The Sheku Bayoh Public Inquiry

Witness Statement

Barry Baker

Taken by [redacted] by MS Teams on 8th August 2024

Witness details and employment history

1. My name is Barry Baker. My date of birth is [redacted] 1965.

2. I am the Head of Operations within the Investigation Division of HSE covering Scotland and the North East of England. I have been in this role for 8 years.

3. I joined HSE as a trainee in 1992. I worked as a regulatory inspector for 10 years until 2002. I was promoted to Principal Inspector in an operational policy unit, covering entertainments, leisure, consumer and commercial services. I did that for seven years and then moved back to manage a multi- disciplinary team based in Glasgow. I also did that for seven years and then I was promoted

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in 2016 to the Head of Operations for Field Operations Division, covering Scotland. My job changed in November 2023 when we reorganised and I'm now the Head of Operations for the Investigations Division, covering Scotland and the North East of England, which is what I do at the moment.

HSE's potential involvement and/or investigation into the death of Sheku Bayoh

4. I had previously covered Alistair McNab's position as Head of Operations between May and December 2014 when he was temporarily promoted, and then I reverted back to my substantive grade. I was appointed on promotion to become the Head of Operations in in 2016.

5. Prior to my promotion, my role was the Principal Inspector based in Glasgow. My remit was to manage the team of inspectors covering essentially the west and southwest of Scotland. When I moved to the Head of Operations role it became a Scotland-wide job. There are four Principal Inspectors in Scotland and I became responsible for all four of them. So anything that related to the work of those groups would fall under my remit.

6. I first became aware of the death of Sheku Bayoh around about the time of the incident. I would have become aware of it either through internal discussion or through the media. However, I did not become involved in the case until I took over from Alistair McNab as Head of Operations – Field Operations Division in May 2016.

7. I didn't become involved in the case in my capacity as Head of Operations until October 2016 when renewed contact came from Crown Office. They wrote to say that they'd been in discussion with Alistair and that they were raising it again. I think they wanted to discuss the issue and take it further.

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8. When I came into the role I was provided with a broad handover note that there were two or three cases of particular importance. In particular, the case of Sheku Bayoh and the M9 deaths. I wasn't given a specific handover for this case. There had also been the Glasgow bin-lorry deaths as well, so I think that the nature of those sort of things would be covered, but there wasn't an in depth briefing about Sheku Bayoh because at that point I don't think we were directly involved. I don't have a copy of this handover note to provide to the Inquiry.

9. I am asked what immediate action I took when I received the renewed contact from the Crown Office. From memory, it's a while ago now, but I believe I reviewed the information we had which was primarily the letter from Alistair McNab to the Crown Office.

10. I think we'd basically got in touch with the Crown Office and said: "Well, you know, if you do want to discuss it, we're happy to do so." And we would take it from there. I think the discussion was primarily around the PIRC report, possibly that it was completed or it was near completion. I think COPFS wanted to see if any of the information within that would have changed our decision not to investigate.

Procedure: initial inquiries

11. I am asked to explain how initial inquiries with HSE begin. I am asked how we receive them and what happens after receipt. We will get information about, in this case, the fatality. It can come in from the police, or it could come in from Crown Office, or it could be brought to our attention by the media. We may have enough information to make a decision to investigate or we may not have enough information. When I say that, I mean the decision not to investigate under the HSWA. In which case, what we might do is make further enquiries with the police, if Police Scotland were the ones that contacted us, or with

Crown Office or with the duty holder themselves to say we've received information about an incident, and we'd like to know a little bit more.

12. Further enquiries could be made by a member of the admin team. It could be done by a Visiting Officer - who sit just underneath the main grade inspectors - an inspector, or indeed, a Principal Inspector and that would be to gather enough information to make a decision on whether to investigate or not investigate the incident -whatever that might be.

13. Further enquiries are generally to gather additional information to allow a decision to be made as to whether an incident meets our incident selection criteria for investigation, or whether it meets our policy on investigation of incidents covered by Section 3 of the Health and Safety at Work etc. Act. Further enquiries could involve contacting a duty holder, such as an employer by email, phone or by a site visit to gather additional information about a particular incident. We could be enquiring about the extent of any injuries to an employee, or asking COPFS and the police whether they have any additional information that they can provide. In relation to a death in custody or death following police contact further enquiries could include gathering information from the police around the circumstances of the incident to allow us to consider the application of our policy on investigating incidents that fall under the HSWA Section 3 and it might also be to confirm with the PIRC whether they were investigating. I am asked whether HSE simply rely on information brought to them by the duty holder, Crown, Police Scotland or otherwise, or if HSE supplement that information by carrying out their own inquiries. It depends on the circumstances, for example on how much information is already available, and whether the decision maker, normally a Principal Inspector, considered that this was enough to decide whether to select an incident for investigation or not. For example, an incident might clearly meet the selection criteria to be

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investigated because of the severity of the injuries, or the extent of the injuries may not be known.

14. I am asked whether, in the process of deciding whether HSE investigate a case, we seek the opinion of independent experts to support decision making. I think it very much depends on the circumstances. There are cases which are very straightforward and there are some where they require specialisation. We might get documentation that would require a specialist to look at it and it's about making that decision, that bridge between initial inquiries where we're trying to establish for example if we're the correct enforcing authority, or if it meets our policy for investigation. It might take quite a time to do that, and then we would make that decision when we have enough information. We then make the decision of whether we're proceeding to full investigation or not, or whether we've got enough and we're actually closing our inquiry at that stage. So it can be quite simple or it could be quite complicated, depending on the circumstances.

15. I have been asked if HSE considered the decision about the incident involving Sheku Bayoh to have been simple or complicated. I think the initial decision in 2015 would have been relatively simple because it followed the guidance in the Memorandum of Understanding PIRC-04624 that the PIRC should investigate the incident. There was more information available in 2016 to consider and to that extent it was more complicated, but I came to the same conclusion not to investigate.

16. It is within HSE's powers to bring in independent experts should they need it. HSE have in-house specialists and we can also call external specialists. For example, if it was something that we had no specialism in within HSE, we would seek somebody who could offer that opinion.

