Brighton & Hove
Audit of Drug Deaths 2024

Public Health Team

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Acknowledgements

Coroner's office

This audit involved reviewing and extracting information from Coroner's inquest reports in Brighton & Hove. We would like to thank Senior Coroner Penelope Schofield and her team for their support and help during this process.

The West Sussex Audit

We undertook the audit using a similar process to that used in the 2019 West Sussex Drug Related Death Audit[1]. The West Sussex audit used Coroner data to compile a dataset to analyse and identify themes and trends. We used their experience to inform our process and would like to credit them here, with particular thanks to Robert Whitehead, Senior Research Officer.

People who died

In undertaking the audit, the team learnt about the lives and experiences of people who died.

We want to ensure that, alongside the learning from the audit to help reduce drug deaths, this report also acknowledges their lives. One of the ways we could do this was by recording some of the personal comments we came across in the audit.

they had a brilliant sense of humour

a lovely person

a very talented musician

loved their family, especially their kids

they spent hours reading books

was passionate about their work,
ensuring voices were heard

a creative intelligent person

loyal and considerate to family, friends and colleagues

always put the needs of others before their own

a loving child who had been caring for their parent

dearly loved their Mum & Dad

Contents

Definitions and limitations

Definitions

The terms drug poisoning, drug related death, and drug misuse death are often used interchangeably, but have different definitions and inform different data collection opportunities.

For the purposes of the audit we used the Office of National Statistics (ONS) definition[2] of a drug poisoning death so we could capture details of all drug deaths including for people who died by substances not controlled under the Misuse of Drugs Act (1971)[3]:

- Deaths involving a causal link with drug dependence, use of illegal drugs or misuse of prescribed drugs. They include deaths stemming from drug abuse and dependence, including accidents and suicides involving drug poisonings, and complications from drug misuse such as deep vein thrombosis or septicaemia from intravenous drug use
- Accidental or intentional self-poisoning, undetermined intent of poisoning involving any substance controlled under the Misuse of Drugs Act[4]
- Deaths caused by accidental or intentional self-poisoning, undetermined intent of poisoning involving any medicinal or clinical substance NOT controlled under the Misuse of drugs act 1971
- Any other death where the persons use of drugs was directly related to their death, including such deaths as falls from height, but excluding motor related deaths.

The Office for Health & Disparities (OHID) collects data on deaths from drug misuse where the "the underlying cause of death [is] mental and behavioural disorders due to psychoactive substance use (excluding alcohol, tobacco and volatile solvents… and… where a drug controlled under the Misuse of Drugs Act (1971)[5] was mentioned on the death record"[6].

Coroner terminology

At the close of an inquest, the Coroner will conclude by determining type of death. We reviewed the following inquest conclusions and identified those which met the ONS definition of a drug death.

For the purposes of this report the analyses reflect the whole audit population unless otherwise specified.

Table 1 summarises the different conclusions and how we applied them to the audit.

Coroner's conclusion	Description
Drug related death (DRD)	A death caused by legal or illegal drugs, complications relating to intravenous drug use, or chronic drug use.
Alcohol & drug related death	A death caused by a toxic combination of alcohol and legal or illegal drugs
Accidental death	The Coroner determines the deceased took no unreasonable or wilful risks related to their use of drugs.
Misadventure	Similar to accidental death, but the distinction is the deceased deliberately undertook an action involving drugs that resulted in their death.
Suicide	A death where, on the balance of probability, the deceased intended to take their own life through use of drugs.
Narrative	For more complex circumstances, the Coroner will set out the facts of a death in more detail, often including more information on the circumstances of the death.

Population data

When calculating rates against population data we have used the 2022 Office for National Statistics (ONS) Brighton & Hove Mid-Year Population Estimates for 2022, unless otherwise stated.

Where number of cases are fewer than five, we have not included the data or we have reflected this as 'fewer than five' according to data protection guidelines.

Limitations of the data

We were only able to gather data that was used by the Coroner at the inquest. Some of these data are incomplete and we were unable to capture comprehensive information on offending behaviour, asylum seekers, religion, veteran status, care experience, neurodiversity, and sexual orientation.

Covid-19

Several of the people who died that had a Coroner inquest recorded during the period 1st April 2020 – 31st March 2023 occurred during the covid pandemic. The covid restrictions in place affected some of the opportunities for face to face treatment and recovery service provision.

Suicide audit

The drug death audit is intended to be the first of two audits by Brighton & Hove City Council. The second audit will focus on deaths by suicide and undetermined injury in the city. There were 27 people in this audit who died from a drug-related suicide, and as such will contribute to the learning in both audits. The two audits will provide a rich data source to draw learning and recommendations for preventing future death from both workstreams.

Introduction

In December 2021 the UK government launched "From Harm to Hope, a 10-year drugs plan to cut crime and save lives"[7]. The plan sets out three core priorities:

1. **Break drug supply chains**
2. **Deliver a world-class treatment and recovery service**
3. **Achieve a generational shift in the demand for drugs.**

There are several aims in the national strategy including the ambition to reverse the upward trend in drug deaths.

In response to the national strategy Brighton & Hove City Council (BHCC) in collaboration with partners, established the Combatting Drugs Partnership (CDP).

The purpose of the CDP is to bring together local partners including in enforcement, treatment, recovery, and prevention to provide oversight and direction to the development and delivery of a combatting drugs strategy and delivery plan for Brighton and Hove.

The partnership will assure a whole system approach to delivery of a combatting drugs strategy against all three pillars of the national strategy.

This audit was conducted to understand better the increase in drug deaths in Brighton & Hove to inform a collaborative approach, across all services, to reduce the number of drug deaths.

Headline results

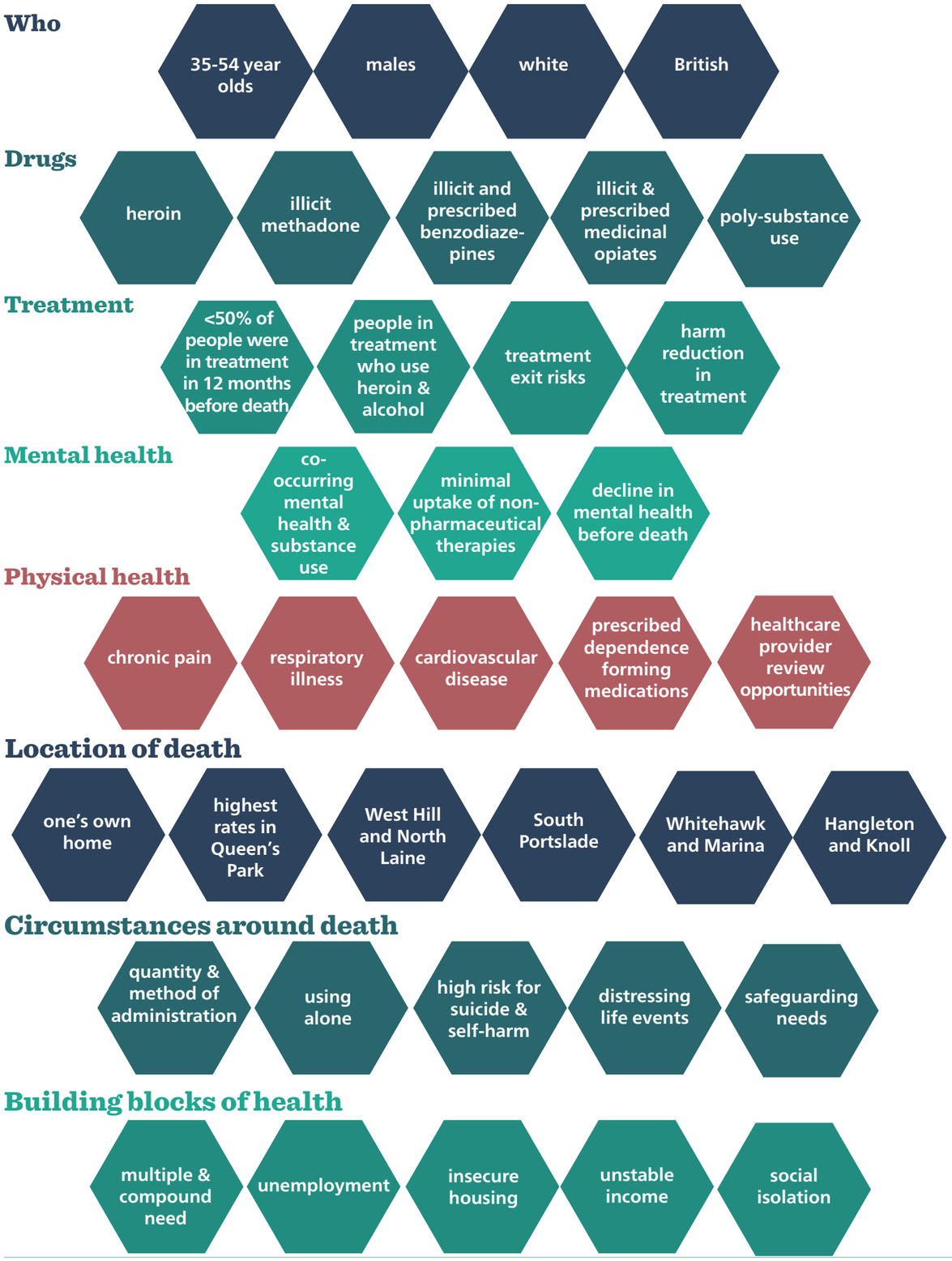
The team audited data from the inquest reports of 138 people who died where a Coroner inquest concluded between 01/04/2020 and 31/03/2023.

