
“Any drug-related death is a tragedy, and everyone agrees more needs to be done... review processes can make a vital contribution to this effort”

DRUG-RELATED DEATHS: **SETTING UP A LOCAL REVIEW PROCESS**

Drug-related deaths: setting up a local review process

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About this document

Who is it for? People who commission and plan the strategic response to drug misuse. This includes service commissioners, members of joint commissioning groups, and those working in local drug partnerships, primary care trusts and other local public health services. Service providers may find it useful in considering their own investigative processes into drug-related deaths.

What is it about? The document contains ideas and examples of local practice in investigating and reviewing the causes of drug-related deaths. All are drawn from existing local systems in England. The document also takes partnerships through the chain of decisions they will want to consider in setting up their own review processes within their existing organisational frameworks.

Partnerships may find it useful to have review processes to investigate, and learn lessons from, drug-related deaths. This document can help by offering real-world examples and advice on what to consider. However the advice in this document does not promote one system as better than another, and what works well for some local areas may not work as well in others.

Methodology: The material in this report is drawn from interviews with 14 local drug partnership areas, plus written material from a further six. All were nominated by NTA regional teams as helpful examples of partnerships running review processes for drug-related deaths. Appendix one lists the areas reviewed. The research and drafting was carried out on behalf of the NTA by Mike Ward, an independent consultant. A steering group oversaw the process. Its membership is set out in Appendix two.

Acknowledgements: The NTA thanks the partnership representatives and NTA regional leads who took part in the research, and the members of the steering group.

Terminology: 'Review process' is used throughout as a convenient term to cover the range of procedures that exist, from confidential inquiries based on statistical data analysis alone, to drug-death reviews that involve elements of evidence and investigation.

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PART ONE

1. Introduction

The numbers of drug related deaths in England grew steadily up until 2001, as the heroin epidemic that started in the 1980s took its toll of injecting drug users. Since then, the number of deaths reduced before a slight rise in recent years, although the latest figures from the Office for National Statistics show a slight decline. Before publishing the 2009 figures, the ONS reviewed its codes for these deaths, resulting in significantly revised figures for 2007 and 2008. These figures show us that even though drug related deaths haven't continued at the same pre-2001 upward rate, the number of deaths is still too high [Fig 1].

Any drug-related death is a tragedy, and everyone agrees more needs to be done. The fastest rise in recent years has been among older, male heroin users. This group is increasingly vulnerable to the adverse effects of risky drug-taking behaviours. Prolonged heroin use causes chronic physical and psychological problems. It is not surprising, therefore, that as entrenched users get older they become more susceptible to infectious diseases such as HIV and hepatitis, collapsed veins and abscesses, liver or kidney disease, and pulmonary complications including the various types of pneumonia that result from depressing effects of heroin on the respiratory system. Alongside these risks, heroin use over a long period of time increases the risk of drug-related death.

A review process can also provide an insight into local treatment practice, which may drive further improvements in that practice.

A range of agencies, from the police to treatment providers, are now working to reduce the number of drug-related deaths. Review processes can make a vital contribution to this concerted effort.

For East Riding Drug and Alcohol Action Team, the benefits of a review process have been evident:

"The review process makes people more mindful of the risks and consequences for their clients. It improves practice, the learning points are taken to heart and it is safeguarding clients."

More partnerships adopted review processes after the 2003 publication of the Department of Health's *Guidance for drug*

action teams on developing local confidential inquiries into drug related deaths. However, there are still areas that have no process or have one that could be revitalised.

This document is a direct successor to the 2003 guidance and aims to replace it and enhance the advice offered to partnerships.

2. What is a review process?

"The aim is to prevent and reduce drug-related deaths. If you are not doing that, it is a waste of time." (Cornwall)

A robust review process can help partnerships learn more about the events leading up to a drug-related death and take suitable measures that might prevent them from happening again.

