Catherine Dyer Statement to Public Inquiry 18 March 2024

My full name is Catherine [redacted] Dyer.

My date of birth is [redacted] 1959.

My address is [redacted]

I have set out the 44 questions that I received from the Inquiry Team under the headings, as they were sent to me on 28 March 2024, and have provided my answers below each question for ease of reference.

I was also sent 15 documents which the Inquiry Team wished me to refer to in considering my answers.

I wish to be as helpful as I can to the Inquiry. I appreciate the gravity of the issues on which evidence is being taken by the Inquiry. However, as a preliminary observation, my evidence in respect of the Investigation is limited.

I did not contribute directly to the Investigation into the death of Sheku Bayoh and in this case, as in many others, I was not party to the detail of the investigation as it progressed between May 2015 and 3 April 2016, when I retired.

In early 2015 I had intimated, to the Lord Advocate and the Permanent Secretary to the Scottish Government (who was my Civil Service Line Manager), my intention to retire at the end of the 2015/16 financial year.

On Sunday 3 April 2016 I retired from COPFS. After that date I was not involved in any COPFS work and did not have access to any of the IT systems or casework.

I did not engage with PIRC in respect of this particular Investigation, or in discussions within Crown Office on the directions given by the Crown to PIRC.

I was not involved in any liaison with the family of Sheku Bayoh or discussion on how that was to be carried out.

I did not take part in deciding the strategy of this Investigation or any decision about proceedings by the Crown.

That is why I am not able to provide fuller information in respect of some of the questions asked by the Inquiry. I have answered below, to that effect, where that is the case.

Where information is known to me in response to any question I have, of course, provided that.

Role and experience

1. What was your position in COPFS during your involvement in COPFS' post incident management and investigation into the death of Sheku Bayoh ("the investigation")? How long had you been in this position prior to the date you became involved? What were your duties and responsibilities in this position?

As stated previously, I did not have direct involvement in this Investigation.

In May 2015 I was a solicitor of 30 years experience and held the combined offices of the Crown Agent and the Chief Executive of the Crown Office and Procurator Fiscal Service (COPFS), colloquially referred to simply as “the Crown Agent”. By then I had been the Crown Agent for just over 5 years, having taken up post in February 2010.

My duties and responsibilities as Crown Agent were wide ranging and varied greatly depending on the requirements of a demand led organisation.

COPFS is Scotland’s sole prosecution service, with responsibility for:

the prosecution of crime (including decisions on whether criminal prosecution is appropriate in individual cases)

the investigation of sudden, suspicious or unexplained deaths

the investigation of complaints of criminal conduct by police officers in the course of their duties

The Lord Advocate is head of the systems of criminal prosecution and investigation of deaths in Scotland as well as a member of the Scottish Government and is assisted in that work by the Solicitor General for Scotland. They are referred to as the Law Officers.

The Lord Advocate’s position as the independent head of the system of prosecution of crime and investigation of deaths in Scotland was preserved by the terms of the Scotland Act 1998, specifically sections 29(2) and 48(5).

The decisions about actions to take with regard to allegations of crime, and fatalities which require further explanation, are taken by the Lord Advocate or by the Solicitor General and the other prosecution lawyers, who work within COPFS, with authority and powers delegated to them in that respect by the Lord Advocate.

The lawyers I refer to above are Procurators Fiscal and their Deputes, solicitors or advocates who are permanently employed by COPFS or Advocate Deputes who are advocates or solicitor- advocates some of whom are not COPFS employees. Advocate Deputes are appointed directly by the Lord Advocate. Together with the Law Officers they are referred to as Crown Counsel.

The Crown Agent leads all the staff of COPFS to deliver the work of the Service in order to support the Lord Advocate in delivery of their duties.

In 2015 COPFS had around 1750 staff located in 49 offices across Scotland.

The Law Officers and Crown Agent are based in Edinburgh, in Crown Office which is the headquarters of the Service. The other lawyers are based at the Crown Office and around a network of local procurator fiscal offices across Scotland. They work with the administrative and other staff who support the delivery of casework and the IT and other infrastructure needed for a nationwide Service.

For brevity the Crown Agent role is often described as that of “principal legal advisor” to the Lord Advocate in respect of prosecution matters. That does not mean that the Crown Agent is aware of the detail of every case or provides detailed advice in respect of every case, although there may be times when they have input into the strategy of particularly complex cases. Clearly, however, given the hundreds of cases which proceed before Sheriffs and Juries or the High Court each year it is not possible for one person to be fully engaged in all of them at the preparation or presentation stage, which is why there is a structure with layers of staff in a hierarchy of expertise and responsibility. As described in the following paragraphs there are also myriad “prosecution matters” other than individual cases which fall within the description of the Crown Agent’s role in advising the Lord Advocate on such matters.

The Crown Agent assists the Lord Advocate to develop prosecution Policy and ensures that systems are in place for the staff of COPFS and Crown Counsel to follow practices that adhere to the Policies and deliver the prosecution outcomes they are designed to achieve.

The role often involves framing preparation of responses to Parliamentary questions and appearing before Parliamentary Committees to answer questions on COPFS work or about proposed legislation.

It also encompasses significant responsibilities as the Civil Service Head of the organisation, Head of Profession for the legal staff, with responsibility for overseeing delivery of all the public services carried out by COPFS and compliance with all statutory obligations that apply in respect of any business and employer and those which impose additional particular duties on public sector bodies.

