



**Confidential Inquiry in to Drug-Related Deaths
January 2007 to December 2008**

**Karen Burch
East Sussex DAAT
Dr Anthony Glasper
Sussex Partnership Trust
Dr Bettina Baier
Sussex Partnership Trust**

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Introduction

Previous Confidential Inquiries into Drug related Deaths covering 2004-2005 and 2005-2006 were completed in April 07 and September 08 respectively. This subsequent inquiry exploring deaths where the Inquest was received by the DAAT between January 2007 and December 2008 is part of an ongoing inquiry process that will reflect on previous recommendations and practice.

Aims and Objectives of the Inquiry

East Sussex DAAT includes a multi-agency Drug Related Steering Group whose purpose is to reduce drug-related deaths in East Sussex. The aims and objectives of this group include: to monitor the number and causes of drug-related deaths in East Sussex; to ensure that information obtained from investigations into drug-related deaths and 'near misses' inform practice and service development; to ensure that best practice guidance on reducing drug-related deaths is implemented locally; and to ensure that recommendations to reduce drug-related deaths are considered by the DAAT when commissioning treatment.

In the national programme of substance abuse deaths ('np-SAD'P, Ghodse et al (2005)¹ defines a drug related death as:

“...a relevant death where any of the following criteria are met at a completed inquest, fatal accident inquiry or similar investigation:

- One or more psychoactive substances directly implicated in death;
- History of dependence or abuse of psychoactive drugs;
- Present of Controlled Drugs at post mortem; or
- Cases of deaths directly due to drugs but with no inquest.”

Np-SAD relies on returns from coroners, which has implications for consistency of classification and for completeness of returns. Whilst this makes it difficult to make direct comparisons between different areas, the national programme provides a useful basis for historical comparison of mortality rates.

Table 1: Np-SAD death rate

East Sussex Np-SAD annual death rate / 100,000		
Year	Rate / 100,000	N
2001	4.00	16
2002	5.97	24
2003	9.32	36
2004	5.68	23
2005	.098	4
2006	5.66	23
2007	3.60	15

The increase in 2003 to a reported annual death rate of 9.32/100,000 may be explained by a note in the report of the local confidential inquiry, McDonnell and Bennett (2004)². The report notes that late in 2004 the coroner reported “a further 12 deaths [from 2003] which may have had an opiate associated with the death were submitted by the coroner, after re-checking the definition used [by St Georges Hospital]”. This suggests that reports to Np-SAD in previous years may have been under-

reported. None of the additional 12 deaths met the local (i.e. Office of National Statistics) definition, underlining the importance of monitoring and reporting locally to the commissioning process. With the release of the 2006 report³ was included a revised text stating that the number of deaths in 2005 was under reported due to an administration error. The figure of 4 is incorrect and 20 deaths for 2005 were reported to the DAAT. It is of course possible that the Np-SAD figures will be revised to reflect the higher figure for 2005 in due course. Early in 2007 the Np-SAD contacted the East Sussex Coroner and deaths are now being correctly reported using a slightly broader definition and it is possible that this might result in a perceived increase in the number of drug related deaths across the county.

Table 2: Deaths included in the local drug related deaths inquiries within the ONS definition

2004	15
2005	12
2006	19
2007	22
2008	22
2009	22
Total	80

The table above shows the total number of deaths, where Inquests have been received, that have been included in the drug related death inquiry process.

Local Definition of a Drug Related Death

This inquiry defines a drug-related death as

‘deaths where the underlying cause is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971) (Office of National Statistics, 2005).

This definition excludes deaths involving alcohol, tobacco, volatile substances and drugs listed under the Misuse of Drugs Act which form part of an analgesic or cold remedy (e.g. co-proxamol); those deaths caused by secondary infections and deaths from road traffic accidents and other accidents which occurred under the influence of drugs.

The reasons for using the above definition are twofold. Firstly, the Department of Health Action Plan (Department of Health, 2001) and the Update Drugs Strategy (Home Office, 2002) targets to reduce drug-related deaths are based on the identification of cases according to the ONS definition. Secondly, other definitions of drug-related deaths, such as that used by the National Programme of Substance Abuse Deaths, are over-inclusive; counting deaths caused by overdoses of antidepressants, anti-psychotics and anticonvulsants in individuals who do not have a history of drug abuse or dependency.

