Discussion Paper

A Proposal for an 'Avoidable Death' Review Process

Scope and terminology

This discussion paper is focussed on a cluster of different but often related classifications/circumstances of deaths, sometimes referred to as 'preventable' deaths, historically these would have been described as drug related deaths, alcohol related deaths and suicide. However, changes to patterns of drinking and drug use and more awareness around suicide risks, fire deaths and mental health and domestic homicides make these 'traditional' differentiations less relevant for a public health approach informed by the wider social determinants of health and wellbeing.

Our working definition of an 'avoidable death' is those deaths where 'in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future deaths could be reduced' (* this is taken from the definition of preventable child deaths). Our working definition is also in line with the official ONS definitions (2017, p4) of amenable, preventable and avoidable mortality (where avoidable mortality is the broadest term):

- *Amenable mortality*: "a death is amenable (treatable) if, in the light of medical knowledge and technology available at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare"
- *Preventable mortality*: "a death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense"
- *Avoidable mortality*: "avoidable deaths are all those defined as preventable, amenable (treatable) or both, where each death is counted only once; where a cause of death is both preventable and amenable, all deaths from that cause are counted in both categories when they are presented separately"

For the purposes of this paper, avoidable deaths include:

- ✓ Deaths directly attributable to alcohol

- ✓ Drug related deaths (traditionally this would mean illegal drugs but there is a case that deaths from abuse of prescription drugs should also be included)
- ✓ Suicide
- ✓ Domestic abuse [DA] leading to homicide
- ✓ Homicide by a person with mental health [MH] problems

Current Situation

Currently there is a well-established suicide audit process which feeds into but is separate from the suicide prevention strategy. The local suicide audit follows national guidance; however, there is no agreed scrutiny process for deaths by suicide (especially for deaths where the person was not in touch with local services). Deaths by suicide are included in the PHOF.

There is also a well-established drug related death process that records deaths and undertakes some audit and scrutiny activity but lacks some of the features that would make it a true audit and scrutiny process. Drug related deaths will be included in the PHOF in future years as a response to the unprecedented rises seen nationally and locally. In addition to 'traditional' illegal drugs we are seeing shifts in substance misuse with many more people abusing prescription drugs (usually acquired illegally) and PHE report that benzodiazepines, anti-depressants and Z drugs are all appearing post mortem at an increasing level.

Alcohol related deaths have only been recorded and counted in the last calendar year previously there was no process at all, largely because of the difficulty collecting data and the added complexity around deaths where there is a fractional attribution. This year we have been recording alcohol deaths in (or near) treatment, i.e. people on waiting lists, currently in treatment or discharged within the previous twelve months.

Domestic Abuse homicides and Mental Health homicides are not routinely recorded and are only subject to scrutiny if a 'responsible' body commissions a serious case review. They are rare events but when they occur they have a very high profile in the media and generate lots of work for involved agencies.

At the moment, Gary Wallace undertakes the audits related to substance misuse and is also been involved in DA homicide reviews. Moira Maconachie runs the suicide

audit process. Carol Harmon, Public Health Analyst has just joined the group to provide additional capacity and expertise.

Over the last year we have stepped up collaboration between us because we have all noted the considerable overlap between the types of deaths discussed above. Several drug deaths might have been classified as suicide, and suicides very often involve substance misuse, either as the method of suicide or in the antecedents prior to suicide. In addition, both DA homicides involved substance misuse by the perpetrators and one included the victim too. Lastly, colleagues from the Fire Service have highlighted the frequency of substance misuse and mental health associated with fire deaths and indicated they are willing to join an Avoidable Deaths Group.

Proposal

Our proposal is to extend the above work (when appropriate) to include a joint review of avoidable deaths. This would involve co-producing a new way of working together with partners so that we share expertise and deepen our understanding of the range of avoidable deaths that occur in the city.

Our local coroner has met with us to discuss this approach and share his ideas, he is fully supportive and has agreed to give us systematic access to information which will significantly improve our ability to review deaths. Our complex needs services have also agreed to participate in a review process and to routinely share SIRI investigations, root cause analysis and other learning points that would feed into and inform different prevention strategies in the city.

With a coordinated approach between our review process and the coroner's office we will be able to routinely offer results of our investigations to the coroner – something which only happens ad hoc currently. This improved access will enable us to carry out audits and reviews more consistently and effectively and to produce results which are directly comparable year on year and with other areas. It will enable us to produce annual reports identifying trends and to collate things like risk factors and correlations that we can feed into risk 'flagging' systems in services.

Finally, should this proposal be implemented we hope to facilitate the establishment of an 'Avoidable Deaths Review Group' (ADRG), comprised of experts

from services including MH, the police and fire service. This group will review those deaths where there is 'system learning' and where there is overlap between multiple factors. The group will not replace or duplicate existing processes, but instead provide an opportunity to review those deaths which cross organisational thresholds and boundaries. The proposed 'Avoidable Deaths Review' has had an initial meeting and partners are supportive of the idea to bring the various audit processes together. The first piece of work is being undertaken by ODPH and is to map all the deaths over the last years in order to develop a better understanding of the size, scope and issues. The aim is for this to be complete by the beginning of April 2019.

We propose that the Health and Wellbeing Board is the strategic body which 'owns' this piece of work and that the ADRG be a sub-group of the H&WBB. This will give the group legitimacy and therefore, any recommendations it makes will have strategic 'reach'.

Summary

1) There is considerable overlap between suicide, substance misuse deaths, fire deaths and domestic homicide deaths
2) There is currently no process that brings reviews together in order to generate learning across our whole system
3) The work currently being done would continue to be done; this proposal suggests we amend our work to include a review process to share learning in order to help reduce the number of avoidable deaths in the city.
4) We propose the Avoidable Deaths Review Group (ADRG) produces an annual report and presents it to the Health and Wellbeing Board.
5) We propose that the ADRG reports to the H&WBB on an exception basis where particular threats, harms or trends require action in year.

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Reference

ONS Statistical Bulletin (2017) **Avoidable mortality in England and Wales: 2015.** Available: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2015