DRUG & ALCOHOL ACTION TEAM
Cornwall and Isles of Scilly
Reducing Harm | Promoting Recovery

SAFER CORNWALL
Kernow Salwa

DRUG RELATED DEATHS REPORT

CONCERNING THE MONITORING OF AND THE CONFIDENTIAL INQUIRIES MADE INTO DRUG RELATED DEATHS WITHIN CORNWALL & THE ISLES OF SCILLY

1st January 2018 to 31st December 2018

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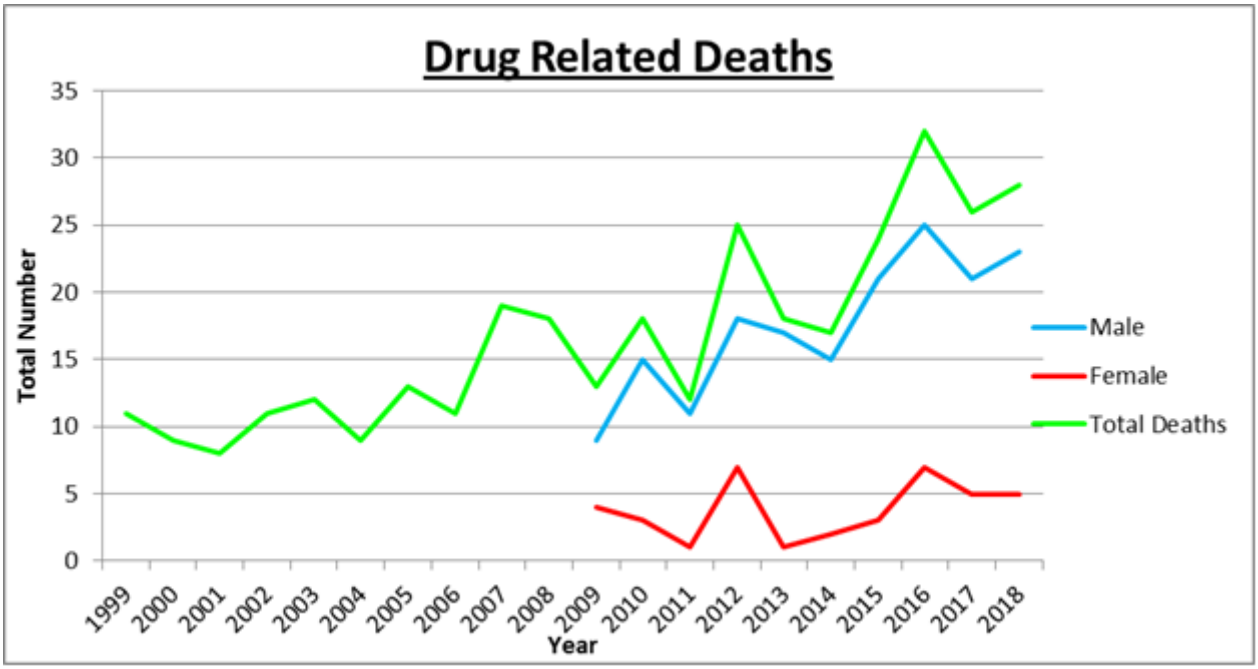
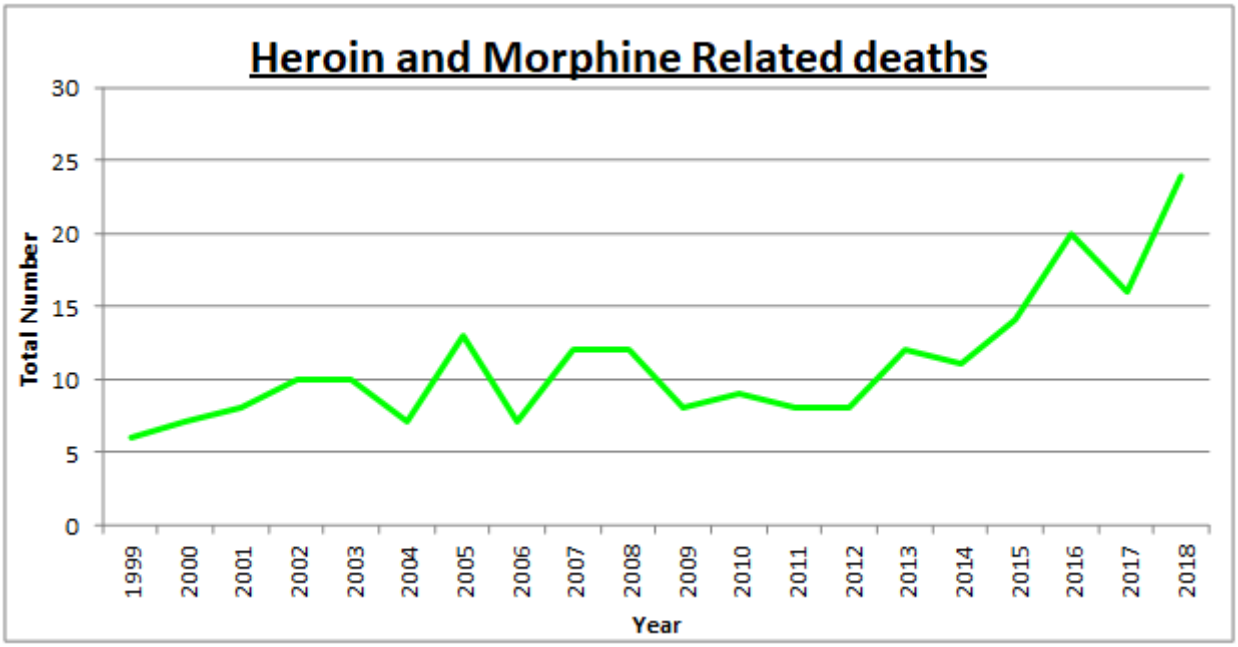
EXECUTIVE SUMMARY

This is the sixteenth annual report concerning drug related deaths prepared by the Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT) under the Community Safety Partnership, Safer Cornwall. The 2018 report covers the period 1st January 2018 to 31st December 2018. It follows the requirements by the Department of Health and Home Office for all local Areas to have in place a system of recording and conducting confidential inquiries into all drug related deaths within their specific areas with the purpose of delivering the Public Health outcome of preventing and reducing drug-related deaths.

Definition
The report uses the same agreed definition of a drug related death as used by The Home Office, all 43 Police Forces in England and Wales, all Health Areas, the Department of Health and Public Health England; '*deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, are involved'.*

The chart and table below illustrates the yearly variance of drug related deaths in Cornwall from 1999 when DAAT records commenced up to the end of 2018;





	2013		2014		2015		2016		2017		**2018**	
Total DRD's	18		17		24		32		26		**28**	
Gender	17M	1 F	15M	2F	21 M	3 F	25 M	7F	21 M	5F	23M	**5F**
% Change	28% decrease from 2012		6% decrease from 2013		41% increase from 2014		33% increase from 2015		19% decrease from 2016		7.7% increase from 2017	
Heroin / Morphine present	12 (9 heroin & 3 morphine)		11 heroin		15 (12 heroin & 3 morphine)		20 (18 x heroin, 2 x morphine)		16 (15 x heroin, 1 x morphine)		24 (22 x heroin, 2 x morphine)	
Methadone present	5 (all illicit- 3 of the deaths where methadone is a significant factor)		5 (3 x prescribed & 2 illicit) 1 of the illicit in combination with lethal levels of prescribed meds		5 (3 x prescribed, 2 illicit) 1 of the illicit where methadone caused death i/c alcohol		5 (4 prescribed & 1 illicit- all in combination with other drugs/ alcohol)		13 (10 prescribed, 3 illicit- all in combination with other drugs/ alcohol)		12 (10 prescribed, 2 illicit- all in combination with other drugs/ alcohol)	
Other CD significantly present	1 x DHC 1 x MDMA 1 x prescribed fentanyl & oxycodone		0		3 x MDMA (includes 1 x poly drug) 1 x Subutex 1 x NPS		2 x cocaine 2 x NPS 1 x amphetamine		1 x cocaine, 1 x MDMA & ketamine, many x poly drug		6 x alprazolam 1 x MDMA	

Main findings from this report for 2018:

- People succumbing to a drug related death are becoming **more complex** in the presenting issues intertwined with their drug and alcohol problems, including the challenge and awareness of multiple adverse childhood experiences, **drug use combined with physical and/ or mental health issues**, **more complex drug interactions leading to heart arrhythmia** and **the number who take their own lives**. A notable number of cases involve people who have serious **underlying medical issues** which have either been **brought on by or exacerbated by drinking and drug taking.**

- The reduction in drug related deaths for 2017 in Cornwall bucked the trend of the national picture with a reduction of 19% (26). **Numbers rose again in 2018 by two people to 28**.

- 26 people (93%) died in Cornwall in 2018 from a death that involved **an opiate drug**-an increase of 13% on the previous year

- **Deaths involving heroin** have increased to 22- an increase of 32%. This is an all-time high representing 79% of the total.

- **Cocaine** features in 15 of the deaths (54%), also an all-time high. Up from 42% in 2017 and is the second successive increase.

- The 40 to 49 age group had the highest rate of drug related deaths for the third year running. 12 (43%) people (42% in 2017). The 30 to 39 age group closely followed with 10 deaths (36%).

- Twenty three (82%) feature the presence of an anti-depressant medicine such as Sertraline or Mirtazapine. Mental ill health is a pervading feature this year by comparison with 58% in 2017.

- Seventeen deaths (61%) feature the presence of the **benzodiazepine drug Diazepam.** (54% in 2017)

- **Alprazolam**, being 10 times more powerful than diazepam (Valium) featured in 6 cases (21%) rising from 3 the previous year. This is the second successive annual increase. All cases are male with ages ranging from 21 to 47, (Avg. 37).

- Twenty one (75%) **do not have any alcohol present** with 2 (7%) having levels of alcohol where there has been a significant contribution to the death. 62% were alcohol free in 2017, so this feature continues to grow

- Twenty Seven (96%) feature being present and contributing to the death. Many feature a wide range of substances, often combining prescribed with illicit drugs and the synergistic action being the cause of death.

- **Gabapentinoid drugs** such as Pregabalin in the main, but also Gabapentin, have seen a slight decline in their prevalence to 12 (43%).All of these involve the combination of Gabapentinoids with an opiate drug.

- Fifteen people died whilst engaged in drug treatment, 1 whilst in alcohol treatment and 2 died within 6 months of leaving treatment. This represents 64.3% of the total deaths and is **a decrease of 5% from 2017**.

- There were 3 deaths noted where **service users have been prematurely discharged from supported accommodation**. These were **vulnerable women**, **who could also be violent, disruptive or other behave in ways which were detrimental to others** in the accommodation.

- There was a single death where only one drug (MDMA) was involved.

- New psychoactive substances were a feature in one death.

INTRODUCTION

1.1 This is the sixteenth annual drug related deaths report for Cornwall and the Isles of Scilly, covering 2018. It follows the guidance and requirements by the Department of Health and the Home Office for all Areas to have in place a system of recording and conducting confidential inquiries into drug related deaths within their specific areas.

1.2 The definition of a drug related death used is that of the Home Office, all 43 Police Forces within England and Wales, the Department of Health and Public Health England; *'deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, are involved'.*

1.3 This report examines issues that have arisen from drug related deaths and associated learning, seeking to improve local understanding, practice and the lives of local residents and their families. These issues have been identified through the local multiagency Drug Related Death Review Panel, informed by current guidance, advice and evidence, including:

- Cornwall Council 'Empowering Independence Service – Complex and/or Mental Health Needs'. March 2019. This document can be found here
- Cornwall Naloxone Report 2016- 2019. This can be found at Appendix 1 on page 36
- Office For National Statistics 2017 report published August 2018- 'Deaths related to drug poisoning in England and Wales: 2016 registrations' https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations
- Routine Enquiry about Adverse Childhood Experiences Implementation pack pilot evaluation (final report) published May 2018 https://www.gov.uk/government/publications/routine-enquiry-about-adverse-childhood-experiences-implementation-pack-evaluation
- Take- Home Naloxone for Opioid Overdose in People Who Use Drugs (Updated version July 2017) - Advice for local authorities and local partners on widening the availability of naloxone to reduce overdose deaths from heroin and other opiate drugs. http://www.nta.nhs.uk/uploads/phetake-homenaloxoneforopioidoverdoseaug2017.pdf
- Health Matters: Preventing Drug Misuse Deaths (Updated September 2017) https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

- Understanding and Preventing Drug-Related Deaths - The report of a national expert working group to investigate drug-related deaths in England. (August 2016) http://www.nta.nhs.uk/uploads/phe-understanding-preventing-drds.pdf

- Improving Clinical Responses To Drug- Related deaths- A summary of best practice and innovations from drug treatment providers.(August 2017) http://www.collectivevoice.org.uk/wp-content/uploads/2017/08/Improving-clinical-responses-to-DRDs-August-2017.pdf

1.4 Nationally

The most recent report from The Office for National Statistics (ONS) was published 6th August 2018*, reporting on deaths registered between1st January 2017 to 31st December 2017 inclusive. Appendix 2 on page 44 shows a comparison between the ONS 2017 statistics and local CIOS data. The report's main headlines for 2017were:

- There were 3,756 deaths relating to drug poisoning in England and Wales in 2017, a rate of 66.1 deaths per 1 million population, and similar to levels seen in 2016.

- Around two-thirds of drug-related deaths in 2017 were male (2,521 deaths compared with 1,235 female deaths). The male age-standardised rate decreased from 91.4 deaths per 1 million population in 2016 to 89.6 in 2017, the first decrease since 2012. In contrast, the female age-standardised rate increased for the eighth consecutive year, although the changes for both males and females between 2016 and 2017 were not statistically significant.