The data collected have been analysed and are documented in detail in the results section. The results have been themed and will provide the starting point for a multi-agency approach to developing recommendations for action to reduce drug deaths. These recommendations will explore opportunities for improved harm reduction, drug and alcohol service delivery, physical and mental health service delivery, risk management, and improving the environment in which we live.

The themes represent:

- **Who is at highest risk of a drug death**
- **What drugs are most commonly identified as causing or contributing to death**
- **Engagement with treatment and recovery services**
- **Risk factors associated with mental health needs (treated or untreated)**
- **The impact of poor physical health**
- **Location of death**
- **Circumstances around death**
- **The building blocks of health**

There were 138 deaths



In summary the audit results explore:

Who is at highest risk of a drug death

Over half of all the drug deaths were in people aged 35-54. The Coroner's conclusions of accidental death, misadventure, and narrative conclusion are minimally seen in under 35s and over 55s. However, suicides by drug use, drug related and drug & alcohol related deaths are reflected in all age groups. Knowing who and when people are most at risk helps to focus resource and target services and messaging.

The cohort was predominantly white British and two thirds were men.

What drugs are most commonly identified as causing or contributing to death

Toxicology reports showed that 121 people who died (88%) had more than one substance in their system, and 68 people (49%) had more than five substances present.

The most common substances present at time of death, in order of frequency, were benzodiazepines, anti-depressants, heroin, cocaine, medicinal opiates, alcohol, and methadone. The substances that most caused or contributed to death were, in order, heroin, benzodiazepines, methadone, medicinal opiates, and alcohol.

Heroin, methadone, and medicinal opiates caused the greatest number of fatal poisonings. Benzodiazepines contributed to the most deaths but may not have killed the person if used in isolation or without the presence of other risk factors.

Knowing what drugs are most indicated in deaths helps target interventions and develop specific harm reduction messages, however recommendations from the audit should not ignore increasing national evidence on the impact of novel synthetic opiates even if they are not identified as issues here.

Engagement with treatment and recovery services

56 people (41%) were in drug and alcohol treatment at some point in the 12 months before they died. 82 people (59%) had no record of receiving treatment in the 12 months before they died.

Where people were in treatment, the primary substance for which they were receiving treatment was heroin or alcohol. Secondary substances of concern were crack, cocaine or benzodiazepines.

Of the whole audit population, not just those in treatment, 59 people (43%) had heroin cited as a cause or contributary cause of death.

30 people (22%) had methadone cited. Of these, 15 people were prescribed methadone at time of death and 15 people died using methadone who had not been prescribed it in the 3 months before death. This equates to <1% of people receiving opiate substitute treatment with Brighton & Hove treatment services (based on the number of people in treatment prescribed opiate substitute treatment as of 04/06/2024).[8]

These results highlight the importance of developing harm reduction approaches to mitigate risks including: illicit use of methadone; leaving treatment; single lapse or more sustained relapse.

Risk factors associated with mental health needs (treated or untreated)

114 people (83%) had a diagnosed mental health condition e.g. depression, or health and wellbeing condition for which they were prescribed medication e.g. insomnia. Treatment was predominantly by means of medication, with two thirds of people receiving two or more prescriptions at the time of death.

Only eight people of the 27 people who were referred for talking therapies in the 12 months before death had received therapy. The audit population had significant co-occurring needs with poor access or poor uptake to non-pharmaceutical therapies to address these.

91 people (66%) had recorded evidence of decline in their mental health prior to their death.

Understanding the extent and management of poor mental health particularly in a population that includes co-occurring substance use will help to inform pathways into treatment and access to appropriate and timely support.

The impact of poor physical health

106 people (77%) had one or more physical health diagnoses, most notably chronic pain, respiratory conditions and cardiovascular disease. 103 people were prescribed medication for physical health, including medicinal opiates, benzodiazepines and gabapentinoids. Many people were prescribed multiple medications, some of which are considered dependence forming medications. 83 people (78%) with a physical health diagnosis had healthcare contact in the 6 months prior to death, which may indicate potential opportunities to assess medication related risk.

Where people lived

Of the 138 people who died, 126 were resident in Brighton & Hove (88%) from all wards in the city except Brunswick and Adelaide, Central Hove, Rottingdean and West Saltdean and Woodingdean.

Risk factors

There are multiple risk factors that are indicated in drug deaths and services can consider how to mitigate these.

Risk factors include: history of non-fatal overdose, accidental overdose from high strength drugs, quantity of drugs consumed, using substances on one's own, having a recorded risk of self-harm or suicide, experience of bereavement, adverse childhood experiences, and being care experienced. We also identified that where reports were available, 25% of people had ongoing safeguarding needs at the time of death.

The building blocks of health

Aside from individual life experiences, many people who died experienced inequalities and multiple compound need caused by unemployment, poor or insecure housing, insecure or unstable income, financial difficulties, or poor family or social networks.

Brighton & Hove current position

Drug poisoning deaths

ONS data

The most recent ONS data on drug poisoning deaths[9] for the rolling three-year period 2020-2022, show that of 153 upper tier local authorities, Brighton & Hove has the 9th highest age standardised mortality rate of drug poisoning deaths in England, at 15.4 per 100,000 people, almost double the rate in England (8.1 per 100,000).[10]

Table 2 shows the trend in Brighton & Hove compared to England. The rolling three-year rate increased from 8.9 to 15.4 per 100,000 between 2014-2016 and 2020-2022 in Brighton & Hove and from 6.2 to 8.1 per 100,000 across England.[11]

Table 2: Number and age standardised rate of drug poisoning deaths per 100,000 population, 2014-2016 to 2020-2022, in Brighton & Hove and England

Year	Number of drug poisoning deaths in Brighton and Hove	Drug poisoning deaths per 100,000 population – Brighton & Hove	Drug poisoning deaths per 100,000 of population – England
2020-2022	133	15.4	8.1
2019-2021	116	13.4	7.9
2018-2020	109	12.5	7.9
2017-2019	102	11.6	7.1
2016-2018	99	11.3	6.7
2015-2017	96	11.3	6.4
2014-2016	76	8.9	6.2

Drug misuse deaths

OHID data

The most recent Office for Health & Disparities (OHID) data on drug misuse deaths (the rolling three-year period 2020-2022) show that of 153 upper tier local authorities, Brighton & Hove has the 7th highest age standardised mortality rate of drug misuse deaths in England, at 12.7 per 100,000 people, more than double the rate in England (5.2 per 100,000). [12]

Table 3 shows the trend in Brighton & Hove compared to England. The rolling three-year rate has almost doubled between 2014-2016 and 2020-2023 from 6.5 to 12.7 deaths per 100,000 in Brighton & Hove whereas across England it has increased by 24%, from 4.2 to 5.2 deaths per 100,000 people. [13]

Table 3: Number and age standardised rate of drug misuse deaths per 100,000 population, 2014-2016 to 2020-2022, in Brighton & Hove and England

Year	Number of drug misuse deaths in Brighton & Hove	Drug misuse deaths per 100,000 population – Brighton & Hove	Drug misuse deaths per 100,000 of population – England
2020-2022	110	12.7	5.2
2019-2021	98	11.3	5.1
2018-2020	95	10.8	5.0
2017-2019	89	10.0	4.7
2016-2018	85	9.6	4.5
2015-2017	74	8.5	4.3
2014-2016	56	6.5	4.2

Source: Office for Health Improvement and Disparities. Public Health Profiles. Drug related deaths. Available at: Public health profiles – OHID (phe.org.uk)

Audit aim

The aim of the audit is to reduce drug deaths in the city through identifying themes and patterns and developing recommendations for action across multiple local organisations, that can help to address the contributary factors.

Following the publication of the audit report the public health team will:

- review the current service provision to identify interventions and approaches that can strengthen our city-wide work to prevent drug deaths
- disseminate learning through adults', and children and young people's health and social care services to reduce the risk of future drug deaths.
- Develop recommendations for action at a multiagency workshop following the dissemination of the audit results.

Methodology

The Brighton & Hove drug death audit steering group provided oversight to the audit process. The audit team comprised members of the BHCC drugs and alcohol programme team.

His Majesty's Coroner Service granted the audit team privileged access to their online case management system, from which the team could review the records associated with each death. Information on drug deaths was not identified from any source other than evidence submitted to the Coroner in the inquest process. The audit team signed up to an ethics and confidentiality agreement (appendix A).

The Coroner's inquest process considers information from multiple sources which document a range of information relating to the person and their death, including:

- demographic data
- cause of death
- GP records and reports
- toxicological analysis
- police reports
- clinical reports from mental and physical health specialists
- family testimony.

The information available varied greatly. Some inquests benefited from input from multiple sources often providing a richer picture of the person's life and circumstances surrounding death.

The scope of the audit

The audit included all Coroner concluded inquests, as detailed in table 1, between 1st April 2020 and 31st March 2023 that involved legal or illegal drugs, and as per the ONS definition.

There were 138 concluded inquests during the three years of the audit period.

The inquests identified anyone who died in Brighton & Hove, including non-residents who died in the city (12/138), but did not include residents who died outside of the city.

The audit did not include:

- homicides by drugs, whether a suspect was convicted or not. These cases are investigated by the Police and are often not part of the Coroner's inquest process
- deaths as a result of only alcohol, or alcohol related ill health unless a legal or illegal drug was cited alongside as contributing to their death.

Process

The audit team developed a spreadsheet with multiple fields for data capture. They went through the records for each death extracting data to populate the spreadsheet.

5 cases were used to pilot the data fields, and further refinements and additions were made to the spreadsheet as a result.

The final spreadsheet enabled us to capture information under key headings. (see appendix B for all data fields):

- Demographics
- Death registration and medical cause of death
- Circumstances around death
- Substance use, treatment history & toxicology
- Relationships; accommodation; education, training & employment; finances
- Mental health & wellbeing
- Physical health
- Criminal justice system involvement
- Safeguarding, including care experience, social services support.

