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Alcohol-Involved Death: A pilot study

Final Report

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Alcohol Involved Death: A pilot study. Final Report

Aims

This exploratory study was carried out in two Coroner Districts using data routinely collected as part of the process of investigating deaths reported to coroners. The main aims of this study are to:

- Establish methods to identify deaths where harmful use or alcohol dependence is relevant (but not necessarily formally attributed as the main or contributory cause of death).
- Explore in detail a sample of deaths which fall into this wide definition of deaths where alcohol is relevant.
- Describe what, if any, specialist and non-specialist interventions or support from statutory and independent sector services were accessed prior to death.
- Consider how the identified sample relates to all deaths, not just those reported or investigated by the Coroner.
- Specify areas for further development and research.

Background

The nature and extent of alcohol induced harm is of interest to policy makers and service providers. There is a plethora of definitions, statistics and estimates of alcohol harm each with marked limitations. The most commonly cited and internationally comparable statistics on mortality are Alcohol Related Death figures, produced by the Office of National Statistics (ONS), which require a 'single, statistically and medically defensible definition of alcohol related mortality' to monitor the public health burden and to report on trends both geographically and over time. This feasibility study goes beyond the definition of alcohol related death used by the ONS and considers a wider range of deaths where alcohol is relevant to the events leading up to death or as a significant and harmful part of the lifestyle of the deceased. This exploratory study used Coroner records to identify deaths which fall into this definition. Although the sample of deaths explored did not include all deaths where alcohol is a contributory factor, it provided sufficient information in a readily accessible form to meet the exploratory aims of the work. It had the advantage of including deaths that would not otherwise have been recorded as involving alcohol.

Using coroner's records to explore death and mortality (see for example Howarth et al 1997 and Langer et al., 2007) and indeed alcohol involved death, is not without precedent (see for example, Warner et al., (2000) and Bedford et al., (2006). Both research teams used coroners' files to examine the role of alcohol in particular deaths. Warner's focus was on drowning and Bedford and colleagues looked at accidents and suicides.

The next section provides a brief account of how the coronial system operates in England and Wales and puts this feasibility study in the context of that system.

Coronial System

When a death occurs the attending doctor completes a medical certificate of cause of death (MCCD). However, with some deaths it is not possible to issue the MCCD immediately and such deaths are reported to a coroner. There are also some deaths where the doctor certifies the death and still refers the death to a coroner. For a detailed list of the type of deaths routinely referred to a coroner see Appendix 1.

If the medical cause of death is reasonably clear but there is some uncertainty, or the doctor who attended the patient during the final illness is not immediately available to sign the MCCD, the matter is often resolved by a discussion with the coroner directly, or via the coroner's officer. If satisfied that neither an inquest nor a post mortem examination is necessary, the coroner will issue Pink Form A, which allows the Registrar of Births and Deaths to register the death so that the deceased can be cremated or buried.

The coroner will usually request a post mortem examination if there is uncertainty over the cause of death, or where the death was sudden and the cause unknown. If the post mortem reveals that the death was not unnatural, the coroner will issue Pink Form B to the Registrar, which means that the death can be registered and the body released for cremation or burial.

However, if the coroner finds that the death was unnatural, an inquest will be held. This happens in about 12% of all cases referred to coroners. Individuals whom the coroner believes may be able to provide relevant information are asked to submit a statement. Witnesses may be called to give evidence in

person or may be required to submit written evidence to be presented at the inquest.

A death certificate has two parts. Part I lists the condition or sequence of conditions leading directly to death, whilst part II lists associated conditions which contributed to death but are not part of the causal sequence. The underlying cause of death is coded according to the International Classification of Diseases 10th edition. It is this which appears in the analysis of official statistics.

Design and Methods

Sampling Strategy

To establish how best to sample death records to identify deaths where alcohol is relevant a different strategy was employed in each Coroner's Office.

Office A

The intention was to use a pre-defined sample which the Coroner had categorised as involving alcohol in some way, either at the time of death or as part of the lifestyle of the deceased. This pre-defined categorisation, (in relation to alcohol) augmented the routine record keeping in Office A, and was not part of the standard procedures in Office B

Office B

The intention was to use a *simple* electronic search of the 'Cause of Death' (CoD) fields of the database of deaths reported to the Coroner resulting in either a Pink Form A, Pink Form B or Inquest. We used 'alcohol' as the search term in 1a, 1b, 1c and 2 CoD fields.

