CORNWALL AND ISLES OF SCILLY

DRUG AND ALCOHOL ACTION TEAM

DRUG RELATED DEATHS

REPORT CONCERNNG MONITORING AND CONFIDENTIAL INQUIRIES INTO DRUG RELATED DEATHS WITHIN CORNWALL & ISLES OF SCILLY

1st January 2012 – to – 31st December 2012

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Executive Summary

1. From 2004 all Drug and Alcohol Action Teams are required by the Department of Health and Home Office to have in place a system of monitoring and surveillance of all drug related deaths within their area of responsibility.

2. All Drug and Alcohol Action Teams, Police and Department of Health work to the standard definition of a drug related death ***'deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, were involved'.***

3. In 2009 a new database was set up to routinely record all drug related deaths throughout Devon and Cornwall. This database is maintained by Devon and Cornwall Police with researchers appointed to trawl daily occurrence logs and input suspected drug related deaths. Cornwall & IOS DAAT has access to this database and has also back recorded onto the database all Cornwall & IOS drug related deaths since 2004. The database was updated during 2011 to ease search facilities and continues to be an effective monitoring tool.

4. The system of monitoring and surveillance of drug related deaths introduced by Cornwall & IOS DAAT and known as 'The Cornwall Model' continues to be effective and is acknowledged and recommended by the National Treatment Agency (NTA)as good practice. This model was subject of a national review by the NTA in July 2009 and a report on its findings is included at Appendix B. A further review conducted by the NTA in 2011 has declared the Cornwall DAAT process as 'gold standard'. A copy of the model which outlines the respective roles and responsibilities is included at Appendix F.

5. This report is prepared in draft for consideration by the Cornwall Drug Related Deaths Review Panel on 18th December 2012 and to be included in the planning process for the 2013-2014 DAAT annual plan.

6. The following table shows all deaths reported in 2012:

	2012	2011	2010	2009
Total suspected drug related deaths reported	**27**	21	24	21
Confirmed / suspected non drug related deaths	**6**	9	6	6
Heroin / Morphine	**8***	8	9	8
Methadone	**11***	**2**	7	5
Other controlled drug	**2* Mephedrone Cocaine**	2 MDMA + other	2 x cocaine	0
RTA/Suicide (+ CD as included above)	**1 x RTA 5 x sus. suicide as above***	2 Phenobarbitone	1 (Heroin)	2 (traces cannabis)
Total drug related deaths	**21**	12	18	13
% **Increase** or Reduction	**75 % Increase from 2011**	Reduction 38% from 2010	Increase 38% from 2009	Reduction 27% from 2008

7. The new Devon and Cornwall database assists in screening out most non-relevant deaths that do not involve controlled drugs. Of those reported throughout 2012 as suspected to be drug related 6 are now confirmed as not drug related deaths.

8. Deaths from illicit Heroin alone have decreased slightly from 8 in 2011 to 5 during 2012 which represents a reduction of 37% this slightly better than the national average reduction in Heroin related deaths of 25% . One of the Cornwall recorded Heroin deaths is suspected to involve suicide. There has also been three Morphine deaths, these are unprecedented for the purposes of this report and are now outlined within the following paragraph.

9. Unexplained deaths from Morphine, (this being the pharmaceutical preparation), have not previously come to light for the purposes of this report however during 2012 there were 3 deaths involving a significant overdose of Morphine, in two cases the Morphine was not prescribed to the deceased. All three of the Morphine deaths are suspected to be suicides however this will be a matter for HM Coroner for Cornwall to direct and no inferences should be drawn until HM Coroner's Inquisition is completed.

10. Methadone related deaths have increased considerably on all previous years and are the highest since DAAT records commenced in 1999. Methadone related deaths total 11 for 2012 compared to just 2 deaths in 2011, this represents a 450% increase. Of these deaths 6 involve 'displaced' Methadone which has been supplied unlawfully. One death is yet another suspected suicide involving Methadone prescribed to the deceased and four other deaths also involve Methadone prescribed to the deceased.

11. It is unfortunately not possible to identify reasons for the continuing decrease in Heroin related deaths and equally, despite continuing close scrutiny and urgent reviews of these deaths with the permission of HM Coroner it has not been possible to identify any trends or patterns that would account for such a large increase in the deaths involving Methadone.

12. All of the deaths reported to DAAT and suspected to be drug related are subject of immediate investigation to determine the circumstances and to ensure effective measures are introduced to prevent similar fatalities.

13. The number of recorded drug related deaths shows a considerable increase of 75% from 2011 (21 compared with 12 in 2011). Toxicology reports kindly provided by HM Coroner for Cornwall indicate cases where controlled drugs confirm such deaths to be 'drug related' in accordance with Department of Heath directives, toxicology results have been received for all but one of the 27 suspected drug related deaths during 2012, the outstanding report is suspected to identify concentrations of illicit Methadone as an empty Methadone bottle was located at the scene.

14. The following tables offer a brief synopsis of the recorded 2012 deaths:

Male

	2012	2011	2010	2009
Total Drug Related Deaths	**21**	12	18	13
Males	**14 66%**	11 91%	15 88%	9 69%
Mean age	**42.9**	35.8	40.3	27.09
Oldest	**63 (6 x o/40 yrs)**	53 (5x o/40 yrs)	64 (5 x o/40yrs)	39
Youngest	**27**	24	29	27
Males –	**4**	8	9	7

Heroin/alcohol/benzos				
Males –Methadone	**9**	1	5	2
Males – other controlled drug	**1**	2	2 (cocaine)	2 (traces cannabis)
Males in Treatment	**6**	5	5 (incl 1x ref/assessed)	4 + 1 referred not seen

Female

	2012	2011	2010	2009
Total Drug Related Deaths	**21**	12	17	13
Females	**7 33%**	1 9%	2 12%	4 31%
Mean age	**37**	24	27.5	29.75
Oldest	**59**	24	31	49
Youngest	**17**	24	24	17
Females – Heroin/alcohol/benzos + Morphine	**4**	0	0	2
F/males-Methadone	**2**	1	2	2
Females - other c/drug	**1**	0	0	0
Females in Treatment	**1**	0	2	3 + 1 referred not seen

England & Wales

From the ONS Drug Death Reports 2011,2010, 2009 and 2008. The 2012 ONS report will not be available until late August 2013. The table below shows the ONS 'drug misuse deaths', this covers all illicit and pharmaceutical drugs.

	2011	2010	2009	2008
Total Drug Related Deaths	**1605**	1784	1876	1939
Male	**1192**	1382	1512	1506
Female	**413**	402	364	433

Heroin & Methadone Deaths England & Wales 2010 / 2011 ONS Statistics

	2011	2010	+/-
Heroin	596	791	-195 (25%)
Methadone	486	355	+131 (36%)

Heroin & Methadone Deaths England & Wales 2010 / 2011 NpSAD Statistics

	2011	2010	+/-
Heroin	820	1061	-241 (22%)
Methadone	765	503	+262 (52%)

Heroin & Methadone Deaths Scotland. General Register Office Statistics

Here for the first time in the UK deaths from Methadone have overtaken Heroin related deaths.

	2011	2010	+/-
Heroin	206	254	-48 (18%)
Methadone	275	174	+101 (58%)

12. DAAT has introduced or been involved in a number of new initiatives throughout 2012 aimed at preventing and reducing drug related deaths these are outlined within section 6 of the main report.

15. All DAAT areas are required to prepare an annual report identifying the process of recording and inquiry into drug related deaths together with any preventative measures introduced. This is the report prepared by the Cornwall and IOS Drug and Alcohol Action Team.

1. INTRODUCTION

1.1 This is the ninth annual report concerning drug related deaths prepared by the Cornwall and Isles of Scilly Drug and Alcohol Action Team (DAAT). The report follows a requirement by the Department of Health and 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 2012 report follows a similar format to that of 2011, 2010 and 2009 these varied from previous years and now include more statistical analysis, more case studies together with findings and recommendations. There is more emphasis on the pro-

active measures that Cornwall & IOS DAAT has introduced throughout the year to prevent and reduce drug related deaths.

