



Friday 11th December 2020

A comprehensive and thorough review into 58 deaths from Gamma-hydroxybutyrate (GHB) poisoning across London between June 2011 and October 2015 was carried out following the murders committed by Stephen Port.

The results of the extensive reviews were presented at two case closure panels that included senior officers and independent advisors from the LGBT+ Independent Advisory Group. The panel were satisfied the reviews did not identify that any death was a homicide. The review concluded with a final report in 2019.

Organisational learning was identified and this has been accepted and action taken to improve our service and investigative approach. This is alongside the issues identified following the offences committed by Stephen Port and the action taken since then to learn and improve. A toolkit and a checklist document have been created to provide guidance for front-line officers and investigating officers on how to best respond to allegations of drug facilitated sexual assault or sexual assault following chemsex. We have also developed a chemsex 'flag' on our crime reporting systems to make it easier to identify such offences.

In 2016, all frontline officers across the Metropolitan Police Service (MPS) received extra training on rape, which included the issue of chemsex and associated offences. Additional training on chemsex and LGBT+ issues was also given, with the help of Galop and other LGBT+ partner organisations, to specialist officers who investigate rape and sexual offences.

Following a number of deaths occurring across sauna venues, the MPS worked closely with businesses and community members to mitigate risk and focus on long-term solutions through partnership working. The risks identified within sauna venues included the practice of chemsex within increased temperature environments.

The MPS took a collaborative long-term approach and built stakeholder trust by holding meetings & consulting with all related community businesses, which helped to create strong professional relationships and ensured barriers were broken down. The MPS worked closely with Public Health, local authorities and the charitable sector to promote public health safety. The MPS's collaboration with local business leaders led to the establishment of Safer Saunas; an initiative to work together to improve public safety and wellbeing within MSM premises (premises where men have sex with men) by adhering closely to licensing guidelines even though the saunas themselves were not licensed premises.

The initiative was supported by all the businesses involved and professionalised through the MPS's partnership with Safer Business Network, under the provision of the Business Crime Reduction Partnership. A website was established and information sharing processes implemented to ensure all partners could communicate effectively, share best practice and reduce risks. This resulted in the formation of strong relations between businesses, increased community confidence in the police, and significantly reduced the risk of harm to people visiting sauna venues.

Advice about chemsex, developed in partnership with the LGBT Independent Advisory Group (IAG), features on our website at:

<https://www.met.police.uk/advice/advice-and-information/cs/chemsex/>

The review further increased our understanding of chemsex and highlighted the dangers involved. In 2018, the MPS and National Probation Service established the London Chemsex Working Group, with other partners. It aims to reduce harm and vulnerability related to chemsex and raise awareness amongst professionals in order to increase identification of chemsex cases, encourage information sharing between agencies and identify those who are vulnerable .

The MPS continues to work hard to support the Coronial Inquests touching the deaths of those murdered by Stephen Port which commence in January 2021. It is not appropriate to comment on the Inquests until all the evidence is heard. However the presiding Coroner has agreed that the sharing of this GHB deaths review will not impact on the Inquest and it is now being shared to show some of the work undertaken since Stephen Port was arrested and convicted for a range of offences including the murders of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor.



**METROPOLITAN
POLICE**

TOTAL POLICING

OFFICIAL - SENSITIVE

**Metropolitan Police Service
Homicide and Major Crime Command**

Review of GHB Deaths

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17th July 2019

INTRODUCTION

The Principle Aims of an Investigative Review

In 1998 the then Association of Chief Police Officers (ACPO) issued review guidelines in respect of murder investigations. Prior to the Stephen Lawrence Inquiry a limited number of reviews were undertaken, albeit largely on an ad hoc basis.

The ACPO guidelines were reinforced in 2000 by HMIC's 'Policing London, Winning Consent' where it was identified that a review process should have three principle aims:

- i) To identify and develop investigative opportunities that will progress an investigation.
- ii) To act as a form of quality assurance in relation to both the content and process of an investigation.
- iii) To identify, develop and disseminate good investigative practice.

The Home Office identified a number of benefits for a robust review process:

- Reducing the likelihood of problems escalating to the detriment of the investigation.
- Improving individual performance through the identification and sharing development opportunities.
- Decreasing the potential for a costly reinvestigation at a later date.
- Reducing the chance of litigation.
- Providing support to officers during protracted or difficult investigations.
- Increasing public confidence in the integrity and ability of police investigations.

As a consequence of the above, the Metropolitan Police Service developed a structured review process for major investigations.

The Human Rights Act 1998, which came into force on 2nd October 2000, also stipulated that there must be an element of review to any investigation.

Review of GHB Deaths - Terms of Reference

- i) To conduct a mature peer review of the 58 GHB-related male deaths occurring in London between 1st June 2011 and 15th October 2015;
- ii) To examine whether any of the above cases involved foul play;
- iii) To identify and develop investigative opportunities that might progress an investigation
- iv) To act as a form of quality assurance in relation to both the content and process of an investigation.
- v) To identify, develop and promulgate good practice
- vi) To promote community confidence and public reassurance

IDENTIFYING DEATHS FOR REVIEW

Background

In November 2016, Stephen PORT was convicted of 22 drug-facilitated offences, including the murders of four young men.

At that time it was too early to state with any degree of certainty that those offences represented the sum total of Port's offending, or exclude the possibility that a similar mechanism of foul play might have been adopted by others operating within the Chemsex arena.

