SHEKU BAYOH INQUIRY

WITNESS STATEMENT

Name: Erin [redacted] Campbell

Date of Birth: [redacted] 1983

Address: Crown Office, Chambers Street, Edinburgh

Occupation: Advocate Depute

Paragraph 1

I do not have a precise note of the date I became involved in the Sheku Bayoh investigation however, from memory, I became aware that I was to become involved in August 2015. At that time I was a Procurator Fiscal Depute of 9 years experience and I worked within the Serious and Organised Crime Division (SOCD) of COPFS in the Organised Crime Unit. My role at that time was primarily the investigation and case preparation of high level organised crime cases in Scotland. I had held that role within COPFS for around two years.

Paragraph 2

In August 2015 I received a telephone call from Lyndsey Miller, informing me that I was to be seconded to the Criminal Allegations Against the Police Division (CAAPD) to assist in the investigation into the death of Sheku Bayoh. I understood my role was to be that of case preparer, following receipt of the PIRC report, I was to assist in the preparation of a precognition examining whether there was a sufficiency of evidence to support criminal proceedings against any of the police officers involved in My Bayoh's detention. I cannot recall precisely when my secondment began but it was a significant period after the phone call and my secondment was not uninterrupted. I worked on Mr Bayoh's case intermittently as I remained engaged in Organised Crime Cases.

I understood that, regardless of the outcome of any consideration of criminal proceedings, there would be a mandatory Fatal Accident Inquiry as Mr Bayoh's death occurred while in police custody however, the first consideration, and the focus of most of my involvement was to explore whether the evidence supported the raising of criminal proceedings. I was to assist in preparing a precognition for Crown Counsel in which a recommendation would be made as to whether there was a sufficiency of evidence to support criminal proceedings. In doing so, I reviewed the evidence, was involved in directing further investigation where necessary, obtained precognition statements from certain witnesses and drafted a narrative. My involvement with the Sheku Bayoh case finally ended in mid-2017 when I was promoted to Principal Depute in the Sheriff and Jury Unit in Hamilton. This was before the precognition had been completed and before any such recommendation had been made.

Paragraph 3

My understanding then, as it is now, is that the Lord Advocate is responsible for the investigation of all sudden, suspicious, accidental and unexpected deaths in Scotland and that COPFS conduct these investigations on behalf of the Lord Advocate. In examining the circumstances of such a death there requires to be a consideration of whether there is evidence of a crime, whether the circumstances are such that an FAI is mandatory or whether there requires to be further investigation in order to determine if a discretionary FAI is in the public interest. In considering these factors, COPFS is responsible for directing any further investigation and ultimately preparing a report for Crown Counsel in which a recommendation will be made either for criminal proceedings or an FAI or no further proceedings at all. If proceedings are instructed by Crown Counsel then any criminal proceedings or FAI will then be conducted by either Crown Counsel (an Advocate Depute) or a Procurator Fiscal Depute. Throughout the investigation, COPFS has a duty to keep the next of kin of the deceased person fully informed throughout the process and the views of the next of kin are an important factor in determining the question of public interest when considering what further action should be taken.

Paragraph 4

Prior to my involvement in the Sheku Bayoh case, I had limited experience of deaths in police custody. Death investigations in COPFS became centralised around 4 or 5 years after I had joined in 2006. All death investigations since then have been dealt with by the dedicated unit within COPFS known as the Scottish Fatalities Investigation Unit (SFIU) or, in criminal cases, the Homicide Team, the Health and Safety Investigation Unit or the Road Traffic Fatalities Investigation Unit depending on the type of crime. However, I had had experience of death investigations (both criminal and non-criminal) prior to the inception of SFIU and was allocated death cases within the local office. From recollection none of these cases involved deaths in police custody nor was race a factor to consider.

Paragraph 5

I did have experience and received training in family liaison in deaths cases. The level of liaison varied on a case by case basis. Some families wished to be more involved than others. I do not recall race being a factor to consider in any of those cases.

Paragraph 6

Prior to my involvement in the Sheku Bayoh case, I had no involvement in dealing with PIRC.

Paragraphs 7-13

I do not feel that I can answer the questions in paragraphs 7-13. I was not involved in the instruction of PIRC. The majority of the work that I undertook in the case took place after the receipt of the PIRC report.

Paragraph 14

I have examined my notebook at page 62 and I see that I have made this note under the heading "Questions Inquest May Raise" I have no recollection of writing these questions or the context in which they were written. "Inquest" is not a word I would use to describe an FAI or a Public Inquiry and so it may refer to the organisation "INQUEST" headed up by Deborah Coles. In terms of whether I investigated this question, it was not my role at that time to examine the actions or provide an opinion on the actions of the PIRC investigators. My role was to investigate the question of whether there was a sufficiency of evidence to establish that a crime had been committed and to assist in preparing a recommendation for Crown Counsel.