Findings

Testing the sampling strategies in Office A and Office B

To test whether or not the prospective recording applied by the coroner in Office A or the retrospective searching of the electronic records in Office B is sufficient to find most or all of the cases of interest, we carried out a further manual search

of a sample of the paper files and compared this with the deaths identified by the alternative methods over the same time period.

Range and quality of data

The mechanisms employed in Office A and B identified a sample of deaths where alcohol was involved or contributory. We adapted and augmented the Drug Related Death form (DRD1) to extract demographic information and, where it was available, the service utilisation information for each of the cases we identified. The intention was to establish the range and quality of the information available as part of the Coroner's records and to highlight any significant gaps in information. It was anticipated that this would fall short of the processes undertaken in the confidential reviews of drug related deaths, where additional reports from agencies are requested. However, as the findings indicate, the Coroner's records proved to be a rich source of data.

Definition of Alcohol-Involved Deaths

Part of the process of conducting the study was to operationalise a broad definition which we will refer to as Alcohol-Involved Deaths (Alc-ID) which is practical and has utility for further studies following from this pilot. The research team's understanding of the current research, policy and practice literature, discussions with the Coroners and the Community Safety Officer and analysis of Coroner's records informed the development and refinement of the definition

Alcohol-involved deaths: Untimely deaths where the deceased person's consumption of alcohol played a significant part in his or her death.

We suggest that, where there are doubts as to whether a particular case meets this definition, the following question should be asked:

If this person had not consumed alcohol, would death have occurred in this way at this time?

Answering **no** or **probably not** would indicate a relevant case, that is, an Alcohol Involved Death.

What follows is an explanation and exposition of this definition, and how it could be utilised to identify cases for the purposes of further research and to inform Alc-ID Reviews.

We suggest that alcohol-involved deaths can be divided into two main categories of alcohol involvement, which we have designated as chronic and acute. Chronic cases would be those where the long-term use of alcohol, usually over a number of years, has led to a disease which has resulted directly in the person's death or played a significant role in that death. These cases would be identified by the listing of alcohol or an alcohol related disease in the recorded CoD. Examples would include "alcoholic cirrhosis of the liver", "alcoholic liver disease", "long term alcohol (ab)use" or "alcoholism". Most of these cases would be amongst those designated by the ONS as Alcohol Related Deaths.

Acute cases would be those where it is the consumption of alcohol immediately prior to the time of death which has led to that death, irrespective of whether the use of alcohol has been a long term contributor to ill-health. These can be further divided into direct and indirect cases. Direct cases would be those where the consumption of very large quantities of alcohol, effectively an overdose of alcohol, has led directly to the death. Here "alcohol toxicity" or some similar phrase would be listed as a CoD, possibly alongside some other factor such as hypothermia or the use of drugs, illegal or legal. Many but not all of these cases would appear in the ONS statistics for Alcohol Related Deaths.

Indirect deaths would largely come under the general heading of accidental death, although we suggest that the coroner's verdict of misadventure, with its implication of putting oneself in harm's way, should be borne in mind when considering this group. These are cases where the cause of death would be unlikely to refer to alcohol and therefore will not appear in ONS Alcohol Related Death statistics. They would be identified by an examination of inquest records of potential cases for mention of alcohol (with or without behavioural disturbance) in post mortem toxicology reports or witness reports in the period leading up to the person's death. We suggest 80mg/100ml (the legal limit for driving a motor vehicle) as a suitable guide lower limit in identifying cases from toxicology reports where there is little or no other information indicating alcohol use in the time leading to death. Most of the cases we examined exceeded this lower limit by a considerable amount.

We suggest that this is a more suitable means of identifying appropriate cases than a reliance on the listed CoD, the inquest verdict or the brief description of the circumstances of death because we have observed a tendency to underestimate or disregard the role of alcohol in some deaths. This can be illustrated by two examples of such underestimation in post mortem examination reports of cases we have recently examined.

