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

# 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 2016 to 31st December 2016

## EXECUTIVE SUMMARY

This is the fourteenth annual report concerning drug related deaths prepared by the Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT). The 2016 report is based on the period from 1st January 2016 to 31st December 2016 inclusive. The report follows the requirements by the Department of Health and the Home Office for all Drug and Alcohol Action Teams to have in place a system of recording and conducting confidential inquiries into all drug related deaths within their specific areas.

The report adheres to the agreed definition of a drug related death as used by The Home Office, all 43 Police Forces within England and Wales, all Drug and Alcohol Action Teams, all Health Authority areas and the Department of Health; '*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 has been compiled to look at issues that have arisen from drug related deaths and associated learning. The guidance and advice contained in the below-listed publications has steered this report and attached hyperlinks can take the reader to the full documents;

- 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

According to The Office for National Statistics (ONS) there were 3,674 drug poisoning deaths (deaths attributable to both legal and illegal drugs) registered in England and Wales in 2015, the highest since comparable records began in 1993. Of these, 2,479 (or 67%) were drug misuse deaths involving illegal drugs. The mortality rate from drug misuse was the highest ever recorded at 39.9 deaths per million population. The reports other main headlines were:

- The mortality rate from drug misuse was the highest ever recorded, at 43.8 deaths per million population.
- Males were almost 3 times more likely to die from drug misuse than females (65.5 and 22.4 deaths per million population for males and females respectively).
- Deaths involving heroin and/or morphine doubled in the last 3 years to 1,201 in 2015, and are now the highest on record.
- Deaths involving cocaine reached an all-time high in 2015 when there were 320 deaths – up from 247 in 2014.

People aged 30 to 39 had the highest mortality rate from drug misuse (98.4 deaths per million population), followed by people aged 40 to 49 (95.1 deaths per million).

There is much to be learned by investigating drug related deaths and the dissemination of that learning needs to be rapid and insightful. Each case 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 cases in question can be found later in this report but the main findings and over- arching issues stemming from this years' report can be seen in the below chart and paragraphs.

| | 2013 | | 2014 | | 2015 | | **2016** | |
|---|---|---|---|---|---|---|---|---|
| Total drug related deaths | 18 | | 17 | | 24* | | **32** | |
| Gender *(male –M, female – F)* | 17 M | 1 F | 15 M | 2 F | 21 M | 3 F | **25 M** | **7 F** |
| % Increase or Reduction | 28% decrease from 2012 | | 6% decrease from 2013 | | 29% increase from 2014 | | **25% increase from 2015** | |
| Heroin / Morphine present | 12 *(9 Heroin & 3 Morphine)* | | 11 | | 14 *(12 Heroin & 2 Morphine)* | | **18 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)** | |
| Other controlled drug | 1 x DHC<br>1 x MDMA<br>1 x prescribed Fentanyl & Oxycodone | | 0 | | 3 x MDMA *(includes 1 x poly drug)*<br>1 x Subutex<br>1 x NPS | | **2 x Cocaine, 2 x NPS, 1 x Fentanyl, 1 x Amphetamine** | |
| Underlying cause drug related (not overdose) eg. Long history of drug use. New category for 2014 | Not recorded | | 1 | | 3 | | **1** | |

***** When the 2015 report was written there was one death that could not be included in the above table as toxicology and pathology were awaited. Those reports and the associated inquest have now been processed and the 2015 figure for the total number of deaths rose as a result to 24. The above table now rectifies that of the 2015 report.

The rise in drug related deaths is mirrored across the Devon and Cornwall Peninsula with a rise of 25% for 2016 as compared to 2015 in Cornwall alone.

Heroin deaths in Cornwall have risen from 14 deaths in 2015 to18 for 2016. All of these deaths involve poly drug use to a greater or lesser degree and the level of heroin represented by toxicological examination shows heroin being of significant presence. The poly drug use derives from either heroin plus other illicit drugs and/ or in combination with lawfully prescribed medicines.

19 cases show the presence of one or more anti- depressant medicines such as Sertraline or Mirtazapine. These cases may or may not feature Diazepam. Diazepam features in 20 cases with some overlap between the anti- depressant medicine cases. Mirtazapine features in 11 cases, Amitriptyline in 8 and Sertraline in 6.

Two cases involve significant levels of alcohol being present in the toxicology. Whilst these cases also involved at least one other drug, there is a case to be answered that these cases could have been independently fatal when considering only the presence of the alcohol dependent upon tolerance etc.

Poly drug use continues to be of concern across the cases with toxicology reports often mentioning the synergistic effects of drugs. Again, as with alcohol presence, some cases refer to a combination of drugs being significant but within those cases some individual drug levels are independently fatal. These cases point to a cohort of drug users who continue to dangerously combine a range of drugs. The poly element of the cases can be a combination of

illegal drugs and/ or legal medicines prescribed to the person in question or involving those medicines having been diverted from their original lawful recipients.

The 2015 report stated that deaths involving Pregabalin and Gabapentin had significantly reduced from the previous year. The 2016 report further states that, in the main, the presence of these drugs in toxicology screens has been in cases where lawful supply has been apparent albeit in some cases that drugs have been consumed other than in accordance with the prescription. These drugs feature on 10 of the cases.

Previous reports have highlighted the concern with deaths being witnessed and/ or not acted upon quickly enough to render first aid or seek medical assistance. Whilst this continues to be a concern, this year sees a greater proportion of those who have died being alone in predominantly their home address. That said, the deceased person has been found alone but not necessarily alone at death. There is no doubt that some cases will have involved another but by the nature of these deaths and the often involvement of illegality, some scenes will have been presented to emergency services as having only involved the deceased.

In 2014 there were 88% (15) of the 17 cases where the deceased was either in drug and/ or alcohol treatment at death or had been out of treatment for 6 months or less. In 2015 there were 57% (13) of the 23 cases where the deceased was either in drug and/ or alcohol treatment at death or had been out of treatment for 6 months or less. In 2016 there were 47% (15) of the 32 cases where the deceased was either in drug and/ or alcohol treatment at death or had been out of treatment for 6 months or less. As the trend in drug related deaths increases upwards in Cornwall the relative number in treatment has decreased.

Complexity of case and issues therein is high again this year. Below is a summary of those issues together with a brief mention of some of the on-going work to address these issues;

- Drug use combined with physical medical issues. Cases reviewed for this report include persons who have suffered from treatable and terminal cancer, chronic obstructive pulmonary disorder (COPD), obesity, cardiomegaly (enlarged heart), liver disease including cirrhosis and hepatitis B and C, encephalopathy (disease of the brain), bronchopneumonia. An extraordinary meeting of the Cornwall Drug Related Death Review Panel in early 2018 will thematically explore these and similar cases. A newly formed panel of clinical experts including specialist prescribers, pain medicine consultants and the Kernow Clinical Commissioning Group will assist in this work. This will link in to the recommendations from Health Matters: Preventing Drug Misuse Deaths (Updated September 2017) where it is specifically recommended that local authorities and NHS Commissioners develop pathways that facilitate people who use drugs being screened for health conditions and then treated when appropriate, for example, when leaving prison and for conditions such as liver disease, lung disease including COPD, cardiovascular disease and mental health problems including depression and anxiety.

- Drug use combined with mental medical issues/ dual diagnosis. Serious addiction to drugs where there was no intention to give up these drugs despite being in treatment, suicidal ideation including planning and previous attempts, self- harm, depression, bipolar disorder, anxiety. Closer working with the Cornwall Suicide Surveillance Group and Cornwall Partnership NHS Foundation Trust now makes these linked enquiries far more efficient with good information sharing in place.

- Cases where heart arrhythmia is a likely factor if not specifically identified as such within the inquest. This is an on- going piece of work looking at the link between heart arrhythmia and drugs that interfere with the hearts natural rhythm. These drugs include Methadone, Citalopram, Cocaine and Amphetamine as well as the effect that a sudden cessation of alcohol consumption may have in cases where the cause of death has been given as sudden unexpected death in alcohol misuse (SUDAM). In line with the first bullet point above an extraordinary meeting of the Cornwall Drug Related Death Review Panel in early 2018 will thematically explore these and similar cases.

- Adverse childhood experience (ACE). Many cases are now flagging up that the subject had experienced early childhood trauma such as physical, mental and sexual abuse,

witnessed domestic violence, divorce or separation of parents, early introduction to and/ or use of drugs and alcohol, death of a close relative or other person. There is now greater emphasis on reviewing cases with ACE issues in mind. This also now translates to cases where the drug/ alcohol treatment is starting or is on-going.

- Overuse and reckless use of prescribed medicines sometimes in combination with alcohol and/ or illicit drugs. This work is coupled with closer scrutiny of prescriptions and whether those prescriptions continue to be appropriate in the circumstances. Cases have been referred to the Kernow Clinical Commissioning Group highlighting issues.

- Greater prevalence of cocaine in toxicological evidence. Two of the deaths are from an overt cocaine toxicity with no other agents present with a further 8 cases showing cocaine present. The cocaine present in these other 8 cases is likely to have had either a synergistic effect on the subject and/ or an effect on heart arrhythmia.

- Internet sourced medicines in cases where there is an element of self- medication and other cases where there is abuse of the medicines sourced for their psychoactive effects for example. One case highlighted the naivety of GP's in relation to their knowledge of the availability and accessibility of such medicines to their patients. There is to be closer working with GP practices with presentations now planned for practices where there may be greater risk.

- Increased value in working with safeguarding partnerships. Three cases involved such co- working in 2016 and going forward into 2017/ 18 there is now a monthly safeguarding adult review group that the Cornwall DAAT attend to review cases which overlap.

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## 1. INTRODUCTION

1.1 This is the fourteenth annual report concerning drug related deaths prepared by the Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT). The report follows the requirements by the Department of Health and the Home Office for all Drug and Alcohol Action Teams to have in place a system of recording and conducting confidential inquiries into all drug related deaths within their specific areas.