The review processes in local areas draw from the two main approaches found in the field:

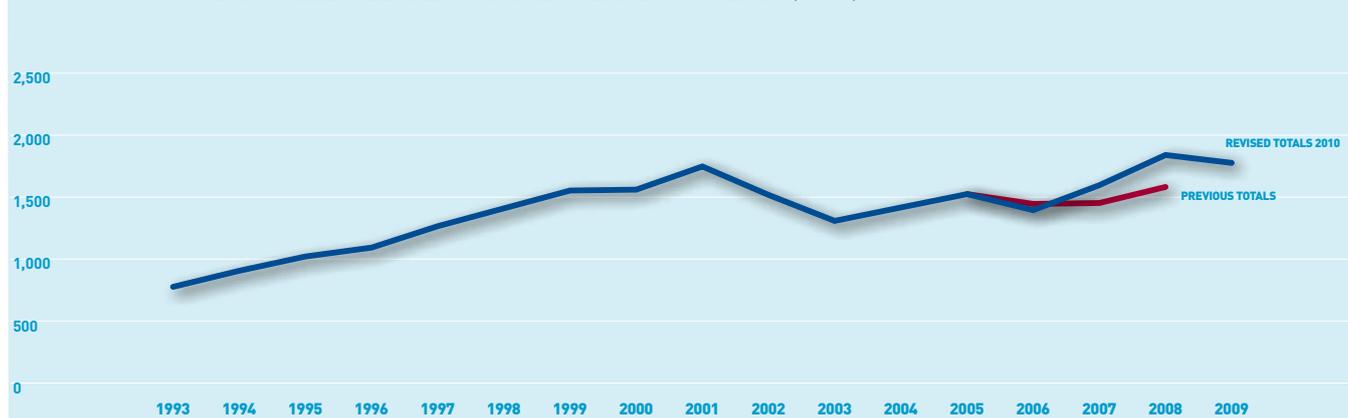
- confidential inquiries based on statistical data analysis
- drug-death reviews involving specific evidence-gathering and investigation.

The confidential data inquiry: this focuses on gathering and analysing statistical data. It attempts to establish an accurate number of drug-related deaths and, from the available data sources, to analyse reliable information about their causes, changes in trends and the emergence of relevant new drugs or new ways of using drugs locally.

The drug-death review: this is a more investigative process. It involves receipt of reports on individual cases and an analysis of the narratives found. It attempts to identify ways to improve services, remedy system failures, develop opportunities for shared learning, and challenge and change practices through interpretation of the details of individual cases and groups of cases.

Most review processes contain elements of both these approaches. Drug-death reviews require more detailed information gathering and robust information sharing, whereas confidential data inquiries require expertise in statistical methods. The final structure of any review process will reflect the degree

FIG 1: DRUG RELATED DEATHS IN ENGLAND 1993-2009 (ONS)



to which it favours one or other of these procedures. Therefore partnerships looking to develop or revamp a review process may want to consider what procedures will best help them achieve their aims before devising an appropriate system.

3. How to build a review process – a summary

When developing a review process, partnerships may find it useful to ask themselves the following series of questions and to consider the issues that each individual question raises. This summary brings together the key points emerging from the research conducted among partnerships with working review processes.

Full details on each point can be found in the next section of this document, along with quotes and cases studies from the partnerships involved in the review.

What is the purpose of the review process?

- Some partnerships take a quantitative, confidential inquiry approach that seeks to obtain a robust set of statistics
- Others adopt a more qualitative procedure that explores aspects of service practice and delivery before a drug-related death
- Most review processes take elements of both approaches.

What defines a drug-related death?

- A definition is essential. Most areas use the Office for National Statistics definition: *A death where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are used*
- Some partnerships use a local definition that includes a wider range of causes, such as volatile substance abuse or drug-related homicides
- The actual cases that go to review may be only those that offer the best opportunities for learning
- Most deaths reviewed are acute cases, usually overdoses, where the cause and effect is easier to link than those involving long-term physical decline
- Acute deaths also involve more agencies, such as the police, and provide more data
- Another option is to review non-fatal overdoses, though most partnerships choose not to.

Who leads the review process locally and who are they responsible to?

- A lead officer for reviewing drug-related deaths is a common feature and can ensure consistent focus, though one lead's experience may vary from another's depending on their professional background
- The officer often analyses data and drafts reports. This approach is simple, but offers limited expertise. Can a consultant psychiatrist, for example, clearly scrutinise the way police handled the scene of death? Can a police officer meaningfully scrutinise the clinical decisions of a psychiatrist?
- Is the overseeing group in a position to identify and analyse such matters?
- Most partnerships have a drug-related death group or a harm reduction group that sits within the partnership, PCT or

community safety framework. These groups are typically chaired by joint commissioning managers, public health directors, partnership clinical governance leads or PCT medical directors

- Good practice suggests a management framework is needed, but what works well in one area may not work well in another.