The inquests of all deaths in East Sussex that occurred between 1st January 2007 and 31 December 2008, where the inquest had been heard and identified as drug-related by the Coroner *and the inquest received by the DAAT* were reviewed. In addition to those, one death which occurred in 2005 was reviewed as the inquest was received by the DAAT after the previous inquiry was completed. – in

total, 22 deaths reviewed in this inquiry. Those inquests not received at the time of this inquiry will be included in an ongoing process of review. Only those cases that met the ONS criteria of a drug-related death were selected for inclusion in the study. The cases excluded from this inquiry included one death that followed a fall where cannabis had been used but was not the cause of death and another where cocaine had been used but was not the cause of death. One other death was a verdict of misadventure where a non-controlled substance was implicated.

Method

A minimum dataset which includes a minimum data set which included the subject’s demographic details, their history of drug misuse, mental illness, contact with partner agencies housing or employment services, contact with any drug treatment service and the circumstances surrounding the death was extracted from the Coroner’s files and recorded in addition to the information provided by the Coroner on the Inquest form (appendix 1).

The agencies involved in the care and management of people with substance misuse problems in East Sussex were, where appropriate, contacted and asked to provide information about each case.

Statistical analyses were not used to compare the results from this local inquiry with those from national studies as the number of drug-related deaths that occurred in East Sussex were too small to be statistically significant, data was therefore analysed qualitatively and several broad themes identified as in the previous inquiry.

Subjects

Of the 22 drug related deaths

- 17 were male and 5 were female - two of the 5 females (40%), compared to 13 of the 17 males (76%), were known drug addicts or know drug abusers
- 20 were White, 1 was Pakistani and 1 was Black Other
- 8 (36%) lived in Hastings and Rother and 12 (55%) in Eastbourne, Downs and Weald, 1 (5%) lived in Hove and 1 (5%) individual was of no fixed abode
- 16 individuals died at home

Age

The most common age range associated with drug related deaths was 36 – 45, and 68% of all deaths occurred between the ages of 36 and 57 - the average age was 38, compared to 33 in the last inquiry.

Table 3: Age at time of death

Age Range	16 - 25	26 - 35	36 - 45	46 - 55	56 - 65
Number of DRDs	2	5	10	3	2

Employment

Although the majority of the deceased were unemployed (9), 8 were recorded as being either employed (6) or self employed (2). The remaining 5 covered the categories retired, student, invalidity/sickness, other and not known.

Accommodation

The living arrangements of the deceased are shown in the table below which shows that 11 individuals were living alone.

Table 4: Living Arrangements

	No
Alone	11
With partner	4
With partner and children	2
With parents	2
NFA	2
Retired	1

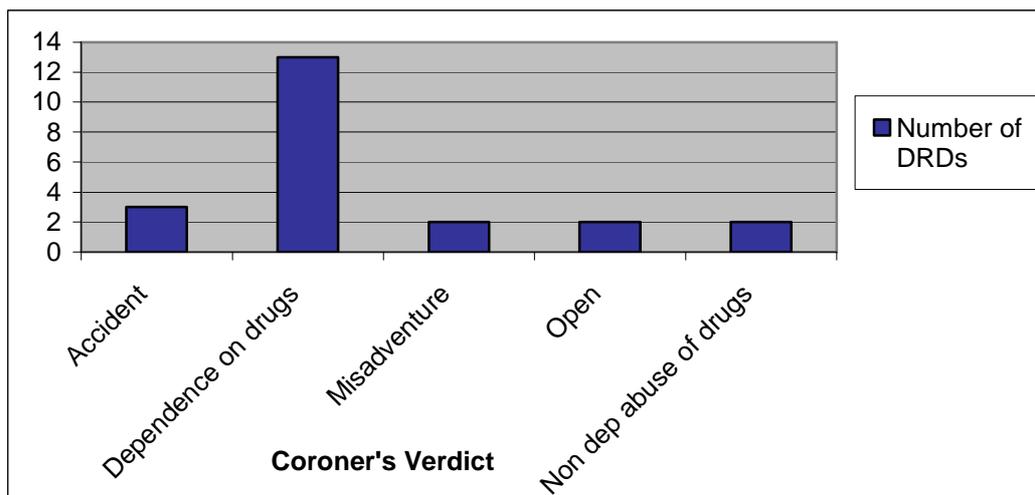
The previous inquiry found that 3 of the deceased who died shortly after leaving prison were staying with others at the time of their death also that 7 of the 22 cases were subjects living with friends or staying at others houses.