1.2 The 2016 report is based on the period from 1st January 2016 to 31st December 2016 inclusive.

1.3 The 2016 report follows a similar format to that of previous reports where statistical analysis, case studies together with findings and recommendations are thought to be a useful way of presenting the full picture. The emphasis on proactive measures is of paramount importance and is, to a certain extent, guided by the case studies of the reporting period. Where relevant, the case studies include a comments section together with lessons learned and on-going work associated with the case. There is often overlap between cases where shared concerns prevail.

1.4 The increase in the staffing of HM Coroner's Office and the change to The Coroners Rules (2013) has contributed to a more efficient processing of cases that go to inquest. All cases subject of this report and treated as substance misuse deaths have been or are going to inquest. The vast majority of inquests are now heard within 6 months of the death. This increased efficiency allows a greater rapidity in disseminating the learning from cases as well as being of greater comfort to grieving family and friends.

1.5 Reports since 2009 have detailed a robust system of monitoring and recording of drug related deaths throughout Cornwall and the Isles of Scilly. This model of recording has been regarded as best practice, and has been promulgated regionally and nationally. The Cornwall model of recording and monitoring drug related deaths is likely to be the most effective and has proven to be sustainable.

1.6 Confusion unfortunately still continues amongst the media and interested parties regarding the actual number of annual drug related deaths. This arises from the many varying criteria for recording drug related deaths within the respective annual reports. The Home Office, all 43 Police Forces within England and Wales, all Drug and Alcohol Action Teams, all Health Authority areas and the Department of Health operate specifically within the nationally agreed definition of ***'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'.***

1.7 In September 2015 The Office of National Statistics (ONS) released their annual report concerning drug related deaths throughout England and Wales for 2014. All drug related deaths are included however this is also filtered to include deaths within the above definition involving drug misuse. Deaths during the latter part of 2014 are not routinely included owing to the time delay in collecting this data, hence parts of the report could relate to matters almost two years previously. The ONS report attached various caveats with its' latest data including;

- Figures for England and Wales include deaths of non-residents. The figures for England and Wales separately include only deaths of residents of those countries, so will not sum to the England and Wales total.
- The drug misuse indicator was revised in 2014 with 20 new substances. Therefore figures for drug misuse may not match those previously published.
- Figures are for deaths registered, rather than deaths occurring in each calendar. Due to the length of time it takes to complete a coroner's inquest, it can take months or even years for a drug-related death to be registered.
- All figures presented in the ONS 2015 report for the 2014 deaths are based on deaths registered in a particular calendar year. Out of the 3,346 drug-related deaths registered in 2014, half (1,682) occurred in years before 2014

According to The Office for National Statistics (ONS) there were 3,346 drug poisoning deaths (deaths attributable to both legal and illegal drugs) registered in England and Wales in 2014, the

highest since comparable records began in 1993. Of these, 2,248 (or 67%) were drug misuse deaths involving illegal drugs. The mortality rate from drug misuse was the highest ever recorded at 39.9 deaths per million population.

Furthermore, deaths involving heroin and/or morphine increased by almost two-thirds between 2012 and 2014, from 579 to 952 deaths.

The latest ONS annual report can be accessed via the link below:
http://www.ons.gov.uk/ons/dcp171778_414574.pdf

1.8 The figures concerning drug related deaths published by the Cornwall & IOS DAAT 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 partners include Addaction, Bosence/ Boswyns rehabilitation and detox unit, Devon and Cornwall Police, HM Prison Service, HM Coroner and her officers, SW Ambulance Service, Probation Service and supported housing projects. Cases often involve interaction with toxicologists, pathologists, pharmacists and GP's. The information and data, efficiency of various agency meetings and communication allows the DAAT the confidence to deliver an accurate annual report.

## 2. RECORDED DRUG RELATED DEATHS – Cornwall & IOS 2016

2.1 This current report incorporates all reported suspected drug related deaths throughout Cornwall & IOS for 2016 and has been prepared for the information of the Cornwall & IOS Drug Related Deaths Review Group and for the Peninsula Drug Related Deaths Review Panel. The report is also for the information of the DAAT Board and Cornwall Council (Public Health), together with HM Coroner for Cornwall. Thereafter copies will be circulated to commissioned providers and DAAT partners.

2.2 The following table shows the total number of drug related deaths within Cornwall & IOS DAAT throughout 2016 as compared to the previous 3 years:

| | 2013 | | 2014 | | 2015 | | **2016** | |
|---|---|---|---|---|---|---|---|---|
| Total drug related deaths | 18 | | 17 | | 24 | | **32** | |
| Gender *(male –M, female – F)* | 17 M | 1 F | 15 M | 2 F | 21 M | 3 F | **25 M** | **7 F** |
| % Increase or Reduction | 28% decrease from 2012 | | 6% decrease from 2013 | | 29% increase from 2014 | | **25% increase from 2015** | |
| Heroin / Morphine present | 12 *(9 Heroin & 3 Morphine)* | | 11 | | 14 *(12 Heroin & 3 Morphine)* | | **18 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)** | |
| Other controlled drug | 1 x DHC<br>1 x MDMA<br>1 x prescribed Fentanyl & Oxycodone | | 0 | | 3 x MDMA *(includes 1 x poly drug)*<br>1 x Subutex<br>1 x NPS | | **2 x Cocaine, 2 x NPS, 1 x Fentanyl, 1 x Amphetamine** | |
| Underlying cause drug related (not overdose) eg. Long history of drug use. | Not recorded | | 1 | | 3 | | **1** | |

2.3 As with previous reports, the total number of drug related deaths comes after a filtering process which takes all reported suspected drug related cases from a number of sources. All those cases that involve a person who was in drug and/ or alcohol treatment at death will be investigated thoroughly. Likewise, all cases that involve a person who has been in drug and/ or alcohol treatment within 6 months will be investigated. Whilst internal scrutiny and reporting is necessary in these treatment cases, not all of them appear in the drug related death figures having been filtered out with the assistance, for example, of toxicology and pathology. DAAT also monitors deaths where drugs have featured but where the drug does not come under the standard drug related death definition. This has been the case in previous reports where the synthetic opiate analgesic drug Tramadol was prevalent in drug deaths when it was not defined under The Misuse of Drugs Act 1971. Tramadol is now classified as a Class C controlled drug under that act. DAAT will continue to monitor similar concerns, some of which will be apparent in the later paragraphs and case studies.

2.4 Deaths from heroin toxicity or where heroin has been significantly implicated has risen by 33% to 18 deaths. Some of the heroin deaths involve other drugs and/ or alcohol but the presence of the heroin in these 18 deaths has been either independently fatal or in such an amount as to have been a major contributor to the death. From the commencement of Cornwall DAAT records in 1999, deaths from heroin overdose have fluctuated between 6 -13 annually.

2.5 Deaths from methadone toxicity (or where it has been implicated in death) have remained static at 5 deaths per year since 2013. Of the 5 deaths in 2016, only one was from an illicit source and this was the fatal agent as concluded in toxicological examination. The other 4 cases involved a lawful supply of methadone initially but were combined with other drugs and/ or alcohol.

2.6 The last 3 years have seen the numbers of those dying from a drug related death and having also been in treatment remain static at 14 or 15 service users. With the increasing numbers of deaths over those years, however, the proportion of those in treatment has dropped as a percentage from 88% in 2014, 58% in 2015 and to 47% in 2016.

| | 2013 | 2014 | 2015 | **2016** |
|---|---|---|---|---|
| Total drug related deaths (cases in treatment or within 6 months of treatment) | 18 (8) | 17 (15) | 24 (14) | **32 (15)** |
| In current drug treatment | 6 | 10 | 10 | **14** |
| Died within 6 months of leaving drug treatment | 2 | 1 | 2 | **1** |
| In current alcohol treatment | 0 | 3 | 1 | **0** |
| Died within 6 months of leaving alcohol treatment | 0 | 1 | 1 | **0** |
| Not known to treatment | 10 | 2 | 10 | **17** |

2.7 Complexity of case and issues therein is high again this year. Below is a summary of those issues together with a brief mention of some of the on-going work to address these issues;

- Drug use combined with physical medical issues. Cases reviewed for this report include persons who have suffered from treatable and terminal cancer, chronic obstructive pulmonary disorder (COPD), obesity, cardiomegaly (enlarged heart), liver disease including cirrhosis and hepatitis B and C, encephalopathy (disease of the brain), bronchopneumonia. An extraordinary meeting of the Cornwall Drug Related Death Review Panel in early 2018 will thematically explore these and similar cases.

- Drug use combined with mental medical issues/ dual diagnosis. Serious addiction to drugs where there was no intention to give up these drugs despite being in treatment, suicidal ideation including planning and previous attempts, self- harm, depression, bipolar disorder, anxiety. Closer working with the Cornwall Suicide Surveillance Group and Cornwall Partnership NHS Foundation Trust now makes these linked enquiries far more efficient with good information sharing in place.
- Cases where heart arrhythmia is a likely factor if not specifically identified as such within the inquest. This is an on- going piece of work looking at the link between heart arrhythmia and drugs that interfere with the hearts natural rhythm. These drugs include Methadone, Citalopram, Cocaine and Amphetamine as well as the effect that a sudden cessation of alcohol consumption may have in cases where the cause of death has been given as sudden unexpected death in alcohol misuse (SUDAM). In line with the first bullet point above an extraordinary meeting of the Cornwall Drug Related Death Review Panel in early 2018 will thematically explore these and similar cases.
- Adverse childhood experience (ACE). Many cases are now flagging up that the subject had experienced early childhood trauma such as physical, mental and sexual abuse, domestic violence, divorce or separation of parents, early introduction to and/ or use of drugs and alcohol, death of a close relative or other person. There is now greater emphasis on reviewing cases with ACE issues in mind. This also now translates to cases where the drug/ alcohol treatment is starting or is on-going.
- Overuse and reckless use of prescribed medicines sometimes in combination with alcohol and/ or illicit drugs. This work is coupled with closer scrutiny of prescriptions and whether those prescriptions continue to be appropriate in the circumstances. Cases have been referred to the Kernow Clinical Commissioning Group highlighting issues.
- Greater prevalence of cocaine in toxicological evidence. Two of the deaths are from an overt cocaine toxicity with no other agents present with a further 8 cases showing cocaine present. The cocaine present in these other 8 cases is likely to have had either a synergistic effect on the subject and/ or an effect on heart arrhythmia.
- Internet sourced medicines in cases where there is an element of self- medication and other cases where there is abuse of the medicines sourced for their psychoactive effects for example. One case highlighted the naivety of GP's in relation to their knowledge of the availability and accessibility of such medicines to their patients. There is to be closer working with GP practices with presentations now planned for practices where there may be greater risk.
- Increased value in working with safeguarding partnerships. Three cases involved such co- working in 2016 and going forward into 2017/ 18 there is now a monthly safeguarding adult review group that the DAAT attend to review cases which overlap.

