2013 FAC 8

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT STIRLING

DETERMINATION

of

SHERIFF FIONA TAIT

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

in respect of

the Fatal Accident Inquiry into the death of

SHARON HARKIN (born 8 June 1962)

.

Stirling, 3 April 2013

The Sheriff, having considered the cause, determines:

1. In terms of section 6(1)(a), Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Sharon Harkin, born 8 June 1962, formerly residing at 18/6 Norfolk Court, Glasgow, then while in lawful custody at HMP Cornton Vale, Stirling, died in ward 26 of Stirling Royal Infirmary and was pronounced dead at 0823 hours on 11 January 2010.

2. In terms of section 6(1)(b) of the said 1976 Act that the causes of death were 1(a) complications of peritonitis and sepsis and 1(b) metastatic carcinoma of the colon.

Note

The Evidence

Evidence in the inquiry was led on 4, 5, 6 and 7 March 2013. Mrs.Valerie Barber-Fleming, Principal Procurator Fiscal Depute represented the Crown. Mr. Calum MacNeill QC represented Mr. Paul Harkin, the brother of Sharon Harkin. Mr. Stefano Rinaldi, Solicitor represented Forth Valley Health Board. Mrs. Laura Donald, Solicitor represented Dr. Craig Sayers and Miss Gemma Hay represented the Scottish Prison Service.

The Crown led evidence from John Burns, Claire Glencross, Dr. Craig Sayers, Mr. Christopher Shearer, Mr. Angus Smith and Mr. Peter King. Mr. Burns is a prison officer at HMP Cornton Vale. Ms. Glencross is a staff nurse, based at the time of Miss Harkin's death at Stirling Royal Infirmary and now at Forth Valley Royal Hospital. Dr. Sayers is a general practitioner and medical officer based at HMP Cornton Vale. Messrs. Shearer and Smith are consultant surgeons based at the time of Miss Harkin's death at Stirling Royal Infirmary and now at Forth Valley Royal Hospital.

Mr. King is a consultant general surgeon at Aberdeen Royal Infirmary. He was instructed by the Crown to review Miss Harkin's medical records, post mortem report, internal hospital review and various witness statements. He was then requested to report on a number of specific questions. His report is Crown production number 13.

On behalf of Paul Harkin, evidence was led from Marie Paterson, Hilda Robertson, Murray Dickie and Dr. Nat Wright. Mrs. Paterson is the sister of Sharon Harkin. Ms. Robertson was a fellow inmate and friend of Miss Harkin and was still a serving prisoner at the date of the inquiry. Mr. Dickie is a community member of the HMP and YOI Cornton Vale Over 21 Visiting Committee, having joined the committee in March 2009.

Dr. Nat Wright is the clinical director for vulnerable groups, NHS Leeds. He was instructed on behalf of Mr. Harkin and Mrs. Paterson to provide a clinical review and opinion on the standard of care provided to Miss Harkin. There were provided to him the post mortem report, prison medical records, Mr. King's report, reports from Dr. Sayers and from Messrs. Shearer and Smith together with various witness statements. Dr. Wright's report is production number 1 lodged on behalf of Mr. Harkin.

A Joint Minute of Admissions was entered into on behalf of the parties. In terms thereof, the post mortem report, Crown Production number 5, the cause, time and place of death and Miss Harkin's status as a prisoner serving a term of life imprisonment were agreed. Further, it was agreed that Miss Harkin died while handcuffed to an escort officer employed by Reliance Secure Task Management Limited (hereinafter referred to as 'Reliance'). The day to day management of Miss Harkin's detention and security was carried out by Reliance, while the Scottish Prison Service retained an overarching responsibility. Any decision in relation to the handcuffing or removal of handcuffs would have been taken by Reliance. Finally, in terms of the Joint Minute, the report of Her Majesty's Inspector of Prisons on HMP Cornton Vale dated May 2006, production number 7/1 lodged on behalf of Mr. Harkin, was received in evidence without being spoken to.

No evidence was led on behalf of Forth Valley Health Board, Dr. Sayers or the Scottish Prison Service.

The Submissions

In submissions, all parties were agreed on the findings in terms of section 6(1)(a) and (b). I was not invited to make any findings in terms of section 6(1)(c) or (d). I am content that there should be no findings in terms of section 6(1)(c) or (d) of the 1976 Act.

