



**Confidential Inquiry in to Drug-Related Deaths
January 2008 to December 2009**

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June 2010

Introduction

This inquiry into drug related deaths in East Sussex as part of an ongoing annual process of inquiries. The inquiry exploring deaths where the Inquest was received by the DAAT between January 2008 and December 2009 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', 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
2008	1.44	6

The table shows the number of drug related deaths per 100,000 East Sussex population reported to St Georges since 2001². The table below reports the number of deaths included in the local inquiry process since 2004.

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
2010	14
Total	124

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 2008 and 31 December 2009, where the inquest had been heard and identified as drug-related by the Coroner *and the inquest received by the DAAT* were reviewed.

14 deaths are included in this inquiry, two deaths occurred in 2008 and 12 in 2009. 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 4 cases excluded from this inquiry included two road traffic accidents, and one suicide. One other death was an open verdict 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 14 deaths:

- 10 were male and 4 were female
- - 12 were known drug users, 3 female and the remaining 9 male and
10 were White, 1 was Black Caribbean and 1 Black African
- 3 lived in Hastings and Rother and 9 in Eastbourne, Downs and Weald, 1 lived in Worthing and 1 individual was of no fixed abode and
10 individuals died at home and 2 at a friends 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	1	6	3	3	1

Employment

6 of the deceased were unemployed, 6 were recorded as being either employed or self employed.

Accommodation

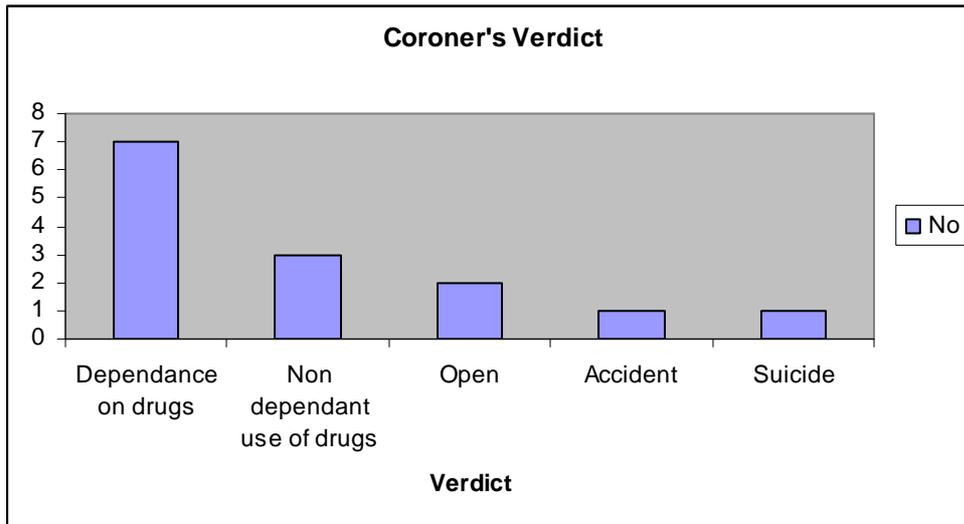
6 of the deceased lived alone, 1 was of no fixed abode and 7 lived with a partner.

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



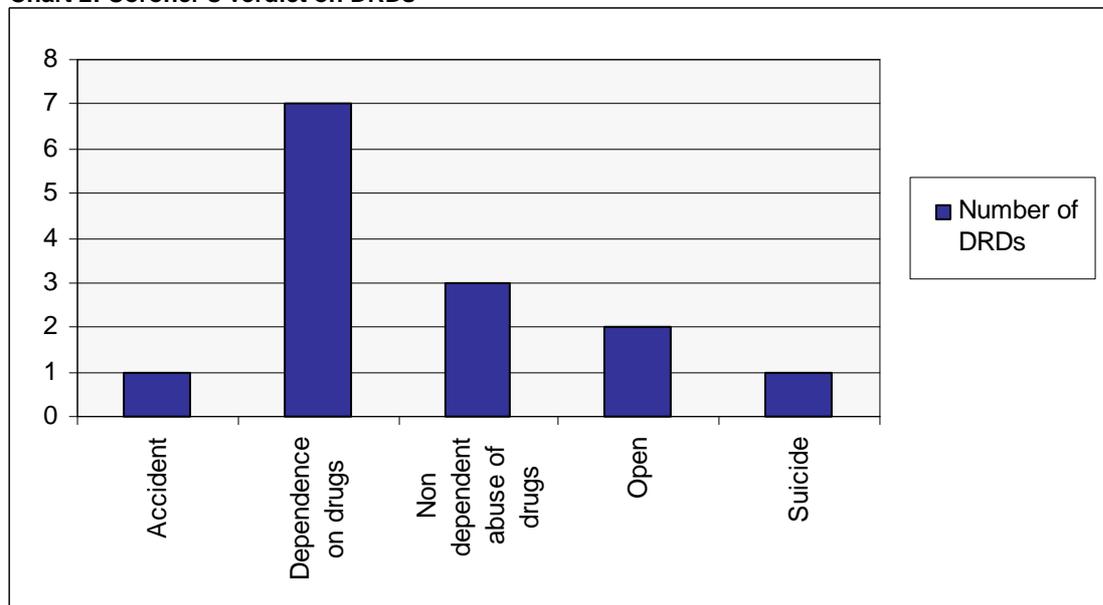
The Coroner determined that 7 of the deaths were as a result of dependence on drugs and 3 of a non-dependant use of drugs. 2 deaths were recorded as an open verdict, 1 as an accident and 1 as a suicide.