## 3. BRIEF CIRCUMSTANCES/CASE STUDIES 2016

3.1 Five of the 32 suspected drug related deaths in 2016 are awaiting inquest hearing by H.M. Coroner for Cornwall - Dr. E. E. Carlyon. 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.

3.2 The following paragraphs have been suitably anonymised and the locations kept vague. However, this additional information has been included within this report, in the interests of preventing and reducing drug related deaths. The learning from these deaths is of paramount importance if we are to effectively prevent future deaths of this kind. These tragic deaths help to inform the DAAT and other agencies as to possible prioritising of treatment, trends and targeting of resources.

3.3 All 32 drug related deaths are now briefly outlined below.

3.4 **Drug Related Death 1 – Jan 2016**

- 38 year old female and mother to young children who died at home in the Redruth area and who was not known to drug/ alcohol services.

- Cause of death given as 1a. Ischemic heart disease, 1b. Coronary artery thrombosis, 1c. Coronary artery atherosclerosis and 2. Mixed drug toxicity (sertraline and aminoindane). The inquest concluded that this case involved a combination of natural causes and drug use.
- Medical conditions of high blood pressure, anxiety and stress the latter possibly linked to having a marriage breakdown four years ago and young children.
- Latterly she had been in good mood, had planned to see a man on a date the evening that she died and was interacting positively daily with family and friends.
- Prescribed anti- depressant (sertraline), beta blockers and recently took therapeutic amounts of co-codamol (paracetamol and codeine).
- New psychoactive drug use identified (the amphetamine analogue drug aminoindane)
- The drug combination of high Sertraline use and NPS use on top of medical conditions of the heart were responsible for this death. The deceased was diagnosed with severe triple vessel coronary artery atherosclerosis.
- Low mood but suicidal intention and plan were ruled out.

**Findings and applying the learning**

- No obvious learning here other than this case does highlight the dangerous combination of prescribed drugs with new psychoactive drugs and a serious underlying medical condition of the heart. Latter stress deriving from looking after her children and her marriage breakdown appeared to be being positively balanced with getting her life back on track.

3.5 **Drug Related Death 2 – Jan 2016**

- 43year old male who died at his home near to Truro. He was not in drug/ alcohol treatment and very limited contact with any medical service apart from 2 years previously when he collapsed and there was no medical reason for this collapse that was identified.
- Cause of death was given as 1a. Mixed ethanol and morphine overdose with an open conclusion at inquest.
- Alcohol level was over 3 ½ times the UK drink/ drive limit and verging on the toxic.
- Potentially lethal levels of morphine which could independently of the alcohol have been fatal. It was not clear where the morphine came from nor when he took it but this man's father was prescribed Morphine however none of his prescription was obviously missing. The intention behind taking the morphine was not clear from evidence at inquest hence the open conclusion.

**Findings and applying the learning**

- This case involved a man where there was very little known about him and any drug use. The possibility was that the man was able to take morphine medicine from his father over a period but there was insufficient evidence to support or fully disclose the means whereby the cause of death arose.

3.6 **Drug Related Death 3 – Jan 2016**

- 62 year old male who died at his home in Newquay. He had no drug and alcohol treatment history.
- Cause of death given as 1a. Bronchopneumonia 1b. Hepatocellular carcinoma 1c. Hepatitis C induced liver cirrhosis 2. Opiate and cocaine misuse. The inquest returned an open conclusion.
- Diagnosed with Hepatitis C and was latterly being treated for liver cancer although he was not good at keeping his hospital appointments. He also suffered from rheumatoid arthritis.
- Tendency to overuse prescribed medicines such as Morphine and Diazepam.
- He was on a range of high strength medicines like Morphine Sulphate, sertraline and diazepam. The pathologist notes that the high levels of Morphine might be as a result of this man having high tolerance to opiates (Morphine)
- Cocaine and its metabolites were identified as being present and suspected illicit controlled drugs were located at the scene.
- Mental health issues such as chronic anxiety and social isolation.

**Findings and applying the learning**

- This case is again an example of serious medical conditions worsened by illicit drug use.
- Although medical attention and help was being afforded, this man chose not to take up all help available to him to ease the pain of his medical issues.

3.7 **Drug Related Death 4 – Feb 2016**

- 28 year old man who was found at his home address in the Penzance area. He was in drug treatment near to the time of his death.
- The cause of death was given as 1a. Heroin toxicity and the inquest concluded that this was a drug related death.
- Suffered from COPD and had been a heroin user for several years.
- Used heroin with a parent on occasion.
- Lived in premises frequented by other drug users who used premises for taking drugs.
- Previous successful residential detox with 3 months of being drug free.
- The level of heroin post mortem prompted the toxicologist to state that 'death is likely due to acute heroin toxicity'.
- This man had officially been out of treatment for 10 days although he had expressed a desire to leave treatment months previous with his last pick up of methadone from a pharmacy being in late September 2015.
- Despite attempts to re-engage him in opiate substitute medication and continued warnings as to his use of illicit heroin he did continue to use heroin. This service user continually asserted that he did not want to go back on a prescription as he felt it restricted his movements and potential employment opportunities.

**Findings and applying the learning**

- Despite close working between the GP, Addaction and the shared care provider this service user never gave up or wanted to come off heroin apart from a brief period of detox.
- Risk management was crucial in this case but this man was open in his telling treatment workers of his desire to keep using heroin.

3.8 **Drug Related Death 5 – Feb 2016**

- 43 year old male found deceased at home address of a friend in the Torpoint area.
- In drug treatment outside of Cornwall.
- Cause of death given as 1a. Methadone toxicity and the inquest concluded that this was a drug related death.
- Prescribed methadone but it appears that he was supplementing with extra methadone sources illicitly.
- He has a diagnosis of poly substance misuse alongside paranoid psychosis with depressive episodes.
- Adverse childhood experiences; In care from age 7, disclosed abuse from age 9, using heroin from age 14, diagnosed with drug induce psychosis aged 16 and 18.
- Previously suffered blackouts due to drugs and alcohol.
- Overall he had been responding to treatment well and had been abstinent for long period up until his last week of life.
- Risk assessment was updated 4 days before his death that he had significantly relapsed and his risk of overdose was high. Appointments and plans were in place for the week of his death with an urgent review of his prescribing due to take place the day after the death.
- A long history of mental health problems, diagnosis of depressive episodes and paranoid psychosis, however he had been reviewed regularly by consultant psychiatrist and his mental health was assessed as stable.
- All known associates were part of the drug using scene so it would have been difficult if not impossible for him to remove himself completely without then isolating himself.

**Findings and applying the learning**

- No obvious reason(s) for his relapse back into illicit drug use but this was risk assessed as urgent 4 days prior to his death. His situation was being carefully monitored and plans were in place to review his prescribing days before he died.

- His accessibility to illicit drugs was easy through his cohort of friends.
- The drug team were acting fast around a rapidly changing situation but this man had his freedom and, in the time spent away from the drug team, his worsening drug taking was at the mercy of his easy access to drugs.

3.9 **Drug Related Death 6 – Feb 2016**

- 29 year old male died at the home address of another and was not in drug or alcohol treatment.
- Cause of death given as 1a. Drug misuse with an inquest conclusion of a drug related death.
- Had been referred to Addaction but he did not engage.
- This man attended the flat of a friend in the Bude area and they used heroin together. Friend found the deceased the next morning.
- Toxicology found Pregabalin, Heroin, Diazepam all of which were illicit. These drugs have been used on top of prescribed Tramadol and Nitrazepam. These 5 drugs acted synergistically upon and depressed the central nervous system of this man

**Findings and applying the learning**

- The friend was in Addaction treatment and was immediately reviewed after this death. Due to his intoxication at the scene he was unable to assist in a meaningful way although he did call the ambulance and tried to resuscitate the deceased the next morning. First aid and more awareness training have been now given. The friend has also now been trained in the use of Naloxone as well as being issued with Naloxone.

3.10 **Drug Related Death 7 – Apr 2016**

- 55 year old woman who died at RCHT, Truro after an overdose at her home in the St Austell area. She was not in drug or alcohol treatment.
- Cause of death given as 1a. Mixed drug toxicity and the inquest concluded that this was a drug related death.
- A suicide conclusion was considered but insufficient evidence to conclude this. This woman had, however, tried taking her own life on many previous occasions and there were some differences of opinion amongst the family members giving evidence at inquest and of the number of times that this had happened.
- A total of 7 drugs present in toxicology of which the morphine from prescribed medicine and illicit heroin was potentially independently fatal likewise for the prescribed levels of Tramadol.
- Chronic back pain and 2 previous referrals to the Community Mental Health Team but the deceased did not attend either appointment.
- Daughter brought back heroin for both her and her mother to use. This final occasion the daughter smoked the heroin whilst her mother injected it with fatal consequences.
- Daughter was unable to administer first aid properly without ambulance assistance via landline telephone and was intoxicated at the time.

**Findings and applying the learning**

- A long history of drug use and suicidal ideation coupled with actual attempts to take her life seemed to have led to a sense of ambivalence from certain family members.
- There was no real support at home for this woman and the access and availability of illicit drugs was made easier by her daughter who herself had just come out of a residential detox.
- This woman's ambivalence and history of taking medicines in large amounts contrary to her prescribed dosage eventually and fatally caught up with her.
- The daughter has been in drug treatment since early 2014 in Cornwall and was being supported by her mother. Treatment continues with the daughter.

