CORNWALL COUNCIL
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DRUG RELATED DEATHS REPORT

CONCERNING THE MONITORING OF AND THE CONFIDENTIAL ENQUIRIES MADE INTO DRUG RELATED DEATHS WITHIN CORNWALL & THE ISLES OF SCILLY

1st January 2024 to 31st December 2024

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Executive summary: Drug and Alcohol related deaths in CIOS (2024)

In 2024, Cornwall and the Isles of Scilly (CIOS), despite best and concerted efforts, recorded the highest number of drug and alcohol deaths (DARDs) to date, with **58 deaths**-a **41%** increase on 2023. This includes **42 men** (up 35%) and **16 women** (up 60%).

This marks a significant increase, particularly among women and reflects concerning national trends. The average age of death was highest among individuals aged 50-59, especially among men, while women were most affected in the 30-39 age group.

Key Findings:

- **Synthetic opioids** continue to pose a growing threat. Four deaths involved synthetic opioids, none of whom were engaged in treatment at the time. Testing for synthetic opioids is not routinely undertaken, raising concerns about underreporting.
- **Polydrug** use was prevalent, with 81% of deaths involving between 2-11 substances. Cocaine was implicated in more deaths than heroin, continuing a trend since 2020. Cocaine was implicated in the most deaths (13) of those not in treatment. Methadone was implicated in the most deaths (18) of those in treatment. Diazepam and pregabalin were particularly prevalent in the deaths of those in treatment. Alcohol was a factor in 12 (21%) of deaths.
- **Mental health** issues were widespread: 78% of men and 87% of women experienced conditions such as anxiety, depression, post-traumatic stress disorder (PTSD) and psychosis.
- **Physical health** complications were common, including chronic obstructive pulmonary disorder (COPD), heart conditions and chronic pain.
- **Neurodiversity** was identified in approximately 1 in 4 individuals, though the data is incomplete.
- **Adverse Childhood Experiences (ACEs)** were under-recorded, despite their known link to the risk of physical ill-health and premature death.
- **Domestic abuse** was a significant factor for women (62% victims), while 24% of men were identified as abusers.
- **Complex vulnerabilities** such as using substances from an early age, a long-time user of substances, criminal justice involvement and child removal were prevalent, especially among women.

Priorities for 2025-2026:

1. **Substance specific interventions:** Targeted responses to cocaine, methadone, pregabalin and "so-called" recreational drugs like MDMA and ketamine.
2. **Prescribing Practices:** working with prescribers to address the risks of opiates and drug interactions and promoting non-pharmacological pain management.
3. **Early Intervention:** Enhanced screening, improved referral pathways and mandatory ACEs training.
4. **Workforce Development:** Trauma-informed care, assertive outreach, and a package of support for workers to enable better engagement for those with multiple vulnerabilities.

The data underscores the urgent need for enhanced treatment engagement, preparedness for the growing threat of synthetic opioids, and gender-responsive interventions to address the complex interplay of trauma, health and substance use.

1. Introduction

1.1 A priority in the National Drug Strategy is to rebuild drug treatment and recovery services and to reduce drug related deaths and harm.

1.1.1 The Office for Health Improvement and Disparities (OHID) has set out five priorities in a Drug and Alcohol Related Death (DARD) Action Plan for 2025/2026, which are:

a) More harm reduction

b) Changes in prescribing practice

c) Focus on physical and mental health

d) Improving the treatment offer

e) Focusing on stimulants and alcohol

1.2 All areas are recommended to have in place a system of recording and conducting confidential enquiries into all drug related deaths and to co-ordinate initiatives to deliver the Public Health Outcome: Reducing Drug Related Deaths.

1.3 The Drug & Alcohol Team in Cornwall has a dedicated role within the team to fulfil requirement. All notifications of potentially drug related deaths in Cornwall are logged and investigated to identify relevant findings and learning which will influence future prevention activities.

1.4 The definition of a drug related death used is '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'. This is the second year we have included those who die of an alcohol related death where they were in treatment at the time of their death, as recommended nationally.

1.5 Reducing drug related deaths is an issue which needs collaborative and informed action. At a local level, success is reliant on partners working together to understand their population and how drugs are causing harm in their area, any challenges in their local system and the changes that are needed to address them.

1.6 The Community Safety Partnership, Safer Cornwall has a responsibility to assess and respond to need around alcohol and drugs in the local community. This is aligned to the Safeguarding Adults and Children's Boards, and the chair of the group is also the Senior Responsible Officer for the Drug Strategy.

1.7 This annual report examines issues that have arisen from the review of drug related deaths within 2024 and compares with the findings and learning from previous years, seeking to improve local understanding, identify gaps in the provision of service and prevent future drug and alcohol related deaths.

1.8 This report has been compiled by drawing upon the expertise of partner agencies, data sharing and joint working. Below is a non-exhaustive list of groups who have contributed to and reviewed this report.

- Cornwall and Isles of Scilly Drug Related Death Review Panel (and subgroup)
- The Experts by Experience team
- With You Drug and Alcohol Service
- DAAT Clinical Governance Group

- Cornwall and the Isles of Scilly Controlled Drug Intelligence Network
- Devon and Cornwall Police
- Cornwall and the Isles of Scilly Suicide Surveillance Group
- HM Coroner's Office
- Multi-Agency Suicide Prevention Group

1.9 This report is the twenty second CIOS Annual Drug Related Death report and covers the period 1st January 2024 to 31st December 2024. It analyses and reports on drug related deaths which occurred within the calendar year of 2024. At the time of writing the report 44 deaths have been confirmed as drug and/or alcohol related deaths at inquest. A further 14 deaths are still awaiting an inquest. A death cannot be registered until confirmed at an inquest. With regard to the deaths yet to be heard at inquest, there is sufficient evidence especially the toxicology reports to suggest there will be a conclusion of drug or alcohol related death at inquest.

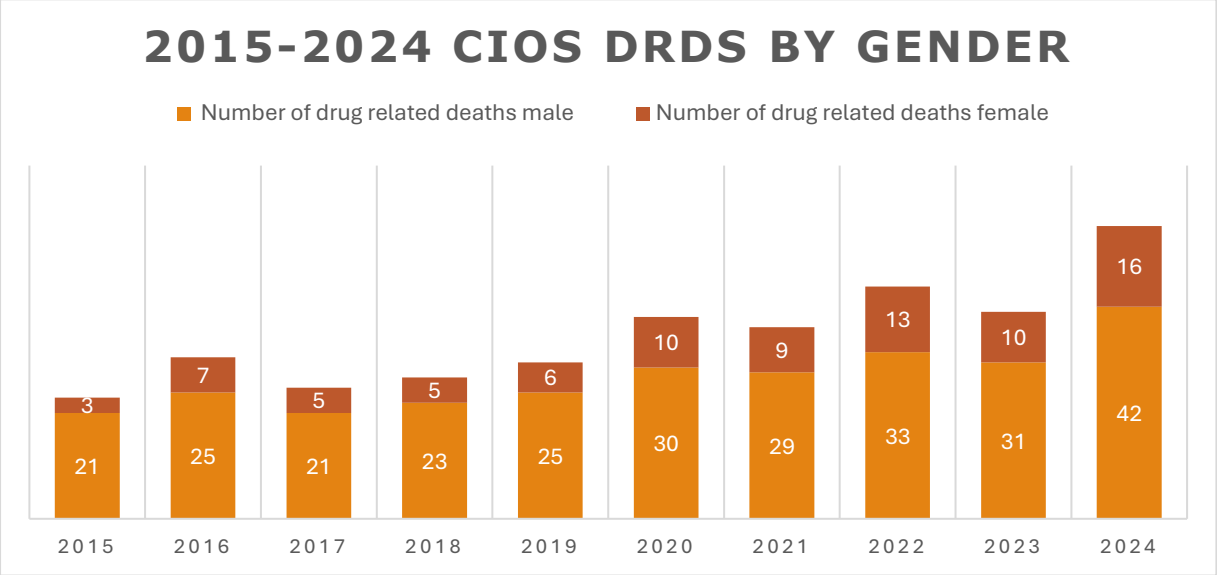
1.10 There is a discrepancy with the Office for National Statistics (ONS) data. In England and Wales, almost all drug-related deaths in the statistics are certified by a coroner following an inquest. The death cannot be registered until the inquest is completed, which can take many months or even years. In common with most other mortality statistics, figures for drug-related deaths are presented for deaths registered in a particular calendar year, rather than deaths occurring each year. This enables figures to be published in a timelier manner, but can make the trends more difficult to interpret, especially for smaller geographical areas.

1.11 The cause of death is confirmed at inquest and these conclusions are analysed within the report. To clarify:
Manner of death refers to the intentionality of the death. Cause of death refers to the circumstances that lead to death, which are categorised on the death certificate issued by the coroner, as follows:
Cause 1a: The immediate cause of death (and underlying if no 1b or 1c cited)
Cause 1b: Any disease/circumstances underlying Cause 1a
Cause 1c: Any disease/circumstance underlying Cause 1b
Cause 2: Any disease/circumstance that did not cause the death but contributed in some way.
It is not a requirement for a Cause 1b, 1c or 2 to be cited for all deaths.

1.12 Within the report, the information relating to the types of drugs causing or contributing to the death are informed by the toxicology report undertaken following a suspected drug related death. They analyse the drugs that have been taken and where possible identify how much of a particular substance or what combination of substances has caused the death.

2. Demographics

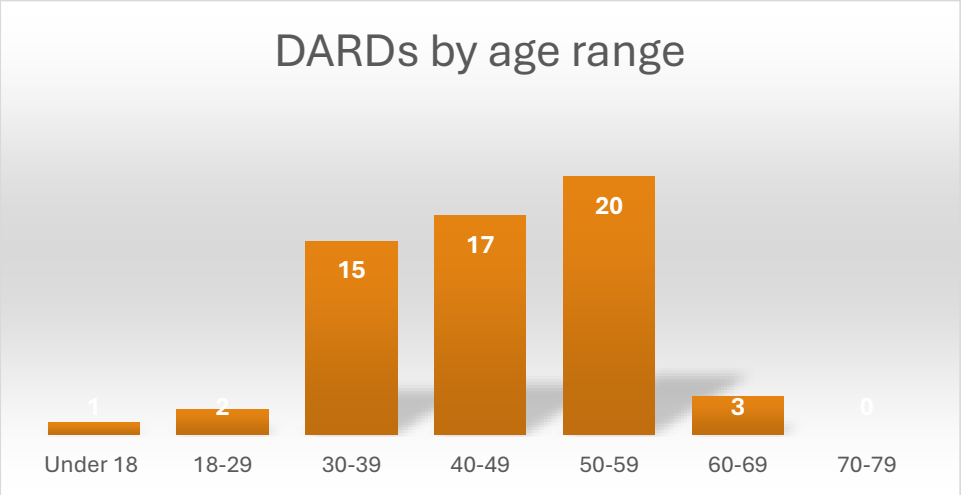
2.1 The chart below illustrates the number of drug related deaths for both men and women since 2015.



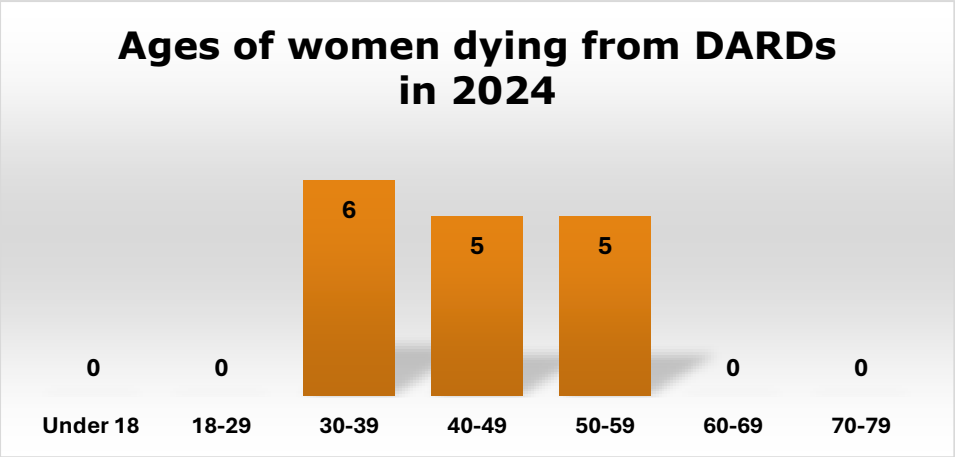
2.2 There is an increase in Drug and alcohol related deaths (DARDs) from 2023 to 2024 (11 more men and 6 more women*) (35% & 60% respectively).

*The figure for women in 2023 has reduced by 1 from the 2023 report due to a conclusion of natural causes at inquest rather than an alcohol related death as anticipated.

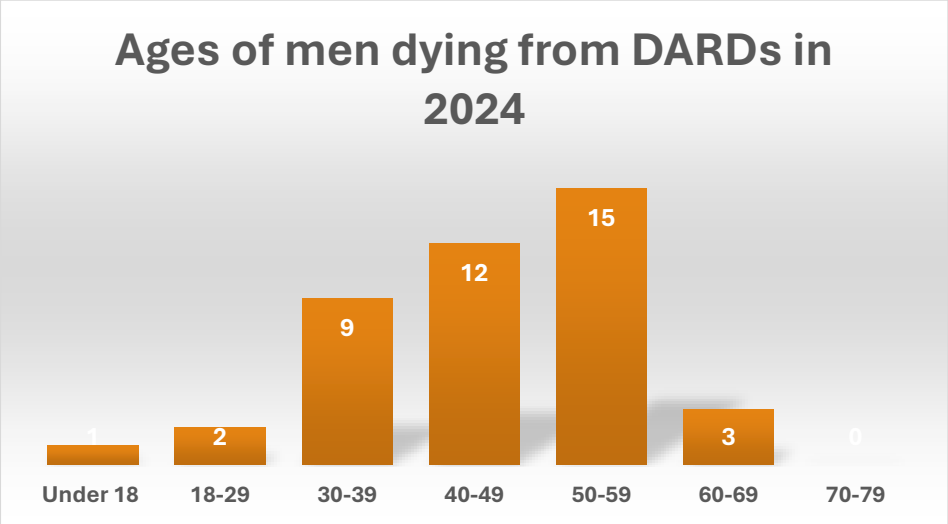
2.3 The **average age** at which individuals are dying from drug related deaths are those in the **50-59 age range**. Historically deaths have been higher for Generation X (those born in the mid-1960s-to late 1970s).



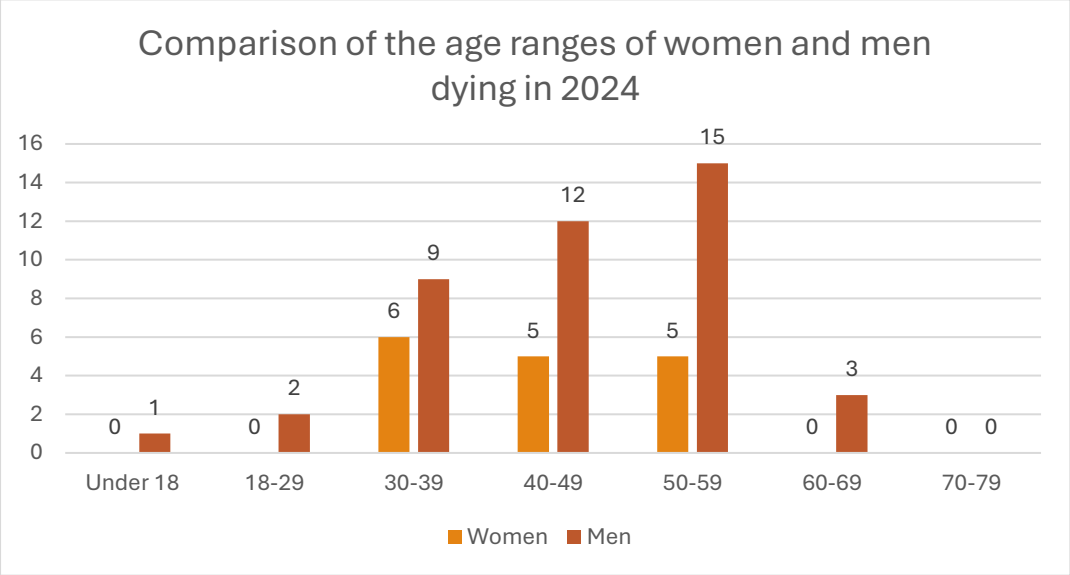
2.4 **Sixteen women** died of DARDs in 2024 which is the highest number recorded in CIOS. The age range with the most deaths for women is **30-39**.



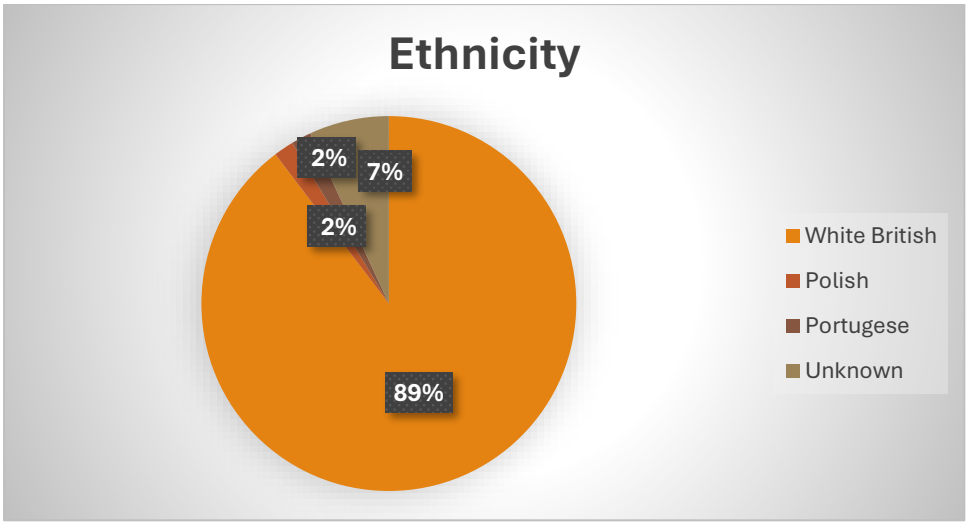
2.5 **Forty-two men** died of DARDs in 2024 again the highest recorded in CIOS. The highest age range for men in 2024 is in **50-59 age range** reflecting national trends.



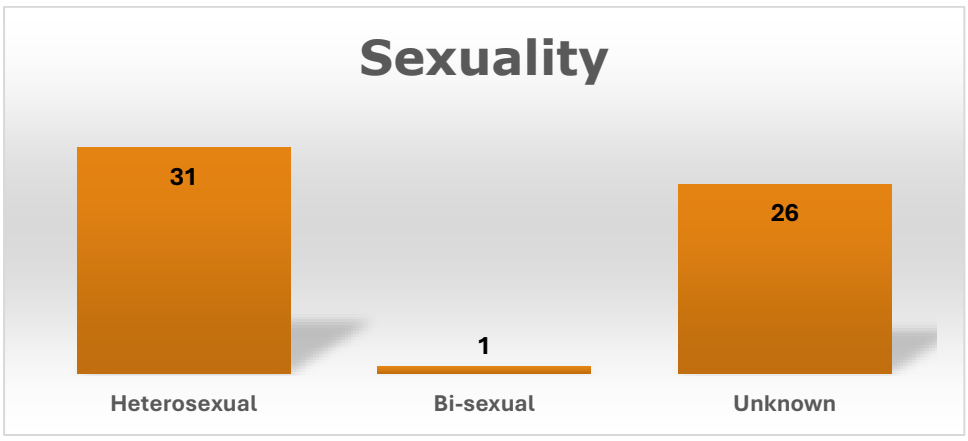
2.6 Comparison of the age ranges of men and women dying in 2024:



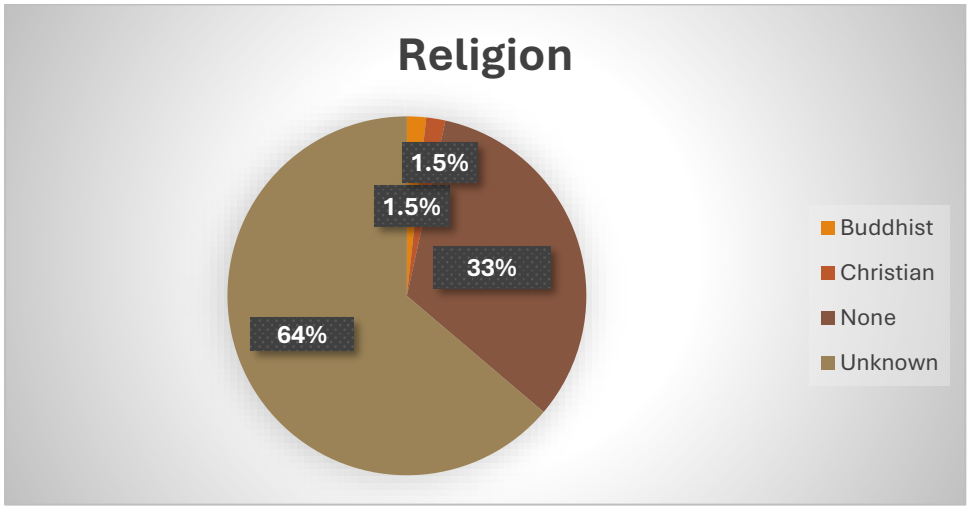
2.7 **Ethnicity**-in line with 2023, most of those dying from drug related deaths are White British.



