



**Confidential Inquiry into Drug-Related Deaths
2004 to 2010**

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1. Introduction

This inquiry has been carried out in order to identify preventable causes or themes in drug related deaths to inform plans to reduce the number of deaths. An inquiry into drug related deaths (DRD) in East Sussex is part of an ongoing annual process. Historically, inquiries have grouped subjects based on when the Coroner's file is received by the DAAT rather than by year of death. However, this inquiry will look at all 94 deaths received since 2004 that fits within the Office of National Statistics (ONS) definition.

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)¹'.

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.

2. National Programme on Substance Abuse Deaths (np-SAD)

An annual report is produced by the national programme on Substance Abuse Deaths (np-SAD) to inform the Government's monitoring of this public health issue. 'The Programme's principal function is to provide high quality and consistent surveillance, and to detect and identify emerging trends and issues in respect of this phenomenon².' 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.

Np-SAD 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 of more psychoactive substances directly implicated in death;
- History of dependence or abuse of psychoactive drugs;
- Presence of Controlled Drugs at post mortem; or
- Cases of deaths directly due to drugs but with no inquest³'

¹ Office of National Statistics (2010) Statistical Bulletin: Deaths related to drug poisoning in England and Wales, 2009. Newport: ONS <http://www.statistics.gov.uk/pdfdir/dgdths0810.pdf>

² Annual Report 2010: <http://www.sgul.ac.uk/research/projects/icdp/pdf/np-SAD%2011th%20annual%20report%20Final.pdf> p1

³ Annual Report 2010: <http://www.sgul.ac.uk/research/projects/icdp/pdf/np-SAD%2011th%20annual%20report%20Final.pdf> p92

3. Aims and Objectives of Inquiry

East Sussex DAAT includes a multi-agency Harm Reduction Group, whose objectives include reducing drug related deaths in the county by:

- Monitoring the number and causes of drug related deaths in East Sussex
- Ensuring that the information obtained from investigations into drug related deaths and 'near misses' inform practice and service development
- Ensuring that best practice guidance on reducing drug related deaths is implemented locally
- Making sure that recommendations to reduce drug related deaths are considered by the DAAT when commissioning treatment

This inquiry will attempt to identify any trends over the past 7 years with regards to the profile of those subjects involved in drug related deaths, the drugs implicated in their deaths, prior involvement with the substance misuse services, Community Mental Health Teams (CMHT) or any other mental health involvement, prison releases, resuscitation attempts and if the implementation of the Naloxone programme in June 2008 has had an impact.

Since 2004, a total of 94 deaths have fitted within the ONS definition, with the dip in 2008 being corroborated by the *St Georges Drug related Deaths in the UK Annual Report for 2010*⁴, despite the different definition used for that study. Also of note is that the low number recorded for 2010 is not a true reflection of the number of deaths within the year. It can often take some time for the inquest to be heard, with the DAAT only receiving the notification of the death once this process has been completed.

The table below shows the number of drug related deaths included in the local DRD inquiries by year of death, as well as the number of deaths per 100,000 East Sussex population reported to St Georges since 2004.

Table 2: Deaths included in the local DRD inquiries and deaths reported to St George's: by year of death

Year of Death	Number included in local DRD inquiry	East Sussex np-SAD annual death rate	East Sussex np-SAD Rate per 100,000
2004	15	24	5.93
2005	12	4	0.98
2006	17	23	5.66
2007	17	15	3.60
2008	7	9	2.16
2009	21	23	5.51
2010	5	-	-

3.1 Method

A minimum dataset which includes 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. 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.

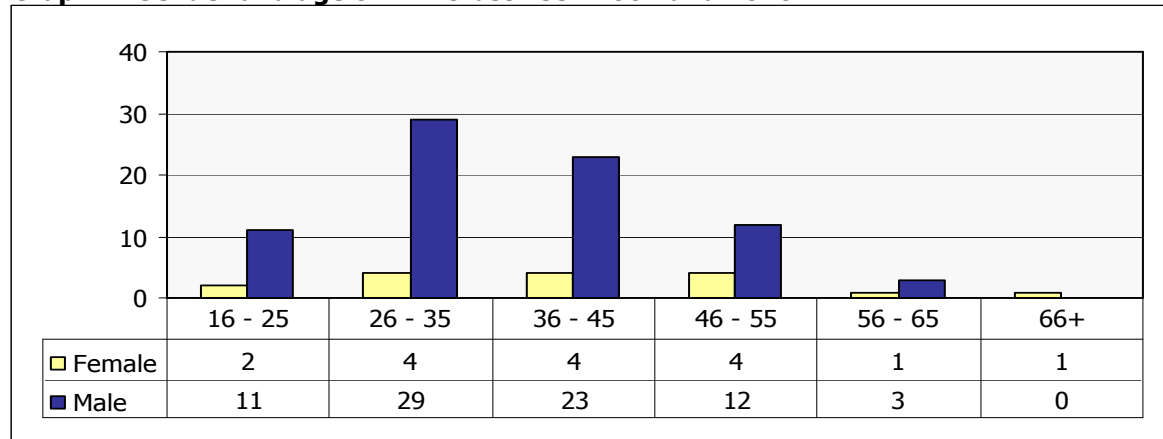
⁴ Annual Report 2010: <http://www.sgul.ac.uk/research/projects/icdp/pdf/np-SAD%2011th%20annual%20report%20Final.pdf>

Findings

4. Personal Profile

Less than 5% of the individuals involved in the inquiry were aged 56 or older at the time of death, with the largest numbers (63.8%) falling into the 26 to 45 age group. The youngest person in the inquiry was 17, while the oldest was 84.