Paragraph 15

My understanding of COPFS' role in liaison with the deceased's family in deaths cases is that the family will be contacted by COPFS from an early stage, as early as the point at which a post mortem is instructed. COPFS will then regularly update the family through various stages of the investigation and will (in relevant cases) seek their views on whether they would wish a Fatal Accident Inquiry to take place. The extent and nature of the contact with the family can vary on a case by case basis depending on the wishes of the family themselves and the type of proceedings that a deaths case will result in ie a criminal prosecution or an FAI. The majority of deaths cases reported to COPFS can be resolved without the need for further investigation. In some cases a Family Liaison Officer will have been appointed by Police Scotland and they will have been the first point of contact for the family. In cases where this happens, there is liaison between the Family Liaison Officer and COPFS' Victim Information and Advice (VIA) officers and a handover takes place.

Paragraph 16

I cannot comment on the practice in PIRC investigations however, COPFS' responsibilities would remain the same.

During the precognition process, COPFS will regularly update the family in death cases about the investigations that are taking place and the results of

those investigations and the family will be notified once Crown Counsel's Instructions are received. This is most often done by VIA officers although, where complex evidence or law requires to be discussed or where a sensitive decision requires to be communicated, meetings usually take place where a Depute, Principal Depute and sometimes Crown Counsel will be present who can explain matters more fully.

I am unable to comment on whether any handover took place in the case of Mr Bayoh between PIRC and COPFS. I was not involved in the case at that early stage. I cannot recall who was involved in family liaison in the case of Mr Bayoh or if there was a dedicated VIA officer. I know that, during my involvement, contact with Mr Bayoh's family was made through their legal representative Mr Anwar. This is not normal practice in COPFS deaths cases. It is unusual for next of kin in deaths cases to have their own legal representative who acts as a conduit between them and COPFS but my understanding was that this was done at the wishes of Mr Bayoh's family. From memory, the level of communication with Mr Bayoh's family through their legal representative was extensive.

Paragraph 17

Other than my attendance at meetings with the Lord Advocate, I was not involved in Family Liaison in the case of Mr Bayoh. I cannot recall if there was a dedicated VIA officer to the case.

Paragraph 18

I was present at some meetings between the family, Mr Anwar and the Lord Advocate. I cannot recall exactly how many meetings I was at and I no longer have notes of them all. I am sure I was at least two but possibly three. I was definitely at at least one meeting with the then Lord Advocate Frank Mulholland QC and one with his successor James Wolffe QC.

I can see from the notes provided by the Inquiry at COPFS-05207 that the first meeting that I attended appears to have been on 5 November 2015. I have

noted 2014 but that cannot be correct and, as it was the first meeting I was at, it must have been 2015. Present at that time was the Lord Advocate, Frank Mulholland QC. I have not noted who else was present but I recall the family of Mr Bayoh being present including Kadijatu Bayoh and her husband Adeymi Johnson. Also present was Mr Anwar , Les Brown, Lyndsey Miller and Stephen McGowan. There may have been others from COPFS or Mr Anwar's office there but I cannot recall.

The notes I have prepared were not verbatim but I can see from them that I was introduced to the family and it was explained that I was currently carrying out a reconciliation of witness statements and CCTV. The family were informed that we were considering whether there was a Health and Safety aspect to the case but that the Lord Advocate did not have the power to instruct the Health and Safety Executive to investigate. The Lord Advocate appears to have explained that PIRC had been directed to investigate the issue of whether there was institutional racism within Fife Constabulary. He expressed concerns that Dr Karch had compromised his integrity and impartiality as an expert witness in light of his recent comments in the media. There is reference to audio recordings being disclosed to the family but I have no recollection of what recordings those were. The family were informed that Dr Lipsedge had been instructed. The question was raised over whether the police had breached their duty of care to Mr Bayoh which would be carefully looked at. I have noted that the Lord Advocate gave his word that he would sit down with the family and go over the evidence with them.