Which agencies are engaged in the review process?

- Review processes may involve a wide range of agencies and individuals, who either provide information or work on steering groups
- Larger groups offer better insight and wider dissemination of findings, but also pose more challenges when it comes to sharing information
- The sort of groups and individuals who have been involved include service users, children's services, drug treatment providers, police, probation, prisons and mental health services.

Have information-sharing and confidentiality issues been addressed?

- Every review process needs a procedure for sharing information on drug-related deaths. However, different agencies may have different interpretations of the law on what can be shared, when and with whom.
- Securing the next of kin's agreement is often a good way to avoid problems
- Other ways include an information-sharing protocol between agencies; taking information primarily from coroners' files; asking the coroner's office to request information from NHS agencies
- It is important to consult NHS Caldicott Guardians when setting up a review process.

Are links being developed with neighbouring areas?

- Some partnerships run a joint review process, others prefer to work alone
- Working jointly can mean more deaths to review, better opportunities for learning, wider expert opinion and possible economies of scale
- Some partnerships perceive drawbacks to joint processes, feeling the solitary approach better suits the large urban or county areas they cover, that their drug-related problems are unique, and that it eases information sharing.

Has the coroner been engaged?

- Involving the local coroner can greatly enhance a review process
- Local coroners tend to support review processes in principle, and usually offer at least some access to records
- Day to day contact is often via the coroner's officers
- Some coroners are unwilling to engage. In this case, partnerships will need to consider other ways of identifying deaths and obtaining information about them.

Are other agencies notifying deaths?

- Other agencies can notify deaths instead of (or as well as) the coroner. The most common alternative sources are the police and drug services
- Some partnerships have a specific form for reports of drug

deaths. Others receive direct calls or emails

- Other potential sources are A&E units, the ambulance service and even local newspapers, though reliability is not guaranteed and additional checking may be needed
- Another possible approach is to require reporting as part of service provider contracts.

How does the review process relate to other, similar processes?

- Mental health trusts and other bodies have processes for investigating critical incidents involving violence or self-harm
- The most common are serious untoward incident (SUI) processes. SUIs review drug-related deaths within trusts and can identify drug-related aspects in other incidents
- Most partnerships try to avoid duplicating these processes, but look to learn lessons from them
- Drug-death review groups often receive anonymised recommendations from relevant SUI reports.

How does the timing of the review process relate to the coroner's verdict?

- Most partnerships wait until after the coroner's verdict before launching a review. This ensures they review only confirmed drug-related deaths
- Some areas start earlier, usually when rapid action is needed to change the way things work
- A problem with waiting for a coroner's verdict is the time lag: more than five months in some cases.

Is it a 'no blame' or 'fair blame' system?

- The review process may uncover poor practice by a member of staff, but all partnerships describe their systems as 'no fault' or 'no blame'
- In reality, most partnerships recognise reviews might identify negligence, so have a procedure for managing such situations
- This makes their systems more akin to those usually described as 'fair blame', which is a more realistic approach
- Incidents would generally be notified to appropriate managers within the relevant agency.

Are face to face interviews or written data-gathering methods used?

- Most review processes are based on written material, including completed forms, inquest documents, files and internal reports
- Only a few systems interview staff face to face about the deceased.

Are people involved in investigative processes appropriately skilled?

- No specific or standardised training exists for those undertaking review processes, although all of the leads interviewed are experienced in conducting investigations and this would seem to be a minimum requirement
- Lead officers have a range of skills, including conducting SUIs, root-cause analysis and qualitative research methods
- The lead needs a broad understanding of the effects of drugs and the principles of harm reduction, or the overseeing group

should provide extra support

- Leads also need to be able to work effectively with a wide range of people, including professionals and families.

Are relatives/carers involved?

- Relatives and carers of the deceased may be involved in investigations which contribute to the review process, but none of the partnerships interviewed currently involve relatives or carers of deceased drug users in the review process itself
- Involving relatives and carers can add an important key perspective to the process and may be increasingly expected of an NHS which has committed to working in partnership with families and carers (NHS constitution, 2010). It may also ease information sharing if the next of kin release notes
- The process may be emotionally hard for families, making it difficult to maintain a 'fair blame' approach and causing services to resist sharing information.

