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 April 2014 to 31st March 2015

EXECUTIVE SUMMARY

This is the twelfth 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 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;

	2011		2012		2013/14		2014/15	
Total drug related deaths	**12**		**25**		**15**		**18**	
Gender *(male –M, female – F)*	11 M	1 F	18 M	7 F	14 M	1 F	**16 M**	**2 F**
% Increase or Reduction	34% decrease from 2010		52% increase from 2011		40% decrease from 2012		**17% increase from 2013/14**	
Heroin / Morphine present	8		8		9 (7 heroin)		**12**	
Methadone present	2		11		7		**8 (3 x prescribed, 5 illicit)**	
Other controlled drug and other	2 MDMA + other		2 Mephedrone 1 cocaine		1 x MDMA		**3 x poly drug 1 x alcohol plus cumulative drug history**	
RTA/Suicide (+ CD as included above)	2 Phenobarbitone		1 x RTC 5 x sus suicide as above		1 suicide		**0**	

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 17% for 2014/15 as compared to 2013/14 in Cornwall alone.

Heroin deaths have risen by 58% from 7 deaths to 12. Whilst some of these deaths involve poly drug use, the level of heroin represented by toxicological examination shows heroin being of significant presence. There is only one death where a sole agent has been the cause of death and that is heroin.

6 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.

6 cases involve the neuropathic pain inhibitor and epileptic drug Pregabalin (1 case involves 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.

6 cases have involved a situation where the administration of the toxic agent(s) has been witnessed by at least one person. The subsequent care of the person suffering the overdose and ultimately the death has been of deep concern as there have been responses from those present that have ranged from being naïve or ignorant to uncaring. These 6 cases are known to have had witnesses present upon examining the evidence as laid out for the coronial process. The suspected reality is that more of this years' cases have been witnessed so increasing the level of concern.

This year has seen the cases consist almost exclusively of those that have either been in drug and/ or alcohol treatment at death or having been out of treatment for less than 6 months- 17 out of the 18 cases. Last year saw nearly a 50/ 50 split of those in treatment against those not known to treatment. The fact that so many people have died having been in treatment is of concern but not one which has an easy explanation as to why this should be. There is a greater amount of research and investigation that can be done, however, when there is a treatment history that can be mapped and examined in fine detail. This leads to more information being available to prevent future deaths through the investigative process.

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.

CONTENTS

1. INTRODUCTION

1.1 This is the twelfth 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 2014/15 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.

1.3 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.

1.4 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.

1.5 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'.***

1.6 In September 2014 The Office of National Statistics (ONS) released their annual report concerning drug related deaths throughout England and Wales for 2013. 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 2013 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 2014 report for the 2013 deaths are based on deaths registered in a particular calendar year. Out of the 2,955 drug-related deaths registered in 2013, 1,488 (just over half) occurred in years before 2013

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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_375498.pdf

1.7 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 2014/15

2.1 This current report incorporates all reported suspected drug related deaths throughout Cornwall & IOS for 2014/ 15 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 2014/ 15 together with a breakdown of the main agents involved. Comparative figures for 2013/14, 2012, and 2011 are shown alongside:

	2011		2012		2013/14		2014/15	
Total drug related deaths	**12**		**25**		**15**		**18**	
Gender *(male –M, female – F)*	11 M	1 F	18 M	7 F	14 M	1 F	**16 M**	**2 F**
% Increase or Reduction	34% decrease from 2010		52% increase from 2011		40% decrease from 2012		**17% increase from 2013/14**	
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Other controlled drug and other	2 MDMA + other		2 Mephedrone 1 cocaine		1 x MDMA		**3 x poly drug 1 x alcohol plus cumulative drug history**	
RTA/Suicide (+ CD as included above)	2 Phenobarbitone		1 x RTC 5 x sus suicide as above		1 suicide		**0**	

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 have increased by 5- from 7 to 12 (increase of 58%). 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 increase in 2014/15 from 7 to 8 although this figure needs some explanation. Of those 8 cases, 3 cases involved the person dying being lawfully prescribed methadone whilst the other 5 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 last years' 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 has seen a significant difference. Further detail can be found in the synopsis section on page 16 but, in summarising the 18 drug related deaths, the breakdown of those in treatment is as follows;

- In drug treatment at death- **8**
- In alcohol treatment at death- **3**
- Died within 6 months of being in drug treatment- **3** (1 client at 1 month and 2 clients at 2 months)
- Died within 6 months of being in alcohol treatment- **3** (1 client at 1 month, 1 client at 1 ½ months and 1 client at 4 months)
- Died not in treatment nor within 6 months but having had a history of drug/ alcohol treatment- **1**

3. BRIEF CIRCUMSTANCES/CASE STUDIES 2014/15

3.1 Some of the 2014/15 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 18 drug related deaths are now briefly outlined below.

