GIG CYMRU NHS WALES

Iechyd Cyhoeddus Cymru

Public Health Wales

SUBSTANCE MISUSE PROGRAMME

Harm Reduction Database: Fatal and Non-Fatal Drug Poisonings 2014 and 2015

About Public Health Wales

Public Health Wales exists to protect and improve health and wellbeing and reduce health inequalities for people in Wales. We work locally, nationally and internationally, with our partners and communities.

The Substance Misuse Programme works to address both the current and emerging public health threats in Wales and in line with the overarching strategic objective to '**reduce health inequalities, and prevent or reduce communicable and non-communicable disease, wider harms and premature death related to drugs and alcohol**'.

Substance Misuse Programme
Public Health Wales
No.2 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Tel: 02920 404499

www.publichealthwales.org/substancemisuse

Published: Gareth Morgan and Josie Smith, Substance Misuse Programme, Health Protection Division, Public Health Wales, 2016.

Contents

1. Executive summary

The review of fatal and non-fatal drug poisonings was initiated in Wales following implementation of guidance by Welsh Government in June 2014. The guidance provides framework and procedures for a timely local review process in which recommendations and lessons learnt can be developed surrounding the circumstances underpinning drug poisonings in Wales. The Harm Reduction Database (HRD): Drug Poisoning Database was developed in order to support both the collection and analysis of data relating to such reviews, and as such has provided a mechanism in which trends in both fatal and non-fatal drug poisonings can be monitored both locally and nationally in Wales. This report provides data on the implementation of fatal and non-fatal drug poisoning reviews in Wales as recorded on the HRD: Drug Poisoning Database from 1st June 2014 to 31st December 2015.

Implementation of Drug Poisoning Reviews:

- From implementation of guidance in June 2014 to 31st December 2015, a total of 83 fatal and 174 non-fatal drug poisoning reviews have been conducted in Wales
- Phased implementation of the guidance has meant that of the seven Substance Misuse Area Planning Board (APB) regions in Wales, five have implemented a fatal drug poisoning review process only, one has implemented non-fatal drug poisoning reviews only and one area has achieved full implementation to date.
- Comparisons with Office of National Statistics (ONS) data in relation to Drug Misuse Deaths in Wales indicates that the proportion of Fatal Drug Poisoning cases being reviewed in Wales has increased from 25.6% in 2014 to 32.1% in 2015
- Data collection processes and service provider information requests were initiated and collected via the HRD for 42 fatal and 107 non-fatal drug poisoning incidents
- The mean number of information requests sent by the Case Review Coordinator via the HRD to local services was 11 notifications per case for fatal poisonings and 9 notifications per case for non-fatal poisonings

Fatal Drug Poisonings

- Of the 83 fatal cases reviewed in 2014 and 2015 over 80 per cent were male, with median age of 36 years, and over 50 per cent were reported as living in non-secure housing or having no fixed abode (NFA) at the time of death
- In over 80 per cent of cases the drug poisoning incident occurred within a private residence, with less than 10 per cent occurring within a hostel facility.
- In nearly 90 per cent of cases death was pronounced at scene, and where reported, resuscitation was attempted in nearly 60 per cent of cases
- Where reported, substances and/or paraphernalia were found at scene in 63 per cent of cases. Due to the availability of associated packaging (e.g. blister packs, boxes) both Benzodiazepines and Prescription only Medicines (POM) were the most commonly listed substances. Where paraphernalia was found at scene, paraphernalia associated with injecting was identified in 60 per cent of cases
- For cases where service information requests were sent via the HRD (n=42) 60 per cent of cases had 'no known contact' with a statutory and voluntary sector substance misuse services in the 6 months prior to death

- Where any service contact was reported within 6 months prior to death, 80 per cent were reported to have been poly-drug users, and nearly 83 per cent reported as having history of mental health illness or suicidal/self-harming behaviour

Non-fatal drug poisonings

- Whilst both gender and housing status profiles of non-fatal drug poisonings remain consistent with those observed within the fatal drug poisoning cases, the age profile of non-fatal cases appeared younger (median = 33 years)
- A greater number of cases under age 25 years was reported amongst non-fatal drug poisonings compared to fatal cases, 16 per cent and 6 per cent respectively
- Contact with services was greater amongst non-fatal drug poisonings, with contact within 6 months prior to incident being reported in 66.4 per cent of cases
- Where service contact was reported within 6 months prior to incident, 62 per cent were reported as poly-drug users

RECOMMENDATIONS

1. CRCs should ensure that information requests are disseminated to a broad range of services in order to maximise the quality and accuracy of information returned, and to better identify gaps in service provision and contact.

2. APBs should ensure that Primary Care and GP engagement is built in as part of the review process. Such links are pivotal in obtaining information in relation to an individual's physical and mental health, and prescribing history.

3. Welsh Government and Public Health Wales to work to establish a consensus seminar to better develop information sharing mechanisms between fatal drug poisoning review processes and coroners / toxicologists in Wales and work to agree standardised toxicology test requests. The seminar to include APB Drug Poisoning reviews, CRCs, lead coroners, police coroners officers, toxicologists, and pathologists.

4. APBs should ensure that all recommendations generated during drug poisoning multi-disciplinary reviews are recorded on the HRD: Drug Poisoning Database. These should be clearly listed within sections 'Summary and Conclusions' and 'Recommendations and Actions' so that they may be used to support national reports, policy, and guidelines in relation to Drug Poisoning Prevention.

2. Guidance on fatal and non-fatal drug poisoning reviews

In June 2014 Welsh Government published new guidance outlining the framework and procedures in relation to the review of fatal and non-fatal drug poisonings in Wales[1]. The guidance, developed in line with the key aims of the Welsh Government Substance Misuse Strategy Delivery Plan 2013-15 (Outcome 3.1)[2], provides guidance for all stakeholders within Wales who have a remit for reducing fatal and non-fatal drug poisonings related to substance misuse. This encompasses all stages for effective review including, instigation, multidisciplinary working and data collection, and the identification, implementation and dissemination of recommendations and lessons learned.

Implementation of the guidance supersedes the previous confidential review process[3] where fatal drug poisonings were reviewed post coroner's inquest. Under the new guidance 'case reviews' are undertaken locally and initiated as soon after the fatal drug poisoning as possible. Thus providing more timely information in relation to circumstances related to death and where best evidence indicates lessons could be learned. The confidential review process highlighted the success of Drug Related Death Review Panels where community and partnership working supported the identification of recommendations which support the reduction of both fatal and non-fatal drug poisonings locally and nationally.

Unlike the historic guidance, the new stipulates not only the review of fatal drug poisonings but the also the addition of non-fatal drug poisonings (case definitions of which are defined within the guidance). Responsibility for the review of both poisonings types sits with a nominated Case Review Co-ordinator (CRC) as identified by the local Area Planning Board's (APB) Harm Reduction Group. The CRC co-ordinates partnership and collaborative working, between the Coroners service and support services within the locality in order to underpin circumstances related to death and ensuring accurate information is available for analysis. This includes the dissemination and collation of information requests, and establishment of multi-agency review meetings to assess evidence, and establish lessons learned.