Findings

Manner of Death

The Coroner's verdict of the manner of death is shown in the graph below

Chart 1: Coroner's verdict on DRDs

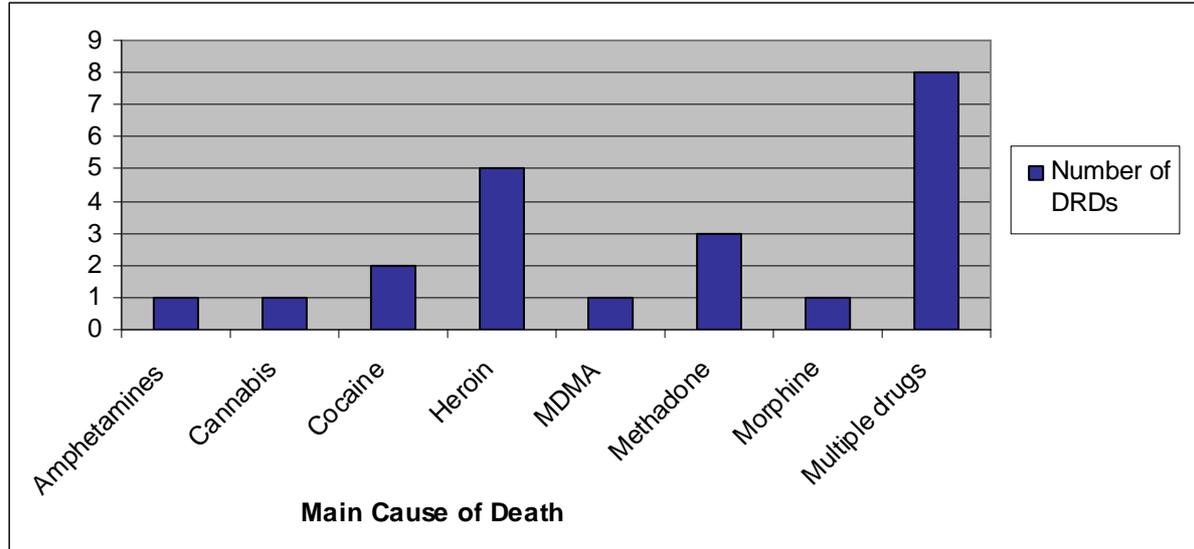


According to the Coroner's files, the deaths of 13 individuals were as a result of dependence on drugs. Three more of the deaths were recorded as accidental, and another 2 were recorded as misadventure. There were also 2 verdicts of non dependent abuse of drugs as well as 2 open verdicts.

Drugs Implicated in Main Cause of Death

The main cause of death as recorded by the coroner was multiple drugs, with 8 of the 22 (35%) taking a fatal mixture of at least 3 substances prior to death. These deaths cannot therefore be associated with a single drug, as the coroner stated that it was the combination of drugs, as well as in some cases alcohol, that led to death. Five of the deceased took large amounts of Heroin prior to death which led to Heroin Poisoning.

