GUIDANCE FOR UNDERTAKING FATAL AND NON-FATAL DRUG POISONING REVIEWS IN WALES

Welsh Government

Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Welsh Government’s consultation on guidance for undertaking fatal and non-fatal drug poisoning reviews in Wales.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales offers the following responses to the following specific questions raised in the Welsh Government’s consultation document:

Overall document

The document sets out proposals for the restructuring of the mechanisms and bodies in Wales who have a remit for reducing fatal and non-fatal drug poisonings (previously referred to as Drug Related Deaths and Near miss overdoses). Please provide any general comments that you have regarding the restructuring below.

We would note what appears to be a degree of confusion in the consultation document in that some of the fatalities discussed do not seem to us to fall into the remit of the consultation (e.g. citalopram, dosulepin and paracetamol which are included within the statistics provided).

Given that the numbers presented in the document are comparatively small, and the underlying addiction problems are similar, we would also question why alcohol-related deaths have not been included in the proposed guidance. From medical experience, we would note that this represents a far greater number of cases and therefore has a much greater financial implication. We would suggest that the introduction of a single method of investigation/assessment could also avoid confusion – especially for those who die, or are harmed, as a result of a combination of drugs and alcohol.

Given that the majority of fatalities are of individuals who are not in contact with any drugs services, we would consider that it is difficult to know what could be done to easily prevent them from occurring. In the final analysis, we would note that individuals do have responsibility for their own health.
Chapter 4 – Review of Fatal Drug Poisonings. Processes and Structures – Definition

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

It is proposed that the wider definition above is retained as a working definition for the identification for review of fatal drug poisoning when developing and implementing standard operating procedures. Do you agree with this wider definition? If not, please say why and suggest an alternative definition.

We would note that the proposed definition would appear to include any incidents of overdose, and not just those of illicit drugs. BMA Cymru Wales would therefore suggest that a thorough investigation of anyone who dies by a drug and/or alcohol overdose should perhaps be undertaken. This would assist in reducing the stigma on those regarded as addicts.

Given the complex interaction that often exists between mental illness, drug abuse and alcohol abuse, we would therefore suggest that there would be merit in all such deaths being thoroughly investigated.


It is proposed that the existing National DRD Monitoring Group be supplanted by a National Implementation Board for Drug Poisoning Prevention. Do you agree with the proposed role and membership of this board?

In the view of BMA Cymru Wales, surely the coroner’s service and the police currently investigate all such deaths? If we accept the premise above that every death from drug and/or alcohol should be investigated, then we would suggest that a uniform approach should be developed to achieve this.

Given that significant changes are currently being considered in the death certification process, we suggest that it would be best for those proposals to also be considered in order to incorporate them into any proposed new process that might arise from this consultation.

There are also parts of this consultation document that seem to us to be quite threatening, especially mentions of the regulations governing controlled drugs which apply to the medical/pharmacy professions rather than to the realms of drug and alcohol addiction. We would suggest that in seeking to achieve an open and frank discussion of cause and effect in these cases, threats of legal action may not assist in developing the level of transparency that would be desired.

Chapter 5 – Information Sharing Agreements/Protocols

The Data Protection Act 1998 does not apply to deceased individuals. Do you have any comments in relation to the matrix at 5.3 which outlines the sources/organisations and the types of information likely to be relevant in the event of a drug related death?

In our view, no assumption should be made that GPs will have the time or the resources to prepare lengthy reports. Likewise, we would also note that a GP’s duty of care ends with a patient’s death.

We would, however, suggest that a review of the Access to Medical Records Act be undertaken, as this might apply in this case more than the Data Protection Act. If there is legal clearance to provide such data from general practice, then a summary generated by the standardised primary care computer systems (the Welsh Clinical Gateway) might perhaps provide all the clinical data that the GP holds with minimum effort on behalf of a practice.
Chapter 6 – Procedures – fatal drug poisonings and non-fatal poisonings

*It is intended that rapid case reviews replace the existing confidential review process and should be led by a responsible individual/Lead Officer within the Harm Reduction Group (which should be coterminous with the Area Planning Board.) The core standards require Area Planning Boards to ensure that a system is in place which, as a minimum, should enable the regular review of drug related deaths and near fatal incidents*. What barriers do you see to the procedures outlined for implementing the rapid case review process for fatal and non-fatal drug poisonings?

We would contend that the coroner’s court system is the basis for all investigations of sudden or unexpected death. Given that the new death certification process will include an investigational element, with a medical examiner type role, then we would suggest this process could perhaps be built upon rather than an additional investigative system being created.

Chapter 9.2 – Data Collection Forms

*It is proposed that case review co-ordinators use revised forms DRD 1 and DRD 2 to notify relevant agencies of a fatal drug poisoning and ask that the DRD 3 questionnaire be completed within 5 working days. The information to be collected on the forms is extensive; however is there anything else you feel should be included on these forms?*

We would suggest that the coroner’s court system and the new proposed death certification process be reviewed to ensure there will not be any overlap between them. We would note that a legal opinion regarding the Access to Medical Records Act would certainly be needed prior to any disclosure of medical information. We would also suggest that all deaths by overdose should be thoroughly investigated through the use of a uniform process.

Other issues

*We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:*

BMA Cymru Wales would wish to reiterate our view that before any decision is taken which could lead to the establishment of an additional investigative process, reviews should be undertaken of the potential use of the Access to Medical Records Act to facilitate the disclosure of medical records and the impact of the proposed new death certification process together with its interaction with the coroner’s service.

We would also kindly request that, if approved in law, extracts of GP records should be able to be provided in a manner which would allow them to be easily retrieved electronically. This would assist in easing the potential creation of an additional bureaucratic burden on general practice.

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