In order to monitor progression of the guidance across Wales the National Implementation Board for Drug Poisoning Prevention (NIBDPP) was established and provided with responsibility for ensuring that Health Boards / APBs and all other stakeholders progress to full implementation of both existing and emerging recommendations as per the reviews. Furthermore it is the NIBDPP's role to work alongside professional membership bodies e.g. Royal Collage 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.

In order to better support timely and accurate collection of data in relation to fatal and non-fatal drug poisoning reviews Welsh Government and Public Health Wales have supported the development of a robust database via the Harm Reduction Database (HRD) Wales (see *Section 2* for more information). The HRD provides a central system for the secure storage and collation of data, along with a mechanism in which information can be requested by the CRC from all stakeholders involved in the review of a drug poisoning event.

---

[1] Welsh Government (2014), Guidance for undertaking fatal and non-fatal drug poisoning reviews in Wales. Available at: http://gov.wales/docs/dhss/publications/140701substanceen.pdf

[2] Welsh Government (2013), Working Together to Reduce Harm Substance Misuse Delivery Plan 2013–2015 (Outcome 3.1). Available at: www.wales.gov.uk/docs/substancemisuse/publications/130219StrategyDeliveryPlan13-15en.pdf

[3] Welsh Assembly Government (2005). Guidance on developing local confidential reviews into drug related deaths in Wales. Available at: www.wales.gov.uk/dsjlg/publications/commmunitysafety/guidancedrugdeaths/guidancee?lang=en

It is the purpose of this report to provide an overview of the data captured on the Harm Reduction Database for reviews conducted since implementation of the guidance (June 2014) up until 31st March 2015.

3. Harm Reduction Database: Drug Poisoning Database

What is the Harm Reduction Database?

In 2010 Public Health Wales, supported by Welsh Government, introduced the Harm Reduction Database (HRD). The HRD is a web-based tool for recording anonymised demographic, substance use, risk and outcome data on a range of interventions including needle and syringe programmes, Take-home Naloxone, blood borne virus testing and long-acting reversible contraception. The implementation and use of such modules has resulted in the HRD being used in over 263 NSPs, and 49 THN registries Wales wide. Current stakeholders include statutory and third sector substance misuse services, community pharmacy, Integrated Offender Intervention Services (IOIS), homelessness and housing support, prisons, and police. As such the HRD has been recognised as an effective data recording system in Wales.

HRD: Drug Poisoning Database

To better support the collection, recording and management of data relating to the review of both fatal and non-fatal drug poisonings in Wales the HRD was developed during 2014/15 to include a distinct and separate module known as the HRD: Drug Poisoning Database. The development of which has provided a robust mechanism in data collection, enabling a better understanding of the circumstances underpinning drug poisonings and processes/interventions required to prevent future events.

Configuration and access to the HRD: Drug Poisoning Database is securely managed by Public Health Wales, with area specific recording and reporting permissions issued to Case Review Co-ordinators (CRCs) and drug poisoning leads across the 7 Area Planning Boards in Wales. The HRD: Drug Poisoning Database provides CRCs with the following functionality:

- **Disseminate electronic information requests** as per the Welsh Government guidance to sentinel contributors and local services via the system's secure network
- **Development of local service networks** for the review of drug poisonings and manage/support/audit services in responding to information requests
- **Review key milestones** e.g. multi-disciplinary review meeting dates
- **Record findings** relating to toxicology, pathology, histology, and final coroners verdict
- **Consolidate and collate information** provided by services to support development of recommendations and lessons learnt for APB and NIBDPP review
- **Generate time defined local aggregate reports**

Implementation of HRD: Drug Poisoning Database

The HRD: Drug Poisoning Database was implemented by Public Health Wales in full in June 2015 following system configuration and development in line with the Welsh Government Guidance for the undertaking of fatal and non-fatal drug poisoning reviews. At this point review processes had already been implemented and initiated within a number of Area Planning Boards and as such data in relation to such reviews was being collected using local data collection processes. Upon implementation of the HRD: Drug Poisoning Database a back population exercise was completed to ensure that all compatible data was securely stored onto the system.

Data captured

The data captured via the HRD: Drug Poisoning Database can be categorised by the means in which it is entered onto the database; either via the CRC, or via local services. As such the following data items can be recorded:

By the Case Review Co-ordinator:

The following information is collected and populated on the HRD: Drug Poisoning Database by the reviewing APB CRC from notification of a drug poisoning incident up until close of review.

1) **Case Details**

The 'case details' section is a profile of a case individual's demographic information and key contacts as indicated by the Case Review Coordinator following notification of a drug poisoning incident, as such it includes:

- **Individual details** including – NHS number, home address, home postcode, and registered GP
- **Demographics** including – age at time of incident, gender, ethnicity
- **Incident details** including – date of incident, location of incident, coroner (if fatal)

2) **Circumstances and nature of death (fatal drug poisonings only)**

The 'circumstances and nature of death' section provides an overview of information relating to early findings and circumstances surrounding a fatal drug poisoning as reported to the Case Review Coordinator, as such it includes:

- **Location details** including – location individual was discovered, location individual was pronounced dead
- **Items found at scene** including – substances and paraphernalia found at scene
- **Resuscitation attempts provided**

3) **Investigative tests** including – Toxicology (samples taken and result), pathology, and histology findings

4) **Coroners verdict (fatal drug poisonings only)** including – medical cause of death, outcome of inquest, and date of inquest

By local services:

Information is collected and populated onto the HRD: Drug Poisoning Database by the local services following the issue of an information request by the reviewing CRC of a drug poisoning incident. Upon receipt of the information request local services are given the opportunity to state whether the case individual was 'known' or 'not known' to the service. Where 'known', the service is asked to provide further details surrounding the reason for contact and key information relating to the individual in order to aid the multidisciplinary review and support the development of lessons learnt. As such the following information may be provided:

- **Contact details** including – date of first contact, date of last contact, reason for contact
- **Mental health and physical/medical conditions**
- **Substances used (non-prescribed)** including – substance (drugs and alcohol), frequency, route of administration, length of use
- **Opiate prescribed medication** including – type of medication, dose, frequency, date issued, prescribed by
- **Other prescribed medication** including – type of medication, dose, frequency, date issued, prescribed by
- **Custodial history (Prison and Police services only)** including – custody within one month prior to incident, location, duration, date of discharge
- **Interventions offered**
- **Onward referrals made by the service, and other known service contacts**
- **Known barriers to support**

4. Implementation of drug poisoning reviews in Wales

Following publication of the new guidance in June 2014 local APBs in Wales have worked to establish and implement mechanisms in which multidisciplinary reviews are conducted immediately following notification of a drug poisoning event. This work has included the appointment of local Drug Poisoning Case Review Coordinators and support, identification of multidisciplinary review network, and the development of information sharing protocols and pathways. This work has resulted in implementation of the guidance across Wales taking a staggered approach. By end of December 2015 all bar one APB region (Betsi Cadwaladr University Health Board) were conducting fatal drug poisoning reviews (see *Table 1*). This has resulted in 83 fatal drug poisoning reviews having been conducted from June 2014 to December 2015.

