried out by a PIRC member of staff. This is particularly true of specialist tasks, e.g. Road Policing 'drive throughs' or specialist POLSA searches, crash scene investigations etc.

If the Scottish Government feel that it is necessary that every single task carried out as part of a PIRC investigation should be carried out by a PIRC member of staff, I would suggest that a significant increase in funding and staffing levels would be required, and in order to fill the required 'specialisms', there would be even more of a reliance of retired officers, as there are very limited pools that the PIRC can recruit from if you want experienced investigators in terms of criminal and death investigations.

(c) Training opportunities; and

I am not aware of what the training provision/strategy/budget was during the time in question. I was a trainee and was not involved at this level and had no real knowledge of the wider training provision for the department at that time. I was aware of what was available to/expected of me as part of my 2 year traineeship and that was about it.

I have detailed my recollection of the traineeship in my answers to questions 14-18 (inclusive) at the 'Training' section of this questionnaire.

(d) Expertise of staff.

At the time in question, the PIRC had a number of Investigators and managers with experience in death investigations and major investigations, both from a police and a non-police background. The PIRC also had a number of investigators with experience in Scene Management and Family Liaison.

If not, why not?

Please see answers above

11. Do you feel that your non-police background (PIRC-04515) has any advantages or disadvantages for your work at PIRC? If so, please provide full details. What impact, if any, does not having a background in the police have on your ability to provide direction to officers from Police Scotland during investigations in which PIRC require to provide such direction?

I feel that my non-police background has advantages and disadvantages. The primary advantage is that I do not necessarily approach things in the same way as my colleagues with a background in the police. Everybody is moulded by their own experiences and it would be disingenuous to suggest that someone from a police background looks at circumstances in the same way as someone without that background. I have experience in working with vulnerable individuals and individuals in care, who would often come into

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contact with the police. Their experiences of the police, and the way that I have seen police officers deal with them, gives me a different perspective on certain situations. I have often contributed a different opinion or point of view in work related scenarios, and this additional and different experience can presumably only be beneficial.

The most obvious disadvantage of my not having a police background is probably that I had a 'knowledge gap' to fill in respect of police practice and procedure and knowledge of the criminal law. The training received, academic, in-house and through 'learning on the job' has since provided me with the necessary knowledge to fulfil my role.

Continuous Professional Development and gaining operational experience is crucial to gaining and maintaining the necessary knowledge and competence to be able to continue to fulfil the role. However, this is also true for my colleagues from a police background.

Not having a background in the police has not affected my ability to provide direction to officers from Police Scotland during investigations in which PIRC are required to provide such direction. More often than not, the Police Scotland officers will not necessarily know that I do not have a background in the police. Even if and when they do, I have never felt as if this has affected my ability to provide direction to them when required. If I did, I would immediately have raised this with my Senior Management and would have expected this to have been acted upon immediately.

There have been occasions when I have explained to police officers that I do not have a police background, perhaps when certain terminology is being used that I have been unfamiliar with, or to reassure them that I have no vested interest in, or preconceived notions about, what is being investigated. I have often found it to be an advantage that I have no police background, particularly when dealing with members of the public who may have had bad experiences with the police, or may have an anti-police attitude.

12. In 2015-2016 PIRC had various staff members who had previously held roles within the police. Do you feel that PIRC as an organisation was impacted positively or negatively by staff having held roles within the police? Please explain why you hold this view.

As mentioned in my answers to previous questions, there are very limited pools that the PIRC can recruit from if you want experienced investigators in terms of criminal and death investigations. As such, I think that it is inevitable that the PIRC have had to rely on recruiting a certain amount of staff who have previous experience in policing. Particularly in the early days of the PIRC, when it was still a relatively new organisation, I feel that in order to establish an effective investigatory agency, capable of undertaking criminal and death investigations, that there was a requirement to recruit some ex-police officers. There were definitely many positives about having ex-police officers as their knowledge and experience of police procedures, policies and practices provided a degree of insight into the way the police works.

I also understand that the public perception of ex-police officers providing 'independent' oversight of the police is a bit of a 'mixed bag'. Some realise that a degree of knowledge and experience of policing is beneficial, whereas others feel that being a retired officer may mean that you have some degree of allegiance or loyalty to the police service in general terms and that this may affect their ability to be independent. My personal experience is that my colleagues with a police background are interested in ensuring that the police are held to account and they are dedicated and professional in their approach to this.

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I also feel that having members of staff with non-police backgrounds is essential for the PIRC, not only to mitigate some of the perceived criticism attached to retired officers working for the PIRC, but also to provide different skills, approaches and opinions to those who have only ever previously worked for the police. I feel that the PIRC would benefit from greater representation of staff with non-police backgrounds within the upper echelons of management. This is not a criticism of the senior members of staff that have held (or hold) those positions. It is for the reasons already given and a belief that a broader mix of experience and background in these positions could only be a good thing.

From memory, at the time in question, the PIRC had a number of investigators from non-police backgrounds, including; ex-fire service investigator, ex-military investigator, a former procurator fiscal, an ex-HMRC investigator and a Senior Manager with a social work / Care Commission background. The Commissioner themselves, are not allowed to have previously worked for the police, as far as I am aware.

13. Prior to 3 May 2015, what experience, if any, did you have of PIRC investigations of deaths in police custody, or deaths following police contact? In what ways were these investigations similar or different to the investigation following the incident involving Mr Bayoh on 3 May 2015?

Prior to 3 May 2015, I had had some involvement with the investigation of around 10 deaths in custody or following contact. None were in similar circumstances, whereby there had been a physical confrontation or when there had been an overt 'use of force' by the police. Some had involved physical hand on contact with the police in the lead up to the death, however not is a similar manner to the this case.

Training

14. What training did you receive as part of PIRC's trainee programme? What subjects were covered? How were they covered? Who was responsible for creating, delivering and coordinating the trainee programme? How was the work of trainee investigators monitored, supervised and checked? Do you feel that the trainee programme adequately prepared staff to take on an investigator role at PIRC? If not, why not?

The traineeship had two main elements. Academic courses and on the job training. Across the two years I attended a short course in Criminal Law and Procedure at the University of West of Scotland, (Hamilton Campus). I also completed Scientific Detective 1 and Scientific Detective 2 modules at the University of Abertay (Dundee Campus) and a year long Crime Scene Investigation module, also at the University of Abertay (Dundee Campus).

As part of my on the job training I initially shadowed my 'mentor' Inv Ross Stewart as he completed standard tasks such as noting witness statements, seizing evidence, performing house-to-house enquiries, conducting CCTV scoping exercises and engaging and producing audio and video transcripts and timelines. Once I have observed how this was done I would have a turn of doing these tasks myself and would progress from simple statements to more complex ones etc. I would undertake these tasks alongside Inv Stewart, then by myself (showing Inv Stewart what I had produced) and then gradually would be entrusted to do these tasks more independently. There was a 'trainee portfolio' of key tasks and areas of investigation that it was expected/hoped I would be involved in throughout the my traineeship, however always with the recognition that we were at the mercy of what types of investigations came in. E.g. as we only had a very small number of Senior Officer

Misconduct investigations, it may be that I would not have an opportunity to participate in one of these during my traineeship.

I do not know who had overall responsibility for creating, delivering and coordinating the trainee programme, although I do recall having some discussions with the then Head of Investigations, Irene Scullion (since retired), who played a role in agreeing which academic courses should be attended. It was monitored by means of completing the aforementioned trainee portfolio and through regular supervision meetings with my line manager, then DSI William Little.

15. Following completion of the trainee programme, what further training have you undertaken in your role? Is the training that you have completed in your role at PIRC covered in full within the training records received by the Inquiry (PIRC-04577)?

I believe my training record is noted within pages 31-32 of the document referenced. I say believe as there are no names on the records as far as I can see, however from the combination of courses listed I would say that this was my record. I expect that I have likely completed further generic courses as part of the PIRC's annual training refresher I have also recently attended the Advanced Investigators Course at the Scottish Police College at Tulliallan, I believe it was in August of 2023.

16. How different, if at all, was the training that you received as an investigator from a non-police background to the training received by your colleagues from police backgrounds?

I do not really know how my training has differed from an Investigator from a police background, other than that they are not expected to complete a 2 year Trainee Investigator program. The other courses that I have been sent on are also courses that my colleagues with a police background may also have the opportunity to be sent on, if they are seen by management as courses that would benefit them. There was a one week bespoke Investigators Course that was provided at the Police College at Jackton that PIRC trainees attended which I don't recall other colleagues attending. Other than that, the training received by PIRC investigators would have been much the same.

17. In 2015, how was it identified that investigators and staff required, or would benefit from, training? Was it necessary for investigators and staff to request training, or were training needs identified by line managers and other senior members of staff at PIRC? Who was responsible for ensuring that PIRC's investigators were sufficiently well trained?

The decision on whether or not to send individual investigators of courses for 'specialisms' such as Scene Manager, Family Liaison Officers and Sexual Offences Liaison Officers, would be down to individuals and their line managers (as agreed with more senior managers) and would be part of their individual CPD plans and focussed towards the needs of the organisation. I do not know if a single individual was responsible for training overall, or if the Senior Investigators and the Senior Management Team (Head of Investigations, Director of Operations, Head of Corporate Services, the Commissioner) would have responsibility for this.

18. Did you feel adequately trained to carry out your role at PIRC? Please explain why, or why not. What, if any, additional training would have assisted you in your involvement in the investigation?

I think that I had sufficient experience and knowledge to carry out the tasks that I was asked to perform throughout the investigation. My involvement in the initial stages/early days of the investigation was largely to shadow experienced PIRC Investigator John Ferguson (now deceased). I was there to corroborate what was going on, to observe and assist when requested to do so. Although I was there to assist in any way I could, it was also a learning experience for me. I was never asked to do anything that I felt went beyond my competency, and effectively I had little or no decision-making responsibilities, due to my level of experience at that time. Then DSI Harrower (promoted to Senior Investigator in the intervening years) was our senior officer 'on the ground' as it were. He allocated tasks and responsibility for the body recovery to Inv John Ferguson, who was an experienced retired Detective Sergeant who had many years of Scene Management experience. As I saw it I was there to observe and assist Inv Ferguson.

19. Is there any process within PIRC to assess "lessons learned" from investigations? If so, what does this process entail? Did any "lessons learned" exercise take place following the investigation following the death of Mr Bayoh? If so, what did this involve? If not, why did this not take place? Do you think PIRC would have benefited from such a "lessons learned" exercise following that investigation?

At that time there was no formalised 'lessons learned' process within the PIRC that I am aware of. There was no official or organised 'debrief' that I can remember. I was surprised that no such 'debrief' or 'lessons learned' session was held once the initial, or even the second report was submitted to COPFS. I think that a number of members of staff probably felt that this would have been a useful exercise, myself included.

Your involvement with the PIRC investigation
Sunday 3 May 2015

Call from DS Harrower

20. Your PIRC statement (PIRC-00358), at page 2, notes that around 1030 hours on 3 May 2015 you were contacted by Deputy Senior Investigator Keith Harrower and made aware of the incident involving Mr Bayoh. Was this the point at which you learned of the incident involving Mr Bayoh? If not, when did you first become aware of the incident? What did you discuss with DSI Harrower on this call?

Yes, the phone call from then DSI Harrower was the first I was aware of this incident. My recollection was that this was a very brief conversation, basically consisting of him letting me know that a male had died following an interaction with a number of police officers in the street in Kirkcaldy. I believe that there was brief mention that an officer may have struck the male with a baton and that CS and or PAVA had been used. DSI Harrower instructed me to attend at our offices at Hamilton House as quickly as possible, where we would be updated on what information was known about the incident.

21. Were you made aware of Mr Bayoh's race when you spoke to DSI Harrower at 1030 hours? What, if anything, did you discuss with DSI Harrower in relation to Mr Bayoh's race on this call?

My best recollection is that yes, I was made aware that the male who had died was black, during this brief call from DSI Harrower. I do not recall the fact that he was black being further discussed at this time, but I think I was told that he was black.

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22. When speaking with DSI Harrower at 1030 hours, what were your initial considerations and priorities at the outset of the PIRC investigation? What impact, if any, did Mr Bayoh's race have on those initial considerations and priorities?

I did not discuss investigative considerations or priorities with DSI Harrower at this time. This was simply a call to tell me that there had been an incident and that I was to attend at PIRC premises to be briefed, prior to the on-call team deploying to Kirkcaldy. I was a trainee with limited investigative experience at this time. My expectation was that I would be assigned specific tasks and would be briefed as to what was expected of me. Investigative priorities and considerations would be for DSI Harrower, SI Richard Casey and others to determine. Race was not discussed any more than the fact that the deceased male was black.

23. At this stage, what was your understanding of the legislative basis upon which PIRC were instructed to investigate the incident by the Crown Office and Procurator Fiscal Service (COPFS)? Was your understanding that the investigation was instructed under section 33A(b)(i) or section 33A(b)(ii) of the Police, Public Order and Criminal Justice (Scotland) Act 2006? Were you aware of the legislative basis upon which PIRC were instructed to investigate changing during the investigation? If so, how did the legislative basis for the investigation change? What difference, if any, does the legislative basis upon which PIRC are instructed to investigate by COPFS make to a PIRC investigation?

I cannot recall when I was made aware that this was a COPFS directed investigation. I was aware during the course of the 3 May 2015, but I cannot recall the exact moment. My understanding in 2015 was that these types of incidents, Deaths in Police Custody, would probably be initially referred to the PIRC by Police Scotland via a senior PSD officer. This would be at as early a stage as possible. As a Death in Police Custody would normally at least lead to a mandatory Fatal Accident Inquiry (FAI), this would likely be referred to PIRC by COPFS in pretty short order. At the time of this incident, I was probably unclear as to the mechanics of this, by which I mean who would phone who and when. However, my understanding was that there would likely be a phone call between a Procurator Fiscal and the Lead Investigator for PIRC and that a verbal instruction would be given, confirming that PIRC would be the lead agency investigating the death, under Crown instruction. This would likely be followed up with a formal written referral emailed to PIRC within a day or so.

As stated, I do not recall exactly when I was made aware that this was a COPFS instructed investigation, but I imagine I knew this pretty early on. I am not sure that I was specifically informed what section this was initially referred under; 33A(b)(i) 'criminal', or 33A(b)(ii) 'death investigation'. Either way, I would not have performed any of the tasks allocated to me any differently. The same standards in respect of management of the scene and recovery of evidence would have applied at the early stages of the investigation. It seemed clear that as the investigation progressed, as the lead department within COPFS that the PIRC were liaising with was the Criminal Allegations Against the Police Division (CAAP-D), that lines of inquiry specifically addressing the possibility of this being a 'culpable homicide', rather than simply an accidental death, were being considered and progressed. Had it been only the possibility of an accidental death that was being considered, I would have expected that it would likely have been the Scottish Fatalities Investigation Unit (SFIU) that would have been the lead department within the COPFS.

On call system

24. Your PIRC statement (PIRC-00358), at page 2, identifies that you were on call on 3 May 2015. You identify that, in addition to yourself, DSI Harrower, Investigator Maurice Rhodes and Senior Investigator Richard Casey were part of PIRC's on-call team that day. Was this the normal number of investigators that would be on call on a Sunday morning in May 2015? What was PIRC's system for allocating investigators to the on-call rota? What consideration, if any, was given to investigators' skills, expertise and experience when setting the on-call rota?

From memory, and this is going back almost 10 years, I think that this was about usual for an on-call team. An SI, DSI and two (maybe 3) investigators. I cannot recall exactly. I remember that for the first 6 months or 12 months during the traineeship, I don't think trainees did on-call. I think it was decided that trainees would only go onto the on-call register once they had been out and about with their 'mentors' for a few months and had gained a little bit of experience. This is just my recollection but I can't be certain.

Again, as far as I can remember, the on-call rota meant that you were normally on-call within your own team. With your own DSI and the investigators in your team. Teams normally consisted of a DSI and three investigators, although my team only had a DSI (William Little) and two investigators, Inv Ross Stewart and myself. We were a smaller team than the rest of the teams. Not for any particular reason, I think it just worked out that way. The SI with responsibility for your team was normally also on-call with the team. I am not sure why I was on-call with DSI Harrower on this occasion. I don't know if I was covering for someone else, or vice versa if DSI Harrower and Inv Rhodes were covering for other people. DSI Harrower was not my DSI at the time.

In way of explanation, on-call stints ran for 1 week and one team passed over on-call to the next team. On-call was for responding to serious incidents, primarily deaths or firearms discharges, that occurred outside the normal PIRC working hours All day at the weekends and the 6 mandatory public holidays when the office was shut, were covered by the on-call team. Out-with working hours, which were Monday – Thursday (0800-1600) and Friday (0800-1530), was also covered by the on-call team. This ran in a cycle so that each team took a turn in order and then the cycle repeated. At the time I think there were maybe 6 teams. You would know your weeks in advance, probably for the whole year. If your on-call week fell on dates that you had a holiday planned, or if you had an important appointment or family event on a day your were due to be on-call, you could arrange with a colleague to cover for you, either by swapping for their on-call week/day, or by them just doing it for you. This had to be agreed in advance and the DSI had to be OK with it.

I do not know what consideration, if any, was given to Investigators' skills, expertise and experience when setting the on-call rota. The make-up of the teams was decided by management. There appeared to be a spread of experienced investigators across the teams, but this question would be better answered by those in management positions at the time, it was not something that I was involved in.

25. In May 2015, how common was it for PIRC staff that were not on call to be asked to report for duty immediately and participate in an investigation? In circumstances where staff who were not on call were asked to attend work, how were those staff chosen?

I do not know the frequency with which non-rota'd staff were called to supplement on-call teams when an incident occurred. My recollection is that this was a decision for the lead investigator on-call, i.e. the supervisors (SIs and DSIs). I do not know how the staff were

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chosen, although I would presume that this might be task-related, e.g. if a Scene Manager of a Family Liaison Officer were required (and there were none within the on-call team) then it may be that staff with those skillsets would be contacted first. Again, you would have to ask those who were supervisors at the time. It would also depend on who answered their phone. There was no obligation to be available or turn out if you were not on the on-call rota. It was the based on the goodwill of the individual investigators contacted, whether or not they would report for duty and assist the on-call team. This is still the case today.

26. What did being "on call" as a PIRC investigator involve? How many times had you performed this role prior to 3 May 2015? On how many occasions had you been required to deploy to an incident whilst you were on call prior to 3 May 2015? On how many occasions did those deployments relate to deaths in police custody, or deaths following police contact?

As stated above, I think (as I was a trainee) I didn't get added to the on-call rota until I had been at PIRC for 6-12 months. Therefore, I would only have been part of the on-call rota for approximately 1 year prior to this incident. I had never been called out prior to this incident. This was my first deployment to an incident that was still in its initial stages. I had worked on death investigation previously, but as a member of the general inquiry team in the days and weeks following the death. This was the first time I had been deployed to a 'current' incident.

Being on-call for the PIRC meant that you had to be available 24/7 during your rota'd week. It was really for out-of-hours incidents. You had to be within an hours' travelling distance to the PIRC office and available by phone at all times. You had to be ready to drop whatever you were doing if you got a call, get a suit on and get yourself in to the office. Then you would likely have to travel to wherever in the country the incident had occurred. You would be involved in the management of the incident / initial stages of the investigation, and would continue to do this until the next 'working day', at which point the investigation would be allocated to whichever DSI or SI would be carrying it through to its conclusion (not necessarily the DSI or SI who caught the job whilst on-call. This would depend on workloads and was a decision for management).

Resources

27. On the basis of the information you had available to you on 3 May 2015, did you consider PIRC had sufficient resources to respond to the incident that day? What discussions, if any, did you have with DSI Harrower in relation to PIRC's level of resources on 3 May 2015?

The initial PIRC considerations on the day, as I remember it, primarily focused on two scenes that were of particular importance, Hayfield Road and the deceased at Victoria Hospital. There was the issue of Family Liaison Officers being deployed to assist with the family of the deceased and then there was the need to seize officers' clothing etc. which took place back at Kirkcaldy Police Office. There were a number of other scenes that appeared to be connected to the chain of events that led to Mr Bayoh being on Hayfield Road, reportedly in possession of a large knife.

I am not sure that it has ever been envisaged that the PIRC would be a large enough and well enough funded organisation to be in a position to have the numbers of staff on-call to manage every aspect of an incident on this scale. It certainly wasn't in 2015. In hindsight I think it would be fair to say that we could have done with a few more members of staff to assist with the core tasks that we were focussing on. It had always been my understanding

that the PIRC would have to use police staff to assist in such circumstances, albeit that the decision-making would lie with the PIRC. I believe that efforts were made to use police resources from out-with the Kirkcaldy area to assist with key tasks, including assistance from the Police Scotland Major Investigation Team (MITs), in an attempt to provide as much separation as possible between the officers and supervisors involved in the immediate incident, and those involved in the initial stages of the investigation.

I did not have any discussions with DSI Harrower about resourcing levels that day. I was a trainee at this time and therefore it was not within my competency to make decisions about this, or really to have an informed opinion about it at that time. This was very much a decision for more senior PIRC staff.

28. Within his evidence to the Inquiry, Detective Superintendent Patrick Campbell stated, with reference to the level of PIRC's resources on 3 May 2015 (day 47, page 128, line 23):

> ***A. … I had slight concerns round about their awareness of capability and also the capacity round about the number of resources that turn up at that time to take on an investigation such as this, which was gathering pace, there was significant media attention around it. So it wasn't just investigative side, there were other areas that were playing out at that time.***
>
> ***Q. When you say you had concerns about their capacity, what do you mean by that?***
>
> ***A. Resources-wise. I think we had about – I recall at one time we had probably about 20, 22 resources on it at one time from Police Scotland, detective officers involved in the investigation. I think at that day, I think they turned up with four or five PIRC.***

DS Campbell also stated in this regard (day 49, page 174, line 5):

> ***A. … it's clear it was insufficient for the job on 3 May, and that's why from a Police Scotland perspective we'd significant resources pulled from all over the country, as well as from the Major Investigation Teams, to support the PIRC in respect of the investigation.***

What are your views in relation to DS Campbell's comments regarding the level of resources available to PIRC on 3 May 2015? Do you agree that the level of resources available to PIRC on that day was "insufficient for the job"? Please explain why you hold this view.

I believe that I have covered this as fully as I am able to in my answer to question 27. I do not have anything more to add, other than that Police Scotland had 17,272 full-time equivalent (FTE) police officers in Scotland on 30 June 2015 (Police Officer Quarterly Strength Statistics Scotland, 30 June 2015 – as found on the National Records for Scotland website). From memory, the PIRC had approximately 20-25 members of staff in the Investigations Department.

<u>Briefing at PIRC offices</u>

29. Within your PIRC statement (PIRC-00358), at page 2, you state that you attended a briefing at PIRC's offices in Hamilton on 3 May 2015. What was the purpose of that briefing? Was it PIRC's standard practice to convene investigators at PIRC's offices prior to deployment? If so, was this practice based on a PIRC standard operating procedure (SOP)? If not, why were PIRC investigators convened at PIRC's offices on 3 May 2015? When you spoke with DSI Harrower earlier on 3 May 2015, what, if any, consideration was given to PIRC's investigators convening in Kirkcaldy instead of in Hamilton?

It is standard practice that Investigators on-call would convene at PIRC offices in Hamilton when informed of an incident that PIRC will be deploying to. This is not within any PIRC SOP or document that I am aware of, but it is what happens. Effectively this is a decision for the Lead Investigator on-call. Apart from anything else, this is where the PIRC vehicles are based so staff need to attend at the office to collect a vehicle and any other equipment required.

It is also standard practice that the Lead Investigator on-call (in this instance DSI Harrower) would provide a quick briefing to the on-call team as to the information known up to then, and to identify what initial actions are being considered or are to be implemented.

When I spoke with DSI Harrower earlier, when he called initially to advise that there was a call out and that I was to attend at Hamilton House, we did not discuss the possibility of individually attending directly at Kirkcaldy. I'm not sure why this would have been considered. This would have meant individual members of PIRC staff attending at the PIRC office to collect a vehicle, not engaging with colleagues, then attending at Kirkcaldy Police Office in dribs and drabs without any real understanding of what we were attending and what was initially expected of us. PIRC staff don't all live in Hamilton, so would be arriving at the PIRC office at different times and then leaving in PIRC cars to attend at Kirkcaldy at different times. The other alternative was for DSI Harrower to brief each of us individually over the phone and then asking us to attend at Kirkcaldy. This would have been extremely time-consuming, particularly at a time when DSI Harrowing would no doubt have been receiving numerous phone calls with updates from Police Scotland and would have other important tasks to deal with, such as potentially briefing upwards to more senior PIRC managers and developing a plan of how to approach the initial stages of the investigation, and what further information he might require from Police Scotland in order to do this.

30. What was discussed during this briefing? What information was provided to you by DSI Harrower in relation to the incident involving Mr Bayoh and the contact he had with the officers who attended the scene at Hayfield Road? What information, if any, was provided to you in relation to Mr Bayoh being in possession of a knife? Were you informed that Mr Bayoh was in possession of a knife when he came into contact with the police officers at the scene?

From memory, DSI Harrower briefed that a number of police officers had attended at the locus, Hayfield Road, Kirkcaldy, following numerous reports to the police from members of the public relating to a black male, in possession of a knife. An altercation had taken place between this male and the officers, during which time CS spray and/or PAVA had been discharged an officer, or officers, had used their baton. During their contact with the male, he had lost consciousness and stopped breathing and CPR had been carried out. He had been taken to a nearby hospital but has since died.

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I was not specifically informed that the male had been in possession of a knife at the time of his contact/altercation with the police officers. I had not been told that any officers had been attacked with a knife. I was told that the initial reports from members of the public had mentioned a knife.

I believe there was some mention that there may have been a pre-cursor incident, and that a woman believed to be the deceased's partner/girlfriend had contacted the police. There was still work on-going by Police Scotland to establish events that led to this police contact.

31. What decisions were made at this briefing? What discussion, if any, was there in relation to PIRC's investigative strategies at this briefing? What discussion, if any, was there in relation to the status of the officers as witnesses or suspects? What discussion, if any, was there in relation to the separation of the officers involved in the incident to mitigate the risk of conferral?

I was paired with Inv Ferguson and we were all to attend at Kirkcaldy Police Office. SI Casey remained at the office to coordinate the PIRC response from Hamilton House. DSI Harrower told Inv Ferguson and myself that we would be involved in the scene management of a side room within the Accident and Emergency department of the Victoria Hospital, Kirkcaldy, from where the deceased's remains were to be forensically recovered and transported to the mortuary (in conjunction with a Police Scotland Crime Scene Manager CSM).

PIRC Investigators Maurice Rhodes, Garry Sinclair and Alex McGuire were also present at the PIRC office for this briefing. Invs Rhodes and Sinclair were to deal with the scene at Hayfield Road, and Inv McGuire was paired up with DSI Harrower. We would be attending Kirkcaldy Police Office in the first instance, at which point we would likely be given an up to date briefing from the Police Scotland senior officers who were involved in dealing with the aftermath of this incident.