Findings

Manner of Death

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

Chart 2: Coroner's verdict on DRDs

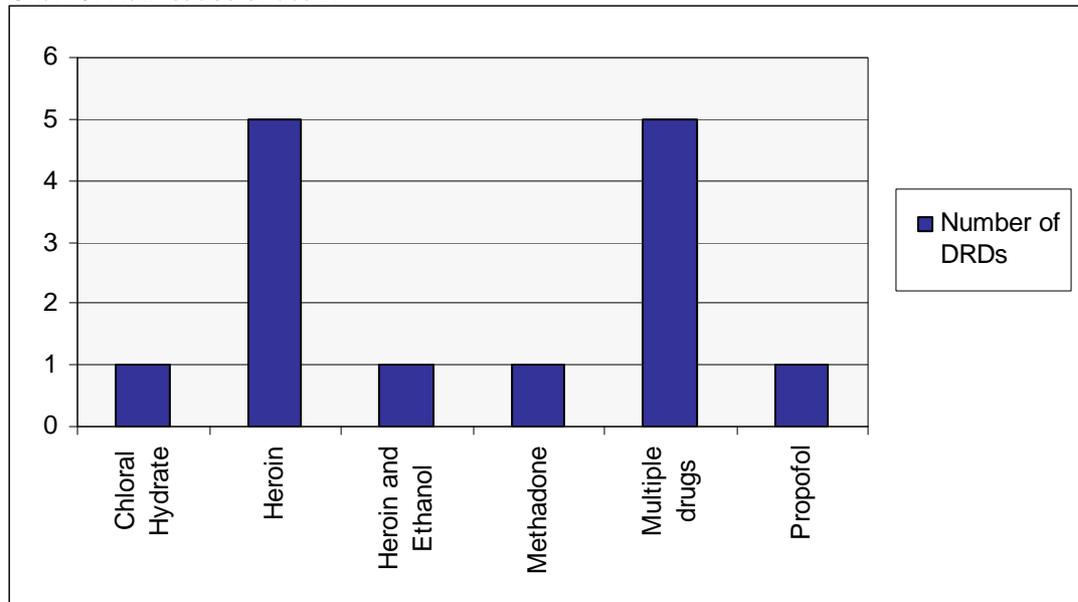


The Coroner's files show that half of the individuals died as a result of a dependence on drugs, while another 3 were recorded as non dependent abuse of drugs. There were also 2 open verdicts, 1 of suicide and another recorded as accidental.

Drugs Implicated in Main Cause of Death

When looking at cause of death, the main types recorded by the coroner were Heroin Poisoning and Multiple Drug Poisoning with 10 of the 14 (71%) deaths be attributed to these 2 causes. The multiple drugs deaths involved a fatal mixture of at least 3 substances prior to death, and therefore cannot be associated with a single drug as the coroner stated that it was the combination of drugs, and in some cases alcohol, that led to death.

