FAI 18

SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

DETERMINATION of Sheriff W Seith S Ireland, Sheriff of North Strathclyde at Kilmarnock

Following a Fatal Accident Inquiry in terms of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976

Into the death of Andrew John Sorley, date of birth 10 October 1967

1. **Determines in terms of Section 6(1)(a) of the aforementioned Act, that Andrew John Sorley diet at 10.17 am on 20 June 2008 in the Southern General Hospital, Glasgow, whilst still within lawful custody of H M Prison, Kilmarnock,**

2. **In terms of Section 6(1)(b), the cause of death was Streptococcus Pneumonia Meningitis,**

3. **Determines in terms of Section 6(1)(c) that it would have been a reasonable precaution whereby the death could have been avoided if Nurse Richardson had, after her initial assessment of Mr Sorley at approximately 11.45 pm on 16 June 2008, arranged to carry out a further assessment of his medical condition within a period of 2 hours or thereby thereafter, which may have likely shown that Mr Andrew Sorley's condition was deteriorating This is likely to have prompted Nurse Richardson to have arranged to either contact Dr Kopal, the Prison Doctor who was on call who could have then attended, or to have requested Mr Sorley's removal to hospital. It was likely by that time Mr Andrew Sorley's meningitis was rapidly developing, but that he was still conscious, in which circumstances medical intervention for Meningitis was more likely to have a positive outcome which could have prevented the death of the said Andrew Sorley.**

KILMARNOCK : 9th March 2012

Introduction

This Inquiry took place before me at Kilmarnock Sheriff Court over a period of 21 days (including 19 days of evidence and submissions) over a period of months . The hearing of such cases with periods of separation between diets , unfortunately, can

happen frequently to accommodate the availability of witnesses, solicitors and others pressures on the time of the Court.

This was a mandatory Inquiry, given that the late Mr Sorley had, immediately prior to his death, been a prisoner within H M Prison Kilmarnock (Section 1 of the aforementioned Act).

The Crown was represented by the Procurator Fiscal Depute, Ms Kim Philp. Mr Gerard Brown, Solicitor Advocate, represented Mr and Mrs Sorley, the parents of the deceased. Mr James Stewart, Solicitor, appeared for Doctor Hamid Kopal (the prison doctor at H M Prison Kilmarnock at the relevant period). Ms Catriona Watt, Solicitor, appeared for 3 of the nurses at H M Prison Kilmarnock, namely, Sandra Richardson, Frank Ngulele, and Mark Fullarton. Ms Laura Irvine, Solicitor, appeared for the operators of H M Prison Kilmarnock, SERCO, and Mr George Rolfe, Solicitor, appeared for the Scottish Ministers who have responsibility for the Scottish Prison Service.

Evidence was led on behalf of the Crown from Mr George Courtney, a Reception Officer at H M Prison, Bowhouse, Kilmarnock, Mr Emmanuel Hammond, a mental health nurse, c/o H M Prison, Bowhouse, Kilmarnock, Ms Linsey Bunton, Prison Custody Officer at the Prison, Ms Sandie Ross, Prison Custody Officer, Mark Fullarton (Nurse), Craig Brennan, Prison Custody Officer, Francis Martin Knox, Prison Custody Officer, Sandra Richardson (Nurse), Frazer Fitzsimmons, Prison Custody Officer, Peter Simpson, Stewart Honest, H M Prison, Bowhouse, Kilmarnock, Gordon Walker, James McGuinness, Frank Ngulele, Mental Health

Nurse, Doctor Hamid Kopal, Constable Aileen Finlay of Strathclyde Police, Ayr, Mr Likhith Alkandy, Consultant Neurosurgeon from the Southern General Hospital, Glasgow, Doctor Julie Marden from Crosshouse Hospital, Kilmarnock, Ms Catherine Carlyle, Paramedic from Scottish Ambulance Service, Kilmarnock, Mr Robert Duggan, a Senior Health Care Manager from SERCO.

Parties had joined in the agreement of certain evidence within a Joint Minute of Agreement, and with the tendering of that, Miss Philp for the Crown, closed the evidence for the Crown.

Mr Gerard Brown, Solicitor Advocate for Mr and Mrs Sorley, called Mrs Irene Waters, a nursing consultant, whose evidence was heard over 3 days, between May and September 2011. Mr Brown also called Professor Andrew Coyle as an expert witness, inter alia, on prison procedures and management.

Mr Stewart, Miss Watt, and Mr Rolfe, indicated to the Court that they were not calling any witnesses, whereafter Miss Irvine called Mr Ian Murray, a senior manager from SERCO, presently based at H M Prison, Bowhouse, Kilmarnock.

There being no further evidence , parties were in agreement that they could further assist the Court by preparing written submissions. Sufficient time was allowed to allow parties to prepare their written submissions, and a day of oral submissions took place prior to my making avizandum.

Having had an opportunity to reflect upon all of the evidence before the Inquiry, and the submissions upon the evidence made by all the parties before the Inquiry, together with the Joint Minute of Agreement, I have made the above Determination.

I now intend to set out the facts which I have found established, and thereafter, in my note, to give explanation of why I made certain findings where there was dispute about the evidence. In this case there was, ultimately, notwithstanding, appropriate cross examination, especially on behalf of Mr Brown, on behalf of the Sorley family, not a great deal of factual dispute, but rather anxious and most proper submission by all parties as to whether, and indeed then as to what extent, the Court should made any determination in terms of Section 6 (1) (c),(d), and (e) of the 1976 Act. I also within my note, give the statutory framework in which such an Inquiry takes place, and acknowledge authoritative and persuasive judicial pronouncements on the scope of such an Inquiry and the duties of the Sheriff presiding over same.

1. On 12 November 2007, Andrew John Sorley, prisoner number 21834, date of birth 10 October 1967, was sentenced to a term of 24 months imprisonment in relation to a charge of assault to severe injury at Paisley Sheriff Court.

2. On 28 November 2007, said Andrew John Sorley, was transferred from H M Prison, Greenock, to H M Prison, Kilmarnock.

3. That the said Andrew John Sorley diet at 10.17 am on 20 June 2008, in the Southern General Hospital, Glasgow, whilst still within lawful custody at H M Prison Kilmarnock.

4. Crown production 2 is a report containing the results of a post mortem, carried out on the said Andrew John Sorley by Pathologist Doctor Linda Isles, who concluded that Andrew John Sorley died of Streptococcus Pneumonia Meningitis.

5. Crown production number 4 are the Prison Health Care Records relating to Andrew John Sorley.

6. Crown Production number 5 are the medical records from Crosshouse Hospital, Kilmarnock relating to Andrew Sorely.

7. Crown Production number 6 are medical records from the Southern General Hospital, Glasgow relating to Andrew John Sorley.

8. Crown production number 9 are the GP medical records of Andrew John Sorley.

9. Crown production number 15 is a statement taken from (Nurse) Alan Thornton by PC Aileen Finlay on 6 January 2009 at H M Prison Kilmarnock.

10. Crown production number 8 is a report containing an investigation carried out by Eric Pearson, and Ellie Teasdale on behalf of SERCO into the death of Andrew John Sorley.

11. Crown label number one, is a DVD containing a true and accurate record on CCTV footage of "D" wing within H M Prison Kilmarnock between 22.58 hours on 16 June 2008, and 12.05 hours on 17 June 2008.

12. Crown production number 16 is a typed version of the handwritten CCTV log of events contained within annex 17 of Crown production number 8.

13. H M Prison Kilmarnock contains 2 house blocks within which of each are 4 wings. House Block One holds long term prisoners, and House Block 2 holds remand and short term prisoners. "D" wing within House Block 1, where Mr Sorley was detained in Cell 29, is an enhanced wing, which is nominally drug free, and holds prisoners believed to be well behaved. Within "D" wing prisoners are expected to remain drug free, and are drug tested on a regular basis. If a prisoner is found to be taking drugs, then he is removed from the enhanced wing.

14. It is not unusual that Prison Officers find prisoners within that enhanced wing who have, in fact, taken drugs, and on a previous occasion Dr Kopal has treated a prisoner on the drug free wing who has asked to go on a detoxification programme.

15. Mr Andrew Sorley was transferred from H M Prison Greenock to H M Prison Kilmarnock on 28 November 2007. On arrival he was seen by a Prison Custody Officer (Courtney) who completed the required prison form, and thus established there was no issues in terms of risk in relation to Mr Sorley. The

question of risks refers to whether a prisoner requires protection within the prison regime, or whether they may be suicidal. A Prison Custody Officer does not see any medical records which accompanies the prisoner on his transfer in normal course.

16. On 28 November 2007 Mr Sorley was then seen by Nurse Emmanuel Hammond. The Nurse requires to complete another form, detailing the prisoner's medical history as revealed by the prisoner under questioning. These notes include, for Mr Sorley, that he had previously had addiction problems with heroin. Mr Sorley was not assessed as suicidal. The information that he had previously suffered from meningitis was not mentioned by Sorley at this assessment

17. A transferred prisoner would see a doctor within 24 hours. Mr Sorley was seen by Dr Hamid Kopal on 29 November 2007, who took a past medical history. Mr Sorley did not mention that he had meningitis 5 years earlier.

18. From November 2007 until June 2008, Dr Kopal had occasion to see Mr Sorley in relation to issues Mr Sorley had with his heart, chest pains, and associated breathing difficulties, a lung infection, addiction issues, cluster headaches, and gastric issues.