32. What was your understanding of the scope of PIRC's investigation at the point the briefing was held? Did your understanding of the scope of PIRC's investigation change over the course of the day on 3 May 2015? Based on your understanding of events at this time, were you content with the scope of the investigation instructed by COPFS? Did your views about the scope of PIRC's investigation, and the appropriateness of the division of responsibilities between PIRC and Police Scotland, change over the course of the day on 3 May? If so, in what way?

My understanding at that point was that we would be attending to oversee the scenes as described in my answer to question 31. It was clear that further information would be required to definitively identify the deceased male and any pre-cursor events that led to this interaction with the police. The deceased's remains would need to be taken to the mortuary and the scene at Hayfield Road would have to be recorded and examined. Any significant evidence/productions would have to be secured, including PPE/clothing from officers involved.

It became clear throughout the day that there were a number of scenes linked to this incident and that the scenes of primary importance to the Crown instructed PIRC investigation were the deceased (Victoria Hospital) and Hayfield Road, the scene of the interaction with the police. The other scenes, although still important, would be managed by Police Scotland, however in close consultation with the PIRC Lead Investigator, to ensure that PIRC were sighted on any relevant information and were in a position to ensure that any PIRC investigative priorities were given due consideration. Police Scotland would also be carrying

out the initial House-to-House enquiries and that any information garnered would be shared with the PIRC at the earliest opportunity.

It also later became apparent that Police Scotland FLOs would not be engaging with the family, which was a divergence from what was agreed on at one of the meetings between PIRC and senior officers within Police Scotland. This led to DSI Harrower and Inv McGuire attending at the home of family members of the deceased. My initial understanding was that it had been agreed that Police Scotland FLOs would be deployed as no PIRC FLOs were available, and PIRC FLOs would have a 'handover' with Police Scotland FLOs at some later point, in the next day or two.

As previously described, I was still a trainee and did not have a lot of experience at this time. I was primarily focused on paying attention to what I specifically was being asked to do. I was not paying a great deal of attention to the wider machinations going on around me. I was also not really in a position to have an opinion regarding the scope of the investigation and the division of responsibilities between the PIRC and Police Scotland at this time. The direction of travel seemed to make sense to me, but opinions and decisions about this were well above my pay grade and my competency. I was aware at the time of a degree of disharmony in respect of the 'change' in position regarding Police Scotland FLOs being deployed but I was not particularly aware of why this had happened or what discussion/decisions led to this.

33. Your PIRC statement (PIRC-00358), at page 2, states that, along with Investigator John Ferguson, you were instructed to deal with scene management of a side room within the Accident and Emergency department of Victoria Hospital and the forensic recovery of Mr Bayoh's body to the mortuary. What did this role involve? What is involved in the recovery of a body following a death in custody? How were responsibilities for this role split between yourself and John Ferguson? How many times had you carried out this role prior to 3 May 2015? Had you performed this role in a death in custody investigation prior to the incident involving Mr Bayoh? What were your initial priorities and considerations in relation to the Victoria Hospital scene and the recovery of Mr Bayoh's body?

This involved recording of the deceased by way of still photography. It involved taking tapings from the surface of the deceased's body, at his head (including his face), his neck and his arms. This was so that any minute, trace evidence could be obtained. His nose and mouth were to be swabbed in an effort to capture any traces of CS Spray of PAVA. His clothes were to be removed and searched (pockets etc.) and were to be forensically packaged so that their forensic integrity would be protected for any potential future examination.

Finally, plastic bags are secured/tied around the deceased's head and hands, again to protect the forensic integrity (avoid contamination) for any future examination, notably the post mortem.

All of the above has to be done is a forensically aware environment, with all individuals being dressed in the appropriate forensic clothing, with masks and gloves etc. Everything has to be meticulously packaged and labelled and recorded so that it stands scrutiny.

The majority of this work was done by the SPA Scene Examiners, as this is their day job and they are the experts. The work is overseen and directed by the Scene Manager, however the approach to be taken is discussed beforehand so that everyone present knows what their

role is, and to avoid lengthy discussions etc. whilst everyone is dressed in PPE dealing with the deceased. That does not mean that there is no room for discussion and further consultation when required.

In fact, during the recovery of items etc. from the deceased, there was some discussion around the removal of medical intubation equipment. Due to there being blood within the deceased's mouth and nostrils, a discussion took place which resulted in a decision to remove and retain the intubation tube for potential future examination. It was also decided not to obtain swabs from inside the deceased's nose or mouth. This was discussed between Inv Ferguson, the Police Scotland Crime Scene Manager (CSM) Peter Grady and the Senior of the two SPA Scene Examiners, Gordon Young. A doctor who had worked on the deceased removed this, along with other items attached to the deceased in terms of 'medical intervention', cannulas etc.

I stood back and observed. I took notes in relation to what was going on and the productions / items that were seized. These notes were then transferred into my statement. I do not believe that I kept these notes as they were pretty much duplicated exactly in my statement. Due to my relative inexperience, I was not involved in any decision-making. I had never been involved in a body recovery prior to this date.

The initial priorities were to assess the body for any indications of significant injuries, so that this could be reported back to DSI Harrower. Although a number of small injuries/marks were apparent, in the form of cuts, bruises and abrasions, there were no obvious signs of significant injuries. This certainly seemed to be the prevailing opinion of my more experienced colleague. I did not observe any obvious injuries that I believed could have resulted in death, although that was a layman's opinion. I recall there being a nasty bruise/abrasion to the deceased's forehead.

Following that, the preservation and recovery of any potential trace evidence was prioritised, as per the tapings and swabbing previously described. Then it was the removal and packaging of items/productions, in terms of clothing and medical interventions, as previously described. From memory, the deceased's t-shirt was bagged in a special nylon bag due to the belief that it was likely heavily contaminated with PAVA and/or CS Spray.

Local undertakers were contacted and attended at Victoria Hospital, to convey the deceased to the Edinburgh City Mortuary via private ambulance. Inv Ferguson and I followed directly behind the private ambulance, with it in sight at all times. DC Grady also attended at the City Mortuary to assist, as he was aware of the local arrangements. As it was late at night the Mortuary was closed and DC Grady had made arrangements to get possession of the keys. Once we had all gathered at the Mortuary, DC Grady afforded us entry and he and Inv Ferguson filled out details in the Mortuary book and the deceased was moved inside the mortuary. Arrangements were made with DC Grady in respect of attending at the Post Mortem alongside Inv Ferguson and I the following day.

34. Following DSI Harrower's briefing, were you clear in relation to your role and responsibilities within the investigation? If not, why not?

Yes, I was.

35. On 3 May 2015, what involvement, if any, did DSI Harrower have in the management of the scene at Victoria Hospital and the decisions made in that regard? Did DSI Harrower sign off on all "priority actions" in relation to the scene at Victoria

Hospital, as set out within PIRC's scene management log (PIRC-01464, page 6)? Who at PIRC was ultimately responsible for the management of the scene at Victoria Hospital?

A Forensic Strategy Meeting was held at Kirkcaldy Police Office prior to our attendance at the Victoria Hospital scene. This was attended by all PIRC staff including DSI Harrower. It was also attended by a number of senior Police Scotland officers, as well as Police Scotland Crime Scene Managers.

The approach that was going to be taken at the Victoria Hospital was discussed at this meeting and agreed by those present. Foremost amongst them for the PIRC was DSI Harrower. I am not sure when the Scene Management Log was completed as I did not do this, however having read this (it having been provided by the Inquiry Team) I do not see anything contained within the priority actions that were not agreed with DSI Harrower.

The overall strategy for the investigation and its priorities is set by DSI Harrower. He will discuss his aims in respect of what he wants to achieve at each scene with the relevant Scene Manager, in this case Inv Ferguson. The Scene Manager will give advice and agree on the approach with the Lead Investigator, DSI Harrower, and will report anything that comes up during the processing of the scene that appears significant, or any changes to the approach agreed upon that may be suggested/required once a full assessment of the scene has been carried out by the Scene Manager. The strategy is determined by the Scene Manager in consultation with the Lead Investigator, however the management of the scene ultimately lies with the Scene Manager actually 'on the ground'.

36. Your PIRC statement (PIRC-00358), at page 2, identifies that SI Casey did not deploy to Kirkcaldy and remained in Hamilton, "coordinating the PIRC response from Hamilton House". Why did SI Casey remain in Hamilton, rather than deploy to Kirkcaldy with the rest of PIRC's investigators?

I do not know why SI Casey did not deploy to the scene, other than as stated in my original statement.

37. Following the briefing, what contact did you have with SI Casey on 3 May 2015? In what way did SI Casey coordinate PIRC's response to the incident on 3 May 2015? Did you regard SI Casey or DSI Harrower as being in charge of PIRC's investigation in relation to the incident involving Mr Bayoh?

This was my first on-call deployment to an incident with the PIRC so I had no real awareness of what the expectations of the role of the SI were in such circumstances. I had limited contact with SI Casey on the day in question and took my instructions from DSI Harrower. I did not receive any instructions from SI Casey and I was unaware of what discussions he may have had with DSI Harrower or other managers at PIRC, or with COPFS or Police Scotland on 3 May 2015. I was concentrating primarily on what I was being asked to do.

38. What involvement, if any, did you have in compiling the scene management log for Victoria Hospital (PIRC-01464)? What was the purpose of this scene management log?

I was not involved in compiling the Scene Management log for Victoria Hospital. Scene Management Logs are used to record decision-making and what information was known at the time decisions are made. It also records who attends a scene, who is given entry, if they

are appropriately forensically dressed. It records all significant details of a scene for the duration of the time it is being processed.

39. The scene management log for Victoria Hospital (PIRC-01464), at page 5, appears to identify that you and John Ferguson would "assume scene management for deceased and Kirkcaldy PO". Was it ever considered necessary for Kirkcaldy Police Office be designated as a "scene" on 3 May 2015? If so, for what reason? Should the reference here to "Kirkcaldy PO" instead refer to "Victoria Hospital"?

I can only assume that this is a 'typo'. I was never under the impression that Inv Ferguson was to be involved in Scene Management at Kirkcaldy Police Office.

Cooperation with Police Scotland

40. Your PIRC statement (PIRC-00358), at pages 2 and 3, identifies that management of the scene at Victoria Hospital, and the forensic recovery of Mr Bayoh's remains, was to be completed in conjunction with a Police Scotland Crime Scene Manager. Was PIRC or Police Scotland in charge of the scene Victoria Hospital? What were PIRC and Police Scotland's respective responsibilities in relation to the scene at Victoria Hospital?

It had been clearly articulated throughout the day that the PIRC had primacy over the scene at Hayfield Road and the scene at Victoria Hospital (the deceased). This meant that any decisions made would be directed by the PIRC. The strategy and approach to the scene had been discussed and agreed upon at Kirkcaldy Police Office, with DSI Harrower and Inv Ferguson at the forefront of decision-making. Everyone knew that this was a PIRC scene and what was expected in relation to this. Police Scotland's roles was to facilitate and assist. For example, making contact with SPA Scene Examination through the police Area Control Room to ensure Scene Examiners would attend. To ease access at the hospital, as most medical staff would have no idea who the PIRC are and may be concerned about allowing PIRC access to the deceased. Assistance in terms of local arrangements, e.g. which undertakers are for police incidents in that locale. Assistance with after-hours access to the mortuary. Inv Ferguson reiterated to DC Grady and the Scene Examiners that PIRC had primacy at this scene during our discussions prior to leaving for the hospital.

41. Is it standard practice for PIRC to manage a scene in conjunction with Police Scotland during a PIRC investigation following a death in police custody or death following police contact? If so, what are the benefits of this approach? If not, why was this approach adopted in this investigation?

It was not (is not) uncommon for PIRC staff to work alongside staff from Police Scotland in relation to the management of scenes. I was not involved in the decision for there to be a Police Scotland Scene Manager involved in the scene at Victoria Hospital, however I was not concerned about it either. The Police Scotland Scene Manager had 'local knowledge' of procedures and access to the information required to facilitate the scene examination.

It is also true that procedures and practices in relation to Scene Management change and are updated. PIRC Scene Managers are utilised much less often the Police Scotland Scene Managers. It may be the case that Police Scotland Scene Managers would be able to provide advice or information regarding any updates in processes and procedures that may be relevant. They also have a much closer working relationship with the SPA Scene Examiners as they are working with them all the time. PIRC cover the whole of Scotland,

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and will not necessarily be aware specific local arrangements at hospitals or with undertakers etc. Local knowledge from Police Scotland staff is extremely important in assisting in the smooth processing of a scene. PIRC's primary role is to ensure that the decision-making is independent of the police (i.e. if PIRC's domain) to ensure that the priorities of the PIRC Investigation are carried through.

42. During a PIRC investigation following a death in custody or death following police contact, is it possible for PIRC to manage a scene without the assistance of Police Scotland? If not, why not?

It is possible for the PIRC to manage the processing of a scene without the assistance of Police Scotland and my understating is that this has been done on a number of occasions. For example, if there were no Police Scotland Scene Managers available to assist, e.g. if there was another major incident like a murder locally that Police Scotland were having to resource. If the PIRC investigation related to a relatively simple scene, like an apparent drugs death within a police cell, this could be processed without the assistance of Police Scotland. Scenes normally require a number of people to process though, like locus protection officers, a scene loggist, a productions officer etc. Other scenes may require additional risk assessments in respect of members of the public, road closures, due to the presence of firearms or ammunition etc. Or there may be related criminality that the PIRC does not have jurisdiction to investigate, like a prior assault on the deceased by a member of the public before contact with the police. It is rarely clear-cut as 'this is a PIRC scene' and the police have no reason or right to be there. PIRC's role is to ensure a thorough and independent investigation. That may involve the assistance of the police.

43. What impact, if any, does the continued involvement of Police Scotland in the management of scenes following a death in custody or death following police contact have on PIRC's actual or perceived independence?

The most important thing for any scene is that it is secured, that evidence is preserved and that the conditions are in place for the fullest harvesting of any potential evidence. If working in conjunction with officers from Police Scotland is necessary to ensure all of this, then I think this is what needs to be done. When the PIRC have primacy over a scene it means that the decision-making as to how this scene is managed is independent and allows for the focus/priorities of the PIRC investigation to be paramount.

I think that the role of the PIRC and the size/resources of the PIRC is not particularly well understood by the wider public, or those who comment about the PIRC in the media. If the expectation is that every single aspect and task carried out in a large, complex investigation should be carried out specifically by a PIRC employee, then the level of funding, staffing, resources (including premises across Scotland) that would be required would need to be vastly increased. The PIRC is (and particularly in 2015) a fairly small organisation with a fairly small budget.

I have never felt that the integrity or independence of a scene that I have attended for the PIRC has been compromised by the continued involvement of Police Scotland. That is not to say that it would always be appropriate for the continued involvement of the police at the scene in a PIRC investigation. I suppose that it would depend on the circumstances. I understand that the perceived independence of the PIRC may suffer from continued involvement of the police at a scene in a PIRC investigation.

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44. Was PIRC sufficiently independent from Police Scotland? How was this independence ensured?

In my opinion, the PIRC was sufficiently independent in respect of the management of the scene at Victoria Hospital. As detailed above, although discussions were had with Police Scotland in respect of the management of all of the numerous scenes related to this incident, primacy for the scene at Victoria Hospital (the deceased) lay with the PIRC, who were supported by DC Grady. As previously described, this was reiterated by Inv Ferguson to all those who participated at the scene prior to leaving Kirkcaldy Police Office. Nothing happened during the processing of this scene that interfered with the PIRC investigation.

The only issue related to the two DCs who were standing by the scene and who had not been wearing forensic suits. They had also put a number of what should have been separate items into one single bag. Two boots, some clinical waste and blood samples. This was noted by Inv Ferguson. I believe that these officers had been present within the A&E department whilst medical staff were still working on the deceased, well before PIRC involvement.

45. Had the Hayfield Road scene been identified as a potential crime scene what, if any, steps would have been taken differently by PIRC in relation to the management of the scene at Victoria Hospital and the recovery of Mr Bayoh's body on 3 May 2015?

One of the basic principles of an investigation into an unexplained death is that it should be treated as a potential homicide, until/unless evidence to the contrary shows otherwise. At this point the cause of Mr Bayoh's death was unknown. In respect of the processing of the scene at Victoria Hospital, it was processed in line with this.

Arrival at Kirkcaldy Police Office

46. Your PIRC statement (PIRC-00358), at page 3, identifies that you arrived at Kirkcaldy Police Office at around 1400 hours. Having been informed about the incident at 0935 hours, do you consider there was any delay in PIRC's investigators arriving in Kirkcaldy? If so, what impact, if any, did the delay in PIRC's arrival at Kirkcaldy have on the investigation?

DSI Harrower would have had to contact senior management within PIRC to alert them, liaise with Police Scotland and potentially COPFS to establish as much information as possible and then alert the on-call team. I was contacted by DSI Harrower at about 1030 hours, within an hour of him first being made aware of the incident. Once I got dressed into my suit and grabbed my folder etc. I made my way directly to the PIRC office in Hamilton. We received a briefing from DSI Harrower and then made our way directly to Kirkcaldy. I'm not sure that this represents a significant delay.

As previously mentioned, I do not feel that PIRC staff heading directly to Kirkcaldy without having been briefed on the information known to that point, and without an idea of what the initial PIRC priorities were, would have been a useful way to proceed.

The PIRC cover the whole of Scotland from a single premises in Hamilton. Staff are expected to be within an hour's drive of the office should they be contacted whilst on-call. The PIRC does not work shift patterns with members of staff ready to be deployed at a moment's notice to any part of Scotland. I have previously explained that the PIRC is not set up or funded to be able to achieve this.

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The Lead Investigator on-call is expected to liaise with the police to advise what he/she expects will be done (or not done) by the police before the PIRC will be able to attend. This will be recorded in their notes. The PIRC decision-making starts pretty much immediately. However, the logistics involved may mean that PIRC staff having 'boots on the ground' may take some time, depending on location and circumstances.

47. Prior to your arrival at Kirkcaldy Police Office, what, if any, communication did you and John Ferguson have with Police Scotland's officers in relation to the management of the Victoria Hospital scene and the recovery of Mr Bayoh's body?

I had no contact with anyone at Police Scotland in relation to the management of the scene at the Victoria Hospital. As previously described, I was a trainee and would be observing/corroborating what went on and assisting as directed by my experienced colleague Inv Ferguson. I am unaware as to whether or not Inv Ferguson spoke with anyone at Police Scotland prior to us leaving for Kirkcaldy. I cannot remember if he did or didn't.

48. When you arrived at Kirkcaldy, what investigation, if any, did you consider Police Scotland to be carrying out? Was that investigation appropriate? Do you consider the delay in arriving at Kirkcaldy to have, in any way, affected PIRC's ability to lead the investigation? If so, in what way was PIRC's ability to lead the investigation affected?

As previously described, I was concentrating primarily on what I would be asked to do at the Victoria Hospital. My best recollection is that Police Scotland had secured a number of scenes and were largely standing by them. I believe that efforts were being made to find out what Mr Bayoh's movements had been in the run up to the incident. I think there was information that his partner, Colette Bell had contacted the police and that she and potentially other civilian witnesses were being spoken to about what they knew. There was also discussion about attempts to verify the identification of the deceased.

There was discussion around the deployment of Police Scotland FLOs, although this had not been done by the time we arrived at Kirkcaldy. I think there may have been discussions about road closures and messages to be prepared for the media in respect of road closures etc. I don't recall much detail in respect of this. I do not remember thinking that anything that was being done was inappropriate, however I had limited experience at that time so probably wasn't making those sorts of judgements.

It obviously took time for us to travel to Kirkcaldy from Hamilton, I'm not sure that I would call it a delay. As previously described, the PIRC Lead Investigator on-call would normally be in near constant contact with a counterpart at Police Scotland on the phone (whilst travelling to the location) to discuss what was happening prior to the arrival of PIRC staff. I was not travelling with DSI Harrower so I don't know what contact he was having with Police Scotland during his journey, or what instructions he may have given. He would be better placed to comment on how his ability to lead the PIRC investigation was affected.

<u>Gold Group meeting 1400 hours</u>

49. Your PIRC statement (PIRC-00358), at page 3, notes that you attended a meeting with Police Scotland staff, chaired by ACC Ruaraidh Nicolson, at approximately 1400 hours. What was discussed at this meeting? What decisions were taken in relation to scene management and the recovery of Mr Bayoh's body?

From memory, the local Detective Inspector (DI) Colin Robson provided an overview of the information known up to that point. This included that a number of members of the public had called in to report a black male with a knife in the street/road in Kirkcaldy, near to a hospital I think (possibly a local psychiatric hospital, although I couldn't be certain about this). Possibly some mention that the male had been chasing or attacking cars. At least some of these callers had stated that he was in possession of a large knife.

Officers had attended from Kirkcaldy Police Office and there had been a confrontation with the male. This had led to Pava and/or CS Spray being used on the male, and a baton. There was mention of a female officer having been assaulted by the make, possibly by being kicked and struck to the back of the head. I think it was known that she was not seriously injured and did not require any extensive medical treatment.

The male had become unconscious and later stopped breathing. CPR was carried out and he was taken to a local hospital by ambulance. He had later died at hospital.

If I recall correctly there was also mention of a knife being recovered from a grassy area near to where the officers had engaged with the male. I do not recall there being any suggestion that the male had presented the knife at officers or had used it during the confrontation. The knife had been photographed by a detective officer at the scene on his own phone and had recovered/seized it after this, possibly due to inclement weather conditions. (I am not entirely sure when this was first mentioned, but I think it was at this meeting, to the best of my knowledge. It was a long time ago).

I'm pretty sure that there were discussions about some kind of precursor event or events and that there were witnesses (the deceased's partner and friend) being spoken to by Police Scotland officers to try to gain further information about this. It was possibly known at this point that there had been a fight between the deceased and Saeed Zahid.

A number of loci had been identified. The two of primary significance to the PIRC were identified as Hayfield Road and the Victoria Hospital (deceased). The other loci were being progressed by Police Scotland.

I do not remember any decisions being taken in relation to the management of the scene at the Victoria Hospital or the recovery of the deceased's body being taken during this meeting. The locus was being 'stood by' by detective officers, but nothing was being progressed at that point.

50. What were PIRC's priorities in relation to the investigation at the time of the Gold Group meeting at 1400 hours? How were these priorities communicated to Police Scotland during the meeting?

I remember there being importance attached to ensuring that FLOs (Police Scotland FLOs at this point) being deployed to the family. I remember that the 2 aforementioned scenes were to be the PIRC's focus, i.e. the preservation and recovery of evidence from these scenes. Attending officers were to be asked for witness statements and their clothing and PPE was to be seized.

51. Was PIRC in charge of the investigation at the point the Gold Group meeting was held at 1400 hours? How was this demonstrated to be the case? If not, why not? At what stage on 3 May 2015 did you consider PIRC to be in charge of the investigation?

Signature of Witness [redacted].....

If you did not consider PIRC to be in charge of the investigation at the point the Gold Group meeting was held at 1400 hours, who did you think was in charge?

COPFS had instructed the PIRC to investigate the death, the lead up to the confrontation with police officers at Hayfield Road was to remain under investigation by Police Scotland, with the PIRC kept updated on developments and to be consulted on any significant decisions that needed to be made, to ensure that these were made in line with PIRC investigative priorities for the wider death investigation. That was my understanding at the conclusion of this first meeting at Kirkcaldy Police Office.

It had been clearly articulated that the PIRC had primacy over the scene at Hayfield Road and the scene at Victoria Hospital (the deceased). This meant that any decisions made would be directed by the PIRC. The PIRC Lead Investigator would be responsible for ensuring that their investigative priorities were discussed and agreed, however this would be a collegiate discussion, with PIRC ensuring independence of decision-making. It is not a case of the PIRC arriving and shutting down the police response and taking over every aspect of what follows. It is a discussion, with PIRC ensuring independence and integrity of the investigation.

52. Following a death in police custody or a death following police contact, are meetings in relation to the investigation usually chaired by an officer from Police Scotland? If not, why was the Gold Group meeting at 1400 hours chaired by ACC Nicolson?

Following a death in police custody, or following police contact, there are a number of considerations that need to be addressed. Although the investigation into the circumstances of the death is of paramount importance, it is not the only consideration. Many of these other considerations are within the police's domain, not the PIRC's. For example, the possible wider community impact (i.e. will there be reprisals relating to a death, are other members of the public at risk, is it likely that family members or members of the public may attend at scenes, do road closures need to be put in place, does the media/public need to be informed of any disruption or road closures etc.) There may be significant implications for police resourcing, to back-fill any officers that have been involved in an incident and are no longer able to be committed to their usual duties, as well as to assist in locus protection for 7 scenes, or other tasks. Sometimes custody centres, or parts of custody centres are shut down for a period (to allow an investigation to be progressed) and prisoners may need to be re-routed to other police offices, or they may need transferred out of the custody centre in question, and moved elsewhere. The welfare of the officer's involved will also need to be addressed and it is the police that are their employers and have responsibility for them.

A Gold Group Meeting is a meeting that the police will be having regardless of PIRC involvement as it is where senior officers on duty address all of these considerations. The practice has developed that the PIRC Lead Investigator or a senior PIRC manager (and sometimes others as in this case) will attend these meetings. This prevents policing decisions that may impact on a PIRC investigation from being taken out-with the knowledge or input of the PIRC. This is where the most up-to-date information and strategies will be discussed.

53. The typed minutes of the Gold Group meeting (PS07268), at page 2, refer to a "Loci Strategy" as part of the "Investigative process". What did this loci strategy comprise? Who was responsible for creating this strategy? What input, if any, did

PIRC provide in relation to the creation of the loci strategy? Were you content with the content of the strategy in relation to the scene at Victoria Hospital? If not, why not?

I do not know what particular 'loci strategy' this refers to, or whether this was simply identifying that loci strategies would need to be developed for each individual loci. I did not contribute to the compiling of these minutes. My clearest memory of discussion of loci strategy was later, involving PIRC staff and DCI Stuart Houston.

54. The typed minutes of the Gold Group meeting (PS07268), at page 3, refer to consideration of "community issues" and, at page 4, refer to "cultural issues". What community and cultural issues were discussed at the Gold Group meeting and what consideration did PIRC give to such issues on 3 May 2015? Did you consider that any such issues were relevant to the management of the scene at Victoria Hospital and the recovery of Mr Bayoh's body? If so, in what way?

I do not recall any specific discussion around 'community issues' or 'cultural issues' at this meeting. That's not to say that it didn't take place. But I don't remember it. Again, I wonder if this was simply a note identifying that this was a task that should be undertaken.

As far as I know, a Community Impact Assessment (CIA) would normally be carried out by the police in circumstances such as these, but this would be tasked to an individual and not be completed during a Gold Group Meeting. Someone with local knowledge would complete a CIA and then report back anything of significance that his might throw up. That is just my understanding though, a Gold Group Meeting is ostensibly a police practice and therefore someone from Police Scotland may be better placed to elaborate on this if required.

I do not recall any specific mention of cultural issues that were relevant to the management of the scene at Victoria Hospital at that time.