1.3 Reports prior to 2009 have detailed the robust system of monitoring and recording drug related deaths throughout Cornwall and the Isles of Scilly. This model of recording has been regarded as best practice and presented at many regional and national conferences. The Cornwall & IOS DAAT is frequently requested to forward details of the Cornwall recording process together with any recent annual report to other DAAT areas or interested parties. The Cornwall 'model' of recording and monitoring drug related deaths will not be described again within this report except to confirm that the system remains most effective and has proven to be sustainable. Some reference will however be made to the Cornwall DAAT system of recording as recognised by reports commissioned by the National Treatment Agency into the drug death review processes throughout the country and following certain requests the Cornwall 'model' itself will be included for reference purposes at Appendix F.

1.4 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 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'.***

1.5 On 29th August 2012 the Office of National Statistics (ONS) released their annual report concerning drug related deaths throughout England and Wales for 2011. All drug related deaths are recorded however this is also filtered to include deaths within the above definition involving drug misuse. There is some criticism of the ONS report as, through necessity it reports mainly on deaths during 2010. Deaths during the latter part of 2011 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.

1.6 ONS reported that the total 'drug misuse deaths' for England and Wales during 2011 was 1192 for males which represents a reduction of 14% from 2010. However over the same period the number of female deaths rose slightly by 3% to 413. 596 of the deaths that related to drug poisoning involved Heroin or Morphine but this was a reduction of 25% from the 791 deaths in 2010. Deaths associated with Methadone however increased from 355 deaths in 2010 to 486 in 2011, a significant increase of 36.9%

1.7 The National Programme for Substance Misuse Deaths (NpSAD) produced a report for the year 2010 on 7th November 2012. Funding for this programme actually ceased in July 2011 however the team involved in collecting the data have remained and a little funding was obtained for the publication of the 2010 figures. The data collected by this programme relies upon the completion 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 by the prime author of the NpSAD report John Corkery. Cornwall DAAT has been in contact with Mr Corkery and obtained details of the number of NpSAD recorded deaths for England and Wales involving Heroin and Methadone . This indicates, along with the ONS findings and the emerging pattern within Cornwall that Heroin deaths are decreasing. There were 820 Heroin related deaths in 2011 compared with 1061 in 2010, a reduction of 241 which represents a decrease of 22%. Methadone deaths however increased significantly from 503 in 2010 to 765 in 2011 an increase of 262 which represents a rise of 52%.

1.8 Figures released by the General Register Office for Scotland on 12th August 2012 reported a similar reduction in Heroin related deaths of 18% (206 compared with 254 in 2010) but quite alarmingly for the first time within the UK deaths from Methadone overdose have overtaken Heroin deaths and represent a significant increase of 58% (275 compared with 174 in 2010). Deaths in Scotland from drug misuse rose by 99 deaths, Methadone deaths alone rose by 101 deaths.

1.8 The figures concerning drug related deaths published by the Cornwall & IOS DAAT are suggested to be consistently accurate. 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. The database will be described later within this report.

2. UPDATE TO 2011 REPORT

2.1 The Cornwall & IOS DAAT report into Drug Related Deaths for 2011 was published on 20th December 2011. Early publication was completed to allow appropriate review and inclusion within the consultation process for the 2012/13 DAAT Annual Plan and this has been the practice for the past four years. It has normally been necessary to amend the previous year's report as certain other deaths came to notice following the publication of the report. However for 2011 there is just one amendment which involves the death of a 53 years old male that occurred on 30th December 2011. This male was in treatment with the Cornwall Drug and Alcohol team (CDAT) for drug dependency and died following an overdose of illicit Heroin. Records for 2011 have been amended included in the year on year chart at Appendix A.

2.2 The total number of drug related deaths recorded at 20th December 2011 was 11 this has now risen to 12 and included within all charts and tables hereafter.

2.3 The following table shows an amended comparison for the years **2011**/2010/2009/2008:

	2011	2010	2009	2008
Total suspected drug related deaths reported	**21**	24	21	25
Confirmed Not drug related deaths	**9**	6	6	7
Heroin / and methadone	**8**	9	8	11
Methadone only	**2**	7	5	6
Other controlled drug	**2**	2 cocaine	0	1 x amphetamine.
RTA/Suicide +CD	**0**	1	2 (traces cannabis)	0
Total drug related deaths	**12**	18	13	18
+ /- %	**-33%**	+ 38%	-27%	

3. RECORDED DRUG RELATED DEATHS –Cornwall & IOS 2011

3.1 This current report now incorporates all reported suspected drug related deaths throughout Cornwall & IOS for 2012 and has been prepared for the information of the Cornwall & IOS Drug Related Deaths Review Group sitting on 18h December 2011; this is the steering and monitoring group for all drug related deaths matters. The report will also be forwarded to the Peninsula Drug Related Deaths Review Panel for the next meeting on 15th March 2013 and the DAAT Board together and HM Coroner for Cornwall, thereafter copies will be circulated to commissioned providers and DAAT partners.

3.2 The following table shows the total number of suspected drug related deaths reported to Cornwall & IOS DAAT throughout 2012 together with a breakdown of the commodities involved. Comparative (and now amended) figures for 2011, 2010 and 2009 are shown alongside:

	2012	2011	2010	(2009)
Total suspected drug related deaths reported	**27**	21	24	21
Confirmed / suspected non drug related deaths	**6**	9	6	6
Heroin / and methadone	**8**	8	9	8
Methadone only	**11**	2	7	5
Other controlled drug	**2**	2 MDMA + other	2 x cocaine	0
RTA/Suicide + CD	**1 RTA 5 x susp. suicide**	2 (Phenobarbitone**)**	1 (heroin)	2 (traces cannabis)
Total drug related deaths	**21**	12	18	13
% **Increase** or Reduction	**Increase 75%**	Reduction 38% From 2010	Increase 38% from 2009	Reduction 27% from 2008

3.3 Early indications show the database system introduced in 2009 filters out many of the non-relevant deaths that do not involve controlled drugs hence 6 of the reported deaths are either confirmed or suspected to be non drug related. DAAT also monitors deaths where Tramodol features as a contributory factor, Tramodol is not a controlled drug and therefore is not part of the DAAT recording process however DAAT and HM Coroner are particularly concerned regarding this drug and the frequency with which it features in Cornwall deaths**.** Deaths involving Tramodol will be outlined at the end of Section 4 of this report.

3.4 Deaths from Heroin toxicity have actually decreased by three such deaths from 8 to 5 This represents a decrease of 37% this is more than the national average of 25% (ONS 2010/2011) and 22.7% (Np-SAD 2011)). One of the Heroin deaths involved suspected suicide by hanging. Two of the Heroin deaths were initially thought to have involved a 'bad batch' of Heroin which was believed to be particularly strong however subsequent police analysis revealed this was not so and the purity of the Heroin concerned was just 6%.. Tramodol has previously been present in Cornwall Heroin deaths however it did not feature within any Heroin related death during 2012. 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 at Appendix A.

3.5 Deaths from overdose of Methadone which fell sharply during 2011 from 7 to just 2 have risen significantly during 2012 from the 2 in 2011 to now 11 in 2012. Six of these

deaths involve displaced Methadone supplied unlawfully, of the remaining five all were all prescribed Methadone ,one of which also involves a suspected suicide.

3.6 Unfortunately it is not possible to identify either the reason for the reduction of Heroin related deaths or the considerable increase in Methadone related deaths. Concerted efforts to engage people with treatment providers together with overdose awareness initiatives and harm reduction programmes may have contributed to some of the reductions but street purity issues surrounding Heroin may have encouraged some users to seek out illicit Methadone, not prescribed to them. Purity levels of street Heroin as ascertained from Police seizures during 2012 have ranged from 6% to 16% purity, this is very low when compared with previous years when on occasions it has been as high as 69%.

3.7 The number of those whose death occurred whilst receiving treatment is slightly higher than in 2011. During 2012. 8 of the 21 deceased were receiving treatment for drug dependency, in 2011 those receiving treatment numbered 5 of the 11 deceased. The percentage ratio of those in treatment to overall drug deaths is slightly lower during 2012, 38% compared with 45% during 2011. All of these deaths have been subject to DAAT Review, together with the PCT/CFT Serious Incident process for those receiving treatment and H.M. Coroner's Inquest. Learning points, where appropriate are disseminated by DAAT.