Graph 1: Gender and age of DRDs between 2004 and 2010



Across the 7 year period, the average age is 36.7, with 83% of all cases involving a male subject. Although the average age of those involved in drug related deaths during 2005 and 2006 was between 33 and 34, since 2007, this has shifted in an upwards direction, with the mean age in each of the years between 2007 and 2010 being above the group average.

Although almost half (44.7%) of those included in the inquiry were unemployed at the point of death, a further 39.4% were listed as being either employed or self employed.

Table 3: District of residence of subjects involved in the inquiry: 2004 to 2010

District	Total	% of Total
Hastings	32	34.0%
Eastbourne	24	25.5%
Lewes	17	18.1%
Wealden	7	7.4%
Out of Area	5	5.3%
Rother	5	5.3%
NFA	4	4.3%
Total	94	

Over half (59.6%) of the subjects were resident in the urban areas of Eastbourne, Hastings and St Leonards on Sea, while much smaller numbers are evident in the more rural areas of Wealden and Rother. Also of note is that there were 5 drug related deaths in East Sussex involving people who live outside the county, while 4 deaths involved individuals of no fixed abode.

5. Verdict

The Coroner delivered a verdict on all 94 deaths during the 7 year period, and over half (56.4%) of the deaths were as a result of dependence on drugs. Although, it is apparent

that half (49.1%) of these individuals had previously been in contact with the treatment services, seeking help for their substance misuse, half had not, which suggests a gap in knowledge or access to treatment. However, objectives within the Treatment Plan 2011/12 include developing a social marketing approach to identify the people who could benefit from treatment and promote services in ways that encourage them to access treatment, as well as improving access to treatment by developing marketing plans that segment the population and that address potential service users of different ages, genders, using different drugs and so on, and setting stretching ambitions to reach more of these populations.

A further 13.8% delivered a verdict of non-dependent abuse of drugs, while small proportions of deaths within the inquiry returned verdicts of suicide or misadventure.

Table 4: Coroner’s verdict by year of death

Year of Death	Dependence on drugs	Non-dependent abuse of drugs	Accidental	Open	Suicide	Misadventure	Total
2004	8	1	2	1	3	0	15
2005	5	4	1	1	1	0	12
2006	13	2	1	0	1	0	17
2007	12	1	1	1	0	2	17
2008	2	0	2	2	0	1	7
2009	12	3	1	3	1	1	21
2010	1	2	2	0	0	0	5
Total	53	13	10	8	6	4	94
% of Total	56.4%	13.8%	10.6%	8.5%	6.4%	4.3%	

6. Toxicology

Drugs implicated in the deaths are listed in each individual’s toxicology results. In general each subject ingested multiple drugs prior to death, which means that the total adds up to more than 100%. The key substances, as shown in the table below, appear to be Opiates (i.e. Heroin, Methadone or another Opiate), Benzodiazepines and Alcohol.

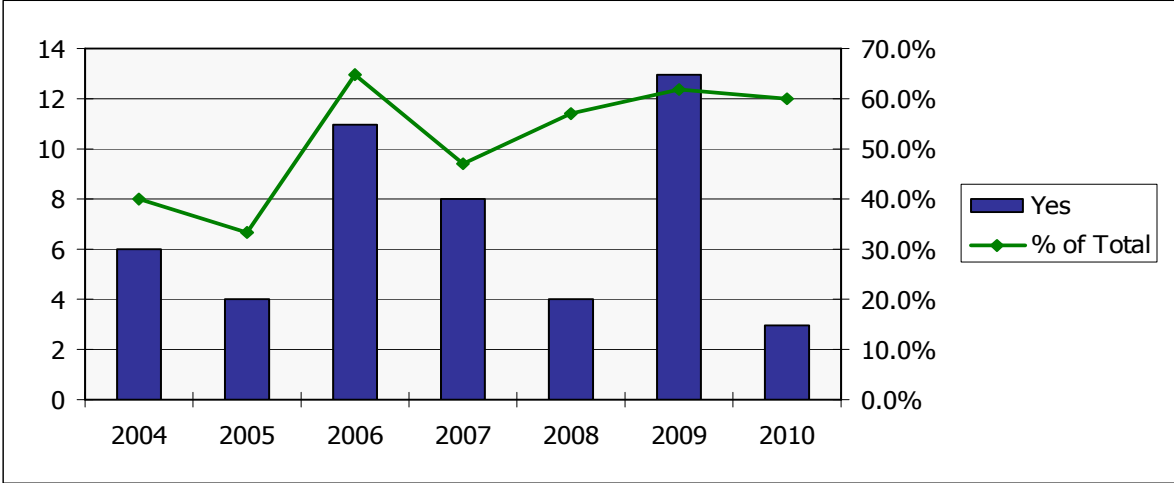
Table 5: Key substances listed in toxicology results