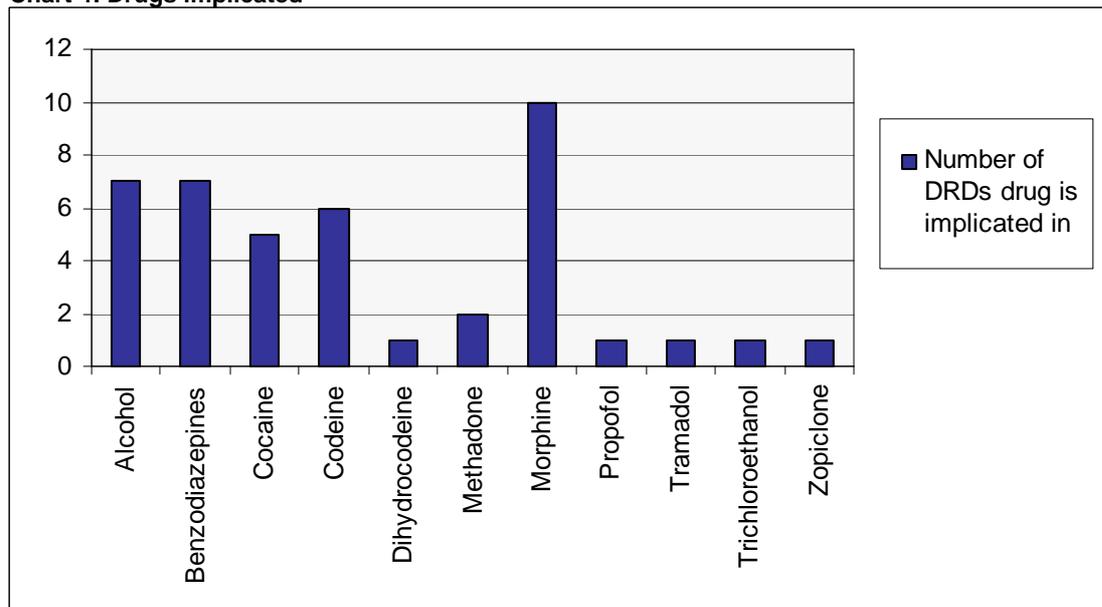
Chart 3: Main cause of death



Toxicology and Drugs Implicated

The drugs implicated in the 14 deaths, and their frequency of detection in the toxicology is shown below:

Chart 4: Drugs implicated



The reports show that the drug implicated in the largest numbers of deaths was Morphine (a metabolite of heroin), although there only appears to be one case where the Morphine was prescribed. Cocaine was implicated in 5 deaths, while Codeine was apparent in 6.

Alcohol

Alcohol was evident in 7 (50%) of the toxicology results, compared to 45% for deaths broadly in 2004/05, and 55% in the previous inquiry where 12 of the deaths implicated alcohol.

Benzodiazepines

Benzodiazepines were evident in 7 deaths, compared to 3 in the previous inquiry, and compared to 10 of 22 deaths in 2004/05. None of the individuals in Orion had declared Benzodiazepines as the primary, secondary or tertiary substance of misuse at the time of assessment.

Methadone

Methadone was evident in 2 deaths, and although they were both 'in treatment', only 1 was being prescribed Methadone. However the other individual's partner was also 'in treatment' and being prescribed Methadone.

Substance Misuse Treatment

4 individuals show that they had some contact with the East Sussex drug treatment services. Of the 4:

- 2 died whilst in treatment
- 1 individual was discharged 'Treatment Complete' approximately 20 months prior to death
- Another person dropped out without receiving any modalities roughly 4 and a half years before their death

At the time of presentation to treatment, only 1 individual declared significant alcohol consumption and declared drinking alcohol daily. This person was in Structured Alcohol Intervention and died whilst in treatment.

When presenting to treatment, a further 2 individuals said they used Heroin, although there was no further information with regards to the quantity or frequency of use. The final person declared using Crack daily.

It is also noted that 2 individuals completed Review TOPs prior to deaths:

- 1 completed the TOP approximately a month before death and stated that their physical health status and quality of life was 15 (on a scale of 1 – 20; 1 being low and 20 being high).
- The other person completed the form 9 months prior to death and said that they viewed their physical health status and quality of life as 4 (though no subsequent care plan reviews were recorded).

Prison

Of the 14 cases, 6 had been in prison at some stage but none of those released had been released within the 6 months prior to their death. None of the releases were since the introduction of the Drugs Interventions Programme (DIR).

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.

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 7 of the 14 cases here. In 5 cases, circumstances indicate that Naloxone would have been appropriate to use.

Dual Diagnosis

The coroner noted that 4 of the 14 deceased were on prescribed psychoactive medication, although it was also noted that none of these individuals were in contact with Mental Health Services at the time of their death.