3.8 Of the two deaths involving 'other controlled drug' in the above table one relates to a road traffic accident where the driver appeared to be significantly impaired from the effects of Mephedrone. Mephedrone was originally one of the new wave of synthetic drugs initially referred to a 'Legal Highs' (now designated Novel Psychoactive Substances). Mephedrone was classified as a controlled drug in April 2010 and will be addressed later within this report. The other death included a cocktail of Cocaine and Amphetamine which was identified as 'Cocaine and Amphetamine toxicity' and the primary cause of death, this will also be outlined later within this report.

3.9 The following tables are included to show the national trend regarding the reduction in Heroin deaths and the increase in Methadone.

Heroin & Methadone Deaths England & Wales 2010 / 2011 ONS Statistics

	2011	2010	+/-
Heroin	596	791	-195 (25%)
Methadone	486	355	+131 (36%)

Heroin & Methadone Deaths England & Wales 2010 / 2011 NpSAD (Unofficial figures for 2011)

	2011	2010	+/-
Heroin	820	1061	-241 (22%)
Methadone	765	503	+262 (52%)

Heroin & Methadone Deaths Scotland. General Register Office Statistics

Here for the first time in the UK deaths from Methadone overdose have overtaken Heroin related deaths.

	2011	2010	+/-
Heroin	206	254	-48 (18%)
Methadone	275	174	+101 (58%)

4. BRIEF CIRCUMSTANCES/CASE STUDIES 2012

4.1 Many of the 2012 suspected drug related deaths are ***sub-judice*** and await inquisition by H.M. Coroner for Cornwall Dr. E. E. Carlyon. Requests have however been made following previous DAAT annual reports to include herein brief details of individual circumstances with particular references to place of death, i.e. public toilets etc, care and treatment of the deceased and the concoction of drugs and other substances or other material considered to have caused death.

4.2 The following paragraphs are therefore suitably anonymous and the location vague. Where known, the treatment provider will however be included together with the commodities of drugs and brief summary of toxicology. Requests for this additional information have been acceded to within this report solely in the interests of preventing and reducing drug related deaths.

4.3 All 21 reported suspected drug related deaths are now briefly outlined below.

4.4 Sadly, the first death of the year was discovered on New Years day and involved a 45 years old homeless female found deceased within a derelict house at Camborne. This person was not in treatment for any drug dependency and toxicology results indicated an overdose of Methadone. An in depth Police investigation was launched to identify the source of the illicit methadone and although a number of people were arrested no charges were made. An Inquest is awaited.

4.5 Near the end of January a 17 years old girl died following a car accident near Sheviock, toxicology results indicated a high level of Mephedrone of .36mg per litre of blood. There is currently little known data surrounding concentrations of Mepherdrone and it's relationship with deaths. One previous death involving Mephedrone within Cornwall involved a post mortem blood sample analysed at .32mg/L. Some results nationally have detected Mephedrone levels of .1 to .15 and have also been recorded as high as 22 and 63 mg/L. The NpSAD records for 2011 in respect of Mephedrone have identified 70 deaths where Mephedrone was detected as being present within toxicology results, 30 of these deaths related to instances where Mephedrone is suspected to be a primary cause of death whether this is through poisoning/overdose of the drug itself or whether the drug influenced some other mechanism of death. DAAT has prepared reports for HM Coroner for Cornwall regarding Mephedrone and an Inquest into this death is scheduled for 20.12.12.

4.6 In early February a 63 years man was found deceased at Goldsithney.This man was not in treatment for any drug dependency and subsequent toxicology results indicated an overdose of Methadone. The Methadone was supplied by an acquaintance who has been charged with this offence and awaits a court appearance. An Inquest on the deceased will be held after the court appearance.

4.7 Also in February a 39 years old man was found deceased at Looe, it is suspected that the primary mechanism of death was asphyxia from hanging however the toxicology results identified a high level of Heroin together with Cocaine and benzodiazepines. An Inquest is Scheduled for 19th December.

4.8 In early March a 47 years old man was found unconscious at St Austell, he was treated by paramedics and conveyed to A & E, Treliske but despite medical interventions he died at hospital later the same day. This man was in treatment with the Cornwall Drug and Alcohol team (CDAT) and prescribed Methadone. Toxicology results indicated an overdose of Methadone combined with Heroin and Diazepam. A full Serious Incident Investigation has been conducted and the report passed to HM Coroner for Cornwall and an Inquest is awaited.

4.9 Near the end of March DAAT was notified of the first of three deaths which are suspected to involve 'pharmaceutical' Morphine. This involved a 35 years old female near Bodmin with a history of depression. The source of the Morphine is not known however the deceased was prescribed other medication including Tramodol, Amitriptyline,Zopiclone and Venlafaxine, Comment from the analyst suggests there is a potentially fatal concentration of Morphine and Tramodol. DAAT routinely records instances where Tramodol features within toxicology results and other instances will be described later within this report. An Inquest is awaited.

4.10 At the end of March a 59 years old man was found deceased at his home address in Newquay. He was found face down with injuries to his face however the house was secure and it was established that he collapsed and fell straight to the floor without attempting to save himself. Subsequent toxicology analysis revealed a high level of Cocaine at 1385 micrograms (µg) per litre of blood, this is the highest DAAT has recorded within Cornwall to date, Amphetamine was also present at 747µg/L. This man had been in treatment with CDAT for 15 years between 1996 and 2011 but, in August 2011, because he was free from all street drug use was discharged from further treatment however he did have the option of returning at any time in the future if he so wished. The cause of death was determined as 'Cocaine and Amphetamine toxicity' causing cardiac arrest, and Inquest was held on 14.12.12 and a verdict of Accidental Death returned.

4.11 In April a 45 years old man was discovered hanging from a door handle at his home address in Newquay. This act was committed within a very short time frame and also he had been to a nearby pharmacy to collect his prescribed Methadone. This man was in treatment with CDAT for drug dependency and although receptive and compliant with his treatment had expressed concerns regarding certain reduction in benefits. This death has been subject to a full Serious Incident Investigation and a copy of the report forwarded to HM Coroner. An Inquest is awaited.

4.12 In May a 40 years old man was found deceased within a residential home at Newquay. The deceased was homeless but had befriended an elderly resident and would secretly arrive in the morning and sleep throughout the day. This man had received some treatment from CDAT back in 2010 but did not continue owing to prison sentences. On his release he never engaged with any treatment provider. Toxicology results indicated an overdose of Methadone and Diazepam. He was prescribed the Diazepam but the Methadone came from an unknown illicit source. An Inquest was held on 28.11.12 and a verdict of accidental death returned.

4.13 In early June a 27 years old man was found deceased within a shop doorway in Looe. This man was not in treatment for any drug dependency and toxicology results revealed an overdose of Methadone. A full Police Investigation took place to identify the source of the Methadone which was suspected to have originated from an associate who was in treatment for drug dependency and prescribed Methadone. The Police investigation was inconclusive and an Inquest is awaited.

4.14 Also in June a 36 years old man was found deceased at his home address in Newquay. This man was receiving treatment from CDAT for drug dependency and prescribed Methadone and Diazepam. Toxicology results identified a high level of alcohol, 319 mg/100ml, almost four times the drink drive limit, together with significant Methadone and Diazepam the combined effects having a detrimental effect on cognitive, motor and respiratory function. A full Serious Incident Investigation has been conducted and a copy of the report forwarded to HM Coroner . An Inquest is awaited.

4.15 In early July a 39 years old man was found deceased at his home address in Newquay. This man had never been involved with any treatment agency and toxicology results revealed a high level of methadone and a high level of Codeine,

both at levels which are considered to be independently fatal. Neither drug was prescribed to the deceased and the source remains unknown. An Inquest is awaited.

4.16 In mid July a 33 years old man died following a pedal cycle accident in Newquay. This man was not in treatment for drug dependency however he was involved with an organisation assisting him with counselling and support. Subsequent toxicology results revealed an overdose of street Heroin and Codeine. It is understood the accident arose following attempts at certain 'stunts' on the pedal cycle and an Inquest is awaited.

