



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 2025 to 31st December 2025

Foreword

This report sets out the data on drug related death in Cornwall and the Isles of Scilly. These figures are vital for understanding trends, identifying risks and informing our response. However, it is important to pause and recognise what sits behind these numbers. Each one represents a person, with a life, relationships, experiences and hopes and dreams that are not reflected in the data.

Whilst data helps us to see the scale and nature of the issue, it can never fully convey the human impact. These individuals were more than the circumstances of their deaths. They were sons, daughters, parents, partners, friends, colleagues and people who mattered, whose absences is felt and whose lives had value. The quotations captured below aim provide a snapshot of the characters of some of those who lost their lives in 2025.

Holding onto this perspective matters. It ensures that our work remains grounded in compassion as well as evidence, and that the urgency to act is shaped not only by the trends and figures, but by a recognition of the real loss behind them.

This report is therefore not just a collection of data, but a reminder of our shared responsibility to learn from these deaths, to reduce harm wherever possible, and to prevent further loss in the future. A big thank you goes to the Sub-group members of the drug related death review panel for their commitment and dedication. Despite demanding schedules, they generously devote their time to reviewing the deaths and analysing the lessons learned. This work is vital to ensuring that no death goes unnoticed or is in vain.

"He had a massive heart and was very protective of people and his friends."

"He was headhunted for a company and worked as a software developer and thrived in the role." "She was a wonderful mother and did an amazing job raising our children."

"He was a very keen musician, and this was one of his great passions. He would perform at gigs, and I believe he attended Glastonbury on one occasion."

"She was a sister and a daughter and never forgot a birthday. She loved to cover cards with glitter." *"He was a lovely man".* *"He was a retired Doctor."*

"He was an incredibly likeable person" *"Most warm beautiful soul you could ever meet"* *"He went the extra mile to help people."* *"He seemed to enhance the lives of everyone he met with his kindness and generosity of time and thoughtfulness"*

"He was my only child." *"She was liked by everyone and had an amazing ability to draw."*

He was a lovely boy who cared deeply for his family." *"He had a love of music and a master's degree."* *"He went onto become a DJ and was an artist."* *"He was a kind man and supported several friends who were struggling at the end of his life"*

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Executive summary: Drug and Alcohol related deaths in CIOS (2025)

In 2025, there were 45 drug and/or alcohol related deaths (DARDs) in Cornwall, (with none in the isles of Scilly). These comprised 34 men and 11 women. Although the number of deaths in 2025 decreased compared with 2024, a three-year rolling trend analysis indicates that deaths remained stable until 2019, increased year on year thereafter, and have plateaued since 2024 at a higher level. Similar trends were observed among both males and females, although the proportional increase was greater among females. In 2025, the highest number of deaths (17) occurred among individuals aged 50 to 59 years. Encouragingly, deaths among younger age groups continue to decline, albeit from a relatively small baseline.

Polydrug use remains the most significant feature of drug related deaths, with 87% of cases involving multiple substances. Methadone remained the most common substance identified among those engaged in treatment, while diazepam and alprazolam featured more prominently than in recent years. Cocaine continued to be the most frequently implicated illicit drug featuring in 38% of deaths, although this was a slight decrease from 2024. Deaths involving heroin increased, highlighting a renewed area of concern.

Alcohol was implicated in 20% of deaths with 3 deaths concluding as alcohol related deaths.

Treatment engagement data indicates an increasing proportion of people were in treatment at the time of death. However, 27% of individuals had no recorded treatment history demonstrating the ongoing need to improve identification, outreach, prevention and harm reduction initiatives for people not engaged with services. While deaths amongst people who had left treatment decreased compared to the previous two years, this group remains at elevated risk.

The ongoing threat posed by synthetic opioids remains a concern. Although only two deaths involved synthetic opioids in 2025, these substances are highly potent, remain available and carry an increased risk of fatal overdose. Local preparedness arrangements remain in place to respond to emerging synthetic opioid threats.

A concerning trend is the increase in individuals dying alone, accounting for 56% of all deaths. This significantly reduces opportunities for lifesaving intervention, including naloxone administration and emergency response. Evidence also suggests a continued need to improve public awareness of overdose signs and appropriate responses.