Once the data were collected, the auditors had a free text opportunity to capture information that didn't fit into the spreadsheet.

The audit team, with support from the Public Health intelligence team, analysed the data captured and identified common themes.

Results

Where percentages have been shown, they have been rounded to the nearest percent.

Demographics

Age

Table 4 shows the breakdown of deaths by age and compares this to the proportion of the population in that age group.

Over half of deaths were in people aged 35-54 years of age (79 people, 57%), but this age group only makes up 28% of the population of the city.

23% of deaths were in the 15-34 age range compared to 32% of the population, and 21% were in people aged 55 years or over compared with 26% of the total population in that age group.

Table 4: Deaths by age group, number, crude rate per 100,000, as a percentage of all drug deaths, and age group as a percent of total population

Age group	Number of deaths	Crude rate per 100,000	Percentage of all deaths	Age group as a Percentage of population
15-24	12	8.6	9%	17%
25-34	18	14.5	13%	15%
35-44	32	27.6	23%	14%
45-54	47	38.9	34%	14%
55-64	20	20.1	14%	12%
65+	9	7.6	7%	14%
All ages	138	16.5	100%	

Source: Brighton & Hove drug death audit and Office for National Statistics Mid-Year Estimates 2022

Table 5 shows the proportion of deaths in each age group by Coroner's conclusion. This helps to identify the higher risk groups to focus on. People aged 35-54 years had the greatest number of deaths across all conclusions, but we can see that suicides by drug use, along with drug related and drug & alcohol related deaths, are an issue across all age ranges.

Table 5: Coroner's conclusions by age and the proportion of deaths by conclusion in that age range

Coroner conclusion	Under 35 years	35-54 years	55 years or over
Drug related death, and alcohol & drug related death	19 (63%)	36 (46%)	14 (48%)
Accidental death	<5	6 (4%)	<5
Misadventure	<5	15 (19%)	<5
Suicide	5 (16%)	12 (15%)	10 (34%)
Narrative	<5	10 (7%)	<5
Total	30 (100%)	79 (100%)	29 (100%)

Source: Brighton & Hove drug death audit

Gender

Gender was identified based on the data provided in the Coroner's case information. This may not always accurately reflect gender assigned at birth, non-binary or transgender status. Fewer than five people were identified in the coroner records as having a gender other than that asigned at birth.

91 men died (66%), and 47 women (34%). Men are overrepresented in the proportion of deaths at 66%, but make up 49% of the Brighton & Hove population.[15] The breakdown of deaths by age and gender is shown in Table 6.

Table 6: Deaths by gender and age

Gender	Under 35 years	35-54 years	55 years or over	Total
Male – number (% of all male deaths)	20 (22%)	53 (58%)	18 (20%)	91 (100%)
Female – number (% of all female deaths)	10 (22%)	25 (54%)	11 (24%)	46 (100%)

Source: Brighton & Hove drug death audit

Ethnicity

Ethnicity was recorded for 122 of the 138 people in the audit (88%) and missing for 16, therefore some caution needs to be taken in interpreting this information.

Due to the small numbers in this audit, for this analysis the category Black or Racially Minoritised ethnicity was applied to any person who is not of white British ethnicity.

Of the 122 people where ethnicity was recorded, 100 people were white British (82%), compared to 74% of the population of Brighton & Hove, and 19 people (16%) were in a Black or racially minoritised group compared to 26% of the populaton of the city.[15]

Substance use

Toxicology and cause of death (COD)

The Coroner's conclusion is in part informed by toxicology data which identifies substances in a person's blood and urine. Toxicology data can help identify whether a substance was present in likely fatal quantities, and therefore potentially the cause of death, or present in therapeutic quantities.

The exact amount of a substance consumed is difficult to determine in toxicological analysis and is dependent on the substance and variables specific to the individual including age, diet, history of previous drug use, kidney and liver function[16]. Often the person's known drug use history contributes to the assessment of toxicology. Not all substances present will necessarily have contributed to someone's death.

The substances identified in toxicology reports may not have been intentionally ingested: illicit drugs are often mixed with other substances.

Not all substances consumed will always be included in the toxicology report, especially in the case of novel drugs, which may not yet be part of a routine laboratory test, or where substances have a short half-life. Nitazenes are novel extremely potent synthetic opiate compounds. Their use is spreading in England having been first detected in toxicology analysis in the UK in 2021. They have since been found in the UK in products intended for use as benzodiazepines, heroin and Oxycodone, and cannabis products[17].

The Pathology Department at the Royal Sussex County Hospital started routinely screening for nitazenes in January 2023, and in this audit, nitazenes were identified in fewer than five deaths. Recommendations from the audit should not ignore increasing evidence on novel substances even if they are not identified as issues here.

Medicinal opiates refer to Oxycodone, oral morphine, morphine and fentanyl patches, codeine, Zapain, Tramadol, or Tramadan and can be prescribed or used illicitly.

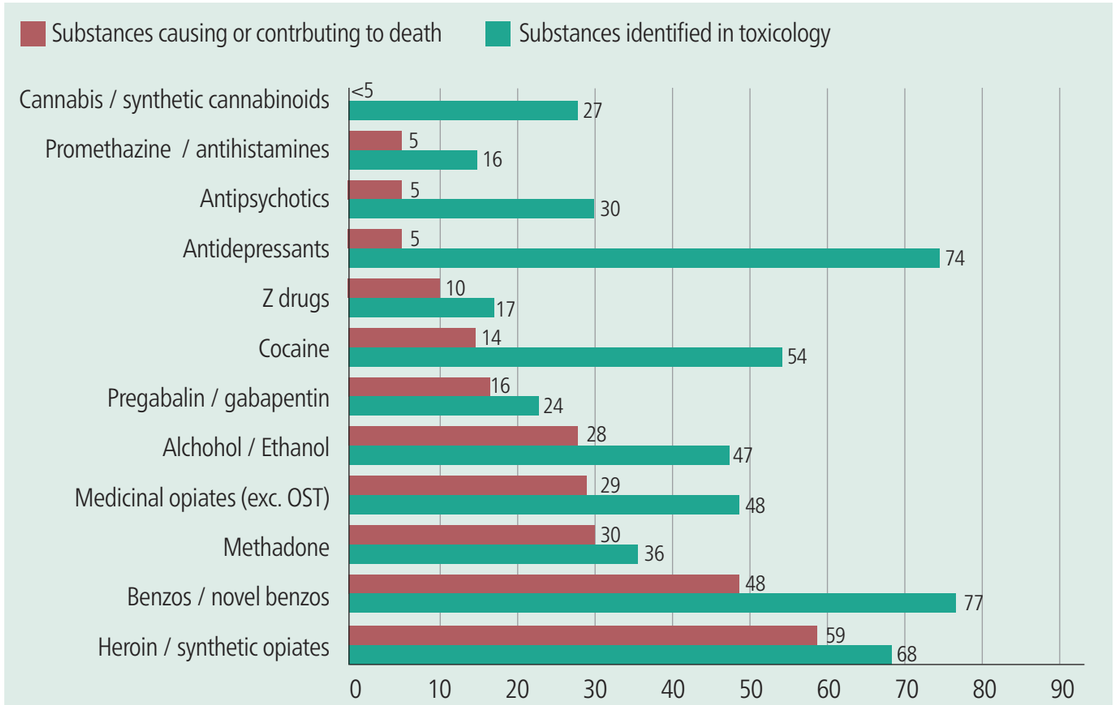
'Z' drugs refer to non-benzodiazepine hypnotics and are often prescribed in the UK as sleeping tablets under brand names Zolpidem and Zopiclone.

Figure 1 shows that the most common substances causing or contributing to death were heroin (59 people, 43% of deaths), benzodiazepines (48 people, 35%), methadone (30 people, 22%), medicinal opiates (29 people, 21%), alcohol (28 people, 20%), pregabalin / gabapentin (16 people, 12%), cocaine (14 people, 10%) and 'Z' drugs (10 people, 8%).

Figure 1 also shows that the most common substances found in toxicology reports were benzodiazepines (77 deaths, 56%), antidepressants (74 deaths, 54%), heroin (68 people, 49%), cocaine (54 people, 39%), medicinal opiates (48 people, 35%), and alcohol (47 people, 34%).

Heroin and methadone had the most similar profiles of drug use and contributing/ causing death. Antidepressants, cocaine, antipsychotics, and cannabis were commonly used, but contributed to or caused fewer deaths.

Figure 1: Substances which caused or contributed to death (red bars) and substances identified in toxicology (green bars), ordered on caused/contributed to death.