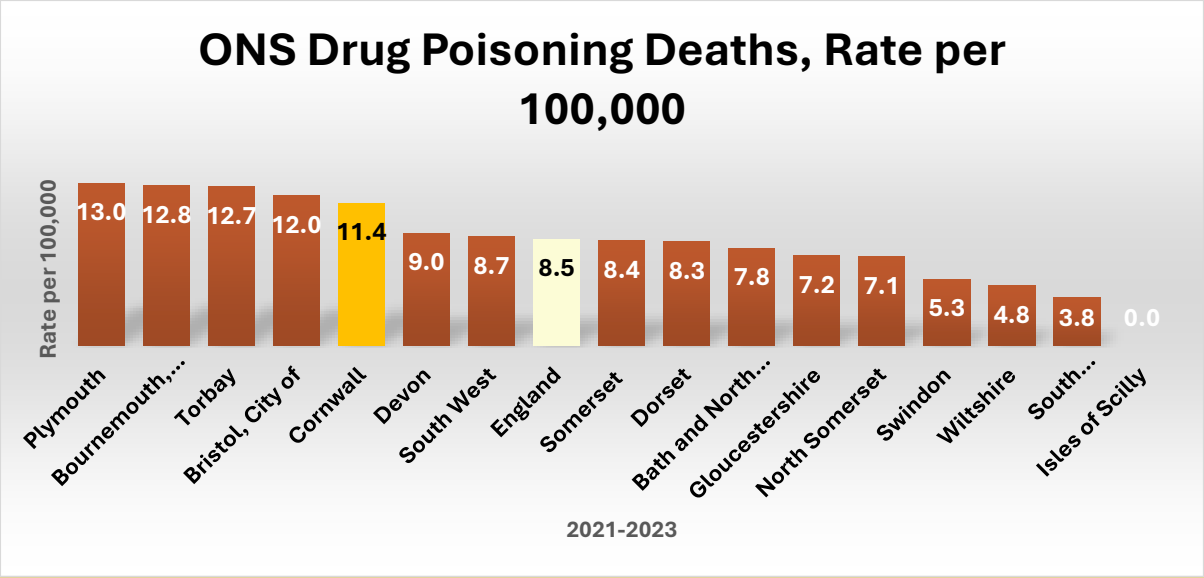
2.8 **Sexual Orientation** -the data is incomplete but the information we have confirms that 31 (53 %) out of 58 identified as heterosexual.



2.9 The data is incomplete but suggests most people do not have a **religion**.



2.10 Local drug and alcohol related deaths compared against the National figures (ONS). The data for 2024 is currently unavailable so the chart shows the results for 2021-2023.



*The definition used by the ONS is that of drug poisoning. Drug poisoning deaths involve a broad range of substances, including controlled and non-controlled drugs, prescription medicines (both prescribed and obtained by other means) and the over-the-counter medications. As well as deaths from drug abuse and dependence, figures include accidents and suicides involving drug poisonings and complications from drug abuse such as deep vein thrombosis or septicaemia from intravenous drug use.

3. Drug Trends and toxicology results

3.1. Synthetic opioids

The risk of synthetic opioids continues to be a major cause for concern. Synthetic opioids are manmade opioids including Fentanyls and a class of compounds called Nitazenes.

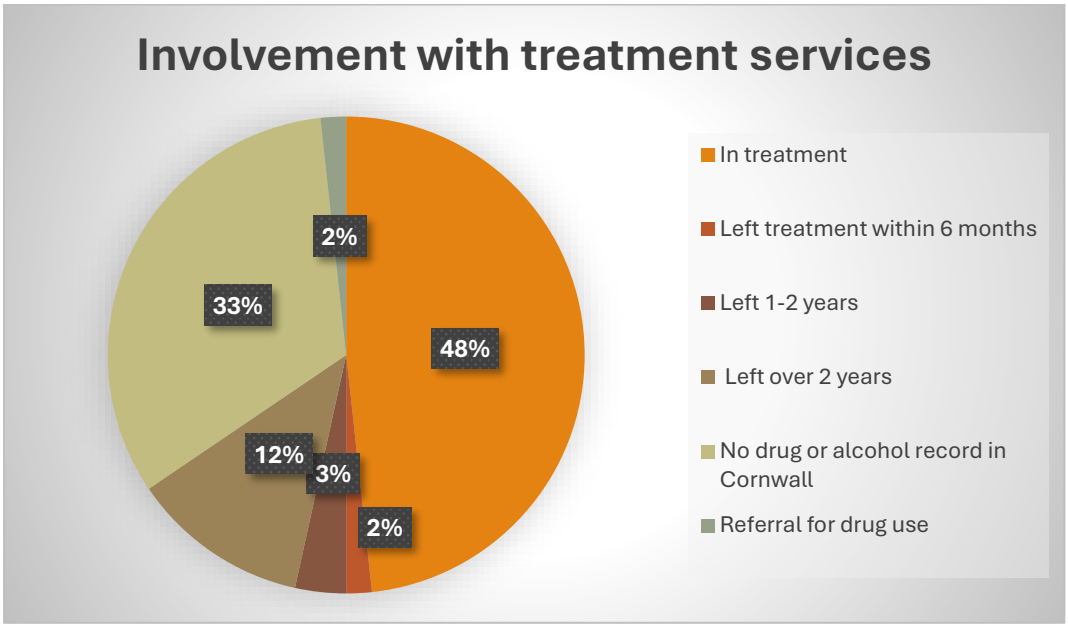
Nitazenes, technically known as 2-benzyl benzimidazole opioids, is a diverse group of synthetic opioids. Like the fentanyl analogues, many are far more toxic on a weight-for-weight basis than heroin. Even a small amount can be enough to kill, especially without immediate naloxone or medical attention.

Local authorities are required to have a Synthetic Opioid preparedness plan in place. An easy read version is available on the Safer Cornwall website: https://safercornwall.co.uk/synthetic-opioids/ or email daat@Cornwall.gov.uk for the original version.

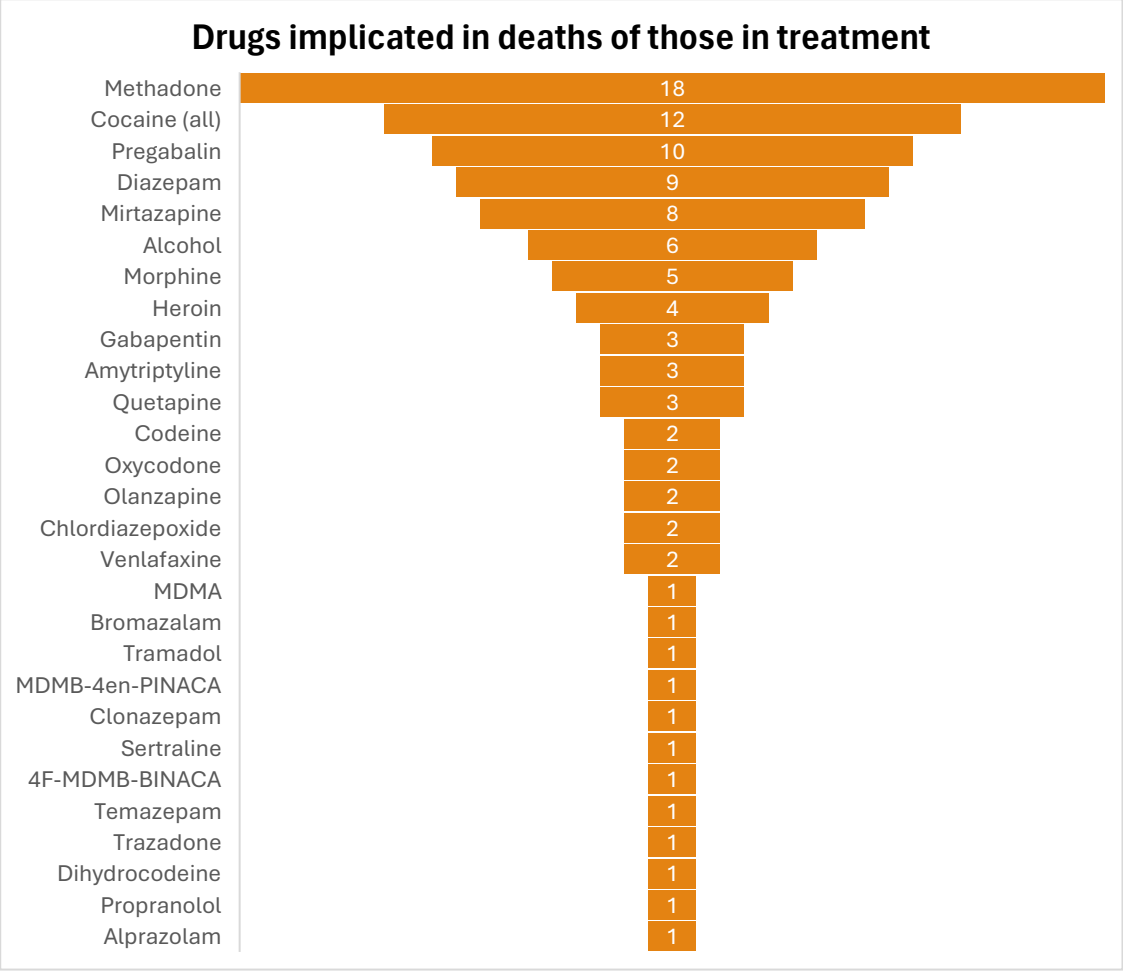
There were four deaths (3 men, 1 woman) involving synthetic opioids in 2024 (2 in 2023). All of the individuals concerned were not engaged with treatment. One was from London visiting Cornwall on holiday, one had left treatment within 6 months, one had left treatment 1- 2 years ago and one had left treatment over 2 years ago.

Testing for synthetic opioids is not routinely undertaken. Where there is no explanation for the death and/or the levels of drugs found are not particularly high or unusual, the coroner may request the additional testing for synthetic opioids. It is therefore possible that we may be missing the presence of synthetic opioids in some drug related deaths.

3.2 Engagement with treatment services

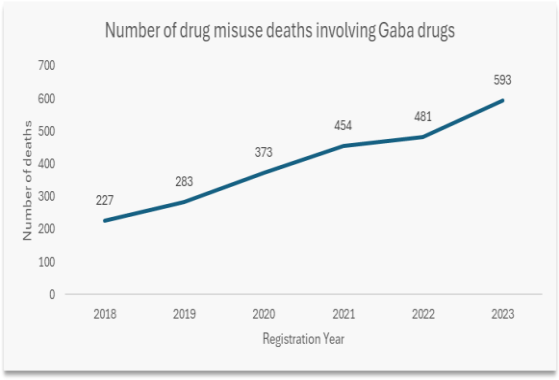


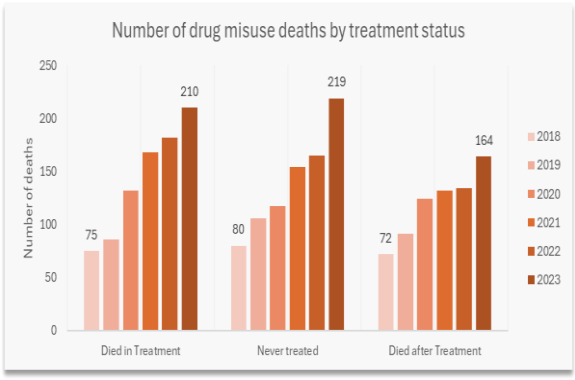
3.3 Drugs implicated in the deaths of those in treatment



Pregabalin was implicated in 10 deaths of those in treatment. The Office for Health Improvement and Disparities (OHID) has highlighted the increased use of Gaba drugs for those in treatment.

Deaths involving Gaba drugs have increased substantially over the past five years particularly where the deaths have occurred during treatment





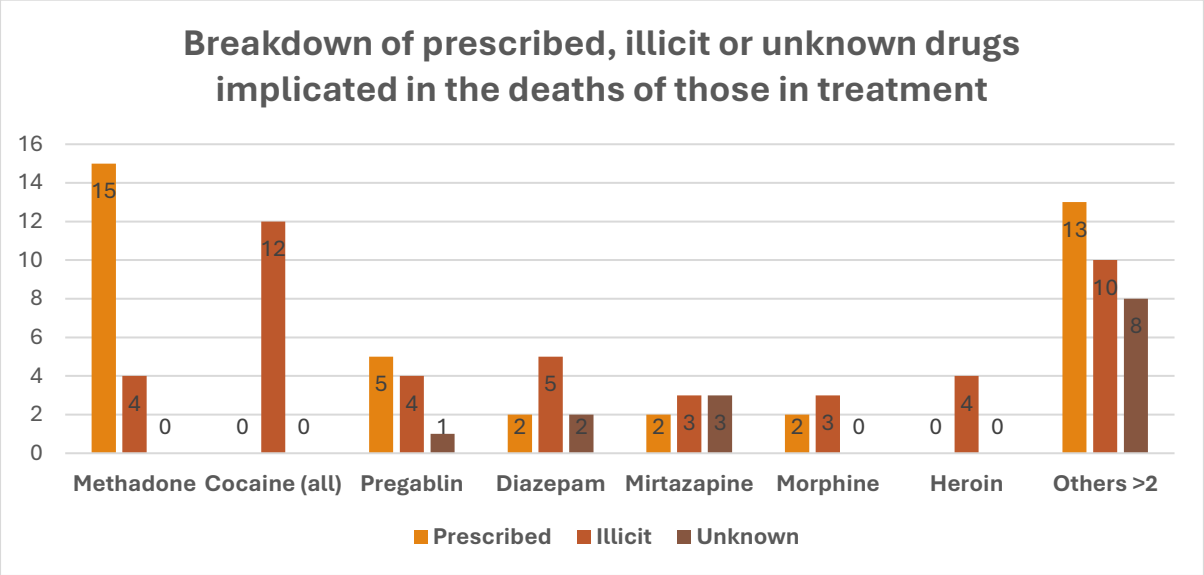
Office for Health Improvement and Disparities

In CIOS, **pregabalin** was implicated in the deaths of 10 out of 28 (36 %) of **those in treatment**. (5 prescribed, 4 illicit and 1 unknown).

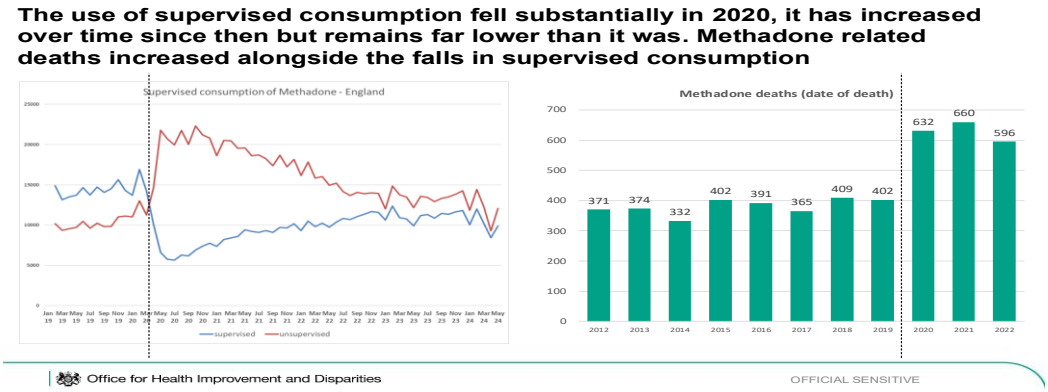
For those **not in treatment**, **pregabalin** was implicated in the deaths of 6 out of 29 (21%). (2 prescribed, 1 illicit and 3 unknown).

There is an initiative within CIOS to reduce the prescribing of gabapentinoids for the population at large but for those with dependency, it needs careful consideration to avoid forcing them into the illicit market. Treatment services to enquire about gabapentinoid use during prescribing reviews.

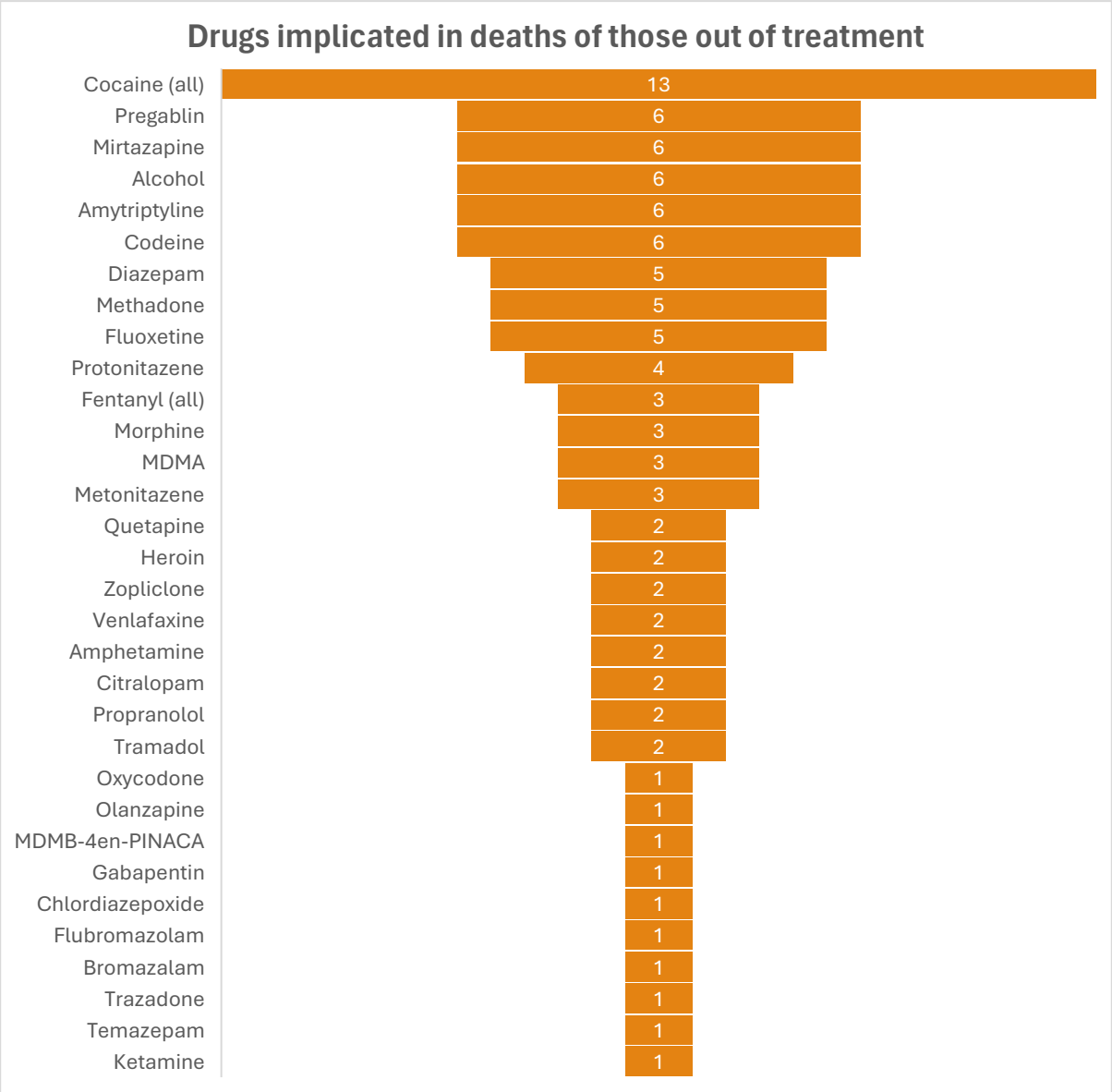
Reducing gabapentinoids.pdf



3.3.1 We can see that in 15 of the deaths, prescribed **methadone** was implicated for those in treatment. Methadone toxicity was the cause of death in 5 of these deaths and the data suggests the individuals were not under supervised consumption. Consideration of the risks to those on an OST, the balance of flexibility and encouragement of taking OST versus the safety factor of supervised consumption or alternatives to methadone. The Office for Health Improvement and Disparities (OHID) confirm