A good deal of work was needed before the MPS could arrive at such a view, and a sizeable task lay ahead in terms of analysing a significant number of deaths across a broad geographic area and timeframe.

Exploring the Possibility of Further GHB-Facilitated Murders

The police have a duty to investigate those cases where there is a suspicion that a criminal offence may be linked to, or caused, the death of an individual. But not all deaths need to be reported to the police or the Coroner. In most cases the deceased's own doctor is able to supply a medical certificate citing the cause of death. However deaths in the following circumstances must be reported to the Coroner:

- a. When no doctor has treated the deceased during his or her last illness, or
- b. When the doctor attending the patient did not see him or her within 14 days before death, or after death, or
- c. When the death occurred during an operation or before recovery from the effect of an anaesthetic, or
- d. When the death was sudden and unexplained, or attended by suspicious circumstances, or
- e. When the death might be due to an industrial injury or disease, or to accident, violence, neglect or abortion, or to any kind of poisoning, or
- f. When the death occurred in prison or in police custody

In light of the foregoing, it is safe to say that any sudden or unexplained death will be brought to the attention of either the Coroner or police, or both, irrespective of whether foul play was initially suspected.

Members of the Operation Lilford Gold Group deemed it appropriate to re-examine all 'non-suspicious' GHB-related male deaths occurring within the Greater London area over recent years. Specifically:

- a. Occurring within the Greater London area between 01.06.2011 and 18.10.2015;
- b. Previously categorised as 'sudden' or 'unexplained'; and
- c. Where GHB poisoning had been confirmed

A starting point of 1st June 2011 was selected on the basis that:

- i) Chemsex is a relatively new phenomenon, triggered in part by the recent proliferation of social networking sites;
- ii) Stephen Port was arrested on 15th October 2015, which would curtail his activities and prevent the commission of further offences on his part; and
- iii) LGC Forensics, the (then) principle toxicology provider to both the Met Police and London Coroners, could readily provide data in a useable format going back to June 2011.

Since the police and H.M. Coroners Service occasionally inquire into the death of a person in relative isolation, a dual scoping process was adopted to ensure that all recognised cases of GHB poisoning were identified by the police inquiry team. This incorporated:

i) H.M. Coroners and Forensic Toxicology Providers

Due to the inability of coronial and police systems to reliably search and retrieve post mortem data, the review focused heavily on information gathered from the forensic toxicology laboratories that provide the results of GHB testing. Eight service providers are utilised by coroners and police services across the south east of England, all of whom were contacted by the Operation Lilford inquiry team.

The review team was also charged with gathering the coronial data needed to commence the review. With a view to establishing details of all known GHB-related deaths registered with the Coroners Service, officers liaised with a number of key stakeholders, including the Chief Coroner for London and various forensic toxicology providers.

ii) Police Research

In general terms research was extended to incorporate GHB-facilitated deaths across the MPD. Checks included:

- Police intelligence databases (e.g. CRIS, Crimint, custody records);
- Open Source; and
- Media reports

Result of Research

The above research identified 58 deaths thought to be the result of GHB poisoning across London between June 2011 and October 2015. However, three of these cases were later set aside following a more detailed examination of the police files, taking the final figure down to **55** deaths.^{1 2}

¹ It transpired that in two cases no GHB had been detected in toxicology samples.

² A third incident involved the death of a female. This was captured erroneously during the research process, which had been devised to identify male victims

THE REVIEW PROCESS

It was recognised that a case-by-case review on such a sizable scale would require a structured approach and reporting style, thus ensuring that all relevant areas of investigation were properly examined. To this end, a four-tier evaluation process was devised.

Stage 1 – Incident Mapping

Researchers examined the occurrence of hotspots in certain areas and why they happened, while analysts examined the techniques used to perform the research. It is accepted practice that the use of maps may help develop knowledge and understanding of different areas and possibly why the use GHB occurs there.

Stage 2 - The Triaging and Basic Investigation Process

Original documentary records (e.g. case papers, inquest records) were obtained for inspection wherever possible.

This stage also involved the Special Casework Investigation Team (SCIT) pursuing relatively straightforward lines of enquiry that might reasonably assist in resolving the status of a case at the earliest opportunity.

It was recognised that affected families (or potentially partners and friends) might also possess relevant information, or indeed harbour their own concerns about the case. In consequence, detectives very occasionally re-contacted family members if they believed it was necessary or might add value to the review process.

Stage 3 – The Mature Progress Review

This phase of the process involved a thematic review focusing on relevant areas. Review officers used a pre-formatted checklist to record areas researched, issues identified and to log comments on minor matters.

The initial format for any resulting reports followed a number of key areas:

- Brief circumstances
- Initial action at scene

- Intelligence
- Witness evidence
- Forensic evidence
- Arrest, search and interview strategies (if appropriate)
- Toxicology findings
- Media
- Family liaison
- Coronial proceedings
- Key recommendations
- Other recommendations

Stage 3 – Data Analysis

There were three main purposes to this phase of the review process, namely:

- Hotspot identification
- Crime and incident trend identification; and
- Crime and incident series identification

i) Hotspot identification

Hotspots are locations that display significantly higher than usual levels of crimes and/or incidents - in this case GHB poisonings. Analysis was hoped to identify potential priority locations for problem-solving responses.

ii) Crime and incident trend identification

This type of analysis looks at trends in crime or incidents. A crime or incident trend is a broad direction or pattern that specific types of incidents are following. It was anticipated the work could identify two types of incident trend:

- overall trend – highlights if the problem is getting worse, better or staying the same over a period of time
- seasonal, monthly, weekly or daily cycles of incidents – identified by comparing previous time periods with the same period being analysed

iii) **Crime and incident series identification**

A 'series' is where a number of similar crimes or incidents are identified as probably being committed by one offender or group of offenders because they are linked by modus operandi, signature behaviour, intelligence or forensic evidence.