- Rate of deaths relating to drug misuse in males fell for the first time since 2012. As with previous years, most drug poisoning deaths in 2017 were from drug misuse, which accounted for 2,503 deaths out of 3,756, or 67%. The rate of death relating to drug misuse in 2017 was 43.9 deaths per 1 million population; although this was lower than the rate of 45.6 found in 2016, the difference is not statistically significant.

- The highest rate of deaths relating to drug misuse continued to be in people aged 40 to 49 years, with 103.3 deaths per 1 million population, decreasing from 108.2 in 2016. Rates for those aged 50 to 69 years and those aged 70 years and over increased in 2017 to 42.2 deaths and 12.5 deaths per 1 million population, respectively, although these increases were not significantly significant.

- Number of deaths involving heroin and morphine decreased for the first time since 2012. In 2017, there were 1,164 deaths involving heroin and morphine, a decline of 4% (45 deaths) and the first decline since 2012. The National Crime Agency (2018) reports that **heroin purity levels have remained stable between 2016 and 2017**. Deaths involving heroin and morphine had increased from 579 deaths in 2012 to 1,209 deaths in 2016; the increase between 2012 -2015 followed the "heroin drought", which occurred in 2010/2011. This was subsequently followed by **increased purity of heroin**, thought to be one factor in increased overdoses.

- **Deaths from fentanyl continued to rise** in 2017. Despite deaths from most opiates declining or remaining steady, fentanyl deaths have increased by 29%, rising from 58 deaths in 2016 to 75 deaths in 2017. Fentanyl and its analogues have been found mixed with heroin, causing accidental overdose in users.

- **Deaths from new psychoactive substances (NPS) halved in 2017 to** 61, which equates to an age-standardised rate of 1.0 death per 1 million population. This is a statistically significant decrease from the 123 deaths in 2016 (2.1 per 1 million).

- **Cocaine deaths rise for the sixth consecutive year**. There were 432 deaths related to cocaine in 2017, compared with 371 deaths in 2016.

- North East had the highest rate of drug misuse deaths. Rates of drug misuse in England were highest in three northern regions: North East, North West and Yorkshire and The Humber, with 83.2, 64.7 and 54.5 deaths per 1 million population, respectively. The rate in the North East was statistically significantly higher than each of the other regions of England. London had the lowest rate of deaths, which saw a statistically significant reduction from 32.3 deaths per 1 million population in 2016 to 24.6 in2017. The rate in London in 2017 was significantly lower than each of the other regions of England.

*In relation to the ONS report the below caveat must be considered- '*In England and Wales, almost all drug-related deaths are certified by a coroner following an inquest. The death cannot be registered until the inquest is completed, which can take many months or even years, and we are not notified that a death has occurred until it is registered.*

In common with most other mortality statistics, figures for drug-related deaths are presented for deaths registered in a particular calendar year, rather than deaths occurring each year. This enables figures to be published in a timelier manner, but can make the trends more difficult to interpret, especially for smaller geographical areas.

1.5 There is much to be learned by investigating drug related deaths and the dissemination of that learning needs to be rapid and insightful. Each death that has been investigated and taken through to inquest covered by this report has presented its own unique set of circumstances and associated learning. Case specific learning is addressed dynamically so that the benefits can be immediately felt by all relevant parties and agencies. The deaths in question can be found later in this report.

1.6 The figures concerning drug related deaths published by the Cornwall & Isles of Scilly Drug and Alcohol Action Team (CIOSDAAT) are seen as consistently accurate. This report contains a summary of investigations and recommendations which would not have been possible without an open, robust and efficient working relationship with many partner agencies and personnel. These include Addaction, Bosence/ Boswyns rehabilitation and detox unit, Devon and Cornwall Police, HM Prison Service, HM Coroner and her officers, SW Ambulance Service, the National Probation

Service and supported housing projects. Cases often involve interaction with toxicologists, pathologists, pharmacists and GP's. The information and data, efficiency of agency meetings and communication affords us confidence in the accuracy of our report.

1.7 This report has been prepared for the Cornwall & IOS Drug Related Deaths Review Group, the Peninsula Drug Related Deaths Review Panel and the Safer Cornwall Board. The report is also specifically for the information of HM Coroner for Cornwall.

2. RECORDED DRUG RELATED DEATHS – Cornwall & IOS 2018

2.1 Total deaths 2013- 2018

	2013		2014		2015		2016		2017		**2018**	
Total DRD's	18		17		24		32		26		**28**	
Gender	17M	1 F	15M	2F	21 M	3 F	25 M	7F	21 M	5F	**23M**	**5F**
% Change	28% decrease from 2012		6% decrease from 2013		41% increase from 2014		33% increase from 2015		19% decrease from 2016		**7.7% increase from 2017**	
Heroin / Morphine present	12 (9 heroin & 3 morphine)		11 heroin		15 (12 heroin & 3 morphine)		20 (18 x heroin, 2 x morphine)		16 (15 x heroin, 1 x morphine)		**24 (22 x heroin, 2 x morphine)**	
Methadone present	5 (all illicit- 3 of the deaths where methadone is a significant factor)		5 (3 x prescribed & 2 illicit) 1 of the illicit in combination with lethal levels of prescribed meds		5 (3 x prescribed, 2 illicit) 1 of the illicit where methadone caused death i/c alcohol		5 (4 prescribed & 1 illicit- all in combination with other drugs/ alcohol)		13 (10 prescribed, 3 illicit- all in combination with other drugs/ alcohol)		12 (10 prescribed, 2 illicit- all in combination with other drugs/ alcohol)	
Other CD significantly present	1 x DHC 1 x MDMA 1 x prescribed fentanyl & oxycodone		0		3 x MDMA (includes 1 x poly drug) 1 x Subutex 1 x NPS		2 x cocaine 2 x NPS 1 x amphet,		1 x cocaine, 1 x MDMA & ketamine, many x poly drug		6 x alprazolam 1 x MDMA	

The reduction in drug related deaths for 2017 in Cornwall bucked the trend of the national picture with a reduction of 19%. This rose again by 2 deaths in 2018.

26 people (93%) died in Cornwall in 2018 from a drug related death that involved an opiate drug and this has increased from 81% in 2017. Deaths involving heroin have increased to 22 from 15 (+32%) in 2017. This is an all-time high since DAAT records began in 1999 and represents 79% of the total.

2.2 Male deaths 2013- 2018

	2013	2014	2015	2016	2017	2018
Total Drug Related Deaths	18	17	24	32	26	**28**
Males	17 (94%)	15 (88%)	21 (87%)	25 (78%)	21 (81%)	**23 (82%)**
Mean age	35	40	40	40	41.6	**40**
Youngest	2 x 21	27	2 x 25	21	19	**2 x 21**
Oldest	58	61	63	62	62	**51**
Spread of ages	20's- 5 30's- 7 40's- 2 50's- 3	20's- 2 30's- 6 40's- 5 50's- 1 60's- 1	20's- 4 30's- 7 40's- 5 50's- 3 60's- 2	20's- 6 30's- 6 40's- 7 50's- 5 60's- 1	teens-1 20's- 3 30's- 5 40's- 7 50's- 3 60's- 2	**20's- 2** **30's- 8** **40's- 11** **50's- 2**
Heroin/ Morphine	9 x Heroin, 2 x Morphine	10 x heroin	12 x Heroin 1 x Morphine	14 x Heroin 2 x Morphine	13 x Heroin 1 x Morphine	**19 x Heroin** **2 x Morphine**
Methadone significant and/ or present	7 (5 x illicit- 2 in combination heroin, 2 i/c alcohol, 1 i/c poly drug) & (2 x prescribed both in combination heroin)	5 (1 x illicit in combination prescribed meds) & (4 prescribed- 1 O/D i/c meds, 1 i/c illicit Pregabalin and alcohol, 1 i/c heroin, 1 i/c alcohol)	5 (2 x illicit methadone - 1 i/c alcohol, 1 i/c heroin) & (3 prescribed- 1 diabetes related, 2 i/c heroin)	5 (4 prescribed & 1 illicit- all in combination with other drugs/ alcohol)	10 (9 prescribed, and 1 illicit- all in combination with other drugs and/ or alcohol)	**10** (9 prescribed, and 1 illicit- all in combination with other drugs and/ or alcohol)
Other controlled drug significantly present	1 x DHC, 1 x MDMA, 1 x Oxycodone & Fentanyl	0	1 x MDMA, 1 x NPS, 1 x Subutex	2 x Cocaine, 1 x NPS, 1 x Amphet	1 x Cocaine 1 x MDMA & Ketamine	6 x Alprazolam
Treatment (includes discharged from treatment within 6 months of death)	8 drugs	16 (10 drugs and 4 alcohol)	13 (11 drugs and 2 alcohol)	13 drugs	15 (14 drugs and 1 Alcohol)	**15** **(14 drugs and 1 Alcohol)**

2.3 Female deaths 2013- 2018

	2013	2014	2015	2016	2017	**2018**
Total Drug Related Deaths	18	15	24	32	26	**28**
Females	1 (6%)	2 (12%)	3 (13%)	7 (22%)	5 (19%)	**5 (18%)**
Mean age	58	32	40	32	41	**32**
Oldest	58	34	49	55	45	**42**
Youngest	58	30	32	15 months	32	**15**
Heroin/ Morphine	1	1 x Heroin + NPS + medical issues	1 (awaiting inquest but medicine containing morphine was prescribed)	4 x Heroin	2 x Heroin	**3 x Heroin**
Methadone	0	1 x tramadol, Pregabalin & illicit methadone	0	0	3 (1 x prescribed 2 x illicit)	**2 (1 x prescribed 1 x illicit**
Other controlled drug significantly present	0	0	1 x combination of MDMA and medical issues 1 x MDMA and multiple prescribed meds	1 x Fentanyl, 1 x NPS, 1 x multiple combination of medicines	0	**1 x MDMA**
Treatment	0	1	0	2	3 drugs	**3 drugs**

2.4 The average age of men dying from a drug related death during 2018 has decreased very slightly returning to 40 (in the same rate as 2014 to 2016) Men represent 82% of the total number of deaths (23 out of the total of 28) which has increased from 2017 at 81% (21 out of the total 26). Female deaths have stayed at 5 (18% of the total) from the previous year with the percentage of the total deaths being almost the same.

2.5 Cornwall figures accord with the most recent national figures with the highest rate of drug related deaths being in the 40 to 49 age group. Twelve people in Cornwall were in this age range (42.8% of the total).

2.6 Deaths from heroin toxicity or where heroin has been implicated in the death, have increased a by 21%.All these also involve poly drug use to a greater or lesser degree. Where heroin is present in toxicology, the death will be reported as a heroin-related death. There will be occasions, however, where the level of heroin is low and the deceased had high tolerance to opiates. The death may have been due to the synergistic action of other drugs that were present in more significant levels.

The poly drug use either involves other illicit drugs, and/ or alcohol, or a combination with lawfully prescribed medicines. As a general trend from 2013 the percentage of heroin related deaths have steadily risen but 2018 has seen the most marked increase - 2013 (50%), 2014 (65%), 2015 (50%), 2016 (56%), 2017 (57.7%), 2018 (79%)

2.7 Deaths from **methadone toxicity,** or where it had been implicated in the death, rose in 2017 by 160% to 13 deaths. Of those 13 deaths, 10 were cases where methadone has been present due to having been lawfully prescribed, with 3 cases involving illicitly sourced methadone. 2018 has seen the number of deaths where methadone has been present reduce to 12 (43%) with 2 involving illicit methadone.

2.8 Having never featured in any significance historically, **Cocaine*** has now, once again, risen in prominence in drug related deaths for the third year running with 15 out of the 28 cases showing its presence. This now represents 54% of all drug related deaths locally. This is mainly in the form of **crack cocaine.** This aligns with the local intelligence picture about surrounding crack cocaine.

*Toxicology only indicates cocaine and its metabolites so where a person has used crack cocaine only cocaine metabolites are indicated but where possible we review cases and draw information from medical records where a history of crack use has been identified. The access to this information indicates strongly that crack cocaine use is now fairly prolific and linked to a changing picture of organised crime.

2.9 Twenty three deaths (82%) feature the presence of an anti-depressant medicine such as Sertraline or Mirtazapine. **Mental ill health** is a pervading feature and this would be apparently more so with a 24% rise in the number of cases featuring an anti-depressant medicine as compared to 2017. Diazepam features in 17 deaths (61%) with some overlap with those where anti- depressant medicine was found. This is an increase of 7% from the previous year. Whilst these medicines can be useful in the treatment of mental health disorders such as anxiety and depression, they can act synergistically to enhance the toxic effects of other drugs on the cardiorespiratory system. Table 2.12 shows the number of cases where individual medicines have been present (as identified in toxicological analysis). The information is not always available but in the vast majority of cases, if not all, anti-depressant medicines appear in the toxicology lawfully by way of the relevant person having been prescribed.

2.10 Two deaths (7%) involve significant levels of **alcohol** being present in the toxicology. Whilst the level of alcohol in each of these cases could have been independently fatal in some, they occurred in cases where the deceased had regularly consumed large amounts of alcohol and, therefore, had tolerance. Each case involved the potentiating action of the alcohol with other depressant drugs. Twenty-one (75%) involved no alcohol at all with the remaining 5 (18%) involving alcohol at insignificant or light use level only.

2.11 Poly drug use or synergistic interaction between drugs/ alcohol has again been one of the main findings within toxicology with only one death in2018 involving a single agent (MDMA overdose and death). All other deaths have involved at least 2 substances. It would be lengthy and unpractical to list all these substances against each set of circumstances but the table below shows the full list of substances present in toxicology. Many of the deaths in 2018 have involved comments from the toxicologist and pathologist highlighting the synergistic and potentiating effects of drug combinations.

