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 2013 to 31st March 2014

CONTENTS

1. INTRODUCTION

1.1 This is the eleventh 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 2013/14 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 There have been many changes since the 2012 report with the main ones being:

- The Coroners Rules have changed whereby inquests are now recommended to be held a maximum of six months from the date of the death.
- 4 community alcohol treatment providers have been merged into one, with the contract being awarded to Addaction as of 1st April 2013.
- There has been a change of staff in relation to the Drug Related Death Prevention Co-ordinator post as of 1st June 1013.
- The DAAT team transferred into Public Health and then into the Council from 1st April 2013.

1.4 Reports prior to 2009 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 & IOS DAAT frequently receives requests for copies of the Cornwall recording process, together with any recent annual reports, from other DAAT areas or interested parties. 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 August 2013 the Office of National Statistics (ONS) released their annual report concerning drug related deaths throughout England and Wales for 2012. All drug related deaths are included; however this is also filtered to include deaths within the above definition involving drug misuse. There has been some criticism of the ONS report as, through necessity it reports mainly on deaths during 2012. Deaths during the latter part of 2012 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 latest ONS annual report can be accessed via the link in Appendix C.

1.7 The National Programme for Substance Misuse Deaths (NpSAD) has produced a report for the year 2012. The data collected by this programme relies upon the completion of NpSAD forms by HM Coroners following inquests into drug related deaths. HM Coroners continue to routinely forward these forms and the data is still being collected. This is a voluntary arrangement so exact numbers are never achieved. The 2012 report had a return rate of 78.4% of the forms from participating HM Coroners. The latest version of this report can be accessed via the link in Appendix C.

1.8 The figures concerning drug related deaths published by the Cornwall & IOS DAAT are seen as consistently accurate. The DAAT works closely with other agencies and the Suicide

Audit Group to ensure there is no double counting and that high standards of monitoring and recording are maintained. A database for recording and monitoring drug related deaths was introduced in 2009 which ensures all Peninsula DAATs and the Devon and Cornwall Constabulary work to a common format. A more localised and case specific database has now been introduced for Cornwall which further improves accuracy of reporting. Accuracy is still further improved with increasingly closer working with HM Coroner and the Coroners Officers. This is discussed further in Section 5.

2. RECORDED DRUG RELATED DEATHS –Cornwall & IOS 2013/14

2.1 This current report incorporates all reported suspected drug related deaths throughout Cornwall & IOS for 2013/ 14 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 2013/ 14 together with a breakdown of the main agents involved. Comparative figures for 2012, 2011and 2010 are shown alongside:

	2010	2011	2012	2013/14
Total drug related deaths	**18**	**12**	**25**	**15**
% Increase or Reduction	**38** % Increase from 2009	**34**% decrease from 2010	**52** % Increase from 2011	**40 % decrease from 2012**
Heroin / Morphine present	9	8	8	9 (7 heroin)
Methadone present	7	2	11	7
Other controlled drug	2 x cocaine	2 MDMA + other	2 Mephedrone Cocaine	1 x MDMA
RTA/Suicide (+ CD as included above)	1 (Heroin)	2 Phenobarbitone	1 x RTA 5 x sus. suicide as above	1 suicide

2.3 Early indications show the database system introduced in 2009 filters out many of the non-relevant deaths that do not involve controlled drugs hence 9 of the reported deaths are either confirmed or suspected to be non-drug related. DAAT also monitors deaths where drugs have featured but do not come under the standard drug related death definition. Tramadol was one such drug which had featured as a contributory factor in previous deaths in Cornwall with concerning frequency. Its availability on prescription and also its increasing value in the illegal drug dealing scene meant that it had become a drug worthy of increased vigilance by many agencies. Previous DAAT reports have helped to advertise this concern and the drug is now classified as a Class C controlled drug for the purposes of The Misuse of Drugs Act 1971. 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 implicated have slightly decreased by one such death from 8 to 7. Of these 7 deaths one toxicology report is awaited but all evidence available thus far, points to a fatal administration of heroin. In the other case toxicology was not available due to their only being ante mortem samples taken which screened negative to heroin. The latter situation conflicts with evidence from the scene of the heroin overdose so remains an anomaly at this time. Tramadol has previously been present in Cornwall heroin deaths and it featured in two deaths in 2013/14. One case was at a level which would have detrimentally combined with the heroin level. The other case was not quantified although this case was overwhelmingly dominated by other drugs in combination with heroin and alcohol. In all but one case which cannot be verified due to ante mortem samples screening negatively, the deaths involving heroin have all involved other drugs

and/or alcohol in combination. 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.

2.5 Deaths from methadone toxicity (or where it has been implicated in death) fell during 2013/14 from 11 to 7. Five of these deaths involved displaced methadone supplied unlawfully. The other 2 cases involved one person recklessly consuming his methadone prescription in combination with other prescribed medication and another person who appears to have 'topped up' his methadone prescription with street drugs (methadone and heroin).

2.6 The number of heroin deaths for this period has remained almost the same as the previous three reported periods. Whilst the proportion of deaths with heroin present is higher for 2013/ 14 compared with 2012, this is partly due to a large overlap in 2013/ 14 between incidents, where heroin and other drugs have been present in amounts described as either fatal or fatal in combination. Although still too high, the number of deaths where methadone has been present is encouragingly lower compared with the high numbers in 2012. This proportion is lower again when considering that the methadone deaths are partly comprised of poly drug use, and not methadone exclusive deaths.

2.7 There have been 5 cases in 2013/14 where the deceased has been in current drug treatment. One of those cases involved the male subject having died after consuming just his own medication, however, he consumed a number of days medication all at the same time. The other four cases all involve street sourced drugs - some in combination with medication and some with alcohol. A further 3 cases involved one male being out of drug treatment for two months having had a long drug treatment history, another male being referred but never engaging with treatment services, and a third male was referred, but never engaged. All these deaths have been reviewed to see if there was any learning to emerge from them, particularly as these cases involved people who had died, and who had had a far greater interaction with professional workers in the substance misuse field. The detail of these cases can be found in the next section. Interestingly, the numbers of those dying from a drug related death whilst in current drug treatment has hardly changed in the last 4 years of surveillance - 2010 (5), 2011 (5), 2012 (6), 2013/14 (5).

3. BRIEF CIRCUMSTANCES/CASE STUDIES 2013/14

3.1 Some of the 2013/14 suspected drug related deaths are still sub judice and await inquisition 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.