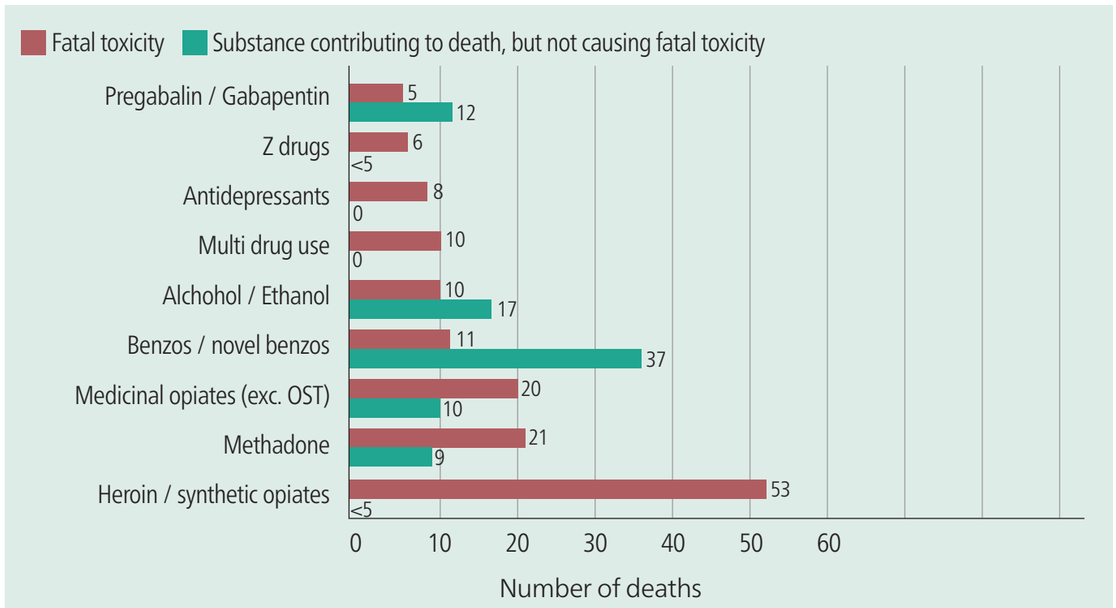
Note: The chart only shows substances where the substance was present in toxicology in 15 or more deaths. Other substances include drugs such as Levamisole, Buprenorphine, Propranolol, Ketamine, MDMA, Paracetamol, methamphetamine, GHB, Sodium nitrate, Pentobarbital, Sildenafil, Atenolol, amphetamines, anti-convulsant medications and substances used in anaesthetics.

Source: Brighton & Hove drug death audit

Figure 2 shows the top 9 drugs that caused fatal poisoning / toxicity (red bars), where there were 5 or more deaths, compared to the substances that contributed to death but may not have killed the person if used in isolation or without the presence of other risk factors such as poor mental health or a physical illness. (green bars)

Heroin, methadone, and medicinal opiates caused the greatest number of fatal poisonings. Benzodiazepines contributed to the most deaths but may not have killed the person if used in isolation or without the presence of other risk factors.

Figure 2: Substances causing fatal poisoning/toxicity (red bars) and substance that contributed to death but may not have killed the person if used in isolation/without the presence of other risk factors (green bars)

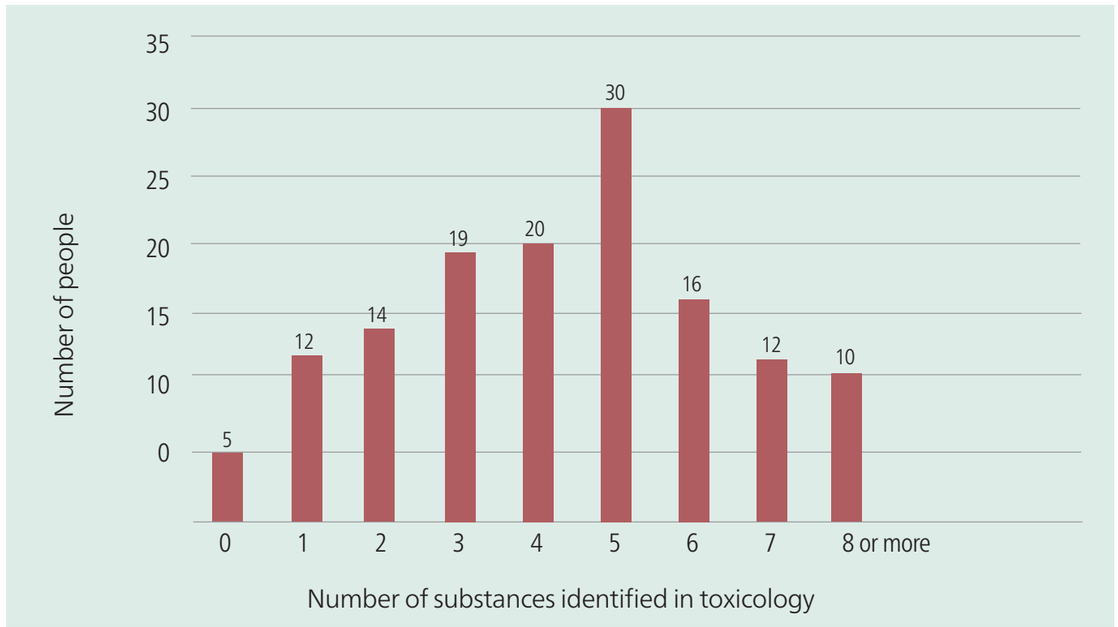


Source: Brighton & Hove drug death audit

Figure 3 shows that almost nine in every ten deaths had more than one substance identified (121 of the 138 people who died, 88%). 68 people (49%) had five or more substances present at the time of death.

For five people there was no or inconclusive toxicology, but the inquest ruled a drug related death.

Figure 3: Number of substances identified in toxicology



Source: Brighton & Hove drug death audit

Figure 4 below shows the most frequent combinations of drugs identified in toxicology, grouped by the top three substances causing fatal poisoning (heroin, methadone and medicinal opiates).

Figure 4: frequent combinations of substances causing fatal toxicity

Drug deaths - Most frequent combinations of substances identified in toxicology grouped by substances causing the most fatal toxicity.

People can appear within more than one combination

Heroin

- with benzodiazepines (47)
- with cocaine (40)
- with anti-depressants (38)
- with benzodiazepines and anti-depressants (30)
- with benzodiazepines and cocaine (29)
- with anti-depressants and cocaine (20)
- with alcohol and cocaine (18)
- with benzodiazepines and alcohol (15)

Methadone

- with benzodiazepines (27)
- with cocaine (22)
- with benzodiazepines and anti-depressants (17)
- with benzodiazepines and cocaine (16)

Medicinal opiates

- with anti-depressants (33)
- with benzodiazepines (30)
- with benzodiazepines and anti-depressants (23)

Heroin

Heroin was the most frequently identified substance causing death. By understanding more about heroin use it is possible to identify opportunities for harm minimisation and engagement:

- 38 people (28%) were known to inject drugs at time of death, or to have a recorded recent history of intravenous drug use
- 26 people (18%) had a blood borne virus (BBV) at the time of death. 8 people were treated and 18 were not treated, including people who declined treatment, or where infection was discovered post mortem
- Of the 18 people with an untreated BBV, 10 people were in tier 3 treatment for heroin use at time of death
- Fewer than five people had a record of snorting heroin and / or opiates with some of these instances causing fatal toxicity.

The audit provided limited information around the use of Naloxone. From the information available there were fewer than five potential opportunities for naloxone administration, (i.e. a witness present and conscious), but in all cases was not administered until paramedics attended.

It is possible that there were greater opportunities for naloxone administration, but witnesses will not always be willing to acknowledge their presence.

Drugs and alcohol treatment and recovery services

Collecting information on contact with drugs and alcohol treatment services helps to understand where treatment pathways can be developed or strengthened.

Substance use treatment comprises:

Tier 2 interventions: information and advice, assessment, referral to structured treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare. These interventions may be delivered in the same setting as Tier 3 treatment.

Tier 3: structured treatment including specialist assessment and co-ordinated and planned care and treatment. These interventions are often delivered in specialised premises or through outreach. Tier 3 interventions may be delivered alongside Tier 2 interventions.

Tier 4: residential specialised drug treatment, which is planned and coordinated to ensure continuity of care and aftercare and is usually defined by the availability of 24-hour support.

Of those who died

- 56 people (41%) were in drug and alcohol treatment in the 12 months before they died, 54 of these were residents of Brighton & Hove.
- just over half of people aged 25-54 were known to treatment services in the 12 months before they died
- 13 people (9%) were residents of Brighton & Hove had no record of ever accessing drug and alcohol treatment services in Brighton & Hove. Of these, 11 people were identified as regularly using illicit drugs or alcohol.

Of the 56 people who had been in treatment in the 12 months preceding their death:

- 37 (66%) were in tier 3
- 12 (21%) had been in both tier 2 and tier 3 treatment
- 7 (13%) were in tier 2

The primary substance of concern for people seeking treatment was heroin (37 people), and alcohol (12 people).

The secondary substance of concern for people seeking treatment was crack or cocaine (23 people) and benzodiazepines (6 people).

For people in treatment in the 12 months prior to death, the five most common substances causing or contributing to death were:

- Heroin / synthetic opiates (30 people)
- Benzodiazepines / including novel psychoactive benzodiazepines (27 people)
- Methadone (20 people)
- Alcohol (14 people)
- Medicinal opiates (9 people)

The five most common substances identified in toxicology were:

- Benzodiazepines / novel benzodiazepines (41 people)
- Heroin / synthetic opiates (37 people)
- Antidepressants (31 people)
- Cocaine (28 people)
- Methadone (25 people)

Comparing deaths between people in treatment and not in treatment

Of the whole audit population, 59 people (43% of people who died) had heroin cited as a causing or contributing to death. Of those, 31 people were in drug or alcohol treatment in the previous 12 months, and 16 people were receiving opiate substitute treatment (OST) in the three months before they died.

30 people (22% of people who died) had methadone cited as a cause or contributary cause of death.

Of those:

- 20 people were in substance use treatment in the 12 months before their death.
- 15 people in treatment were prescribed methadone at time of death
- 15 people died using methadone who had not been prescribed it in the three months before they died.

In this audit, 15 people were in receipt of a methadone or physeptone prescription at time of death and died with methadone as causing or contributing to death. This equates to <1% of people receiving opiate substitute treatment with Brighton & Hove treatment services (based on the number of people in treatment prescribed opiate substitute treatment as of 04/06/2024).[18]

Table 7 shows a greater proportion of people in substance use treatment in the 12 months prior to death died with heroin, benzodiazepines, alcohol cocaine and methadone in their system at time of death. A greater proportion of people not in substance use treatment in the 12 months before death died with medicinal opiates in their system.