The meeting then turned to a number of issues raised by Mr Anwar. I cannot read all of my handwriting here but it appears that Mr Anwar has indicated that it took a significant period to build the family's confidence. He alleged that members of PIRC had threatened the family that they could be taken to court to be precognsoced if they refused to give statements and he compared this to the way that the police officers had been dealt with and the length of time it had taken them to give statements. He expressed concern that Police Scotland were not dealing with the family well. He said that PIRC need to be made to understand that they should not treat the family the same way they treated the police officers. Mr Anwar mentioned that issues of data protection were still being looked at. PIRC have checked the officers access to police systems

but questioned whether their friends had been checked. He raised the issue of harassment of the black community in Kirkcaldy. He raised that Peter Watson had approached Zahid Saeed and left calling cards for him stating that he was investigating for the purposes of a Fatal Accident Inquiry. The Lord Advocate appears to have offered to contact Peter Watson about this. Mr Anwar raised concerns that the officers were briefing the media and referred to Dr Stephen Karch's comments on excited delirium and cardiology findings. He raised the query over whether PIRC were briefing the press. Mr Anwar expressed concerns that PIRC were failing in their duty to liaise with the family and mentioned the tone of the Commissioner, Kate Frame's letters. There was discussion of Dr Cary and examination of Mr Bayoh's heart but I have not noted that very fully. A question was asked about who chose Dr Karch and surprise expressed if PIRC recommended him. Concerns were expressed about the PIRC investigator Keith Harrower and the fact he remained with Dr Cary while samples were being taken and there was a suggestion that he had been dishonest about that. The question was asked if Mr Harrower's involvement had now been tainted and should he be removed from the investigation.

There was a request made that consideration be given to instructing an expert in behavioural science to consider the question of "pack mentality" in light of the mindset of the officers that they were attending a terrorist attack. A query was raised over how many samples had been taken from Mr Bayoh and what the chain of evidence was and whether it was possible to now DNA test the samples.

There was no date fixed for the next meeting. I cannot comment on anything about the meeting beyond what is contained in my notes.

I recall also being at a meeting with the Lord Advocate James Wolffe QC and Mr Bayoh's family together with Mr Anwar, Mr Brown and Lyndsey Miller. I cannot recall if Stephen McGowan was there and there may have been others. I do not appear to have retained any notes of this meeting and no further notes have been provided by the Inquiry. There is therefore nothing I can say about this meeting other than it occurred. I believe it occurred shortly after the new Lord Advocate had been appointed but I cannot be sure.

Paragraph 19

Routinely in deaths investigations, VIA are the main point of contact for the deceased person's next of kin. There will usually be an appointed VIA officer who will act as a single point of contact and provide updates on the progress of the investigation and support to the family. A VIA officer is not the only person who will be involved in liaising with the family. As discussed above, the case preparer, Depute or Crown Counsel do also meet with family members in order to explain more complex situations and seek their views. I cannot recall if there was a dedicated VIA officer in this case. There may have been. However, as discussed above, the interaction with Mr Bayoh's family during my time in the case was not routine. This was a complex and high profile case in which the family had instructed their own representative. During the times I was involved, there was regular contact with Mr Anwar. Case materials, that would not routinely have been disclosed to family members, were disclosed to him and meetings took place with the family which were led by the Lord Advocate and at which members of Senior Management of COPFS were present. The Lord Advocate was keen to ensure that the family felt fully involved in the process.

Paragraph 20

Prior to my involvement in the case, I was aware of Mr Bayoh's death in the media. It had been widely reported. I knew he had died following an arrest by police officers but I had no further knowledge of the circumstances. I did not follow the coverage closely at that time.

Paragraph 21

When I first became involved in the case, I was briefed on the circumstances by Les Brown I cannot recall what description he gave but he outlined the circumstances. I thereafter reviewed case papers including witness statements and CCTV. I think I also reviewed an early draft or interim PIRC report but I am not sure.

Paragraph 22

I don't think I can really answer this question. My role in the case was to ingather evidence, critically examine it and determine whether there was sufficient in law to establish that a crime had been committed. In my preparation of any case, I approach the evidence independently with an open mind.

I was not involved in the preparation of the analysis or the recommendation as the case preparation was not at that stage by the time my involvement in the case ended. I had not reached a concluded view of my own.

Paragraph 23

During my involvement with this case, my understanding was that there would be a Fatal Accident Inquiry regardless of whether there was a criminal prosecution or not. Even if there had been a prosecution, it would have been unlikely that it would have explored the wider circumstances of Mr Bayoh's death in sufficient detail and so I anticipated there would be an FAI following any such proceedings. I took the view that Mr Bayoh was in *de facto* police custody at the time of his death, and so an FAI was mandatory under s.1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. I was not involved in the preparation for an FAI. The first task of the Crown was to consider if there should be a criminal prosecution before moving to prepare for an FAI and that decision had not been reached by the time my involvement with the case ended. I do not know why an FAI was not held or who took that decision.

Paragraph 24

I did not precognosce any of the response officers involved with Mr Bayoh at the time of his arrest. At the time I was dealing with the case, it would not have been appropriate to do so given that there remained the prospect of criminal proceedings being raised against them. I did consider the statements

provided by all the officers and compared their accounts with each other along with the other civilian witnesses who saw the incident. I did not prepare an analysis in which a view on the overall credibility and reliability of the statements might be expressed but I did identify inconsistencies between the accounts of the officers and between their accounts and the accounts of the civilians. These inconsistencies are set out in the narrative that I prepared which is entitled COPFS-04390.