On behalf of Paul Harkin, Mr. MacNeill invited me under section 6(1)(e) of the 1976 Act to set out two sets of facts which he submitted were relevant to the circumstances of the death and so fell within the ambit of section 6(1)(e). He accepted that neither contributed to nor could have prevented the death, such as to fall within the ambit of section 6(1)(c) or (d) of the 1976 Act.

Mr. MacNeill relied upon the observations of Sheriff Kearney in his Determination in the Fatal Accident Inquiry into the death of James McAlpine (Glasgow, October 1985) in the following terms:

'Finally, the provisions of section 6(1)(e) are very widely stated and, in my view, entitle and indeed oblige the Court to comment upon and, where appropriate make recommendations

in relation to, any matter which has been legitimately examined in the course of the inquiry as to a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation.'

He further drew my attention to the observations of Sheriff Hammond in his Determination in the Fatal Accident Inquiry into the death of Thomas Strain (Kilmarnock, 28 September 2010) in the following terms:

'Causation is relevant in determining what findings can be made under section 6(1)(c) or (d) but section 6(1)(e) permits consideration of any other facts which are relevant to the circumstances of the death, even though a causal link has not been established.'

The two sets of facts which Mr. MacNeill contended were relevant to the circumstances of Miss Harkin's death and so fell within the ambit of section 6(1)(e) were:

(1) a delay in Miss Harkin's referral by the medical officer at HMP Cornton Vale back to Stirling Royal Infirmary after her symptoms arose on 20 November 2009 and
(2) Miss Harkin was handcuffed to a Reliance custody officer at the time of her death.

Written submissions were lodged on behalf of all parties. Those lodged on behalf of the Crown, Dr. Sayers and Mr. Harkin addressed point 1 in detail. Those lodged on behalf of the Crown, the Scottish Prison Service and Mr. Harkin addressed point 2 in detail. It is unnecessary to rehearse the submissions in detail.

The thrust of the submission on point 1 on behalf of Mr. Harkin was that the management of Miss Harkin's care by the medical centre at the prison (more specifically the nurse led triage system to which I refer below) between 20 November and 2 December 2009 demonstrated a lack of urgency, a lack of curiosity and a lack of appreciation of the severity of Miss Harkin's condition. As a consequence there was an unnecessary delay in the appropriate management of her symptoms in the concluding phase of her life.

On behalf of the Crown, it was submitted that there was no evidence to support the contention that the triage system in operation at HMP Cornton Vale failed Miss Harkin and that had she been admitted to Stirling Royal Infirmary earlier, she would have suffered less.

On behalf of Dr. Sayers, Mrs. Donald urged me to make no finding under section 6(1)(e) in relation to Dr. Sayers as that would be in effect act as a criticism which in all the circumstances would not be appropriate. Primarily, she submitted that if I were to accept Dr. Sayers' evidence, then no criticism arose. Her secondary position was that Dr. Sayers' involvement with Miss Harkin ended five weeks before her death and given that there is no suggestion that anything done prior to Miss Harkin's readmission to Stirling Royal Infirmary on 2 December 2009 might have changed the eventual outcome, the remoteness in time of Dr. Sayers' involvement made it inappropriate to classify it as relevant to the circumstances of death under section 6(1)(e).

In respect of point 2, Mr. MacNeill submitted that the circumstances of Miss Harkin's death include the fact that she was handcuffed at the time. He refuted the position adopted by the Crown and Scottish Prison Service that the fact of being handcuffed was not 'linked to the circumstances' of the death. Such terminology does not reflect the terms of section 6(1)(e), he submitted. He did not seek to suggest a causal connection. Nonetheless Miss Harkin was handcuffed to a Reliance custody officer at a time when it could not be suggested that she represented a danger to herself or to others or a flight risk.

Further, he submitted that the Scottish Prison Service retained responsibility for the detention and security of prisoners notwithstanding that they have contracted out certain escort duties to Reliance (per paragraph 4 of the Joint Minute of Admissions). I was invited to recommend that the Scottish Prison Service review their handcuffing policies, and those with which they require escort service providers to comply, for hospital visits.

Respectively on behalf of the Crown and Scottish Prison Service, it was submitted that there was no evidence to suggest that the restraint of Miss Harkin was linked to the circumstances surrounding her death. Miss Hay expanded, on behalf of the Scottish Prison Service, that the issue had been addressed in terms of the Joint Minute of Admissions wherein it was agreed that any decision taken in respect of restraint of Miss Harkin would have been taken by Reliance. She reminded me that no evidence had been led from anyone at Reliance and that Reliance was not an interested party at the inquiry.