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17. I am asked to provide details of the in-house specialists that HSE have at their disposal. It's essentially occupational risk management specialisms. For example, we have mechanical specialists, civil specialists, electrical specialists, human factors specialists, process safety specialists. I think we've also got some marine specialists. We've got a wide range of occupational risk management specialisms. All of those specialists have links to other specialists. There's quite a range, but they are focused on occupational health and safety.

Procedure: investigation

18. I am asked to explain what it would have looked like had Sheku's death resulted in a HSE investigation. Once the decision to investigate is made, it's normally allocated by the Principal Inspector to an inspector.

19. That'll be logged in our system and a case will be opened. We will then follow the investigation procedure (contained within HSE-00007) and the inspector will start the process of statement taking visits. Any assessment of documentation that's required will be carried out under regular review of the principal inspector. We just move it through the stages of justifying why is this investigation continuing? What are the lines of inquiry? We would also need to get to a point where we've dealt with any ongoing risk, which are risks that could be continuing after the incident, for example from poorly maintained equipment, hazardous levels of toxic or dangerous substance that require action to control any risks. We work to have identified the immediate and underlying causes of an incident, for example where the immediate cause of an incident was a failure of equipment and the underlying cause was a lack of an effective maintenance regime. We would have applied HSE's Enforcement Management Model, which is referred to as document HSE-00017 to get an idea on whether there's a risk gap and that gives us a better feel for the likely enforcement action that we may or may not need to take. The HSE's

Enforcement Management Model (HSE-00017) helps us to consider where a duty holder should be in terms of managing a particular risk and where they actually are in practice, and if there is a difference we describe that as the risk gap.

20. I am asked whether HSE have powers to bring in independent experts during the investigation stage. Yes. Whether you bring on any additional opinions depends on the sufficiency of evidence before HSE.

Timescales and reporting of incidents to HSE

21. It is noted to me that under RIDDOR reporting obligations that the duty holder *should* file a report on an incident within 10 days of the incident taking place. I am asked whether that timeline is adhered to in practice. It does vary. For most, there is a legal duty, so most people stick to it.

22. Sometimes it's not clear whether something's reportable or not, so then they may wait for medical reports or further information. So it's possible it can go beyond that time period.

23. Generally, for fatalities, that's not the primary way that we would find out about a death. I think it's rare for it not to be reported to us either by Crown Office or normally by the police.

24. I have been asked how long it would generally take the police and or Crown Office to report a fatality to us. Normally we would hear about a work place fatality from the police on the day it has happened or very shortly afterwards because they will have attended the scene as part of the emergency response. In some cases Crown Office may provide us with information about a death that we may not have been aware of, for example when a death has not been reported under RIDDOR, but it has been reported to them by the police. This

is normally, although not always, shortly after the Crown has become aware of the death.

25. I have been asked if there are any regulations or laws that require the police or Crown to report an incident to HSE. There is no legal requirement on the police or COPFS to report an incident to HSE, unless the incident involved one of their own employees and they require to report under RIDDOR.

26. I am asked about the situation where HSE had heard about a fatality that they felt should be reported to them in the first instance, but a significant period of time has passed and no reports have been made. I am asked whether HSE would chase this up. I think we would make inquiries, if we thought there had been an incident that hadn't been reported to us to establish whether it should have been reported. We would want to know what was happening. It's not a case that if we don't receive a RIDDOR that the incident doesn't exist. We would always act on the information that we were aware of.

27. It is noted that I became aware of Sheku's death quite soon after the incident, however that incident was not reported to HSE until 1st June 2015. I am asked whether attempts were made to get in contact with Police Scotland when it became clear that more than 10 days had passed since the incident. I wouldn't have been involved in that because at that point I was simply covering the West of Scotland in my role as a Principal Inspector based in Glasgow. In general, as a notification of the incident, we wouldn't have needed the RIDDOR report because we already knew that there had been the death.

28. I am asked if I am aware why it took so long for the police to report Sheku's death to HSE. The police are required to give formal notification of a death to HSE where it is reportable under RIDDOR. They may have been waiting to see what the results of see the post mortem or further enquiries were. So a month

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may have been a quite legitimate period where they were still deciding on what action they would need to take. I think that's probably really a matter for the police to explain their thought process in that period before they finally committed to submitting it.

29. I am asked how long HSE have to make the decision not to investigate after the RIDDOR report is submitted. There is an investigation procedure which stipulates we should take action within five days of receiving a RIDDOR or when we have enough information to decide whether to investigate. I can't remember exactly the procedure, but it's laid down in terms of once we get documentation provided to us. There's an expectation that decisions will be made and will flow from that. We may have already decided to do something by the time we get a RIDDOR or we may have had prior knowledge of it. But in terms of the formal mechanism, it does sit within the overall investigation procedure and a decision to investigate should be made within the timeline laid out within our investigation procedure.

30. I am asked to consider a situation where the case is more complicated than anticipated. I am asked if there is an upper time limit, beyond five days of receipt of the RIDDOR report, placed upon HSE within which they must investigate. I think there's always a chance that for workload purposes or resourcing, that something might take longer. The important thing is you record the decision-making process, so if we've had a RIDDOR or a complaint or concern and we haven't acted on it, there should be a record of it. This is to show what we were doing, to explain that we had, for example 10 RIDDOR reports at that point. So what we did was we allocated them and a particular case took a little bit longer to get to. There's nothing in law that says we must do something by such and such a date. It's more about making sure we control the progress and pace of investigations.

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31. I am given the situation where a case proceeds to investigation and HSE are working towards a conclusion. I am asked whether any time limits exist in reaching a conclusion on that case. Our internal metric is that we will endeavour to complete fatality investigations within 12 months of receiving primacy from the police and complete non-fatality investigations within 12 months of the incident. We endeavour to complete within 12 months of receiving notification. I think that's an internal KPI.

32. I am asked whether there are any regulatory bodies that oversee HSE's work and its adherence to procedures and time limits. We are an agency of DWP so obviously we are reviewed but not in the same way that Inspector of Constabulary or Inspector for Prisons oversees the police and prison services. However, it's primarily internal review.

33. We obviously work with Crown Office, so they would be keen to ensure that the cases are progressed if they're heading towards prosecution. But other than that, I think we are responsible for progressing them.

34. We are ultimately open to either complaints to the Ombudsman or at Judicial Review, if somebody felt that we weren't investigating an incident where we should have been, or we were taking far too long to investigate a particular incident.