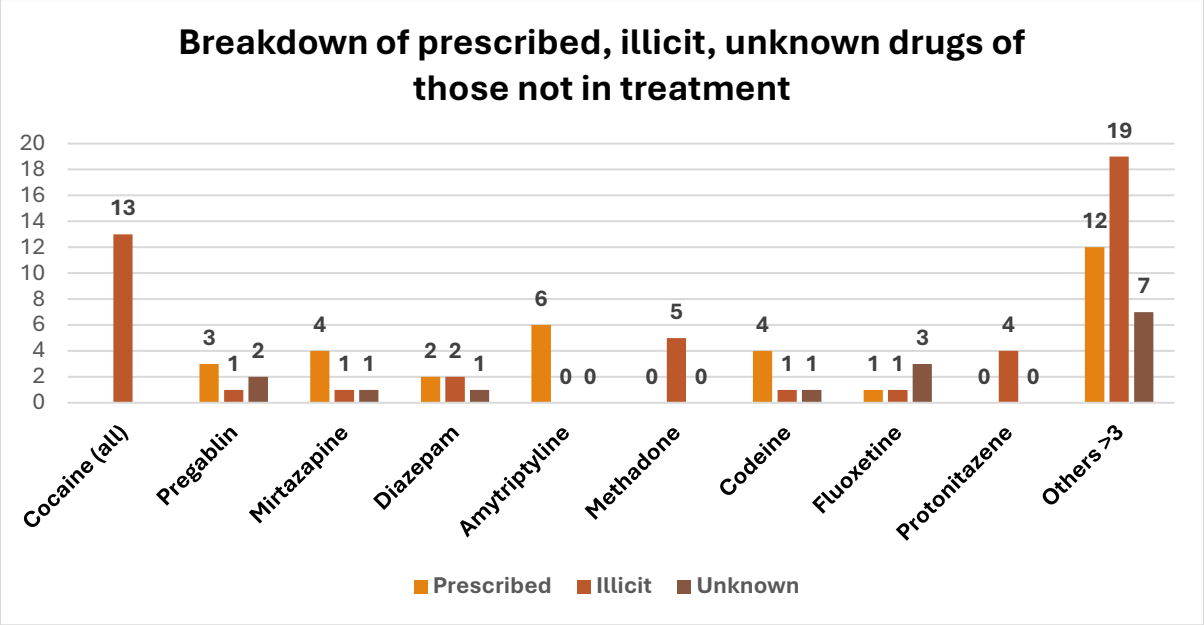


3.4 Drugs implicated in the deaths of those not in treatment

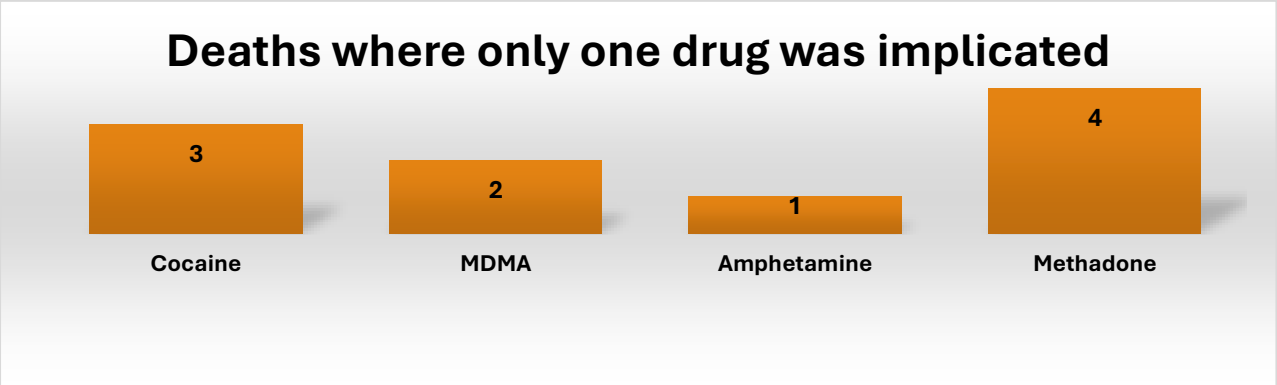


3.4.1 D**iazepam** featured in the deaths of 9 people in treatment (2 prescribed, 5 illicit, 2 unknown) and in the deaths of 5 people out of treatment (2 prescribed, 2 illicit and 1 unknown).

3.4.2 Mirtazapine (an anti-depressant medicine) featured in 8 of the deaths of those in treatment (2 prescribed,3 illicit, and 3 unknown) and 6 of the deaths of those not in treatment (4 prescribed, 1 illicit and 1 unknown).



3.5 Deaths where only one drug was implicated

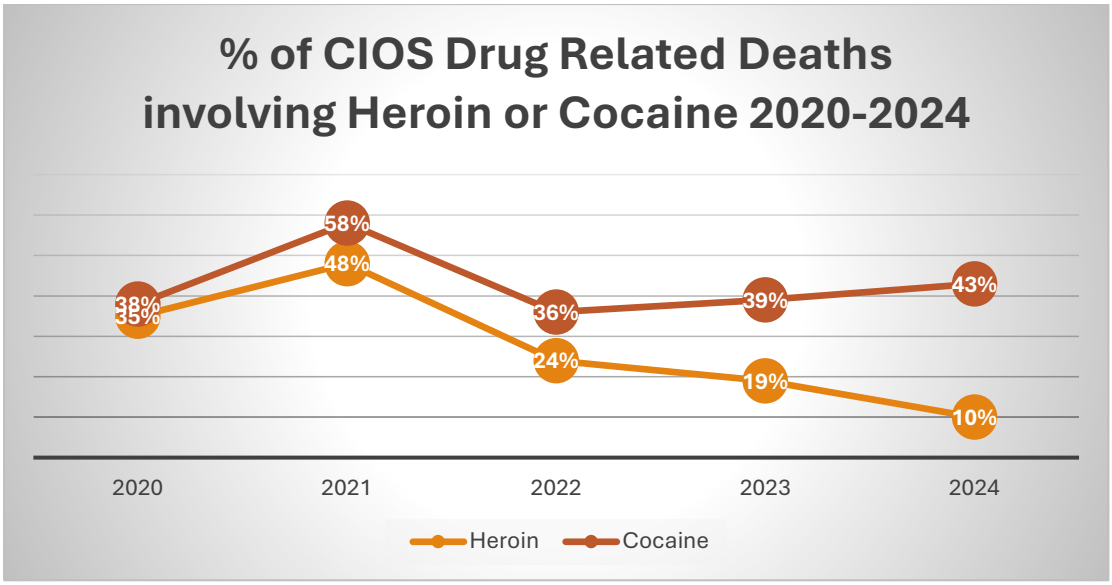


3.6 Polydrug use continues to be a major cause of DARDs.

81% of the DARDs involved between 2-11 different drugs. (2 toxicology reports unavailable at the time of writing the report). Alcohol was involved in 12 deaths (21%) (6 who were in treatment and 6 who were not). The charts at 3.3 & 3.4 illustrate the wide range of drugs implicated.

3.7 There were a greater number of deaths where Cocaine* featured compared to Heroin which is a continuation of a trend first seen in 2020. Deaths featuring Heroin continue to decrease (6 deaths) whereas those featuring Cocaine are up from 2023 (39% to 43%) (25 deaths).

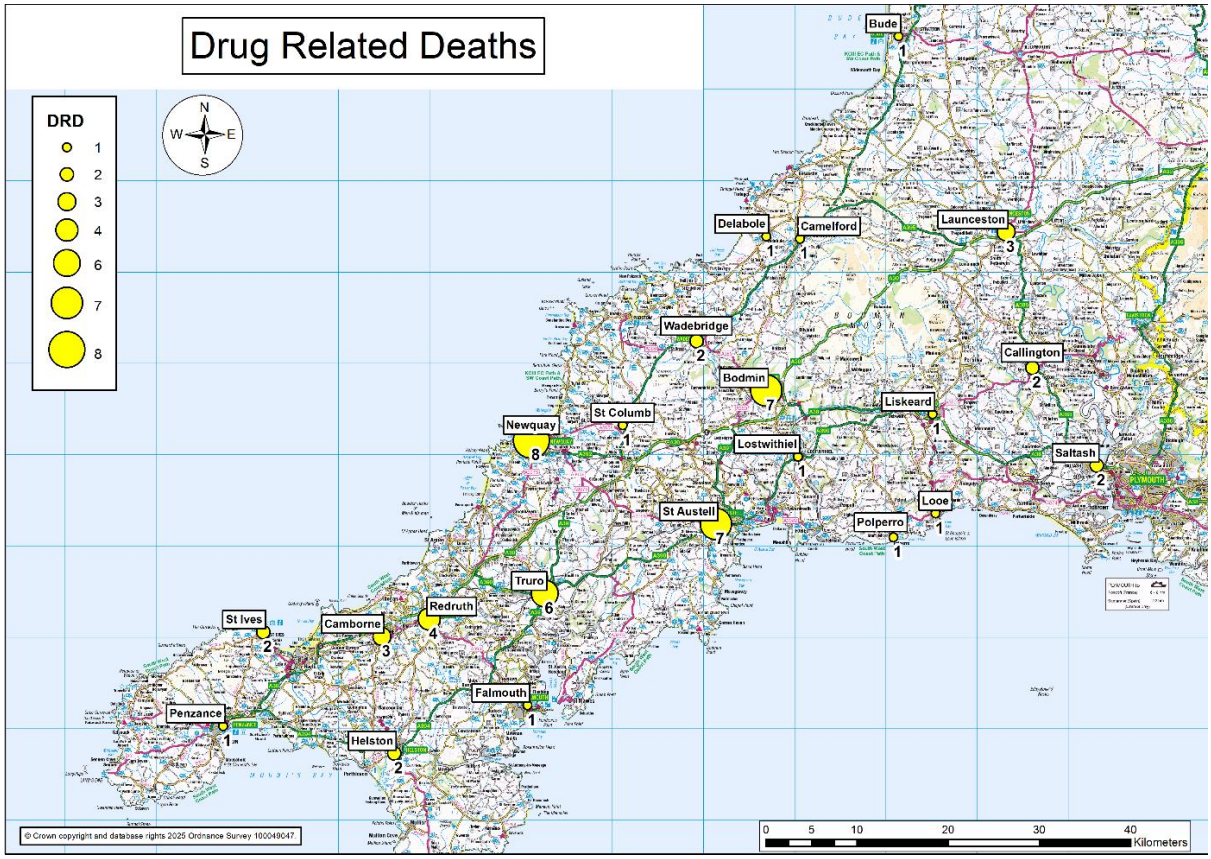
* Toxicology only indicates cocaine and its metabolites, so where a person has used crack cocaine, only cocaine metabolites are indicated.



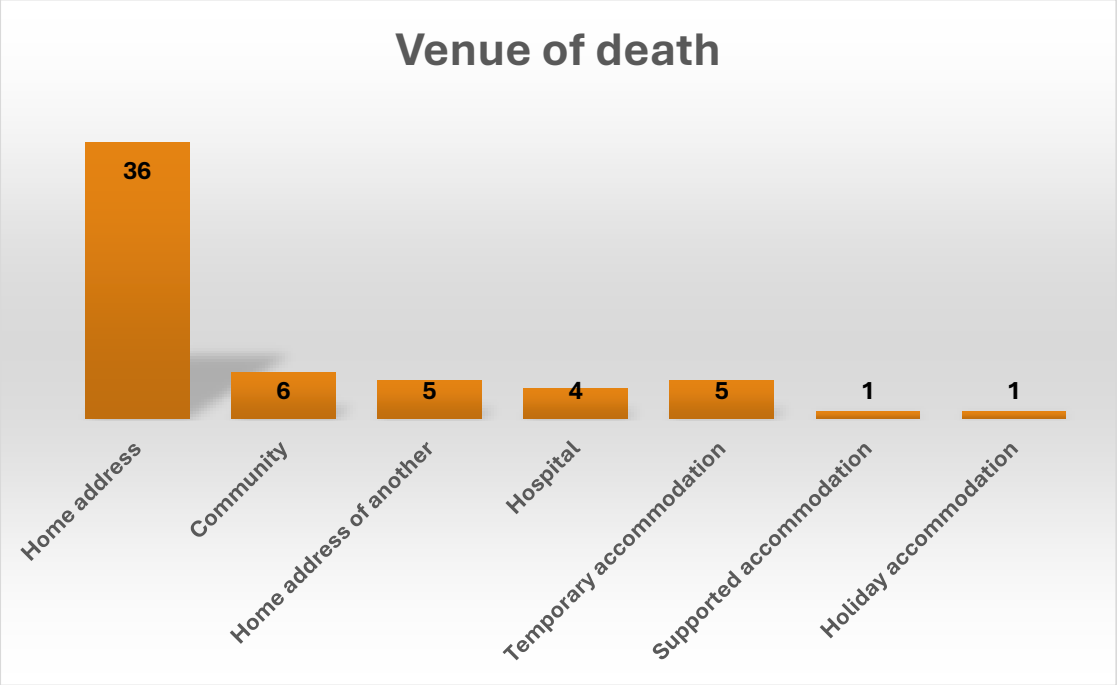
3.8 Cocaethylene is a toxic mix produced when cocaine and alcohol are taken together. It can cause permanent damage to the liver and heart of users. There were 5 individuals whose toxicology reveals the presence of alcohol and cocaine (3 with no drug and alcohol record and 2 in treatment). The toxicology detected cocaethylene in 3 reports (2 with no drug and alcohol record and 1 who was in treatment).

4 Circumstances of death

4.1 The map below illustrates the number of drug related deaths per town.



4.2 Where the deaths occurred.



4.3 Children

From the information we have, and of the deaths concluded at inquest 50 children (under 18 years old) were affected by their parent's drug related death in 2024. To ensure these children are supported, a notification of a potential drug related death is forwarded to Together for Families (TFF) who are able to check if there are any children of the deceased. Where children are identified, TFF ensure support is put in place for those children residing in Cornwall.

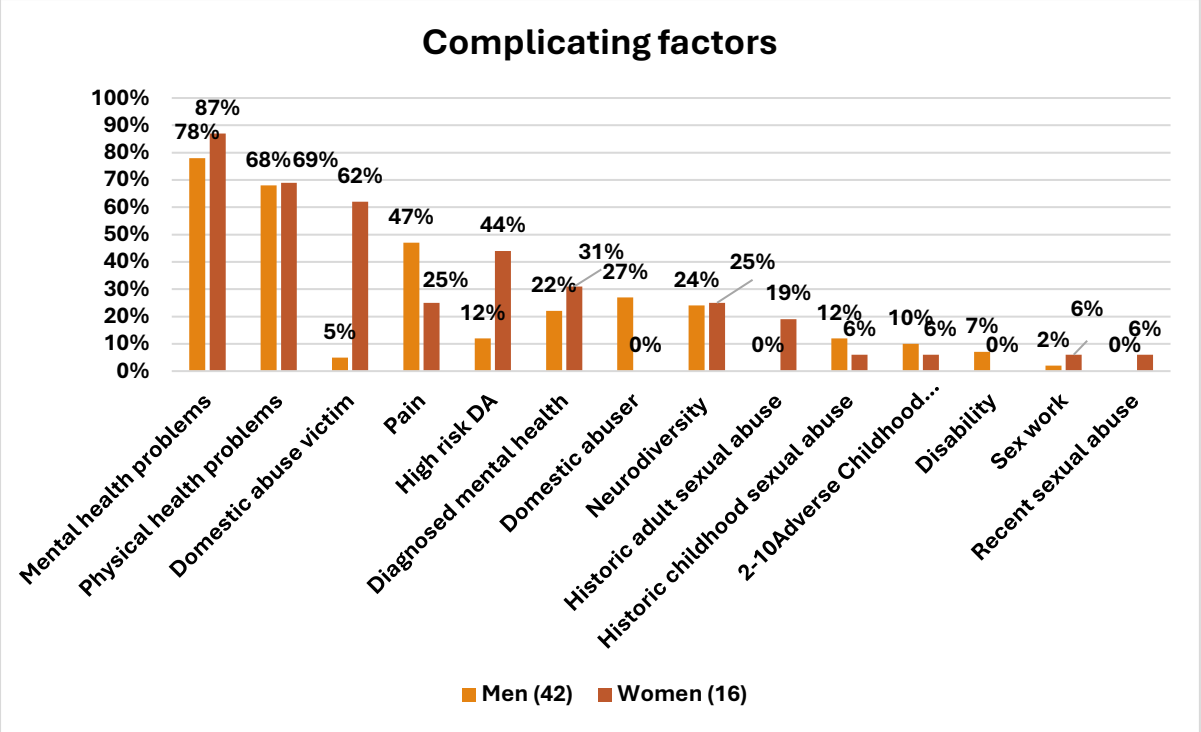
4.4 Died alone

29 out of 58 were alone when they died (50%). They are at much greater risk because there is no one to intervene and administer Naloxone or call for help when things go wrong. Both nationally and locally we are looking to raise awareness and exploring safeguarding measures to help counteract some of the risks involved for those who use alone.

5. Complicating Factors

5.1 Drugs and alcohol are often taken as a way of coping with the emotional trauma of adverse childhood experiences such as neglect, living with a parent who uses drugs and alcohol, a parent in prison, being in the care system, and sexual/domestic abuse. In other cases, the use of alcohol and drugs suddenly becomes problematic when an individual experiences adverse life events such as a bereavement or relationship breakdown. It is difficult to say to what extent these factors contributed to the drug and alcohol use of those who have died but it is helpful to inform preventative work.

The two charts below detail some of the information we have ascertained about the lives of those who died from drug and alcohol related deaths in 2024. The picture is incomplete because we tend to have more information on those who engaged with treatment and/or if a detailed background statement was obtained for the inquest.



Mental health problems are a significant factor for those dying from DARDs. 78% of men and 87% of women experienced poor mental health including anxiety 27 (47%) and depression 30 (52%), self-harm and suicide ideation 16 (28%), insomnia and sleep disturbances 7 (12%), Post traumatic stress disorder (PTSD including complex PTSD) 7 (12%), Psychosis 7 (12%) Bi-polar disorder 6 (11%), Emotionally Unstable Personality Disorder 4 (7%), Schizophrenia 3 (5%).

Physical health problems are another complicating factor in DARDs. 68% of men and 69% of women experienced physical health problems inter alia asthma 7 (12%), chronic obstructive pulmonary disease COPD 7 (12%), skin abscess/deep vein thrombosis 7 (12%) heart problems 5 (9%), fibromyalgia and chronic fatigue syndrome 3 (5%).

