




Llywodraeth Cymru
Welsh Government

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Guidance for undertaking fatal and non-fatal drug poisoning reviews in Wales

June 2014

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1 Purpose

This guidance outlines the framework and procedures to undertake reviews of fatal and non-fatal drug poisonings in Wales from July 2014 onwards in line with the key aims in the Welsh Government Substance Misuse Strategy Delivery Plan 2013-2015 (Outcome 3.1).¹ This document provides guidance for all stakeholders within Wales who have a remit for reducing fatal and non-fatal drug poisonings related to substance misuse in Wales and replaces previous guidance.² The guidance encompasses all stages of review including instigation, collaborative working with statutory bodies in data collection, establishment and implementation of recommendations/lessons learned and dissemination of information for action.

2 Background

2.1 Fatal drug poisoning related to substance misuse

The term 'fatal drug poisoning' replaces the historic terms 'drug overdose or drug death'. As part of the Welsh Government Substance Misuse Strategy 'Working Together to Reduce Harm 2008-2018', the third Delivery Plan 2013-15 sets out the action to 'Reduce the number of substance misuse related deaths and non-fatal overdoses/alcohol poisonings in Wales'¹, measured specifically in relation to drugs by:

- i. Reduction in the number of Substance Misuse Related Deaths;
- ii. Decrease in hospital admissions for poisoning with drugs.

Previous mechanisms utilising the 'confidential review' process for investigation of the circumstances of drug related deaths for the period 2005-2013 are outlined in Appendix 5. In addition to the Substance Misuse Strategy Delivery Plan, reducing fatal drug poisonings cuts across a number of other programmes of Welsh Government and Public Health work including the Child Death Review programme and the National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014.³

2.2 Non-fatal drug poisoning related to substance misuse

Non-fatal drug poisoning replaces the historic term 'Near miss overdose'. Whilst the local informal notification of non-fatal drug poisonings has historically occurred, and harm reduction advice issued as appropriate, to date there have been no uniformly applied mechanisms for undertaking non-fatal drug poisoning reviews across Wales.

The Welsh Government commissioned a survey of opiate overdose comprising two parts: a *quantitative questionnaire survey* of injecting opiate users to find out the prevalence of non-fatal overdose, and a *qualitative interview survey* of a subset of the respondents to find out the nature and circumstances of overdose events.

The key findings from the *quantitative questionnaire survey* are that almost half (47%) of all opiate users said that they had overdosed at least once in their lives and 15 per cent said that they had done so in the last 12 months.

3 Review of fatal and non-fatal drug poisonings: processes and structures

From 2014, local investigations or 'case reviews' should be undertaken, replacing the confidential review process outlined in Appendix 5. The case review process does not require the completion of an inquest and is initiated as soon after the fatal drug poisoning as is practical. The case review aims to provide timely information in relation to the 'manner of death' where best evidence indicates a potential drug poisoning as per the wider definition outlined below in order to optimise the 'lessons learned'. Subsequent toxicology data and inquest findings would be incorporated to the review file, as it became available, for final analysis and to ensure completeness of the final case review file.

The review process focuses on drug poisonings. It is beyond the remit of this guidance to include a review process of mortality resulting from chronic ill-health and disease as a result of long term drug use and dependency.

Over recent years, Drug Related Death Review Panels have been successful in highlighting the recommendations and lessons learned from the post-inquest confidential reviews. This case review process of all fatal drug poisonings occurring in the community, and closer partnership working, will further inform those responsible for reducing both fatal and non-fatal drug poisonings locally and nationally.

This guidance does not recommend inclusion of the following within the remit of the local fatal drug poisoning case reviews:

- Domestic homicide reviews where drugs are cited. Home Office resources and guidelines are in place to support Community Safety Partnerships in their duty to hold domestic homicide reviews.
- Deaths from chronic ill-health related to long term substance misuse, e.g. deaths from hepatocellular cancer as a consequence of hepatitis C infection. Separate surveillance systems exist to record these deaths and model future burden of disease.
- Deaths within Police custody. Robust mechanisms exist for the investigation of these deaths (Independent Police Complaints Commission)⁴ and aggregate data relating to all drug poisoning deaths, including those in custody, will be collated on an annual basis to inform the National Implementation Board for Drug Poisoning Prevention and all relevant stakeholders.
- Deaths within the Prison estate. Robust mechanisms exist for the investigation of these deaths (Prison and Probation Ombudsman for England and Wales)⁵ and aggregate data relating to all drug poisoning deaths, including those in prison or recently released, will be collated on an annual basis to inform the National Implementation Board for Drug Poisoning Prevention and all relevant stakeholders.

3.1 Definitions

Welsh Government guidance on drug related death reviews² issued in 2005 outlined two tiers of review utilising two distinct definitions:

A wide definition, specifically:

'A death is defined as 'drug-related', where it is probable that a direct consequence of the non-therapeutic taking or administration of any drug or volatile substance (excluding alcohol alone) to a person, was a causative or contributory factor in his or her death.'

and the ACMD definition of a drug-related death, also utilised by ONS:

'Deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971 (as amended) were involved'.⁶

The wide definition is to be used as a working definition for the identification for review of fatal drug poisonings when developing and implementing standard operating procedures (SOPs). This definition allows for a more complete picture of the scale of fatal drug poisonings.³ Information on all case reviews will be collated and compared with the annual ONS drug related and drug misuse death data to provide analysis on the efficacy of the case review process in accurately identifying relevant fatal drug poisoning cases and improving future procedures.

3.2 Redevelopment of existing structures

The case review framework and procedures are designed to ensure:

- Clear delineation of roles and responsibilities, and co-ordination between, National/Area Planning Board, and local provider level.
- Effective implementation across all Health Board areas in Wales of the existing lessons learned and recommendations relating to fatal and non fatal drug poisoning prevention.
- Timely response to fatal and non-fatal drug poisonings at a local level, including information gathering and clarification of circumstances of death.
- Innovative and effective collaborative working between those with a statutory investigative role (Coroners, Police, Serious Untoward Incident (SUI) Accountable Officers) and those charged with undertaking case reviews, establishing lesson learned and recommendations for fatal and non-fatal drug poisoning prevention.
- Information and recommendations established at a local level (for both fatal and non-fatal poisonings) are disseminated to Health Board (APB) level and National Implementation Board for consideration and national implementation.
- Robust collation, data analysis, co-ordination and effective dissemination of data and recommendations to prevent fatal and non-fatal drug poisonings across Wales, the wider UK and beyond.

3.3 Roles and responsibilities

3.3.1 Welsh Government

Reducing fatal drug poisonings is both a key outcome indicator within the Welsh Government's Programme for Government (available at: Welsh Government Programme for Government) and a performance measure within the Welsh Substance Misuse Strategy Working Together to Reduce Harm "Measuring Success Indicators".¹

As the reduction of fatal drug poisonings has been identified as a Ministerial priority, Welsh Government have, within the Substance Misuse Delivery Plan 2013-15, stated the actions "Action 3.1 Reduce the number of substance misuse related deaths and non-fatal overdoses/alcohol poisonings in Wales" (p.6) with the performance measures specified as:

- Reduction in the number of Substance Misuse Related Deaths.
- Decrease in hospital admissions for poisoning with drugs.

To support the achievement of these measures, Welsh Government will establish and ratify a National Implementation Board (outlined below) and provide support to ensure that the lessons learned and recommendations, both existing and emerging, are implemented across Wales and, where possible, barriers to implementation are resolved. In addition, Welsh Government support the establishment of a robust database for fatal and non-fatal drug poisonings via the Harm Reduction Database (HRD) Wales and the wider dissemination of information, evidence and findings through a dedicated website.