55. The typed minutes of the Gold Group meeting (PS07268), at page 4, state:

> ***PIRC looking for definitive point of contact with knowledge of all circumstances.***

What were PIRC looking to achieve in this regard? What steps, if any, were taken by Police Scotland to accommodate this request? Did you feel at this stage that you had sufficient knowledge of the circumstances of the incident to allow you to manage the scene and recover Mr Bayoh's body, as you had been tasked to do? If not, why not?

I do not remember this aspect of the Gold Group Meeting. I do not recall this being mentioned or what was meant by this. It would not have been me who asked for this.

I was not going to be managing the scene, it would be Inv Ferguson who would be managing the scene on PIRC's behalf, with the assistance of DC Grady. I would be there to observe and perform any task asked of me by Inv Ferguson or DSI Harrower. I cannot stress enough that I was slightly less that two years into my career at the PIRC and was still a trainee. I was in no way responsible for decision-making regarding any aspect of scene management. I was an extra pair of hands, a corroborating officer and largely an observer.

Following our meeting with DSI Harrower and DCI Houston later that afternoon, we had a clear idea of what we were to do. The SPA Scene Examiners were not involved in that meeting, I'm not even sure if they had arrived at that point. Inv Ferguson and I would go on

to have a meeting with them, and DC Grady, to relay the relevant information to the SPA Examiners, who would be performing a lot of the hands on tasks.

56. The typed minutes of the Gold Group meeting (PS07268), at page 4, state:

> ***As above prioritising***
> ***- scenes – initial locus, hospital/ambulance***

What, if any, involvement did you have in managing the scene at the ambulance in which Mr Bayoh was taken from Hayfield Road to Victoria Hospital?

I had no involvement in managing a scene in relation to an ambulance. I do not recall being asked to have any involvement in dealing with an ambulance. I do not recall if the ambulance was back in service or whether it had been taken off the road.

57. At this stage on 3 May 2015, what was your understanding of the status of the officers involved in Mr Bayoh's arrest? Were they witnesses or suspects? How did you come to be aware the officers' status on 3 May? What discussion, if any, was there in relation to the officers' status at the Gold Group meeting at 1400 hours?

I don't remember specifics but my understanding was that the officers involved were witnesses, as they were to being asked to provide statements. If they were being considered suspects in relation to a crime at that time they would not have been asked to provide statements. I think DSI Harrower confirmed that they were witnesses, but I don't remember in any detail. My understanding was that Inv McGuire was taking notes of behalf of DSI Harrower.

58. What are the circumstances in which a person is treated as a suspect by PIRC? Do you consider that it is PIRC's responsibility to decide whether to categorise a person as a witness or a suspect during an investigation? What is the significance of treating a person as a suspect?

If there is a reasonable suspicion held that an individual has committed a criminal offence then they should be treated as a suspect. In order to have committed an offence you need to have committed the illegal act and have intended to do so. If you had not necessarily intended to commit the act, then you need to have been so reckless in your conduct that led to the act being committed, that your intent (or otherwise) is irrelevant.

If a person is being treated as a suspect, then they have obvious legal rights that would need to be considered, e.g. right to remain silent (i.e. not to incriminate themselves by providing evidence that may be used against them), the right to legal representation etc. You would not approach a suspect for a witness statement, for example.

In circumstances such as these, i.e. a death following a 'use of force' / restraint, if a PIRC investigation identified an individual (police officer or member of police staff) as a suspect, it would be my expectation that there would be immediate liaison between the PIRC Lead Investigator and COPFS to determine how to progress, e.g. suspect interview rather than witness statement.

59. Within Detective Chief Superintendent Lesley Boal's operational statement (PS00669), pages 2 – 3, she states:

About 1330hrs Mr HARROWER and other PIRC investigators attended. A briefing, which provided the same information as provided at the Gold Meeting was provided. It was confirmed at this time that Sheku Ahmed Tejan BEYOH's sister was his next of kin and that she lived [redacted]. I highlighted to Detective Superintendent CAMPBELL that, given the information and chronology established along with identification by photograph, there was an urgent need to notify her of the death.

In the absence of any strategy being discussed, I suggested that, in the interim, each police lead would draw up a strategy, for example forensic strategy, house to house strategy etc and obtain Mr HARROWER's agreement and sign off prior to implementation. This didn't receive clear endorsement. The only real information provided was that there would be PIRC investigators deployed to the hospital to undertake body transfer to the mortuary; a couple of PIRC investigators would be deployed at the main scene at Hayfield Road, Kirkcaldy and Family Liaison would be handed over to the PIRC at an early juncture.

What strategies had PIRC considered or developed prior to the Gold Group meeting at 1400 hours? Did you attend the briefing to which DCS Boal refers? If so, would you agree with DCS Boal's assessment that there was an "absence of any strategy" discussed at the meeting? If so, why? If not, why not? What strategies were agreed with Police Scotland at this meeting? With whom did responsibility for the development of investigatory strategies lie at this stage?

As previously stated, I was a trainee investigator at the time of this incident, with limited experience. I was not involved in the development of PIRC strategies. I was there to assist my more experienced colleague, Inv Ferguson, with any specific tasks asked of us. We were asked to progress the scene at Victoria Hospital and have the deceased taken to Edinburgh City Mortuary. This was the extent of my involvement and what I was focused on.

I believe I was at a meeting where DCS Boal was present. I had believed that this was the meeting that is recorded as the Gold Group Meeting within PS-07268. It was attended by ACC Nicholson as well, as far as I can recall. I can't recall if there was an initial 'briefing' meeting (with pretty much all the same people attending) that was then followed by a Gold Group Meeting.

I find it strange that a Detective Chief Superintendent would come away from such a meeting where they felt that there was an "absence of any strategy" discussed. She was the senior detective officer in attendance for Police Scotland, so a lack of discussion around strategy would presumably be a omission by her, as much as by anyone else there. I appreciate that the PIRC Lead Investigator would be responsible for ensuring that their investigative priorities were discussed and agreed, however this would be a collegiate discussion, with PIRC ensuring independence of decision-making. It is not a case of the PIRC arriving and shutting down the police response and taking over every aspect of what follows. It is a discussion, with PIRC ensuring independence and integrity of the investigation.

60. Were you aware on 3 May, or at any point subsequently, of any concerns expressed by staff or officers from Police Scotland about PIRC's management of the investigation? If so, how were you made aware, and what did you understand those concerns to be? Did you share knowledge of these concerns with others at PIRC? What did you do, if anything, to address those concerns?

Signature of Witness [redacted] .....

I do not remember being aware of concerns raised by officers from Police Scotland about PIRC's management of the investigation. The main point of friction that I remember was around the deployment of Police Scotland FLOs. It was my understanding from fairly early on, after arriving at Kirkcaldy Police Office, that Police Scotland FLOs were being deployed and that PIRC FLOs would complete a handover at a later point. The next day at the very earliest. It later emerged that Police Scotland did not (or were not able to) deploy FLOs. I can't really remember the specifics of why this was. I think I only became aware of this whilst Inv Ferguson and I were at the Victoria Hospital scene, although I couldn't be sure.

Meeting with DCI Houston

61. Your PIRC statement (PIRC-00358), at page 3, refers to PIRC staff meeting with DCI Stuart Houston to discuss "the specifics of Scene Management arrangements". John Ferguson's PIRC statement (PIRC-00363), at page 3, states that during a meeting with DCI Houston at 1515 hours "agreement was reached on how the now deceased's body would be dealt with at the hospital". What was discussed with DCI Houston at this meeting? What was agreed? What, if any, instructions or direction did you and John Ferguson provide to DCI Houston at this meeting in relation to the scene at Victoria Hospital and the recovery of Mr Bayoh's body?

I remember that a summary was provided in relation to each of the scenes that had been identified at that point. I remember that there was specific discussion around the use of PAVA and/or CS Spray. The results of possible interaction between these two substances was something that we were conscious of. The effects of these substances when combined was an unknown to those present, therefore something that we wanted to take cognisance of when it came to swabs and tapings etc. so that hopefully we could show if there were quantities of either, or both, of these substances on the deceased, to inform any future testing or analysis.

It was confirmed that the scene at Victoria Hospital (deceased) and at Hayfield Road (locus of interaction between the deceased and the police) would be overseen by PIRC investigators with the assistance of Police Scotland Scene Managers. From memory, Inv Ferguson took the lead on discussions with the Police Scotland representatives, in respect of what actions would be taken at the hospital. I do not remember there being any great divergence of opinion as to what required to be done at the hospital and with the deceased.

PIRC Investigators Sinclair and Rhodes would be overseeing the Hayfield Road Scene, with the assistance of a Police Scotland Scene Manager. I do not recall specifics of what was mentioned in respect of this scene. There may have been discussions about searches of gardens or drains, but I really can't remember clearly. It was a long time ago and this was not a scene I was going to be involved in.

Again, as I was a trainee, I was not making suggestions or giving directions. I was observing and paying particular attention to what I was being asked to assist with specifically. I do not remember their being any great divergence of opinion as to what required to be done at the hospital and with the deceased, so there was broad agreement with what had to be done. It was not a case of PIRC staff directing and telling Police Scotland staff what to do, or not to do. I believe swabs were to be taken from the deceased's nose/mouth for any potential PAVA/CS Spray. He was to have tapings taken from his head/face/neck and arms. Clothing was to be forensically seized and there was particular mention of an item of clothing, I think a t-shirt, that had to go in a nylon bag due to exposure with PAVA/CS Spray. Any items

within clothing were to be seized and documented and the body was to be bagged in a particular was, prior to removal to Edinburgh City Mortuary.

There was a discussion between experience professionals as to what evidence/productions would need to be taken and what swabs/tapings might be expected. There was agreement on the best way forward and PIRC staff would be there to oversee what was going on and provide input on any decisions that may need to be made. Police Scotland staff Scene Managers would assist with logistics, local knowledge and any relevant advice.

62. What discussions, if any, took place at this meeting in relation to the status of the police officers as witnesses?

I do not recall discussion taking place during this meeting regarding officers' status. They may have done but I just can't remember. Again, this was not my focus as it was not something that involved what I was being tasked to do. We would not have been treating the scene at Victori Hospital or the deceased any differently, as I have alluded to in a previous answer.

Meeting at 1645 hours

63. Did you attend the forensic strategy meeting at 1645 hours on 3 May 2015? If so, what was discussed at this meeting? What was agreed? Did PIRC adopt Police Scotland's forensic strategy (PS01298) in its entirety at this meeting? Were you content with the strategy set out in relation to the recovery of Mr Bayoh's body (PS01298, page 3) and within the minutes from the forensic strategy meeting (PS01298, page 6)? If not, why not?

I do specifically remember the meeting between PIRC staff and DCI Houston, it was in a different room within Kirkcaldy Police Office, compared to the larger briefing / Gold Group meetings. Today, I honestly cannot recall if I then attended an additional forensic strategy meeting involving others from Police Scotland. I see in Inv Ferguson's statement that he mentions discussions around photographing PC Nicole Short in relation to injuries she claimed she had, at this 2nd meeting. I do recall some form of discussion around this, that she had been seen by a doctor and was not seriously hurt and that she had agreed to have injuries photographed.

64. Beyond the forensic strategy, what further strategies, if any, were put in place in relation to scene management during the course of PIRC's investigation?

As previously mentioned, I was not involved in the development of PIRC scene strategies. I am not aware of, or cannot remember additional strategies regarding PIRC scene management, other that what I have previously described.

65. Is it standard practice for PIRC's investigative strategies to be based on those created by Police Scotland? If so, what are the benefits of this approach? If not, why was this approach adopted in this investigation?

It is not a standard practice for PIRC investigative strategies to be based on those created by Police Scotland. It is normally always the case that by the time the PIRC have been alerted to an incident having occurred, there will already be a degree of scene management underway. The first attending officers would normally instigate locus protection and possibly a scene log and Common Approach Path. Detective officers would normally already be in

attendance, and a Police Scotland Scene Manager may already be in attendance and taking early decisions (perhaps due to inclement weather etc.) There will likely already be an initial working strategy and risk assessment of a scene.

When PIRC become involved it would be fairly common practice to ask what has been done up until the point that PIRC have become involved, and what the Scene Manager had been intending to do going forward. It would be at this point that PIRC investigators may then give specific directions, which can include waiting until PIRC investigators attend before progressing.

As previously described, Police Scotland Scene Managers are specialists who are attending scenes on an extremely regular basis. They are aware of local arrangements and any updates to processes and procedures, so their assistance and advice is invaluable. However, from the time that the PIRC become involved, decision-making regarding what happens at scenes should be done in consultation with, or at the direction of PIRC staff.

66. Could an approach have been agreed with Police Scotland in relation to the scene at Victoria Hospital, and in relation to the recovery of Mr Bayoh's body, prior to this meeting at 1645 hours? If not, why not? If so, what impact, if any, did the delay in agreeing an approach have on PIRC's investigation?

There were a number of scenes involved in this incident and other aspects of the investigation which also had to be discussed between the PIRC Lead Investigator and senior police officers. It is important that all those attending a scene are aware of the possible implications from other scenes and have some understanding of what it is believed has happened. I am not sure what particular benefits there would have been in agreeing an approach prior to this meeting. I am not sure what 'impact' any perceived delay had.

67. Alex McGuire's notebook (PIRC-04184), at page 5, under the heading "1645 Forensic Strategy mtg", states:

Religious considerations.

What consideration was given to Mr Bayoh's religion at this forensic strategy meeting? What consideration, if any, did you give to Mr Bayoh's and/or Mr Bayoh's family members' religion(s) on 3 May 2015? As at 3 May 2015, what awareness did you have of the impact that a deceased's religion might have on the recovery of their body or their post-mortem? What, if any, training had you received in this regard? What, if any, written guidance was available to you in this regard?

I cannot recall discussions regarding Mr Bayoh's religion at this meeting, if indeed I attended this meeting. That is not to say that there weren't discussions regarding this, but I don't remember them. My first real memories of discussing Mr Bayoh's religion was probably at the Post Mortem the following day. I don't recall how I came to know that it was believed that Mr Bayoh was Muslim. To discuss it at the Post Mortem I must have been told about it prior to that, possibly at this meeting. However, I just don't remember. As it related to the scene at Victoria Hospital (and the deceased) I would have imagined that I would have been made aware of this as soon as it was known, however, as above, I really don't remember much about that aspect.

On 3 May, I do not specifically recall any discussions around Mr Bayoh's religion, or that of his family members. My first real recollection was that it was discussed at the time of the Post Mortem, with the Procurator Fiscal Bernie Abblett.

I'm afraid to say that my own personal knowledge at that time could best be described as pretty limited. I think at that time I was aware that there were implications regarding cutting of hair and possibly fingernails, although specifically what that involved I am not sure I was aware at that time. I perhaps believed that it was generally not permitted to cut the hair of the deceased if it was at all avoidable. I think I probably also knew that Muslims are never cremated and are buried, normally as quickly as possible. And that they are washed by either family members of religious figures or elders. And probably only by people of the same sex. This would have been my own general awareness, not due to specific training or guidance I had received, as far as I can recall.

I had received no specific training regarding this. Not that I recall or am aware of.

I am not aware of any written guidance that was provided by PIRC in respect of this. I was not a Scene Manager and did not have any experience of attending post mortems where the deceased was Muslim.

68. Within DCS Boal's operational statement (PS00669), on page 3, she states:

> ***About 1700hrs I attended the Forensic Strategy Meeting which, albeit all PIRC investigators were present, was chaired by Detective Chief Inspector HOUSTON.***

Within the forensic strategy meeting agenda (PS17896), at page 1, DCI Houston is also noted as being the chairperson of this meeting.

Would you agree that DCI Houston chaired this forensic strategy meeting? Why was it considered more appropriate for the meeting to be led by DCI Houston, rather than PIRC? Who was in charge of the scenes at Hayfield Road and Victoria Hospital at this point on 3 May 2015?

As previously discussed, I cannot be entirely sure if I attended this meeting, over and above the meeting with DCI Houston and PIRC staff that took place closer to 1500 hours. As such, I don't really have an opinion on who was 'chairing the meeting' and whether this was appropriate.

A lot of the questions I am being asked appear to want black and white definitive answers about 'who was in charge' and who directed who etc. My general memory is that the larger meetings with senior police staff were normally 'chaired' by a Police Scotland senior officer. This however did not mean that the PIRC opinion or direction was not sought and accepted. I have previously described how this was a complex incident with numerous scenes and lines of enquiry (witnesses, house-to-house, FLO, CIA, road closures, police staff welfare, CCTV). It was not the case that the PIRC would be making every operational decision about every aspect of this incident. The PIRC were consulted in respect of these areas to ensure that the direction of travel was not contrary to the aims of the PIRC investigation.

The scene at Hayfield Road and the Victoria Hospital were of particular importance to the PIRC so our resources (boots on the ground) were dedicated to these. DSI Harrower liaised with senior police staff in respect of PIRC expectations for everything else.

Signature of Witness [redacted].....

69. Within DCI Houston's operational statement (PIRC-00165), page 3, DCI Houston refers to it being agreed at this meeting that you and John Ferguson would "accompany Detective Constable Grady to recover the deceased". How was the responsibility for the recovery of Mr Bayoh's body split between DC Peter Grady and yourself and John Ferguson? Following a death in police custody and COPFS's instruction of PIRC to investigate, why was it necessary for DC Grady, and Police Scotland more generally, to be involved in the recovery of Mr Bayoh's body?

It had been clearly articulated throughout the day that the PIRC had primacy over the scene at Hayfield Road and the scene at Victoria Hospital (the deceased). This meant that any decisions made would be directed by the PIRC. The strategy and approach to the scene had been discussed and agreed upon at Kirkcaldy Police Office, with DSI Harrower and Inv Ferguson at the forefront of decision-making.

Everyone knew that this was a PIRC scene and what was expected in relation to this. Police Scotland's role was to facilitate and assist. For example, making contact with SPA Scene Examination through the police Area Control Room to ensure Scene Examiners would attend. To ease access at the hospital, as most medical staff would have no idea who the PIRC are and may be concerned about allowing PIRC access to the deceased. Assistance in terms of local arrangements, e.g. which undertakers are for police incidents in that locale. Assistance with after-hours access to the mortuary. Inv Ferguson reiterated to DC Grady and the Scene Examiners that PIRC had primacy at this scene during our discussions prior to leaving for the hospital.

It was not (is not) uncommon for PIRC staff to work alongside staff from Police Scotland in relation to the management of scenes. I was not involved in the decision for there to be a Police Scotland Scene Manager involved in the scene at Victoria Hospital, however I was not concerned about it either. The Police Scotland Scene Manager had 'local knowledge' of procedures and access to the information required to facilitate the scene examination.

It is also true that procedures and practices in relation to Scene Management change and are updated. PIRC Scene Managers are utilised much less often the Police Scotland Scene Managers. It may be the case that Police Scotland Scene Managers would be able to provide advice or information regarding any updates in processes and procedures that may be relevant. They also have a much closer working relationship with the SPA Scene Examiners as they are working with them all the time. PIRC cover the whole of Scotland, and will not necessarily be aware specific local arrangements at hospitals or with undertakers etc. Local knowledge from Police Scotland staff is extremely important in assisting in the smooth processing of a scene. PIRC's primary role is to ensure that the decision-making is independent of the police to ensure that the priorities of the PIRC Investigation are carried through.

Meeting at 1800 hours

70. Your PIRC statement (PIRC-00358), at page 3, refers to a meeting you attended with John Ferguson, DC Grady, Senior Scene Examiner Gordon Young and Scene Examiner Judith Harley of the Scottish Police Authority (SPA). What was discussed at this meeting?

As per my original statement (PIRC-00358), consideration was made of the following; the scene was to be recorded by means of still photography (SPA evidential, and PIRC

independent briefing photos), tapings to be taken of deceased's head and hands, recovery of deceased's t-shirt within a nylon evidence bag due to contamination with Pava /CS spray, SPA body recovery kit and contents confirmed, local undertaker details discussed.

As per the comments relating to cultural considerations* (sought by Inv Ferguson from Procurator Fiscal via DC Grady). As this was a Crown directed investigation it was decided, by the PF, that there was nothing that would impinge on the recovery of evidence at this time.

**I can only presume that this related to the handling of the body and removal to the mortuary. As mentioned earlier, I am not sure when cultural considerations were first discussed, but as my statement (noted much closer to the time) suggests that this formed part of the discussions with DC Grady and the SPA Scene Examiners, I can only presume that this had already been raised at some point.*

It would appear from my statement that Inv Ferguson and DC Grady were involved in obtaining some direction from the PF in this regard. I was not personally involved in any discussions with the PF on 3 May 2015.

It was agreed that Inv Ferguson and myself would follow the private ambulance to Edinburgh City Mortuary, Cowgate, Edinburgh, following the forensic recovery of the body from Victoria Hospital.

71. How did PIRC's role in the investigation interact with the roles of the scene examiners from SPA on 3 May 2015? Between PIRC and the scene examiners, who led the recovery of evidence from Mr Bayoh's body on 3 May 2015?

During the physical examination of the deceased and the removal of items/clothing etc., I was primarily located in an anti-room, attached to but just off the actual room the deceased was in. I could see the deceased but was not generally in close proximity. I did visually inspect the deceased when we first entered so that I have an idea of the condition of his body and to see if I could observe any obvious injuries or marks of note. I thereafter observed from the anti-room and took some notes.

I remember that as the items of clothing were bagged and labelled, I then took a note of these descriptions (labels) as well. I believe these notes were later transferred into my notebook and my statement and that any original notes I made were then binned/destroyed. I certainly no longer have possession of any notes taken at the time, other than in my notebook and statement. I also remember counting the cash that was found within the clothing as a double check for accuracy.

From memory, I believe it was the Scene Examiner Gordon Young from SPA who physically removed any clothing or items. These were then sealed the evidence bags and the 'Descriptions' and seizure details were completed. The Scene Examiners also took the tapings and swabs.

72. Your PIRC statement (PIRC-00358), at page 3, notes:

> ***Cultural considerations (sought by Inv Ferguson to Procurator Fiscal via DC Grady) As this was a Crown directed investigation it was decided that there was nothing that would impinge on the recovery of evidence at this time.***

Signature of Witness [redacted].....

John Ferguson's PIRC statement (PIRC-00363), at page 4, notes:

> ***Clarification on this this was sought re cultural considerations by me to the PF via police witness DC Peter Grady. This resulted in the agreement that the recovery would be sensitively carried out and further discussion may be required at the mortuary with the Pathologist.***

Which "cultural considerations" were identified and discussed? What was decided in this regard? Who made this decision? In what way was the recovery of Mr Bayoh's body to be "sensitively carried out"? What does it mean that "As this was a Crown directed investigation it was decided that there was nothing that would impinge on the recovery of evidence at this time"? In this investigation, what might have impinged on the recovery of evidence?

As previously noted, I do not remember what specifics were discussed regarding 'cultural considerations' on 3 May 2015. It would appear that Inv Ferguson had a discussion with the PF either himself or via DC Grady. I was not involved in that call. I can only assume that the discussions that were had regarding the potential requirements to take hair and/or other samples from the deceased at the Post Mortem were discussed at this point. I remember these being discussed on the 4 May with the Pathologist and that PF Bernie Ablett had advised that any samples that the Pathologist required to take were to be taken and that the evidential requirements were of paramount importance.

I have no reason to doubt what was written in my statement at the time, I simply do not remember it clearly now. As such I don't have any further details to add. As previously stated, I do not have a clear memory of this on 3 May. I remember slightly better that mention was made of this on 4 May 2015, prior to the Post Mortem.

As detailed above, my memory is that on 4 May 2015, PF Bernie Ablett advised that hair or other necessary samples could be taken and the Post Mortem was to be progressed by the Pathologist and that evidential priorities would take precedence. I seem to recall in particular that there was discussion of cutting a sample of hair as this could be used to assist in analysis of any potential drug use on behalf of the deceased.

As previously stated, I do not have a clear memory of this on 3 May. I remember slightly better that mention was made of this on 4 May 2015, prior to the Post Mortem. I do not have a memory of what was discussed on 3 May 2015 regarding anything different being done in respect of the recovery of Mr Bayoh's body, that meant that it was more sensitively carried out than would otherwise have been the case.

My understanding is that hair samples can be used to determine if there has been longer term drug use (prescription or illegal drugs) as traces leave the blood much faster than they do hair. Therefore, not being able to take hair samples may have precluded such information/analysis from being used in this investigation.

<u>Attendance at Victoria Hospital</u>

73. Your PIRC statement (PIRC-00358), at page 4, refers to you and John Ferguson attending the scene at Victoria Hospital at 1900 hours on 3 May 2015. Was this the first time that you attended Victoria Hospital on 3 May 2015?

Yes, this was the first time we attended at Victoria Hospital.

Signature of Witness [redacted] .....

If so, why did you first attend the scene at Victoria Hospital on the evening of 3 May 2015 when you had been tasked by DSI Harrower with management of that scene in the morning and arrived at Kirkcaldy around 1400 hours? What impact, if any, would your arrival at this scene earlier on 3 May 2015 have had on the investigation? What are the benefits of managing a scene at the locus itself, instead of remotely?

As previously detailed, there were other scenes and aspects of the incident that DSI Harrower had to contend with. A believe that DSI Harrower was keen for a coordinated approach to be taken, so that as much was known about the incident and precursor events as possible, prior to the PIRC scenes being processed. There was a Forensic Strategy Meeting being held at around 1640 hours, so I don't suppose it would have made much sense to start processing the scene prior to that. I'm not sure if the Scene Examiner's were available that early either. I am not sure exactly when they arrived, but I do not recall speaking to them until around 1800 hours. From memory we left of the hospital not long after we had concluded a meeting with DC Grady and the Scene Examiners, to confirm the approach to be taken.

There were two detectives standing by the deceased who was within a side room. Nothing was at risk of being 'lost' evidentially by us taking a more considered approach, as far as I was aware.

I do not know what impact an earlier arrival at the scene would have had on the investigation. The only issue from the scene that I remember related to the fact that a number of separate productions had been placed in the same bag by the detective officers who had arrived at the hospital whilst the deceased was still being worked on by medical staff. This was well before the PIRC were alerted to the incident and certainly well before we could have attended at the hospital.

The fact that these two officers were not wearing forensic suits is probably the primary criticism I could level at our not attending earlier. Had we attended earlier and discovered that the officers were not forensically dressed, we could have rectified that situation more quickly. These officers could have contacted the investigation team or their supervisors at any time if there were any issues (i.e. they needed forensic PPE dropped off to them), and as detective officers they would have had experience of scenes related to unexplained deaths and what they should and should not do. That said, I accept that earlier PIRC attendance, or even Police Scotland Scene Manager attendance at the scene, may have been preferrable.

I am not sure if this made any material difference to the integrity of any evidence, or if it could be said to have impacted on the investigation. That is perhaps for others to offer an opinion on. I genuinely don't know if this had any impact on the investigation.

I would suggest that it would always be preferrable to manage, or process a scene, at the locus itself. For the reasons above, if you have 'eyes on' a scene you will pick up any issues more quickly. This was a relatively secure scene. It was confined within a separate side room within the hospital, with two detective officers ensuring that the scene was secure.