How are the findings to be reported and disseminated?

- Partnerships keep a record of findings and recommendations, ranging from the minutes of the meetings to public reports. Some publish an annual report, others send details to the coroner
- Internally, the findings tend to be disseminated by agencies, along with members of the drug-related death or harm reduction groups.

How are proposed actions reviewed?

- Partnerships have a variety of structures for monitoring review processes and the action that emerges from them. Often the lead officer reports to the steering group on progress
- Recommended actions from a review process can be written into treatment plans.

PART TWO

1. How to build a review process

What definition of drug-related deaths is used?

A definition of the type of death to be reviewed is essential. Most areas interviewed used the Office for National Statistics definition:

A death where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved.

However, some partnerships use a local definition, which gives them the opportunity to include a wider range of deaths, such as volatile substance abuse cases or deaths in cars while intoxicated. Birmingham reviewed the case of a man who was stabbed to death but was found surrounded by drug paraphernalia.

The definition used to identify drug-related deaths may differ to that used to decide what deaths go to a review. Local partnerships may well not review all deaths, but rather those that offer the most (or specific) learning opportunities.

In general, the deaths reviewed tend to be acute incidents, usually overdose. This is because the links between cause and effect are easier to trace in an acute incident than in a death that involves several years of physical decline. Acute deaths are also likely to require the resources of more agencies, such as the police or ambulance service. Nottingham and Nottinghamshire also review deaths from bacterial infections, although they can experience difficulty in obtaining this information.

Most partnerships were not looking at 'near-miss' non-fatal overdoses within the drug death review process but this is an option that can be considered. Three partnerships reported action on this, but none within the drug death review system itself.

East Sussex: *"We have just introduced a programme to look at near misses. We have a form with the ambulance service. It has just started and we have had no cases so far. The form will go to a treatment service for them to make contact with the person who overdosed... we will also gather data on the number of near misses and the number who then enter treatment services."*

East Riding: *"We have just had a discussion about near misses with the accident and emergency unit. At the moment we don't receive that sort of information because of the lack of a data sharing agreement, the trust is now considering whether to review this. A substance misuse liaison nurse at the hospital is now in post to pick these up and make contact."*

Who leads the process locally and who are they responsible to?

Cornwall and Leeds have each appointed a dedicated drug-related death investigation officer. Having a dedicated post ensures a consistent focus on the issue. Beyond that, no evidence emerged about where the leadership was best placed.

The partnerships interviewed had all identified a lead officer for the review process. However, actual practice varied greatly. Local leads included:

- Consultant psychiatrist
- Community safety officer
- Service manager
- Joint commissioning manager
- Partnership clinical governance lead
- Partnership coordinator
- Partnership harm reduction lead
- Public health specialist.

In many systems the lead officer is the main person analysing data and drafting reports. This is a simple system but has the disadvantage that only one area of expertise is brought to bear on the information. Will a consultant psychiatrist identify issues about how the police handled the scene of death? Will a community safety officer pick up connections between the death and other health problems suffered by the deceased? If a single lead is to review the data, it is important to ensure those overseeing the process have the opportunity and expertise to identify these links.

The leads will be responsible to a particular group. In most of the partnerships reviewed this is either a specific drug-death group or a harm-reduction group. These groups are chaired by joint commissioning managers, directors of public health, partnership clinical governance leads or medical directors of the PCTs, and they tend to sit within a partnership, PCT or community safety framework.

It is impossible to say which of these approaches is the most effective. However, effective practice requires some form of management framework, i.e. oversight of the process and links into other agencies or other parts of an organisation.

What agencies are engaged in the review process?

A wide range of agencies and individuals may be involved in reviews, either as sources of information or members of steering groups. The list below summarises the range of participants identified as group members around the country. Larger groups offer the benefit of better oversight and wider dissemination of findings. However, one point to note is that in larger groups information-sharing may become more challenging.

- Service users
- Children's services
- Drug treatment providers
- Public health
- Police
- Probation
- Ambulance service
- Prisons
- Pharmacy
- Social care
- Drug Interventions Programme

- Mental health services
- Hostels and other homelessness services
- Hepatitis C/blood-borne virus nurses
- Sexual health project
- Primary care
- Fire service
- Young people's substance misuse service
- Specialist substance misuse midwife
- Health Protection Agency.