The first of these was a man who had a neurological condition which resulted in him being unsteady on his feet. He fell down the stairs at home, sustaining injuries from which he died shortly afterwards; these two factors were given as the likely causes of death in the report of the post mortem examination. This was reflected in the inquest findings as to cause of death. However, the high levels of alcohol indicated in the post mortem toxicology report, and his partner's eye-witness report that he had drunk "almost three flagons" of cider in the hours leading up to the fall, were not remarked upon. However, this level of intoxication seems to represent at least as likely a cause of the fall which resulted in his death as the reported neurological condition. In all likelihood the two factors interacted with each other. This case will not appear in the standard ONS Alcohol Related Death figures.

The second example occurred in several cases where the toxicology report showed high (but non-lethal) levels of both alcohol and illicit drugs. In such cases, the sedative effects of alcohol and drugs interact to produce an effect that is greater than the sum of the parts, leading to lethal respiratory depression. The post mortem examination reports concluded that, while neither the alcohol nor the other drugs were likely to have caused death on their own, the likely cause of death was given as illicit drug use. Alcohol was recorded as a contributory factor. This was reflected in the recommended CoD and in the inquest findings. There appears to be no clear reason for this; the conclusion could equally have been of death from alcohol consumption with illicit drug use as a contributory factor but in each case drug use was assigned primacy in causation. Thus these cases are unlikely to appear in the ONS Alcohol Related Death figures.

A further category which is related to accident and misadventure is that of suicide, which can be seen as a special case of "putting oneself in harm's way". These deaths caused us some difficulty in our task of identifying cases suitable

for inclusion in Alc-ID Reviews; this can be illustrated by consideration of two case examples.

The first is a man who, according to the witness report of a friend, had been severely affected by the recent death of his partner and had since begun to drink heavily. The toxicology report indicated high levels of alcohol at the time of death and there were numerous empty bottles which had contained alcohol at the scene of death. However, the determined CoD was an overdose of over-the-counter medication, the use of which indicates planning in acquiring the necessary dose. There were other factors which indicated prior planning.

The second was a man who was described as a drug addict and alcoholic, which were listed as background contributory factors in his cause of death and thus unlikely to appear in ONS Alcohol Related Death figures. He died as a result of an overdose of prescribed methadone. His post mortem examination did not indicate the presence of alcohol at the time of death but it did show that he was suffering from very advanced cancer which had spread throughout his body. A further complicating factor is that the two main sites of his cancer, the bowel and the pancreas, are associated with cancers resulting from heavy drinking. In each of these cases we found some difficulty in answering our question (*If this person had not consumed alcohol, would death have occurred in this way at this time?*) with a firm no.

However, we identified a number of cases where the well known effects of the consumption of large amounts of alcohol on impulsivity, disinhibition, cognitive functioning, mood and emotional lability appeared to have played a significant part in an act of suicide. These cases can be identified using the same criteria as those for deaths from accidents. These deaths will not appear in the ONS Alcohol Related Death figures

A final group of acute indirect Alc-IDs which we suggest could be identified using these criteria is victims of homicide. Although we have not encountered any relevant cases during our examination of coroners' records, our thinking is influenced by the high rate of deaths from violence among young adult males and the frequency of the occurrence of these deaths late at night in or around establishments selling alcohol. We suggest that there are likely to be cases where the deceased's consumption of alcohol plays a significant part in the events leading up to their homicide victimisation. Again, this would appear to be

a special case of “putting oneself in harm’s way” as a result of alcohol consumption. These deaths will not appear in the ONS Alcohol Related Death figures.

Formulating policy and practice implications

The detailed exploration of the sample of deaths which fall into our definition of Alc-ID provide some insight into what, if any, specialist and non-specialist interventions or support from statutory and independent sector services were accessed prior to death.

Coroners records

As describe above, the majority of deaths reported to the Coroner have three possible administrative outcomes.

Pink Form A to the Registrar of Births and Deaths (this is where neither a post-mortem nor inquest is deemed necessary)

Pink Form B to the Registrar (this is where a post-mortem determines that the death is natural)

Inquest (this is where the coroner finds the death was unnatural).

Most of the cases disposed of in each of the ways 1-3 will have an identified cause of death. In addition, cases disposed of by an inquest will have an inquest verdict. In a very small number of cases the cause of death will be undetermined. Where a death is subject to criminal charges (for example, murder, causing death by dangerous driving) the inquest will be opened and adjourned and in most cases not resumed.