As Accountable Officer for COPFS, the Crown Agent is directly accountable to the Scottish Parliament for the way in which the public money it has voted to the organisation, as the annual budget, is spent. The total budget that is allocated by the Scottish Parliament is to cover delivery of every aspect of prosecutorial investigation, prosecutorial decision making and action, and investigation in respect of fatalities which require further explanation.

The Crown Agent must be able to demonstrate that COPFS operates within the budget and meets all necessary financial and audit standards and must produce the Annual Accounts of COPFS which are laid before the Scottish Parliament.

The Crown Agent heads up a structure of lawyers and other staff working on the cases reported to COPFS and the many other pieces of work that are part of what COPFS carries out in association with delivery of the Service.

There is a network of lawyers and administrators, in roles of increasing expertise, headed up by staff in management and leadership roles supporting the Crown Agent who can delegate aspects of the role to appropriate staff.

The structure of the Service had changed in 2002 from the historical position where every case was reported to, and initially dealt with, by the Procurator Fiscal in the confines of their jurisdiction, which covered the boundaries of the Sheriff Court District in which their office was based. The size of office varied from those with a

single Procurator Fiscal and one or two administrative staff, to offices such as Glasgow with significant numbers of legal and administrative staff.

As the use of modern investigative and scientific methods in the investigation of crime increased exponentially, along with the emergence of increased need for specialism in preparation of cases for trial, that meant that the casework was better served by allocation to staff who had particular skill sets and expertise and were able to be called upon from a wider pool, rather than simply by location of incident. Six Area Procurator Fiscal posts were introduced to manage the work across the PF offices grouped within each of the six geographical Sheriffdoms. So single Procurator Fiscal offices were no longer expected to deal with every case which occurred in that locality and the cases could be allocated to the staff best equipped to deal with them at any office across the Area.

While the Area model was successful in improving workflows and ensuring staff with the most expertise were able to cover the relevant caseload, by the end of the decade there had been further change as it had become clear that even better outcomes could be achieved with a model which brigaded the six Areas into three geographical Federations, North, West and East each headed up by COPFS lawyers of the grade immediately below that of Crown Agent. The Crown Agent acted as their direct line manager. By 2015 a number of specialist units were then also located within the Specialist Casework Function, including the Scottish Fatalities Investigation Unit which was overseen by a Director of Specialist Casework also immediately below the grade of the Crown Agent.

In 2015 a further Change Programme was in the final stages of moving to a model based on staff working for periods of time to allow building up of further level of expertise in Functional teams which dealt exclusively with cases which were prepared and presented in local courts, the High Court or in some instances working on a specific crime type for example sexual crime, large scale fraud, Health and Safety crime and Environmental crime.

As Crown Agent I met weekly with all of the Federation Procurators Fiscal and Director of Serious Casework in what was termed as the meeting of the “Executive Team”. I also chaired the monthly Management Board which all attended, and which was later entitled the Executive Board. As well as the most senior COPFS post holders, that Board had non-Executive members who had been appointed by the Scottish Government via the Public Appointments process and by the Lord Advocate. The Minutes of the meetings are published on the COPFS website as are those of the Audit Committee with non- executive members, one of whom chaired it, and which I attended with other senior members of COPFS including the Deputy Chief Executive and Head of Finance. I also attended the COPFS Equalities Advisory Committee which had non- executive members and representatives of various organisations working for equalities and assisted us in scrutinising our Policies and discussing our practices in connection with casework and community engagement.

The Crown Agent is also a member of the Justice Board for Scotland, contributing to the achievement of the aims and objectives of the Justice Strategy for Scotland and working collaboratively with the other organisations in the Justice System, including the Scottish Courts and Tribunals Service, to deliver cross-cutting, criminal justice-wide reforms.

In addition, the Crown Agent also holds office ex officio as the King's and Lord Treasurer's Remembrancer, overseeing the claiming of Bona Vacantia and the operation of the Treasure Trove system in Scotland.

In 2015, in addition to work on the overall running of the Service, I worked extensively on the responses to the official complaints by some of the families of those who had died in the tragic incident in Glasgow in 2014, where a bin lorry driver had collapsed at the wheel and collided with a number of people, and the families of two young girls who had died in an earlier incident in 2010 involving a driver of a car who had collapsed and collided with them. There was, understandably, a great deal of comment on the decision of the Crown not to prosecute in both cases on the basis that in law there was insufficient evidence to support a prosecution. I was then also engaged in the preparation of the case for the Crown in respect of the subsequent application for a Private Prosecution by those families in 2016 until I retired on 3 April 2016.

2. When did you first become involved in the investigation? What were the circumstances in which you became involved?

As stated previously, I did not have direct involvement in this Investigation.

I first became aware of the Investigation in the days immediately following the 3 May but I cannot recall the exact date or time.

3. What do you understand to be COPFS' role in suspicious, non-suspicious and unexplained deaths in Scotland as at the date you became involved in the investigation? What do you understand COPFS duties and responsibilities to be in this regard?

As stated previously, I did not have direct involvement in this Investigation.

My understanding is that Lord Advocate has the sole authority to investigate any death which appears to be suspicious and might be subsequently identified as the result of criminal actions; and any death which is unexplained or appears to require further investigation to determine the cause of death. COPFS supports the Lord Advocate in the discharge of these functions.

Reports regarding Fatalities are received by the Crown from several sources including Police Scotland, General Practitioners, Hospital Doctors and some Specialist Reporting Agencies such as the Health and Safety Executive.