Leeds reported having advisory members who did not attend the group meetings but who could be asked to inform the process. These comprised the coroner and a representative each from the NTA and the accident and emergency unit. It was reported that the coroner's membership added status to the group and encouraged other people to join.

Have information sharing/confidentiality issues been addressed?

Information sharing arrangements will have to be in place between all parties to the review. This has presented problems in a number of areas because different agencies have interpreted the law around information sharing in different ways. Some NHS trusts have refused to share information without permission from the next of kin. Partnerships identified the following concerns:

"This issue has rumbled on and the review leads have had to leave the acute trusts aside and are simply doing it within the existing organisations. The mental health trust has signed up. We are now going out to secure agreement with individual organisations. We have had information from GPs in the past but it has not been consistent."

"The main problem has been how to send out the information collection proforma. But we came to an agreement with the PCT clinical governance lead about how to share it."

"In some NHS services the Caldicott Guardians have been extremely unwilling to share information unless it was at the request of the family or the coroner."

"We have had problems with the mental health trust who feel that the SUI covers this responsibility. We can get reports via the coroner but are not getting direct cooperation."

"One GP invoiced us £45 for supplying information."

"We cannot access data from GPs. However, we do receive information from the hospital."

Securing the agreement of the next of kin is the surest way to avoid problems (see 'Are relatives/carers involved?' on page 9). Partnerships identified various other means to ease the process:

- An information sharing protocol between agencies, e.g. Cornwall
- Gathering information from coroners' files, e.g. Nottingham and Nottinghamshire

- The coroner's officer sending out the information requests to NHS agencies on behalf of the partnership, e.g. East Riding.

The legal framework for sharing, and even transmitting, information about a deceased person is complex and partnerships will need to consult with all partners to establish the boundaries for the process. It will be important to consult Caldicott Guardians within the NHS when establishing review processes.

Are links being developed with neighbouring areas?

The research identified areas where multiple partnerships were working together on a joint review system. These included the South West Peninsula and Teesside. Other systems worked across two neighbouring partnerships, e.g. Leeds and Wakefield, who have different systems but the same investigator, and Nottingham and Nottinghamshire.

Working with other areas has the benefit of providing a larger sample of deaths to review. This can increase the potential learning, and introduce economies of scale and a greater range of expert opinion to the process. These benefits may be particularly important for smaller partnerships. Other motivations are that the same coroner covers adjoining areas or that treatment services are shared.

However, single partnership processes operated in the majority of areas reviewed. This was because disadvantages were perceived in joint processes. In some cases the unitary approach was felt to be appropriate because the partnerships covered large urban or county areas. In other places it was felt local problems were unique or different to neighbouring areas. Indeed one partnership felt having its own system worked better than a previous shared system because partners were more willing to share information.

Has the coroner been engaged?

The majority of partnerships reviewed had engagement with their local coroner, although none were actually involved in the detailed process. In general the relationship focused on support for the principle of the review and varying degrees of access to the coroner's records.

Those partnerships with involvement stressed how much this eased the process:

East Sussex: *"We have full access to the coroner's data. We receive a notification and inquest report from the coroner and have unrestricted access to the files."*

Nottingham and Nottinghamshire: *"The coroner was invited to sit on the group but decided because of time constraints he could not do it. He has supported the process and we have free access to the files. The coroner does not alert the partnership to the deaths: they are generally identified by primary reporting from the police and the provider agencies. However, the partnership lead goes to the coroner's office on a quarterly basis and checks the day book to ensure we have not missed any deaths."*

East Riding: *“The coroner’s involvement has made the process a great deal easier. In some NHS services the Caldicott Guardians were unwilling to share information unless it was at the request of the family or the coroner. At the beginning we had to contact families. This was not popular, but now the coroner’s officer sends out the information request to NHS agencies and this smoothens the partnership.”*

Leeds: *“The coroner is engaged and fully supports the process... he gave unfettered access to the files.”*

Brighton: *“The coroner keeps her own tallies as she does for all sorts of other deaths. The drug death review lead goes to the coroner’s office about once every couple of months.”*

Cornwall: *“The drug death review lead is invited to every drug-related inquest. The coroner is also asking the lead to come to some alcohol related deaths. Protocols are in place to cover this.”*

In many cases, partnerships had day-to-day contact with coroner’s officers, who can be an important link in the process.