3.4 **Drug Related Death 1 – April 2014**

- 27 year old male who died at a friends' house in the Liskeard area. He was located on his back in an upstairs bedroom.
- This man and his friend had both been discharged from a detox unit days before the death. DRD1 was in detox for alcohol and his friend was being treated for opiate dependence.
- Both males injected heroin together and this death was witnessed by the friend.
- An Addaction client who was engaged for alcohol issues but died of a DRD.
- 2 ½ times legal limit for alcohol in combination with fatal level of heroin having been injected.

- Inquest determination of a drug related death with a cause of death given as heroin misuse.

Findings and applying the learning

- This is a case where early naloxone intervention could have made a positive outcome but neither friend had naloxone issued to them.
- Friend quoted as saying 'I was surprised as it (heroin) was a small amount' and when his friend collapsed 'I didn't know what to do'. A clear educational need for this client has been identified but it also is in need of addressing further across the whole treatment population to instil prevention awareness.
- The detox and rehabilitation unit Bosence/ Boswyns in conjunction with Addaction have now put in to place an intervention for all those it receives who have an alcohol only issue. The intervention educates on the risks and measures to be taken post discharge and particularly on the use of drugs such as heroin. The risks include post discharge tolerance, poly drug use and combining alcohol with drugs. This intervention was traditionally only aimed at those engaged in drug treatment.
- The naloxone awareness and availability is increasing in Cornwall but there is more work to do. This includes getting more service users to hold naloxone and this includes drug and alcohol clients. Furthermore, access to naloxone through supported housing is currently being improved with the DAAT working with Addaction and various supported housing projects. Bosence/ Boswyns are very close to being able to offer naloxone to those clients with the most need. This will be a major step forward in naloxone availability within Cornwall.

3.5 **Drug Related Death 2 – April 2014**

- 34 year old woman who died at her home address in the St Columb area. She was located deceased in an upstairs bedroom lying face down on the bed and fully clothed. The house was all secure and she is believed to have died alone with no third party involvement. She was not located for two weeks after her death.
- Referral made to Addaction a month before her death as a result of a drink driving arrest but she never engaged with the treatment team. She had historic drug issues that had been treated by the Cornwall Drug and Alcohol Team (CDAT) and was on a GP prescription for many drugs including pregabalin, tramadol, diazepam, temazepam and amitriptyline.
- Toxicological examination revealed potentially fatal levels of tramadol and pregabalin but there were many other prescribed and illicit drugs present which synergistically acted to depress this persons' respiration fatally. She has previously informed health professionals that she augmented her prescription drug regime with illicitly sourced methadone and morphine. Her GP reported that she had a tendency to overdose on her prescription medicines.
- Downward spiral in her physical and mental health after her mother died in 2005.
- GP, pain clinic and mental health involvement as well as sporadic drug and alcohol treatment over her life.
- An inquest determined a drug related death with a cause of death given as mixed drug toxicity

Findings and applying the learning

- Complex client suffering with chronic pain, substance misuse, anxiety, depression, agoraphobia and difficulty in coping with bereavement.
- Her many interactions with various medical/ mental health agencies saw her overusing her medications that took away, for example, some of her pain.
- Street drugs supplementing her prescriptions.
- Very difficult to know whether this was a suicide or one of her many over- use episodes of drugs. No obvious evidence of a suicide.
- Poly drug use and mental health overlap various issues that this client had.
- Increased work to be done in relation to pain relief medicines especially when combined with people having drug and alcohol issues.

3.6 **Drug Related Death 3 – April 2014**

- A 41 year old man who died at his home address in the Newquay area. He was found deceased in a chair in his lounge with evidence that he had groin injected prior to death.

- A long standing service user with intravenous drug use being prevalent who was in drug treatment at death.
- Was making good progress in treatment with less use of heroin combined with a better interaction with his family and less interaction with the judicial system.
- The last service user in Cornwall to be changed from diamorphine ampoule medication to methadone ampoules- this prescribing pattern was in progress when the client died. This prescribing was being managed well at community level.
- Determination at inquest of a drug related death with the cause of death given as an opiate overdose.

