David [redacted] Harvie

Born [redacted] 1970

C/O [redacted]

I have prepared this statement to the best of my recollection having had access to materials provided to me by the Assistant Solicitor to the Sheku Bayoh Inquiry. The paragraphs are numbered to accord with the questions I received from the Inquiry team.

1. At the time of Sheku Bayoh's death I was Procurator Fiscal, West of Scotland, responsible for Sheriff Court prosecutions in the Sheriffdom's of North Strathclyde, South Strathclyde Dumfries and Galloway, and Glasgow and Strathkelvin. I was appointed Crown Agent in April 2016, which position I held until September 2022.

2. I do not recall being directly involved in the investigation as Procurator Fiscal West of Scotland. As Crown Agent, I was involved in limited aspects of the investigation as reflected in the materials which have been provided by the Inquiry team.

3. COPFS conducts death investigations on behalf of the Lord Advocate, who has responsibility for the investigation of all sudden, suspicious, accidental and unexplained deaths in Scotland. COPFS duties and responsibilities in cases where further investigation is required to establish a cause of death, where there is evidence of a crime, where there is a requirement for a mandatory FAI or to inform whether a discretionary FAI is required are extensive, but include deciding whether to instruct a post mortem examination, instructing the police or other investigating authority to conduct further enquiries, liaising with family members, preparing reports for consideration by Crown Counsel, conducting Fatal Accident Inquiries, and prosecuting criminal cases arising from said investigations.

4. From recollection, I conducted a FAI following a death in police custody in Aberdeen in 2000/1. Race was not a factor in that case. The inquiry looked at the police response to dealing with a highly intoxicated individual. As PF Edinburgh and Borders, I think in 2009/10, I was responsible for various teams, including those who carried out the investigation of deaths in Lothian and Borders. I cannot recall any investigation of deaths in police custody, or deaths during or following police contact whilst I was in that role in which race was a factor. As Deputy Crown Agent, then entitled Director of Serious Casework, a role which I

held prior to being appointed PF West of Scotland, I was involved in the creation and senior management oversight of the Scottish Fatalities Investigation Unit.

5. Between joining COPFS in June 1996 and leaving in September 2022 I had experience of family liaison in various roles, including as a depute in Paisley, principal depute in Aberdeen, and as PF Edinburgh and Borders. Race was considered as a factor in some criminal cases I was involved in, including homicide, which involved family liaison.

6. I was Deputy Crown Agent when the Scottish Parliament passed the Police and Fire Reform (Scotland) Act 2012. As such, I was involved in discussions about the role of PIRC during the legislative stage.

7. I understood PIRC's role in the investigation was to make full use of the powers available to them to independently investigate the death of Sheku Bayoh, ingather all of the available evidence and provide a full report to COPFS.

8. I do not know whether PIRC were instructed to investigate under either or both of sub sections 33A (b)(i) or (ii) of the 2006 Act. In all investigations instructed under section 33A the PIRC must comply with the prosecutor's lawful instruction. The PIRC must comply with an instruction from the Lord Advocate in relation to the reporting of alleged offences for consideration of prosecution in respect of investigations carried out under section 33A(b)(i).

9. As above, it is my understanding that COPFS have the power to supervise and issue direction to the PIRC in relation to investigations under section 33A.

10. Other than those matters in relation to which the Inquiry team have provided me with materials, I do not recall communicating decisions and instructions to PIRC during the investigation. My expectation is that decisions and instructions are recorded in writing, including decisions and instructions initially communicated orally.

11. Other than those matters in relation to which the Inquiry team have provided me with materials, I do not recall assisting PIRC with their questions or providing advice in relation to the investigation. Normal practice would be to assist PIRC in answering their questions where possible.

12. My understanding of COPFS role in liaison with the deceased's family in death cases is that as set out in the Family Liaison Charter first published six months after I was appointed as Crown Agent.

13. To the best of my recollection, I did not have any involvement in family liaison in the investigation.

14. Not that I recall.

15. I did not write the email of 10 June 2015 to John Logue, numbered COPFS-01309. Looking at the email chain, it appears the author was [redacted]. As far as I can see, I do not feature in the email chain, even as a copy addressee. I am not able to comment on the circumstances of the promise referred to. I do not recall ever being aware of the promise.