74. Beyond the meetings and discussions noted above, what other tasks required to be completed at Kirkcaldy Police Office prior to your attendance at Victoria Hospital?

There were no other allocated tasks. As Inv Ferguson was a retired Detective Sergeant with many years of experience as a Scene Manager, I imagine that DSI Harrower was keen to seek his advice or opinions in respect of what was discussed/agreed regarding the other scenes, that Police Scotland had primary responsibility for. Police Scotland had staff at each of these scenes and had deployed a senior detective in a specialist role (Scene Coordinator) specifically to have someone with knowledge across all of the scenes involved. I would think that being able to consult with Inv Ferguson, and for that part Inv Sinclair, would have been important to DSI Harrower, however that is speculation on my part. Obviously DSI (now SI) Harrower would be better placed to speak about that.

75. The PIRC Scene Management SOP that was in force in May 2015 (PIRC-03873) identifies, at paragraph 1.3.3, the process to be followed to identify if any additional resources are necessary to manage a scene. Were you content on 3 May 2015 that sufficient resources were available to manage the scene at Victoria Hospital? If not, why not?

Yes, I felt that there were sufficient resources to manage this scene.

76. Following your arrival, what steps did you take to manage the scene at Victoria Hospital and to progress the recovery of Mr Bayoh's body?

The steps taken are recorded within my statement (PIRC-00358). I don't have anything to add to what is recorded in my statement, or elsewhere in this response.

77. Your PIRC statement (PIRC-00358), at page 4, identifies that you were met by DCs Ryan Balsillie and DC Andrew Brown upon your entry to the hospital. You identify that neither of these officers had been forensically dressed whilst they had been in the room where Mr Bayoh was situated. What was your view in relation to these officers not being forensically dressed? Were you content with the explanation provided by the officers? If not, why not? What is best practice in this regard? Why is this best practice? What impact, if any, did the fact that the officers were not forensically dressed have on PIRC's investigation and the recovery of evidence from Victoria Hospital?

I was surprised. I felt that the officers should have been forensically dressed as per protocol. I appreciate that they initially attended the hospital whilst Mr Bayoh was still alive and being worked on by medical staff. However, once it became clear that he was deceased and that they were being tasked to stand-by the body, within an enclosed space, I would have expected that they would have requested appropriate PPE and equipment to fulfil this task (i.e. forensic clothing and production bags etc.) Inv Ferguson spoke with the officers on our arrival at the hospital. I do not remember the conversation in any detail. I do recall that Inv Ferguson was not impressed with the fact that they were not in forensic clothing and the way in which productions had been packaged.

DNA techniques are extremely sensitive and the fact that these officers were not forensically dressed meant that they may have been shedding skin cells, hair etc. that may have contaminated the deceased or any items/productions. Should any DNA testing be done, it may have thrown up these officers' DNA, or led to mixed DNA results, whereby there was a mixture of a number of individuals' DNA detected, which has negative implications for any analysis that can be done. A lack of gloves and masks could mean that any items that the officers touched would be covered in their DNA and fingerprints, etc.

Signature of Witness [redacted]……

My understanding was that best practice would dictate that these two officers should have worn forensic clothing, including a white forensic suit with hood. They should have worn double gloves and should have had boot coverings.

This did not impact of our ability to recover evidence from this scene, however it had the potential to complicate things if any of their DNA or fingerprints showed up in any analysis further down the line.

78. John Ferguson's PIRC statement (PIRC-00363), at page 6, identifies that four samples of blood were within the room in which Mr Bayoh was located and were "contained within 1 orange plastic bag which was neither sealed nor labelled". Was this best practice? If not, why not, and what impact, if any, did this have on the recovery of evidence from Victoria Hospital?

The correct practice, as far as I know, would be for samples to have been removed from the orange plastic bag and then all 4 vials to be placed into a single evidence bag, which would then be sealed and labelled with a description of its contents. The evidence bag would also have details of when and where they were seized, and from whom. The orange plastic bag could then be placed into a separate evidence bag and sealed and labelled accordingly. This would have allowed the vials to be visible within the transparent evidence bag and the orange bag could be retained in case of any challenges/issues at a later date. I believe that this is, in effect, what was done once we arrived. I do not recall the reason that this was not done initially by the detective officers. It was possibly due to them lacking the appropriate equipment / evidence bags. I'm not sure that this really had any detrimental impact on the eventual recovery of evidence from this scene, however it was not particularly professional and Inv Ferguson was not impressed.

79. The scene management log for Victoria Hospital (PIRC-01464), at page 9, identifies that no outer cordon was in place at that scene. On the same page it is identified that no scene entry log was in place "due to limited access". Should an outer cordon and/or a scene entry log have been in place for the scene at Victoria Hospital? If so, why, and what impact, if any, did the failure to put either or both of these in place have on the investigation?

Some scenes have 'natural barriers' that help to contain and protect a scene. The deceased was in a room that was not being used by others and had officers on hand to ensure that no-one entered. However, I do not recall any signage of barrier tape that let people know not to enter, so yes, some barrier tape or signage to alert people to the fact they were not to enter would have been useful. This room was off the 'resus' area of the hospital and as such there was limited access to the public and the staff knew that the area was out of bounds and that the deceased was there. An 'outer cordon' would have been difficult to achieve as access needed to be maintained to the 'resus' area for medical staff to be able to treat patients.

No scene entry log had been started or maintained by the two officers who had been standing by the deceased within the side room, to the best of my knowledge. I know that after our arrival, other than Inv Ferguson, DC Grady, and the two SPA Examiners, Gordon Young and Judith Harley, only Dr Lorna Jackson entered the room, prior to the undertakers arriving to remove the deceased. Dr Jackson was there to assist in removing items of medical intervention from the deceased, which were then retained as a production.

By keeping notes of what happened from our arrival onwards, as transferred into my statement (PIRC-00358), I did record the details of everyone who attended the scene

thereafter. This is corroborated by the statements of the others in attendance. So not starting a log after our attendance did not really have a detrimental effect on the investigation. I do not believe that this had any actual impact on the investigation, however the perception of the investigation could have been negatively impacted by this.

80. PIRC's Scene Management SOP (PIRC-03873), at page 12, as part of an appendix titled "Considerations when attending an incident in the capacity as a PIRC scene manager", states that "PIRC will begin and maintain a scene entry log". What consideration, if any, was given to PIRC commencing its own scene entry log for the scene at Victoria Hospital on 3 May 2015? Why was no such PIRC scene entry log created?

I was not a Scene Manager. I do not know why no Scene Entry Log was commenced once Inv Ferguson and I, along with DC Grady and the Scene Examiners arrived. Perhaps, with it being a number of hours after the room was established as a 'scene', it was felt that 'that ship had sailed'. Of the five of us who attended from Kirkcaldy Police Office, I was by far the person with the least experience attending scenes, as this was my first. That said, I recognise that I could have suggested that we start a log when we arrived, and I did not. I cannot remember if this is something that I thought of at the time or not. If I had thought of it I imagine that I would have suggested it to Inv Ferguson. But I do not remember doing that, so I can only assume that I did not.

By keeping notes of what happened from our arrival onwards, as transferred into my statement (PIRC-00358), I did record the details of everyone who attended the scene thereafter. This is corroborated by the statements of the others in attendance. So not starting a log after our attendance did not really have a detrimental effect on the investigation.

However, I appreciate now, with all the scrutiny that the investigation is under, that it would have been better if a log had been started. As I have mentioned in a previous answer, the lack of an earlier visit by PIRC or Police Scotland to the scene meant that this omission on the part of the two detectives was not picked up earlier. Assumptions were probably made in respect of what the two detectives would have done prior to our attendance. I do not believe that this had any actual impact on the investigation, however the perception of the investigation could have been negatively impacted by this.

81. Who compiled the scene manager's log (PIRC-04173)? What involvement did you have in this process? What was the purpose of the scene manager's log? Was this log compiled contemporaneously?

I believe that this document was compiled by Inv Ferguson. I had no involvement with this document. I do not know what the purpose of this document was, although it appeared to be a 'rolling' log of all scene management and forensic considerations that Inv Ferguson felt were worth recording. As far as I am aware Inv Ferguson updated this log throughout the duration of the PIRC Investigation. I do not know if this was done contemporaneously to the events that are detailed within, or if this was produced from other documents that were contemporaneous to the events that they describe.

82. The scene manager's log (PIRC-04173), pages 79 – 119, contains a review of the management of various scenes, including, at points, PIRC commentary on the management of those scenes. Who carried out these reviews? Was a similar review carried out in relation to the scene at Victoria Hospital and the recovery of Mr Bayoh's body? If not, why not?

I do not know who carried out these 'reviews', or at whose direction they were carried out, if anyone's. I do not know if a 'review' was carried out re: the scene at Victoria Hospital and the recovery of Mr Bayoh's body. As I do not know who carried out these 'reviews', why, or at whose behest, I cannot answer why one was not carried out for the Victoria Hospital scene, if indeed there was not one carried out.

83. Your PIRC statement (PIRC-00358), at page 8, identifies that productions recovered at Victoria Hospital were handed over to DC Peter Gilzean at Kirkcaldy Police Office at 2255 hours on 3 May 2015. Why was it necessary for the productions to be handed over to Police Scotland, rather than retained by PIRC? Is it normal practice for Police Scotland to retain the productions seized following a death in police custody?

I do not recall why the productions were taken to Kirkcaldy Police Office and handed over to DC Gilzean. I do not recall why the productions were not retained by the PIRC at this point, or if this was discussed and agreed with DSI Harrower. I do not know if this was because the other productions seized that day (at the other scenes), officers' clothing etc. was being stored at Kirkcaldy in the first instance.

It was 11pm by this point and myself and Inv Ferguson still had to accompany/escort the deceased to Edinburgh City Mortuary and complete the necessary paperwork relating to this. After this we still had to travel back to Hamilton from Edinburgh to drop off the work car before heading to our respective homes for some rest, before returning to the PIRC office in Hamilton later in the morning of 4 May 2015 to collect a PIRC car and equipment (evidence bags etc.) so that we could travel from Hamilton to Edinburgh City Mortuary by 1130 hours.

From memory, PIRC had to hire a van to transport the productions to PIRC premises the next day. It would be fair to say that this was far and away the largest quantity (and physical size) of productions that the PIRC had seized in a single day, up to that point in any PIRC investigation (and possibly still to date).

I would say that it is not necessarily 'normal practice' that this is done, but it is not unusual. It would be fair to say that the majority of PIRC death investigations are less 'controversial' than this investigation, in that there is not the same seeming lack of trust in the integrity of the police, and the PIRC for that matter. In many cases, there is no perceived issues with productions being stored by the police. Where possible/practical, the PIRC would normally look to retain productions itself, at PIRC premises. Sometimes, for health and safety or security reasons, this is not possible, for example in the case of firearms or quantities of drugs or chemicals etc.

84. Were you content with the steps taken by Police Scotland to recover and preserve evidence from the locus at Victoria Hospital on 3 May 2015? If not, why not? What, if anything, should Police Scotland have done differently in this regard?

As stated above, I think assumptions were made in respect of how the two detective officers would fulfil their task in relation to standing by the scene in the first instance, probably by the PIRC and Police Scotland. There was a degree of dissatisfaction that this was not done in the way expected. Other than this, the assistance provided by DC Grady was valuable and appreciated, as were the discussions held with DCI Houston. Police Scotland could have had a Scene Manager assess this scene at an early stage, which may have allowed for the

cordon, forensic clothing, and production seizure/labelling issues to be addressed sooner. The same criticism could also be levelled at the PIRC.

85. Your PIRC statement (PIRC-00358), at page 8, identifies that Mr Bayoh's body was taken to Edinburgh City Mortuary by an undertaker and the "private ambulance transfer was followed by Inv Ferguson and myself who remained with the deceased throughout to maintain integrity". Your notebook (PIRC-04198), at page 5, identifies that you and John Ferguson "followed the private ambulance to Edinburgh City Mortuary, keeping it in sight at all times". To ensure that the chain of custody is maintained, is it sufficient to keep the ambulance in which a deceased's body is being transported in sight? Is it best practice to proceed in this fashion, rather than travel in the ambulance along with the body itself? If so, why? If not, why was this not done on this occasion?

Yes, I would opine that keeping the private ambulance in sight is sufficient to maintain the chain of custody in respect of transporting the deceased's body. This allowed us to maintain a visual on the private ambulance at all times, and therefore we knew that no-one had access to the deceased's body at all throughout the transfer to the mortuary. I was not, and am not aware that 'best practice' dictates that we should have travelled within the private ambulance. I am not even sure that there is sufficient space or seating to allow this to take place.

Primary control of scene

86. PIRC's Scene Management SOP (PIRC-03873), at page 10, as part of an appendix titled "Handling of Shared Scenes by Police Service of Scotland (PSS) and the Police Investigations and Review Commissioner (PIRC)", states:

> ***Where, following an incident, PIRC have primary interest in a scene, the PS SIO will ensure that primary control of the scene, in whole or in part as required (and in accordance with the principles set out in this document), is passed to the PIRC SI/DSI as soon as practicable.***

At what point on 3 May 2015 did you consider that PIRC had "primary control" of the scene at Victoria Hospital? Please explain why you hold this view.

In essence, from the point of PIRC being instructed by COPFS to investigate the death, I would have assumed that PIRC had primacy in respect of decision-making regarding the scene at Victoria Hospital. It is clear that Police Scotland had physical control of the scene and were responsible for securing it and protecting any evidence, until PIRC staff actually attended at the hospital. I would suggest that the responsibility for ensuring that this was done effectively up until the point that the PIRC staff arrived was probably a shared responsibility. PIRC had overall say on what happened at the scene, from the point of referral, however, Police Scotland had a professional and operational responsibility to ensure that their officers fulfilled their duties in the correct way until the scene was physically controlled by the PIRC.

PIRC investigation on 3 May 2015

87. In hindsight, what, if any, decisions would you have made differently in relation to the management of the scene at Victoria Hospital and the recovery of Mr Bayoh's body on 3 May 2015? What impact would this have had on PIRC's investigation?

Signature of Witness [redacted].....

With the benefit of hindsight I can see that an earlier attendance at the scene at Victoria Hospital, or an insistence that a Police Scotland Scene Manager attend and assess the scene at an early juncture, including cordons and appropriate contamination controls etc. would have been beneficial. It may not have prevented the previously detailed issues, but it may have allowed them to be addressed and an earlier point. As previously detailed, I am not sure what, if any, real impact this had on the PIRC's ability to recover evidence and Mr Bayoh's body.

In respect of 'cultural considerations', I am not sure that there is anything in particular that we should have done differently. Perhaps the fact that one of the Scene Examiners was female may not have been ideal, or seen as acceptable. I am not sure that there are sufficient resources within the SPA that would have allowed for there to have been a choice about this.

88. Were you content with the decisions taken by PIRC's investigators who attended Kirkcaldy on 3 May 2015? If not, why not?

I was primarily focused on what I had been tasked to do with Inv Ferguson, in relation to the scene at Victoria Hospital (and the deceased). I was content with the decisions made in regards to the approach that would be taking with processing the scene. I think, with the benefit of hindsight, that we should have attended the hospital earlier to do a quick assessment of the scene, as detailed in my answer to Question 87.

More generally, I was content with the PIRC decision-making at that time. I was less aware of decisions that were being made as the day went on as Inv Ferguson and I began to focus on the task at hand. I don't think that there was a lack of information about the other scenes and aspects of the investigation, it's just that I was not involved in them so I required less detailed information about them.

89. Were you content with the support that you received from Police Scotland in relation to PIRC's investigation on 3 May 2015? If not, why not? What impact did this have on PIRC's investigation?

In general terms I was content with the support that I received by those that I worked/liaised directly with, i.e. DC Grady and DCI Houston. In more general terms, I feel that the issue that developed in respect of thinking that Police Scotland FLOs would engage with the family initially, and then that falling apart and DSI Harrower and Inv McGuire having to attend the family home at fairly short notice, put DSI Harrower under a lot of additional pressure when he was already dealing with a lot. The early contact that Police Scotland had with the family appeared to have a massive impact on the family and their willingness to engage with Police Scotland and with the PIRC. This definitely appeared to me to have had a detrimental impact in relation to the Family Liaison aspect for the rest of the PIRC investigation.

90. Did you have any contact with the COPFS on 3 May 2015, or subsequently during the investigation? If so, what was the nature of this contact? Were you content with the direction, instruction and support that PIRC received from COPFS in relation to PIRC's investigation on 3 May 2015 and throughout the investigation? If not, why not?

I did not have any contact with COPFS on 3 May 2015. As previously detailed, I was the most junior member of the PIRC contingent that day and would have no reason to have any

contact with COPFS at that point. I was not particularly aware of the level/extent of COPFS direction or instruction on 3 May 2015, so do not feel in a position to comment on this.

As the investigation was quickly handed over to DSI William Little to progress, and I was a member of his team, I continued to work on this investigation for many months, and years. I had contact with members of COPFS on numerous occasions throughout this. I dealt with staff from COPFS more directly in relation to a couple of aspects of the investigation. Analysis of Airwave material and 'point-to-point' communications, as well as the analysis of downloaded material from witness Ashley Wyse's mobile phone. I felt that these interactions were constructive. I had one issue with contact with COPFS that I was disappointed with. This is detailed in my response to Question 157.

91. Did you consider that you and your colleagues, as PIRC investigators, had sufficient powers to progress the investigation on 3 May 2015? If not, why not? What additional powers would you and your colleagues have benefited from to progress the investigation?

I felt that we had sufficient powers to progress the investigation.

92. What, if any, hypotheses did PIRC have in relation to the incident on 3 May 2015? On 3 May 2015, did you give consideration to whether race could be a factor in the incident? If so, in what way? If not, why not?

As previously detailed, I was an inexperienced member of staff who was concentrating on the specific tasks I had been asked to assist with. I had no involvement in developing a hypothesis on 3 May 2015 in relation to the events that took place that day.

It seemed clear that the deceased had been involved in an altercation with his friend earlier that morning and that a number of independent members of the public had called the police with serious concerns regarding his conduct, i.e. that he was walking around Kirkcaldy in broad daylight, in possession of a large knife, possibly striking out at vehicles. Officers who were only just coming onto shift got the call and made their way to the locus at Hayfield Road as quickly as possible and intercepted the deceased. An interaction took place whereby the officers engaged with the male and this led to him being sprayed with PAVA and/or CS Spray and being struck with a baton. There was mention that he may have assaulted a female officer, although she was not seriously injured. I do not recall any suggestion that he had used the knife on officers or had presented the knife at officers.

He ended up on the ground and involved in some form of restraint during which he fell unconscious and stopped breathing. CPR was administered and he was taken to hospital, where tragically he died.

There was nothing within the information available to the PIRC on 3 May 2015 that suggested that race was a factor in Mr Bayoh's death. I do not recall any discussions that day that touched on the possibility that the way the police officers responded may have been affected by Mr Bayoh's race.

The primary focus of the PIRC's investigation on 3 May 2015, as far as I remember it, was to secure all relevant evidence in the immediate aftermath of the incident, so that the cause of death could be established. At this stage the physical cause of death was unknown, and it had to be determined if blunt force trauma was involved, or asphyxiation due to physical restraint, or drugs, or any other physical cause. The PIRC were also keen to develop as

much information as possible in relation to the background of Mr Bayoh and his movements leading up to his interaction with the police, so that any relevant factors could be taken into consideration. Independent witness evidence and the police officers' accounts were going to be of paramount importance, as well as any CCTV that may have shown relevant events.

93. Did you consider that the police officers with whom you had contact on 3 May 2015 had an awareness and understanding of PIRC as an organisation and PIRC's role within the investigation? If not, what, if any, steps did you take to address this on 3 May? What impact, if any, did the officers' awareness, or lack thereof, of PIRC's role have on the investigation? Following the establishment of PIRC on 1 April 2013, and prior to the incident on 3 May 2015, what steps had been taken to raise awareness and understanding amongst police officers of PIRC as an organisation and PIRC's role within an investigation?

As mentioned previously, I'm not sure that Det Supt Campbell's comments in respect of his expectations of PIRC staffing of this incident reflected a particularly deep understanding of the size and scope of the organisation at that time. He mentioned that PIRC only had 4 or 5 staff members in attendance (actually 6) when at one point Police Scotland had 20 or 22 people 'on it'. If his expectation, or that of Det Ch Supt Boal was that the PIRC would turn up with 20-25 members of staff to take over every aspect of this incident, I would suggest that their understanding of the PIRC as an organisation was limited.

I am not sure what awareness of the PIRC the officers that I had contact with on 3 May 2015 had. As previously mentioned, the two officers that I would say I was most involved with were DC Grady and DCI Houston. Both appeared to understand the role of the PIRC and there were no issues in respect of a lack of understanding impacting on the tasks that I was asked to do.

I was a trainee at this time so was not involved in any wider strategy in respect of raising the awareness of the PIRC amongst officers and staff within Police Scotland, or other policing bodies that the PIRC covers. I am aware that more senior PIRC staff did inputs to the Probationer course at the Police College and also I believe to the First Line Manager (Sgts) course and possibly to the Senior Investigating Officer (SIO) course. I am not sure if this was already happening in May 2015 or if this came later. I was not involved in arranging or delivering these inputs. I did accompany DSI Little to an awareness session that was provided to some C3 (police call centre) staff at Bilston Glen, fairly early in my service with the PIRC, but I couldn't in all honesty give you a date of when this took place.

94. A briefing note was prepared for PIRC's Director of Investigations in relation to the events of 3 May 2015 (PIRC-03694). What role, if any, did you have in preparing this document?

None

95. Did you have any communication with representatives from the Scottish Police Federation (SPF) on 3 May 2015? If so, with whom did you communicate and what did you discuss?

No

Signature of Witness [redacted] .....

96. Did you liaise with or speak to the media on 3 May 2015, or otherwise during the investigation? If so, in what way did you liaise with the media and to whom did you speak?

No

97. On 3 May 2015, what awareness, if any, did you have of media coverage surrounding the incident? What awareness, if any, did you have of reports of a female police officer being stabbed and the source of those reports? What, if anything, did you do in response to those reports? Were you aware of any details of the incident on social media?

On 3 May 2015, I was unaware of any media reporting of this incident. I had no awareness of media reports of a female officer having been stabbed at that time. I was not aware of any details of this incident on social media at this time. I was focussed on the task in hand and did not have time or reason to check out this incident on traditional or social media at that time.

Monday 4 May 2015

98. Your notebook (PIRC-04198), at page 5, identifies that you attended Hamilton House at 0800 hours on this day. Did you attend a briefing on the morning of 4 May 2015 at PIRC's office? Who delivered this briefing? Do you remember what was said? If so, please provide details.

I do not recall whether or not I attended a briefing at the PIRC office on the morning of 4 May 2015. If my notebook states that I was there at 0800 hours, I can only guess that Inv Ferguson and I would have left for the mortuary at about 1030 hours, so I presume that I would have been at any briefing that was given that morning. I do not remember this specifically. Again, I was probably focussed on my task for that day, i.e. attending the port mortem. I do not recall who delivered any briefing that morning, or any specifics of what may have been said.

99. Was DSI William Little put in charge of the investigation at this briefing? If not at this briefing, do you know when was this formally confirmed? Why was DSI Little put in charge of the investigation at this stage? At what point was SI John McSporran put in charge of the investigation alongside DSI Little?

I certainly became aware first thing that morning that DSI Little would be the Lead Investigator for this investigation going forward. As was the usual practice, every DSI would report to and by supervised by a Senior Investigator (SI). In this case it was SI John McSporran. This would also have been communicated on the morning of 4 May 2015, as far as I can remember. In general terms it was the role of the SIs to decide which DSI was next in line to take on a new investigation. The person who 'caught' an incident on-call would not necessarily continue as the Lead Investigator. I was a trainee and was not party to any discussions as to who would take charge of the investigation going forward, or the reasons why. This was for Senior Investigators with possible input from the Head of Department and maybe the Director of Operations. I really don't know, you'd have to ask them.

100. Do you recall what handover you and other members of PIRC staff who were involved in the investigation on 3 May 2015 provided to DSI Little? If so, please provide details. What involvement did you have in this handover?

Signature of Witness [redacted].....

My understanding was that DSI Little was briefed by DSI Harrower. I was aware that DSI Little would be attending the post mortem later that day. I did not brief DSI Little that I recall. Inv Ferguson may have advised him of what we had dealt with the previous day, but I really don't know. Again, my role was going to be primarily as an observer, to maybe take some notes and to be an extra pair of hands if required. I had attended a post mortem only once before, as an awareness/training exercise. It was more to familiarise myself with what to expect, I played no active part (e.g. seizing productions). This took place at the Southern General, I do not remember the date. I think it might be in my training record. I think it was prior to the incident on 3 May 2015. This was my only experience of a post mortem prior to the 3 May 2015. Therefore, Inv Ferguson was really the PIRC member of staff who was going to be primarily involved in the post mortem.

101. An extract from DS Campbell's evidence to the Inquiry (day 49, page 73, line 5) is as follows:

> ***A. I think -- sorry, I think the problem with the PIRC deployment at that stage, other than the resources, is that over the course of 24, 36 hours they changed the lead investigator. So Keith had --***
>
> ***Q. What issues did that cause?***
>
> ***A. Just obvious challenges, the fact is you're bringing someone on fresh into the investigation when you've been there for 12, 13 hours at that stage, you know what I mean, before that ... before Billy Little's appointed around that. So again, there was challenges with the fact that the change of a senior investigator from PIRC at such an early stage of a critical investigation would undoubtedly cause challenges.***

Do you agree with DS Campbell that the handover of responsibility for the investigation to DSI Little caused "challenges"? If so, what were these challenges and what did PIRC do to mitigate them? If not, why not?

The handover did not appear to me to cause DSI Little any challenges. I am not sure I understand what challenges Det Supt Campbell is trying to articulate here. He doesn't actually appear to identify any specific challenges as far as I can ascertain from this. Just 'obvious challenges', whatever is meant by that.

<u>Post-mortem</u>

102. Your PIRC statement (PIRC-00358), at page 9, identifies that you were present at Mr Bayoh's post-mortem on 4 May 2015. Why did you attend the post-mortem? What was your role at the post-mortem?

I believe that the reason I was to attend the post mortem alongside Inv Ferguson was that we had been involved in the recovery of the body from the Victoria Hospital to Edinburgh City Mortuary the night before. It was to provide continuity. We knew what had happened during the management of that scene so it made sense that we continue this through.

Inv Ferguson was an experienced Scene Manager from his days as a Detective Sergeant and had a lot of experience of post mortems for unexplained deaths, suspicious deaths and homicides. At the PIRC we would always work in pairs, for a variety of reasons. Firstly, to be

able to corroborate each other for statements or seizing of evidence etc. Also, for health and safety and security reasons. Also because two brains are usually better than one. Also, in my case, to gain experience in new and challenging situations alongside a more experienced colleague.

My understanding from discussions at the PIRC office earlier that day was that Inv Ferguson would continue to be involved in relation to Scene Management and Forensic considerations for the duration of the investigation and that I was effectively to shadow/assist him in this regard. I believe that this was direction I was given by DSI Little. I was to be involved as part of the 'core team' that would be working on this going forward.