In addition to the fatal drug poisonings two APBs have implemented the process for the review of non-fatal cases (see *Table 1*). This work has resulted in 174 non-fatal drug poisoning reviews having been conducted from time of implementation up until December 2015.

Table 1: Total Fatal and Non Fatal Drug Poisoning Reviews Conducted (June 2014 – December 2015)

Health Board	Fatal DP Reviews	Non-Fatal DP Reviews
ABMU*	1	146
Aneurin Bevan	21	-
BCU**	-	-
Cardiff and Vale	11	-
Cwm Taf	38	28
Hywel Dda	11	-
Powys Teaching	1	-
Total	**83**	**174**

* Fatal Drug Poisoning review process implemented December 2015
**Fatal Drug Poisoning review process implemented May 2016

This report provides data in relation to the fatal and non-fatal drug poisoning reviews conducted in Wales as recorded (or back populated) on the Harm Reduction Database Wales (HRD) during the period 1st June 2014 to 31st December 2015 (as per *Table 1*).

Table 2: Total Fatal Drug Poisoning Reviews and ONS Drug Misuse Deaths, by Year

	2014	2015
Fatal drug poisoning case reviews	29	54
Drug Misuse Deaths reported by ONS[4]	113	168
% Case reviews vs. reported by ONS	**25.6%**	**32.1%**

Comparisons with Office of National Statistics (ONS) data in relation to Drug Misuse Deaths in Wales indicates that the proportion of Fatal Drug Poisoning Cases being reviewed in Wales has increased over the two years since the new guidance was implemented (see *Table 2*). Geographic analysis indicates regional variance in the number of Drug Misuse Deaths reported by ONS and the number of fatal drug poisonings reviewed (see *Figure 2*). **As such further work needs to be completed to ensure total coverage of cases throughout Wales.**

[4] Office for National Statistics (2015) Drug related deaths in England and Wales, 1993-2014. Available at: http://www.ons.gov.uk/ons/dcp171778_414574.pdf

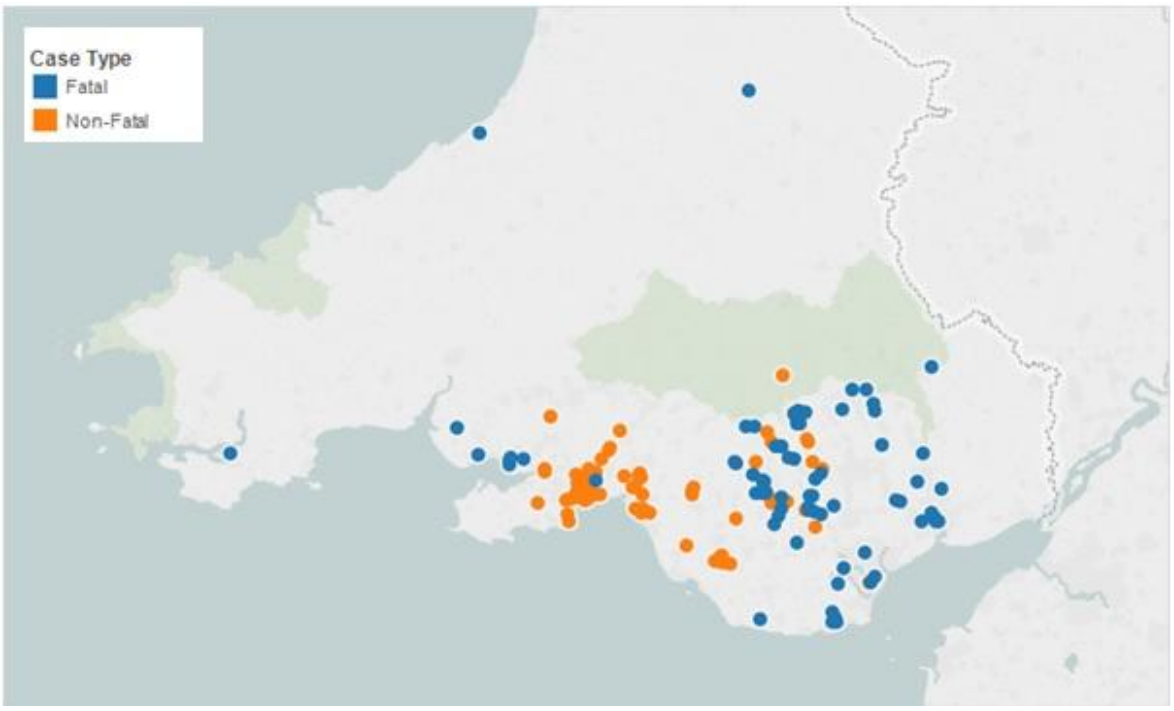
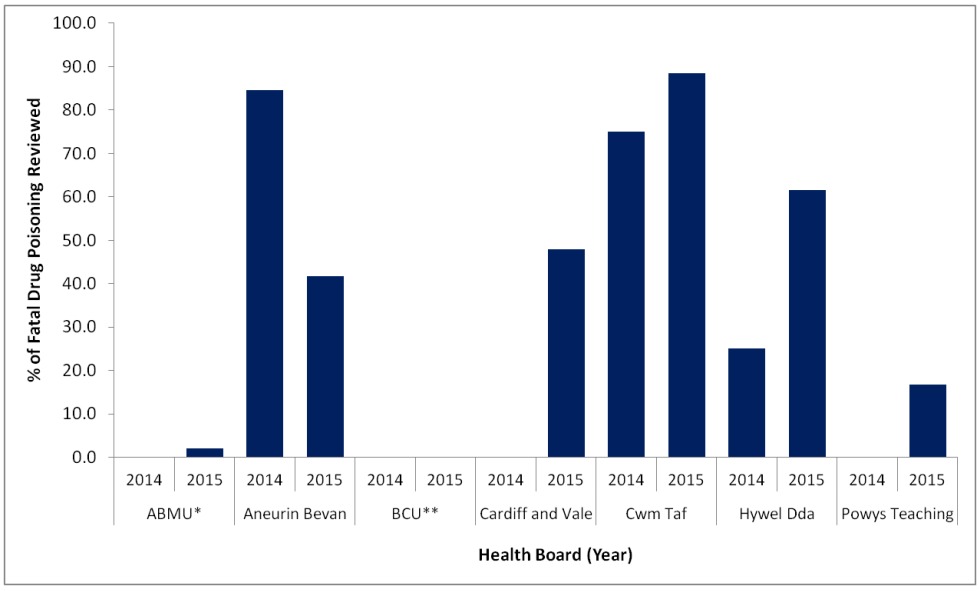


Figure 1: Postcode of residence - locations of fatal and non-fatal drug poisoning cases (June 2014 – December 2015)



* Fatal Drug Poisoning review process implemented December 2015
**Fatal Drug Poisoning review process implemented May 2016

Figure 2: Proportion of ONS Drug Misuse Deaths vs. Fatal Drug Poisoning Cases Reviewed, by Health Board and by Year

5. Fatal drug poisoning reviews

Demographics

The demographic profiles for the 83 fatal drug poisoning reviews conducted across Wales in 2014 and 2015 can be viewed in *Table 3*. Overall, the most frequent age band reported was 35-39 years, representing 30.1 per cent (n=25) of cases reviewed. This differed between genders with age ranges 40-44 being the most often reported amongst female cases (see *Figure 3*). **Analysis on individual years found patterns in gender and age ranges to be consistent with that reported by ONS [5] [6].** Housing status information was collected for cases reviewed from 2015 onwards. Where reported (51.6 per cent; n=28) over half of cases were listed as living in non-secure (e.g. hostel accommodation) or having no fixed abode (e.g. street homeless, 'sofa surfing').