19. Dr Kopal took detailed notes of these medical examinations, and where appropriate, in his medical judgement, referred Mr Sorley to outside medical agencies as appropriate. Mr Sorley did not mention his previous history of

meningitis to Dr Kopal in any of these consultations between November 2007 and June 2008.

20. Mr Sorley's medical records were not available on his transfer to either Nurse Emmanuel, nor Dr Kopal. From time to time prisoner's medical records on transfer do not always accompany the prisoner on the same day to the receiving prison.

21. The absence of medical records to Nurse Emmanuel, and Dr Kopal, on 28 and 29 November 2007, had no bearing on the events of 16 and 17 June 2008. It is appropriate medical practice by nurses and doctors to treat the patient who is presented to them with regard to the patient's expression of his medical history, and the nurse's observations and examination, and the doctor's diagnosis.

22. The medical services at H M Prison Bowhouse, Kilmarnock, seek to replicate, as far as is possible within the context of a custodial institution, the care that would be afforded outside prison through a General Practitioner's practice.

23. Within H M Prison Kilmarnock, any prisoner feeling unwell can ask to see a nurse at triage sessions which are held within the Prison wings each morning. The nurse, thereafter, can make an appointment for a prisoner to see the prison doctor. A prisoner can also fill out a form, available in the prison wing, to request an appointment with a doctor. Prison Officers can contact the Health Care Unit at the prison at any time to request a nurse to see a prisoner. If the position is not urgent, the prisoner is seen by a nurse on the next visit to the hall

by a nurse, eg when medicines are being distributed generally to prisoners. In an emergency situation a Prison Officer can put out a call for emergency medical response. A nurse is on duty at all times within the Prison, who has a radio, and there is an emergency response backup, who can attend immediately, after such a call.

24. There is a fully qualified doctor on the staff of H M Prison, Kilmarnock. At the relevant period this was Dr Hamid Kopal. Dr Hamid Kopal, whilst not on duty in the Prison, was available, and was "on call" for any consultation as regards the health of any prisoner within the Prison, and was willing, and available, to attend at the Prison out of hours to render medical assistance. There was procedures in place within the Prison whereby Prison Officers could contact nurses, who, if so advised thereafter, could if the circumstances demanded, could contact the prison doctor.

25. Between the approximate hours of 18.00 and 18.30 on 16 June 2008, whilst Mr Andrew Sorley was housed within Cell D29, in D wing, House Block One, H M Prison Kilmarnock, he complained to Prison Custody Officer Linsey Bunton of feeling generally unwell, and that the last he had felt so unwell was when he had been in hospital previously with meningitis. Prison Custody Officer Linsey Bunton contacted the Health Care Wing, and spoke to a nurse who indicated that when the nurse was issuing medication to prisoners on that wing later in the evening, the nurse would then see Mr Andrew Sorley.

26. It is more likely than not that the nurse who was spoken to at that time was Nurse Frank Ngulele, although he has no recollection of that.

27. On or around 20.00 hours on 16 June, Prison Custody Officer Sandie Ross took Mr Sorley to see Nurse Mark Fullarton at the triage room within the prison which is just outside "D" wing, and is used, inter alia, to dispense medication to prisoners who require it.

28. Prison Custody Officer Sandie Ross took Mr Sorley in a wheel chair because Mr Sorley had indicated that he was feeling unwell, had a headache, and was feeling faint.

29. Staff Nurse Fullarton listened to what Mr Sorley was telling him, and he took a history from Mr Sorley which included Mr Sorley's comment that he had a past history of meningitis, and he was concerned that that had returned. Mr Fullarton took Mr Sorley's pulse and temperature. He checked for any obvious rash upon Mr Sorley's body, he also checked for rigidity, and checked whether or not Mr Sorley was clammy. Mr Fullarton spoke to Mr Sorley to check his hearing, alertness, and orientation, and did a check for photosensitivity. Mr Fullarton had carried out those checks because of knowledge he had about the symptoms of meningitis. Mr Fullarton concluded that Mr Sorley had viral flu type symptoms, based on Mr Sorley having general aches and pains, and feeling generally unwell. Although Mr Fullarton found a headache which could be symptom of meningitis, he concluded that because of the general aches and pains, and the absence of the other symptoms that it was a viral, flu type illness.

Mr Fullarton dispensed paracetamol and ibuprofen. He advised Mr Sorley to keep taking fluids, and that if he felt he was deteriorating then he should contact the Prison Custody Officers and ask them to contact Health Care. Mr Sorley had left the triage room walking, and had walked back to the wing. Mr Sorley seemed to observing prison staff to have accepted this position.

30. Mr Andrew Sorely continued to complain of feeling unwell. Prison Custody Officer Sandie Ross attended Mr Sorley's cell with another prisoner, Mr Stuart Honest. Mr Sorley was lying on the bed, but when he attempted to stand up he appeared to slide to the floor and lie there. Although Prison Custody Officer Ross tried to persuade Mr Sorley to get onto his bed he stayed on the floor, saying he was more comfortable there. Prison Custody Officer Ross left Mr Sorley lying on the floor, but he had a cover over him. Whilst not normal, it is not unknown for prisoners to find it more comfortable to lie on the floor of their cell. At approximately 22.00 hours, Prison Custody Officer Sandie Ross required to check all of the cells in "D" wing under Prison procedure, to check that all prisoners are in their cells before final lock up of that wing for the night. Mr Sorley was till lying on the floor. Whilst this was not usual, the Prison Custody Officer was unconcerned, given the information obtained from Staff Nurse Fullarton.

31. After roll call was completed, Prison Custody Officer Bunton, and Prison Custody Officer Ross, handed over to the night shift officers on duty, Prison Custody Officer Craig Brennan, and Prison Custody Officer Martin Knox. During the verbal handover, information was passed to Prison Custody Officers

Brennan and Knox, that a nurse had been to see Mr Sorley, and that he may call for assistance from Prison Officers during the night. Before Prison Custody Officers Bunton and Ross left the wing, i Mr Sorley then pressed his call button, and Prison Custody Officer Craig Brennan attended at his cell. The call button exists to allow any prisoner to call for assistance. It remains sounding until a prison officer attends and turns it off.

32. Prison Custody Officer Craig Brennan attended at cell D29, and spoke to Mr Andrew Sorley through the door panel. As it was after lock up, the cell door had been locked for the night. Mr Sorley, on enquiry, advised that he wished to see a nurse. Either Mr Brennan, or his supervisor, Mr Russell Clark, telephoned Health Care, and made a request that a nurse come to see Mr Sorley. Mr Sorley was advised that a nurse had been requested. There was no sense of urgency in the request for a nurse, or in the instructions relayed to Health Care.

33. Because the request came after lock up of the Prison, when prisoners are confined to their cells, special procedures exist for accessing the wing and any individual cell after lock up. The senior officer on duty was carrying out other duties in the lock down of the entire prison, and he has to arrange for Nurse Richardson to be escorted to Mr Sorley's cell. Prison procedures require that when a cell is opened after lock up there must be 3 Prison Custody Officers present as there was on this occasion.

34. There is a record of CCTV footage covering "D" wing. The clock on the CCTV is running approximately 11 minutes fast. A written chronological log of the CCTV is contained within Crown production number 16.

35. On or around 23.45 hours, Nurse Sandra Richardson entered Cell D29, and the timings from the CCTV show that she was in the cell for approximately 8 minutes.

36. Prior to her attendance at D wing, from earlier discussions in the evening with Nurses Ngulele and Fullarton, she was aware that Mr Sorley had been seen. There was some mention of possible pneumonia, and from Staff Nurse Fullarton, flu like symptoms after he had seen him. There had been no intimation of possible meningitis.

37. Staff Nurse Richardson entered the cell. Mr Sorley was lying on the floor of his cell. She asked him to get up of the floor, and after a couple of requests, he did so, and got, unaided, onto the bed. He complained to Staff Nurse Richardson that he was "dying of meningitis", and that he thought this was the case because he had had that illness 5 years previously. Staff Nurse Richardson examined him to find out if he had any signs or symptoms of meningitis. Staff Nurse Richardson has been qualified for over 30 years, and has had spells in general hospitals, working as a midwife, working as a district nurse, and as a matron of a nursing home. She has extra qualifications in health visiting. She has previously seen meningitis in a young child.

38. Staff Nurse Richardson checked Mr Sorley for photophobia (dislike of light). There was no sign of that. She checked his temperature and pulse, which were both normal. She listened to his airways with a stethoscope, and listened to his lungs to make sure that there was no difficulty (because of the possible report of pneumonia). She checked for a rash, which is a possible sign of meningitis. She checked his skin colour and pallor, and whether he was cool, clammy, or warm. She checked whether he was unsteady on his feet. She also checked for any neuromuscular deficit, as that can be a sign of a stroke. There was no adverse finding, apart from the continuing headache suffered by Mr Sorley.

39. Staff Nurse Richardson asked Mr Sorley whether he had taken illicit drugs, but he replied that he had in the past, but not any more. Whilst Staff Nurse Richardson did not believe that Mr Sorley had taken drugs, she did ask the Prison Officer to carry out a drug test the following morning to confirm the position. Such a drug test, to be carried out by Prison Officers subsequently, was not an untoward occurrence within the prison setting. There is a need to confirm whether or not drugs had been taken by any prisoner.

40. Staff Nurse Richardson was aware of the classic symptoms of meningitis, and one of those was continued headaches, and it was because of that she carried out the other tests. She advised Mr Sorley after the tests that could not find symptoms of meningitis, and tried to reassure him.

