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 2015 to 31st December 2015

EXECUTIVE SUMMARY

This is the thirteenth 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.

The 2015 report is based on the period from 1st January 2015 to 31st December 2015 inclusive. The previous two years reports have been based on the financial years of 2013/ 14 and 2014/15. The 2015 report re-establishes the calendar year reporting and back record converts the two previous financial years' data into chronological calendar years. This is illustrated on all tables hereinafter.

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'.*

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;

	2012		2013		2014		2015	
Total drug related deaths	**25**		**18**		**17**		**23***	
Gender *(male –M, female – F)*	18 M	7 F	17 M	1 F	15 M	2 F	**20 M**	**3 F**
% Increase or Reduction	52% increase from 2011		28% decrease from 2012		6% decrease from 2013		**26% increase from 2014**	
Heroin / Morphine present	8		12 *(9 Heroin & 3 Morphine)*		11		**14 *(12 Heroin & 2 Morphine)***	
Methadone present	11		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***	
Other controlled drug	2 Mephedrone 1 cocaine		1 x DHC 1 x MDMA 1 x prescribed Fentanyl & Oxycodone		0		**3 x MDMA *(includes 1 x poly drug)*** **1 x Subutex** **1 x NPS**	
Underlying cause drug related (not overdose) eg. Long history of drug use. New category for 2014	Not recorded		Not recorded		1		**3**	
RTA/Suicide (+ CD as included above)	1 x RTC 5 x sus suicide as above				0		**0**	

***** As at the writing of this report, one suspected drug related death cannot be included in the final figures as the toxicological report and pathology report are still awaited over three months after the death. In the interests of accuracy and timeliness the 2015 report is submitted noting that the final total of deaths during this period may rise to 24.

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 rise in drug related deaths is mirrored across the Devon and Cornwall Peninsula with a rise of 26% for 2015 as compared to 2014 in Cornwall alone.

Heroin deaths have risen slightly from 11 deaths in 2014 to 12 for 2015. Whilst all of these deaths involve poly drug use to a greater or lesser degree, 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.

4 cases involve significant levels of alcohol being present in the toxicology. Whilst these cases also involve at least one other drug, there is a case to be answered that 3 of the cases could have been independently fatal when considering only the presence of the alcohol.
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.

It was reported in the financial year 2014/ 15 report that 6 out of the 18 cases involved the neuropathic pain inhibitor and epileptic drug Pregabalin (1 case involved Gabapentin- a close relative of Pregabalin). The growing prevalence of this drug in drug related deaths is in line with a national trend where the drug appears to be a preferred choice of a cohort of heroin users who, amongst other factors, have had a recent history of being in prison. The calendar year 2015 report, however, finds that out of the 23 deaths, 2 deaths involve prescribed Pregabalin and another involves Gabapentin. These three deaths, however, involve Pregabalin and Gabapentin at their therapeutic range so whilst there may have been some synergistic effect, these deaths have been caused by much larger doses of other drugs.

Whilst the 2015 deaths show a lower number of cases where there have been witnesses present who have either not responded to the situation effectively, compassionately and/ or contacted the ambulance soon enough, there remains a concern that people at these traumatic scenes need further education and awareness training. The key to this is to be able to reach out to these people and offer such assistance. As in previous years, the suspected reality is that more of this years' cases have been witnessed so increasing the level of concern.

This year has again seen cases involving high numbers of drug and alcohol service users but not to the same level as the financial year 2014/ 15 where almost all of the deaths involved someone with a drug and alcohol treatment history. 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. As a further comparison, the calendar year 2014 figures show that, of the 17 deaths, 15 had a link to treatment at death or within 6 months.

In varying degrees a proportion of the cases have seen scrutiny of the working relationship between mental health services and drug/ alcohol treatment. The overlap between those presenting with drug and alcohol issues and mental health issues appears to be of greater significance and the various agencies involved are working towards a more integrated approach. Some cases have involved those who fall through the gaps in services by the nature of their respective issues but also by what a service expects of its' service users. An example of

this is where a man is recommended for mental health assessment and he has a drug and/ or alcohol problem. His intoxication can lead him to never attending an assessment or, if he attends intoxicated, the assessment cannot take place. The cycle then continues. Some mental health issues manifest when drugs and alcohol enter the equation and some drugs and alcohol mask mental health symptoms. There are many complex issues that involve a multi- agency approach and this is an area where further work is a necessity.

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1. INTRODUCTION

1.1 This is the thirteenth 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 2015 report is based on the period from 1st January 2015 to 31st December 2015 inclusive. The previous two years reports have been based on the financial years of 2013/ 14 and 2014/15. The 2015 report re-establishes the calendar year reporting and back record converts the two previous financial years' data into chronological calendar years. This is illustrated on all tables hereinafter.

1.3 The 2015 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 2015

2.1 This current report incorporates all reported suspected drug related deaths throughout Cornwall & IOS for 2015 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 2015 together with a breakdown of the main agents involved. Comparative figures for 2014, 2013, and 2012 are shown alongside:

	2012		2013		2014		2015	
Total drug related deaths	**25**		**18**		**17**		**23***	
Gender *(male –M, female – F)*	18 M	7 F	17 M	1 F	15 M	2 F	**20 M**	**3 F**
% Increase or Reduction	52% increase from 2011		28% decrease from 2012		6% decrease from 2013		**26% increase from 2014**	
Heroin / Morphine present	8		12 (9 heroin)		11		**14 (12 heroin & 2 morphine)**	
Methadone present	11		7 (5 not prescribed)		6 (2 not prescribed)		**5 (2 not prescribed)**	
Other controlled drug and other	2 Mephedrone 1 cocaine		1 x Dihydrocodeine, 1 x prescribed Oxycocdone & Fentanyl		3 of the 17 involve meds such as Pregabalin & Tramadol		**3 x MDMA (2 significant levels, 1 Poly drug), 1 x NPS**	
RTA/Suicide (+ CD as included above)	1 x RTC 5 x sus suicide as above		1 x suicide		0		**0**	

***** As at the writing of this report, one suspected drug related death cannot be included in the final figures as the toxicological report and pathology report are still awaited over three months after the death. In the interests of accuracy and timeliness the 2015 report is submitted noting that the final total of deaths during this period may be 24.

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. 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 slightly risen to 12 deaths. Some of the heroin deaths involve other drugs and/ or alcohol but the presence of the heroin in these 12 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 as may be seen in the year on year comparison chart in Appendix A. Further analysis of the deaths involving heroin can be found on page 17 in the synopsis section.

2.5 Deaths from methadone toxicity (or where it has been implicated in death) have seen a slight decrease in 2015 from 6 to 5 although this figure needs some explanation. Of those 5 cases, 3 cases involved the person dying having been lawfully prescribed methadone whilst the other 2 cases involved the person having taken methadone from an illicit source. Further explanation of the deaths where methadone has been present can be found in the synopsis section on page 17.

2.6 In the 2014/ 15 financial year report it was reported that the numbers of those dying from a drug related death whilst in current drug treatment had hardly changed in the last 4 years of surveillance - 2010 (5), 2011 (5), 2012 (6), 2013/14 (5). The figure regarding the 2014/15 period saw a significant difference- 8 in drug treatment at death and a further 3 in alcohol treatment at death. The 2015 report seeks to consolidate the 2 years where financial year reporting took precedence. The below table takes the number in treatment figures from the financial year reports of 2013/ 14 and 2014/ 15 and puts them in calendar years.