3.11 **Drug Related Death 8 – Apr 2016**

- 52 year old man who died at his home in the Penzance area.
- Cause of death given as 1a. Bilateral bronchopneumonia 2. Opiate abuse. The inquest result was a drug related death. The pathologist commented that previous chronic use of methadone would have contributed to the development of bronchopneumonia.

- Suffered from severe COPD and chest problems with bronchitis being a regular winter illness for him. This man had also smoked cigarettes for many years.
- Opiate addiction for over 20 years with illicit sourcing of morphine sulphate tablets for the last 2 years.
- Daily supervised methadone prescription from Addaction.
- Methadone and cocaine metabolites present in toxicology.
- Only a 2 month treatment history with Addaction up until death but this man was able to stop using illicitly sourced MST tablets and methadone stabilising on a lawful methadone prescription.

**Findings and applying the learning**

- This man did take up structured drug treatment and was able to stabilise on a methadone prescription negating his need to use street source methadone. He also was able to stop using street sourced Morphine tablets but the damage had been done with bronchopneumonia already having started it appears.

3.12 **Drug Related Death 9 – Apr 2016**

- 30 year old man who died at the home address of a friend in the Hayle area.
- Cause of death given as 1a. Heroin intoxication with an inquest conclusion of a drug related death.
- He was 5 ½ months out of Addaction drug treatment but with a long standing alcohol dependence.
- The friend witnessed this man fall down/ collapse at about 10pm but the alarm was not raised until after 5:30pm the following day. An ambulance attended and confirmed death.
- The friend is alcohol dependent.
- There were over 16 previous accident and emergency admissions to hospital that were drug and/ or alcohol related.
- Started using alcohol aged 13 and was a dependent drinker in his teens.
- Long criminal justice history with periods of imprisonment for drug related offences and acquisition offences.
- Ambivalent heavy drinking and drug combinations despite continual warnings about the risks.
- Many periods of this man not attending appointments or dropping out of treatment but targeted outreach was used to good effect to try to keep him in treatment.

**Findings and applying the learning**

- As this man had been out of treatment for 5 ½ months there is no record of what happened in that ensuing time with regard to his drug and alcohol use. He was known to still be drinking heavily and was well known to local Police as a homeless street drinker.
- Assertive outreach had been used to good effect previously but that was when this man was more receptive to it. Once he had disengaged from treatment and had not responded to further assertive outreach there was very little that the treatment team could do.
- There was no support for him from friends etc as they too had their own issues with intoxicants.

3.13 **Drug Related Death 10 – Apr 2016**

- 48 year old man who died at his home address in the Bugle area.
- Cause of death given as 1a. Effects of amphetamine on a background of coronary atherosclerosis and myocardial interstitial fibrosis and small vessel disease most likely as a consequence of long- term amphetamine use.
- The inquest concluded that this was a drug related death.
- In drug treatment for amphetamine use although he had also been in treatment for heroin use. The heroin use had ceased as had the replacement medication that he used to take. This man used amphetamine as he thought that it assisted his creativity when it came to writing poetry. As a consequence he was not positively working towards giving up amphetamine.

**Findings and applying the learning**

- There were staff shortages with the drugs team in and around this incident. There is a policy in place not to send lone workers to the area where this man lived due to concerns for their welfare. The staffing was worked around by giving this man nearer appointments for drug treatment and the like. Staffing has now improved but it is not thought that this man suffered as a result of the temporary staffing shortage.
- The cause of death clearly states the role that amphetamine played and this man clearly stated his intention to carry on using amphetamine for what he said was for creative purposes.
- This is another death that features in the on- going work to scope the role of certain drugs with their potential to cause heart arrhythmia. This man also was prescribed Citalopram which is a drug which can cause with heart arrhythmia as a side effect.
- The pathologist stated in live evidence that amphetamine users can suddenly get these sorts of problems irrespective of tolerance and length of use. Recreational non-dependent users of amphetamine with small amounts being used can produce toxic effects including heart arrhythmia.

3.14 **Drug Related Death 11 – June 2016**

- 36 year old man who died whilst staying at his sister's home in the Newquay area.
- Cause of death given as 1a. Poly drug toxicity (heroin and cocaine) with an inquest conclusion of a drug related death.
- No link to local drug and alcohol treatment as had moved within the previous 2 months to Cornwall.
- Had a 20 year history of using heroin and had been dependent on alcohol since the age of 17. He had stated that he did not want to use methadone in response to trying to get off of heroin as he didn't get on with it.
- This man used to suffer from seizures if he stopped drinking. He last had an alcohol related seizure in Feb 2016 in Leicester but he refused hospitalisation.
- Injected heroin in the bathroom of the premises and was found collapsed about 20 minutes later whereupon first aid was administered by sister.

**Findings and applying the learning**

- An accidental and fatal heroin overdose that happened to a man who specifically did not want to enter drug treatment because of his dislike of methadone. This mind set led to him not accessing treatment to see what other opportunities there might be available to him for his heroin dependence.
- Despite his issues with alcohol and the manifestation of alcohol related seizures, there was no alcohol present post mortem but there were 6 different types of drug present.

3.15 **Drug Related Death 12 – June 2016**

- 15 month of female child who died at her home address in the St Austell area in circumstances where a Fentanyl transdermal patch had become affixed to her stomach.
- The cause of death was given as 1a. Fentanyl toxicity.
- The inquest in this case is awaited

**Findings and applying the learning**

- Due to the sensitive nature of this investigation further details are awaited.

3.16 **Drug Related Death 13 – June 2016**

- 21year old woman who died in her bedroom at her home address in the St Austell area.
- Cause of death given as 1a. Multiple drug intoxication and an accidental conclusion given at inquest.
- Toxicology was a mixture of prescribed medication and internet sourced drugs; Tramadol, Chlorodiazepam, Lorazepam, Morphine and Imipramine. Chlorodiazepam is described as a 'designer drug' with no licensed use within the UK for medical purposes.
- Previous self- harm and overdose attempts with a plan on January 2016 to complete suicide. History of bullying and weight issues. Depression related to all her issues.
- Diagnosed with cancer at age 18- ovarian tumour removed. Re- diagnosis of cancer about a year prior to death.

- This woman would tend to self- diagnose on the internet.
- Mental health treatment but this woman notably went downhill according to her mother when her mental health worker was changed. Became a recluse with over 22 hours a day being spent in her bedroom.
- Whilst there was a record of low mood, self- harm and suicidal ideation, she was latterly planning for a family birthday and a deliberate overdose leading to her death was ruled out.
- 2 months prior to death she confided in her GP that felt suicidal so a plan was put into place which included weight management and small goal setting.

**Findings and applying the learning**

- The GP practice has a new policy of overdose awareness in place in relation to prescription medicines.
- Self- harm recognition to be communicated better around the GP practice.
- Internet sourcing of drugs/medicines is very problematic and, although the GP was aware of this, it was difficult to safely prescribe against this background. The main thing here is to be aware and to communicate well between patient and GP as well as within general practice. There is sometimes a naivety with some health professionals surrounding the ease of access to medicines via the internet so communication of these issues is of importance.
- A recommendation from Adult mental health services (Cornwall) that a patient should ideally not be engaged with NHS and private mental health services/ counselling at the same time.
- Cornwall DAAT are to be attending this practice to talk in depth about the issues of this case and associated issues around prescribed medicines including awareness of what is appearing in toxicology when a death occurs.

3.17 **Drug Related Death 14 – July 2016**

- 38 year old man who died at his home address in the Penryn area.
- Cause of death given as 1a. Polydrug toxicity and an inquest conclusion of a drug related death.
- In drug treatment with Addaction.
- Mental health issues such as depression, fluctuating mood and drug induced psychotic episodes.
- History of benzodiazepine abuse. The toxicology showed the presence of Alprazolam and Etizolam both of which had been unlawfully sourced. Alprazolam can only be lawfully sourced in the UK by a private prescription and it is not available on the NHS. Etizolam is not licensed as a medicine in the UK. Etizolam is thought to be 6-10 times more potent than diazepam and this man also had Diazepam present. Synergistic toxicity has come about by the combination of the benzodiazepine drugs but further compounded by anti-psychotic and anti- depressant medicines that this man had been prescribed and recreational use of Ketamine.
- This mans' latter treatment was showing very positive steps forward- he was clear of opiate drugs and alcohol.
- The deceased's mother had recently moved to the area and was positive link between her son and treatment.
- Latter clarity from ceasing opiate and using less alcohol gave him greater insight into other issues such as organising his life- this was being worked on with the treatment team.

**Findings and applying the learning**

- This death was unexpected and went against the grain of this man's general improvement. He did, however, continue to use drugs in a reckless and synergistically dangerous manner.
- Access to internet medicines/ drugs is very difficult to prevent and is an on-going piece of work for many agencies.

3.18 **Drug Related Death 15 – July 2016**

- 49 year old man who died at a temporary address St Austell area who was in drug treatment at death.

- Cause of death given as 1a. Ischaemic heart disease and Multiple drug toxicity 2. Hepatic cirrhosis. The inquest concluded that this was a drug related death with the combination of drugs worsening the effects of each other.
- Markedly reduced windpipe as a result of throat cancer and was in remission at death.
- This man was on a range of medicines for opiate substitute medication, diabetes, hypertension and peripheral neuropathic pain. He also had a long history of abusing street drugs such as heroin and cocaine.
- Toxicology showed heroin and cocaine in combination with his many medicines.
- Oncology evidence that his cancer could have been caused by his tobacco smoking, alcohol use and crack cocaine smoking.
- Being fed through a tube due to an inability to swallow normally.
- Girlfriend of the deceased bought heroin and crack cocaine for 'stress relief' due to the recent moving house. The house that they were staying at was that of a drug dependent person whose birthday it was when they moved. The deceased was unable to inject so the heroin was used rectally. This man was found deceased the following morning.