41. On her return to the Health Care centre Staff Nurse Richardson checked the prison health records for Mr Sorley, which confirmed his admission to hospital

in or around 2002, for suspected meningitis. She wrote up a full record of her examination in Mr Sorley's record, in the Health Care centre communication's book, and completed the SERCO injury to prisoner form.

42. As a result of the discussion in Mr Sorley's cell regarding drugs, Prison Custody Officer Brennan arranged for a drug test to be carried out on Mr Sorley at a later time (Crown Production number 8, page 312), this request arises from the discussion between Mr Sorley, the Nurse, and Mr Brennan, about the possibility of drugs having been taken. Staff Nurse Richardson felt it was appropriate to invite Prison Custody Office Brennan to carry out a drug test in the morning, standing the prison environment where drugs can be taken, and to eliminate that matter. If the test had been done it would be carried out later on by security staff.

43. During the night shift lock down of prisoners, Prison Custody Officers do not actually monitor prisoners. They control the wings and look for obvious issues. Prison Custody Officers require to patrol twice and hour, up to approximately 4.30 am.

44. Between the approximate hours of 12 midnight, and 02.00 am, Mr Sorley continued to complain about headaches. He used his call button, and other prisoners also used their call buttons, because of their concerns about Mr Sorley's health. These other prisoners were reassured by the 2 Prison Custody Officers on duty, Brennan and Knox, that Mr Sorley had seen the nurse. That did not seem to satisfy the other prisoners. Prison Officers are used to complaints from prisoners during the night, and have to seek to reassure

prisoners, and indeed, other prisoners about an individual prisoner that the prisoners are concerned about.

45. Prison Custody Officers Brennan and Knox, as part of their patrols, but not on every patrol, checked on Mr Sorley. Between the approximate hours of 02.30 am and 04.40 hours, Prison Officers are seen on the CCTV to look through the door panel on cell D29 every time they passed. The Prison Officers reported that Mr Sorley appeared to be asleep, and did not ask them for anything. CCTV (giving accurate timings, given the 11 minutes time delay discovered in the system) are seen at D29 cell at 02.30, 02.36, 02.38, 02.46, 02.48, 03.13, 03.46, 04.09, and 04.39.

46. To the observing Prison Officer, Mr Sorley appeared to be asleep. Prison Officers checked Mr Sorley as they were aware that if there signs of vomit that would be significant if, for example, illicit drugs had been taken, and at that point they would have immediately have phoned the Health Care centre for further medical advice, and action.

47. From the knowledge of the Prison Officers Brennan and Knox, it is not unusual that sometimes prisoners sleep on the floor, on the mattress, rather than sleep on the mattress on the bed. Neither of the Prison Officers felt that Mr Sorley had deteriorated to the extent that they needed to phone the nurse again.

48. Andrew Sorley's medical condition deteriorated whereby he was still suffering from a headache, and was progressing in his illness of meningitis into

unconsciousness, and this happened over a period of hours after Nurse Richardson's visit at 11.45 pm before he likely lapsed into unconsciousness sometime after 2am.It is likely that when PCOs saw what they thought was Mr Sorley sleeping, he was lapsing into unconsciosness.

49. The night shift patrol stops at 04.30 am approximately. The day shift Prison Officers come on duty at approximately 06.30 am. Prison Custody Officers Brennan and Knox finished their night shift duties at approximately 07.00 on 17 June 2008, and handed over to Prison Custody Office Fraser Fitzsimmons and Prison Custody Officer Michelle Hunter. Prison Custody Officer Fitzsimmons therefore learned that Mr Sorley had been complaining of headaches during the night, that a nurse had been to the cell to assess Mr Sorley, and that no further action had been taken after the nurse had seen Mr Sorley. He, Fitzsimmons, learned that Mr Sorley had been up complaining until about 04.00 am or 04.30 am. He also spoke to the Prison Custody Officer Ross, the nurse who had been on duty the previous evening, and learned that Mr Sorley had been seen by 2 nurses, and no further action had been taken. Mr Fitzsimmons knew Mr Sorley. He knew him to be quite prisoner, who kept himself to himself, and that Mr Sorley attended full time education within the Prison environment. He was known to be a good prisoner, who did not cause any problems.

50. The CCTV (Crown Label 1) shows Prison Custody Officer Fitzsimmons going to the door of Mr Andrew Sorley cell, D29, at approximately 07.00 hours, and the cell door being opened. Mr Fitzsimmons is at the cell for approximately 17 seconds. During that roll call procedure the Prison Officer requires to obtain

some response from the prisoner in his cell as a safety check. Police Custody Officer Fitzsimmons called Mr Sorley's name 2 or 3 times before getting a response which was a wave of a hand, and a grunt, Prison Custody Officer Fitzsimmons was aware that prisoners do lie on the floor, and he was not concerned that Mr Sorley was lying on the floor. As would be normal prison practice, the cell door was locked again.

51. At approximately 07.14 hours the Prison Custody Officer went back to Mr Sorley's cell to leave milk on the cell door handle. At 07.19 hours, Prison Custody Officer Fitzsimmons returned to cell D29 to unlock it for the full day. He saw Mr Sorley in the same position, and that Mr Sorley appeared to be snoring. At around 07.45 am, Prison Custody Officer Fitzsimmons realised that Mr Sorley was still sleeping, which would be unusual then, as Mr Sorley would usually go to an education activity Mr Sorley enjoyed. Prison Custody Officer Fitzsimmons was not overly concerned, given that Mr Sorley had been up during the night, and might be tired. However, as a prisoner requires to be signed off by a nurse, to allow any prisoner to miss education or work, Prison Custody Officer Fitzsimmons spoke to his supervisor, and a decision was made to ask for a nurse to come and see Mr Sorley. This was for the purposes of signing him off from education, not because it was thought there was anything seriously wrong with Mr Sorley.

52. The intimation to the nurse was made on or around 08.15 am. Nurse Ngulele was on duty that morning dispensing medication. CCTV shows Nurse Ngulele attending at cell D29 at 08.39 hours. Nurse Ngulele saw Mr Sorley lying on the floor. He assessed his airway breathing and circulation, and checked his pulse.

He shouted at Mr Sorley in an attempt to arouse him, but Mr Sorley was unresponsive and appeared to be in at least a deep sleep. He did have a pulse and was snoring loudly and was breathing. Nevertheless, Nurse Ngulele was sufficiently concerned about Mr Sorley's condition, that he decided that a call to a senior nurse on duty ought to be made. This was Nurse Alan Thornton, who was not a witness at the Inquiry, having emigrated, but whose account was available to the Inquiry via a Police statement.

53. Nurse Ngulele spoke to Alan Thornton, and asked Alan Thornton to come and help him. Mr Thornton said he was engaged in other duties, including the methadone round, but he would look at the medical night notes for Mr Sorley from the night before. Nurse Ngulele was told by Mr Thornton that the symptoms sounded like Mr Sorley may have taken a drug overdose. Mr Thornton reported to Nurse Ngulele that he, Mr Thornton, would speak to the doctor, Dr Kopal, who had come on duty that morning at 08.00 hours.

54. Nurse Ngulele left the wing to get a medical bag from the triage room at approximately 08.45 hours.

55. Sometime after the arrival of Dr Kopal in the prison, he spoke to Alan Thornton, but there was no sense of urgency imparted to Dr Kopal about Mr Sorley.

56. There was a subsequent phone call between Dr Ngulele with Dr Kopal. Dr Kopal formed the view from information given to him over the phone, and from

earlier reports to him by Mr Thornton, that there could be a variety of conditions, especially as Mr Sorley appeared to be unconscious. He instructed Nurse Ngulele to administer 10 milligrammes of Narcan, which is a drug which reverses opiate effects in anyone's system. If someone has taken an overdose, then the administration of this drug ought to waken the person. Dr Kopal was aware that Mr Sorley had previously been on a detoxification programme, and that opiate use in prison was very common. Nurse Ngulele did not have Narcan in his medical bag, and had to go and fetch some. Nurse Ngulele, attended at Mr Sorley's cell at 09.14 (09.25) am. 5 milligrammes only of Narcan was administered at that point as that was all that was available. Accordingly, at 09.19 (09.30) am, Nurse Frank Ngulele left the cell to go and fetch other Narcan, he returned at 09.29 (09.40) am, and administered a further 5 milligrammes. There was no effect, so Nurse Ngulele phoned Dr Kopal again at 09.32 (09.43) am.

57. Dr Kopal, on being advised by Nurse Ngulele, that the Narcan had no further effect, immediately attended at the wing at around 09.42 (09.53) am. Dr Kopal found Mr Sorley lying on the floor of his cell. He was unconscious. Dr Kopal checked Mr Sorley's airways, breathing and circulation, and noticed that Mr Sorley had vomited. Mr Sorley still had a pulse, and was breathing. Dr Kopal used the Glasgow Coma Scale which assesses persons in terms of possible coma. The least responsive out of 15 a person is, that is the lower the score, indicates the stronger likelihood of coma. Mr Sorley was assessed by Dr Kopal as 3/15, which is a deep coma. Dr Kopal asked the nurses to administer more Narcan. Whilst there was nothing to suggest that there had been a drug

overdose, it had not yet been fully excluded to the Doctor's satisfaction, given there was a history of drug use, and further Narcan was therefore administered. Narcan often has to be administered more than a few times for it to be effective as it is often short lived. Further Narcan produced no further reaction which led Dr Kopal to the belief there was something seriously wrong, and that it was not an overdose. Dr Kopal formed the view that Mr Sorley may have suffered a stroke, or had suffered intra-cranal bleeding.