During the actual post mortem examination, I was not involved. I was within a viewing room alongside DSI Little, DCI Keith Hardie from Police Scotland and I believe SI Richard Casey was also there. If I remember correctly, a Procurator Fiscal Bernard or Bernie Ablett was also present in the viewing room. I believe the viewing room had a small screen that received a video feed from a camera that looked down at the deceased from above. There was a dial on the monitor or keyboard that I had to keep adjusting as the camera kept slowly moving and the shot of the deceased would disappear. I had to regularly adjust this so that the view of the deceased was maintained.

Inv Ferguson and DC Grady were in the post mortem room with the Pathologist. They were in full forensic dress as far as I recall. They were handed various items which the Pathologist would identify to them. I believe they were writing out production labels for the vials etc. that were the samples were being put into by the pathologist. They were recording what samples were being taken by the Pathologist. I believe a DC Peter Gilzean was also present on the day, although I cannot remember his exact role, possibly a Productions Officer.

103. What was PIRC's involvement in the post-mortem examination on 4 May 2015? Was this normal practice for PIRC? In 2015, was PIRC's involvement in relation to a post-mortem governed by any SOP? If so, please identify the SOP in question.

PIRC staff, Inv Ferguson and I attended to facilitate access to the deceased for the Quaser examination. We also briefed the Pathologist with the basic information that was known to date. I believe Inv Ferguson had to be involved with the identification of the deceased, as the family would not be attending. Inv Ferguson, as a trained and experienced Scene Manager would be assisting the Pathologist in terms of seizing and packaging productions (i.e. samples etc.) DSI Little was there to liaise with the Pathologist and the Procurator Fiscal about any issues that may arise.

104. Were you present when the pathologist was briefed in relation to the circumstances surrounding Mr Bayoh's death? If so, what information was passed to the pathologist during this briefing? Who provided this briefing? Are you content that the information passed to the pathologist was comprehensive and accurate?

Inv Ferguson and I had a discussion with the Pathologist Kellyanne Shearer where we provided the details of what had happened, as was known or suspected up until that point. From my statement (PIRC-00358) I can see that Inv Ferguson and I spoke with the Pathologist at around 1230 hours within a downstairs conference room. My statement records:

'Amongst the various topics discussed were nail scrapings, swabs from nose and mouth for CS/PAVA, the need to take samples of hair (possible cultural implications as deceased

believed to be muslim) to prove/disprove chronic drug use, possible blunt force trauma (as early information from Police Scotland suggested possible baton strikes), positional asphyxia, excited delirium, urine and hystology samples, brain retention and samples to be analysed at Glasgow University.'

I have nothing to add to this as I do not remember any more detail that this already provides. Only the Pathologist Kerryanne Shearer, Inv Ferguson and I were present during this briefing, as far as I recall. I am content that this was an accurate account of the information that seemed to be relevant to the post mortem at that time.

105. Who created the document titled "Pathologist Briefing" (COPFS-02540)? What was the purpose of creating this document? Was this document created to allow John Mitchell to provide Les Brown with details of the briefing on 20 May 2015 (PIRC-02955, pages 2 – 3)? If not, why was this document created? Does this document accurately set out the information that was provided to the pathologist on 4 May 2015? If not, what information is missing or inaccurate?

I don't know who created this document. I don't really recognise this document. As such, I do not know the purpose of this document.

Within my own statement you will note that there is mention of positional asphyxia and 'excited delirium'. These do not appear in the Pathologist Briefing document (COPFS-02540). This was not discussed with the Pathologist in any great detail. My memory, scant though it is, is that due to the information that the deceased had been restrained for a period of time, possibly by a number of officers, positional asphyxia would be a possible cause of death that might be explored in respect of the post mortem. Likewise, the term 'excited delirium' was obviously mentioned. This would again have been in relation to the information available at the time, in respect to the deceased's bizarre behaviour that witnesses had reported, seemingly randomly attacking cars with a knife. Although 'excited delirium' is a controversial term, neither Inv Ferguson nor I had any medical training and it was not for us to dis-count any potential hypothesis.

106. Your PIRC statement (PIRC-00358), page 9, identifies that the topic of excited delirium was raised in a discussion between yourself, John Ferguson and Dr Kerryanne Shearer at 1230 hours. Who first raised the topic of excited delirium? What was discussed in this regard? What awareness did you have in relation to excited delirium at this time?

I think it would probably have been either Inv Ferguson or myself that would have mentioned 'excited delirium'. Again, as mentioned above, although this is now a somewhat discredited term, or at least a controversial one, in 2014 it was still a term that was used.

As I understood it at the time, 'excited delirium' was a state of excitement or agitation which may have been accompanied by auditory or visual hallucinations, voices or distorted reality. It was believed to be drug-induced or perhaps to do with underlying mental illness. It led to the sufferer behaving in a hyperactive and often aggressive or violent way, and seemingly possessing great strength and being impervious to pain. It may be accompanied by things like increased heart-rate and a dangerous rise in core body temperature. They may be hot to the touch and possibly sweating profusely.

Signature of Witness [redacted].....

I was aware that people who were suspected to be suffering from this condition, or at least these symptoms, would often come into contact with the police. If that contact led to a physical restraint, there appeared to be an increased risk of fatality.

This terminology is not used anymore. As stated, neither I nor Inv Ferguson were medically trained. It would be for the Pathologist and other qualified experts to decide on the validity of such things. But it was brought up in the briefing so that it could at least be considered by the Pathologist.

107. Your PIRC statement (PIRC-00358), at page 9, identifies that at 1245 hours DCs Peter Grady and Peter Gilzean arrived at the mortuary, but did not have a death report or the medical notes from the hospital to be provided to the pathologist. What impact, if any, did this have on the post-mortem and PIRC's investigation?

I believe efforts were made to get a copy of the Death Report sent over electronically. The medical notes had been misplaced by staff at the hospital and were not available. I do not know what impact that had on the post mortem. That is probably a question for the Pathologist. The medical notes were traced a few days later and were seized by the PIRC. I presume that these were passed on to the Pathologist as soon as possible.

108. The scene manager's log (PIRC-04173), at page 23, identifies that:

> ***DC Grady was not present at the PIRC briefing this time but later spoke to K.Shearer privately prior to the PM out with PIRC Hearing.***

Why did DC Grady speak privately with Kerryanne Shearer prior to the post-mortem taking place? Did you consider it appropriate that he did so? If not, why not?

I do not know why DC Grady spoke privately to the Pathologist. I was not particularly aware that he had. As I don't know what was said, I'm not sure that I can comment on whether or not it was appropriate that he would do so. As this was a PIRC led investigation, I would probably not find it appropriate if he had been providing further information or making additional requests of the Pathologist without the prior approval of the PIRC Lead Investigator. However, as stated, I am not aware of the content of any such discussions.

109. Your PIRC statement (PIRC-00358), at page 9, states:

> ***DSI Harrower had previously informed Inv Ferguson and I that the deceased's family were not engaging with PIRC and that they would not be in attendance at the Mortuary to carry out identification of the deceased.***

What was your understanding of the relationship between Mr Bayoh's family and PIRC at the point the post-mortem took place? In what way did you understand Mr Bayoh's family not to be engaging with PIRC? What was discussed with COPFS in this regard?

I was aware at this point that the Police Scotland FLOs had not been deployed in the end and that DSI Harrower and Inv McGuire had attended at the home of the next-of-kin where they met with a significant number of people gathered at the address. The deceased's sister had been identified as next-of-kin and her husband had been put forward as the family spokesperson, or point of contact. My understanding was that DSI Harrower had not received a very positive reception and that when he had asked to speak to a smaller number

of people that this had been refused. My understanding was that the family were unhappy at what they felt was conflicting information that the police had given to them at various points across 3 May 2015, although the exact details elude me.

The family had stated that they did not want the post mortem to proceed until further family members (possibly including the deceased's mother) could travel up from England. They had refused to do the formal identification until these relatives had arrived. The family had refused to engage in the post mortem and identification process on 4 May 2015 as they wanted the post mortem to be delayed until family members arrived, although I do not think they were in a position to say exactly when that would be.

I did not discuss anything with COPFS, however I was told by either DSI Harrower or DSI Little (or both) that COPFS had instructed that COPFS had instructed that the post mortem would go ahead without the family doing the formal identification and that the ID would be done by other means.

110. Were you aware at the time that the post-mortem took place of any suggestion that the family had requested that the identification of Mr Bayoh's body be delayed pending the arrival of other family members? If so, how were you made so aware and what was discussed in this regard? If you were aware of the family's wishes, do you know why the post-mortem went ahead when it did?

As far as I was aware, the family had stated that they did not want the post mortem to proceed until further family members (possibly including the deceased's mother) could travel up from England. They had refused to do the formal identification until these relatives had arrived. The family had refused to engage in the post mortem and identification process on 4 May 2015 as they wanted the post mortem to be delayed until family members arrived, although I do not think they were in a position to say exactly when that would be. This was all information that was relayed to me, probably by DSI Harrower or DSI Little.

I was a trainee at the time. I was in no way involved in the decision-making in respect of whether or not the post mortem would or should go ahead on 4 May 2015. It was not a discussion that I was involved in at all.

111. What involvement, if any, did you have in compiling the scene management log for the mortuary (PIRC-01465)? What was the purpose of this scene management log?

None

112. Within the scene management log (PIRC-01465), at page 23 of the pdf, why is it noted that Collette Bell confirmed Mr Bayoh's identity when she was not present at the post-mortem to participate in a formal identification of his body? Is it normal practice for reliance to be placed on a prior identification when completing this section of the scene management log? If not, why was reliance placed on a prior identification on this occasion?

I do not know as I did not contribute towards this document and was not involved in the identification of the deceased. I do not know if it is normal practice for reliance to be placed on prior identification. My understanding that it is usual for the identification to be made by next-of-kin or a close family member, who would view the actual body. However this can also be done by two people who knew the individual.

Signature of Witness [redacted]…….

I believe that this entry states 'P/S via Colette Bell (Partner)'. My recollection was that a female detective, I thought Detective Sergeant Samantha Davidson, had looked at images of Mr Bayoh on her mobile phone (either via pictures on Facebook or pictures supplied by Colette Bell or [redacted]) and made a visual comparison against the deceased when she attended at Victoria Hospital on the morning of 3 May 2015. This was a visual ID by DS Davidson against photos she had access to and/or distinguishing scars or marks that she had been made aware of.

My understanding was that as the family would not be attending the post mortem on 4 May 2015, that fingerprints (I think a thumb print) were taken from the deceased [redacted]. Again, I was not directly involved in this, but was aware that Inv Ferguson was involved in this on the day of the post mortem. Inv Ferguson and DC Grady also identified Mr Bayoh as they had been involved in dealing with the deceased at Victoria Hospital. Inv Ferguson told me that the fingerprints were to identify the deceased 'in life' and that he and DC Grady identified him 'in death'. This was not terminology that I was familiar with at that time.

113. An "Officers Note" was subsequently prepared in relation to the post-mortem (PIRC-04148). Who prepared this note? What, if any, involvement did you have in preparing this note?

I do not know who prepared this note and I was not involved in preparing this note. I presume, due to the level of detail of events, the fact that it is on PIRC headed note paper, and was date 5 May 2015, that this was likely prepared by Inv Ferguson or DSI Little. However, I do not really recognise this document so could not say for sure. I do not recognise and am not familiar with the terminology 'Officer's Note'.

114. The note (PIRC-04148), at page 2, identifies that:

> ***The area of cultural issues was highlighted with DCI Hardie confirming that the deceased was Muslim, again the pathologist were happy to proceed after being advised by Mr Ablett that the investigation would take precedent.***

Your PIRC statement (PIRC-00358), at page 9, states:

> ***Amongst the various topics discussed were … the need to take samples of hair (possible cultural implications as deceased believed to be muslim) to prove/disprove chronic drug use.***

What awareness did you have of Mr Bayoh's religion at this stage of the investigation? Was it known that he was Muslim, or was he "believed to be" Muslim? What discussions took place in relation to Mr Bayoh's religion and the impact that that may have had on the post-mortem? What, if anything, was done to address any concerns or sensitivities identified in this regard?

At the time that Inv Ferguson and I were discussing this with Pathologist Kerryanne Shearer, I believed that Mr Bayoh was a Muslim as this is the information that had been communicated to me, I think by DSI Harrower in the first instance. I had not spoken to or been in the presence of DCI Hardie at that point. It is possible that DCI Hardie confirmed that the deceased was a Muslim out-with my presence, possibly when speaking to DSI Little, SI

Casey, PF Bernie Ablett of the Pathologists. I do not recall this. The primary consideration seemed to be around whether or not a sample of hair should be taken, to allow for testing for possible chronic drug use. If it was not felt necessary to take a hair sample then I'm sure that it would not have been taken. However, the pathologists obviously felt that it was necessary. I do not remember mention of further concerns or sensitivities being discussed.

115. In what way was the pathologist advised by Bernie Ablett that the investigation would take precedence in this regard? During a post-mortem, is it normal practice for an investigation to take precedence over any cultural or religious sensitivities associated with a deceased person? If not, why did it take precedence on this occasion?

My memory of the discussions around the 'cultural sensitivities' was that it was discussed in a small room, with both pathologists present, along with DSI Little and SI Casey and the PF Bernie Ablett. Bernie Ablett was unequivocal in his assertion/direction that any samples that the pathologists thought were necessary should be taken, and that the investigation took precedence over 'cultural sensitivities'. Although I think only a small amount of hair was taken from a discreet area.

My understanding is that ultimate responsibility for the thorough investigation of unexplained deaths in Scotland lies with COPFS. Therefore it would ultimately be the PF who would have the final say on whether or not the aims of an investigation outweighed possible cultural or religious sensitivities. I have limited experience of post mortems and have not come across this during any other post mortem, so I do not feel in a position to be able to offer an opinion on whether this is normal practice or not.

116. The scene manager's log (PIRC-04173), at page 24, identifies that:

> ***Discussion took place (KeryanneShearer [sic] to IO Ferguson) during the PM and technician present, that in some cases female members of Muslim families have been known to in the past attend at the mortuary and wash the body. This however was identified as rare.***
>
> ***At the time of the PM there was no other religious concerns made known to investigators by family members.***
>
> ***From information provided later by IO Lewis (FLO PIRC) no cultural issues where* [sic] *raised by Mr and Mrs Johnson.***

Whilst "no other religious concerns" had been made known to PIRC's investigators by Mr Bayoh's family members, at the time of the post-mortem what, if any, steps had PIRC taken to ask Mr Bayoh's family if they had any concerns in relation to the post-mortem on account of Mr Bayoh's religion? Should PIRC have proactively sought this information from Mr Bayoh's family prior to the post-mortem taking place?

I am not aware of what steps, if any, the PIRC had taken to engage with the family on this matter specifically. I had no contact with the family at any point throughout the investigation. I do not know what information was provided to Inv Lewis in this regard, or when this information was provided to him. I believed that PIRC were in contact with the family on the morning of the post mortem, and that PIRC FLOs were attempting to meet with the family. I believe that the family were aware at this point that the post mortem was going ahead that afternoon. I am not aware of the family passing on any specific instructions or concerns to

the PIRC in relation to the deceased being a Muslim. I do not know if this was a question that was specifically asked of them by PIRC staff. I am not a trained FLO so do not know what the expectation is in this regard.

117. The note (PIRC-04148) identifies that DC Gilzean, DC Grady and DCI Hardie were present at Mr Bayoh's post-mortem. Following a death in police custody, is it common for the post-mortem of the deceased to be attended by police officers? If not, why were police officers in attendance at Mr Bayoh's post-mortem? What purpose is served by police officers attending a post-mortem following a death in custody?

I do not think that it would be uncommon for police officers to attend a post mortem when there has been a death in custody. I suppose it would depend on the circumstances. For example, if there was a drugs death in custody, it may be that the police would be involved due to implications for the wider public, or in pursuit of evidence relating to the supply of the drugs, neither of which are in the PIRC's remit. Information from the post mortem may be pertinent to their legitimate enquiries.

I do not know exactly why there were police officers from Police Scotland at Sheku Bayoh's post mortem. That is not a decision I was involved in. I would imagine that COPFS would have a role in deciding who should or shouldn't be in attendance. PIRC management may also have a role to play in advising whether or not it was appropriate for Police Scotland to have been present.

118. In your experience, what is the normal period of time between a death in custody or death following police contact occurring and a post-mortem taking place? Who did you understand was ultimately responsible for the decision that the post-mortem would go ahead on 4 May?

I do not have a lengthy experience of post attendance at post mortems and have only attended a handful in my time with the PIRC. It is not unusual for post mortems to be held within a day or two of the death, in my limited experience.

My understanding was, and still is, that the ultimate decision is made by COPFS.

119. What discussions, if any, took place in relation to informing the family of the results of the post-mortem? What was agreed in this regard? How were the family to be informed? Who was responsible for informing the family?

My understanding was that this would normally be done by the FLOs. My understanding was that this was to be done by the PIRC FLOs in this instance as well. I would imagine that there would have been close consultation with the Lead Investigator, DSI Little prior to this actually happening. I was not involved in discussions about how this was going to be done as this was not an area of the investigation that I was involved in.

120. Are you aware of when the family was informed that the post-mortem had taken place? When were the family so informed? Was the family informed directly, or via their legal representative? Who informed the family or their legal representative that the post-mortem had taken place? How did you become aware that the family had been informed that the post-mortem had taken place?

I was not involved in informing the family that the post mortem had taken place. That would normally be the role of the FLO in consultation with the Lead Investigator. I do not really

remember who did this, when, or when I became aware of this. I was not involved in this aspect of the investigation. I have some memory that the family engaged a solicitor at a very early juncture, but the ins and outs of it were not something that I particularly remember.

121. Your PIRC statement (PIRC-00358), at page 11, states that 1900 hours there was a discussion between John Ferguson, DC Grady and DC Gilzean and yourself in relation to productions in which there was a "re-emphasis that PIRC must be sighted in all decisions relative to this enquiry". What was discussed in this regard? Why was it necessary for there to be a "re-emphasis" of this point? Were PIRC sighted in all decisions made by Police Scotland in relation to the productions relevant to this investigation? If not, why not?

I believe that as initially the productions were lodged at Kirkcaldy Police Office, the details of the productions were being entered onto HOLMES, which is a police investigation management system used for major incidents and large investigations. As such, DC Gilzean, who was performing a role as Productions Officers in relation to this incident on behalf of Police Scotland, was asked to provide PIRC with a list of all productions that had been seized to date. My recollection is that in fairly short order (within a couple of days) that PIRC staff took possession of all the productions and these were thereafter relocated to PIRC premises.

As these were productions in a PIRC investigation, it was important to remind these officers that it would be for PIRC to decide if and when these productions were to be moved or sent for analysis and this was to be done under PIRC authority. It was important that Police Scotland did not proceed as they would normally have done if this was a Police Scotland led investigation, i.e. submit items for tests/analysis. These would be decisions for the PIRC.

I believe that there may also have been some discussion around slightly different methodology that was used by Police Scotland in the East of the country at that time, in relation to 'labels in lieu'. This was where (in the East) if you seized say some CCTV footage from a premises, in most of the country you would only fill in a production label for the disc that you had physically seized. However, there was a practice in the East of the country where police officers would also produce a label for the CCTV system that remained in the premises. This was called a 'label in lieu', as the article itself (the CCTV system) was never actually seized. This was a practice at the time that was peculiar to the East of the country and not one that was really understood or used elsewhere. The PIRC did not use the 'label in lieu' practice, so it was important that we had some understanding of what these labels in lieu that may appear on production lists provided by Police Scotland actually meant.

It was not necessary because of any specific concerns that officers would do, or were doing, anything to the contrary. However, it seemed prudent that when we had a chance to speak directly with the Police Scotland productions officer that we made sure that everyone knew what was expected of each other.

As far as I am aware, yes we were. For example, it was the PIRC who coordinated the Forensic strategy meeting that would take place on 12 May 2015, where the items to be analysed, and the order that this should be done, was discussed and agreed. As stated previously, I believe that by this point all productions that had been seized by the PIRC or by Police Scotland had been taken into PIRC's physical possession by that point.

6 May 2015

Signature of Witness [redacted].....

122. Your notebook (PIRC-04198), page 7, identifies that you met with DCI Houston along with John Ferguson at 1700 hours regarding "scene management/forensics". What was discussed at this meeting? Following the expansion of PIRC's terms of reference on 5 May 2015 to incorporate the events prior to Mr Bayoh's arrival at Hayfield Road, did this meeting with DCI Houston constitute a handover of responsibility for scene management from Police Scotland to PIRC? If so, were you content with the handover and assistance provided by Police Scotland in this regard? If not, why not?

We were updated as to the current 'state of play' in respect of each of the scenes. I have fairly limited recollection of the details that were discussed during this meeting, although I do recall that we discussed all of the scenes relevant to the events of 3 May 2015, and not just Victoria Hospital (the deceased) that Inv Ferguson and I had been specifically involved in. This included details of productions seized from the various scenes, which at this point were:

- Victoria Hospital (and the deceased)
- the locus at Hayfield Road
- Collete Bell's address (deceased's home address)
- the home address of witnesses Martin Dick and his partner Kirsty McLeod (where deceased had been in the early hours, watching the boxing with friends)
- the home address of witness Zahid Saeed (where he lived with other family members)
- Mr Saeed's Seat Toledo motor car parked at the home address (which deceased had travelled in and potentially struck with a knife) – *I can't recall if this was being treated as a single scene (included in the address), or if at this point it was effectively being treated as a 'separate scene'. I think the latter as the home had to be returned to the Saeed family as quickly as possible as there was an elderly or infirm individual who resided there.*

I couldn't tell you now all of the items that were found at the various scenes, however this will be available within documentation I am sure. I believe that a DI Stuart Wilson had updated DCI Houston to advise that Collete Bell's address had been stood down as a scene and returned to her. A Police Scotland Scene Manager had done a 'walk-through', it had been photographed and items had been seized. Of note were a number of packets of pills, and or loose pills. Also knives from a knife block (for comparison with the knife found at Hayfield Road locus).

Martin Dick's address had also been stood down as a scene. It had been photographed and items had been seized. No items that I particularly remember.

The car, the Seat Toledo was still to be examined in respect of possible damage caused by stab marks to the bodywork or paintwork. I think it had either been taken to a recovery yard, or was to be taken there. This all related to witness evidence suggesting that the deceased may have attacked this car with a knife.

By this point, Inv Ferguson had been given responsibility for on-going scene management and forensic considerations. I was to assist him in this regard. This was always in consultation with Lead Investigator DSI Little who ultimately made any decisions, but Inv Ferguson was charge with gathering all relevant information in relation to this strand of the investigation and being a main point of contact for liaising with officers from Police Scotland and the SPA, Pathologist and other labs/scientists (such as Toxicology at Glasgow University etc). So I suppose this probably was a 'handover'. I can't recall if it was described as such to me at the time by Inv Ferguson, or DSI Little.

Signature of Witness [redacted] .....

My memory was that it was a productive meeting and that there was a high degree of cooperation. I do not remember coming away from this meeting with any burning issues or concerns, although I was very much the junior partner. I think Inv Ferguson was pretty content with how things had gone.

8 May 2015

123. You were present when Investigator Brian Dodd took a statement from Martyn Dick (PIRC-00031). Mr Dick does not appear to have been asked whether he provided consent to Police Scotland's seizure of his property on 3 May 2015. What consideration, if any, was given to asking questions of Mr Dick to clarify the legal basis upon which his property was seized by Police Scotland? Later in the investigation, was consideration given to obtaining a further statement from Mr Dick to explore this line of questioning? If not, why not?

I do not recall any consideration being given to asking Mr Dick, on 8 May 2015, whether or not he had given consent for Police Scotland to seize his property on 3 May 2015. Likewise, I do not recall any consideration being given to asking Mr Dick to clarify the legal basis upon which his property was seized by Police Scotland. We had not been tasked to investigate the police's interactions with Mr Dick and I do not particularly recall him raising this as an issue with us.

If he had, I imagine that DSI Dodds would have made some note of it, although I do not imagine he would have spent much time on it. If Mr Dick had mentioned this it is likely that we would have advised him to make a complaint to Police Scotland regarding this and that DSI Dodds or I would have brought this to the attention of DSI Little. None of that happened.

I was never tasked, later in the investigation, to note a further statement from Mr Dick exploring this. I was not involved in determining lines of inquiry. I do not recall being involved in any discussions regarding this returning to Mr Dick to explore this.

12 May 2015

124. Your PIRC statement (PIRC-00358), at pages 13 – 14, refers to your attendance at a forensic strategy meeting with representatives from COPFS, Police Scotland, SPA, pathologists and other PIRC staff. What was the purpose of this meeting? Were any concerns raised about the recovery of evidence up to this point in the investigation? If so, what concerns were raised?

The purpose of this meeting, as explained by SI McSporran in his opening remarks, was to 'discuss and agree the prioritisation of the forensic examination of productions seized during the PIRC investigation to the death in police custody of Sheku Ahmed Tejan BAYOH on Sunday 3 May 2015'.

I do not recall any concerns about the recovery of evidence up to this point being raised during this meeting.

125. Who led this forensic strategy meeting? Were you content with the decisions made in relation to forensic strategy at this meeting? Was any forensic strategy agreed beyond that which is contained in PIRC-04161, PIRC-03860 and PIRC-04173 (pages 41 – 55)? If so, where is this forensic strategy documented? Who collated the

separate minutes from the meeting set out in these three documents? Did you take the minutes contained within PIRC-03860?

SI John McSporran chaired and 'led' the meeting. A Forensic Strategy Meeting is a forum for discussion, so many people contributed. Les Brown, from COPFS also had a role is decision-making, as far as I recall, as this was a COPFS instructed investigation, although I do not recall any decisions being made where there was any disagreement voiced in the room. Again, I was a trainee so my opinion as to the content of the decisions was not particularly relevant at the time. In my limited experience to that point, I was content with the decisions that were made.

This was the primary Forensic Strategy that was followed thereafter, as far as I can recall.

PIRC-04173 was a document maintained by Inv Ferguson, it was not a document that I was particularly aware of at the time and was not a document that I contributed to or worked from. I cannot recall exactly when I became aware of this document.

I took the minutes at this meeting. I recognise PIRC-03860 as the minutes that I typed up and provided to SI McSporran for checking. I believe that PIRC-04161 is the finalised version that SI McSporran had sent round all of the participants, following his review of my initial effort. I imagine that any changes between the two would have been made by SI McSporran, either himself or me doing so at his direction. He would have 'proofed' the final version before it was emailed to the participants.

126. Why did Police Inspector Darren Faulds attend this meeting? (PIRC-04161) If Inspector Faulds was required for part of the meeting was any consideration given to him attending only the relevant section? How common is it for Police Scotland's officers and staff to continue to be involved in PIRC investigations into deaths in police custody as those investigations progress? What steps do PIRC take to ensure that such investigations are independent from Police Scotland?