**Findings and applying the learning**

- This man had a long history of drug use and took prescription and illicit drugs against a background of a compromised and diseased heart. His ability to breathe properly was a major factor due to the central nervous system depressant nature of the drugs in question.
- His support and long term partner was also the source of the illicit drugs so some of this man's being looked after was misplaced.
- There was openness in the drug use and recognition of this by all medical professionals involved in the various medical issues of this man.

3.19 **Drug Related Death 16- Aug 2016**

- 49 year old man who died at the home address of a friend in the Newquay area. This man was from Essex and visiting Cornwall.
- Cause of death given as 1a. Acute cocaine toxicity with an inquest conclusion that this was a drug related death.
- This man was an ex-soldier who was visiting a friend from the Army both of whom had met whilst in 'Combat Stress' rehabilitation.
- Both friends met, had a few drinks in a local pub and then spent the night chatting at the friends' home. During the night the deceased had consumed an amount of cocaine that was deemed to be potentially lethal.
- This man had recently been rebated £10,000 and had purchased a large amount of cannabis and cocaine for his own use.
- This death was totally unexpected with the deceased previously being in good spirits with family speaking of his happiness about going to see his friend in Cornwall.

**Findings and applying the learning**

- This man clearly suffered from post-traumatic stress disorder but he died in circumstances that were purely accidental albeit he was a willing participant in taking a large amount of his drug of choice. His mental health issues were being addressed and his mood/ mental state was good with him being excited to see and stay with his friend/ fellow ex comrade- in- arms in Cornwall.
- This man had the means to purchase and access to controlled drugs in large amounts.
- Whether or not the controlled drugs may have been part of this man's self- medication is not clear but it does appear that he may well have used them recreationally as opposed to a dependence upon them.

3.20 **Drug Related Death 17- Aug 2016**

- 34 year old man who died at an address well known to be used for drug taking in the Penzance area. He was on supervised leave from a hospital as he had been sectioned under the Mental Health Act. He ran away from his carers and was later found suffering from the effects of what is believed to be a drug overdose.
- This case is awaiting an inquest in front of a jury.

3.21 **Drug Related Death 18- Aug 2016**

- 46year old woman who overdosed on heroin in public toilets in Truro.
- The cause of death was given as 1a. Heroin toxicity 2. Coronary artery atherosclerosis and hepatic cirrhosis. The inquest concluded that this was a drug related death.
- Addaction treatment form April 2013 which was sporadic due to homelessness and terms of imprisonment disrupting the contact.
- This woman had been released from prison a week prior to her death so reduced tolerance to opiates was an issue.
- A friend witnessed her to prepare and inject herself with heroin and she then passed out. Sometime later he noticed she was unconscious and not breathing. CPR was carried out but she died in RCHT after the ambulance had been called.
- Relevant issues; homelessness, previous overdose, poly drug use, periods of imprisonment and behaviour which saw her being ejected from premises that were in place to support the likes of these complex cases.
- Previous overdoses included one where this woman overdosed with others outside the gates of prison upon release.

**Findings and applying the learning**

- This case flags up how complex a case can be with a service user and how important those around the service user are to look after and be aware of their needs and safety.
- Addaction are now working closer with the Prison service and one prison in particular to scrutinise the needs and issues generated by female complex users.
- This case came at a time when there were regular issues in Truro with street drinkers, aggressive begging and a growing cohort of homeless people. A multi-agency assertive outreach approach was adopted to reduce street drinking, drug litter and engaging some of the most vulnerable adults across the county in packages of care which meet their needs. Many of the cohort that this woman was from were engaged with and helped as part of this intensive initiative.

3.22 **Drug Related Death 19- Aug 2016**

- 28 year old male found deceased at his temporary home address (guest house) near Newquay.
- Cause of death given as 1a. Morphine overdose with an inquest conclusion that this was a drug related death.
- Body had been decomposing at the premises, no third party involvement known and no drug paraphernalia present.
- This man moved around many areas in the latter months of his life.
- This man was in treatment with Plymouth drug services and was due to return to Plymouth on 1st September 2016. He also left messages with his treatment provider that he was to be re-assessed at the George Hostel in Plymouth upon his return. The main plan was to again detox this man in Broadreach House, Plymouth.
- An array of prescribed medicines which included Morphine sulphate, Olanzapine, Diazepam, Pregabalin, Venlafaxine, Paracetamol and Naproxen.
- Toxicology showed that there was a potentially lethal level of morphine present but due to the time frame in finding the body of this man, the tests carried out could not differentiate between street heroin and morphine that may have derived from street heroin. He had lawful access to morphine based medicines.
- This man would use bad behaviour in order to put pressure upon professionals to get medicine for himself.
- Very supportive and rapid work carried out from drug services to get this man to detox, for example.
- Relevant issues included; Multiple overdoses on prescribed and illicit drugs, suicidal thoughts, physical and sexual abuse when he was child, his sister was raped and murdered abroad, poly drug use. Main risk identified was mental health psychosis from drug use.

**Findings and applying the learning**

- Very good dynamic outreach work employed to try to get this man to continue treatment.

- Treatment summaries upon discharge from treatment of have died to be borne in mind by this treatment provider.
- Overall a fine balance of prescribing against a background of complexity and regular overdoses.

**Drug Related Death 20- Sept 2016**

- 35 year old man who died in RCHT following a drug overdose at his home address in the Wadebridge area 2 day previous.
- Cause of death given as 1a. Severe hypoxic brain injury 1b. Drug and alcohol toxicity. The inquest concluded that this was a drug and alcohol related death.
- Long term drug treatment for 11 years continuous.
- Good communication between GP and Addaction services.
- Alcohol was the drug of choice for this man and he used heroin to deal with alcohol withdrawal.
- Accidental overdose in 2003.
- Diazepam prescription due to severe anxiety and the anxiety manifested in abdominal pain.
- Good friend of this man was looking out for him as he (the friend) had also had drug problems previously. The friend found this man collapsed after the drug overdose and called ambulance. He had gone to see him as they had arranged previously the same day to go out for a drink together. The friend often did this to get this man out of his flat and change of scenery. Complete shock as to why this happened but reinforced the view of the friend that this was an accident and not deliberate.
- Other witnesses saw this man on the day of his death and he was in a good mood.
- Emotional plea from the father of the deceased saying 'I wanted to help but I couldn't- no one told me anything'.

**Findings and applying the learning**

- Contingency plans are to be put in place when a service user does not pick up their medication from the pharmacy, cannot be contacted or where there is cause for concern. This is now being routinely covered when a service user, for example, is first engaged and triaged. An alternative number/ contact details are sought for immediate contact should concerns arise.

3.24 **Drug Related Death 21- Sept 2016 (cross ref DRD 29 in para 3.32 and DRD 30 in para 3.33)**

- 32 year old man who died in supported accommodation in the Falmouth area. This is one of three deaths that occurred in premises owned by the same landlord and a separate but same supported accommodation provider. This death occurred at one premises whilst the other two occurred at another premises in the same area. Initially there were concerns that led to a safeguarding alert. These were investigated in tandem with the DRD process and separate inquests were held. The investigation team concluded that the deaths were not linked through any neglect etc but learning had come from investigating the three cases.
- The cause of death was given as 1a. Acute bronchial pneumonia from hypoxic ischaemic encephalopathy 1b. Morphine toxicity. The inquest concluded that this was a drug related death.
- In drug treatment at death.
- This man succumbed to a heroin overdose at the accommodation and spent the night in the room of a friend who looked after him realising that the man had overdosed. The friend fell asleep and later found the man unresponsive so he administered Naloxone. The alarm was raised and supported accommodation staff administered first aid. The man later died in RCHT.
- A curfew is in place at this premises forbidding residents to stay overnight in each other's rooms. The supported accommodation staff were not aware nor made aware of this overnight stay so could not react to the overdose quicker.
- Naloxone was available at the premises for such incidents but this was utilised too late.

**Findings and applying the learning**

- The naloxone policy and first aid issues have been re-iterated to all residents since this death.
- There is every likelihood that this death could have been avoided through more prompt reaction to the overdose and staff being made aware.

3.25 **Drug Related Death 22- Sept 2016**

- 33 year old woman who died at her home address in the Saltash area.
- The cause of death was given as 1a. Combined toxic effects of Heroin, alcohol and diazepam. The inquest came to an open conclusion.
- In drug and alcohol treatment at death.
- On assessment in 2015 she disclosed childhood repeated rape, mental health issues of anxiety, depression, self-harm and poly drug use including benzodiazepine, alcohol and cannabis. She reported being a regular intravenous injector and had shared injecting equipment in the past. This included allowing others to inject her.
- Several overdoses in the past resulting in hospital admission and neglecting food when using substances.
- History of being in abusive relationships with men.
- Addaction gave this woman a stable environment, and helped her to access other support services and to try and address her anxiety and depression. Appropriate referrals to Adult Safeguarding and CMHT were made, and joint working with probation, housing and WRSAC was in place.
- She was due to enter another residential detox and then go on to secondary residential rehabilitation in the same month that she died. Despite her circumstances, she presented in a positive frame of mind, her plans to access residential treatment and work towards a drug free life suggests that she was someone who was looking forward to the future.
- Alcohol, cannabis, heroin, cocaine, and prescription drugs were found in toxicology.
- Latter medical signs that she was very ill included coughing up blood. This was being addressed by her GP.

**Findings and applying the learning**

- There was a lot of work being done in this case due to the complexity of the subject and her life being in a constant state of instability.
- Addaction and other agencies addressed the below issues;

1. Service users who report that they are concerned for their own safety are either encouraged and/ or supported to contact the police, or if appropriate and necessary Addaction report the concerns to Adult Safeguarding Services
2. Adult/Housing Services for emergency accommodation
3. Explicitly addressed the issue of being injected by peers; including poor technique, hygiene and blood infections, blood borne viruses and overdose
4. If a service user is presenting with coughing up blood, for example, Addaction make a GP appointment or refer them straight to A&E
5. Screening for suicidality or self-harm when the service user is facing an adverse life event, even if they appear to be optimistic about the future.