58. Dr Kopal, as the responsible medical officer, was concerned sufficiently to instruct a Prison Officer to call for an ambulance. The ambulance was to be sought on a "blue light", which is to say emergency basis. A Prison Custody Officer telephoned for an ambulance .

59. Scottish Ambulance records (Crown production number 14), shows that the call for the ambulance was received at 10.03 hours. The crew consisted of a paramedic, Catherine Carlisle, and an ambulance technician, Thomas Scott.

60. It is prison procedure at H M Prison Kilmarnock that every vehicle, including emergency vehicles, which attends at the Prison, may be searched on arrival. Discretion can be used with emergency vehicles, and such a vehicle can be permitted access without requiring to be searched. There has been no change in policy between 2008 and 2011.

61. Scottish Ambulance Service operate a policy whereby the ambulance responding to a "red" call (namely a high emergency, and more serious call)

must require the ambulance to be at the site of the emergency within 8 minutes of the call being received. The call was received at 10.03 am on 17 June 2008, and Crown production number 13 (the Ambulance Service log) that at 10.09.45 the Ambulance arrived at the side door of "D" wing. An approximate gap of 6 minutes 45 seconds, which is within the target time of 8 minutes.

62. Dr Kopal spoke to the ambulance crew, and described how he had found Mr Sorley, and what medication he had been given. Prior to Mr Sorley being removed from the Prison, he was placed in shackles, as this is standard prison procedure. The presence of shackles on Mr Sorley, prior to his being removed from the prison, had no effect on his medical treatment, either by the paramedic crew, nor by the receiving doctors at Crosshouse Hospital as the latter expect that a prisoner from H M Prison Kilmarnock would be handcuffed on arrival at the Hospital. It does not impinge on the doctor's treatment of the patient, and did not impinge on the treatment of Mr Sorley either by the paramedic or any doctor.

63. Mr Sorley's arrival in the ambulance at Crosshouse Hospital at 10.38. He was treated principally by Dr Julie Marden, assisted by 2 other doctors. Dr Marden had some information as to the background of Mr Sorley having collapsed, having been given Narcan, and having been seen by a nurse, and a general practitioner. She also had information of a past history of meningitis, and a skull fracture. Notwithstanding, she could not recall the source of the information, that is what she recalled, and in any event, she personally then

examined Mr Sorley fully, and would have done so in that manner, whether or not she had received any prior information.

64. On examination, Dr Marden formed the view that Mr Andrew Sorley may have suffered an intra cranial bleed. He also had a bruise on his right arm, which could have suggested meningitis or trauma, and therefore she had cause to have antibiotic medication for meningitis to be given to Mr Sorley. There was a CT scan performed, suggesting there may be a bleed in the brain, and after consultation with a doctor at the Southern General Hospital, who indicated that it could be a bleed or an infection, Dr Marden arranged for Mr Sorley's transfer to the Southern General Hospital, where he was subsequently diagnosed as having pneumocomo-meningitis (Crown production number 5, page 129). The Southern General Hospital is a specialist unit for intra-cranial bleeding, and also for meningitis in the West of Scotland.

65. The form of meningitis from which the late Mr Sorley ultimately suffered, was the bacteriological form. This is rapid in onset and progression, and is often the type with the worst prognosis. Treatment should begin as soon as possible after formal diagnosis. A difference of an hour or less can make a difference in the outcome. This particular strain needs treatment as soon as possible. This strain, if diagnosed, can be treated.

66. Meningitis is a progressive illness, and becomes most critical when a patient loses consciousness, at which time medical intervention is less successful, and the prognosis poorer. If the patient is still conscious, is able to give information

to the assessing medical practitioner, and be assessed by him or her as possibly suffering from meningitis, full medical intervention, including the administration of antibiotics, and other medical treatment is more likely to be successful in saving the patient.

67. It is a lively possibility that had Mr Sorley been seen again by Nurse Richardson in the early hours of 17 June, within the approximate time frame of 2 hours after Nurse Richardson's last visit to Mr Sorely, at approximately 11.45 am, that Mr Sorley's deteriorating condition, whilst he was still conscious, could have been further assessed by Nurse Richardson at that time. Accordingly, a reasonable precaution would have been for Nurse Richardson to have re-attended at the wing within that time frame. Nurse Richardson had by that stage after the first visit to Mr Sorley, heard from him of his complaints of meningitis, and had seen mention of this in the medical records on her return to the health care in the prison. It would have been open to her then, when it would be likely that Mr Sorley would still have been conscious and tell of his condition, and after a further assessment by her to have contacted Dr Kopal to seek his opinion as the responsible medical officer.It would have also been open to her to seek Mr Sorley's evacuation from the prison to hospital

Note

I intend, in the first instance, to set out parties submissions as to the determinations in terms of the Fatal Accident and Sudden Deaths Inquire (Scotland) Act 1976 parties submitted I ought to make

I was favoured by detailed written submissions by all of the parties who appeared before the Inquiry, and I am extremely grateful for the depth and level of all of those submissions. However, as my determination falls to be made within the statutory headings of the aforesaid Act, I have been drawn to the view that it would be most appropriate to state the broad submission as to the Determinations the Court may be drawn to make, or not, and thereafter, in a further section of this Note to deal, where necessary, with particular submissions from parties on matters of evidence where there was any substantial issue and where, importantly, in terms of the purpose of a Fatal Accident Inquiry, there required to be determination of any factual question. Thereafter, I intend to deal with parties' submissions in terms of the relevant sections of the Act in so far as they will assist the reader to see how it came to be that I made the determinations which I have done.

Submissions of the Crown

Miss Philp moved me to make formal findings in terms of Section 6(1)(a) [where and when the death took place]; Section 6(1)(b) [the cause or causes of such death], she also invited me to make a determination in terms of Section 6(1)(c) [the reasonable precautions, if any, whereby the death could have been avoided]. She submitted that relevant precautions could have been that Staff Nurse Sandra Richardson made a follow up check on Mr Sorley after she had initially examined him at 11.45 pm on 16 June 2008 in order to determine if he had deteriorated. Further, that the Prison Officers, Craig Brennan and Martin Knox, could have asked Sandra Richardson to see Mr Sorley again after midnight on 17 June 2008, given he was continuing to complain

of being unwell, was agitated and noisy within his cell. The Crown sought no finding in terms of Section 6(1)(d) [defect, if any, in any system of working which contributed to a death, or any accident resulting in a death] on the basis that any "failings" were of a personal nature and not related to a defect in the system of working within the Prison. As regards Section 6(1)(e) [any other factors which are relevant to the circumstances of the death] the Crown submission was that whilst issues had been raised in the evidence which the Court may wish to comment upon in a Note, from the Crown's perspective none of those issues could be said to be relevant to the circumstances of Mr Sorley's death.

Mr Rolfe, for the Prison Service, submitted that no evidence before the Inquiry justified other than formal findings in terms of Section 6(1)(a), and 6(1)(b).

Mr Stewart, solicitor for Dr Hamid Kopal, submitted that formal finding only in terms of Section 6(1)(a), and 6(1)(b), ought to be made.

Ms Catriona Watt, solicitor for the 3 nurses, submitted that formal findings should be made only in respect of Section 6(1)(a), and 6(1)(b).

Miss Irvine, solicitor representing SERCO, submitted that the Court should make formal findings and determination only in terms of Section 6(1)(a), and Section 6(1)(b).

Mr Brown, solicitor for Mr and Mrs Sorley, the deceased's parents, like the other solicitors, had made detailed written submissions on the evidence, and proposed

determinations in terms of Section 6, which he, together with all parties, supplemented at the oral hearing on submissions. During those oral submissions, Mr Brown refined his position. Mr Brown agreed with all other parties as to the circumstances the Court should determine in terms of Section 6(1)(a), and 6(1)(b). As regards Section 6(1)(c), Mr Brown submitted a reasonable precaution would have been for Staff Nurse Richardson to advise the Prison Custody Officers on duty at the time of her visit, as to what would be a deterioration, and that they should phone her. Also she herself should have returned on her own volition to see Mr Sorley, and/or caused him to be moved to the medical unit for observations. As regard Section 6(1)(d), there were defects within the system of work in that the deceased's medical records ought to have been available on his transfer to H M Prison Kilmarnock, and should have been read by nursing and medical staff; subject to issues of patient and confidentiality. Further with the consent of Mr Sorley, information ought to have been made to all Prison Custody Officers as to his previous medical condition. Assessments ought to be conducted by nursing staff properly qualified and trained, and able to recognise a potentially serious and infectious illness, such as meningitis. All communications, verbal and written, should have been comprehensive and accurate. There ought to be proper training supervision, and control of nursing staff, for the recording of nursing and other notes. As regards Section 6(1)(e) [other facts which are relevant to the circumstances of the death] concerns about the possible use of prohibited drugs within the Prison, should not, in the absence of any reliable evidence that any individual has taken drugs, divert attention from other serious medical problems which the individual may be suffering from. The Ambulance Service, and paramedics, arriving at a prison as a result of an emergency call, should be apprised of all the circumstances surrounding the condition of an individual. The

necessity of handcuffing and shackling a prisoner should be carefully considered in light of medical and nursing professional advice and security advice.

Before examining the submissions made by parties, and the determinations which parties invited me to either make, or indeed to decline from making, and their reasons therefore (the latter, of course, turns particularly, and in more detail on the evidence under certain chapters, and the submissions pertinent thereto) it is useful, and indeed, important to set out the statutory framework under which such an Inquiry is held, and judicial comment as to the purpose and scope of same.