A series can also occur where the offenders are able to locate temporarily vulnerable targets and places, or where offenders are new to a crime type or area. The method of analysing crime series or linked events is called comparative case analysis (CCA). It is used to find patterns within the detail of an incident or crime event that will potentially link them because they are distinct enough from other events.

Stage 4 – Case Closure Process

The Commander's Case Closure Meetings played an important part of the learning cycle.

The Commander's Case Closure Panel dealt with each case at a point where all lines of enquiry had been exhausted, review recommendations completed and the investigation was unable to proceed any further.

The NPCC MPS Homicide lead chaired the Panel and attendees included the following representatives:

- OCU Commander
- Operation Lilford Head
- SCIT Reviewing Officer
- Independent advisors – LGBT+ Advisory Group
- Specialist Crime Review Group

REVIEW FINDINGS

The Specialist Casework Investigation Team (SCIT) commenced the review process in February 2017. Initially, the team consisted of one detective sergeant, four detective constables and one civilian investigator.

In March 2018, due to structural reorganisation within the MPS, the review team was reduced to two detective constables. The process concluded in December 2018, when the last of the 58 cases were presented to the to the case closure panel.

The following initial actions were undertaken in relation to each death:

- i) All police officers linked to a case were contacted and any correspondence held requested, including copies of any pocket book notes.
- ii) All case files for the 58 cases were requested from the relevant coroner.
- iii) All CRIS, Crimint and Merlin Reports for each case were obtained.
- iv) All CAD reports for each case were obtained.
- v) All interview tapes and transcripts for persons arrested relating to each case were requested from the relevant officers and boroughs.
- vi) After examination of the above material, a full research package for each case was requested from Met Intelligence Bureau (MIB) in respect of:
 - o the deceased
 - o the deceased's home address
 - o the location the deceased was discovered; and
 - o any persons deemed 'of interest' in the case (including key witnesses identified).

Point (vi) above resulted in the completion of some 244 research packages.

Officers conducting the review encountered a number of issues during the initial stages of the process:

- i) Police officers regularly stated that all material paperwork had been passed to the coroner and no paperwork had been filed within the MPS. Officers

were frequently unable to locate pocket books detailing original notes and actions taken at the time of the event.

- ii) Officers frequently declared little or no involvement in investigations, whereas material subsequently gathered from coroner's files contradicted this position. Officers often had to re-contacted and challenged.
- iii) The coroners, at times, were reluctant to provide full copies of their files. When files were eventually obtained, they were found to be missing key documents, which again had to be requested separately.
- iv) One coroner was unable to locate a particular case, believing it to have been lost over time.
- v) The research packages completed by the Met Intelligence were found to differ in content and quality. This was largely dependent upon the researcher involved, and had to be addressed by the review team. The timeliness of the research was at times affected by competing demands within the MPS.

Each case was assigned to an officer on the SCIT, with that officer then reviewing all material gathered in relation to the particular case and conducting further investigative enquiries where necessary.

In two cases it was considered necessary to contact family and friends of the deceased. This was done to clarify certain facts of the case, and to obtain further details regarding deceased's lifestyle. On both occasions the family/friends were fully advised of the review process and the outcome of the review.

Upon completion of each review and the corresponding final report, a second member of the SCIT would peer-review the case and provide feedback. The review was then passed to the operational lead for any further observations before the final report was signed-off.

A number of issues were highlighted during the course of the review. This included individuals being linked to more than one cases and multiple deaths occurring at the same venue – specifically male saunas (see below).

Each review report provided the rationale for case closure, together with recommendations as to the enquiries it might have been appropriate to conduct at the time the death.

Each case was presented to the case closure panel for final review prior to closure.

Sauna Related Deaths & Venues

'Sauna A'

'Operation Lilford 2' identified four deaths occurring at 'Sauna A' that involved Chemsex drugs during the prescribed date parameters.

Broader research revealed that a further three men were discovered in a state of collapse inside the venue and later died in hospital. However, these events occurred in 2008, 2010 and 2015 respectively – outside the parameters of this review – and are therefore not included in the statistics.

In addition, a further five men were identified as having collapsed at the venue but subsequently made full recoveries due to medical intervention. These incidents were also outside the parameters of this review but are included for information.

'Sauna B'

Operation Lilford 2 identified one death occurring at 'Sauna B', which occurred in June 2012.

'Sauna C'

Operation Lilford 2 identified one Chemsex-related death occurring at 'Sauna C' in July 2012.

This venue is to be demolished and new flats constructed on the site, and as such it has ceased trading.

- *It is recommended that the Safer Sauna project implemented as a consequence of the above deaths continues, and that engagement between police and such establishments is supported following the BCU mergers. Action: Commander Frontline Policing to review*

ANALYTICAL FINDINGS

Analysis was conducted across all 58 cases. Just one case related to the death of a female³. The remaining 57 cases reviewed related to the deaths of males. For the reasons mentioned on page 6, the analysis is based on the 55 cases of males that died during the time period with links to GHB use.

