Please be aware that this is an anonymised copy of what was a real report and litigation has ended. The names in this report are all false.

Medical Report by Dr Alastair H Bint

Dated
24th June 2010

Area of Expertise
General Practice

On behalf of the
Procurator Fiscal, Mrs Ralph,
Elgin
Ref Mr Rupert Bear XXXXXXXXXXX

Subject
Issues surrounding the prescribing of methadone, benzodiazepines, olanzapine and venlafaxine, an overdose of which caused the death of Mr Bear

Written by
Dr Alastair Bint, St Lukes Surgery, Warren Road, Guildford, UK, GU13JH

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Appendices

Report

1. Introduction

1.01 The Expert

I am Dr Alastair Halford Bint. My specialist field is General Medical Practice. Full details of my qualifications and experience entitling me to give expert opinion evidence in this case are in appendix 1.

1.02 Summary background of the case

Mr Rupert Bear, aged 25 years died of intoxication with methadone, venlafaxine, benzodiazepines and olanzapine. The family have raised concerns regarding the doses of these medications from his General Practitioner (GP) especially the methadone dose.

1.03 Summary of my conclusions

The prescribing of diazepam, venlafaxine and olanzapine appears to have been within reasonable boundaries, however the initiation dose of methadone prescribed by Dr Yellow the day prior to Mr Bear's death was, in my opinion, unreasonably high, and may well have been a lethal dose, although one cannot discount the significantly contributory and synergistic effects of intoxication from the many other substances that Mr Bear took that day including several illicit medications.

1.04 The parties involved

Mr Mr Rupert Bear deceased.
Dr Yellow, GP.

1.05 Technical terms and explanations

I have indicated any technical terms in **bold type**. I have explained common medical abbreviations in brackets within the text of the report. Direct quotes from records are in *italic* script. In appendix 3 I have identified any references to published works as identified during the report by a superscripted number

2 The instructions and issues addressed

2.01 To comment on the standard of GP care provided to Mr Bear with particular reference to the prescribing of his medications prior to death.

3 My investigation of the facts, history of events

3.01 Mr Bear had a history of drug and alcohol problems from at least the year 2001, when he was aged 17. By that age he was regularly abusing heroin, cannabis, ecstasy, LSD, valium (diazepam) and alcohol. Mr Bear underwent unsuccessful drug rehabilitation in 2001 and he did not follow up his appointments. Further drug and alcohol rehabilitation was offered between the years 2007-9 but Mr Bear did not attend 8 of the 12 appointments arranged for him. The conclusion from the Moray Council on Addiction dated 30th April 2009 was for 'maintenance' therapy.

3.02 Mr Bear was therefore being issued with supervised daily pick up methadone prescriptions from his GP. There was supervised consumption of methadone on a daily basis from May 2007 until October 2008. Over this period the dose was reduced from 30mls daily down to 5mls daily as maintenance. The last prescription for 5ml was issued on 14th October 2008. The methadone was then restarted by Dr Yellow the day before Mr Bear's death and I will come on to that later in the report.

3.03 On the 19th February 2009 Mr Bear consulted his GP, Dr Yellow and disclosed that he was taking prescribed diazepam but also supplementing this with diazepam he was buying on the street. Dr Yellow made attempts to reduce Mr Bear's diazepam use and it was at this point that he started to prescribe olanzapine.

3.04 In March 2009, Dr Yellow added the antidepressant, venlafaxine, as there were concerns regarding Mr Bear's mental health, depression and anxiety. Mr Bear was also attending cognitive behavioural therapy. Mr Bear had previously been prescribed mirtazapine in early 2009 and fluoxetine some years prior to that.

3.05 Initially, during March and April of 2009, the prescriptions for diazepam, venlafaxine and olanzapine were issued on the condition that they were given daily, for consumption on the premises. However from mid April onwards they were no longer for consumption on premises but were to be dispensed daily. The timing of this change does correlate with a phone call between Dr Yellow and Mr Bear dated 16th April 2009 '*says feels better on venlafaxine, things more stable now, continue same treatment*.'

3.06 Mr Bear disclosed to Dr Yellow on the 30th April 2009 that he was still buying diazepam on the street. He stated that he was mainly using this for anxiety. Mr Bear also disclosed the same to Dr Pink on the 21st May 2009.

3.07 By the 5th June 2009, Mr Bear had deteriorated. He consulted Dr Yellow, as he was back on heroin, having sold everything to fund it. He stated that everything was going out of control and he felt like slitting his wrists in the bath. He was noted to be shaking with severe drug withdrawal symptoms and was going to get a relative to look after him over the weekend.

3.08 Dr Yellow stated in the medical records that Mr Bear was '*begging for methadone'* and had '*stated not going to OD'*(overdose).

3.09 Dr Yellow re-started the methadone for Mr Bear, giving him a prescription for 150 mls of 1mg/ml methadone with a view to taking 50ml per day (equivalent to 50mg). There was to be 50ml supervised consumption on Friday 5th June, 50ml supervised consumption for Saturday 6th June and a further 50ml which would not be supervised as it would be a Sunday). His consumption for the Friday was supervised and he was observed in the waiting room for an hour by Dr Yellow. There is no documented assessment of how much heroin Mr Bear was currently using although it was noted that he had been back using it for 8 days.