2.12 Drugs Present and contributory to death (figures in brackets are for 2017).

Substance	All cases	Male	Female
Alcohol			
Alcohol present/ insignificant	5 (7)	5 (6)	0 (1)
Alcohol present/ significant (above 200 mg/ 100ml)	2 (3)	2 (3)	0 (0)
No alcohol present	21 (16)	16 (12)	5 (4)
Illicit drugs, Controlled Drugs (Misuse of Drugs Act 1971) and other substances			
Heroin	22 (15)	19 (13)	3 (2)
Methadone	12 (13)	10 (9 prescribed & 1 illicit)	2 (1 prescribed & 1 illicit)
Cocaine	15 (12)	14 (10)	1 (2)
Diazepam	17 (14)	15 (11)	2 (3)
Cannabis	3 (5)	2 (5)	1 (0)
Amphetamine	2 (4)	2 (4)	0 (0)
MDMA/ MDA (Ecstasy)	3 (3)	2 (3)	1 (0)
Morphine	3 (1)	3 (1)	0 (0)
Ketamine	0 (1)	0 (1)	0 (0)
Mephedrone	0 (1)	0 (1)	0 (0)
Etizolam	1 (0)	1 (0)	0 (0)
Buprenorphine	1 (0)	0 (0)	1 (0)
Volatile substance (gas)	0 (1)	0 (1)	0 (0)
Other drugs (Medicines Act 1968)			
Alprazolam	6 (3)	6 (3)	0 (0)
Amitriptyline	3 (2)	2 (2)	1 (0)
Citalopram	4 (2)	4 (1)	0 (1)
Chlordiazepoxide	3 (0)	2 (0)	1 (0)
Dihydrcodeine	1 (0)	0 (0)	1 (0)
Fentanyl	1 (1)	0 (1)	1 (0)
Fluoxetine	2 (2)	2 (2)	0 (0)
Gabapentin	3 (0)	3 (0)	0 (0)
Mirtazapine	6 (5)	6 (5)	0 (0)

Olanzapine	2 (0)	2 (0)	0 (0)
Pregabalin	9 (12)	7 (10)	2 (2)
Quetiapine	2 (1)	1 (1)	1 (0)
Sertraline	4 (1)	4 (1)	0 (0)
Tramadol	4 (0)	3 (0)	1 (0)
Trazodone	3 (1)	3 (1)	0 (0)
Venlafaxine	0 (2)	0 (2)	0 (0)
Zopiclone	1 (1)	0 (1)	1 (0)

2.13 Throughout 2018 the Gabapentinoid drugs Pregabalin and Gabapentin were subject of a Medicines Health Registration Association (MHRA) consultation which resulted in them being scheduled as a Class C drug under the Misuse of Drugs Act from 1st April 2019. This, in part, is down to the increased misuse of these drugs. This misuse and appearance regularly in toxicology for drug related deaths has been evident in the last three years in Cornwall. It has been reported as a drug of concern because of its reported potentiating effects to opiates such as heroin. The effect that reclassification may have upon the availability of Gabapentinoids and their role in drug related deaths will be continue to be closely monitored in 2019. Whilst there has been a slight drop in the prevalence of Gabapentinoids in the drug related deaths for 2018 (12 cases or a 3% decrease) all saw the combination of mainly Pregabalin with mainly heroin.

2.14 Alprazolam, mainly marketed under the trade name of Xanax, is a potent, short-acting benzodiazepine drug which is not available on the NHS Formulary and is only lawfully available in the UK with a private prescription. It is approximately 10 times more powerful than Diazepam and is becoming very sought after in the illicit market, particularly amongst young people. Six deaths (21%) featured this drug. All were male and all combined the drug with other drugs. Alprazolam is significant in its presence due to its potency and synergistic action with other central nervous system depressant drugs. This drug has come to notice in Cornwall over the last three years with the number of cases, although small, steadily increasing from 2 in 2016 (6%) to 3 in 2017 (11%) and 6 in 2018 (21%). Alprazolam is not specifically mentioned in the latest version of the ONS report.

2.15 In 2018 there were 15 cases (54%) where the deceased was in drug treatment at death- one was in alcohol only treatment and 2 where the person died within 6 months of leaving drug treatment. Some received both alcohol and drug treatment. The remaining 10 had either no link to treatment at all or were outside of the 6 month period post discharge and had not represented.

Table 2.16 shows the numbers in drug and alcohol treatment who have died from a drug related death with their numbers in brackets after the total number for the respective year.

2.16 Drug Related Deaths and Numbers in Treatment

	2013	2014	2015	2016	2017	**2018**
Total drug related deaths (people in treatment or within 6 months of treatment)	18 (8 – 44%)	17 (15-88%)	24 (14-58%)	32 (15-47%)	26 (18-69%)	**28 (18-64%)**
In current drug treatment	6	10	10	14	16	**15**
Died within 6 months of leaving drug treatment	2	1	2	1	1	**2**
In current alcohol treatment	0	3	1	0	1	**1**
Died within 6 months of leaving alcohol treatment	0	1	1	0	0	**0**
Not known to treatment	10	2	10	17	8*	**10**

2.17 It was noted in the annual report of 2017 that the increased complexity of people using drugs was significant. The people who have died in 2018 are no exception to this and, in some ways, the complexity is more marked.

It is clear that a growing number of those dying from a drug related death are physically and/or mental unwell also. Their ability to recover from a drug overdose therefore is compromised and their cognitive approach to the taking of the drugs in the first place may also be compromised.

With **82% of cases in 2018 involving a person who has combined illicit drugs or multiple medicines with anti-depressant medicines it is clear that mental ill health is manifest in drug related deaths far more in 2018.**

The **physical health issues evident in deaths in 2018 include Chronic Obstructive Pulmonary Disease, asthma, enlarged heart, neuropathic pain including leg and back pain, leg ulcerations, septic arthritis, hypertension, liver disease, pneumonia, emphysema, cancer, deep vein thrombosis, angina, coronary heart disease, and alcohol dependence**

At the Child Death Review of a 15 year old girl it was noted that there is **a risk associated with selective serotonin reuptake inhibitor (SSRI) medicines and drugs such as MDMA**. This information is not new but has not been adequately communicated and appears to require greater emphasis and dissemination.

People with multiple problems and vulnerabilities taking their own lives. Whilst these deaths are counted separately and do not feature in this report, the links between drug related death and suicide are often inextricable and are therefore kept under review.

2.18 Venues deaths occurred

Venue	Number of DRD's
Home address	19
Home address of another	3
Hospital after an overdose elsewhere	2 (one at H/A, one at licensed premises
Supported accommodation	1
Street, sports area or other public place	3

As per previous years the home address of the deceased person or the home address of related others are the venue where most deaths occur. Overdose deaths in public toilets or other public spaces, for example, are significantly lower as a percentage.

Were deaths in public places to be higher or in a particular venue then targeting multi-agency resources would be an easier task relatively speaking. Behind closed doors of private living accommodation is a very difficult venue to target. This tends to suggest that there are sufficient resources and working practices to be able to intervene effectively outside of the home address (as this used to be where more deaths occurred). Where there is more than one occupant of a home address there is more scope to intervene in a timely manner after an overdose but the vast majority of home address deaths are where the person has used drugs alone.

2.19 Area where deaths occurred, by the nearest town,

Area	Number of DRD's
Newquay	6
Penzance	4
Truro	3
Camborne	2
Redruth	2
St Austell	2
Bodmin	1
Bude	1
Hayle	1
Helston	1
Launceston	1
Liskeard	1
Lostwithiel	1
Penryn	1
Perranporth	1
St Ives	1

3. BRIEF CIRCUMSTANCES/CASE STUDIES 2018

3.1 Six of the 28 suspected drug related deaths in 2018 are awaiting inquest hearing by H.M. Coroner for Cornwall. Requests have been made following previous DAAT annual reports to include brief details of the individual circumstances regarding places of death, (i.e. public toilets etc.), levels of care, treatment of the deceased and the combination of drugs and other substances or other material considered to have caused death. There follows a brief summary of all 28 deaths with any lessons learned;

3.2 **Drug Related Death 1 – Jan 2018**

- 45 year old man found in a decomposed state at his home address with drug taking paraphernalia close by. The decomposition meant that toxicological samples were from the liver only and, therefore, not as accurate as from other and usual body samples.
- Cause of death given as 1a. Illicit drug use
- Alprazolam in combination with alcohol and morphine derived from heroin.
- Serious medical issues of chronic neuropathic pain secondary to previous leg abscesses and operations, septic arthritis, injecting into abscesses, poor eyesight meant his injecting was even more reckless and dangerous, compartment syndrome causing pain due to injecting an arm and pressure building up.
- Long history of drug treatment and suffered PTSD as a result of a friend being shot as part of a drug deal. Depression and previous treatment at Broadreach House.
- Previous overdoses and previous detoxes. Amitriptyline prescription stopped due to over use.
- His latter injecting into septic shoulder joint illustrates how unwell this man was and his physical and mental condition prior to death.
- Discharged from Addaction on 04/12/2017 due to non-engagement although his Recovery Worker had been persistent and attempted to contact him through letters, phone and text. He was aware that he could refer himself at any point as he had done on previous occasions.
- Addaction not made aware that this man had been hospitalised on 15/12/2017 following a suspected deliberate drug overdose as the admission was coded for his septic shoulder.

Findings and applying the learning

- It was concluded that this was an accidental overdose and a drug related death.
- This was the first Alprazolam related death of 2018 in a year which saw an increase in deaths related to Alprazolam up from 3 in 2017 to 6 in 2018. There has been a concerted effort to widely advertise the dangers of Alprazolam. Whilst anecdotally this drug is used by younger people, the deaths where Alprazolam is cited range in age from 31 – 45
- This is one extreme example this year of a person with serious physical health problems combined with mental ill health and drug use. Tangible close working

relationships between agencies working with complexities was very evident, including the Hospital Outreach Team. This is now feeding into the development of the Integrated Multi-Agency Prevention and Assessment of Crisis Team (IMPACT) at Royal Cornwall Hospital - a team dedicated to treating people with co-morbid conditions where communication is key to the better understanding and treatment of people such as this man. Addaction should have been made aware of the admission to RCHT the day he was admitted. Teams such as the Addaction Hospital Outreach Team and the new IMPACT Team are tasked with preventing this from happening in the future.

3.3 **Drug Related Death 2 – Feb 2018**

- 29 year old woman who was admitted to hospital following a possible heroin and amitriptyline overdose in the toilets of licensed premises. She suffered an ischaemic brain injury and died 5 days later.
- Cause of death was given as 1a. Ischaemic brain damage and 1b. Illicit drug misuse
- In treatment with Addaction for drug and alcohol issues. Known to misuse amitriptyline and was a dependent user of alcohol and Tobacco.
- No ante mortem samples available at RCHT for toxicology so it could not be proved beyond reasonable doubt that heroin was present. This was adduced in evidence, however, with testimony from witnesses corroborating the use of heroin.
- Required to leave early from planned detox due to an allegation that she had supplied medicine to another resident of the detox unit.
- Previously arranged supported accommodation from whence she had come into detox and was due to return post detox was suddenly made not available to her. This meant she was effectively homeless upon discharge from detox. Temporary accommodation was arranged.
- Her down time after the overdose was too long for her to recover from although there was at least one other person with her when she overdosed.
- Large amount of support from family. Multiple detoxes.
- Could be disruptive especially in a male and female supported accommodation environment.
- Multiple issues of mental ill health, sexual assault victim, homelessness, inappropriate relationships, drug/ alcohol use, multiple hospital admissions, crime, rule breaking within supported accommodation and self-harm.
- Not offered or issued with naloxone at point of discharge from detox.

Findings and applying the learning

- RCHT have changed processes for ante and post mortem sample collection now which makes samples more accessible to HM Coroner and Police. There have been notable examples of this now happening as identified by Police since this case.

- A meeting has taken place between Addaction, DAAT and two supported accommodation providers and the detox providers to discuss ways of mitigating the risks to service users who might fall outside of 'house rules' and may be required to leave early. The new Cornwall Council tender for supported accommodation offers more to complex need clients and better access to long term accommodation and is now live. The situation will be monitored throughout 2019 to ensure people are not excluded from treatment/accommodation irrespective of their complexities.
- Whilst it has not happened yet, the relevant supported housing providers have agreed to meet with the family to discuss this case further and the nuances of providing accommodation for people with multiple vulnerabilities and problems.
- The training of all staff at the Assessment, Stabilisation and Detox unit has been revisited in relation to the issue of Naloxone and the need to do this at every discharge.

3.4 **Drug Related Death 3 – Mar 2018**

- 51 year old man with long psychiatric history and in drug treatment. He was found deceased in his supported accommodation room.
- Disclosure of significant childhood trauma following witnessing domestic violence, suffering anxiety and nightmares
- Cause of death given as 1a. Heroin and other central nervous system depressant drug poisoning.
- Tobacco smoker who used Ventolin inhaler to assist breathing, excessive use of alcohol and had depression and anxiety.
- Cocaine and heroin found in toxicology together with a further 5 drugs including prescribed anti-depressants and an anti-psychotic drug.
- Previous heavy drinker who had been abstinent from alcohol for 9 weeks to which he was very proud and bragged at his supported accommodation how well he was doing.
- Had not been seen by staff at accommodation for over 3 days but was a long term resident, well known and not suspected of being at risk, suicidal or vulnerable.
- Previously engaged with Addaction for alcohol issues and is completed. The latest treatment episode commenced January 2018 and, whilst recovery plans had been put in place, he had only one session with a recovery worker.

Findings and applying the learning

- This man was isolating himself to remain abstinent but his situation and circumstance meant that he was at a high risk of relapse.
- He had given permission for Addaction to talk to his supported accommodation provider, but it did not happen, in part due to the short time he actually engaged with Addaction again. The true extent of his drug use should have been better identified by the accommodation provider and discussed at the earliest opportunity. This has formed a joint working exercise between providers to learn from this

3.5 **Drug Related Death 4 – Apr 2018**

- 31 year old man who was found deceased at his home address.
- The cause of death was given as 1a. Heroin and cocaine poisoning.
- Prescribed beta blocker Propranolol and anti-depressant Mirtazapine.
- Multiple drug treatment episodes with the last one ending 3 months before his death, at his request.
- Recovery worker saw this man in the street during the intervening 3 month period and he was doing well.
- Pattern of treatment for this man was that he would self-refer when he wanted treatment and this had gone on for 6 years.
- June - October 2017 this man had successfully completed a methadone and benzodiazepine detox.