Sexuality

GHB overdose disproportionately affects the male gay community. In 46 of the 55 cases (83%) the deceased self-identified as gay; in one case the deceased was bisexual; and in another case the deceased identified as heterosexual⁴. In seven cases the sexuality of the deceased was not ascertained.

Age Factor

Available data suggests males aged between 31 and 40 years are at a heightened risk of GHB overdose.

Fig.1 below provides a graphical depiction of the age of the deceased at the time of death.

³ This death was captured erroneously during the research process, which had been devised to identify male victims

⁴ It is recognised that some men may choose to withhold their sexual orientation

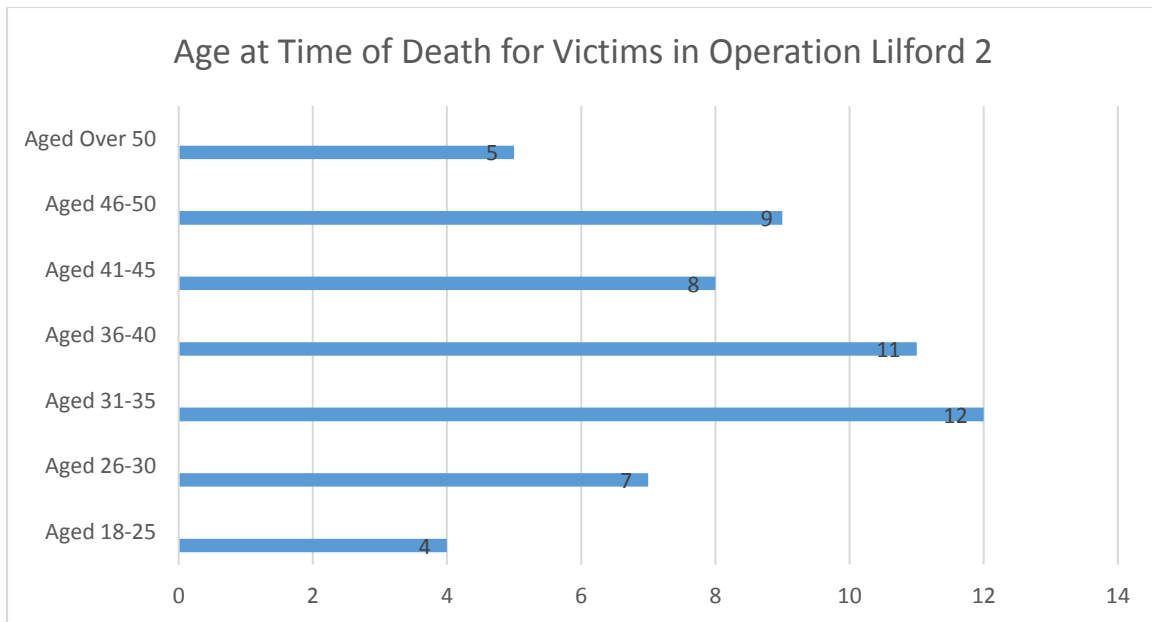


Fig.1

Demographics

A significant number of deaths involved individuals who would not identify themselves as British or were born outside of the United Kingdom.

29 of the cases (53%) related to the death of an individual who would be categorised as British, while 23 (42%) related to individuals who were born outside of United Kingdom or did not identify as being British.

Such statistics are unsurprising. London is a multi-racial city. Data from the 2011 UK Census suggests that about 37% of the London's populace is based on international immigration.

Location and Venue Type

Although the review identified the deaths as having occurred across a relatively broad range of venue types, the majority of incidents took place within residential premises (see Fig.2 below).