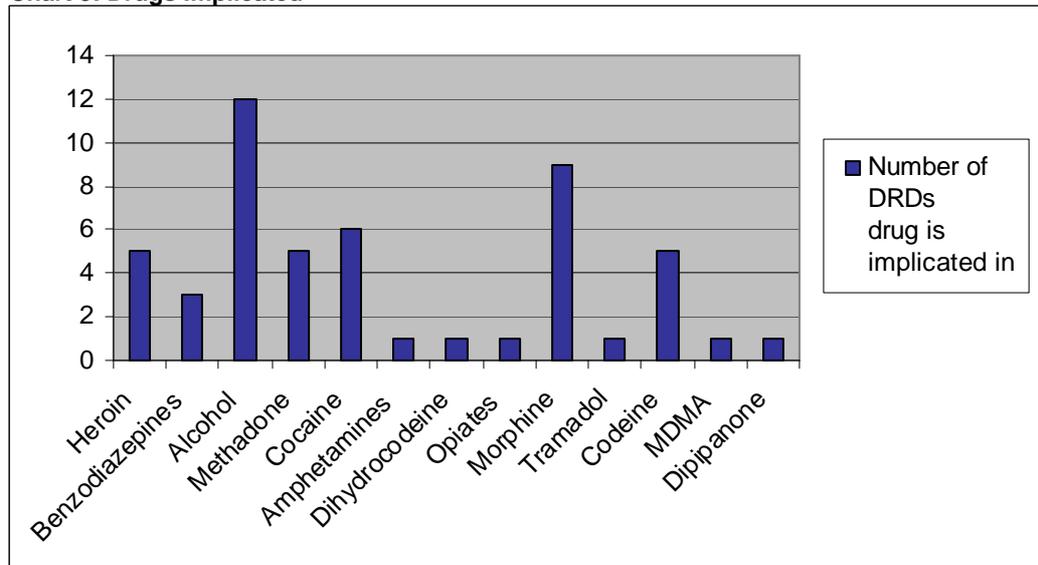
Chart 2: Main cause of death



Toxicology and Drugs Implicated

The drugs implicated in the 22 deaths, and the frequency with which they contributed to the death is shown in the chart below.

Chart 3: Drugs Implicated



Reports showed that Heroin, Methadone or Codeine was implicated in 5 deaths and Morphine, in 9 of the deaths (only one case where morphine was prescribed). The recording of specific Opiates within the toxicology results was not defined.

Alcohol

Alcohol was implicated in 12 (55%) of the 22 deaths compared to 45% for deaths broadly in 04/05, and 55% in the previous inquiry where 12 of the 22 deaths showed alcohol to be implicated.

Benzodiazepines

According to the National Drug Treatment Monitoring System (NDTMS), 16% of drug users who began their treatment journey in East Sussex between 2004 and 2005 reported using benzodiazepines. The previous assessment highlighted that in 2007, 20% of drug users entering treatment reported using benzodiazepines, and the Drug Treatment Needs Assessment 2008 found that fewer, 14% of adults receiving treatment during 07/08 had reported using benzodiazepines as either a primary, secondary tertiary substance.

Benzodiazepines were implicated in 3 deaths, compared to 10 of 22 deaths in 04/05 and 6 of 22 in the previous inquiry. Only 1 individual in treatment had declared Benzodiazepines as their secondary substance of misuse at the time of their assessment.

Methadone

Methadone was implicated in 5 deaths and 3 of the 5 were 'in treatment' and were being prescribed methadone. The remaining 2 individuals had not been assessed by treatment services.

Substance Misuse Treatment

10 individuals showed that they had some contact with treatment services in East Sussex. Of the 10:

- 1 individual died 2 months after completing an aftercare intervention and having left treatment in a planned way .
- 1 person had been assessed and was waiting to start a treatment intervention.
- 1 presented to treatment wanting a subutex detox but refused to attend a medical assessment so was discharged as 'treatment declined'
- 4 were discharged as 'dropped out/left' [between 6 and 24 months prior to their deaths
- 3 were in treatment (1 having been referred to a prescribing intervention but not started)

At the time of presentation to treatment, 4 individuals had declared significant alcohol consumption at ranging from 20 units per day to 35 units per day. In one case, an inpatient detox had been completed prior to their death. In another case, following an appropriate recommendation for daily contact after being drunk on presentation for assessment, the individual refused treatment. Alcohol dependent patients will continue to have to attend the service daily to be breathalysed before being dispensed their medication for safety reasons as recommended in the national guidelines. However, access to alcohol treatment will have been made easier: instead of the only point of access being through the alcohol provider, opiate dependent patients can access alcohol treatment by seeing the alcohol liaison nurse who works regularly in the dispensing clinic.

5 individuals declared that at presentation to treatment they used heroin daily and 1 declared that they used 2-6 times per week. 1 individual declared that they used cocaine daily, 1 declared benzodiazepines daily, and 2 declared that they used crack a few times a week.