Information about cases disposed of by Pink Form A is limited to basic information such as sex, date of birth, age and cause of death. Information about cases disposed of by Pink Form B include is more detailed and for many includes a paragraph about the circumstances leading up to the death, post-mortem reports, toxicology results (in many cases) and histology results (in some cases). The most detailed information is available for those cases disposed of by an inquest. Inquest files include witness statements taken from people present at the time or discovery of the death, family members and other people who knew

the deceased. Reports from NHS substance misuse services and mental health services and voluntary sector organisations were present in some inquest files. These reports are produced at the request of the Coroner. They are a retrospective account of service involvement. In a small number of cases primary health care (GP) information going back many years was available.

As this is an exploratory study which involves the development and testing of methods to identify alcohol involved deaths, no claims can be made that the sample identified in either Coroner's Office is representative. The samples identified cannot be used to estimate the total number of alcohol involved deaths in either area. Nonetheless we did examine a large number of case files in each office and have gained considerable knowledge about how to identify relevant cases, and the quality of information available for further work.

Case files examined

We examined 380 case files during the course of the study. This included 192 Inquest files. Some of the files were examined as part of the process of determining and testing methods to identify deaths where alcohol was involved. Once it had been determined that alcohol was not involved in the death, no further examination of the file was necessary. Where alcohol appeared to be involved, the file was subject to more detailed examination and a judgement made about whether the death fell into our definition of AlCID. In most cases the decision about whether the death fell into our working AlCID definition was uncomplicated. Complex cases such as the road traffic accident victim and the fatality following house-fire (detailed below) allowed us to test the robustness of the definition in differentiating case and non-case. Future studies will refine the application of the definition by further testing and discussion.

Office A

In total 185 case files, including 69 Inquest files, were examined.

We examined in detail all the files between November 2006 and March 2009 which the Coroner had noted as deaths which involved alcohol. Alcohol involvement was either in the registered cause of death, in the circumstances surrounding the death or as a notable part of the lifestyle of the deceased.

To test whether our retrospective examination of the paper records would match this list we examined all the Pink Form B files and Inquest files 1 January-30 April 2007 noting all cases with any reference to alcohol in the files including cause of death, toxicology or lifestyle. We compared both lists of alcohol involved deaths with a list compiled solely from the registered cause of deaths.

Of the 247 deaths reported between 1 January 2007 and 30 April 2007, 119 were Pink Form A, 99 were Pink Form B (and thus subject to a post-mortem) and 29 resulted in an Inquest. We found the same 9 deaths noted on the Coroner's list of deaths involving alcohol using the CoD search. Hand searching identified a potential further 3 deaths.

Method of identification	Alcohol involved Deaths
Coroner's List	9
Cause of death	9
Hand searching	12
Detailed examination	10

We examined the three additional files in detail and determined that two of the three were irrelevant. For example, in one case the deceased was aged over 90, the reference to alcohol was minor and alcohol was not significant in toxicology, histology or post-mortem examination. The one file which we would consider retaining as a case within our definition related to young man who died in a house-fire cause by his serious carelessness at the end of a night of drinking. The deceased was reported to be intoxicated in witness statements and the toxicology results confirmed this description. .Thus it is likely that the accident could be attributed to the deceased's intoxication. This individual played an active role in causing the fire which resulted in his death.

The similarities in the number and identity of cases found by each method suggests that the use of the electronic search using alcohol as a search term will identify most of the cases of interest. It also suggests that the Coroner's working definition of alcohol involved death is similar to our provisional definition. However, by extending our comparison over a greater time period we found that between November 2006 and March 2009 the Coroner's prospective process

identified 22 more deaths than the electronic searches of the CoD (Parts 1 and 2).

We examined in detail each of the Pink Form B and Inquest files indicated on the Coroner's list to establish whether all the cases matched our provisional definition of Alc-ID. We found one case which we would consider eliminating as a case within our definition. This case involved the death of a passenger in a road traffic accident. Although the deceased was intoxicated at the time of death, the accident itself was not attributable to her intoxication; as a passenger she played no role in the accident and could be described as passive.

Office B:

202 case files including 123 Inquest files were examined.

As stated above, in Office B our initial method of identifying alcohol involved deaths was to rely on the computerised records and electronic searches. The current system allows each cause of death field to be searched. Using 'alcohol' as a search term produced a list of 83 deaths in 2007. These numbers were reduced by eliminating a few cases which were "Liver Cirrhosis non alcoholic".