Section 1(1)(a) provides, inter alia, that if the person who died, was at the time of his death, in legal custody, then the Procurator Fiscal ". . . . . **shall investigate those circumstances, and apply to the Sheriff for the holding of an Inquiry under the Act into those circumstances. Legal custody is defined in Section 1(4) of the said Act, meaning a person who is detained, or subject to detention in a prison, remand centre, detention centre . . . . . all within the meaning the Prison (Scotland) Act 1932.** Accordingly, this was a "mandatory" Inquiry in terms of the said Act.

Section 6 of the aforesaid Act provides that "……. the Sheriff shall make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction –

(a) where and when the death, or any accident resulting in a death, took place,

(b) the cause or causes of such death in any accident resulting in a death,

(c) a reasonable precaution, if any, whereby the death and any accident resulting in a death, might have been avoided,

(d) the defects, if any, in any system of working which contributed to the death, or any accident resulting in a death,

(e) any other facts which are relevant to the circumstances of the death.

A Fatal Accident Inquiry is not a proper forum for determination of questions of criminal or civil liability.Nor is it a general public inquiry The Inner House of the Court of Session in the case of *Black v Scott Lithgow Limited, 1990, SLT 612, in the opinion of Lord President Hope (at page 615),* said the following –

"there is no power in this section [6(1) of the 1976 Act] to make a finding as to fault, or to apportion blame, between any persons who might have attributed to the accident. It is plain that the function of the Sheriff at a Fatal Accident Inquiry is different from which he is required to perform at a proof in a civil action to recover damages. His examination, and analysis, of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, in so far as this can be done to satisfaction. He has before him no record or other written pleadings, there is no claim of damages by anyone, and there are no grounds of fault upon which his decision is required".

As regards Section 6(1)(c) and (d) further assistance can be drawn by me from determinations issued by fellow Sheriffs over the years, and their analysis of the scope of Section 6. Many of these decisions have been digested, and can be found in the

leading text book “Sudden Deaths and Fatal Accident Inquiries” by Ian Carmichael, Third Edition (2005).

I had regard to and indeed agree “That in making a finding as to reasonable precautions …. it is clearly not necessary for the Court to be satisfied that the proposed precaution would, in fact, have avoided the accident, or the death, only that it might have done, but the Court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied the precaution was a reasonable one”.

“The phrase “might have been avoided” is a wide one. It means less than “would, on the balance of probabilities, have been avoided, and to the contrary, directs ones mind to the direction of “lively possibilities”.”

“A Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death …. might have been avoided, and the defects, if any, in any system of working, which contributed to the death. The Sheriff is required to proceed on the basis of the evidence, without regard to any question of the state of knowledge requited at the time of the accident. The statutory provisions are concerned with the existence of reasonable precautions, or defects, in the system at the time of the accident or death, and are not concerned with whether they could, or should, have been recognised. They do not relate to the question of foreseeability of risk at the time of the accident. The statutory provisions are widely drawn, and are intended to permit retrospective consideration of matters, with the benefit of hindsight ….. There

is no question of the reasonableness of any precautions, depending on the foreseeability of this. Reference to reasonableness relate to the question of availability, and suitability, or practicality of the precautions, at the time of the accident resulting in death.

Sheriff Fiona Reith, QC, in January 2003 (death of Shamin Weir, 23 January 2003) said –

"In my opinion, the purpose of a Fatal Accident Inquiry is to look back, as of the date of the Inquiry, to determine what can now be seen as reasonable precautions, if any, whereby the death might have been avoided, and any other facts which are relevant to the circumstances of the death …. the purpose of the conclusions drawn is to assist those legitimately interested in the circumstances of the death, to look to the future. They, armed with hindsight, the evidence led at the Inquiry, and the determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future".

It may be said that the question of "reasonableness" is directed to the precaution which is identified. The issue is **not** whether an individual, or an organisation, behaved in a reasonable, or unreasonable, way, but whether or not there is a precaution which **is** a reasonable one, and which might have made a difference.

As regards Section 6(1)(d) [the defect, if any, in any system or working which contributed to the death,] it has been observed that before making any determination under Section 6(1)(d), the Court must, as a pre-condition to making any such

recommendation, be satisfied that the defect in question did, in fact, cause or contribute to the death.

It may, therefore, be taken that there must be a clear causal connection between the defect and the death. It is worth pausing to observe that the Act does not refer to defects which "might" have contributed to the death.

As regards Section 6(1)(e) (other facts which are relevant to the circumstances of the death), in my respectful submission, this has been well stated in Mr Carmichael's text book. The wording of this paragraph, although it gives the Sheriff wide scope, nonetheless, provides that the facts which the Sheriff finds established under this heading, must be relevant to the circumstances of the death. It means, it is submitted, that the circumstances of the death as they may affect the public interest.

Determinations

As invited to do by parties, and in terms of the matters agreed in the Joint Minute, and in the other evidence led before the Fatal Accident Inquiry, I am able to make the Determinations in terms of Section 6(1)(a), and Section 6(1)(b).

The more anxious matter in light of parties submissions has been whether I am able to make determinations in terms of Section 6(1) (c) (reasonable precautions), Section 6(1)(d) (any alleged defect in the system of work), and Section 6(1)(e) (any other circumstances relevant to the death).

Possible Determination in terms of Section 6(1) (c)

The question as to where I might be drawn to make any determination in terms of Section 6(1) (c) has been a most anxious one.

Very important evidence which bears on whether or not such a determination is appropriate in this case came from Mr Likhith Alakandy, the Consultant Neurosurgeon, who was called by the Crown to give evidence, and who, at the request of the Crown, had on 4 November 2009, prepared his Medical Report for the Court (production 10).

As to Mr Alakandy's eminence there is not doubt, nor was there any contradictor. Mr Alakandy is a Fellow of the Royal College of Surgeons of London, and also, of Edinburgh, and a fellow of the Royal College of Surgeons (Neurosurgery). As Mr Alakandy explained in evidence in chief, meningitis is in general terms, an infection of the lining of the brain and spinal cord. In most cases it can be dealt with by antibiotics. He is a Consultant Neurosurgeon, and has occasion to deal with the most complex cases of meningitis, for example, where pressure builds up in the fluid surrounding the brain, or where there is pus present. There are broadly 2 types of meningitis – viral, and bacteriological. The viral form, which is not present in this case, is the rarer. Bacteriological meningitis, which is the type which ultimately caused Mr Sorley's death (streptococcus pneumonia) has a number of different types.

These are much more rapid in the onset and progression, and are those with the worst prognosis. With this variant of meningitis, the treatment should begin as soon as possible. A difference of an hour or less can make a difference in the outcome. The symptoms can be a combination of headache, stiffness, and photophobia, agitation, a decreased level of consciousness, high temperature, and rash. Its is rare to have all of these symptoms present in one individual. If these are all present together, then that would make the presentation highly suspicious. For a doctor's diagnosis to be definitive will involve examination of the Cerebal Spinal Fluid, as this allows the isolation of the organism. Some forms of bacteriological meningitis can be relatively simply treated if, uncomplicated ,by antibiotics. However, the more complex form of the illness can lead to raised pressure within the brain which has to be released by lumbar puncture, or a drain from the brain. In preparing his report, Mr Alakandy had sight of the post mortem report (production number 2), the records of the Prison Service Health (production number 4), the medical records from Crosshouse Hospital (production number 5), and the medical records of the Southern General Hospital (production number 6). He had also seen statements of the treating nurses at the Prison, and of Prison Officers.

With reference to the post mortem report Mr Alakandy explained that the streptococcus pneumonia meningitis is of the bacteriological family. It causes inflammation, damage to the small blood vessels whereby areas of the brain are thereby starved of oxygen, causing, thereafter, an infart. Whilst this is a dangerous form of meningitis, it is actually once of the most common, not necessarily the most dangerous. However, this strain needs treatment as soon as possible. If it is diagnosed as being of this variant, it can be treated. If there is no prompt treatment,

this particular type of meningitis has rapid progression. This variant develops complications, that is to say increased pressure and damage to the blood vessels leading to infarts.

Mr Alakandy, in answer to a question from the Crown said that even if a person has had meningitis before, it does not necessarily make them more susceptible to suffer from meningitis again. Having seen previous medical records relating to Mr Sorley, all Mr Alakandy could say was there had been a possible (but as I understand him not certain) diagnosis of meningitis in 2002. His earlier examination of the earlier medical records led him to the view that it could not be confirmed that Mr Sorley had previously suffered from a particular strain of bacteriological meningitis. Whilst a skull fracture, a condition which Mr Sorley had, can mean that someone is more prone to catching meningitis again, Mr Alakandy's view, ultimately, was that here the best that could be said was a possibility, but no definite proof, that Mr Sorley had had a skull base fracture, and no certainty that he had previously had meningitis, although it was probable. It may be seen in the matters that follow, that possibility was not of such compelling significance given I have accepted that Mr Sorley's complaints that he had previously had meningitis were taken seriously by the appropriate nurses to whom he had imparted this information, and that their assessment of Mr Sorely at the various consultations was appropriate.

Mr Alakandy was asked specifically about the examinations by Nurses Fullarton and Richardson, and he was of the view that the assessments carried out by each of the 2 nurses were appropriate in terms of the tests which they had carried out to see whether the complaint of meningitis from Mr Sorley showed symptoms. In particular, as

regards Nurse Richardson, to whom Mr Sorley had said that he was "dying of meningitis …." Mr Alakandy was of the opinion that Nurse Richardson had carried out all the necessary examinations against a background specifically to look to see if there was confirmatory symptoms of meningitis. He was of the opinion that the continuing raised headache was a particular factor which would cause the nurse, as she did, to look for meningitis.