Substance	Number	% of Total
Opiates (Heroin, Methadone, Other)	78	83.0%
Alcohol	49	52.1%
Benzodiazepine	36	38.3%

6.1 Alcohol

As the table above shows, over half (52.1%) of the cohort had taken alcohol prior to death. Although consumption of alcohol in drug related deaths fluctuates from year to year, a smaller proportion of subjects had consumed alcohol prior to death in 2004 and 2005 than in later years. Approximately 60% of individuals had consumed alcohol alongside other substances between 2008 and 2010, while only 30% to 40% had drunk alcohol prior to death in 2004 and 2005.

Graph 2: Number and proportion of those with alcohol listed in toxicology by year of death



Two thirds (61.2%) of those consuming alcohol prior to death were resident in the urban areas of Eastbourne and Hastings, with the majority of those living in Hastings district once being resident in St Leonards.

6.2 Heroin

The numbers of individuals taking Heroin prior to death fluctuates from year to year.

Table 6: Heroin listed in toxicology by year of death

Year of Death	Yes	Total	% of Total
2004	8	15	53.3%
2005	7	12	58.3%
2006	9	17	52.9%
2007	4	17	23.5%
2008	1	7	14.3%
2009	11	21	52.4%
2010	1	5	20.0%
Total	41	94	43.6%

There is currently a drought in the availability of Heroin in Europe, which has been evident since September 2010. It has been estimated that 90% of the world’s Heroin comes from Afghanistan, and reasons cited for the recent drought include police activity in the dismantling of UK distribution networks, a fungus devastating the Afghan crop, and the affects the flooding had on the country in 2010, creating logistical problems for the Heroin supply routes. Although, it is too soon to see the impact the current drought is having on drug related deaths in East Sussex, it is crucial to take this into account for future inquiries, as this drought has the potential to have a detrimental if not fatal impact on the health of the UK’s illicit drug users. It has been reported that ‘on the retail market, suppliers are responding to the shortage by raising their prices and reducing the purity of their product. As the absence of Heroin began to take hold, numerous reports appeared of alternative active ingredients being used in supplies of so-called Heroin. These have included Buprenorphine, Codeine, Paracetamol and especially Benzodiazepines.⁵’ The same report goes onto to say that there have been reports of people who have taken ‘Heroin’ testing negative for the

⁵ IDPC Briefing Paper: The Heroin Shortage in the UK and Europe: http://idpc.net/sites/default/files/library/IDPC-briefing-paper-heroin-draught_p3

presence of Opiates, while testing positive for Benzodiazepines. There have also been reports of users attending A&E after overdosing on the contaminated substance, where emergency staff have administered Naloxone to counteract the affects of Heroin, but it has failed to revive them as the overdose was in fact due to Benzodiazepines.

In East Sussex, it was reported that at the end of 2010 a number of people were hospitalised within a couple of days after taking a suspect substance. A multi agency approach was quickly adopted in order to create awareness and warn users of the potential dangers, with the Police issuing drugs updates to service providers, and a joint agency press release being delivered. No similar drug alerts have been issued since.

The Home Office Drug Strategy 2010 entitled *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life⁶* states that the Heroin using population is ageing, with the largest proportions of those newly presenting to treatment being aged 40 and above. Two thirds (65.9%) of those with Heroin listed in their toxicology results were aged 22 to 36. However, only 8 (29.6%) of these individuals had been in contact with the treatment service, which is proportionately lower than the older age group, in which 57.1% had sought treatment for substance misuse. Also of note with the group of 16 known to the treatment services:

- 14 (87.5%) listed Heroin as their primary substance
- 11 (68.8%) were involved in prescribing interventions
- 5 (31.3%) also had Methadone listed in their toxicology results
- 7 (43.8%) died whilst in treatment and a further 5 (31.3%) dropped out. Only 3 (18.8%) are recorded as completing their treatment journey prior to death

Three quarters (75.6%) of those who used Heroin prior to death lived in Eastbourne and Hastings, with over two thirds of those subjects resident in the latter district living in St Leonards.