Of those 83 deaths, 17 were subject to an inquest, 11 were Pink Form B and subject to post-mortem. The remaining cases were Pink Form A and had no detailed information. From our work in Office A, we knew that relying on the CoD information alone would not be sufficient to identify all the cases we were interested in; we tested the process nonetheless.

We examined all the inquest files from January 2007 to June 2007. This hand-searching identified 23 deaths where alcohol was involved either at the time of death or as a part of the lifestyle of the deceased. Of those 23 deaths, 8 were identified by searching all the Cause of Death fields on the database.

Cause of Death	8
Hand-searching	23

The 15 cases which were not identified by electronic searches of the CoD were found by reviewing all the Inquest files over the 6 month period specified, looking for references to alcohol in witness statements, toxicology or post-mortem

reports. Where the only reference to alcohol was in the toxicology report and the Blood Alcohol Level was low we did not include the case on the list of Alc-IDs.

Identifying alcohol involved deaths

From our examination of nearly 400 case files and comparison of different methods of identifying alcohol involved deaths we concluded that most, if not all deaths of interest could be easily identified either retrospectively or prospectively by establishing a simple method of tagging the cases as they are reported to a Coroner's Office.

The retrospective identification is possible by combining the electronic search using relevant search terms. In this feasibility study using just 'alcohol' as a search term in all CoD fields, combined with a review of Inquest files for reference to alcohol use found all the cases of interest in the time period we reviewed. Further testing over a longer time period will determine whether additional search terms and searching in other fields on the database, identify the cases of interest more readily.

Although there were differences in the order and presentation of information in Office A and Office B, it was possible to quickly establish which sections of the Inquest file required particular attention in determining the involvement of alcohol. This first filter of deaths inevitably includes deaths due to accidents, self-harm and crime, in addition to pathological causes of death directly related to short or long term alcohol use. At first sight this may appear to be over inclusive. However, a further filter using an operational definition of Alc-ID, which has been devised during the course of this study, identifies a sample of deaths which could form the basis of a Confidential Reviews of Alc-ID. The process of examining almost 100 Inquest files highlights the importance of utilising a wider category of deaths than those found by searching the CoD and indeed highlights the importance of going beyond the ONS Alcohol Related Death cases.

Exploring the records in more detail

The detailed examination of files in both Office A and Office B revealed a rich source of information, particularly (but not exclusively) where an Inquest had taken place. We identified over 35 different categories of information, including

demographic information such as sex, age, marital status, occupation, living arrangements and so on, for almost all the cases we examined. In addition, witness statements, medical and other reports from service provider agencies, toxicology, histology and the circumstances leading up to the death were available for many of the cases.

Other categories of information included:

- whether or not the deceased alcohol use was a cause for concern for family or friends;
- whether it was known to their general practitioner;
- other health problems;
- whether specialist or non specialist alcohol treatment services had been offered or rejected (or sought and found unavailable);
- whether or not the deceased had reduced or increased their alcohol consumption in the period leading up to their death

The range and quality of information in some of these categories varied from case to case. For example, where no service use information was recorded in the file it may have been because there was no service involvement or because this information had not been collected as part of the inquest process.

Systematising the collection of each category of information, either as part of the coronial process or as part of a confidential review process, has considerable potential to inform detailed analyses of Alc-IDs and thus inform policy and practice, and harm reduction strategies.

Given the size of the samples, the time period represented and the varying methods of identification used in each office, a formal analysis of the information we collated in this pilot study would inevitably be misleading. However, it is important to convey the potential of the data available for analysis in any future research. Appendix 3 sets out the categorical data that can be extracted from the files. Some of this emerges from rich qualitative data, which provides insights into the everyday circumstances of the deceased persons' lives and history. The following examples are illustrative:

Example 1

This man was described as suffering from an alcohol abuse problem and died following a fall at home. A close family member described that for 'many years'

he had a drink problem and that he had stated that he drank due to stress at work. At the time of his death the close family member knew that he was drinking heavily because of the number of empty wine and vodka bottles that were found. Although this man was in receipt of ongoing medical treatment for disease caused by chronic alcohol misuse, he had rejected specialist help with his drinking and he did not see its value.