Determination

In terms of section 1(1)(a)(ii), Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, the present inquiry is mandatory as Miss Harkin was in legal custody at the time of her death, being detained in, or subject to detention in, a prison in terms of section 1(4)(b) of that Act.

Miss Harkin died while admitted as a patient at Stirling Royal Infirmary and the evidence led focused on her medical treatment both within HMP Cornton Vale and Stirling Royal Infirmary. Under reference to Miss Harkin's prison medical records, Crown Production number 3, and hospital records, Crown Production number 4, the evidence disclosed the following uncontroversial medical history:

- Miss Harkin was treated within HMP Cornton Vale from October 2007 until January 2009 for dyspepsia, which she described as a longstanding condition.
- When it was noted in early 2009 that anti-acid medication was no longer relieving her symptoms, consideration was given to a diagnosis of biliary tract problems and in March 2009 Miss Harkin was referred for an ultrasound scan of the abdomen. On 3 April 2009, a diagnosis of gallstones was made and no other abdominal abnormalities were noted. Appropriate blood tests showed no abnormalities.
- She was referred for and underwent an apparently straightforward laparoscopic cholecystectomy on 9 November 2009. She was well enough to be discharged the same day.
- On 11, 12 and 17 November 2009 satisfactory wound checks were performed. It was noted on 17 November 2009 that Miss Harkin was losing weight.
- *I deal with the period from 20 November to 2 December 2009 below.*
- On 2 December 2009 Miss Harkin was referred as an emergency to Stirling Royal Infirmary and admitted under the care of general surgery.
- Her presentation suggested intra-abdominal infection, thought to be due to complications following her laparoscopic cholecystectomy, most likely some form of bile leak. Collections of fluid were identified by CT imaging and a drain was inserted on 4 December 2009. Repeat CT imaging and barium enema X-ray were undertaken.

- Miss Harkin was treated conservatively until 19 December 2009 when the decision was taken to perform a laparotomy as there had been no significant improvement in her condition since readmission on 2 December 2009.
- She underwent a laparotomy on 21 December 2009 when a complex situation was encountered consistent with intra-abdominal abscess collections. A segment of small bowel was damaged during the procedure, was resected and the bowel repaired.
- During the laparotomy, a mass was identified in the upper right quadrant of the abdomen. It was not possible to determine the nature of the mass and it was considered prudent to conclude the surgery, to allow Miss Harkin to recover and then to undertake further investigation.
- Miss Harkin remained an in-patient, was under observation and was treated conservatively until her unexpected death on 11 January 2010.

Post mortem was carried out on 18 January 2010 by Dr. Benedikt Vennermann. The report is Crown Production number 5 and is agreed in terms of paragraph 1 of the Joint Minute of Admissions. The report concluded that taking the history and findings as a whole, the cause of death was complications of peritonitis and sepsis thought to be due to metastatic cancer of the colon. The area of the surgical removal of the gall bladder appeared unremarkable and did not reveal findings that would suggest that this was the origin of the accumulation of pus or abscesses within the abdominal cavity. Rather, these complications were thought to be due to the metastatic cancer of the colon which appeared to have formed ulcerations and fistulae towards the abdominal cavity. Any content leaking through the fistulae would have led to peritonitis and pus formation within the abdominal cavity as described in Miss Harkin's medical notes.

As noted above, Mr. Peter King, consultant general surgeon was instructed by the Crown. His report is Crown production number 13. In agreeing with the cause of death as stated in the post mortem report, he observed that the deep ulceration of areas of tumour, consistent with perforation and leakage of bowel content, was the reason for Miss Harkin's intra-abdominal infection. Further, the presence of tumour deposits in the liver, as noted at post mortem and consistent with metastatic spread from the colon tumour, confirmed to him an advanced tumour.

Having explored Miss Harkin's treatment both within HMP Cornton Vale and at Stirling Royal Infirmary, Mr. King identified no steps that reasonably could have been taken at the time which would have altered the outcome for Miss Harkin. He concluded that by the time her underlying condition might reasonably have been diagnosed, Miss Harkin was sadly beyond effective treatment.