Mental and physical health problems were highly prevalent. Both primary and serious mental health issues were identified in 88% of men and 100% of women, while physical health affected 76% of men and all women. Trauma, adverse childhood experiences, bereavement, domestic abuse, homelessness and relationship breakdown were also common factors. Domestic abuse remained a key gendered issue, affecting nearly two-thirds of women who died.

Overall, while the reduction in deaths is encouraging, the findings highlight the continuing impact of polydrug use, poor mental and physical health, historical trauma, social isolation and an ageing population who continue to use drugs. Ongoing investment in prevention, harm reduction, dual diagnosis, trauma-informed practice and responses, gender-responsive services and engagement with individuals outside treatment remains essential to further reduce drug and alcohol related deaths across Cornwall.

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) set out five priorities in a Drug and Alcohol Related Death (DARD) Action Plan for 2025/2026, which are and remain

- 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 this 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 third year we have included those who die of an alcohol related death where they were in treatment at the time of their death, in line with the national approach to reviewing drug and alcohol-related deaths subsequently formalised in OHID guidance published in 2024.

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. [Preventing drug and alcohol deaths: partnership review process - GOV.UK](#)

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 Partnership 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 2025 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
- 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 third CIOS Annual Drug Related Death report and covers the period 1st January 2025 to 31st December 2025. It analyses and reports on drug related deaths which occurred within the calendar year of 2025. At the time of writing the report 31 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. However, these figures may alter, and we will update once all of the inquests have concluded.

1.10 There is always a discrepancy between the data in this report and those published by the Office for National Statistics (ONS). Most drug-related deaths are subject to a coroner's inquest, and a death cannot be formally registered until the inquest has been completed. As a result, ONS publishes data based on the year in which a death is registered, rather than the year in which it occurred. Because inquests can take many months, and sometimes years, to conclude, deaths occurring in one calendar year may not be registered until a later year. In contrast, this report analyses deaths that occurred during the reporting calendar year, regardless of when the death was formally registered. Consequently, the number of deaths reported here may differ from ONS figures for the same period.

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. Progress of the Drug-Related Death (DRD) Review Process (2023-2026)

Between 2023 and 2026, significant progress has been made in strengthening the Cornwall & Isles of Scilly Drug-Related Death (DRD) review process, with clear developments in governance, data quality and operational delivery.

During the period 2023-2024, DRD reviews were undertaken through a quarterly review panel. However, the process faced several challenges, including an increasing number of deaths requiring review and a substantial backlog of cases, particularly those occurring prior to and during 2023. Consequently, only a small proportion of deaths were reviewed by the panel during this period. Data collection at this time was limited, especially in relation to protected characteristics.

In response to these challenges, improvements were initiated following the publication of the Office for Health Improvement and Disparities (OHID) partnership review guidance in September 2024. [Preventing drug and alcohol deaths: partnership review process - GOV.UK](#) This led to a revision of the Terms of Reference and membership of the DRD review panel, strengthening governance arrangements and aligning the local approach with national expectations.

During 2025, the introduction of a dedicated DRD review sub-group marked a significant step forward in addressing the backlog and improving review coverage. However, some challenges remained. Although information requests were circulated in advance of meetings, response rates from partner agencies were variable, and case discussions were often reliant on representatives attending sub-group meetings to provide updates and contextual information.

A key milestone was reached in May 2026 with the transition to a real-time surveillance model for DRD reviews. This has significantly improved the timeliness and responsiveness of the review process. Real-time information requests are now issued, and this approach has yielded an excellent response rate, indicating stronger multi-agency engagement and improved information sharing.