Table 7: Top 7 substances found in toxicology of people who were in substance use treatment and those who were not, in the 12 months before death

Substance reported in toxicology	People in treatment < 12 months prior to death (n=56)	People not in treatment < 12 months prior to death (n=82)
Heroin / synthetic opiates	37 (66%)	31 (38%)
Benzodiazepines	41 (73%)	36 (44%)
Alcohol	22 (39%)	25 (30%)
Cocaine	28 (50%)	26 (32%)
Methadone	25 (45%)	11 (13%)
Medicinal opiates	17 (30%)	31 (38%)
Pregabalin / gabapentin	11 (19%)	13 (16%)

Table 8 shows heroin and methadone caused more fatal poisonings for people in treatment in the 12 months before death, with medicinal opiates and benzodiazepines causing more fatal poisonings for people not in substance use treatment in the 12 months before death.

Table 8: Top 7 substances causing fatal poisoning / toxicity of people who were in substance use treatment and those who were not in the 12 months before death

Substance causing fatal poisoning / toxicity	People in treatment < 12 months prior to death (n=56)	People not in treatment < 12 months prior to death (n=82)
Heroin / synthetic opiates	28 (50%)	25 (30%)
Benzodiazepines	<5	7 (9%)
Alcohol	<5	6 (7%)
Cocaine	<5	<5
Methadone	14 (25%)	7 (9%)
Medicinal opiates	<5	17 (21%)
Pregabalin / gabapentin	<5	<5

Table 9 shows benzodiazepines, alcohol, pregabalin / gabapentin, methadone, medicinal opiates and cocaine contributed to more deaths of people in treatment but may not have caused death if other risk factors such as poly drug use or poor health had not been present.

Table 9: Top 7 substances contributing to death (that may not have caused death without the use of other substances or other risk factors) in people who were in substance use treatment and those who were not in the 12 months before death

Substance contributing to cause of death	People in treatment < 12 months prior to death (n=56)	People not in treatment < 12 months prior to death (n-82)
Heroin / synthetic opiates	<5	0
Benzodiazepines	23 (41%)	14 (17%)
Alcohol	9 (16%)	8 (10%)
Cocaine	5 (9%)	<5
Methadone	6 (11%)	<5
Medicinal opiates	6 (11%)	<5
Pregabalin / gabapentin	8 (14%)	<5

Mental health

It is estimated that around one in six people in the UK aged over 16 (17%) have experienced symptoms of a common mental health problem in the past week[19]. Brighton & Hove has above average mental health needs estimated at around one in five people (20%) experienced symptoms of a common mental health problem in the past week[20].

114 people who died in this audit (83%) had a diagnosed treated or untreated mental health condition in the 12 months before their death. Of these, 80 people (70%) were managed in primary care for their mental health need and 29 people (21%) were managed in secondary or tertiary care. For five people treatment service was unknown.

Seven people (5%) had a mental health inpatient admission in the 12 months before death.

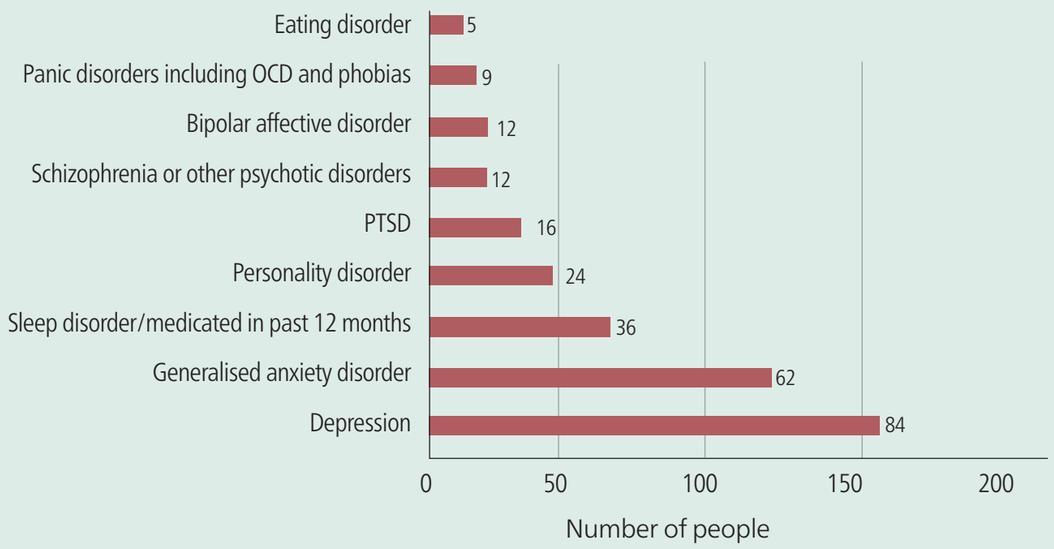
In addition, we identified:

- 91 people (66%) had a record of experiencing a decline in their mental health shortly before they died.
- 56 people (41%) had recently experienced distressing life circumstances, such as relationship breakdown, loss of employment, eviction and housing uncertainty, cuckooing, and safeguarding concerns.

The most common mental health or wellbeing conditions recorded on GP notes (Figure 5) were:

- depression (61%)
- anxiety (45%,)
- sleep disorders (26%)
- personality disorders sometimes referred to as complex emotional relational needs (CERN) (17%,)
- post-traumatic stress disorder (PTSD) (12%)
- Other diagnoses: bipolar affective disorder (9%), schizophrenia or other psychotic disorders (9%), panic disorders, OCD and phobias (7%).

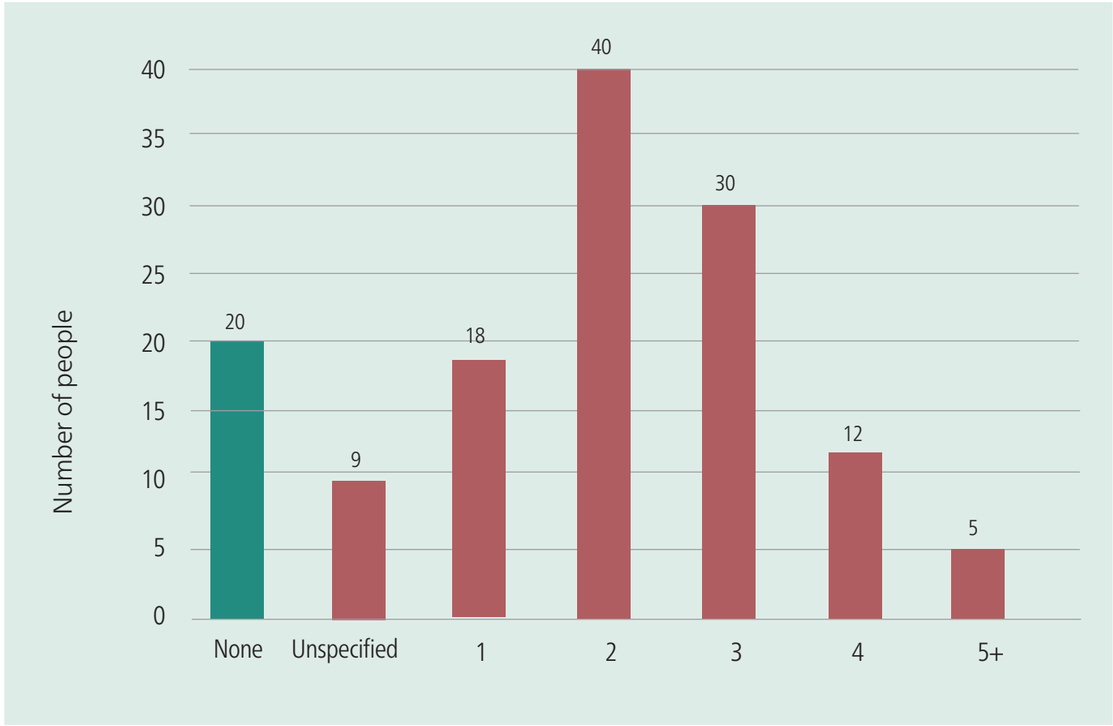
Figure 5: GP recorded mental health and wellbeing condition in the audit population



Source: Brighton & Hove drug death audit

Figure 6 shows the number of mental health diagnoses in people who died. 87 people (63%) had two or more diagnosed mental health conditions.

Figure 6: Number of people who died and number of mental health diagnoses



Of the 114 people with a diagnosed mental health condition, two thirds had two or more prescriptions for mental health medications at time of death. There were 21 people who had one prescription, most of these were for anti-depressants. 15 people with a recorded mental health condition had no prescription recorded.

Talking and change oriented therapies

27 people (20% of the audit population) had a record of being referred to or accessing talking or change oriented therapies in the year before their death.

Only eight people had commenced talking therapy / change oriented therapy in the year before they died. Five people were referred but did not meet the service eligibility criteria, eight people declined the service offer, and the remaining six people had not commenced therapy.

Navigating mental health support

Accessing mental health support can be complex for people who use drugs. Mental health services may not extend their service to people with co-occurring substance use, and similarly some substance use treatment services may not support people with co-occurring needs. Accessing mental health services is also difficult for those who do not meet the criteria for secondary mental health support, but whose symptoms are considered outside the scope of primary care mental health management. [21] [22]

The audit found:

- 11 people declined to engage with mental health services
- 8 people were excluded from talking therapies or secondary mental health services on the grounds of substance use
- 8 people were declined support from talking therapies or secondary mental health services for reasons not substance use related.