Paragraph 25

I reviewed Mr Nelson's statement and I was also involved in the precognition of Mr Nelson at Kirkcaldy Procurator Fiscal's Office on 6 October 2016. Mr Nelson gave an account at precognition that he saw Mr Bayoh run into the middle of the road and swing a punch at a female police officer's head. He said he caught her with the punch and tried again and missed as she had stumbled to the side. He then said *"At this point I left my livingroom window to go outside. It would have taken me about 10 seconds to get from my livingroom window, unlock the front door and get outside."* He then stated that *"once outside I saw two officers struggling to restrain Mr Bayoh."* I do not recall if Mr Nelson was asked to comment on the statements given by PC Walker and PC Tomlinson about the alleged stamping on PC Short but it would not be ordinary practice during this type of precognition for me to read the statements of other witnesses unless there was something glaringly contradictory. Mr Nelson appeared clear in his precognition that his view of the incident was interrupted by him leaving the house around the point the stamp is said to have taken place which was not, on the face of it, inconsistent with what the officers said. I do not believe that we directly asked him if he saw a stamp as his answer to that would have been recorded within the precognition statement.

Paragraph 26

The evidence of the officers was reviewed along with the evidence of the civilian witnesses who were precognosced. The airwave transmissions were also considered. The issue of whether or not there was a stamp to PC Short

was not the main focus of the investigation during my involvement. My main aim was to try and establish the length of time, position and circumstances in which Mr Bayoh was restrained, whether that level of restraint amounted to a criminal action and whether the evidence could support a causal link between that and his death. I tried to do that by reference to the independent evidence from the eye witnesses, timings of airwave transmissions and CCTV/video footage that was recovered rather than rely on the accounts of the police officers. Whether PC Short had or had not been stamped on would have had no impact on my assessment of those matters albeit (if it could have been established definitively that she wasn't) then that would have undermined the credibility of the officers but there was nothing in the evidence in my view, including in the account given by Mr Nelson, that definitively excluded the stamp from occurring.

Paragraph 27

I reviewed the witness Ashley Wyse's statement and I precognosced her along with Alasdair MacLeod on two occasions. The first occasion was on 4 October 2016 at Kirkcaldy Procurator Fiscal's Office and the second on 2 November 2016 again at Kirkcaldy PFO. In terms of preparation, I reviewed her statements and the statements of the other witnesses and identified what I wanted to cover with her. I would not have drafted scripted questions. it would not be my practice to do that. It would have been my intention to take an account from her by asking her open questions and probing for further detail where appropriate, much in the way I would if I was taking evidence from her in court. I do not recall having any involvement in obtaining information from her mobile telephone.

Paragraph 28

During our precognition of the witnesses, Alasdair MacLeod and I agreed in advance that one of us would ask questions of the witness and the other would note the precognition. Those notes would then immediately be typed up after the precognition and the other person would review it for approval. We

switched roles at various points. Both Alasdair and I were present for all the precognitions. In the case of Miss Wyse, my memory is that I asked her questions and explored her evidence and Alasdair took the notes hence why my notes of her precognition were limited.

Paragraph 29

The omission from Ashley Wyse's statement was significant and it meant that, during my first precognition of her, I was not appropriately prepared. I note John McSporran's response although that email exchange is not what forms COPFS-02280. That document is an email from myself to Les Brown. I cannot comment on whether it is a satisfactory explanation or not. I had no evidence to suggest that it was an untrue explanation and I note that the relevant part of the statement that was missed did appear in the PIRC report so there was no reason to think that the omission had been deliberate. I did take a further precognition from Miss Wyse on 2 November 2016 at which time this part of her statement was put to her and she indicated that it had jogged her memory and accepted that what was contained within her statement was accurate.

Paragraph 30

I have read the email to Les Brown that forms COPFS-03750 and I can confirm that I was referring to the statement of Ashley Wyse. When I said *"I think this is going to be an issue further down the line"* I was referring to issues that the absence of material in a typed version of a statement raises in any case. For example, it is often the typed statement that is disclosed first and is read by Crown Counsel in the preparation of the case. If important information is missed from that then it can cause problems. I was also acknowledging the fact that a very significant part of the statement had been missed from the typed version which raised the possibility that there might have been more missed out from the statement. It is for that reason that I suggested we get the handwritten statement in. I also recognised that this would inevitably result in further distrust from the family of Mr Bayoh towards PIRC. I can confirm that PIRC did provide us with the handwritten statement along with a letter to Les

Brown dated 26 October 2016. I can confirm that I also personally checked the handwritten statements of Miss Wyse against the typed versions and could see nothing else missed. PIRC was also asked to carry out a check of all handwritten statements to make sure nothing else had been missed from any of the typed statements. They confirmed in the 26 October 2016 letter that that had been done.