However, some areas had no contact with the coroner. No mechanism exists to compel coroners to cooperate. They have the right not to participate in review processes. Files from inquests are the property of the coroner and they control how they manage this information. If a coroner is unwilling to share information, partnerships will need to consider other means of identifying deaths and acquiring information on the deceased.

Are other agencies notifying deaths?

Other agencies can also notify deaths. In some cases, this is instead of coroner notification; in others, alternative notifications work alongside the coroner’s information.

The main other agencies that have been reported as notifying deaths in some areas are the police and the local drugs services. Some partnerships have a specific form for reporting. In others, these agencies have been expected to email or call the lead officer. In Blackpool, the police notify the lead via a regularly updated spreadsheet or monthly report.

One partnership had attempted to secure reporting from prisons, the accident and emergency unit, and the ambulance service, but was receiving little from these sources. Another area used the local newspaper as an additional source of information.

No examples were found of a requirement to report being included as part of service provider contracts. While this is an approach that could be considered, it would be likely to require consideration of suitability by the local Caldicott Guardian.

As part of the operation of their local review process the local drugs partnership may seek agreement from all partners in the process that they will share news of a death as part of appropriate data sharing arrangements. East Riding provides an example of such an agreement.

How does this process link to, and avoid duplication with, other review processes?

A number of acts of violence or self-harm are subject to inquiry processes, which include:

- Part 8 child death reviews
- Internal serious untoward incident (or critical incident) processes in mental health services (covering homicides, suicides, violent acts and serious self harm)
- Independent mental health homicide inquiries
- Inquiries into homicides related to domestic violence.

Where possible, it would be advisable for partnerships to:

- Avoid duplication with these processes
- Seek to learn relevant lessons from them.

Of these the most relevant, because they are most frequent, are Serious Untoward Incident (SUI) or Critical Incident processes within local provider services based in mental health trusts. It is reasonable to expect that SUIs will review drug-related deaths occurring within trusts and have the expertise to identify drug-related aspects in other incidents.

In East Sussex the link is secured because the lead for the review process is a local consultant psychiatrist who is automatically involved in SUIs.

In Nottinghamshire, if a drug user dies, while under the care of drug services provided by the local mental health trust or PCT, the Confidential Inquiry Review Group (CIRG) researchers will use the findings of the trusts’ own Serious Untoward Incident investigations, to avoid duplication of work.

Plymouth has a DAAT SUI policy that all providers are expected to adhere to, that is co-owned with the PCT. In a recent joint review with mental health services, the DAAT investigated the substance misuse elements, and the mental health services reviewed the mental health elements to provide a joint report of findings and recommendations. The DAAT can lead the SUI process if the deceased was in drug treatment.

In Cornwall, the DAAT officer investigates every single drug-related death and the subsequent report is considered as part of the SUI process.

At the least, it is reasonable to expect that drug-death review groups will receive anonymised recommendations from relevant SUI reports.

The other inquiry processes mentioned above are far less frequent than SUIs but partnerships will want to be aware of the possibility of learning from such inquiries.

How does the timing of the process relate to the coroner’s verdict?

A small but significant issue is how the timing of the review process relates to the coroner’s verdict on the case.

The majority of partnerships contacted wait until after the coroner's verdict before launching a review. The advantage of this is that it avoids reviewing deaths that the coroner concludes are not drug-related.

Blackpool: *"If it was done pre-inquest at least a third would not be our cases because the coroner comes up with a different verdict."*

However, some areas, e.g. Leeds, Lincolnshire and Birmingham, see an advantage in an earlier or 'hot' review process. In some cases it may be felt there is a need for rapid action to change the way things work. The Leeds process delivers findings within 10 weeks of the death, which is the time it takes for toxicology reports to be available. East Riding can call a meeting within a fortnight of a death being reported.

A particular problem with waiting for the coroner's verdict is the time lag involved. Partnerships interviewed reported waits of four to five months or longer.

In Cornwall the partnership lead officer is more closely involved in the inquest process itself and can make suggestions to the coroner about a case.

Is it a 'no blame'/'fair blame' system?