16. I do not know if I reviewed Stephen McGowan's letter to the Commissioner dated 15 March 2017, numbered COPFS-02576. As is clear from the first paragraph of the letter, I had asked Stephen to reply as I was on leave.

17. As far as I recall, I was not involved in Lindsey Miller's discussions with the Commissioner referred to in said letter numbered COPFS-02576.

18. I do not know whether I discussed the section of COPFS-02576 highlighted by the Inquiry team with Stephen McGowan. I have no recollection of doing so.

19. In respect of the meeting invitation, numbered COPFS-02040, in the absence of any other materials being provided to assist, I am sorry but I do not remember anything specific about this meeting.

20. Where there is a possible unauthorised release of information about an investigation to the media by a COPFS official, normal practice would be to conduct an investigation. Depending on the nature of the information, there would be the potential for there to be a breach of data protection obligations and/or employment terms, or in some circumstances, official secrets legislation. Where COPFS is one of two or more organisations privy to the information, investigations should extend to those other organisations. I cannot think of any difference between the unauthorised release of documents or of the information contained therein.

21. I believe I became aware of the Mail on Sunday article, numbered PS18106, after it was published, but cannot recall whether that was on 23 September 2018 or between then and Lindsey Miller's email of 26 September 2018, numbered COPFS-03571.

22. I do not think I had a specific role or involvement in the investigation within COPFS, the terms of which were agreed between two Deputy Crown Agent's, Lindsey Miller and John Logue, as set out in said email of 26 September 2018, other than being updated on the outcome by John Logue.

23. Lindsey Miller will be better placed to comment on her expectations, but I agree, having re read the terms of her email, numbered COPFS-03571, that it appears to have been her expectation that there would be an investigation into a possible leak of information within COPFS, but there was no suggestion of a leak of documents.

24. LOB stands for Law Officers Briefing, a meeting usually held weekly involving Law Officers and senior COPFS officials. I do not remember what was discussed at the LOB in January 2019.

25. As Crown Agent, I along with other senior colleagues in COPFS would receive regular updates, I think provided by Kantar via our Communications team, which would cover a wide range of media reports relating to COPFS, court cases and investigations, including the investigation into the death of Sheku Bayoh. I am not aware of my colleagues having been influenced by what was reported in the media about this investigation. There was a general awareness and recognition that the investigation was significant and that there would be, rightly, public scrutiny.

26. Whilst I was regularly sighted on draft media lines across a wide range of cases and COPFS related coverage, I cannot recall any specific lines which were discussed. I was not involved in direct contact with the media in relation to the investigation.

27. Whilst I liaised with HSE in previous cases earlier in my career, as far as I recall, I did not do so in relation to this investigation. Unlike Police Scotland and PIRC, there is no power for the Lord Advocate or COPFS to direct HSE. COPFS requested their involvement to examine the training provided to officers on use of force in the context of potential health and safety related charges. It was possible that HSE may have been able to bring expertise in relation to the health and safety obligations of Police Scotland in the context of this investigation.

28. I was not aware of an investigation into Sheku Bayoh's death being carried out on behalf of SPF.

29. I was involved in discussions with Stephen McGowan regarding article 2 of the ECHR in the context of his letter of 15 March 2017, numbered COPFS-02576. As far as I can recall, those discussions post-dated the letter.

30. As I stated earlier in answer to question 16, I do not know if I reviewed the said letter of 15 March 2017 before it was issued. It was issued whilst I was on annual leave. I do recall a discussion with Stephen McGowan about article 2, which I think post-dated the letter. There are ongoing article 2 procedural obligations to carry out an effective investigation where an individual has died, involving standards of independence, adequacy, expedition, public scrutiny and participation of next of kin. PIRC conducted an investigation under the supervision and direction of COPFS and thereafter submitted a report. That was not an end to the investigation, as exemplified by Stephen McGowan's Minute to the Law Officers dated 29 August 2016, some sixteen days after PIRC submitted its final report. Regardless of the reporting authority involved, COPFS retain overall responsibility to ensure investigations have been thoroughly and effectively conducted. As at 17 March 2017 when he wrote his letter to the Commissioner, those investigations into the cause of Sheku Bayoh's death, and whether any force used by police officers in arresting him was justified, were ongoing and as such remained subject to the standards outlined above. There was no departure from normal practice.