Patient contacts are recorded on the Health Patient Information Management System (PIMS). According to eCPA, only 3 subjects had contact with the Trusts' services in the 6 months prior to their death:

- Two of the deceased were referred to CMHT and were in contact with mental health services prior to their death; one was last seen by CMHT less than a month before death, while last contact for the other was 4 months prior to death
- At the last contact with CMHT, it was reported that one of the individuals was abusing Diazepam to treat back pain and was requesting more Benzodiazepines be prescribed
- Although the third individual had previously been treated by their GP for anorexia and depression, they had been referred to SWIFT and died whilst in treatment with the service. It was reported that they were trying to restrict their alcohol intake and wanted their Diazepam dose increased. Although the GP initially refused to do this, the dosage was later increased to treat alcohol cravings

A further 4 individuals had information entered into PIMS, with their last contact ranging between 11 months and 12 years prior to their death.

- Two were in contact with mental health services, although one ceased treatment 12 years prior to death, and no details of psychiatric history are provided for the other
- However, one of the deceased went on from CMHT to engage with the adult drug treatment service, Eastbourne SMS, and died whilst in treatment
- Another individual had engaged with Hastings SMS although completed Specialist Prescribing and Structured Psychosocial Intervention modalities and was discharged 'Treatment Complete' 20 months prior to death

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 that one of the deceased had a number of children. For this case there was a final incident report produced following a review of the circumstances surrounding the death revealing that the family were allocated to a Social Worker. The findings of the Serious Untoward Incident (SUI) review identified the following:

- That there was a lack of oversight in relation to permission for collection of a script by a partner whilst the client was in prison (the deceased had collected the script with a letter of agreement from the patient – continuing to do so whilst they were in prison)
- There was a lack of communication with the pharmacist (the relevant checks were not made at the point of script collection)
- There was a lack of communication with the prescriber and the prison (the prescriber should have been aware that the script should have ceased)
- Communications with the treatment provider not actioned in the absence of the keyworker (the keyworker was not at work and so the message was not picked up until their return)
- No risk assessments undertaken by the Community Mental Health Team (there was an identified issue but no risk assessment carried out appropriately, the issue not being identified to the prescriber)

The action plan addressing the findings includes actions to:

- Introduce procedures for the collection of scripts in these circumstances to be clarified
- That closer communications are promoted with the Prison Service (HMP Lewes)
- That inward messages to the treatment provider are recorded in a duty book and responded to by a designated person on a daily basis
- That the procedures for consideration and recording of risk for patients only seen as outpatients are to be clarified with medical staff

The report was noted to be in the Coroner's file but was not advised previously to the Harm Reduction Group within the realms of the Confidential Inquiry process. The process of SUI inquiries should align to this process in order that learning from both processes can inform ways that deaths as above might have been avoided. The recommendation here is that all SUIs should be shared with the Confidential Inquiry team.

SUI Summary

Further to the SUI outlined in the 'Children' section above, a further 2 SUI reports were completed in relation to 2 other DRDs within the Inquiry:

- Only a brief synopsis of one is known, with no mention of a history of illicit drug use being highlighted in the report. At the time the report was written, the cause of death was not known for certain, although the unofficial reports the author received from the coroner's office suggested that the cause was a Clozapine overdose. **The action plan following this SUI focused on the care pathway for Clozapine prescribing.**
- The SUI review for the other individual found that their care consisted of regular contact from their care co-ordinator to monitor their mental health. They had a history of Diazepam misuse, although tended not to attend out patient appointments as they knew they would not be prescribed any more Diazepam. However, findings show that the care co-ordinator and GP had worked well together to agree weekly prescriptions of Diazepam. The SUI also reported that they regularly refused referrals to the adult drug treatment service, and that approximately 2 weeks prior to death staff refused to give the individual extra Diazepam.

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
- Processes are in place to liaise on every drug related death to investigate all possible prison leavers from HMP Lewes
- Treatment providers provide an appropriate summary following such a death to include information about any lessons that might be learned and shared with other treatment providers

- 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.

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
Exploring dual diagnosis further	A brief gap analysis to be explored within the drug treatment needs assessment and progressed further into a wider project	March 10
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	Feb 10

Recommendations As A Result of This Inquiry

- The recommendation from this inquiry is that all SUIs should be shared with those producing the confidential inquiries at the time of completion
- That the Naloxone programme should continue to provide training to drug users and their carers on how to manage an overdose situation.

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 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 report² 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.