	2013	2014	2015
Total drug related deaths (cases in treatment or within 6 months of treatment)	**18 (8)**	**17 (15)**	**23 (13)**
In current drug treatment	6	10	**9**
Died within 6 months of leaving drug treatment	2	1	**2**
In current alcohol treatment	0	3	**1**
Died within 6 months of leaving alcohol treatment	0	1	**1**
Not known to treatment	10	2	**10**

3. BRIEF CIRCUMSTANCES/CASE STUDIES 2014/15

3.1 Some of the 2015 suspected drug related deaths 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 23 drug related deaths are now briefly outlined below.

3.4 **Drug Related Death 1 – Jan 2015**

- 33 year old female who was hospitalised during the early hours of New Years Day 2015 and died on 5th January 2015 at RCHT Truro
- She had been staying in the Porthleven area with her husband and friends for the Christmas and New Year period.
- She had been suffering from undiagnosed debilitating headaches for 6 months and she suffered one of these headaches on the evening of New Years Eve.
- She consumed MDMA (ecstasy) and possibly some cocaine with friends then retired to bed due to the severity of her headache. She stopped breathing at the scene and a combination of CPR and ambulance attention was able to keep her alive until she was hospitalised.
- Inquest narrative determination of 'the combined effects of natural causes and drug use'. The cause of death was given as 1a. Hypoxic encephalopathy 1b. Cardiac arrest 1c. Myocarditis and amphetamine use
- Insufficient blood sample to enable a toxicological screen from drugs but witness testimony supports illicit drug use on New Years Eve

Findings and applying the learning

- Although there was deliberation over the exact cause of death in this case the pathologist commented that there was a likely scenario of systemic viral underlying infection which worsened the headaches in combination with MDMA.
- There were few learning opportunities here. The illicit drug use making the underlying medical issues worse was highlighted as an obvious factor to be removed where possible in future cases.

3.5 **Drug Related Death 2 – Jan 2015**

- 32 year old male who died as a result of a fatal heroin overdose in public toilets in Bodmin. He also had near toxic levels of alcohol in combination with the heroin with Police reporting a huge intake of alcohol by this man prior to death.
- Inquest determination of a drug and alcohol related death with a cause of death given as poly drug toxicity.
- A regular service user within drug and alcohol treatment who had dropped out of alcohol treatment with Addaction a month before his death. Although engaged in alcohol treatment in the latter part of his life, he had a long drug history and associated treatment,
- A recent move to the Bodmin area from another Cornish town meant that he lost some contact with the treatment team as he did not leave contact details. Nevertheless, Addaction keyworkers tracked him down but he did not re-engage with services in the last month of his life.
- Residential detox offered to this man several times but it was always declined by him.

- Previous overdoses and some of them in the same location as his ultimate death. These previous incidents were treated with ambulance attendance and hospitalisation, for example, so they did feature in his treatment.

Findings and applying the learning

- A long term drug and alcohol client who was well aware of the risks involved with combining alcohol with drugs (particularly opiates).
- Addaction are looking at the situations where clients disengage prematurely from treatment and/ or where contact could be improved for a number of reasons. In this case, the keyworkers involved undertook to seek out this man when he disengaged from treatment and did re-establish contact with him. He did not respond to their requests to attend appointments and resume treatment but he had the opportunity to.

3.6 **Drug Related Death 3 – Feb 2015**

- 57 year old man who died at the premises of another in the Newquay area after having been put to bed to 'sleep off' an intoxication of methadone and alcohol.
- Inquest awaited but toxicological examination has concluded that this man had a potentially fatal use of methadone.
- Long drug and alcohol history plus an associated long treatment history- this client received information on the risks of combining alcohol with opiates
- Risky drinking behaviour combining alcohol with illicitly sourced methadone. A man known to local Police to be a big drinker.
- The fatal combination of alcohol with methadone appears to have been witnessed by 2 friends who put him to bed to 'sleep it off'.
- No one appears to have been available to monitor and care for this man after he became intoxicated.
- This client was in a period of stress with eviction looming and criminal justice issues on-going.

Findings and applying the learning

- This case is another example where an overdose has been witnessed and the person overdosing has been left alone prior to dying.
- This years 'overdose prevention' week will concentrate on the care and awareness of those in overdose.
- Despite pressures in this mans' life, he had assistance from a range of people and services. Subject to coronial scrutiny and conclusion this appears to have been a tragic accident linked to alcohol and illicit drug use.

3.7 **Drug Related Death 4 – Feb 2015**

- 43 year old man who was found at his home address in the Penzance area. He was alone and in a state of collapse from a heroin overdose. Witness attempted CPR when the man was found not breathing. A few hours prior to him being found there had been a number of witnesses who saw him injecting heroin.
- Inquest awaited but toxicological examination concludes that there is a potentially fatal misuse of heroin apparent in combination with prescription gabapentin and illicitly sourced diazepam.
- This is another case where the person taking the drugs, overdosing and dying has been witnessed to take the drugs and yet be found alone with no apparent monitoring and care.
- Long history of client drug and alcohol use with self-reported cannabis, amphetamines and hallucinogens use from the age of 15 and using heroin from the age of 26.
- Periods of low tolerance to opiate drugs due to prison and treatment episodes.
- Client with complex issues including being disruptive in treatment. This included intimidation, use of illegal drugs, gambling and non-conformity to rules.
- Treatment services willing to take back client despite the issues in the previous bullet point.

Findings and applying the learning

- There is a need within Cornwall for residential treatment that caters for this type of client where the client has yet to stabilise sufficiently to integrate into abstinent based

treatment locations. It is noted here, however, that treatment facilities do need to care for all of their clients and be aware that one client can disrupt the others.

- It appears that this man was willing to be treated despite his behaviour and was given the opportunity to re-attend both a detox facility and a second stage rehabilitation facility after various qualifying periods.
- This man was in the process of re-engaging with Addaction after one such period of having to leave a facility due to his behaviour.
- The problem of aftercare in overdose is present in this case and another program of awareness and education is needed in Cornwall. Whilst this is an on-going process, the number of deaths featuring these preventable situations is unacceptable.

3.8 **Drug Related Death 5 – Mar 2015**

- 47 year old male found deceased and alone at his home address in the Newquay area.
- Inquest awaited but toxicological examination concludes that, although the levels of some drugs (heroin and amphetamine) are not high, they could be fatal in combination with other therapeutic drugs found in his system.
- Primarily an alcohol client who appears to have died from a drug related death pending the findings of HM Coroner at inquest.
- Impaired liver function of this man with cirrhosis caused by heavy alcohol use over the years combined with poly drug use (prescribed and illegal).
- Poor engagement with drug/ alcohol services in the last 2 years of his life.
- Attempts by Addaction staff to engage with this man by using contacts within pharmacy and GP surgery.
- The retention of clients in treatment is a perennial problem and this case shows how a client can have a long treatment history yet still retain multiple risks which can at any time prove fatal.
- Further reporting is awaited in this case to investigate further.