4.17 The next death depicted herein is one of two deaths that occurred within two days of each other in July and both were initially suspected to be subject of a particularly strong batch of Heroin alleged to have originated from Exeter and available within the Camborne/Redruth area. In this case a 47 years old man was found deceased at his home address near Camborne, he was in treatment for drug dependency with CDAT and prescribed Methadone. Subsequent toxicology results indicated an overdose of street Heroin together with Methadone, Amitriptyline and Diazepam, these three drugs were prescribed however the Heroin is from an illicit source. This death prompted the Peninsula drug early warning scheme to be put in place having regard to the Police intelligence regarding the particularly strong batch of Heroin, however this later transpired not to be so. A full Serious Incident Investigation has been conducted and a copy of the report forwarded to HM Coroner. A Inquest is awaited.

4.18 The second death, initially believed to be connected to this 'bad batch' of Heroin concerns 36 years old man found deceased at his home address in Truro. This man was discovered with a hypodermic syringe still in his arm and heightened fears that the 'bad batch' of Heroin was claiming more deaths. HM Coroner contacted DAAT and directed that not only should the Peninsula cascade warning be repeated in the light of this death but also details should be now released to the press and media to alert potential users that a 'bad batch' of Heroin appears to be on the streets. The presence of the syringe still in the deceased's arm is indicative of a strong dose of Heroin rendering the deceased unconscious very quickly. This man was in treatment for drug dependency with CDAT and was prescribed Methadone however no Methadone was identified from the toxicology analysis but illicit Heroin was identified 'consistent with fatal illicit Heroin misuse'. A full Serious Incident investigation has been completed and a copy of the report forwarded to HM Coroner. The Police Drug Liaison Officer obtained a forensic analysis of the fluid remaining within the syringe removed from the deceased, this was, as anticipated, identified as illicit Heroin however contrary to all initial beliefs the purity was just 6%. An Inquest is awaited.

4.19 The next death occurred at the end of July and involved a 37 years old female who died in Bude. She was receiving treatment for drug dependency with CDAT and was prescribed Methadone and Diazepam. Toxicology results identified a potential overdose of Methadone and Diazepam the combination of which may have increased the risk of death. A full Serious Incident Investigation has been conducted and a copy of the report forwarded to HM Coroner. An Inquest is awaited.

4.20 The second 'Morphine' overdose occurred in August and involved a 59 years old female. This matter is suspected to be a suicide but is particularly sensitive and further details are withheld at this time except to include the toxicology result which identified a significantly high level of Morphine which was potentially fatal and acute prior to death. The Morphine was of pharmaceutical origin however the source is unknown and it was not prescribed to the deceased. An Inquest is awaited.

4.21 The next death also occurred in August and also involved a 'Morphine' overdose which is suspected to be an act of suicide however as in all similar cases this will be

a matter for HM Coroner for Cornwall to direct. This case involves a 28 years old female at Liskeard who was disabled and prescribed medication including Morphine. A short window of opportunity to take the Morphine occurred and the toxicology results indicate a high and potentially fatal level of Morphine. An Inquest is awaited.

4.22 In early September a 54 years old man was found deceased at his home address in Falmouth. He was receiving treatment for drug dependency with CDAT and had associated physical health problems. He was prescribed a large quantity of medication including methadone, Temezepam, Dihydrocodeine and others, the toxicology results indicated that whilst all of the drugs remained within accepted therapeutic levels the combination may prove fatal if not tolerant to any of the drugs concerned. A full Serious Incident investigation has been completed and a copy of the report forwarded to HM Coroner. An Inquest is awaited.

4.23 Also in September a 38 years old female was found deceased at St Stephens. This person was not currently in treatment for drug dependency but had been back in 2009 but was discharged from further treatment because she did not attend appointments. Toxicology results indicated an overdose of Heroin and benzodiazepines, the deceased was known to purchase drugs locally however a Police investigation failed to identify the source. An Inquest is awaited.

4.24 In November a 36 years old man was found deceased near Camborne. This man had been in treatment for drug dependency with CDAT but was discharged in April 2012 as he failed to attend appointments. He was not prescribed any medication of methadone and although toxicology results have yet to be received it is strongly suspected that this will transpire to be Methadone related as empty, anonymous Methadone bottles were recovered at the scene. This has been included to complete the 2012 record of suspected drug related deaths and those pertaining to methadone alone.

4.25 DAAT also monitors deaths where the presence of 'Legal Highs', the Novel Psychoactive Substances that caused much concern nationally when 'Mephedrone' first appeared. There were no deaths associated with any Novel Psychoactive Substance within Cornwall during 2012.
In October 2011 the Advisory Council on the Misuse of Drugs published a comprehensive report regarding Novel Psychoactive Substances ('Legal Highs') and recommendations to address their supply and use. The National Programme for Substance Abuse Deaths (NpSAD) produced a similar report in July 2012. Links to both reports are is included at Appendix B.

4.26 DAAT routinely records and monitors all deaths involving Tramodol which although not a controlled drug has featured within a number of deaths and attracted recommendations from HM Deputy Coroner for Cornwall, Mr Cox that this should be carefully prescribed and considered for re-classification by the Advisory Council on the Misuse of Drugs. In addition to the Tramodol associated with the death outlined at 4.9 above there were 7 other deaths during 2012 where Tramodol was detected. In 4 of these deaths Tramodol is considered to be the primary cause of death by poisoning/overdose with concentrations ranging between 9000µg/L to over 40,000µg/L. Tramodol was prescribed to the deceased in all cases except the largest concentration mentioned here which involved a 22 years old female and is suspected to be an act of suicide as indeed are the other cases involving high amounts of Tramodol. DAAT, through the CD LIN and Prescribing Forum has circulated such findings to all GP surgeries and Out of Hours Services regarding restricting the prescribing of Tramodol in large amounts.

5. SYNOPSIS 2010 DRUG RELATED DEATHS

5.1 Male

	2012	2011	2010	2009
Total Drug Related Deaths	**21**	12	18	13
Males	**14 66%**	11 91%	15 88%	9 69%

Mean age	**42.9**	35.8	40.3	27.09
Oldest	**63 (6 x o/40 yrs)**	53 (5x o/40 yrs)	64 (5 x o/40yrs)	39
Youngest	**27**	24	29	27
Males – Heroin/alcohol/benzos	**4**	8	9	7
Males –Methadone	**9**	1	5	2
Males – other controlled drug	**1**	2	2 (cocaine)	2 (traces cannabis)
Males in Treatment	**6**	5	5 (incl 1x ref/assessed)	4 + 1 referred not seen

5.2 Female

	2012	2011	2010	2009
Total Drug Related Deaths	**21**	12	17	13
Females	**7 33%**	1 9%	2 12%	4 31%
Mean age	**37**	24	27.5	29.75
Oldest	**59**	24	31	49
Youngest	**17**	24	24	17
Females – Heroin/alcohol/benzos + Morphine	**4**	0	0	2
F/males-Methadone	**2**	1	2	2
Females - other c/drug	**1**	0	0	0
Females in Treatment	**1**	0	2	3 + 1 referred not seen

5.3 England & Wales

From the ONS Drug Death Reports 2011,2010, 2009 and 2008. The 2012 ONS report will not be available until late August 2012. The table below shows the ONS 'drug misuse deaths', this covers all illicit and pharmaceutical drugs not prescribed to the deceased.

	2011	2010	2009	2008
Total Drug Related Deaths	**1605**	1784	1876	1939
Male	**1192 (74%)**	1382	1512	1506
Female	**413 (26%)**	402	364	433

Heroin & Methadone Deaths England & Wales 2010 / 2011 ONS Statistics

	2011	2010	+/-
Heroin	596	791	-195 (25%)
Methadone	486	355	+131 (36%)

Heroin & Methadone Deaths England & Wales 2010 / 2011 NpSAD Statistics

	2011	2010	+/-
Heroin	820	1061	-241 (22%)

Methadone	765	503	+262 (52%)

Heroin & Methadone Deaths Scotland. General Register Office Statistics

Here for the first time in the UK deaths from Methadone overdose have overtaken Heroin related deaths.