3.3 All 15 drug related deaths are now briefly outlined below.

3.4 **Drug Related Death 1 – April 2013**

- 36 year old male who died at his home address in Camelford.
- Ambulance responded to a friend that witnessed the death, and who had purchased heroin with the deceased earlier that day. They then used heroin together.
- The deceased's final words were "It's strong gear".
- Known to drug treatment services for 12 years, he had just had his case moved to Addaction from CDAT.
- Subject drank alcohol heavily; used street drugs on top of his methadone prescription and street sourced the anti-psychotic drug quetiapine and the anti- depressant drug mirtazapine.
- Toxicology revealed fatal amounts of heroin in combination with high social levels of alcohol and methadone which appeared to exceed the subjects own prescription levels of

methadone. In October 2013 HM Coroner returned a verdict of Accidental Death with heroin misuse as a contributory factor.

Findings and applying the learning

- This is a case where early naloxone intervention could have made a positive outcome, especially as the subject employed a 'buddy' system with his purchase, and the type of drugs involved. The friend's attempts at first aid would have been maximised with naloxone availability.
- The deceased had been assessed for therapeutic discharge, because his dangerous drug and alcohol use conflicted with his medication program.
- Information about the subjects deteriorating health from the pharmacist to the drug treatment team was valuable, but the pharmacist did not receive any feedback.
- It is recognised that pharmacists are a valuable assets in the drug treatment journey, and often see the clients more than the drug workers do. To that end, the matter of feedback has been raised at various meetings including the Pharmacy and Prescribing forum for Cornwall, where best practise recommends that pharmacists should have a dynamic two way conversation with treatment teams. Furthermore, the matter was addressed at recent DAAT/ Addaction training given to pharmacists at three events around Cornwall. This feedback does appear to be an isolated incident and came at a time where there was much change between a departing and a newly appointed treatment team.
- This is another case where quetiapine and anti-depressants have been street sourced. These drugs can have a detrimental effect on the body when combined with opiates and alcohol. The DAAT is concerned at this development and is keeping a close watch on the prevalence of these drugs.

3.5 **Drug Related Death 2 – April 2013**

- 24 year old male who died at a friend's house in the Hayle area.
- Peer pressure and a certain amount of 'egging on' were involved with the deceased drinking the methadone of another user.
- The toxicology supports alcohol and methadone toxicity, and can be 'fatal in a naïve user or a non- tolerant individual' according to the toxicologist.
- An inquest held in May 2014 determined that this was one of the cases that highlight the danger of 'social' methadone use, especially in combination with alcohol.

Findings and applying the learning

The DAAT consider that this 'experimentation' in the social scene is of concern and is worthy of widespread and further advertising to raise awareness. Whilst DAAT have not been involved in the investigation of any criminality in this case and the illegal supply of methadone, it was highlighted in emotional ways at the inquest by the mother of the deceased. The issues raised by this case are concerning, and ongoing in relation to the casual approach that some take towards methadone. There are elements of this case that echo the well-publicised 'neknominate' or 'drink or dare' cases where a challenge to drink certain things can lead to massive intoxication if not death.

3.6 **Drug Related Death 3 – May 2013**

- 31 year old male who died at RCHT after being admitted with a suspected heroin overdose that he received in a premise in Penzance.
- Toxicology does not assist this case as all ante mortem samples were negative but witnesses maintain an injecting of the deceased by another.
- An inquest held in June 2014 returned an open determination as, although the circumstantial information pointed towards a heroin overdose, the conclusive evidence from pathology and toxicology was not present

3.7 **Drug Related Death 4 – June 2013**

- 21 year old male who died at his home address in Redruth.
- Died after consuming 10 cans of lager and some of his mother's prescribed Oramorph medication (opiate based analgesic).
- Toxicology supported this fatality as being 'potentially fatal in a non-tolerant individual'.
- The inquest in October 2013 recorded a verdict of accidental death with underlying morphine overdose.

Findings and applying the learning

It is unlikely that this could have been avoided except perhaps for the medication having been locked away. That said, the deceased was not a child and there is no evidence to support him having consumed his mother's medication before. This appears to have been curiosity and opportunity combined with alcohol. This type of 'experimentation' is difficult to address when people are together, let alone an individual deciding to experiment with no others present to potentially assist if problems occur.

3.8 **Drug Related Death 5 – July 2013**

- 21 year old male who lived in Newquay and died there, after an evening out with friends in the town's bars and clubs.
- Deceased took cocaine and crystal MDMA (ecstasy) during the evening. He began to convulse in a nightclub, exhibiting all the symptoms of ecstasy overdose. He was a regular user of cocaine and MDMA.
- Received treatment from door staff, an off duty nurse and ambulance staff before being admitted to RCHT A&E Dept. He died in hospital at 0550 the following morning.
- An inquest held in January 2014 delivered a verdict of accidental death with overdose of MDMA and cocaine utilisation.

Findings and applying the learning

- It is unlikely that this death could have been avoided. The deceased was a regular ecstasy and cocaine user, was with friends at the time, and this episode seemed to be like any other of his previous nights out.
- All first aid and medical treatment he received was faultless.
- The toxicology showed very high levels of metabolites from ecstasy, and lesser levels of cocaine metabolites. The toxicologist commented 'the MDMA concentration was potentially fatal independent of other mechanisms of death'. It is noted that ecstasy deaths are rare.
- This death is a slight anomaly when compared with the other deaths that are reported upon, which often involve alcohol, opiate type drugs and/or other drugs of sedation.

3.9 **Drug Related Death 6 – August 2013**

- 29 year old male who died in temporary and emergency housing in Newquay, he was not found for some 6 days after his death.
- He was in recent drug treatment with Addaction and was also receiving mental health treatment with the Cornwall Mental Health Team.
- He self- disclosed a daily alcohol consumption of 30 to 40 units.
- Criminal Justice interventions mainly stemming from his chaotic lifestyle.
- Used street sourced methadone in combination with many other drugs.
- Accommodation was unsuitable for this client who was surrounded by others that used drugs and alcohol.
- The inquest determination was one of a drug and alcohol accident with morphine toxicity.

Findings and applying the learning

- The drug treatment team were presented with a client having serious needs who lived a chaotic lifestyle, with dangerous drug use combinations being the norm. The team did not have sufficient contact time to stabilise the deceased before his death, but he did get treatment through Probation teams, in conjunction with those that supported the Criminal Justice intervention model.
- The accommodation in this case seemed woefully inadequate and, although this was emergency accommodation and not 24/7 care, it is concerning that a person presenting with so many problems could die and not be found for 6 days. This and other accommodation issues relating to chaotic drug users are being addressed within the DAAT and other agencies.
- The inquest held in May 2014 heard from witnesses from Police, Probation, Mental Health and Drug/ Alcohol Treatment Services. All reiterated the difficulties of dealing with a client with so many issues, and his very large alcohol consumption.