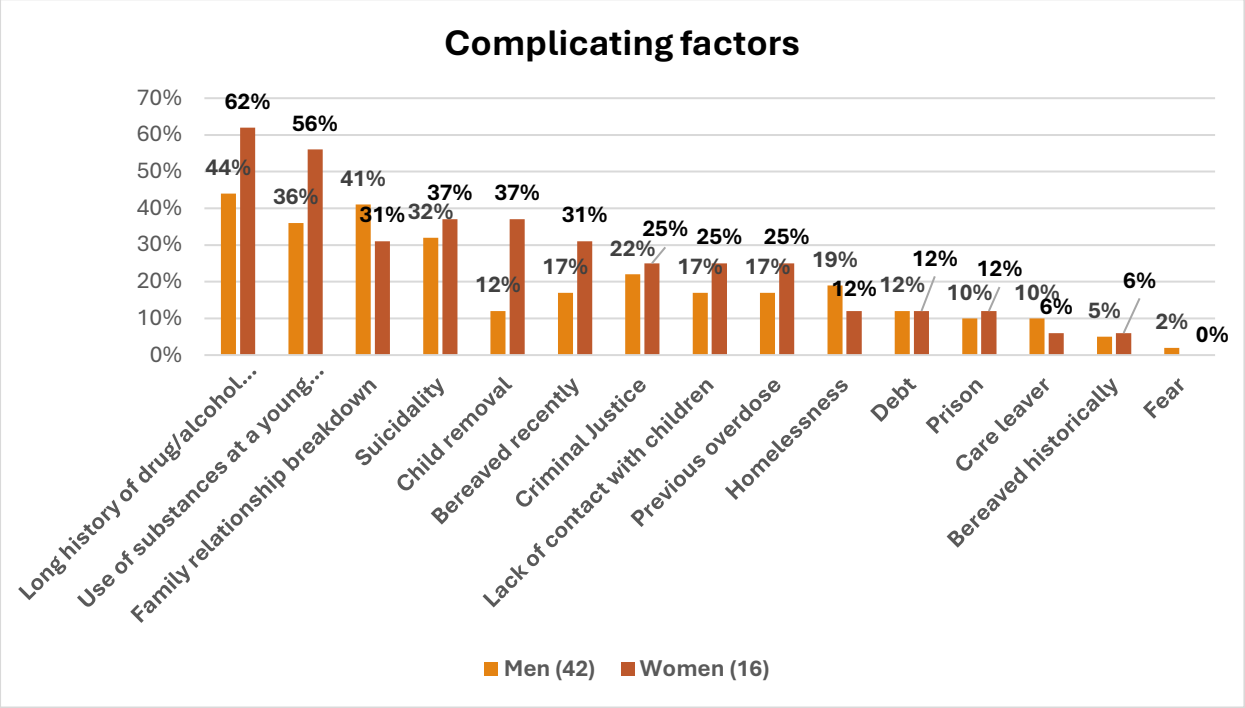
Neurodiversity-data on neurodiversity has been collated for the first time and although the data is incomplete, we can see 24% of men and 25% of women had some form of neurodiversity or suspected neurodiversity. Support services need to be enquiring about neurodiversity and how this might impact an individual in terms of self-medicating, and barriers to support and housing.

Adverse Childhood Experiences (ACEs)- suggest 4 men (10%) experienced between 7 and 10 ACEs and 1 woman (6%) experienced 2 ACEs. For those in treatment, workers should be enquiring about ACEs, but the data suggests this is not happening. Researchers have established a clear link between ACEs and the risk of developing poor physical health and premature death. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study - PubMed. A review of the barriers to professionals asking about ACEs and routine training for all new staff may improve the situation.

One notable and differentiating factor between men and women is **domestic abuse**. 10 (62%) of the women are domestic abuse victims with 7 (44%) being high risk* victims of domestic abuse. Two (5%) of the men were victims of domestic abuse but 11 (27%) of them were the abuser with 5 (12%) being high risk abusers.

*High risk domestic abuse victim refers to those at risk of death or serious injury. In the case of a high-risk abuser, they are at risk of causing death or serious injury to another.

Five (12%) men experienced childhood **sexual abuse** as opposed to 1 (6%) woman whereas 3 (9%) women experienced historic adult sexual abuse and 1 (6%) woman recent sexual abuse.



The notable factor in the above chart is just how many complicating factors affect the women. This is particularly pertinent given the fact that 6 (38%) women died in their 30s. Ten (62%) women had a long history of drug/alcohol use and 9 (56%) had used substances from a young age. Seven (37%) had children removed from their care and 4 (25%) had been involved in the criminal justice system with 2 (12%) having been to prison.
More men 4 (10%) were care leavers (1 woman) and 17 (40%) men had experienced family relationship breakdowns.

Non-fatal overdoses- From the information we have, seven men and four women experienced non-fatal overdoses prior to their deaths.

- 5 men had a history of intentional overdose, 1 unintentional, and 1 unclear (occurred the day before death and toxicology showed nitazenes whereas ED reported alcohol intoxication).
- 6 men received follow-up (psychiatric liaison, GP letters, referrals to With You and Adult Social Care).
- Follow-up for the man who died the next day is unclear, likely due to timing.
- 2 women had previous intentional overdoses—one linked to child removal. (One was referred to adult safeguarding and an MDT was held, and one appears to have received no referrals.
- 2 women overdosed due to medication overuse (one woman refused hospital admission and wasn't referred. One was referred to mental health services, but they couldn't engage her)

Next Steps via NFO Pathway: The sub-group will explore improvements including:

- Trauma stabilisation training for treatment staff
- Shared safety plans with a 28-day forward view

6. Priorities for 2025-2026

6.1 Addressing Substance Specific Risks

Risks to the general public

- **Cocaine:** Raise awareness of heart and stroke related risks, associated with cocaine use, especially among the wider public, to include residents who use recreationally.
- **MDMA & Ketamine:** Increasing awareness of the risks posed by MDMAs and other substances such as Ketamine, including the risks of them being contaminated, to recreational drug users particularly young adults.

Risks to people in treatment

- **Methadone** -address the risk of overdose by those on an Opioid Substitution Treatment (OST) by ensuring regular prescription reviews take place every 3-6 months and balancing the flexibility of access with the safety of supervised consumption options or alternatives to methadone.
- **Pregabalin, Diazepam, Mirtazapine**:
  Regular prescribing reviews to identify both prescribed and non-prescribed use by those in treatment. Where prescribed outside of treatment (e.g. by GPs or mental health services), evidence that joint reviews and clear communication between prescribers has happened. Where sourced illicitly, the treatment plan to include and evidence strategies for stabilisation, reduction and alternative interventions.

Pain Management-Improving Prescribing Practices to prevent dependency and reduce the risk of overdose.

Adequate and effective pain management for people with histories of opiate dependency is a significant challenge to recovery as well as posing a risk of overdose. If people cannot manage pain adequately, they are more at risk of relapse and overdose. This therefore requires the combined efforts of treatment, GPs and hospital services to get right and makes joint care plans and reviews imperative.

- Treatment provider, GPs and hospitals to jointly address the risks associated with prescribing opiates for pain management and post operative treatment to those with a history of substance dependency.
- Improving joint reviews and clear communication between GPs and treatment provider (including access to case notes) to address the synergistic risks of combined prescribed and illicit drugs.
- Treatment providers to collaborate more effectively with pain management clinicians and services to promote both appropriate medications and non-pharmacological alternatives for managing pain.

6.2 Strengthening Early intervention and Prevention to identify issues early and support individuals before problems escalate.

The highest impact activity and action that any service can take it to employ simple, validated alcohol and drug screening questions. In Cornwall, we promote the use of Assyt-LITE to do this.

- Expand screening and identification across all frontline professionals to identify risks from substance use sooner.
- Increase visibility of support services available for individuals and families affected by substance use.
- A reinvigorated rollout of routine enquiry into Adverse Childhood Experiences (ACEs) as part of the Compassionate Cornwall All Age Framework.

6.3 Build trust to ensure individuals with multiple vulnerabilities receive consistent, trauma-informed support.

- Rollout of My Team Around Me (Creative Solutions) multiagency approach.
- Where a person's keyworker is due to change, wherever possible, introduce new workers whilst the trusted existing worker is still in post to sustain engagement and to maintain the continuity of care.
- Train more practitioners in trauma stabilisation to increase availability for individuals with complex trauma.
- Use assertive referrals -not just signposting for those facing multiple challenges.
- Engage flexibly and creatively: joint visits, problem-solving, and flexible outreach for those experiencing homelessness or instability.

Continuation of the priorities identified in the 2023 DRD report (Appendix B)

- Increased coverage of Naloxone
- Non-fatal overdose pathway
- Housing – Identifying appropriate placements that consider vulnerabilities like neurodiversity and the challenges of shared housing for neurodiverse individuals. -Alternative safe, suitable houses for women with multiple complex traumas-
- DAAT/DASV protocol-Including a review by DASV services on their abuser screening resources to avoid colluding with abusers in post separation abuse Respect Male Victims Toolkit | Respect
- Pain management
- Dual diagnosis
- Bereavement
- Using alone

Appendix A

Drug Related Death 1

- 59-year-old woman who was discovered unresponsive by her lodger. A concern for her welfare was raised when she did not turn up for work.
- Cause of death: 1a) Mixed drug toxicity and sudden unexpected death in alcohol misuse. All of the drugs taken were prescription medication and only one of those drugs is a controlled drug under the Misuse of Drugs Act 1971.
- She had sustained a fourteen-year period of abstinence from alcohol following a successful detoxification programme and rehabilitation, but the death of three family members seems to have triggered a return to drinking alcohol.
- The inquest found abuse and trauma in her early life triggered her use of alcohol.
- Her GP and mental health services placed the onus on her to seek further support from alcohol treatment services and mental health which she was unable to do.

Learning and actions

- A dual diagnosis approach would have helped her address her co-existing conditions of mental health problems and alcohol use.
- Earlier intervention for those who have experienced abuse and trauma from childhood or as young adults.
- The drug related death review panel felt that signposting is not adequate for certain people. The professional needs to make the referral on the part of the individual and/or provide assertive support to help them access specialist services.

Drug and alcohol related death 2

- 35-year-old woman whose friend raised a welfare concern when she received a text from her. She claimed to have taken tablets and drank some alcohol and had left her home to try and work things out. A high-risk search and rescue were launched by the police, and she was later found in the estuary.
- Cause of death: 1 a) Mixed cocaine and alcohol intoxication. 2 Drowning.
- The inquest found that trauma and abuse in her youth triggered her drinking and although she was not dependent on alcohol, she would binge drink to cope with her emotions.
- She had previously taken an overdose of prescription tablets and had been admitted to hospital due to alcohol intoxication.
- The inquest concluded that due to the cocaine and alcohol intoxication she had ended up in the estuary and had been unable to get out resulting in her drowning.

Learning and action

- She was not known to treatment services. A referral following her admittance to hospital and/or by her GP might have helped. Improved screening for those using alcohol and illicit drugs.
- The inquest heard she had a CAMHS worker and was working through her trauma. Routine ACEs enquiry may have allowed her to access this support sooner.

Drug related death 3

- 57-Year-old male who had a cardiac arrest and a subsequent stent fitted 4 days prior to his death. He was found collapsed in his wheelchair by his friend and attempts to resuscitate him were unsuccessful.
- His mother had recently died and was buried days before his hospital admission. He self-discharged from hospital against medical advice.
- Cause of death: 1 a) coronary artery disease II Drug misuse.
- Significant cardiotoxicity was attributed to the use of cocaine.
- He was referred to the drug and alcohol treatment service by his GP in 2013 but attempts to engage him in treatment were unsuccessful.
- He suffered with lower limb ischemia and complex regional pain syndrome to the extent he repeatedly requested an amputation.

Learning and actions

- Awareness raising of the effect of cocaine and its metabolites on the heart and the introduction of routine Electrocardiograms (ECGs) for those known to be using cocaine.
- Repeated screening and referral to allow individuals multiple attempts to access treatment.
- Alternatives to medication for pain management.

Drug related death 4

- 55-year-old male who was discovered by his housing worker who was attending for a home appointment. Paramedics pronounced him dead
- Cause of death: 1a) Multiple Drug Toxicity
- He had successfully completed a detox in 2001 and not used alcohol since.
- He experienced the co-existing conditions of mental health and substance use.
- He had experienced a previous overdose and suicide ideation.
- He had distanced himself from his family and friends.
- Longreach referred him to With You when he was admitted in 2018, but the worker was unable to engage him, and he had been signposted on a number of occasions.

Learning and actions

- Assertive attempts at engaging clients, especially those with mental health problems.
- A dual diagnosis approach may have helped
- The non-fatal overdose referral pathway would have picked him up and possibly assisted him in accessing treatment.
- His key worker failed to refer him into treatment or was not aware of his drug use. Professional curiosity training for workers.

Drug related death 5

- 52-year-old male found in bed unresponsive by friend. Emergency services were called but he was pronounced dead at the scene.
- Cause of death: 1a) Mixed drug overdose.
- He self-referred to the drug and alcohol treatment service in 2019 disclosing a long history of drug use (and heroin use for the past three years). He had no physical health conditions at that time, but disclosed he had a diagnosis of schizophrenia for which he was prescribed 75 mg quetiapine. He reported this stabilised his mental health and enabled him to manage it.

- Opiate Substitute Prescribing was initiated in April 2019 and the amount reduced over time, and he engaged with the treatment provider up until his death.
- His health started to deteriorate in 2020 with him reporting swollen feet and legs and experiencing falls due to dizziness. Investigations were undertaken by his GP but without any conclusive outcome.
- A risk assessment prior to his death highlighted the risks of polydrug use and overdose and the risk of continued crack use and smoking nicotine on his health, especially to his lungs. In the months leading up to his death he reported feeling unwell and his presentation reflected this.
- He disclosed childhood sexual abuse and was estranged from his family having grown up in the care system.

Learning and actions

- The DRD review panel found that GPs often over prescribe medications to those already on an opiate substitution therapy prescription and that there is national opioid prescription epidemic. Treatment providers to work with GPs to mitigate the risk associated with over prescribing for those in drug and alcohol treatment.
- He may have benefitted from opportunities to work through his trauma.
- The drug taking and smoking impacted his physical health as he aged.

Drug related death 6

- 33-year-old male who was discovered by his friend whose house he was staying at. The friend struggled to comprehend what had happened but told another friend who immediately called for an ambulance. Paramedics found him deceased.
- Cause of death: 1a) Multiple drug toxicity
- He used substances from an early age-drank alcohol age 13, illicit Amphetamines as a young teenager and cannabis and ecstasy, Heroin from 24 years and later illicit opiates, benzodiazepines and crack cocaine.
- Multiple admissions to hospital due to overdose and intensive interventions by the With You hospital team.
- Main priorities to address polydrug use and housing.
- He slept on father's kitchen floor so was not seen as a housing priority.
- Neurodiversity and learning difficulties meant he struggled to manage his emotions and relate to people.
- Referred into the STAR project but decided not to accept-inappropriate for him to live in shared housing because of his neurodiversity.

Learning and actions

- Package of support from adult social care ended December 2023 as they could not meet his needs within the allotted 4 hours. There may have possibly been challenges for the carers due to his neurodiversity, use of substances and housing situation. A possible review of care companies used and specialist training.
- Housing to take neurodiversity into account when housing individuals and develop a better understanding of the challenges of shared housing for neurodiverse individuals.

Drug related death 7

- 57-year-old male who had gone to bed to rest due to a bad back. His wife checked on him during the afternoon and saw he was sleeping. She returned early evening to find him unresponsive so called for an ambulance.

- Cause of death: 1 a) Mixed Drug Toxicity (Methadone, Cocaine, Benzodiazepines, Pregabalin, Zopiclone)
- He had used heroin between the ages of 17-27 but had completed a successful period of detoxification and rehabilitation.
- He became addicted to Oxycontin following abdominal surgery in 1994. He continued to suffer with abdominal pain for the eight years prior to his death.
- He self-referred to With You in November 2020 and was supported up to his death.

Learning and action

- He was referred to the pain clinic at Derriford hospital who looked at alternatives to medication. They could find no underlying cause for the pain and adopted a holistic care plan for him. There is a continued need for pain specialists and substance misuse teams to continue to work together using for example the Ten Footsteps for Living with Pain programme which is available as a resource online. There is a necessity for workers in the field of substance use to be aware of alternative measures of pain relief and to work with colleagues in primary and secondary care to develop more holistic care packages for those service users who are using prescribed, over the counter and illicit substances as a means of alleviating their chronic pain. With You's Clinical Lead is leading this work locally.
- Awareness raising within hospital settings on the risks of prescribing drugs that can cause relapse into addiction for those who are in recovery.
- The risks of taking prescribed and illicit drugs whilst on an opiate substitute prescription needs to be highlighted. With You prescribers are in regular contact with clients' GP's, keeping them up to date with any changes to prescriptions. They also have access to client medical records. With You are in the process of recruiting a Medical Lead who will be tasked with improving relations between prescribers, GP's and Recovery Workers with regard to pharmacological decisions and regular drug testing with relevant results being communicated to both prescribers and GPs to enable safer case management.
- Many individuals are on lists of prescribed medication in conjunction with illicit drugs and alcohol and awareness raising and education around the harmful effects of drug interactions needs to be prioritised.
- Clients on long-term OST, especially methadone, are experiencing gastrointestinal complications (e.g. diverticulitis, constipation, piles) often exacerbated by polypharmacy and poor diet.

Drug related death 8

- 43-year-old male who was discovered unresponsive by a fellow resident. Concerns for his welfare had been raised by his new partner. An ambulance was called but it was not possible to save him.
- Cause of death: 1a) Multiple drug toxicity. The toxicology revealed high levels of cocaine metabolites and bromazolam (illicit benzodiazepine).
- His family said he loved music and had worked as a DJ covering festivals in his youth.
- He was not known to drug and alcohol treatment services.
- He was known to secondary mental health services because he had made previous attempts on his life and was diagnosed with bi-polar affective disorder. He experienced anxiety and depression and difficulty sleeping.
- In December 2023 he fell downstairs and injured his leg which caused him significant pain.

- At the time of his death, he was feeling positive about his new relationship and making plans for his birthday.
- He was open to Integrated care mental health treatment, but his care coordinator left, leading him to fear he'd 'drop out the system'.

Learning and actions

- His GP and mental health team did not screen him for drugs and alcohol which may have led to a referral to With You. Improved screening processes need to be implemented and utilised.
- Introduction of new workers whilst the trusted worker is still in post, so clients feel confident in the continuity of their care.
- Awareness raising for GPs of over prescribing medication.
- Alternatives to medication for pain management.

Drug related death 9

- 59-year-old female whose mother raised welfare concerns when she could not reach her. Police and ambulance service found her unresponsive, and resuscitation was unsuccessful.
- Cause of death: 1a) Methadone Toxicity 2 Myocardial fibrosis
- She was engaged in treatment and had successfully stopped drinking alcohol fourteen years ago. She was in receipt of a weekly pick up of opiate substitute prescription of 100ml of methadone at the time of her death.
- She was diagnosed with Cauda Equine Syndrome which led to significant pain due to nerve damage and had type 2 diabetes.
- She struggled with her mental health including admissions to mental health wards.
- Her mother told the inquest that her daughter was looking forward to a holiday they had booked but felt her daughter was experiencing forgetfulness so may have inadvertently taken too much of her medication.

Learning and actions

- It is With You's policy that patients on 100 ml methadone receive 3 monthly Electrocardiograms (ECGs). The GPs who prescribe under a shared cared arrangement must be reminded of this to ensure this policy is adhered to in practice. This is over and above the National prescribing guidelines (Drug misuse and dependence: UK guidelines on clinical management)
- A dual diagnosis approach may have helped.

Drug related death 10

- 52-year-old male who was discovered unresponsive by his partner.
- Cause of death: 1a) Polydrug toxicity, 1b) Right Upper limb amputation,1c) Motorcycle Accident,11 Ischaemic and hypertensive heart disease
- A motorcycle accident in his youth had led to his upper right arm being amputated. He suffered from pain as a consequence.
- Prior to his death he had experienced unconscious episodes, but he did not seek medical help with this.
- All of his medication was prescription.
- Toxicology confirms the presence of Fentanyl at levels associated with fatalities, but this is dependent on tolerance.

Learning and actions

- Alternatives to medication for pain management

- Awareness of the risks associated with using more than the prescribed amount of medication.

Drug related death 11

- 42-year-old male who had been assisted to his friend's house as he was intoxicated. He was placed to sleep on the floor with a duvet. Later that day, they discovered him unresponsive and administered Naloxone and called for an ambulance.
- Cause of death: 1a) Pneumonia and Cardiac Failure 1b) Cardiomegaly 1c) Acute and Chronic Drug Toxicity
- He had used drugs and alcohol in his teenage years and was diagnosed with attention deficit hyperactivity disorder in his youth. He had struggled with problematic drug and alcohol use for many years.
- He had maintained periods of abstinence but frequently relapsed.
- He was from a large supportive family.
- He had experienced bullying and abuse in his childhood.
- He had recently separated from his wife and was homeless at the time of his death.