- Two recommendations came from the review that was carried out by the Cornwall Partnership NHS Foundation Trust as part of the serious incident review; 1. Consultant Psychiatrist and Mental Health Team to review patients notes to review the caseload to ensure that caseload sizes are reduced. 2. Community Mental Health Team at Liskeard had recruitment issues and on-going staff absences. The situation had now improved with increased staffing levels.
- It was identified that the above two factors had contributed to the delay in this woman's assessment and updating of the associated health record.

3.26 **Drug Related Death 23- Sept 2016**

- 27 year old man found deceased at his home address in the Wadebridge area.
- Cause of death given as 1a. Combined toxicity of Zopiclone, alcohol and Methadone with an inquest conclusion that this was a drug and alcohol related death.
- In drug treatment at death.
- Alcohol levels were at potentially toxic but were in combination with prescribed medicines which have previously been seen in cases where they have caused fatalities. Prescribed

methadone was also present lending this case to the synergistic reaction of drugs and alcohol.

- The early evening of the day before the death this man attended his GP to say that his prescription of Zopiclone, Mirtazapine, Gabapentin, Diazepam and Cyclizine had been stolen from his car that day. He was re-issued with a 14 day supply of these drugs.
- A Few months previously this man had made a similar report to his GP that his prescription had been lost. A break away to London to address his addiction in 2016 saw this man also tell a prescribing agency that his medicines had been stolen in a mugging of himself.
- GP suspected that man was selling his prescription but still re-issued the medicines.
- No illicit medicines featured in the toxicology. The GP did consult with shared care practice regarding what to do about stemming the flow of possible diverted medicines.
- Addaction were trying to refer this man into mental health services but he refused to be referred partly because his parents worked in mental health.
- Evidence of intravenous drug use at scene although this did not feature in the toxicology.
- This man had become increasingly distressed since his father had left his mother 2 years previous. Further trauma when his fiancée died in a road traffic collision.
- This man appeared to be medicine dependent who used codeine to self- medicate his anxiety. This was being successfully addressed. All related issues surrounding the codeine were being well communicated between GP and drug treatment teams.
- His last month of life saw him heroin free.
- Father did not believe that the medicines had been stolen. This man described as sometimes being deceptive, was educated and could be manipulative.

**Findings and applying the learning**

- This case has been referred to the Kernow Clinical Commissioning Group to see whether there is any further advice or assistance that can be afforded to GP's in the situation of having to make the judgement of whether a patient is lying set against the clinical need of the patient.
- Family clearly frustrated at the confidentiality afforded to this man although he did expressly request that his family were not involved in his treatment.
- Information sharing protocols are always negotiated between the drug treatment provider and service user at initial assessment.
- The GP in this case had asked for assistance about the medicines re-issue from specialist GP's but the death intervened before a reply was sent back.

3.27 **Drug Related Death 24- Oct 2016**

- 53 year old man who died in a bedroom of the home address of his ex- partner in the Camborne area.
- Cause of death given as 1a. Multiple drug toxicity (Heroin, Alprazolam and Methadone) 2. Mild coronary artery disease. The inquest concluded that this was a drug related death.
- Issues of being overweight, atherosclerosis and an enlarged heart were worsening conditions, prescribed and illicit drugs were abused.
- Evidence from the ex- partner (17 years together) that this man had used heroin for all their relationship and would excessively use all types of drugs.
- This man was expecting to imminently go to prison for drug supply offencesso he turned up at the premises to store his property. He was moved from sleeping in his car into the premises by Police according to the man and was allowed to sleep in a spare room.
- Evidence of heroin and methadone use found in the spare room after deceased had been found.
- Car of this man searched and evidence including heroin found which pointed towards drug dealing.
- Disclosure to the drug team that this man witnessed domestic violence in his home as a child, heavy drinking parents, sexual and physical abuse as a child. His early teenage use of drugs he put down to masking this early trauma.
- Another case where Alprazolam features. This drug can only be prescribed on a private prescription as it is not available on the NHS. There are an increasing number of inquests where toxicology is showing the presence of Alprazolam and this is featuring in some of the deaths in 2017.

**Findings and applying the learning**

- There were a number of risk assessments and recovery plans updated through this man's treatment history which clearly outlined the level of complexity of need.
- His treatment was quite fragmented at times. He had a history of disengaging from treatment which presented the drugs team with a challenge around trying to approach the work systematically via an holistic recovery plan and a continually updated risk assessment.
- The drug team are now working more systematically in putting together the risk assessments and recovery plans of service users with complex needs.
- This man's problems with drug use were in tandem with his business of selling drugs so this was a 'chicken and egg' scenario where the link between him and drugs was also his means of making money and access to drugs. This produces unique and difficult challenges for treatment co-existing with criminal justice issues.

3.28 **Drug Related Death 25- Oct 2016**

- 56 year old man who died at his home address in the Liskeard area.
- Cause of death given as 1a. Ill effects of multiple drugs 2. Right lower lobe pneumonia. The inquest concluded that this was an accidental death.
- This man was not in drug or alcohol treatment.
- Described by his partner who was also his carer that this man 'preferred to live his life in a permanent drowsy state rather than real life'.
- Family history of suicide and this man had tried to take his own life on two separate occasions by overdose. He had also previously thrown himself in front of a car.
- There was mental health team engagement but he was never assessed as serious enough for a section nor any major mental ill health or psychosis.
- Furthermore from witnesses, he seemed to have had an addiction with medication. He would attend the doctor's and almost fabricate illnesses just to get prescribed medication.
- 6 weeks prior to his death he had been referred to hospital for an oesophago-gastroduodenoscopy (OGD) but he did not answer letters and terminated landline calls on the subject so never had the investigatory work done.
- Apart from prescribed medicines at non- fatal levels he did have methadone in his system which was not prescribed to him.

**Findings and applying the learning**

- There is no obvious learning here other than the case highlighting again the dangers of combining prescribed and illicit drugs. It appears that this man's drug use never featured in a treatment environment so he continued to self- medicate with evidence that he was a person who sought out medicines for medical issues that he had or though that he had.
- The case also highlights with others in this report that the combination of drugs with serious medical conditions can have fatal consequences. There is on- going work with General Practice to highlight these issues.

3.29 **Drug Related Death 26- Oct 2016**

- 55 year old man who died within a sleeping bag in the shed of his home address in the Truro area. He had slept in the shed since his marriage had broken down and he had become separated from his wife who still lived in the house.
- The cause of death was given as 1a. Morphine toxicity 2. Hepatic cirrhosis (viral hepatitis B and C).
- The inquest into this case is awaited with a safeguarding process on-going. The inquest is likely to be in 2018.

3.30 **Drug Related Death 27- Oct 2016**

- 21 year old man who died en-route to hospital after reports that he had overdosed at an address in the Penzance area. He had informed his girlfriend that he had taken a lot of

cocaine although other information stated that he had used crack cocaine for the three days prior to his death.
- The cause of death was given as 1a. Cocaine toxicity and the inquest concluded that this was drug related death.
- The cocaine metabolite level in this case was 24 times greater than the lethal range.
- No drug and alcohol treatment history.
- GP history- headache/ migraine and an unexpected death. No history of depression or mental ill health.
- Pathology found no physical issues and that the man was fit and healthy before this fatal overdose.

**Findings and applying the learning**

- No specific learning has become apparent from this case although the deceased is said to have stated that he was becoming dependent upon cocaine according to his girlfriend. He appears not to have sought treatment.

3.31 **Drug Related Death 28- Oct 2016**

- 40 year old man pronounced dead at RCHT but who had overdosed on heroin earlier the same day in the Newquay area at his home address. He had been given basic life support at home by family and 105 minutes of advanced life support by paramedics.
- Cause of death given as 1a. Heroin toxicity and the inquest concluded that this was a drug related death.
- No drug and alcohol treatment with Addaction but this man was known by family to be an habitual heroin user.
- This man bought heroin on the day of his death and injected it in the bathroom of his home with others aware that he was doing this.
- Toxicological findings reported that the proportion of free morphine to total morphine indicated that this man died within 3 hours of using it. Whilst witnesses support that, it appears that the heroin used in this case was either of a purity that this man was not used to and/ or that he used a lot of heroin on the day in question.

**Findings and applying the learning**

- This case highlights the 'Russian Roulette' nature of using heroin, particularly intravenously. No user is aware of the purity of the heroin prior to use and, although this man had witnesses and support after the use of the heroin, he had consumed too much or was not able to tolerate what amount of heroin he used with fatal consequences.
- Advice to anyone who chooses to use heroin is that they have some support mechanism in place in case things go wrong. Despite a long period of basic and advanced life support after the drugs were used, this was sadly insufficient to save him. An early intervention of naloxone would possibly have made a difference noting here that this man was not in drug treatment.

3.32 **Drug Related Death 29- Oct 2016 (cross ref DRD 21 in para 3.24 and DRD 30 in para 3.33)**

- 47 year old man who died in his room at supported accommodation in the Falmouth area.
- Cause of death given as 1a. Central nervous system drug toxicity 2. Cardiomegaly (enlarged heart). The inquest concluded that this was a drug related death.
- In August 2016 he was diagnosed with leukoencephalopathic changes due to exposure to drug abuse (methadone and heroin). This is the vanishing of white matter in the brain and can be brought on by exposure to drugs of abuse.
- This man was in drug treatment with Addaction and they were actively dealing with this diagnosis by trying to gradually reduce and stop his methadone prescription. Stopping the prescription without gradual reduction would have been also counter- productive with the risks of this man going into withdrawal and possibly supplementing with street drugs.
- This man was not a well man and also suffered from obesity, asthma, hypertension, type 2 diabetes with a reported 20 year drug and alcohol history.
- Family described this man as a bit of a loner. He was last seen going to his room about three days previous to being found deceased. It was not unusual for this man to not be

seen for days as he used to take himself off without letting the accommodation staff know. He also sold The Big Issue and would sell in different towns staying in those areas sometimes.