3.10 **Drug Related Death 7 – August 2013**

- 38 year old male who lived in Penzance and died there overnight, whilst at a friend's house with his friend sleeping on a couch beside him.

- The deceased attended a local music festival on the day of his death with others. There are various versions as to what amounts of alcohol he consumed on the day, however, there are no witnesses that have confirmed any drug taking by the deceased.
- Toxicological examination pointed towards 7 separate intoxicants which, in combination, are likely to have been the reason for death. These included alcohol, morphine (derived from heroin), codeine, ketamine, diazepam and BZP (one of the piperazine group of drugs). The toxicologist commented that all drugs in the presence of alcohol would have a detrimental effect on motor function, respiratory and consciousness levels. There was a potentially fatal administration of heroin close to death.
- The inquest held in April 2014 determined that this was a drug related death with opiate and alcohol toxicity.

3.11 **Drug Related Death 8 – August 2013**

- 39 year old male who died at his home address in Liskeard and had a long drug treatment history.
- Mental health issues with his last period of drug treatment as a result of him self- referring for groin injecting new psychoactive substances.
- Died after having shared heroin with a friend who was also at the scene of the death and called the ambulance.
- Toxicology results revealed fatal levels of heroin, and other levels of NRG2 (methylethcathinone- one of the more recent mephedrone derivatives), diazepam and ketamine).
- An inquest held in May 2014 determined that this was a drug related death with overdose of heroin potentiated by use of benzodiazepines and ketamine.

Findings and applying the learning

- This is another example of a drug death where a friend was present and called an ambulance to the scene. Had the friend been able to access naloxone then the outcome may well have been different.
- The possible presence of a higher purity heroin is what the friend stated at the inquest and this highlights one of the dangers of purchasing heroin at street level where the purity is never known.
- The deceased had been a drug injector and dangerous site injector for many years. He was not an alcohol drinker but there is wide range poly drug use evidence in this case.

3.12 **Drug Related Death 9 – August 2013**

- 48 year old male who lived and died in Looe.
- Big alcohol drinker with daily self-reported intake of 40 units.
- Toxicology has revealed that this man had high levels of alcohol in his body as well as illicitly sourced methadone.
- Inquest determination of a drug related death.
- A propensity for violence and erratic behaviour combined with a home address which could be unsafe for care/ treatment workers to visit, made the engagement with this male in treatment extremely difficult. Whilst referrals were made, this person never engaged.

Findings and applying the learning

- Another example of very high levels of alcohol drinking with illicitly sourced methadone
- The subjects' behaviour limited agencies abilities to engage with him and illustrates a case where a multi- agency risk assessment approach may assist this hard to reach type of case. It is noted here that the subjects' commitment to engage with his various referrals was not present.

3.13 **Drug Related Death 10 – August 2013**

- 37 year old male who died at his home address in Penzance.
- He was in drug treatment on and off from 2006 with CDAT and from April 2013 up until 18th July 2013 with Addaction.
- He had a long standing drug use problem which went back to his early teens.
- There were family stresses in his early life and the deceased was 'squatting' by the age of 17.
- Toxicology found fatal levels of dihydrocodeine in combination with benzodiazepines. The inquest held in April 2014 determined that this was a drug related death with dihydrocodeine overdose.

Findings and applying the learning

- The deceased received very good drug treatment but the treatment personnel were fighting against client ambivalence and an undercurrent of benzodiazepine use.
- The deceased was often warned that his continued use would undermine any positive gains hoped to be made with his opiate treatment.
- The sketchy nature of the deceased's engagement interspersed with time away led to a treatment team having to pick up the pieces every time the deceased returned to treatment. The deceased's role in this was key but his engagement was never to change sufficiently for treatment to override his use of the benzodiazepines.

3.14 **Drug Related Death 11 – November 2013**

- 58 year old female with an apparent suicide by falling from cliffs at Newquay.
- Mental health issues and alcohol issues having recently been treated in Cornwall.
- Overdosed a week before her death on her prescription morphine.
- The toxicology revealed morphine levels to be at 'potentially fatal levels'.
- Inquest awaited.

3.15 **Drug Related Death 12 – December 2013**

- 24 year old male who died at his home address in Truro.
- Limited contact with Addaction after prison release mid- November. No substitute medication.
- Disclosed to the Police in December upon arrest, that he was using ½ gram of heroin per day.
- Toxicology showed that there were levels of methadone, gabapentin, mirtazapine, metabolites of diazepam and amphetamine in his system.
- Possible tolerance issues with recent prison release.
- Inquest awaited and currently sub-judice applies.

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

- 47 year old man from Falmouth who died in a Falmouth street.
- The deceased had a long drug and alcohol history but poor engagement with drug and alcohol services. He had been in treatment with Addaction since April 2013.
- The deceased had been diagnosed with alcoholic liver disease with associated ascites (a condition requiring regular draining of fluid from the abdomen).
- Three hospitalisations since April 2013 for stab wound to abdomen, draining of the abdomen and umbilical hernia operation.
- Fell in the street head first without trying to break his fall.
- He informed witnesses to the fall that he'd taken a large amount of heroin.
- Toxicology bears out a large and recent administration of heroin in conjunction with tramadol.
- An inquest was held on 6th October 2014. Although the subject had consumed large amounts of heroin prior to his fall, he had also received medical treatment to counteract this. The fall led to massive haemorrhaging in his abdomen, and the determination was passed as accidental death.
- Furthermore, 11 litres of abdominal fluid had to be drained from the subject in the emergency department at hospital pointing to a seriously unwell individual in relation to liver health.

Findings and applying the learning

- Long standing drug and alcohol history of a person who was seriously unwell and getting worse.
- His continued excessive use of alcohol during treatment and sporadic engagement with the treatment team always undermined any positive steps being taken.
- Although the inquest of this death has determined its cause to be accidental, the underlying substance misuse issues have meant that it is still being recorded as drug related for the purposes of this report.

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

- 50 year old male who died at his home address in St Austell.
- Long drug treatment history and he was with Addaction staff at the time of his death.

- Witness stated that the deceased took multiple days' doses of his medication in one go, which was normal behaviour for him.
- Toxicology supports the involvement of the deceased's medication only.
- An inquest held on 21st July 2014 determined this case to be a drug related death with central nervous system depression and mixed drug toxicity.