Table 3: Demographics: All Wales

	2014 *(n=29)*	**2015** *(n=54)*	**All** *(N=83)*
% Male	72.4%	85.2%	80.7%
Median Age (range)	40 years (25-54 years)	35 years 6 months (18-52 years)	36 years (18-54 years)
% < 25 years	nil	9.2%	6%
% BAME*	nil	< 5%	< 5%
% Non-secure housing / NFA*	N/A	53.5%	53.5%

* Black and Asian Minority Ethnic groups- Where data was available

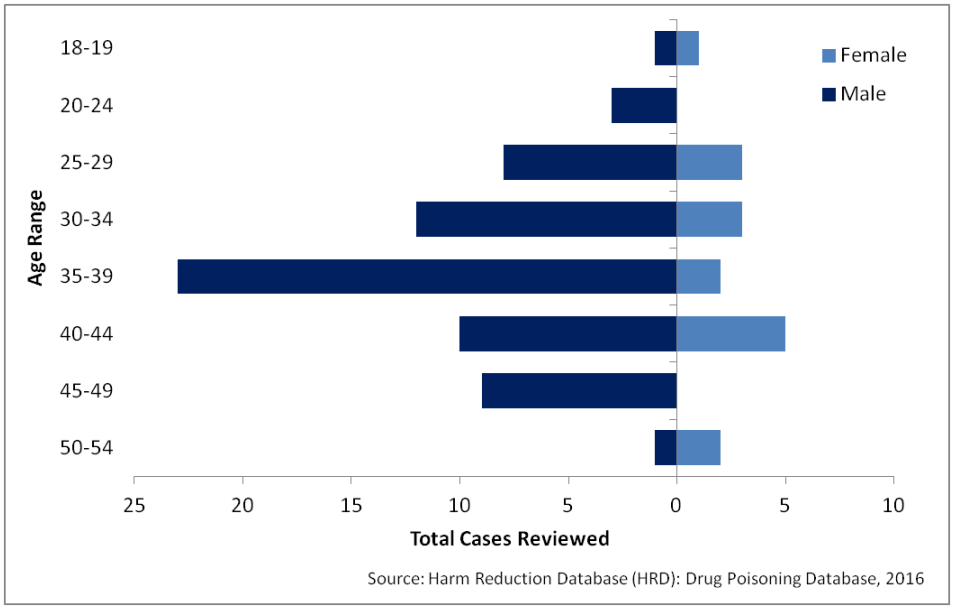


Figure 3: Gender and Age Range at Time of Death for Fatal Drug Poisoning Cases Reviewed in Wales (June 2014 – December 2015)

[5] Reading Between the Lines: The Annual Profile of Substance Misuse in Wales, Health Protection Division, Public Health Wales (2015)
[6] Piecing the puzzle: The Annual Profile of Substance Misuse in Wales, Health Protection Division, Public Health Wales (2016)

Circumstances and nature of death

Location of fatal drug poisoning

Location of death was recorded for 90.3 per cent (n=75) of all fatal drug poisonings reviewed during 2014 and 2015. There was no notable difference between years in reported location of incident. For the majority of fatal drug poisonings reviewed death occurred within a private residence (see *Figure 4* for detail). Despite over half of fatal drug poisoning cases having been identified as living in non-secure or no fixed accommodation, death occurred within a hostel environment in less than 10 per cent of cases. Evidence indicates that lifetime and 12 month drug poisoning rates are highest amongst those users attending a hostel environment[7]. However, it is likely that those using within such services have increased contact with support services, and exposure to fatal drug poisoning preventative measures e.g. Take Home Naloxone and harm reduction information.

Where recorded, 88 per cent (n=66) of fatal drug poisoning cases were pronounced dead at scene. Fewer than 12 per cent of cases were pronounced dead in a secondary location such as A&E or in hospital.

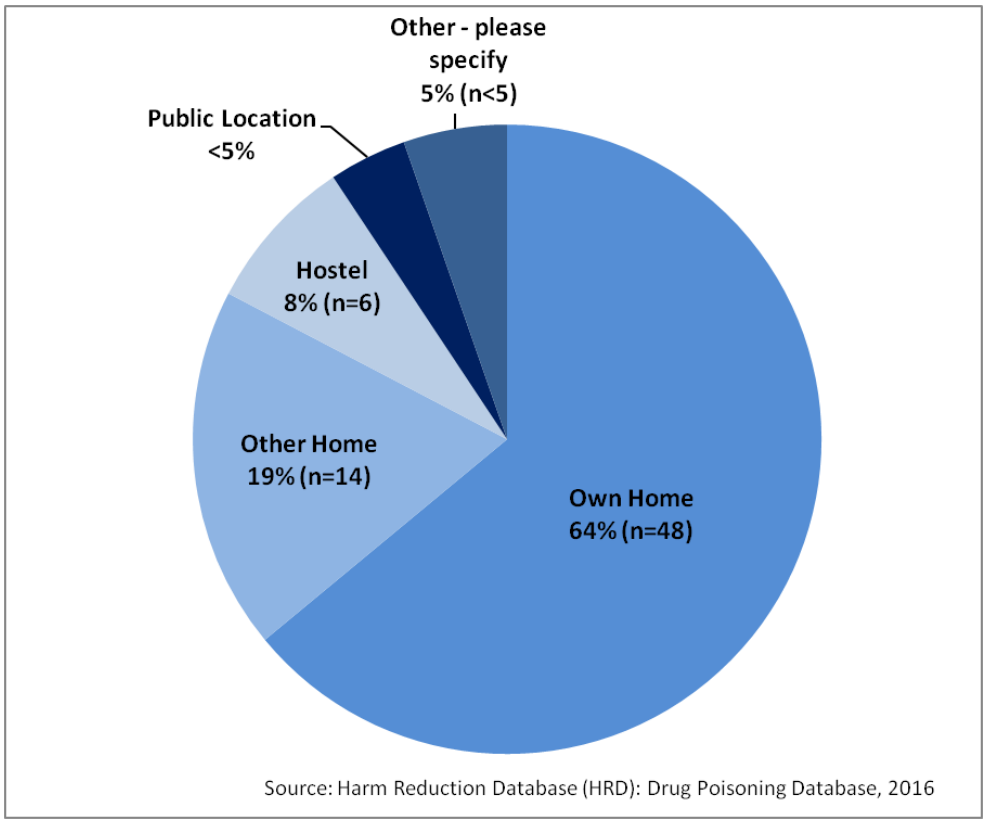


Figure 4: Location of death for fatal drug poisoning cases reviewed (June 2014 – December 2015)

[7] Holloway K R, Bennett T H, & Hills R. (2016) Non-fatal overdose among opiate users in Wales: A national survey. *Journal of Substance Use*; 00 (00)

Substances found at scene

Where information was available (86.7 per cent, n=72), both substances and/or paraphernalia were found at scene in 62.5 per cent (n=45) of fatal drug poisoning cases (see *Figure 5*). Where substances were found at scene, multiple substance were reported in 50 per cent (n=16) of events indicating poly-drug use.

