Drug-related Deaths

A drug-related death (DRD) is a death caused by a drug(s) listed under the Misuse of Drugs Act (1971). 99 cases of DRD were reviewed by a multi-agency case review group in Lothian in 2014.

In the majority of cases (58), more than one substance was implicated in the final cause of death. Methadone was implicated in the final cause in 57 deaths. The number of cases of heroin-related deaths continues to rise (see below). The new psychoactive substance ethylphenidate (e.g. ‘Burst’) was implicated alongside controlled drugs in 6 cases.

Heroin-related deaths in Lothian

2011: 12 cases (out of 81 cases)
2012: 18 cases (out of 84 cases)
2013: 29 cases (out of 79 cases)
2014: 46 cases (out of 99 cases)

Patients at most risk (based on case review data)

- Single, unemployed males in their early forties.
- History of long-term polysubstance misuse.
- History of alcohol misuse.
- Depression.
- Co-morbidities; conditions such as COPD.
- History of non-fatal overdose.

Notices

- The DRD Review Co-ordinator, Peter Fairbrother, provides notification in writing and a short questionnaire (relating to the medical history of the deceased) to all GPs of a suspected drug-related death of a practice patient. Please complete the questionnaire as this information is used to support case review and is added to the National Database of Drug-related Deaths in Scotland.
- Notification of the final cause of death is provided once it is known. This is usually 8 weeks after date of post-mortem.
- The final report from the Pathology Unit and the toxicology results may be requested by emailing the Procurator Fiscal.

Interventions to minimise risk

- Ask about experience of non-fatal overdoses.
- Discuss TAKE HOME NALOXONE with all opiate users, their family and carers. Prescribe as Prenoxad or signpost to local drug service for supply.
- Consider co-morbidities which may increase risk.
- Be cautious when co-prescribing - e.g. amitriptyline or prolonged QT e.g. citalopram. Keep vigilant regarding the prescription of drugs liable to misuse. (Note LOCAL AIDS Sheet no 132 ‘Gabapentin and Pregabalin’.)
- Share information with, and seek advice from, other professionals – e.g. community pharmacist or local substance misuse service.
- Consider supervised methadone consumption if there are signs of unstable drug use (e.g. unprescribed drugs in toxicology or repeated poor attendance) and ensure regular review. See LOCAL AIDS Sheet no 124 for advice on methadone prescribing in Lothian. Remember that these patients may be at increased risk of overdose. Refer to local specialist service if necessary. Ensure naloxone supply.

For further learning or information about a specific case

- Attend the local DRD case review meeting involving a practice patient. (The DRD Review Coordinator can provide details.)
- Involve members of the local DRD Review Group in SEA following a DRD at the practice (the DRD Review Coordinator will provide assistance.)
- Contact PCFT for practice based learning about drug-related deaths and take home naloxone.
- Read the annual report of drug-related deaths in Lothian. (A copy is posted to all practices. It is also available on the Lothian DRD website www.drdlothian.org.uk.)
- For queries relating to drug-related death in Lothian get in touch with Peter Fairbrother, Drug-related Deaths Review Coordinator, NHS Lothian. Tel. 0131 465 5654 Email peter.fairbrother@nhs.net