Findings and applying the learning

- Naloxone availability prior to ambulance attendance may have made a positive difference.
- Information regarding the subject's consumption of his medication was not communicated in this case, and this was a key factor. As a result, preventative measures were not put into place. This highlights the need for information to flow not only from the subject, but from the wider family and support networks.

3.18 **Drug Related Death 15 – March 2014**

- 39 year old male who had moved two months previously from East Anglia to his parents address in St Austell where he died.
- Had an injecting heroin history but had not sought treatment in Cornwall.
- Used drugs paraphernalia found at the scene (deceased's bedroom).
- Toxicology returned a conclusion that the morphine levels derived from heroin were in the potentially toxic/ lethal range and commented upon the presence of alcohol.
- Inquest awaited.

4. SYNOPSIS 2013/14 DRUG RELATED DEATHS

4.1 Male

	2010	**2011**	**2012**	**2013/14**
Total Drug Related Deaths	18	12	25	**15**
Males	15 88%	11 91%	14 66%	**14 93.33%**
Mean age	40.3	35.8	42.9	**34 ½**
Oldest	64 (5 x o/40yrs)	53 (5x o/40 yrs)	63 (6 x o/40 yrs)	**50 (20's- 5, 30's- 6, 40's- 2, 50's- 1)**
Youngest	29	24	27	**2 x 21**
Males – Heroin/alcohol/benzos	9	8	4	**
Males –Methadone	5	1	9	**
Males – other controlled drug	2 (cocaine)	2	1	**1 x MDMA/MDA**
Males in Treatment	5 (incl 1x ref/assessed)	5	6	**5**
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)**

****** Comparison data for this report has proved difficult as the majority of the toxicological screens for 2013/14 show poly drug use with several including alcohol. There is, therefore, huge overlap between heroin and methadone, for example, where they appear in combination and with other drugs/ alcohol. This overlap has been tabulated below to show the various combinations.

Toxicological Result	Number of male deaths
Heroin only	2 (1 x circumstantial evidence with no tox, 1 x tox awaited but strongly believed to be a heroin death)
Heroin, methadone, alcohol and others	3
Heroin and others	2
Methadone and alcohol	2
Methadone, benzodiazepines and others	2
Morphine and alcohol	1
Morphine and benzodiazepines	1
Benzodiazepines, alcohol and others	1
Other controlled drug	1 x MDMA/MDA

4.2 Female

	2010	2011	2012	**2013/14**
Total Drug Related Deaths	17	12	25	**15**
Females	2 12%	1 9%	7 33%	**1 (6.67 %)**
Mean age	27.5	24	37	**58**
Oldest	31	24	59	**58**
Youngest	24	24	17	**58**
Females – Heroin/alcohol/benzos + Morphine	0	0	4	**1 x morphine and benzo's**
F/males-Methadone	2	1	2	**0**
Females - other c/drug	0	0	1	**0**
Females in Treatment	2	0	1	**0**

4.3 In examining the venues where these deaths have occurred, the majority were at the home address of the deceased - 9 in total. One of these deaths was a temporary home address in Council emergency housing. 2 deaths were at the home address of another and one death was as a result of a yet to be determined suicide, at cliffs near Newquay. The remaining 3 deaths were in hospital as a result of drug consumption elsewhere: a) home address of another, b) nightclub and c) in the street.

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

- Penzance 3, Newquay 3, St Austell 2, Camelford 1, Hayle 1, Redruth 1, Liskeard 1, Looe 1, Truro 1, Falmouth 1.

Examination of these cases by area does not reveal any links. Likewise, there do not appear to be any links through association, drug batch, venue, area of death or other criteria. Each death appears to be completely separate, albeit the exact source of heroin, for example, is rarely known and even when it is, the exact same batch is rarely known either. Two cases involve comments where the heroin involved is suspected to have been of a higher purity. One comment was made by a person shortly before his death and another comment was made by a witness to a heroin death, where the witness overdosed on the same batch of heroin. There are insufficient numbers of deaths across Cornwall during 2013/14 to establish that a particular area or town is more at risk from its inhabitants befalling a drug related death.

4.5 The average age of males dying from a drug related death during 2013/14 is 34 ½. Males represent 93.33% of the total number of deaths (14 out of the total of 15). It is of particular concern that the average age of male drug related deaths in this reporting period, is low,, the average age is lower than in previous periods because 5 of the males were in their twenties (2 x 21, 2 x 24 and 1 x 29).

4.6 Poly drug use remains a concern, as has already been outlined, with the overlap in deaths where heroin and methadone feature both together or in combination with other drugs.

4.7 Alcohol use with any drug, whether street sourced or prescribed, remains of concern and features in many of this period's case studies.

4.8 Despite widespread awareness initiatives, incorporation into treatment regimens and general advice, methadone experimentation and/ or street sourcing featured in the case studies to such an extent, that continued vigilance and advertising of this important subject is strongly advised.

5. NEW MEASURES /INITIATIVES / PROGRESS 2013/14 into 2014/15

5.1 **Peninsular Database**

The database that has been developed for use across the peninsular and maintained by Devon and Cornwall Police continues to be the focus of the DAAT and Public Health teams. Whilst there is still much work to be done in trying to get each area across the peninsular to work in the same way, when it comes to drug related deaths, this database sits at the centre of collating the numbers of deaths. It is from this platform that the Peninsular Drug Related Deaths Review Group endeavour to develop linked working. Unfortunately due to differences across the Coronial areas in the Peninsular there are differences within the way the DAAT and Public Health Teams are allowed to work. Ready access to toxicological reports, for example, is very different across the Peninsular and this information is key to assisting with dynamic and meaningful investigation. The database is informed by such information and needs to be equitable across the Peninsular. Devon and Cornwall Police analyst and researcher staff, still assist the Police Drug Liaison Officers and the greater drug related death review process, by collating all suspected incidents which may inform the database.

5.2 **Local database**

This database is new for 2013/ 14 and builds on the previous good work laid down by the peninsular database. It is informed by a wider spectrum of information and is more case specific so it assists a wider group having an interest in drug related deaths. On a day to day basis it works as a 'work control' for the Drug Related Death Prevention Coordinator and acts as an ideal information source for reports such as this annual report. Likewise the statistical analysis performed by the Cornwall Public health Amethyst section, for example, is assisted by this database in the production of the 'pivot tables'. The database is used at a variety of meetings and training events, where the information can be readily viewed and depersonalised accordingly. This database has now been adopted by Plymouth Office for Public Health (previously DAAT).