Standing the first of the two sets of facts which Mr. MacNeill contended were relevant to the circumstances of Miss Harkin's death and so within the ambit of section 6(1)(e), I shall now address Miss Harkin's care within HMP Cornton Vale after her symptoms arose on 20 November 2009 until her referral back to Stirling Royal Infirmary on 2 December 2009.

Mr. MacNeill fairly acknowledged that the evidence before the inquiry was that Miss Harkin had expressed appreciation of her care from the medical team within the prison up until 20 November 2009. Further, Mr.MacNeill very properly made it clear to Dr. Sayers, the prison medical officer, at the outset of cross-examination that it was accepted that Dr. Sayers could not have done anything to avoid Miss Harkin's death.

Miss Harkin's prison medical records are Crown Production number 3. They record the following contact with Miss Harkin:

- On 20 November 2009 there is recorded complaint of abdominal pain and vomiting. Miss Harkin was seen by a nurse who in turn spoke to the on call doctor, Dr. Jeyasingh, who prescribed analgesia and an antiemetic. It was noted that if the pain continued, review at Stirling Royal Infirmary may be required.
- On 21 November 2009 Miss Harkin was reviewed by Dr. Jeyasingh. Dr. Jeyasingh recorded the situation as resolved.
- On 23 November 2009 Miss Harkin was seen by nursing staff within her cell as she was unable to attend the medical centre. Further complaint of abdominal pain and vomiting was noted. It was also noted that Miss Harkin was apparently not distressed and was able to tolerate fluids. After discussion with the medical officer (acknowledged by Dr. Sayers as most likely to be him) a full blood count, urea and electrolytes, liver function tests and amylase were instructed. Amylase, renal and hepatic functions were normal.

- On 26 November 2009 Miss Harkin was again seen by nursing staff in relation to abdominal pain, vomiting and continuing constipation. She was examined and complained of difficulty and pain on passing urine. In light of urinalysis, Miss Harkin was referred to Dr. Sayers for prescription of antibiotics. Urinary tract infection was suspected. Antibiotics were prescribed the following day. Miss Harkin was advised to contact the medical centre if there were no improvement.
- On 1 December 2009 Miss Harkin was seen by nursing staff and complained of vomiting, constipation, abdominal pain and anorexia. The nurse referred Miss Harkin for review by Dr. Sayers on the following day.
- On review and examination by Dr. Sayers on 2 December 2009, he was concerned by a possible reduction in bowel sounds, Miss Harkin's failure to improve over a ten day period, her lack of response to antibiotics and that despite normal test results from 23 November 2009.
- Miss Harkin was referred for surgical review to Stirling Royal Infirmary.

In his evidence, Dr. Sayers described the operation of the medical centre within HMP Cornton Vale. It is a nurse-led triage service, with the nursing staff as the initial point of contact. The outcomes of the initial contact are variously that no treatment is required, that simple treatment is given without the need to see a doctor, input is sought from a doctor or that a case is referred for medical officer attention. Nurses do not prescribe medication. Dr. Sayers is available full-time, providing cover between 8am and 6pm on weekdays, and one of a team of four doctors providing on call cover at all other times.

Given the specific role of the nurses, Dr. Sayers described them as an experienced team. He found them to refer appropriately and had no concerns about how they operated the triage system. He spoke to medical provision which was easily accessed via a request through residential staff within the prison block and arguably more readily accessible than in the community.

When recalled on the fourth day of the inquiry, Dr. Sayers was examined on the distinction, if any, between practice nurses and nurse practitioners. The need to recall Dr. Sayers arose from certain aspects of Dr. Wright's evidence which went beyond the terms of his report and which had not been put to Dr. Sayers. In particular, Dr. Wright drew a distinction between

practice nurse and nurse practitioner, describing the latter as having the same level of clinical practice in routine cases as a general practitioner and a higher level of authority in clinical practice than a practice nurse. Dr. Wright ascribed the nursing entries in Miss Harkin's medical records to what he would expect of a practice nurse.

When recalled, Dr. Sayers was not familiar with Dr. Wright's categorisation. However, he went on to describe the nurses' role as to operate as independent practitioners and to make clinical assessments. It seemed to me, that Dr. Sayers was describing what Dr. Wright had termed a nurse practitioner.