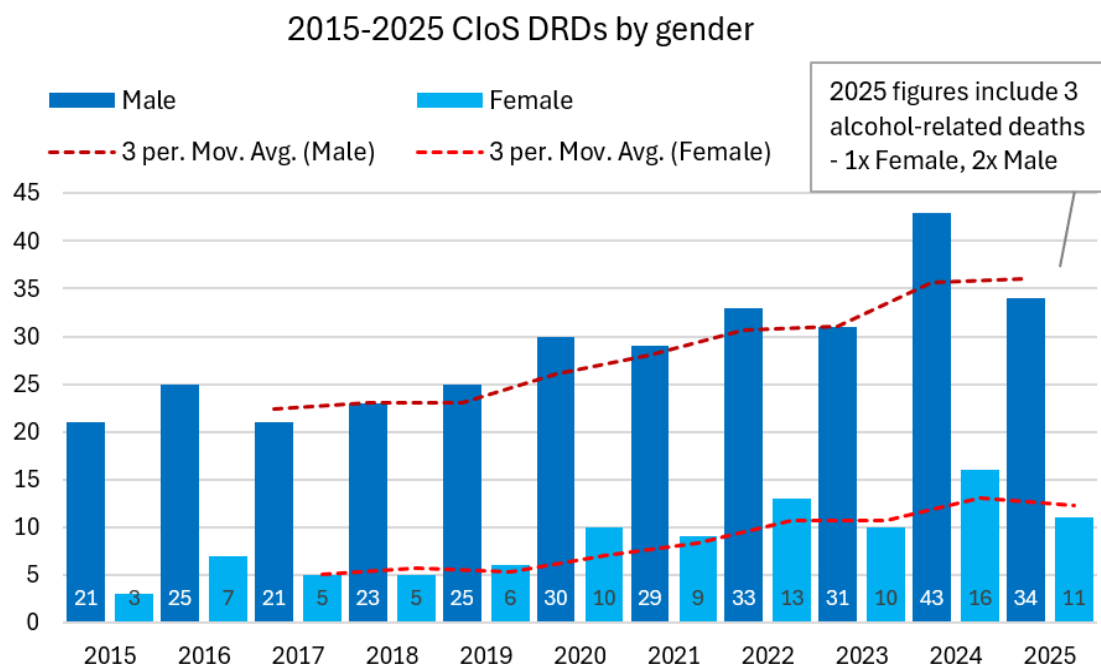
A learning log is maintained following each review, informing the recommendations outlined in this report.

Overall, the DRD review process has evolved from a limited, retrospective model with incomplete data, to a more structured, responsive and comprehensive system. Continued focus on real-time surveillance, partner engagement and completion of more timely reviews will be critical to sustaining progress and ensuring that all deaths are systematically reviewed to inform learning and prevention.

There is also a clear need to strengthen alignment across all preventable death processes to ensure a more coordinated and effective approach. This includes greater integration between drug and alcohol related death reviews, domestic abuse related deaths, adult and children's safeguarding frameworks, and suicide prevention initiatives. During 2026, work is actively underway across all these areas to achieve improved alignment and collaboration. Enhancing partnership working and information sharing will support a more holistic understanding of risk factors and vulnerabilities, enabling more timely and effective interventions to reduce preventable deaths.

3. Demographics

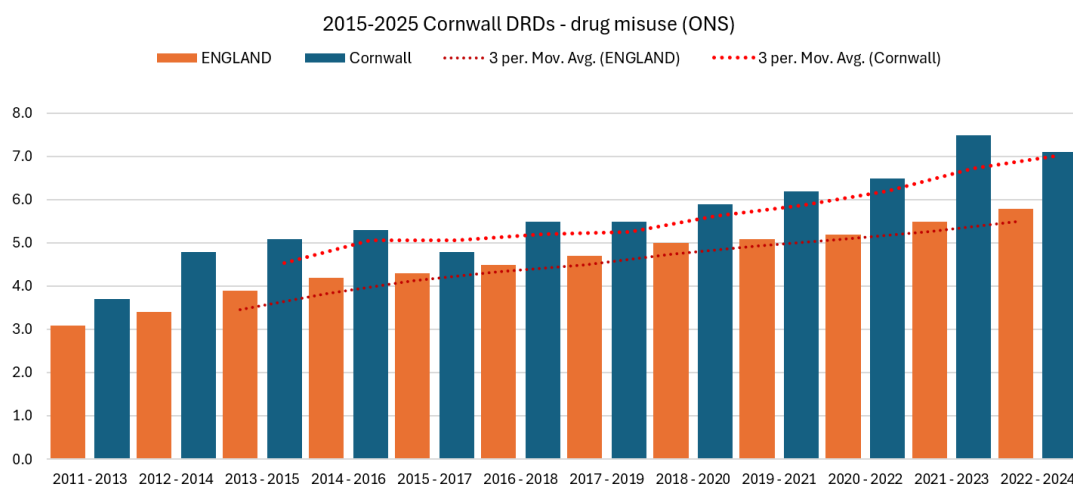
3.1 The chart below illustrates the number of drug related deaths for both men and women since 2015.



