

**INQUIRY UNDER THE FATAL ACCIDENT AND INQUIRY ACT INTO THE SUDDEN DEATH OF JORDAN
MCLAUGHLIN**

Sheriffdom of South Strathclyde, Dumfries and Galloway at Hamilton

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

(hereinafter referred to as "the Act")

DETERMINATION

by

Sheriff V Smith Esquire

Sheriff of South Strathclyde

Dumfries and Galloway at Hamilton

in

FATAL ACCIDENT INQUIRY

regarding

Jordan McLaughlin

Hamilton:

The sheriff, having considered all the evidence adduced, determines:-

(1) In terms of section 6(1)(a) of the Act that Jordan McLaughlin, residing at 16 Hamilton View, Uddingston and who was born on 17th February 1986, was formally pronounced dead at 6.50 am on 30th September 2004 within ward 26, Monklands District General Hospital, Airdrie.

(2) In terms of section 6(1)(b) of the Act that the cause of death was -

(a) Waterhouse Friderichsen Syndrome

(b) Meningococcal Septicaemia.

NOTE

This inquiry was held in terms of section 1(1)(a)(ii) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Jordan McLaughlin who was pronounced dead on Thursday, 30th September 2004 within ward 26, Monklands District General Hospital, Airdrie (hereinafter referred to as "Monklands hospital").

The inquiry began on 14th August 2006 and further evidence was heard on 15th August, 16th August and 18th August 2006.

The procurator fiscal was represented by Mrs Sinclair, procurator fiscal depute. Mr Holmes appeared on behalf of the Medical and Dental Defence Union and in particular Dr. Musharaf Shah. Mr. Jessiman appeared on behalf of Mr. W T A Todd, consultant. Mr Stewart appeared on behalf of Mr. Peter Paterson, consultant and Mr Crerar appeared on behalf of Lanarkshire Health Board and Monklands District General Hospital, Airdrie. There was no other representation at the inquiry.

Evidence was led from 14 witnesses. There were seven productions lodged by the Crown and two productions lodged by those acting on behalf of Dr. Peter Paterson.

The following is a list of those witnesses who gave evidence to the inquiry, together with details, where appropriate, of their status at the relevant time.

1. Mr. James McLaughlin, father of Jordan McLaughlin.
2. Mrs. Mary McDowall, aunt of Jordan McLaughlin.
3. Mr. Brian Glass, divisional training officer, Scottish ambulance service.
4. Dr. Musharaf Shah, general practitioner.
5. Dr. Jai Kural, general practitioner.
6. Dr. Ram Mukkamala, senior house officer, Monklands hospital.
7. Dr. Balvinder Singh Mann, consultant pathologist, Wishaw general hospital.
8. Dr. Rifat Rashid, senior house officer, Monklands hospital.
9. Dr. Dominique Von der Straten, senior house officer, Monklands hospital.
10. Mr. Peter Paterson, consultant anaesthetist, Monklands hospital.
11. Dr. Norman Wallace, general practitioner.
12. Mr. William T.A. Todd, consultant physician in infectious diseases, Monklands hospital.
13. Mr. Simon Nadel, consultant paediatric intensivist, St. Mary's hospital, London.
14. Mr. Thomas Cripps, consultant anaesthetist, Borders general hospital.

At the outset the procurator fiscal depute stated that the parents of the deceased would not be represented at the inquiry. The father of Jordan McLaughlin would be called to give evidence but his mother could not attend as she was still very distressed about the entire matter.

It may be helpful, particularly for the relatives, if I set out the duties and powers of the sheriff in respect of this determination. These are contained within section 6 of the Act. This section provides as follows:-

"(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, 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 and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the 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 the death; and

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

There are certain preliminary matters worth mentioning and these are that:-

(a) An inquiry of this nature is not determining any question of civil fault or liability (*Black v Scott Lithgow Ltd* 1990 SLT 612).

(b) Any determination cannot be founded upon in any subsequent proceedings (section 6(3) of the Act).

(c) Despite the wording of section 6(1)(c) the sheriff does not have power to make findings of fault or to apportion blame.