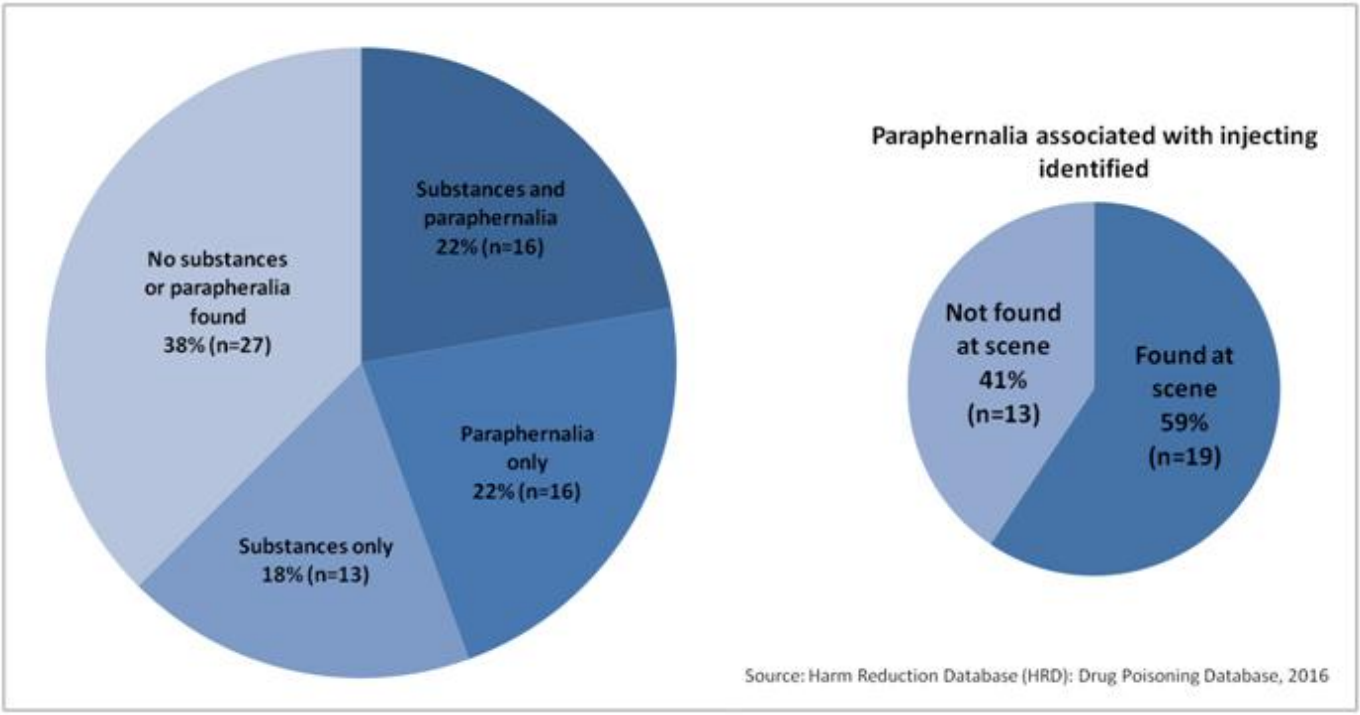


Figure 5: Fatal drug poisoning review cases where paraphernalia and/or substances found at scene

Substances found at scene included cannabis, unconfirmed heroin samples, benzodiazepines, and range of prescription only medicines, and anabolic steroids. Where substance were found at scene, Benzodiazepines and other prescription only medicines were listed in 48.3 per cent (n=14) of cases. This data should be treated with caution as compared to illicit drugs the identification of POMs can often be supported by the availability of packaging found at scene e.g. blister packs and boxes.

Resuscitation attempts

Information related to resuscitation attempts was listed in 38.5 per cent (n=32) of fatal drug poisoning cases reviewed. Where details of resuscitation attempts was not listed (n=51), over three quarters (n=39) of such cases were not reviewed utilising the HRD, reflecting a lack of consistent data collection amongst Health Boards prior to HRD implementation.

Resuscitation was attempted in 59.3 per cent of cases (n=19) where information was recorded. Further analysis indicates that in cases where resuscitation was not provided (n=13) all fatalities had been pronounced at scene. Take Home Naloxone use was reported in 31.6 per cent (n=6) of cases, of which four were admitted to hospital / A&E before death was pronounced. Past surveys have indicated that a large proportion of non-fatal drug poisonings events occur in the company of

others,[8] which has acted as a protective factor in order to reduce death. Such surveys have emphasised the willingness of non-paramedic bystanders to perform life-saving actions including the administration of Take Home Naloxone. Currently there is no information available to suggest whether those fatalities where resuscitation was not provided occurred in isolation or in the company of others.

6. Non-fatal drug poisoning reviews

The demographic profiles for the 174 non-fatal drug poisoning reviews conducted in 2015 can be viewed in *Table 3*. Whilst both gender and housing status profiles of non-fatal drug poisonings remain consistent with those observed within the fatal drug poisoning cases, the age profile of non-fatal cases appeared younger. A greater prevalence of cases under age 25 years was reported amongst non-fatal drug poisonings compared to fatal cases.

Table 3: Demographics: All Wales

	2015 *(n=174)*
% Male	79.9%
Median Age (range)	33 years (17-60 years)
% < 25 years	15.5%
% BAME*	nil
% Non-secure housing / NFA*	47.1%

* Where data was available

The most common age range observed amongst female non-fatal cases (25-29 years) was younger than that reported in fatal cases (40-44 years) for the same time period. Research indicates that on average, the rate of non-fatal drug poisonings amongst individuals who had lifetime history of drug poisoning events was 2 survived events per year[9]. As such fatal drug poisoning cases would likely have a preceding history of non-fatal drug poisonings events. This is likely to explain the age contrast between fatal and non-fatal drug poisonings and highlights the important role the non-fatal review process should play in preventing fatal drug poisonings.