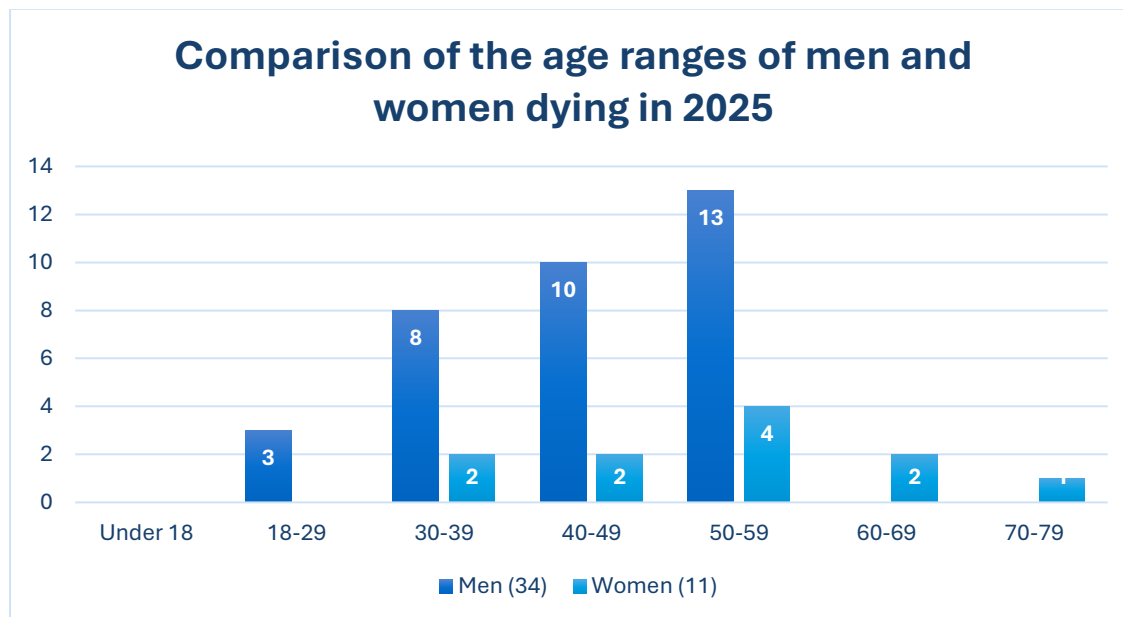
3.2 Based on a rolling three-year trend, numbers remained stable until 2019, increased year-on-year thereafter, and plateaued from 2024 at a higher level. Trends were similar for males and females, although the proportional increase was greater among females.

*The figure for men in 2024 has increased by 1 from the 2024 report due to an additional DRD which was not included in the original data.

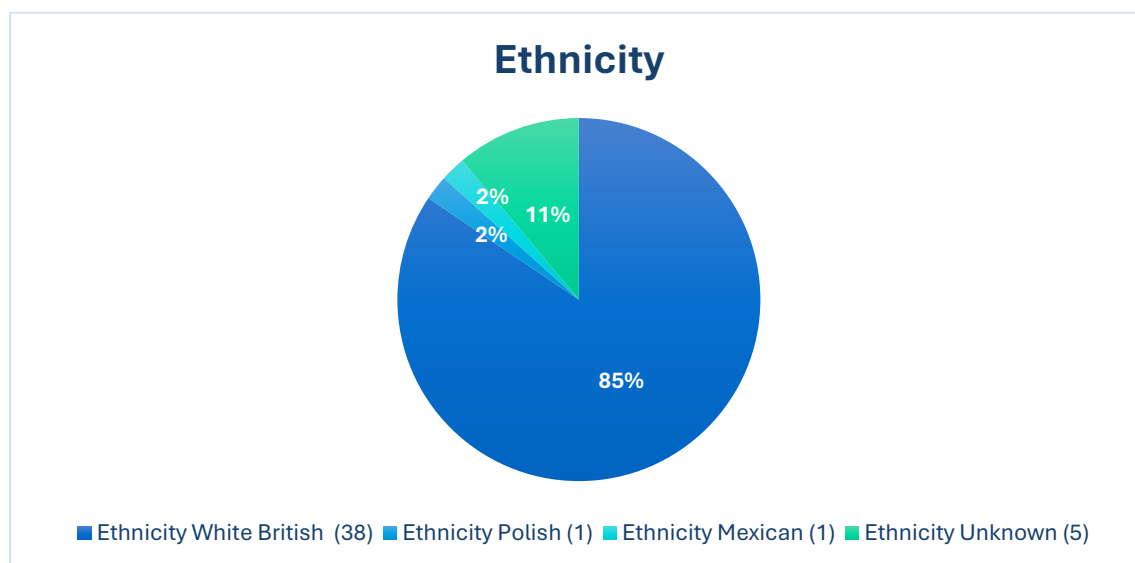
3.3 Comparison with ONS data shows Cornwall DRDs are higher than the national average for England.



