

TITLE OF REPORT: Drug Related Death Annual Report 2015 and 2016 Update

1 Purpose of the Report

- 1.1 The purpose of this report is to present the Drug-related Death (DRD) Annual Report for 2015 and give an overview of the 2016 DRDs.

2 Background

2. As a reminder for partners, the Gateshead DRD Panel is a local multi-agency group that undertakes inquiries into all deaths where drugs are suspected to be a direct cause of the death of a person in Gateshead.

- 2.2 The purpose of the Panel is to:

- carry out case reviews following a drug-related deaths in Gateshead;
- establish whether there are lessons to be learnt from the case – particularly in relation to the way in which local partner agencies and services work; and
- make recommendations on both clinical practice and non-clinical policy and practice in order to reduce the risk of further drug-related deaths in the future.

- 2.3 Each year an Annual Report is produced which pulls together key learning from the deaths.

3 Annual Report for 2015

- 3.1 The attached report provides:

- An overview of drug-related deaths nationally;
- The Gateshead drug-related deaths process;
- Gateshead drug-related deaths in numbers;
- Key themes arising from the deaths; and
- Key actions and recommendations for 2016/17 which have been included in the action plan at the back.

4. Summary of DRDs 2016

- 4.1 There were 17 DRDs in 2015. To date (January-May) there have been 13 potential DRDs in Gateshead, which is a significant increase. These are deaths which the Coroner believes to be drug related however, this has not been confirmed through post-mortem.

- 4.2 These cases will be looked at and discussed at the next DRD Panel however a brief synopsis of the cases and information gathered to date shows that the

lessons from these cases are identical to those which have been highlighted in the 2015 annual report in particular:

- Dual Diagnosis;
- Involvement with Social Services and the Criminal Justice System
- Unemployment;
- Not in Drug Treatment;
- Prescribing
- People present at the death not being aware of the signs of an overdose (snoring loudly);
- Previous overdoses (intentional and accidental); and
- Complex/chaotic lifestyle.

5 Recommendations

5.1 Members are asked to:

- (i) Comment on and discuss the attached Annual Report and action plan (Appendix 1)
- (ii) Agree to receive future updates

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