3.9 **Drug Related Death 6 – Apr 2015**

- 32 male with a history of illicit drug use who died at West Cornwall Hospital, Penzance after running from the scene of a violent crime where he had been one of the perpetrators and collapsing.
- Whilst he displayed multiple bruises and abrasions, no definitive cause of death could be deduced for this male. Officially the cause of death was unascertained but there was a possible suggestive link of the male being under the influence of methadone and heroin.
- The Assistant Coroner delivered an open determination.

Findings and applying the learning

- There was deliberation over the cause of death with the known facts that the toxicological screen had found methadone and heroin in the males system. One scenario discussed was the combined effects of methadone and heroin with the stress of the incident (crime scene). This was not officially registered, however, as it was not usual but may have been present at this unusual scenario.
- No obvious learning was taken from this case or inquest. It presented a unique set of circumstances which were unlikely to reoccur soon.

3.10 **Drug Related Death 7 – Apr 2015**

- 63 year old man who was in drug treatment at death but who also had alcohol dependency.
- He died in RCHT Truro after taking an overdose of heroin in public toilets at Truro.
- A friend had witnessed the deceased go to the toilets to use heroin and after the deceased did not return, the friend located him, administered CPR and called an ambulance. Death was the following day in hospital.
- Long list of non- attendance with community mental health team.
- The deceased had lost a son to a drug overdose a year before.
- Chaotic drug and alcohol user with long periods of imprisonment, overdose history and non- engagement with services (very little engagement with drug services in the last 7 months of life).

- Client more prone to suicidal ideation and accidental drug overdose when intoxicated with alcohol.
- Post mortem showed evidence of high alcohol consumption over his life but also that the amount of heroin taken would almost certainly have been fatal.
- Cause of death given as 1a Morphine toxicity and a determination of a drug related death was delivered.

Findings and applying the learning

- Critical incident review revealed some recommendations to treatment workers and the larger organisation to try to encourage continuity of treatment with the client. These are listed below;
- Work to be done to ensure that time between referral and triage is done in a timely manner.
- Workers to ensure that they follow up clients when they contact the service in a distressed manner.
- Ensure more effective communication between staff to share information about service user.
- Review of workers caseload to ensure that recording is accurate and appropriate, and clients are seen in a timely manner.
- The above points have been incorporated into treatment worker working practises and supervision.

3.11 **Drug Related Death 8 – May 2015**

- 25 year old man who died at the house of a friend in Perranporth after an evening of drug taking with friends and/ or like-minded people.
- Witnesses describe the deceased as binging on drugs and alcohol for a couple of days prior to the death.
- Although a referral to drug services had been made there was no treatment given as the deceased failed to engage with services.
- The cause of death was given as 1a. Poly drug toxicity (mainly heroin and cocaine) and a determination of a drug related death was given.

Findings and applying the learning

- This is another case where the drug use, intoxication and aftermath have been witnessed to varying degrees by various people. It is clear that others at the scene were intoxicated and the true facts as to who has done what may never be known.
- The case underlines the dangers of those involved in risky drug and alcohol taking and insufficient support being available if things go wrong.
- Training and awareness to various groups is on-going to try to address responsibilities within these scenes and to make sure first aid, early ambulance attendance and care for the person(s) needing it is always a consideration.

3.12 **Drug Related Death 9 – May 2015**

- 46 year old man who died at his home address in Redruth.
- Diabetic sufferer with the condition probably brought about and worsened by long term alcohol use. This male did not control his diabetes well.
- All aspects of this males health and treatment were being worked with including a close friend who looked out for him.
- Cause of death given as 1a. Acute pneumonia and 2. Ketosis, diabetes and methadone toxicity. Coronial determination given as natural causes in circumstances where there has been a background of drug dependence and diabetes.

Findings and applying the learning

- Many medical and treatment interactions did not deter this male from using opiate drugs on top of his methadone prescription. He had previous overdoses and warnings of the dangers involved. This was on top of his underlying diabetes issues.
- This case flags up neuropathic pain issues with a complex client but all issues were inter- related at the end of his life. It is likely that some of the illicit opiate use was for self- medication purposes.

- Toxicology reflects therapeutic interventions only and the cause of death appears to be as a result of this males culminating issues as opposed to a direct overdose or poisoning.
- A side issue has become apparent and is being looked at by drug treatment services- that of clients with mobility issues who are also using drugs on top of their prescription. This centres on the safety of having such a patient in receipt of potentially larger amounts of opiate substitute medication. Whilst this is case specific, it is to be considered more fully going forward.

3.13 **Drug Related Death 10 – June 2015**

- 39 year old man who died at his home address alone in Bude.
- He was in drug treatment and had other medical issues related and otherwise.
- He had regular GP, drug treatment and home help courtesy of his mother.
- This complex case was made easier to manage due to the assistance of a sympathetic pharmacist and the deceased's mother who greatly assisted information flow and medication continuity.
- Toxicology points towards high levels of prescription medicines in combination with rapid acting heroin ingestion.
- The cause of death was given as 1. Ill effects of multiple drugs 2. Fibrinous pericarditis and lower respiratory tract infection.
- An inquest is awaited in this case.

Findings and applying the learning

- Having been reviewed internally and independently there have been no recommendations stemming from this case other than some minor process within the treatment team for procedure and administration.
- The DAAT will have a representative at the forthcoming inquest to report further on any learning from the case.

3.14 **Drug Related Death 11 – June 2015**

- 50 year old man who died in temporary guest house accommodation in Newquay.
- Plymouth resident who had been in Newquay for a couple of weeks and was due to return. He remained on an opiate substitute prescription (methadone) from Plymouth drug services during this time which was picked up weekly.
- Toxicology shows an illicit use of a morphine based drug other than methadone.
- The cause of death was given as 1a. poly drug toxicity and a coronial determination of a drug related death.
- This male reported to his treatment worker three days before he died that he was content in Newquay and that he was hoping to be housed soon by Plymouth City Council.

Findings and applying the learning

- The only apparent learning here was better communication between the service user and his treatment team. His GP was unaware of his temporary move to Newquay. That said, this man had a long history in treatment, seemed to be contented about his imminent return to his home town and was complying with his opiate substitution medication regime. The overdose and death was not foreseen and was a shock to those that knew and treated him

3.15 **Drug Related Death 12 – June 2015**

- 34 year old man who died at his home address in Padstow who was not known to drug and alcohol treatment services but was known to his GP as alcohol dependant.
- Apparent home alone use of various new psychoactive drugs in combination with alcohol.
- The cause of death was given as 1a. 6 and 5 (2- aminopropyl) Benzofuran misuse and a determination of a drug related death.

Findings and applying the learning

- There was no peer review published literature in this case regarding the clinical effects or toxicity of the drugs taken. The pathologist, in consultation with the toxicologist, stated that 'on balance (the drugs) caused cardiac effects'.
- Nothing from other evidence could assist with future preventative strategies.

3.16 **Drug Related Death 13 – July 2015**

- 43 year old man who died in RCHT Treliske after having been admitted 4 days earlier.
- History of illicit drug use for 21 years.
- The case flags up the immense difficulties involved in prescribing opiate substitute medication to a chaotic service user who also had pain issues and multiple risk factors.
- All agencies had to work against a backdrop of this mans' risk of overdose, self-neglect, health risks, high level of criminal offending, self- harm and suicide and risk of non-engagement with services.
- Many and varied medical interventions as well as being supervised by Police and Probation.
- The cause of death was given as 1a acute pulmonary haemorrhage 1b cavitating bacterial pneumonia 1c intravenous drug use and endocarditis. The coronial determination was a drug related death.