Dr. Nat Wright was instructed on behalf of Paul Harkin and Marie Paterson to review Miss Harkin's medical care. His report is production number 1 lodged on behalf of Mr. Harkin. Dr. Wright provided an opinion on the following aspects of Miss Harkin's primary care within HMP Cornton Vale:

- whether there was a delay in the initial referral for specialist surgical opinion with an adverse effect on Miss Harkin's life expectancy and
- following upon laparoscopic cholecystectomy, whether there was a delay in referral back to specialist surgical services with an adverse effect on Miss Harkin's life expectancy.

Dr. Wright concluded that the primary care treatment offered to Miss Harkin in the period prior to her initial referral to surgical services was reasonable. Primary care clinicians could not reasonably be expected to suspect a diagnosis of carcinoma of the colon. The decision to consider an alternative diagnosis of gallstones was timely and confirmed by the ultrasound findings. The subsequent referral for surgical opinion also took place within a reasonable timescale.

However, in relation to the question of delay in referral back to specialist surgical services following laparoscopic cholecystectomy, Dr. Wright concluded that there was a delay between complaint of symptoms on 20 November 2009 and referral on 2 December 2009. He attributed significance to Miss Harkin's inability to attend the medical centre on 23 November 2009 due to her symptoms. Dr. Wright considered that when consulted by nursing

staff on 23 November 2009 with a view to blood test investigations being instructed, Dr. Sayers' failure to visit Miss Harkins represented a missed opportunity for general practitioner review of her care. Dr. Wright was of the opinion that a general practitioner should only request test results in such a clinical scenario if he had taken a full history and performed an abdominal examination. Further, he opined that had Dr. Sayers reviewed Miss Harkin at that time, she would have been referred to surgical services. Significantly, that opinion is predicated, in Dr. Wright's written report, on the witness statements of Murray Dickie and Hilda Robertson which he takes to concur that Miss Harkin was complaining of persistent abdominal pain and vomiting, that her symptoms were sufficiently severe to prompt a complaint against the medical centre and for Mr. Dickie to contact the medical centre to discuss Miss Harkin's situation.

Dr. Wright concluded that the delay between 23 November and 2 December 2009 in referring Miss Harkin for acute surgical opinion, whilst not adversely affecting her life expectancy, did cause unnecessary physical distress. Earlier referral would have provided an opportunity for more timely investigation and management by surgical services of Miss Harkin's symptoms of pain and vomiting.

In his evidence, Dr. Wright spoke to his report but also expanded upon it with specific criticisms of the lack of abdominal examination on 23 November 2009, of the considered diagnosis of urinary tract infection and prescription of antibiotics and of the scope of entries for the relevant period in Miss Harkin's medical records. He considered the notes to be wholly lacking in relation to history taking and specification. He extrapolated that the deficiency in the notes may reflect deficiencies in the consultation itself. He expressed the trenchant view that on 23 November 2009, there ought to have been either a referral to surgical services or no less than an abdominal examination, urgent blood tests and early review.

Dr. Sayers did not accept Dr. Wright's conclusions and responded to them with detailed explanation of the consideration which he and his nursing staff had given to Miss Harkin's symptoms as described to them, to her presentation, to the history of recent surgery and to the objective findings of blood and urine analysis. He was not dogmatic in maintaining that Miss Harkin had been treated appropriately. He did so after proper reflection. To me, he presented as a considered and careful witness. Messrs. King and Smith confirmed that Dr. Sayers'

response was appropriate, in particular in instructing blood analysis and in considering a urinary tract infection. While it is correct to note that neither Mr. King nor Mr. Smith practises in primary care, it was fairly accepted by Mr. MacNeill that similar presentations to that of Miss Harkin would arise in the hospital setting.

In assessing Dr. Wright's evidence, he was undermined at the inquiry by his reliance on the witness statements provided to him. It was entirely proper for him to have regard to those in preparing his report but he was unable to reconsider his opinion in light of the actual evidence given by Mr. Dickie to the inquiry and in light of the discrepancy between Ms. Robertson's evidence on the one hand and that of Mr. Dickie, Dr. Sayers and the documentary evidence in the medical notes on the other. Faced with a different factual basis, I agree with Mrs. Donald's submission that Dr. Wright expanded his opinion beyond the fairly careful terms of his report to a general and somewhat absolute criticism of Miss Harkin's care in the ten days before her readmission to Stirling Royal Infirmary.