5.3 **Peninsula Drug Related Death Review Panel**

This panel has already been mentioned in section 5.1 above and continues to meet quarterly. The Panel's aims are to prevent future deaths with regard to drug misuse, as well as trying to standardise working practices, in turn, leading to consistent investigation and comparison. Best practise is always a feature of these meetings and information is flow encouraged, from a wide range of practitioners across the drug and alcohol field. This year has also seen a series of meetings between Cornwall and Plymouth which has led to a re-launch of the popular annual conference discussed in more detail in section 5.4 below. It is acknowledged here that Plymouth, Devon and Torbay areas do not have a dedicated post which is solely responsible for drug related death prevention. Cornwall DAAT understands the added pressure that this brings to bear on those departments tasked to look at drug related deaths in conjunction with many other tasks. In many ways the main aim for this panel could be viewed as having the goal of standardising procedure and process across the Peninsular. This consistent approach, could, if more widely adopted, impact positively on preventing future deaths.

5.4 **Drug Related Deaths Conference**

There has not been a conference of this nature in Devon and Cornwall since 2011 but on 19th September 2014 a conference went ahead at The China Fleet Club, Saltash, Cornwall. The theme of the event and slightly revamped title was 'Improving health- reducing

substance misuse death'. The re-launch included diverse topics such as nutrition within a substance misuse setting, clinical governance and liver health. Workshops on a range of topics also encouraged awareness and debate. The feedback received has been largely positive and supportive of an annual conference once again. In the main the negative feedback was what was left off the agenda, so this will form part of the discussion in planning future events.

5.5 Service of Remembrance

Saturday 20th September 2014 saw the first Service of Remembrance for those who have died from substance misuse in Cornwall. The service was held at Truro Cathedral and concluded a week of overdose awareness publicity. This finale to the week was a reminder to the families and those left behind, that this unique and often untimely death is one which hasn't been forgotten. There are sometimes very different circumstances surrounding a drug related death that families and friends have to deal with. However, the sense of loss that the bereaved feel is just as personal as in any non-drug related death. The event and its advertising further raised the profile of overdose and substance misuse death, which will hopefully lead to increased debate as to how this type of death could be prevented in the future. The event was a success, with a large and diverse congregation who were able to witness personal testimony from those who have been touched by untimely substance misuse deaths. As well as this, there was live music and a service structure dedicated to this important subject. The positivity that came from the emotional and poignant service, was evident at the after service refreshments, which the majority of the congregation attended and shared their thoughts. Next years' service has already been set for 26th September 2015 at Truro Cathedral. The DAAT is grateful to all those who contributed to this event and for their on-going support.

5.6 **DAAT Governance Group (previously known as the Prescribing and Pharmaceutical Services Forum)**

This forum has continued since the last report and is well-attended and productive. There have been three pharmacist training events held by Cornwall DAA T so far in 2014 and these have seen very good attendance from pharmacists, technicians and other pharmacy staff. The training involved needle exchange, naloxone supply, supervised consumption, and drug related death awareness issues from a pharmacy perspective. As a result there has been increased interest in offering needle exchange across Cornwall as well as an acknowledgement that a two way conversation between pharmacy and treatment provider is of great importance especially with the unique position the pharmacist finds him/ herself in, with the service user. Improved intelligence and information flow leads to improved treatment. This forum has proved to be of great value when considering some of the pharmaceutical drugs which are starting to feature in drug related and alcohol deaths.

5.7 **Controlled Drugs Local Intelligence Network (CDLIN)**

The Drug Related Deaths Prevention Coordinator routinely attends meetings of this network where all Accountable Officers for controlled drugs meet and report circumstances involving concerns or risks involving controlled drugs. Controlled drugs as listed in the schedules of the Misuse of Drugs Act 1971 as amended, are the criteria for recoding drug related deaths (agreed definition as paragraph 1.5). This forum affords yet another opportunity to ensure all drug related deaths are accurately recorded and monitored, together with addressing recommendations from drug death reviews. The Cornwall Drug Related Death Prevention Coordinator has spoken at the three CDLIN's covering Devon and Cornwall in October 2014 in order to inform others of the 'Cornwall model'. This will help to go some way towards standardising procedure as highlighted in paragraph 5.1 and 5.3 above. Controlled Drugs Accountable Officer for NHS England and chair of the three regional CDLIN's Bridget Sampson has specifically requested that this training take place acknowledging the 'Cornwall model' as best practise.

5.8 **Changes in working practise with HM Coroner and staff**

The working relationship between HM Coroner for Cornwall and the Cornwall DAAT has always been good and this has led to a very robust and reliable investigation/ review process. Changes made to The Coroners Rules from July 2013 and other changes listed below, has enabled an even more efficient review process.

a) Weekly HM Coroner review meetings now dynamically assess the investigation and information requirement for each death. This leads to less wastage of time and a more

focussed investigation with a view to finalising the inquest within 6 months. The Drug Related Death Prevention Coordinator assists with these weekly meetings. Early receipt of the weekly review list allows early research and reports back to HM Coroner prior to these meetings.

b) The Drug Related Death Prevention Coordinator now receives weekly notification of the register of Deaths for Cornwall. This allows early research with for example; the Police and treatment teams in order to facilitate any early requests for reports and information that may be required by HM Coroner for the inquest process.
c) The central role of the Drug Related Death Prevention Coordinator has now been improved by HM Coroners kind permission to use more electronic means of information transfer. Treatment reports, for example, are now exchanged prior to hard copy with improved efficiency. The ability to 'copy in' various agencies via email with updates on specific cases further improves efficiency. HM Coroner is now accepting some electronically signed documents and reports to this end.
d) The continued accessibility to toxicological reports and the relatively new easier access to pathological reports via the weekly meetings put Cornwall in a very strong position to review and report on drug related deaths. Furthermore the yearly reporting and comparison data can be relied upon to be accurate. Early toxicology and pathology awareness means that deaths can be more easily attributed to being drug related or otherwise. This is a key objective from the peninsular perspective, in helping other areas obtain the same sort of investigative assistance.

5.9 **DAAT Drug Related Deaths Review Group**

This group also continues from the last reporting period and is well attended by Addaction, Police, Bosence Farm, DAAT, RCHT Psychiatric Liaison and others. The group is becoming more action focussed and is based upon case specifics. These meetings are of a dynamic nature, and are informed by the local database and the attendee's first-hand knowledge of the specific cases of suspected drug related deaths. The variety of information and views aired comes from a wide range of services/ agencies, and this significantly assists in the progression of initiatives or lessons learned. Due to its importance in preventing future deaths it is recommended that these meetings continue. A group of this sort is also recommended as best practise for other areas serious about targeting this issue.