Findings and applying the learning

- Communication between multiple agencies is imperative with a service user case such as this. Certain terms of engagement were re-established in this case which needed to be done partly due to reducing budgets for all agencies.
- Assertive outreach was seen as the last possible opportunity to re-engage this service user. It did not occur and reasoning was given by all relevant agencies. Re-prioritising core functions within reducing budgets by Police and Probation, for example, has informed drug treatment teams as to the reality of assertive outreach. Assertive outreach is still a useful tool in some cases but can be resource intensive.
- Coronial inquest found that this service user had many people from many agencies working with his issues and he did not lack any treatment.

3.17 **Drug Related Death 14 – July 2015**

- 61 year old man who died at his home address in Falmouth.
- Cause of death given as 1a Heroin toxicity 2 Chronic obstructive pulmonary disease.
- An inquest is awaited although pathology and toxicology point strongly to this being a drug related death.
- He had fallen out of drug treatment for 4 months but his last treatment episode had been getting more erratic in attendance and saw his heroin consumption escalating.
- Latter health issues included a terminal illness diagnosis and it appears that from this point on he began disconnecting from services.
- Treatment review flagged up greater effort needing to be made in contacting service users such as this when they fail to engage with services.
- This case also flagged up the large numbers of cases being held and managed by treatment workers.

Findings and applying the learning

- The cases of service users who do not attend appointments and start to disengage from services will be more critically viewed within keyworker and line manager supervision time. This is to double check all that can be done has been attempted or considered.
- Treatment teams and personnel are to ensure that service users are given appropriate harm reduction advice at the point of exit from treatment and that this is recorded.

3.18 **Drug Related Death 15 – Aug 2015**

- 26 year old man who died at his home address in the Callington area who was in drug treatment at death.
- Opiate substitute medication of buprenorphine (Subutex).
- Awaits inquest.

- Toxicology shows that buprenorphine is present at potentially toxic/lethal levels.
- Service user was the main carer for his father.
- All aspects of treatment were positive as was this mans' attitude. The death came as a complete shock to those around him with no warning signs or obvious precursors.

Findings and applying the learning

- Subject to hearing all the evidence at inquest there does not appear to be obvious learning at the writing of this report.
- The level of the buprenorphine as indicated by toxicological metabolites present does not appear to match that of his prescription.
- A doctors review of the deceased two days before the death reported that although the service user was suffering from a flu like virus, the overall impression was that he was engaging well.

3.19 **Drug Related Death 16- Aug 2015**

- 49 year old woman who was found deceased in a car at a music Festival near Looe.
- She was not in drug or alcohol treatment but had a medical history of heart problems.
- Toxicology shows a cocktail of prescription and illicit drugs. She was prescribed multiple drugs for a range of medical issues.
- Two of the prescription medicines (amitriptyline and pethidine) were at potentially toxic concentrations and were combined with what has been described as recreation levels of cocaine and recent ecstasy use.
- An inquest is awaited.

3.20 **Drug Related Death 17- Sept 2015**

- 25 year old man who died at his home address in Newquay after having used heroin within a 2 hour period of being alone at the address.
- He was in drug treatment at death and an inquest is awaited.
- Toxicology shows an independently fatal level of heroin in combination his prescribed diazepam and methadone at therapeutic levels.
- Latter treatment lost some continuity due to staff changes, annual leave and sickness.
- A thorough review resulted in a case analysis with staff within the drugs team. Although sharpening of process was identified, the pressures of workload and staff absence was also seen as a contributor to the ability of the team to service some cases as well as would be expected and desired.

Findings and applying the learning

- Some of the things that fell out of the local treatment review were;
- Review the time frames within the local prescribing pathway in the clinical governance group.
- Raise awareness in the local team meetings about the importance of safer injecting assessments and recording.
- More timely allocation of service users to workers.
- More active engagement with safer injecting clinics and imparting clearer information around the associated risks
- More timely reviews when prescribing opiate substitute medicines to higher risk service users – poly drug users and intravenous drug users.

3.21 **Drug Related Death 18- Sept 2015**

- 32 year old man from Cornwall who died in RCHT Truro after being admitted to hospital 7 days previously having collapsed with a lower leg swelling and suspected deep vein thrombosis. He made many trips back to theatre in hospital for serious complications of injecting drugs over years.
- Cause of death given as 1a Septicaemia and liver failure 1b Lower limb abscess, intravenous drug use and liver cirrhosis.
- An inquest into his death was not required but all medical reports and treatment indicate a man with life ending illnesses linked to alcohol and illicit drug use.

- Drug and alcohol treatment sporadic since 2007 with his last period in treatment being a month at a second stage rehabilitation unit 2 months before he died. He was asked to leave this unit, however, due to a suspicion that he had been using heroin. He did not re-engage with treatment thereafter.

Findings and applying the learning

- To discuss with secondary treatment services the need for robust contingency plans and the need to notify a named person when a service user leaves treatment unexpectedly. This is to subsequently be recorded on the Halo record.
- Review systems and process for closure of the community treatment record when a service user enters detox or rehab.
- Explore outreach opportunities for homeless and other 'hard to reach' service users.

3.22 **Drug Related Death 19- Oct 2015**

- 51 year old male found deceased at his home address near Newquay.
- No link to treatment, Police systems or other relevant agency. There is no history of this man taking illicit substances.
- Possibly a prepared scene where he died as a note was affixed to the door to the area. He was located with a small self- seal bag close by, small pieces of cling film underneath him and a small glass medicine pipette in his hand.
- Inquest awaited but the toxicology results show that this male had taken a level of MDMA (Ecstasy) which was far higher than other cases where it has been the main agent and cause of death.

3.23 **Drug Related Death 20- Oct 2015**

- 28 year old homeless man who died in a tent in the Camborne area.
- He had only been in Cornwall for a few months and was homeless the whole time. He was referred to drug treatment services but never engaged. It appears that he had an illicit drug and alcohol habit before he came to Cornwall. Any further information will be forthcoming from the inquest.
- Toxicology shows that his alcohol level was potentially independently fatal but that he had also used heroin prior to death.
- Inquest awaited.

3.24 **Drug Related Death 21- Nov 2015**

- 30 year old man who died in the Gunnislake area after reportedly drinking from a bottle marked 'morphine sulphate' and consuming 8- 9 tablets which he described as 'fake valium'. He had been drinking locally in a pub and was described as drunk prior to consuming the suspected drugs sometime after the pub closed.
- Witnesses tried to persuade him not to consume the drugs. He was heard snoring loudly at 8am the same morning but had died by late afternoon.
- No links to drug or alcohol services.
- Inquest awaited.

3.25 **Drug Related Death 22- Nov 2015**

- 39 year old woman who died at a doctors surgery in Torpoint after being taken there for a routine appointment. On route she had a seizure and was treated in the car park of the surgery.
- No treatment record from local drug and alcohol services but she is known to have a history of drug and alcohol misuse. Liquid morphine was being prescribed to her with Diazepam for issues other than drug dependence.
- Cause of death was given as 1a Fatal Acute Toxicity from Paracetamol, Codeine and Morphine ingestion 2 Chronic alcohol misuse.
- Toxicology confirmed the presence of a large amount of morphine, paracetamol, codeine, amitriptyline and a lower level of alcohol.
- Inquest awaited.