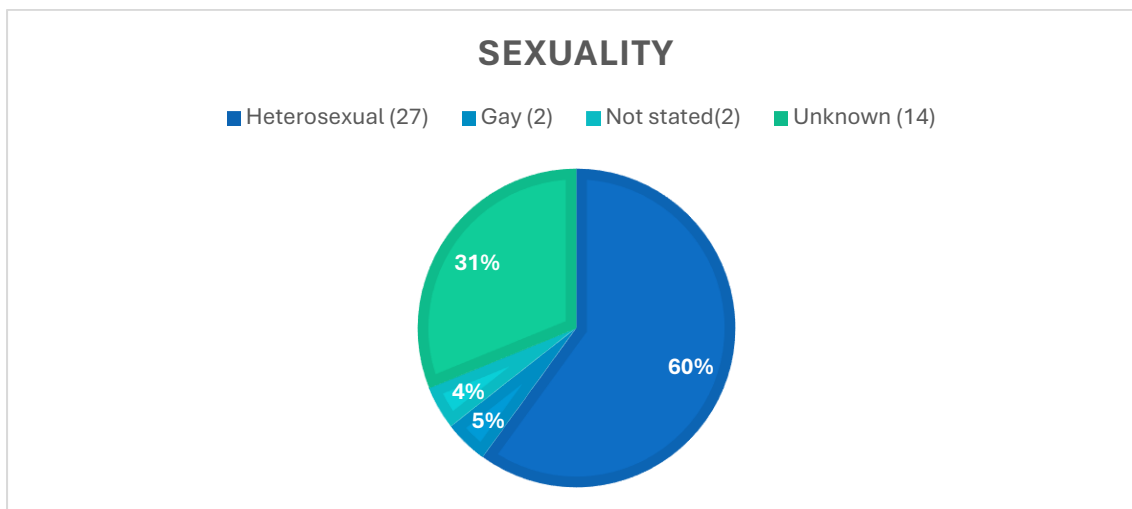
3.4 The **average age** at which individuals are dying from drug related deaths are those in the **50-59 age range**. This is true for both men and women. Historically deaths have been higher for Generation X (those born in the mid-1960s-to late 1970s).



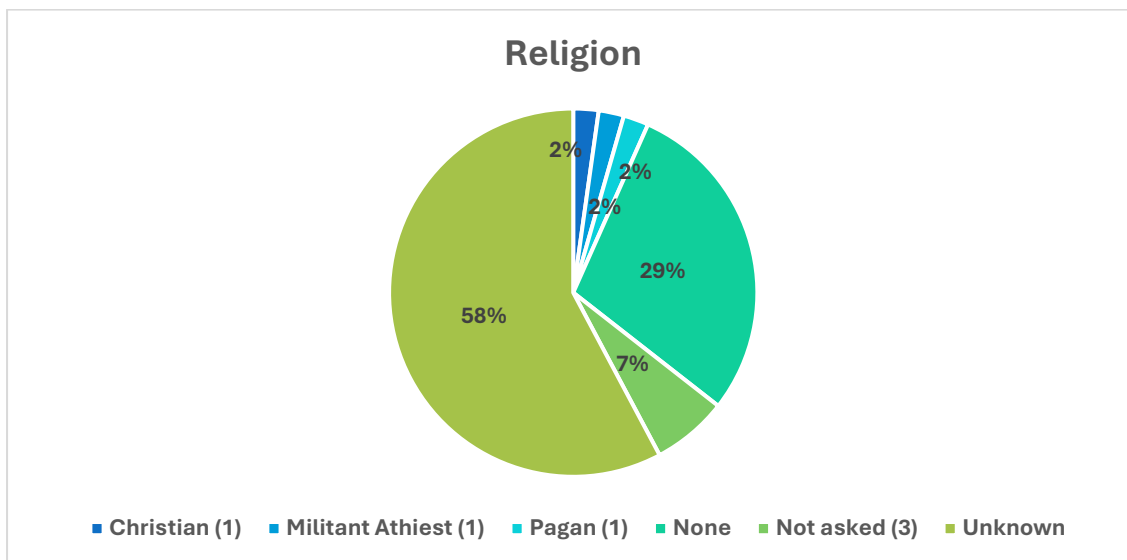
3.5 **Ethnicity**-in line with 2023 and 2024, most of those dying from drug related deaths are White British.