3.3.2 National Implementation Board for Drug Poisoning Prevention

The existing National DRD Monitoring group will be replaced by a **National Implementation Board for Drug Poisoning Prevention** (NIBDPP). This high-level board will have responsibility for the establishment of a plan to ensure full implementation of the existing recommendations and lessons learned. The NIBDPP will also have a monitoring role to ensure that Health Boards/APBs and all other stakeholders, including Primary Care and Pharmacy, progress to full implementation of both existing and emerging recommendations.

The NIBDPP will also have a role in:

- working with the Royal College of General Practitioners Wales and liaising with other relevant UK and European bodies with a remit for reducing drug related deaths and non-fatal poisonings;
- evaluating new national and international research and findings and assessing the potential impact on future policy;
- identifying areas of good practice and disseminating information with regard to progress and existing barriers to progress in relation to implementation, to all relevant stakeholders.

Membership of the NIBDPP should include senior representation from the following organisations, and meet at least on a biannual basis:

- Substance Misuse Area Planning Boards
- Consultant Psychiatry
- Health Board Emergency Department Lead
- Coroners Service
- Pathology/Toxicology
- Police/Criminal Justice Substance Misuse Commissioner (CJSMC)/NOMS
- Public Health Wales
- Youth Justice Board
- RCGP Wales
- Royal College of Nursing
- Royal Pharmaceutical Society
- UK DRD representative e.g. np-SAD
- Wales Community Rehabilitation Company
- Wales Council for Voluntary Action (WCVA)
- Welsh Ambulance Service Trust (WAST)
- Welsh Government.

3.3.3 Substance Misuse Area Planning Boards (APBs)

The Welsh Government National Core Standards for Substance Misuse Services in Wales⁷ require APBs to have area wide plans in place to:

- i. Identify health improvement requirements related to substance misuse;
- ii. Respond appropriately; and,
- iii. Measure improvements and the reduction in inequalities;

and to "... have a system in place which, as a minimum, should enable the regular review of drug related deaths and near fatal incidents ..."

APBs should ensure that the Core Standards for Substance Misuse⁷ and other relevant standards are embedded in all service planning and delivery systems with appropriate arrangements in place for performance management and review.

The Chair or nominated representative of the Harm Reduction Group (co-terminus with the Area Planning Board) is responsible for the reporting of fatal drug poisoning case reviews to the APB at each meeting, and where required, out-with of normal meeting arrangements, alert the APBs to exceptional events including clusters of fatal and non-fatal drug poisonings, for action.

3.3.4 Harm Reduction Groups

Rapid case reviews should be led by a responsible individual/Lead Officer within the Harm Reduction Group – with the role referred to explicitly as the Case Review Co-ordinator (CRC). Where possible, this individual should have experience of undertaking investigations (in line with the Accountable Officer role or Serious Untoward Incident (SUI) investigator within the Health Board). It is recommended that where in place, this role be undertaken by the Regional Substance Misuse Lead or equivalent within each Health Board/APB area.

Where they are not already in place, Harm Reduction Groups (co-terminus with the APBs) should be established. Membership should include representation from the following organisations:

- Tier 2, 3 & 4 substance misuse services
- Police
- Ambulance
- Coroners service
- Community Mental Health
- Youth Services/Youth offending Teams
- Social Services
- Housing and Homelessness
- Coroners service
- Criminal Justice Substance Commissioners (CJSMC)/Probation
- Local Intelligence Network
- SUI investigator (Health Board)
- Commissioners
- Pathology
- Primary Care
- Probation
- Prison
- Welsh Government.

Partnership and collaborative working, particularly with the Coroners services, in supporting the investigation of the circumstances of death, is vital in ensuring that accurate information is available for analysis. Information relating to the circumstances of a fatal drug poisoning should be sought from those involved with the deceased individual (peers/family/carers/drug/alcohol workers/social services/housing/prescribers/Primary care etc). Standardised information/recording form **DRD3 revised** (see appendix 3) should be used to ensure, where possible, all appropriate information is collected.

Case review documentation should include:

- Demographics
- Details on the circumstances around the death including current medication and details regarding contact with health/social care/criminal justice services in the previous six months
- Summary of risk indicators/factors.

Alongside the formal case review process, and through local investigation to establish those in prior contact with the deceased, information relating to peers who may require psychosocial interventions (including grief counselling) should be established. Contact should be made on an informal basis (e.g. via outreach support services) and appropriate support offered to limit the likelihood of further fatal or non-fatal poisonings within the deceased's peer group.

Once all the available information is collated by the CRC, and within 14 working days of the incident, all relevant professionals (as outlined above) should be invited to attend the multi-agency case review to assess the evidence,

establish 'lessons learned' and make the appropriate recommendations. If unable to attend in person/tele/video conference, members should contribute in writing. Where possible, immediate changes to current service provision or practice should be implemented, reported and monitored. In addition, the recommendations should be presented to the wider Harm Reduction Group, APB and National Implementation Board for assessment/evaluation, implementation and dissemination.

Where insufficient information is available to complete a review, this should be recorded by the Harm Reduction Group and APBs and the case 'pending' on the Harm Reduction Database until completion of the inquest.

The information collected at each case review stage should subsequently be 'tied' to the final Coroner's report, with final analysis, in order to achieve case review closure. All anonymised data will be collated on the Harm Reduction Database – Fatal Drug Poisoning element and a final summary report available for all involved in the case review process.

Fatal drug poisonings amongst individuals who are current NHS patients are investigated via **Serious Untoward Incident** (SUI) reviews. An SUI is:

- an adverse incident that arises from an NHS activity and which results in serious injury, major or permanent harm or death (or the risk of) to a service user, member of staff, contractor or member of the public, or that has a significant impact on public health;
- the action of a member of staff, in the course of NHS duties, that is likely to cause significant public or professional concern;
- an event that impacts on the delivery of an NHS service causing urgent invocation of a business continuity plan, or which may reflect a serious breach of standards.

In recognition of the importance of potential cross over between community based fatal drug poisonings and those undergoing SUI review, close working to ensure consistency is recommended. Clearly, duplication of effort should be avoided where possible and in the event of a SUI review, an additional case review should not be undertaken. However, where possible and appropriate the SUI investigator should be supported to gather all relevant details utilising the Case Review mechanism to ensure close collaborative working and relevant lessons learned should be shared with the Harm Reduction Group via information sharing protocols (ISP).

3.3.5 Providers, Outreach and peer workers

Evidence from previous Drug Related Death Confidential Reviews in Wales indicates that the majority of drug related deaths occurred in individuals who were not currently in contact with treatment services. In 2012, only 22% of the cases reviewed involved patients in substance misuse treatment. This reinforces the need for increased capacity for proactive outreach roles to engage high risk individuals and provide prevention initiatives including Take-home Naloxone and training, information and contact details for services as outlined in the Welsh Government Substance Misuse Treatment Framework Health and Wellbeing compendium⁸. In 2012, the majority (51%) of fatal drug poisonings occurred in individuals who had left treatment within the previous two years so continued informal outreach engagement should be facilitated.

In the event of single or multiple non-fatal poisoning events in a given locality, informal review and data capture should be undertaken. Where possible, engagement with the individuals who have experienced non-fatal drug poisonings should be pursued by outreach and peer mentor providers and prevention interventions undertaken. Evidence indicates they are at increased risk of subsequent fatal poisoning.^{9,10,11} In addition, anonymised information relating to non-fatal poisoning events, particularly where a number occur in a given setting, should be recorded and disseminated via local networks and existing web-based and other networks (e.g. Harm Reduction Database for those accessing needle and syringe programmes).

