Sheriffdom of Tayside Central and Fife at Perth

Determination

of

Sheriff Michael John Fletcher, Sheriff of Tayside Centre in Fife at Perth

in the cause

Fatal Accident Inquiry into the death of Norman Ferrie who died on 3rd July 2004.

Perth 18th August 2008.

The sheriff, having resumed consideration of the cause, determines:

1. In terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Norman Ferrie died at 1900 hrs on 3rd July 2004 within Ward 118, the Royal Infirmary of Edinburgh.

2. In terms of section 6(1)(b) that the cause of his death was submassive hepatic necrosis.

Note

[1] In this Fatal Accident Inquiry there was unchallenged evidence relating to the date and place of Mr Ferrie's death. Similarly the cause of his death as given in the above determination was not in dispute. A post mortem report dated 7th July 2004 found the cause of death to be submassive hepatic necrosis. To all intents and purposes the evidence relating to these matters and in fact all matters of substance relating to his death came first of all from his sister Miss Elaine Miller Ferrie who explained that Mr Ferrie had normally been in good health apart from painful arthritis in his knees. He normally did not go to see his doctor and normally was never ill. There had been some question as to whether he might require knee

replacements because of the arthritis but it was not known whether that had been discussed with his doctor. He had begun to take Glucosomine because the arthritis in his knees was painful. At first he had bought the substance from a shop locally and then had begun ordering it from Goalshield Pharmaceuticals by post.

[2] Miss Ferrie had not been aware of any illness in relation to her brother until about four weeks before his death when she phoned and discovered that he had been feeling unwell, was very tired and had no energy. He had attended his doctor and had stopped taking Glucosomine. He told her that the doctor had said that he appeared jaundiced. She expressed the view that stopping the tablets had done no good and he had simply deteriorated until he was very seriously ill. He had attended Ninewells hospital for blood tests on 16th June 2004 and was told to come back on 30th June 2004 when he was admitted to hospital in a serious condition. He was transferred to the Royal Infirmary of Edinburgh on 2nd July 2004 but died the following day. A liver transplant had been considered but his condition deteriorated to such an extent that that became impossible. She listed a number of concerns which she had in relation to the death of her brother. In particular she was concerned that the public should be aware that there are risks in taking herbal remedies. There should be a system in place to see that medicines are safe.

[3] The second witness called by the Crown was Dr John Dillon who is a consultant gastro-enterologist at Ninewells Hospital in Dundee and has been employed as such for 12 years. His speciality was the treatment of liver disease. Mr Ferrie was admitted into Ninewells hospital in connection with liver problems which were serious enough for Dr Dillon to consider a liver transplant but he died before it was possible to carry out the transplant. The disease was well advanced by the time Doctor Dillon saw Mr Ferrie. Doctor Dillon carried out various tests and it was seen that his blood tests had been deteriorating to a worrying degree. The tests excluded hepatitis B and C as well as a number of other common causes of liver disease. It was possible that the damage was caused by some sort of viral infection but there was no test which would identify that or indeed exclude that.

[4] Doctor Dillon explained that it was possible that a reaction to a drug could cause such a problem and he had been informed by his patient that he had been taking Glucosomine. It appeared that his symptoms had become apparent shortly after he began taking that preparation. That had rung alarm bells in the mind of Doctor Dillon because he

was aware of two other cases within his own experience where patients had become ill after taking Glucosomine. This made him suspicious as to whether that drug was causing liver failure in some patients. In any event Mr Ferrie was advised to stop taking Glucosomine and not to restart it. Mr Ferrie had to be admitted to hospital because his kidneys were not functioning correctly and steps had to be taken to improve his renal function. At the same time consideration was given to the question of transplantation and he was in fact transferred to Edinburgh to allow that to happen if possible but his condition deteriorated rapidly and sepsis made it impossible to continue with the question of transplant and he died the following day. He had not responded to the therapy to treat the infection.