Paragraph 31

I do not recall being involved in instructing any forensic analysis of PC Short's vest.

Paragraph 32

I do not recall being involved in the obtaining of a toxicologist's opinion in relation to samples taken from Mr Bayoh. The only involvement in requesting the analysis of samples of Mr Bayoh that I have any record of is in drafting a letter of instruction to Professor Tony Freemont who was an osteoarticular pathologist. He was asked to examine samples taken from the fracture that had been identified to Mr Bayoh's left first rib. In the letter, he was asked to comment on the possible mechanism of the fracture, the force required to cause such a fracture and whether this is the sort of fracture that could have been caused as a result of administration of CPR. I do not recall the outcome of the letter or receiving a report from Professor Freemont. I do not recall if Professor Freemont was able to prepare a report. It is possible that that had not been prepared by the time my involvement in the case ended.

Paragraph 33

I was not involved in the ingathering or analysis of evidence received from Ms Collette Bell, Mr Zahid Saeed, Mr Martyn Dick or Ms Kirsty MacLeod. From what I recall, analysis of items such as these would not have assisted me in

determining whether the actions of the police officers in restraining Mr Bayoh amounted to a criminal offence.

Paragraph 34

I had no involvement in considering any actions of police or civilian staff relating to searches of Mr Bayoh or Mr Anwar on police systems. My role in the case would not have required me to have any involvement in this.

Paragraph 35

I am not 100% sure what multimedia presentation is being referred to here. I did request that the multimedia unit of SPA create a compilation of the various clips of video footage that we had ingathered in a chronological format. This was to assist in seeing if we could obtain a clearer picture of the length of time Mr Bayoh was restrained and it would also have had a presentational benefit in the event of a criminal trial.

Paragraph 36

I did not have any involvement in ingathering statistical data that I can recall.

Paragraph 37

I did not have any involvement in the ingathering or analysing evidence in relation to the training of the officers.

Paragraph 38

The issue of race was a live consideration but I was no longer involved with the case at the time that an analysis of the evidence was prepared. In ingathering the evidence that I did, I understood that the question of whether any criminal

offences that may be identified were racially aggravated would have to be addressed in the analysis by reference to the evidence that had been obtained.

Paragraph 39

I did not prepare an analysis of evidence for Crown Counsel.

Paragraph 40

I did not prepare an analysis of evidence for Crown Counsel.

Paragraph 41

I do not recall in what context the words "Institutional Racism within Police Scotland?" were written or why I wrote them. I suspect this may have been a continuation of the questions on the next page. ie the pages are back to front which would suggest that I have written this as a question that may require to be addressed in the future.

Paragraph 42

I do recall the family of Mr Bayoh and Mr Anwar proposing lines of enquiry in the case. That is clear from my notes taken at the meeting with the Lord Advocate Frank Mulholland QC. I do recall them being taken forward. For example, a request was made to find out how many samples were taken from Mr Bayoh and what the chain of evidence was and I wrote a letter to the pathologist asking that these questions be addressed. I do not have a copy of the response. I also recall Les Brown directing PIRC to examine issues raised by the family although I have no memory of what the precise issues were.

Paragraph 43

I cannot recall from memory which witness I was referring to. However, I see from page 11 of my draft narrative that I included in red "*Revise on*

precognition of Sean Mullen" so that suggests it would have been him. I do not know if COPFS ever managed to precognosce Mr Mullen or whether a precognition on oath was considered. I have no record of me precognoscing him.

Paragraph 44

I cannot recall what further enquiries I instructed in relation to those passages of the narrative.

Paragraph 45

What is contained in the email is what it means. I felt that the narrative prepared gave a clearer picture of the timeline involved together with the length of time the restraint lasted. Questions of how long the restraint lasted and whether continued restraint was justified would have been questions to consider when analysing the evidence and assessing legal sufficiency for criminal proceedings.

Paragraph 46

I do not recall what footage this note refers to.

Paragraph 47

My notes at page 38 were compiled before the final PIRC report was received and were simply to flag up to me that this was a question I would like to know the answer to. As I recall the answer was addressed within the PIRC report.

Paragraph 48

These notes in my notebook do not refer to a meeting with the Lord Advocate James Wolffe QC. They refer to a meeting with the Lord Advocate Frank

Mulholland QC. I am confident of that. What I can say about the meeting (having referred to the notes) is set out above in my answer to paragraph 18 of the questions.

Paragraphs 49-53

I have no clear recollection of the meeting or what was said. The meeting took place 8 years ago. In my account of the meeting in the response to paragraph 18 above, I am entirely dependent on my notes. I do not feel able to expand upon what is contained within them or on what is contained within my response to Paragraph 18 of the questions.