(d) In terms of section 4(7) of the Act the rules of evidence shall be as nearly as possible those applicable in an ordinary civil cause brought before the sheriff.

(e) The standard of proof is the balance of probabilities and facts and circumstances can be established without the necessity of corroboration.

At the end of the inquiry I was asked by Mrs. Sinclair to make determinations in respect of sections 6(1)(a) and (b) of the Act only i.e. the time and place of death and the cause of death as stated on the death certificate. These are sometimes referred to as formal findings. I was not asked by the depute to make any further findings in my determination. This submission was adopted by all other legal representatives. However, I decided that Jordan's family ought to be included and given the opportunity to state their own case and to ask the court to consider their submissions about possible findings. Members of the family had been present throughout the inquiry. Jordan's father and aunt had given evidence at the start and had remained in court thereafter. The family was not represented at the inquiry and on questioning by the court it was stated that they had been unable to secure legal aid to allow them to instruct a solicitor. In these circumstances I thought it appropriate to give them the opportunity to raise any matter which they wished me to consider in reaching my determination. Mrs. McDowall, the aunt of Jordan who had given evidence, spoke on the family's behalf. She raised certain matters which I shall deal with in due course but to do so it is necessary to set out the background to this very sad case.

SUMMARY OF EVENTS

Jordan McLaughlin was eighteen years of age when he died. He was a tall, fit, healthy young man with no history of any significant illness. On 29th September 2004 he had been unable to attend his employment due to the fact that he was suffering from 'flu like symptoms, had an earache, a headache and was generally feeling listless although he did not have a high temperature. That same night he developed a rash and as a result an emergency doctor, Dr. Musharaf Shah, employed by Medicare Lanarkshire, was called out arriving at 10.50 pm. The doctor noted his history and symptoms, carried out an examination and performed certain tests (production 2). Due to the presentation Dr. Shah considered meningitis but could find no signs of this and reported this in his note. In particular the rash, which was all over the body was itchy, and was non haemorrhagic. It was of the blanching variety i.e. when pressure was applied it disappeared momentarily. If the rash had been haemorrhagic or non blanching and not itchy then this could have been an indication that

meningitis was present but the standard tests to ascertain if there was possible inflammation of the meninges or covering of the brain and spinal cord were negative. Dr. Shah concluded that the rash was caused by an allergic reaction and also diagnosed an upper respiratory tract infection prescribing antibiotics and an antihistamine. Approximately two hours later a further call was made to Medicare Lanarkshire. The doctor who dealt with the second call decided that Jordan ought to be taken to hospital primarily because he had already been seen that night and his condition was not improving. He arrived, by ambulance, at the accident and emergency department of Monklands hospital, Airdrie at 01.49 on 30th September 2004. Upon examination there by Dr. Ram Mukkamala it was noted that there was a rash which was confined to a relatively small area on his neck but was purpuric i.e. was haemorrhagic or non blanching and which was rapidly spreading all over the body. That the rash was now haemorrhagic signified that blood was escaping from the vessels. This, taken with a weak pulse, a fast heart beat, additional sounds in his lungs and bowels, a tender upper abdomen and the other symptoms described by Jordan caused Dr. Mukkamala to make a provisional, working diagnosis of meningococcal septicaemia. This diagnosis was later confirmed to be correct from blood samples taken at that time. It should be pointed out that at no time did Jordan have meningitis. Dr. Mukkamala immediately prescribed the appropriate antibiotics and other fluids and these were being administered to Jordan within minutes of his arrival.

The on duty senior house officers were contacted viz. Dr. Rifat Rashid, who specialised in infectious diseases and Dr. Dominique Von der Straten, a specialist in anaesthetics. They both arrived as quickly as possible. They noted that the rash was spreading rapidly and they agreed with the original diagnosis.

Of the four doctors who had so far examined Jordan none had experience of meningococcal septicaemia. This is a rare condition which can be very difficult to diagnose and it may be of assistance to provide some detail of its background as given to the inquiry.