Decision making: accountability and adequate resources

35. I am asked whether HSE have a legal team that they can go to on matters where they require expertise on the application of the law. There are different operations of HSE in England and Wales to Scotland. In England and Wales, HSE is a prosecuting authority in its own right, so it has a team of enforcement lawyers. Back in 2015, HSE was using mainly solicitor agents to prosecute cases in England and Wales It's now moved to primarily prosecuting its own

cases with its own lawyers. So there always was a facility if we wanted access to legal advice.

36. In Scotland, if we wanted advice about the application of a particular piece of legislation, or how guidance on the application of a piece of legislation, then we could go to HSE's Legal Services Division, and ask for clarification on its application in Scotland. I think we would also be able to go to the Crown Office and say: "This is how far we've got with this investigation" because we do have a good working relationship with Crown. They've got a specialist health and safety unit, so rather than try and double guess it, we may go to Crown and say: "Well, this is the situation, this is the issue we have about the application of the law to the circumstances. Do you have a view on this in terms of how you like us to proceed or what sort of evidence would you need for this?"

37. We've got a two-tiered approach where we can seek advice from HSE; we can seek limited advice from Crown; and HSE itself can go to wider UK government lawyers. It's got the facility to go to the Government Legal Department for example if there is a question about the application of the law in a particular situation, which we have done in the past.

Resources of HSE, PIRC and Police Scotland

38. I am referred to Work-related deaths – protocol for liaison document (HSE-00006) where it states:

"The Procurator Fiscal has no authority to issue instructions to HSE or other investigating authorities other than the police, as these have their own investigatory needs, but will assist the Procurator Fiscal and police where they have the skills, competencies and resources to do so."

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I am asked whether I felt that HSE had the skills, competencies and resources to assist COPFS and Police Scotland as at 3rd May 2015. I'm confident we would have had the skills, competencies and resources to investigate to the extent of the risk management parts. However, we've not got any experience in restraint so we would have reached a point, where we would have established as far as we were able what had happened.

39. I think we would have had to do what the PIRC did and seek external expert evidence about the context of the restraint, as we don't have the experience to make that type of value judgement.

40. I am asked if HSE have acquired experience and knowledge on restraint since 2015. We would need to seek expert external advice on restraint should it arise in a case now.

41. I am asked how many people would have been resourced to the case, or cases of this type, as at 3rd May 2015. I am further asked to reflect on whether the resourcing would be the same now. As a general rule of thumb, we are geographically located, so it would have fallen to the Edinburgh office. A fatality would normally be allocated to an inspector under the management of the Principal Inspector and then what we do next would depend on whether there were additional resources brought in. Many fatalities are investigated by one inspector with the assistance of a number of specialists.

42. I am asked to clarify the structure of the team allocated to a fatality case. The team allocated to a fatality case would be Head of Operations, a principal inspector and an inspector. You have visiting officers who are limited warrant holders who can take statements in certain circumstances, gather and authenticate documentation, and assist with that type of stuff. We also have

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trainee inspectors who are warranted inspectors so they can also do that. That's essentially the management span.

43. I have been asked what the allocation of resource was in this case. As the incident was not investigated by HSE there was no allocation of resource in the way that I have described above.

44. I have been asked, as at today's date, whether HSE is adequately resourced and if another investigation of this kind was to come to HSE whether I feel it would be adequately resourced to investigate it. At this date my teams in Scotland have over 20 ongoing investigations into fatal incidents. HSE does face pressures on resources, but we will manage our them to ensure that investigations of fatalities and serious incidents is done as effectively as possible.

45. I am asked whether I had any views on the suitability of PIRC to carry out the investigation as at 3rd May 2015. No, PIRC are the body that are set up to do that work. We wouldn't want to double guess the activities of another regulator.

Criteria for investigation

46. I am shown HSE's Position Statement (SBPI-00647) and referred to 8A. I am asked to elaborate further on the decision making in this case. In particular, I am asked to elaborate on the 'interest of justice' test and the use of the striking the balance policy document (HSE-00016) when deciding whether to investigate cases. To one extent the striking a balance policy is one that links into Section 3 of the Health and Safety at Work etc Act. There's also the consideration of whether another body is more appropriate to deal with an incident. You have the Memorandum of Understanding with PIRC, which makes it clear that PIRC would normally lead on the initial investigation. You would follow that through and say well, that's the MOU and there is guidance

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on how we respond. We would ask ourselves the question: So has HSE met that guidance for responding, both the guidance in the MOU with the PIRC and the guidance around HSWA S3. And if it's not for HSE, because it goes to PIRC and Crown in the first instance, we would, I think, make that decision that we would not investigate at that point.

47. If PIRC were to come back or Crown was to come back and say, well, here's the results of the investigation, we think now it would meet the criteria for investigation, we would reconsider. I think then at that point the striking the balance policy (HSE-00016) would be part of the way that we would investigate it. We would be looking at the criteria and how they had managed the occupational risk management parts of any intervention. I think striking the balance makes it quite clear there are areas that we wouldn't get involved in and there are areas we would, so it wouldn't form part of the initial decision on whether to investigate or not. But were we to move to it, that's the sort of guidance that we would be using to implement as part of the investigation.

48. I am asked to consider a letter from Alistair McNab, HSE, to Stephen McGowan, COPFS, dated 31st March 2016 (COPFS-01954). I am drawn to page 2 where Alistair discusses criterion (c) from the paragraph 9 FOD guidance (HSE-00002) in considering whether to investigate. I am asked why the post-mortem result, which couldn't exclude restraint as a contributory factor to death, wouldn't suffice to meet this criterion. I think the cause of death is twofold, you have the activity which is the restraint, and you have the condition which is the drugs intoxication. I think taking it back to the Memorandum of Understanding with PIRC PIRC-04624 our view, and it is perhaps not fully articulated in detail in the letter (COPFS-01954), is that the MOU would say that PIRC were investigating this incident. If they came back and said that there looks to have been a breach of health and safety legislation here, for whatever reasons, for example if the police had not managed training or supervision in

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relation to the death, we might then think that this is something more than PIRC can look at and that would form part of the decision making. Restraint was a factor identified in the death but there was insufficient evidence at that time that is was as a result of the factors in HSE-00002 that would have indicated HSE should investigate. In our view, PIRC were best placed to investigate to determine how the restraint was carried out, which is consistent is with the MOU and our policy, HSE-00002. Alistair did confirm that we would consider any further information that was provided to us as the investigation progressed.