Paragraph 54

Prior to my involvement in this case I had little awareness of the investigations by the police/CPS into race in England and Wales. During my involvement in the case, I became aware of the independent review into the death of Mr Sean Rigg and I did read the report. However, it was not my role in the case to critically examine the actions of PIRC or to recommend or implement protocols in dealing with deaths in police custody. My role was to try and get as clear a picture as I could of the circumstances surrounding Mr Bayoh's restraint and death and consider whether the actions of the police officers gave rise to a criminal offence. Investigations remained ongoing at the time my involvement ended and so I did not reach a concluded view on this. The review report was helpful in underscoring the need to robustly examine the actions of the officers independently of the PIRC report both in terms of their use of force and restraint and the need to address the issue of whether they took appropriate measures to ascertain whether he was suffering from some form of mental health distress before their use of force.

Paragraph 55

Before I read the Review Report, I was already aware that the officers involved in Mr Bayoh's restraint did not give statements for some considerable period

after Mr Bayoh's death and I already was of the view that this was not best practice. The experience I already had as a prosecutor meant that I was aware of the importance in securing evidence quickly and that the circumstances, both in what happened to the officers after Mr Bayoh's death (eg they were not separated) and the length of time elapsed before giving statements opened up their accounts to suggestions of collusion. I kept this in mind when assessing the weight to give to the accounts of the police officers. The Review Report recognises these as failings in the case of Mr Rigg but it did not change my approach. Likewise, I was already aware of the issue of race in Mr Bayoh's case and recognised the need to be live to any actions on the parts of the police officers that may be construed as either racially motivated or which betrayed racial bias. Reading the Review Report did not change my approach. My involvement in Mr Bayoh's case ended around a year before the precognition was reported in 2018 so I had read the report before then.

Paragraphs 56-57

I cannot recall to what extent I considered the investigation into the deaths of Rodger Sylvester and Rocky Bennet. They are referred to in my notebook along with Sean Rigg and so I must have. I would have been interested in understanding and learning from any approach taken by the CPS.

Paragraphs 58-59

Again, I cannot recall writing these questions or why they were written. I cannot recall if these were questions that I raised or whether they were questions raised by someone else.

Paragraphs 60-63

To the best of my recollection, I was not involved in the instruction of any forensic analysis by SPA during my work on the investigation.

Paragraph 64

I was not involved in the instruction of experts by PIRC. Please see my answer to the questions in paragraph 32. I drafted a letter of instruction to Professor Tony Freemont. I cannot recall if we ever got a report from Professor Freemont and I cannot recall how we identified him as an expert. From my letter, I see that he was provided with a "package" containing relevant information. I cannot recall precisely what would have been in that although it will no doubt be listed in his report if one was prepared. I am sure it would have included the post mortem reports, and statements from the officers who spoke to hearing a rib break and who administered CPR. Arrangement would also have been made to provide him with access to the relevant samples.

I was also involved in attempting to identify an expert who could give an opinion on restraint techniques and an expert in the behavioural and physiological effects of drugs. I do not recall if we were able to identify such an expert before my involvement with the case ended.

Paragraph 65

At that time I had been a prosecutor for almost 10 years and had considerable experience of instructing experts in a variety of cases. In terms of formal training, COPFS should be able to provide my training record to the Inquiry and would be better placed to answer that question.

Paragraphs 66-67

As far as I can recall, I was not involved in any consultations with expert witnesses and I was not involved with the case at the time an analysis of their evidence was prepared.

Paragraph 68

I was no longer involved with this case at the time the matter was reported to Crown Counsel.

Paragraph 69

I was not involved in obtaining precognitions of experts. The footnote in this question refers me to COPFS-03753 however this is email correspondence unrelated to precognitions and was sent in 2019, almost two years after my involvement with the case ended.

Paragraph 70

I have read the email. This was part of an email chain when we were trying to identify an expert to opine on the behavioural impact of the drugs that had been ingested by Mr Bayoh. I cannot recall what response I got. From memory, my suggestion was not taken any further and I do not think I contacted Dr Stevenson. In my email I say that he "might" have been the chief casualty surgeon for Police Scotland but I do not know that he was and, had we considered moving ahead with that suggestion, I would have checked the position. I had no reason at all to have any concern about Dr Stevenson's independence but if he had been chief casualty surgeon at the time, I was concerned that Mr Bayoh's family may not have been happy with his instruction given their deep mistrust of Police Scotland. We were conscious that any experts we engaged required the faith of the family. That is what I mean in my email.