6.3 Methadone

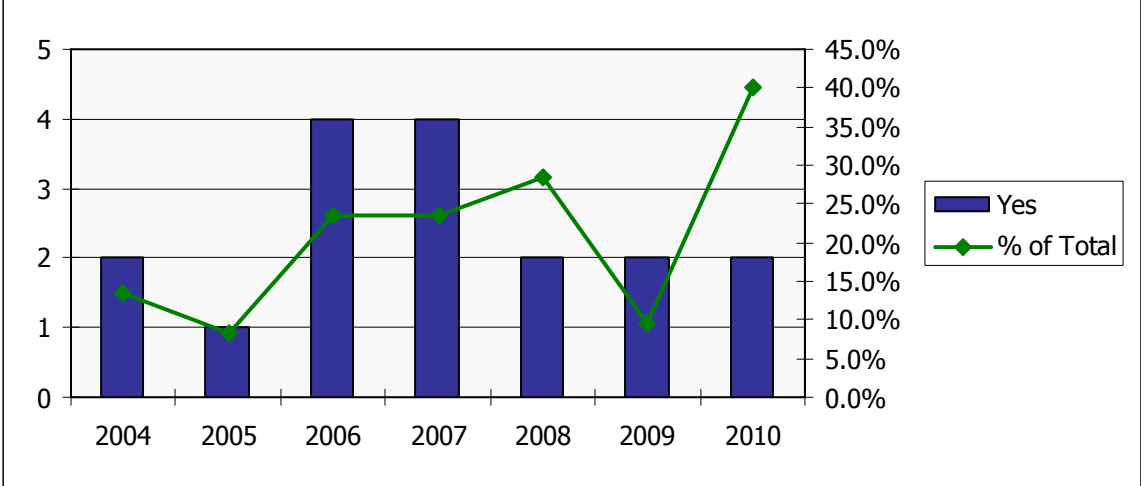
Methadone consumption is initially supervised to ensure the patient is taking their prescribed medication, and reduce the risk of diversion to the illicit market. Current (2007) Department of Health guidelines recommended that for the first 3 months of treatment, Pharmacists, or other health professionals, should directly supervise the consumption of Methadone. However, in the majority of cases it will be a community pharmacist who supervises the consumption. Although annual reports on drug related deaths still report deaths due to Methadone, it is widely believed that introduction of supervised consumption has led to a reduction in the number of deaths.

Looking back, the Confidential Inquiry published in 2007 states that although supervised consumption with pharmacies is common practice within the boroughs of Hastings and Rother, none of the community pharmacists working in Eastbourne, Lewes and Wealden supervise the consumption of controlled drugs. However, at April '11, the numbers of pharmacies that offer supervised consumption in Eastbourne, Lewes and Wealden have surpassed Hastings and Rother, with East Sussex now having a total of 40 pharmacies that offer this service; 23 in Eastbourne, Lewes and Wealden (35% of pharmacies in the 3 districts), and 17 in Hastings and Rother (46% of pharmacies in the area).

⁶ Drug Strategy 2010: <http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary>

In total, less than a fifth of individuals involved in DRDs had Methadone listed in their toxicology. The drug was implicated in 17 (18.1%) of the deaths, with 13 of the subjects having been involved with the substance misuse services. However, only 10 of the individuals were receiving prescribing interventions, which suggests that the other 7 may have obtained the substance illegally. Also of note is that all but 1 of the individuals were in treatment at the point of death.

Graph 3: Number and proportion of those with Methadone listed in toxicology by year of death



NICE guidance states that 'there is a risk of death early in Methadone treatment as a result of excessive initial doses, failing to recognise cumulative effects, giving Methadone to people with impaired liver function (due to chronic hepatitis) or failing to inform patients of the dangers of overdose if they are using drugs at the same time⁷.' Of those receiving a prescribing intervention at their time of death, only 1 individual had been in treatment less than 3 months; they had only been receiving a Specialist Prescribing intervention for 4 days before they died. It is noted in their SUI that they were in the titration phase of treatment. The significance of this relates to the heightened risk of overdose when patients are being stabilised. It is not possible to establish if the client in treatment for less than 3 months was obtaining their script from a pharmacy that offers supervised consumption. However, it could be suggested that the increase in the availability of this option in pharmacies across the county since 2007 has had a slight impact on Methadone toxicity. Since 2008, there have only been 4 deaths involving individuals in treatment in which Methadone was implicated, compared to 6 between 2005 and 2007.

6.4 Benzodiazepines

According to NDTMS published data⁸, 19.6% of individuals in treatment during quarter 4 2009/10 reported using Benzodiazepines as either a primary, secondary or tertiary substance. This is broadly in line with previous years, when 18.9% and 17% of individuals in treatment at the year end reported use of Benzodiazepines in 2007/08 and 2008/09 respectively. However, it has been suggested that this could be an underestimate of the true extent of Benzodiazepine use, as the information entered into the NDTMS database is based on patients' self-report rather than on objective measures such as the results of drug