[5] Doctor Dillon now had three patients one of whom, Mr Ferrie, had died who had developed liver failure and who were all taking Glucosomine. That raised the suspicion of a connection. Doctor Dillon made enquiries to see whether there had been reports from other doctors of a possible connection between Glucosomine and liver failure. He described a "yellow card" system of information in relation to drugs or at least reaction to them. The system involved any doctor who came across an idiosyncratic reaction in relation to a drug reporting that reaction by means of a yellow card to a central authority who would process it. When the system first began it was restricted to prescription drugs but in the recent past it has been extended to include what might be called herbal remedies and now any doctor coming across a reaction to a prescription drug or to a herbal remedy is expected to report it using the yellow card system. Doctor Dillon reported his patients' reactions and also checked to see whether other doctors had reported similar reactions to those he had found. He was unable to trace any other report similar to his and although it might be expected that if other doctors had been aware of a similar reaction but had failed to report it for any reason, his report might have "prodded" then into making a report when they saw three cases being reported by Doctor Dillon. However by the stage when Doctor Dillon gave his evidence no other report had been made of a similar reaction.

[6] Doctor Dillon and another doctor, Doctor Aileen Smith wrote an article reporting the findings in relation to the three patients and describing their symptoms and raising the question of their suspicions of a connection between Glucosomine and liver disease and submitted it to a specialist medical magazine called GUT but so far it had not been published. Doctor Dillon thought that the magazine did not think their findings were important enough

to choose to publish it. He remained suspicious however of the possibility of a connection between Glucosomine and the liver failure suffered by his three patients.

[7] When Miss Ferrie addressed me she indicated that she hoped that the inquiry would be able to hold it proved that Glucosomine had caused the liver disease which killed her brother. The only medical evidence led was that of Doctor Dillon and he was unable to pitch his evidence any higher than saying that he was "suspicious" that Glucosomine might be the cause. His suspicions might have been firmed up if others had made similar reports but the fact that there were no such similar reports and that remained the position even after the yellow card reports made by Doctor Dillon seems to me to reduce the strength of those suspicions at least for the purposes of this inquiry. I got the impression that Doctor Dillon was still of the view that it was possible that Glucosomine was the cause of the liver disease based, I think, on the fact that despite his experience in the field he was not able to identify another sensible reason for the problem faced by Mr Ferrie. That, taken along with the fact that there were two other cases within Doctor Dillon's experience made it more likely that in these patients at least there was a connection. He cannot be said however, to have accepted it as proved that that was the cause in this case and similarly the evidence led before me is not sufficient even on a balance of probabilities for it to be said that that was the cause of the liver disease. Thus I cannot make a determination in these terms.

[8] As I have mentioned above evidence was led from Doctor Dillon about the yellow card system. It was clear that that system began in relation to prescribed drugs and was designed to identify problems which might have become apparent after prescribed drugs were put into general use. Doctor Dillon described the kind of side-effects which might or might not cause a drug to be withdrawn from general use if too many yellow card reports were posted. He illustrated that information by explaining that in his field one drug had been withdrawn because one person in 15,000 suffered liver damage as a result of its use. He also pointed out that the system now covered herbal remedies of the kind with which this inquiry is concerned and he pointed out that members of the general public could use the yellow card system if they themselves found unpleasant side-effects from using such preparations. However it was not impossible that very few members of the public were aware that they could make such a report. He considered it to be important that publicity was available especially at places where such medicines could be bought to make sure people were aware that such reports could be made. That seems sensible and I do not think that any harm could

be done by recommending that literature be made available on packaging or in packaging of herbal remedies spelling out the yellow card system and explaining where it might be used and warning persons taking such remedies to inform their medical practitioners on any occasion they need to consult their medical practitioner while taking them. It might be appropriate to devise some kind of literature warning persons taking herbal remedies that like all drugs they can have idiosyncratic effects on individuals.

[9] These suggestions contained in the previous paragraph above make sense in my view but the question which has to be addressed is whether the evidence in this case justifies making such a determination in terms of the Act. The purpose of this inquiry is set out precisely in the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. If there was clear evidence that Glucosomine was the cause of death, that would be a determination necessary to make. Similarly if there was clear evidence of a connection between the death and some failure in the yellow card system or some failure to provide appropriate warnings on containers for drugs such as Glucosomine it would be appropriate to make a finding in relation to that. On the other hand what I am being asked to make in the way of findings would I think require more wide-ranging evidence in relation to the system, how it works, what if any defects arise, what deficiencies if any there are in the knowledge of medical practitioners about the system and what deficiencies if any there are in the public perception of the system. The Crown suggest that I should hold that there was evidence of an association between Glucosomine and liver failure which warranted further investigation and which in turn demonstrated the need for reporting of adverse reactions to be maximised and that the yellow card system was an important means of achieving that. I am then asked to consider that although the evidence did not identify any gap in the regulatory framework, under reporting remained an ongoing challenge and a recommendation should be made that in publicity campaigns to promote the use of the yellow card system advertising should be undertaken or articles placed in health and lifestyle magazines. Further I am asked to consider recommending legislation or voluntary agreement with retailers of food supplements requiring the display of information about the yellow card scheme and that consideration should be given as to whether it was possible to secure voluntary agreement that products perceived as health products should be required to have as part of their packaging information or advice sheets warning of possible adverse reactions and advising of the yellow card scheme.