Benzodiazepine prescribing

According to National Institute for Health and Care Excellence (NICE) approximately 1.4 million adults in the UK received a prescription for benzodiazepines between 2017-2018. This equates to roughly 2% of the UK population.

NICE recommends that benzodiazepines should only be prescribed for short term relief (2 to 4 weeks) and not for long term use[23]. People who take benzodiazepines can experience difficulty withdrawing from the drug after taking it regularly for more than a few weeks[24]. Risk of over-sedation, respiratory depression, coma, and death increase if used in combination with opiates[25].

42 people, 30% of the audit population were in receipt of a benzodiazepine prescription. Benzodiazepines are commonly used illicitly and are sometimes found in illicit substances intended for other use. We know that although 42 people had a prescription, toxicology reports identified benzodiazepine in 77 people who died.

Benzodiazepine prescribing was highest in those aged 45-64 years (38%), followed by 35-44 years (31%), but much lower in those aged 25-34 years (17%). No one under the age of 25 was prescribed a benzodiazepine. However, 6 people under 25 had benzodiazepines in their system at time of death. Young people aged under 18 accessing substance use treatment services in Brighton & Hove cite benzodiazepines as their primary substance of concern in 9% of cases.

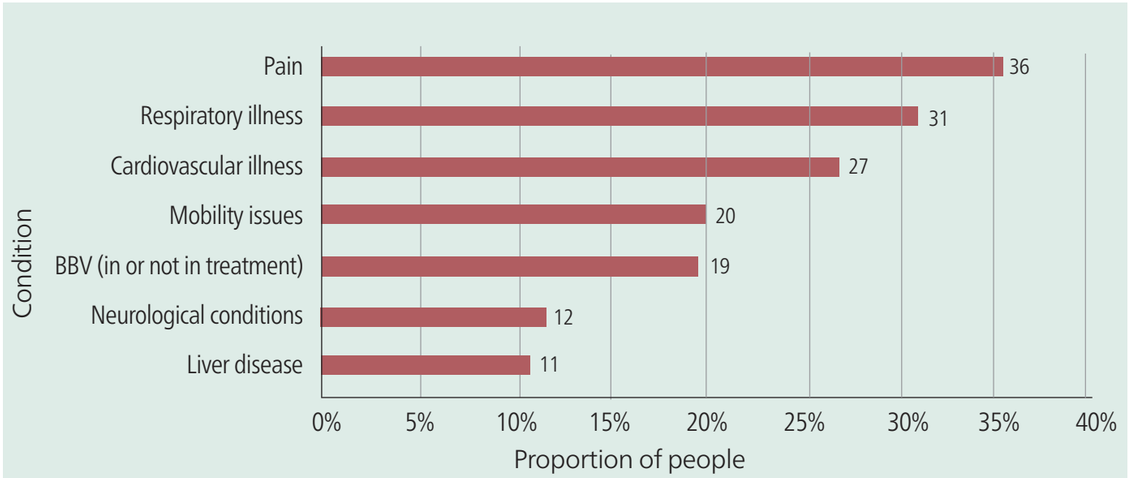
Physical health

Poor physical health was a feature in the audit population with 106 people, (77%) having one or more physical health diagnoses.

Figure 7 shows the most common conditions identified in Coroner records as: chronic pain (50 people, 36%), respiratory illness (43 people, 31%) and cardio-vascular illness (37 people, 27%).

Chronic pain was recorded in healthcare professionals' contributions to the inquest and was associated with a variety of physical health problems including arthritis, osteoporosis, musculo-skeletal damage, amputation, cancer diagnosis, chronic gastro-intestinal disease, migraine. In nearly all cases, chronic pain was treated with medicinal opiates, benzodiazepines and / or gabapentinoids.

Figure 7: Physical health status of the audit population



Source: Brighton & Hove drug death audit

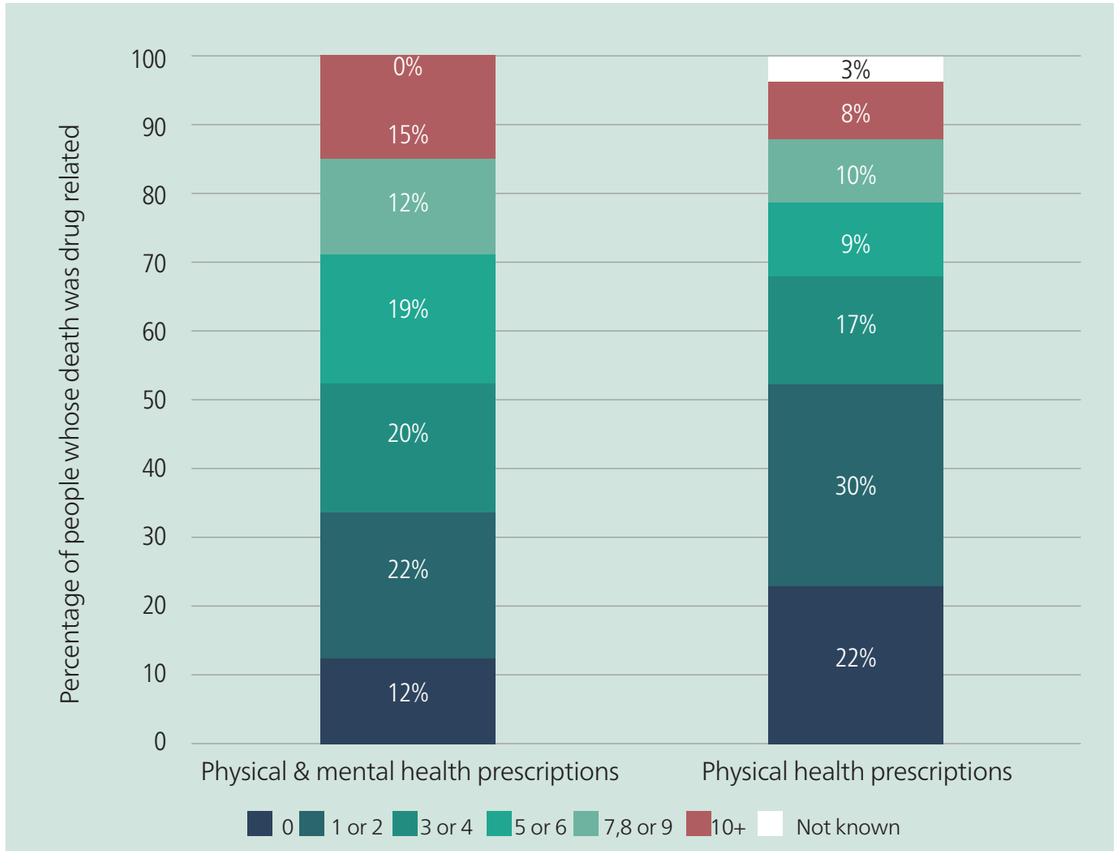
77 people who died (56%) had two or more physical health diagnoses and 16 people (12%) had five or more conditions.

103 people (75%) had a prescription for physical health conditions, and of these, 44 people (43%) were in treatment with drug and alchohol services in the 12 months before they died.

61 people who died (45%) had three or more medications prescribed for physical health conditions at the time of death and 25 people (18%) had seven or more medications prescribed for physical health conditions.

121 people who died (88%) had at least one prescription for either a mental health or physical health condition and only 17 people in the audit (12%) had no prescribed medication for physical or mental health (although may have a prescription for opiate substitute therapy (OST).

Figure 8: number of prescriptions for physical and / or mental health conditions compared to people who only had a prescription for physical health conditions (excluding OST)



Source: Brighton & Hove drug death audit

Nearly half the people who died (63 people, 46%) were prescribed 5 or more medications for physical and mental health related conditions.

Contact with healthcare providers

The audit captured details of A&E attendances, face to face, telephone or virtual reviews with other healthcare providers including outreach appointments, as a way of considering potential opportunities for pathway development and interventions.

Of significance is the timeframe of the audit, April 2020 – March 2023. Covid-19 restrictions were in place or just being eased and this impacted on the opportunity for face-to-face engagement with services.

Accident & Emergency

- In total, there were 150 A&E attendances in the year before their death, by 65 people (47%)
- 73 people (53%) had no record of attending A&E in the 12 months before death
- There were eight people with five or more attendances in the year before death, with the highest number of attendances being 15
- Those aged 35-44 years had the highest average number of A&E attendances (2.3 attendances per person).

