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19th September 2017

Strictly Private and Confidential
H.M Coroner
County Hall
Topsham Road
EXETER
Devon
EX2 4QD

Dear Sir/Madam

Re: Carly Marie Gordon D.O.B. 11/04/1980

Deceased D.O.D. 27/05/2016

Thank you for your regulation 28 report on Carly Gordon.

I note your concerns during the course of the inquest were twofold for our practice.

1) **The long term use of shorter acting Benzodiazepine instead of longer acting Benzodiazepine in accordance with the British Association of Psychopharmacology (BAP) Guidelines should be followed when patients are prescribed this drug to avoid dependence.**

I have read thoroughly both:

a) BAP updated guidelines: Evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity (May 2012)
b) Benzodiazepines: Risks and benefits. A reconsideration (Nov 2013)

The key points for Benzodiazepine dependence from Guideline (May 2012) are:

- "Where dependence is established, gradual dose reduction of prescribes Benzodiazepine is recommended".

  During my regular reviews of Carly this was discussed and carried out. It was made clear at the start of prescribing this should not be for long term use, however as I will discuss later, clinical indications meant the use of Lorazepam continued longer than either myself or the patient would have wanted at initiation.

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- "Switching from a short half-life Benzodiazepine to a long half-life Benzodiazepine before gradual taper should be reserved for patients having problematic withdrawal symptoms".

  In this case at the time I felt the clinical indication for Lorazepam outweighed the risks. I did not swap for a long active Benzodiazepine. I have reflected on this decision and I will change any future prescribing practice.

- "Additional psychological therapies increase the effectiveness of gradual dose reduction particularly in individuals with insomnia and panic disorder".

  I asked Carly to call (which she did) the Depression and Anxiety Service twice and referred her to our local Psychiatric team.

The Key points I have taken and reflected upon from the BAP paper in 2013:

"Whenever Benzodiazepines are prescribed, the potential for dependence or other harmful effects must be considered. The balance of risks and benefits with Benzodiazepines or alternative interventions in an individual patient can be hard to assess, and is ultimately a matter of clinical judgment".

- I felt and recall in numerous review consultations that the benefits of prescribing in the first 6-12 months for Carly outweighed the risks. In point 7 of the BAP commentary on page 971 it makes the point:

  'Many health professionals have been dissatisfied with the previous guidance that Benzodiazepines should be used for short-term treatment only and no longer than four weeks in regular dosage. All patients should be made aware of the risks of dependence if they continue Benzodiazepines in regular dosage over a longer period. (I recall discussing this with Carly). A clinical judgment has to be made as to whether alterations may be more suitable for each patient, and for proposed medication'.

  When it became obvious little progress was being made I sought specialist consultant psychiatric advice. Carly was told at that appointment to stop the Lorazepam. We then embarked on a gradual reduction (although her perception at the consultant appointment was to stop it immediately) however she did not use the alternative antidepressant as suggested.

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"Benzodiazepines anxiolytics should be prescribed primarily either for the short-term relief of severe anxiety symptoms, or where anxiety disorders are disabling and severe and causing both significant personal distress and substantial impairment of daily activities".

"Dependence is more likely with higher dosages but can also occur with lower doses and formulations of compounds at lower strengths and with longer half-lives may be useful in helping patients reduce from higher doses. Even after short-term use, a tapering off regime, i.e., at least two weeks at reduced dosage, should be considered to minimize the risk of rebound phenomena, that is the reappearance of symptoms present prior to treatment".

In regard to my own personal prescribing I have audited every patient I have prescribed Lorazepam to between 27/05/2016 and 13/09/2017.

There have been thirteen patients in total. I have looked at all the notes. Of those thirteen, ten patients are not currently being prescribed Lorazepam. Those ten were either given one off scripts or very limited amounts (all less than two months).

The remaining three have Lorazepam on repeat prescription.

I have thus also audited every patient in the practice who has Lorazepam on repeat prescription; there are eighteen (including the three I have prescribed for in the above time period). Of those eighteen, five patients live in long-term residential care for learning disabled and their medication is managed by a consultant psychiatrist.

The practice currently has twenty patients whom have either 2mg or 5mg of a long-acting Benzodiazepine, Diazepam, on repeat: two of which live in the aforementioned residential home.

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2) **All patients who receive this drug for an extended period of time should be reviewed by their medical advisors to reassess their suitability for the long term use of this particular medication.**

Reviewing medication is regular practice at our surgery. However we have now considered a structured systemic approach for patients on Benzodiazepines to those reviews following our own significant event discussion of this case and the regulation 28 report.

For those patients who have a Benzodiazepine on repeat prescription, each have received a personal letter from their own General Practitioner asking them to contact us for a targeted medication review of their Benzodiazepine.

We have made a commitment not to add (or continue repeat prescriptions from patients registering from other practices) Benzodiazepines to a repeat prescription if not already on repeat.

For those thought requiring acute prescriptions we have reminded prescribing staff of the requirement to discuss with patients about the short term use of Benzodiazepines and regular reviews of both symptoms and prescriptions; also, not to add these medications to repeat prescriptions. I hope my own personal audit evidences that.

Further action taken:

- I have referred myself voluntarily to the Deputy Medical Director/RO Appraisal, Revalidation, Performance Lead NHS England Devon, Cornwall, Isles of Scilly Area Team, [redacted] This is in order for her to review my performance in the management of Carly Gordon.

- I have significantly reflected on this case and will discuss this with my appraiser.

I would like to say on a personal note how sorry I am that I could not help Carly more. She and I had an excellent rapport and for a long period of time she was really improving from her lifelong anxiety; she found a job and was becoming more confident. I was and still am deeply shocked by her death and my thoughts go out to her family.

Yours sincerely

[redacted] M.B. Ch. B. M.R.C.G.P