[10] As I have already said it does seem to me that these suggestions are sensible but I think that any recommendations of the kind being suggested should be made only after proper enquiries have been made by appropriately qualified persons so that any regulations or recommendations are based on solid sensible information and will enable precautions to be taken which are most likely to be effective.. For instance Mr Fry indicated in his evidence that he was not sure what impact advertising in a magazine actually had and it was expensive, so research or at least information might be required on that before a recommendation is made. I doubt if the fatal accident inquiry such as the one held in relation to the death of Mr Ferrie is the appropriate forum to consider technical regulations of the kind suggested. It has to be borne in mind that most of the Regulations in relation to medicines are European in origin and changes are made only after proper research. It would be only in cases where there was clear evidence of a defect which could be shown to have resulted in a death that recommendations should be made in an inquiry such as this. Having said that the evidence in the case does illustrate the need to be vigilant in relation to the use of health products and for the authorities to keep in the foreground of their thinking the need to keep the public aware of possible risks associated with taking any preparation which is thought to be therapeutic in any way. The evidence in this case demonstrates the fact that idiosyncratic results may arise in relation to any such product.

[11] It is fair to say in this case evidence was led from Mr Michael Fry of the Medical Health Regulations Agency which is the UK drug licensing authority and which carries out post marketing surveillance in relation to drugs. He explained that the regulation of medicines was governed mainly by EU regulations. He also gave a short history of the yellow card scheme which was instituted in 1964 after the thalidomide tragedy. At one time reports were received entirely in writing but now within the new electronic age many reports were received via their web site. He indicated that about 20,000 reports were received each year and the computer system picked up drugs which were receiving excess reports so that experts could consider whether action had to be taken. Mr Fry did indicate in his evidence that there were gaps in the reporting system because people did not tell their professional advisers that they were taking herbal remedies and so might not be advised to make a report themselves nor would their doctor do so. However he went on to say that there was a national campaign through general practitioners to encourage such reporting as well as in

community pharmacies. Similarly teaching materials for undergraduate training and ongoing training were available.

[12] Taking into account the evidence that most drug regulation is done under the auspices of the European Union and that consideration has already been given to making sure that the yellow card system is properly publicised I do not think it can be said that the kind of recommendation suggested by the Procurator Fiscal in this case is merited.

[13] Mr Fry also indicated that there had been a total of six reports about Glucosomine and a number of reports about various other health products including for instance grapefruit juice and cranberry juice. In cross-examination he looked at documents detailing the number of reports in relation to aspirin, paracetamol, ibuprofen and cod liver oil. Each had a larger number of reports than did Glucosomine. However that might be because people had regarded them as medicines rather than health products because they are known to be dangerous if taken in larger doses than recommended.

[14] Evidence was also given by Mr David Graham Carter of the Medicines Borderline Section of the Agency. He spoke to a document entitled "A Guide to What is a Medicinal Product" and explained that where anyone claimed that the product had an effect on the human body it would be regarded as a medicine rather than the food. He also indicated a new registration system was to be instituted in about two years time so that health products making these claims will have to be registered. He pointed out that a very large number of Glucosomine tablets were sold in United Kingdom and perhaps as many as one billion per month were sold worldwide. That evidence was interesting and informative but I do not think that it really advanced the information required to make the kind of recommendations suggested.

[15] Mr Leith in his submissions argued that there was insufficient evidence to justify anything other than a formal determination. As will have been seen I have come to the same conclusion. I do not consider that the evidence led in this case justifies a finding on the balance of probabilities that glucosomine was the cause of death here nor is there evidence from which it can be said that recommendations under section 1(6)(e) can be made and I have therefore made a formal determination.