Having considered the evidence in the precognitions from other prisoners, and from Prison Officers, that Mr Sorley had been agitated after the departure of Nurse Richardson in the early hours of the morning, and that there had been further banging on his cell door, this was some indication opined Mr Alakandy, that there was a deteriorating situation. This led to the development of a decreased level of consciousness by approximately 06.45 hours when he was lying on the floor, when he did respond, but was apparently not talking to the Prison Officer.

Mr Alakandy was of the view that if a patient such as Mr Sorely is taken into hospital at the time he was conscious, then that **might** make a difference, so that then he could then be diagnosed as actually suffering from meningitis, and receive antibiotic treatment. Mr Alakandy did say that even with treatment there can be rapid deterioration, and that even with treatment there can be "bad outcomes". He did qualify his remarks as to what others may have done by acknowledging that he sees people in the environment of a hospital, not in a prison wing, or primary care environment. The significant factor for Mr Alakandy in this particular illness is this: the patient is losing consciousness, or has ultimately lost consciousness, and that is indicative of significant brain damage, and then the likelihood of recovery is

substantially reduced. When Mr Alakandy was asked specifically about the administration of Narcan to Mr Sorely, on the morning of the 17 June, he specifically advised that Narcan would have no adverse fact, and indeed, it would be appropriate to give Narcan to eliminate the possibility that his condition was caused by a drug overdoes.

Mr Alakandy was asked by the Crown in examination in chief whether there was anything different that could have been done may have changed the outcome, and Mr Alakandy's reply was that looking at the matter overall, only that Mr Sorley was not assessed further after the last assessment by the nurse at approximately 11.45 pm (Nurse Richardson). Perhaps a further review in an hour or two thereafter to assess the position of Mr Sorley would have been appropriate. He commented the nurse (Richardson) could have checked Mr Sorley's condition with the Prison Staff a couple of hours after her first visit, or arranged to go back and see him on her own volition.

In cross examination by Mr Brown, for the family, amongst other matters, but perhaps of significance to this Inquiry, and the possible presence of rash as an indicator of onset of meningitis, Mr Alakandy's view was that the rash that was apparently discovered in the post mortem examination was not necessarily significant as the rash can appear at any time, and often is actually more widespread that in just one area. I took it from that that he was not affording any weight to the presence of the rash at the post mortem examination as an indicator of meningitis. Again, in cross examination, Mr Alakandy indicated that his view was that Nurses Fullarton and Richardson had done all that a doctor might have done to test for meningitis, and they found nothing more or less than any doctor examining Mr Sorley at the 2 relevant

periods would have found. Mr Alakandy was asked by Mr Brown if Mr Sorley was last seen by Nurse Richardson at 11.45 pm or thereby, and that he was at the hospital approximately 11 hours later at Crosshouse, could the doctor opine, when Mr Sorley's condition became reversible. The doctor advised it was impossible to say that, but at sometime during the 11 hour period there would be a progressive time period during which brain injury would be irreversible. Mr Brown also asked Mr Alakandy as to his report (page 9) "I also think the patient's description of his or her symptoms being similar to a previous serious illness should not be ignored. Although I would not expect a nurse or a health care provider in a primary care setting to obtain in-depth history about the characteristics of the headache ….. I think arrangements should have been made to perform a repeat assessment in a short while, or instructions given to be contacted if the condition deteriorates". Mr Alakandy clarified that headaches are best diagnosed by a specialist, such as himself, and that he would not expect a nurse, or someone in primary care, to go into depth if there was only a headache. Mr Brown asked what either of the 2 nurses could have done in the evening to rule out that Mr Sorley **did not** have meningitis, and he said it very much depends on the place. In a prison, the persons examining would go on the clinical findings, whilst he, in a hospital might be able to perform a lumbar puncture, which although helpful, itself might not be definite. What one might do depends on the setting. He could not say whether the nurse should have taken Mr Sorley to the Health Centre, but reiterated that it was the reassessment a couple of hours later which could have been significant. When he was asked whether it ought to have been a nurse or a doctor who saw him at any reassessment, Mr Alakandy's answer to Mr Brown was that it would normally be the nurse first, to see if there had been any improvement or not, and if not, she could then refer the patient to the doctor.

On being asked questions by Miss Watt the solicitor acting for the interests of Nurses Fullarton and Richardson, he agreed that Nurse Fullarton's examination was entirely appropriate, and complete. In respect of questions regarding Nurse Richardson's examination of Mr Sorely, the doctor had been taken through the notes made, and the evidence given by Nurse Richardson. Mr Alakandy agreed that she had acted entirely appropriately in her examination of Mr Sorely, and described it as "thorough", which included looking out for the signs of meningitis. Miss Watt put Nurse Richardson's evidence to Mr Alakandy that if she had been in any doubt at all she would have phoned the doctor, and indeed, an ambulance, and Mr Alakandy confirmed that that would be appropriate. It was put to Mr Alakandy that Nurse Richardson had told Mr Sorley that he could get more analgesic later, and if he was not well he was to let the Prison Custody Officers know. Miss Watt asked if that was appropriate, and Mr Alakandy replied that either tell that to the patient, or practically arrange to visit to him, either of these options is acceptable, and that he agreed it was a reasonable option that she took (to tell Mr Sorley to let the Prison Officers know). He also agreed that it was reasonable that on her return to Health Care, Nurse Richardson had looked at Mr Sorley's note (see production number 4, pages 111 to 112), and made a note herself. Mr Alakandy agreed that it had been a reasonable step for her to take as she had recognised what Mr Sorley had said about the meningitis, and took steps to look. Mr Alakandy seemed to agree with Miss Waters that the options available to Nurse Richardson were herself to reassess Mr Sorley, or await a further call, and if there was grave concern, she could go back and reassess. Mr Alakandy seemed to agree with Miss Waters that Nurse Richardson had acted reasonably. In answer to Miss Irvine, Solicitor for SERCO, Mr Alakandy said a nurse would not necessarily

have the training to make all the links between headaches and agitation leading to loss of consciousness. Whilst he is obviously not nurse trained himself, he thought that a nurse might be able to spot any deterioration. In answer to further questions allowed by me to be put by Mr Brown, Mr Alakandy commented in the following way. He was asked regarding Nurse Richardson's instructions to Mr Sorley that she was to be called again if Mr Sorley continued to be unwell, and thereafter, Mr Brown invited the Doctor to consider as to whether it was preferable for him to be assessed in about 2 hours after the first examination. Mr Alakandy replied that he though both were reasonable options, but the preference would be, in his view, that the Nurse assess the patient again.

I now wish to deal with the submission as to whether I ought to make a determination in terms of Section 6(1)(c) as regard whether it would have been a reasonable precaution for Nurse Richardson to have seen Mr Sorley within a period of approximately 2 hours after her first visit to him at approximately 11.45 pm.

The Procurator Fiscal Depute submitted that a reasonable precautions in terms of the Act would have been for Nurse Sandra Richardson to make a follow up check on Mr Sorley after she had initially examined him at 11.45 pm, to determine if he had deteriorated, and for the Prison Officers , Craig Brown and Martin Knox, to ask Nurse Richardson to see Mr Sorley after midnight on 17 June 2008, given that he had continued to complain of being unwell, was agitated and noisy within his cell, to the point that other prisoners were complaining about the noise. To that effect the Procurator Fiscal Depute was particularly relying on the evidence Mr Alakandy. The Crown also relied on Nurse Richardson's own evidence that if she had gone back to

see Mr Sorley again that night, and he was still then complaining of headaches, she would have sought advice from the on-call doctor, or she might have called an ambulance if she thought one was required. I was asked to consider that whilst there was no certainty that Mr Sorley would have survived if he had been treated earlier, the thrust of the Consultant's evidence was clear that there was a possibility that he would have. The Crown submitted there was a real or live possibility, therefore, that Mr Sorley's death could have been avoided had he been seen again during the early hours of 17 June, and the Crown invited me to make findings in that respect.

On this particular point, Miss Irvine submitted that the doctor had confirmed that Nurse Richards had done all that was appropriate and complete, and that it was acceptable to tell the prisoner to call if more analgesic was necessary, or for her to go back to actually visit Mr Sorley. Both nurses, including Nurse Richardson, had looked for signs of meningitis, and that they had done what anyone else would have done. The Prison Officers on duty overnight were acting on the reassurance that Nurse Richardson had given to Mr Sorley that he did not have symptoms of meningitis. They had formed the view that Mr Sorley was agitated because he did not get what he wanted from the nurse, and that he eventually he quieted down, and went to sleep. It now appears that Mr Sorley was agitated because of his actual medical condition, and that his apparent going to sleep (to the view of the Prison Officers) was more likely a deterioration in his state of consciousness. She submitted Mr Alakandy confirmed that he would not expect someone without medical training to know that agitation and loss of consciousness were symptoms of meningitis. She submitted there was a system in place which allowed the Prison Custody Officers to contact Health Care to request a visit from a nurse, and that whilst they had taken a decision

not to contact Health Care, the decision cannot be based on medical knowledge of the signs and symptoms of meningitis, but must be based on the reassurance received from a medically trained member of staff earlier that night. I ought not, submitted Mrs Irvine,to have regard to Professor Coyle's comment in "criticism" of Nurse Richardson that she did not monitor Mr Sorley any further overnight. She submitted that with the utmost respect to the learned Professor, he was straying into areas of medical matters which were not within his competence or expertise. The Prison Custody Officers in their own evidence said that they had observed Mr Sorley more closely than other prisoners because they had some concern about him, following upon the visit from Nurse Richardson, but they were entitled to rely upon the fact that he had been seen now by 2 nurses, and were relying upon reassurances provided by medically trained staff (Nurses Fullarton and Richardson). The Prison Custody Officers had said that they would have contacted a nurse again if they had thought he had deteriorated, but they did form the view that he was unhappy because the nurse had not given him what he wanted, but thereafter, he had fell asleep.