49. I have been asked if the criteria for investigation have changed since 3rd May 2015. The Incident Selection Criteria has not changed since then and the current version is dated 2014 and our policy, HSE-00002, on enforcing Section 3 of HSWA has not changed since May 2015.

HSE's initial decision not to investigate

50. It is put to me that HSE made an initial view on whether they intended to investigate or not prior to issuing their initial decision. I am told that this view may have been given without sight of the underlying evidence. I am asked if this is common practice. I think, for example, a decision could be made that an incident should go to PIRC because we apply the MOU PIRC-04624, between HSE and the PIRC and that's the extent of initial enquiries. There's not really any debate, it will go to them and that'll be that.

51. In other cases, for example, we do frequently get reports from Crown Office in relation to deaths that aren't reportable to us. Completed suicide in mental health facilities being one example and we would make a decision that is based on the initial information and sometimes that is enough for us to consider that it does or doesn't meet our criteria for investigation. We won't make any more enquiries and that would be the extent of it. Initial enquiries can be just the assessment of what we've been told and applying a specific policy or guidance

document to it and making that decision. Or it might be that there isn't a specific policy or guidance document that allows you to use it to make that decision. Initial enquiries are then about trying to place the incident in the context of whether it is an incident that HSE should have a role in investigating. That means considering what and when we do those enquiries, and they might take some time to carry out before we can decide on an investigation or not.

52. I am asked about the initial decision not to investigate. I am asked if I am aware of whether Alistair, who carried out the initial decision, referred the case, or elements of it, to HSE's operational policy team. I am further asked if I am aware of whether Alistair had any assistance in making then initial decision. The official decision was relatively straightforward from what I can see. It was that PIRC would be leading the investigation and the HSE would not be involved. I think that would have been a fairly straightforward decision based on the Memorandum of Understanding that we have with PIRC which is referred to as PIRC-04624. So I don't think it would have required a degree of further interaction with colleagues.

53. I am referred to a Guidance for FOD (HSE-00002). It is put to me in a letter (COPFS-04978(a)) that Crown explained that whilst there was police training on single office restraint as at 2015, there was no training on multiple officer restraint. In reference to this statement, I am asked to consider HSE-00002 page 2 at criterion 9(c) where it states that:

"(c) a clear and likely causal link has been established between a failure to achieve those expected standards and the resulting harm (it may be appropriate to wait for a post mortem to confirm causality); and"

I am drawn to phrase "a failure to achieve those expected standards" and I am

asked how HSE would assess a case against this criterion where no standard existed for training.

One of the things that might be the case is that there might be standards that aren't occupational risk management standards, so again PIRC were already investigating the training in relation to the restraint. I think they've got to the point where they had been using specialists, so if there's no standard, it's possible you would have to go back to first principles. First principles in such a case would be to try to establish if what had been done adequately controlled risk or not, and that is where you might require a specialist or expert opinion. I think that's a decision to be made about whether we decide actually there are no occupational risk management standards here. There are other standards, but they may relate to practical policing or in other cases, for example to matters of clinical judgement, so it depends whether it's a complete blank slate or whether there are actually policies and procedures in place that that may not be considered to be specifically about occupational risk management. You make that decision of either: there are occupational risk management standards that apply; or it's in that occupational risk management space, by which I mean there may be guidance that is not primarily a health and safety or occupational risk management standard but does provide some guidance to a duty holder on controlling risks. It's a first principle thing where there is nothing that actually says on a bit of paper what the standard is. This is what we do in cases without specific health and safety standards or guidance.

54. I think the decision had been made at this point that PIRC were the most appropriate body to be reviewing the way the training was carried out and implemented. I think Alistair's view in the letter (COPFS-01954) was that PIRC were already engaged in that. We think they are the most appropriate people to continue with that. If they come back with any significant concerns, then it's something we can look at again.

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55. I am shown the document, Guidance for FOD (HSE-00002). It is highlighted that there is a difference between the wording used in criterion 9(c) of FOD Guidance and the wording that I use in reference to that section in my letter to Les Brown, COPFS, dated 24th January 2017 (COPFS-04735(a)). Respectively, the wording used:

"(c) a clear and likely causal link has been established between a failure to achieve those expected standards and the resulting harm (it may be appropriate to wait for a post mortem to confirm causality);"

and my application of that criterion in my letter

"*A direct and causal link between the death and the use of CS/PAVA spray and/or the restraint has been established beyond reasonable doubt, and"*

I am asked if there is a reason that the wording varied between the two. I am further asked if, therefore, it is possible that there was an application of a different, higher standard of proof.

The decision making was still the same. I think it would have been more helpful to mention a clear and likely causal link right the way through. There was no change in the application of the test.

56. I am again asked about the variation of wording, this time in relation to the use of the standard of proof 'beyond reasonable doubt'. It is put to me that this standard does not feature in the FOD Guidance. I am asked why this is the case and to explain my use of this standard. I think it would have been more helpful just to use the same wording and be consistent throughout and see a clear and likely causal link.

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57. I think the only reason for referring to reasonable doubt is that that's the standard that we work to. It's not referred to specifically in the FOD guidance, I don't think. But I think I was trying to maybe make the distinction between balance of probabilities and beyond reasonable doubt. We always work to criminal standard of proof because we're a regulating and enforcing agency.

58. I am referred to HSE-00002 at paragraph 12 which states:

"FOD does not investigate incidents to members of the public that are connected to the level of service provided by public authorities, such as the emergency services, carrying out their functions. This includes protecting or rescuing people from risks that do not arise directly from the public authorities' undertaking. However, FOD may be properly involved in these incidents if there is evidence that the public authority introduced another risk to an emergency situation; or through their actions, exacerbated ongoing risks and this caused death to members of the public (or the injuries are so serious that death might have resulted)."

I am asked if the correct interpretation of this guidance is that Sheku's case could have been investigated under paragraph 12 due to the death occurring.