Every partnership contacted described its system as a 'no fault' or 'no blame' system. Birmingham commented that this *"helped to get people on board in the first place."* Cornwall, Devon and Plymouth said: *"We emphasise training needs rather than blame."*

In absolute terms these cannot be 'no blame' systems. The guidance document: *Clinical governance in drug treatment: A good practice guide for providers and commissioners* (NTA 2009) talks about this as 'fair blame':

"It is an important principle of effective clinical governance that encouraging an appropriate culture of openness underpins the approach to dealing with untoward incidents. This is sometimes referred to as a 'fair blame' culture. While this does not remove or replace appropriate accountability for poor practice or negligence, it is an approach that anticipates that errors are inevitable in human practice and in organisations."

In reality, most partnerships recognised that reviews might identify negligence, though only one had identified an issue that came close to negligence. So a process needs to be in place for managing such situations. In general it was reported that incidents would be notified to appropriate managers within the relevant agency.

Are face to face interviews or written data-gathering methods used?

The majority of review processes do not gather data through interviews with workers. Most are based on written materials: completed forms, copies of materials from the inquest, file material or reports from internal inquiries. Two systems were identified (Leeds and Cornwall) where staff, such as drug service workers, were interviewed face to face about the deceased.

Are people involved in investigative processes appropriately skilled?

The focus here is on the skills of the individual leading the review process but, as one partnership made clear, the whole review group contributes to the investigation so the combination of required skills may be found in different individuals.

No specific or standard training exists for undertaking drug-related death reviews. In the partnerships reviewed the leads had a range of backgrounds and training: two leads were former police officers, one lead had training in SUIs, and two had training in root-cause analysis. Other training included qualitative research methods.

All of the leads interviewed were experienced in conducting investigations and this would seem to be a minimum requirement. Some groups had considered the competencies required of their leads and identified training needs which they planned to address.

It will be important to ensure those leading the process have either a broad understanding of the response to drugs as well as the principles of harm reduction, or that the group overseeing the process can provide additional support.

Leads also need to be able to work effectively and sensitively with a wide range of people, including professionals from a range of different disciplines and members of the public, perhaps including the families of the deceased. The police, for example, receive training in how to handle recently bereaved people and deal with them sensitively.

Are relatives/carers involved?

Relatives and carers of the deceased may be involved in investigations which contribute to the review process, such as coroners' inquiries or SUIs, but none of the partnerships interviewed involved relatives and carers in the review process itself. However, in Derbyshire the police recommend a local service for the family of drug users as a support to the relatives of the deceased. In those systems where the lead attends the inquest, such as Cornwall and the East Riding, family members may be encountered although they are not subsequently involved in reviews.

Involving relatives and carers is complex, and it is recommended that partnerships carefully consider how they approach this issue. Involving relatives and carers may add an important perspective to the process and may be increasingly expected of an NHS which has committed to working in partnership with families and carers (NHS constitution, 2010). It may also make information sharing far easier because next of kin can give permission for the release of notes.

However, under these circumstances it may be harder to maintain the 'fair blame' approach and services may be more resistant to sharing information. Moreover, the process may be emotionally difficult for family members.

How are the findings to be reported and disseminated?

Partnerships will want to keep some record of findings and recommendations. In the partnerships reviewed, records ranged from the minutes of the meeting to a public report. Brighton has been publishing an annual report for the past seven years. Nottingham and Nottinghamshire produce an annual report, which is sent to local commissioning bodies and distributed to relevant individuals and organisations.

Dissemination tends to be either via the members of the drug-related death or harm-reduction group or via agencies. East Sussex presents the report to agencies and their staff and then it goes to the coroner. Derbyshire expects individual agencies to take responsibility for feeding back learning to their own organisation. In Brighton, data also feeds in to the needs assessment.

How are proposed actions reviewed?

A variety of monitoring structures were identified. Often the lead officer reports to the steering group on progress. In Birmingham the lead reports back to the drug-death group. In East Sussex, the joint commissioning manager takes the recommendations and works on them. They can be written into the treatment plan. Local leads also look back at the inquiries to see what has happened.

2. Processes in action

Each partnership consulted had developed review processes in different ways. Aims, methodologies and outputs all varied. This document is not promoting one system as better than another. This section simply highlights examples of how partnerships have put these systems into operation. East Sussex offers a comprehensive process that addresses the majority of the issues raised above. Derbyshire is included as an example because it uses internal inquiry processes to provide the drug-related death group with information for its reviews. Lincolnshire runs an example of a 'hot' review process: the reviews take place within a fortnight of the death.