Miss Watt submitted that Staff Nurse Richardson had said in evidence that if she had thought at any time that Mr Sorley was displaying signs and symptoms of meningitis, she would have called an ambulance. The Court was entitled to rely upon her as she was a very experienced nurse indeed. She was exercising clinical judgement based on a long standing clinical experience, and importantly, on the clinical picture presented to her when she saw and examined Mr Sorley in his cell at 11.45 pm. Whilst she accepted that one option was for Mr Sorley to be transferred to Health Care for observation, she said that if she had had any doubt at all, then she would have done that. She agreed that that was an option, but she did not believe it was necessary. The

clinical picture presented at that time was of a bad headache. The Court was reminded that after examination, Staff Nurse Richardson had returned to the Health Care centre, and checked the prison health records for Mr Sorley, which confirmed his admission to hospital for suspected meningitis in 2002, and that she had taken account of that, she had written up a full record of her examination in his Health Care record (Crown production 4). Whilst the expert witness, Mrs Waters, called by Mr Brown, had criticised Staff Nurse Richardson for not arranging for Mr Sorley to be admitted to the Health Care centre, Mrs Waters was not aware of the procedures involved, namely, that 3 Prison Custody Officers require to be present with a prisoner when the prison is in lock down, and indeed, was unaware that 3 Prison Custody Officers require to be present when prisoners are observed in the Health Care Unit. Miss Waters, the nursing expert, had said that Nurse Richardson ought to have phoned the wing to check on Mr Sorley, but it was submitted by Miss Watt that the Prison Officers were observing Mr Sorley, and had the opportunity, if they wished, to contact the nurse. As regards Mr Alakandy's view that one option was that Staff Nurse Richardson could have returned to carry out a further assessment of Mr Sorley on the wing. She submitted that this was only one of a number of options. Whilst Mr Alakandy had suggested a possible visit at 2.00 am, or thereby, approximately 2 hours after Staff Nurse Richardson's first visit, as an appropriate step, Miss Watt submitted there was no evidence specifically adduced that this was a reasonable precaution that might have avoided the death of Mr Sorley. This was because all the doctor could say was that that visit and reassessment might have been an option, but was unable to say when medical intervention might have avoided Mr Sorley's death, except to say that it ought to be sooner rather than later. It was submitted there was insufficient medical evidence to be able to say when medical intervention would have saved Mr Sorley,

and insufficient evidence to say what might have been found by Nurse Richardson had she made any visit, when than visit would need to have been made, and what would have been a realistic possibility of altering the outcome. If, for example, even telephoning the wing, might have been held on one view to be "a reasonable precaution" then on the evidence of the 2 Prison Custody Officers on duty, it would have not have had anything to report to the nurse, and eventually Mr Sorley had quietened. Accordingly, no finding should be made in terms of Section 6(1)(c) as to anything based on something done, or not done, by Nurse Richardson. Miss Watt submitted further that where the Court is considering the acts and omissions of an individual, it should only make a finding under Section 6(1)(c) when what was done could not be regarded as being reasonable. Further, that where a precaution is in the realm of a clinical decision, the action taken can be said to be unreasonable only when the course adopted is one which no professional person of ordinary skill would have taken if acting with ordinary care. The test is the standard of the ordinary skilled person exercising or professing to have that special skill. A professional acts reasonably if they act in accordance with a practice accepted as proper by a responsible body of professionals skilled in that particular act. I ought not to make a findings in terms of Section 6(1)(c) in this case.

Mr Brown submitted that Nurse Richardson ought to have made further enquiries of the remaining staff for the remainder of her shift during the night, and ought to have directed them to keep an eye on him, and to report any concerns that would have assisted. The Prison Officers did not revert to Nurse Richardson. Mr Brown submitted that I should prefer the evidence of Miss Waters, the nursing expert called by him, that Staff Nurse Richardson ought to have contacted the doctor, especially

after seeing his medical records. She should have then contacted the Prison Custody Officer again, and directed them to watch Mr Sorley's demeanour, perhaps also removing him to Health Care that would have been good practice, so that Mr Sorley could have been observed, and so that a further assessment could be carried out, and then again the doctor contacted if there was an apparent deterioration. Under reference to nursing standards spoken to by Miss Waters, Nurse Richardson should have gone back to see Mr Sorley.

Reasoning

In making a Determination in terms of Section 6(1)(c), I was particularly impressed by the evidence of Mr Alakandy, and to some extent, by the testimony of Miss Waters, the nursing expert called by Mr Brown, on behalf of the Sorley family, as to appropriate nursing actions which might be expected.

Whilst I do accept Miss Watt's criticisms of much of what was led in evidence by Mr Brown from Miss Waters as being very much after the event, and very much based on information relayed to Miss Waters by Mr Brown, and from statements from precognitions (and I observe too much centred on civil court doctrines of "standard of care" and by inference, departure from them being "negligent"), I am able to accept her evidence, taken with the judgement of Mr Alakandy, that it would have been appropriate nursing, and thus a reasonable precaution in the circumstances for Staff Nurse Richardson to have returned to see Mr Sorley within 2 hours of her initial consultation with her.

Whilst, of course, Nurse Richardson, and I accept this, had carried out all necessary examinations, and tests of Mr Sorley's at approximately 11.45 pm on 16 June 2008, and had found no signs of meningitis (pausing also to say that Mr Alakandy, and Dr Kopal's, evidence in terms confirms that the assessments made then by Nurse Richardson were appropriate at that time), I am drawn to the view that had she returned to visit Mr Sorley within the hall it is likely that she would have seen a deterioration in Mr Sorley, and been able to hear further complaints from him, and to re-assess him at that time. Moreover it was within her knowledge that Mr Sorley had been seen by Nurse Fullarton, and by herself, some hours apart, and yet there was still complaints from Mr Sorley as to how he was feeling. To that may be added Nurse Richardson's own, at that point, appropriate noting up of Mr Sorley's condition, and the check of his medical records which revealed the possibility that he had earlier, some 5 years before, or thereby, suffered from meningitis, and was now complaining again of similar symptoms, albeit her own assessment at that time was not able to confirm that. Such further assessment at the later period of two hours or so later after her initial assessment was, in my view, likely to have found that Mr Sorley was still in pain, and with headache, and was deteriorating. From the evidence of Mr Alakandy as to the importance of dealing with a conscious patient, potentially suffering from meningitis, as early as possible, she would have been able to carry our her own further assessment, and drawn on his continuing complaint, now of some hours duration. That would have afforded her the opportunity to contact Dr Kopal even in the early hours of the morning.

Whilst I do accept there is absolutely no certainty that such an assessment would necessarily have saved Mr Sorley's life by having him removed to hospital at that

stage, rather than at approximately 10.00 am in the morning by ambulance to Crosshouse, it is, in my view, standing the evidence of Mr Alakandy, and Miss Waters, and evidence from Dr Kopal as to his knowledge of the progressive nature in the onset of meningitis and the importance of early intervention, a lively possibility that intervention with Mr Sorley at that stage is likely to have had some positive effect. In my view, therefore, it would have been a reasonable precaution for Staff Nurse Richardson to re-assess Mr Sorley. I do have regard to the reality that an arranged visit by Nurse Richardson at around 2am would have necessitated the presence of additional prison officers as there would be the opening up of Mr Sorley's cell after "lock down". This had been necessary at her first visit . However, if the Prison is to seek to replicate medical facilities available in the community then arrangements would have required to be made to open up the cell to allow Nurse Richardson to carry out that further assessment. It is my view, based on the evidence from Ms Waters that it was appropriate for a nurse to make a later check on the patient ,Mr Sorley, against Nurse Richardson's knowledge of her own and her colleagues' earlier examinations showing persistent headache and continuing feelings of malaise and the examination of Mr Sorley's medical records Nurse Richardson had carried out on her return to health care after her assessment of Mr Sorley, that it would have been a reasonable precaution for Nurse Richardson to make arrangements to see Mr Sorley in the cell within 2 hours to see how he was. It is likely she would have found a deterioration in Mr Sorley's presentation as evidenced,, by the evidence of not only the prisoners but the evidence of the two PCOs on duty that Mr Sorley was continuing to complain about his condition, which would have prompted her either to contact Dr Kopal for advice and/or at her own hand arranged for Mr Sorley's transfer to hospital.

I respect Miss Watt's careful analysis of legal principles as to professional care, but these are more relevant to Civil Courts, and questions of negligence with which the Inquiry is not dealing, only with precautions whereby the death could have been avoided.

Mr Brown also invited me, as did the Procurator Fiscal, to consider the actions of the 2 Prison Officers on duty on the night shift as to whether they ought to have alerted Nurse Richardson. I am drawn to the view that notwithstanding I accept that Mr Sorley may well have been expressing dissatisfaction, and accepting in part, the evidence of other prisoners that there was noise emanating from Mr Sorley's cell, those Prison Custody Officers were, in my view, not medically qualified persons and were entitled to accept the inference at 11.45 pm, or thereby, from Nurse Richardson that there was in terms nothing further for them to do. In my view, it is an important circumstance that both these Officers are not medically qualified, nor should Prison Custody Officers reasonably be expected so to be, and, in my view, they are entitled to rely on advice tendered by medical professionals to them and to expect that those medically qualified persons carry out further assessments as they deem appropriate..