GP primary care consultation

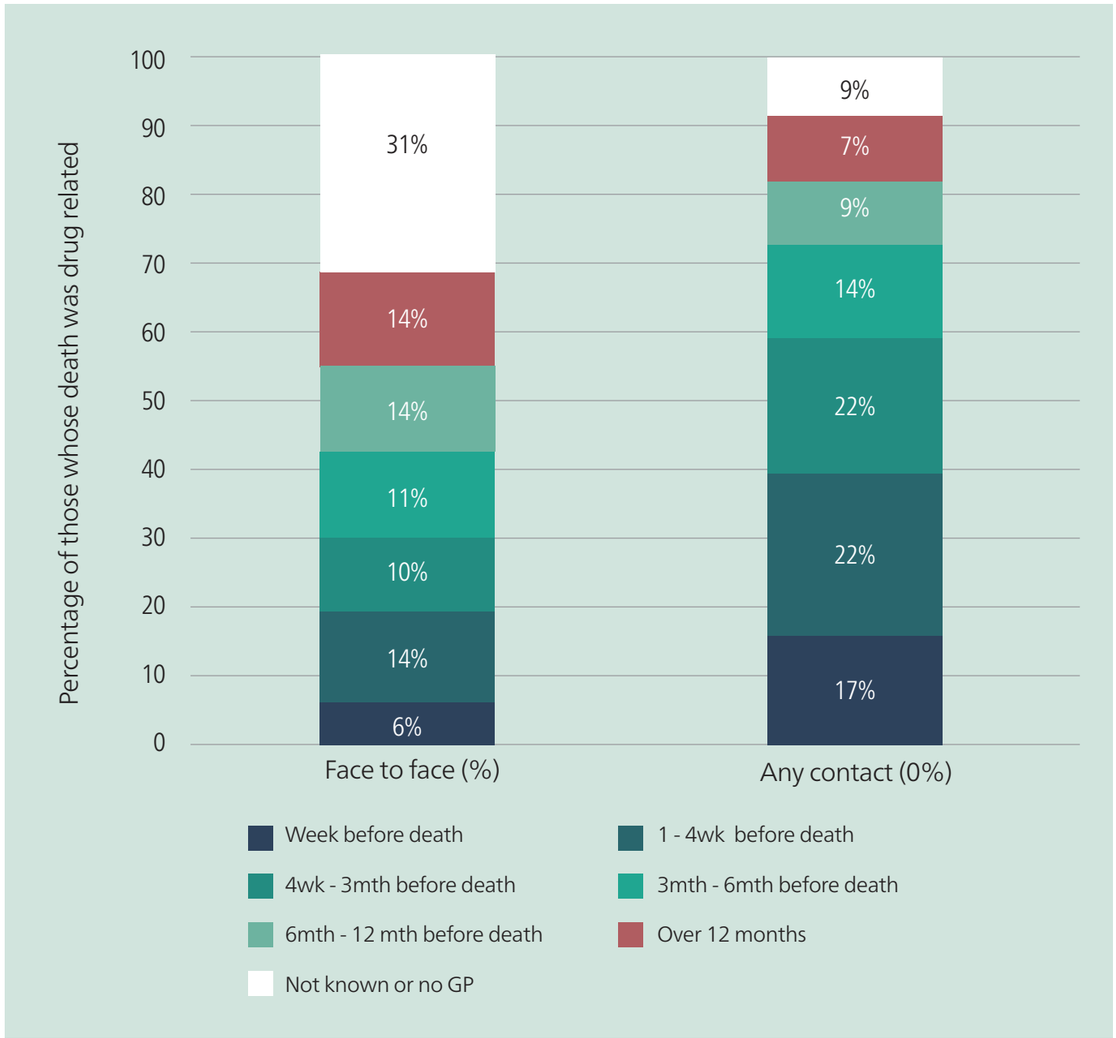
- The highest number of GP consultations in the 12 months before death was 50
- Almost half of people had 1-5 consultations (66 people, 48%)
- 22 people (16%) had more than five GP consultations
- 50 people (36%) had no recorded GP consultation in the 12 months before death.

The mean number of consultations in the year before death was 4.5 per person (Figure 9). This was highest for those aged 65 years or over, at 6 attendances, followed by 5.5 attendances for those aged 35-44 years and 4.8 for those aged 45-54 years. Those aged 15-24 (3 consultations) had the lowest number of consultations.

Eight people (6%) had face-to-face contact with a healthcare professional linked to their GP in the week before their death and one in five (28 people, 20%) had face-to-face contact in the four weeks prior to death.

Over half had a face-to-face contact within six months prior to death, and 84% had any contact within the six months prior to death.

Figure 9: people who had face to face, or any, contact prior to death with GP practice as a percentage of the audit cohort



Source: Brighton & Hove drug death audit

In analysing the physical health of the audit population:

- There was recorded evidence in inquest documents of 20 people (14%) overusing prescribed medications in the year before death
- 18 people (13%) were in poor physical and mental health and were prescribed dependence forming medications without recorded evidence of face-to-face healthcare provider review, in the 12 months before death
- 17 people (12%) were recorded as having batch prescriptions of dependence forming medications
- 13 people who died (9%) had a record of a professional or family member expressing concern they were using illicit drugs for physical pain relief.

Residence

Place of residence

- Of the 138 people who died, 126 were resident in Brighton & Hove (88%), which includes five people experiencing homelessness in the city, and there were 12 people who died in the city, but who were resident outside of Brighton & Hove
- All wards with the exception of Brunswick and Adelaide, Central Hove, Rottingdean and West Saltdean and Woodingdean had residents who died and are included in this audit
- Table 10 shows wards where five or more residents died of a drug death over the three-year period of the audit
- The highest number and rate of deaths per 100,000 people was in Queen's Park ward (14 deaths, 44.9 per 100,000), followed by West Hill and North Laine (11 deaths, 34.6 per 100,000). Regency, South Portslade, Whitehawk and Marina, Hangleton and Knoll and Kemptown all had rates above 20 per 100,000 population, but the small numbers at ward level will means care needs to be taken in interpreting these differences.

Table 10: Drug deaths by ward of residence, number and rate, Brighton & Hove residents only

Ward of residence	Count	Crude rate per 100,000
Queen's Park	14	44.9
West Hill & North Laine	11	34.6
Regency	9	30.1
South Portslade	8	26.9
Whitehawk & Marina	10	26.9
Hangleton & Knoll	10	21.9
Kemptown	7	20.4
North Portslade	6	19.8
Westbourne & Poets' Corner	5	16.3
Coldean & Stanmer	5	16.1
Hollingdean & Fiveways	5	11.0

Note: This includes only those wards with five or more deaths in the three-year period.

Most areas of Brighton & Hove are within 30 minutes public transport travel time of drug and alcohol treatment services – in plotting location of death, 11 people were further than 30 minutes away from services.

Most people died at home 99 people (72%), or in someone else's home, 20 people (14%). Other locations included hotels, on the street, a car/private garage, an outdoor public space, and public toilet.

Risk Factors

Non-fatal overdose

28 people, (20%) had a recorded non-fatal overdose in the 12 months prior to death.

It is likely the number of people with a non-fatal overdose is higher than recorded as these are not always reported, emergency services may not be contacted, and the information may not be included in the coroner records.

Overdose

69 people appeared to die from an accidental overdose.

Of these

- 42 people had a mental health need
- 20 people were in poor physical health or had unmet physical health need
- 12 people had no recorded history of using the substance that caused their death
- 10 people had recently achieved a period of abstinence
- High-risk injecting practices and snorting opiates were implicated in 6 deaths.

Using alone

Using substances when on one's own, particularly opiates, presents a significant risk of fatal overdose. 84 people (61%), were recorded as dying alone.

Suicide and self-harm

Knowing about individual risks associated with suicide and self-harm can provide helpful intelligence to guide support for people to reduce drug death risks.

- 52 people (38% of people who died) had a risk of suicide recorded by a service contributing to the inquest
- 26 people (19%) had a risk of self-harm recorded
- 16 people (12%) had a suicide attempt recorded in the 12 months prior to death.

Experience of bereavement

31 people (22%) had a recorded recent bereavement of family members, friends, or partners. Of these nine were known to be drug related and eight were known to be suicides.

Adverse childhood experiences (ACEs)

The World Health Organization defines ACEs as being "intensive or frequently occurring sources of stress that children may suffer in early life".[26]

These experiences include: multiple types of abuse; neglect; violence between partners or caregivers; household dysfunction such as alcohol and substance abuse; and peer, community, and collective violence.

Around one in three people in the audit had recorded single or multiple ACEs. This is likely to be a significant underestimate given that the prevalence is estimated to be around 47% nationally for all people.[27] Information around ACEs may not have been shared as part of the inquest proceedings as they may not have been needed to establish cause of death.

Care Experience as a child or young person

14 people (10%) who died had recorded experience of residing in care as a child or young person. This figure may be higher, given the potential for non-disclosure, and that this information is not needed to establish cause of death.

It is difficult to reflect the number of adults in the UK today who were looked after during their childhood due to changes in definitions of looked after children and record keeping requirements over time. The NSPCC estimates that nationally around 105,400 children in 2021/2022 were looked after. This equates to approximately 1% of under 18's. This is a similar proportion to Brighton and Hove.[28]

Safeguarding

Adult Social Care reports were not always included at inquest, and often Adult Social Care involvement was reflected in GP or substance use treatment service reports. Where information was available:

- 39 people (28%) had self-neglect risks identified by an agency contributing to the inquest. Of these, nine people were receiving packages of care
- 35 people (25%) had ongoing safeguarding needs at time of death
- 14 people (10%) were victims of domestic abuse or sexual assault in the previous 12 months
- 10 people (7%) were alleged or convicted perpetrators of domestic abuse or sexual assault in the 12 months prior to death
- 10 people were subject to a safeguarding enquiry in the 12 months before death
- Seven people (5%) reported they were victims of cuckooing
- Seven people (5%) were released from prison in the 12 months before death.

Building blocks of health

The Health Foundation defines the building blocks of health as the foundations required for a thriving community:

"To create a society where everyone can thrive we need all the right building blocks in place: stable jobs, good pay, quality housing and good education" [29]

Inequality can be caused by unemployment, insecure finances, lack of stable housing and / or poor mental health, and the compound nature of these – where more than one is experienced, has a greater impact. These are issues that affect a significant proportion of people who use drugs, and it is important to understand how relevant these factors are to people who died in Brighton & Hove.

Multiple compound needs (MCN)

Brighton & Hove has benefited from the Changing Futures programme since 2022. Changing Futures Brighton & Hove offers multi-disciplinary support to people who experience multiple compound needs defined as:

"people who experience three or more of the five primary disadvantages or needs at the same time: homelessness, current or historical offending, substance misuse, violence & abuse, and/or poor mental health"[30].

The audit captured information on all five of these disadvantages where available. The data offers some idea of the extent of compound disadvantage in the audit population.

50 people (36%) may have met the criteria for a referral to Changing Futures.