Learning and action

- He self-referred to With You, a month before his death, when advised to do so by St Petrocs. Earlier support from With You may have helped in his recovery journey. Improved screening and referrals to treatment services.
- He was discharged from Talking therapy treatment but due to his homeless status, he did not receive the letters. It is extremely challenging for individuals to engage in therapy whilst homeless and agencies need to consider the mode of communication before discharging clients.
- He had been referred to adult social care in January 2024 and they were not able to reach him. Given his vulnerabilities, a multi-agency meeting may have helped as he had a number of high-risk factors such as homelessness causing him to move around, sex working, increasing drug use, and relationship breakdown.
- Reduce diagnostic delays, improve continuity of care, and better engagement with neurodivergent individuals.
- Recognise the impact of child separation on fathers as well as mothers.

Drug related death 12

- 43-year-old Polish male who had travelled to Cornwall to celebrate his friend's birthday. They had all consumed alcohol on the way down except the driver who describes catching up with the others on arrival. There were 5 men all Polish (2 living in London and three from Poland). Two of the men took drugs whilst the others were resting. The others discovered them collapsed on the caravan floor and called an ambulance and started CPR.
- Cause of death: 1a) Multi organ failure 1 b) Mixed drug overdose.
- One of the men survived but police did not take a statement from him, and he returned to Poland. We do not therefore know where the drugs came from and what they believed they were taking.
- The deceased was described by his wife as very much a family man who spent a lot of time taking their son to football. She managed the family finances, and they had an honest and open relationship, and she was unaware of his drug taking. He was a hard-working construction worker.
- The drugs led to a cardiac arrest and subsequent brain injury leading to multi-organ failure.

Learning and action

- Increased drug and alcohol taking during holidays. There have been a number of drug related deaths whilst people are in Cornwall on holiday. Awareness raising for the risks associated with recreational drugs and synthetic opioids.
- A police statement from the other affected man as to where the drugs were from and what they believed they were taking would have been helpful.
- The toxicology revealed the presence of synthetic opioids. Drug related deaths from synthetic opioids are on the increase and we are taking steps to combat the risk for all of our populations. There has never been a more dangerous time to take drugs, says NCA as annual threat assessment is published - National Crime Agency

Drug related death 13

- 39-year-old female whose partner called an ambulance when he discovered her unresponsive after they had both taken heroin. He was unable to administer Naloxone or carry out CPR because he too was adversely affected and was later admitted to hospital for week due to the ill effects. The toxicology revealed the presence of nitazenes.
- Cause of death: 1a - Mixed Drug Toxicity & Coronary Artery Atherosclerosis
- She had a traumatic childhood and started using drugs from a very young age.
- She successfully detoxed and remained abstinent from substances for nine years, but the loss of her son and her involvement in an abusive relationship caused a relapse into substance use.
- She self-referred to With You in 2019 and successfully completed a detox and rehabilitation and her case was closed.
- She self-referred to With You again in December 2020 having relapsed. The therapeutic alliance between her and her recovery worker broke down when the worker referred her children into social care due to concerns for their welfare.

Learning and actions

- Bereavement as a theme in drug related deaths causing relapse into drug and alcohol use has been recurring for several years. Following an open tender process, a provider has been selected to provide comprehensive, accessible and timely bereavement support service to residents aged 18+ in Cornwall and Isles of Scilly. This service will be open access, regardless of the type of bereavement, including those bereaved by drug related deaths. The service is expected to commence Autumn 2025.
- It is a fine balance maintaining a trusted relationship with an individual where there are safeguarding concerns. In this case, the relationship broke down. Reflective practice sessions between workers and managers can help improve ways of dealing with challenging decisions and share learning.
- The early drug use which was forced upon her, and the childhood trauma require early intervention.
- She disclosed the abusive relationship to her drug worker, but she was not referred to Safer Futures (Domestic Abuse service). We are implementing a Drug and Alcohol treatment/Domestic Abuse sexual violence protocol to ensure a more joined up approach between these services.
- Her heart problems were not detected prior to her death. More routine heart screening for those who have used drugs for a long time.
- The toxicology revealed the presence of synthetic opioids. Drug related deaths from synthetic opioids are on the increase and we are taking steps to combat the risk for all of our populations. This death highlights the inability (of all those who

have taken the substances) to administer Naloxone or any lifesaving intervention due to the potent and disabling effects of synthetic opioids.

Drug related death 14

- 42-year-old male who was sleeping rough. A passerby raised concerns for his welfare having seen him in the same position for several hours. Paramedics arrived to find him deceased.
- Cause of death: 1a) Drug Misuse
- He had a long history of drug use from an early age.
- He was engaged with drug and alcohol treatment service at the time of his death.
- He was homeless having left the home of his partner several days prior to his death.
- His mother told the inquest that the death of his grandfather when he was a teenager had a huge impact on his wellbeing.
- He had experienced a non-fatal heroin overdose in April 2023.
- He had sought assistance from his GP to withdraw from pregabalin in May 2023.

Learning and actions

- Bereavement support- as detailed above.
- A non-fatal overdose referral pathway has been implemented with SWAST which would ensure he was referred into treatment so workers would be aware of the overdose and reinforce safety advice around his drug taking.
- The Office for Health Improvement and Disparities (OHID) has identified a trend of increased pregabalin use amongst those who use drugs particularly where they are in treatment. This will be a focus of national attention in the forthcoming year.
- His home address was in North Cornwall resulting in him accessing Derriford hospital. Royal Cornwall Hospital Trust (RCHT) has an excellent working relationship with With You. With You are in the process of establishing a good working relationship with Derriford. RCHT has a pathway with Boswyns whereby their empty beds are filled with patients. For the patients who aren't accessing RCHT, this pathway is unavailable.

Drug related death 15

- 61-year-old male who was seen outside his property by a neighbour who later observed him in the same place and position. An ambulance was called and CPR and naloxone administered.
- Cause of death: Methadone toxicity. At the time of his death, he was in receipt of a weekly methadone prescription.
- At the age of 8 he had been placed in care. He had a large number of children but was not in contact with any of them.
- The inquest heard during the winter of 2019/2020 his father, sister and nephew all died within a few months of each other, and he struggled with this.
- He first used heroin aged 32 to cope with physical pain.
- He was diagnosed with emotionally unstable personality disorder (EUPD).

Learning and actions

- A number of people are introduced to opiates by being prescribed for pain. Where there is a history of addiction, the prescribing decision needs to be reviewed, and NICE guidance adhered to. Overview | Palliative care for adults: strong opioids for pain relief | Guidance | NICE
- Bereavement service- as detailed above.

- Alternatives to medication for pain management
- Early intervention for childhood trauma

Drug related death 16

- 31-year-old female was at home with her children when she asked them to call her friend as she was feeling faint. Friend returned from shop and found her unresponsive. CPR commenced and an ambulance called.
- Cause of death: 1a) Acute Cocaine Toxicity
- She started using alcohol aged 13 due to a traumatic childhood including domestic abuse and parental imprisonment.
- She experienced high risk domestic abuse.
- She was sent to prison and experienced significant mental distress whilst awaiting the decision due to having young children and being pregnant.
- Whilst in prison, her abuser claimed to be a victim of domestic abuse, obtained legal aid and was granted 50% contact with their children.
- She had complex PTSD, but mental health services struggled to engage her. A trauma specialist reported a positive first meeting, but this was shortly before her death

Learning and actions

- Alternatives to prison for women with multiple vulnerabilities. She was deemed unsuitable for a Mental Health Treatment Requirement. Women's Justice Board begins plans to send fewer women to prison - GOV.UK
- Domestic abuse services need to review their abuser screening resources to avoid collusion with post separation abuse. Respect Male Victims Toolkit | Respect
- The importance of a trauma informed approach and the use of trauma specialists for those with multiple vulnerabilities.
- Ensure routine enquiry into adverse childhood experiences is happening by front-line workers and/or provide training for workers to feel more confident in asking and thereafter supporting and engaging individuals with multiple vulnerabilities.

Drug related death 17

- 44-year-old woman who was found deceased at her home address by the police following a friend raising a concern for her welfare.
- Cause of death: 1a) Combined Drug Toxicity
- She had a happy childhood and supportive family
- She had fled to Cornwall in 2014 after experiencing high risk domestic abuse out of county. The independent domestic violence advocate (IDVA) was unable to contact her by telephone, so no further support was offered.
- Her children were in the care of her mother, and they were living a considerable distance from Cornwall.
- Her father died in 2003 and her mother in 2019.
- She suffered from anxiety and depression, yet secondary mental health felt her mental health problems stemmed from her substance use.
- Her GP was aware, from 2015, that she was dependent on opiates and used illicit drugs yet no referral to drug and alcohol treatment service was made.
- Her housing worker referred her to adult social care who encouraged referrals to First Light, support groups for her diabetes and citizen's advice all of which she declined.

Learning and action

- The fact she was a high-risk victim of domestic abuse should have triggered a more proactive approach by the IDVA such as a joint visit with the police.
- Bereavement –as detailed above.
- A dual diagnosis approach may have helped this individual
- Awareness raising with GPs of the need to screen and refer to drug and alcohol treatment services.
- We need to look at the barriers for individuals accessing support and whether a trusted worker is able to assist with navigating the plethora of services in line with the "My Team around me guidance".

Drug related death 18

- 53-year-old male who was discovered by his sister when concerns for his welfare were raised following him failing to collect his opiate substitution therapy prescription.
- Cause of death: 1a) Methadone toxicity.
- He had chronic asthma managed with Ventolin and Sabutamol inhalers and suffered from back and knee pain following a road traffic accident, for which he was prescribed Tramadol and Amitriptyline. He was also diagnosed with diabetes mellitus which he did not manage well.
- He developed a groin infection from intravenous drug use and was treated by his GP for a chest infection shortly before his death.
- Although he had no formal mental health diagnosis, he experienced anxiety and sleep disturbances. Prior to his death, he exhibited signs of psychotic thinking, reportedly triggered by his neighbours' attitude towards him.
- He was engaged with treatment from 2014 (referred by GP) up until his death and was in receipt of 95 mls of methadone picked up three times a week although he found prescribing protocols difficult to comply with.
- His GP attempted twice to refer him to community mental health services due to suspected psychosis, but both referrals were declined, possibly due to his substance use.
- He found it difficult when workers changed.
- He had spent periods homeless but was in secure accommodation at the time of his death.
- He had a supportive family.

Learning and actions

- It is important to closely monitor service users on high dosage methadone scripts especially if they have cardiac or respiratory issues with routine electro cardio grams (ECGs).
- The risks to those on an OST, balance of flexibility and encouragement of taking OST versus the safety factor of supervised consumption or alternatives to methadone.
- A dual diagnosis approach would have benefited him, and this death highlights the need to continue to implement the dual diagnosis guidelines.
- Trauma informed staff who understand the challenges to individuals when staff change and, assertive attempts to engage clients including peer led work.
- Support staff resilience

Drug Related Death 19

- 58-year-old woman discovered unresponsive by her Carer.

- Cause of death: 1a) Venlafaxine and Morphine Toxicity II Chronic Obstructive Pulmonary Disease.
- The inquest heard she experienced mental health difficulties for 35 years including anxiety, depression, EUPD and agoraphobia meaning she didn't leave her house.
- Her physical health was deteriorating including COPD which was not well controlled. She received frequent courses of anti-biotics, smoked heavily and had poor nutrition. She had fibromyalgia with increasing pain, and her mobility was worse resulting in increasing dosages of opiates.
- Childhood trauma**-** the inquest heard her mother was sexually abusive to her.
- Bereavement-her partner died suddenly.
- She was estranged from her children which caused her a great deal of stress and upset. She had left her children when they were very young, and they had cut ties with her in their adulthood. Her daughter said there was a report of domestic abuse against her partner prior to his death.

Learning and actions

- Childhood trauma and no opportunity to work through and address, impacted her own ability to parent. Routine ACEs enquiry and subsequent work to address this may have helped.
- Capacity assessment-her health was so poor she could have been admitted to hospital without her consent, but this does not seem to have been explored. She frequently refused admittance to hospital despite the fact she was told she was at risk of death. She had taken her usual prescribed medication not an excess amount but had taken it against a background of respiratory disease and being unwell.

Drug related death 20

- An ambulance was called to a 42-year-old female living in supported accommodation when she collapsed having injected cocaine. She had injected the cocaine with two men; one of whom purported to be her partner.
- Cause of death: 1a Cocaine intoxication
- The inquest heard how she had a very happy childhood and had excelled at school obtaining a degree and a master's in criminology whilst pregnant.
- She had a number of abusive relationships all of which placed her at great risk of harm and one of which introduced her to drugs. As a result of these relationships, social care became involved due to concerns for the wellbeing of her children.
- She self-referred to With You in July 2020 due to the involvement of social care with the welfare of her son. Her journey was closed in April 2021 as she was not taking any drugs and social care had closed her son's case. She was hoping to complete a nursing degree and feeling positive about her life.
- Between 2021 and her death she moved between Cornwall, Leicester and Liverpool with a further two abusive relationships. She was placed in mixed temporary accommodation for those who use substances.

Learning and actions

- The suitability of her accommodation given her vulnerability. She had several high-risk domestic abuse relationships and had been heard at the multi-agency risk assessment conference ten times. Housing must consider this when placing vulnerable women in mixed accommodation. Alternative safe, suitable houses for women with multiple complex traumas should be provided.

- The inquest heard that she moved to Leicester with a new partner after Covid and then to Liverpool to another abusive relationship where he was injecting her with heroin without her consent, so she moved back to Cornwall during 2023.
- She was engaged with Safer Futures as early as 2014 due to high-risk domestic abuse from three relationships including her return to Cornwall in 2023. Domestic Abuse workers should consider referrals to or working with With You whenever there is a domestic abuse victim who is using substances.

Drug related death 21

- 60-year-old man who was discovered collapsed in the garden of their accommodation, by a fellow resident.
- Cause of death: 1a) Mixed Drug Overdose 2) Coronary Artery Atherosclerosis & Advanced Alcohol Related Fatty Liver Disease
- He had left treatment over 2 years ago.
- The toxicologist concluded: Death is likely due to the combined effects of ethanol, protonitazene and metonitazene.
- He had a history of homelessness and at the time of his death he was residing in interim nightly paid accommodation.

Learning and actions

- Repeated referral pathways into treatment.
- Synthetic opioid death. Develop and deliver messaging specifically for people not currently in treatment. Synthetic opioid preparedness plan.
- Naloxone expansion
- Non-fatal overdose pathway and improvement.

Drug related death 22

- 35-year-old male who arrived at his sister's house under the influence of alcohol and ketamine. She left him at her home to sober up whilst she went to visit another sister. Her son called her reporting her brother had collapsed. Both sisters returned home to find him collapsed in the kitchen. An ambulance was called, and CPR administered but he was pronounced dead by paramedics.
- Cause of death: 1a) Ketamine toxicity.
- The family reported that his drug and alcohol spiralled after he was made redundant in 2020.
- He had been signposted to treatment services by his GP, and an adult safeguarding referral was made in 2023 following suicidal concerns.

Learning and action

- His GP signposted him to drug and alcohol services in 2021. It may have been more effective for the surgery to complete the referral or arrange for him to be seen by a recovery worker at the surgery.
- Similarly, the mental health interventions could have referred him into drug and alcohol treatment.
- Increased awareness for families to be able to refer their loved ones into treatment.
- Raising awareness of the risks associated with Ketamine for users and professionals.

Drug Related Death 23

- 57-year-old male admitted to hospital having been found unresponsive by a council support worker.
- Cause of death-1a) Cardiorespiratory Failure 1b) Methadone and Temazepam Toxicity II) Chronic Obstructive Pulmonary Disease.
- Moved to Cornwall following the death of his mother and him being a victim of cuckooing.
- He was estranged from his siblings.
- He spent time in a young offender's institute from the ages of 14-16 and his sister told the inquest, she believes he was sexually abused during this time.
- He had spent time in prison and psychiatric units during his life.
- He was referred to treatment by several organisations and was engaged with treatment at the time of his death and in receipt of a 50 mls methadone opiate replacement therapy medication collected twice weekly.
- He had a history of low mood, bi-polar, and anxiety that affected his daily life.
- He had a non-fatal overdose the year prior to his death but was not referred to the psychiatric liaison service.
- He was described as being financially exploited by peers.
- He was due to move into a new flat on the day of his death.

Learning and actions

- He was an entrenched rough sleeper for most of his life and the new flat may have caused him anxiety resulting in him taking too much medication.
- He appeared to develop positive relationships with a number of professionals, and he was variously described as being kind and thoughtful and philosophical with a good sense of humour.
- He was provided with Naloxone.
- There was evidence of multi-agency working.
- He was not referred or flagged to mental health services following his overdose.
- Bereavement support.
- Work to address the underlying trauma of his childhood.
- He was known to the respiratory team but closed to the service a year prior to his death. Flexible and assertive communication may have helped him engage.
- Explore a trauma-informed, health integrated housing pathway for individuals with complex needs who do not meet traditional service thresholds but are at high risk of harm or death.
- Staff to understand transition and loss (trauma informed care) and potential "pulling away" behaviours as potential distress signals.
- Explore how loneliness and social isolation can be framed as eligible social care needs or staff to recognise the importance of peer visits, structured social check-ins.

Drug Related Death 24

- 37-year-old male who was found unresponsive in bed in his father's annexe where he was residing.
- Cause of death: 1a) Multiple drug toxicity
- He reported starting to drink alcohol aged 13 and taking cocaine aged 20, with his drinking becoming problematic in his 30s.
- He had a past medical history of alcohol use, overdose of medication, peripheral neuropathy, pancreatitis, autism spectrum disorder, attention deficit disorder, health anxiety and diabetic ketoacidosis.

- In early 2023, he entered detox and rehab in Essex where he was living at the time.
- Following relapse in September 2023, he moved to Cornwall to explore further treatment.
- His father told the inquest that his neurodiversity was a significant cause of his challenges.
- He had very supportive parents.

Learning and actions

- The support from secondary mental health was delayed which may have helped with anxiety and his need to self-medicate.
- He could have been referred more quickly for a detoxification given the high level of his drinking however, it may not have been prioritised given the need across the county. It may well have been helpful to include his father who was aware of the situation in a whole systems approach along with liaison with his GP.
- Recovery Workers need guidance/reflective practice to support with complex cases.
- The DRD review panel heard how more individuals with drug and alcohol problems are presenting with diabetes. Pathways from Homelessness 2025 on Vimeo

DRD summary 25

- 53-year-old male whose parents raised a concern for welfare when they couldn't reach him. They live out of county, so police attended and found him deceased.
- Cause of death: 1a) Multiple Drug Toxicity 2) Ischaemic Heart Disease
- The toxicology confirmed the synergistic effects of his prescription medication caused respiratory depression. He was on prescription medication in attempt to alleviate the pain he felt from fibromyalgia. He also suffered with chronic fatigue syndrome, and type 2 diabetes. He had exhausted all strategies for pharmaceutical ways to manage his pain, and it was recommended he attend the body reprogramming initiative, but this is not available in CIOS.
- He had been in an abusive relationship which ended in 2017 and was believed to be suffering from PTSD as a result. He had been dependent on alcohol previously but was not drinking at the time of his death.

Learning and actions

- Management of pain is a recurrent theme in drug and alcohol related deaths. There is work around pain management being undertaken and there are pain cafes around the county. A possible exploration of the body reprogramming initiative and its potential to be considered.
- His GP referred him to First Light, and he engaged with the service for some time. His fibromyalgia made it difficult to attend on a regular basis.
- His pain was all encompassing leading to a very negative mindset which he was not able to break free from.

Drug related death 26

- 41-year-old male who was found deceased by his partner.
- Cause of death: 1a) Multiple drug toxicity
- He moved to Cornwall from Manchester after his flat had been cuckooed, and he was hoping for a new start.
- He reported starting to use cannabis at age 11 years followed by amphetamines aged 13. He stated that he had continued to use amphetamines all his adult life

only stopping six months prior to coming to Cornwall. He had used heroin and crack cocaine from the age of 19 continuously until the age of 39.
- He had a severely inverted left foot as a result of perioperative sepsis and was awaiting an amputation at the time of his death.
- He was significantly nutritionally compromised.
- At the time of his death, he was in receipt of a weekly 80 ml methadone prescription.