It seemed to me that Dr. Wright held firmly to the mindset that Miss Harkin's symptoms were persistent and so severe as to necessitate a complaint about lack of proper medical attention. The evidence which I heard did not support such a factual basis. Notwithstanding the complaint which was made by Miss Harkin that she was told that there was no medical provision over the weekend, the medical records recorded that Miss Harkin was seen by a nurse and doctor respectively on the Friday evening and Saturday morning of the weekend in question. There was no challenge to those entries. The entries in the medical records did not support persistent symptoms but recorded a variable picture. The medical records, Mr. Dickie and John Burns, prison officer, did not speak to persistent vomiting. In contrast, Ms. Robertson said that Miss Harkin required a bucket in her cell and that their cell doors were kept open such was her concern about the persistent vomiting. Ms. Robertson's evidence was not challenged but assessing it in light of all of the evidence which I heard, I conclude that she was unreliable in her recollection of the level of Miss Harkin's vomiting. Similarly, there was no suggestion that Mrs. Paterson, Miss Harkin's sister, had not correctly recorded her sister's comments about her health in her diary. On close analysis, the dates of the entries were not inconsistent with the medical records although the level of pain was arguably greater than that recorded in the medical records.

Assessing the evidence as a whole, I am not satisfied that the evidence indicated that Miss Harkin's care between 20 November and 2 December 2009 demonstrated a lack of urgency, a lack of curiosity and a lack of appreciation of the severity of Miss Harkin's condition, as submitted by Mr. MacNeill. Nor am I satisfied that as a consequence there was an unnecessary delay in the appropriate management of her symptoms in the concluding phase of her life. In respect of this point, I make no finding under section 6(1)(e) of the 1976 Act.

Mr. MacNeill's second submission under section 6(1)(e) was that the circumstances of Miss Harkin's death included the fact that she was handcuffed at the time of her death. I agree with Mr. MacNeill that the relevant test is not whether the facts are 'linked to the circumstances of the death'. Section 6(1)(e) permits, adopting the reasoning and wording of Sheriff Kearney referred to above, comment upon and, where appropriate recommendations in relation to, any matter which has been legitimately examined in the course of the inquiry as to a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation. However, I heard no evidence from the Reliance officers on duty at the time of Miss Harkin's death and who would have undertaken the relevant risk assessment. While clearly Miss Harkin was gravely ill, it would be unwise and inappropriate to comment on or make recommendations on such operational matters in the absence of evidence. Accordingly, I decline to do so.

Mr. MacNeill invited me to comment upon two further matters, albeit not to make findings under section 6(1)(e). Those are:

- an alleged failure to inform Miss Harkin's family of the circumstances of her death and
- the co-operation of the Scottish Prison Service in inquiry preparations.

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In relation to the first matter, communication of the cause of death ought to be made to a deceased's family with sensitivity and some urgency. The Crown advised me that either the Procurator Fiscal or police will contact the family following upon post mortem. In Miss Harkin's case, I do not understand Mr. MacNeill's specific submission and attempted to explore the matter during oral submissions. As a matter of fact post mortem examination took place on 18 January 2010. Miss Harkin's funeral was due to take place the following day and

her body to be received into church that evening. The death required to be registered. The family's undertaker collected Miss Harkin's body immediately following upon the post mortem and delivered the death certificate to the family and it was then that they discovered the cause of death. On Mrs. Paterson's evidence, the process took place within a matter of hours. The cause of Miss Harkin's death was neither known nor suspected prior to the post mortem. Accordingly, there was no reasonable opportunity for contact with Miss Harkin's family before delivery of the death certificate. My position in this specific case does not detract from a general expectation that there should be a system in place for early and sensitive notification to a deceased's family.

The second matter related to the circumstances in which prison officers in the employment of the Scottish Prison Service were made available for precognition, and in particular whether it was reasonable for a legal representative of the Prison Service to be present. I understand that this matter was dealt with at a preliminary hearing and I decline to make further comment.

Mr. MacNeill requested that a copy of this Determination should be intimated to the Justice Secretary as Minister responsible for the Scottish Prison Service and that will be done in terms of section 6(4)(a)(iv) of the 1976 Act.

Finally, I should like to extend my sympathy to Miss Harkin's family. Her brother, Paul Harkin, one of her sisters, Marie Paterson, and one of her nieces were present at the inquiry. They showed dignity through what must have been an upsetting experience.