	2011	2010	+/-
Heroin	206	254	-48 (18%)
Methadone	275	174	+101 (58%)

5.4 The above three tables are self explanatory however the death of males in Cornwall is slightly below the national average however 6 of the deceased males were all over the age of 40 years. Exposure to a history of drug abuse or addiction is increasing with age. Older drug users are defined as those aged over 40 years at the time of death and with a known history of drug use or addiction. However they need not necessarily have been known to treatment services. The survival rate of older drug users has increased over the years. The median age at death for those with a history of drug abuse was 32 years in 2000, by 2009 this had risen to 37 years and the combined male/female overall median age at death being 39 years.

6. NEW MEASURES /INITIATIVES / PROGRESS 2012

6.1 **Database**

Although not new for 2011 but very current is a peninsula wide database that was introduced in January 2009 following liaison between Devon, Cornwall, Plymouth and Torbay DAATs together with the Devon and Cornwall Constabulary. Two researches within the Devon and Cornwall Constabulary were appointed with special responsibility to identify and record on the database all instances of suspected drug related deaths that arise within the two counties. During 2011 only one researcher was responsible for monitoring suspected drug death occurrences alongside other research tasks.

There are 67 different fields within the database to record nominal details, toxicology results and the progress of that particular case. All the fields are input and maintained by the police researcher and Drug Liaison Officers however, DAATs have access to and influence over input data. The database is routinely updated and sent via secure e-mail to nominated DAAT recipients. Throughout 2011 these fields were amended to facilitate search requirements. It is a very welcome document and ensures all drug related deaths are accurately recorded. The accepted practice of the Drug Liaison Officer notifying the Cornwall & IOS DAAT Drug Related Deaths Prevention Coordinator continues as indeed does the 'Cornwall Model' for monitoring and recording drug related deaths. Similarly the Department of Health recording criteria and data sheets will continue to be maintained by DAAT. This new database enhances current recording methods and ensures a consistent approach across the peninsula. DAAT has also back recorded onto the database all Cornwall & IOS drug related deaths since 2004.

6.2 **Peninsula Drug Related Death Review Panel**

Along with the introduction of the above database a Review Panel has also been introduced to identify best practice across the peninsula and share information from various partners to develop measures for the prevention and reduction of drug related deaths. Having a wider data set will assist in identifying particular trends and vulnerability amongst drug users. Initial meetings commenced in 2009 to determine the terms of reference and membership which consists of all DAATs, Police Drug Liaison Officers, the database researchers, HM Coroners Officers, Ambulance Managers, A&E staff, HM Prison staff and others are co-opted as necessary. The review panel continues to be an effective forum which focuses on

case studies to identify best practice and ensure all lessons learned from drug related deaths reviews are promptly disseminated throughout services within Devon and Cornwall. The Cornwall & IOS Drug Related Deaths Prevention Coordinator is currently Chair of this review panel..

6.3 **National Programme for Substance Abuse Deaths (NpSAD)**

The recording criteria for NpSAD varies from that of DAAT and the Peninsula Database and inconsistencies between published reports have stimulated previous press and media interest. In 2009 the Cornwall & IOS DAAT Manager and Drug Related Deaths Prevention Coordinator visited NpSAD to make appropriate representations regarding the recording criteria. DAAT was then advised that the NpSAD programme and annual report had only secured funding until March 2011. The team responsible for collating all relevant data remain although largely have other duties alongside NpSAD work. Data still continues to be gathered by the team and Cornwall DAAT maintains contact with the prime author of the NPSAD report, John Corkery. Mr Corkery has supplied 'unofficial' figures fro the yet unpublished 2011 NpSAD report which helps in identify the national trend of decreasing Heroin deaths but increasing Methadone deaths.

6.4 **Drug Related Deaths Conference**

An annual conference dedicated to issues connected with preventing drug related deaths has been identified as good practice and has previously been well received by service users and providers alike. A 2012 Drug Related Deaths Conference was planned to be held at Buckfast Abbey, Buckfastleigh in May 2012 however Torbay DAAT declined to contribute to the conference and Devon DAAT were unable to secure sufficient delegates to attend , therefore and reluctantly the conference was cancelled. Plymouth and Cornwall DAATs regard such conferences as very beneficial to the process in preventing and reducing drug related deaths and it is planned to now hold a slightly smaller conference to explore and develop further initiatives beneficial to Cornwall and Plymouth DAATs.
stimated costs of a drug related death along lines similar to those published.

6.5 **Prescribing and Pharmaceutical Services Forum**

DAAT has introduced a Prescribing and Pharmaceutical Services Forum with a responsibility to oversee and develop good practice with matters of supervised consumption, needle exchange and to assist with pharmaceutical matters affecting drug related deaths. The Drug Related Deaths Prevention Coordinator is a member of this group. The expertise of pharmacists is regularly called upon to assist with enquiries involving drug related deaths where other, mainly pharmaceutical drugs are leaked onto the streets often enhancing the effects of street drugs resulting in death. Drug Related Death is a standing agenda item at each meeting.

6.6 **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 within the agreed definition as at paragraph 1.4. 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.

6.7 **NTA Best Practice for Recording & Monitoring Drug Related Deaths**

In July 2009 the NTA commissioned research of all DAAT areas to identify best practice in recording, monitoring and introducing meaningful initiatives to reduce drug related deaths. Devon and Cornwall DAAT representatives were questioned at length regarding the measures introduced throughout the two counties to reduce drug related deaths. The researcher was asked at the end of the interviews how Devon and Cornwall fared alongside the rest of the country and intimated that

Devon and Cornwall was amongst the best and possibly the best so far that he had interviewed. A report of these findings was eventually published on 5th January 2011 and identified that Cornwall had some of the best procedures in the country. This report is fairly brief and a copy may be found via a link at Appendix B.

Cornwall DAAT has been contacted by Michelle Judge, Programme Manager for the National Treatment Agency in London for details of the actual process Cornwall DAAT uses to collect information and review drug related deaths. Full details were forwarded to Michelle who has since been used this in certain training sessions.

6.8 **DAAT Drug Related Deaths Review Group**

Following the introduction of the Devon and Cornwall Drug Related Deaths Review Panel and a recommendation of the Cornwall & IOS Drug Related Death Task Group a new Cornwall wide Drug Related Deaths Review group has been introduced. This now forms the steering and monitoring group for all drug related deaths throughout Cornwall and the Isles of Scilly. This review group comprises of all service providers, Police Drug Liaison Officers, HM Crooner's Officers, Risk Manager from the Cornwall Foundation Trust together with representatives from the Ambulance Service and Accident and Emergency departments. Others may be co-opted as necessary. This group has specific terms of reference which were developed during 2011 and now meets every four months to review collectively those deaths suspected to be drug related that have occurred since the previous meeting. Progress from previous reviews is presented together with current ongoing enquiries. The first recommendation of this group was to introduce a comprehensive information gathering process to be forwarded to every treatment provider whenever a death was notified. A new user friendly electronic form has been developed for this and a copy is included at Appendix C. This is now routinely forwarded to every treatment provider following notification of each suspected drug related death.

6.9 **Serious Incident Reports (SIs)**

In partnership with the Cornwall & IOS Primary Care Trust DAAT has developed a reporting process for all commissioned providers (Addaction, Bosence Farm Community, Freshfield Service and Gwellheans Ltd) to immediately notify DAAT of any serious incident affecting clients, staff or the organisation itself. The introduction of this process aimed predominantly to identify 'near miss' situations at the earliest opportunity and put in place prompt remedial action. The introduction also brings DAAT responsibilities in line with Department of Health requirements.

It was anticipated that this initiative would identify 'near miss' scenarios such that individuals may be identified and encouraged into treatment. This has not been particularly successful Addaction has its own system of reviews and undertakes some 20 reviews in any six month period however many of these relate to alcohol only and others are of no relevance to the DAAT reducing drug related deaths process.

The DAAT met with Cornwall Partnership Trust Head of Quality on 21st December 2011 and reviewed the then Serious Untoward Incident (SUI) reporting process. This was re-visited during early 2012 and all commissioned providers reminded and encouraged to report all 'near misses' to DAAT and not solely instances where death has arisen. Those agencies that have been involved in this process so far will see that it is relatively simple and if reported promptly much of the work may be undertaken by DAAT.