Identification of all those who may be affected by a fatal drug poisoning, particularly those at potential risk of subsequent fatal or non-fatal poisonings (drug using peers of the deceased), should be identified where possible and the provision of appropriate psycho-social support made available.

3.3.6 Controlled Drug – Local intelligence networks (CD LINs)

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 require Health Boards to nominate an Accountable Officer (AO) who are responsible for establishing and monitoring arrangements in relation to controlled drugs such as auditing and safe disposal. The regulations require Health Board AOs to establish Local Intelligence Networks (CD LINs) that must include specified 'responsible bodies' such as the local Health Board, Healthcare Inspectorate Wales, local authority, local police and a number of other bodies. A CD LIN may also include other bodies not specified in the regulations; however only those specified in the regulations as 'responsible bodies' have statutory requirements to share information.

The key purpose of the LIN is to share information about the use of CDs and about individuals (such as those prescribing or managing controlled drugs) who give cause for concern. Specifically, the regulations require that responsible bodies share information on request from other responsible bodies, removing any patient identifiable details or seeking consent from patients where possible. The regulations require that information be managed in line with the Data Protection Act; however the regulations also specify that the regulation does require disclosure of personal data under section 35(1) of that Act.

In addition to the LIN, an Accountable Officer may consider setting up an Incident Panel of individuals from relevant 'responsible bodies' to review and make recommendations following an incident that gives cause for concern.

It is important that Health Board AOs leading a CD LIN ensure that their arrangements for information sharing are robust and up to date.

Information Sharing Agreements (ISAs)

When dealing with information, the Police service is also required to work to the guidance for the Management of Police Information (MOPI). This requires police forces to have in place ISAs with all its agencies in which they share information, this will include CD LINs. It is recommended that Health Board AO CD LIN Chairs make contact with their local police force and ensure that ISAs are in place and are compliant.

4 Information Sharing Agreements/Protocols

The following operational guidance for information sharing in relation to drug related deaths is drawn from a number of sources including the East Riding Safer Communities 'Drug Related Death Operational Procedures' manual 2009.¹² This section outlines the mechanisms by which the proposed case reviews in Wales may be successfully and safely completed.

4.1 Key legislation and guidance

The Data Protection Act 1998 (DPA) does not apply to deceased individuals. With regard to personal information relating to living people associated with the deceased or those who have suffered non-fatal poisonings, all information will either be anonymised in line with the Information Commissioner's Office Anonymisation Code of Practice¹³ (meaning that, as it can no longer be used to identify an individual, it is no longer considered 'personal information' and is therefore no longer covered by the DPA) or will be shared according to Information Sharing Protocols (ISPs) developed in line with the Wales Accord on the Sharing of Personal Information (WASPI).¹⁴ This approach will apply to all information sharing detailed in this and following sections and will ensure robust and legally compliant procedures at all points.

4.2 Purpose of information sharing

- To identify lesson learned and disseminate recommendations to all relevant organisations and partnerships.
- To identify gaps in service provision.
- To recommend changes to policies and practices.
- To identify trends in substance misuse and risk behaviour and changes in the harms related to specific substances including new psychoactive substances/drugs that are not classified under the Misuse of Drugs Act 1971 in line with the Welsh Government WEDINOS programme.
- To validate local data with other national data sources including np-SAD and ONS and contribute to the UK wide evidence on interventions to reduce drug related deaths.

4.3 Matrix of sources and type of information to be requested

The matrix provides an outline of sources/organisations and the types of information likely to be relevant in the event of fatal drug poisonings:

| | GP/NHS Medical records including mental health and emergency services | NHS Substance misuse treatment services | Third Sector incl. Mental health and substance misuse | Housing/hostels | Social services | Police | Probation | Prison and Youth Offending Teams |
|--|---|---|---|-----------------|-----------------|--------|-----------|----------------------------------|
| Medication and Substance misuse history | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medical history inc. Mental health | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| Care/treatment plan (inc. in relation to substance use | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| Risk/assessment plan | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| History of non-fatal poisoning | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| Onward referrals | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Frequency of contact | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Date of last contact | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Reason for leaving contact/treatment | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| Criminal justice history | | | | | | ✓ | ✓ | ✓ |
| Other linked incidents | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

N.B. Proactive engagement/partnership working between the CRC and the Coroners Service in investigation of a fatal drug poisoning, is essential to ensure that the process for establishing 'lessons learned' and formulating recommendations is optimised and may prove effective in reducing/preventing subsequent fatal and non-fatal drug poisonings

4.4 Collation of data

The Case Review Co-ordinator (CRC) is responsible for the initiation of a case review and creation of database record with a Unique Case Number (UCN). UCNs will be generated through the harm reduction database. All requests for information relating to the deceased (via DRD3 revised form) should utilise the UCN. The CRC will collate all incoming data on to the Harm Reduction database – Drug Poisoning module. Following return of all completed DRD3 revised forms, and when available, the Coroners and Toxicology report, the case is complete. Annual aggregate case review data will be analysed against retrospective surveillance of fatal drug poisonings as reported by the Office for National Statistics and np-SAD, with analytic support from Public Health Wales.

5 Procedures

5.1 Fatal drug poisonings

(Outline process map for fatal drug poisonings may be found at Appendix 4a).

1. Notification of drug related death by Coroner or Police Lead to the fatal drug poisoning Case Review Co-ordinator within the Harm Reduction group (Case Review Co-ordinator – hereafter 'CRC') via DRD1 form (revised – see appendix 1).
2. Case review is initiated. CRC assigned unique case number (UCN) and opens secure database. The initial UCN database section is password protected and is the only part of the database that contains patient identifiable data e.g. name, address and date of birth.
3. The designated key contact within all relevant organisations is contacted for further information with a covering letter (DRD2 revised – see appendix 2) and attaching a standard proforma questionnaire utilising the UCN (DRD3 revised – see appendix 3). The letter requests all information to be returned to the CRC within 5 days using the UCN and not patient identifiable data.
4. Alongside requests for information, providers and front line staff monitor and offer appropriate support, or make referrals to appropriate support, for all those close contacts or peers of the deceased who request it.
5. For all relevant organisations, the CRC monitors:
 - Date of request of information.
 - Deadline for return of information.
 - Date of return of information.
 - Information in relation to organisations in contact with the deceased. If the organisation had no contact, the proforma option 'not known to this organisation' will be ticked.
 - Coroner and CRC work collaboratively, where possible, to ensure information relevant to the investigation is available.
6. The case report with the UCN is compiled detailing the circumstances around the death, history of substance misuse, toxicology and any other key details.

7. Multi-disciplinary case review meeting called for all relevant organisations to review evidence and establish learning points/recommendations for practice change.
8. Learning points/recommendations for practice change are fed to wider Harm Reduction Group, Area Planning Board and National Implementation Board.

N.B. As previously noted, if the death occurs in an existing NHS patient, then the Authorised Officer will undertake the SUI review but should ensure that an anonymised case report (utilising a UCN) is completed along with learning points/recommendations and made available to the Harm Reduction Group lead for dissemination of findings.

9. On an annual basis, collation and analysis of the aggregate data from case reviews, ONS and np-SAD data will be undertaken by Public Health Wales. This will include deaths occurring in prison and custody. This analysis will be published within the 'Annual profile of drug and alcohol in Wales' and presented to the National Implementation Board for Drug Poisoning prevention further discussion.

5.2 Non-fatal poisonings related to substance misuse

(Outline process map for non-fatal poisonings may be found at Appendix 4b).