No, I think this applies more to say where the actions of an emergency service themselves create a risk. So I think, for example, if the fire brigade were trying to rescue somebody from a building and they hadn't maintained some of their equipment and it collapsed during the rescue operation, that would have introduced a new risk. We're not saying that the actual rescue attempt is the issue here. It's that they used out-of-date, damaged or improperly installed equipment. So it's more the activity of the emergency situation that involves that type of additional risk. There wasn't that risk before you started. You introduced it and that caused an incident. That's the sort of thing we've been

investigating, not the position of where you have this work activity that is taking place. I think that's not what that paragraph is designed to cover.

59. It is put to me that Crown stated that there was only police training in place for single officer restraint, not the multiple officer restraint which took place. I am asked if it would be possible that the lack of training on multiple officer restraint would equate to introducing a new risk where otherwise ordinary duties were being performed under paragraph 12 of HSE-00002. I don't think so because I think then you go back to the primary activity which is the restraint that was taking place and apply paragraph 9 of this policy and the criteria that require to be met for an investigation to take place which I think is the most relevant part of our policy in this case.

60. I am referred to paragraph 14 and 15 of the same document. I am drawn to the section which states that:

"14. … A Head of Operations can decide not to investigate a non-RIDDOR incident if they do not have adequate resources available within the Unit."

I am asked whether I considered this section at all when reviewing the decision not to investigate. No, I didn't consider this section.

61. I am drawn to paragraph 15 of the same document, where it states that:

"15. This decision should be recorded on COIN for both RIDDOR reportable incidents and for those non-RIDDOR reportable incidents that meet the criteria in paragraph 9a-d."

I am asked if HSE have a copy of the decision which was recorded on COIN. I couldn't find a copy on COIN, so no.

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62. I am referred to paragraph 16 and 18 of the same document (HSE-00002), where it states:

"16. It is HSE's policy that investigations are kept under regular review by Principal Inspectors. Investigations involving members of the public will only be continued if the emerging evidence suggests that one or more of the circumstances described in section 16 of the Enforcement Police Statement (EPS) apply. Examples include, but are not limited to: reckless disregard of health and safety requirements; repeated breaches which give rise to significant risk, or persistent and significant poor compliance; and where the dutyholder's standard of managing health and safety is found to be far below what is required by health and safety law and to be giving rise to significant risk.

…

18. Once a decision not to investigate, or to curtail an investigation, has been made, FOD will only reconsider this decision if substantive new information becomes available."

I am asked whether I consider these sections in my review of the decision at all. Really, that is more to do with an investigation that's ongoing. I think in this case we never got to that stage, so this isn't something that we would have reviewed.

Review of decision not to investigate

63. I am asked to confirm that I carried out the review of the initial decision not to investigate. Yes.

64. I am asked whether had I been in Alistair McNab's role in 2015 whether I would have done anything differently. No, I think having reviewed it, Alistair's decision

Signature of Witness…..[redacted]……..

was one that I agreed with it. It seemed relatively straightforward. Although dealing with a really horrible incident, the actual decision seemed to be fairly straightforward.

65. I am asked whether I had any support in reviewing the initial decision not to investigate. It was essentially myself. We have a series of operational policy units. There is one that deals with police and I think I had a couple of conversations by phone with them, but primarily it was my decision. I mean basically the decision tends to fall on the regulators who are dealing with whatever the particular incident is, and that would have been myself in this instance. We do have a legal services division, we do have operational policy colleagues, so if there was a particular aspect of a decision where the guidance wasn't clear or it needed clarification, you could go to them. But if it was fairly straightforward or aligned with the published guidance, you could make that decision on your own.

66. I am referred to a letter that I wrote to Stephen McGowan, COPFS, on 17th November 2016 (COPFS-01955). I referred to a section within the first paragraph which states:

"I have discussed these cases with HSE senior managers and colleagues in our operational policy sector, and also reviewed the information that we had already received."

I am asked to whom I am referring when I say "senior managers and colleagues in operational policy sector". I would have discussed this with the Director of Scotland. I reported at the time to the Director of Scotland so they obviously have the overview for all the cases in Scotland and the North East of England. I would have been letting them know what we were, what I was doing, and what the decision making was. I think I said I'd spoken to colleagues

in our operational policy sector about it. So this is a small group who deal with current police and other emergency services nationally. That's who they would have been.

67. I am asked who the Director for Scotland and the North East would have been as at the date of the letter. That would have been Mike Cross.

68. I am referred again to the first paragraph of this letter (COPFS-01955) which states:

"*I have discussed these cases with HSE senior managers and colleagues in our operational policy sector, and also reviewed the information that we had already received"*

I am asked if I can recall the information that I had reviewed prior to this letter. I think that would only have been Information that Alistair had and communicated back. I don't think at that point we had had anything other than the letters from Crown and I think the confirmation from PIRC that they were leading on it. I don't think there was anything at that stage further than that.

69. I am drawn to paragraph 2 within the same letter (COPFS-01955):

"In the case of Sheku Bayoh, we would only consider investigation if there was compelling evidence that the method of restraint used by officers caused his death and that there are no plausible, conflicting explanations."

I am asked to explain where this wording and application of the test came from. I think this is an attempt by me to explain how the Section 3 HSWA policy works. I'm obviously going back eight years to try and remember exactly what I was trying to say, but I think what we're saying was that the evidence would need to meet the test in the Section 3 guidance, referred to as HSE-00002,

and it would need to clearly meet the test. I think I go on and the point I'm trying to make is that if there were non-causal issues that wouldn't necessarily of itself be enough for us to investigate. Instead, what we might want to do is to seek improvement.

70. From memory, I think the gist of what I was trying to get over was that it would need to be firmly within our policies for HSE to investigate. If it was non-causal, it was more likely we would be looking to improve things than to report to COPFS.

71. I am asked to elaborate on what "compelling evidence" could have been in this case. To begin to investigate it, for HSE, there would need to be evidence that there were systemic failures by Police Scotland in the way that they had approached the management of officer restraint. That is the sort of test, in terms of the MOU, referred to as PIRC-04624 and of our section 3 policy, that we would be looking for. For HSE to consider investigation, there would have to be evidence here that links the activities of Police Scotland and/or the officers directly to it. I think at that point, we would review our Section 3 policy to see whether that brought it into scope or not.

