Wigan Council

FOI 17403 - DRUG/ALCOHOL RELATED DEATHS. Wigan Council

1. Broken down by name of substance/drug and calendar year, the number of non-fatal overdoses and near-fatal overdoses recorded in the calendar years 2023 and 2024

   Not available.

2. Broken down by name of substance/drug and calendar year, the number of drug-related deaths recorded in the calendar years 2023 and 2024.

Breakdown by name of substance, a single death may have multiple substances implicated. These figures are deaths occurring in the stated year, but they are reported to the multi-agency/partnership panel on conclusion of the coroner inquest which may take several months.

Full year data is not yet available for 2024.

2023

Deaths occuring in 2023	Count of cases with drug implicated in death	% of cases
Heroin	9	33.3%
Methadone	6	22.2%
Other Opiates	5	18.5%
Benzodiazepines	*	11.1%
Amphetamines	*	14.8%
Cocaine	13	48.1%
Hallucinogens	0	0.0%
Anti-depressants	*	3.7%
Alcohol	7	25.9%
Other Drugs	7	25.9%
Novel Psychoactive Substances	*	3.7%
Total confirmed drug related deaths in 2023:	27	-

2024

Deaths occuring in 2024	Count of cases with drug implicated in death	% of cases
Heroin	*	25.0%
Methadone	*	50.0%
Other Opiates	*	25.0%
Benzodiazepines	0	0.0%
Amphetamines	0	0.0%
Cocaine	*	50.0%
Hallucinogens	0	0.0%
Anti-depressants	0	0.0%
Alcohol	0	0.0%
Other Drugs	*	50.0%
Novel Psychoactive Substances	*	25.0%
Total confirmed drug related deaths in 2024:	*	-

*Figures under 5 have been supressed.

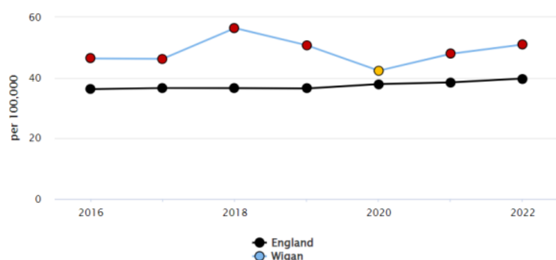
Other publicly available information can be found at:
Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

3. Broken down by calendar year, the number of alcohol-related deaths recorded in the calendar years 2023 and 2024.

   2024 count and rate not available.

   2021. Count: 157. Directly standardised rate (per 100,000) 47.9.
   2022. Count: 171. Directly standardised rate (per 100,000) 51.0.

Alcohol-related Mortality (persons)



Recent trend: No significant change

Period		Wigan Count	Wigan Value	Wigan 95% Lower CI	Wigan 95% Upper CI	England
2016	●	146	46.4	39.1	54.6	36.3
2017	●	144	46.3	38.9	54.5	36.6
2018	●	180	56.4	48.4	65.3	36.6
2019	●	164	50.7	43.2	59.2	36.5
2020	●	137	42.3	35.5	50.1	37.9
2021	●	157	47.9	40.7	56.1	38.5
2022	●	171	51.0	43.6	59.2	39.7

Source: OHID, based on Office for National Statistics data

Indicator Definitions and Supporting Information

Definition

Deaths from alcohol-related conditions based on underlying cause of death, registered in the calendar year for all ages. Each alcohol related death is assigned an alcohol attributable fraction based on underlying cause of death (and all cause of deaths fields for the conditions: ethanol poisoning, methanol poisoning, toxic effect of alcohol). Alcohol-attributable fractions were not available for children.
Mortality data includes all deaths registered in the calendar year where the local authority of usual residence of the deceased is one of the English geographies and an alcohol attributable diagnosis is given as the underlying cause of death.
Data source: Alcohol Profile - Data | Fingertips | Department of Health and Social Care

4. Broken down by calendar year, the number of deaths in drug and alcohol treatment (including people who left treatment within 6 months of their death) recorded in the calendar years 2023 and 2024

The number of deaths recorded by the drug and alcohol treatment provider for each year based on the date of death. There may be additional cases to be added for the 2024 year, for example where the treatment provider hasn't yet been informed of the death.

2023 = 47
2024 = 47

Source: Liverpool John Moores University

5. Details of the membership of your local drug information systems (LDIS) panel and multi-agency/partnership panel to review cases of drug and alcohol-related deaths (DARDs) and non-fatal overdoses and near-fatal overdoses – does the panel have a lead officer and chair? How many members does each panel have (if they are distinct) and what are their expertise in relevant disciplines as per LDIS guidance (Drug Alerts & Local Drug Info Systems) medical, policing, pharmacology, drugs specialists, etc?