**Findings and applying the learning**

- There is on- going work in relation to the issue of heart arrhythmia and the impact of various drugs on that. That may have been one issue at play with this man although he did suffer from a range of conditions that were potentially made worse by his use of drugs.
- This and the linked cases have seen improvements to service delivery from the supported accommodation, landlord and drug treatment provider. These are summarised in the case below ( DRD 30 para 3.33).

3.33 **Drug Related Death 30- Nov 2016 (cross ref DRD 21 in para 3.24 and DRD 29 in para 3.32)**

- 30 year old woman who died in a communal bathroom of her supported accommodation in the Falmouth area.
- Cause of death was given as 1a. Multiple drug toxicity and the inquest concluded that this was a drug and alcohol related death.
- This woman was in drug treatment at death but was not on a substitute prescription for her opiate dependence.
- Heroin overdose in combination with alcohol.
- Early trauma of sexual assault aged 17. Drug usage started after this assault.
- According to family this woman 'ping- ponged' in and out of relationships with the 'wrong types' including one man who was injecting her with drugs when she was younger.
- The actual taking of the drugs by this woman and the prevention of it on these premises was never a reality but there was an inordinate amount of time after she died to when she was found- 6 days. The bulk of this review and associated learning has come from what agencies are now doing to avoid a repeat of the aftermath. This learning will also make it harder for residents to overdose on the premises although this is not impossible.
- Non- attendance at treatment appointments, reluctance to disclose personal matters, difficulty in contacting her and other issues made this case a difficult one to keep in continuous treatment.
- This woman responded far better to treatment in a residential setting and was easily swayed from her treatment when she was community based with strong characters around her who also used drugs and alcohol.
- Communication issues between treatment and supported accommodation due to this woman's wish for confidentiality.

**Findings and applying the learning**

- A lot of work has been done by the supported accommodation provider particularly in relation to; better inter- agency and client communication, service level agreements between landlord and accommodation support, CCTV improvements, first aid and naloxone training of all staff, naloxone being installed on all landings and main office, dedicated Addaction worker now with these premises spending allocated days at the premises.

3.34 **Drug Related Death 31- Dec 2016**

- 31 year old man who died at his home address in the St Austell area.
- This man was found deceased beside another man who died and subject of the case in para 3.35 below.
- Very little detail known about these cases as at the writing of this report but toxicology did show a large amount and wide range of prescription medicines some of which might have been illicitly sourced.
- The inquest in this case is awaited and will be set in 2018.

3.35 **Drug Related Death 32- Dec 2016**

- 22 year old man from the Plymouth area who was found deceased in the same premises and at the same time as the case above in para 3.34.
- As per the above case very little detail known about these cases as at the writing of this report but toxicology did show a large amount and wide range of prescription medicines some of which might have been illicitly sourced.
- The inquest in this case is awaited and will be set in 2018.

## 4. SYNOPSIS 2016 DRUG RELATED DEATHS

### 4.1 Male

| | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| Total Drug Related Deaths | 18 | 17 | **24** | **32** |
| **Males** | 17 (94%) | 15 (88%) | 21 (87%) | **25 (78%)** |
| Mean age | 35 | 40 | 40 | **40** |
| Oldest | 58 (20's- 5, 30's- 7, 40's- 2, 50's- 3) | 61 (20's- 2, 30's- 6, 40's- 5, 50's- 1, 60's- 1) | 63 (20's- 4, 30's- 7, 40's- 5, 50's- 3, 60's- 2) | **62** (20's- 6, 30's- 6, 40's- 7, 50's-5, 60's- 1) |
| Youngest | 2 x 21 | 27 | 2 x 25 | **21** |
| Males – Heroin/ Morphine | 9 x Heroin, 2 x Morphine | 10 x heroin | 12 x Heroin 1 x Morphine | **14 x Heroin 2 x Morphine** |
| Males –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 in combination alcohol, 1 in combination heroin) & (3 prescribed- 1 diabetes related, 2 in combination heroin) | **5 (4 prescribed & 1 illicit- all in combination with other drugs/ alcohol)** |
| Males – other controlled drug | 1 x DHC, 1 x MDMA, 1 x Oxycodone & Fentanyl | 0 | 1 x MDMA, 1 x NPS- New Psychoactive Substance, 1 x Buprenorphine (Subutex) | **2 x Cocaine, 1 x NPS, 1 x Amphetamine** |
| Males in Treatment | 6 drugs | 14 (9 drugs and 3 alcohol) | 10 (9 drugs and 1 alcohol) | **12 drugs** |
| Males in treatment within 6 months of death or treatment referred/offered but never commenced (New category for 2014) | 2 drugs | 2 (1 drugs and 1 alcohol) | 3 (2 drugs and 1 alcohol) | **1 Drugs** |

**4.2 Female**

| | 2013 | 2014 | 2015 | **2016** |
|---|---|---|---|---|
| Total Drug Related Deaths | 18 | 15 | 24 | **32** |
| **Females** | 1 (6%) | 2 (12%) | 3 (13%) | **7** |
| Mean age | 58 | 32 | 40 | **32** |
| Oldest | 58 | 34 | 49 | **55** |
| Youngest | 58 | 30 | 32 | **15 months** |
| Females –Heroin/ Morphine | 1 | 1 x Heroin + NPS + medical issues | 1 (awaiting inquest but medicine containing morphine was prescribed) | **4 x Heroin** |
| F/males-Methadone | 0 | 1 x Fatal levels of tramadol & pregabalin in combination with illicit methadone | 0 | **0** |
| Females - other c/drug | 0 | 0 | 1 x combination of MDMA and medical issues<br>1 x MDMA and multiple prescribed meds | **1 x Fentanyl, 1 x NPS, 1 x multiple combination of medicines** |
| Females in Treatment | 0 | 1 | 0 | **2** |

4.3 Examination of the venues where these deaths have occurred reveals the following;

- Home address- 17
- Home address of another- 5
- Hospital after an overdose at home address- 5
- Supported accommodation- 3
- Ambulance after an overdose when of no fixed abode-1
- Public toilets- 1

Overwhelmingly and even more so than in 2015 there is bias towards the home address or home address of another being the premises where most drug related deaths take place (30 out of the 32 if we consider the supported accommodation as being a home address for the time being). The key to making a difference here is whether there are witnesses at the home address when the drug taking occurs or whether the overdose and death is a lone venture.

4.4 A breakdown of which area these deaths occurred in, denoted by the nearest town is as follows:

- St Austell- 7
- Newquay- 5
- Penzance- 4
- Falmouth- 3
- Truro- 2
- Wadebridge- 2
- Bodmin- 1
- Bude- 1
- Camborne- 1
- Hayle- 1
- Liskeard- 1
- Penryn- 1

- Redruth-1
- Saltash- 1
- Torpoint- 1

4.5 The average age of males dying from a drug related death during 2016 has remained at 40 for the third consecutive year. Males represent 78% of the total number of deaths (25 out of the total of 32) which is down from 2015 at 88% (21 out of the total 24). Female deaths have risen to 7 for 2016 from 3 in 2015. Whilst one of these deaths is of a young child with the dynamics of the death being completely different from the other six deaths, the fact that female deaths are on the rise is of note. Female deaths hit seven in number last in 2012 and have never been seen since DAAT records began in 1999.

4.6 Poly drug use remains a concern again this year. There are only three deaths attributable to a sole agent being involved that agent being cocaine in two cases and Fentanyl in another case that has yet to be heard at inquest. All other cases have at least one other contributory substance- drug and/ or alcohol. Several cases involve multiple drugs with or without alcohol. Alcohol has significantly featured in 2 of this period's case studies. The rise in cocaine use across Cornwall is manifesting in drug related deaths. Although cocaine prevalence has only recently been charted, outside of it being an actual cause of death, the last two years and going forward to 2017 have seen increased incidence of cocaine I toxicology. This links up with what some service users are reporting and self- disclosing use of cocaine as well as the intelligence picture from various agencies confirming this. This new dynamic is adding to the complexity of some service users as well as proving to be challenging for those that prescribe substitute medication.

4.7 Still of concern is the number of deaths where the drug/ alcohol intoxication has been witnessed and/ or the fatal consequences have also been witnessed as they happen. This has featured in at least 16 of the 32 cases. There will inevitably be more cases where the intoxication and perhaps death has been witnessed due to the illegality surrounding drug use and some people not wanting to make emergency services aware or be present when they attend. This can be no more apparent than when a scene of a death is completely devoid of drugs and paraphernalia when emergency services attend. These statistics have been taken forward and used in the constant education and advice of people from all walks of life. The overdose awareness and first aid is a staple of treatment and is and will remain a feature of initiatives such as International Overdose Awareness Day (31st August each year).

4.8 The prevalence of mental health issues is increasing as shown by the number of issues apparent in these cases. 19 of the 32 deaths featured anti- depressant medicines in toxicology where some of these cases also featured Diazepam. 20 cases featured Diazepam some of which overlap the anti- depressant cases. The presence of the medicines is shown below with some cases featuring more than one medicine;

- Sertraline- 6
- Amitriptyline- 8
- Diazepam- 20
- Mirtazapine- 11

4.9 South Western Ambulance Service NHS Foundation Trust data has been received for the months of January 2016 to November 2016 inclusive. This shows a total of 259 administrations of naloxone by SWAST staff in Cornwall which is an average of 23.5 per month. This is an increase of over 5 per month compared to the average monthly naloxone administrations in 2015. By comparison to Devon, Dorset and Somerset their total SWAST naloxone administrations and monthly averages in brackets respectively are; 639 (58), 354 (32) and 153 (14). These naloxone administrations are recorded onto the SWAST electronic database against certain medical conditions- Asthma, COPD, Fall- non injury, poisoning opiate and so on. As such, and without being able to interrogate the medical record of each case, there may be some element of mis- recording and/or dual recording of naloxone in the relevant cases. For example, the records show one case where someone with 'COPD' received naloxone, another where the medical issue in 7 cases was 'overdose non- opiate' and another under the medical condition of 'stroke'.