DAAT completes all Serious Incident Reports on behalf of Cornwall Foundation Partnership Trust for all deaths concerning persons who are or have been in recent treatment with CDAT for drug dependency.

6.10 **Pharmacy Campaign**

Between January and March 2012 a harm reduction campaign was launched by Cornwall Primary Care Trust and DAAT amongst all 89 pharmacies together with all minor injuries units, cottage hospitals and drop in centres throughout Cornwall and the Isles of Scilly. Prior to the launch front line staff at each pharmacy were trained at three venues throughout the county by DAAT and associated trainers. DAAT also included training on alcohol consumption and units as it was suggested that often people visiting pharmacies would be more willing to discuss alcohol issues rather than directly talking about drug related concerns. All front line staff was enthusiastic towards this campaign and no les than 740 DAAT services directories were issued, 5,000 safer injecting leaflets, 5,000 detox and reduced tolerance leaflets, 3,000 methadone cards, 500 overdose leaflets and recovery position cards together with posters, and other leaflets. Subsequent evaluation of this by front line staff, by service users acting a 'secret shoppers' and by general reports by service users to treatment providers reported this to be very successful. Staff were considered to be helpful and knowledgeable and were either able to help directly of signpost the user to an appropriate agency.

DAAT originally did a similar campaign with Cornwall Primary Care Trust in 2009 and evaluated this as a very worthwhile campaign hence the repeat of this campaign during 2012. using specially prepared safer injecting packs.

The facility to get this information into 89 pharmacies where users of both drugs and alcohol are likely to go for over the counter remedies is really valuable in disseminating advice regarding harm reduction and treatment services.

6.11 **Overdose Awareness Week**

In previous years DAAT has promoted an overdose awareness week with the Cornwall Drug and Alcohol Team. This has previously coincided with an attempt to engage pharmacies with this promotion. This year, because of the very positive pharmacy involvement at the beginning of the year early 2012 it was decided to the overdose awareness week to CDAT clients only. This was deliberately delayed until week commencing 5th November to allow good harm reduction work by CDAT staff to have an effect before the Christmas period which is often seen as a particularly vulnerable time for some. This project was overseen by CPN Vanessa Bowden who secured basic life support training for clients along, overdose prevention material, safer injecting and also Naloxone administration training in anticipation that a Naloxone programme may be rolled out during early 2013.and overdose prevention material. It is understood this was well received by all clients attending CDAT clinics throughout the week.

6.12 **Ambulance attendance data**

Following certain requests by DAAT, South West Ambulance Trust kindly provided records for their attendances at suspected overdose reports throughout 2009, 2010 and 2011. The data provided is very welcome and in 2011 identified that within Cornwall ambulance personnel attend on average 21 opiate overdoses each month (these include both accidental and deliberate overdose). In 2010 similar attendance records show this to be 20 attendances each month.
DAAT regards this information as most useful in identifying the real scale of potential drug deaths throughout Cornwall. In addition to the known and recorded drug related deaths there also now appears to be a further potential 21 opiate overdoses each month which, but for the swift intervention of paramedics and Naloxone administration may have resulted in further deaths.
DAAT was able to secure additional details regarding the administration of Naloxone by paramedics at suspected opiate overdose instances which during 2011 amounted to 213 for the year, an average of 17.75 each month (in 2010 similar Naloxone administrations amounted to 156, an average of 13 each month).
The data from the ambulance service for 2011 is now included at Appendix D.

6.13 **DAAT Website Overdose Awareness Page**

DAAT has introduced an overdose awareness page within the DAAT website. This page has been developed throughout the year by DAAT Administrator, Leanne Tarbox, who has been able to link all of the Exchange Supplies drug information leaflets to the DAAT website where each of the leaflets and some booklets may be viewed page by page on line. This is an excellent resource and was referred to regularly throughout the pharmacy campaign as outlined above.

6.14 **Naloxone Programme.**

Cosagarne Hall at St Austell has had Naloxone available in an emergency since late 2009 and has been used successfully in March 2010 by the Hostel Manager to revive a resident who had suffered an opiate overdose. DAAT now plans to introduce Naloxone to other establishments including Freshfield Service, Gwellheans and to re-introduce it to Cosgarne Hall where the remaining stock is nearing it's 'sell by' date and new staff need appropriate training. It is also planned to equip service users in receipt of substitute opiate medication with Naloxone for their own / home use in an emergency.

7. OTHER AND ALCOHOL DEATHS

7.1 All toxicology result forms are forwarded to DAAT via the Drug Liaison Officer. Those involving controlled drugs and specific levels of alcohol are routinely recorded. Others which may involve over the counter medicines or prescription only medication are screened to identify any significant trends or patterns which may either indicate a drug of abuse or have some other significance. Throughout the year DAAT had examined 76 additional toxicology results (56 in 2011 and 67 in 2010). These forms were examined to detect any unusual patterns concerning pharmaceutical drugs that may be relevant to the CD LIN or the Pharmacies and Prescribing Group however no material information was identified. Detailed research of 'Citalopram' was conducted on behalf of the Pharmacy and Prescribing Group who raised concerns that this drug may, if prescribed with methadone have a detrimental effect however nothing regarding this was discovered. DAAT routinely separates all references to 'Tramodol' from these toxicology results and records these separately for the information of the Advisory Council on the Misuse of Drugs.

7.2 DAAT also examined 22 cases of sudden unnatural death where alcohol played a relevant part in affecting motor and cognitive functions (20 in 2011 and 25 in 2010). Many of the toxicology forms examined within paragraph 7.1 featured alcohol but for the purposes of this report only those which were over twice the drink drive limit have been recorded. These included 18 males and 4 females with ages ranging from 21-63. DAAT has not investigated any of these deaths and it is not known how many may relate to road traffic accidents or acts of suicide..

7.3 A table of these deaths is included at Appendix E for information.

7.4 DAAT does not routinely review alcohol deaths but does attend certain inquests at the request of HM Coroner for Cornwall where DAAT may be requested to review certain aspects of treatment or alcohol detox and will undertake Rule 43 directions to address such issues on behalf of HM Coroner.

7.5 Cornwall Council has recently released certain statistics concerning fatal accidents within Cornwall between January 2003 and December 2010, a total of 258 fatal road accidents. Of these 64 involved motorcyclists with 8 involving alcohol. 19 pedestrians also received fatal injuries during this time span with 18 of these being 'intoxicated', 14 of which were either lying in the carriageway or walking in the carriageway as opposed to walking on the kerbside or side of the road. There are no released figures regarding cars or other vehicles however deducting the motorcyclists and pedestrians appears to leave 175 'other' motorists having fatal

accidents, a large proportion potentially involving alcohol. There are no similar figures available for 2011or 2012.

8. CONCLUSION

8.1 This report has endeavoured to describe what is a drug related death and which such deaths must be recorded. Also how they are accurately and consistently recorded across Devon and Cornwall and , how DAAT is required to investigate and review such deaths.

8.2 DAAT has maintained accurate statistics on all drug related deaths within Cornwall and Isles of Scilly for the past eleven years commencing in 1999. A comparison of year on year figures is shown at Appendix A.

8.3 At the time of preparing this report the maximum number of drug related deaths for Cornwall & IOS throughout 2012 is 21 which is 9 more than 2011 and an increase of 75%. Deaths from Heroin have reduced by three but there have been three other deaths involving pharmaceutical Morphine which has not occurred previously within DAAT records. Of great concern though is the significant rise in Methadone related deaths from just 2 in 2011 to 11 in 2012. No explanation can be made for this sudden increase except that as reported herein the quality and purity of street Heroin is poor and it is a consideration that many may have attempted to use Methadone as a more effective alternative. This seems to be a national trend for which again there does not appear to be any rational explanation.

8.4 The report next describes the brief circumstances surrounding each of the suspected drug related deaths along with their inclusion within the recording process. The details that have been requested to be included are considered as comprehensive as legally possible and if the information provided herein does not satisfy such requests then this section may be omitted from future reports.

8.5 DAAT, in line with service providers, also works throughout the year on many measures aimed at harm minimisation and overdose awareness. Section 6 of the report outlines chronologically specific matters introduced or developed during 2012 which DAAT feels assist in addressing measures to prevent or reduce drug related deaths.