It is also noted that another individual completed a Treatment Outcome Profile three days before she died and her Psychological state was recorded as 9 (of a scale 1-20 1 being low and 20 being high).

The previous inquiry found that 4 of the deceased had attended treatment services for an assessment, but lost contact with the treatment service before starting their treatment. The 'single assessment' introduced in January 08 was intended to address this issue along with the co-location of the non-medical provider with the prescribing team with a focus to engage clients in treatment at an early stage.

The indications are to date that since the introduction of the single assessment process, a lower proportion of individuals present to treatment and then drop out when compared to the period before the new assessment was introduced. Data in relation to Tier 2 interventions i.e. outreach has not been collated locally even though such interventions are more widely used than previously particularly when working with people who might be reluctant to engage with treatment services. An upgraded substance misuse case management system will enable local data collection to inform the effectiveness of this level of intervention at the beginning of 2010.

Whilst undertaking this and previous inquiries and whilst using the quantitative data obtained from the case management system, often it is difficult to obtain more qualitative information about the individuals from those who might have been in contact with them at the time of their death due to staff changes for example. Discussions have explored the merits of an additional part to the process, to include recent information within these inquires and treatment providers have already agreed to provide such information soon after the death of a client in treatment. This will provide the opportunity for treatment providers and key workers involved in the care to offer information soon after the death that may inform service development and lessons that might be learned.

Prison

Of the 22 cases, 9 of the individuals had been in prison. Although 6 had been released at least 19 months before their deaths, 3 had died within 6 months of their release:

- One individual had been imprisoned 7 times between 1997 and 2007 and reported continued use of heroin and subutex whilst in prison. They were released from HMP Ford 1 day before he died however no files mentioned treatment at the prison and no records appear on Dirweb suggesting no contact with CJITs or transfer out of prison directly to CJITs. The coroner's report stated that the cause of death was multiple drug toxicity, and a verdict of dependence on drugs was recorded.
- An individual was released from prison HMP Bullingdon 8 days prior to their death but no files mentioned treatment at the prison and no records appear on Dirweb suggesting no

contact with CJITs or transfer out of prison directly to CJITs. The coroner's report stated that the cause of death was Heroin poisoning, and recorded a verdict of dependence on drugs.

- The male was imprisoned for 3 weeks and released 6 months prior to their death, and the coroner noted that the individual had consumed alcohol, Methadone and Cocaine prior to death. A verdict of dependence on drugs was recorded.

The Drug Treatment Needs Assessment (2008) showed that of those leaving prison who had been referred to treatment through the Drugs Intervention Programme (DIR), whilst access to treatment is generally within one week, approximately 50% of people did not start their treatment. The Needs Assessment also showed that of the people referred into treatment through the Criminal Justice route, of those discharged from treatment, 55% were discharged in an unplanned way without return to prison.

The Integrated Drug Treatment System (IDTS) has been to some extent operational since April 2009 with clear links between the IDTS and community services particularly around the pathways from community into prison and continuity of care upon release. The DAAT treatment plan identifies objectives to ensure that the links between prison healthcare, CARAT and CJIT are reinforced to deliver effective continuity of care arrangements.

At present all drug and alcohol users coming into custody are offered evidence based treatments that include Methadone, Suboxone and Lofexadine for opiate users, the former two being either a maintenance or detoxification regime depending on the individual circumstances. Diazepam and Chlordiazepoxide are used for benzodiazepine and alcohol misuse.

There are robust regimes already in place ranging from 14 to 21 day detoxification programmes. All newly appointed health care staff spend time with the drug treatment nurses and are aware of the procedures of administering Suboxone and Methadone together with the implications and treatment of overdose etc.

It is envisaged that more prisoners will be receiving a maintenance prescription and will be released from court or prison still being prescribed medication and already established good links with the local community clinics are being built on.

Release planning will be an essential element of the treatment journey and as well as an established naltrexone policy a retoxification policy will also be developed to use as appropriate. The prisoners under the care of the drug treatment nurses will be encouraged to participate in the normal prison regime and activities which involves education and the workshops. The local DIP workers, AA, NA will be encouraged to visit the IDTS wing on a regular basis to develop a healthy working relationship.

The CARAT team at HMP Lewes are starting pre-release clinics offering support with housing issues, benefit applications, medical interventions and access to services and this will involve the local DIP treatment providers prior to release.