I understand the role to be providing instruction and guidance for Police Scotland, doctors and all other specialist reporting agencies (SRAs) to report all fatalities to COPFS where the cause of death had not been established; or it appeared that a crime had been committed or may have been committed; where suicide was

suspected; any death in, or where circumstances might indicate, a matter of concern which was not criminal in nature but " non-suspicious" where the evidence of what had happened might point to actions that would prevent similar deaths occurring in the future such as adjustment to a medical procedure or care, or product design, or where it was important to draw information to public attention in effort to prevent further deaths occurring in similar circumstances.

The guidance is extensive as there are many situations where a death must be reported to COPFS. The list where this applies is extensive -

Deaths in legal custody:

Any death of a person subject to legal custody. This includes (but is not restricted to) all persons:
detained in prison
arrested or detained in police offices
in the course of transportation to and from prisons, police offices or otherwise beyond custodial premises e.g. a prisoner who has been admitted to hospital or a prisoner on home leave

Unnatural cause of death:

Any death which cannot be entirely attributed to natural causes (whether the primary cause or a contributing factor) including:

- Suspicious deaths – i.e. where homicide cannot be ruled out
- Drug related deaths - including deaths due to adverse drug reactions reportable under the Medicines Healthcare Products Regulatory Agency (MHRA) (Yellow Card Scheme)
- Accidental deaths (including those resulting from falls)
- Deaths resulting from an accident in the course of employment
- Deaths of children from overlaying or suffocation
- Deaths where the circumstances indicate the possibility of suicide

Natural cause of death:

Deaths which may be due in whole or part to natural causes but occur in the following circumstances:

(a)Any death due to natural causes where the cause of death cannot be identified by a medical practitioner to the best of his or her knowledge and belief

(b)Deaths as a result of neglect/fault

Any death:

- which may be related to a suggestion of neglect (including self neglect) or exposure
- where there is an allegation or possibility of fault on the part of another person, body or organisation

(c)Deaths of children

Any death of a child:

which is a sudden, unexpected and unexplained perinatal death
where the body of a newborn is found
where the death may be categorised as a Sudden Unexpected Death in Infancy (SUDI)
which arises following a concealed pregnancy

Any death of a child or young person under the age of eighteen years who is 'looked after' by a local authority, including:

a child whose name is on the Child Protection Register
a child who is subject to a supervision requirement made by a Children's Hearing
a child who is subject to an order, authorisation or warrant made by a Court or Children's Hearing (e.g. a child being accommodated by a local authority in foster care, kinship care, residential accommodation or secure accommodation)
a child who is otherwise being accommodated by a local authority

(d)Deaths from notifiable industrial/infectious diseases

Any death:

due to a notifiable industrial disease or disease acquired as a consequence of the deceased's occupation in terms of column 1 of Part 1 of Schedule 3 to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 and which poses an acute and serious risk to public health due to either a Notifiable Infectious Disease or Organism in terms of Schedule 1 of the Public Heath (Scotland) Act 2008 any other infectious disease or syndrome,

(e)Deaths under medical or dental care

Any death:

the circumstances of which are the subject of concern to, or complaint by, the nearest relatives of the deceased about the medical treatment given to the deceased with a suggestion that the medical treatment may have contributed to the death of the patient.

the circumstances of which might indicate fault or neglect on the part of medical staff or where medical staff have concerns regarding the circumstances of death

the circumstances of which indicate that the failure of a piece of equipment may have caused or contributed to the death

the circumstances of which are likely to be subject to an Adverse Event Review (as defined by Healthcare Improvement Scotland)

where, at any time, a death certificate has been issued and a complaint is later received by a doctor or by the Health Board, which suggests that an act or omission by medical staff caused or contributed to the death

caused by the withdrawal of life sustaining treatment or other medical treatment to a patient in a permanent vegetative state (whether with or without the authority of the Court of Session).

which occurs in circumstances raising issues of public safety.

(f)Deaths while subject to compulsory treatment under mental health legislation

Any death of a person who was, at the time of death:

•detained or liable to be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or Part VI of the Criminal Procedure (Scotland) Act 1995; or

•subject to a community based compulsory treatment order or compulsion order under the above provisions.

(g)Any death not falling into any of the foregoing categories where the circumstances surrounding the death may cause public anxiety.

The role is to ensure that deaths which need further explanation are appropriately and promptly investigated. This includes all sudden, suspicious, unexpected and unexplained deaths and any deaths occurring in circumstances which give rise to serious public concern. The primary purpose of the investigation is to ascertain a cause of death, although there are a number of other aims of the investigation, including:

- To ensure any criminality is discovered and where appropriate, prosecuted;
- To allay public anxieties about particular deaths;
- To alert family members to any genetic causes of death, which may be avoidable; and
- To maintain accurate death statistics.

Information on the COPFS website advises that in 2014/15 just over 9000 fatality reports were received by COPFS.

Once a death has been reported, COPFS has legal responsibility for the deceased's body, until a cause of death has been established. This is often provided by the procurator fiscal accepting a certificate issued by a doctor certifying the cause of death. Such deaths are categorised as "routine deaths".

If the cause of death cannot be certified or if a cause of death is believed to be known, but there are other concerns surrounding the death, further investigation may be required, such as: a post-mortem examination, witness statements being obtained and liaison with nearest relatives and professionals. Such deaths are categorised as "deaths requiring investigation".

In 2014/15 there were 7179 deaths reported which required further investigation.