As far as I can recall, PI Darren Faulds attendance related to the potential for PIRC using specialist 360 degree laser scanning equipment to survey and record the scene at Hayfield Road, for potential future digital scene reconstruction purposes. It was a piece of equipment utilised primarily by the Roads Policing department within Police Scotland in relation to fatal Road Traffic Collisions, although it could also be used at other types of scenes. He was there to advise on how and when it can be used and any considerations around this.

I do not know what, if any, consideration was given to asking him to attend only a certain section of the meeting. It would suggest that this would have been a decision for SI McSporran and Les Brown to consider, not me.

It is not uncommon for specialist officers to provide advice of assistance throughout the course of a PIRC investigation into deaths. PIRC is a small organisation with limited resources and areas of expertise.

As previously stated, the PIRC make all efforts to ensure that the decision-making within any PIRC investigation is independent of the police force (officers) or police body that is under investigation. Wherever possible, the PIRC use its own staff to conduct all aspects of investigations. However, due to the size of the PIRC as an organisation, and the particular specific areas of expertise that some PIRC investigations require (e.g. Crash Scene Investigation), it is not possible for PIRC staff to undertake every action or task that is

required. This can lead to a degree of reliance on using particularly specialist staff from within the police force that is being investigated. There is also a certain reliance on working together with officers from within the police's own Professional Standards Department to enable the PIRC to obtain certain information that requires access to police systems and databases etc. This is the reality of how the PIRC operates.

14 May 2015

127. Within an email dated 14 May 2015 that you sent to [redacted], SPA (PIRC-02624), you state:

> ***Having spoken to Gordon Young of SPA, following the Forensic Strategy Meeting held … on 12/5/15, you are aware that the Crown has instructed that the PIRC has sole responsibility for the investigation into this matter and that any requests from Police Scotland in relation to this matter are not to be processed unless prior authorisation has been given directly (from PIRC) to SPA to allow this. My understanding is that you will be notifying your colleagues of this.***

Prior to this point had requests been made by Police Scotland to SPA which, within the context of Crown-directed investigation following a death in custody, PIRC considered inappropriate? If so, what requests were made by Police Scotland?

I cannot remember if any requests had been made by Police Scotland prior to this communication. I suppose it is possible, for example for Scene Managers involved in the initial 'non-PIRC' controlled scenes to have requested that any photographs taken by SPA Scene Examiners be sent to them instead of the PIRC, prior to the decision being made that all scenes would come under the updated terms of reference from COPFS. I cannot remember if this did happen or not though.

If not, why did this point require to be communicated to SPA? Did any further issues arise in this regard throughout the investigation?

As the role of the PIRC was still not especially well known, or understood, by all partner organisations at this time (including the SPA), I imagine that I would have been communicating this to ensure that those who were dealing with requests for imaging (at the SPA) were fully aware that this was a PIRC investigation and that this meant that images were to be sent to the PIRC and not to Police Scotland. SPA staff work with Police Scotland on a daily basis, they are the primary users of SPA services. The PIRC had only engaged the services of the SPA on a very limited basis by May 2015, so it would be possible that staff at the SPA could mistakenly think that they should 'copy in' the police to any emails, or send via emails via their usual channels, or not really know the difference between the PIRC and the Police.

This had already become a very high profile investigation by this point, so I was probably just being cautious in this regard.

I do not recall any issues regarding this arising throughout the investigation.

26 May 2015

128. A Clue Action (PIRC-03024) identifies that on this day you met with Mark Gleeson, Airwave Communications Team Leader, to discuss the data contained within the Airwave Call Data Activity spreadsheets. What was the purpose of meeting with Mark Gleeson? What was discussed? How did this assist PIRC's investigation? Why PIRC not obtain a statement from Mark Gleeson to cover the guidance provided during this meeting?

The CLUE Action was allocated to me on 26 May, the text contained in the Action explains that I met with Mark Gleeson on 28 May 2015. I met with Mark Gleeson so that I could gain a better understanding of the information that was contained within PIRC Productions:

Label No Call Data Report 2 (and certificate of authentication)
Label No Call Data Report 1 (and certificate of authentication)

This related to information about the use of the personal issued police Airwave radio handsets, that officers use as their primary mode of communication between each other and the Area Control Room (ACR) whilst they are on duty, responding to calls. Information is recorded regarded when certain buttons are pressed on these handsets and what information is transmitted when certain buttons are pressed, e.g. how long a transmission lasts, whether these are direct transmissions between individual handsets that are only heard by those officers (known as 'point-to-point), or whether the transmissions are broadcast on the 'open channel' that all officers in tuned in to that channel can hear. Whether the 'emergency button' is pressed on any handsets etc.

This was a meeting with Mark Gleeson to discuss how this all worked. It was to teach me what was captured and what was not and to assist me in learning to interpret this information. This was to allow me to start a piece of work for DSI Little, analysing this information in relation to the radio handsets used by the officers who attended the locus at Hayfield Road. I was there to learn, not to note a statement. I did later note a statement from then Airwave Services Coordinator, Colin Gill (previously a witness for the Public Inquiry) and he also provided me with a document describing a lot of this with better technical explanation than I would have been able to articulate. I had similar phone calls and conversations with Colin Gill throughout the investigation, again so that I could learn how to better understand this data.

4 June 2015

129. On 4 June 2015, you were present when Investigator Ross Stewart took a statement from Sergeant Scott Maxwell (PIRC-00266). When a statement is taken "in the presence of" a PIRC investigator, what is that investigator's role within the interview? May that investigator ask questions of the witness? If so, what, if any, lines of questioning did you seek to explore with Sgt Maxwell?

There is usually a lead interviewer and a '2nd'. The lead interviewer asks the majority of the questions and notes the answers. The 2nd might interject at certain points, maybe if they are not clear that a question has been clearly understood, or the answer for that fact. They may rephrase a question or seek clarity. They may remind the lead interviewer of a point that they said they would come back to. Different people have different styles. Some are less keen on interruptions from the 2nd than others. I had worked a lot with Inv Stewart so I knew that he did not mind me interjecting on occasion if I had something to add or clarity to seek. He would also likely ask me at certain points if there was anything else that I wanted to ask before he moved on to a new topic, or anything that he thought I had missed.

Signature of Witness [redacted].....

If I did ask any questions the answers would have been recorded in the statement by Inv Stewart. It would not likely note that it was me specifically that has asked them. I did not take a note of any questions that were asked by me, as opposed to by Inv Stewart. It is a joint enterprise. Inv Stewart would have asked the vast majority of questions though. I would also likely have been keeping an eye on the clock, so that comfort breaks or meal breaks could be taken. I may have taken some notes about breaks etc., only because this was a lengthy interview.

130. In the process of this statement being taken from Sgt Maxwell, what, if any, contact did you have with your colleagues from PIRC who were taking statements from other officers on 4 June 2015 to allow the accounts received from the officers who attended Hayfield Road to be compared and contrasted for any gaps or inconsistencies? If you did have such contact with your colleagues, in what way did that influence the lines of questioning that were put to Sgt Maxwell when taking his statement?

From memory, the interviews were set out in such a way that DSI Little and possibly also Inv Lewis (although I could be wrong) were in a separate room, not interviewing any individual. We had been instructed that if anything of real significance came up, that needed to be communicated to DSI Little straight away, that this could be done and he could feed any such information into other interviews if required. I do not recall us having to do this with any information provided by A/PS Maxwell. Also when we stopped for breaks, there was an opportunity for us to feed into DSI Little of colleagues conducting interviews in other rooms.

However, there were a number of officers being interviewed simultaneously, and in significant detail, so there was no option or direction for constant comparing and contrasting ‘live time’. At the end of the day, these were witness statements. If required, further witness statements could be requested once these statements were compared to other witness statements and known or suspected information.

131. Was Sgt Maxwell’s statement obtained in line with PIRC’s witness interview strategy (PIRC-04182)? If so, what involvement, if any, did you have in the preparation of the witness interview strategy? Was it standard practice for PIRC to obtain statements from witnesses using a document of this nature? Prior to Sgt Maxwell’s statement being taken, did you have any discussions with other PIRC staff in relation to the lines of questioning to be explored with Sgt Maxwell and/or the other officers that attended Hayfield Road? If so, what was discussed?

From memory a generic witness strategy was produced, I think by a member of PIRC staff who had been a trained Interview Adviser in their previous career as a detective. I was not involved in the preparation of the generic witness strategy.

It was not unusual for staff to prepare a witness or interview strategy. These are not necessary for simple, short statements. However, in more ‘involved’ or complex statements, it would be fairly standard for there to be an interview strategy. Sometimes a Lead Investigator would want to see these prior to an Investigator carrying out the interview. Sometimes the Lead Investigator would provide one to the Investigator, or have a significant input, to ensure that they would get answers to the questions that they felt were pertinent to their investigation.

Signature of Witness [redacted] …….

From memory, we were then asked to do a bit of further reading regarding our own specific interviewee, and their role in the incident as far is it was know to that point. We could then add questions that were specific to our interviewee and their part in events.

132. The questions contained within the witness interview strategy (PIRC-04182) largely focus on the "what", "when", "who" and "where" of the circumstances of the incident. Only two questions ask the officers "why" certain actions were taken – why use of force and CS/PAVA forms were not completed and why there are no entries in the officers' notebooks in relation to the incident. When preparing to take the officers' statements, was consideration given by PIRC to asking the officers why they took certain decisions or chose particular tactical options in responding to the incident involving Mr Bayoh? If not, why not?

There are lots of follow-up questions, like "why", or "what was your thinking behind that", which would not necessarily be written down in an interview strategy. This is to avoid them becoming cumbersome and unwieldy big documents. Experienced statement takers and interviewers know to ask these types of questions to elicit as much information as possible. Inv Stewart was an experienced former detective who was, in my own many years of experience working with him, a very diligent, thorough and well-prepared interviewer. It would not be expected that every question that would be asked at interview would be explicitly written in an interview plan, or strategy. PIRC Investigators are and were encouraged to ask "why".

I was involved in the interview of Sgt Maxwell. As previously described, we we're asked to research our own specific interviewees so that we could ask questions that were relevant to them. Sgt Maxwell was not involved in restraining Sheku Bayoh and did not use force or tactical options in this regard. Therefore, neither Inv Stewart nor I asked this or added it to our witness strategy.

133. The Police Service of Scotland (Conduct) Regulations 2014, within Schedule 1, identify that as part of the Standards of Professional Behaviour with which officers require to comply:

> ***Constables use force only to the extent that it is necessary, proportionate and reasonable in all the circumstances.***

How important is understanding why officers took certain decisions or chose particular tactical options to a determination as to whether or not a use of force was necessary, proportionate and reasonable in all the circumstances?

I would say that it is very important to understand why officers took certain decisions and why they chose one course of action over another. This is particularly true when trying to understand any justification given for use of force, and why one tactic or technique was used over another.

134. There are no questions relating to the impact that Mr Bayoh's race may or may not have had on the officers' response to the incident. What consideration, if any, was given to including questions within the witness interview strategy in this regard?

I do not recall there being any consideration given to this line of questioning.

Signature of Witness [redacted]…….

135. The minutes from PIRC's morning briefing on 3 June 2015 (PIRC-04156), at page 40, with reference to an update that DSI Little provided, state:

> ***A generic interview plan has been completed by IO Sinclair. Everyone has to do their own individual reading for their specific officers to add to the generic plan.***

What material did investigators require to read in addition to the witness interview strategy when preparing to interview the officers? What material did you read prior before Sgt Maxwell's statement was obtained in your presence?

I do not have a clear memory of what documents I read prior to the interview, it was a very long time ago. If there is not direct mention of specific documents within any CLUE Action, then I couldn't tell you specifics. But what I can say, is that it is likely that I read any briefing papers, STORM Incidents or witness statements available that related to the incident at Hayfield Road. If there were training documents or SCOPE records relating to the officer I would have read them. I would have listened to any Airwave recordings that involved the officer that we had access to, and would have viewed any CCTV footage that I believed would show the officer's actions.

136. The minutes from PIRC's morning briefing on 3 June 2015 (PIRC-04156), at page 40, identify that there would be a "further meeting this afternoon to discuss tomorrow's interviews". Did you have any discussions with other PIRC staff in relation to the lines of questioning to be explored with the officers? If so, what was discussed? With whom did you have those discussions?

I have no recollection of any further details regarding 'lines of enquiry' that may have been discussed at this afternoon meeting. I think there was a meeting that discussed the logistics of the interviews and the instructions regarding bringing 'stand out' pieces of information to DSI Little at the central room if required so that this could be communicated to others if required. Instructions to escort the officers for their lunch break and to ensure there was no opportunity for them to discuss the interviews amongst themselves during any breaks etc. This may have been what was discussed about tomorrow's interviews. What was contained in the generic witness strategy, with my own additional notes (in red) is, I believe, the final version of witness strategy that I would have taken to the interviews.

As I was going to be working with Inv Stewart, I am pretty sure that we would either have discussed the interview plan, or worked on it together, in the build up to the interview. What specifically we discussed, I do not remember.

137. A separate version of the witness interview strategy (COPFS-05955) contains your own notes in relation to the interview of Sgt Maxwell. What was the purpose of taking these notes? What is the distinction between the notes made in red and those made in black? Were PIRC's investigators encouraged to add their own questions to the witness interview strategy prior to or during the interview? Were PIRC's investigators encouraged to ask "why" the officers took certain decisions or actions during the incident, despite questions in that regard not being explicitly set out within the witness interview strategy?

These notes would have been prompted by the additional reading that we were asked to do in relation to our own individual interviewee, as detailed above.

Signature of Witness [redacted] …….

I believe the red notes would have been those added after my prep reading, but before the interview took place. I think the black notes are likely to be my scribbles taken down during the interview itself.

You are always encouraged to use your own initiative. The generic witness strategy would be information that the Interview Adviser and Lead Investigator were clear that they wanted answered. However, asking one Interview Adviser to do bespoke plans, for 8 or 9 officers for the same day, would be impractical. It was our interview and therefore our responsibility to customise it to our interviewee. That was my recollection and expectation.

There are lots of follow-up questions, like "why", or "what was your thinking behind that", which would not necessarily be written down in an interview strategy. This is to avoid them becoming cumbersome and unwieldy big documents. Experience statement takers and interviewers know to ask these types of questions to elicit as much information as possible. Inv Stewart was an experienced former detective who was, in my own many years of experience working with him, a very diligent, thorough and well-prepared interviewer. It would not be expected that every question that would be asked at interview would be explicitly written in an interview plan, or strategy. PIRC Investigators are and were encouraged to ask "why".

138. Following a death in custody or a death following police contact, was it common for officers to be re-interviewed by PIRC after they had already been interviewed by PIRC? After Sgt Maxwell's PIRC statement had been obtained (PIRC-00266), did you consider that there were any matters that required to be clarified with Sgt Maxwell? If so, what were these matters?

It is not uncommon for officers to be re-interviewed for clarification of points within their original statement, or if additional information comes to light that requires additional questions to be asked. Of course you try to ask all questions in the first instance, however it may be that their account conflicts or is at odds with other accounts or information that the interviewer was not aware of at the time. Or it may be that due to the seriousness of the matter being investigated, the Lead Investigator of Fiscal dealing with the case requires a more detailed or nuanced response. This does not happen in all investigations but it is not uncommon.

It was not my role to determine whether or not additional questions needed to be asked of Sgt Maxwell. The statements would be read by those directing the investigation, including DSI Little, and I would have expected to be tasked by him to re-interview Sgt Maxwell if this was required. It would not be for me to make that judgement.

139. In the course of Sgt Maxwell's interview on 4 June 2015 (PIRC-00266, page 10), you received a statement from Sgt Maxwell that he had prepared in the days following the incident (PIRC-00267). What, if any, comparison did PIRC carry out between the accounts contained within Sgt Maxwell's two statements to identify areas of consistency and inconsistency? What, if any, involvement did you have in this process?

I do not recall what work was done in relation to comparing the accounts within Sgt Maxwell's statement noted on 4 June 2015, to the self-prepared statement that he handed over to us that day. Any comparison that would have been requested would probably have come in the form of a CLUE Action.

Signature of Witness [redacted].....

I certainly read the pre-prepared statement that Sgt Maxwell provided to us, but I think we may have had people in the role of 'statement readers', whose job it was to read statements and documents that came in to the investigation and create suggested 'Actions' arising from these statements or documents, for review by DSI Little who would then decide to allocate or the Action, or not. I do not recall being allocated an Action to review the pre-prepared statement against the statement noted by Inv Stewart.

140. Did PIRC compare and contrast the statements received from the officers that attended Hayfield Road to identify areas of consistency and inconsistency? What involvement, if any, did you have in this process?

This was not something that I was involved with. I am sure that this would have been done but it is not a specific task I was involved with. I do not recall being allocated any 'Actions' in relation to this. I did contribute to some work that was done to compare officer's accounts (from their statements) in relation to their physical movements around the Hayfield Road locus, against Area Resource Location (ARL) data from their person issue handheld Airwave radio sets, which I have detailed in my response to question 144 of this Questionnaire.

141. What consideration, if any, was given to taking further statements from the officers to question inconsistencies between their respective accounts? Why were further statements not taken from the officers to clarify inconsistencies between different witnesses' accounts?

These would have been decisions that would be made by the Lead Investigator and tasked out to Investigators like me. If further statements were to be taken, I would have expected to have received an 'Action' detailing what was required of me. I do not recall receiving any Actions to take further statements from officers to query inconsistencies. I do not recall if other Investigators did receive Actions in relation to this.

142. After Sgt Maxwell provided his statement, PIRC's terms of reference were expanded by COPFS to look at whether there was inappropriate conferral between police officers and to investigate issues of race and conduct. What consideration, if any, was given to obtaining further statements from the officers that attended Hayfield Road to explore these areas with the officers? Why was it decided that further statements did not require to be obtained? Whose responsibility was it to decide if further statements required to be obtained from any of PIRC's witnesses?

Again, these would have been decisions that would be made by the Lead Investigator and tasked out to Investigators like me. If further statements were to be taken, I would have expected to have received an 'Action' detailing what was required of me. I do not recall receiving any Actions to take further statements from officers in relation to conferring, race or conduct. I do not recall if other Investigators did receive Actions in relation to this. I do not recall being involved in any discussions around whether or not additional statements should have been noted regarding this area of inquiry. That would have been a decision for those leading the investigation in conjunction with COPFS I would imagine.

The Lead Investigator would be responsible for deciding if further statements were required, I would imagine following discussion with more senior staff such as Senior Investigators and/or Heads of Department. Possibly even the Commissioner. By this point this had become an extremely contentious and 'political' investigation. Approaching officers to re-interview them in relation to conferring, race and conduct would have been a decision that I would have thought would have been taken at a high level, and probably in conjunction with

senior members of COPFS. However, I was not involved with any of these decisions so cannot comment as to what decisions were made, by whom, or who was consulted.

143. Had you dealt with a situation prior to May 2015 in which officers did not provide statements for several weeks after an incident? What was the outcome? Have you dealt with such a situation since May 2015? What was the outcome?

I have never before, or since, dealt with a situation where officers have refused to provide a statement for several weeks.

29 June 2015

144. Your PIRC statement (PIRC-00358), at page 21, identifies that, alongside DSI Ian McIntyre, you produced a document titled "ARL (GPS) Analysis of Officer's Movements", at SI McSporran's request. Please can you confirm that this document is PIRC-03842. You also seized a document titled "ARL Report of Officer and Vehicle Movements" from John Wilson, Police Scotland Communications Team Leader, on 2 July 2015 (PS17474). How did PIRC use Automatic Resource Location (ARL) data to plot the officers' movements on 3 May 2015? What involvement did you have in this process? To what extent were you able to use the ARL data obtained during PIRC's investigation to corroborate or challenge the accounts of the officers within their statements?

The data from each officer's personal issue radio records it's longitudinal and latitudinal position via GPS on a regular basis, sometimes numerous times per minute. It is possible to take these positions and mark (plot) them on a map. As the data also gives a timestamp (to the minute not second), this allows you to track where that individual radio handset is over a period of time.

This is not so accurate as to allow you to ascertain exact positions and how long exactly a radio handset was in that exact position. However, it would allow you to say, for example, that an officer was at a particular location and then travelled to a different location and then travelled back to the original location, with a certain degree of accuracy (in relation to location and time).

So if a radio travelled from say, Kirkcaldy Police Office, to Hayfield Road, then to the Victoria Hospital, you could track that radio on a map and say where it was and at what time. As officers have personal issue radio handsets (with an unique 7-digit 'ISSI' number), which are predominantly attached to their person, you can then say that the officer was at a certain place, at a certain time. You would be required to confirm that the officer had possession of their own radio at the time.

The same can be done for vehicle mounted radio sets, such as those found in police cars and police vans etc. I got a list of all of the ISSI numbers for the primary officers involved, and the vehicles that had been used to attend Hayfield Road, and had Police Scotland technical staff plot these on their mapping system using the ARL data (the list of longitudinal and latitudinal data points). They did each of the radio sets on individual maps and in sequential order (by time). This allowed me to see the movements of the officers (handheld radios) and compare this against the officer's movements as described in officer statements.

Having completed this analysis, I produced a document titled 'ARL (GPS) Analysis of Officer's Movements'. This was effectively the result of the analysis carried out, combined

with some technical explanations (and health warnings) regarding how ARL works. This was so that there was a more accessible summary that could potentially be used in any PIRC Report, if deemed appropriate.

I obtained the data from Police Scotland (in an Excel Spreadsheet). I had Police Scotland plot the data on mapping software that they use. I had them send me two maps per ISSI number (per radio/officer) one general view of Kirkcaldy and one zoomed closer in on Hayfield Road, so that I could see officer's general movements throughout the incident, as well as gaining as much detail as possible around the Hayfield Road locus. I asked for the same for the radio sets mounted within 6 police vehicles used, however only 2 of the vehicles had recorded the data.
**Unfortunately, due to the number of plots per officer on the zoomed in Hayfield Road locus, many of the dots were overlayed on top of one another. This meant that the officers had likely remained pretty still over a period of time, or had not moved very far, so the plots were bunched very close together.*

The ARL data only threw up one seeming anomaly from officer's accounts. The data for PC Walker's handheld radio suggested that, contrary to his statement, he did not return to Kirkcaldy Police Office with the other officers, but instead travelled to a location in or around Victoria Hospital. However, within PC Alan Smith's statement, he stated that he (PC Smith) had picked up an Airwave radio and set of car keys that were lying near Sheku Bayoh on the ground. He stated that the Airwave radio belonged to PC Walker. PC Smith then drove the ambulance that Sheku Bayoh was in to Victoria Hospital, before later returning to Kirkcaldy Police Office. The account in PC Smith's statement did corroborate the ARL data in relation to why PC Walker's radio was tracked at Victoria Hospital.

3 July 2015

145. Your PIRC statement (PIRC-00358), at pages 22 and 23, identifies that you produced documents titled "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396) and "Transcript of Police Scotland Airwave Talkgroup 'Kirkcaldy 1' on 3rd May 2015 between 0600 and 0800 GMT" (PIRC-01399). How did you create these documents? What data and information did you use? How did you attribute the Airwave transmissions to particular officers within these documents? Why were you tasked with producing these documents? What support and oversight did you receive from colleagues when completing these documents? Did any colleagues check the transcripts that you produced?

"Transcript of Police Scotland Airwave Talkgroup 'Kirkcaldy 1' on 3rd May 2015 between 0600 and 0800 GMT" (PIRC-01399) is what I would describe as a traditional audio transcript. This was created by listening to an audio track, in this case a recording of Police Scotland Airwave Talkgroup 'Kirkcaldy 1' between 0616 and 0800 hours GMT*, and writing down what you hear.

**this incident took place in BST so these times are 1 hour earlier than the real time (i.e. the recording actually relates to 0716 to 0900 hours on 3 May 2015) – this is because of the way this information is produced by the company who supplies/manages it for Police Scotland, they do not change their data to account for the change to BST in the UK).*

'Kirkcaldy 1' is the general channel that police officers operating within Kirkcaldy that day would set their radios to. This is where general information and tasking would be passed by

transmissions between officers and supervisors working in the Kirkcaldy area, as well as to and from the ACR.

I listened to the recording many, many times, at different speeds and volumes, and recorded any speech that I felt that I could clearly make out. If any of the transmissions were inaudible to me or were only partly audible, I would indicate this with symbols, as per the key at the beginning of the document. Many of the transmissions start with the officer 'shouting in' or identifying themselves by the 'callsigns' that they operated under on that shift, e.g. 'Control from four one one', which is callsign 411 trying to contact the Area Control Room.

In respect of "Transcript of Police Scotland Airwave Talkgroup 'Kirkcaldy 1' on 3rd May 2015 between 0600 and 0800 GMT" (PIRC-01399), once I had a note of all of the callsigns that were being used, I phoned the Area Control Room Sgt at via the 101 service. I advised who I was and asked if he was able to look at the callsigns for Kirkcaldy for the early shift on 3 May 2015 and tell me which officers were assigned to which callsigns. He then read out the officer's shoulder numbers and names to me. This allowed me to match up the callsigns with the shoulder numbers/names, e.g. call sign 'four one charlie' (41C) being shoulder number P0691, PC Ashley Tomlinson.

In respect of "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396), I obtained a note of all of the ISSI numbers that were attributable to each of the officer's personal issue Airwave radio sets, I think from John Wilson (Communications Team Leader, ICT, Police Scotland Fife or 'P' Division). Effectively any transmission data attributed to that ISSI number was attributed to the corresponding officer, as per below:

Personal Issue ISSI (radio ID)	Officer the ISSI (radio ID) was issued to
6550694	PC Alan PATON
6550523	PC Craig WALKER
6551014	PC Nicole SHORT
6550691	PC Ashley TOMLINSON
6551035	PC Alan SMITH
6550203	PC Kayleigh GOOD
6550724	PC Daniel GIBSON
6550435	PC James McDONOUGH
6550349	A/PS Scott MAXWELL
6550918	DS Samantha DAVIDSON
6550405	DC Derek CONNELL
6550919	DI Colin ROBSON
6550285	A/PI Steven KAY
6550048	PC Mark HAY

I obtained the Call Data Reports for all the officers for a predetermined time period, as set by SI McSporran if memory serves me. This time period was to cover the initial response to the incident and the immediate aftermath. Usually a period of around 2 hours or so for most officers. Slightly longer for officers that were known to have attended at Victoria Hospital I think.

I was then able to look at the sequence of which ISSI numbers (officers radios) had been pressed to allow them to speak on the 'Kirkcaldy 1' channel in order, and then match that up with the transcript that I had created, "Transcript of Police Scotland Airwave Talkgroup 'Kirkcaldy 1' on 3rd May 2015 between 0600 and 0800 GMT" (PIRC-01399). By combining

the transcript (i.e. typed version of what as said on the audio recording) with the sequence of when each officer actually pressed buttons on their personal Airwave radios, I was able to produce a document that had near exact accuracy of who said what at exactly what time (pretty much to the second). This is what the document "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396) aimed to do.