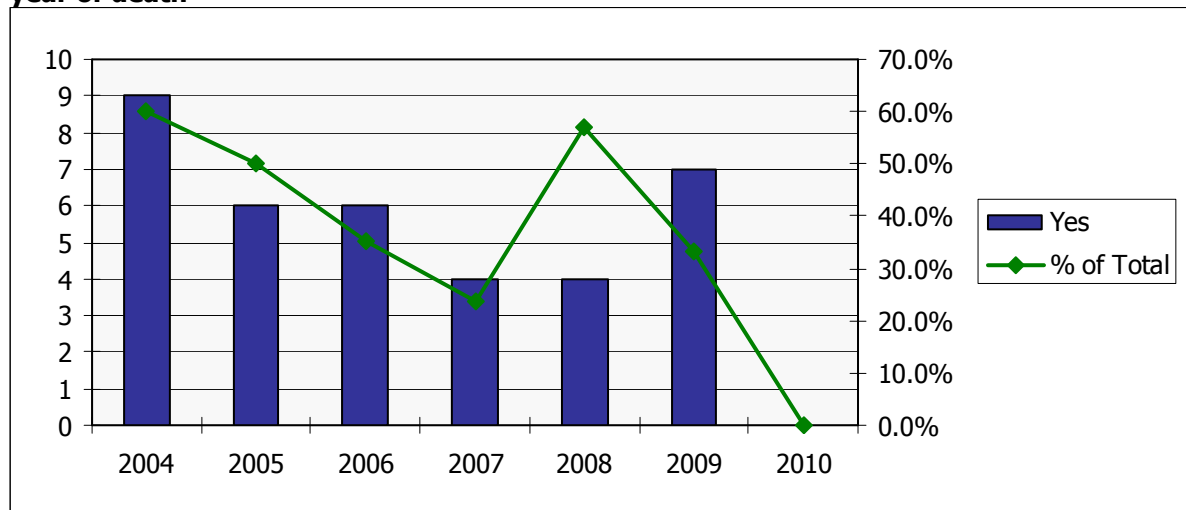
⁷ NICE Guidance: Methadone and Buprenorphine for the management of opioid dependence: <http://www.nice.org.uk/nicemedia/live/11606/33834/33834.doc> p9

⁸ www.NDTMS.net

screens. With this in mind, some patients may have failed to disclose recent Benzodiazepine use.

Between 2004 and 2010 Benzodiazepines were evident in 36 deaths, and 17 of these individuals were known to the substance misuse services. 10 of these individuals were involved in prescribing interventions, and the Coroner’s form identified 5 as being on prescribed psychoactive medication. However, due to the change in case management system that occurred in August 2010, it is not possible to ascertain if any of the subjects were being prescribed Benzodiazepines. Historically, it has been noted that less than 5% of patients treated by the substance misuse prescribing services in East Sussex are prescribed Benzodiazepines by these services, indicating that the majority obtain Benzodiazepines from other prescribers or by illicit means. It is thought that a similar proportion is evident today, with a very small number being prescribed for detox only, and quite a few more being prescribed by GPs.

Graph 4: Number and proportion of those with Benzodiazepines listed in toxicology by year of death



Between 2004 and 2007, there was a downwards trend in the proportion of deaths involving Benzodiazepines. However, the sudden peak in 2008 could be attributed to the small cohort, as the actual numbers of deaths involving the psychoactive substance were the same as the previous year.

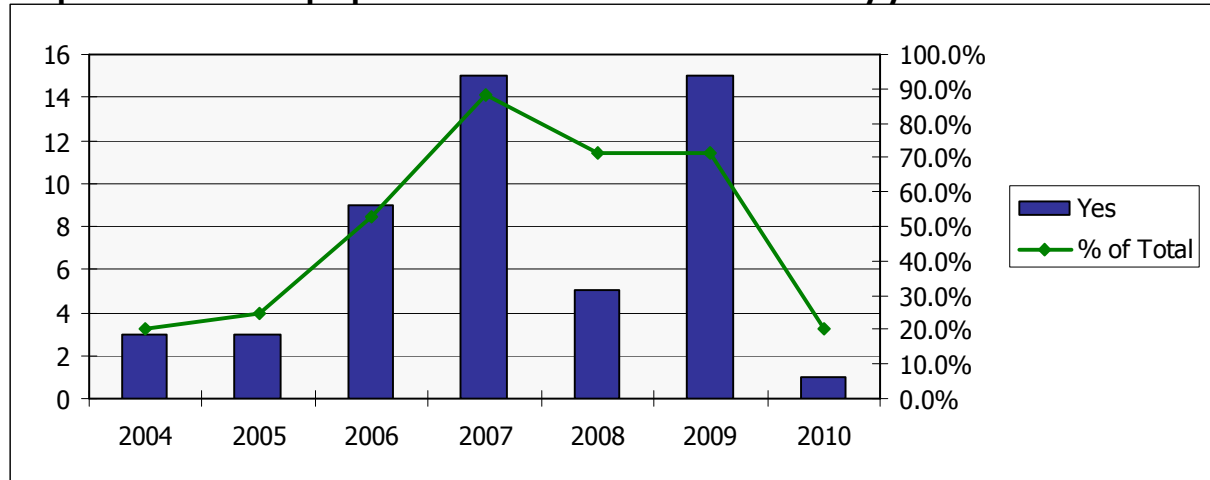
7. Substance Misuse Treatment

Historic inquiries state that pre 2008, approximately a fifth of people accessing the treatment system left before starting treatment. It was thought locally that this was largely due to the assessment process being carried out, often over three appointments with the client. However, in January 2008, the Single Assessment was introduced, which combines the old triage and comprehensive assessments, including risk and healthcare assessments, as well as the parenting capacity and Start TOP form. Indications are that since the introduction of this process, a lower proportion of individuals present to treatment and then drop out, when compared to the period before the new assessment was introduced.