In certain circumstances, such as a death in custody, a Fatal Accident Inquiry must take place before a Sheriff who will hear the available evidence to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances. In other circumstances the Crown may instruct a Fatal Accident Inquiry.

4. Prior to the date that you became involved in the investigation, what experience did you have in investigations of deaths in police custody, or deaths during or following police contact? Please provide details and the outcomes of the cases? Was race a factor to investigate in any of these cases?

As stated previously, I did not have direct involvement in this Investigation.

From 1994 for some two years, I was a Principal Depute in the High Court Unit based in Crown Office. Part of the duties of the Head of the High Court Unit was to consider reports that were submitted for Crown Counsel consideration and instruction and I read a number of these to assist the Head of the High Court Unit. These would have included deaths in police or prison custody or deaths following police contact. I cannot recall race being a factor to investigate in any of these simply because of the passage of time but I certainly was aware that could present in any case as a possibility.

I was then appointed as the Head of the only specialist unit in COPFS dealing exclusively with fatalities reports which was based in Glasgow.

While in that post, I dealt personally with the case of the death of a young man following police contact.

There was no allegation of assault by police officers, but they had arrested him as a result of his behaviour in the street and suspected that he was under the influence of alcohol. As I recollect, they had processed him at the police station but then become concerned that he might be unwell and had taken him to hospital. There he became aggressive towards medical staff and was returned to the police station. He subsequently died from a head injury which it transpired he had sustained before contact with the police, but which had not been diagnosed given that he was removed from the hospital. The behaviours he had displayed are recognised as potential consequences of head injury but had not been so recognised by the police or medical staff. As I recall a Fatal Accident Inquiry was held. Race was not a factor in that case.

I also dealt with a case where two off-duty police officers from Strathclyde Police were socialising in a pub when a customer advised bar staff that there was a man in the toilets who was saying he intended to shoot someone and appeared to be in possession of a firearm. When the man emerged the off-duty officers observed what appeared to be a firearm in the waistband of his trousers and attempted to detain him. There was a struggle as they sought to remove the gun and the man fell to the floor as the officers restrained him. One officer was on top of the man's back trying to restrain his arms, as the other officer and members of the public took hold of the man's legs and attempted to get the gun. After a short time of continuing to struggle the man stopped moving. Resuscitation was attempted and ambulance called but the man died. As far as I can recollect the cause of death was positional asphyxia. As this was before the creation of Police Scotland the incident was investigated on behalf of COPFS by another police force. There was no evidence of criminality. A Fatal Accident took place. Race was not a factor in that case.

I have dealt with a case which was not which was not a death in police custody or following contact with the police but where race was a factor. It was a stabbing of a young Asian man. The case had started in the unit in the Glasgow office that dealt with High Court cases but was transferred to me, at the request of Crown Counsel, in what was then referred to as the Deaths Unit, (the Scottish Fatalities Investigation Unit (SFIU) is the national successor). I was asked to deal with it because there was complex medical evidence to investigate about infection that had not been detected while the young man was in hospital.

It was not considered by the pathologists conducting the postmortem that the stab wound itself was fatal, and indeed the young man had apparently been recovering well for some days before he collapsed and died while still in hospital. The infection was the principal cause of death. There was the issue of whether the infection could be considered part of the consequences of the assault or was an intervening matter which broke the chain of liability for the death. I fully investigated the case and as I recollect, I recommended that the case be prosecuted in the High Court as attempted murder and that is what happened, and the perpetrators were convicted. I was aware of the cultural and religious considerations for the family and dealt

personally with them to explain what had been investigated and the reason for the eventual prosecution decision.

5. Prior to your involvement in the investigation, what experience did you have in relation to family liaison in deaths cases? Was race a factor to consider in family liaison in any of these cases?

As stated previously, I did not have direct involvement in this Investigation.

I have many years experience in relation to family liaison in deaths cases.

All protected characteristics were factors to consider in relation to family liaison in all cases and race was in some.

Race and religion and associated cultural practices were factors to be considered in every relevant family liaison as soon as these were known.

6. What experience did you have in dealing with PIRC prior to the date that you became involved in the investigation?

As stated previously, I did not have direct involvement in this Investigation.

As Crown Agent I had regular routine meetings a few times a year with the Commissioner to ascertain if working relationships between the PIRC staff and COPFS staff were healthy and if there were any current issues with which I could assist. We did not discuss the detail of any cases.

I met with Professor John McNeil when he was Commissioner and I met with Kate Frame when she was Commissioner.

The Commissioner also had a standing invitation to meet with me at any time between our routine meetings if any particular matter arose that the Commissioner wished to discuss about any aspect of the working relationship or process issues between COPFS and PIRC.

7. What was your understanding of PIRC's role in the investigation?

As stated previously, I did not have direct involvement in this Investigation.

Prior to the creation of Police Scotland the Crown would have instructed the Chief Constable of a different Scottish Police Force to have carried out the investigation into any death in police custody to make sure the investigation was fair and impartial. The legislation creating PIRC set out that following the creation of Police Scotland the Crown would instead direct PIRC to carry out such investigations. PIRC's role was to investigate at the direction of the Crown in a similar way.

I understood that meant generally, that in every case in which the Crown directed PIRC to investigate, PIRC would interview witnesses and gather all relevant

evidence and report the result of the investigations to the Crown for decision as to any proceedings.