Findings and applying the learning

- Review of this case shows that this man had very good care and treatment despite his ambivalence, poly drug use and his presenting intoxicated at appointments. He was signposted to other agencies including CMHT and he was encouraged to attend Addaction Mutual Aid Programme groups and similar.
- Evidence shows that engagement in Aftercare for 3 months post detox is the most effective means of maximising the gains from treatment and sustaining recovery/reducing relapse. Introduction of 3 months' aftercare and monitoring to be added to contractual requirements for 2019-20.

3.6 **Drug Related Death 5 – Apr 2018**

- 39 year old man found deceased in a decomposing state at his home address in the Bodmin area.
- In long term drug treatment - 17 years in total.
- Cause of death given as 1a. Synergistic toxicity of several central nervous system depressants.
- Medical issues: an abnormally fast heart rate, lower leg swelling, hypertension, lumbar spine pain and obesity.
- Prescribed methadone, sertraline, Temazepam, Pregabalin and tramadol.
- The tramadol level in toxicology alone was potentially fatal in its own right but was combined with the above-mentioned medicines and a small amount of alcohol.
- In essence this was **a death by prescribed medicines** but the tramadol appears to have been taken other than in accordance with the prescription.

Findings and applying the learning

- Whilst evidence was not fully available, it looks like this man might have been self-medicating for pain over and above what his GP was prescribing -s a credible explanation for the high levels of tramadol in the absence of suicidal ideation. This man informed Addaction that he was reluctant to reduce the medication as he found it assisted with managing the pain that he experienced.

- Due to the presentation of the scene of the death this death appears accidental and not a planned overdose.
- From the viewpoint of Addaction's provision of services for drug and alcohol treatment, this man was relatively stable regarding his use of the opiate substitution prescription and it had enabled him to cease use of street drugs.

3.7 **Drug Related Death 6 – Apr 2018**

- 46 year old man who died at his home address. He was not in treatment.
- This Inquest yet to report.
- Significant and lasting medical issues which included brain injury as a result of going through a car windscreen in 1995, frozen shoulders, compressed vertebrae, diabetes, and lung disease.
- Diagnosed with depression when he was 46 as he had all of these problems from a relatively young age.
- On the day of his death he began self-harming by cutting his arms and legs with a knife, was drinking whisky and from a bottle of morphine. Police were able to force an entry to his home address but despite ambulance treatment this man died at the scene.

Findings and applying the learning

- Inquest awaited where more evidence will be heard and an expected long look at the possibility of this being a suicide.

3.8 **Drug Related Death 7 – Apr 2018**

- 21 year old man who died at his home address.
- Cause of death given as 1a. Acute ethanol toxicity. He also had diazepam and cocaine in his toxicological screen.
- He had been out drinking with friends and returned home in the early hours to be put to bed on the lounge sofa to 'sleep it off'. Evidence from a witness that the subject had also taken diazepam whilst out.
- No drug or alcohol treatment history.

Findings and applying the learning

- The evidence did not identify fully the scale of drug use and had to be explained retrospectively by toxicology. This appears to be an accidental fatal overdose where friends were socialising perhaps naïve or ambivalent to the interaction of alcohol with other drugs.
- It does highlight the need for more information being made available to recreational users, including what to do when someone has overdone it (aftercare).

3.9 **Drug Related Death 8 – Apr 2018**

- 35 year old man of no fixed abode who died in a shop doorway overnight.

- Cause of death given as 1a. Poisoning by a combination of drugs and 2. Pneumonia.
- Health challenges: Hepatitis C, Pneumonia, diagnosis of ADHD and emotionally unstable personality disorder.
- Toxicology showed the presence of cocaine, heroin, methadone, amphetamine, Pregabalin, cannabis, methylphenidate and diazepam.
- He had been on a methadone prescription for 6 days having been engaged into treatment through outreach work. He had 2 previous treatment episodes.

Findings and applying the learning

- This case flagged up the value of outreach work and the tenacity of an Addaction recovery worker who persisted in trying to engage this man despite his earlier insistence that he didn't want treatment. Addaction were able to issue him with naloxone and get him on to a prescription. This was all done by seeking him out as often as they could. Sadly he could not be stabilised within the very short time he was in treatment due to lack of accommodation. Police Officers on duty in the early hours saw this man in a shop doorway and knew of him as a local rough sleeper so they decided to check on his welfare. They were able to raise him and he sat up and spoke to them. Between that check and him being found dead, it looks like he used numerous drugs.
- There were a lot of people looking out for this man so there is no identified learning.

3.10 **Drug Related Death 9 – Jun 2018**

- 47 year old man who died in his home address alone after an overdose of prescription and non-prescription drugs.
- Cause of death given as 1a. Synergistic toxic effect of several CNS depressants.
- Previous medical history of asthma, emphysema, depression, anxiety, chronic obstructive pulmonary disease (COPD), alcohol and drugs, including a history of heroin use.
- Weakened immune and respiratory system combined with central nervous system depressant drugs.
- 5 years in continuous drug treatment but drug testing whilst in treatment was not as frequent as per policy in the latter part of this treatment journey.

Findings and applying the learning

- HM Coroner was concerned about issues of communication between drug treatment provider and mental health team so a Regulation 28 notice was issued to address the following points;

(1) To review the operation of the Cornwall dual diagnosis policy and the interface between A CMHT.
(2) To review the development and implementation of the delivery plan concerning the relationship between CMHT and Addaction.
(3) To consider how best to encourage a closer working relationship between CMHT and Addaction.

The concerns were addressed jointly through:

- 'A multi-agency steering group set up to review the strategy and develop an implementation plan. The steering group consists of key organisations (including CFT and Addaction) and is being supported by the commissioning organisations. The steering group will report progress into the Mental Health Crisis Care Concordat who will report to Safer Cornwall. The Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis and sets out how organisations will work together. These arrangements will ensure the review of the strategy and its implementation, as well as appropriate oversight of progress and effectiveness. Key to the strategy is the safe and timely sharing of information and communication between organisations that specifically include CFT and Addaction, as well as other organisations involved in supporting individuals with co-existing needs.
- Drug testing policy reiterated to all treatment staff and emphasising the need to record this on all case notes.'

3.11 **Drug Related Death 10 – Jun 2018**

- 44 year old man who was found deceased at his home address surrounded by drug paraphernalia.
- Cause of death given as 1a. Heroin and cocaine toxicity.
- Medical issues of back pain, depression, panic attacks and asthma.
- Heroin and cocaine had been used in combination with 4 medicines on prescription.
- Month period between this man moving on from second stage rehabilitation to his death. He was not in treatment at death but did have on-going informal access to the rehab unit.

Findings and applying the learning

- This man successfully completed 3 months of residential rehabilitation. This death was a shock to all. The 3 month period out of treatment could not be fully evidenced at inquest as to what caused this man to fatally relapse, but reinforces the need to try to assertively engage people successfully completing in a 3 month aftercare programme.

3.12 **Drug Related Death 11 – Jun 2018**

- 45 year old man who died in his own flat.
- Cause of death given as 1a. Drug misuse.
- Medical issues: depression, emphysema, pulmonary oedema, deep vein thrombosis, COPD and neuropathic pain associated with injecting sites.
- Another example of a heroin and cocaine related death in combination with medicines which included prescribed methadone.
- Apart from terms of imprisonment and criminal justice issues this man also suffered from physical ill health, was a homeless person often sleeping rough,

used dangerous illicit drugs in combination and had overdosed on at least one occasion that resulted in his hospitalisation.
- Many times this man was repeatedly imprisoned, released from prison, needing to be resettled and stabilised by community drug team.
- He repeatedly received offers of housing, but never took up the opportunities.

Findings and applying the learning

- A need for more persistent and assertive engagement.

3.13 **Drug Related Death 12 – Jun 2018**

- 33 year old man who had been out of an evening and returned home alone to go to bed and was found deceased in the morning. Little evidence of his drug taking and movements immediately prior to death.
- The cause of death was given as 1a. Pneumonia and respiratory depression by several drugs.
- Medical problems: insomnia and depression.
- This man had been out of drug treatment for over 2 years but methadone was found in toxicology in combination with heroin, cocaine and medicines. All non-prescribed.

Findings and applying the learning

- Police were looking into the fact that this man may have been in debt to local dealers but no obvious learning coming from the intervening 2 years where this man was out of treatment.

3.14 **Drug Related Death 13 – Jun 2018**

- 50 year old man who died in his home address after being witnessed using heroin. He spent the day sleeping on his sofa and never woke up.
- The cause of death was 1a. Heroin poisoning and 2. Undifferentiated carcinoma of the lung.
- Medical issues of lung cancer, pneumonia and leg pain. He had a notable swelling to his neck area which made eating and breathing difficult. He was in an emaciated state.
- Out of drug treatment for 2 years.
- This man's cancer had progressed from the lung to his neck and tonsil area so his likelihood of surviving any use of respiratory depressant drugs was minimal.
- Illicit methadone was used in combination with heroin, cocaine and one medicine.

Findings and applying the learning

- A feature of the deaths in 2018 has been the number of people with serious medical conditions

- This man had disengaged from treatment for 2 years and was not complying with his cancer treatment in any serious and concerted effort. It appears that he had given up.

3.15 **Drug Related Death 14 – Jun 2018**

- 41 year old man who died at his temporary home address in an office of a gym.
- Cause of death given as 1a. Multiple drug intoxication.
- No drug treatment records.
- This man had previously held 3 world records in various weightlifting categories.
- Toxicology showed the use of heroin, tramadol, Etizolam, MDMA and diazepam, 4 drugs which depressed this man's respiration and MDMA which was mooted that he used to train in the gym with.
- This man had relationship problems resulting in him being in temporary accommodation.
- Many and varied drugs, medicines found at the scene as though illicit sales had been taking place.

Findings and applying the learning

- This man was regularly involved with weight training and running a gym.
- His use of drugs fatally contributed to his death.
- This was a reminder to repeat information about drug related risks to gyms.

3.16 **Drug Related Death 15 – Jul 2018**

- 15 year old girl who died in hospital after taking 3 tablets of MDMA in a park with friends. Two others were also hospitalised but survived.
- Not in drug treatment but was prescribed an anti-depressant medicine which did not appear in toxicology.
- Cause of death given as 1a. Multi organ failure and 1b. Toxic effects of MDMA.
- Previous deliberate overdose in reaction to parental break up.
- Evidence that the three tablets were taken in one rather than being stacked and taking a little at a time. Forensic analysis of a tablet found high purity MDMA.
- This girl was registered with the Child and Adolescent Mental Health Service (CAMHS).

Findings and applying the learning

- High levels of denial found amongst professionals about drug use amongst young people in Cornwall.
- Early inter-agency cooperation meant that the type of tablets used could be circulated on social media and traditional news media to advertise the dangers of this particular tablet. There were no further reports about the use of this type of tablet.
- Sub judice matters on-going in relation to the supply of the tablets.

- The young people's service from Addaction (YZUP) and others are using this case to speak to young people about the dangers of drugs such as MDMA and related matters.
- Information was available at the child death review meeting about how SSRI medicines can interact with MDMA, and the ensuent risks. Whilst not applicable in this case due to the subject not having taken her medicine for a while, the issues of the interactions were very much of interest with the adult drug taking population. As such one of the paediatric consultant psychiatrists presented the evidence to the 2019 drug related death conference. This piece of work is being developed, to increase the awareness within prescribing practice and in relation to other drug interactions with anti-depressant medicines. This report highlights that **82% of drug deaths in 2018 had an anti-depressant medicine apparent in toxicology.**

3.17 **Drug Related Death 16- Jul 2018**

- 31 year old man found deceased at his home having last been seen 2 days before.
- Cause of death given as 1a. Unascertained with an open conclusion.
- Toxicology carried out with liver homogenate only with no fluids available therefore the tests were confirmatory and not used to estimate the amount of the drugs used. Morphine, Codeine and Sertraline were confirmed.
- Diagnosed with Asperger's Syndrome, anxiety and depression.
- Evidence that this man had previously had ambulance attention due to his ketamine use and that unidentified brown powder was found at the scene of the death in a bowl and in a plastic bag. This was not forensically examined.

Findings and applying the learning

- Local testing by Police has now established that the powder was heroin making it far more likely that the morphine in the tests derived from heroin.
- No evidence of attempts to reduce risk with him, following ambulance call outs and ketamine-realted incidents. A missed opportunity.

3.18 **Drug Related Death 17- July 2018**

- 42 year old woman who died in hospital 4 days after suspected drug and alcohol use.
- This case is awaiting inquest.
- History of poor mental health, vulnerable adult, domestic violence victim, multiple emergency admissions with intravenous drug use and alcohol.
- Hospital tests identified hypokalaemia (low potassium).
- Urine analysis only available for toxicology therefore drugs could not be quantified. Methadone was present which is likely to be from prescription. Cocaine was illicit and present. All other drugs appear to have been from hospital intervention.
- The awaited inquest will hopefully elucidate, but this death appears drug related at the time of writing of this report.

Findings and applying the learning

- This woman did not engage well with the structured appointment system so a more flexible, assertive outreach approach was used to keep her engaged with treatment and help to support her with other agencies. The changing patterns of her drug use made her a higher risk person as she often reduced her use, sometimes presenting as drug free and then would start to use higher amounts (including alcohol) within a short period of time. The dangers of using in this way were covered with her regularly and she was given a naloxone kit with her worker checking regularly that she still had this.
- An example of a woman who would have benefitted from a women only treatment or accommodation which would have allowed time to address some of the issues she experienced in her relationships with high risk men. These places are now being made available as a result of the new contracts awarded by Cornwall Council to supported accommodation.