[8] Holloway K R, Bennett T H, & Hills R. (2016) Non-fatal overdose among opiate users in Wales: A national survey. *Journal of Substance Use*; 00 (00)

[9] Holloway K R, Bennett T H, & Hills R. (2016) Non-fatal overdose among opiate users in Wales: A national survey. *Journal of Substance Use*; 00 (00)

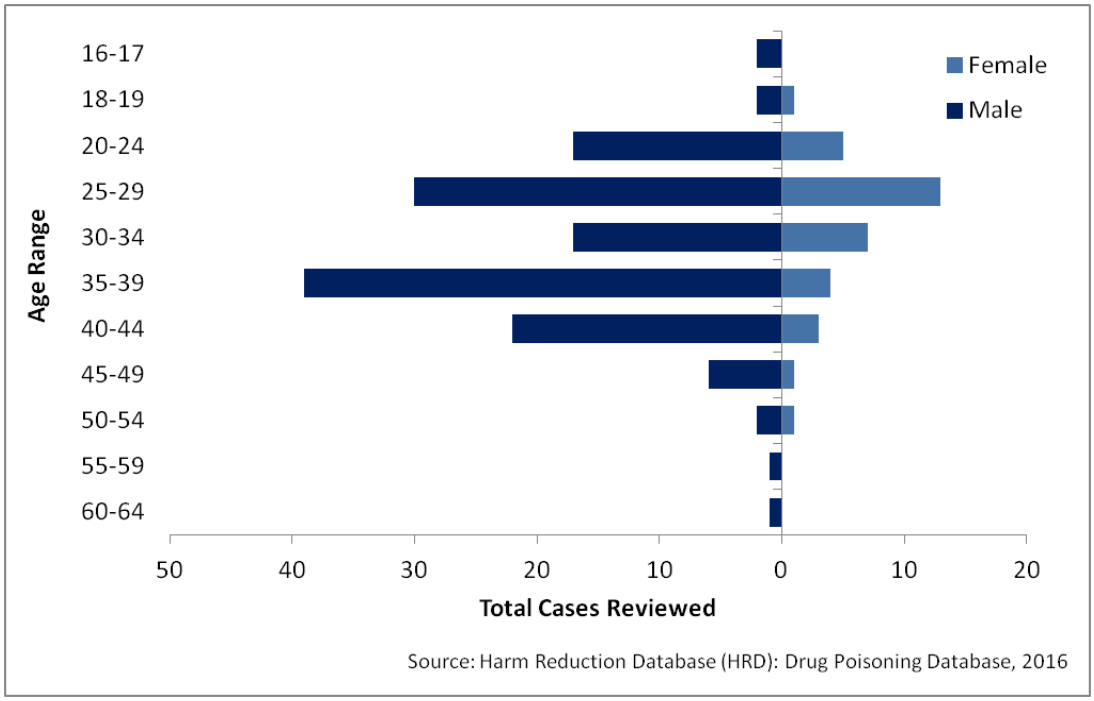


Figure 6: Gender and Age range at time of death for Fatal Drug Poisoning cases reviewed in Wales (June 2014 – December 2015)

7. Fatal & non-fatal drug poisoning reviews via Harm Reduction Database

As the new drug poisoning review process was implemented in Wales prior to the development of the HRD: Drug Poisoning Database, APB CRCs were required to develop their own data collection methods in line with data collection protocols as listed in the guidance. The development of the HRD: Drug Poisoning Database in June 2015 provided a unified platform for data collection, recording to support reviews across Wales. Whilst much of the data collected prior to June 2015 has been back populated onto the database, some gaps remain. As such following section includes only those cases reviewed where data collection processes and service provider information requests were initiated and collected via the Harm Reduction Database: Drug Poisoning Database (Fatal Drug Poisoning reviews n=42; Non-Fatal Drug Poisoning Reviews n=107).

Table 4: Total Fatal and Non Fatal Drug Poisoning Reviews Conducted via HRD: Drug Poisoning Database

Health Board	Fatal DP Reviews	Non-Fatal DP Reviews
ABMU	1	79
Aneurin Bevan	11	-
BCU	-	-
Cardiff and Vale	6	-
Cwm Taf	23	28
Hywel Dda	1	-
Powys Teaching	0	-
Total	**42**	**107**

Feedback from Services

For those drug poisonings reviewed via the HRD, the mean number of information requests sent by the CRC via the HRD to services was 11 notifications per case for fatal poisonings and 9 notifications per case for non-fatal poisonings. The number of information requests sent by the CRC to services varied across APB regions (see *Table 6* for detail).

Table 6: Mean number of information request per case sent via the HRD to services by APB

	Fatal DP *M (range)*	**Non-Fatal DP** *M (range)*
Aneurin Bevan	**24** (18-25)	-
ABMU	**9** (9)	**10** (2-15)
BCU	-	-
Cardiff and Vale	**19** (1-24)	-
Cwm Taf	**5** (2-7)	**4** (1-6)
Hywel Dda	**5** (5)	-
Powys Teaching	-	-
Wales	**11** (1-25)	**9** (1-15)

Recommendation 1

It is essential that CRCs ensure that information requests are disseminated to a broad range of services in order to maximise the quality and accuracy of information returned, and to better identify gaps in service provision and contact.

The type of services receiving information request included; voluntary and statutory sector substance misuse services, young people's substance misuse services, community mental health teams, CAMHS, IOIS, HM Prisons, probation (NPS & CRC), police, social services, local authority housing, homelessness support (inc hostels), and A&E.

At the time of writing this report only one APB, Aneurin Bevan, disseminates information requests to GP practices following a fatal drug poisoning. Ensuing GP engagement as part of the review process is pivotal in obtaining information in relation to an individual's physical and mental health, and prescribing history.

Recommendation 2

APBs should ensure that Primary Care and GP engagement is built in as part of the review process. Such links are pivotal in obtaining information in relation to an individual's physical and mental health, and prescribing history.