8. In your understanding was PIRC being directed to investigate Sheku Bayoh's death under section 33A(b)(i) or (ii) of the Police, Public Order and Criminal Justice (Scotland) Act 2006? What is the difference in COPFS' liaison with PIRC, if any between investigations being carried out under paragraph (i) compared to (ii) of this section?

My understanding, throughout the time from the death being reported until I retired, was that the full circumstances of the interactions between police officers and Sheku Bayoh, and an exact cause or causes of death were not initially clear and that further investigation by PIRC, along with any further investigations considered necessary by Crown Counsel, were ongoing to ascertain these.

I would expect that the outcome of the investigations would then be available to Crown Counsel to consider whether or not there was any criminal aspect to the actions of any police officer involved.

In my experience uncertainty as to which category a fatality case is ultimately going to be recorded in, is not an unusual occurrence in a number of the fatalities cases which are reported each year.

The purpose of the investigation instructed by COPFS includes attempting to ascertain whether suspicion of criminal actings contributing to the death can be established or fully ruled out. These cases can also take some considerable time to investigate.

My experience is that, regrettably, in a number of cases because of the contradictory nature of evidence available, or actual lack of evidence of some aspect, such certainty of categorisation can never be fully resolved.

In such cases the circumstances cannot absolutely be described as non – suspicious; but neither can they definitely be labelled as providing enough evidence for a criminal prosecution.

Criminal proceedings cannot be brought by the Crown where there is not a sufficiency of evidence that would allow a court to be addressed, from the outset, on the basis that there was evidence available to the Crown which would justify assertion that if believed, it would allow a Jury to find an accused guilty beyond reasonable doubt.

9. What is your understanding of COPFS' role in relation to PIRC's investigation? For example are COPFS supervising or directing?

My understanding of COPFS' role in relation to PIRC investigations is that COPFS directs PIRC.

The wording of section 33A of the statute in 2015 is clear that COPFS role is directing PIRC :

b)where directed to do so by the appropriate prosecutor—

(i)to investigate any circumstances in which there is an indication that a person serving with the police may have committed an offence;

(ii)to investigate, on behalf of the relevant procurator fiscal, the circumstances of any death involving a person serving with the police which that procurator fiscal is required to investigate under the Fatal Accidents and Sudden Deaths Inquiry Act (Scotland) Act 1976

The words “where directed” remained when the statute was amended by the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

However, I do not think that would preclude discussions between COPFS staff and PIRC staff about the best investigative approach to follow in certain circumstances.

I am not clear what the question is referring to when it refers to “supervising” and if it envisages something more than this?

10. What is normal practice for COPFS staff communicating decisions and instructions to PIRC? Please explain your involvement in this during the investigation.

As stated previously, I did not have direct involvement in this Investigation.

In my experience the normal practice for COPFS staff communicating decisions and instructions to PIRC could be by a variety of methods.

Communicating instructions and decisions to PIRC could entail telephone conversations, email exchanges and face to face or video meetings.

Depending on the nature of the exchange, and the importance of the decision or instruction, there could be follow up email correspondence or a formal Minute or other written instruction thereafter.

11. What is normal practice for COPFS staff answering questions from PIRC and advising them on their investigation? What, if any, involvement did you have in assisting PIRC with their questions and providing advice?

As stated previously, I did not have direct involvement in this Investigation.

In my experience there would be a variety of ways in which COPFS staff could answer questions from PIRC and advise them on their investigations.

That could entail telephone conversations, email exchanges and face to face or video meetings. Depending on the nature of the exchange, and the importance of the query, there could be follow up correspondence or a formal Minute or written instruction thereafter.

I did not personally carry out any work or provide any advice or instruction in respect of this Investigation.

I did not assist PIRC with any questions or provide PIRC with any advice in respect of it.

Family liaison

12. What is your understanding of COPFS' role in liaison with the deceased's family in deaths cases? How does COPFS role interact with the role of Police Scotland and PIRC in family liaison?

My understanding is that COPFS role is to support the deceased's family by advising of the stages in the processes that lead to decision making by COPFS and to provide information that can be given at various stages to family members.The nature of the information that can be made available can change at different stages and depending on whether or not family members are themselves witnesses in any proceedings.

The COPFS Victim Information and Advice Service (VIA) has staff specially trained in that regard who have undergone bereavement training.

The Police and PIRC have Family Liaison Officers who can support the family at the stages of an Investigation when they have involvement.

There is usually a handover between the staff carrying out similar roles when the case passes to the next organisation after the work done by each is completed to a sufficient degree. This to ensure that as the matter moves from Investigation by Police or PIRC to consideration of evidence they have gathered by COPFS the relevant organisation dealing with the matter at each stage, has a support person or team of people in place to deal with any queries the family may have and to ensure they are kept informed about decisions or the reason for the length of time that some investigations can take.

13. What involvement, if any, did you have in family liaison in the investigation?

As stated previously, I did not have direct involvement in this Investigation.

I did not have any involvement in family liaison in the investigation.

14. Insofar as not covered above, did you have any dealings with either of the Lord Advocates in office during the course of the investigation?

As stated previously, I did not have direct involvement in this Investigation.

I had almost daily dealings on multiple matters with Frances Mulholland who was the Lord Advocate in 2015 until I retired on 3 April 2016, but I do not think I had any significant dealings with him in respect of this Investigation although I was obviously aware that the Investigation was ongoing. That would not be unusual, as I have explained above. There was a very experienced team of lawyers dealing with the Investigation and as I understood it the investigative stage which PIRC was conducting at the direction of the Crown was still ongoing when I retired some 11 months from 3 May 2015.