72. I am asked whether, at the point of reviewing the decision, I considered the final post-mortem result. I saw information later on when Crown provided some of the PIRC report to me. I don't believe I ever saw the full post-mortem. I think probably all we got was the summary. I certainly don't remember seeing the full post-mortem.

73. I am asked whether the summary I saw was that of the final post-mortem. I think it's only that final sentence where it talks about the intoxication and the restraint.

Signature of Witness…… [redacted] ……..

74. I am asked why this was not considered compelling, especially where they mention the restraint. You have the condition and you have the activity I think what makes this part of any consideration quite difficult is when you are dealing with a police force. The police can use lawful force, so restraint per se is not something that must be avoided by them. The police are entitled to use restraint in certain circumstances. Any decision to investigate by HSE would need to link back to the systematic management of risk, and the fact there is a death, and it is associated with restraint is not in itself a reason to investigate.

75. There has to be something around the way the risk management of the restraint was dealt with that would involve HSE rather than say the PIRC into an investigative role. I would refer back to the HSE policy (HSE-00002), on investigating incidents that fall under HSWA S3, and that the conditions listed have to be met before we would become involved; for example that that there has to be a defined health and safety standards and evidence of a clear and causal link between a failure to achieve those standards and the death.

76. I referred again to COPFS-01955 where it states at paragraph 2:

"Even if systemic failures to train, carry out refresher training or assess competence with a view to re-training have been identified and not addressed by Police Scotland a proportionate response for us would involve securing improvements rather than seeking admonishment and I think it is unlikely that we would report to COPFS recommending prosecution unless any identified failures demonstrated a clear and causal link to the death of Mr Bayoh."

I am asked why HSE would seek to secure improvements and not admonishment. I think this goes back to the non-causal aspects. So if PIRC said: "Well, look there are some issues that aren't directly related to death. We think we're not able to deal with them because they fall into the remit of the

Health and Safety Executive". We would have looked at that and then it's a decision on whether we go for proportionate enforcement. But I think for the non-causal aspects, which I think I'm trying to say here, we would have been more likely to say: "Well, here's the things that need to be improved." Rather than to say: "We're going to report this to Crown", we would have dealt with it as a regulator, rather than as a reporting agency.

77. I am asked what it would look like, practically speaking, if the recommendation was to secure improvements. It would generally form one of two things and it would depend on the enforcement decision. We use the Enforcement Management Model (HSE-00017) as a rough guide so we would do a risk-gap analysis and that generally would come out on the level of action, which is generally either verbal advice, written advice, or a formal enforcement notice.

78. Short of prosecution and short of prohibition, they are the three methods by which we seek to gain improvement, we either: tell somebody you have to improve this; we write to them; or we will provide them with a formal improvement notice to do this. The formal improvement notice would stipulate certain conditions that have to be done within the stipulated time.

79. I am referred to COPFS-01955 at paragraph 1 where it states:

"If PIRC have obtained new information that might cause us to reconsider our position I'm happy to arrange a mutually convenient date by phone or email."

I am asked if I can recall why it took so long for HSE to receive the PIRC reports. I don't know. We didn't receive them directly from PIRC and the information was provided to HSE by the Crown Office.

Signature of Witness…… [redacted] ……..

I am asked to confirm that my letter to Les Brown, COPFS, dated 24th January 2017 (COPFS-04735(a)) was confirming my final decision. I am further asked whether I can recall any other information that I reviewed, aside from the PIRC reports, when making this final decision. It's difficult looking back to remember exactly what was in the report. I think there were a number of specialist reports relating to restraint and medical opinions that were included in the PIRC file that was provided to me by Crown Office. Whatever Crown provided to us was what I reviewed. I didn't make a list of the of all of the reports I referred to, but from recollection they were all part of the overall PIRC report. There was a narrative and then I think there were some specialist reports relating to the medical evidence. I think, although I can't be sure, some specialist report evidence around about restraint.

80. I am referred to COPFS-04735(a) at page 2, where it states:

"It remains our view that PIRC are best placed to comment on matters of safe restraint and to comment on whether the Standard Operating Procedure (SOP) and training syllabus used by Police Scotland adequately addresses the issue. There appears no indication within the additional information provided that the training of the police officers in restraint was inadequate to ensure the health and safety of officers and others, so far as is reasonably practicable, or that it was a significant factor in the death of Mr Bayoh."

I am asked what additionally information was this conclusion based on. From memory, it would have been the specialist reports prepared for PIRC. I think by the experts. I think [redacted] is referenced further down, so from what I've written, there was nothing in the additional evidence to say that Police Scotland couldn't have achieved a safe restraint. I think that was the key point; it didn't change the original decision. That PIRC were the appropriate body to investigate it, and there was nothing coming back from that to say there's a

Signature of Witness…..[redacted]……..

systemic breach that would have triggered the MOU PIRC-04624, for PIRC to come back and say: "We think you should now be involved."

81. I am drawn to the emboldened section below where it states:

"***There appears no indication within the additional information provided that the training of the police officers in restraint was inadequate to ensure the health and safety of officers and others,*** *so far as is reasonably practicable, or that it was a significant factor in the death of Mr Bayoh."*

It is highlighted to me again that Crown raised the issue of the lack of training on multi-officer restraint. I am asked whether the lack of training on multi-officer restraint formed part of my decision-making. I remember that being referred to in the letter from Crown. However, I think we still remained of a view that PIRC were best placed to follow that through. They identified it and they were actively involved in it and we weren't. I think if they had identified that issue, then they could have taken it forward or they could have sought further advice at that point.

82. I think from my response I'm saying that there's nothing in here that changes our original decision and that PIRC were the appropriate body to investigate it.

83. I think my view was that the PIRC report indicated that training had been provided to officers involved in the restraint and that it was to an adequate standard. HSE had no expertise in restraint, and my view was that the experts on restraint that were being used by the PIRC were best placed to assess the concerns from COPFS about the training that had been carried out and form an opinion on the importance of a potential lack of multi-officer restraint training in relation to the restraint of Mr Bayoh. We could have considered any further

Signature of Witness… [redacted] ……..

information received against the criteria for investigation in paragraph 9 of our investigation policy, HSE-00002.