Resuscitation

In June 2008, East Sussex substance misuse services began to implement a naloxone distribution programme where opiate dependent patients are trained to give basic life support and administer naloxone to an overdose victim. Treatment providers report that naloxone has been successfully used in a small number of cases since implementation.

Inquiries show that resuscitation was attempted in 2 cases here. One patient had previously overdosed and had been resuscitated by a family member. Given the case history of overdose and the willingness of the family member to resuscitate, the patient would have been a very good candidate for naloxone training.

Dual Diagnosis

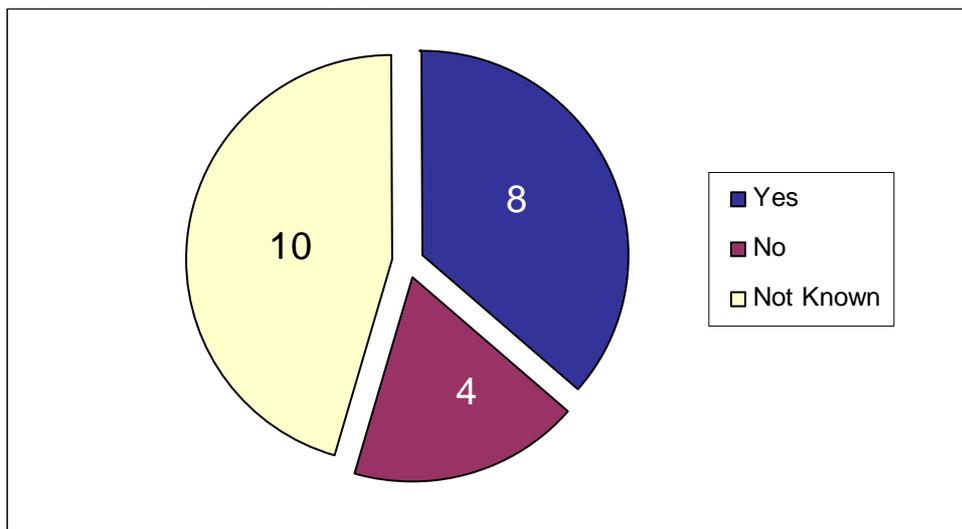
The coroner noted that 8 of the 22 (36%) were on prescribed psychoactive medication, and it is also noted that 6 of these individuals had been in contact with Mental Health Services at some stage. With regards to the other 8, they were either not on medication or not known, and 2 had previously either requested help or received help for mental health issues.

Only one of the 10 individual with some treatment history was recorded as 'dual diagnosis' which for National Drug Treatment Monitoring System purposes is broadly defined as receiving care from mental health services for a reason other than substance misuse (mental health service refers to any PCT/NHS provision as well as other privately provided services).

Patient contacts are recorded on the Health Patient Information System shows that in 13 cases a contact was recorded in PIMS and that 7 records showed a history of referrals to the Crisis Home Resolution Teams (1 within 9 weeks prior to their death), in 2 cases, referrals to Mental Health in Primary Care and 2 to a Homeless Health Team.

The Sussex Partnership NHS Trust Clinical Guidance (2008) states that should any individuals have received treatment from mental health in-patient care, any discharge with no enhanced mental health Care Programme Approach (CPS) but substance misuse care only would have been taken very carefully due to medicolegal (of allegations of lack of follow-up and care)⁴. The same guidance also states that where there is an opiate prescribing need, the care should be shared between the Mental Health Trust and the Substance Misuse Service and responsibility for prescribing agreed between the two teams.

Graph 1: Number prescribed psychoactive medication



Children

A recommendation from the previous inquiry is that children should be an area specifically explored within the inquiry process. It was noted from the Coroner's file and other information that 4 of the deceased had children living with them, and 2 other individuals had children but not living with them at the time of their death. One individual had been assessed by East Sussex treatment providers but not started treatment at the time of their death.

A new procedure of recording and advising on recent suspected drug related deaths will be introduced in East Sussex. Where Police Officers suspect that a death may be drug related, a standardised form will be sent to a defined group including the DAAT. This will enable both adult and young people's substance misuse case management systems to be scanned in relation to any children who might be in contact with or living with the deceased and Children's Services advised where appropriate.