Accommodation type

Accommodation type was not recorded for 31 people who died (22%) and so these data should be interpreted with caution.

- 69 people, (50%) had "significant changes" to their accommodation in the 12 months before they died. This included being evicted or threatened with eviction, cuckooing concerns, multiple changes of accommodation, moving into student accommodation, moving to or from Brighton & Hove, and prison release
- 28 people (20%) were recorded to be living in insecure housing. This includes people living in supported accommodation, emergency and temporary accommodation, sofa surfing and street homelessness
- 9 people had been discharged from residential drug and alcohol treatment in the 12 months before they died, with the majority of these discharged between 3 – 12 months before they died.

Occupation

- At the time of death, 87 people (63%) were unemployed or not available for work due to sickness or disability
- 17 people (12%) had significant changes to their occupation in the 12 months before death. These included threat of, or investigation/suspension from work or university; being made redundant; loss of work related to Covid-19 restrictions; or significant sickness related absences from work
- 15 people (11%) were working full or part time
- Eight people (6%) were full-time students.

When looking at occupations for all those who died from a drug death, including past occupations of people who were unemployed or retired, the most common occupation types were:

- Students (10 people)
- People working in the creative arts (9 people)
- People who owned businesses (8 people)
- Care workers (8 people)
- People in manual occupations (8 people)
- Chefs (5 people)

Other occupations included teaching, volunteers, and health and social work professionals.

Financial difficulties

31 people (22%) had a record of financial difficulties in the 12 months before death. These included financial difficulties associated with job loss, significant loans / debt, or financial exploitation by others.

A history of problematic gambling was recorded in fewer than 5 people who died a drug death.

Relationships, family and social networks

65 people who died (47%) were recorded as being single. In addition, 20 people (14%) had significant experiences of social isolation or were confined to their home due to mental or physical health needs.

Parental status was not routinely recorded, and these data should be interpreted with caution. Men had less information recorded on parental status: 35% of men in the audit population had no information on parental status recorded compared to only 8% of women.

- 25 people (12 women and 13 men) were recorded as parents of one or more child under 18 years
- 14 people (56%) with a parental status recorded had contact with children's services in the year before death. The majority of these were women
- 8 people (32%) with a parental status recorded had children removed from their care.

Next steps

The drug death audit identified a number of themes and factors that will help to develop recommendations for action to reduce deaths.

The themes identify opportunities for focussed harm reduction messaging, targeted activity in the drug and alcohol treatment service, improved pathways between services supporting co-occurring needs, managing risk factors associated with individual experience, the presence of chronic pain and poor physical health, and the impact of multiple compound need.

The next steps are to develop recommendations for action at a multi-agency workshop to develop and disseminate across commissioners, providers, and services. This will ensure agencies understand the contribution they can make to reducing drug deaths in Brighton & Hove.

Appendix A – Brighton & Hove drug deaths and suicide audit ethical use agreement

On 19/09/2023 the Public Health team, Brighton and Hove City Council gained consent from HM Coroner Ms Penelope Schofield to undertake an audit of Drug Deaths in Brighton & Hove.

Consent was granted:

- To collect data from electronic records (WPC database) and paper files, for completed inquest records in Brighton & Hove between the dates of 01/04/2020 and 31/03/2023, where the death is identified to be drug related or drug poisoning, and for a subsequent audit of deaths by suicide for the same time period.
- For the data to be stored on an Excel database held securely by Brighton & Hove City Council (BHCC), for analysis and will be removed (destroyed) after the production of a report.
- To undertake a 5-10 case audit on 02/10/2023 and 06/10/2023 to pilot the audit process.
- For the audit team to have access to the WPC database on their BHCC laptops for the purposes of undertaking the audit. Other members of the audit team will be added to this agreement as they join the audit.
- The project lead will identify the appropriate cases for the pilot.
- An auditor should not audit any case if they know the person or have prior knowledge of a case.

Brighton & Hove City Council acknowledge that auditors will have access to the WPC database on BHCC laptops from 02/10/2023 until the audit is complete or they are no longer part of the audit team.

The auditors will:

- Only access the WPC database, cases and evidence relevant and necessary for the purposes of undertaking the audit
- Consent to removal of access to WPC at the earliest opportunity once they are no longer part of the audit team
- Not remove or discuss any details of case review or audit except for a specifically agreed process of undertaking the audit.

Although the General Data Protection Regulation (GDPR) and the Data Protection Act does not cover personal identifiable data once a person has died, the auditors will review the personal information of the deceased and those who knew them with respect, confidence, and without judgement or assumption, and with the same high standards of management of data relating to persons still alive.

No details of cases reviewed, including any intimate or identifiable personal details will be shared outside of the audit team, under any circumstances.

Should any auditor have cause to think that they have reason to share details outside of the audit team programme of work this must be discussed in the first instance with both the project lead and lead consultant.

Signed	
Name	
Position	
Date	

Appendix B – audit fields

Demographics
- Age
- Date of birth
- Date of death
- Gender identity
- Sexual orientation / identification or relevant behaviours
- Deceased home postcode
- Ethnic background
- Racialised identity / heritage
- Was the deceased an asylum seeker or refugee (regardless of settled status)
- Religion or belief
- Did the deceased at any time service in the armed forces

Death Registration
- Coroner's conclusion
- Drug related death definition
- Medical cause of death 1a, 1b, 1c & 2

Details of death
- Location of incident / discovery
- Location postcode of incident / discovery
- Where was deceased pronounced dead
- Witnesses to death
- First person on the scene
- Was Naloxone administered

Substance use
- Community substance use treatment tier in past 12 months
- Residential substance use treatment in past 12 months
- How long ago was planned exit from residential treatment (if applicable)
- Relevant substance use / treatment history
- What was primary substance
- What was secondary substance
- Frequency of any substance use in the 12month before death
- Frequency of substance implicated in death in 12 months before death
- Injecting history in 12 months before death
- Drug consumption route info
- Was deceased prescribed opiate substitute treatment (OST) in the 3 months before death?
- OST type in past 3 months
- OST prescribing at time of death
- Was alcohol consumed at time of death (ATD)
- Average number of units per week (if known)
- Risk of overdose in past 12 months
- Evidence of non-fatal overdose in past 12 months

Toxicology
- Heroin / synthetic opiates
- Medicinal opiates (excluding OST)
- Methadone
- Benzodiazepines / novel benzodiazepines
- Alcohol
- Pregabalin / gabapentin
- Z drugs
- Cocaine
- Promethazine / antihistamines
- Antidepressants
- Antipsychotics
- Propranolol
- Cannabis / synthetic cannabinoids
- Ketamine / MDMA
- Paracetamol
- GHB
- Methamphetamine
- odium Nitrate
- Other
- How did deceased access substances?

Relationships, accommodation, ETE & finances
- Relationship status ATD
- Accommodation ATD
- Living with ATD
- Significant changes to accommodation in past 12 months
- Experience of residing in care as child or young person
- Pregnancy in past 12 months
- Any children under 18
- Children services involvement with dependent children in past 12 months
- Nature of children services involvement
- Occupation
- Occupation state ATD
- Sex work in past 12 months
- Any changes to employment status in past 12 months
- Engaged in education or training
- Evidence of financial difficulties / unmanageable debt
- Any suggestion of problematic gambling
- Links to other drug deaths, suicides, or other deaths
- Any online suicide / self-harm related experience

Mental health & wellbeing
- Any mental health issues in past 12 months
- In patient treatment for mental health in past 12 months
- Mental health management level
- Services involved in mental health management
- Referred for talking or change oriented therapies in past 12 months
- Discharged from any community mental health provider in past 12 months
- Brand & type of mental health medications prescribed (excluding OST)
- Any contact recorded with mental health rapid response services
- Suicide risks recorded by any agency
- Self-harm risk recorded by any agency
- Any suggestion of adverse childhood experiences (ACEs)
- Summary of mental health engagement / experience in past 12 months

Mental health or wellbeing diagnoses

- Schizophrenia or other psychotic disorder
- Bipolar affective disorder
- Depression
- Anxiety disorders
- Panic disorder including obsessive compulsive disorder & phobias
- Post traumatic stress disorder
- Eating disorder
- Dementia
- Personality disorder
- Sleep disorder / medication for sleep in past 12 months
- Adjustment / reaction disorder

Neurodiverse conditions (NDC)

- Evidence of neurodiverse conditions
- If yes was it autistic spectrum disorder, ADHD, learning disability or other
- Was deceased receiving any support for NDC
- Service providing NDC support

Physical health

- GP surgery
- Last face to face contact with GP
- Last (any) contact with GP
- Reason for last contact
- Number of consultations with healthcare provider at GP surgery in past 12 months
- Number of prescribed medications for physical health
- Number of A&E / hospital admissions in the past year
- Physical health diagnoses
- Respiratory illness
- Cardio-vascular condition
- Liver condition
- Pain management needs
- Blood borne virus
- Mobility issues
- Neurological conditions
- Other

Criminal justice system contact

- In prison or young offenders institute in past 12 months
- If yes, was Naloxone issued on release
- Contact with Police in past 12 months
- Supervised by Probation in past 12 months
- Evidence of hate crime victimisation (in person or online) in past 12 months
- Evidence of cuckooing (victim of perpetrator) in past 12 months
- Domestic violence or sexual assault (victim or perpetrator) in past 12 months

Safeguarding

- Risk of self-neglect recorded by any agency
- Any safeguarding referrals made in past 12 months
- Care act assessments undertake in past 12 months
- Receiving support from adult social care or care & support package in past 12 months?

Narrative fields

- Any other service involvement
- Details of Coroner identified learning to prevent future deaths (PFD)
- Any learning identified in provider reports
- Auditors view on the contributing or preventative factors

References

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