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

A SIRI (sometimes called a Critical Incident or Serious Untoward Incident), is defined by the National Patient Safety Agency (NHS) as: "An incident that occurred in relation to NHS-funded services and care resulting in one of the following:
• Unexpected or avoidable death of one or more patients, staff, visitors or members of the public
• Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm, or will shorten life expectancy, or result in prolonged pain or psychological harm • A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure
• Allegations of abuse
• Adverse media coverage or public concern about the organisation or the wider NHS (and LA health commissioners since April 2013)
• One of the core set of 'Never Events' as updated on an annual basis and currently including:
— wrong site surgery
— retained instrument post-operation
— inpatient suicide using non-collapsible rails
— intravenous administration of mis-selected concentrated potassium chloride…"

Following the extensive review by the DAAT Clinical Governance Lead - Russ Hayton - it is now recommended that:

- Any potential SIRI must be notified to the DAAT within one working day.
- Never events may include serious errors of CD prescribing that threaten life or cause serious harm.
- Most SIRIs relating to drug and alcohol service provision are likely to arise from unexpected deaths. A SIRI process will be required for anyone who dies unexpectedly

in treatment, or within 6 months of leaving treatment. That investigation will usually be led by the DAAT Drug Related Death Prevention Coordinator.

- SIRI investigations may be led by the DAAT commissioner, when required.
- The Local Authority may decide to initiate an independent, external SIRI investigation or review, in rare circumstances.

5.11 **Pharmacy Campaign**

The pharmacy campaign for 2013/ 14 did not go ahead due to various issues and time constraints. However, the close working relationship with DAAT and the DAAT Governance Group (previously Prescribing and Pharmaceutical Services Forum) has been kept informed of intentions to keep this very useful conduit open for 2014/ 15 interventions linked with overdose awareness and other issues.

5.12 **Overdose Awareness Week**

The overdose awareness week ran from 2nd December 2013 to 6th December 2013 and involved service users from the second stage rehabilitation unit at Chy Colom, Truro, producing artwork and associated words for a leaflet aimed at raising awareness of the various overdose issues. Some of these issues were borne out of the DAAT's attendance at drug related death inquests where it was obvious that some friends and family of the deceased's were not aware of some of the signs of someone in drug overdose. As is so often the case, early awareness and intervention can literally mean a matter of life and death. So the 'DOSE' campaign was born with the letters standing for:

D - Do get help, do not abandon
O - Other drugs and alcohol
S - Sleeping position
E - Excessive snoring and unrousable sleep

These various elements of overdose were further explained in the leaflet using the writing of one service user and the illustration of another. The whole experience was very positive with the residents and staff of Chy Colom being very accommodating with their invaluable assistance. The fact that service users with their own very real issues had taken the time to think of others in similar predicaments was a very positive statement to make. The leaflets were distributed by Addaction and the DAAT in venues such as treatment waiting rooms, clinics, GP surgeries, St Petrocs homeless shelter, Street Pastors and awareness via Cornwall Council Councillors. The leaflet was further promoted together with other overdose issues on Radio Cornwall's live broadcast 'The Laurence Reed' show on 5th December 2013. The DAAT Commissioning Manager Kim Hager and the Drug Related Death Prevention Coordinator were joined live in the studio by a young man who was a year into his recovery journey and spoke eloquently on the subject of drugs and his own story. His mother rang the show during the broadcast and the interaction between her and her son was emotional. It is felt that their inclusion in the broadcast greatly helped to dissolve some of the taboos surrounding drug users and their issues- exactly what the aim of the broadcast was, from the DAAT perspective. The overdose awareness week ran from 15th September 2014 to 20th September 2014, and was a promotion that sought to advertise the end of the week's conference ('Improving health- reducing substance misuse death') and the service of remembrance. These two events greatly raised the profile of drugs awareness issues in Cornwall.

5.13 **Ambulance attendance data**

In previous years, The South West Ambulance Service has provided the DAAT and partners, with data, that showed the numbers of incidents by County where naloxone had been administered to accidental and deliberate overdose patients. This included incidents of accidental overdose of lawfully held opioid medication, however, in most cases it detailed incidents of opiate overdose administered as a street sourced drug. As such the figures are important evidence in any debate trying to gauge the size of a particular drug problem. The figures for 2010 and 2011 showed a monthly naloxone administration rate by ambulance staff, of 20 and 21 respectively. The figures for 2012 do not appear available and the request for this data has been renewed for this report. So far, only 6 months of data for this reporting period is available (May to October 2013 inclusive). This shows an average of 16 monthly naloxone administrations with a low of 12 in May and a high of 21 in July. It is difficult to assess this apparent drop in administrations with any accuracy but it does fit in with the drop in deaths overall for the 2013/ 14 period as compared to 2012. As of May 2014 the South

West Ambulance Service is piloting an electronic records system for patients in the Taunton area. If successful this system will also be rolled out across Devon and Cornwall. This will lead to better data capture and hopefully an even better information exchange, to illustrate where the naloxone administrations are being made, why they are being administered, for what drugs they are administered for and be a generally more accurate system. The data available for this report is included at appendix B.

5.14 **Naloxone Programme**

2013 saw a giant leap forward in Cornwall with the start of the provision of naloxone. A generous donation made by the Devon and Cornwall Police has allowed naloxone kits to be purchased and match funding by the DAAT. The DAAT has also assisted in the training aspect of the naloxone provision. In August 2013 various agencies and organisations within Cornwall put forward people to become trainers at a training event held in conjunction with harm reductionist and international trainer Stephen Malloy and Martindale Pharmaceuticals (suppliers of Prenoxad naloxone kits). Since then, Addaction have been widely involved in the training of staff and service users, utilising a training package aimed at the families and carers of service users. Prescriptions for this medicine are now being issued to service users, and as a result, should they take an opiate overdose, now have a greater chance of survival. The wider availability of this medicine means that is now more likely to be found at the scene of a potential overdose. The legislation around naloxone allows the medicine to be used on anyone, by anyone, so the situation perhaps of an overdose at a party could be positively reacted to by anyone present and capable of using the easy to use naloxone kits. As can be seen from several of the case studies in section 3, naloxone could have made a difference to the outcome. Naloxone is already available in some supported accommodation in Cornwall, and this availability is to be extended. The use of naloxone will be monitored and reported on in the next report. Early results show that it has already been used since the initial training on at least 5 occasions, where lives are likely to have been saved.

6. OTHER DEATHS INCLUDING ALCOHOL

6.1The 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 2013/ 14 period.