3.19 **Drug Related Death 18- Aug 2018**

- 46 year old long term fisherman found collapsed in the street
- The cause of death was given as 1a. Heroin and cocaine toxicity. 2. Cardiomegaly and left ventricular cardio hypertrophy.
- Medical issues of cardiomegaly (enlarged heart), fatty liver, pulmonary oedema, hypertension, alcohol dependence and hepatitis C.
- High levels of alcohol in combination with heroin, cocaine and medicines.
- He was due to be assessed for his depression.
- At one point this man was consuming 300 units of alcohol per week. Psychotic symptoms and most medical issues were assessed as stemming from his dependent drinking.
- 9 doses of naloxone did not work at the scene of the overdose.
- Evidence from people who had witnessed the overdose and used drugs with the deceased person prior to assisting with first aid.
- Family had previously lost another son to substance use.
- 2 alcohol treatment episodes. None for drugs. Last episode was new (one month).

Findings and applying the learning

- Described as an entrenched drinker by those who witnessed him, describing this as symptomatic of his long term job of being a fisherman When he drank less, his mental health improved, including less suicidal thoughts, memory loss and depression.
- No mention of the role that alcohol played in this death within the conclusion of the toxicology report and the death was concluded as drug related only.
- Planning dedicated resources that meet the working styles of people who work at sea/away for periods of time.

3.20 **Drug Related Death 19- Aug 2018**

- 36year old woman found deceased at the home she shared with her fiancée.
- Cause of death given as 1a. Mixed drug misuse and 2. Acute pyelonephritis. Diagnosed: Crohns disease, irritable bowel disease, anxiety and acute inflammation of the kidney (pyelonephritis).
- No history of drug or alcohol treatment.
- This woman suffered years of pain and was advised not to use tramadol due to an adverse reaction. Her toxicology revealed excessive use of tramadol in combination with many medicines which were prescribed.
- The tramadol belonged to her partner who was prescribed it. Both partners experienced chronic and enduring illnesses.
- No evidence of suicide as this woman was in a good place with her relationship after enduring many years of domestic abuse in a previous relationship and she was due to celebrate her recent engagement with a party.

Findings and applying the learning

- Having heard all the facts at inquest it was apparent that this was a tragic accident with the woman having taken too many medicines and, crucially, too much of a drug that was not prescribed to her and that she had previously had an adverse reaction to.
- Pain management guidance.

Drug Related Death 20- Sept 2018

- 39 year old man who died in his home address which was a premises where other drug users frequented and/ or lived
- Cause of death given as 1a. Poly drug toxicity.
- History of lower back pain, diagnosed personality disorder and history of depression.
- Evidence heard at Inquest that this man had been groomed when he was 14 years old and he had never recovered.
- Engaged in treatment with Addaction that included outreach and close inter-agency working.

Findings and applying the learning

- The family had issues with the premature discharge of their son from detox due the allegation that he had been dealing drugs/ medicine at the unit. It has been agreed that the family can meet with staff to talk this through although it is accepted that the timing of the discharge was not directly relevant to the death but the family were of the opinion that it did not help their son's situation. It is hoped that situations such as these premature discharges for breaking house rules and the like will be more efficiently managed in future due to the new contracts in place between Cornwall Council and housing providers. The immediate issue of discharge and potential homelessness will be manged by crisis meetings involving multi-agencies.

- In line with the previous point, the suitability of accommodation here could have been better as there were other people co-located who would have potentially been tempting to this man in that they also used drugs. Finding enough suitable accommodation is in itself a large challenge.

3.21 **Drug Related Death 21- Sept 2018**

- 47 year old man who died in the morning at his home address and was known to have been using heroin the night before.
- The cause of death was given as 1a. Poly pharmacy drug misuse.
- Medical problems: leg cellulitis, leg ulcers and enlarged liver. Deep vein thrombosis in both legs.
- This man was in drug treatment and on oral substitute medication;
- Toxicology showed alcohol, heroin cocaine, alprazolam, methadone and medicines.
- 2 brief drug treatment episodes followed by the third one which lasted 2 years up until his death. A complex case to manage with drugs, alcohol, medical conditions, homelessness and anti-social behaviour being some of the issues that had to be addressed and co-ordinated as part of his treatment.
- Multi-agency working to maximise the effect of drug treatment so overcoming this man's homelessness was one of the key parts of the plan. Prior to his death he had been supported in obtaining his own flat in May 2018 with his wife. A period of relative stability then followed up to his death. This stability involved reporting less alcohol consumption and his illicit drug use being kept in check by his opiate substitute medication.

Findings and applying the learning

- The trajectory of this man's recovery in treatment was in the right direction but this case illustrates that drug and alcohol use can be fatal when someone relapses from what was a general improvement. If this man was indeed using less or no illicit opiates towards the end of his life then this does present problems of low tolerance should any person return to those drugs even very briefly. The risky combination of these drugs is something that this man was well aware of having reviewed his case notes.
- There is no doubt that Addaction deployed as much resource to this man as they could within their caseloads and allowed time frame. Complex cases are more resource intensive but the inter-agency working here allowed for progress to be made perhaps quicker than one agency trying to solve all issues.
- There does not appear to have been a reason for the relapse as identified from the available evidence

3.22 **Drug Related Death 22- Sept 2018**

- 42 year old man who died at the home address of his mother.
- The cause of death was given as 1a. Multiple drug intoxication.
- Medical issues: alcohol dependence, hypertension, anxiety and asthma. He also was a tobacco smoker.

- No drug treatment records.
- This man had been suffering from pleurisy and was in pain. He regularly looked after his mother who was in palliative care and on the occasion of his death he attended her address and consumed morphine liquid that was not prescribed to him.
- Toxicology identified morphine, alprazolam and medicines. Both the morphine and alprazolam were illicit and combined fatally to cause this death. Despite having a history of alcohol dependence there was no alcohol in his body at death.

Findings and applying the learning

- Evidence at inquest that this man was self-prescribing and using Oramorph and alprazolam for his pain that had been on-going for 12 months. This was despite him seeking advice from his GP and he had spoken to his GP 2 days before the death. At that last appointment he was prescribed doxycycline and prednisolone with an x-ray being advised. These medicines did not appear in the toxicology.
- This is another case where alprazolam has featured. 2018 has seen 6 alprazolam related deaths which is a 100% increase from the previous year. It appears from the evidence in this case that this man used the illicit alprazolam for pain relief but he clearly was ambivalent to or ignored the dangers of taking this medicine with or without other drugs/ medicines.

3.23 **Drug Related Death 23- Oct 2018**

- 21 year old man found deceased at his temporary home address which was supported by a local charity.
- The inquest is awaited.
- Toxicology identified heroin, alprazolam, cocaine and two medicines which synergistically caused this man to die. The toxicologist stated that the heroin and alprazolam alone were potentially fatal.

Findings and applying the learning

- There is an outstanding query as at the writing of this report that a referral from drug services to a service that provides psychological interventions went unanswered. It is expected that the inquest will hear more evidence of this and remedial measures to prevent it happening in the future.
- Communication between drug services and mental health team was fractured at the time, but much work has been carried out since this, and, whilst other deaths have occurred where this was also an issue, joint working is improving in a concerted manner.
- An escalation process has been agreed between Addaction and the Community Mental Health Teams to address circumstances where there is any disagreement between the teams. However, in this instance, it seems that support was being provided from each team, but independently and not communicated or co-ordinated as well as it could have been.

3.24 **Drug Related Death 24- Oct 2018**

- 38 year old woman who was homeless but who died in a chair at a friend's house.
- The inquest is still pending.
- Long term drug and alcohol treatment client (8 years) who had many deep seated issues including poly drug use, mental ill health, high risk and history of overdose, victim of historic sexual assaults and rape, suicidal and self- harming, aggressive and threatening behaviour towards others, finding social situations difficult.
- Physical illnesses included COPD, deep vein thrombosis and tuberculosis.
- An example of a person with multiple health needs who found it hard to engage. She was described as too complex for IAPT services and did not meet the criteria for community mental health team. She found attending assessments and the like very challenging so these were often missed.
- This woman was street homeless for much of her later treatment journeys as, due to her challenging behaviours and complex needs; it was difficult to find suitable accommodation, with the right support level for her needs. This led to many evictions and bans from housing projects and led to her often being imprisoned and discharged from prison street homeless. Her physical and mental health deteriorated rapidly during her periods of street homelessness.
- Toxicology identified cannabis, diazepam, Pregabalin, amitriptyline, heroin, Dihydrcodeine and methadone.

Findings and applying the learning

- This is one of the cases that have helped to inform the design of the service specification for Cornwall Council contracts for supported accommodation and a greater awareness and ability to deal with those people who have multiple complex issues. The new contracts have recently been awarded and there is great anticipation that the very complex cases such as this one will receive more focussed attention.
- The inquest is awaited to hear more of the learning coming from this case. This woman received a lot of support from drug and alcohol services as well as other partner agencies but her ability to adhere to the rules of these various organisations often dissolved and she would end up homeless again.

3.25 **Drug Related Death 25- Oct 2018**

- 35 year old man who was found deceased at his home address surrounded by drug paraphernalia.
- Inquest awaited.
- Toxicology identified alprazolam, MDMA, heroin and cocaine. Whilst a cause of death is not known at this time the toxicologist states that; *'The concentrations detected suggest that death is more likely due to a combination of cocaine and MDMA, but it is possible that the sedative drugs including illicit heroin have increased the risk of death'.*
- A few days before the death there had been a chemical burns incident where the partner of the deceased was still in hospital at the time of the death of this man.

- This man completed a drug detox in Plymouth, returning to Cornwall for residential rehabilitation for 17 weeks, leaving the unit after a successful completion in February 2018. He had effectively been out of treatment for 8 months when he died.

Findings and applying the learning

- The rehab was successful with much evidence of this man finding the whole experience and various interventions of great use. He responded well to staff and fellow service users. He was able to move into a flat with his partner post rehab and had the opportunity to attend the rehab unit once a week for aftercare. There were other positive interventions that he could get involved with such as a local gym.
- The intervening 8 months out of treatment will hopefully be illuminated upon at inquest but this death was a surprise to all involved.

3.26 **Drug Related Death 26- Nov 2018**

- 34 year old man who died at a friend's house.
- The cause of death was given as 1a. Multiple drug toxicity and 2. Right basal pneumonia and coronary artery disease.
- Toxicology identified the presence of illicit methadone, amphetamine, diazepam, Pregabalin, heroin, cocaine, tramadol, cannabis and two prescribed medicines.
- No drug treatment records.
- Witnesses saw this man taking drugs and expressed concern about to how much he was taking. This man went to sleep on the sofa and at least one other person slept in a separate room

Findings and applying the learning

- Witness and person finding the deceased had significant mental health challenges which impacted upon his ability to call an ambulance for about one hour. Irrespective of this the deceased person was on his own sleeping and had consumed a lot of drugs ultimately ending his life.
- There has been a lot of advertising of how to deal with and recognise a drug overdose in Cornwall and this work continues daily. Cornwall DAAT is due to hold another overdose awareness event on 30th August 2019 (International Overdose Awareness Day) .where first aid and immediate action after an overdose is taught and disseminated as well as a range of related issues.
- Multiple drug use combined with a serious respiratory condition, featuring a wide range of physical illnesses. These are to be the subject of the 2019 Drug Related Death Conference in September and will include TB testing, lung health, spirometry and stop smoking.

3.27 **Drug Related Death 27- Nov 2018**

- 35 year old man who died at his home address.
- The cause of death was given as 1a. Misuse of synthetic cannabinoids and heroin. 2. Cardiomegaly and significant coronary heart disease.
- Medical issues: COPD, pulmonary hypertension, adrenal suppression, angina, back pain, asthma and coronary heart disease.
- White powder located that the scene of the death was identified as a synthetic cannabinoid referred to as Qpit. This was consumed in combination with other substances such as heroin and buprenorphine.
- Evidence was heard at inquest that this man purchased illicit buprenorphine patches from the internet for pain relief. Whilst this drug did feature in the toxicology it was not significant unlike the heroin and cannabinoids.
- This man was doing very well in his drug treatment which had spanned 3½ years. He was weaning himself off of all drugs with assistance and he was due for an assessment at the Pain Clinic of RCHT. He had also stopped smoking in January 2018.

Findings and applying the learning

- Partner of the deceased person said that she didn't realise that he was using drugs again until 19 days before he died.
- It is suspected that the arrival of a person temporarily back in the area and known to the deceased was a catalyst for this man to start taking drugs again. His worsening medical conditions since he had last taken drugs did not put him in a good place to then start taking drugs again latterly.
- The family were very grateful for the role that Addaction played in treating and support.

3.28 **Drug Related Death 28- Dec 2018**

- 46 year old man who died at the home address of a friend having been temporarily requested to leave his supported accommodation two days previous.
- The cause of death was given as 1a. Methadone overdose.
- Alcohol dependent in treatment for alcohol issues only.
- Toxicology identified illicit methadone, morphine, cocaine and medicines.
- This man had not disclosed nor been treated for drug issues.
- He was asked to leave his supported accommodation for a weekend as he had put the safety of a staff member and another resident at risk after a violent altercation. A previous and recent incident where he was violent saw him being sent to his room to cool off but the latest incident was a dangerous escalation. Family and witnesses agree that the temporary expulsion was the right thing to do. The man knew he could return in 48 hours.
- The taking of drugs by this man appeared opportunistic but out of character. He was seen ingesting methadone.