The DARD review panel is chaired by Liverpool John Moores University (LJMU) and has 60 members invited, who represent the following sectors:
Community Pharmacy
Department of Work and Pensions (DWP)
Housing Provider/Homeless Services
Integrated Care Boards (ICB) / Primary Care
Mental Health Team
NHS Hospital - Drug/Alcohol Specialist Teams
Palliative Care Provider
Police
Prisons
Probation
Public Health & Local Authority Other
Social Care & Adult Safeguarding
Social Care & Childrens Services
Treatment Provider - Drug and Alcohol
Veterans Support Service

6. Details of the geographic area (eg is it limited to your council area or a larger area) covered by your multi-agency/partnership panel which reviews (a) drug-related deaths (b) alcohol-related deaths (c) deaths in drug and alcohol treatment (including people who left treatment within 6 months of their death) (d) near-fatal overdoses

The multi-agency/partnership panel reviews all cases for the Wigan local authority area, the scope of the group covers all drug-related deaths, alcohol toxicity deaths (but not necessarily all alcohol related deaths), and all deaths of people who were in drug and alcohol treatment at the time of death or within the last 6 months. This group has not previously included review of near-fatal overdoses.

7. Name and description of the local partnership group into which that multi-agency/partnership panel reports eg combating drugs partnership (CDP)

Learnings feed into the local Combatting Drugs Partnerships and the GM D&A commissioners and provider meeting, as well as our locality Prevention Transformation Board.

8. Copies of, or a hyperlink to (if online), the terms of reference for your multi-agency/partnership panel

https://ims.ljmu.ac.uk/PublicHealth/Reference/DRD-monitoring-Terms-of-Reference-2022.pdf

9. Broken down by calendar year and the name of the substances/drugs suspected to be involved in each death, the number of reviews your multi-agency/partnership panel carried out in the calendar years 2023 and 2024 for (a) drug-related deaths (b) alcohol-related deaths (c) deaths in drug and alcohol treatment (including people who left treatment within 6 months of their death) (d) near-fatal overdoses

The breakdown of cases reviewed by the panel during 2023 and 2024 will include cases where the date of death was in a previous year. All confirmed drug and alcohol related deaths are reviewed and presented for the review panel. However, in the situation that there are more cases than can be discussed within the meeting a selected number of cases will be discussed in detail as per the OHID guidance.

2023

Number of cases reviewed in 2023	(a) drug-related deaths	(b) alcohol-related deaths	(c) deaths in drug and alcohol treatment (including people who left treatment within 6 months of their death)	(d) near-fatal overdoses
Heroin	5			
Methadone	*			
Other Opiates	*			
Benzodiazepines				
Amphetamines	*			
Cocaine	7			
Hallucinogens				
Anti-depressants				
Alcohol	*	*		
Other Drugs	*			
Novel Psychoactive Substances				
Not Known	*			
Total Number of cases reviewed	16	*	22	0

2024

Number of cases reviewed in 2024	(a) drug-related deaths	(b) alcohol-related deaths	(c) deaths in drug and alcohol treatment (including people who left treatment within 6 months of their death)	(d) near-fatal overdoses
Heroin	5			
Methadone	7			
Other Opiates	*			
Benzodiazepines	*			
Amphetamines	*			
Cocaine	9			
Hallucinogens	0			
Anti-depressants	*			
Alcohol	*	6		
Other Drugs	7			
Novel Psychoactive Substances	*			
Not Known	*			
Number of cases reviewed	18	6	44	0

*Figures under 5 have been supressed.

10. Copies of, or a hyperlink to (if online), any evaluation carried out in the calendar years 2023 and 2024 by your multi-agency/partnership panel of its impact/work

    Not available

11. Copies of, or a hyperlink to (if online), any published records of findings and actions carried out by your multi-agency/partnership panel (such as an annual report) in the calendar years 2023 and 2024

    Not applicable - system reports including findings and actions are not published, beyond those professionals involved in the DARD review process.

12. Details of any data sharing process agreed with a coroner by your multi-agency/partnership panel – is a process agreed and what is the name of the coroner's office(s) involved?

Data sharing is agreed with the Manchester West coroner office for the purpose of the multi-agency/partnership panel. Information shared is limited to a DARD reporting form and Toxicology.

13. Details of any notification process for near-fatal overdoses agreed with ambulance services, integrated care boards and/or hospital trusts by your multi-agency/partnership panel - is a process agreed and what are the names of the ambulance service(s), integrated care board(s) and/or hospital trust(s) involved?

    Not available.