31. I was not directly involved in either investigating or taking decisions in relation to whether or not there required to be a prosecution in this case. To the extent that I was involved, race was not a factor in my actions.

32. I recall having some experience of racism being a factor to investigate in relation to suspicious or unexplained deaths. In particular I remember a death in Edinburgh, I think, in 2010. I was District Procurator Fiscal for Edinburgh and Borders at the time. In that case, prosecutors in the Sheriffdom were alert to the question of possible racial motivation, albeit the original police investigation had concluded that the motivation was robbery. The family perceived that the attack was racially motivated. From recollection, the Crown decision after precognition was that there was insufficient evidence to show that the attack was racially motivated. Following an internal investigation, Lothian and Borders Police issued a public apology.

33. Prior to this investigation, I cannot recall dealing with another death in custody or death during or following police contact where race may have been a factor. There have been many other investigations not involving such deaths where race was considered as a possible factor. The Lord Advocate's guidelines on offences aggravated by prejudice were first introduced in 2010. Per those guidelines, police and prosecutors are required to ascertain the perception of victims, witnesses and families as to the motive for the crime. Since that date there have been many cases brought before the courts relating to incidents aggravated by prejudice. That position predates this investigation and to my knowledge has not changed.

34. As I no longer work for COPFS, I do not have access to my training record. I did receive training on diversity and equality issues both prior to and after this investigation. COPFS also ran internal diversity networks at which I was a regular attendee. I was also involved in piloting and thereafter consolidating a reverse mentoring program on diversity and equality, during which I benefitted greatly as a mentee.

35. See 34 above.

36. See 34 above.

37. To the extent I was involved in this investigation, I did not make use of any course guidance or reference materials.

38. Training is always of benefit. The reverse mentoring program, which post-dated the investigation, was one example of training which was very useful. Doubtless there are other examples of training which could and should be made available to justice sector professionals.

39. For those who are conducting investigations, there is a requirement to retain records including statements, precognitions, documentary productions and records of decisions.

40. I was not directly involved in the investigation, but would have retained emails containing documents prepared by others. I did not depart from normal practice in this case.

41. Prior to the email of 29 October 2017, numbered COPFS-05262, I cannot recall having any specific awareness of investigations by the police and/or CPS into race in England and Wales.

42. See 41 above.

43. As far as I remember, the Lord Advocate called to advise that Dame Elish had been in touch and that, given the nature of the issues addressed in her report, it was likely that its publication would prompt media requests in respect of the Sheku Bayoh investigation. 'Lines for consideration' is a request from the Lord Advocate to the investigation and media teams to liaise and prepare draft responses to anticipated media enquiries.

44. I believe I read the 2017 Angiolini report at the time. I recall being involved in discussions which subsequently led to Dame Elish being commissioned, I think in mid-2018, by the Cabinet Secretary for Justice and the Lord Advocate to conduct an independent review of complaints, investigations and misconduct in policing. I was thereafter involved in the Ministerial led oversight group which progressed both the interim recommendations in Dame Elish's report of 2019 and the further recommendations in her final report in 2020. My recollection is that one of the recommendations in either the 2019 or 2020 report highlighted the learning in the 2017 report and that that was taken forward under the auspices of the Ministerial led group.

45. The investigation was detailed and took time, as did following up on further investigations required by Crown Counsel and the subsequent review. Both procurators fiscal and Crown Counsel to lead on the investigation were identified at an early stage. I would have preferred it to have taken less time. Others closer to the investigation will be better placed to comment, but my sense was that there were delays in identifying and instructing appropriate experts and receiving and thereafter assessing their reports. The availability of suitably qualified experts who are willing and able to provide reports continues to be a challenge across a range of investigations. As I recall, there were delays in the provision of operational statements from the officers involved on the day.

46. Even had there been a prosecution, I had held the view that there would possibly be a public inquiry for some time. My sense was that a Fatal Accident Inquiry would not be able to fully examine the post incident investigation and in particular the early interaction between Police Scotland, PIRC and COPFS.

47. My involvement, decisions and actions were consistent with normal practice.

48. I do not recall there being any other particular difficulties or challenges in respect of my involvement.

49. I was not involved in sharing findings with Police Scotland. I am not aware of that having happened.

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.

11 April 2024