I had no dealings with James Wolffe in that capacity as he became Lord Advocate after I retired.

15. Please read the email chain between you, Stephen McGowan and Mr John Logue dated 6 May 2015. In the minute to the Scottish Ministers set out in Mr Logue's email of 14.34, the Lord Advocate explains that it would be important to build and maintain the confidence of the deceased's family in the independence and thoroughness of the investigation. Do you agree with this? What was done to ensure that this was built and maintained throughout the investigation? Do you think COPFS were successful in achieving this? If not, what went wrong and what could have been done differently?

I do agree with that explanation given by the Lord Advocate in the minute.

As stated previously, I did not have direct involvement in this Investigation so I do not know what was done to build or maintain that throughout the Investigation and I do not know if anything went wrong or could have been done differently in that respect.

The Investigation

16. Please read the email the email chain between you and John Logue dated 3 September 2015 where you state *"Agree we don't get drawn in. I still think we should get PIRC to look at CAAP – I have discussed before and Les did a note agreeing that made sense* [redacted] *Can we talk re that on Monday?"* Why did you say " Agree we don't get drawn in". What did you mean by [redacted] Why were you of this view? What was discussed with Mr Logue on Monday,7 September 2015?

My words were with reference to the Investigation into the death of Colin Marr in 2005 [redacted] I was fully involved in that case until I retired and [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

As I recollect what I wanted to discuss with Mr Logue on Monday 7 September was the note I had seen from Les Brown Head of CAAPD as to whether PIRC should be directed to investigate the position of the actings of the police officers originally involved in 2005 in addition to all the previous investigations that had taken place since 2010.

17. Please see the invite to attend a meeting with the Lord Advocate on 14 March 2016 to discuss Sheku Bayoh. Did you attend this meeting? What was discussed at the meeting? Do you have notes from this meeting? Did you have any action points from this meeting?

I do not know if I attended this meeting. If I did, I cannot recall what was discussed.

I do not have notes from this meeting. As previously explained I do not have access to COPFS electronic or paper based filing systems following my retirement on 3 April 2016.

At meetings I had with the Lord Advocate on specific cases it was usual for his Private Secretary to take notes and for members of the team dealing with the case who were present to take notes.

If I did attend and did take notes, and they were of any consequence, I would have either handed them to my Personal Assistant to type up and she would then have emailed them to me, or I would have typed up the note for myself and a copy would be on the COPFS IT systems.

I do not know if I was tasked with any action from the meeting.

<u>The Health and Safety Executive ("HSE")</u>

18. What involvement, if any, did you have in liaison with HSE? Why did COPFS request their involvement? What benefit would HSE have provided to the Investigation?

As stated previously, I did not have direct involvement in this Investigation.

I did not have any involvement in liaison with HSE.

As I did not take part in deciding the strategy of investigation or any decision about proceedings by the Crown or involvement of other regulatory or investigative agencies, I do not know if or why COPFS requested the involvement of HSE or what benefit HSE would have provided to the Investigation.

European Convention on Human Rights ("ECHR")

19. During the Investigation, were you involved in discussing or otherwise considering COPFS' obligations under Articles 2 and 14 of the ECHR in respect of Sheku Bayoh and his family? If so what was your understanding of these obligations and how, if at all, did this affect your involvement in the Investigation?

As stated previously, I did not have direct involvement in this Investigation.

I was not advised as to the detail of it as it progressed between May 2015 and March 2016, when I retired.

I did not take part in deciding the strategy of investigation or any decision about proceedings by the Crown.

I was not involved in discussing or otherwise considering COPFS' obligations under ECHR in respect of Sheku Bayoh and his family.

Media Engagement

20. Were you following the media reporting of the matter? To what extent, if any, was your involvement in the Investigation influenced by what was reported in the media? Were you aware if any of your colleagues or the Investigation generally were influenced by what was reported in the media?

As stated previously, I did not have direct involvement in this Investigation.

I did see some of what was reported in the media in 2015 and until I retired on 3rd April 2016. I was not influenced by it.

I was not aware of any of my colleagues, or the Investigation generally being influenced by what was reported in the media while I was in post.

21. What involvement did you have, if any, in COPFS' media engagement? This may include discussing media lines with colleagues, liaison with the COPFS media department, direct contact with the media or providing information to colleagues dealing with the media?

As stated previously, I did not have direct involvement in this Investigation.

I had some specific engagement at many times throughout my term as Crown Agent and Chief Executive in respect of a numerous other matters. My recollection is that I did not have any involvement in respect of any aspect of this Investigation, including media engagement in respect of this Investigation.

22. Please read the email dated 24 June 2015 regarding sighting the Law Officers on the coverage of the Sheku Bayoh post mortem examination results in the Sun newspaper. This email was forwarded to you, why? What involvement did you have?

As a matter of routine, the Communications Team would forward messages of any anticipated or published media coverage to me. Such emails made me aware that it was being dealt with by senior staff who were involved with the case and, at times also the Law Officers, as it was in this case.

I did not have any other involvement.

23. Please read the email dated 24 June 2015 regarding the Law Officer's approval of proposed media response. This email was forwarded to you, why? What involvement did you have?

As a matter of routine all messages that the Communications Team considered I should be aware of regarding media coverage of any matter involving COPFS were forwarded to me.

I did not have any other involvement.