Findings and applying the learning

- None of the other clients that had been on a diamorphine prescription in Cornwall responded to the script being changed by self-harming or overdosing.
- The service user was given several months to prepare for the change in his prescription, and this was negotiated with him to the extent that he was given a choice of different medication to transfer onto. He understood the process and seemed more than prepared to go along with it.
- Addaction identified that a better peer-support structure and Addaction support structure around him might have made a difference, and this could have been better provided by an Addaction office in the town, in which group activities and mutual aid etc is available. This has now been addressed with a 'mutual aid partnership' (MAP) having been established for 2 months now. Furthermore, there is a 'brief intervention' group now running in Newquay helping to cover the towns' substance misuse populations' needs.
- The Coroner recommended at inquest that the keyworker be involved in subsequent reviews of deaths of their clients. Whilst this was happening at that time on a more limited basis, the whole review and reporting process has been reviewed jointly by Addaction and the DAAT. The feedback and involvement of the keyworker is more in depth now together with more robust and probing review of treatment by Addaction.

3.7 **Drug Related Death 4 – May 2014**

- 33 year old man who died in his bedsit at supported accommodation in the St Austell area.
- Determination at inquest of a drug related death with the cause of death being heroin toxicity in company with pregabalin and diazepam (no prescription for the latter two drugs).
- Long standing drug use and associated drug treatment history with CDAT and Addaction.
- Criminal justice issues linked to his drug use.
- There were issues of domestic tension with his partner and access to his children was impaired due to his drug use. Increased domestic tension would manifest in increased drug use which is what occurred in this case although a suicidal ideation or intent has been ruled out in this case.
- Drug treatment workers sometimes have to overcome client dishonesty and there was evidence in this case of him going to some lengths to avoid drug detection. Eg. Falsifying drug screening tests
- This death is another where poly drug use is apparent and features a lawful prescription only medicine.

Findings and applying the learning

- This service user had access to many support workers and a range of opportunities. Overall he can be described as a client making progress with opportunities such as a job interview being imminent prior to death.
- Further work to be carried out with supported accommodation in order to maximise the availability of naloxone. An anticipated relaxation of the legislation surrounding the prescription only medicine naloxone in October 2015 can only assist this process.
- Cases involving perpetrators and/ or victims of domestic violence may need further attention. From this case forward all suspected drug related deaths are notified to a range of domestic violence agencies with a view to collating this link between domestic violence and drug use. Any learning from this will be taken forward accordingly.

3.8 **Drug Related Death 5 – May 2014**

- 61 year old male died in Treliske Hospital after having been admitted following a drug overdose at his home address in the Newquay area.

- Inquest determination of an open verdict with the cause of death given as multiple drug and alcohol use.
- 4 ½ months out of Addaction treatment when he died.
- Very high alcohol content near toxic in its own right (292 ml/ 100ml in blood with the UK legal driving limit being 80ml/ 100ml as a comparator).
- Many previous deliberate overdoses self- reported and sometimes at police stations.
- Many reports at inquest from psychiatric liaison, A&E, his GP and Cornwall Foundation Trust (Mental Health).
- All referrals from A&E post overdosing resulted in this man failing to attend his follow up appointments.
- Although police S136 arrests were relevant here and other mental health assessments, he had sufficient insight and awareness of his actions to negate sectioning. He, therefore, was assessed many times but did not engage with MH services.

Findings and applying the learning

- Addaction review makes recommendation that high risk clients such as this should be seen quicker once they are referred in. Processes are now in place to address this time frame for high risk clients.
- Pattern of 'cry for help' type overdosing/ suicidal ideation needs to be picked up earlier in line with previous bullet point.
- Aged 61, this is the eldest service user to die 2014/15. Social inclusion was an issue for a long time and was being picked up in the week prior to death.
- CFT reviewed the case and highlighted disengagement issues and self- neglect.
- Clients who continually fail to attend their appointments pose a challenge and this constitutes a piece of work currently being done by Addaction. This does need to conjoin with associated non- attendance within mental health scenarios.

3.9 **Drug Related Death 6 – June 2014**

- 38 year old man died in a bed in the bedroom of a friends' house in the Camelford area after being left to 'sleep off' his intoxication.
- An inquest determination of an accidental death with the cause of death given as alcoholic liver cirrhosis in combination with prescribed methadone, diazepam, pregabalin and alcohol. Diazepam and pregabalin were not prescribed and the alcohol level was very high at 242ml/ 100ml in blood (3 ½ times the UK driving limit as a comparator).
- The case identified a need for improvement of information coming from HM prisons to Addaction in the prison release alert system. This stemmed from a query as to whether enough information about a client's medical history was available to community drugs teams, for example, to appropriately prescribe methadone when a client had acute liver problems. In this case, the ability of the client to metabolise methadone was in question from both pathology and toxicology.
- The community pharmacist played an important part in this case by accurately passing back valuable information to treatment teams. This highlights the important pharmacist role in drug treatment.
- Illicit pregabalin was sourced prior to death and used in combination with opiates (prescribed methadone in this case). This is an issue which has been highlighted by a January 2015 Drugscope publication especially amongst prisoners and post prison discharge. This case involved a man who was in and out of prison regularly.
- This mans' care at the scene of the death is questionable with several other people being present to monitor his health. One such person identified at this scene and at another death later in the year is in Addaction treatment also. That person has already been engaged further and has received more intense interventions based around drug and alcohol overdose.
- At the time of this case there was a difficulty in Camelford clients being able to get to Bodmin for their appointments as there was insufficient Addaction coverage in Camelford.