Of the 94 deaths included in this inquiry, 41 (43.6%) are recorded as being known addicts while 33 (35.1%) had at some point been in contact with the substance misuse services. During 2004 and 2005, less than a quarter of all individuals linked to a drug related death had received specialist treatment for their substance misuse. However, the proportions

increase sharply between 2007 and 2009, with over 70% of all individuals during this period having been in treatment.

Graph 5: Number and proportion of those in contact with SMS by year of death



The majority of those in treatment (66.7%) declared Heroin as their primary substance, while single individuals also listed Alcohol, Crack, Cocaine, Benzodiazepines and Amphetamines as their main drug.

Over half (54.5%) of those who had been in contact with the services lived in Eastbourne or Hastings, with only a third of individuals being resident in the more urban/rural mixed demographic areas of Wealden, Lewes and Rother. However, this is in line with findings from the *Adult Drug Treatment Needs Assessment 2010*⁹ which states that the largest numbers of individuals engaging with the services live in the more urban areas of Eastbourne and Hastings, with over three quarters (78%) of the in treatment population living in these 2 areas alone. It goes on to cite the location of the main treatment services and the deprivation profiles of these urban areas as potential reasons why the numbers in treatment are much higher.

A verdict of Dependence on Drugs was reached on 26 (78.8%) of the individuals within this group. The Coroner's forms also cites that 21 (63.6%) were known drug addicts and 12 (36.4%) were on prescribed psychoactive medication. Prior to death, only 2 individuals completed their treatment journey, with the majority (39.4%) choosing to drop out.

A total of 12 (36.4%) individuals died within 12 months of leaving treatment, while a further 14 (42.4%) died whilst in treatment with the substance misuse services. Although the Safer Communities Team has attained Serious Untoward Incident (SUI) reviews for a number of the later deaths, the information has not been collected for the earlier ones. The alignment of the two processes is important as it can inform ways that deaths might have been avoided. A recommendation in a previous inquiry was for all SUIs pertaining to patients in treatment should be shared with the Confidential Inquiry Team, and mechanisms are currently being put into place to ensure that this clear pathway of communication is in place between the services and the team writing the inquiry.

⁹ Adult Drug Treatment Needs Assessment 2010: p14

Also of note within the group that died whilst in treatment is that 10 (71.4%) were receiving prescribing interventions at the point of death, and all but 1 of these individuals had Methadone listed in their toxicology results. However, since 2008, there have only been 4 individuals in treatment with substance misuse services when they have been involved in a drug related death, compared to 10 between 2005 and 2007.

Five subjects were treated in A&E within 2 months of their death. Paramedics took 1 individual to A&E the day before they died due to an overdose, while another attended a week before their death having overdosed on Heroin and Alcohol. Although the latter self discharged from hospital, there does not appear to be any more information with regards to any referrals that were made from A&E to drug treatment services or any follow up actions that were made after they had left hospital. This suggests that there are gaps in care pathways between services, and improved links with local A&E departments to encourage drug users at high risk of overdose being referred into treatment should be forged.

Also of note is that 18 (54.5%) of those known to the treatment services were noted as having mental health problems, with it being documented that 8 (44.4%) of these individuals had been in contact with Community Mental Health Teams (CMHT). Although it is recorded that only a third (38.9%) of these individuals were on prescribed psychoactive medication, it is also detailed that 5 of the deceased who are *not* recorded as having mental health problems were also on prescribed psychoactive medication. This could suggest that there are gaps in the research that is carried out and the information that is collated for each drug related death over the years.