24. Please read the emails dated 4 September 2015, 16 October 2015 and 4 December 2015 regarding the media relations. Please explain the purpose of these emails. What was your role in dealing with such correspondence?

    As stated previously, I did not have direct involvement in this Investigation

    As explained above, at my answer to questions 22 and 23, I received emails from the Communications Team on media enquiries, and was copied into responses that had been issued, for information regardless of whether I was actually working personally on the particular case.

    Where I have contributed to the drafting or personal approval of media responses in any case, that would be recorded in email exchanges with colleagues and the private offices of the Lord Advocate and Solicitor General, as necessary, depending on who needed to authorise the wording or simply be advised by being copied into the response.

Parallel Investigation

25. Were you aware of an investigation into Sheku Bayoh's death being carried out on behalf of the SPF? Did you have any concerns about this? If so, what decisions and actions did you take?

As stated previously, I did not have direct involvement in this Investigation.

I was not aware of it until later correspondence received by the Lord Advocate was made known to me.

I took no decisions or actions in this respect.

26 [redacted]

Race

27. Insofar as not already covered, to what extent, if any, was Sheku Bayoh's race a factor in any of your decisions and actions outlined in this statement?

As stated previously, I did not have direct involvement in this Investigation.

28. Do you have any experience of racism being a factor to investigate for any reason in an investigation relating to: (i) a death in custody during or following police contact;(ii) a suspicious or unexplained death, or (iii) the actions of on-duty police officers. If so please provide details of the year(s) you were involved, how race was a factor, how you investigated the race aspects and the outcome.

Please see my reply at question 8 above.

29. Prior to your involvement in the Investigation, in your experience, did COPFS routinely consider race when dealing with a death in custody or death during or following police contact? Has that position changed between when you were involved in the Investigation and now?

As stated previously, I did not have direct involvement in this Investigation.

In my experience prior to 2015 and until I retired in April 2016, COPFS did routinely consider race when dealing with a death in custody or death during or following police contact.

I do not know if the position has changed now.

30. Please read page 57 of the Guide For Specialist Reporting Agencies dated 2006 which states "In cases where it appears that the deceased's family may have specific cultural or religious needs the death report and associated criminal report should clearly specify both their ethnic and religious background to ensure that liaison can take place in a manner which is sensitive to their cultural and religious needs". In your opinion do you think that the liaison with the family was conducted in a manner that was sensitive to their cultural and religious needs. Please explain why.

As stated previously, I did not have direct involvement in this Investigation.

I do not therefore know if the liaison with the family was conducted in a manner that was sensitive to their cultural and religious needs.

31. Page 54 of the Guide refers to the Stephen Lawrence Inquiry Report by Sir William McPherson. Had you read the report prior to your involvement in the Investigation? Is so what did you understand to be the issues? What did you understand to be the importance of race in issues raised? How did you apply any of these considerations and learning to your involvement in the Investigation?

As stated previously, I did not have direct involvement in this Investigation.

I had read the McPherson Report when it was published and on several other occasions, prior to 2015 and since.

I understand the issues to be that in that case, and others, there had been examples of overt racism by police officers dealing with the victims of crime and their families but also examples of unconscious bias which had caused assumptions to be made and actions to be taken or not taken by police officers which had led to the standard of investigation into the death of Stephen Lawrence, and the care and compassion owed to his family by a public service being less than it should have been and different from that which others might receive, because of their ethnicity - all of which amounts to discrimination.

That means that an organisation could be described as demonstrating institutional racism if it fails to take steps to ensure that the culture it promoted did not recognise and mitigate the effects of lack of cultural knowledge or care among the staff, to ensure that there is not discrimination leading to unfairness in the way a person

coming into contact with an organisation is treated as a result of their known, or perceived, ethnicity.

Training

32. At the time of your involvement in the Investigation, what training had you completed that was relevant for your role in the Investigation? Please provide details of the type of training and explain what you can recall from the session.

As stated previously, I did not have direct involvement in this Investigation.

33. Insofar as not already covered, what training had you completed at the time of your involvement in the investigation?

As stated previously, I did not have direct involvement in this Investigation.

35. Insofar as not already covered, what training had you completed by or during the time you were involved in the investigation in relation to equality and diversity issues? Which aspects of this training, if any, were applicable to your role?

As stated previously, I did not have direct involvement in this Investigation.

However, by May 2015 I had received extensive training in relation to equality and diversity issues.

I received training throughout the 1990s and have continued to attend relevant events and courses thereafter, including training provided by various public sector bodies and charities that I have worked with over the eight years since my retirement from COPFS in 2016. The latest training session I attended was provided by the Fair Justice System for Scotland in February this year

When I was Assistant Procurator Fiscal Procurator Fiscal for the COPFS Area of Glasgow & Strathkelvin in 2003, and also from December 2003 until May 2008 when I was Procurator Fiscal for that Area, I worked closely with the West of Scotland Racial Equality Council (WESREC) which was subsequently renamed the West of Scotland Regional Equality Council.

I was invited to attend all WESREC Executive Committee meetings as an observer throughout my time as Asistant Procurator Fiscal Procurator Fiscal Glasgow & Strathkelvin which provided me with further insights and the opportunity to learn from the equality and diversity expertise within WESREC.