Example 2

This young man was described as suffering from an alcohol abuse problem. He was found dead in the toilet of licensed premises. This man's recent life history included bereavement, separation from his immediate family and homelessness. His interaction with primary care and substance misuse was problematic. He was intoxicated at times of assessment and ongoing support. Although he expressed some interest in detoxification, he died before being put on the waiting list.

Example 3

This man was known to have an alcohol abuse problem. He died following a fall down stairs. His partner described knowing that his drinking was a problem from early in their life together and through out the time that their children were growing up. She described him as a binge drinker who had stopped drinking during a period of illness which meant that he was off work. On his return to work (in the days before his death) he resumed drinking every night.

Example 4

This woman was known to have a drink problem. She was found dead in bed. Her partner was aware that her problem drinking was worsening. Although she had not seen a doctor for a number of years, she had been treated in the past for kidney and liver problems. The post-mortem described severe jaundice. Her liver showed advanced macronodular cirrhosis. She had suffered a gastrointestinal haemorrhage.

Example 5

This man lived alone and was known to have health concerns and a drink problem. He was found dead in an expanse of water. A close relative and other

people who knew him described a number of difficult circumstances including financial problems. His partner had died of an alcohol related condition a few years earlier. Sometimes his consumption of alcohol used all his financial resources and he was unable to feed his electricity meter. More than one of the witness statements referred to him spending all his money on drink. The information suggests that he was in regular contact with primary care, but there is no reference to substance misuse services.

With each category of AlCID we have specified whether or not the deaths will or are likely to appear in the ONS Alcohol Related Death figures. We found that approximately 40% of all the cases we categorised as AlCID would not appear in the ONS figures. Of those deaths subject to an inquest, we found nearly half the AlCID cases would not appear in the ONS figures. Our figures can only be approximate as inquest files are coded manually and require individual judgements to be made. This is in contrast to deaths reported to the Registrar which are coded by computer routines.

Implications

Alcohol Involved Death Reviews

Consideration should be given to whether combined Drug Related Death Reviews and Alcohol Involved Death Reviews will be practical, desirable or effective. Appendix 2 details the recommended constituent members of a Drug Related Death Review group. Introducing Alcohol Involved Deaths to the review process might require additional members. Similarly some members of the existing review groups might not be able to contribute to Alc-ID Reviews. Nevertheless, there is a great deal to be gained by building upon the experience of developing and implementing Drug Related Death Reviews.

One of the practical considerations not only for implementing a combined DRD and Alc-ID Reviews but also for Alc-ID Reviews *per se* is the number of deaths falling into the category of Alcohol Involved Death. There are several approaches to achieving a manageable number of deaths for the review process.

1. Restrict the confidential reviews to only deaths where a coroner's inquest has taken place

This has a number of advantages: cases would meet the criterion of being untimely and the number of cases to be examined would be reduced to manageable proportions. Many deaths which would serve as relatively poor material for a review process would be entirely or almost entirely excluded. An example of this would be deaths from alcohol-related illnesses in very elderly people.

Large amounts of information are routinely collected for inquests and much of this is information, for example witness statements, is not available from other sources, such as Medical Records. A particularly useful example of this is witness statements by relatives and friends of the deceased person, giving details of the deceased's life history. Collecting data from this source would also circumvent the many difficulties, experienced by academic researchers and others, in gaining access to information held by the NHS.

2. In each region covered by confidential reviews of Alc-IDs, a random sample of deaths could be examined, restricted either to deaths where a coroner's inquest has taken place or to Pink Form B and deaths where a coroner's inquest has taken place. Including the Pink Form B cases has the advantage of including a wider range of Alc-IDs. The disadvantage is that less information is routinely collected by the coroner for these cases as an inquest is not deemed necessary.

3. A purposive sample where the target sample is chosen to reflect particular themes or categories of Alc-ID. Information rich examples of deaths which fall into particular areas of interest could be used to explore particular issues. For example, cases where alcohol consumption was directly involved in the death, deaths of young people under the age of 25, deaths where the deceased was known to substance misuse services, deaths of older people and so on. Specially constituted review groups could be used for particular areas of interest either nationally or regionally.

Research and Review Data

During the course of the feasibility study we established what sort of information is available or could be made available if requested by the coroner. For

example, accounts from substance misuse services, mental health services and primary care information was found in many of the files. This information could be requested routinely as part of the coronial process if the death is considered to fall within our definition of Alc-ID. The cases which include primary care information, in the form of the GP computer printout were particularly illuminating.