3.6 **Sexual Orientation** -the data is incomplete but the information we have confirms that 27 (60 %) out of 45 identified as heterosexual.



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



4. Drug Trends and toxicology results

4.1. Synthetic opioids

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

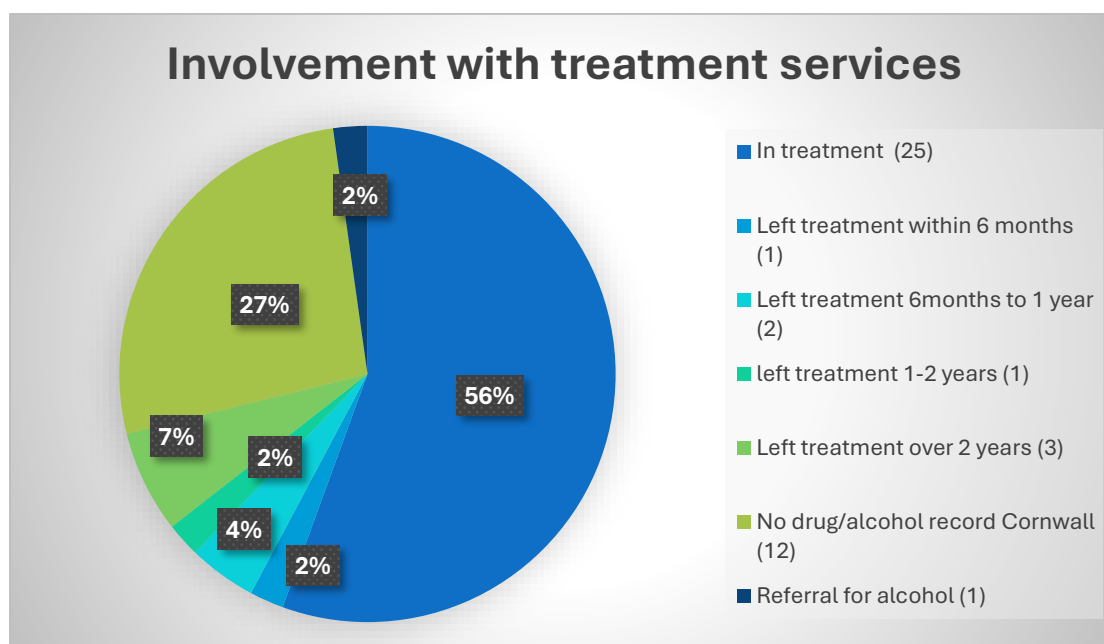
Nitazenes, technically known as 2-benzyl benzimidazole opioids, is a diverse group of synthetic opioids. Like the fentanyl analogues, many are far more toxic on a weight-for-weight basis than heroin. Even a small amount can be enough to kill, especially without immediate naloxone or medical attention.

Local authorities are required to have a Synthetic Opioid preparedness plan in place. An easy read version is available on the Safer Cornwall website:

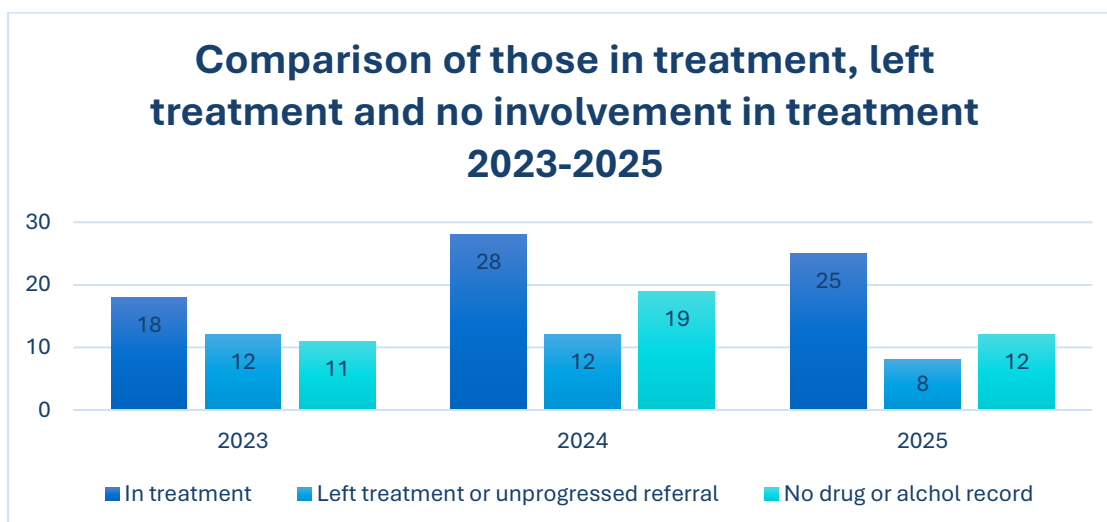
<https://safercornwall.co.uk/synthetic-opioids/> or email dat@Cornwall.gov.uk for the full version.

There were 2 deaths (both men) involving synthetic opioids in 2025 (4 in 2024, 2 in 2023). One involved the substance Isotonitazene (identified in oxycodon OP80 green tablets) and one Etonitazene. Of the two men, one was in treatment and the other was not.

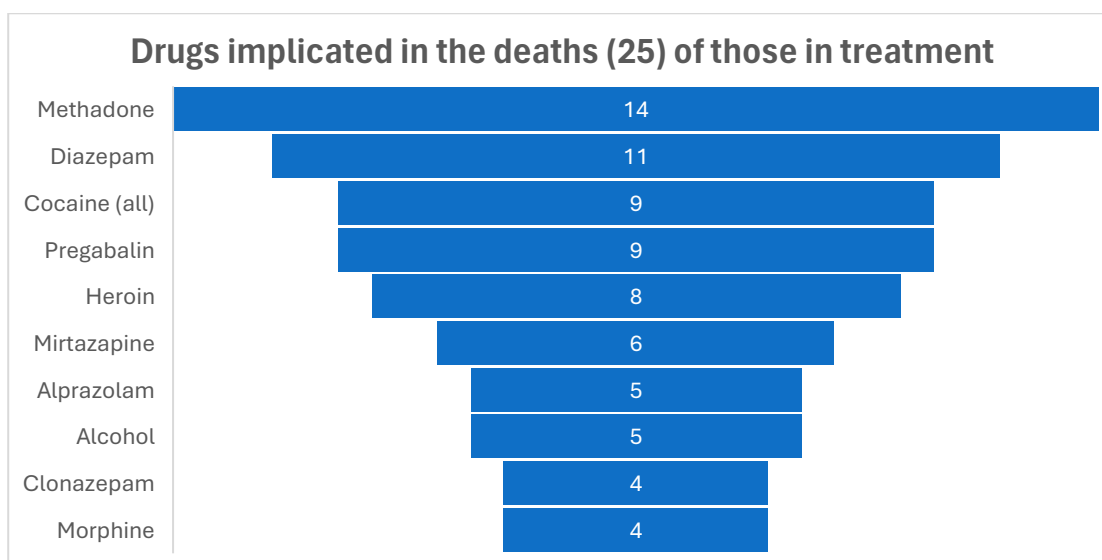
4.2 Engagement with treatment services



4.3 The chart below compares year on year trends. The proportion in treatment has steadily increased each year whilst the number leaving treatment is lower in 2025 (18%). Those with no recorded drug or alcohol treatment history accounted for over a quarter of the deaths in 2025 (27%), (32% in 2024 & 27% in 2023). This cohort represents individuals who had never engaged with treatment services, highlighting the importance of extending prevention efforts beyond those already known to services. Continued focus on harm reduction messaging, awareness raising, and improving access to support for hidden or underserved populations remains a key priority.