1. Notification of non-fatal poisonings by outreach, Ambulance, Emergency Department staff, NSP providers and/or peers to the Case Review Co-ordinator (CRC) within the Harm Reduction group (Case Review Co-ordinator – hereafter 'CRC').
2. CRC assigned unique case number (UCN) and opens non-fatal drug poisoning database – only non-patient identifiable data is recorded, e.g. demographics including age, gender, area of residence.
3. The CRC assigns a key individual from a relevant provider service to engage with the person who has experienced non-fatal drug poisoning. Support and interventions should be offered including the provision of take-home Naloxone if relevant along with the offer of continued low threshold contact or referral to specialist services.
4. The key individual will report back to the CRC on the nature of the poisoning and interventions provided and this information should be recorded on the database alongside the UCN.
5. Regular reviews of the nature and frequency of the local non-fatal drug poisonings, utilising data from the database as an accurate record, should be undertaken to identify trends and establish the presence of hot-spot areas that may then be targeted for specific outreach and health interventions. Learning points and recommendations should be recorded.
6. Aggregate data, along with the learning points and recommendations, should be reported to the wider Harm Reduction Group, Area Planning Board and the National Implementation Board for Drug Poisoning Prevention. Recommendations, once formally agreed, should be implemented.

7. On an annual basis, collation and analysis of the aggregate data from case reviews (both fatal and non-fatal), ONS and np-SAD data will be undertaken by Public Health Wales. This will include deaths occurring in prison and custody and non-fatal drug poisonings within the community. This analysis will be published within the 'Annual profile of drug and alcohol in Wales' and presented to the National DRD Implementation Board for further discussion.

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DRD 1 (revised) form

To be completed by the Case Review Co-ordinator

Unique Case Number

Coroner's Identifier

Name

Other names: aliases or nicknames

Gender Male Female

Date of birth (DD/MM/YYYY)

Date of death (DD/MM/YYYY)

Age at death

Home address

Postcode

Ethnicity

| | | | |
|-------------------------|--|---------------|--|
| White | | Black African | |
| Black Caribbean | | Black other | |
| Indian subcontinent | | Unknown | |
| Other – please specify: | | | |
| | | | |

Living arrangements

| | | | |
|---------------------------|--|--------------------------------|--|
| Living alone | | With partner | |
| With partner and children | | With children, without partner | |
| With parents | | With friends | |
| Multiple occupation | | Hostel | |
| Street homeless | | Unknown | |
| Other – please specify: | | | |
| | | | |

Criminal Justice System

| | | | |
|--------|--|-----------|--|
| Prison | | Probation | |
| Remand | | | |

If in custody within one month of death give details of location, duration of custody, date of discharge

| |
|--|
| |
|--|

Place of Death

Where was the individual discovered?

| | | | |
|-------------------------|--|---|--|
| Own home | | Other's home | |
| Public place – indoors | | Public place – outdoors (eg park, carpark, etc.) | |
| Hostel | | | |
| Other – please specify: | | | |

Drugs found at scene (including prescription drugs)?

Yes No

If YES, please list:

Drugs paraphernalia at scene?

Yes No

If YES, please specify:

Where was the individual pronounced dead?

At Scene A&E Hospital

Details of any resuscitation attempts (eg CPR, fluids/drugs administered):

How long was the individual in hospital before death?

N/A

Hours

Days

| Most recent contact with services prior to death | Within 24 hours | 1-6 days | 1 week | 1 week to 1 month | 1 month to 6 months | More than 6 months | Waiting for access | No contact with service |
|--|-----------------|----------|--------|-------------------|---------------------|--------------------|--------------------|-------------------------|
| GP | | | | | | | | |
| A&E | | | | | | | | |
| Ambulance Service | | | | | | | | |
| Mental health | | | | | | | | |
| Drug & Alcohol Treatment Service | | | | | | | | |
| Police Surgeon | | | | | | | | |
| Police | | | | | | | | |
| Arrest Referral | | | | | | | | |
| Probation Service | | | | | | | | |
| Prison | | | | | | | | |
| Social Services | | | | | | | | |
| Youth Offending Team | | | | | | | | |
| Education Service | | | | | | | | |
| Youth Service | | | | | | | | |
| Voluntary Agencies | | | | | | | | |
| Hostels | | | | | | | | |
| User Groups | | | | | | | | |
| Other | | | | | | | | |

Toxicology

Samples tested (eg blood, urine):

| |
|--|
| |
|--|

Tests performed (eg alcohol, drugs of abuse, volatiles, general screen)

| |
|--|
| |
|--|

Results

| | | Blood Concentration | Urine Concentration |
|------------------------------------|--|---------------------|---------------------|
| Morphine/Heroin | | | |
| Other opiates | | | |
| Methadone | | | |
| Alcohol | | | |
| Benzodiazepines | | | |
| Cocaine | | | |
| Amphetamines | | | |
| MDMA/MDEA | | | |
| Volatile substances | | | |
| Other substances – please specify: | | | |
| | | | |

Pathology

Evidence of injury

Details:

Histology performed

Yes No

Medical cause of death

1a 1b 1c II

Coroner's verdict/trial outcome

Date of Inquest

Details of medical conditions:

Details of physical medical conditions (eg Asthma, Epilepsy, Diabetes)

Details of psychiatric conditions

Details of drug use (length and nature of use, history of current/previous injecting, etc)

Is there any evidence that the deceased was a hazardous alcohol drinker?
(Hazardous = consumes more than the weekly recommended alcohol units)

Yes No Not Known

Is there any evidence that the deceased was a dependant alcohol drinker?
(Dependent = experiences physical withdrawal symptoms in absence of alcohol)

Yes No Not Known

Was the deceased on prescribed medication?

Yes No Not Known

If yes name drugs and doses, and when last dispensed:

If deceased was on prescribed opiates or opiate substitutes who prescribed these?

Was consumption of prescribed opiates or opiate substitutes supervised?

Signed:

Full Name:

Case Review Co-ordinator

Date:

DRD 2 (revised) form

Address

Details of the
Case Review
Co-ordinator

Dear Colleague,

Case Review of Fatal Drug Poisoning

The [relevant health board APB/Harm Reduction Group] has established a Fatal Drug Poisoning Case Review Process to investigate these deaths locally, in order to make recommendations and improve service provision and reduce further fatal and non-fatal drug poisonings. The case review investigates the circumstances of individuals who die as a result of drug poisoning (illicit and licit substances and prescribed drugs).

Confidentiality

The outcomes of the review will be disseminated via the [relevant health board APB/Harm Reduction Group] to its membership for internal action. Wider circulation to the National Implementation Board for Drug Poisoning Prevention, the general public and service users will only take place in the form of general recommendations or guidance aimed at reducing risk or improving services, as recommended by the review.

Enclosed is a standard questionnaire, relating to the individual involved in the following incident:

[Name of Deceased] **[Date of birth]** **[Unique Case Number]**

(based on available information. Unique case number mandatory)

[Date of Incident] **[Time of incident]** **[Location of Incident]**
(if ambulance attended)

The questionnaire is being sent to all the agencies concerned. It contains questions about contact with the deceased and knowledge of other services involved.

The responses will inform the review process, enabling lessons to be learned.

Please ensure that this form is completed by those most closely involved with the individual within your organisation.

Please return the completed questionnaire within 5 working days, along with any other information you consider may be useful. During future correspondence please refer to the incident using the following Unique Case Number [Unique Case Number]. If you require any further assistance please contact me.

Thank you for your help.

Yours faithfully

[Full name and details of the Case Review Co-ordinator]

DRD 3 (revised) Form

Unique Case Number (To be completed by Case Review Co-ordinator)

Q1: What is the name of your organisation?