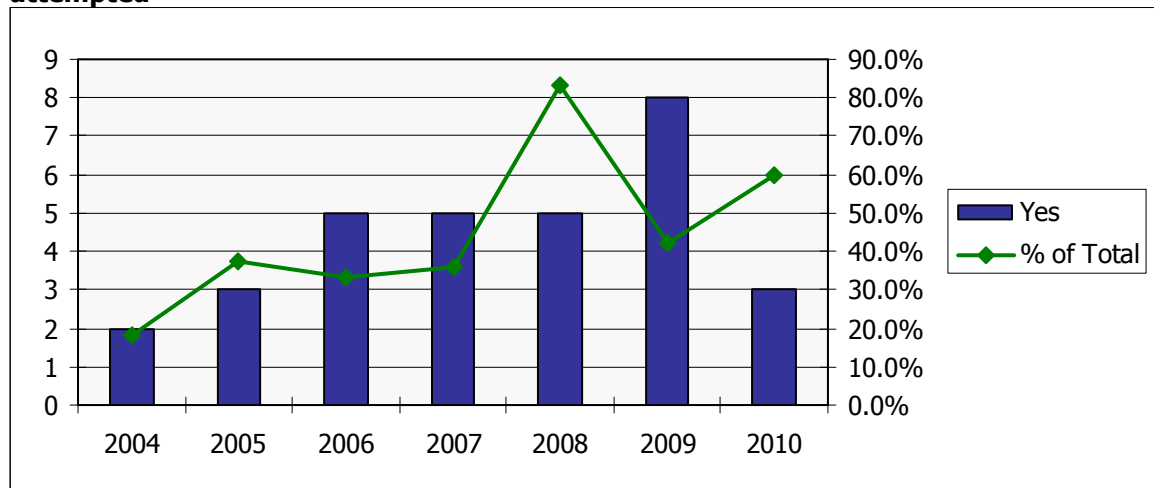
8. Resuscitation

Previous inquiries have reported that research carried out on patients attending Methadone maintenance programmes have shown that most opiate misusers in treatment have witnessed someone overdose, with the majority expressing some willingness to take some action to help the victim. Given the extensive witnessing of overdoses, peer drug takers are considered to be a valuable target group for training in resuscitation techniques. Increasing the numbers of drug users and their carers, family members or friends who attend the overdose management programmes will increase the likelihood that overdose victims are resuscitated, thereby reducing the numbers of overdose fatalities.

In May 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. Currently in East Sussex brief one to one Naloxone training is being offered to those individuals who don't have the time or inclination to attend the more comprehensive group training that is being run in parallel. In both instances, individuals are provided with a Minijet Naloxone on attendance. Treatment providers report that Naloxone has been successfully used in a small number of cases since implementation.

In over a third of cases (39.4%) resuscitation was attempted either by a friend or family member, or by paramedics when they arrived on the scene. It is also noted that between 2005 and 2007 Naloxone was administered on 5 occasions, 4 of which were by paramedics and 1 was by a friend. However, use of Naloxone has not been either recorded or noted down in the paperwork of any subsequent deaths.

Graph 6: Number of subjects with Opiates listed in their toxicology and resuscitation attempted



As the graph above shows, in just over a third (39.7%) of cases in which Opiates were used prior to death, resuscitation was attempted. Naloxone was only administered in 4 instances, this being between 2005 and 2007, but based on the above, could potentially also have been administered on a further 27 occasions. Also of note is that in over half (53.7%) of the deaths in which Heroin was used prior to death, resuscitation was not attempted.

9. Prison

During the 7 year period, 29 (30.9%) of the individuals involved in the inquiry process had at some stage, been in prison. The majority (51.7%) died within 6 months of their release, with a quarter (27.6%) dying within the first 31 days.

Table 7: Time elapsed between release from prison and death

	Total	% of Total
More than 4 years	12	41.4%
1 to 6 months	7	24.1%
1 week to 1 month	6	20.7%
Unknown	2	6.9%
Within 1 week	2	6.9%
Total	29	

All but 3 (89.7%) of the subjects were male, while prior to incarceration, over half (55.2%) lived in the urban areas of Eastbourne and Hastings. 4 of the individuals were of no fixed abode when they were imprisoned, while less than 10% lived in the more rural areas of Wealden and Rother. As cited previously, this could in part be attributed to the deprivation profile of these areas, with both rural districts being noted as far from deprived areas, while in contrast, Eastbourne and Hastings host some of the most deprived areas in the country. Also of note is that three quarters (79.3%) of the subjects were unemployed.

Although it has been recorded on the Coroner's forms that two thirds (65.5%) are known drug addicts, only 14 (48.3%) have been in contact with the substance misuse services:

- 5 subjects were in treatment and had dropped out, before they were sent to prison
- 6 engaged with the services after they had been released from prison, although only 2 were referred into treatment through Criminal Justice routes such as Probation and through a Drug Rehabilitation Requirement (DRR)
- 2 were in contact with the treatment services both before and after prison

- The details for 1 individual is unknown

Home Office guidance states that in the case of an offender's release from prison, the prison Counselling, Assessment, Referral, Advice and Throughcare (CARAT) should involve the relevant Criminal Justice Integrated Team (CJIT) from the outset in the release planning process and keep the CJIT informed of any developments and changes so that there is a seamless transition from prison to the community.

When looking specifically at HMP Lewes, historically, the prison faxed the Drugs Intervention record (DIR) to the CJIT teams approximately 6 weeks prior to release. They then followed this up with telephone/email communication. Hastings is the single point of contact for the East Sussex CJIT, and as such, pass any relevant contacts directly to Eastbourne. HMP Lewes has recently confirmed that they are currently using the Home Office Alert Form, which has replaced the DIR for the Prison's. Although this is not compulsory practice, they are finding it useful.