Findings and applying the learning

- Alcohol underpinned the violent outbursts of this man although the last incident happened when he was not intoxicated.
- This issue of expulsion has been discussed at length and it is a last resort by accommodation providers. When this does happen though the question has to be asked as to where the person is housed. It is now hoped that the crisis meetings that are to be held upon expulsion, as recommended in the new contract of Cornwall Council and housing providers for complex needs clients, will ensure a level of continuity for the relevant people.
- In this case, the man was not made homeless as a friend volunteered his home address to be used in the interim.
- Need for awareness raising amongst supported accommodation providers, and screening and identification of drug use (especially with people seen primarily as having alcohol problems).

4. PROACTIVE MEASURES /INITIATIVES / PROGRESS 2018

4.1 **Cornwall DAAT Drug Related Deaths Review Group**

This panel of local experts in their field has continued to provide advice and support for the investigation and prevention of drug related deaths. Cases are reviewed by the panel, with reports from prescribing, toxicology, and pathology, as well as case records. The Group has access to experts from Pain medicine at Royal Cornwall Hospital Treliske, psychiatry, psychology and mental health services, Shared Care General Practice, Specialist drug and alcohol treatment, the Head of Prescribing and Medicines Optimisation at NHS Kernow and from the Cornwall Partnership NHS Foundation Trust. This group and its findings help to inform the reports to HM Coroner and to improve services for residents.

4.2 **Reducing Drug Related Deaths Conference**

The South West Peninsula Drug-related Death Review Group holds an annual conference to address issues which arise from reviews of the year. It will builds upon previous themes and conferences to explore how good communication and cooperation between agencies, and individuals can help reduce the number of drug related deaths across the peninsula as well as sourcing the most up to date evidence to improve our local practice and learning. The conference is open to service users, carers, service managers, drug and alcohol workers, commissioners, Police, Coroners and their officers, with an eagerness to encourage a good mix of workers from all disciplines.

The event is informed by deaths which have occurred in the previous year as well as those that have occurred subsequently. The 2019 event will feature;

- SSRI/ MDMA and other drug interactions
- Lung health, spirometry, smoking cessation
- TB screening within the homeless community
- Help for Homeless Lead GP to cover his work and alternative approaches to treatment

- Public Health Devon- web based portal for drugs identification
- Police- partnership agency information sharing form
- Psychologically informed environments and trauma led approaches for those in supported housing
- Invasive Group A Streptococcal Infections (iGAS) and preventative measures
- Drug and alcohol workers- a perspective from the frontline focussing on some of the aspects a recovery worker will face and have to deal with personally.

The conference will be reported on in the next annual report but the interest generated thus far in the 2019 event is showing that this annual event is as popular as ever and is an important part of the Cornwall DAAT's work.

4.3 **Acorn Service of Remembrance**

It is important to keep the memory of those who have died in the so-called 'war on drugs', as alive as any other avoidable death. However, following three years of our formal service of remembrance at Truro Cathedral, we are looking for a more lasting memorial of new trees. We aim to hold a series of smaller services in combination with tree planting ceremonies. This will keep the theme going of the tree emerging from the acorn and will also link in with the Council's intention to plant more trees as part of the Green Agenda. The lasting memory of a loved one linked to the positivity of a growing tree is a popular idea and is receiving positive feedback from family and friends that have been spoken to after inquests. This on-going piece of work will start to roll out later in 2019 when the tree planting season is upon us and could be a rolling program of remembrance in this way.

4.4 International Overdose Awareness Day 2018

International Overdose Awareness Day

International Overdose Awareness Day (IOAD) is a global event held on August 31st each year and aims to raise awareness of overdose and reduce the stigma of a drug-related death. It also acknowledges the grief felt by families and friends remembering those who have met with death or permanent injury as a result of drug overdose. Overdose Day spreads the message that the tragedy of overdose death is preventable.

Taking its key themes as prevention and remembrance, its goals are:

- To provide an opportunity for people to publicly mourn for loved ones, some for the first time, without feeling guilt or shame.
- To include the greatest number of people in Overdose Awareness Day events, and encourage non-denominational involvement.

- To give community members information about the issue of fatal and non-fatal overdose.
- To send a strong message to current and former drug users that they are valued.
- To stimulate discussion about overdose prevention and drug policy.
- To provide basic information on the range of support services that exists in the local community.
- To prevent and reduce drug-related harm by supporting evidence-based policy and practice.
- To remind all of the risks of overdose.

This year, we held a street event in Penzance to take these key themes to the public. The event ran from 9:00am to 4:30pm and consisted of staff from Addaction and DAAT engaging with as many people as possible. This included handing out information leaflets/posters, giving a range of advice and first aid training including 'hands on' resuscitation practice.

This year we were lucky enough to be helped by Karen, a mother who had lost her 29 year old daughter to drug related death earlier in the year. Karen's insight and her willingness to change people's minds presenting facts and advice were invaluable to the event.

Jo from Addaction giving some sound advice on life saving skills

Related information was also posted and available at the various Addaction offices located around Cornwall.

With 145 people having died from a drug related death in Cornwall between 20013 and 2018 and many more dying from alcohol and prescription medicine misuse, this

was an opportunity to talk about the many complexities surrounding drug and alcohol use.

A wide cross section of people engaged with the team including those who needed treatment, those seeking treatment for others, wider education issues and children wishing to learn first aid skills- the first aiders of the future!

This annual event is planned to be held in St Austell town centre in August 2019.

First aiders of the future learning about CPR

5.5 Closer working with mental health services

The interface between drug and alcohol services and mental health services has been the source of much discussion over the years with a proportion of deaths occurring where the subject has died 'falling between services'. Whilst these cases have continued in 2018 the closer working between agencies is now starting to show results.

Various gaps in treatment have been identified through scrutiny of the cases and the accurate reporting to HM Coroner. In the main these gaps have occurred in instances of dual diagnosis where the person in question has had drug/ alcohol issues in combination with mental ill health. Whilst mental ill health can occur as a result of the drug and alcohol use, there are also cases where mental ill health can lead to drug and alcohol use.

Some notable inquests in 2017, 2018 and 2019 have heard evidence of these gaps which has led to HM Coroner issuing 'prevention of future deaths' notices under Paragraph 7, Schedule 5 of The Coroners and Justice Act 2009 and Regulations 28 and 29 of The Coroners (Investigations) Regulations 2013. The Coroner will issue these notices if the inquest has revealed matters giving rise to concern. If the Coroner is of the opinion that there is a risk that future deaths will occur unless action is taken, a Regulation 28 notice will be issued to those deemed best placed to address the issues and report within a 56 day period.

Ultimately these notices will change procedures, assessments and a range of other related issues to address the dual diagnosis gaps. The notices naturally bring services closer together to tackle the issues and it is the closer working between services that is needed going forward.

The DAAT continue to be involved in suicide investigation with notable cases involving not only the suicide but elements of domestic homicide. This has been in place since March 2017 and has already been valuable in gaining more understanding of issues relating to dual diagnosis as well as related issues such as domestic homicide reviews. The DAAT's interaction with the Cornwall Suicide Surveillance Group continues and Addaction now regularly attend this group ever more forging closer links between drug and alcohol services and mental health services.

Mental health clinicians and practitioners will be attending the annual Drug Related Death Conference in September 2019 where there is a large emphasis on networking.

5.6 Physical health with drug and alcohol use

The number of deaths in 2018 and going through to 2019 shows that the physical ill health of the individuals is becoming more of a factor. Various work streams are now becoming apparent in part identified by the drug related deaths. They have flagged up lung health, infections, heart and brain health. Some of the inclusions in the 2019 Drug Related Death Conference are directly as a result of the cases investigations and findings. Cornwall DAAT are fortunate to work with partner agencies that expertly advise and this allows for more informed reporting to HM Coroner and at inquest. The valuable assistance of the RCHT Pain Clinic consultant Keith Mitchell, for example, has led to some changes in RCHT practice which benefits the inquest process and evidence gathering post mortem.

5.7 Naloxone

Appendix 1 on Page 36 shows the Naloxone Report for Cornwall for the period between 2016 and 2019 and has been compiled by Marion Barton- Social Inclusion Lead with Cornwall DAAT. The report details the value of Naloxone and the continuing work being carried out to ensure that this life saving medicine is as widely available as possible across Cornwall. The period of 2018/19 has shown the largest number of people being trained to use Naloxone since its' initial roll out. The number of lives being saved is testament to the value of the Naloxone scheme continuing in Cornwall. With some Police Services now allowing Police Officers to carry Naloxone on duty and the availability of Naloxone administered nasally it is anticipated that there will be even greater availability of Naloxone in future.

6. CONCLUSION

6.1. Several new issues and challenges have emerged through our review of the drug related deaths of people in Cornwall and the Isles of Scilly in 2018. This learning is, in part, responsible for an increasing awareness of the experiences of people who have multiple vulnerabilities:

- the vitally important understanding of the experiences of people with joint substance and poor mental health.
- The complexities surrounding the physical ill health of the drug and alcohol using population;
- Homelessness and the vulnerability to exploitation;
- Poly drug use and its interactions;

Additionally, the deaths of local residents show the scale of the issues that need to be addressed if drug related deaths are to be reduced:

- 93% died in Cornwall in 2018 from a drug related death that involved **an opiate drug**- a record high since DAAT records began
- 79% died from a drug related death that involved **heroin-** another record high
- 54% died from a drug related death that involved cocaine which is the second successive yearly increase. Realistically these deaths are as a result of the increased use of **crack cocaine** across Cornwall.
- 82% featured the presence of an **anti-depressant medicine** highlighting again complexity of mental ill health and substance use
- 61% featured the presence of the benzodiazepine drug **Diazepam** with the vast majority of its presence being from lawful prescription
- 96% featured **more than one substance** being present and contributing to the death- this includes alcohol and again shows the significance of **drug combinations** whether they are licit or illicit.
- **Physical ill health** being significant particularly when issues of lung and heart health are compromised
- A number of deaths where the subject has been either removed from **supported accommodation and/ or been flitting between accommodation**. 2018 flags up a cohort of service users that are **difficult to**

house where issues such as violence and unruly behaviour can quickly unsettle supported environments.

There is a growing awareness of the change in the way some drug dealers (organised crime groups) operate now and exploit women, children and the vulnerable, but a less developed response that balances enforcement and support.

The issues of tackling physical and mental ill health are key to allowing people to concentrate on and recover from their comorbid substance use issues. There are a number of plenary sessions at the 2019 Drug Related Death Conference that are dedicated to addressing the specific physical ill health issues. The communication between agencies is notably better in the light of some key inquests highlighting the need for greater collaborative working.

At least three deaths have involved the deceased having been required to prematurely leave supported accommodation due to their respective behaviours. These cases have helped to inform the Cornwall Council 'Empowering Independence Service – Complex and/or Mental Health Needs'. This Contract is one of five locality based contracts delivering the Empowering Independence Service across Cornwall. Service Providers will be expected to work in partnership to ensure that people with high risk behaviours and complex needs are supported appropriately. In the three inquests in question there could have been better partnership working to ensure that the subjects had continuous support. They have also flagged up the need for improved provision of suitable accommodation for vulnerable women. The Contract specifies the need to support this group of service users specifically.

The five contracts have just been awarded as below;

Area	Provider
Area 1 - West Cornwall	Home Group
Area 2 - West to Mid Cornwall	Coastline
Area 3 - Mid Cornwall	Live West
Area 4 - Mid to East Cornwall	Cosgarne Hall
Area 5 - East and North Cornwall	Home Group

The learning from the specific deaths has been detailed in Section 3 of this report starting on page 16 where there appears a summary of all 28 deaths for 2018. The lives behind these cases have all been cut short and there are personal details in almost every case that have not been mentioned here but that are sometimes harrowing, sometimes heart breaking but always worthy of remembering so that we can learn from these lives to prevent these deaths.

Produced By Sid Willett
Drug Related Death Prevention Coordinator
Cornwall & Isles of Scilly Drugs and Alcohol Action Team

Appendix 1

Naloxone Report 2016-19

Updated figures

Table 1: Naloxone distributed

Naloxone continued to be supplied by Addaction to accommodation providers as per the agreement in the Naloxone Guidance for Complex Needs providers document.

Number of kits distributed				
Provider	**2016/17**	**2017/18**	**2018/2019**	
Coastline	14	3	9	26
Cosgarne	22	15	22	59
LiveWest	10	5	0	15
FreshStart	8	0	2	10
Glen Carne	4	3	0	7
Homegroup	28	2	0	30
St Petrocs	15	0	1	16
Grand Total	**101**	**28**	**34**	**163**

Table 2: Naloxone training delivered

Accommodation providers continued to train their staff, residents and volunteers

	NUMBERS TRAINED			
Training delivered	**2016/17**	**2017/18**	**2018/19**	**Total**
Residents	147	63	148	358
Staff	98	43	96	237
Student placement	2	2	0	4
Volunteer	8	27	29	64
Work placement	3	0	0	3
Grand Total	**258**	**135**	**273**	**666**

In Cosgarne, 114 people were trained (18 staff; 3 volunteers; 84 residents and 9 external agency staff) prior to 2016 when the naloxone project was rolled out more widely. Some other complex needs providers had also undertaken training prior to this time.