Q2: Was the named individual known to your service? Yes No

If your response to Q2 is "No" – please return the questionnaire to the Case Review Co-ordinator.

Q3: What was the main reason for the named individual to be in contact with your service? **(Please tick one box only)**

| | | | |
|---------------------------------|--|------------------------------------|--|
| Mental Health Treatment (Adult) | | Employment and Educational Support | |
| Physical Health Treatment | | Housing Support | |
| Drug Support & Treatment | | Financial Support | |
| Alcohol Support & Treatment | | Family & Relationship Support | |
| Criminal Justice (Community) | | Psychological Support/ Counselling | |
| Criminal Justice (Custodial) | | YOT | |
| Arrest Referral | | CAMHS | |
| Social Care Support | | Safeguarding | |
| Other – please specify: | | | |
| | | | |

Q4: What support did your service provide to the named individual?
(Please tick all that apply):

| | | | |
|--|--|--|--|
| Opiate replacement prescribing | | Medication Prescribing (non-opiate replacement) | |
| Emergency Medical Treatment | | Assisting with Personal Care/Home/Social Support Needs | |
| Health Advice | | Offender Behaviour Work | |
| Specialist Health Consultation/Treatment | | Victim Support | |
| Brief Interventions | | Safeguarding | |
| Harm Reduction Advice | | Housing/Financial Support and Advice | |
| Harm Reduction Intervention (eg needle exchange) | | Psychosocial Intervention | |
| Mental health support | | | |
| Other – please specify: | | | |
| | | | |

Q5: Date of first contact with your service (dd/mm/yyyy)

Q6: Date of most recent contact with your service:

If contact has not been within the last 6 months do not answer the remaining questions but please return the questionnaire to the Case Review Co-ordinator.

Q7: Please list ALL interventions offered to the individual by your service in the six months prior to death and please further specify which were accepted:

Q8: If in prescribing role, please specify ALL medications you prescribed to the individual in the last 6 months (including dose) (a printed summary of prescribed medication is acceptable):

Q9: Did you or anyone within your organisation refer the individual to any other services? Please specify:

Q10: Please list other services you know the individual was in contact with (within the last 6 months)

Q11: Please indicate any barriers that you believe may have prevented the individual from accessing additional services within the last 6 months (Please tick all that apply):

| | | | |
|--------------------------------------|--|--|--|
| Distance to travel/Lack of Transport | | Lack of Reliable Client Address and Phone Number | |
| Physical Ill Health | | Level of Substance Use (Drugs and Alcohol) at Time of Referral | |
| Mental Ill Health | | Organisational Error | |
| Length of Waiting List | | Inability to read and/or write | |
| Funding | | Criminal Justice/Offending | |
| Other – please specify: | | | |
| | | | |

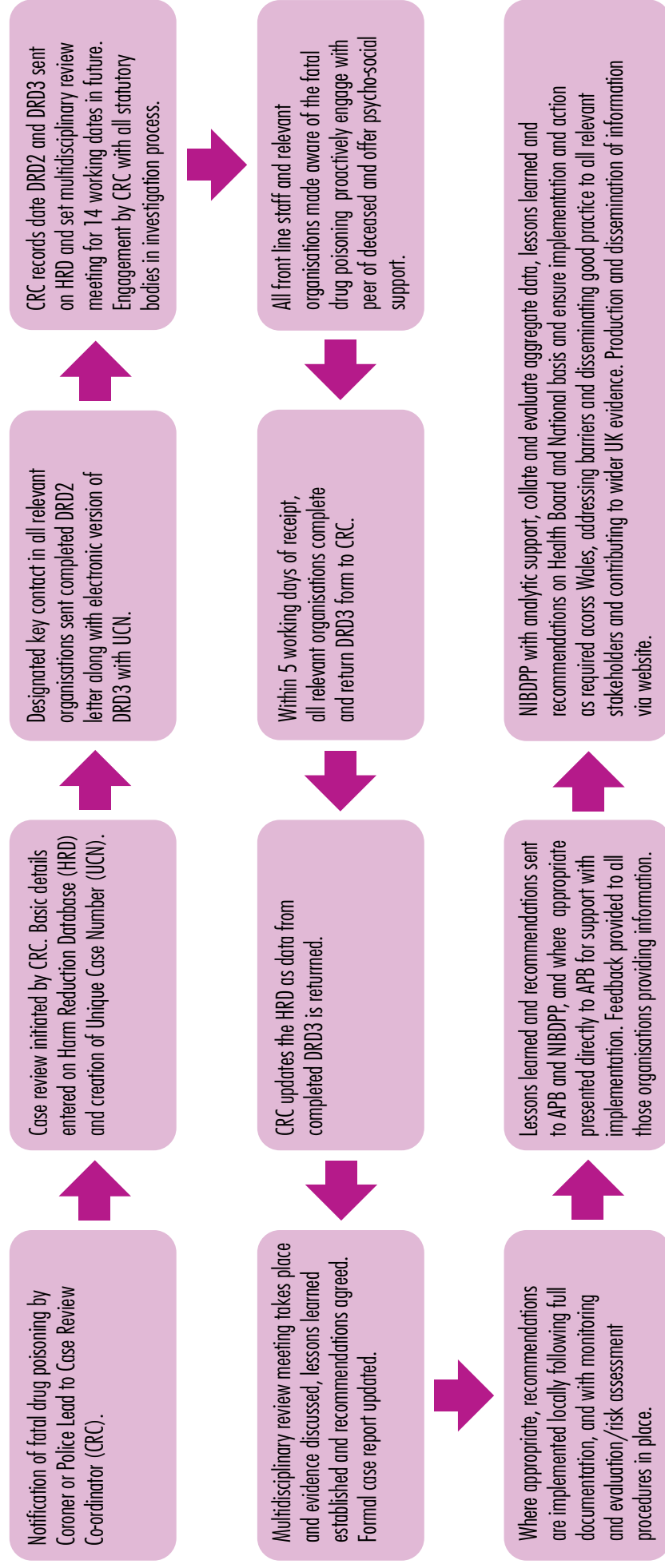
Q12: (Primary Care Practitioners only) From your medical notes and observations, please describe your involvement with the deceased and your conclusions about the cause of death where relevant:

Q13: Please add any information in the box below which you feel may be pertinent:

Thank you for completing this questionnaire, please return to the Case Review Co-ordinator.