Findings and applying the learning

- Reviews by HMP, Addaction and the DAAT have concluded that the prescription of methadone was appropriate but there was a need to improve communication. This has now been addressed with a revamped HMP alert form which incorporates greater detail of patient/ clients medical needs and assessments whilst in prison. This, in turn, leads to a more informed treatment option for the client and this is applicable across the prison population for those being discharged to community treatment teams.

- HM Coroner praised the efforts made in this case from both the investigative and process changing angles as well as the positive way the enquiry helped the relatives of the deceased. The latter had a number of concerns and questions which were all addressed and answered to their satisfaction.
- Addaction have put more resources to the Camelford area for the gap to be bridged between community and the treatment team.

3.10 **Drug Related Death 7 – August 2014**

- 46 year old male who died at the roadside in the Bodmin area some while after having been released on bail from Bodmin Magistrates Court. Although the inquest is awaited in this case it is believed that he fell asleep at the roadside after consuming his prescribed medication and alcohol.
- The Independent Police Complaints Commission report on this case is awaited due to the proximity of the death to police and court custody. Furthermore, an internal Police investigation will need to be completed to look at the issues. From here, there may be learning and recommendations forthcoming relevant to drug and alcohol clients being discharged from courts in the future.
- The alcohol level was 2 ½ times that of the UK legal driving limit as a comparator. This was seemingly combined with this mans' lawful prescription of methadone and diazepam although it is difficult to know whether the toxicological findings equate to his prescribed amounts or any extra that he was able to source.
- Long term service user in Cornwall on substitute medication for a long standing opiate addiction.

3.11 **Drug Related Death 8 – September 2014**

- 45 year old man who was in alcohol treatment when he died at his home address in the Bodmin area.
- At inquest a determination was given of a drug related death with a cause of death given as acute respiratory failure linked to heroin misuse.
- No alcohol was found in the toxicological screen but the morphine levels derived from illicit heroin were in potentially fatal concentration.
- Whilst this man was in alcohol treatment there were no obvious signs of drug misuse to the treatment team. His last mention of drug use whilst in treatment was July 2013.
- Family member had regular contact and monitored his welfare.

Findings and applying the learning

- No obvious learning points in this case. This man self- medicated his various issues by using alcohol excessively for many years. The drug use was sporadic and not detected in his last 14 months of treatment.
- This mans' engagement with the treatment team was sometimes erratic and Addaction have identified a need generally for staff to be more proactive in pursuing their caseload clients if attendance is poor, erratic and/ or decreasing.

3.12 **Drug Related Death 9 – September 2014**

- 37 year old male died in his home address in the Bodmin area. Indications at the scene suggest that he died alone, possibly accidentally and not in a suicidal situation.
- The inquest is awaited but toxicology has found the presence of methadone and diazepam. These are known to have been illicitly sourced and this man was not receiving prescribed substitute medication although he had been in the past. He was a long term drug treatment client.
- Less significant but illicitly sourced prescription only medicines also feature here with the man sourcing anti-depressant medications.
- This man was responding well to treatment having been heroin free for 9 months and he was volunteering within Addaction to help others.
- Domestic issues with an ex- partner and child access issues were able to take this man off track from his treatment and are seen as a trigger to relapse.

Findings and applying the learning

- The source of the methadone is known and this source is also a person who is in drug treatment. The prescription surrounding that person's access to methadone has been adjusted to prevent further diversion.

- The access to and the wish of many street drug users to also incorporate prescription only medicines into their drug taking routine is being investigated. The whole subject will feature at the 2015 conference for 'Improving Health and reducing Substance Misuse Death'. Plenary speakers, workshops and a range of personnel will be involved in this event.
- This is another case where domestic and child access issues have appeared to have been playing on the mind of the deceased prior to death. The link between these issues being causation and/ or a factor in the death is being looked at across the range of drug related deaths. Whilst low in number at this point, the link will be further monitored with domestic violence agencies across the region.