Table 3: Naloxone training by Provider

2016/17

Name of trainer	FreshStart	Coastline	Cosgarne	LiveWest	Glen Carne	St Petrocs	Homegroup	Total
Addaction			1	3			10	14
Addaction & St Ps						11		11
Coastline		75						75
Cosgarne			60		16			76
DCH				18				18
FreshStart	16							16
Homegroup							27	27
Martindale	4	10		3		2	2	21
Grand Total	**20**	**85**	**61**	**24**	**16**	**13**	**39**	**258**

2017-18

Name of trainer	FreshStart	Coastline	Cosgarne	LiveWest	Glen Carne	St Petrocs	Homegroup	Total
Coastline		56						56
Cosgarne			44					44
Homegroup							13	13
FreshStart	14							14
LiveWest				7				7
Grand Total	**14**	**56**	**44**	**7**	**0**	**0**	**13**	**134**

2018/19

Name of trainer	FreshStart	Coastline	Cosgarne	Newstart	Addaction	Glen Carne	St Petrocs	Homegroup	Total
Coastline		81							81
Cosgarne			118		7			11	136
Homegroup									
Addaction & FreshStart	45								45
LiveWest				11					11
Grand Total	**45**	**81**	**118**	**11**	**7**	**0**	**0**	**11**	**273**

Use of Naloxone

Table 4: Use of Naloxone 2016-17

Provider	Recovered from overdose	Deceased (naloxone administered)	Deceased (no naloxone administered	Not an overdose situation	Grand Total
Coastline	2				2
Cosgarne	7			4	11
LiveWest	2				2
FreshStart	1				1
Homegroup	1	1	2		4
St Petrocs				1	1
Grand Total	13	1	2	5	**21**

Use of Naloxone: 2017-18

Provider	Recovered from overdose	Deceased (naloxone administered)	Deceased (no naloxone administered	Not an overdose situation	Grand Total
Coastline	2				2
Cosgarne	7		1	1	9
LiveWest (DCH)					0
FreshStart					0
Homegroup	1			1	2
St Petrocs (Outreach)	1				1
Grand Total	**11**		**1**	**2**	**14**

Use of Naloxone: 2018-19

Provider	Recovered from overdose	Deceased (naloxone administered)	Deceased (no naloxone administered	Not an overdose situation	Grand Total
Coastline	3				3
Cosgarne	11	1		1	13
LiveWest (DCH)	1				1
FreshStart					0
Homegroup			1 (alcohol use)		1
St Petrocs (Outreach)	1				1
St Petrocs (Day Centre, Truro)	1				1
Grand Total	**17**	**1**	**1**	**1**	**20**

2016 – 2019

Provider	Recovered from overdose	Deceased (naloxone administered)	Deceased (no naloxone administered	Not an overdose situation	Grand Total
Coastline	7				7
Cosgarne	25	1	1	6	33
LiveWest	3				3
FreshStart	1				1
Homegroup	2	1	3	1	7
St Petrocs	3			1	4
Grand Total	**41**	2	4	8	**55**

Lives saved in supported housing (Prior to the full naloxone rollout)

Since December 2009 and the start of this project in April 2016, there were **25** lives saved in supported housing projects using naloxone. 19 of these were at Cosgarne Hall; 4 at Coastline Housing; 1 at FreshStart and another 1 at a Homegroup service.

Summary of all lives saved using naloxone across complex needs services

Dates	2009 - 2016	2016-17	2017-18	2018-19		TOTAL
Numbers	25	13	11	17		**66**

Gender

Out of the 41 individuals who recovered, 5 were female and 36 were male.

One of the deceased individuals was female and 5 were male. (One was attributed to alcohol)

In treatment

All of the individuals who died were in treatment with Addaction.

From the 41 individuals who recovered from an overdose over the 3 years, 35 were in treatment with Addaction. Some of those who overdosed were resident's visitors or not known to services so providers were unsure if they were in treatment or not. Following the overdose incidents, joint reviews generally take place between the individual, their Housing worker and their Addaction Recovery Co-ordinator. This ensures a clear plan of action which has included naloxone refresher training; harm reduction advice; a review of current script. In one case the plan included volunteering and use of time credits and in instance included end of life care planning.

Time of year of overdoses

The highest number of overdoses over the past 3 years took place in November with the second and 3rd highest taking place in July and September respectively.

Table 5: When overdoses took place

Month	Number of overdoses/deaths by month			
	2016-17	2017-18	2018-19	Total
Jan	1	1	1	3
Feb	0	0	1	1
March	0	1	1	2
April	2	0	2	4
May	2	0	2	4
June	0	0	1	1
July	2	0	5	7
Aug	0	3	1	4
Sept	3	2	1	6
Oct	1	2	1	4
Nov	4	3	3	10
Dec	1	0	0	1
TOTAL	**16**	**12**	**19**	**47**

Time it took for ambulance to arrive

Providers are advised to contact the ambulance service for all overdoses. This has happened on most occasions over the course of the project except in a couple of instances when service users have not alerted staff to the overdose. When this happened service users have undergone further training around overdoses, the use of naloxone and the necessity of calling the ambulance on all occasions. On one occasion recently (this financial year) the ambulance did not attend the incident as they felt that the staff had resolved the situation by administering naloxone. This has been picked up by the Governance group to ensure we secure a standard response.

The ambulance generally arrived promptly and on 9 occasions it arrived within 5 minutes. There were 4 other occasions when the ambulance took over 45 minutes to arrive; on 2 occasions over an hour and on one occasion almost 2 hours due to high demand on their service at that time. These individuals survived. Projects reported that Emergency call handing staff have been helpful on these occasions in keeping in touch to ensure that the project has everything under control.

Doses of Naloxone

The majority of those who recovered required 4 doses of naloxone. However, one individual required 16 doses. One person refused naloxone but was monitored by staff at the project and the Ambulance Service was called. The individual advised he had used another drug that was not opiate based.

Doses of naloxone administered 2016-17

Doses of naloxone administered	Male	Female	Total number of individuals administered that dose
0	1		1
1	2		2
2	2		2
3		1	1
5	3	1	4
7		1	1
16	1		1
			13 overdose situations (Recovered)

Doses of naloxone administered 2017-18

Doses of naloxone administered	Male	Female	Total number of individuals administered that dose
0	1	1	2
2	3		3
5	2		2
8	1		1
10	3		3
			11 overdose situations (Recovered)

Doses of naloxone administered 2018-19

Doses of naloxone administered	Male	Female	Total number of individuals administered that dose
0	3	0	3
1	1		1
2	3		3
3	1		1
5	3	2	5
6	1		1
8	1		1
10	2		2
16	1		1
			18 overdose situations (17 people recovered)

Appendix 2

DRUG & ALCOHOL ACTION TEAM
Cornwall and Isles of Scilly
Reducing Harm | Promoting Recovery

A Comparison of Office for National Statistics Drug Related Death Data for England and Wales to Cornwall and Isles Of Scilly Data for the period 1st January 2017 to 31st December 2017

Introduction

This report has been compiled to summarise the findings of the latest Office for National Statistics (ONS) report published 6th August 2018 in relation to drug related poisonings and drug misuse deaths. The report serves to compare the ONS data with locally collected and analysed data within Cornwall and the Isles of Scilly (CIOS).

The data from the ONS is not directly comparable with the CIOS data as the ONS only use data from the deaths that have been registered in the year being investigated. In other words up to 50% of deaths mentioned in their 2017 report come from deaths that occurred in 2016 but were not registered until 2017. The registration process is where the death can be officially registered after an inquest has taken place and HM Coroner has concluded the inquest.

The CIOS data only uses data from deaths that have occurred in the year in question so some deaths are still awaiting coronial inquest when the CIOS Drug and Alcohol Action Team (DAAT) publish their reports. The deaths have been scrutinised by a panel of experts and various reports are submitted to HM Coroner as part of the coronial process. All of the deaths that form part of the CIOS DAAT data have complied with the standard definition for a drug related death- the ONS use the same definition for a drug misuse death;

'deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, are involved'.

This report lists below the main findings of the ONS report and then compares the findings from the CIOS DAAT. ONS data and statements are highlighted with the CIOS response following on.

1.0 There were 3,756 deaths relating to drug poisoning in England and Wales in 2017, a rate of 66.1 deaths per 1 million population, and similar to levels seen in 2016.

The CIOS DAAT does not routinely record drug poisoning deaths. Drug poisoning deaths involve a broad spectrum of substances, including controlled and non-controlled drugs, prescription medicines (either prescribed to the individual or obtained by other means) and over-the-counter medications. As well as deaths from drug abuse and dependence, figures include accidents and suicides involving drug poisonings as well as complications of drug abuse (such as deep vein thrombosis or septicaemia from intravenous drug use). They do not include other adverse effects of drugs (for example, anaphylactic shock), or accidents caused by an individual being under the influence of drugs. More than half of all drug poisoning deaths involve more than one drug and sometimes also alcohol, and it is often not possible to tell which substance was primarily responsible for the death.

The ONS report elaborates that the similar levels of drug poisoning deaths for 2016 and 2017 is borne out by a difference of only 12 deaths with 3,744 people dying in these circumstances in 2016 as opposed to 3,756 in 2017.

1.1 Around two-thirds of drug-related deaths in 2017 were male (2,521 deaths compared with 1,235 female deaths). The male age-standardised rate decreased from 91.4 deaths per 1 million population in 2016 to 89.6 in 2017, the first decrease since 2012. In contrast, the female age-standardised rate increased for the eighth consecutive year, although the changes for both males and females between 2016 and 2017 were not statistically significant.

As with Para 1.0 above the CIOS DAAT does not have directly comparable data due to the ONS data in this statement relating to drug poisoning deaths but the following paragraph 1.2 does have comparative data in the form of drug misuse deaths.

Just over three-quarters (76%) of drug related deaths (drug misuse deaths as per ONS) in CIOS were male and this is exactly the same as for 2016.

1.2 Rate of deaths relating to drug misuse in males falls for the first time since 2012. As with previous years, most drug poisoning deaths in 2017 were from drug misuse, which accounted for 2,503 deaths out of 3,756, or 67%. The rate of death relating to drug misuse in 2017 was 43.9 deaths per 1 million population; although this was lower than the rate of 45.6 found in 2016, the difference is not statistically significant.

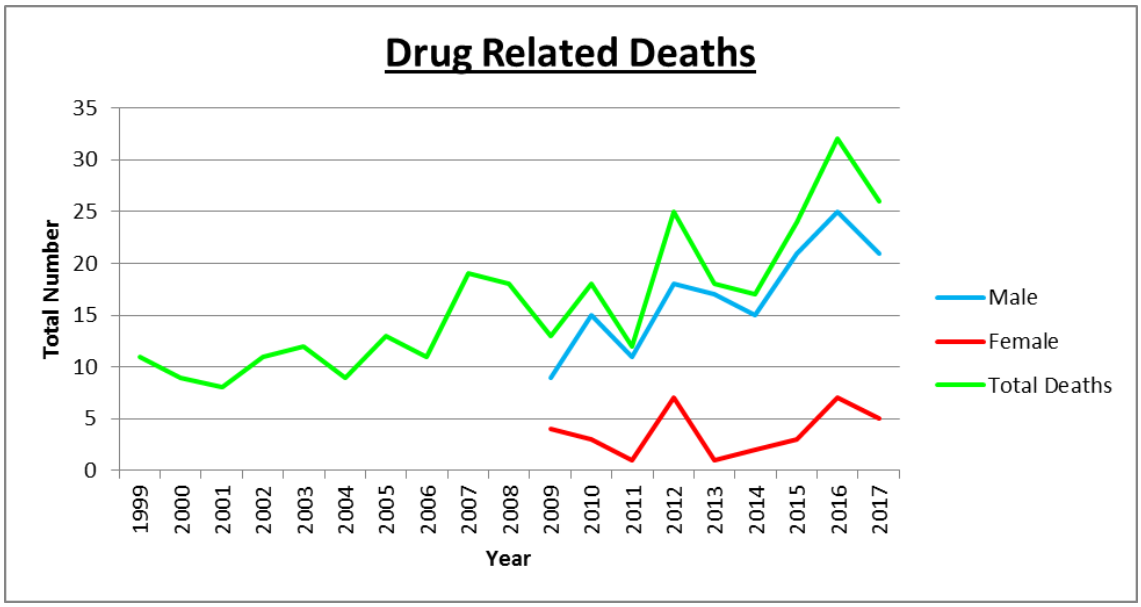
The CIOS rate of deaths for males is at slight variance to the ONS data. Unlike the situation in England and Wales where there has been a steady climb in male deaths since 2012 to the slight decline in 2017, the CIOS male deaths trend can be seen to overall climb from 2012 and also decline in 2017. Female deaths are also included in Figure 1 below which also shows a decline in the rate of death for 2017.

Figure 1

Year	2012	2013	2014	2015	2016	2017
Male Deaths	18	17	15	21	25	21
Female Deaths	7	1	2	3	7	5

The below graph at Figure 2 shows the total amount of drug related deaths in the CIOS since 1999 when DAAT records began. At the writing of this report the same amount of detail cannot be located for male and female deaths before 2009.

Figure 2



1.3 The highest rate of deaths relating to drug misuse continued to be in people aged 40 to 49 years, with 103.3 deaths per 1 million population, decreasing from 108.2 deaths in 2016. Rates for those aged 50 to 69 years and those aged 70 years and over increased in 2017 to 42.2 deaths and 12.5 deaths per 1 million population, respectively, although these increases were not significantly significant.

The CIOS data concurs with this finding and, as per national statistics, the 40- 49 age group has had the highest rate of deaths for the second year running. The rate of deaths for those aged 50 to 69 years in the CIOS decreased in 2017 from 2016 and the numbers in question since 2013 are shown in Figure 3 below. The CIOS has not had a person die as a result of a drug related death who is over the age of 70 years old.