84. I have been asked why a potential lack of training in multi officer restraint would not be considered a systemic failing. It could be a failing if there was an expected standard on multi officer training that was known at the time and there was an identified failure to carry it out. However. if there was no known and expected standard on multi officer restraint training, and training on single officer restraint had been carried out to an acceptable standard then it might an issue applicable to the training of all police officers involved in restraint that should be considered in future. Our view was as I have explained above was that this was a matter best addressed by the experts in restraint being used by PIRC.

85. I am asked to explain what would happen if we decided to re-evaluate a decision. I am asked whether we would discuss it with colleagues again. It can be a straightforward decision made by a principal inspector who can say I've reviewed extra information, the same information or from a different point of view, and I've made that decision. It depends then, whether there's sufficient complexity or another reason to require me to get involved. It might be because it initially applies wider than that specific subject and might be something that's got a national or UK implication. And then If there was enough dubiety for somebody to say: “Well, actually I have reviewed it and I don't know enough about the additional information” then we would make a decision about whether we need to try and achieve clarity about what's being said. That would involve then either a discussion with our internal legal services, operational policy, colleagues, specialists. It could be a very straightforward response, such as: “Thank you for that. But the information's enough to confirm that we stand by our decision.” or “Thank you for that. We need to go away and take this away for further consideration.” We don't have a vested interest in standing

by a decision if it's clearly something that we need to change. At the same time, we won't change our decision just because somebody has requested a change. It has to be based on the evidence, that has in turn to be based on our policies and procedures. In some cases, it can escalate up to being quite complicated or it could be quite straightforward.

86. I am referred to an email correspondence between Les Brown, Stephen Brown and other COPFS staff (COPFS-03758) dated 28th March 2017. I am drawn to a section of the email which states:

"As you are aware Stephen and I met with the HSE lead, Barry Baker, to discuss the executive's view that there was no basis for them to conduct enquiry into the circumstances of the police action."

I recall attending this meeting with Stephen McGowan and Les Brown to discuss that, because I had picked up the PIRC information prior to Christmas and I think this was the meeting to discuss the conclusions. I don't remember in detail, but I do remember there was a there was a meeting.

87. I am asked if I am aware of why PIRC weren't involved in this meeting. No.

88. I am asked if HSE offered any assistance to Crown during this investigation. I think following the review of the PIRC information and the meeting, I think we just confirmed that we would not be investigating it.

Hypothetical scenario: If HSE did proceed to investigate the death of Mr Sheku Bayoh

89. I have given the scenario whereby restraint was absolutely said to have caused Sheku Bayoh's death and HSE chose to investigate. I am asked how HSE

would respond to this. In particular, how HSE would have addressed Crown's concern at the lack of training on multiple officer restraint. I think it is tricky with a hypothetical scenario. I think had PIRC said we were best placed to investigate it and, for example, the UK had no system for multi-officer restraint, now that might be something that has been identified as a gap. Now we have no expertise in restraint, so it's not an area where we could say we have guidance and there are regulations about that. That might require a response from the police as a UK body to say this has identified a previously unknown gap. We might be interested in that because it might play into occupational risk management. As we don't have any guidance and standards on what restraint would look like, it's likely we would be looking for the end result rather than saying: "Well, we can tell you exactly what to do here." This is different to a situation where we go in and there is a lack of training, for example, for confined space entry or fork lift truck use, where we can point to our own guidance to say this is what you have to do and this is the end result.

90. I think in this case, we're one stage back from that. We don't have guidance that gives us ready information about restraint and we would be reliant on others. If PIRC had already considered restraint to be a potentially significant issue in the investigation, and had brought in specialists to consider it then I think they would have been best placed to take this forward. In this hypothetical scenario where we were investigating, any relevant information could then have been shared with us by PIRC in line with MOU PIRC-04624.

91. I am given the hypothetical scenario where Police Scotland, or indeed individual officers, were found to be at fault. I am asked what the outcome of an investigation might look like. Hypothetically, there are two real aspects. There's controlling risk and holding to account. We would look to control the risk and seek improvements to ensure that the risks were identified, controlled and not replicated in future. That's always going to be part of it. Then there's

the holding to account, where you have to assess whether the breach is of sufficient severity that a recommendation is made to Crown to consider prosecution. Effectively, it can be both or it can be one or the other.

92. I am given the hypothetical scenario where Police Scotland are given a formal enforcement notice on the use of CS and PAVA spray. I am asked what that would look like practically. Formal enforcement could be a written letter saying you have to improve and stipulating what needs to be improved. If we felt it was a more serious breach that required a formal notice, an Improvement Notice could be served. That would identify what the failure was, identify the a health and safety legislation that was being breached and would outline what needed to be done to comply with the Notice. A formal improvement notice allows you to stipulate the time frame and it gives a schedule that we can use to assess compliance with.

93. There is a facility to prohibit a work activity, where there is a serious risk of personal injury in allowing the activity to continue and it needs to be stopped until the situation has been dealt with, but we would have to assess that on a case by case basis before serving a Prohibition Notice.

94. There's also the ability to report to Crown Office. That report to Crown isn't dealing with the management of risk. It's more holding to account.

95. We would be looking to control risks through either a letter, an improvement notice and hypothetically, in the most extreme cases, saying: “You must stop doing the thing you're doing and here’s a prohibition notice until you fix it.” So they are the escalations that we can use.

96. I am asked if there are any consequences for failure to comply with an improvement notice. I am asked if there is a tiered escalation from

improvement notice to prohibition notice. It generally does work in tiers. We have a published Enforcement Management Model (HSE-00017) which allows people external to HSE to have some sort of reassurance that we're using it consistently. The published enforcement management model will allow you to look at the sort of risk gap analysis, to see where a duty holder should be as opposed to where they are. It then takes you through a sort of a decision making tree about the definitiveness of the guidance, the definitiveness of the legal requirements, the degree to which they're in breach and that guides inspectors towards whether it should be a letter or an improvement notice.

97. Prohibition notices would tend to come at the beginning, because you're dealing with the ongoing risk immediately. It's not something you would tend to do through the process. You'd be saying there's something that needs to be stopped immediately, because I can see that that's a risk. Then we'd investigate and then say right, here's what you need to do to bring you up to compliance.