3.13 **Drug Related Death 10 – October 2014**

- 48 year old male who died at the address of another in the Redruth area.
- An Addaction alcohol client who dropped out of treatment in September 2014 and there is no mention of drugs being used by him from April 2014 to September 2014. He had historic drug issues which had been treated.
- Witnesses at the scene of the death state that this man did use heroin.
- Toxicology supports heroin use by this man prior to death in combination with prescription medication (pregabalin and citalopram) which he lawfully held.
- A history of suicidal ideation and suicide attempts but this case has been investigated and deemed not have involved suicidal intent.
- Inquest determination of a drug related death with a cause of death given as acute respiratory failure linked to acute aspiration with morphine, alcohol, pregabalin and citalopram.
- Previous memory loss linked to an ex-wife dying and a resultant failed suicide attempt. Latter sporadic memory reinstatement led to this man having to re-live past tragic events and he dealt with this by taking drugs and alcohol.
- This man choked on vomit and died whilst intoxicated. His 'sleeping off' of this intoxication was witnessed and he was not alone when he died.

Findings and applying the learning

- Tragic events in this mans' life came back for him to re-live when his memory started to come back. He dealt with this by self-medicating with drugs and alcohol.
- The care of those being intoxicated through drink and/ or drugs is to be re-addressed in this year's overdose awareness week. This case highlights how a lack of awareness of a persons' vulnerability through intoxication can lead to death. This situation is preventable.

3.14 **Drug Related Death 11 – November 2014**

- 30 year old woman who died at her home address in the St Austell area.
- Inquest determination of a drug related death linked to a cardiac arrest resulting from a major pulmonary embolism arising from deep vein thrombosis that is likely to have been caused by high levels of groin injecting over a lengthy period.
- Complex client who died whilst in drug treatment.
- History of overdose – the most recent recorded as being in May and October 2014.
- History of poor physical health and self-neglect.
- Prior to custody there was a history of groin injecting, abscesses, including being hospitalised as a result of this. The groin injecting also involved new psychoactive substances (NPS).
- History of risk of domestic violence from her partner and she was a vulnerable adult. This client was initially due to be re-housed following her release from custody out of the St Austell area, however she returned to the relationship shortly after release. This negatively impacted on this client engaging with treatment.

Findings and applying the learning

- As this client had most recently reportedly taken legal highs it was recommended by Addaction that there should be continued work regarding raising the awareness of legal highs with staff and increasing confidence and knowledge in this area. All staff are to attend comprehensive training in New Psychoactive Substances as required.
- Continued work to develop service delivery for clients using New Psychoactive Substances, which is already in progress with a service delivery action plan.
- Continued work with staff regarding quality of risk assessments and risk management plans, with high risk clients to be signed off by the line manager.

- Further development of sharing clinical practice in criminal justice team meetings.
- On-going development of joint work with HM Prison Service and the use of prison visits to try to improve engagement and manage risk, particularly with the Turnaround cohort of clients. Increased use of prison visits for Turnaround clients to ensure continuity of care and encourage effective engagement upon release from custody.

3.15 **Drug Related Death 12 – November 2014**

- 37 year old male who died at the home address of a friend in the Bodmin area.
- Inquest determination of a drug related death with a cause of death given as morphine toxicity (derived from illicit heroin). Alcohol, illicit methadone, tramadol, diazepam, mirtazapine and pregabalin were also present which acted synergistically with the heroin to further depress the respiration of this client who was in drug treatment over a long period.
- This man had made plans to give himself up to Police as he had been recalled to prison. As part of that process he had wanted to have one 'last hit' of heroin. By prior arrangement an ex- girlfriend met at the friends address and brought with her some naloxone (opiate antidote drug) in case the drug taking went wrong.
- The man injected heroin, collapsed and the same syringe was used by the ex-girlfriend to inject him with naloxone in an attempt to rouse him. This failed to work and he died at the scene.
- Long standing drug treatment history linked to a very early initiation into alcohol and drug consumption by this man.

Findings and applying the learning

- From all the evidence available this appears to have been a tragic accident with preparatory acts having been made to offset any negative consequences of taking the heroin.
- The form of the naloxone was not that that is supplied to Addaction clients and its' origin is still unknown. This client was issued with the standard 'Prenoxad' naloxone and the ex-girlfriend is still an Addaction client who is aware of overdose and naloxone issues.
- The ex-girlfriend has received further interventions from Addaction due to this death and also another death that she was witness to during this reporting period.
- This is another case where illicit pregabalin appears in the toxicology. The drugs prevalence in this and other deaths has prompted an inclusion in this years 'Improving Health and Reducing Substance Misuse Deaths conference due to be held in October. Plenary speaker(s) and workshops will focus on the issues surrounding this and similar drugs currently being in vogue.