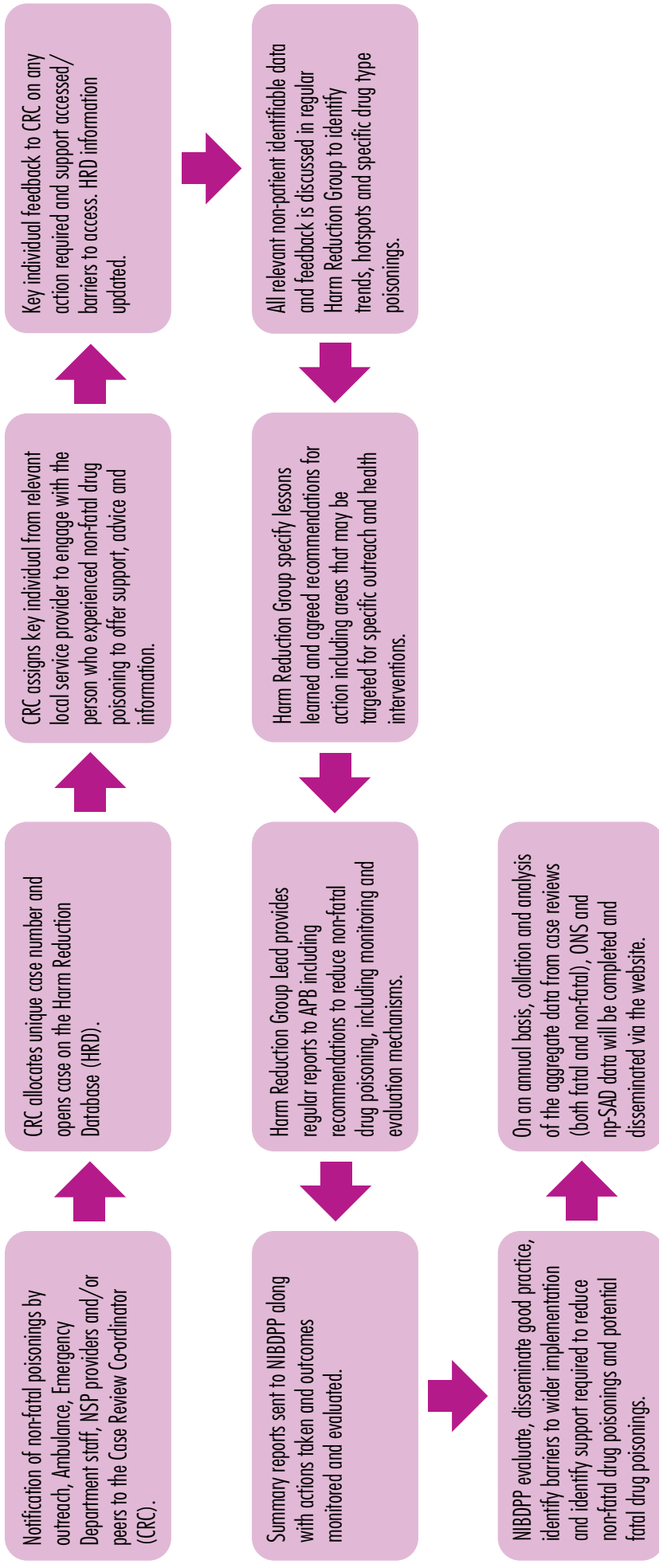
Appendix 4a

Outline process map for undertaking fatal drug poisoning reviews



Appendix 4b

Outline process map for undertaking non-fatal drug poisoning reviews



Prior structures and process pre 2014

Following publication of the document 'Guidance on developing local confidential reviews into drug related deaths in Wales'² by Welsh Assembly Government in 2005, regional Drug Related Death (DRD) review panels were established, co-terminus with Police Force areas in Wales.

Membership of the DRD review panels included representation from:

- Probation
- Police
- Pathologist
- Social Services
- Substance misuse specialist clinicians (Doctors and Nurse)
- Substance misuse treatment management
- A & E Consultants
- Pharmacy
- Coroners service
- Public Health
- Welsh Government.

The DRD review process was two-fold and was initiated post-inquest:

- Identification of all deaths where drugs were a contributory factor and the recording of basic information onto a confidential database via DRD1 forms.
- From this database, all deaths falling within the ACMD definition⁴ were identified, data collated (using DRD3 questionnaires) and a sample of these deaths were selected for in depth confidential review in order to establish what lessons could be learned to prevent future drug related deaths.

Alongside the membership of the DRD panels, 1 wte DRD Co-ordinator and a 0.3 wte police liaison were allocated to this work.

As a consequence of review post-inquest, there was significant delay between day of death and day of confidential review.

Findings to date from the regional DRD panels and National Monitoring Group are available online at: www.wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/research/drdreport2010/?lang=en

Following a number of years progress and the initiation of a range of effective interventions aimed at reducing drug related deaths, including the implementation of the take-home Naloxone programme, a Drug Related Death (DRD) workshop was held on 20th June 2012. At this meeting a series of recommendations were made for future progress as outlined below:

- Area Planning Boards to consider the amalgamation of their Local Intelligence Network, Harm Reduction and DRD groups at a regional level.
- DRD3 form to be reviewed.

- The Drug Related Death guidance to be reviewed to consider widening the scope of the reviews and to minimise duplication with Serious Untoward Incident (SUI) reviews.
- Early intelligence/warning of new substances to be shared with toxicologists.
- To discuss whether there is a national co-ordination role for Public Health Wales.
- To discuss the recording of all drug related deaths in one place with health statistics.
- The anonymity of the reviews and the need to learn lessons rather than point the finger to be disseminated widely to GPs and other relevant organisations.
- National meetings to be held in Cardiff to encourage better attendance.
- Exploration of whether a national drug related death enquiry could be undertaken similar to the national suicide enquiry.

In addition to these recommendations, a number of areas for concern were noted:

- Poor representation at DRD meetings – after initial enthusiasm.
- Delays in receiving information about a death were resulting in minimal impact.
- Potential for DRD panels to focus in too much detail on individual cases rather than on key themes and recommendations.
- Lack of clarity with regard to role of DRD panel from some members.
- Lack of priority given to findings and recommendations within APBs.
- Repetition of work especially with Serious Untoward Incidents (SUI).
- Fewer groups were required with a more regionalised approach.

Baseline incidence data Wales 2012

Fatal drug and drug misuse poisonings

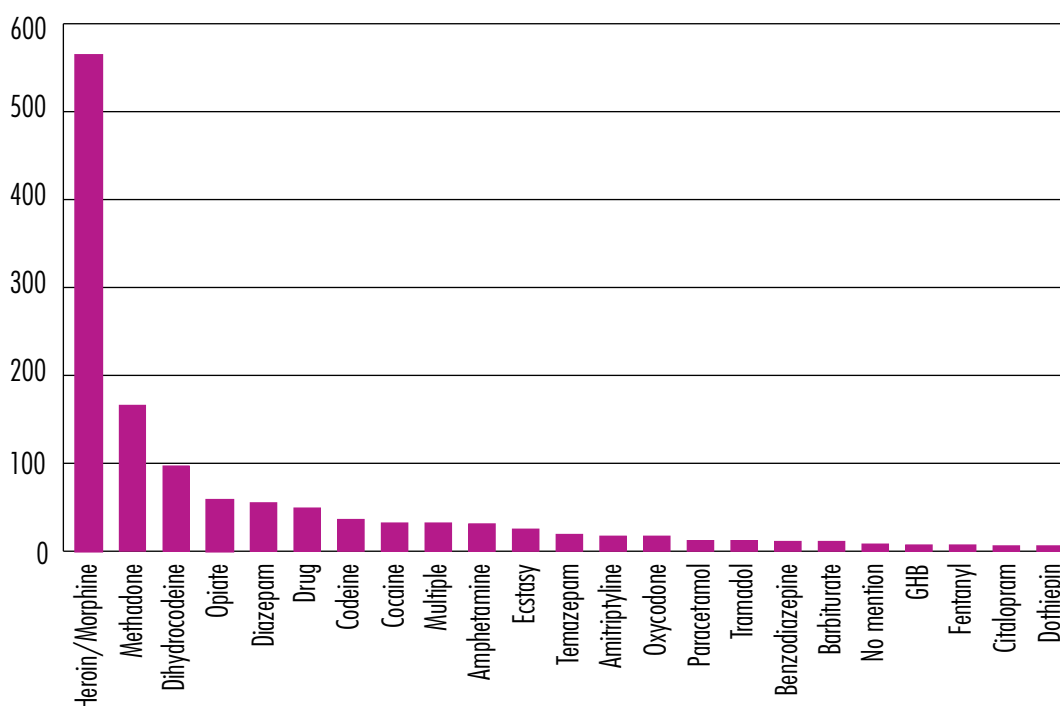
Data on fatal drug poisonings are provided by two national bodies: Office for National Statistics (ONS) and the National Programme on Substance Abuse Deaths (np-SAD). Different definitions are utilised by these bodies (see appendix 7).