98. If there the duty holder failed to comply with the improvement notice, we would normally report breaches of notices to Crown Office. It would then be their decision on whether to prosecute. It is a criminal offence to breach an improvement notice. Obviously, duty holders can appeal against the requirements and that goes to an employment tribunal. But if they don't do that, or if they do that and lose and they fail to comply, then at that point we would be seeking to prosecute for that. We may then need to take further enforcement action, so we may prohibit if it was felt that the failure to comply with improvement notice was leaving a risk that was becoming unsustainable because of a lack of assurance that they were taking proper action. But generally you're proceeding towards the most serious action, which is prosecution.

Signature of Witness…… [redacted] ……..

Joint investigation with another organisation

99. I am asked to explain what a joint investigation by PIRC and HSE would look like had it taken place. I think it would probably have mirrored the way that we would work with the police. It's about sitting down deciding who's responsible for taking what; the documentary evidence, production evidence, witness statements, agreeing the timelines, agreeing the question sets, and agreeing the review. It's also about having clarity about the purpose of the joint investigation and what the various aims of each organisation are. We have done joint investigations with other bodies in the past. We're used to that way of working and clearly it would have involved Crown Office at that point as well. We have a number of joint investigations ongoing at the moment and that's the general way that work: tripartite meetings, reviewing the ongoing lines of inquiry, moving it forward and then closing out the various parts and making decisions about who stays in and who retracts from the investigation.

100. I am referred to PIRC-04624 which is a Joint Protocol between PIRC and HSE. I am asked if this something that I would consider when deciding whether to enter into a joint investigation. It would normally be referred to. I mean it does layout how HSE and PIRC work and, broadly, what areas we should be looking at.

101. I am now referred to HSE-00006 which is the Joint Protocol for work-related deaths. I am asked whether I would consider this protocol when deciding whether to enter into a joint investigation. For example, would this protocol be considered where HSE were considering a joint investigation with Police Scotland. I would consider it in any work-related death investigation when we were working with Police Scotland. No, we didn't consider this protocol in the present case. Not for Mr Bayoh's case.

Signature of Witness…… [redacted] ……..

102. I am asked if HSE can offer ad hoc advice to other agencies, such as Crown or PIRC. I think it can be difficult, if you don't have a clear line. Because if other people are actively investigating it, it's not an area where I would feel particularly comfortable giving ad hoc advice from the sidelines. I think it could cause more problems than it would solve. I would always prefer it to be on a more formal basis. I don't think there's anything particularly wrong with having a discussion at the beginning when things are still formulating. However, I think once the decisions been made about who's investigating, I think it's problematic then to say: "We're not investigating it, but we're we will provide you with some informal advice." I don't think you can have it both ways.

103. I am asked if HSE would ever take an advisory role where the case has not proceeded to a HSE investigation. I think we would always try to support Crown and other regulatory bodies. I think it's just that danger of crossing a line and influencing or creating a conflict or muddying the waters, so I wouldn't say never, but I think you'd have to approach it with some degree of caution to make sure you weren't cutting across another body. You wouldn't know the whole context and you might be giving advice in good conscience about the question that was asked, but actually there was a subtext or context that causes a problem. So it's something I would try and avoid it if possible without wanting to seem too unhelpful.

104. I am referred to paragraph 2 of COPFS-03758 where it states:

"In order to progress this I suggest that we approach Rod Sylvester Evans (who has acted as an expert for the Crown and Health and Safety considerations in other cases) now to provide an overview of the restraint methods employed by police and the adequacy of training provided so far as is known to date and to suggest other areas of enquiry. In order to do this I

Signature of Witness… [redacted] ……..

recommended that he is given access to Vol 1 of the PIRC report on a confidential basis on a similar basis to Barry Baker."

I am asked if I recall why this expert was to be approached. If I do recall the purpose of this potential instruction, I am asked what anticipated benefit he may have added to the case. I know the name and I know he's provided expert assistance to Crown in the past. I couldn't say whether he's an expert in restraint or not. I never saw his report, so I can't comment.

Evaluation of Police Scotland training

105. I am referred to PS11533 which is a review and evaluation report on Officer Safety Training dated April 2015 at page 22 where it states:

"*There are no standardised risk assessments in place for techniques and venues"*

I am asked if this was a document that was brought to the attention of HSE when considering whether to investigate Sheku Bayoh's death, or deaths in similar circumstances. I do not recall this report being part of the file that was provided to me in 2016 by the Crown. However I cannot say that it was not provided, simply that I do not remember seeing it and if Crown say that it was provided then I would not dispute that.

106. I am asked to consider the scenario where I had sight of this report when reviewing the decision on whether to investigate this case or not. I am asked how it may have impacted my decision-making. So on the one hand they are reviewing issues which is good and using the information they gather hopefully to make improvements. Having had the opportunity to read the report for the purposes of this statement it would not have influenced my decision not to

Signature of Witness… [redacted] ……..

investigate the death of Mr Bayoh because it was a wide report around general issues and standardising procedures.

107. In this case there was specific information about restraint which was provided in expert reports that had been obtained by PIRC concerning this incident which were more relevant.

108. I do not believe this report was subsequently provided to HSE in relation to other deaths in custody or deaths following police contact.

109. I have been asked about the statement included in the report that "There are no standardised risk assessments in place for techniques and venues". The report appears to be produced to assist Police Scotland in standardising policies and procedures. Having read the document my sense is that this statement is saying that while there may be risk assessments in place for venues used for training and for carrying out the training these were different from location to location and for the training being carried out in the different areas of the country. It seems that this is because the legacy police forces each drew up their own policies and procedures. I do not take it to mean that there were no assessments in place, although that would need to be confirmed by the author.

Communication with other witnesses

110. I am asked if I know or have spoken to any other witnesses to the Inquiry. Not other than those in HSE.

Signature of Witness…… [redacted] ……..

Involvement with investigation since 3rd May 2015

111. I am asked how I have been involved in the investigation since 3rd May 2015. I have been involved in my capacity as Head of Operations with HSE, as described above.

112. I am asked if I have been following the Inquiry via social media or the news. I have watched some of it on YouTube and I'm aware that it does occasionally feature in news articles.

Declaration

113. 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.

Signature ..... [redacted] ..... Date ..... September 13, 2024 | 4:59 PM BST