Knowing who said what and when on an Airwave channel can be very important to an investigation. It allows you to know who was saying what in real time during an incident. What information was known and passed to officers and what their reactions to unfolding events were. I don't know why in particular I was tasked with doing this. Creating a transcript is a fairly standard job that could be given to any investigator, or a reasonably experienced trainee investigator, as I was at that time. I had created transcripts before. Probably not one covering such a long time period or with so many different people speaking throughout it.

I am not sure what 'support and oversight' I received. I know that DSI Little and SI McSporran were interested in the results and kept abreast of this as I went along, as the information within these documents had the potential to be very useful to the investigation.

From memory, Inv Ross Stewart 'corroborated' the transcript, "Transcript of Police Scotland Airwave Talkgroup 'Kirkcaldy 1' on 3rd May 2015 between 0600 and 0800 GMT" (PIRC-01399). By 'corroborated it' I mean that he listened to the audio recording, independently of me, to confirm that he could also hear the words that I have recorded on the transcript, and that as far as could be ascertained, I had attributed it to the correct person. Attributing it to the correct person would be by combination of them hopefully identifying themselves by using their call sign or name at the beginning of each transmission, or because you could recognise the voice from previous transmissions when they had identified themselves. Obviously, it was easier to be accurate when they actually identified themselves at the beginning of the transmission.

If there were words that I heard (and put in the transcript) that Inv Stewart could not hear, or heard differently we would both listen to that passage again. If we did not agree on what was heard, then it did not go in the transcript and it was marked '!!!!!' which indicated 'unclear speech'.

I'm not sure who, if anyone, checked "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396). Effectively the words attributed to the officers came straight from "Transcript of Police Scotland Airwave Talkgroup 'Kirkcaldy 1' on 3rd May 2015 between 0600 and 0800 GMT" which Inv Stewart had corroborated.

However, the rest of the information contained within "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396) related to technical data from Airwave Call Data Records, i.e. information about the sequence of which ISSI numbers (personal handheld radios) were used to make transmissions throughout the conversation. Which buttons the officers had pressed on their radios, for how long, if they had hit their emergency button etc. I do not recall Inv Stewart checking this, or corroborating this. I'm not sure that he would have been able to as he had not had the explanations of what this data meant and how it could be interpreted, in the way that I had from Pauline Donaldson, John Wilson, Mark Gleeson and Colin Gill, the specialist Police Scotland staff that I had communicated with in respect of this type of data.

146. What steps, if any, were taken to compare and contrast the officers' accounts within their statements with the Airwave transcripts you produced, both to review the

accuracy of the Airwave transcripts themselves and to corroborate or challenge the officers' accounts of the incident? What involvement did you have in this process? Who within the investigations team was responsible for instructing analysis of this nature?

This was not something that I was involved with. I am sure that this would have been done but it is not a specific task I was involved with. I do not recall being allocated any 'Actions' in relation to this.

However, if I am remembering this correctly, an early draft of the "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396) document was available to PIRC Investigators to inform their preparation for the interview of the primary officers that took place at Tulliallan on 4 June 2015. I think that this may have formed part of the further reading/research that the interviewing pairs were asked to do in preparation. So that they knew who said what and in which order, over the radio. It was not presented to the officers as a production during these interviews as I think it was still in draft form. It was for PIRC Investigators information only.

147. The minutes from PIRC's morning briefing on 26 May 2015 (PIRC-04156), at page 26, with reference to an update that you provided regarding the completion of the Airwave transcripts, state:

> ***There appears to be a missing section after the emergency button is pressed, so he will clarify this with the SPA.***

What issue did you identify here in relation to the Airwaves? What clarification did you receive from the SPA? What impact, if any, did this have on the Airwave transcripts you produced?

I do not remember what issue this relates to. I am also not sure that I would have been checking anything with the SPA in relation to this, as I did not deal with the SPA in relation to Airwaves.

When the emergency button is pressed on an officer's radio, it cuts across anything else that people are trying to broadcast on the same 'channel', as it reverts to an 'open mic' so that if the officer who pressed their emergency button can't hold down the 'press to talk' button on their radio, they can still shout information and the mic on their radio will pick it up and transmit it on the channel. This only lasts for a few seconds. This comment in the minutes may have related to how this looks on the spreadsheet of data that I was working with. But this is really me speculating, 8 or 9 years later. I really don't know what this comment in the minutes was relating to. As such, I'm not sure that I can answer the follow up questions. Whatever it was, I'm not sure that it had a significant impact on the transcripts produced, if any.

148. The minutes from PIRC's morning briefing on 2 June 2015 (PIRC-04156), at page 37, with reference to an update that you provided regarding the completion of Airwave transcripts, state:

> ***- A few anomalies, but working through them.***
>
> ***- A draft transcript document is available for the interviews, however it has not been corroborated, so cannot be used as a production yet.***

Signature of Witness [redacted] .....

What anomalies did you identify in relation to the Airwave transcripts? How were these anomalies clarified or resolved? How was the draft Airwave transcript used by investigators in the officers' interviews?

I think the primary anomalies that came up when I was creating this document related to some ISSI numbers that I was not able to identify at that time. The ISSI numbers in question did not make any transmissions, but I wasn't able to identify them at that time. I think, and I could be misremembering this, but I seem to recall that one of them was thought to possibly be either an old machine that was no longer in use, or possibly a machine within the ACR. I think either John Wilson or maybe Colin Gill believed that the other 'unknown' ISSI number probably belonged to a machine within the ACR, as it appeared to be responsible for turning off the 'Emergency Status' (following PC Paton and PC Tomlinson pressing their emergency buttons) which is something that could only be done by someone within the ACR. Having looked at "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396) again today, I think these anomalies related to ISSI numbers 6574619 and 6157102.

As per my answer to Question 146, an early draft of the "Combined Airwave Call Activity Data (Kirkcaldy 01) and Transcription" (PIRC-01396) document was available to PIRC Investigators to inform their preparation for the interview of the primary officers that took place at Tulliallan on 4 June 2015. I think that this may have formed part of the further reading/research that the interviewing pairs were asked to do in preparation. So that they knew who said what and in which order, over the radio. It was not presented to the officers as a production during these interviews as I think it was still in draft form. It was for PIRC Investigators information only.

149. Later in the investigation, within a letter dated 27 April 2017 from DSI Little to Alasdair MacLeod, COPFS (PIRC-02069(a)), it is identified that within the Airwave transcripts (PIRC-01396, page 5 and PIRC-01399, page 6) the transmission "Officer down. PC Short, male" was wrongfully attributed to PC Alan Smith and should instead have been attributed to PC Alan Paton. How did this error occur? What impact did this have on PIRC's investigation? Following the identification of this error, what steps, if any, did PIRC take to confirm that the other transmissions noted within the transcripts were accurately transcribed and attributed to the correct officers?

It seems clear what happened from the rest of the content of the email, which notes that in the sequence of officers pressing their buttons to broadcast, PC Alan Smith was the officer who next hit his button and I had therefore assumed that the next person to broadcast on the channel (saying "Officer down. PC Short, male") was PC Smith. I had also felt that the voice for the other broadcasts attributable to PC Alan Smith was similar to that which had said "Officer down. PC Short, male" on the audio recording. However, PC Alan Paton had hit his emergency button directly after PC Alan Smith had pressed his 'push-to-talk' button, which had the effect of cutting off PC Alan Smith's attempted broadcast. This coupled with the information provided by these two officers during their interviews with the PIRC, led to a correction being made, as PC Paton said it was him who had stated that an officer had been injured and PC Smith stated that he had heard PC Paton saying something after an 'emergency activation', which PC Good had confirmed was PC Paton stating that an officer was injured'.

The different pitch/sound to PC Paton's voice, as I had interpreted it (and attributed to PC Smith), was perhaps on account of PC Paton being in a heightened state during that

particular broadcast (having just hit his emergency button). Transcribing is not an exact science and is open to subjective interpretation, and to human error.

I do not know what, if any, impact this had on the PIRC investigation. It was obviously picked up somewhere along the line, either by the PIRC or COPFS. It is of course unfortunate if any aspect of reported information is inaccurate. However, I'm not sure that this had a much of an impact of the investigation. I am perhaps not best placed to answer that.

This was a lengthy and complicated transcript to create, that was listened to and corroborated by a second PIRC Investigator. I do not know what, if any, additional checking was done after this error was discovered.

2017 – 2018

Airwave

150. You received an email from John Wilson dated 3 April 2017 (PIRC-02720(c)), containing responses to a number of queries you had raised in relation to the functionality of the Airwave system. What prompted you to seek answers to these questions in March 2017? Were John Wilson's responses sufficient to successfully complete this line of inquiry? If not, what matters remained unresolved in this regard?

I had had face-to-face discussions with John Wilson so that he could explain technical aspects of the Airwave system to me. I was aware that I would have to be able to explain some of this in layman's terms to supervisors within PIRC and to staff at COPFS. I would also need an 'evidential' copy of these explanations for when this was looked into in more detail and so that if any of the Airwave information/evidence was referenced within any PIRC Reports or correspondence with COPFS, then there was a source production of statement from those who actually have the knowledge and expertise. I printed and certified this email so that it could be held as a production and enter the chain of evidence.

I remember at points within the investigation, although I cannot remember dates, that staff from COPFS became interested in the capabilities of the Airwave system and what information it could provide. I was in contact with someone from COPFS who wanted some further work or explanation done around this. I think it may have been Alasdair MacLeod, or it could have been Fiona Carnan. I can't really remember..

From memory, I believe that the response provided by John Wilson was sufficient at that stage of the inquiry.

151. You took a statement from Pauline Donaldson, Airwave Communications Officer, on 21 December 2017 (PIRC-00285). You thereafter took a statement from Colin Gill, Airwave Services Coordinator, on 14 February 2018 (PIRC-00507). Mr Gill also provided a short report in relation to technical aspects of the Airwave system at this time (PIRC-03838). What prompted these lines of inquiry to be explored with Ms Donaldson and Mr Gill at this time? Was the evidence obtained from Ms Donaldson and Mr Gill sufficient to successfully complete this line of inquiry? If not, what matters remained unresolved in this regard?

Very similar answer to the previous question really. I was aware that I would have to be able to explain some of this in layman's terms to supervisors within PIRC and to staff at COPFS. I would also need an 'evidential' copy of these explanations for when this was looked into in

Signature of Witness [redacted].....

more detail and so that if any of the Airwave information/evidence was referenced within any PIRC Reports or correspondence with COPFS, then there was a source production of statement from those who actually have the knowledge and expertise.

Again, as far as I can remember, the information that was provided was sufficient at that stage of the inquiry.

152. What impact, if any, resulted from you not having this information available to you when you carried out analysis and transcription of the Airwave transmissions in 2015?

I would say that I probably had most of this information already, from discussions with John Wilson, Pauline Donaldson, Mark Gleeson and Colin Gill. This allowed me to progress with the analysis of the Airwave data. The only information that I did not have in 2015 related to the more specific data regarding 'point-to-point' activity. However, the 'point-to-point' data does not include recordings of what was actually said in these 'two-way' private conversations, so it would not have assisted with any transcripts.

It would be true to say that the additional information regarding the 'point-to-point' activity was useful for analysis of which officers had contacted other officers in the aftermath of the incident.

153. On 15 January 2018, you produced a document titled "Airwave Point to Point and Telephony Analysis" (PIRC-03839), which includes a summary of point-to-point Airwave calls made by officers involved in the incident involving Mr Bayoh between 0700 hours and 0900 hours on 3 May 2015. What was the purpose of analysing the officers' point-to-point calls? Why was this considered necessary at this point of the investigation? How did you go about the task of identifying the calls made by the officers? Was this using the data provided to you by Pauline Donaldson by email on 18 December 2017 (PIRC-03833)? What was done with the analysis once you had collated it and how was it incorporated into the investigation?

This all related to queries from COPFS, either from Alasdair Macleod or Fiona Carnan. This information allowed us to understand what 'point-to-point' activity took place between certain ISSI numbers (officer's radios) over a certain time period. What is actually said in these 'two-way' private transmissions is not recorded. But the times and sequence of the 'conversation' is recorded within the data.

I analysed this information because I was tasked to do it. I was not involved in the rationale behind requesting this. I guess the point of analysing this information would have been to gain a better understanding of who officers contacted in the hours following the incident at Hayfield Road.

I have never worked as a police officer so I am not especially familiar with how often officers would use the 'point-to-point' facility throughout the working day. There are probably a lot of times when officers are communicating with one another during their shift when the content would not be useful or appropriate to be broadcast on the main channel, to everyone working in that entire area. However, there are obvious drawbacks in the use of 'point-to-point' in respect of transparency. I suppose there was nothing to stop officers using their personal mobile phones to have private conversations with each other. The fact that they used their radio handsets means that it is at least recorded that these 'conversations' took place.

Signature of Witness [redacted].....

As previously described, each individual officer is assigned an individual Airwave personal issue radio handset, with an unique 7-digit ISSI number. The data records supplied by Pauline Donaldson not only had the ISS number but actually contained the name of officer that the transmission originated from (that started any given conversation). It also had the ISS number of the other radio sent involved. As I had a list of all the officers and their ISSI numbers, as previously detailed, I can then ascertain who had contacted who. The data sheets also, very helpfully, distinguish between different 'call types', i.e. between transmissions on the general channel 'Kirkcaldy 1' or the private 'point-to-point' calls made between two radios (officers) only. It gives the sequence of the conversation, i.e. who transmits and for how many seconds, and then if the other party responds etc.

The information was contained in the data supplied by Pauline Donaldson by email on 18 December 2017 (PIRC-03833). I later seized certified copies of this information as productions on 21 December 2017.

I was not asked to obtain or provide any further information or statements in relation to this line of inquiry, so I can only assume that they were content that this line of inquiry was complete. It was not for me to choose lines of inquiry, I was tasked with Actions to complete. Any further Actions that might come out of the results was for those leading the investigation to decide and task out accordingly. It was this information that I used to produce a document titled "Airwave Point to Point and Telephony Analysis" (PIRC-03839), which includes a summary of point-to-point Airwave calls made by officers involved in the incident involving Mr Bayoh between 0700 hours and 0900 hours on 3 May 2015. I had data files for each of the individual officers. This document was the 'point-to-point' data separated out from other data in the data files, to show only the 'point-to-point' activity, for all the officers, all in one document.

I do not know what was done with the analysis or how it was incorporated into the wider investigation. That would have been for those in charge of the investigation to decide.

154. The information contained within the analysis (PIRC-03839) identifies that, for example, PC Craig Walker received a call from Austin Barrett at 07:50:41, PC Alan Smith made calls to Sgt Scott Maxwell at 07:54:27 and 08:31:40, and PC James McDonough made calls to PC Daniel Gibson at 07:52:04 and DS Samantha Davidson at 08:18:46. What consideration, if any, was given to obtaining statements from the officers concerned to identify why these point-to-point calls were made?

I do not know what consideration was given to obtaining statements from these officers to identify why these point-to-point calls were made. This was not something that I would be involved in. Extending lines of inquiry and allocating additional tasks or Actions in this regard would be for those in charge of the investigation.

155. The analysis (PIRC-03839) summarises point-to-point calls made between 0700 and 0900 hours on 3 May 2015. Data provided for Sgt Scott Maxwell (ISSI number 6550349) identifies that he made various point-to-point calls after 0900 hours on 3 May 2015, including to: DI Colin Robson (ISSI number 6550919) at 09:20:58; PC Alan Paton (ISSI number 6550694) at 08:24:25, 08:24:39 and 08:24:45 (all calls apparently unanswered); PC James McDonough (ISSI number 6550435) at 08:24:54; and DS Samantha Davidson (ISSI number 6550918) at 10:43:57 (PS17396). What consideration, if any, was given to expanding the scope of the analysis to include

point-to-point calls made later on 3 May 2015? Why did the analysis not cover the calls made after 0900 hours on 3 May 2015?

I do not know what consideration was given to expanding the scope of the analysis to include point-to-point calls made later on 3 May 2015. I cannot remember being involved in any discussions regarding this, although I may have been. This was not something that I would be involved in making any decisions about. Extending the scope of this analysis would be for those in charge of the investigation. I do not know what that particular time-scale was chosen. It would have been me who requested the data from Police Scotland to be within particular timescales, but the setting of those time parameters would not have been my decision. This kind of decision would have been made by DSI Little or SI McSporran, but I cannot remember who made this decision.

156. Within his Inquiry statement (SBPI-00036, paragraph 88), PIO Stephen Kay states: "At that time I'm sure I shouted up to control to say that there was to be no point to point. If we do point to point, it doesn't come over the airwaves, and I said keep it transparent, make sure everything's recorded". What concerns, if any, did PIRC have about a lack of transparency surrounding the officers' use of point-to-point calls to communicate on 3 May 2015? Were these concerns communicated to COPFS? If so, to whom?

As far as I am aware PI Kay did not mention this during his statement to the PIRC. I also do not see that within the transcript covering the 'Kirkcaldy 1' channel for that time period. I am not aware of PI Kay having made these comments.

As previously stated, as I do not have a police background I do not know how frequently officers would normally use point-to-point to communicate throughout a shift, and why exactly they would choose to communicate sometimes via the main channel, and other times through use of point-to-point. I would think it would be natural to be interested in what officers were discussing after the event, particularly when the PIRC's terms of reference were expanded to include allegations of conferring. How that should be investigated was really a decision for those in charge of the investigation for PIRC and those directing further enquiries on behalf of COPFS. I was not involved in any discussions about how this would best be achieved and was not tasked with further Actions in respect of this, other than the technical analysis discussed in earlier questions.

Examination of Ashley Wyse's phone

157. On 21 February 2018, you sought guidance from COPFS in relation to PIRC's examination of the download of Ashley Wyse's phone (PIRC-02587). You sought guidance as to whether COPFS was content for PIRC to only examine the files from the download that related to the incident on 3 May 2015 (as opposed to all files from that date). On 27 February, Les Brown replied and stated:

> ***PIRC should pursue all legitimate investigative avenues in order to legally obtain and evaluate evidential material that assists in the inquiry instructed by the Crown.***

What were your thoughts on receipt of this email? Were you satisfied with this response? In your experience, was this level of guidance characteristic of the guidance provided by COPFS across PIRC's investigation?

Signature of Witness [redacted]……

I thought this email response was 'passing the buck'. I had contacted those dealing with this incident at Crown and was looking to keep myself and the PIRC right in respect of what legally we were entitled to do with the phone, as I was unclear in my own mind. They are the legally qualified prosecuting authority who would be responsible for leading any evidence in court, should there ever have been legal proceedings. I thought it a perfectly sensible thing to do, to ask for their expert guidance, as this was, after all, a COPFS instructed PIRC investigation. I was disappointed with the response. I did not feel that it answered the questions I had asked.

I did not have much need to contact COPFS for this level of advice for other aspects of this investigation, most communication between COPFS and the PIRC would have been done above my level, by DSI Little of SI McSporran. As such I could not really comment as to whether or not this level of 'guidance' was characteristic or not. I certainly didn't find it very helpful.

158. On 27 February you forwarded this exchange to DSI Little and there follow emails within the same chain between DSI Little and SI McSporran in relation to the examination of Miss Wyse's phone (PIRC-02587). Within his email dated 12 March 2018, SI McSporran states, with reference to the download from Miss Wyse's phone:

> ***Examine all the material to determine whether it has a bearing, if it has, produce it as evidence.***

Were you made aware of SI McSporran's instruction to examine the full download from Miss Wyse's? Did you understand his reasoning? Did you agree with SI McSporran's rationale in relation to the examination of the phone? If not, why not? What, if any, further discussion was there between PIRC staff in relation to this matter, beyond the discussion within this email chain?

I was made aware of SI McSporran's instruction to examine the full download, most likely by DSI Little. I am not sure if his reasoning was shared with me or not. Even if it was, I wasn't really in a position to challenge it. Not only was he my line manager's line manager, and overseeing the entire investigation, he was also a retired Detective Superintendent with extensive experience in the 'Intelligence' side of policing, which would have included the seizure and download of mobile phones.

I was clear that SI McSporran was instructing me to examine the full download and had no reason to doubt his decision or rationale in respect of this. I had flagged up what I thought may have been an issue and brought it to the attention of those who were responsible for deciding what was to be done. I felt as if I had done my part. It would appear from the email chain that DSI Little also thought that there was some merit to the concerns I had raised, and was similarly unimpressed by the response from COPFS. I do not know what further discussion he had with SI McSporran regarding this, if any.

159. Why was further examination of the data contained within Miss Wyse's phone required in 2018? How was the analysis of this data incorporated into the investigation? What steps, if any, had been taken by PIRC prior to this point to establish the timings of Ashley Wyse's Snapchat videos to allow this evidence to be factored into the interpretation of events during Mr Bayoh's restraint? What, if any, involvement did you have in this process?

Signature of Witness [redacted] …….

Without seeing the Action that was allocated regarding this piece of work, I would struggle to be able to comment fully on this. I do not recall why further examination was required specifically in 2018. I think this was at the request of COPFS, PF Alasdair McLeod. He had been liaising with DSI Little and PIRC Inv Kevin Rooney in respect of the Snapchat videos from Ashley Wyse's phone, and specifically the timings, if I recall correctly. I think initially only 4 videos were downloaded from Ashley Wyse's phone by Police Scotland, back at the beginning of the investigation. I think in 2018 COPFS asked for a full download of the phone to be carried out.

Although myself and Inv Maurice Rhodes were tasked with identifying relevant data from the download of the phone, which was to then to be sent to Peter Benson at Cybercrime to compile a technical report on, the specifics of the Ashley Wyse video clips and timings I think was really looked into by Inv Rooney. Inv Rooney was involved with the CCTV and video footage pertaining to the investigation more generally, and I think made efforts to sync the footage from Ms Wyse's phone to other known footage, in an attempt to get as accurate timings as possible. However, what the result of this was I could not tell you.

160. Within an email dated 15 March 2018 from you to Fiona Carnan, COPFS (COPFS-06313) you state:

> ***It would appear following our initial examination that the Snapchat videos are not going to be able to be timed accurately from the information contained on the phone or its memory card.***

What steps did PIRC take to establish the timings of Ashley Wyse's Snapchat videos in 2018? What involvement did you have in this process? Was PIRC ultimately able to confirm the timings of the Snapchat videos, relative to other evidence, such as the CCTV from Gallagher's Pub? If not, what impact did this have on the investigation?

I believe that Peter Benson at Police Scotland's Cybercrime unit was asked about this and made some comment regarding timings within his report. I also remember some discussion that Snapchat did not engage with law enforcement, or were notoriously bad at engaging. I think that I might have been involved in asking Peter Benson for his thoughts on it, as I was dealing with Peter more broadly in respect of the phone download. I was not involved in any attempts to contact Snapchat.

Please see answer to Question 160. I think Inv Rooney or DSI Little would be better placed to comment on this. I do not know if we were ever able to confirm the timings of the Snapchat videos of not, or what impact that may have had on the investigation. I do remember that considerable time and effort was focussed on this, but as I have mentioned, it was really Inv Rooney that was pursuing this as far a I can recall.

161. Within a letter dated 21 March 2018 from DSI Little to Les Brown, COPFS (PIRC-02081(a)), at page 5, it is identified that you examined data on Miss Wyse's phone before data considered relevant to the incident was passed to Police Scotland's Cybercrime Unit. How did you examine the data contained within Ashley Wyse's phone? Upon what basis did you distinguish data that was relevant to the incident from data that was irrelevant?

Peter Benson provided the PIRC with the necessary software to view the information downloaded from the phone. He then provided me with instruction on how to navigate this software, allowing me to filter and search the data, and importantly to select the files that

PIRC felt may be of relevance to the investigation. By filtering by date, i.e. nothing prior to 3 May 2015 we were able to disregard the vast majority of the content from the phone, to focus on any pictures/videos/messages/chats/calls/web searches, that took place from the time of the incident onwards. This narrowed down hundreds of thousands of files on the phone to around 3 to 4 thousand files.

Each of these files was briefly viewed by myself and Inv Maurice Rhodes (corroborating PIRC member of staff) to see if they could be thought to pertain to the events under investigation, e.g. photos or videos of the incident/locus, chat or emails or messages that Ms Wyse (who had witnessed the incident) sent to (or received from) others that appeared to mention the incident that she had witnessed. Of these 3 to 4 thousand files from 3 May 2015 onwards, we identified 900 that appeared to relate to the incident under investigation. I highlighted these and using the software created a file containing these 900 of so pieces of data which was then sent to Peter Benson at Police Scotland Cybercrime to produce an analytical report. This was report was then sent on to COPFS. Only files that related to the incident, e.g. messages to friends that described what Ashley Wyse had seen, or images or videos that appeared to be of the scene, were selected. No files that did not reference the incident were selected.

162. What involvement did you have in relation to the preparation of a "joint report" by Peter Benson, Police Scotland Cybercrime Unit, in relation to the data contained within Ashley Wyse's phone (as referred to within PIRC-00510, page 2)? How was the examination of this data, and the production of Mr Benson's report, incorporated into PIRC's investigation?

The description of my actions, in filtering the data from the download to limit it to 900 pieces that specifically referenced the incident, and sending this selection to Peter Benson, was pretty much the sum total of my involvement. I don't know how it was incorporated into the wider investigation, per se. That would probably be a question for DSI Little of SI McSporran. I do know that it was shared with COPFS as quickly as possible as they were chasing a deadline for their own report to senior staff within COPFS.

163. Within Peter Benson's statement dated 15 May 2018 (PIRC-00510), at page 4, with reference to the examination of the data within Miss Wyse's phone:

> ***It was noted during the examination that chat activity was present after seizure. Chats and other messages on the phone after the seizure date are likely to be down to poor seizure discipline. Phones should always be switched off after seizure. If they are left on and connected to the network messages will continue to come in to them and apps which can sync with other devices will update.***
>
> ***...***
>
> ***It was also noted that the device had connected to a Wireless Network 'InfraTechUkLtdPoint2' at 16:42 on 06/05/2015 and on 02/06/2015 at 11:40 and again at 11:45.***

Within an email dated 10 April 2018 addressed to you (PIRC-03834), Peter Benson speaks to the data which appeared on Miss Wyse's phone following its seizure, stating:

> ***It would be foolish to fail to mention what seems to have happened when the device was out of our hands and possible [sic] yours. If there is a reason for the activity that can be explained i.e. someone switched it on to look for something let me know and I can add something in. If I do not mention it in some form then any future defence examination will attempt to use it to discredit the seizure and examination – they may still but at least we are being up front.***

How did chat activity post-dating the seizure of Miss Wyse's phone come to be included in the data downloaded from her phone? Was this matter explored with Infratech, as instructed within an email you sent to Kevin Rooney on 12 April 2015 (PIRC-02588)? If so, what were the results of this line of inquiry? If not, why not?

As explained by Peter Benson, it would appear that when the phone was initially obtained by Police Scotland, the phone was not switched off. This meant that activity on any of Ms Wyse's accounts or Apps, either on another phone, or a laptop or tablet, could have also appeared within these accounts and Apps on the phone, up until the point that the battery died or the phone was switched off.