According to ONS, 'drug related death data', including both licit and illicit drugs, ICD-10 codes for drug deaths include:

- Mental and behavioural disorders due to drug use (excluding alcohol and tobacco).
- Accidental poisoning by drugs, medicaments and biological substance.
- Intentional self-poisoning by drugs, medicaments and biological substances.
- Poisoning by drugs, medicaments and biological substances, undetermined intent.
- Assault by drugs, medicaments and biological substances.

ONS 'drug misuse death data' includes only illicit drugs. Utilising the definition for drug misuse related deaths⁶ there have been a total of 19,946 deaths in England and Wales over the period 2001-2012, of which around 6.6% (n=1,325) were amongst Welsh residents.¹⁵ The highest number of fatal drug misuse poisoning records have heroin/morphine recorded as cause of death* which in Wales, over the same period, accounted for over 44% as indicated in Chart 1.

Chart 1 – Fatal drug misuse poisonings in Wales by drug 2001 to 2012

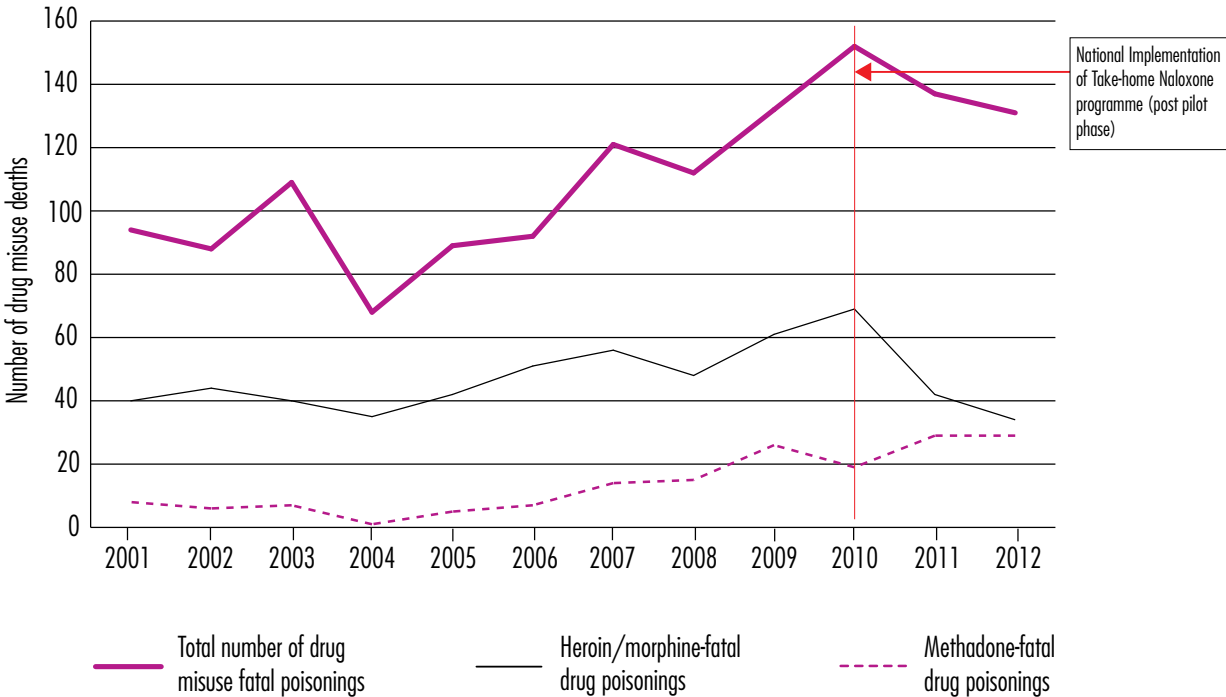


ONS 2012 *Data provided directly to Public Health Wales
 N.B. graph only indicates those drugs indicated in 5 or more deaths.
 The remaining 34 deaths involved a further 24 other drugs.

Over the period 2001-2012, the annual number of fatal drug misuse poisonings in Wales fluctuated but with an upward trend as indicated in Chart 2. However, in 2011 and 2012, the number of fatal drug misuse poisonings have decreased; by 9.9% in 2011 (from 152 deaths in 2010 to 137 in 2011), and by 4.4% (to 131 deaths) in 2012.¹⁵ This may be accounted for by the relative decrease in the number of fatal poisonings from heroin/morphine, and/or the impact and usage of Take-home Naloxone in opioid poisoning events, despite an increase in methadone related fatal poisonings.

Drug misuse poisonings accounted for 61.2% of the total number of fatal drug poisonings (n=214) in Wales in 2012.¹⁵

Chart 2: Total fatal drug misuse poisonings in Wales by year and by specified opioid (heroin/morphine and methadone) 2001 to 2012



ONS 2012 *Data provided directly to Public Health Wales.

Within the overall fatal drug misuse poisonings data in Wales for 2012, there is marked regional variation. Fatal drug misuse poisoning rates vary from 7.64 per 100,000 population in Cwm Taf Health Board area to 2.19 per 100,000 population in the more rural Powys Teaching Health Board area.¹⁶

Suicide

In Wales, over the period 2001-2011, a total of 3,450 deaths within the general population were reported as suicides or undetermined verdict. Of these, 22% were as a result of self-poisoning (overdose).¹⁷ In the same period, 23% of the general population suicides were identified as patient suicides, i.e. suicides amongst those who had had contact with mental health services in the previous 12 months.¹⁷ Within this patient population, 24% died as a result of self-poisoning. The substances most often involved were opiates and tricyclic antidepressants, accounting for 21% and 14% of suicide deaths respectively. 56% of the patient

suicides occurred in patients with known history of drug and/or alcohol misuse in Wales 2001-2011: 48% (n=380) with history of alcohol misuse; 33% (n=258) with history of drug misuse. In 2011, there were an estimated 25 suicide deaths where the patient had a history of drug misuse and had contact with mental health services within the previous 12 months.¹⁷

Based upon ONS data provided directly to Public Health Wales, in 2012, a total of 39 drug deaths were recorded as intentional self poisoning. Of these, 41% (n=16) were recorded as drug misuse deaths and were recorded as intentional self-poisonings (suicide) and a further 8.7% (n = 12) were of undetermined intent.¹⁶

Drug Deaths within custodial settings

Police custody – Fatal drug poisonings in or following custody

Fatal drug poisonings in or following police custody are referred to the Independent Police Complaints Commission (IPCC) for review. Reports to 2010 relating to deaths in custody, including drug poisonings, are published.⁴

Prison – Fatal drug poisonings within the prison setting

Fatal drug poisonings within prison are reviewed by the Prison and Probation Ombudsman and, subsequent to each review, recommendations and lessons learned are disseminated across the prison estate and made publically available.⁵ The HMPS Prison Service Instruction (PSI 64/2011) for Safer Custody for use across the prison estate in England and Wales provides mandatory actions for prisons to carry out and includes actions following any death in custody. This includes prisoners who are released on temporary license for medical reasons.