3.27 **Drug Related Death 23- Dec 2015**

- 40 year old man pronounced dead at Derriford Hospital but who appears to have died at his fathers' house in Looe. He was in drug treatment at death.
- He had been asked to leave a second stage rehabilitation unit in Cornwall the day before he died as he was using and offering drugs on the premises.
- Discharge process involved offering naloxone which he declined, overdose advice and securing accommodation.
- Drug treatment agency was due to visit the service user at his new address.
- Inquest awaited but early indication from toxicology and pathology is that this is a drug related death by virtue of toxicological findings and a cumulative history of substance misuse combined with medical reason

4. SYNOPSIS 2015 DRUG RELATED DEATHS

4.1 Male

	2013	2014	2015
Total Drug Related Deaths	18	17	**23**
Males	17 (94%)	15 (88%)	**20 (87%)**
Mean age	35	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- 4, 50's- 3, 60's- 2)**
Youngest	2 x 21	27	**2 x 25**
Males – Heroin/ Morphine	9 x Heroin, 2 x Morphine	10 x heroin	**12 x Heroin 1 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)**
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)**
Males in Treatment	6 drugs	14 (9 drugs and 3 alcohol)	**10 (9 drugs and 1 alcohol)**
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)**

4.1a

Toxicological Result	Number of male deaths (2015)
Heroin in significant amount	12
Heroin only	2
Heroin and other drugs	8
Heroin and significant alcohol level *(80ml/100ml in blood is UK driving limit)*	2 (alcohol levels of 285mg/ 100ml and 433mg/ 100ml)
Non- prescribed methadone	2 (1 in combination with heroin and 1 in combination with alcohol)
Prescribed methadone with other	3 (2 in combination with heroin and 1 combined with medical conditions- pneumonia and diabetes)
Significant presence of alcohol level *(80ml/100ml in blood is UK driving limit)*	4 (alcohol levels of 285, 433, 205 and one not quantified due to pathological reasons but all other evidence points towards high alcohol consumption prior to death)
Underlying cause drug related and not overdose (drug use over prolonged period etc)	3 Case 1- Cause of death (COD) 1a. Acute Pneumonia 2. Ketosis, diabetes and methadone toxicity. Coroners determination of natural causes in circumstances where there has been a background of drug dependence and diabetes. Case 2- COD 1a. Acute pulmonary haemorrhage, 1b. Cavitating bacterial pneumonia, 1c. Intravenous drug use and endocarditis. Coroners determination given as a drug related death. Case 3- COD 1. Septicaemia and liver failure, 1b. Lower limb abscess, intravenous drug use and liver cirrhosis. This case did not go to inquest.

4.2 Female

	2013	2014	**2015**
Total Drug Related Deaths	18	15	**23**
Females	1 (6%)	2 (12%)	**3 (13%)**
Mean age	58	32	**40**
Oldest	58	34	**49**
Youngest	58	30	**32**
Females –Heroin/ Morphine	1	1 x Heroin + NPS + medical issues	**1 (awaiting inquest but medicine containing morphine was prescribed)**
F/males-Methadone	0	1 x Fatal levels of tramadol & pregabalin in combination with illicit methadone	**0**
Females - other c/drug	0	0	**1 x combination of MDMA and medical issues 1 x MDMA and multiple prescribed meds**
Females in Treatment	0	1	**0**

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

- Home address- 10
- Home address of another- 3
- Hospital end of life related to drug dependence- 2
- Street/ roadside- 2
- Public toilets- 2
- Other- 1 x non- supported temporary accommodation, 1 x car at music festival, 1 x homeless living in a tent, 1 x holiday let

Overwhelmingly there is bias towards the home address or home address of another being the premises where most drug related deaths take place (15 out of the 23 if we consider the temporary accommodation and homeless person in a tent as for the time being a home address). 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:

- Newquay- 5
- St Austell- 2
- Penzance- 2
- Callington/ Gunnislake- 2
- Looe- 2
- Bodmin- 1
- Truro- 1
- Porthleven- 1
- Perranporth- 1
- Bude- 1
- Falmouth- 1
- Camborne- 1
- Padstow- 1
- Redruth-1
- Torpoint- 1

4.5 The average age of males dying from a drug related death during 2015 has remained at 40. Males represent 87% of the total number of deaths (20 out of the total of 23) which is slightly up from 2014 at 88% (15 out of the total 17). Female deaths have risen to 3 for 2015 and whist the average age has gone up from 32 to 40, the number of female deaths does not allow for meaningful analysis.

4.6 Poly drug use remains a concern again this year. There are only two deaths attributable to a sole agent being involved that agent being heroin. All other cases have at least one other contributory substance- drug and/ or alcohol. Several cases involve multiple drugs with or without alcohol. Alcohol use with any drug, whether street sourced or prescribed, remains of concern and significantly features in 4 of this period's case studies.

4.7 The 2014/ 15 financial year report highlighted that Pregabalin (used for neuropathic analgesia and epilepsy amongst other things) had been shown to be present in 6 of the 18 deaths of which only 2 were prescribed this medication. Pregabalin is becoming more prevalent for opiate users to combine Pregabalin (or its' close relative drug Gabapentin) with opiate drugs, particularly heroin. The 2014/15 report heard that 'experienced' and long term drug users had been combining pregabalin with heroin. This indicates that this combination is more than merely experimental and had added some actual or perceived value to their respective drug taking habits. It was identified that this drug combination needed further investigation and research so that treatment and resources could be better informed. Whilst this piece of work is on- going, the 2015 report shows that Pregabalin and Gabapentin feature in 3 of the cases. One case showed a heroin death where the deceased was prescribed Gabapentin but that it had not been found in his toxicological screen. The other 2 cases were service users who were prescribed Pregabalin and their toxicological screens showed therapeutic amounts. These two deaths were heroin overdoses combined with multiple other prescribed and illicit drugs although one death is still under investigation and other medical issues are likely to have to be considered. The findings of the 2015 report do

not add any weight to the debate over the importance of Pregabalin and Gabapentin in drug related deaths. That said, we do not know the relevance of either of these drugs in those cases where a person may have overdosed and lived through the experience.

4.8 Still of great 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 featured in 6 of the 18 deaths (33%) for the 2014/ 15 financial year report. This has not been overtly mirrored in the 2015 cases but there is still the possibility of witnesses to the various overdose circumstances not having been identified or not having come forward. This is always a possibility anyway when the aspects of illegality are factored in to a drug related death scenario. Identifying these witnesses is important to ensure that they receive any follow up support that they need. Awareness of overdose, naloxone training, first aid and basic overdose scene expectations are some of the things that could provide someone, who is likely to encounter other such scenes, with a greater chance of saving life in future.

4.9 In varying degrees a proportion of the cases have seen scrutiny of the working relationship between mental health services and drug/ alcohol treatment. The overlap between those presenting with drug and alcohol issues and mental health issues appears to be of greater significance and the various agencies involved are working towards a more integrated approach. Some cases have involved those who fall through the gaps in services by the nature of their respective issues but also by what a service expects of its' service users. An example of this is where a man is recommended for mental health assessment and he has a drug and/ or alcohol problem. His intoxication can lead him to never attending an assessment or, if he attends intoxicated, the assessment cannot take place. The cycle then continues. Some mental health issues manifest when drugs and alcohol enter the equation and some drugs and alcohol mask mental health symptoms. There are many complex issues that involve a multi- agency approach and this is an area where further work is a necessity.