The information collected by the Coroner's processes has the potential to be utilised in two ways. Firstly as research data and secondly as review data. Where the information has not been collected as part of the coronial process the AlcID Review process will include a request for this information. The collection of additional information for Alc-ID Reviews and the review process itself will generate additional research data.

We did find some difference across the two Coroner's Offices in the range and type of information routinely and exceptionally collected. There are likely to be idiosyncrasies in the collection and storage of information in each coroner's office. Particular interests, for example, alcohol involved death in Office A might serve to categorise sets of files in particular ways. We were able to consider the whole range of information and construct a model for the optimum data set to inform an investigation of Alc-ID. This dataset includes both quantitative and qualitative data.

We propose that for the purposes of further research and to inform any consequent or incidental reviews that a pro-forma (computerised) is used to collect the optimum dataset. Appendix 3 provides a draft version of the pro-forma data fields. As might be expected, this draws heavily on the Drug Related Deaths Database Tables and Fields (npSAD dataset) but is augmented by categories which emerged from an examination of coroners' files and our understanding of alcohol related death.

Research study

This pilot study has also served to provide a platform to develop further research studies. The type and range of data we have demonstrated is available for study and the method of identifying cases could form the basis of an in-depth cross Wales study. This will be discussed in more detail in a separate submission.

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Appendix 1: Deaths Reported to a Coroner

For some deaths the doctor may certify the cause and report the case to the coroner, or the registrar may report it. Deaths that should be referred to a coroner include those where:

- the cause is unknown
- the deceased was not seen by the certifying doctor either after death or within the 14 days before death
- the death was violent, or unnatural, or suspicious
- the death may have been due to an accident (whenever it occurred)
- the death may have been due to self-neglect or neglect by others
- the death may have been due to an industrial disease, or related to the deceased's employment
- the death occurred during an operation or before recovery from the effects of an anaesthetic
- the death may have been a suicide
- the death occurred during or shortly after detention in police or prison custody
- there was no doctor available who was legally qualified to certify the death

Taken from

Letter from Deputy Chief Medical Statistician An updated version of this letter is now included with each new death certificate booklet sent out by Registrars of births and deaths.

Appendix 2: Drug related Deaths Review Group Membership

(Taken from Guidance)

- public health physician/epidemiologist,
- addiction psychiatrist or a general psychiatrist or representative of
- the local mental health service,
- general practitioner with experience of substance misuse treatment issues,
- senior representative of local government,
- senior member of the local primary care groups/trusts,
- senior representative of the local police,
- one or more CSP chairs or a nominated representative,
- senior Social Services manager,
- senior probation officer preferably of assistant chief officer rank,
- A&E consultant,
- paediatrician,
- representative from a local prison, preferably of Governor grade,
- pathologist,
- coroner,
- pharmacist,
- representative of the Ambulance Trust.

Appendix 3: Optimum dataset

Details of Deceased

Forename

Surname

Alias

Sex

Date of birth

Place of birth

Age

Address street

Address town

Address county

Postcode

Ethnicity

Employment status

Occupation

Marital status

Living arrangements

Details of Death

Date of death

Place where death pronounced

Location of incident/accident leading to death

Circumstances of death

Cause of death 1a

Cause of death 1b

Cause of death 1c

Cause of death 1d

Secondary cause of death

Inquest Verdict

Location of inquest

Date of inquest

Substance Details

Registered drug misuser

Registered user ID

Not registered but recent history of drug misuse

Drugs misused

Recent history of drug misuse by injection

Drugs injected

History of volatile substance misuse

History of alcohol misuse

Known to family

Known to GP
Known to alcohol misuse services
Currently in contact with AM services
Date of discharge
Self-discharge
Recent detoxification
Recent reduction in consumption
Recent increase in consumption
Alcohol related convictions
Rejected interventions
Turned away by services

Medical conditions

Health conditions
On prescribed medication
Medication prescribed
GP Records

Post-mortem

Blood Alcohol
Other toxicology
Histology
Liver condition
Other

Qualitative data

Witness statement extracts
Post mortem summary
Coroner's Officer summaries
Inquisition summary
Letters or reports from service providers
Life events