3.10 The next day, the 6th June 2009, Mr Bear was found in his room having collapsed and died. The cause of death was given as methadone, benzodiazepine, olanzapine and venlafaxine intoxication. Blood toxicology screens showed several benzodiazepines in the blood, diazepam, temazepam and oxazepam. Only diazepam was actually prescribed by the GP. The methadone metabolite level was within the potentially lethal toxic range. On scene, Police found multiple empty blister packs for diazepam, venlafaxine and olanzapine, amongst others. The blister packs were mostly for very small supplies e.g. olanzapine 2x5mg tablets, venlafaxine 2 x75 mg, diazepam 4 x10mg.

3.11 In addition the Police found evidence to suggest that Mr Bear had consumed dihydrocodeine, co-codamol and mirtazapine. The last time a GP had prescribed Mirtazapine was 19th March 2009 and according to the records, Mr Bear had not been prescribed co-codamol or dihydrocodeine previously.

4 My opinion

4.01 Mr Bear had significant drug and alcohol problems and had not been compliant with rehabilitation programmes. Mr Bear was abusing prescription medication which he was obtaining from sources other than his GP. To concentrate on the medications that he was prescribed;

4.02 Regarding the methadone;

4.02.1 The methadone prescribed initially, from 2007 until October 2008 was prescribed in a suitable way with daily supervised consumption and doses changed as appropriate, which is in keeping with current national guidance. The Addiction centre also sanctioned and supported the maintenance dose. In this regard I believe the GP acted reasonably.

4.02.2 The dose of methadone prescribed by Dr Yellow on the 5th June 2009 was 50mg methadone daily for 3 days, yet guidelines generally do not advocate more than 20-30mg a day as an initial dose, even in heroin habituated patients, because the risk of toxicity is high.[1-7] The Methadone Briefing, considered a definitive text, advises the very maximum initial dose as being 40mg. In my

view the dose of 50 mg was unreasonably high as an initial dose and Dr Yellow has made a mistake in issuing such a high dose. Because Mr Bear had not received methadone for 7 months prior to this, his body was effectively methadone naïve and needed to be treated with caution.

4.02.3 Although Dr Yellow observed Mr Bear for an hour in the waiting room there is no evidence that he clinically monitored Mr Bear by measuring the pulse rate, blood pressure or temperature. In this respect it is my view that Dr Yellow did not adequately monitor Mr Bear and was therefore unable to safely detail whether the dose issued may have been having toxic effects.

4.02.4 Most guidance suggests a 2-3 day initiation period on methadone, when the dose is titrated according to symptoms. In giving a three day supply of methadone on a Friday without the ability to safely and effectively monitor Mr Bear on the Saturday or Sunday was, in my view, dangerous and unreasonable practice, even in the face of a patient clearly withdrawing and '*begging for methadone*.' With the benefit of hindsight, Mr Bear should have either been referred for local specialist addiction services, or his methadone treatment delayed until Monday when there could have been continuity in monitoring for several days. Failing that, he should have been given a substantially lower dose of methadone, probably in the region of 20 mg.

4.03 The diazepam prescribing was a maintenance dose schedule and the GP had made reasonable efforts to get Mr Bear off it, including partially substituting with olanazpine, but Mr Bear continued to purchase diazepam illegally. There is little any GP could have done to prevent this. One could argue that the GP should have stopped prescribing diazepam all together but given Mr Bear's circumstances, this is unlikely to have helped the situation, in fact it would probably have made it worse. Therefore I am of the view that the Dr Yellow acted reasonably in continuing to give diazepam and he did so in a very reasonable manner, by initially advising daily supervised consumption, then when things were stabilising, moved to daily dispensing.

4.04 The olanzapine was started for reasonable reasons and was in my opinion, a good choice for a patient like Mr Bear for it is much less addictive as other drugs and it helps counteract the paranoia symptoms that drug abusers often suffer. Again, this medication was offered as a daily pickup, which was a very reasonable action.

4.05 The venlafaxine was a recent addiction and was being used as an antidepressant, which was a reasonable choice by the GP, having tried others that had not worked. Venlafaxine is also less likely to interact with methadone than many other antidepressants. In fact there is evidence that Mr Bear was feeling better with it. One could make an argument that this was a time to ask for Psychiatric input and move the prescribing of these atypical psychiatric medications (olanzapine and venlafaxine) to secondary care. However, Mr Bear had a habit of not attending follow up appointments or drug rehabilitation appointments, and so the choice for his GP to prescribe these medications independently is a reasonable one.

4.06 In addition, dihydrocodeine medication was found by the Police in Mr Bear's residence. This does not appear to have been prescribed by the GP and so was probably obtaining illicitly. The combination of high dose methadone and dihydrocodeine is especially lethal.[7]

4.07 The biggest risk with this cocktail of medications was increased sedation, which if excessive, can be fatal. There is an interaction between methadone and olanzapine which can increase the risk of arrhythmia (irregular heart beat).