8.6 DAAT is also concerned regarding alcohol deaths and although not required to record such deaths, DAAT does monitor all sudden unnatural deaths where alcohol affects motor or cognitive functions. 22 of these which identify alcohol at twice the drink drive limit have been examined all of which involve 18 men and four women aged 21-63 years

8.7 This report has been prepared as a first draft for the initial consideration of the Cornwall & IOS Drug Related Deaths Review Group sitting on Tuesday 18h December 2012. Thereafter following consultation and approval it will be forwarded to the DAAT Board.

K.Hager.
Manager
Cornwall & IOS DAAT

APPENDIX A

Tackling drugs to build a better Britain

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**	**Remarks**
Total suspected drug deaths reported to / researched by DAAT	31	25	14	19	15	20	23	14	24	25	21	24	21	**27**	
Opiates – **Heroin** (may include methadone)	6	7	8	10	10	7	13	7	12 *	12 *	8	9	8	**8 ***	*Includes suicides
Methadone (only or with non-relevant other drug)	5	2	0	0	1	1	1	2	6	5	5	7 *	2	**11 ***	
Other controlled drug (e = ecstacy, c = cocaine ,a = amphet)	0	0	0	1	1	1 e	0	2c1a	1a	1 a*	0	2c	2e	**1C 1 Mep.**	
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**	
Cornwall DAAT recorded	11	9	8	11	12	9	13	11	19	18	13	18	12	**21**	

'drug related deaths'															
npSAD recorded /published DRDs for Cornwall & IOS	19	6	7	10	2	2	2	15	35	14	27	32	N/A	N/A	

APPENDIX B

National Treatment Agency (NTA) Report

Drug Related Deaths: Setting up a Local Review Process

To access a copy of this report please visit:

http://www.nta.nhs.uk/uploads/drug_related_deaths_setting_up_a_local_review_process.pdf

Advisory Council on the Misuse of Drugs (ACMD) Report.

Consideration of the Novel Psychoactive Substances ('Legal Highs')

To access a copy of this report please visit:

http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/acmdnps2011

**********need also NpSAD report July 2012.

APPENDIX C

Cornwall and Isles of Scilly Drug and Alcohol Action Team

CONFIDENTIAL INQUIRY INTO DRUG RELATED DEATHS

1	**Name:**	
2	**Other Names:** Aliases or nicknames	
3	**Date of Birth:**	
4	**Date of Death:**	

5	Did you know this person yourself?	Yes/No
6	Was this person know to be an illicit drug user? **(if no, proceed to question 8)**	Yes/No
7	If yes, what drugs do you know they were using in the month before their death, how long they had been using drugs & were they injecting:	
DRUG		**DURATION**
8	Injecting	Yes/No
9	Were they taking any over the counter medications that you are aware of? Yes/No **If yes, please provide details of this medication below:**	
DRUG		**DOSE**
10	Was this client an alcohol user? Yes/No **If yes, please provide details of alcohol use that you were aware of:**	
11	Did you know this person had died?	Yes/No
12	Were you aware of any suicidal intent?	Yes/No
13	If yes, please give details:	

14	How did this person first make contact with you/your organisation? **Please give details:**	
15	When did this person first contact your organisation? **Insert date:**	
16	When was the most recent contact? **Insert date:**	
17	Compared to other users of your service was their contact: **(please tick)** Very frequent ☐ Frequent ☐ Average ☐ Infrequent ☐ Seldom/Never ☐	
18	During the month before their death were their contacts: (**please tick)** More frequent ☐ The Same ☐ Less Frequent ☐	
19	Did you/others in your organisation refer this person to other services? **If no, proceed to Q19**	Yes/No
20	Name of the organisation this person was referred to:	
22	Please list other services you know this person was in contact with:	
23	Please list other services you, or your organisation had contact with about this person:	
24	What were their goals regarding drug use? **(please tick all that apply)** No Goals ☐ Harm Minimisation ☐ Controlled Use/ Stabilisation ☐ Abstinence ☐ Don't Know ☐ Other ☐	

25	Please comment on the person's situation, or behaviour regarding the following areas:	
a.	Housing	
b.	Homelessness	
c.	Finances	
d.	Employment	
e.	Physical Health	
f.	Criminal Justice System	
g.	Prison	
h.	Relationships	
i.	Contact with Family	
j.	Children	
k.	Own Children in Care	
l.	Childhood	
m.	School Expulsion	
n.	Bullying	
o.	Looked after System	
p.	Child Abuse	
q.	Domestic Violence	
r.	Bereavement	

26	Were you, or your organisation involved in prescribing medications for this purpose? **If no, proceed to Q25. If yes, please provide details below:**	Yes/No

DRUG PRESCRIBED	**DOSE**	**REGIME** (i.e. daily, injected, oral)

27	If your organisation was prescribing to this client, do you feel they were stable on their prescription?	Yes/No
28	Please describe in detail all prescriptions in the last month before death:	
29	Please give any other information that may help explain how and why this person died. If you are aware of any change in behaviour in the immediate weeks before death, please record here: **(please use additional paper if necessary)**	

Your Name:	
Your Organisation:	
Your Position within this Organisation:	
Your Email Address:	
Date of Completion:	

APPENDIX D

South Western Ambulance Service Trust (SWAST)

CORNWALL - Ambulance Service Data from 01/01/2009 - 31/12/2009

Presenting Condition Code	Description	Number of Incidents	SWAST Total
M46	Alcohol overdose	800	4467
M47	Accidental Opiate Overdose	92	526
M48	Accidental Non Opiate Overdose	224	1158
M49	Accidental Overdose substance unspecified	243	1250
D01	Deliberate Opiate Overdose	147	823
D02	Deliberate Non Opiate Overdose	763	3612
D03	Deliberate Overdose substance unspecified	359	1658
TOTAL		**2628**	**13494**

Naloxone Administrations = 171

BODMIN	
D01	11
D02	53
D03	26
M46	34
M47	4
M48	8
M49	11
Total	**147**
BOSCASTLE	
D02	1
M46	1

BUDE	
D01	7
D02	16
D03	12
M46	11
M47	1
M48	2
M49	4
Total	**53**
CALLINGTON	
D01	1
D02	9
D03	5
M46	7
M48	1
M49	5

KEY	
D01	**Deliberate Opiate OD**
D02	**Deliberate Non Opiate OD**
D03	**Deliberate OD unspecified**
M46	**Alcohol OD**
M47	**Accidental opiate OD**
M48	**Accidental non opiate OD**
M49	**Accidental OD unspecified**

Total	**28**
CALSTOCK	
D03	1
CAMBORNE	
D01	10
D02	51
D03	25
M46	50
M47	4
M48	22
M49	27
Total	**189**
CAMELFORD	
D02	4
D03	3
M46	3
M49	**2**
Total	**12**
DELABOLE	
D02	4
D03	1
M46	2
Total	**7**
FALMOUTH	
D01	9
D02	24
D03	19
M46	69
M47	2
M48	15
M49	10
Total	**148**
FOWEY	
D01	1
D02	4
D03	4
M46	3
M47	1
M48	1
Total	**14**
GUNNISLAKE	
D02	4
M46	2
M49	1
Total	**7**
HAYLE	

D01	1
D02	11
D03	7
M46	10
M47	3
M48	11
M49	4
Total	**47**
HELSTON	
D01	10
D02	24
D03	5
M46	24
M47	2
M48	6
M49	11
Total	**82**
LAUNCESTON	
D01	9
D02	35
D03	15
M46	21
M47	8
M48	5
M49	6
Total	**99**
LISKEARD	
D01	10
D02	42
D03	14
M46	26
M47	1
M48	9
M49	28
Total	**130**
LOOE	
D01	1
D02	11
D03	7
M46	7
M47	3
M48	1
M49	4
Total	**34**
LOSTWITHIEL	
D02	3

D03	2
M46	1
M48	1
Total	**7**
MARAZION	
D02	1
D03	1
M46	2
Total	**4**
NANPEAN	
M46	1
NEWQUAY	
D01	12
D02	54
D03	22
M46	159
M47	12
M48	26
M49	31
Total	**316**
PADSTOW	
D02	4
D03	4
M46	1
M48	2
M49	2
Total	**13**
PAR	
D01	1
D02	14
D03	5
M46	3
M47	2
M48	7
M49	2
Total	**34**
PENNYGILLAM	
M46	1
PENRYN	
D01	2
D02	4
D03	6
M46	12
M48	1
M49	4
Total	**29**