The bacterium known as meningococcus, also called Neisseria Meningitis, resides in the nasal passages of approximately 10% of the population. It is acquired and will not necessarily cause harm. The body is normally able to contain this organism but on occasions the bacterium enters the system. When it does so it can focus solely on the meninges, the membranes that cover the brain and spinal cord which become inflamed leading to the condition known as meningitis. However the bacterium can also invade the blood stream poisoning that system and when that happens the subsequent condition is known as meningococcal septicaemia. There then occurs what is known as a cascade reaction whereby the organs of the body are influenced and rapidly cease to function properly. The body has difficulty coping with this and subsequently there is a high mortality rate. The survival rate of meningococcal septicaemia has not changed significantly over the past forty years with a mortality rate of between 25% - 35%. This is considered to be a high mortality rate and is due to the fact that the condition involves an organism which can trigger off dramatic changes in the body which it turn can produce very severe illnesses. Some virus triggers off this invasion of the blood system and the sequence of events thereafter but the exact reason why this should be so is not known although often there appears to be a link between the invasion of this bacteria and a 'flu like illness or sore throat being present. It is not understood as yet why some patients decline so rapidly and why there is such a high mortality rate. Nor is it understood why on occasions the bacterium focuses solely on the brain and the patient develops meningitis and why on rare occasions the bacterium enters the blood system with such dramatic consequences. Not everyone develops meningitis who has meningococcal septicaemia and this was true in Jordan's case.

In its early stages it is very difficult to diagnose meningococcal septicaemia but the signs and symptoms include a 'flu like illness, and then as the organism grows and spreads the temperature

risks, the patient becomes very unwell, possibly confused, there is a faster heart rate and fast breathing. These are all signs of the body becoming toxic. The body will react to combat the organism and this in turn leads to haemorrhages on the skin. In later stages this haemorrhaging produces a purpuric rash, that is where blood leaks into the skin and when pressed does not blanch or disappear. This is what was noted by the doctors upon Jordan's admission to hospital.

The term Waterhouse Friderichsen Syndrome applies to haemorrhages in the adrenal glands associated with meningococcal septicaemia. The adrenal glands produce, *inter alia*, hormones which address blood pressure and with this syndrome the adrenal glands collapse. This is what happened in the current case. Meningococcal septicaemia is a severe disease and often it is unpredictable as to how the condition will develop. It requires constant observation with intervention procedures depending upon progress. It can progress at an astonishing rate. Once toxins are released it is difficult to reverse the process and accordingly the sooner the disease is diagnosed and treatment given the greater the chance of success. By the time this patient had arrived at the hospital complications had already commenced and it was unlikely that the process could have been halted, in particular the continuing damage to the organs. In effect the organs were shutting down. The administration of antibiotics was in an effort to eliminate the organism and then to allow time to look for and treat any other problems caused by the condition.

TREATMENT OF JORDAN McLAUGHLIN

A plan was prepared to treat Jordan. This included the immediate administration of antibiotics and fluids in accordance with the guidelines adopted in such presentations, catheterisation, transfer to the intensive care unit and the insertion of a central venous line. Other procedures were necessary including the taking of x-rays and the analysis of blood samples to measure the progress of the condition. Catheterisation and a central venous line assisted the medical staff in measuring the level of fluids in the body. A central venous line provided the more accurate measurement of the level of fluids in the body with a view to deciding how much would be administered. It is also possible to administer drugs via a central venous line and it provides a better assessment of the heart and venous pressure. The insertion of a central venous line is a potentially dangerous procedure as it involves placing a needle and line into the left side of the neck, close to major blood vessels. A local anaesthetic is administered and it is a sterile procedure with the medical staff wearing masks and gowns. With Jordan a problem arose before a central venous line could be inserted. Blood pressure has to be monitored constantly and an early blood test had shown that there was abnormal blood clotting caused by sepsis and it would not have been appropriate to insert a central venous line until any blood abnormality had been corrected because a side effect of inserting a central venous line was that it in itself may cause bleeding. As a result fresh frozen plasma was to be given to address this problem and only once it was resolved could a central venous line be attempted.