In these circumstances, I have not deemed it appropriate in terms of Section 6(1)(c) to make any determination in respect of Prison Custody Officers Brennan and Knox. Questions as to whether Nurse Richardson should have given **specific** direction to those Officers as to what they were to look for, are, in my view, not to the point. Again, those Officers are not medically qualified, albeit they are experienced in observing prisoners. I accept that had they themselves been particularly concerned, they would, in terms of protocols, have contacted the Health Care Unit again, but their

observations did not inform them to take that step. In my view, it would not be reasonable to expect some detailed check list could have been, or ought to have been, left by Nurse Richardson with those 2 Officers to inform them to what extent, and to when, they ought have contacted the Nurse again. She was the medically qualified person; it was for her to carry out any further nursing assessments.

Possible Determination in terms of Section 6(1)(d)

I have, after due anxious consideration, been drawn to the view that in the circumstances of this Inquiry, it is not open to me to make a determination in terms of Section 6(1)(d).

I am satisfied on the evidence led before me, that there is a robust Health Care system within H M Prison, Kilmarnock, as to the systems of work. Prisoners can request to be seen, and evidence suggests they are seen by professional medical practitioners such as nurses, and ultimately, the Prison doctor. Prison Custody Officers are aware, as indeed the prisoners are, of the systems for obtaining such medical advice, and in my view, the events of the evening of 16 June, whereby Mr Sorley was seen appropriately by Nurse Fullarton, and then again, later in the evening, prior to midnight, by Staff Nurse Richardson, are indicative that the systems of communication are, indeed, robust. There is "coordination" between the Prison Custody Officers, and the medical professionals, in that the Prison Custody Officers can have recourse to professional medical advice and assistance, and ultimately, to the prison doctor. In my view, it would not be reasonable, as I believe Mr Brown was seeking to submit to the Inquiry for there to be any further formal systems in place

involving prisoners, Prison Custody Officers, and the medical professionals within the Prison.

Under this general heading, I would deal, too, with any suggestion that there was lacking any proper arrangement for handing over a prisoner from the Prison to the Scottish Ambulance Service. I should say that I preferred the evidence as to the terms of the handover given by Dr Kopal, rather than Ms Carlyle, and only briefly comment further to say that in any event, as was confirmed by Dr Marden, at Crosshouse, she, from her own clinical observations, was able to take all necessary steps that she felt appropriate, and there was no detriment to her work, or that of her medical colleagues at Crosshouse, by any alleged defect of information. And I say there was none, in the handover from the Prison, via Dr Kopal, to Scottish Ambulance Service.

Possible Determination in terms of Section 6(1)(e)

I do understand, and respect, that Mr Brown, on behalf of the family, had other observations that the family were anxious to have raised within the terms of the Inquiry, however, I have to be satisfied that any other finding made is relevant to the circumstances of the death.

I have been unable, after due reflection, to make any finding on any such circumstances, in terms of Section 6(1)(e).

Clearly, from the submissions made by Mr Brown, I recognise that there was family concern about Mr Sorley being in handcuffs whilst unconscious, and whilst being

taken from the Prison. I am satisfied that that factor had no bearing, whatsoever, on the treatment of, or on the ultimately untimely sad death of Mr Sorley. As Dr Marden observed in her own evidence, it was a common occurrence that prisoners coming from H M Prison, Kilmarnock to Crosshouse Hospital, come in some form of handcuff or other restraint, and that historically, and in the present circumstances of Mr Sorley, that presented no difficulty in appropriate medical treatment being afforded. Indeed, Dr Marden commented that Prison Officers can, and do, remove such restraints at the prompting of a doctor, should it prove necessary to assist the Doctor in carrying out medical treatment. I pause simply to comment here, also, that Miss Carlyle's evidence about the handcuffs, whilst clearly shows that she had some **personal** concern, is not based on any objective medical concern, and did not prevent her in any way from affording any treatment which she deemed necessary to Mr Sorley on his transmission from the Prison to Crosshouse Hospital.

As regards medical records, I am entirely satisfied that the fact, as I think more likely than not, that the medical records were not with Mr Sorley on his transfer from Greenock Prison to H M Prison, Kilmarnock, did not have any relevance to Mr Sorley's ultimate sad demise. The receiving personnel carried out the necessary checks, and Mr Sorley was seen by Dr Kopal within the required period. It is clear from the medical records and evidence of Dr Kopal that Mr Sorley from his admission to H M Prison, Kilmarnock, until his removal by ambulance, was treated for a number of varied conditions appropriately by Health Service personnel, including Dr Kopal, at the Prison, but none of these related in any way to any history of possible meningitis, and in my view, objectively the question of records being available is not a circumstances relevant to Mr Sorley's death.

Mr Brown had raised with the Inquiry during his cross examination of witnesses, and in his submissions, questions directed to, broadly, the standards of nursing care within the Prison setting. To a large degree, he founded on the evidence of Ms Waters. Questions as to whether nurses should be general nurses, or mental health nurses, are not, in my view, legitimate subjects for this Inquiry, unless there was evidence that any "balance" between those groups, adversely impacted on Mr Sorley, and was a relevant circumstance. In my view, it is not unreasonable for the Prison Authorities to decide what the appropriate level of nursing care ought to be, and the balance of same in terms of the personnel deployed. There is no evidence before the Inquiry which tends to suggest that any circumstances pertaining to that, was relevant to the circumstances of Mr Sorley's unfortunate demise.

Again, Mr Brown no doubt given the family's concerns, was anxious to advance whether the suspicion of a drug overdose had impacted on the treatment, in the general sense, of Mr Sorley, following upon the visit by Nurse Richardson, and the treatment afforded to him by Nurse Ngulele, and Dr Kopal, on the morning of 17 June 2008.

I am satisfied from the evidence of Prison Officers, Dr Kopal, and indeed, Mr Alakandy, that notwithstanding the efforts made by Prison Authorities, and indeed, by prisoners such as Mr Sorley (whom all regarded as someone who was endeavouring to remain drug free), that even in enhanced drug free halls, there are relapses where prisoners otherwise on the road to recovery, relapse into drug taking. Therefore, there is, understandably, concern that prisoners are tested regularly, and if

there is a suspicion, as there was possibly one, although not borne out in reality, that Mr Sorley's condition may have been influenced by some form of drug taking, it is entirely appropriate, in my view, that Prisons have systems in place to have drug testing carried out. The fact that this may well have taken place sometime on 17 June, had Mr Sorley not, by that stage, been removed to Crosshouse, was not a relevant circumstance. Nor is it a relevant circumstance that Narcan was administered. As Dr Kopal, and Mr Alakandy said, Narcan has no adverse effects in itself, and is an appropriate medication to give if there is any suspicion of an overdoes, when a prisoner is found lacking consciousness, as there may, at the root of that, be an episode of drug overdoes. The administration of Narcan to Mr Sorley on the morning of 17 June, was appropriate. As soon as there was no evidence of the Narcan having a positive effect, for example, that Mr Sorley was not returning to consciousness, appropriately, then, Dr Kopal called for a "blue light" ambulance to be summoned immediately.

Questions raised in the Inquiry by Mr Brown, on behalf of the family, as to the searching of the ambulance on its arrival and departure, did not impact on the treatment of Mr Sorley. It seems to me reasonable that vehicles coming in and out of a prison ought to be searched for what ought to be obvious security concerns. I am satisfied from the evidence of Mr Murray, that the situation in 2008, and in 2011, when the evidence was led, was that dispensation can be given, if appropriate. In any event, the time which elapsed between the summons of the ambulance, and its attendance at the hall, were well within the 8 minutes allowed, and were not interfered with, in my view, by the necessity of any search of the ambulance on its arrival, or indeed, its departure.

Before closing, I would wish to mention the evidence of Professor Coyle. Mr Brown called Professor Coyle, but his evidence was ultimately brief. That, of course, does not reflect on Professor Coyle's eminence in his own field, as a former prison Governor, and now academic, internationally recognised as an expert as to the running of prison establishments. I only comment that Professor Coyle very properly acknowledged that his expertise went to matters of prison organisation, in the broadest sense, and did not trespass at all, and he was ultimately careful, it must be observed, not to comment on matters relating to clinical areas. There is nothing arising from the evidence of Professor Coyle which would cause me to make any findings in terms of Section 6(1)(e).

All the final submissions made by parties had one common theme. They all commended the attendance of Mr and Mrs Sorley throughout the term of this lengthy Inquiry, and indeed, the dignity they had shown in their careful attention to the evidence which was being led before the Inquiry. I mention that because some of the evidence, clearly, would have been upsetting to them. They clearly had concerns that they had instructed Mr Brown to raise on their behalf In doing so they have attended to the interests of their son in having matters examined diligently over many days of evidence.

All parties, also, expressed, most appropriately, their sympathy for the loss that Mr and Mrs Sorley have suffered.

This present determination may be of some form of closure to them. I, too, join with all those who observed them throughout the Inquiry in commending their diligence in attending to the interest of their late son, Mr Andrew Sorley, and the dignity that they exhibited throughout this Inquiry, especially where some of the evidence must have caused them emotional upset.

I, too, therefore express the Court's sympathy for the loss of their son, Andrew Sorley.