6.2 It has been identified by the DAAT that there needs to be more work done to identify alcohol related deaths. There is not currently the capacity to monitor and investigate this type of death to the same degree as drug related deaths. However, there is the capacity to monitor these deaths more closely than is currently the case. The Drug Related Death Prevention Coordinator is now working more closely with the DAAT Alcohol Lead Jez Bayes, in order to develop a process of monitoring these deaths with the data already available. This includes toxicology, register of deaths and the reporting requirement of agencies to HM Coroner for those dying whilst in alcohol treatment. This will give a better idea of the numbers involved and will assist in the production of future alcohol strategy.

6.3 The DAAT receive all toxicological reports with the kind permission of HM Coroner to assist in the investigation and prevention of future drug related deaths. These reports sometimes include drugs which are prescribed or originally sourced from legal medical services. The levels of these drugs in toxicology or the fact that they are being street sourced and abused is one of the many benefits that can be gained from receiving these reports. Case studies have shown the use of some of the drugs that the DAAT are concerned about, in relation to their abuse potential and diversion from lawful supply. These drugs include quetiapine, citalopram, mirtazapine, gabapentin and pregabalin. There appears to be a greater awareness of these drugs amongst those seeking psychoactive change and drug use. The monitoring of toxicological reports will inform the DAAT and partner agencies of these concerns and action will be taken accordingly, if any of these drugs become problematic, for example the recent increased use of tramadol..

6.4 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. Listed below are some of the deaths that fit into this category. These have been investigated as thoroughly as any of the other deaths registered as a drug related death and, in some cases, more so, due to the concerns that have arisen.

6.5 The first of these deaths was in May 2013 and involved a 28 year old male who died in Hayle harbour in a drowning incident. The reason why this death was originally treated as a suspected drug related incident was due to the toxicological report identifying that there were levels of the Class C drug ketamine present in the blood of the deceased. Whilst these levels were not reported to be potentially fatal in their own right, the toxicologist did comment that 'this concentration may have had a detrimental effect on cognitive, cardiac and respiratory function'. The deceased was an accomplished swimmer and he was used to sea swimming. His fascination and passion was to film eddy currents and whirlpool effects in the sea. On this occasion in Hayle harbour he was filming the waters around the harbour as he had done many times before. He was in the water for a period that allowed him to swim around for many minutes being filmed by another as well as filming himself in the whirlpool. He was a meticulous planner but was also a risk taker. Witnesses saw the deceased dive underwater during this period and only surfaced once the tidal conditions and man-made oceanography had sucked him through a channel designed to keep the harbour clear of material. Due to eyewitness testimony at the inquest held in January 2014, HM Coroner determined that this was a drowning and accidental death. The presence of ketamine was acknowledged but did not appear to fit with the deceased being detrimentally affected by it. There is anecdotal information on the internet suggesting that ketamine enhance the effects of water on the skin for some people. Whether this was a factor in this death will never be known, but the DAAT examined this death and will bear it in mind for any future deaths involving ketamine. This does appear to be an isolated incident.

6.6 The second death examined in this category was in August 2013 and involved a 42 year old male from the Penzance area who had a long standing drug and alcohol treatment history and was in drug treatment with Addaction when he died. He died in RCHT having been admitted for other issues and medical conditions, his weight and malnourishment was of concern prior to his admission. A couple of months prior to his death he had been assessed by the DWP as fit to work and had lost some of his state benefits as a result. He was in a very frail state at this time and his keyworker and GP disagreed, and were strongly of the opinion that he was not fit to work. He had informed his treatment team that he was consuming more heroin due to the pressure he felt from the DWP assessments and the prospect of returning to work in his condition. This is well documented in his treatment notes as was the concern felt by the treatment team. The DAAT have identified this as an area of concern. An important feature of this situation was that the assessment process appears to have detrimentally affected this man's drug recovery irrespective of any underlying medical conditions. This situation has been taken forward with the assistance of the DAAT lead on social inclusion Marion Barton as well as Addaction assistance to see if the assessment procedure is unfair in the face of some of the issues that service users have to overcome.

6.7 There were two deaths where the individuals were in current drug treatment and died as a result of other medical conditions- in one instance the client had a heart condition and in another, the client had a fatal epileptic fit. Both of these cases involved the deceased's making very good progress in their drug treatment and there is a certain cruel irony involved when these events happen.

6.8 The final death is of a man in September 2013 from the Penzance area. This case illustrates one of the difficulties that treatment teams sometimes have. Where people do not have criminal justice interventions binding them with treatment by their obligatory engagement with a treatment agency, maintaining meaningful contact can become problematic. This man had an intravenous heroin habit coupled with other drug use and suicidal tendencies. He had been engaged throughout 2012 with CDAT and community mental health teams, but his attendance at best was erratic. There are copious notes within treatment records of failed attempts to contact the deceased, as well as many missed appointments. When he did attend, treatment teams were presented with a man who sometimes had defined suicidal thoughts and who had taken preparatory action along those lines. The drug interactions did not help this situation and infrequent contact meant that advice and treatment was always being interrupted. He was discharged from treatment in mid-August 2013 after a series of non- attendance at appointments. He self-referred late August 2013 and his treatment process was planned to restart, however the deceased did not attend his first appointment

due to him taking his own life in early September 2013. He tried to hang himself outside of his ex-partners home address after an argument with her. He was removed to RCHT where, after 2 days, his life support was turned off due to a fatal prognosis. An inquest in May 2014, determined that this was an open verdict with brain damage and oxygen starvation as a result of hanging. Toxicological examination was not carried out so it is not known if drugs played a part in this death.

7. CONCLUSION

7.1 This report has endeavoured to describe what a drug related death is and when such deaths must be recorded. Furthermore, the 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 a whole host of other interested parties that feed into the process. The DAAT is committed to forging ever stronger links with current partners and seeking out new possibilities to prevent future deaths.

7.2 The DAAT has maintained accurate statistics on all drug related deaths within Cornwall and Isles of Scilly for the past 15 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 2013/14 is 15, which represents a decrease of 40% from 2012. The fall in methadone deaths is encouraging. There is a word of caution here though as the first seven months of the 2014/ 15 reporting period have seen 14 suspected drug related deaths reported where the majority of these deaths have involved people either receiving treatment or having had a recent treatment history . These deaths are all subject to investigation and update.

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. It is acknowledged that further work needs to be done here and this is being addressed. The interaction between alcohol and drugs is ever present and has been included in the planning of the next conference.