Summary of Previous Recommendations

The majority of previous recommendations have been completed which included;

- Reducing the proportion of drug users who are prescribed benzodiazepines by discouraging clinicians from starting to prescribe, encouraging clinicians from other agencies to transfer responsibility for benzodiazepine prescribing to the substance misuse services for detoxification
- For those patient requiring benzodiazepines, encouraging the use of dispensing arrangements such as instalment prescribing and supervised consumption to restrict the diversion of benzodiazepines into the illicit market
- Conducting research to quantify the extend of benzodiazepine prescribing within primary care in East Sussex
- Forging links with local Accident and Emergency departments to encourage drug users at high risk of overdose being referred to treatment
- Improving data quality in relation to dual diagnosis and housing need for patients entering drug treatment through the National Drug Treatment Monitoring System data capture

- Continuing to increase the number of treatment places commissioned for opiate replacement therapy
- Ensuring that future inquiries into drug related deaths explore whether children were a factor in the home environment of the deceased so that Children's Services can follow up the cohort if necessary

There remain a small number of recommendations from previous inquiries where work is already underway but incomplete or yet to be started. The following table provides a summary of those outstanding or where work has completed since the previous inquiries.

Recommendation	Progress	R/A/G
Conduct research to quantify the extent of benzodiazepine prescribing within primary care in East Sussex	This has been included in the DAAT's treatment plan for 2008/09 – the PCT ePACT (electronic prescribing and cost trends) database will be used for source data. Work is currently in progress.	A
Forge improved links with local Accident and Emergency departments to encourage drug users at high risk of overdose being referred for treatment	Nigel Hussey and Joanne Bernhaut (PCT [public health and well being] are working with colleagues in ESHT to deliver training and develop more effective care pathways, particularly in relation to alcohol misuse. Further work is required as indicated in the Treatment Plan.	A
Improve liaison with prisons to investigate and rectify any failings in the referral system	Processes in place to liaise on every drug related death to investigate all possible prison leavers from HMP Lewes.	A
Expand the naloxone distribution program to include offenders leaving prison	Discussions have taken place with Debbie Parker, Head of Healthcare, HMP Lewes to consider as part of IDTS. If funding is not available from IDTS, the Joint Commissioning Group will consider funding from the ring fenced budget	A

Recommendations As A Result of This Inquiry

A number of new recommendations are summarised below.

Introduce a 'lessons learned' approach following any death where the patient was in treatment	Treatment providers will provide an appropriate summary following such a death to include information about any lessons that might be learned and shared with other treatment providers	KB/ALL	Sept 09
Exploring dual diagnosis further	A brief gap analysis to be explored within the drug treatment needs assessment and progressed further into a wider project	KB	March 10
Introduce a system of early notification by Police particularly where children are likely to have been involved in each death	An alert system will be introduced that will identify such cases for all case management systems to be cross checked and Childrens Services advised where appropriate.	KB/VF	Dec 09
Data collection in relation to tier 2 treatment interventions (i.e. outreach, needle exchange and after care) to be implemented	The new case management system will be introduced and used by treatment providers and it will collate tier 2 treatment data for analysis	KB/Providers	Feb 10

Acknowledgements

We would like to thank all those who enabled us to conduct the Inquiry including the East Sussex Coroner and Colleagues, Drug Treatment Providers, GPs and Lewes Prison.

¹ Ghodse H, Corkery, J, Schifano F, Oyefeso A, Bannister D, Annan J. (2005) *Drug Related Deaths in the UK Annual Report 2005*. International Centre for Drugs Policy

² McDonnell, J. and Bennett, J. (2004) *Drug Deaths in East Sussex*. Unpublished.

³ Ghodse H, Corkery J, Oyefeso A, Schifano F, Tonia, T (2006) *Drug-Related Deaths in the UK Annual Report 2006*. International Centre for Drugs Policy.

⁴ Sussex Partnership NHS Foundation Trust - Policy on the Management of people with a Dual Diagnosis of Mental Health and Substance Misuse (inc. alcohol misuse) October 2008. Replacing 047/2007/Clinical/Policy on the management of people with a dual diagnosis of mental health and substance misuse