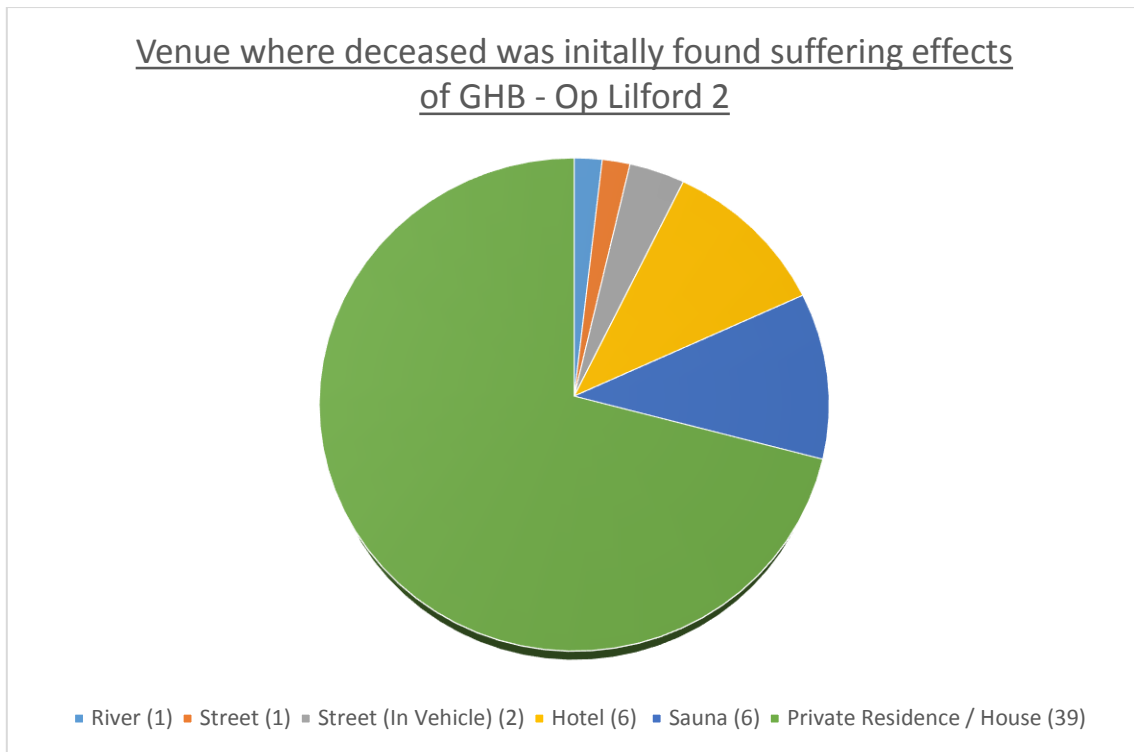


Fig.2

The number of deaths taking place at male saunas and hotels were not insignificant. Outside of the 39 incidents occurring within private residences, these featured as the second highest venue types with six deaths occurring in each during the designated time period.

The London Borough of Lambeth was identified as having the highest GHB mortality rate, with 17 of the 55 deaths (31%) reviewed occurring there. It is worthy of note that Lambeth has a very significant nighttime economy and a large number of male saunas operating within the borough.

Fig.3 provides comparative data for deaths occurring across the various London boroughs during the relevant period (1st June 2011 and 15th October 2015).

London Boroughs in which the 55 GHB related Deaths occurred
01/06/2011 - 15/10/2015

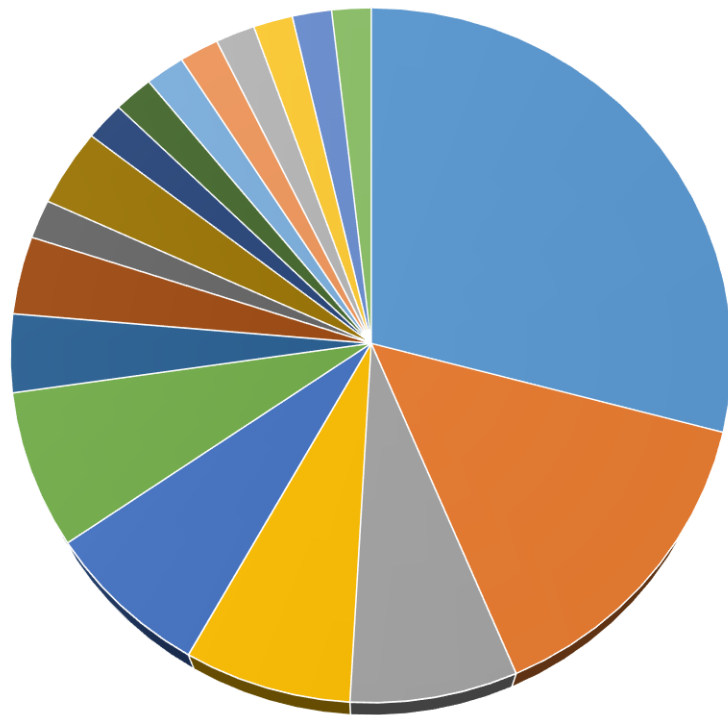


Fig.3

In all but one case the emergency services attended the scene, and in 17 of those cases CPR was administered. In 12 cases life was declared extinct at hospital.

Mechanism of Administration

In 25 (45%) of the cases it was established that GHB had been administered orally, while in 6 (11%) cases it was not possible to rule out the use of a hypodermic syringe⁵. In the remaining 24 cases (44%) the method by which GHB had been administered was not established.

⁵ The pathologist noted evidence of possible intravenous drug use

Toxicology Findings

In 3 of the 55 cases reviewed, the level of GHB in the deceased's system was not determined. This was either due to decomposition (2 cases) or the level of GHB was not quantified (1 case).⁶

Other drugs were detected in toxicology samples in all 55 cases, suggesting the males in question may have been engaged in a broader substance misuse.

In 16 (29%) cases it was established that another person, besides the victim, had taken GHB at the scene.

In 4 cases it was determined that the individual had died by means of suicide.

The levels of GHB recorded during toxicology screening is shown at Fig.4 below.