5.0 South Western Ambulance Service NHS Foundation Trust data has been received which shows the administration of naloxone (antidote to opiate use medicine) for Cornwall as compared to Devon (includes Plymouth and Torbay). This data only covers 1 of the 12 months covered within this report and is shown in the table below;

Monthly naloxone administrations	Cornwall	Devon
May 2014	19	30
June 2014	20	47
July 2014	18	30
Aug 2014	17	31
Sept 2014	16	33
Oct 2014	23	38
Nov 2014	18	30
Dec 2014	18	35
Jan 2015	11	29

The average naloxone use, therefore, by ambulance staff at incidents where an opiate overdose is apparent within Cornwall is 17.75 per month. We are unable to say whether any of these ambulance cases were at an incident that is covered within the scope of this report due to the anonymity of information. We know that ambulance crews administer naloxone at the scene of a suspected opiate overdose even where there is an initial appearance of a person having recently died such is the significance of naloxone in bringing patients back from the brink of death in such cases. Apart from a high in October 2014 and a low in January 2015 the administration of naloxone is fairly constant with no immediate conclusions being able to be drawn from this data. Interestingly, there were no drug related deaths in October 2014. The monthly naloxone administration figures for 2010 and 2011 averaged out at 20 and for 2013/ 14 it was 16. Appendix B on page 24 gives more detail of the spread of the ambulance call outs across Cornwall together with the ambulance attendance codes.

5. PROACTIVE MEASURES /INITIATIVES / PROGRESS 2015 - 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, specialist service providers, mental health services, coroner's officers etc. with reports being available from a range of services including prescribing, toxicology and pathology. This efficient group are invaluable in providing information to HM Coroner and the inquest procedure as well as helping to shape service delivery by making recommendations based on case specific findings. More of an action based approach and increased feedback to the group this year from inquests, for example, has improved the efficiency still further.

5.2 **Peninsula Drug Related Death Review Panel**

Whilst this panel has been pared back to a bi-annual meeting this year going forward, it remains a useful conduit for the sharing of information and best practise between the Cornwall DAAT and Plymouth, Devon and Torbay areas. This forum is also instrumental in queuing up the annual Reducing Drug Related Deaths Conference by providing insightful advice as to plenary speakers and workshop facilitators. The valued administration of 7 conferences has been carried out by our colleagues in The Plymouth Office for Public Health. Devon DAAT now has their own version of the DRD Review Group which will strengthen the review process and will allow more efficient comparison of data. The Cornwall DAAT is experienced in this work and has provided support to other areas.

5.3 **Reducing Drug Related Deaths Conference 2015**

This was the second conference since the re-launch in 2014 and sought to build on last year's success as well as the peninsular desire for the conference to continue. Funded by local DAAT/ Public Health areas, Police and sponsors, the conference this year was held again at The China Fleet Club at Saltash, Cornwall on Friday 23rd October 2015. This years' plenary sessions were, in part, based on information coming from cases contained within this report and included;

- Complex Care in Complex Times
- Care for Entrenched Alcohol Use – The Issues
- The Toxic Trio – The combined impact of Domestic and Sexual Violence, Substance Use, and Mental Health
- Bereaved by Substance Misuse

The plenaries were supplemented with workshops that concentrated on overdose care, addiction and pain management in a prison setting, end of life care for entrenched alcohol use, safeguarding adults and making every adult matter and an update on naloxone. The workshops were able to focus on issues and learning that have been of issue and prominence in the Peninsular. Feedback was overwhelmingly positive and all comments and recommendations will be taken forward to the 2016 conference.

5.4 **Service of Remembrance**

Saturday 23rd September 2015 saw the second service to be held at Truro Cathedral seeking to remember those that have died from a substance misuse-related death and for those family and friends left behind. The service incorporated more of a recovery theme this year. 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. The feedback from last years' and this years' service was that it should continue and, sadly, as this report shows, 2015 saw another 21 reasons why it is still needed. The service was attended by local dignitaries, service users and those involved in providing treatment but the service will always be open to all. Plymouth held their second service in 2015 and it is the aspiration of Exeter to follow suit next year. The sum total of these services across the peninsular is greater awareness and publicity for this important issue.

5.5 Naloxone Program

This report has touched on naloxone within various case studies. The provision of this potentially life-saving drug across Cornwall has improved with a much higher proportion of service users having now been trained in its use. Service users are issued with naloxone if they agree to it but it is not mandatory and it is issued with a prescription. There is still much work to be done in the training of all drug users in relation to overdose awareness and

immediate first aid which should involve naloxone. Service users are getting the training but it is their peers outside of treatment which need to be targeted. Service users will be instrumental in cascading this awareness and training to their peers. Apart from the noticeable good work done by Cosgarne Hall in St Austell with their cohort of clients and naloxone availability, there is work still to be done with other supported housing agencies and establishments. This is work which the DAAT is currently working on as a priority especially in the light of learning from this report.

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

This year has seen increased governance of safety and review of effectiveness over DAAT-commissioned service, particularly in relation to drug related death review and incident reporting requirements. All Provider reports have been with the DAAT within 30 days of their request and incidents such as the death of a service user are reported to the DAAT within 24 hours. Furthermore, local drug and alcohol service scrutiny of such an incident and a Critical Incident Review Group report are relayed to the DAAT within 30 days. The speed of scrutiny, review and reporting dramatically assists the DAAT reporting process to HM Coroner and also speeds up the learning process from such incidents. This, in turn, allows process change, if identified and required, to help prevent future deaths. All learning from such reports and from inquests is returned to all interested parties to fully complete the cycle. The openness of this process and its valuable assistance has been favourably commented upon by HM Coroner for Cornwall.

5.7 **Overdose Awareness and Scene Management**

Already eluded to in section 4.8, awareness of overdose and reasonable expectations of someone having witnessed an overdose are important parts of a preventing future deaths strategy. Awareness talks have begun with the likes of the Addaction chaired Affected Others Group which consists of those people affected by loved ones/ friends etc having substance misuse issues or having lost a loved one to a substance misuse death. Future talks are to take place with supported accommodation clients such as Freshstart and these will be facilitated by the Drug Related Death Prevention Coordinator for the DAAT and a user group representative from Addaction. This two way information flow is invaluable in preventative measures work. The range of these talks will not be bounded but will be focussed on identified need and when opportunities arise.

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 2015 period. The deaths involving alcohol as a contributory factor in a drug related death have been described in sections 3 and 4. As a baseline setting initiative for 2016 onwards the DAAT will collate all alcohol related deaths that have been identified by the deceased having a current link to alcohol treatment or having been out of alcohol treatment for 6 months or less. The DAAT request the treatment reports from Addaction on behalf of HM Coroner for the inquest process already.

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 16 years commencing in 1999. A comparison of year on year figures is shown at Appendix A.