3.16 **Drug Related Death 13 – November 2014**

- 33 year old man who died at his home address in the Penzance area having been found deceased by his girlfriend.
- Inquest awaited but the toxicological screen of this man, who was in drug treatment, shows toxic levels of heroin derived morphine, and illicit pregabalin, methadone and a range of other drugs.
- Very volatile domestic relationship with fellow drug treatment service user girlfriend. Both would display suicidal tendencies when there was a relationship breakdown prior to getting back together. This latter behaviour was fairly frequent.
- This man deliberately and accidentally overdosed on a range of drugs in line with the last bullet point.
- This death occurred at a point in the mans' life where there were many positives but followed another falling out with his girlfriend.
- 18 years of substance misuse with associated crime and health issues.

Findings and applying the learning

- There is on-going research and awareness training around pregabalin and other prescription drugs to highlight the dangers of drug enhancement and poly drug use. It will form part of the 2015 'Peninsular Improving Health- Reducing Substance Misuse Deaths' conference due to its importance and rising profile.
- Cornwall DAAT is currently looking into any links with drug use and domestic violence with Cornwall domestic violence agency partners. This is both from the perspective of the abused and the abuser(s). This research is in its infancy but will be continuing and

focussing on those deaths where there has been a domestic violence aspect. This client's substance misuse often was reactionary to his domestic situation.

3.17 **Drug Related Death 14 – December 2014**

- 39 year old male who died at his home address in St Austell. He was located by a friend deceased and in his bed fully clothed.
- Inquest determination of an alcohol related death with a cause of death given as acute respiratory failure and alcohol toxicity. The alcohol level in this case was independently fatal.
- This death has been included in the drug related death statistics due to the prominence of drugs in this mans' life and in combination with a problematic alcohol use. The many health issues that this service user had were contributed to by his drug and alcohol use over his lifetime.
- Past medical history including a personality disorder with a complex psychiatric profile, vomiting, constipation, pseudo seizures and previous suicide attempts.
- This client refused a local detox in December 2014 two days before his death. A taxi had even been arranged to take him to the detox unit.
- Many interventions with a range of services such as medical, prison (including drug/ alcohol treatment), judicial and community treatment.

Findings and applying the learning

- The Addaction critical incident review group concluded that Addaction, nationally, is looking at the issue of dual diagnosis and how to better support services in working with individuals who present with co-existing substance misuse and poor mental health. Part of this is about enabling individual services to develop better local links with mental health providers to create more robust pathways. In relation to adult safeguarding this was mainly about risk assessment and how this is a dynamic process that is influenced by new pieces of information. All staff are under-going risk assessment training provided by Addaction.
- This case saw a man receiving MH assessments but his various diagnoses were not acute enough to warrant further treatment by mandatory section, for example. This type of complex client needs further scrutiny to avoid them 'falling through the net' between drug and alcohol treatment and mental health treatment.

3.18 **Drug Related Death 15 – January 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.

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

- 57 year old man who died at the premises of another 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.

3.20 **Drug Related Death 17- February 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.

3.21 **Drug Related Death 18- March 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.

4. SYNOPSIS 2014/15 DRUG RELATED DEATHS

4.1 Male

	2011	2012	2013/14	2014/15
Total Drug Related Deaths	12	25	15	**18**
Males	11 91%	14 66%	14 93.33%	**16**
Mean age	35.8	42.9	34 ½	**41**
Oldest	53 (5 x o/40 yrs)	63 (6 x o/40 yrs)	50 (20's- 5, 30's- 6, 40's- 2, 50's- 1)	**61 (20's-1, 30's-7, 40's- 6, 50's-1, 60's- 1)**
Youngest	24	27	2 x 21	**27**
Males – Heroin/alcohol/benzo	8	4	7 heroin, 2 morphine	**11 heroin**
Males –Methadone	1	9	7 (includes overlap with other CD's/ alcohol	**7 (2 deaths where methadone is the cause of death. 5 deaths where methadone is contributory and/ or merely present.**
Males – other controlled drug	2	1	1 x MDMA	**0**
Males in Treatment	5	6	5	**10 (7 drugs and 3 alcohol only)**
Males in treatment within 6 months of death or treatment referred/offered but never commenced (New category for 2013/14)			3 (1 within 6 months, 1 had contact but not commenced, 1 referred but never engaged)	**6 (3 drugs and 3 alcohol only)**