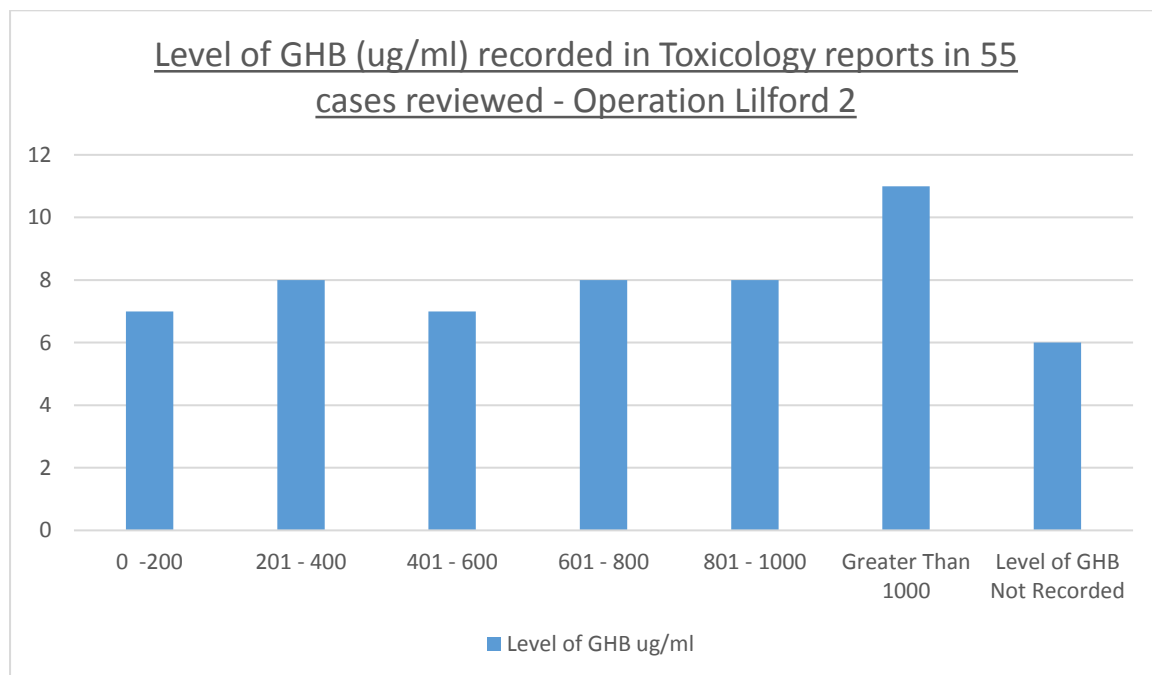


Fig.4

In 37 cases (67%) the deceased had previously come to notice of police or medical professionals for the misuse of GHB.

⁶ In this case the toxicology report stated that a very high, but unquantified, concentration of GHB was present

All 55 cases were subject to a Coroner's Inquest. As one might expect the verdicts varied according to the individual circumstances of each death.

Coroner's Finding	No. of Cases
Open verdict	4
Suicide	4
Accidental death	3
Natural Causes	1
Misadventure	3
Narrative – use of drugs	40

Conclusions

- The deceased identified as gay in 83% of cases.
- The highest death rate occurred in individuals aged between 31 and 40 years – a total of 23 deaths (42%). The next highest number of deaths were found in males aged between 46 and 50 years – 9 deaths (16%).
- 42% of the men were born outside of the United Kingdom or did not identify as being British.
- The predominant venue in which deaths recorded were private residences. The second highest rate of incidence was in saunas and hotels.
- The London Borough of Lambeth accounted for 16 (29%) of the 55 GHB related deaths occurring between 01/06/2011 and 15/10/2015. The London Borough of Westminster had eight deaths (15%) during this time period and the London Boroughs of Kensington, Islington, Camden and Newham each had four deaths.
- In 37 cases (67%) it was established that the deceased had previously come to notice of police or medical professionals for using, or to attempting overdose on, GHB.
- In all 55 cases other drugs were found during toxicology screening.

CASE CLOSURE PANELS

Two case closure panels were held, during which the review officers presented their findings.

The first panel, held on 18th April 2018, heard 20 of the 58 cases. The panel individually reviewed all cases and, where applicable, asked questions of the reviewing officers.

It was unanimously agreed that all 20 cases heard were suitable for closure.

Commander Cundy, who chaired the closure panel, proposed that efforts should be made to reduce the timescales for completion of the remaining 38 cases. It was suggested that an abridged report and executive summary would be sufficient for the remaining cases.

It was observed that the aim of the panel was not to override the finding of any previous inquest, but rather to determine whether a death *might* be suspicious and therefore would warrant further investigation. All material in each case was still to be reviewed in full, albeit the final report would be condensed to incorporate the key areas. It was anticipated that questions would be asked by the case closure panel if further detail was required.

The second case closure panel, held on 26th October 2018, heard the remaining 38 cases. Once again, all cases were individually reviewed by the panel and questions asked where applicable.

It was unanimously agreed that all 38 cases heard were suitable for closure.

Commander Cundy chaired the closure panels and placed on record that all 58 cases had been examined in detail and nothing had been discovered which identified any evidence or suspicion of foul play.

Detective Superintendent Duffield highlighted the fact that any organisational learning borne out of the review would have relevance to the investigation of all unexplained deaths, not exclusively GHB-related cases.

COMMON INVESTIGATIVE DEFICIENCIES

1. Current common practice is for just one of officer to complete a statement, if in fact a statement is completed at all. More commonly statements are provided in response to a request from the coroner's officer. It is recommended that all officers attending the scene or conducting enquiries into to the death of an individual consider the completion of a statement.
2. Frequently statements are not taken from potential witnesses present at the scene. More specifically, it is commonplace for statements not to be obtained from original informants. In consequence, Coroner's officers are very often required to liaise with the individuals direct in an effort to plug evidential gaps.
3. Police paperwork is regularly misfiled. Original documents are often provided to the coroner and no copies retained by the MPS.
4. Original coroner's reports are frequently not retained by police.
5. There are major inconsistencies in the standards of investigation. Very often 'Crime Related Incident' CRIS reports are not completed, resulting in a reduced opportunities to capture key information such as modus operandi, geographical hotspots and developing patterns of activity. Investigations are currently recorded on a variety of MPS databases and the standard of reports vary wildly. Consideration should be given to developing a Service-wide protocol that specifies minimum standards of investigation and a single database for the recording of any action taken. The CRIS database would appear to be the most appropriate reporting tool.
6. Officers seldom obtain background information about the deceased from either the informant, family or friends. Coroner's officers often need to obtain further statements to gain an understanding of the deceased's lifestyle, which could assist in determining whether or not the death is suspicious or non-suspicious.