Figure 3

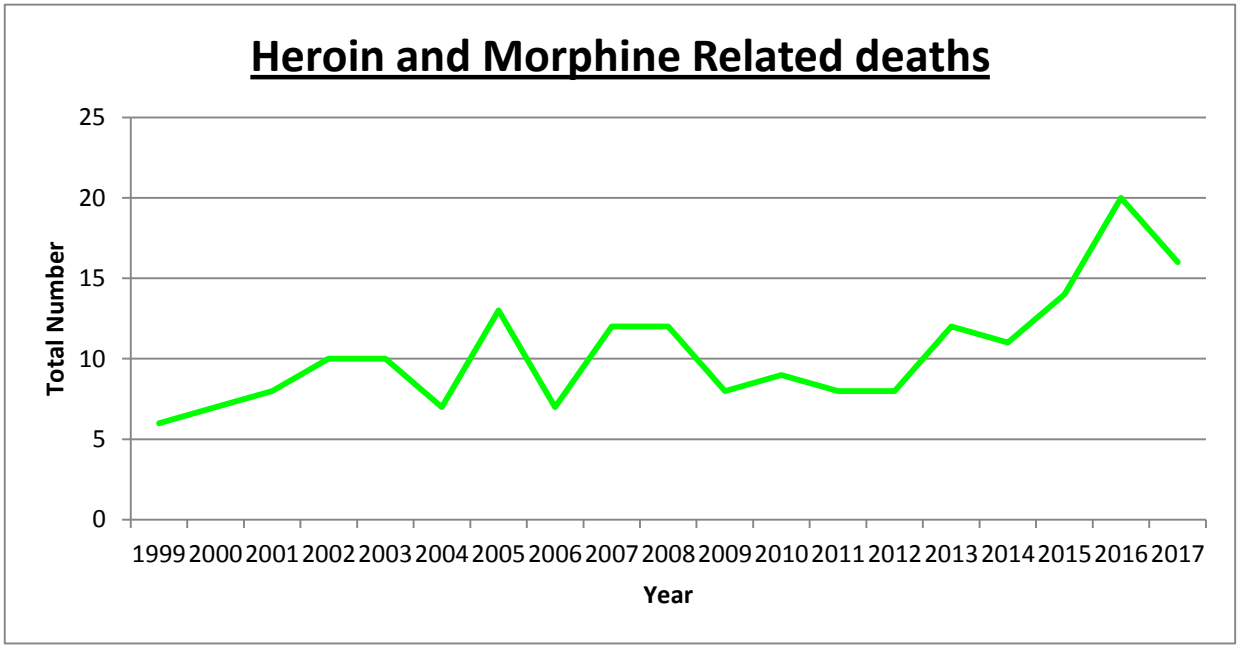
Year	2013	2014	2015	2016	2017
50- 69 Age Group	4	2	5	7	5

1.4 Number of deaths involving heroin and morphine decreased for the first time since 2012. In 2017, there were 1,164 deaths involving heroin and morphine, a decline of 4% (45 deaths) and the first decline since 2012. The National Crime Agency (2018) reports that heroin purity levels have remained stable between 2016 and 2017. Deaths involving heroin and morphine had increased from 579 deaths in 2012 to 1,209 deaths in 2016; the increase between 2012 to 2015 followed the "heroin drought", which occurred in 2010 to 2011. This was subsequently followed by increased purity of heroin, thought to be one factor in increased overdoses.

The CIOS also saw a drop in heroin and morphine related deaths in 2017- heroin deaths particularly fell by 15% as compared to 2016. There will be a small number of deaths that have been attributed to morphine which were likely to have been heroin related. This is because in certain cases the toxicology will only be able to detect the morphine that has been metabolised from heroin use. Other cases will leave a more prominent marker(s) for heroin in the toxicology.

From 2013 onwards the monitoring of drug related deaths and suicides by CIOS DAAT have been independent from each other in order to keep the figures as accurate as possible. Prior to this the heroin and morphine related deaths may have also included suicides (E.g. 2007, 2008 and 2012). From March 2017 CIOS DAAT now investigate suicides to ascertain if drugs and/ or alcohol have been a factor. If this is the case then the death is investigated and reported on to HM Coroner with all findings disseminated in the same manner as drug related death investigations.

Figure 4



1.5 Deaths from fentanyl continued to rise in 2017. Despite deaths from most opiates declining or remaining steady, fentanyl deaths have increased by 29%, rising from 58 deaths in 2016 to 75 deaths in 2017. Fentanyl and its analogues have been found mixed with heroin, causing accidental overdose in users.

The CIOS DAAT has been closely monitoring any incidence of fentanyl including its inclusion in drug related deaths. One drug related death in 2017 involved prescribed fentanyl which was synergistically involved with illicit drugs. All other deaths in 2017 were negative to fentanyl in toxicology. One suicide in 2017 involved fentanyl but this again was in a prescribed form to the deceased. Forensic testing of drug seizures made by Devon and Cornwall Police has revealed very little presence of fentanyl.

1.6 Deaths from new psychoactive substances (NPS) halve in 2017. There were 61 deaths from new psychoactive substances (NPS, or so-called "legal highs") in 2017, which equates to an age-standardised rate of 1.0 death per 1 million population. This is a statistically significant decrease from the 123 deaths in 2016 (2.1 per 1 million). The government introduced the Psychoactive Substances Act in 2016, which established a blanket ban on the importation, production or supply of most psychoactive substances not already covered by the law.

The CIOS now rarely sees NPS drugs in post mortem toxicology. There was only one case in 2017 out of the 26 deaths that involved a drug that has previously been referred to as a NPS drug and that involved mephedrone. This drug was present with high levels of alcohol and other drugs and its contribution to the death was believed to be insignificant. It is arguable whether mephedrone is actually a NPS drug now having been around for about a decade but it was one of the more prominent drugs when NPS drugs became an issue amongst people who use drugs.

1.7 Cocaine deaths rise for the sixth consecutive year. There were 432 deaths related to cocaine in 2017, compared with 371 deaths in 2016.

Cocaine has not routinely been monitored to the same degree as opiates and benzodiazepines in drug related deaths in part due to its relatively small impact upon drug related deaths in Cornwall historically. If present at all in post mortem toxicology it was usually in minor amounts and eclipsed by other drugs such as heroin, alcohol and diazepam.
In the last two years the presence of cocaine in drug related deaths has significantly risen. Cocaine featured in 11 of the deaths representing 42% of the total. It was the only drug to feature in a drug related death in 2017 where it was the sole agent in toxicology and the only contributor to the death. 2016 saw 31% of cases involve cocaine which was 10 out of the 32 cases and two cases also involved cocaine in massive amounts being the sole contributor to the deaths.

In line with the current intelligence picture for Cornwall a high percentage of the cocaine related deaths have involved crack cocaine. The toxicology results do not differentiate between cocaine in its salt form and freebase crack cocaine so the metabolites just show that cocaine has been used by the deceased person. Many of the cocaine related deaths are suspected to have involved crack cocaine due to the history of the respective deceased person.

1.8 North East had the highest rate of drug misuse deaths. Rates of drug misuse in England were highest in three northern regions: North East, North West and Yorkshire and The Humber, with 83.2, 64.7 and 54.5 deaths per 1 million population, respectively. The rate in the North East was statistically significantly higher than each of the other regions of England. London had the lowest rate of deaths, which saw a statistically significant reduction from 32.3 deaths per 1 million population in 2016 to 24.6 in2017. The rate in London in 2017 was significantly lower than each of the other regions of England.

The above rates of death are quoted as per million head of population. In order to equate this to Cornwall, the figures have been adjusted in the

below tables to show the rate of death per 100,000 head of population. This is based upon a dataset that the ONS produced in August 2018 showing the rates of death per geographic area for between the years of 2015 and 2017. The original dataset can be found at;
https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority/current/localauthoritiesregistrations201517.xlsx

The chart at Figure 5 shows the national picture by region whilst the chart at Figure 6 shows the CIOS compared to the South West region local authority areas. The charts show figures in relation to ONS drug misuse deaths so as to more accurately compare with CIOS figures.

Figure 5

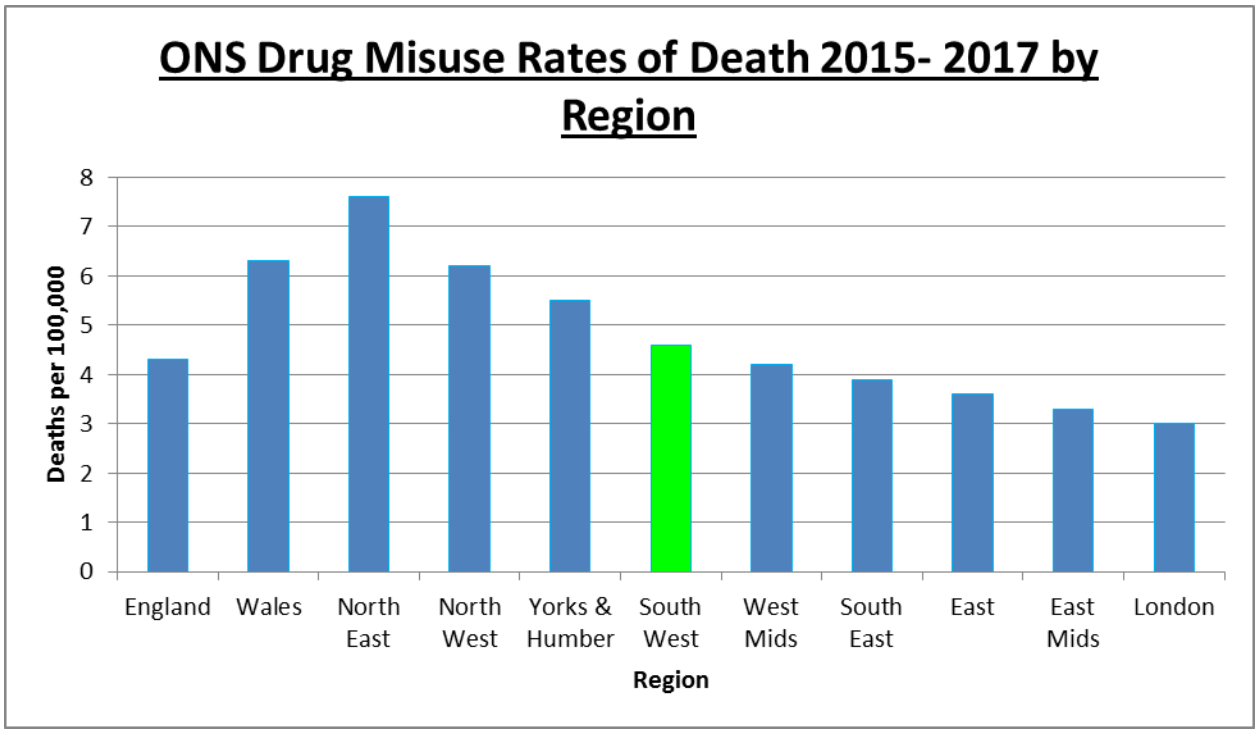
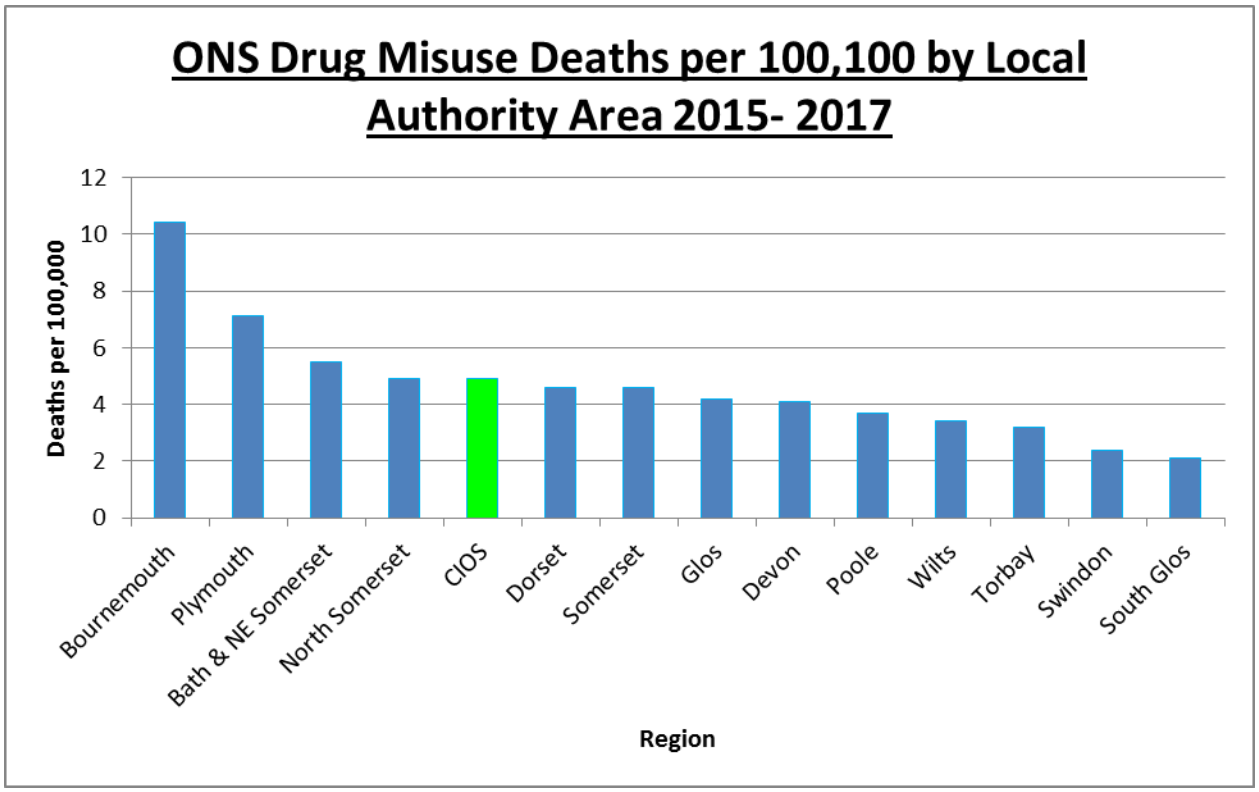


Figure 6



The ONS dataset shows how many deaths there have been in total over this 3 year period with Figure 7 below showing the number of deaths in Devon and Cornwall.

Figure 7

Local Authority Area	CIOS	Devon	Plymouth	Torbay
ONS Drug Misuse Deaths	75	84	52	12

CIOS figures for the period 2015 to 2017 show that there have been 82 drug related deaths compared to the 75 reported by the ONS. This difference will in part be due to the registration of deaths that the ONS rely on for their data collection.