Learning and actions

- The risk of unsupervised methadone prescribing at high levels.
- Pain management.
- Trauma support for ACEs.
- Staff to understand disguised compliance and professional curiosity.
- An assertive mental health outreach team is in development.
- Review those with chronic wounds/tissue damage managing their own care rather than district nursing teams and ensure medical needs are not overlooked due to social and perceived behavioural challenges.

Drug related death 27

- 54-year-old male who was on holiday in Cornwall, staying with a friend. They had drunk some cider the previous evening, but the friend was unaware of any drug taking. When the male failed to appear the following day, another friend went to check on him and found him deceased.
- Cause of death: 1a) Drug Misuse. Post-mortem examination shows pulmonary oedema. Toxicology shows high level of amphetamine. In conclusion his death is attributed to drug misuse.
- He lived with his brother who was aware he was a long-term cannabis user and heavy smoker. He started using cocaine during Covid and his brother told him he would have to leave their family home if he continued. He took this on board. His brother was concerned he may use more drugs whilst on holiday.
- He was described as a family man who was very proud of his children and grandchildren.

Learning and action

- Increased awareness for families to be able to refer their loved ones into treatment.
- Awareness raising of risk of DRDs and serious harm among recreational users during holidays, festivals etc.

Drug Related Death 28

- 51-year-old male who was discovered unresponsive by his partner.
- Cause of death: 1a) Multiple drug toxicity 2 Cardiomegaly.
- He self-referred to With You in 2014, but they were unable to engage him, and the referral was closed.
- The postmortem stated, "while his enlarged heart showed no evidence of being the primary cause of death, it may have been a contributory factor to his inability to survive the multiple drug toxicity".
- He suffered from chronic anxiety, depression, emotionally unstable personality disorder and complex post-traumatic stress disorder
- He was referred to the pain clinic in 2021 due to back pain.

- He had felt suicidal at certain points in his life and had spent time in psychiatric units, but in the months prior to his death, this was not the case.
- His family told the inquest that an operation in 2013 wherein he was prescribed co-codamol led to his addiction.
- The GP was aware he overused his medication but felt that reducing his prescriptions would impact the therapeutic relationship. Safeguards were put in place such as notifying the out of hours service of his tendency to overuse.

Learning and actions

- Assertive attempts and repeated referrals to help him engage in treatment.
- He was referred to Pentreath in 2023 which he found helpful.
- The GP referred him to mental health services on numerous occasions but prior to his death but both the GP and mental health services struggled to engage him.
- Awareness raising of the risk of prescribing opiates to those who may become addicted.

Drug Related Death 29

- 30-year-old male from Plymouth who drove the wrong way down a one-way street in Polperro crashing his van. He then proceeded to climb onto the roof tops of nearby houses but subsequently fell off.
- The area where he fell was inaccessible and fire and rescue had to be called resulting in a delay in CPR being administered.
- Cause of death: 1a) Mixed Drug Toxicity (Cocaine, Methylenedioxymethamphetamine, Pregabalin)
- The inquest heard he had been taking drugs for 3 days with friends. He and another male had driven to Cornwall but there had been an altercation at a nearby petrol station between the men and he had driven off alone.
- A year prior to his death, he had experienced an overdose, and a drug induced incident resulting in hospitalisation.
- He self-referred to treatment in May 2023, but shortly afterwards requested they close his case, and he later disclosed the group work merely put him in touch with associates which led to drug taking.

Learning and actions

- Assertive engagement by treatment providers and alternatives to group work.
- Plymouth now has a non-fatal overdose pathway in place which may have resulted in treatment providers being able to engage him in support.
- Awareness raising of the risk of stimulants.

Drug related death 30

- 57-year-old female who spoke with family members over the telephone. They felt she was delirious and contacted the police when they were unable to subsequently reach her.
- Cause of death: 1a) Methadone toxicity
- She experienced trauma from a difficult childhood and a sexual assault in 2013. She was offered support from Rape Crisis and Women's aid but declined.
- Early use of drugs- At the age of 16 she became part of a travelling community, and she started using drugs when squatting and living with a partner who was a heroin user.
- Child removal- Her first child was adopted by her paternal grandmother when she was 18 and this motivated her to seek support.

- Bereavement - her ex-partner, father and loss of her dog also had a large impact on her prescription stability and led to overuse of her medications to cope with these difficult life events.
- She suffered with sciatic pain in her legs and back pain that affected her mobility and had Fibromyalgia and Chronic Fatigue Syndrome. She was offered a referral to the pain cafes but declined.
- She disclosed periods of high anxiety and experienced panic attacks.
- She advised that she experienced flashbacks and increased anxiety following the incident in 2013 where she was sexually assaulted and that her Opiate use had helped alleviate the trauma she had experienced
- At the time of her death, she was in treatment receiving a methadone prescription of 100mls. She had previously been under supervised consumption due to overusing her medication but at the time of her death, she had requested twice weekly pickups due to financial difficulties and having to sell her car.

Learning and actions

- She had previously overused her methadone, and alternative medications or insistence on supervised consumption may have been safer for her.
- The DRD review panel felt the long-term prescribing of methadone and its health implications including its mood suppressant effects should be reviewed.
- An opportunity to work through her earlier trauma and exploration of her refusal for support. Assertive and imaginative ways to introduce vulnerable clients to support such as joint visits or therapy groups. This may have helped her access support for the sexual assault and her pain.

Drug related death 31

- 48-year-old male who was discovered by his mother when she went to wake him for work.
- Cause of death: 1a) Ischaemic heart disease 1b) Coronary artery atheroma, cardiomegaly 1c) acute and chronic cocaine toxicity.
- H**e** was described as a caring, helpful, kind and hardworking man by all.
- He had moved back in with his parents following a relationship breakup.
- He was not allowed contact with his young son which he found very distressing and whose birthday was a few days prior to his death.
- He confided in a friend that he had taken too many pills a couple of days prior to his death.
- He spent the evening with friends. His friend reported he didn't drink but it was usual for him to have a few lines of cocaine.
- He picked up his friend's daughter, prior to his death and reported feeling unwell.
- His GP was unaware of his drug use.

Learning and actions

- Opportunities for referral to treatment. The GP notes suggest they were unaware of his drug taking. Routine screening and referral.
- Awareness raising of the risks of cocaine to heart health.

Drug related death 32

- 54-year-old male whose friend raised a concern for welfare when she was not able to reach him.
- Cause of death: 1a) Mixed drug toxicity 2 Cirrhosis
- He had recently visited hospital for the drainage of ascites and was discharged with a week's worth of oxycodone.

- He had a past medical history of alcohol misuse, previous overdose, decompensated alcoholic liver cirrhosis and chronic leg ulceration and was prescribed oxycodone and pregabalin.
- He self-referred to treatment in 2014 and remained engaged up until his death. During that time, he completed a number of detoxes.
- As a child in care, he experienced sexual abuse
- He began drinking from an early age and for a long period of time- self reporting it became problematic at the age of 18. He described a drinking career of over thirty years.
- He was a Veteran having served in Northern Ireland.
- He had lost contact with his daughter although he hoped she would make contact with him when she was of an age to do so.
- He experienced domestic abuse from his partner - they both drank, and she gave away his dog. His ex-partner obtained a restraining order against him.
- He reported no history of illicit drug use; however, he was prescribed large amounts of painkillers including Oxycodone: a highly addictive semi synthetic opioid which he became very dependent on.
- He had made previous suicide attempts (Feb 2020) and experienced a nonfatal overdose (April 2019).
- He had a diagnosis of emotionally unstable personality disorder (EUPD) and complex post-traumatic stress disorder (PTSD)

Learning and actions

- He struggled when workers changed. Trauma informed handovers of work.
- Pain management
- His housing was a rented property which became unsuitable due to his decreasing mobility and general health issues, and he was bidding on Home Choice for alternative accommodation prior to his death.
- Early intervention and trauma support.
- Non-fatal overdose referral pathway.

Drug related death 33

- 33-year-old woman who was discovered by her partner. Staff were alerted and CPR instigated, and an ambulance called.
- Cause of death: 1a). Sepsis 1b). Infective endocarditis, pulmonary emphysema and lung abscess 2). Illicit drug use
- She was in very poor physical health having spent 7 weeks in hospital due to lung conditions in the weeks prior to her death.
- She was in a high-risk domestic abuse relationship but staff at the accommodation felt it was safer to monitor the situation than risk evicting the abuser and her following him.
- She had experienced childhood trauma, previous sex working and her husband who she had left was a high-risk domestic abuser.
- She had two children who had been removed from her care who had both been adopted.
- Early drug use- from age of 18
- An adult social care referral was made whilst she was hospitalised, but the assessment was not carried out before her death.
- The IDVA closed her case prior to her death because she was unable to contact her.

Learning and actions

- Assertive attempts to engage clients and using established networks. She was well known to supported housing staff so the IDVA could have engaged via them.
- Opportunities for her to spend time away from her abuser especially when she had tried to end the relationship several days prior to her death.
- Opportunities to work through her trauma.

Drug Related Death 34

- 20-year-old male who stayed with friends after an evening out at the pub.
- Cause of death 1 a) 1a) 3,4-Methylenedioxymethamphetamine toxicity
- The toxicology confirmed that MDMA was detected at a concentration that has previously been associated with fatalities.
- The information is scant because the inquest has not yet taken place, and he was not engaged with treatment services.

Learning and actions

- To be reviewed following the inquest
- Dangers of MDMA use- Many young people assume pills that look the same contain the same dose and take several in close proximity not understanding the risk.
- Use is recreational and situational (festivals, clubs) making targeted outreach and awareness raising more difficult.

Drug related death 35

- 49-year-old male found unresponsive by his wife.
- Cause of death: 1a) Mixed Drug and Alcohol Toxicity (Gabapentin, Mirtazapine, Oxycodone and Quetiapine.) All of the medications were prescribed.
- He reported a difficult childhood and stated he was removed from his parents' care aged 4, spending most of his early life in foster care and children's homes.
- As a young adult, he reported being in the Airborne Infantry which included tours of Bosnia and Iraq.
- He reported his alcohol use began at age 13 and he had a history of illicit drug use. He used 'recreational' drugs including amphetamine, MDMA and cannabis and used heroin and cocaine aged 22.
- He had spent time in prison for GBH.
- He was diagnosed with an emotional unstable personality disorder, bipolar disorder and PTSD associated with childhood trauma and his military service.
- Health conditions included paraesthesia, a displaced scapula in his right shoulder, COPD, chronic idiopathic pain syndrome, non-epileptic attack disorder and kidney problems.

Learning and actions

- There were 3 referrals to community mental health treatment, but all were declined due to his alcohol use. A dual diagnosis approach was crucial.
- GPs need to consider the over prescribing of medication particularly with patients with a history of dependency.
- Trauma support for his ACEs.
- Review service offers for veterans to improve early identification, engagement and sustained support for veterans accessing treatment services, with a focus on reducing stigma, increasing trust and utilising lived experience workers to bridge the gaps.

Drug Related Death 36

- 37-year-old male who was found unresponsive by fellow residents who had taken the same heroin but were not adversely affected. Naloxone was injected and an ambulance called.
- Cause of death: 1a) Drug Misuse.
- The toxicology revealed potentially fatal levels of xylazine heroin, cocaine and protonitazene.
- He was a long-term drug user.
- Prolific offending led to a revolving door of prison sentences.
- He spent periods homeless.
- Bereavement- he was struggling with the recent death of his 4-year-old child and had recently demonstrated suicidal ideation resulting from this and he informed his probation officer that his partner at the time had completed suicide.
- He had been in receipt of a Buvidal prescription the year prior to his death but had told workers he was moving to Wales. Attempts to contact him were unsuccessful (the last contact being in October 2023), so the case was closed to treatment within 6 months of his death.
- He had a positive relationship with his parents but didn't have any regular contact with other family and friends.

Learning and actions

- A routine MDT may have helped when he disengaged in October 2023.
- His offending impacted his ability to access support as he was frequently released with nowhere to live.
- Bereavement – new service provision detailed above.

Drug related death 37

- 41-year-old female-who was discharged from hospital following a 28-day detention under S2 of the Mental Health Act 1983 and placed in temporary accommodation. Prior to her admission, she had been exploited by drug dealers, and it wasn't safe for her return to her home. She told staff at the temporary accommodation that she was going away for a couple of days (she did not leave the accommodation but was discovered dead several days later).
- Cause of death: 1a). Multiple drug toxicity
- Her mental health worker called to visit her but was told she had gone away.
- She was open to treatment at the time of her death.
- Bereavement -The notes mention that her mother passed away in early 2013 from cancer and she had a difficult relationship with her father. There is no mention of other family support.
- Domestic abuse-She had an extensive history of being a victim of domestic abuse and had two sons. The relationship with her son's father was difficult and involved domestic abuse and drug use. She had left the children in the care of their father and there appears to be minimal contact with the children up until her death.
- Lack of secure housing- she was moved around the county in temporary accommodation until her death.
- Mental health- a deterioration in her wellbeing prior to her being detained in August 2024. Despite an MDT on admission to hospital and with professionals all knowing the date of her discharge, no robust plan was made for her to be housed.

Learning and actions

- The temporary housing solutions and her constant moving around the county and outside did not provide a stable environment for her mental health and to engage in support.
- Given her vulnerability, the staff at the temporary accommodation should have enquired about where she was going (professional curiosity and safeguarding) and alerted those supporting her, especially her mental health support.
- The IDVA service change workers depending on the level of risk. The notes show new workers struggled to contact her. Consistency of workers wherever possible is important to the most vulnerable clients.
- Services seemed to be reactive rather than proactive- this could be related to stigma or large caseloads.

Drug related death 38

- 35-year-old male who had been seen acting erratically before collapsing in the street.
- Cause of death: 1a) Acute Cocaine Toxicity.
- He had experienced a mental health incident a month prior to his death where in a call was made to a mental health crisis line and a safeguarding referral completed.
- He was a fisherman.
- He was not known to treatment services.

Learning and actions

- Attempts were made by the GP to contact him following a safeguarding referral but were unsuccessful.
- There doesn't appear to have been an intervention following the call to the mental health crisis line a month prior to his death.
- The toxicology did not test for synthetic opioids or new psychoactive drugs, so we do not know if there were other substances present.
- The DRD review panel raised concerns about fishermen often having links to illicit drugs and the difficulty of engaging in treatment as they are often out at sea for weeks at a time.
- Awareness raising of the risk of cocaine and stimulants to those not in treatment.
- Improved screening, identification and referrals into treatment.

Drug related death 39

- 38-year-old male whose friend raised a concern for welfare call when he failed to meet him for coffee. Ambulance crew found him deceased.
- Cause of death: 1a) Aspiration pneumonia on a background of mixed drug use.
- He reported that he came from an affluent background and had previously worked as a computer programme developer.
- He reported bereavement triggered his drug taking- he had started using heroin at the age of 22 when his partner gave birth to a still born baby. His mother died in January 2022 of liver cancer.
- Drug debts- In April 2023 he moved to Liskeard with a female friend to avoid the drug dealers coming to his property and he sustained a head injury in Nov 2023 from a knuckle duster.
- Child removal -his son was placed in the care of maternal grandparents, and he did not see him. A large number of toys and children's clothes were found in his flat.

- Physical health- significant cardiac problems. He had an implantable cardio-vascular defibrillator and experienced vasovagal syncope. He was also diagnosed with Posterior Reversible Encephalopathy which led to recurrent seizures. The substances that he chose to take both illicit and over the counter enhanced his physical symptoms and also resulted in psychotic episodes and memory impairment which left him with complex vulnerabilities.
- He found the experience of detox difficult and chose not to take the opportunity of attending rehab which may have given him a chance to address some of his underlying issues.
- His father remained supportive of him throughout.
- He was engaged in treatment for the 4 years prior to his death.

Learning and actions

- Bereavement support detailed above.
- Drug debts were highlighted in the 2023 DRD report. The life skills team at With You assist clients with their debts but the fear and risk of serious harm associated with drug debts needs further review and assessment.
- Child removal- a pilot programme to help individuals who experience child removal is being developed and launched within 2025.
- His physical health and mental health were both compromised by his drug taking.

Drug related death 40

- 36-year-old female who was found unresponsive at her home address.
- Cause of death: 1a) Multiple drug toxicity 1b) 1c) 2) Bronchopneumonia, Acquired Immune Deficiency Syndrome.
- She had a difficult childhood due to experiencing domestic abuse and the family having to flee to Cornwall to escape the abuse.
- She had a past medical history of HIV since the age of 15/16 and suffered from epilepsy, had neuropathy and pneumonia. She also had cervical cancer, asthma and anorexia.
- The inquest heard that she was mistrusting of health and social care services because she feared the stigmatisation of her diagnosis.
- The toxicologist concluded-it is possible the death is due to the combined sedative effects of methadone, fentanyl and oxycodone or the arrhythmogenic effects of cocaine, methadone and fentanyl.
- She was known to use recreational drugs by health professionals but was not referred to drug and alcohol treatment services.

Learning and actions

- Trauma informed care which is non-judgmental.
- Improved screening and identification and referral to drug and alcohol treatment services.

Drug related death 41

- 51-year-old male who had recently moved to a newly purchased flat in Newquay. A neighbour contacted the estate agent having noticed the balcony door had been left open for several days. They were asked to close it and in doing so discovered the deceased.
- Cause of death: 1a) Illicit drug use and alcoholic liver disease.
- His brother was unaware he had purchased a flat in Newquay and described him as "a bit of a loner".

- The death has yet to be heard at inquest and as he wasn't known to treatment services, very little is known of his circumstances.

Learning and actions

- To be reviewed following the inquest.

Drug related death 42

- 50-year-old male who was discovered when the police attended his home address following a concern for welfare.
- Cause of death: 1a) Illicit Drug Use 11) Liver Cirrhosis
- He had successfully completed rehab in 2001 after several years of substance use including heroin and alcohol. He relapsed after 6 years.
- Engaged with With You from 2013 to the time of his death. However, he found it challenging to keep appointments, especially as he moved around the county. He was supported by With You's Outreach team for different periods of rough sleeping. There was a pattern of missed collections of his OST and disengaging from treatment but each time he was successfully reengaged.
- He was positive for Hepatitis B and C as well as HIV. There were periods when his drug use increased and his taking his HIV medication declined. He underwent treatment for Hepatitis C in 2018. He was informed he had cirrhosis of the liver in June 2014 and was aware of the impact his drinking and drug use had on his compromised liver.
- With You raised several safeguarding referrals from January 2021 - June 2024.
- He was affected by county lines and homelessness; there were also times when his benefits were stopped due to a lack of paperwork to evidence his right to claim
- He was aware of the risks to his health by continued use of both illicit drugs, and alcohol, but was unable to maintain abstinence for significant periods of time. He did have accommodation at the end of his life, but his health was impacted by his substance use and his disengagement with health professionals.
- He attended hospital in October 2021 following an assault in which he sustained a head injury and was also admitted in March 2024 with PCP (pneumocystis pneumonia) - a specific type of pneumonia consistent with an HIV diagnosis.
- At assessment he stated no issues with his mental health but can sometimes feel low due to his HIV status. There is little mention of his mental health in the case notes apart from in June 2024 when he stopped all his GP medications and was suffering with nightmares, anxiety and paranoia.
- Bereavement -both of his parents were dead.

Learning and actions

- Multi agency meetings may have helped address his housing, substance use and physical health issues in a more holistic way.
- Routine enquiries into ACEs may have helped address any underlying trauma.
- Bereavement support as detailed above.

Drug related death 43

- 59-year-old female whose partner believed he had left her sleeping. He returned to the bedroom mid-morning to find her unresponsive so commenced CPR and called an ambulance.
- Cause of death: 1a) Multiple Drug Toxicity
- Two of the drugs taken were controlled drugs namely tapentadol and clonazepam.

- The police observed that the house was very cluttered (hoarding problems) and dirty living conditions and no bed linen on the bed.
- The property was in a state of disorder with full cat litter trays and flies in the property. There was rubbish piled up outside in black bin bags.
- She suffered from Multiple sclerosis, anxiety and depression.
- She has a history of falls - Last fall 3-4 days prior to her death. Her partner reports no head injury, no medical cause for falls only that her mobility is poor.
- She was a heavy smoker with rare alcohol use and no care package in place.
- She had seen the GP in the week prior to her death.