7. Duty officers and sergeants attending the scene rarely make notes, complete statements or update relevant MPS databases. This frequently results in no recorded justification as to why the death was deemed non-suspicious – a critical aspect of the investigation.
8. In most cases house-to-house enquiries are not completed. It is recommended that local enquiries are conducted in all cases, even if these are limited to immediate neighbours.
9. Frequently, photographs of the scene are not taken.
10. Items seized by officers at the scene are not sent for analysis, most commonly mobile telephones, laptops and drugs.
11. Officers frequently fail to identify the last person in contact with the deceased and the circumstances around this contact.
12. Contact with the next of kin is not sufficiently detailed. Officers often list note time and date of notification, but rarely the content of conversations and details of any subsequent contact.
13. Local CID do not always attend the scene, or if they do they do not complete a statement or make any notes.
14. CCTV during material times is often not considered or examined.
15. Search records are often non-existent or incomplete. Items seized at the scene are rarely scheduled on the principle report, but instead deposited via local property records.
16. Evidence of substance misuse is commonly not searched for, seized or recorded.

17. Officers from the Specialist Crime car are often not called upon to attend or give advice.
18. CSM/SOCO largely not considered to attend or give advice.
19. The scene is not always inspected for any signs of a disturbance, insecure entrances or exits and any weapons (or if it is, this is not recorded).
20. Open source research is commonly not considered.

UNDERSTANDING CHEMSEX

This section of the report is intended to provide the reader with a greater understanding of the relationship between chemsex among gay men and the recent rise in GHB (gamma hydroxybutrate) deaths.

Chemsex is a term commonly used by gay or bisexual men to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with chemsex are crystal methamphetamine (crystal meth), GHB, mephedrone and, to a lesser extent, cocaine and ketamine.

These drugs are widely known to facilitate pleasure or euphoria, but are also associated with a range of harms. The link between drug use and risk taking is complex, but studies suggest there is a clear association between the two.⁷

What is GHB?

GHB is a central nervous system depressant used as an intoxicant, although it produces a stimulant effect at lower doses. Its effects have been described anecdotally as comparable with ethanol (alcohol) and MDMA use, such as euphoria, disinhibition, enhanced libido and empathogenic states. At higher doses, GHB may induce nausea, dizziness, drowsiness, agitation, visual disturbances, depressed breathing, amnesia, unconsciousness and death.

When death is associated with GHB, it is sometimes in conjunction with other drugs, such as alcohol or benzodiazepine which influence the same neurotransmitter (gamma-aminobutyric acid).

The effects of GHB can last from 1.5 to 4 hours, or even longer if large doses have been consumed. Consuming GHB with alcohol is dangerous as it can lead to respiratory arrest and vomiting in combination with deep sleep - a potentially lethal combination.

⁷ Sigma Research. The Chemsex Study (2014).

GHB (gamma hydroxybutrate) and GBL (gamma butyrolactone), are closely related, dangerous drugs with similar sedative and anaesthetic effects. GBL is converted to GHB shortly after entering the body. Both produce a feeling of euphoria and can reduce inhibitions and cause sleepiness. But both can kill and are particularly dangerous when used with alcohol and other depressant or sedative substances.

GHB and the Law

GHB and GBL are both Class C drugs. Possession with intent to supply can carry a maximum of 14yrs imprisonment.

The Prevalence of Chemsex in London

Research has been conducted into chemsex by Lambeth, Southwark and Lewisham Council in conjunction with SIGMA research. Titled 'The Chemsex Study', it was a research project that explored drug use in sexual settings among gay and bisexual men. The three boroughs commissioned the report since they are home to very large populations of gay and bisexual men, and to men living with diagnosed HIV.

Published data from the Antidote Service (part of the charity, London Friend), which sees over 8,000 lesbian, gay, bisexual and transgender people every year, indicates a sharp rise in the number of gay and bisexual men presenting to the service with problems relating to crystal meth, GHB/GBL and mephedrone.

In 2005, these three drugs were responsible for 3% of all presentations among gay and bisexual men, but this had risen to 85% by 2012. Nearly all crystal meth use was reported within sexual settings, while 75% and 85% of mephedrone and GHB/GBL users respectively said they used the drug solely to facilitate sex.

Westminster Council's report called 'Party Drugs and High-Risk Behaviour in Westminster' highlighted a number of major concerns, focusing on the inherent connection between the sex industry and drug use. Most of men interviewed highlighted drug use as a significant problem. This was due to its inherent connection with sex, its ability to prolong wakefulness, reduce inhibitions and heighten sexual desire had made it attractive to both escorts and their clientele.

Between 2007 and 2012 there were 96 ambulance call outs relating to accidental or unknown drug overdose in the Vauxhall area during the hours of the night-time economy.

The drug most commonly associated with emergency admission to St Thomas's Hospital in Lambeth in 2010 was GHB/GBL, resulting in 270 presentations.

The extent to which revelers in Vauxhall are admitted to St Thomas' Hospital has led the hospital to impose a levy on the nightclubs in the area. This pragmatic approach to party drug abuse highlights the sheer scale of the problem.⁸

Criminal Use of GHB and MPS Learning

Over recent years the subject of drug-facilitated sexual assaults (DFSA) has gained widespread media attention. Often referred to as 'drink spiking' and 'drug rape', the substances administered are frequently referred to as 'date rape drugs'.