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 2014/15 sees some exciting new ways of getting these messages across. The media campaign for the Service of Remembrance and the re-launch of the ‘Improving health- reducing substance misuse deaths’ conference saw a multi-agency approach which underlined how Cornwall is taking its part seriously in this important work. The Plymouth public health area also held a service of remembrance on the same day as Cornwall- Devon public health area, and have stated an intention to do the same in 2015. The combined effect of such working can only be for the good of peninsular service users, their friends and families.

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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	2013/14	Remarks
Total suspected drug deaths reported to / researched by DAAT	31	25	14	19	15	20	23	14	24	25	21	24	21	27	**24**	
Opiates – **Heroin** (may include methadone)	6	7	8	10	10	7	13	7	12 *	12 *	8	9	8	8 *	**9 (7 heroin, 2 morphine)**	***Includes suicides
Methadone (only or with non-relevant other drug)	5	2	0	0	1	1	1	2	6	5	5	7 *	2	11 *	**7****	****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**	
Non relevant I.e. other drug /pharmacy / other cause of death	20	16	5	8	3	5	5	2	5	7	6	6	9	6		
RTA / Suicide and controlled drug present	?	?	?	?	?	6	4	0	1h	2h	2 c	1h	0	6	**1**	
Cornwall DAAT recorded ***'drug related deaths'***	11	9	8	11	12	9	13	11	19	18	13	18	12	25	**15**	
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**	

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**

Overdose-related chief complaint codes in Devon and Cornwall, 1st August - 31st October. 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	2	11	5	6		2	3	29
	BOSCASTLE				1				1
	BUDE		3	1	2	1	1	1	9
	CALLINGTON	1	1			1	1	1	5
	CALSTOCK	1						1	2
	CAMBORNE	7	11	10	9	1	5	7	50
	CAMELFORD		2	1	3				6
	DELABOLE	1	1						2
	FALMOUTH		7	4	16		2	2	31
	FOWEY		1		2				3
	GUNNISLAKE		1						1
	HAYLE	1	7	3	5	3		1	20
	HELSTON		10	5	5		3	2	25
	HOLSWORTHY				1			1	2
	LAUNCESTON	1	6	4		1	1	1	14
	LISKEARD	3	10	3	4	3	3	6	32
	LOOE	1	5	1	2		2		11
	LOSTWITHIEL		2	1	1			1	5
	MARAZION			1					1
	NEWQUAY	4	9	13	16	2	5	7	56
	PADSTOW	1							1
	PAR	2	6	5	2			2	17
	PENRYN	2	8	1	5		2	1	19
	PENZANCE	1	12	7	18	2	5	6	51
	PERRANPORTH	1	2	1	1				5
	REDRUTH		12	5	15	2	5	10	49
	SALTASH		10	3	3	2	4	4	26
	ST COLUMB		1						1
	ST IVES		1						1
	ST. AGNES				1				1
	ST. AUSTELL	5	32	14	14	3	7	7	82
	ST. COLUMB		5	1			1		7
	ST. IVES		4	2	1		1	1	9
	TINTAGEL		1	2	2			1	6
	TORPOINT		3	2	4	1		2	12
	TRURO	5	24	11	21		4	6	71
	WADEBRIDGE	1	1		2		1	2	7
Cornwall and Isles of Scilly Total		**40**	**209**	**106**	**162**	**22**	**55**	**76**	**670**
Devon	ASHBURTON			1	2				3
	AXMINSTER	1	1	3			1	1	7
	BARNSTAPLE	2	17	6	21	2	12	4	64
	BEAWORTHY		1	1					2
	BIDEFORD	2	15	6	6	1	2	12	44
	BOVEY TRACEY				1				1
	BRAUNTON		1		1			1	3
	BRIXHAM		7	1	8		3	1	20
	BUCKFASTLEIGH		1	1			2		4
	BUDLEIGH SALTERTON		1	1	1		1	1	5
	CHUDLEIGH KNIGHTON			1					1
	CHULMLEIGH		1				1	1	3
	COLYTON				1			1	2
	CREDITON		4	2	7			1	14
	CULLOMPTON		3	3	2				8
	DARTMOUTH	1	1	2	2		1	1	8
	DAWLISH		11	3	2	1	5	2	24
	EXETER	14	63	44	119	15	24	30	309
	EXMOUTH	1	16	9	22	4	3	6	61
	HOLSWORTHY	1	3	1					5
	HONITON	1	3	3	3	1	2	1	14
	ILFRACOMBE		7	4	3		4	3	21
	IVYBRIDGE	2	8	1	1			1	13
	KINGSBRIDGE		5	2		1	2	1	11
	LYNTON	1							1
	NEWTON ABBOT	2	19	11	17	1	4	7	61
	NORTH TAWTON							2	2
	OKEHAMPTON	1	4	3	1		1		10
	OTTERY ST. MARY	1			1	1	1	1	5
	PAIGNTON	8	22	10	19	3	6	7	75
	PLYMOUTH	40	154	73	132	14	41	31	485
	SALCOMBE	1	1		4		1		7
	SEATON		1	1	5		1	1	9
	SIDMOUTH	1	1	5	5			1	13
	SOUTH BRENT		2		1	1			4
	SOUTH MOLTON		3		3				6
	TAVISTOCK	2	3	2	2		1	1	11
	TEIGNMOUTH	2	5	5	5	1	1	4	23
	TIVERTON	2	11	6	5		2	9	35
	TORQUAY	4	43	31	58	4	17	19	176
	TORRINGTON	1			3			1	5
	TOTNES		5	3	6	1	2		17
	UMBERLEIGH		1						1
	WELLINGTON		1						1
	WINKLEIGH		3	3					6
	WOOLACOMBE				2				2
	YELVERTON	3	7	3				1	14
Devon Total		**94**	**455**	**251**	**471**	**51**	**141**	**153**	**1616**
Grand Total		**134**	**664**	**357**	**633**	**73**	**196**	**229**	**2286**

Number of Naloxone administrations in Devon and Cornwall, 1st August - 31st October

County	Aug	Sept	Oct	Total
Devon	40	30	31	101
Cornwall	15	17	18	50
Total	55	47	49	151

APPENDIX C

To read the latest National Programme for Substance Abuse Deaths (Np-SAD) 2013 report, which reports on the 2012 period, please click on the link below.

This is internet open source material published on. The authors are John Corkery Hugh Claridge, Barbara Loi, Christine Goodair and Fabrizio Schifano

Np-SAD 2013 Report

To read the latest Office for National Statistics (ONS) report on Deaths Related to Drug Poisoning
in England and Wales, 2012 please click on the link below.

This is internet open source material published on 28th august 2013. The authors are The Office for National Statistics

ONS 2013 Report