Learning and actions

- The police report suggests a referral to adult social care may have been appropriate.
- The death has not been heard at inquest so there may be further information and learning to follow.

Drug related death 44

- 47-year-old male found unresponsive his friend.
- Cause of death: (a) Coronary artery athrosclerosis & recreational polydrug usage.
- He had 4 episodes of treatment between 2014 and his death and was engaged in treatment at the time of his death. He was in receipt of 80mls methadone (1mg/ml) daily, to be collected 3 times weekly.
- He had a supportive family, who were very important to him.
- He reported that he first drank alcohol aged 14 years, and this then increased when he started working and had more money. He reported that the amount he drank fluctuated over the years with increases being alongside additional stresses in his life and feelings of depression.
- He attended residential detox in 2015 but returned to drinking after a few months.
- He had hypopituitarism, experienced very poor sleep patterns, petit-mal / absences and physical pain arising from the various injuries sustained over the years.
- He reported that he had experienced depression since the age of 15. At the time of his death, his mental health was overseen by his GP who prescribed medication to support him.
- It is not clear whether he attended his prescribing review and there was an error whereby he was given an extra dose of methadone (and then one less) in the week prior to his death.

Learning and actions

- It is important for treatment services to maintain accurate records, in this case whether or not the prescribing review took place.

Drug related death 45

- 47-year-old male discovered unresponsive in his car by a neighbour.
- Cause of death: 1 a) Drug Misuse.
- He had 4 treatment journeys with the treatment service between 2019 and the date of his death. He had self-referred on the last occasion following a separation from his wife and requested support with his cocaine use.
- He had PTSD- from time serving in the forces in Northern Ireland
- He was a high-risk domestic abuser. His wife had obtained a non-molestation order against him, and this prevented him seeing his children for a period of time

- He had experienced childhood trauma and lived with his grandmother whilst growing up and reported a strained relationship with his parents.
- His daughter completed suicide.
- Work-whilst working in security he reported drugs were part of the scene.
- He had a bad back which caused him chronic pain. He was prescribed a lot of medication by his GP but was referred to a pain management clinic too.

Learning and actions

- He was referred for counselling, but his needs were deemed to be too complex. A review of the offer of counselling in CIOS.
- Continuity of care challenging with moves within Cornwall and out of county.
- Review of his prescription medication in light of his illicit substance use.
- The notes suggest he struggled with workers leaving With You and the loss of the therapeutic relationship.

Drug related death 46

- 44-year-old who was found unresponsive by his mother.
- Cause of death: 1a) Opiate toxicity
- He was living with his mother following a relationship breakdown in 2018. His mother and sister were very supportive.
- He had five treatment episodes seeking to address problematic alcohol use, the last episode being from December 2023 up until his death. He was able to self-refer following a relapse into problematic use.
- An accident in his youth wherein he was severely burnt affected both his mental and physical health
- He engaged with Pentreath (mental health charity) prior to his death which he found beneficial.
- The GP explored various medications to try and manage his pain, and he was referred to the pain clinic who recommended an MRI scan. Following this he was referred back to the pain clinic but died prior to securing an appointment.
- The inquest heard he was taking illicit tramadol and oramorph to try and reduce his chronic pain.

Learning and actions

- Earlier engagement with Pentreath may have improved his mental health.
- Alternatives to medication for pain management.

Drug related death 47

- 49-year-old female discovered unresponsive by her partner.
- Cause of death: 1a Multiple Drug Toxicity.
- She had seven treatment episodes for support with her alcohol use. Her case was closed in January 2023 when she had stopped drinking. She had disclosed during the previous year that she was sourcing illicit drugs to supplement her prescription medication.
- She was assessed for residential detox but due to her complex relationship with food and eating, she was considered unsuitable.
- She was a victim of domestic abuse from both her father and partner and childhood sexual abuse from her grandfather and was referred to DASV services on several occasions, but they were not able to engage her. On one occasion, she was referred into Marac, but the IDVA did not consider her high risk so downgraded the risk, offered her a referral to counselling and the recovery group but when she declined the case was closed.

- She had a past medical history of asthma, anorexia, alcohol dependency, self-harm, low mood and suicide ideation.

Learning and actions

- There were a number of occasions when professionals did not exhibit professional curiosity or develop a trusting relationship with her prior to closing her case. The DAAT/DASV protocol will ensure services work together in an holistic trauma informed way with clients.
- There are a number of individuals who access support for their alcohol use but die from drug related deaths including both prescription and illicit drugs. Worker should be alert to and investigate this risk particularly where clients have not had an opportunity to work through their trauma.
- Work around ACEs and encouragement to address her trauma may have helped.

Drug related death 48

- 61-year-old male whose friend discovered him unresponsive and called for an ambulance.
- Cause of death: 1a) Multiple Drug Toxicity.
- He had a keen interest in sports amongst a host of broad interests.
- He experienced high risk domestic abuse as a child and was placed into foster care where he was abused.
- He reported using illicit substances in his teens, started smoking heroin at 18, and soon progressed to regularly injecting heroin, crack cocaine and amphetamines.
- He reported 40 years of problematic substance use. His alcohol use fluctuated, and he acknowledged becoming aggressive when drinking spirits.
- He was provided with Naloxone and training for overdose response, received regular harm reduction advice, and support was coordinated with his GP, hepatology, housing and other services.
- He was in receipt of an opiate substitute prescription of 40mls methadone (1mg/ml) daily, to be collected from the pharmacy 3 days a week.
- He reported a history of heart attacks, hypertension (reluctant to medicate), COPD, and was diagnosed with Type 2 diabetes and DVT in 2023, for which he received treatment. In September 2024, he used alcohol to manage tooth pain and reported episodes of vertigo with lingering confusion. Concerns about liver health led to support in arranging hepatology appointments at RCHT.
- He reported fluctuating mental health, including panic attacks, anxiety, depression and paranoia, which he linked to long-term drug use-especially amphetamines. He declined mental health referrals, accepting that substance use would continue to affect his mental wellbeing.

Learning and actions

- There was evidence of excellent multi-agency working within his support.
- His drug and alcohol use impacted his physical and mental wellbeing as he aged.
- The inquest revealed significant childhood trauma which professionals were unaware of. Routine ACE enquiry would pick this up and may enable it to be addressed.

Drug related death 49

- 57-year-old male discovered unresponsive by his father with whom he lived.
- Cause of death: 1a) Combined Recreational and Prescribed Drug Toxicity.

- The toxicology report concluded there has been recreational amphetamine use alongside therapeutic fluoxetine and paracetamol. The combination of amphetamine and fluoxetine will increase the risk of a cardiac arrythmia.
- A referral to treatment in 2019 reported 20 years of amphetamine use and expressed a desire to stabilise and eventually stop. He also needed life skills support with benefits and form filling, but engagement attempts were unsuccessful.
- He recently reported chest pains and had a medical history of osteoarthritis and a prolapsed lumbar disc.
- He experienced anxiety, depression and suicide ideation.
- There is limited information because the death has not been heard at inquest.

Learning and actions

- More assertive attempts to engage individuals in treatment
- Earlier screening and referral to ensure individuals access treatment before their physical and mental health deteriorate.
- Awareness raising of the effect of stimulants on the heart.
- To be reviewed following the inquest

Drug related death 50

- 23-year-old male whose employer raised a concern for welfare when he didn't turn up for work. His parents attended his property but were unable to gain entry so called emergency services.
- Cause of death: 1a) Bronchopneumonia 1b) Illicit drug use
- The postmortem states it seems likely that sedative and respiratory depression effects of multiple drugs led to a pneumonia, with a possible aspiration component, from which he was unable to recover. This is likely, but difficult to be certain, that this is a death from unnatural causes.
- He was not known to treatment services.
- He was a victim of domestic abuse.
- The death has not been heard at inquest as yet so there will be more information following the inquest conclusion

Learning and actions

- To be reviewed following the inquest.

Drug related death 51

- 34-year-old male discovered collapsed by his carer who called an ambulance and commenced CPR. He later passed away under palliative care.
- Cause of death: 1a) Sudden Unexpected Death in Chronic Alcohol Misuse.
- He experienced childhood trauma including physical abuse from his father.
- He was placed in 18 different care homes and foster placements, where he experienced sexual abuse.
- He had limited education and literacy skills and was on the Learning Disability Register.
- He began using substances at age 10, drinking alcohol and smoking cannabis daily. By 14, he was binge drinking with peers, and by 16, alcohol became a coping mechanism for his mental health and trauma. In his late twenties, he reduced cannabis use as alcohol cravings intensified.
- He experienced early-onset mental health issues, first attempting suicide at age 10 and being sectioned under the Mental Health Act. He lived with severe, enduring mental illness, including schizoid affective disorder, ADHD with obsessive-compulsive symptoms, autism spectrum disorder and aggressive

conduct disorder. He regularly self-harmed and was highly sensitive to perceived threats, often responding with aggression. He struggled with authority, personal space and night-time anxiety, likely linked to childhood trauma and attachment issues. He was supported by the Community Mental Health Team, had a dedicated nurse, and was prescribed various medications over time, including Olanzapine, Sertraline, Lithium, Venlafaxine, and Paliperidone depot injections to manage hallucinations, paranoia, and intrusive thoughts. He was frequently sectioned under Section 136 and spent time in Bodmin Hospital under Section 2.

- He had a history of childhood meningitis, a benign brain tumour, and epilepsy. He experienced frequent seizures, often indistinguishable from alcohol withdrawal. His liver deteriorated from fatty liver to cirrhosis with varices and ascites, and he lost part of it due to a traumatic injury. He suffered episodes of haematemesis and melaena, along with hypertension, cellulitis, and deep vein thrombosis.
- He frequently presented at the emergency department, with eight visits in the month prior to his death, with multiple self-discharges against medical advice.
- He was estranged from his family at the time of his death, though he had once been close to his sister. During treatment, he often expressed deep pain over feeling abandoned by his family.
- He experienced ongoing homelessness and instability in adulthood, residing in multiple supported housing placements across Cornwall. His stays were typically brief due to challenging behaviours that led to evictions or voluntary departures.
- He self-referred to treatment in 2018 and remained engaged until his death.
- He was supported by a large multidisciplinary team and his case was escalated to the highest level, and in his final days, he had a 24-hour 2:1 care plan.

Learning and actions

- He was well supported by multi agencies who worked together. However, his insecure housing and multiple placements mirrored his traumatic childhood in care. Suitable housing for those with severe trauma who exhibit challenging behaviour.

Drug related death 52

- 45-year-old male who collapsed at home. An ambulance was called but it was not possible to save him.
- Cause of death: 1a) Methadone toxicity.
- He was referred to treatment in 2013 following residential detox and rehabilitation and was engaged up until his death.
- He had experienced childhood trauma as his father was psychologically abusive to him.
- He had one son with whom he had no contact.
- He began using cannabis and alcohol at 14 progressing to oral amphetamines by 16. Following a relationship breakdown, this escalated to heavy ecstasy use (up to 10 tablets daily), then transitioned to smoking and injecting heroin, alongside illicit benzodiazepines and alcohol. He entered treatment at 27 via the Community Drug and Alcohol team. He underwent further detox and methadone reduction in 2013 and 2016
- At the time of his death, he was maintained on 120 ml methadone.
- He sustained a closed fracture of the left distal tibia in 2001 after a fall. This led to chronic bilateral ankle issues, requiring multiple surgeries including bilateral ankle pinning. He experienced ongoing pain, intermittently used crutches, and was prescribed Zapain and Naproxen. In 2022, he was diagnosed with a hiatus

hernia. He was obese, which caused him concern, and he made efforts to improve his health through diet and exercise.

- According to GP records, he was referred for behavioural psychotherapy at 14 and first seen by a clinical psychologist at 15. Throughout his life, he experienced episodes of mental instability, including low-level psychosis, auditory hallucinations and paranoia. He was prescribed Olanzpine, Amitriptyline and Mirtazapine. In February 2014 he was admitted to Longreach and diagnosed with substance use disorder. Post-discharge, he remained under the Home Treatment Team, with ongoing psychotic symptoms attributed to illicit benzodiazepine use. He was later diagnosed with schizoaffective disorder, with possible indications of autism.

Learning and actions

- Alternatives to medication for pain management
- He was on a high dose of methadone and died of methadone toxicity. The inquest heard there were a number of methadone bottles prescribed to other individuals found at the scene. A review of the protocols around methadone prescribing (including where there is a risk of illicit top up use) may assist in understanding the rise in drug related deaths where methadone is implicated for those in treatment.

Drug related death 53

- 43-year-old female who was found unresponsive in the bathroom of the interim nightly accommodation.
- Cause of death: 1a) 1a) Aspiration Pneumonia 1b) Illicit Drug Use
- She came to Cornwall fleeing domestic abuse.
- She reported first using cannabis aged 15 with peers along with amphetamines and "pills". She began using heroin aged 18 and by aged 20 the use had become habitual.
- Adverse childhood-she was put into care at 13 years old after reporting her mother chose her stepfather over her.
- Multiple child removal**-** She had four children, all of whom were removed from her and she struggled to make connections with them.
- She continued to use substances and occasionally alcohol throughout her adult life and was on long term opiate substitute prescribing which she found difficult to comply with. This presented a barrier to safe and consistent prescribing. When she began to use crack/cocaine her life and wellbeing rapidly deteriorated, she lost weight and at times resorted to shoplifting and transactional sex to fund her habit.
- She suffered from the consequences of poor peer injection with sores on her legs at times and a reported history of deep vein thrombosis for which she was prescribed Fragmin. She also had an epigastric hernia and was diagnosed with epilepsy in 2020 and was prescribed Lamotrigene.
- She suffered from anxiety which was exacerbated by her crack cocaine use.
- Housing and homelessness were recurring issues for her as a result of cuckooing and/or domestic abuse. She was street homeless for a period and spent time living in a tent. She moved around various temporary and emergency accommodation sites which were male dominated and led to further abuse. At the time of her death, she died in accommodation that was unsuitable for someone of her vulnerabilities.
- She entered detox and rehab a number of times and maintained periods of abstinence.

- She was described as a lively and bright, with a keen interest in photography and dancing.

Learning and actions

- Suitable (women only) housing for women with multiple vulnerabilities.
- The importance of a trauma informed approach and work around ACEs. A therapeutic alliance was built up with a recovery worker but led to her relapse when the worker left the service.

Drug related death 54

- A male (under 18) took drugs with friends and became erratic. They encouraged him to go outside, where he fell asleep in the garden. They left him with a blanket and pillow. He was found unresponsive the next morning.
- Cause of death: information not received as yet.
- He was excluded from school. Although initially attending, his mother reported he was placed in isolation for weeks, prompting her to home school him. She sought legal advice to reintegrate him into school and left her job to support his online learning.
- He lived with his mother and younger siblings. She noted a decline in his interests and shifting social groups that impacted his behaviour, raising concerns about potential exploitation. Police had been involved following an assault, but he was not open to Children's Services.
- His mother contacted treatment services twice for advice on addressing his daily cannabis use. A worker visited their home and provided harm reduction guidance. She later made a referral, and he was allocated a worker six weeks later, but he declined support at that time.
- He had dyslexia.
- The inquest has not yet been held.

Learning and actions

- Risk of "so-called" recreational drugs on young people.
- School exclusions of vulnerable individuals.
- How to engage young people in treatment.
- Overdose awareness raising.
- Learning to be reviewed once inquest held.

Drug related death 55

- 34-year-old male who had been out for dinner with his parents. He spoke with his ex-partner reporting a nosebleed and coughing fit after using cocaine and said he felt unusual. He was later found unconscious by family and pronounced deceased by emergency services.
- Cause of death: 1a) Cocaine Toxicity
- History of cocaine use, alcohol dependence, self-harm, significant debt and recent domestic abuse concerns including Marac.
- He was subject to bail conditions including an electronic tag at the time of his death due to high-risk domestic abuse.
- He was working well with treatment prior to his death.
- His worker completed an ACEs form with him in which he scored 7.
- Loss-lost his house, wife, work and he had recently been informed of a court decision preventing contact with his children.
- His mental health declined considerably in the months prior to his death including a suicide attempt.

Learning and actions

- A dual diagnosis approach may have helped.
- Raised awareness about the risk to life (by suicide or drug related death) of high-risk abusers of DA. He was referred for healthy relationships work but a clear pathway into a suitable high risk abuser programme is required.
- Opportunities to work through childhood trauma.

Drug related death 56

- 48-year-old male who was returned to his accommodation following an ambulance call out for intoxication. He was later discovered unconscious and bleeding from the head at the bottom of stairs. A few days later, he was found collapsed on the ward with a suspected drug overdose. He became increasingly unwell including sepsis and subsequently died in hospital.
- Cause of death as yet unknown as forensic postmortem ongoing.
- He had started using cannabis at the age of 12, begun to buy alcohol and take ecstasy and amphetamine at the age of 15. He began smoking heroin aged 20 and progressed to injecting at 22.
- He had three journeys with With You and accessed detox and rehab five times with varying degrees of success.
- He was in several long relationships all of which were characterised by substance use and high-risk domestic abuse.
- He carried unresolved trauma and deeply regretted his inability to maintain a relationship with his daughter.
- He had a history of umbilical and inguinal hernias, epigastric pain, and morning nausea linked to alcohol use. He developed gastric ulcers causing hematemesis. An asthmatic, he used inhalers regularly. A 2015 liver scan showed abnormalities that worsened due to heavy drinking, poor nutrition, and self-neglect. He also had Chronic Obstructive Airways Disease and, before his death, sustained a chest wall injury from a fall and experienced bursitis.
- He was prescribed Mirtazapine but discontinued it, feeling it had no effect on his mood. His self-harm and binge drinking appeared impulsive rather than premeditated. He reported auditory and visual hallucinations, possibly related to alcohol withdrawal, and experienced episodes of paranoia and morbid jealousy regarding his partner's interactions with other men.

Learning and actions

- To be reviewed once cause of death is established and inquest is concluded.

Drug related death 57

- 31-year-old woman who was discovered by police collapsed on her landing.
- Cause of death is 1 a) Drug Misuse
- Limited information as she was originally from out of county and was not known to treatment services.

Learning and actions

- To be reviewed following the inquest.

Drug related death 58

- 53-year-old male who collapsed in the early hours of the morning whilst preparing to go to work. His wife heard him collapse and called for an ambulance and administered CPR.

- Cause of death 1a) Tramadol toxicity, 2 Ischaemic heart disease and obesity
- The toxicologist concluded that the level of tramadol detected was at a level associated with fatalities and in combination with other central nervous system depressant drugs such as amitriptyline, codeine and paroxetine are likely to have caused further sedation.
- He suffered from depression and a number of physical health conditions including hypertension, obstructive sleep apnoea, and chronic backpain.
- All of the substances taken were prescribed medications.

Learning and actions

- Awareness raising of the risks of exceeding dose of prescription medication.
- The tramadol was no longer prescribed to him, but he still had the medication in his possession.
- Alternatives to medication for pain management.

Appendix A Drug Related Death Action Plan 2024-2025

National and local outcomes	What we seek to achieve and why	Principles
<u>National Drug Strategy</u>: people live longer, healthier lives - reduce drug related deaths. <u>Cornwall Council</u>: Vibrant, safe supportive communities where people help each other to live well and thrive at home - providing the right care, in the right place, at the right time. <u>Cornwall Council</u>: An empowering and enterprising Council that offers a consistently excellent customer experience and delivers great value for money - Empower staff, partners and communities. - Keep the community well informed and earn trust responding to feedback, learning lessons. <u>Safer Cornwall</u>: Our specialist services protect and support the most vulnerable and reduce harm.	Whole government 10-year harm to hope drug strategy mission: *by the end of 2024/2025 prevent nearly 1000 deaths.* OHID Drug Related Death Prevention Action Plan 5 Priorities: 1. Treatment is protective – get people into treatment; Improve the safety and effectiveness of treatment. Safer and better drug and alcohol treatment practice. Link to numbers in treatment and who is referring in. 2. Better local systems for drug intelligence and for learning from drug and alcohol deaths. The outcome is that 'we receive timely intelligence to inform the picture of risk in our system and where to target our focus and resources'. 3. Improved toxicology and surveillance we have access to the toxicology we require to identify at the earliest opportunity, risks to our residents, and can take action at the earliest opportunity. 4. Tackling the stigma experienced by people using drugs and alcohol. People have a better understanding of who develops problems and why. 5. Addressing poly-drug and alcohol use and the risks from new trends, particularly new synthetic substances.	• Compliment other workstreams linked to the Drug and Alcohol Strategies. • Provide expert advice and data to support the development of local strategies that are cross cutting. • Focus on prevention and early intervention. • Co-production: collaboration with partners, Experts by Experience and communities. • Adopt a Human Learning System approach to continual learning and improvement. • Take a trauma informed approach as per the commitment to a compassionate Cornwall. • End the stigma associated with drug and alcohol related deaths.