GHB is commonly found in liquid form. Odourless and colourless, it can be readily mixed with drinks and given to unsuspecting victims. Victims are incapacitated due to the sedative effects of GHB, which may also induce amnesia.

Police first responders and secondary investigators need to be aware of the emerging threat of drug-facilitated sexual assaults and the associated risk of a fatal overdose. Since GHB is rapidly metabolised, officers are now advised to seek medical assistance (if appropriate) and use an early evidence kit as soon as possible.

An MPS investigators' online toolkit was launched in April 2016, together with a cycle of training for frontline uniform and detective officers.

The MPS has also sought to ensure that officers of all ranks have greater awareness of chemsex and the role GHB and related drugs might play in criminal activity, particularly in respect of crimes perpetrated against the LGBT+ community.

⁸ Westminster Borough Council. Party Drugs and High-Risk Behaviour in Westminster

Important lessons have been learned in respect of community engagement. During the investigation into the activities of Stephen Port, the MPS made use of a wide variety of partners to inform, advise and appeal to the LGBT+ community.

Galop, a leading charity that supports LGBT+ people affected by violence and abuse, acted as an independent and confidential 3rd party crime reporting centre, whilst simultaneously providing appropriate support and advice for victims of sexual violence. Galop's reach extends to over 30 important LGBT+ organisations across the UK and Europe.

The MPS and National Probation Service have since established the London Chemsex Working Group (LCWG) to tackle crimes involving chemsex and improve information sharing between partner agencies about individuals connected with such offences and the supply of drugs.

At the time of publication, the LCWG is working on a best practice guide with a view to improving information sharing to disrupt criminal activity and rehabilitate persons convicted of chemsex related offences.

The LCWG is also seeking to raise awareness of professionals working in the criminal justice system about the prevalence of chemsex, the use of chemsex in sexual and non-sexual offending, identification of persons who may be vulnerable to offending caused by chemsex and intervention to assist them.

Risk Factors and Broader Recommendations

Notwithstanding the limited data available, the dangers posed by sexualised GHB use are difficult to ignore. The recent criminal prosecutions of Stephen Port, Gerald Matovu and Brandon Dunbar also serve to underline the fact that criminals and sexual predators are making use of virtual social networks to groom victims and peddle illicit drugs.

Data from this study indicates various mechanisms are being used to administer GHB and men of all virtually ages are at risk of fatal overdose.

There was a high incidence of GHB overdose in public places, with deceased persons often being in the company of others at the time of death. It is possible that greater public awareness, especially with regards the need for prompt medical intervention, would have a positive impact on mortality rates.

Education and support for the users of chemsex drugs is likely to be very important. The review suggested a clustering of risk factors, with the deceased previously coming to notice for GHB misuse in almost 70% of cases.

It is recommended that the MPS should continue to work with partners to educate the LGBT+ community on the dangers of GHB use and chemsex.

In line with a previous study⁹, there are a number of broad areas related to policy and practice that this research highlights.

1. The production and dissemination of a range of resources that provide drug harm reduction information.
2. Ensuring access for men to gay-friendly drug and sexual health services that are competent to address the psychosocial aspects of their health and any harms arising
3. Co-ordinated work with managers of commercial sex-on-premises venues to facilitate development of clear harm reduction policies and procedures.
4. Co-ordinated engagement (local, national and international) with commercial companies and gay media, including those which provide geo-spatial networking apps and websites, to explore opportunities for health promotion and harm reduction as part of a corporate responsibility to their users.

⁹ Sigma Research. The Chemsex Study (2014).

STRATEGIC RECOMMENDATIONS

- 1. Each death should be recorded on a crime report as a crime related incident 'CRI' on CRIS.*
- 2. Adopt a Service-wide protocol for minimum standards of investigation in respect of unexplained deaths, with full details of any decisions and actions taken recorded on CRIS.*
- 3. Officers attending the scene of a sudden death (including duty officers) and those conducting enquiries into the death of the individual should formally record their decisions and actions prior to going off-duty.*
- 4. A statement should be taken from the informant(s) in relation to each death. If more than one person was present upon police arrival, a statement should be taken from each individual. The last person to have contact with the deceased prior to their death (if not the informant) should be identified and a statement obtained in relation to their last contact with the deceased.*
- 5. All paperwork in relation to the death should be copied and retained in accordance with MPS policy, with relevant details recorded.*
- 6. Wherever a search is conducted of a premises, a search record must be completed listing any items seized. Evidence of substance misuse should be searched for, recorded and seized. Signs of any disturbance, insecure points of entry and exit, and weapons should be searched for and recorded.*
- 7. All items seized (e.g. phones, laptops, drugs) should be considered for examination and analysis. If the items are not sent for analysis, the rationale as to why this has not been done should be recorded.*

- 8. Local enquiries should be conducted and recorded, even if only with the neighbours in close proximity to the venue.**
- 9. CCTV enquiries should be considered for the relevant timeframe.**
- 10. Consideration at each sudden death should be given to calling the local CID, the Specialist Crime Car and CSM / SOCO. If they are not required to attend the reason should be recorded.**
- 11. If officers are unsure as to the circumstances surrounding the death, the scene should be photographed to assist other investigating officers and the coroner.**
- 12. All contact with the family of the deceased should be recorded, including details of the family member spoken to, the time/date of the contact and the content of any conversation. This should be done at the time of informing them of the death and for all contact thereafter.**