The treatment and management plan prepared by Drs. Rashif and Von der Straten was discussed and approved by the two on call consultants who were contacted at home. The consultants, Mr. Peter Paterson, consultant anaesthetist and Mr. William T.A. Todd, consultant physician specialising in infectious diseases, were sufficiently concerned by this case that both came to the hospital to assist in the treatment of Jordan.

Throughout the night Jordan's condition was constantly monitored with the appropriate treatment being administered in accordance with his response. Despite all their efforts the medical staff were unable to halt the rapid progress of this condition or to reverse the situation. The organs had been irreparably damaged and death was inevitable, occurring within five hours after his admission to hospital.

MATTERS RAISED BY THE FAMILY OF JORDAN McLAUGHLIN

Mrs McDowall, the aunt of Jordan, spoke on behalf of the family. She asked the court to consider in its determination certain matters and she did so in a most coherent manner and ought to be commended for what was a daunting and emotional experience for her. As I understood her there were six matters that she wished me to consider and these were as follows.

1. It had been stated in evidence that the ambulance crew would have administered an injection if a haemorrhagic rash had been noted by them but none of the crew had given evidence and therefore the rash could have been present.

I have concluded that I cannot make a determination on this matter in terms of section 6 of the Act. It was correct to say that the ambulance crew who had transferred Jordan to hospital were not called to give evidence. Evidence was heard, however, from Mr. Brian Glass, a training officer with the Scottish ambulance service with 26 years service. He explained to the court that in some circumstances ambulance crews and paramedics could administer medicinal drugs if certain criteria were met. This included administering benzopenicillin and fluids where meningitis or meningococcal septicaemia was present. In the present case the witness understood that benzopenicillin was not administered to Jordan because it was considered that he did not fit the criteria although he himself had not spoken to the ambulance crew. He would have expected that Jordan would have been examined by the ambulance crew to see if there was a rash and if there was a rash to test if this was of the blanching or non-blanching variety. If it was a non-blanching rash then benzopenicillin would have been administered.

Mr. Holmes in his response to what had been said by Mrs. McDowall acknowledged that there was no evidence before the court from the ambulance crew but that there was a protocol that the crew followed when a rash was present and if it was haemorrhagic then penicillin would be administered. If it had been administered then this would have been on the medical notes and from this it could be inferred that a haemorrhagic rash was not present.

I have concluded that I cannot answer this matter as it does not fall within my powers to do so in terms of section of the Act. In the absence of any evidence from the ambulance crew I cannot speculate as to what happened on the journey to the hospital. However it is true to say that the medical history as noted did not include an entry about the administration of drugs or fluids to Jordan by the ambulance crew or any record that they suspected some form of meningococcal disease. Any intervention by the crew would have been important and there may be some merit in the submission of Mr. Holmes that in the absence of such a note it can be inferred that the crew did not notice any condition that merited such intervention.

2. It was stated by Dr. Shah in evidence that to ascertain the type of rash he noted he had carried out tests using his stethoscope and thumb. This detail was not on his note and the family would like doctors to state in future the type of tests they carried out in similar situations.

I have concluded that I cannot make a determination on this matter in terms of section 6 of the Act. It is correct that Dr. Shah was able to expand upon his note when giving evidence but it is not the function of an inquiry to set out medical procedures that must be adopted in practice. Nevertheless what can be said is that Dr. Shah prepared a very full note of what was presented to him and this was commended by Dr. Wallace, an expert in general practice, who gave evidence to the inquiry.

3. When a patient presented with 'flu like symptoms and a rash the family would like to see doctors erring on the side of caution and send these patients to hospital.

I have concluded that I cannot make a determination on this matter in terms of section 6 of the Act. Once more it is not within the power of the court to set out medical procedures that must be followed in practice. It was stated in evidence, however, that a general practitioner may see two or three people every day who present with such symptoms and to send all of these to hospital would be impractical and the system could not cope. There had to be a reason for referring a person to hospital.