Paragraph 71

The letter referred to in this paragraph was drafted at a point when we were in the early stages of trying to identify an independent expert in restraint. My purpose in writing to the hospital was not with a view to instructing someone from the hospital to give an opinion but to ascertain who their training provider in restraint was. This was to enable me to identify whether the training provider could recommend a suitable specialist. I acknowledge that restraining someone in a hospital setting is different from the circumstances in the case of Mr Bayoh however, I was also conscious that patients in the State

Hospital may well require to be restrained while experiencing acute episodes of mental distress and all the physiological consequences of that. Those patients may well also be under the influence of medications or in the process of drug withdrawal all of which make restraint more dangerous. I therefore thought it possible that any training provider for the state hospital may be able to express opinions on the possible effects of prolonged restraint in someone in a heightened state of aggression or distress and the best practice in those situations. I was hopeful that such a person may also have some experience of restraint in a law enforcement context but as I say, this was merely an effort to see if someone could be identified through this channel.

Paragraph 72

The evidence on which I formed this view would have been from the CCTV. From memory, the CCTV showed that matters escalated very quickly after the police arrival and it seemed a very small window of time in which they could have assessed the situation fully or used non-force methods of de-escalation before deploying their spray. It may have been that their actions were in line with their training in all the circumstances or it may not have been which was why I was suggesting identifying an expert in officer safety training. I cannot comment on whether Alasdair MacLeod shared this view or not.

Paragraph 73

I am confident that the Lord Advocate expressed this opinion as a result of Dr Karch's comments to the Sun newspaper. I cannot recall what exactly was discussed about it but I think that the view was taken that Dr Karch would not be relied upon as an expert in any future analysis of the evidence.

Paragraph 74

I was aware of the comments by Dr Karch to the Sun in the course of my involvement with the investigation. They were brought to my attention by someone else within COPFS although I cannot remember who. I would not

have read these comments of my own accord as I do not read this newspaper. My understanding, following the comments, was that Dr Karch would not be relied upon in assessing the evidence in the case. I am not sure if Crown Counsel were aware of Dr Karch's comments or the view that the Lord Advocate had expressed. That is a question better directed to Crown Counsel. I am not aware if this was referred to in the final precognition.

Paragraph 75

Prior to my involvement in this investigation, I had had very little involvement with investigations involving the Health and Safety Executive. There was and is a centralised department for this within COPFS (HSIU) which was established in 2008 and I have never worked within it. I believe I may have dealt with one or two cases involving HSE prior to this centralisation but not in any significant way and likely at summary or sheriff and jury level.

Paragraph 76

I understand that there is a protocol in existence between COPFS and HSE which agrees the framework of liaison between the two organisations. COPFS as a department would be better placed to answer this question.

Paragraph 77

Consideration was given to involving HSE in the investigation and I assisted in drafting a letter to them in early 2016 setting out the circumstances of the case and the areas in which their input may be useful. These areas included Police Scotland's management of CS and PAVA sprays, training provided in the use of these sprays and training provided in restraint techniques. The letter simply invited a discussion as to whether they would be prepared to become involved. I believe the letter was reviewed by a senior member of COPFS staff (I cannot recall if this was Les Brown or Stephen McGowan) and may have been sent in that persons name following revisal. I cannot recall if there was any discussion about the varying resources of HSE and PIRC.

Paragraph 78

I cannot clearly recall what the precise outcome of our efforts to engage HSE were but I am reasonably sure that they declined to become involved. I can't comment on what impact it had on the investigation ultimately.

Paragraph 79

I don't feel able to expand upon what is contained in my notes as I don't have a recollection of the precise discussion however, I do know that COPFS do not have the legal power to direct HSE to become involved in any case. The legal relationship between COPFS and HSE is different to the relationship between COPFS and Police Scotland. COPFS have the power to instruct and direct police investigations but not HSE investigations.

Paragraph 80

I was aware, as I am with any COPFS investigation involving a death, that that investigation required to be Article 2 compliant meaning, among other things, that it required to be capable of withstanding public scrutiny, capable of reaching a determination, prompt, and allowing participation of the next of kin. Article 14 required that the investigation be free from discrimination. I do not recall being involved in any particular discussions about this although I do know that all those involved in this investigation would have been aware of COPFS' obligations under the Convention.

Paragraph 81

Consideration of whether investigations by Police Scotland and PIRC were Article 2 compliant was not part of my role in the case.

Paragraph 82

I was aware of media reporting of the case and I did read/watch some of the coverage during my time involved in the investigation and after my involvement in the investigation. Other than a recognition that the media reporting made the case high profile, my involvement or approach to the investigation/precognition was not in any way influenced by the media reporting. At no point was I aware of any of my colleagues being influenced by the media reporting.

Paragraph 83

I had no involvement in COPFS' media engagement.