## 5. PROACTIVE MEASURES /INITIATIVES / PROGRESS 2016

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

This panel of local experts in their field has continued to provide great advice and support for the investigation and prevention of drug related deaths. Cases are reviewed by a panel of Police, Addaction, specialist service providers, mental health services etc. with reports being available from a range of services including prescribing, toxicology and pathology. 2016 saw the introduction of a 'spin off' group named the Cornwall Pain Medicines Forum and this was set up in light of, amongst other things, more DRD cases involving medicines prescribed for pain and other conditions. The group consists of experts from Pain and Psychiatric medicine at Royal Cornwall Hospital Treliske, Shared Care General Practice, Specialist drug and alcohol prescribing and the Head of Prescribing and Medicines Optimisation at NHS Kernow. Going forward into 2017 and 2018 this group will be merged more into the DRD Review Panel with themed meetings and more use of these experts with the Cornwall cases.

5.2 **Peninsula Drug Related Death Review Panel**

This bi-annual meeting continues to spread best practice and monitor peninsular trends and incidents. The process does, however, need to be re-invigorated and it is envisioned that going forward into 2017 and 2018 will see attempts to integrate this meeting into the Peninsular Drug Strategy Group. This will give the work of the Review Panel higher profile across the Peninsular as well as more equitable input from agencies.

5.3 **Reducing Drug Related Deaths Conference**

This conference was not held in 2016 for financial reasons but, as at the writing of this report, the 2017 conference has taken place and will be fully reported on in the 2017 annual report. In summary though, the 2017 conference was very well received with a range of speakers covering topics such as adverse childhood experience, opiate prescribing and alternative views on current drug legislation.

5.4 **Acorn Service of Remembrance**

Saturday 23rd September 2016 saw the third consecutive service to be held in Cornwall seeking to remember those that have died from a substance misuse-related death and for those family and friends left behind. The service incorporated a combination of remembrance and recovery themes. Personal reflections, music and a focussed service on some of the unique issues presented when a death of this kind occurs further raised awareness as well being a poignant source of remembrance. This year saw the service being held in conjunction with and at the end of the Addaction Hope Festival in Boscawen Park, Truro. Although this service was a success it was not as well attended as previous years due to the event having to be re-scheduled due to bad weather and the day of the service also saw torrential rain. Nevertheless 2016 saw 32 other reasons why this service should continue and, at the writing of this report, the service was held in 2017 at Truro Cathedral. This will be fully reported on in the 2017 annual report.

**5.5 Naloxone Program**

The DAAT has been instrumental in implementing more widely the use of naloxone in line with the guidance contained within the Home Office document published in November 2015 entitled 'Widening the availability of naloxone'. This document can be viewed at; https://www.gov.uk/government/publications/widening-the-availability-of-naloxone

Cornwall was one of the very first areas in England to start using naloxone as part of the strategy to prevent drug related deaths.

The program was started in December 2009 as a small pilot in a supported housing project where there had been a number of deaths. Staff, volunteers and residents were trained in its use. This was very different to a number of areas, where it was first introduced in treatment services alone. A few other housing projects came on board over the following few years and between December 2009 and March 2016, 25 lives were saved using naloxone in such settings.

From April 2014 it was introduced across community drug services (currently provided by Addaction). All of the Addaction staff and volunteers and many of the individuals accessing the treatment service have been provided with a supply and trained in its use. As of October 2017 a total of 1021 kits have been given out to those using treatment services. This includes the kits that have been re-dispensed to individuals due to being used or the kit expiring. Training is either delivered or refreshed whenever a new kit is issued.

In 2015/16, it was rolled out across all supported housing projects and a further 13 lives were saved in the first year of this complete roll out from April 2016 to March 2017. To date over 370 people have been trained in such settings, including staff, volunteers and residents.

5.6 **Serious Incidents Requiring Investigation (SIRI's)**

There are many ways now of SIRIS's being made known to services and equally ways for these to be reported to relevant bodies. The relevant bodies include the Cornwall Controlled Drug Local Intelligence Network (CDLIN), the Cornwall DAAT Governance Group and the Critical Incident Review Group within Addaction reporting internally and also to HM Coroners inquests. Since the drug and alcohol treatment contract was awarded to Addaction in April 2013 there has been steady and progressive efficiency of scrutiny and reporting by Addaction. The summary and organisational learning section of their reports particularly now assists the coronial process.

## 6. OTHER DEATHS INCLUDING ALCOHOL

6.1 The DAAT does not routinely review alcohol deaths but it does attend certain inquests at the request of HM Coroner for Cornwall, where the DAAT may be requested to review certain aspects of treatment or alcohol detox. It will also undertake Preventing Future Death directions on behalf of HM Coroner. There have been no requests of this type during the 2016 period. The deaths involving alcohol as a contributory factor in a drug related death have been described in previous sections. There have been at least 28 deaths of Addaction service users who have been in alcohol treatment and have died in circumstances that are either directly alcohol related and/ or from the complications from a long term use of alcohol. There will be many more deaths attributable to alcohol use where there is not a treatment history present. The 28 cases, however, are notified to the Cornwall DAAT as there is an on-going investigation that may result in an inquest. Other cases where, for example, a death certificate can be issued by a GP and so negating an inquest may not get notified to the DAAT. For these, and other reasons, the recording of alcohol related deaths cannot be deemed accurate in the same way the recording of drug related deaths are.

6.2 In every reporting period, a number of deaths originally suspected as being drug related or involving a service user are examined, and do not get recorded as a drug related death due to toxicological or pathological update for instance. There are, however, notable deaths among these, which require further action, or identify concerns sufficient enough that other agencies need to get involved. These have been investigated as thoroughly as any of the other deaths registered as a drug related death. It is only the identified drug related deaths that make it to this report but the DAAT is very much involved in identifying deaths which fall outside of the standard definition for a drug related death but which may have some future bearing on health and wellbeing of the Cornwall population as a whole. This can involve deaths where new psychoactive drugs are involved, new trends in drug taking or practice and a range of related themes.

## 7. CONCLUSION

7.1 This report highlights how Cornwall and the DAAT strive to make the monitoring and investigation of the deaths as accurate as possible. This comes only with very good working relationships with HM Coroner and her staff, Devon and Cornwall Police, Addaction, Bosence Farm and of other interested parties that feed into the process. The DAAT is committed to forging ever stronger links with current partners in seeking out new possibilities to prevent future deaths. These new or improved relationships often come about due to case specific working.

7.2 The DAAT has maintained accurate statistics on all drug related deaths within Cornwall and Isles of Scilly for the past 18 years commencing in 1999.

7.3 At the time of preparing this report the maximum number of drug related deaths for Cornwall & IOS throughout 2016 is 32, which represents an increase of 25% from 2015 (24 deaths to 32). The main findings in this report and those to be taken forward are;

- Heroin deaths have risen for the fourth consecutive year and have reached an all-time high since DAAT records began in 1999.

- The vast majority of deaths have occurred in the home address of the deceased or the home address of another (30 out of 32).
- The number of cases featuring cocaine in toxicology has risen with 2 cases where cocaine has been the cause of the death and a further 8 where it has been a contributory factor.
- 20 cases feature the benzodiazepine drug Diazepam. All cases have this in combination with one or more other drugs and no cases where Diazepam is the cause of death per se but worryingly present in almost two thirds of the deaths.
- Likewise almost two thirds (19 cases) feature anti-depressant medicines and others with anti- psychotic medicines. Whilst these are predominantly prescribed medicine cases it does show the prevalence of mental health issues in these deaths.
- Adverse childhood experiences feature in the treatment histories as disclosed by the subjects. Whilst it is early days as far as fully scoping the extent of these experiences, these cases flag up a number of people who have reacted to their individual experience with fatal drug and/ or alcohol use.
- A high number of cases where the subjects have used drugs with serious medical conditions.
- At least half of the cases have involved another being present at the scene of the death or in close proximity. This raises again the issue of overdose awareness and first aid. Intoxication of the other(s) present has had a detrimental effect upon the result of the case so education and advice continue to be a most important part of drug related death prevention.
- Internet sourced medicines and drugs feature in a growing number of cases. This has shown also that there is a need for GP's, for example, to be more aware of this growing market place for a vast range of drugs.
- Closer working with supported accommodation providers, safeguarding teams and multi- agency forums (eg. Cornwall Suicide surveillance group) has been shown to improve services.
- 29 of the 32 cases involve either a main drug in combination with other drugs/ alcohol or a synergistic action of all drugs present to cause the death. Only 3 cases have one drug present which has caused the death.
- Going forward work is being done and further needs to be done in relation to those with serious medical illnesses who also use drugs, overuse of prescription medicines and also more scrutiny of the possible over- prescription of medicines.

7.4 The anonymised case summaries in section 4 have been written as comprehensively as possible to provide the relevant information. Follow up comments are invited and this document seeks to not only report what has happened during the reporting year, but to also look at preventative measures as a priority.

7.5 The DAAT is also concerned regarding alcohol deaths and, although not required to record such deaths, the DAAT does monitor all sudden unnatural deaths where alcohol affects motor or cognitive functions. The DAAT facilitates movement of information and documents between the coronial process and treatment, for example, where an alcohol death has occurred and/ or an alcohol treatment client is involved. It can be seen from the synopsis section that there is significant alcohol presence in 2 of the drug related deaths. More of the deaths include alcohol at lower levels but of concern due to the synergistic effects.

7.6 The DAAT and other agencies seek to put in place preventative measures and continue to raise awareness of a range of issues around drug related death. A lot of information has come from the record numbers of deaths this year and the direct effect of these deaths upon families and friends is all too obvious. To combine the information from these deaths, the associated learning and to work with the families, friends and various partner agencies in order to prevent future deaths is the inherent duty of the Cornwall DAAT. That duty will continue to be executed in 2017 for then the families and friends of these subjects may feel that their loved ones have not died in vain and have contributed to the ideal of preventing drug related deaths.

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# APPENDIX A

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