4.08 Mr Bear was initially advised to have supervised consumption of his medications, but in April this was changed to daily dispensing without supervised consumption. It appears this decision was made because Mr Bear was more stable, and in my opinion, this was reasonable practice. Logistically it is impractical and difficult to get patients to consume their oral medications on site. The exception to this was the methadone which remained daily supervised consumption, which was appropriate.

4.09 Preceding his death, Mr Bear may well have been hoarding his dispensed medications, however we do not know the extent of this because although the Police found empty blister packs of medication, they were in a variety of locations in the house and we do not know how old these packs were or when these medications were taken. Although the methadone dose may have been toxic, crucially it may well have been the combination with his other prescribed and illicitly obtained drugs which proved toxic enough to kill him.

5 Statement of compliance

(a) I understand that my overriding duty is to assist the Court in matters within my expertise, and that this duty overrides any obligation to those instructing their Clients or me. I confirm I have complied with that duty and will continue to do so, I am aware of the requirements set out in Part 35 of the Civil Procedure Rules and the accompanying Practice Direction, the Protocol for the Instructions of Experts to give Evidence in Civil Claims, and the Practice Direction for Pre-action conduct.

(b) I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

(c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed.

(d) I consider that all the matters on which I have expressed an opinion lie within my field of expertise.

(e) I have drawn to the attention of the court all maters, of which I am aware, which might adversely affect my opinion.

(f) In preparing and presenting this report I am not aware of any conflict of interest actual or potential save as expressly disclosed in this report.

(g) In respect of matters referred to which are not within my personal knowledge, I have indicated the source of such information.

(h) I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

(i) Where, in my view, there is a range of reasonable opinion relevant to the opinions I express, I have indicated the extent of the range in the report.

(j) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any alteration, correction, or qualification.

(k) I understand that this report will be the evidence that I will give, if required, under oath, subject to any correction or qualification I may make before swearing to its veracity.

(l) I have attached to this report a statement setting out the substance of all the facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

6 Statement of truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matter to which they refer.

Signed by Dr Alastair Bint

Dated 24th June 2010

Appendix 1

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My experience and qualifications:

I am a full time NHS GP in a practice with a 10,000 patient population and I am a trainer of foundation doctors in General Practice. I am Chairman of the South West Thames faculty of the Royal College of General Practitioners and I sit on the executive committee for postgraduate General Practice education in Kent, Surrey and Sussex. I work as a clinical lead and have sat on the Guildford Practice Based Commissioning board, one of the roles of which is appraising clinical pathways and protocols. I am a commentator for the Royal College of GPs on professional regulatory and medico-legal issues.

With reference to this case, I am very familiar with the prescribing of all the medications that Mr. Bear was on and I regularly prescribe all of these medications except methadone. Although my prescribing of methadone is infrequent nowadays because of a very proactive local drug rehabilitation unit in my area, I am fully aware of all guidance surrounding the safe prescribing of methadone.

Qualifications:
- MBChB, Bachelor of Medicine and Bachelor of Surgery, Edinburgh, 1998
- Advance life support; ACLS (1999), ATLS (2000), PALS and APLS (2001).
- DGM, Diploma in Geriatric Medicine, Royal College of Physicians, 2001
- DRCOG, Diploma from Royal College of Obstetricians and Gynaecologists, 2002.
- DFSRH, Diploma from Faculty of Sexual and Reproductive Healthcare, 2002
- FRCGP, Membership of Royal College of General Practitioners, 2003, Fellowship elected 2009.
- MEWI, Membership of Expert Witness Institute 2008.

Memberships:
- General Medical Council number 4546883
- Medical Defence Union number 307265G
- Royal College of General Practitioners number 53602
- Faculty of Sexual and Reproductive Healthcare number D015276
- Expert Witness Institute number 1776

Appendix 2

List of documents examined

Full GP records.

Post mortem report from Dr J H K Grieve, FRCPath.

Report from Grampian Police

Appendix 3

References

1. National Institute for Health and Excellence (NICE) guidance 'Methadone and buprenorphine for the management of opioid dependence'. Issued January 2007, reviewed March 2010

2.British National Formulary as published from time to time by BMJ Group Tavistock Square, London

3. Drug misuse and dependence; UK guidelines on clinical management, joint publication Department of Health, Welsh Assembly and The Scottish Government, September 2007.

4. Home office Advisory Committee on the Misuse of Drugs, 'Reducing Drug Related Deaths' HMSO 2000.

5. The Methadone Briefing, ISDD, London 1996

6. NHS Fife Addiction services 'procedure for methadone dose assessment' Dr Alex Baldacchino, April 2003, available from NHS Fife.

7. National Confidential Enquiry into methadone related deaths (Scotland) 2000, The Scottish Executive, Health Department, Clinical Resource and Audit Group (CRAG Ref 99/05)