Paragraph 84

The decision not to prosecute any of the officers was made a considerable period after my involvement in the case ended. I was not aware of what the ultimate recommendation in the precognition was or what the decision was until it was reported in the media. I did not read the Mail on Sunday article and I was not aware of any internal investigation by COPFS.

Paragraphs 85-87

I don't recall being aware of any such investigation by the SPF.

Paragraph 88

Prior to my involvement in the Sheku Bayoh case, I did not have experience of cases involving death in custody where race was a factor. I have been involved in cases where allegations of racism have been levelled at police officers but I am unable to recall the exact circumstances of these cases or the years in which I was involved.

Paragraph 90

I am unable to answer this question. I had not been involved in a death in police custody or death following police contact where race was a factor prior to my involvement in the case of Mr Bayoh so I cannot comment on what COPFS did as a matter of routine. I have not been involved in such a case since.

Paragraphs 91-94

Prior to my involvement in the Sheku Bayoh case I had been a Procurator Fiscal Depute for 9 years. I had in that time attended multiple training courses and received training on how to prepare a criminal case for Crown Counsel and for trial. These training courses covered all the things listed in paragraphs 91-93 and included equality and diversity training. The Learning and Development division of COPFS should be in possession of my training record and so these questions are best answered by them.

Paragraph 95

I cannot think of any further training that would have assisted me in my role in this case however I would have welcomed any further training or refresher training had it been offered in advance.

Paragraph 96

There is no requirement for me to take contemporaneous notes while carrying out a precognition although (in complex cases) I often will make notes to assist myself. A record is kept of my involvement and there are forms that require to be completed depending on the type of case. In all cases, my name would be recorded as the case preparer on COPFS computer systems and it would appear on case information sheets in a precognition. A record is kept of what witnesses are precognosced and by whom. There is no formal requirement to keep a record of every single email sent or line of enquiry pursued in the course of case preparation although case preparers often will keep a record.

Paragraph 97

I cannot recall what records I kept in relation to the investigation. Any records that I did keep would have been part of the case papers and would have been provided to the Inquiry. I did retain some documents in my COPFS documents profile. These are documents that I was sent or drafted such as the narrative or precognitions of witnesses along with letters I assisted in drafting. I also kept a record of the PIRC report as it was easier to access in this way given the volume of the report. I do not consider that my record keeping deviated from normal practice.

Paragraph 98

In my experience the investigation was lengthy. My involvement in the case was for a limited window and so I cannot comment on whether it was unduly lengthy or not. It was certainly a case with complexities that required careful consideration and there were ongoing investigations at the time my involvement with the case ended. I cannot comment on the reason that it took so long to report the case to Crown Counsel nor would I be able to give an opinion on what could have been done to reduce the amount of time it took to report the matter given that I was part of the case for a limited time.

Paragraph 99

I became aware that a Public Inquiry would be commissioned to examine the death of Sheku Bayoh when it was announced in the media by which time I was no longer involved in the case. I cannot comment on whether this factored in the decision regarding a Fatal Accident Inquiry.

Paragraph 100

This was a high profile and complex case. There was a recognition by senior staff in COPFS that decisions required to be carefully thought out and capable

of withstanding scrutiny. As a result, there was a high level of involvement from senior COPFS staff to an extent which is not generally seen in more straightforward cases but is not necessarily unusual in a highly sensitive case. As a Depute in most cases, I would have had more autonomy in my direction of investigations but in this case any decisions I made or actions I took were discussed with and subject to the approval of senior colleagues before being implemented.

My involvement in the case at all was a deviation from "normal practice" as I was a Depute within the Organised Crime Unit and not a Depute within CAAPD. I cannot comment on why I personally was asked to become involved in the case although I do know that, given the complexity of it, it was felt that CAAPD required additional resources to manage it.

The family of Mr Bayoh were kept informed and allowed an involvement in the case (via their legal representative) to an extent greater than might ordinarily be expected in other cases. For example, it is extremely unusual for next of kin in a death in custody case to be present at repeated meetings with the Lord Advocate.

However, while all of these factors may not be considered "normal" by comparison to other cases, this case has to be viewed in context. It was a very sensitive case involving complex issues which had a high level of public interest. The fact that race was a live issue in considering the events of Mr Bayoh's death and the following investigation added to its sensitivity and complexity. In terms of the nuts and bolts of what I did in the case ie preparing letters to experts, precognoscing witnesses, reviewing the evidence and preparing a narrative, I do not consider that I deviated from normal practice.

Paragraph 101

I cannot recall what, if any, significant difficulties or challenges I encountered during my involvement in the investigation.

Paragraph 102

I am not in a position to answer any of these questions. I was not aware what the final outcomes of the COPFS investigations were as I was no longer involved at the time those concluded.

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]

Erin Campbell

6 November 2023