In respect of the device (Ashley Wyse's phone) connecting to Infratech's wireless network, this could have happened if the 'specialists' at Infratech turned the phone on within their lab without having it in an area free of wireless networks. As with your own phone, if the 'Wi-fi' is enabled your phone will automatically start to scan for any 'available' networks and attempt to connect. This would appear to be what happened at Infratech. I do not know how the technicians at Infratech could have allowed this to happen, as it seems pretty obvious that if the phone is not in a 'sterile environment' in terms of other electrical devices trying to connect with it, then this was a very obvious risk. I believe Inv Rooney was tasked with obtaining confirmation from an appropriate person at Infratech to explain this occurrence. I cannot recall what the outcome of this was. Inv Rooney or DSI Little may be better placed to confirm this.

164. Do you agree with Peter Benson that this issue resulted from "poor seizure discipline"? Who was responsible for the seizure and handling of Miss Wyse's phone? What should have been done differently to ensure that this issue did not arise? What, if any, impact did this have on PIRC's investigation, and any reliance placed on the data contained within Miss Wyse's mobile phone? What, if any, change of practice resulted from this?

I would agree with Peter Benson's assertion that this issue was likely down to poor seizure discipline. I am not sure what, if any, impact this had on the PIRC investigation, or the reliance that can be placed on data contained on the phone. It does appear to have been explained, albeit it is unfortunate. If the phone had been switched off at the time it was initially seized, this would not have been physically possible, as far as I understand it. I will defer to Peter Benson's superior technical knowledge in this regard. The mobile phone in question was initially seized by Police Scotland officers, I am therefore unaware of any changes in practice that may have resulted from this, or if this was highlighted to Police Scotland.

165. During the investigation, were there other occasions where the seizure and handling of productions was not carried out in accordance with PIRC's SOPs (including PIRC's Production/Articles SOP [PIRC-04450]) or best practice? If so, what

Signature of Witness [redacted] .....

were the circumstances and in what way were productions handled contrary to PIRC's SOPs and best practices?

The mobile phone in question was initially seized by Police Scotland officers and was obtained by PIRC investigators at a later date, so the seizing officers should have been working in relation to Police Scotland guidance or SOPs regarding the correct procedures to be followed. I was not involved in the seizure of this item for the PIRC and do not know the circumstances of this.

I am not aware of other occasions where the seizure or handling of productions was not carried out in accordance with PIRC guidance, other than the items that were within the side room at the Victoria Hospital that the two initial attending detective officers had put into a single bag and had not labelled. This was covered in detail in earlier questions.

Statements

166. On 5 and 6 February 2018 you were present when statements were obtained from Alisdair Shaw and David Agnew (PIRC-00501 and PIRC-00503 respectively). What was the purpose of taking these statements at this stage of the investigation? What lines of questioning required to be pursued with these witnesses? Were these lines of inquiry covered within PIRC's original investigation? If not, why not?

These statements were noted by Trainee Investigator Ashleigh Leitch. I was the '2nd' for these statements, there to support and assist. My memory was that COPFS had directed that some additional lines of inquiry be carried out. It was around this time that I was being asked to do additional work around Ashley Wyse's phone, which was another one of these additional lines of inquiry.

Tr Inv Leitch was also a part of DSI Little's team and I worked alongside her regularly. I believe that she was involved in a line of enquiry in relation to ascertaining as detailed an account of what Officer Safety Training (OST), both initial probationer training and the annual re-qualification training, consisted of at the material time. Most of the officers involved at Hayfield Road on 3 May would have had either their initial OST training (if they were newly qualified officers), or annual requalification training in 2014. They would likely have received this either at the Police College at Tulliallan (in the case of new officers) or locally in Fife (probably Glenrothes) if they were just doing their annual requalification.

As such, these two officers were identified as having been involved in OST training at these locations in 2014. They were interviewed in relation not the content and delivery of these courses, and were shown a number of Police Scotland training and guidance documents from the time.

I am not sure the extent to which the OST training of the officers at Hayfield Road had been investigated up to that point. That would have been a decision for those who were leading and overseeing the investigation. I would imagine that a further degree of detail was required and that this is why Tr Inv Leitch had been tasked with taking these statements.

I think that I may have been involved in handing over training related documents to COPFS, along with Tr Inv Leitch, once they had been obtained in relation to this aspect of the investigation. I do not recall being involved in any other aspects of this line of inquiry, Tr Inv Leitch may have been.

Signature of Witness [redacted]…….

Investigation overall

167. On 10 August 2016, PIRC submitted its report to COPFS. Did you have any involvement in writing the report? If so, what was your involvement?

I was not involved in writing the report. I provided a number of short documents in relation to Area Resource Location analysis and Airwave analysis, parts of which may have been used in the report. That would not have been a decision for me. I had worked on numerous aspects of the investigation over a considerable period of time, from having been on-call on the day itself, to being involved in some of the forensic aspects of the investigation alongside Inv Ferguson, doing a lot of work on Airwave and the download of Ashley Wyse's phone, as well as the general business of noting witness statements and seizing evidence. As such I am sure that I would have been approached by DSI Little and or SI McSporran to confirm things and to discuss aspects that I had been involved in, whilst the report was being compiled. I imagine that this would be true of many of my colleagues too. However, I was not involved in drafting any aspects of the report.

168. Were you content with the support and direction that you received from your colleagues at PIRC, including colleagues in positions senior to you, throughout the investigation? If not, why not?

In general terms I would say that I was content with the support and direction that I received from colleagues and supervisors.

169. What roles did Irene Scullion (Head of Investigations), John Mitchell (Director of Investigations) and Kate Frame (Commissioner) play in the management of the investigation? What level of oversight did they have over the investigation? How was that oversight maintained?

I was not involved in meetings between the Senior Management Team as I was a Trainee Investigator and then a newly qualified investigator during this period. My primary interactions in relation to this investigation were with DSI Harrower, DSI Little and SI McSporran. I do not have any knowledge of what level of oversight they maintained over this investigation.

170. Who at PIRC do you consider was ultimately in charge of the investigation following the incident involving Mr Bayoh? Please explain why you hold this view.

The day-to-day management of this investigation rested with DSI Little. He was involved in formulating the investigative strategies, assigning Actions, communicating relevant information to Investigators working on the investigation, and compiling the various reports. My understanding was that SI McSporran had oversight of the management of the investigation. If DSI Little wasn't available it would be SI McSporran that I would have gone to with any queries. I believe he also played a role in compiling the reports. How this was divided up between him and DSI Little I do not know. DSI Little and SI McSporran worked together closely and it was my understanding that DSI Little would often discuss issues and make decisions with SI McSporran, rather than in isolation. I'm sure that they would have discussed any big decisions with the Head of Department Irene Scullions and Director of Operations too, but I was not involved in any of these types of discussions so can only speak to the impression that I got in respect of this.

Signature of Witness [redacted]……

At the end of the day we all work on behalf of the Commissioner and the Director of Operations and the Head of Department are also links in the chain of responsibility. My memory at the time was that PIRC reports were subject to extensive 'Quality Assurance' by all of these levels of management. However, I took my instructions from DSI Little and SI McSporran.

171. Beyond the points covered above, what further involvement, if any, did you have in the investigation?

I remember being asked by DSI Little to assist with a follow-up query in relation to identifying what type of resuscitation facemask had been used during the incident. From memory, Inv Rhodes and I donned appropriate PPE, masks and gloves etc. and laid out some brown paper on a desk (at PIRC office) and I photographed:

Label No Red Plastic Cap

through the sealed production bag. This was decided so as not to compromise any forensic examination of this item that may be requested subsequently. On the same day, using fresh brown paper and gloves etc., Inv Rhodes and I were instructed by DSI Little to open the sealed production bag containing:

Label No Utility Belt (with Baton and Handcuffs) JM 006 - PC 203 Kayleigh Good

I photographed the utility belt including a small black pouch. Inv Rhodes and I emptied this small black pouch which contained two small packs containing resuscitation aids, as well as some other first aid related items. One of the packs contained a mouth-to-mouth resuscitation facemask which appeared to have exactly the same type of (red) valve as:

Label No Red Plastic Cap

The facemask within PC Good's utility belt was fully intact i.e. still had the plastic sheet attached to the red valve. Photographs were taken of all of the above. We then put all of the items back into the pouch as we had found them. The utility belt in its entirety was then placed back inside the production bag which was resealed using tamperproof tape which Inv Rhodes and I both signed and photographed. From memory, the photos were provided to PF Alasdair MacLeod at COPFS. This would have been early 2018, around the time of the other additional Actions that I was tasked with, e.g. analysis of point-to-point data and download of Ashley Wyse's phone.

A few months later, on 2 July 2018, myself and Inv Rhodes created:

Label No Additional Copy - Compilation of CCTV Footage Recovered During the PIRC Investigation into the Death in Police Custody of Sheku Ahmed Tejan Bayoh

which was a copy of a CCTV disc that formed Part 3 of:

Prod No Expert Witness Package (Master Copy) provided to the Lord Advocate

I copied this disc within Hamilton House and signed the PIRC production bag. That same day, Inv Rhodes and I met with Les Brown (Head of CAAPD at COPFS) and handed over

to him at the CAAPD office in Hamilton. I had Mr Brown sign two receipts for this, one which was given to him for his records, one which was retained by the PIRC. This was all done on the instruction of SI McSporran, who I think was by this time Head of Investigations at the PIRC.

I was likely also involved in the transferring of PIRC productions to CAAPD at various other times, but there will be signed receipts for these and 'movements' in the production register.

I believe I may have been involved in noting some other statements that have not been mentioned within this questionnaire, but these were probably relatively minor witnesses, which is why I assume I have not been asked about them within this questionnaire.

I cannot recall anything else of significance.

Equality and diversity

172. How diverse was PIRC as an organisation in 2015? How has the level of diversity at PIRC changed between May 2015 and now, if at all?

I would not describe the PIRC as being particularly diverse in its make up, either in 2015 or now.

173. Who was responsible for diversity and inclusion matters at PIRC in 2015? Who is responsible for such matters now?

I am not aware of who was responsible for diversity and inclusion matters at PIRC in 2015. I would have imagined that it was the responsibility of all of the Senior Management Team, perhaps led by the Head of HR.

174. Has any PIRC policy or practice relating to equality and diversity changed following the Bayoh investigation? If so, which policy or practice has changed and in what way?

I would say that the most notable change, or update, to how this is approached within the PIRC is probably the issuing of a document entitled '*PIRC Guidelines: for dealing with allegations of discrimination when undertaking Investigations and Complaint Handling Reviews*', which was circulated to staff in November 2021. I believe this document was created by then Head of Investigations, John McSporran. I recall him instructing that all staff familiarise themselves with this document and its contents. I read this document at that time. If I was assigned an investigation in which race could potentially play a role, I would have re-familiarised myself with the content of this document at the outset of the investigation. This document covers a number of forms of discrimination but does specifically examine race in detail. It is nearly 50 pages long, so is a fairly substantial document, and is certainly a much better starting place in respect of guidance for investigations in which race is, or could be a factor.

Race

175. Was anything you have stated above done or not done because of Mr Bayoh's race?

No.

176. Prior to 3 May 2015, what experience, if any, did you have of investigations of deaths in custody or deaths following police contact in which the deceased was someone from an ethnic minority? Since 3 May 2015, with the exception of the investigation following the death of Mr Bayoh, what experience do you have such investigations?

None.

177. Prior to 3 May 2015, what experience, if any, did you have in deaths in custody or deaths following police contact in which race was a factor to investigate? As at 3 May 2015, had you ever acted in a PIRC investigation in which the issue of race was within your terms of instruction?

I do not think that I had worked on any death investigations prior to 3 May 2015 in which race was a factor that was specifically investigated.

As of 3 May 2015, I am not aware of having been involved in any PIRC investigation in which the issue of race was including within the terms of reference or instruction.

178. Prior to 3 May 2015, had PIRC ever considered the issue of race within an investigation? If so, in what way was race a consideration? With the exception of the investigation following the death of Mr Bayoh, has PIRC considered the issue of race within an investigation since 3 May 2015? If so, in what way?

Prior to 3 May 2015, no, not that I was aware of or that I worked on.

Since 3 May 2015, I cannot at this time recall any that I have worked on. There may have been investigations that I did not work on, and therefore I had limited awareness of, that involved a racial element. Someone higher up in management who had an eye across all investigations, like the Head of Investigations, would probably be better able to answer this.

179. When PIRC's terms of reference were expanded by COPFS to include issues of race, what involvement, if any, did you have in this aspect of PIRC's investigation?

The only involvement that I remember having in relation to the issue of race, following PIRC's expanded terms of reference, was to accompany DSI Little to Fettes Police Office where DSI Little had arranged to either view or obtain information from Police Scotland's Professional Standards Department, regarding all allegations of racism levelled against police officers, I believe within the Fife area.

I do not recall the specifics as I was not involved personally in going through any of the records or complaints, or more generally in relation to race as a line of inquiry. I think the records that DSI Little was checking went back a number of years. I think that the officer he was dealing with at PSD was an Audrey McLeod who I think was a Chief Inspector, although I could be wrong.

Signature of Witness [redacted] .....

As I stated, I was not tasked with any Actions, as far as I can recall, that related to new terms of reference around race.

180. Prior to the instruction from COPFS to investigate issues of race, had you or anyone at PIRC given consideration to race being a factor in the incident? If so, in what way? If not, why not?

I was aware of allegations that had been made in respect of PC Alan Paton, I believe by a family member, possibly his sister. I recall there being a television documentary that touched on PC Paton and allegations from his past. I believe that the solicitor acting on behalf of the family of Mr Bayoh was also involved in representing PC Paton's sister when the PIRC had contacted her to obtain a statement in relation to these allegations surfacing. [redacted] I do not recall of this was before or after the terms of reference changed.

I do not recall race being discussed as a contributory factor in the death at the early stages of the investigation. I am not aware of anything from the early stages of the investigation that gave cause to believe that race was a motivating factor in respect of the behaviour or actions of anyone who was involved with Mr Bayoh in 3 May 2015. The investigation was progressed with an 'open mind' in respect of what had happened.

181. Is the race or ethnicity of a deceased person automatically considered by PIRC as part of an investigation following a death in custody or a death following police contact? If so, in what way? If not, is the deceased's race or ethnicity only considered when directed by COPFS?

I would not say that the race or ethnicity of a deceased person is automatically considered in terms of a distinct line of inquiry by PIRC as part of an investigation following a death in custody or following police contact.

I would not say that race or ethnicity would only be considered when directed by COPFS. If any of the circumstances, events or evidence suggested that there was even a possible link between the deceased's ethnicity or race and their death, I would expect that this would of course be considered as a line of inquiry and I would also expect that COPFS would be informed of any suggestion that this was the case at the earliest possible juncture.

182. As at 3 May 2015, did PIRC record the race or ethnicity of the deceased person who was the subject of an investigation following a death in police custody or death following police contact? If so, how was such information recorded? If this information was not recorded, why was this? Have PIRC's procedures for recording a deceased person's race or ethnicity changed since 3 May 2015? If so, in what way?

I am not aware of how the PIRC record any data specifically on the ethnicity of deceased persons whose deaths have been investigated by the PIRC. These questions might be better answered by a more senior PIRC manager.

183. What training had you completed by 3 May 2015 in relation to equality and diversity issues, or in relation to unconscious bias? What did this training involve? Which aspects of this training, if any, were applicable to your role? Would you have benefited from additional training in this regard? If so, in what way?

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As part of my induction training, and then repeated on an annual basis (most recently completed 11/09/2023), I complete an i-Hasco online training course on 'Unconscious Bias'. This course takes about half an hour and is in two parts, 1/ Unconscious Bias in the Workplace and 2/ Strategies for Reducing Bias. From memory these focus primarily on Unconscious Bias in the workplace setting (amongst colleagues) however different types of Unconscious Bias are detailed and the awareness of these and how they can manifest themselves is transferrable to Investigations, to an extent. This is awareness of the issue training and not training in respect of considerations of protected characteristics and other aspects of unconscious bias as 'lines of inquiry' in an investigation.

I am not sure that I personally did anything in the course of the investigation that was overly problematic in terms of equality, diversity or unconscious bias. However, I generally feel that more training is always useful. For example, in terms of different religious considerations that may inform practice (or at least awareness/sensitivity) at post mortems may be something that those attending post mortems would benefit from.

184. What areas were covered within the "Equalities" training that you received in October 2014 (PIRC-04577)? How much of this training was focused on race? Who provided this training and how was it delivered? In what ways, if at all, did this training assist you within your role as an investigator at PIRC? Have you received similar training since 2014? If so, please provide details.

I do not recall this training in any detail. It was undertaken over 9 years ago. I cannot answer any of the follow-up questions in relation to this training as I have no real memory of it.

185. The iHasco online training that you completed in April 2014 (PIRC-04577) is noted to have included a module covering "unconscious bias for employees". What areas were covered in this training? How much of this training was focused on race? In what ways, if at all, did this training assist you within your role as an investigator at PIRC? Have you received similar training since 2014? If so, please provide details.

This course takes about half an hour and is in two parts, 1/ Unconscious Bias in the Workplace and 2/ Strategies for Reducing Bias. From memory these focus primarily on Unconscious Bias in the workplace setting (amongst colleagues) however different types of Unconscious Bias are detailed and the awareness of these and how they can manifest themselves is transferrable to Investigations, to an extent.

Race is covered in the course, but it is not it's primary focus. I believe all the 'protected characteristics' are covered, and are probably given relatively similar attention.

This is awareness of the issue training and not training in respect of considerations of protected characteristics and other aspects of unconscious bias as 'lines of inquiry' in an investigation. However, any training, especially repeated training, that highlights the issues surrounding Unconscious Bias and race, is a positive thing and will help to engrain these issues within staff so that they are alive to these considerations in all work that they do.

I receive this i-Hasco Unconscious Bias training on an annual basis.

I cannot presently recall if I have had other similar training since 2014.

Signature of Witness [redacted]……

186. During the Bayoh investigation, did you receive any training in relation to investigating an allegation that race had been a factor in an incident? Would you have benefited from additional training in this regard? If so, in what way?

No I did not. Specific training in respect of any nuances or differences that could occur in an investigation where there is an allegation that race is a factor may have been beneficial. I suppose that would depend on the content of the training.

187. What guidance or reference materials in relation to race were you aware of being available to you on 3 May 2015, had you wished to consult these? Would you have benefited from additional materials being available to you? If so, in what way?

I was not aware of any particular reference materials being available to me in relation to race, as of 3 May 2015, other than what I could have researched myself on the internet. I was not aware of any materials that PIRC may have had. Although in fairness, I did not ask for any.

I may have benefited from having materials available to be. I suppose that would depend on the content of the materials.

188. What guidance, if any, do you recall receiving from senior members of staff at PIRC in relation to PIRC's investigation of issues of race? From whom did you receive this guidance?

I do not recall receiving any guidance from senior members of staff at PIRC in relation to PIRC's investigation of issues of race. I do not recall being involved in that aspect of the investigation, following the change in the terms of reference.

189. Do you think you and PIRC were sufficiently equipped to investigate issues of race relating to deaths in police custody or deaths following police contact on 3 May 2015? Please confirm why this is your view.

At the time I felt that I was sufficiently equipped to perform the tasks that were allocated to me during the course of this investigation. However, as previously stated, I was not really involved in any lines of inquiry that related specifically to race. Had I been involved more specifically in that line of inquiry, I do not know if I would have felt sufficiently equipped to do so, or not. As mentioned, I had not received any specific training in relation to how to approach race related lines of inquiry.

190. With particular reference to the issue of race, is there anything you have stated above that, knowing what you know now, you would have done differently?

I cannot think of any particular action that I would have done differently. I approached the investigation with an open mind and performed my duties to the best of my ability. I am always willing to learn from any mistakes I may have made, and I look forward to hearing the Inquiry's recommendations.

Record keeping

191. In addition to your notebook (PIRC-04198), what, if any, other notes did you take during the investigation? Were the notes within your notebook completed contemporaneously? For what purpose do you use your notebook within your role?

Signature of Witness [redacted].....

What were PIRC's requirements for you to take contemporaneous notes of your actions and decision making during an investigation?

At the time of this incident I would normally complete my notebook either at the time of the recorded event, or as quickly thereafter as was practicable. I primarily used my notebook for recording details of productions that I have been involved in seizing and statements that I had been involved in taking, or corroborating. I did not record the content of statements in my notebook, but always on A4 printed statement templates. I do not necessarily tend to record all appointments or visits, unless they were likely to be of evidential relevance.

I kept a 'rolling' electronic statement on each investigation that I worked on. I would update this regularly and this would usually also contain the details of evidence I was involved in seizing and statements I was involved in taking. It may also have had other entries of relevance, such as particular meetings attended or tasks undertaken etc.

There were no written guidelines that I am aware of in respect of how you were expected to use your notebook. It was a personal thing. I learned from more experienced investigators, primarily my 'mentor' investigator, Ross Stewart.

Throughout the investigation I would have taken some handwritten notes which would then have been transferred into either my notebook or rolling statement, if they were relevant. I did this during the post mortem and the processing of the scene at Victoria Hospital. The notes would have been the basis for my entries in my notebook and my rolling statement. I no longer have the handwritten notes as I would have shred them after transferring them to the two documents just mentioned.

I have never kept a 'daybook'. That is a police practice, one that I have never adopted.

Miscellaneous

192. Knowing what you know now, is there anything you would have done differently within this investigation?

Other than the previously described actions in relation to attending the Victoria Hospital earlier to do a scene assessment, I cannot think of any particular action that I would have done differently. I am more experienced now and would expect that I would probably be more aware of the other aspects of an investigation going on around me (that I was not personally dealing with) than I was on 3 May 2015. I would possibly have taken more notes in relation to this, particularly in the early, faster-paced part of in investigation.

I approached the investigation with an open mind and performed my duties to the best of my ability. I am always willing to learn from any mistakes I may have made, and I look forward to hearing the Inquiry's recommendations.

193. Knowing what you know now, is there anything you feel PIRC as an organisation should have done differently within this investigation?

I think that there is a better understanding of the Post Incident process now, within the PIRC as well as within Police Scotland. I think that at the time, in 2015, this was a process that was primarily used in firearms incidents and was a police process. I think that the value of early PIRC interaction with the PIP process, right from the outset, is beneficial and is now the way that this is done. Although the PIP process remains a police process, the stipulated

PIRC participation, definition of roles and expectations, and better general awareness amongst supervisors, means that we would be in a better place to respond to a similar set of circumstances should it happen today.

Today, the PIRC would send staff specifically to the PIP suite and would liaise directly with the PIM. The PIRC would look to introduce themselves to the key police witnesses and would explain the PIRC part of the process. Certain documentation would be requested, including the basic facts and initial accounts from key police witnesses. The PIRC would then return to interview the key police witnesses a couple of days later.

194. Since PIRC's investigation was completed what, if anything, have you discussed with your colleagues at PIRC in relation to Mr Bayoh's death and the subsequent investigation?

This case has been the topic of conversation over the years, primarily amongst other PIRC investigators who worked on it. This would normally be prompted by new media coverage, or documentaries coming on TV, or with the announcement of the Public Inquiry. I do not recall the exact content of any specific conversations, or even particularly who they were with. It would be fair to say that the fact that this case was still not 'resolved' in terms of the legal process after all these years had been commented on, primarily in terms of how difficult this must be for the Mr Bayoh's family and loved one and others involved.

Do you think your recollection has been affected at all by these discussions?

I don't think that my recollection has been affected by these discussions. My recollection has been affected by the passage of time.

195. What, if anything, have you seen or read about Mr Bayoh's death, the subsequent investigation and the Inquiry within the media? Do you think your recollection has been affected at all by what you have read in the media or have seen in the Inquiry evidence?

I remember I was aware of a couple of documentaries, I believe on BBC Scotland. I did watch them at the time. I do not think that my recollection was affected by this, as I was privy to a lot of information about this case already. I don't think that the programmes affected or influenced me. I have not been an avid follower of the media surrounding this case, but I have read the off thing from time to time. I guess that a lot of this is sub-conscious and you never really know how much this type of thing might affect your point of view, or influence you. I watched a couple of the early sessions of the Public Inquiry, out of professional interest and to an extent to gain an understanding of the process in case I myself might be called to give oral evidence. I thought it was probably best not to watch much of it, as I didn't want it to influence my own evidence. I think I watched some of the early medical evidence, and maybe Zahid Saeed.

196. You completed a PIRC statement covering your involvement in the investigation (PIRC-00358). Please confirm that the content of this statement is true and accurate. Was your recollection of events better when you completed that statement than it is now? Should there be any discrepancy between the content of your PIRC statement and this statement to the Inquiry, which account should be preferred?

The contents of my PIRC self-noted statement (PIRC-00358) are true and accurate.

Signature of Witness [redacted]……

My recollection of events was better when I completed that statement than it is now.

If there is a discrepancy between the content of my PIRC statement and this statement to the Inquiry, in general terms my recollection was better when I completed my PIRC statement.

197. The Inquiry's Terms of Reference are contained within Annex B. If there is anything further that is relevant to the Terms of Reference which you are aware of, but you have not included in your answers to the above questions, please provide detail as to this.

I have nothing further to add.

198. Please include the following wording in the final paragraph of your statement:

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.

[redacted]

Stuart Taylor
Deputy Senior Investigator
Police Investigations and Review Commissioner (PIRC)

Signature of Witness [redacted].....

ANNEX B

Public Inquiry into the Death of Sheku Bayoh

Terms of reference

The aim of this Inquiry is twofold: firstly, the Inquiry will establish the circumstances surrounding the death of Sheku Bayoh in police custody on 3 May 2015 and make recommendations to prevent deaths in similar circumstances, as would have been required under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

Secondly, the Inquiry will assess and establish aspects of the case that could not be captured, or fully captured through the FAI process, namely (a) the post incident management process and subsequent investigation and make any recommendations for the future in relation to these; and (b) the extent (if any) to which the events leading up to and following Mr Bayoh's death, in particular the actions of the officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard.

The remit of the Inquiry is accordingly:

• to establish the circumstances of the death of Sheku Bayoh, including the cause or causes of the death, any precautions which could reasonably have been taken and, had they been taken might realistically have resulted in the death being avoided, any defects in any operating models, procedures and training or other system of working which contributed to the death and any other factors which are relevant to the circumstances of the death;

• to make recommendations, if any, covering the taking of reasonable precautions, improvements to or introduction of any operating models, procedures and training, or other system of working, and the taking of any other steps which might realistically prevent other deaths in similar circumstances;

• to examine the post-incident management process and the investigation up to, but not including, the making by the Lord Advocate of the prosecutorial decision communicated to the family of Sheku Bayoh on 3 October 2018 (and the Victims' Right to Review process that was undertaken by the Crown Counsel in 2019), including: (i) the effectiveness of procedures for gathering and analysing information, (ii) the securing and preserving of evidence, (iii) the roles and responsibilities of those involved, (iv) liaison with the family of the deceased and (v) compliance with any relevant Convention rights; and make recommendations, if any, for the future in respect of these matters;

• to establish the extent (if any) to which the events leading up to and following Mr Bayoh's death, in particular the actions of the officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard; and

• to report to the Scottish Ministers on the above matters and to make recommendations, as soon as reasonably practicable.

Signature of Witness [redacted] Date February 1, 2024 | 11:38 AM GMT