4. According to the evidence of Dr. Nadel, one indication of shock or sepsis was the output of urine or the lack of it yet a urine catheter was not inserted until 3.30 am and a central venous line some time after that. No explanation had been given to the inquiry why this took so long although it was accepted by the family that these procedures were carried out in accordance with the current guidelines. The family sought changes to these guidelines as these procedures ought to be carried out as quickly as possible. This was particularly appropriate in the case of healthy, young people.

Once more it would be inappropriate for this inquiry to dictate medical practice and accordingly I have concluded that I cannot make a determination in respect of this matter in terms of section 6 of the Act. Nevertheless this matter raises some issues which require to be addressed. There appears to be some confusion about the exact time when a catheter was inserted. This confusion may have arisen due to an entry on page 12 of production 6, the medical notes, where it is stated "catheterised at 3.30am". This does sit well with other evidence put before the inquiry and I have concluded that on the balance of probabilities this was an error. Dr. Von der Straten told the inquiry that she arrived at Jordan's bedside at approximately 2.30am and having spoken with the family and appraised herself of the history so far she began to examine Jordan at about 2.45am. The note she made at page 17 of the same production indicates that a urine catheter was already inserted by that time and she was able to comment that this was oliguric i.e. there was not a lot of urine present which could be an indicator of a number of things including impaired kidney function or that the patient was dehydrated. There is also a note on page 7 of the same production that by 3.30am a urine sample had been sent to the laboratory and analysed and the results were documented.

Accordingly I have concluded that catheterisation had taken place earlier than 3.30 am and probably within 40 minutes of Jordan's admission to hospital. The purpose of the insertion of a central venous line has been referred to earlier and it provides, *inter alia*, a more accurate way of monitoring the amount of fluids in the body.

Together with catheterisation this sterile procedure was part of the plan of treatment prepared by Dr. Rashid and subsequently approved. A central venous line was successfully inserted by Dr. Von der Straten at approximately 4.15am according to the notes.

The timing of this procedure was criticised in evidence by Mr. Simon Nadel consultant paediatric intensivist at St. Mary's hospital, London. He was of the opinion that rapid, aggressive treatment was required when dealing with a person so young as Jordan and *inter alia* a central venous line ought to have been inserted earlier to provide a more accurate reading of fluids and pressure in the body. Mr. Nadel conceded that as he was not present at the time he could not comment upon Jordan's response to the treatment given which included his response to the amount of fluids that had been administered and he accepted that the response of a patient was of paramount importance as opposed to the amount of fluids that were received.

Dr. Paterson had explained to the inquiry that when a patient had septicaemia the vessels in the body expanded although the same amount of blood was still coursing through these vessels. As a result pressure dropped. Pressure was required to force blood about the body and to address this

fluids were given intravenously to fill the space caused by the extension of the vessels and to keep the organs functioning.

Dr. Paterson went on to explain that it was also fairly common that an abnormality in the blood stream, known as clotting deranged, occurred within a patient when sepsis was present. This abnormality became apparent in Jordan's case once samples of blood had been analysed.

In this context Dr. Rashid explained that clotting derangement meant that the blood was not clotting as fast as it ought to and the consequence of this was that there was a propensity of bleeding both internally and externally. The insertion of a central venous line was in itself a procedure not without risks, one of which was that the procedure may itself cause bleeding. The clotting derangement had to be addressed before this procedure could take place and this could be done by the administration of fresh frozen plasma. Only then was it safe to insert a central venous line. Even so the administration of fresh frozen plasma was not a simple process. Before it could be given it was necessary to analyse a venous blood sample to ascertain if the clotting was sufficiently deranged to justify its administration. This decision had to be taken by a haematologist.

Accordingly when the results arrived a haematologist had been contacted and asked for an opinion and authorisation was given that fresh frozen plasma should be administered. It took time to take a sample, have it analysed in the laboratory, consider the results, contact the haematologist and thereafter for the haematologist to authorise fresh frozen plasma which then had to be thawed before it could be administered. While the insertion of a central venous line was important Dr. Rashid stated in evidence that if she had inserted this before administering fresh frozen plasma then she would have been negligent.