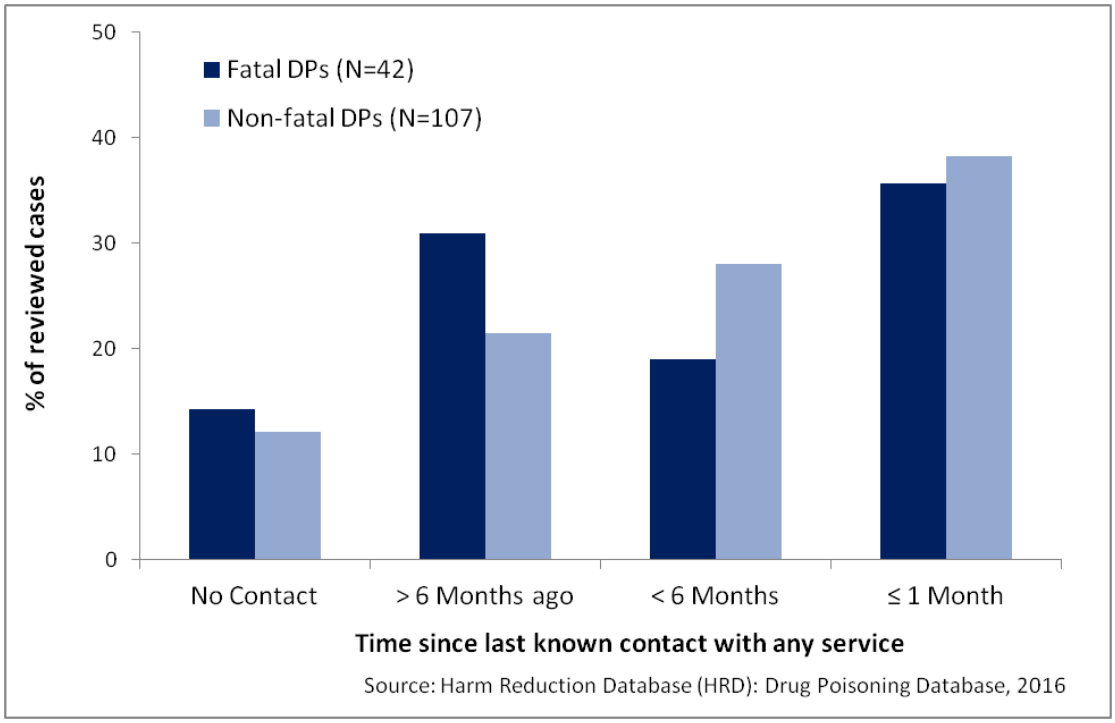


Figure 7: Length of time since last known contact with any service for fatal and non-fatal drug poisoning cases reviewed via the Harm Reduction Database

Fatal Drug Poisonings

Known service contact: Of those fatal cases reviewed, 54.8 per cent (n=23) had been in contact with services within 6 months, and 35.7 per cent (n=15) within a month prior to death. This indicates that in just under half of those cases reviewed 'no known contact' was reported between the deceased and local services within six months prior to death (see *Figure 7*). Furthermore, **nearly 60 per cent of cases (n=25) had 'no known contact' with a statutory and voluntary sector substance misuse services (including Integrated Offender Intervention Scheme (IOIS)) in the 6 months prior to death**.

Known substance history: Substance use was known and reported in 65.2 per cent (n=15) of fatal cases in contact with services six months prior to death. Of which 80 per cent (n=12) were reported to have been polydrug users and having used two or more substances. Heroin/ Morphine use and history of hazardous/dependant alcohol use was reported in 66.6 per cent (n=10) and 73.3 per cent (n=11) of cases respectively (see *Figure 8*).

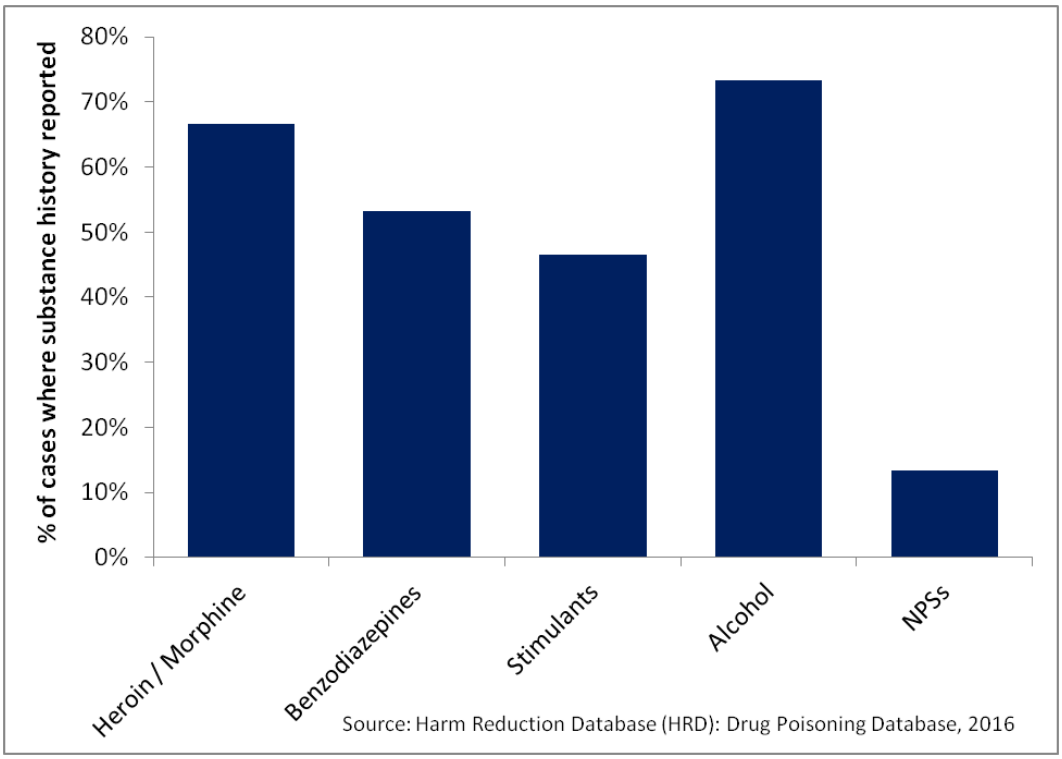


Figure 8: Proportion of fatal drug poisoning cases where substance history reported, by substance (n=15)

Mental Health: Information in relation to mental health was reported in 100 per cent (n=23) of fatal cases in contact with services six months prior to death. Of which 82.6 per cent (n=19) were reported as having history of mental health illness or suicidal/self-harming behaviour. Unfortunately, both the engagement and participation of mental health services as part of the multidisciplinary review processes was low, and as such no further information can be ascertained in relation to these findings.

Non-Fatal Drug Poisonings

Known service contact: Contact with services 6 months prior to incident was greater amongst non-fatal drug poisonings compared to fatal cases, with contact being reported in 66.4 per cent (n=71) of incidents. This indicates a little under a third of cases had not received contact with local services six months prior to incident (see *Figure 6*).

Of those cases in contact with services within 6 months prior to incident, 62 per cent (n=44) were last seen by a statutory and voluntary sector substance misuse service (including IOIS). Of which, 68.1 per cent (n=30) received contact within a month prior to the incident. **Individuals in regular contact with support services are likely to benefit from greater exposure to harm reduction advice and information, including access to fatal drug poisoning preventative measures such as Take Home Naloxone provision.**

Known substance history: Substance use was known and reported in 84.5 per cent (n=60) of non-fatal cases whom had been in contact with services six months prior to death. Of which 61.7 per cent (n=37), were reported to having used two or more substances. Compared to fatal cases, Heroin / Morphine use was reported more frequently amongst non-fatal cases, however, fewer were reported as having histories of benzodiazepines, stimulants, and alcohol use (see *Figure 9*).