4.1a

Toxicological Result	Number of male deaths
Heroin in significant amount	11
Heroin only	1
Heroin and other drugs	7
Heroin and significant alcohol level *(80ml/100ml in blood is UK driving limit)*	3 (alcohol levels of 194, 292 and 285mg/ 100ml blood)
Alcohol only (underlying drug history making this a DRD by definition)	1 (alcohol level of 376mg/ 100ml in blood)
Non- prescribed methadone	5 (1 in combination with illicit diazepam, 2 in combination with heroin and many others, 1 in combination with prescription medication in fatal amounts and 1 in combination with alcohol)
Prescribed methadone with other	3 (1 in combination with scripted morphine and illicit heroin, 1 in combination with 242 ml/100ml alcohol, illicit pregabalin and illicit diazepam, 1 in combination with 215 ml/ 100ml alcohol and scripted diazepam)
Significant presence of alcohol level *(80ml/100ml in blood is UK driving limit)*	6 (alcohol levels of 194, 292, 242, 215, 376 and 285)
Pregabalin presence	6 (4 illicitly sourced by opiate users, 2 lawfully prescribed of which 1 was an overuse of pregabalin and 1 was taken with heroin)

4.2 Female

	2011	2012	2013/14	**2014/15**
Total Drug Related Deaths	12	25	15	**18**
Females	1 (9%)	7 (33%)	1 (6.67%)	**2 (11%)**
Mean age	24	37	58	**32**
Oldest	24	59	58	**34**
Youngest	24	17	58	**30**
Females – Heroin/alcohol/benzos + Morphine	0	4	1 x morphine & benzo'x	**1 x heroin + NPS**
F/males-Methadone	1	2	0	***see box below**
Females - other c/drug	0	1	0	***1 x Fatal levels of tramadol & pregabalin in combination with illicit methadone**
Females in Treatment	0	1	0	**1**

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

- Home address- 9
- Home address of another- 5
- Hospital (after an overdose at home address)- 1
- Supported accommodation- 1
- Street/ roadside- 1
- Public toilets- 1

Overwhelmingly there is bias towards the home address being the premises where most drug related deaths take place (16 out of the 18 if the hospital death is counted as initially being at the home address and the supported accommodation is considered as a temporary 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:

- Bodmin- 5. Whilst representing nearly 28% of the total number of deaths, the actual number of deaths involving a Bodmin resident is 3 of which one of these had only been resident there for a month. The 2 other deaths involved a visitor to a friend's house and a person having just been released from the local magistrates court.
- Newquay- 5. This number of deaths in Newquay also represents nearly 28% of the total but there is nothing to suggest any links between the deaths. The numbers are also too small to draw any meaningful conclusions from the type of drugs taken.
- St Austell- 3
- Penzance- 2
- Liskeard- 1
- Camelford- 1
- Redruth-1

4.5 The average age of males dying from a drug related death during 2014/15 has risen from 34½ to 41. Males represent 89% of the total number of deaths (16 out of the total of 18). Last year's concern about the number of males dying in their twenties (5 out of 15 deaths) has decreased this year where there is only one death in the twenties out of 18 total deaths. The twenties group last year consisted largely of those not in any kind of treatment. Their drug use was mainly 'experimental' and did not form part of any problematic or long standing drug habit. The increased average age for the 2014/ 15 period could be explained by a very high number of deaths involving those being retained in treatment.

As previously highlighted the number of people dying from a drug related death in this period and having a link to current or recent treatment has risen dramatically. Of the 17 service users, 8 were receiving substitute medication for their drug issues. 7 of these cases were being prescribed in secondary care and 1 from primary care (GP with special interests- GPwSI).

The number of females dying has doubled but this is a change from 1 to 2 deaths.

4.6 Poly drug use remains a concern again this year. There is only one death attributable to a sole agent being involved and that is a heroin death. All other cases have at least one other contributory substance- drug 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 6 of this period's case studies.

4.7 Pregabalin has been shown to be present in 6 of the deaths of which only 2 were prescribed this medication. Pregabalin can be prescribed for conditions such as epilepsy and neuropathic pain. It is becoming more prevalent for opiate users to combine Pregabalin (or its' close relative drug Gabapentin) with opiate drugs, particularly heroin. It is obvious from this periods' deaths that 'experienced' and long term drug users have been combining pregabalin with heroin. This indicates that this combination is more than merely experimental and had some value to their respective drug taking habits. It has been identified that this drug combination needs further investigation and research so that treatment and resources can be better informed.

4.8 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 features in 6 of the 18 deaths (33%). These 6 deaths have witnesses who have featured in the evidence gathering phase of the investigations so their presence is known absolutely. Whilst the remaining 12 deaths do not feature such witnesses, by the very nature of drug related death and the illegalities involved, it is suspected that more of these deaths could have been witnessed but that those witnesses have not come forward. Three of the six deaths involved a person being allowed to 'sleep off' the intoxication whilst others were close by- one man actually choked on his own vomit and this starkly illustrates how preventable some of these deaths can be. One death involved a person witnessing the heroin administration and not knowing what to do when his friend collapsed. There is an educational and awareness raising issue here which is on- going but is of particular concern bearing in mind the number of those dying having links to treatment.