Dr. Rashid had encountered some problems in inserting the central venous line. It was accepted that it was not an easy procedure and was described in evidence as being a "blind procedure". Although an anaesthetic was administered it required the patient to remain still while a needle was inserted into the left side of the neck. Care had to be taken not to come into contact with the blood vessels or arteries in that location.

Unfortunately Jordan was most agitated, restless and distressed by that time. Dr. Von der Straten was able eventually to complete this procedure successfully approximately 30 minutes after the procedure was first attempted.

I was reminded by Mr. Stewart in his final submission of the fact that in accordance with the plan prepared various treatments and investigations had to be carried out sequentially and that as the insertions of a catheter and central venous line were sterile procedures they could not be carried out while these were ongoing.

In any event even after these had been inserted they did not disclose anything that was not known before or which caused the medical staff to alter their plan of treatment such as increasing the quantity of fluids to be given.

In all of these circumstances I have concluded that the catheter and central venous line were in place within an appropriate time.

5. It was accepted by the family that the doctors acted with the best intentions and in accordance with the guidelines but it should be explained to all doctors that guidelines are only that i.e. guidelines and every case ought to be judged on its own merits.

I have concluded that I cannot make a determination in respect of this matter in terms of section 6 of the Act. What can be said, however, is that all the medical staff who gave evidence emphasised that while all the guidelines were followed these were adhered to taking into account first and foremost Jordan's response to the treatment that he was receiving. In that respect this case was decided on its own merits.

6. If Dr. Shah had referred Jordan to hospital he would have arrived there some three hours earlier and he may have had a better chance of survival. I have concluded that this is a matter that could come within sections 6(1)(c) of the Act on the basis of whether such a referral would have been a reasonable precaution whereby death might have been avoided.

The questions to be addressed are whether what was presented to Dr. Shah merited an immediate hospital referral and if so could the life of Jordan have been saved. At that time Dr. Shah was working on an irregular basis with Medicare Lanarkshire, an out of hours medical service, helping them out when they were short staffed. He had retired from general practice in 1999 although he continued to work on a part time basis in a general practice. In his 42 years in medicine he had not come upon a case of meningococcal septicaemia. Very few general practitioners would come across this condition because it was so rare according to the evidence of Dr. Wallace, an expert in general practice. Nevertheless Dr. Shah stated in evidence that he was aware of the relevant signs and symptoms of this condition. He had arrived at Jordan's home at 10.50pm. Production 2 was a note prepared by him of the presentation and the conclusion that he reached. This reads : -

Complaints of sore throat, sore ears. Rash all over body: very itchy. No vomiting. No photophobia.

On examination: Inflamed throat. Pupils equal.

No neck rigidity. Kernig's sign negative. Pulse = 80/min.

CVS = Normal heart sounds.

Respiratory = clear

Abdomen = N.A.D.

Neck glands palpable.

Blotchy rash all over.

Very itchy. No signs of Meningitis.

Diagnosis : Upper Respiratory Tract Infection. Allergic Rash.

Treat : Erythromycin, Piriton

The glands being palpable meant that the neck was painful to the touch. The treatment prescribed consisted of an antibiotic and an antihistamine. The fact that Dr. Shah made reference to photophobia, neck rigidity, Kernig's test and rash was significant in that he had considered meningitis as being a possible diagnosis.

It has been stated before that when the bacterium meningococcus enters the system, it may invade the meninges or membranes that cover the brain and spinal cord causing inflammation.

Due to the connection between the brain, spine and neck a patient may have a stiff neck, finding it difficult to place their chin upon their chest. A further sign may be photophobia where light hurts the eyes. This is due to the fact that the brain is attached to the eyes via the optic nerves. Kernig's test is carried out to ascertain if there is inflammation of the membrane surrounding the spine. The patient lies flat and one leg is lifted until it is perpendicular to the floor. This will tighten the spinal cord and will cause pain if the spinal membrane is inflamed.

Testing for all of these signs proved negative.