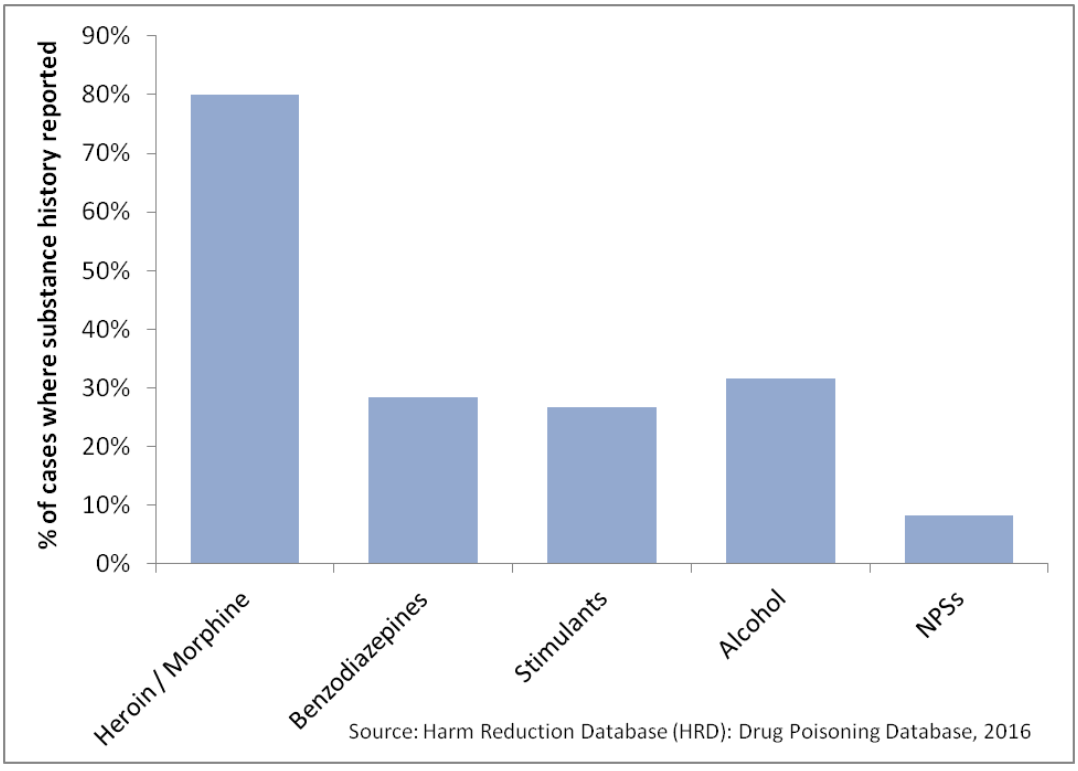


Figure 9: Proportion of non-fatal drug poisoning cases where substance history reported, by substance (n=60)

8. Toxicology and coroners findings

In line with the guidance published by Welsh Government, the HRD: Drug Poisoning Database provides functionality for the recording of both toxicology and coroner's findings as part of the review of fatal and non-fatal drug poisonings.

In order to better support timely identification of circumstances in relation to drug poisonings and the development of lessons learnt, reviews are initiated as soon after the incident as possible before any toxicology and coroner's findings are available. As such all reviews should be treated as 'suspected drug poisonings' until such information becomes available. The availability of toxicology and coroner's findings are therefore an integral part in the closure care reviews and identifying further recommendations.

At the time of writing this report only one area, Cwm Taf, had been in receipt of and recorded toxicology findings on the HRD: Drug Poisoning Database. Furthermore, coroner's findings were yet to be recorded for any case reviewed in Wales. This indicates a disjoint in information sharing between the case review processes and coroners / toxicology offices within Wales.

Recommendation 3

Welsh Government and Public Health Wales to work to establish a consensus seminar to better develop information sharing mechanisms between fatal drug poisoning review processes and coroners / toxicologists in Wales and work to agree standardised toxicology test requests. The seminar to include APB Drug Poisoning reviews, CRCs, lead coroners, police coroners officers, toxicologists, and pathologists.

9. Recommendations and actions following Reviews

The following recommendations and actions have been established following the multi-disciplinary drug poisoning reviews which took place during years 2014 and 2015. Whilst the majority of APBs conducted drug poisoning reviews during this time period, at the time of writing this report only one area, Aneurin Bevan, recorded subsequent recommendations via the HRD.

Recommendation 4

APBs should ensure that all recommendations generated during drug poisoning multi-disciplinary reviews are recorded on the HRD: Drug Poisoning Database. These should be clearly listed within sections 'Summary and Conclusions' and 'Recommendations and Actions' so that they may be used to support national reports, policy, and guidelines in relation to Drug Poisoning Prevention.

Partnership working, pathways and best practice

1. Those working within substance misuse services should be trained in better identifying signs and symptoms of mental health issues including depression, anxiety, and PTSD. Substance misuse services should ensure assessment processes include identification of suicidal risk factors e.g. symptoms of depression, prior suicide attempts, psychiatric co-morbidity, family and social difficulties and dysfunction. Furthermore, close working and communication links need to be ensured between community substance misuse services and mental health services.

2. Drug poisoning in relation to recent prison release has been identified as an area of concern within individual drug poisoning multidisciplinary reviews. Individuals released from custody with a Substance Misuse history are at elevated drug poisoning risk due to reduced tolerance levels should they relapse into previous patterns of use. Further work should be completed in order to ensure development of communication and joint working between custodial and community substance misuse services and primary care teams in order to ensure that the continuity of care following release.

3. APBs should ensure that local substance misuse services are promoted locally and accessible to wide range of substance user groups to ensure open and equal access to harm reduction, psychosocial support and clinical intervention.

4. APBs need to ensure that harm reduction approaches are coherent within Emergency Departments including provision of tailored advice, Take Home Naloxone training and where possible supply, and signposting to relevant support services. Information sharing protocols should be developed between Emergency Departments, local Drug Poisoning CRCs and community substance misuse services to support the non-fatal drug poisoning review process.

Drug Poisoning Prevention Messages and Take Home Naloxone Provision

1. Services should ensure further promotion and delivery of first aid/naloxone training for partners, family and carers of individuals experiencing non-fatal drug poisoning events.

2. Services should ensure promotion and awareness raising of issues relating to poly-drug use (including prescribed medication) and potential contra-indications.

3. All those at risk of opioid drug poisoning should be encouraged not only to access take-home naloxone but also to carry it / have it readily available

Access and engagement

1. APBs, CRCs to ensure adequate support is available for families, carers and friends of fatal drug poisoning cases and offer provision of appropriate bereavement support when required. Added support to be offered to those at scene of incident and who have themselves been identified as at risk of drug poisoning.

2. APBs should audit retention rates to reduce DNA's, tackle waiting times where they exist and ensure that effective support exists whilst clients await access to substitute prescribing

3. Review processes show early indications that engagement and contact with substance misuse services including drug treatment programmes is a protective factor against drug related mortality. Service providers should aim to offer outreach and engagement programmes in order to ensure services are accessible and equitable to hard to reach groups, including; the homeless, young people, individuals only in contact with pharmacy services, BAME and rural communities.

4. APBs and service providers should monitor and audit retention rates in order to reduce DNAs, tackle waiting times (where existing), and ensure regular contact and support is available whilst clients await access to substitute prescribing.

5. Services offering Needle and Syringe Programmes (NSPs) should ensure harm reduction advice and information is offered in relation to all substances used by the client and promote route transition options where appropriate.