Non-fatal drug poisonings

Research undertaken by Public Health Wales amongst current and ex-injecting drug users in Wales indicated that 42% had experienced non-fatal poisoning at least once as a result of their drug use.¹⁸ Accounts from the participants regarding factors leading to non-fatal poisonings are in line with known risks, including recent release from prison and mixing opiates with alcohol and/or benzodiazepines. Furthermore, when looking in more detail at the qualitative evidence provided by drug users about their previous non-fatal poisoning experiences, it was apparent that a significant proportion of the events were the result of deliberate suicide attempts rather than accidental poisoning.¹⁸

Work undertaken in 2013 on non-fatal overdose amongst opioid injecting drug users in Wales provides similar rates, with 47% of respondents indicating at least one previous non-fatal drug poisonings. Of these, 32% had experienced an average of two non-fatal poisonings in the previous 12 months.¹⁹ The findings from this research and further work may support information and advice aimed at reducing future fatal and non-fatal drug poisonings in Wales.

Definitions of drug related deaths

ACMD definition

'Deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971 (as amended) were involved'.⁶

np-SAD definitions of drug related death

An np-SAD case is defined 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;
- Presence of Controlled Drugs*** at post mortem; or
- Cases of deaths directly due to drugs but with no inquest.

Deaths where solvents and other volatile substances are implicated alone are also included. However, we do collect information on these cases separately; further information can be seen at www.vsareport.org. Alcohol is included only when implicated in combination with other qualifying drugs.

* "Psychoactive" substances are those having a direct effect on perception, mood, cognition, behaviour or motor function. Typically these include opiates and opioid analgesics, hypnotics, sedatives, anti-depressants, anti-epileptics, anti-psychotics, hallucinogens, and stimulants (such as amphetamines and cocaine) and "legal highs".

** "Directly implicated" means that drugs were considered by the coroner or other person investigating the death to have been instrumental in the coming about of the deceased's death (e.g. through poisoning or intoxication), or causing their powers of reasoning and/or perception to be so affected as to induce them to take risks which they would not have done had they been sober (e.g. thinking they could fly).

*** "Controlled Drugs" are those drugs specifically classified by the Misuse of Drugs Act 1971 as amended by subsequent legislation. Controlled drugs include opioids, cocaine, amphetamines, cannabis, GHB, hallucinogens and most benzodiazepines.

Who is a drug abuser/dependent?

A drug abuser/dependent case is defined as one with a history of substance abuse where one or more of the following criteria are met:

- Reported as a known illicit drug user by the coroner, based on evidence obtained at inquest;
- Prescribed substitute medication for drug dependence;
- Presence of an illicit drug at post mortem, where not prescribed; or
- Presence of any additional information on the coroner's report suggestive of a history of drug abuse, and where such a history fulfils ICD-10 criteria: (F11-F16 and F19, using the 4-code subdivisions of .0 (acute intoxication), .1 (harmful use), and .2 (dependence syndrome).

“Drug misuse” definition

Cause of death categories included in the headline indicator of “drug misuse” deaths used to monitor progress against the Government’s drug strategy are defined in terms of ICD-10 codes and Controlled Drug Status. The relevant codes from ICD-10 are given in brackets.

The definition comprises two types of deaths:

- a) deaths where the underlying cause of death has been coded to the following categories of mental and behavioural disorders due to psychoactive substance use (excluding alcohol, tobacco and volatile solvents):
 - (i) opioids (F11)
 - (ii) cannabinoids (F12)
 - (iii) sedatives or hypnotics (F13);
 - (iv) cocaine (F14)
 - (v) other stimulants, including caffeine (F15)
 - (vi) hallucinogens (F16); and
 - (vii) multiple drug use and use of other psychoactive substances (F19)

- b) deaths coded to the following categories **and** where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death record:
 - (i) Accidental poisoning by drugs, medicaments and biological substances (X40–X44)
 - (ii) Intentional self-poisoning by drugs, medicaments and biological substances (X60–X64)
 - (iii) Poisoning by drugs, medicaments and biological substances, undetermined intent (Y10–14)
 - (iv) Assault by drugs, medicaments and biological substances (X85); and
 - (v) Mental and behavioural disorders due to use of volatile solvents (F18)

Notes:

1. Deaths coded to opiate abuse which resulted from the injection of contaminated heroin have been *included* in the indicator. This differs from the approach taken in Scotland, where these deaths have been *excluded*. This is because the General Register Office for Scotland (GROS) is able to identify deaths which occurred as a result of the use of contaminated heroin, whereas in England and Wales, these deaths cannot be readily identified. In practice, in England and Wales, they will only be included where the drug was mentioned on the death record and the death was coded to one of the ICD codes on the ONS database of drug-related poisonings and not to an infection code.
2. Specific rules were adopted for dealing with compound analgesics which contain relatively small quantities of drugs listed under the Misuse of Drugs Act, the major ones being dextropropoxyphene, dihydrocodeine and codeine. Where these drugs are mentioned on a death record, they have been excluded if they are part of a compound analgesic (such as *co-proxamol*, *co-dydramol*

or co-codamol) or cold remedy. Dextropropoxyphene has been excluded on all occasions, whether or not paracetamol or a compound analgesic was mentioned. This is because dextropropoxyphene is rarely, if ever, available other than as part of a paracetamol compound. However, codeine or dihydrocodeine mentioned **alone** were included in the indicator. This is because they are routinely available and known to be abused in this form. This approach is taken by both the Office for National Statistics and the General Register Office for Scotland.

3. Drugs controlled under the Misuse of Drugs Act 1971 include class A, B and C drugs.

ICD-10 codes

| Description | ICD-10 Codes |
|--|------------------|
| Mental and behavioural disorders due to drug use (excluding alcohol and tobacco) | F11–F16, F18–F19 |
| Accidental poisoning by drugs, medicaments and biological substances | X40–X44 |
| Intentional self-poisoning by drugs, medicaments and biological substances | X60–X64 |
| Assault by drugs, medicaments and biological substances | X85 |
| Poisoning by drugs, medicaments and biological substances, undetermined intent | Y10–Y14 |

Cause of death categories included in the headline indicator of drug misuse deaths (the relevant codes from ICD-10 are given in brackets):

- a) deaths where the underlying cause of death has been coded to the following categories of mental and behavioural disorders due to psychoactive substance use (excluding alcohol, tobacco and volatile solvents):
 - (i) opioids (F11)
 - (ii) cannabinoids (F12)
 - (iii) sedatives or hypnotics (F13)
 - (iv) cocaine (F14)
 - (v) other stimulants, including caffeine (F15)
 - (vi) hallucinogens (F16); and
 - (vii) multiple drug use and use of other psychoactive substances (F19)

- b) deaths coded to the following categories and where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death record:
 - (i) Accidental poisoning by drugs, medicaments and biological substances (X40-X44)
 - (ii) Intentional self-poisoning by drugs, medicaments and biological substances (X60-X64)
 - (iii) Poisoning by drugs, medicaments and biological substances, undetermined intent (Y10-Y14)
 - (iv) Assault by drugs, medicaments and biological substances (X85); and
 - (v) Mental and behavioural disorders due to use of volatile solvents (F18)

Notes:

1. Deaths coded to opiate abuse which resulted from the injection of contaminated heroin have been included in the indicator. This differs from the approach taken in Scotland, where these deaths have been excluded. This is because the General Register Office for Scotland (GROS) is able to identify deaths which occurred as a result of the use of contaminated heroin, whereas in England and Wales, these deaths cannot be readily identified. In practice, in England and Wales, they will only be included where the drug was mentioned on the death record and the death was coded to one of the ICD codes on the ONS database of drug-related poisonings and not to an infection code.

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3. Drugs controlled under the Misuse of Drugs Act 1971 include class A, B and C drugs.
4. Information on the cause of death categories used to define the indicator in ICD-9 can be found in the report in Health Statistics Quarterly 13. Available to download from the ONS website: www.ons.gov.uk/hsq/health-statistics-quarterly/no-13-spring-2002/index.html