Dr. Shah examined the rash carefully using his torch and pressing upon it using his stethoscope and his thumb. He concluded that the rash was not haemorrhagic. He stated that he was not mistaken in what he saw - a rash which was red/ pink in colour made up of circular weals, that is with the skin being raised a little. It disappeared under pressure. Had it been haemorrhagic

Dr. Shah stated that he would have referred Jordan to hospital but upon what was presented to him and exercising his clinical judgement he concluded that meningitis was absent. In addition there was no evidence before him of septicaemia.

By the time Jordan reached hospital a different type of rash was present. It was no longer covering his body but was confined to a relatively small area in his neck. Dr. Mukkamala confirmed that he had removed Jordan's T shirt and the rash was not present elsewhere. It was now purpuric in nature i.e. indicating that there was bleeding underneath the skin. This rash progressed rapidly covering his body as he was being examined by Drs. Mukkamala and Rashid.

Evidence was heard that a haemorrhagic rash would not disappear and later return and that such a rash would be painful as opposed to being itchy which was how Jordan described it to Dr. Shah. For these reasons I have concluded that the all over rash presented to Dr. Shah was a different rash from that confined to the neck area as witnessed by Dr. Mukkamala. None of the experts who gave evidence to the inquiry criticised Dr. Shah for reaching his conclusion based upon what was presented to him. What was presented to Dr. Shah did not merit an immediate referral to hospital.

There comes a point with meningococcal septicaemia when the deterioration process becomes irreversible and death is inevitable. It is impossible to say when that happened in Jordan's case and could have been at any time, even some hours before Dr. Shah examined Jordan according to Mr. Nadel. Even if Dr. Shah had taken the precaution of referring Jordan to hospital immediately there was no evidence before the inquiry to suggest that death might have been avoided

For all of these reasons I have concluded that no findings would be appropriate in respect of this matter.

I agree with the submission of Mrs. Sinclair and the other legal representatives that no further determinations ought to be made except for those in terms of sections 6(1)(a) and 6(1)(b) of the Act.

There are two final matters that I wish to comment upon. In the first instance I would wish, once again, to express to the family of Jordan the condolences and sympathy of the court. This was a tragic loss to a disease that caused the rapid deterioration of a healthy, hard working, young man who was, as Mrs. Sinclair stated, much loved by all his family and friends.

Secondly there was some criticism made to the inquiry by Mr. Nadel of the treatment administered to Jordan within the accident and emergency unit of Monklands hospital. I concluded that such criticisms were unfounded. Within minutes of arriving at the hospital

Jordan's condition had been correctly diagnosed and the appropriate treatment of antibiotics and fluids had commenced. He remained within the accident and emergency department until he was transferred to the intensive care unit at approximately 5.15am. Throughout his time within the accident and emergency department he was constantly monitored with the proper treatment and procedures being carried out in accordance with a plan that had been prepared and approved, subject always to Jordan's response. Three senior house officers, Drs. Mukkamala, Rashid and Von der Straten were in attendance initially to be joined during the night by two consultants, Mr. Paterson and Mr. Todd who came from home having recognised the seriousness of the situation with a view to assisting in the treatment of Jordan. At the same time laboratory staff were helping to analyse samples, a haematologist was consulted at one stage, radiographers were taking x-rays and the nursing staff were constantly present.

They all made every effort to save Jordan's life. Dr. Mukkamala told the inquiry that he had remained to help even though his shift came to an end at 2am. Drs. Rashid and Von der Straten when giving evidence were clearly still distressed recalling that night and the rapid deterioration of Jordan and his death.

In criticising some of the treatment administered to Jordan Mr. Nadel stated that the measurement he was using was the optimal, gold standard of care that could have been given. Even so he conceded that he could not say that Jordan's death could have been avoided and in all probability Jordan was likely to die. It is not for the court to determine what may or may not be the gold standard of care but I do not agree that the optimal care was not given to Jordan. In evidence both Mr. Paterson and Mr. Todd stated that nothing more could have been done to save Jordan. With that I concur.