

**To:** DAAT Board  
**Report by:** Performance Manager: Safer East Sussex Team  
**Subject:** Confidential Inquiry into Drug Related Deaths  
**Date:** 9<sup>th</sup> December 2013

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## **1. Recommendation**

The DAAT Board is recommended to:

- (i) continue to monitor the number and rate of drug related deaths, using information supplied by the East Sussex coroner and the np-SAD report to produce an annual review.
  - (ii) ensure that all deaths in treatment are treated as Serious Incidents, that a root cause analysis is completed and that lessons learned influence practice.
  - (iii) maintain simple and quick access to effective treatment that includes teaching opioid overdose aid and a naloxone distribution programme.
  - (iv) continue to improve the utilisation of the care pathway from emergency care to drug and alcohol recovery services.
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## **2. Background**

Since 2004, annual confidential inquiries have considered local drug related deaths that fit within the Office of National Statistics (ONS) definition '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)'. 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 ONS definition is used for national statistics. Another definition is used by the National Programme of Substance Abuse Deaths (np-SAD), published by the International Centre for Drug Policy at St Georges, University of London. The np-SAD includes deaths caused by overdoses of antidepressants, anti-psychotics and anticonvulsants in individuals who do not have a history of drug abuse or dependency. This report includes np-SAD data as it is a source that the media has used to report a local rate of 'drug related deaths'.

## **3. Confidential Inquiry 2013**

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 2005.

| Year              | CONFIDENTIAL INQUIRY |                           | np-SAD DATA |                           |
|-------------------|----------------------|---------------------------|-------------|---------------------------|
|                   | Number               | Rate per 100,000 aged 16+ | Number      | Rate per 100,000 aged 16+ |
| 2005              | 12                   | 2.95                      | 23          | 5.66                      |
| 2006              | 17                   | 4.18                      | 20          | 4.92                      |
| 2007              | 17                   | 4.08                      | 17          | 4.08                      |
| 2008              | 7                    | 1.68                      | 9           | 2.16                      |
| 2009              | 21                   | 4.98                      | 26          | 6.17                      |
| 2010              | 17                   | 4.01                      | 25          | 5.89                      |
| 2011 <sup>1</sup> | 12                   | 2.75                      | 16          | 3.67                      |
| 2012              | 5                    | 1.14                      | -           | -                         |
| 2013              | 1                    | 0.23                      | -           | -                         |

In 2011, a confidential inquiry was carried out that looked at all deaths reported to East Sussex DAAT since 2004. A total of 94 individuals were included in the report.

Personal data from deaths in 2011 was not included in a detailed local inquiry. The DAAT board was satisfied that an investigation of these deaths was unlikely to lead to new conclusions or recommendations.

Personal data about drug related deaths received from the Coroner's Office since October 2012 has been reviewed to consider whether there are any indications of opportunities for earlier intervention. However, there is nothing to suggest there might have been. The review concludes that there is no additional information to inform a confidential inquiry. Also of note is that three files were unavailable to research. These files pertain to two deaths that occurred in 2010 and a death that occurred in 2012.

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- (ii) ensure that all deaths in treatment are treated as Serious Incidents, that a root cause analysis is completed and that lessons learned influence practice.
- (iii) maintain simple and quick access to effective treatment that includes teaching opioid overdose aid and a naloxone distribution programme.
- (iv) continue to improve the utilisation of the care pathway from emergency care to drug and alcohol recovery services.

<sup>1</sup> Data from 2011 onwards is based on the revised census population