East Sussex

East Sussex's process has two leads (a psychiatrist and a community safety officer) that are responsible to a specific drug-related death steering group, which in turn links to the local DAAT. Notification of deaths comes from the coroner who supports the process.

After the coroner has notified the leads of five or six deaths an appointment is made to visit the coroner's offices. This happens quarterly to half yearly. A standard form is used to gather quantitative and qualitative information from the coroner's records.

The leads look to see if the cases fit the local definition of a drug-related death and then seek further information. A standard letter is sent to the deceased's GP seeking information. They also look at health records and, if

appropriate, contact prisons to gather further information. The police have a form to submit information for each suspected death. The leads also check if any children are involved and then contact children's services.

The leads review the evidence and write a report on lessons learned and recommendations. The draft report goes to the drug-death group for discussion. This final report is sent to the DAAT board, to local services and the coroner. The joint commissioning manager uses the recommendations in planning.

The drug-related death steering group looks back at past inquiries to see what has happened on any recommendations.

Derbyshire

Derbyshire's process is led by the DAAT clinical governance lead who is responsible to a drug-death group, which in turn is responsible to the joint commissioning group (JCG).

Notifications come to the DAAT via the police on a specifically designed form.

The drug-death group meets bimonthly. Before, members receive the proforma on each death, giving the opportunity to check whether their agency knew the deceased and whether they have any further information. Services share information and any initial findings at the meeting. However, it is expected that a service's own SUI process will then take over and the group will wait for that to be completed and report back. Recommendations come from the service investigations or to a lesser extent via the discussions in the group.

Provider summaries are incorporated in reports for the DAAT board, and the information on the lessons learned is disseminated to clinical groups as appropriate. Providers also feed back learning to their own organisation.

Lincolnshire

In its most recent review, the lead was notified of the death by a local drugs agency within 24 hours. Agencies are required to notify the DAAT. The next week the DAAT hosted a two-hour meeting to look at what had happened. The attendees were determined by who was involved with the client, based on the provider agency's information. The outputs were the minutes of the meeting. These go to the drug reference group and to the JCG. The DAAT expect to have a performance-assurance review group with the provider to pick up on actions.

3. The benefits

Those partnerships running review processes could all identify real benefits:

Cornwall: *"It has highlighted various gaps and problems in the network and system of services. There is also recognition of good practice."*

Brighton: *"Drug-related death rates have come down. Intelligence has been improved and we can identify trends or hotspots."*

Plymouth: *"The review process has developed a joint approach and created collaborative working."*

Leeds: *"The review process has contributed to an overall reduction in deaths... It has also raised significant interest and attention."*

The examples in the previous section highlight there is no single right way of running a review process. The purpose of this document is to encourage each partnership to choose an approach that best suits their local needs. The biggest loss would be not to have a process and to lose the vital information that can be gathered from drug-related deaths.

APPENDIX ONE: LIST OF PARTNERSHIPS CONSULTED

- Birmingham
- Blackpool
- Brighton
- Cornwall
- Devon
- Derbyshire
- East Riding
- East Sussex
- Leeds
- Lincolnshire
- Nottingham
- Nottinghamshire
- Plymouth
- Teesside

APPENDIX TWO: MEMBERSHIP OF THE STEERING GROUP

- Dr Alastair Boyd (medical officer, Department of Health)
- Dr John Dunn (consultant psychiatrist and clinical team lead, NTA)
- Mike Flanagan (consultant nurse in addiction, Surrey & Borders Partnership NHS Foundation Trust)
- Dr Linda Harris (clinical director, primary care substance misuse, Wakefield Integrated Substance Misuse Service)
- Michelle Judge (harm reduction officer, NTA)
- Hugo Luck (national programme lead, policy, NTA) (chair first meeting)
- Emily Makin (risk coordinator, Turning Point)
- Neil O'Byrne (drug-related death investigator, Leeds & Wakefield)
- Beverley Oliver (regional manager, North East region, NTA)
- Si Parry (coordinator, M.O.R.P.H.)
- Dr Mark Prunty (senior medical officer for substance misuse policy, Department of Health)
- Dr Penny Schofield (clinical team GP, NTA)
- Steve Taylor (programme manager, skills and practice development team, NTA) (chair)
- Sue Tutton (coordinator, M.O.R.P.H.)
- Marion Walker (clinical team pharmacist, NTA)