What do we plan to do?	What do we hope this will achieve?	What will change?	When will this be in place?
Maintain a system of recording and conducting confidential enquiries into DRD's and relevant unnatural deaths.	- Better local systems for drug intelligence and learning - Annual DRD report	- Co-ordination of initiatives - Reduce drug/alcohol related deaths	September 2025
Update: This is the responsibility of the Drug Related Death prevention coordinator's role. Last year there was a backlog due to the post having been empty for many months. The back log has now been processed, and we are looking towards achieving a more real time review process from next year (2026). The information on potential drug related deaths is collated and thereafter reviewed by the sub-group review panel during the year. The DRD panel has agreed that a sub-group will sit underneath the main DRD review panel (and meet on an 8-weekly basis) and bring themes and findings to the review panel. The membership and Terms of reference of the DRD review panel has been updated in line with OHID guidance. Preventing drug and alcohol deaths: partnership review process - GOV.UK **Local Drug information system (LDIS) update**: Public promotion was a key priority during quarter 1 (2025-2026). A targeted awareness and reporting campaign was delivered via Safer Cornwall's Facebook and Instagram channels. A Terms of Reference were drafted for all LDIS distribution members to ensure a consistent approach to cascading alerts and information requests. To support the development of the Local Drug Information System, the LDIS lead continued attending meetings to promote the system, with other colleagues doing the same in their respective meetings and contacts. **Synthetic Opiod Preparedness Plan**- all local authorities are required to have a Synthetic Opioid Preparedness Plan in place in line with the Office for Health Improvements and Disparities (OHID) "Guidance for local areas on planning to deal with potent synthetic opioids". The plan was drafted in November 2024 and updated in July 2025 to ensure closer alignment to the Emergency Management plans and in line with OHID's Findings and recommendations for Combating Drugs Partnerships (May 2025).			
Develop a non-fatal overdose pathway and sub-group	- Better local systems for drug intelligence and learning -Ensure all non-fatal overdoses are referred into treatment	- Earlier interventions - Reduce hospital admissions attributable to substance misuse -Reduce fatal overdoses	April 2024
Update: This has been a critical piece of work. Research tells us that anyone experiencing a non-fatal overdose is at risk of a fatal overdose within the following 28 days. NON-FATAL OVERDOSE AS A RISK FACTOR FOR SUBSEQUENT FATAL OVERDOSE AMONG PEOPLE WHO INJECT DRUGS - PMC (nih.gov) The non-fatal overdose referral pathway is in place. Anyone presenting to Southwest Ambulance Service Trust (SWAST) who has experienced a drug overdose is referred to With You (Drug and Alcohol treatment service) by way of a secure NHS email. The referral is made on the basis of safeguarding the individual and it has been agreed that the referral will be made without consent but on the proviso the individual is made aware they are being referred. A sub-group has been established to monitor the progress of the NFO pathway with meetings taking place on a bi-monthly basis. The group will seek to expand the NFO pathway to include police data on their use of Naloxone and gaps in hospital presentations and the ambition is to expand the SWAST pathway to include alcohol related overdoses.			

Colleagues from North Somerset attended our recent sub-group meeting and advised that of those individuals being referred into treatment via their NFO pathway about 50% were already known to treatment and 50% were unknown. If this is replicated in Cornwall, it will assist with our work around those not known to treatment services. In Quarter 1, referral numbers were low, and a test run of the process revealed gaps in the referral pathways. The NFO sub-group has reviewed this and agreed that SWAST will undertake a further promotional campaign to raise awareness of the pathway. Consideration will also be given in Quarter 2 to expanding the pathway to include alcohol overdoses and linking in with colleagues in Plymouth to explore their findings.			
Improve screening and service integration.	- Good cross service protocols - Earlier interventions	- Tackle comorbid mental and physical health issues -reduce drug related deaths	December 2025
A strategic priority for the DAAT in 2025-26 is to encourage and enable use of screening tool and encourage referrals from all services, (target Housing, Probation, Prisons, GP's, Shared Care providers, Adult and Children's Social Care). This will involve securing a Cornwall Council licence for screening tool (ASSYst-lite) and to rollout an implementation plan which will be delivered alongside the promotion of treatment pathways, and online referral routes and also the implementation of the My Team Around Me approach to multi-agency working and rollout of information sharing platform (Manta).			
Develop affected other work	- Whole family approach -those who experience loss of a loved one will feel supported -reduce the stigma associated with DRDs -Develop a co-produced memorial service	- Increased access to treatment - Voice of lived experience and co-production	December 2025
Update: The DRD prevention coordinator and one of the experts by experience have linked in with an affected others group at With You. The delivery plan has been drafted around the ambitions of this work and includes: • A service of remembrance (to take place in the Autumn 2026) for loved ones and staff members to pay their respects to those who have died from drug and alcohol related deaths. This service hasn't taken place for a number of years due to staff capacity and reestablishing this is felt to be of importance both for the emotional wellbeing of those affected and to reduce the stigma associated with DRDs. • Public Health colleagues have obtained funding and are about to launch a generic bereavement service including those affected by Drug related deaths across Cornwall. • The affected others group will provide their views on press coverage of DRDs and work to address future press coverage (if deemed necessary) will be undertaken. • The group will also review and feed into our comms plan on work around International Overdose Awareness Day. • A guidance document following a DRD to include the coronial process to be co-produced.			

Increased coverage of Naloxone	- Gaps identified to increase distribution -peer led distribution -innovative implementation of Naloxone	- Universal coverage of Naloxone - More lives saved	December 2025

Update: The process for requesting training, service level agreement (SLA)and incident reporting has been reviewed and simplified with a push to encourage more incident reporting not just those organisations who have signed an SLA.
A guidance document explaining what Naloxone is and where it can be obtained etc has been drafted and has been added to the Safer Cornwall website and the pages relating to Naloxone have been reviewed.
The training in the administering of Naloxone has continued to be expanded to include pharmacies, probation (although recent changes in the law means they are able to hand out Naloxone directly), DASV services including Krefta Kurnow outreach workers, organisations working out of the recovery communities, library staff, temporary accommodation providers, Falmouth and Newquay town councils, Truro Street pastors and security staff and housing providers. This is in addition to providing training to existing providers by ensuring new staff members are trained to administer Naloxone. The Naloxone training process has been simplified by the creation of an Eventbrite link enabling organisations and individuals to book direct.
Naloxone continues to save lives within the supported accommodation provision.

Dates	**2009 - 2016**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**TOTAL**
Lives Saved	25	13	11	17	21	**87**
Dates	**2021**	**2022**	**2023**	**2024**	**Total (2021-2024)**	**TOTAL (2009-2024)**
Lives Saved	15	20	28	15	**78**	**165**

Investigate pain management	- Evidence based learning	- Implement alternative approach to pain management	December 2025

Update: A review of the 10 footsteps to living well with pain training delivery has been undertaken and this review suggests that due to staff moving jobs the training has not been embedded in services as anticipated. The implementation lead is looking at alternative pain management programmes and links are being made to the pain cafes to offer space within our safe and well hubs. The complex needs team will review the offer of the pain cafes to assess if it is suitable and appropriate for those in drug and alcohol treatment.
There is a necessity for workers in the field of substance use to be aware of alternative measures of pain relief and to work with colleagues in primary and secondary care to develop more holistic care packages for those service users who are using prescribed, over the counter and illicit substances as a means of alleviating their chronic pain. With You's Clinical Lead is leading this work locally.

With You are in the process of recruiting a Medical Lead who will be tasked with improving relations between prescribers, GPs and Recovery Workers with regard to pharmacological decisions and regular drug testing with relevant results being communicated to both prescribers and GPs to enable safer case management. The drug related death coordinator will monitor the progress of With You's initiatives.			
Partnership work to enable better Housing Pathways	- Suitable accommodation options available	- Homelessness prevention - Harm reduction	December 2025
Housing is a local drug strategy priority with a target to increase the percentage of adults in treatment in suitable and stable accommodation. DAT will contribute to the implementation of Homelessness & Rough Sleeper Strategy and Supported Accommodation Strategy in relation to people with complex needs. This will include exploring reasons for unmet needs in homeless or former rough sleeper cohorts and the ongoing Housing Support Grant test and learn project which is designed to enhance existing services. A closed cohort is being monitored and some of the cases are being used to trial the MTAM guidance.			
Awareness Campaigns	- Increased awareness - Reduce stigma -Risk of using alone	- Increased access to services - Harm reduction - Reduce drug related deaths	December 2025
Update: A comms plan has been drafted with a month-long campaign of social media posts, events and initiatives including a lunch and learn to take place during August 2025 culminating with International Overdose Awareness Day on 31 August 2025. The comms plan will be scrutinised by the members of the recovery communities and the affected others group. Once the Naloxone policy has been approved for Cornwall Council staff, a targeted campaign to maximise sign up to Naloxone training will be implemented across Cornwall Council.			
Support for those experiencing repeated child removals	-Targeted support for those who experience repeated child removals -pilot programme which will capture learning to improve systems	- reduce the harm befalling those whose children are removed -Human learning systems approach	April 2025
Update: In 2024/25, it was identified that those who have children repeatedly removed from their care are often not receiving the support they need to recover from the previous trauma and the trauma of having their children removed. In a needs analysis it was identified that nearly all those who have a child removed at birth had experienced domestic abuse, sexual violence, drug and alcohol use and/or childhood trauma. JSCOG were successful in identifying some funding from drug and alcohol grants, domestic abuse grants, and the serious violence prevention fund a pilot to improve our response to these families. The pilot is using a human learning approach to bring partners together to design and implement the pilot model. The design phase is complete, and a model has been developed that not only provides support to those who have repeat children removed but also aims to address some of the system issues that are preventing these families from receiving support at an earlier stage. The implementation phase finished in February with the model going live in Autumn 2025.			

Implementation of the DAAT/DASV protocol	-improved understanding of awareness of domestic abuse by drug and alcohol services -improved understanding of drugs and alcohol by domestic abuse services -joint working of cases -increased referrals.	-those who have problematic drug and alcohol use, and experience domestic abuse will be better supported	December 2025
Update: The DAAT/DASV Protocol was reviewed 2023 and signed off by DASV Partnership Board. In addition, we held three workshops with our Drug/Alcohol and Domestic Abuse commissioned services, one to review the DAAT/DASV Protocol and two with a focus on healthy relationship work. The main asks from the workshops included **1. A need to better understand services (including clear referral pathways), 2. Being enabled to work better together 3. The development of a healthy relationship Train the Trainer program.** The consultations included the voices of experts by experience who continuously inform our response through collaboration and co-production, this has included visits to Bosence Farm and the inclusion of experts by experience to the workshop's events. The development and delivery of Healthy Relationships Train the Trainer to WY and Bosence Farm workers has been completed. In addition, Barnardos have delivered bespoke "Who is causing harm" training to WY workers, with the aim of identifying the primary abuser, raising awareness of coercive control and professional manipulation. The DAAT/DASV protocol working group have been meeting monthly to see how to co-develop an implementation plan for the DAAT/DASV Protocol. Within those meetings we have been looking at the implementation driver's model to ascertain which we have in place, what may need strengthening, and key priorities.			
Implementation of the dual diagnosis guiding principles	-those with problematic mental health and drug and alcohol use will be supported -There will be no wrong door for those seeking support -Outreach mental health team in place	-reduction in escalating mental health issues and problematic drug use as people are better supported -reduction in drug related deaths	December 2025
Update: The Dual Diagnosis Guiding Principles were shared across the system in August of 2024, with many face-to-face, place-based, multi-agency 'Awareness Sessions' following this as part of the guidance's implementation. So far, 272 Professionals from across the system have engaged with these sessions, and the continued roll-out of these remains a priority to develop knowledge and understanding, as well as addressing pockets of resistance to this way of working. Tom Webb, Dual Diagnosis System Lead and Coordinator from the Complex Needs Team is leading on this.			
Review of the process prior to detox and rehab	-Individuals will be adequately prepared for detox and rehab.	-reduction in drug related deaths for those about to enter detox and rehab	December 2025

	-Individuals will be aware of the risks of bingeing on drugs and alcohol prior to detox		
The Tier 4 referral panel is a multi-disciplinary team that reviews referrals before they are approved to go forward for the admissions process. In these meetings consideration is given to preparedness for detox and rehab as well as contingency and aftercare planning. The annual Tier 4 review will happen during Q1/Q2 of 2025-26 and any lessons learned will be shared and addressed as part of contract management activity. The in-patient detox and residential rehab process documentation will be reviewed as part of a wider treatment pathway review including support in the community whilst waiting to be admitted and aftercare.			
Review process for identifying and addressing issues of fear and debt in treatment and housing services.	-those who are affected by fear due to drug debts will be encouraged to disclose and be supported - Holistic support in place	-reduction in families living in fear	December 2025
Update: Those experiencing fear and debt was a theme picked up in the 2023 DRD report. The Life skills team at With You work with clients to address their debts but a wider investigation is required to ensure those living in fear for their lives or at risk of serious harm due to drug debts are identified and safeguarded. The DRD lead will discuss with With You and the DRD review panel members.			

Appendix C

Glossary of terms

Acute -severe and sudden onset.

Amphetamine- are central nervous system stimulants.

Arrythmia-an irregular heartbeat.

Benzodiazepines- have a sedative effect and are usually prescribed to treat anxiety. 'Street benzoes' are illicitly supplied and can be similar in effect but may vary enormously in strength and content.

Bromazalam-is a benzodiazepine only available illicitly in the UK.

Cardiac arrythmia-an irregular heartbeat

Cardiac function-how well or not the heart is functioning**.**

Cardiorespiratory system-consists of the heart, lungs and blood vessels. The purpose of this system is the delivery of oxygen and nutrients to the cells, as well as the removal of metabolic waste products to maintain the internal equilibrium.

Cocaine- is a short acting central nervous system stimulant and local anaesthetic, derived from the naturally occurring Coca bush.

Codeine- is an opiate painkiller.

CPR-Cardiopulmonary resuscitation (CPR) is an emergency procedure consisting of chest compressions and mouth to mouth in order to restore blood circulation and breathing in a person who is in cardiac arrest (their heart has stopped).

Crack cocaine- Crack is produced by mixing ammonia/baking soda and water with the cocaine solution. This mixed solution is then heated and forms rocks that are usually smoked. Crack can be thought of as a concentrated form of cocaine, with a shorter and more intense effect.

Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds.

Demographics- Demography is the study of populations and the groups that make them up. Demographics is the resultant information.

Detoxification- the withdrawal from drugs and/or alcohol for someone dependent upon them

Diazepam belongs to a group of medicines known as benzodiazepines. It is used to treat anxiety, muscle spasms and seizures or fits. Brand names include 'Valium'.

Dual diagnosis is the term which describes someone who has coexisting mental health problems and problematic substance use.

Exploitation-the act of using something or someone unfairly for your own advantage.

Fentanyl is a potent synthetic opioid drug used as an analgesic (pain relief) and anaesthetic. It is also used illicitly.

Heroin is manufactured from the sap of the Opium Poppy. Pharmaceutical name Diamorphine.

Illicit-illegal**,** against the law**.**

MDMA is the shortened chemical name for the synthetic psychoactive drug 3, 4-methylenedioxy-methamphetamine. It can come in powder or crystal form and is also the active ingredient expected to be found in 'ecstasy' pills. MDMA is a stimulant drug that may increase feelings of empathy and is usually swallowed.

Metabolite within the report refers to the product that remains after a medicine is broken down (metabolized) by the body.

Methadone is a synthetic opioid used to help an individual stop taking heroin. It is also used illicitly.

Metonitazene is a synthetic opioid. It was one of the 15 nitazenes made a Class A drug under the Misuse of Drugs Act (1971) in March 2024.

Mitragynine also known as Kratom, is a herbal product, extracted from leaves which, in small doses, acts as a stimulant similar to caffeine, but in larger doses exhibits opioid-like effects.

Modafinil is a non-amphetamine central nervous system stimulant which promotes wakefulness.

Multiple vulnerabilities refer to someone who has several reasons for requiring special care, support, or protection because of age, disability, or risk of abuse or neglect.

Naloxone is a life-saving drug that reverses the effects of an opioid overdoes and can help to prevent overdose deaths.

NICE guidance- The National Institute for Health and Care Excellence (**NICE**) provides national guidance and advice to improve health and social care.

Nitazenes technically known as 2-benzyl benzimidazole opioids, is a diverse group of synthetic opioids. Like the fentanyl analogues, many are far more toxic on a weight-for-weight basis than heroin. Even a small amount can be enough to kill, especially without immediate naloxone or medical attention.

Non-fatal overdose occurs when someone takes too much of a drug or medication leading to dangerous and potentially life-threatening side effects. **A fatal overdose** is when someone takes too much of a drug or medication and dies as a result.

Opiate substitution Treatment- A key element of structured treatment for opiate dependency. People who become dependent on heroin or other illicit opioids often benefit from opioid substitution treatment (OST). The same is true, but much less common, for people who become dependent on opioids prescribed for pain. The pharmacological element involves replacing illicit opioids with a prescribed replacement opioid, such as methadone or buprenorphine. This is most effective when accompanied by structured psychosocial interventions to improve social functioning.

Opioids are a class of drugs that derive from, or mimic, natural substances found in the opium poppy plant. Opioids work in the brain to produce a variety of effects, including pain relief. Opioid drugs include prescription pain medicine and illegal drugs.

Oxycodone is an opioid painkiller. It is used to treat severe pain, for example, after an operation or a serious injury, or pain from cancer.

Polydrug use or polysubstance use is a term for the use of more than one drug or type of drug at the same time or one after another. Polydrug use can involve both illicit drugs and legal substances, such as alcohol and prescribed medications.

Potentiate- to make effective or active or more effective or more active or to augment the activity of (something, such as a drug) synergistically.

Prescribed means (a medical practitioner) advises and authorises the use of (a medicine or treatment) for someone, especially in writing.

Protonitazene is a synthetic opioid. It was one of the 15 nitazenes made a Class A drug under the Misuse of Drugs Act (1971) in March 2024.

Regulation 28 Report also referred to as a prevention of future deaths report are made pursuant to section 7(1) of Schedule 5 of the Coroners and Justice Act 2009 and Regulation 28 of the coroners (Investigations)Regulations 2013. A coroner has a duty to take action to prevent future deaths where: (1) a coroner has been conducting an investigation into a person's death. (2) anything revealed by the investigation gives risk to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future; and (3) in the coroner's opinion, action is required to prevent the continuation of such circumstances or eliminate or reduce the risk of future death created by such circumstances.

Rehabilitation-the action of restoring someone to health through training and therapy after addiction.

Stigma is a set of negative and unfair beliefs that society or a group of people have about something.

Synergistically used in the context of drugs to describe drugs that work together so the total effect is greater than the sum of two (or more).

Synthetic Opioids- are manmade opioids including Fentanyls and a class of compounds called Nitazenes.

Supported housing- In supported housing, accommodation is provided alongside support, supervision or care to help people live as independently as possible in the community.

Ten Footsteps approach- The Ten Footsteps to Living Well with Pain is an evidence-based step-by-step guide to living well with persistent pain.

Therapeutic level- The therapeutic range of a drug is the dosage range usually expected to achieve the desired therapeutic (relating to the curing of a disease or medical condition) effect.

Toxicology- the measurement and analysis of potential toxins, intoxicating or banned substances, and prescription medications present in a person's body.

Tramadol is a strong painkiller from the group of medicines called opiates. It is used to treat moderate to severe pain.