INQUIRY HELD UNDER FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976 INTO THE DEATH OF STEPHEN REYNOLDS v.

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

INQUIRY HELD UNDER FATAL ACCIDENTS AND

SUDDEN DEATHS

INQUIRY (SCOTLAND)

ACT 1976

SECTION 1(1)(a)

SECTION 1(1)(b)

DETERMINATION by EDWARD F BOWEN QC, Sheriff Principal of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at GLASGOW on the TWENTY NINTH day of OCTOBER TWO THOUSAND AND ONE and subsequent days into the death of STEPEHEN REYNOLDS.

GLASGOW, 25 February 2002.

The Sheriff Principal, having considered all the evidence adduced, DETERMINES: in terms of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 Section 6(1) (a) that STEPHEN REYNOLDS, aged 23 years who resided at James Duncan House, 331 Bell Street, Glasgow, died at said address at 10.30 hours on 28 May 2000;

(b) that the cause of death was Multiple Organ Failure secondary to necrotising fasciitis and toxin producing organisms;

(c) that there is no evidence of any precautions which might have avoided the death of the deceased;

(d) that the death of the deceased was not caused by any defect in a system of work;

(e) that the following facts are relevant to the circumstances of death:

(1) The deceased had a drug addiction problem from the age of about 15 years. He was initially a cannabis user but progressed to heroin at least four years before his death. At the time of his death the deceased was a resident of James Duncan House, 331 Bell Street, Glasgow.

(2) At 19.44 hours on 25 May 2000 the deceased was admitted to the Accident and Emergency Department of Glasgow Royal Infirmary. He was complaining of a painful swelling in the right groin where he admitted to having injected drugs. His blood pressure and pulse were normal but his temperature at 38 degrees centigrade was high. He was seen by a senior house officer at 22.10 hours. He was relatively well and co-operative. No groin abscess nor any indication of it such as fluctuant mass was noted, but there was an area of erythema leading to an impression of cellulitis. His white cell count was high at 19.1. It was decided to admit him, to administer flucloxacillin and benzyl penicillin intravenously and to obtain blood cultures if possible.

(3) The deceased was seen on the morning of 26 May. He was a apyrexial. Examination by ultrasound was arranged and this was carried out in the course of the day. It was unremarkable and in particular disclosed no abscess formation. The impression was of swollen lymph nodes likely to be due to underlying cellulitis. He was discharged home with seven days supply of antibiotics.

(4) The deceased was found in bed apparently lifeless by a hostel assistant on the morning of 28 May 2000. Death was confirmed by ambulance attendants who attended at 09.10 hours. A police surgeon who attended pronounced life extinct at 10.30 hours. The surgeon observed numerous old injection marks on the body of the deceased and a fresh injection mark in the area of the groin.

(5) Post-mortem examination revealed an extensive pericardial effusion and small bilateral pleural effusions. There was oedema round the right groin with haemorrhage into tissues and an acute inflammatory infiltrate with possible necrosis of muscle fibres. Microbiological examination of tissues from the groin identified the presence of a clostridium novyi infection.

NOTE:

[1] For my comments on the background to the multiplicity of deaths of injecting drug users in Glasgow during the period April to August 2000 reference is made to the General Note appended to the Determination in the case of Andrea McQuilter.

[2] There is little doubt from the post-mortem findings and in particular the cultivation of clostridium novyi at microbiology that this was a case of multiple-organ failure caused by the spread of toxins from that infection.

[3] The only issue is whether the condition affecting the deceased should have been identified when he was at Glasgow Royal Infirmary on 25 and 26 May. I am satisfied that it could not. The deceased at that stage bore no more than the classic symptoms of cellulitis, a common presentation. The treatment given for that was appropriate and the findings following ultrasound excluded the presence of an abscess and any collection of fluid.

[4] The case is an example of how relatively innocent presenting symptoms can develop to fatal illness with great rapidity where infection caused by the presence of clostridum novyi is present.