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 covers 9 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 2014/15 - 2015/16

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 next years' 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, 2014/ 15 saw another 18 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 Prevention Week**

The theme of this year's awareness raising will be the recognition of overdose and the immediate first aid that can help to save a life. Whilst this is a regular feature within a range of service delivery due to the dangers of drug and alcohol misuse, the number of cases featured within this report illustrate that the education is required. The date for this week has yet to be set but will involve a multi- agency approach to maximise the number of people receiving this input.

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 2014/ 15 period. The deaths involving alcohol as a contributory factor in a drug related death have been described in sections 3 and 4.

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. Two examples of these are described below;

- Male aged 40 who had a link to drug and alcohol services died at his home address after having consumed alpha- methyl tryptophan (AMT) which was a legal new psychoactive substance when he died. The drug has now been made illegal under The Misuse of Drugs Act 1971. This is the only death in Cornwall to feature AMT as at the writing of this report. Whilst there were issues to be picked up from a treatment point of view with this case such as his failure to attend appointments etc the case was not a 'drug related death' according to the standard definition and adhered to within this report.
- Female aged 32 died whilst on holiday in the area and she was not in drug or alcohol treatment. She had a recent medical history of 6 months of debilitating headaches which were still being diagnosed. On New Year's Eve 2014 she had a bad headache but was witnessed to take MDMA (ecstasy) with friends and is suspected to also have consumed cocaine. Her condition worsened and she died in hospital the following day. Toxicological examination was not possible and pathological examination was not clear on the cause of death but favoured infection perhaps in combination with drug use. This case has been debated at the Cornwall Drug Related Death Review Panel with experts in their field and the consensus of opinion was that this death did not fit the standard definition when taking into consideration all of the available evidence. The inquest hearing in this case is awaited.

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 2014/15 is 18, which represents an increase of 17% from 2013/14 (15 deaths to 18). The main findings in this report are;

- 12 of the 18 deaths feature heroin significantly (street sourced illicit heroin and not pharmaceutical diamorphine).
- 8 cases where methadone is a factor in the death either by lawful prescription (3) or illicit source (5).
- 17 of the 18 deaths having been in treatment at death (11) or died within 6 months of being in treatment (6).
- 16 males and 2 females died in this period.
- Average age of the males has increased from 34 ½ to 41.
- Both females who died were in their early 30's,
- High levels of alcohol feature in 6 deaths (33%)
- Pregabalin features in 6 deaths (33%) of which 2 were prescribed and 4 were illicitly sourced. Pregabalin has been used in combination with heroin and appears to be a growing trend.
- Other drugs being illicitly sourced that have contributed to synergistic effects of opiates, for example, have been anti- depressant medicines and benzodiazepines.
- At least 6 of the deaths (33%) have involved another or others as being witness to the drug taking and/ or the consequences.
- Immediate first aid and overdose awareness issues apparent in line with the previous point.
- Only one death involved a witness administering naloxone and, ironically, this was naloxone brought to an address as a preparatory act for heroin use. 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 6 of the drug related deaths.

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 2015/16 will see further ways of getting these messages across. A second year of the Service of Remembrance and the 'Improving Health-Reducing Substance Misuse Deaths' conference are amongst the high profile events that ensure awareness and learning continue. This year has seen more improved agency joint working and this will also be next years' aim. 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.

Produced By Sid Willett
Drug Related Death Prevention Coordinator
DAAT Cornwall & Isles of Scilly

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	2013/14	2014/15	Remarks
Opiates – **Heroin** (may include methadone)	6	7	8	10	10	7	13	7	12 *	12 *	8	9	8	8 *	9 (7 heroin, 2 morphine)	**12**	***Includes suicide
Methadone (only or with non-relevant other drug)	5	2	0	0	1	1	1	2	6	5	5	7 *	2	11 *	7**	**8**	****this includes methadone and relevant other dru 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	**0**	
RTA / Suicide and controlled drug present	?	?	?	?	?	6	4	0	1h	2h	2 c	1h	0	6	1	**0**	
Cornwall DAAT recorded ***'drug related deaths'***	11	9	8	11	12	9	13	11	19	18	13	18	12	25	15	**18**	
npSAD recorded /published DRDs for Cornwall & IOS	19	6	7	10	2	2	2	15	35	14	27	32	N/A	N/A	N/A	N/A	

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
M46 Accidental alcohol poisoning
M47 Accidental opiate poisoning
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