7.3 At the time of preparing this report the maximum number of drug related deaths for Cornwall & IOS throughout 2015 is 23, which represents an increase of 26% from 2014 (17 deaths to 23). The main findings in this report are;

- 12 of the 23 deaths feature heroin significantly (street sourced illicit heroin and not pharmaceutical diamorphine).
- 5 cases where methadone is a factor in the death either by lawful prescription (3) or illicit source (2).
- 13 of the 23 deaths involve a service user who was either in drug or alcohol treatment at death (10) or died within 6 months of being in treatment (3).
- 20 males and 3 females died in this period.
- The average age for male and female deaths is 40.
- Significant levels of alcohol feature in 4 deaths (17%)
- Pregabalin and Gabapentin do not feature as highly this year as in 2014.
- Other drugs being illicitly sourced that have contributed to synergistic effects of opiates, for example, have been anti- depressant medicines and benzodiazepines.
- Immediate first aid and overdose awareness issues are in need of continuous monitoring and re-advertising to a wide range of people.
- Naloxone availability countywide will improve due to relaxation in the relevant legislation in October 2015 together with improved housing protocols being worked on at this time.
- Poly drug use is still a major contributor to death as illustrated in the toxicological screens.
- Agencies agree that there needs to be improved joint working where drug and alcohol clients engage with or are assessed by mental health services to ensure the client does not fall through the gaps between treatment.
- Increased work has been done and is being done in relation to keeping clients engaged in treatment. This has sometimes involved outreach work to clients.
- Less evidence this period to suggest experimental use being a factor in the deaths.
- Using alcohol and/ or injecting drugs on top of treatment regimens and substitute medication is high.

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 4 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. Section 5 of the report highlights some of these measures and 2016 will see further ways of getting these messages across. A second year of the Service of Remembrance and the ‘Drug Related Death Death’ conference are amongst the high profile events that ensure awareness and

learning continue. 2015 has seen more improved joint agency working and this will also be the aim for 2016. The impact of mental health issues on treatment and the complexity of some of the service users cases are in themselves a major challenge. By extension the challenge is to engage more dual diagnosis clients that appear between drug/ alcohol services and mental health services. Tragic as these deaths are, the DAAT and partner agencies will keep working towards substance misuse prevention to ensure that those who have died potentially leave a legacy of change and improvement for others.

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APPENDIX A

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

Cornwall & IOS Drug & Alcohol Team – Recorded Drug Related Deaths

January – December	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Remarks
Opiates – **Heroin** (may include methadone)	6	7	8	10	10	7	13	7	12 *	12 *	8	9	8	8 *	12	11	**14**	***Includes Suicides**
Methadone (only or with non-relevant other drug)	5	2	0	0	1	1	1	2	6	5	5	7 *	2	11 *	5	5	**5**	****this includes methadone and relevant other drugs/ alcohol**
Other controlled drug (e = ecstasy, c = cocaine ,a = amphet)	0	0	0	1	1	1 e	0	2c1a	1a	1 a*	0	2c	2e	1C 1 Mep.	1e & 2 other	0	**1e + poly & 2 other**	
RTA / Suicide and controlled drug present	?	?	?	?	?	6	4	0	1h	2h	2 c	1h	0	6	0*	0*	**0***	***The unavailability of all tox does not allow for analysis**
Cornwall DAAT recorded ***'drug related deaths'***	11	9	8	11	12	9	13	11	19	18	13	18	12	25	18	17	**23**	
npSAD recorded	19	6	7	10	2	2	2	15	35	14	27	32	N/A	N/A	N/A	N/A	N/A	

/published DRDs for Cornwall & IOS																	

APPENDIX B

Overdose-related chief complaint codes in Devon and Cornwall, 1st May - 31st July, by pickup town

Area		D01 Deliberate opiate overdose	D02 Deliberate non-opiate overdose	D03 Deliberate overdose - unspecified	M46 Accidental alcohol poisoning	M47 Accidental opiate poisoning	M48 Accidental non-opiate poisoning	M49 Accidental poisoning - unspecified	Grand Total
Cornwall and Isles of Scilly	BODMIN	1	14	4	7	4	2	2	34
	BOSCASTLE		1						1
	BUDE	1	5	6	4		3	7	26
	CALLINGTON		3		1		1	1	6
	CAMBORNE	2	15	7	12	4	4	7	51
	CAMELFORD			2	1			1	4
	DELABOLE				1				1
	FALMOUTH		14	3	12	2	2	1	34
	FOWEY			2				1	3
	GUNNISLAKE		2	2		1	1		6
	HAYLE	1	7	1	6		1	2	18
	HELSTON		11	6	4	3	3	6	33
	ISLES OF SCILLY				1				1
	LAUNCESTON		6	4	3	1	2	3	19
	LISKEARD	1	9	7	5		4	4	30
	LOOE		2	1	1		1	1	6
	LOSTWITHIEL				1		1		2
	MARAZION	1							1
	NEWQUAY	2	22	10	41	3	3	9	90
	PADSTOW	1			2				3
	PAR	1	3	3	3		2	1	13
	PENRYN	2	3	3	6			1	15
	PENZANCE	8	17	2	25	6	6	7	71
	PERRANPORTH				1			1	2
	PORT ISAAC		1	1					2
	REDRUTH		9	4	9	2	5	2	31
	SALTASH		14	5	5		2		26
	ST. AGNES			1	1		1	4	7
	ST. AUSTELL	9	39	27	11		5	7	98
	ST. COLUMB		1	2		1			4
	ST. IVES	1	2		8	1			12
	TINTAGEL		1		1				2
	TORPOINT		3	1	2	3	2	1	12
	TRURO	4	19	14	21	4	6	7	75
	WADEBRIDGE		4	3	4		1	2	14
Cornwall and Isles of Scilly Total		**35**	**227**	**121**	**199**	**35**	**58**	**78**	**753**
Devon	ASHBURTON	1			3	1			5
	AXMINSTER		3	4	1	3		1	12
	BARNSTAPLE	9	23	9	21	1	5	3	71
	BEAWORTHY		1	2					3
	BIDEFORD	7	16	7	13	3	4	5	55
	BOVEY TRACEY		1		1	1	1	2	6
	BRAUNTON		1	2	1		2		6
	BRIXHAM		10	2	4	2	2	2	22
	BUCKFASTLEIGH			1	1		1		3
	BUDLEIGH SALTERTON			1	2				3
	CHULMLEIGH		2		1		1		4
	COLYTON		1				1		2
	CREDITON	1	2	4	4		1	1	13
	CULLOMPTON		5	3	1	1	2	3	15
	DARTMOUTH		7	1	6		1	2	17
	DAWLISH	2	6		4		3		15
	EXETER	12	54	36	113	12	12	32	271
	EXMOUTH	1	13	2	21	1	2	6	46
	HOLSWORTHY		1	2	2			1	6
	HONITON	1	6	5	5		5	2	24
	ILFRACOMBE		7	4	8			3	22
	IVYBRIDGE		1	1	2		1	3	8
	KINGSBRIDGE	1	1		2		1		5
	LYNTON		1						1
	NEWTON ABBOT	1	21	3	29	3	3	5	65
	OKEHAMPTON	1	4	1	3			1	10
	OTTERY ST. MARY			1	1	1			3
	PAIGNTON	7	27	10	24	1		14	83
	PLYMOUTH	33	158	66	135	13	32	43	480
	PRINCETOWN							2	2
	SALCOMBE						1	1	2
	SEATON	3	2	1	4		1	1	12
	SIDMOUTH		4	1	5			2	12
	SOUTH BRENT		2	1				1	4
	SOUTH MOLTON			1	1	1		2	5
	TAVISTOCK	3	4	2	7	1	1		18
	TEIGNMOUTH	4	8	2	9		4	5	32
	TIVERTON		13	5	7		1	3	29
	TORQUAY	10	39	20	63	2	22	17	173
	TORRINGTON		2		2		1	1	6
	TOTNES	1	7	4	9	2	1	3	27
	UMBERLEIGH				1			1	2
	WOOLACOMBE				3				3
	YELVERTON		1						1
Devon Total		**98**	**454**	**204**	**519**	**49**	**112**	**168**	**1604**
Grand Total		**133**	**681**	**325**	**718**	**84**	**170**	**246**	**2357**