Through DIRWeb, only 4 individuals (13.8%) were identified as being involved in the Drugs Intervention Programme. However, it only appears that 1 was picked up by the CJIT team immediately after their release from prison; the other subjects were brought into contact with the CJIT team at a later stage. It is also evident that all 4 subjects engaged in interventions and were still in contact with CJIT when they died.

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. Each quarter, the National Drug Treatment Monitoring System (NDTMS) publish a performance report based on data taken from IDTS. However, as outlined in the *Adult Drug Treatment Needs Assessment 2010*¹⁰ there is concern currently with the quality of the data, and as such, is going to be addressed through the Treatment Plan 2011/12. The DAAT treatment plan has also identified objectives to ensure the links between prison healthcare, CARAT and CJIT are reinforced to deliver effective community care arrangements.

10. Summary of Findings

- Over three quarters (83%) of the subjects were male
- The average age of those involved in the inquiry is 36.7. However, this has increased over the years, shifting from between 33 and 34 during 2005 and 2006 to an average age of between 36 and 41 between 2007 and 2010
- 59.6% of the subjects were resident in the urban areas of Eastbourne, Hastings and St Leonards prior to death
- 5 of the deaths in East Sussex involved individuals who lived outside the county
- A verdict of Dependence on Drugs was recorded on half of the deaths. Although half of this group had been in contact with the substance misuse services, half had not, which suggests a gap in knowledge or access to treatment
- Consumption of alcohol prior to death has increased over the 7 year period. Approximately 60% of individuals had consumed alcohol alongside other substances between 2008 and 2010, while only 30% to 40% had drunk alcohol prior to death in 2004 and 2005

¹⁰ Adult Drug Treatment Needs Assessment 2010: p32

- Methadone was implicated in 17 (18.1%) deaths, with 13 of the subjects having been involved with the substance misuse services:
 - 10 were receiving prescribing interventions
 - 9 were in treatment at the point of death
- Since 2008, there have only been 4 deaths involving individuals in treatment in which Methadone was implicated, compared to 6 between 2005 and 2007. This could partly be attributed to the increase in pharmacies in the county that offer supervised consumption
- Benzodiazepines were evident in 36 deaths across the 7 year period, although there has been a downwards trend in the proportion of deaths involving the substance
- 41 (43.6%) individuals were recorded as being known drug addicts, and 33 (35.1%) had at some point been in contact with the substance misuse services
- Contact with the treatment services has increased over the years. Less than a quarter of those linked to a drug related death had been in treatment between 2004 and 2005, compared to over 70% between 2007 and 2009
- 42.2% died whilst in treatment, while a further 36.4% died within 12 months of leaving treatment
- 3 individuals were taken to A&E and received treatment for a drug overdose within 2 months of their death. However, there is no more information with regards to any referrals that were made from A&E to treatment services, or any follow up actions that were made after they had left hospital
- Over half (54.5%) of those known to the treatment services were also noted as having mental health problems, with it being documented that 8 of these subjects had been in contact with the Community Mental Health Teams (CMHT)
- Resuscitation was attempted in 37 (39.4%) instances
- Naloxone was administered on 5 occasions, this being between 2005 and 2007, although further use of the drug has either not been recorded or noted down in the paperwork of any subsequent deaths
- Naloxone could potentially have been administered on a further 27 occasions
- 29 (30.9%) of the individuals had at some stage been in prison. The majority (51.7%) died within 6 months of their release, with 8 (27.6%) dying within the first month. Over half (55.2%) lived in the urban areas of Eastbourne and Hastings prior to incarceration, which could in part be attributed to the deprivation profile of these areas. Although 19 (65.5%) of the offenders were recorded as known drug addicts, only 14 had been in contact with the substance misuse services

11. Recommendations

- A check sheet of areas to be researched by the Confidential Inquiry Team to be developed so that gaps in knowledge can be avoided. Areas to include: if resuscitation was attempted / use of Naloxone / prison / mental health involvement / involvement of A&E prior to death i.e. previous overdoses etc...
- As a quarter of DRDs died within the first month of being released from prison, focus needs to be on continuity of care between prison and the community, ensuring that individuals receive the appropriate level of support on release, and all possible efforts are made to help them engage with the substance misuse services if appropriate – Link to Treatment Plan 2011/12
- Continue promotion of Overdose Management Programmes including the Naloxone Distribution Programme – services to potentially develop marketing plans to broaden awareness and increase attendance at programmes
- Performance Manager to be informed of all potential DRDs involving clients in treatment, with the Service Manager to follow this up if the death is confirmed to be

drug related. The SUI to be shared with the Confidential Inquiry Team once it has been completed – Link to Treatment Plan 2011/12

- Improved links to be forged with local A&E departments to encourage drug users at high risk of overdose being referred for treatment
- Improved management of concurrent alcohol abuse / dependence