PENZANCE	
D01	18
D02	65
D03	25
M46	76
M47	20
M48	13
M49	17
Total	**234**
PERRANPORTH	
D01	1
D02	5
D03	6
M46	6
M47	1
M48	3
M49	5
Total	**27**
PERRANWELL	
D03	1
REDRUTH	
D01	5
D02	41
D03	19
M46	70
M47	5
M48	22
M49	19
Total	**181**
RUTHVOES	
M46	1
SALTASH	
D01	2
D02	19
D03	12
M46	15
M47	1
M48	6
M49	5
Total	**60**
ST AGNES	
D02	2
D03	1
M46	5
M48	2
M49	1

Total	**11**
ST AUSTELL	
D01	15
D02	141
D03	55
M46	55
M47	9
M48	17
M49	18
Total	**310**
ST Columb	
D01	5
D02	10
D03	6
M46	4
M47	3
M48	3
M49	2
Total	**33**
ST IVES	
D01	2
D02	13
D03	5
M46	7
M48	7
M49	4
Total	**38**
TINTAGEL	
D02	3
D03	1
M46	3
Total	**7**
TORPOINT	
D01	2
D02	10
D03	7
M46	4
M48	2
M49	3
Total	**28**
TRURO	
D01	11
D02	74
D03	33
M46	92
M47	9

M48	28
M49	13
Total	**260**
WADEBRIDGE	
D01	1
D02	7
D03	4
M46	12
M47	1
M48	3
M49	4
Total	**32**

CORNWALL - Ambulance Service Data from 01/01/2010 - 31/12/2010

Presenting Condition Code	Description	Number of Incidents	SWAST Total
M46	Alcohol overdose	818	4151
M47	Accidental Opiate Overdose	83	494
M48	Accidental Non Opiate Overdose	233	1251
M49	Accidental Overdose substance unspecified	203	1092
D01	Deliberate Opiate Overdose	161	784
D02	Deliberate Non Opiate Overdose	772	3539
D03	Deliberate Overdose substance unspecified	359	1602
TOTAL		**2629**	**12913**

Naloxone Administrations = 156

BODMIN	
D01	12
D02	44
D03	25
M46	39
M47	3
M48	14
M49	8
Total	**145**

KEY	
D01	**Deliberate Opiate OD**
D02	**Deliberate Non Opiate OD**
D03	**Deliberate OD unspecified**
M46	**Alcohol OD**
M47	**Accidental opiate OD**
M48	**Accidental non opiate OD**
M49	**Accidental OD unspecified**

BOSCASTLE	
D02	0
M46	1
BUDE	
D01	8
D02	17
D03	8
M46	17

M47	1
M48	5
M49	3
Total	**59**
CALLINGTON	
D01	1
D02	11
D03	5
M46	5
M48	1
M49	4
Total	**27**
CALSTOCK	
D03	
CAMBORNE	
D01	13
D02	49
D03	25
M46	50
M47	7
M48	19
M49	11
Total	**174**
CAMELFORD	
D02	1
D03	2
M46	4
M48	2
Total	**9**
DELABOLE	
D01	2
D02	2
M46	1
M47	2
M49	1
Total	**8**
FALMOUTH	
D01	5
D02	59
D03	17
M46	74
M47	3
M48	15
M49	9

Total	**182**
FOWEY	
D02	6
D03	1
M47	1
M48	2
M49	1
Total	**11**
GUNNISLAKE	
D02	3
M46	4
M48	2
Total	**9**
HAYLE	
D01	4
D02	18
D03	7
M46	18
M47	4
M48	5
M49	4
Total	**60**
HELSTON	
D01	5
D02	23
D03	13
M46	41
M47	3
M48	12
M49	9
Total	**106**
HOLSWORTHY	
M48	1
D01	1
D02	1
Total	**3**
LAUNCESTON	
D01	8
D02	25
D03	9
M46	13
M47	0
M48	3
M49	11

Total	**69**
LISKEARD	
D01	15
D02	34
D03	24
M46	20
M47	8
M48	15
M49	12
Total	**128**
LOOE	
D01	2
D02	9
D03	3
M46	12
M47	3
M48	7
M49	4
Total	**40**
LOSTWITHIEL	
D02	3
D03	2
M46	3
M47	1
M49	1
Total	**10**
MARAZION	
D02	2
M46	2
M47	1
Total	**5**
NEWQUAY	
D01	13
D02	56
D03	27
M46	151
M47	5
M48	23
M49	24
Total	**299**
PADSTOW	
D01	1
D02	3
D03	4

M46	2
M49	2
Total	**12**
PAR	
D01	4
D02	14
D03	10
M46	5
M47	2
M48	3
M49	1
Total	**39**
PENRYN	
D01	2
D02	14
D03	3
M46	13
M47	2
M48	6
M49	3
Total	**43**
PENZANCE	
D01	12
D02	45
D03	15
M46	62
M47	12
M48	15
M49	14
Total	**175**
PERRANPORTH	
D01	1
D02	4
D03	6
M46	4
M47	0
M48	2
M49	3
Total	**20**
PORT ISAAC	
M49	1
REDRUTH	
D01	9
D02	52

D03	20
M46	73
M47	5
M48	16
M49	25
Total	**200**
SALTASH	
D01	6
D02	24
D03	18
M46	14
M47	3
M48	8
M49	7
Total	**80**
ST AGNES	
D01	1
D03	6
M46	6
M48	0
M49	1
Total	**14**
ST AUSTELL	
D01	19
D02	138
D03	57
M46	69
M47	6
M48	24
M49	16
Total	**329**
ST Columb	
D01	1
D02	11
D03	1
M46	8
M47	0
M48	7
M49	2
Total	**30**
ST IVES	
D01	2
D02	13
D03	5

M46	17
M48	2
M49	3
Total	**42**
ST. MARY'S, IOS	
D01	1
TINTAGEL	
D02	4
D03	2
M46	3
Total	**9**
TORPOINT	
D01	3
D02	11
D03	4
M46	8
M47	1
M48	1
M49	3
Total	**31**
TRURO	
D01	9
D02	69
D03	35
M46	61
M47	9
M48	22
M49	18
Total	**223**
WADEBRIDGE	
D01	1
D02	7
D03	5
M46	18
M47	1
M48	1
M49	2
Total	**35**

APPENDIX E

ALCOHOL RELATED DEATHS – CORNWALL – 2012

Alcohol Level Mgs/l	Male / Female	Age	Remarks / Additional Info.
550	**M**	**41**	***'fatal overdose of alcohol'***
345	**M**	**53**	**Significant detrimental effect on motor/cognitive function**
325	**M**	**42**	**Significant detrimental effect on motor /cognitive function**
308	**M**	**60**	***Fatal ketoacidosis.***
297	M	61	'high alcohol consumption'
294	M	42	'high alcohol consumption'
285	M	35	'high alcohol consumption'
262	F	42	'detrimental effect on motor & cognitive functions'
242	F	60	'detrimental effect on motor & cognitive functions'
237	F	63	'detrimental effect on motor & cognitive functions'
229	M	54	'detrimental effect on motor & cognitive functions'
228	M	47	'detrimental effect on motor and cognitive functions'
222	M	27	'detrimental effect on motor and cognitive functions'
220	M	27	'detrimental effect on motor and cognitive funtctions'
192	M	23	'detrimental effect on motor & cognitive functions
189	M	68	**Fatal ketoacidosis**
179	M	21	high social level may affect motor & cognitive functions
178	M	40	high social level may affect motor & cognitive functions
175	M	41	high social level may affect motor and cog. Functions.
165	M	43	high social alcohol consumption
164	M	59	high social alcohol consumption
163	F	49	high social alcohol consumption

Toxicologists suggest:-

Levels of 400 + equate to potential fatal overdose of alcohol.
Levels 300-400 equate to serious alcohol toxicity.
Levels 200-300 equate to confusion, inability to stand or walk unaided and severe depression of motor and cognitive functions.