The secondment of a WESREC representative, Bushra Iqbal, to the Glasgow office throughout my time there contributed to WESREC funding, but more importantly allowed me and my staff to obtain expert feedback from her on our prosecution approach to cases where it appeared that the victim – and in fatalities cases the deceased's family - might have specific cultural or religious needs arising from both their ethnic and religious background, to ensure that liaison took place in a manner which was sensitive to their cultural and religious needs. The continued success of the learning for us helped us to embed equalities and diversity in the work of the Glasgow office and that led to subsequent secondments from WESREC being taken forward by the three other COPFS Areas, Lanarkshire, Argyll & Clyde and Ayrshire. When COPFS moved to the structure of Areas being brigaded into Federations the Area of Glasgow & Strathkelvin and these other 3 together with Dumfries & Galloway became the Areas which constitute the West of Scotland Federation.

When I became Crown Agent and Chief Executive of COPFS I attended the COPFS Equality Advisory Group (EAG) which had COPFS staff and external members with special interest and expertise in each of the protected characteristics including race and religion and belief. The remit for the EAG was to review operational performance, delivery and practice and to consider corporate objectives and priorities across the quarterly meetings , reviewing practice in each Area, and sharing best practice. the Permanent Secretary to the Scottish Government appointed me as Diversity Champion for the Civil Service in Scotland and Chair of the Public Sector Employers Diversity Network to encourage the sharing of best practice in respect of all aspects of equalities and diversity across public sector organisations and to oversee the implementation of the requirement of the Equalities Act 2010 for all public sector employers to comply with the requirement to publish Equalities Outcome Progress Reports in 2015.

36 What if any training do you consider would have assisted you in your involvement in the investigation ? This may be training you have carried out since the investigation, training you are aware of but have not completed or training that is not as far as you are aware provided by COPFS.

As stated previously, I did not have direct involvement in this Investigation

37. What was your involvement in drafting the Crown Office and Procurator Fiscal Service Equalities Outcomes 2013 to 2017. Drafting the Crown Office "Outcomes Progress Report April 2015? During the investigation do you think that the equality outcomes were implemented.

I was involved in the drafting of both. I dealt personally with the Team who were gathering the Equality Outcomes data, set the requirements and chaired meetings at which we charted progress. I was involved in considering assessments of the impact of policies and actions implemented by COPFS. I revised the draft Reports, approved the final versions and authorised its publication.

As stated previously, I did not have direct involvement in this Investigation.

Accordingly, I do not know if the equality outcomes in the 2015 Report or the 2013 – 2017 Report were implemented during the Investigation into the circumstances surrounding the death of Sheku Bayoh.

Records

38. Is there a requirement for you to take contemporaneous notes or any other record of your involvement in an investigation? Is there a requirement to retain them are there any forms that you must complete in the course of the investigation for internal record keeping?

There are requirements in respect of interviews of witnesses. There are specific requirements to note Crown Counsel instructions and reasons for taking or not taking proceedings in criminal cases. Much of the communication between Procurator Fiscal staff and Crown Counsel takes place electronically and is captured in the electronic forms on the case record. Similarly with Fatalities Investigations. Also most directions or instructions to PIRC or the Police.

39. What records did you keep in relation to the investigation where are these retained and archived to what extent was your record-keeping consistent with normal practice, please confirm the basis for any departures from normal practice.
As stated previously, I did not have direct involvement in this Investigation.

I did not therefore keep any records in respect of it.

40. In your experience was this investigation lengthy? was it unduly lengthy? What is the reason for the length of time required for the case to be reported to Crown Counsel? Could anything have been done differently to reduce the length of time required from Sheku Bayoh's death date to first reporting in the case to Crown Counsel?

As stated previously, I did not have direct involvement in this Investigation.

This does appear to have been lengthy. As I indicated above in my response to question 8 that can occur for good reason in some cases.

I do not know if it was unduly lengthy. I do not know how long it took to report to Crown Counsel or if anything could have been done to reduce that time.

41. At what stage in the investigation if at all were you aware of the possibility that a

public inquiry would be commissioned to examine Sheku Bayoh's death and the Investigation? Was anything done or not done in light of this?

As stated previously, I did not have direct involvement in this Investigation.

When I retired, in 2016, I was not aware of the possibility that a public inquiry would be commissioned. I am not aware of anything done or not done by COPFS in light of this.

42. Insofar as not already covered, to what extent was your involvement, decisions and actions and investigation consistent with normal practice? If there were any deviations from normal practice, please explain your reasoning. In your view was race a factor in a departures from normal practice you have identified?

As stated previously, I did not have direct involvement in this Investigation.

I did not take any decisions, actions or investigation in that respect.

43. Insofar as not already covered, what significant difficulties or challenges did you encounter during your involvement in the investigation? Would any changes to practice or procedure would have assisted you in overcoming these difficulties or challenges? To what extent were these difficulties of challenges normal or expected in your role? To what extent was race a factor in these difficulties or challenges?

As stated previously, I did not have direct involvement in this Investigation.

44. What is your role, and more broadly COPFS role, in sharing the findings of the Investigation or PIRC's investigation with Police Scotland? Do you consider any of your finding in the course of the Investigation, or the findings of PIRC would be of assistance to Police Scotland if they were shared? Did you or, insofar as you are aware, any colleague share these findings with Police Scotland? What are your views on how the Police Scotland should be made aware of the findings of the PIRC and COPFS investigations?

As stated previously, I did not have direct involvement in this Investigation and have not had any role in COPFS since my retirement in April 2016. I do not know what the findings of the PIRC or COPFS investigations are or whether they should be shared with Police Scotland.

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

Catherine Dyer

18 March 2024