Number of Naloxone administrations in Devon and Cornwall, 1st May - 31st July 2013

County	May	June	July	Total
Devon	36	29	28	93
Cornwall	12	13	21	46
Total	**48**	**42**	**49**	**139**

Key to codes

D01 Deliberate opiate overdose
D02 Deliberate non-opiate overdose
D03 Deliberate overdose - unspecified
M46 Accidental alcohol poisoning
M47 Accidental opiate poisoning
M48 Accidental non-opiate poisoning
M49 Accidental poisoning - unspecified

Overdose-related chief complaint codes in Devon and Cornwall, 1st May - 31st July 2014, by pickup town

Month	(All)

Use this drop down list to view breakdown by month

Count of Call Number	Column Labels							
Row Labels	**D01**	**D02**	**D03**	**M46**	**M47**	**M48**	**M49**	**Grand Total**
Cornwall	**51**	**199**	**121**	**156**	**17**	**58**	**78**	**680**
BODMIN	5	17	10	8	1	4	5	50
BOSCASTLE		1						1
BUDE		5	2	1		4		12
CALLINGTON	1	4	2	2		5	1	15
CAMBORNE	4	11	6	7	4	1	5	38
CAMELFORD			2			1	1	4
FALMOUTH	4	11	6	9		1	4	35
FOWEY		2						2
GUNNISLAKE							1	1
HAYLE		1	3	1		2	1	8
HELSTON	2	7	9	6		5	3	32
ISLES OF SCILLY		1						1
LAUNCESTON	2	4	2	3	1	3	3	18
LISKEARD	2	13	5	5		3	3	31
LOOE		2		1				3
MARAZION		1	1				1	3
NEWQUAY	3	7	9	36		5	9	69
PADSTOW	1	1		2			1	5
PAR		5	2			2	4	13
PENRYN		4	1	1	1			7
PENZANCE	7	12	10	13	3	3	7	55
PERRANPORTH		3	1	2		2	2	10
PORT ISAAC				1				1
REDRUTH	5	17	7	11		3	6	49
SALTASH		5	2	3		1	1	12
ST AGNES			2					2
ST AUSTELL	5	32	14	7	5	5	5	73
ST COLUMB		3		1		1		5
ST IVES		2	4	4			5	15
TINTAGEL			1				3	4
TORPOINT	3	8	2	6		1	3	23

TRURO	6	17	15	24	2	5	4	73
WADEBRIDGE	1	3	3	2		1		10

Overdose-related chief complaint codes in Devon and Cornwall, 1st August - 31st October 2014, by pickup town

Month	(All)

Count of Call Number	Column Labels							
Row Labels	D01	D02	D03	M46	M47	M48	M49	Grand Total
Cornwall	**47**	**208**	**91**	**173**	**20**	**71**	**81**	**691**
BODMIN	2	13	4	3	4	5	4	35
BOSCASTLE	1	1						2
BUDE		3	5	4			1	13
CALLINGTON		4	5	1		1	3	14
CAMBORNE	5	9	6	11	3	4	6	44
CAMELFORD	1	2	3	1				7
DELABOLE		1						1
FALMOUTH	2	14	4	15	2	4	6	47
FOWEY		1						1
GUNNISLAKE		2					1	3
HAYLE	3		4	2	1	1	5	16
HELSTON	4	2		1		2	2	11
LAUNCESTON	4	6	2	2		3	2	19
LISKEARD		12	2	2	1	5	7	29
LOOE		4	1	4		1	2	12
LOSTWITHIEL		1						1
MARAZION	1	1	1	1				4
NEWQUAY	5	18	11	37	1	6	9	87
PADSTOW				1			2	3
PAR	2	2	1	2		1	3	11
PENRYN		6	1	7				14
PENZANCE	3	17	6	18	1	7	5	57
PERRANPORTH		4		4			1	9
REDRUTH	2	14		10		6	6	38
SALTASH		5	2	4		5	1	17
ST AGNES		2		3				5
ST AUSTELL	3	36	17	12	4	13	5	90
ST COLUMB		3		1		1	1	6
ST IVES	1	5	3	2	1	1	1	14
TINTAGEL				1			1	2
TORPOINT		2	1	1			2	6
TRURO	8	17	12	18	2	5	4	66
WADEBRIDGE		1		5			1	7

Key to codes

D01 Deliberate opiate overdose
D02 Deliberate non-opiate overdose
D03 Deliberate overdose - unspecified
M46 Accidental alcohol poisoning
M47 Accidental opiate poisoning
M48 Accidental non-opiate poisoning
M49 Accidental poisoning - unspecified

Overdose-related chief complaint codes in Devon and Cornwall, 1st November 2014 - 31st January 2015, by pickup town

Month	(All)

Count of Call	Column

Key to codes

Number	Labels							
Row Labels	D01	D02	D03	M46	M47	M48	M49	Grand Total
Cornwall	**34**	**191**	**88**	**115**	**30**	**47**	**62**	**567**
BODMIN	3	11	5	5	2	3	7	36
BOSCASTLE							1	1
BUDE		6	1	2			1	10
CALLINGTON	1	9	4			2	1	17
CAMBORNE	3	14	7	7	7	4	1	43
CAMELFORD						1		1
FALMOUTH	2	6	5	11		2	2	28
FOWEY		1	1					2
GUNNISLAKE		1	1		1			3
HAYLE	2	3	3	1	3		2	14
HELSTON		7	5	6	2	3	1	24
HOLSWORTHY		2				1	1	4
ISLES OF SCILLY		1				1		2
LAUNCESTON		6	3	3	1		2	15
LISKEARD	1	9	2	1		4	4	21
LOOE	1	4	4			1		10
LOSTWITHIEL	2							2
MARAZION		1						1
NEWQUAY	7	9	5	17	4	5	9	56
PADSTOW	1	1	1	1	1			5
PAR	1	3	3	4		1	1	13
PENRYN	1		1	1	1	1	2	7
PENZANCE	2	11	5	8		1	3	30
PERRANPORTH				1				1
PORT ISAAC		1						1
REDRUTH	1	12	6	10	2	1	3	35
SALTASH		3	2	1		1	1	8
ST AGNES				1		1		2
ST AUSTELL	3	26	12	12	1	5	8	67
ST COLUMB		3	1	1	1		1	7
ST IVES		3	1	4			2	10
TINTAGEL		2						2
TORPOINT		6	2	3	1			12
TRURO	3	29	7	12	3	8	9	71
WADEBRIDGE		1	1	3		1		6

D01 Deliberate opiate overdose
D02 Deliberate non-opiate overdose
D03 Deliberate overdose - unspecified
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