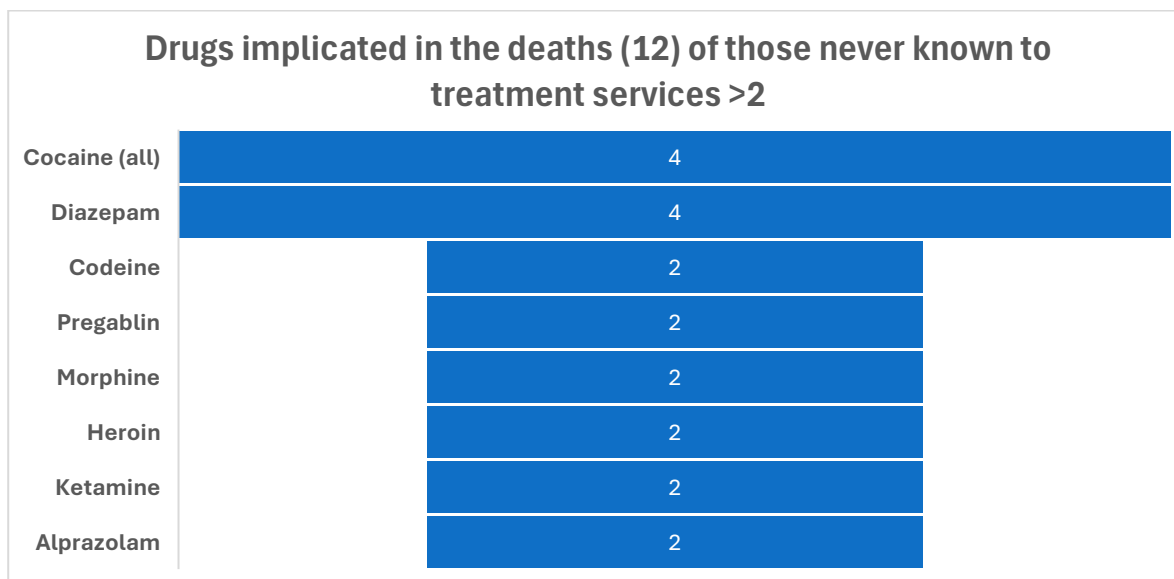


4.4 Drugs implicated in the deaths of those in treatment

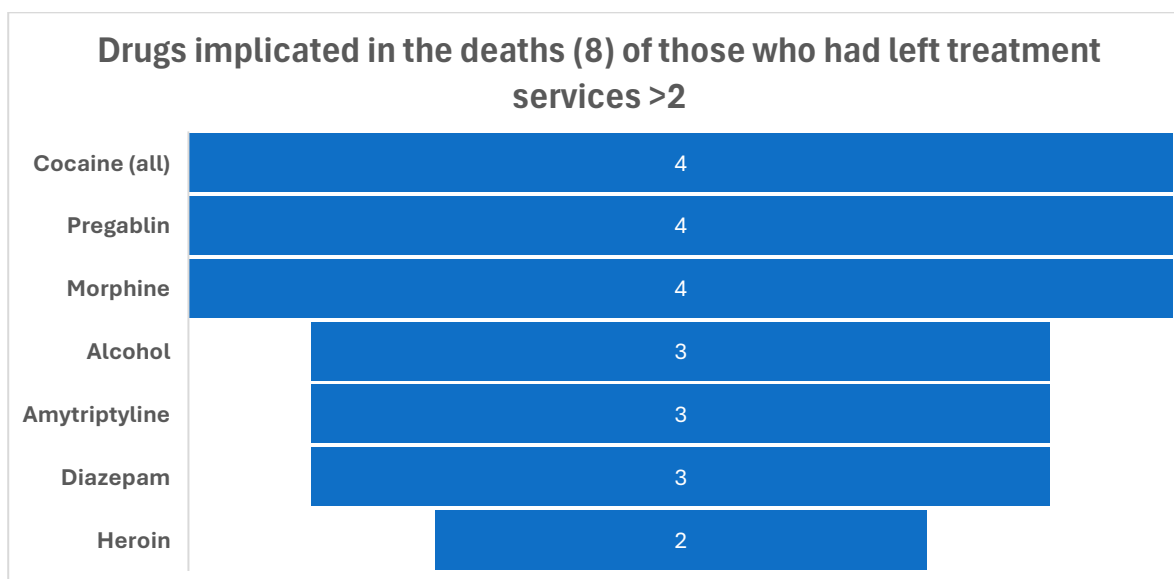


Methadone remains the most frequently identified substance among those in treatment 14 (18 in 2024). Heroin has been identified in 8 deaths of those in treatment (4 in 2024) and alprazolam (prescribed for anxiety and panic disorders) appears to be on the increase 5 (1 in 2024). [Is the UK Sleepwalking into a Pregabalin Crisis? - TalkingDrugs](#)

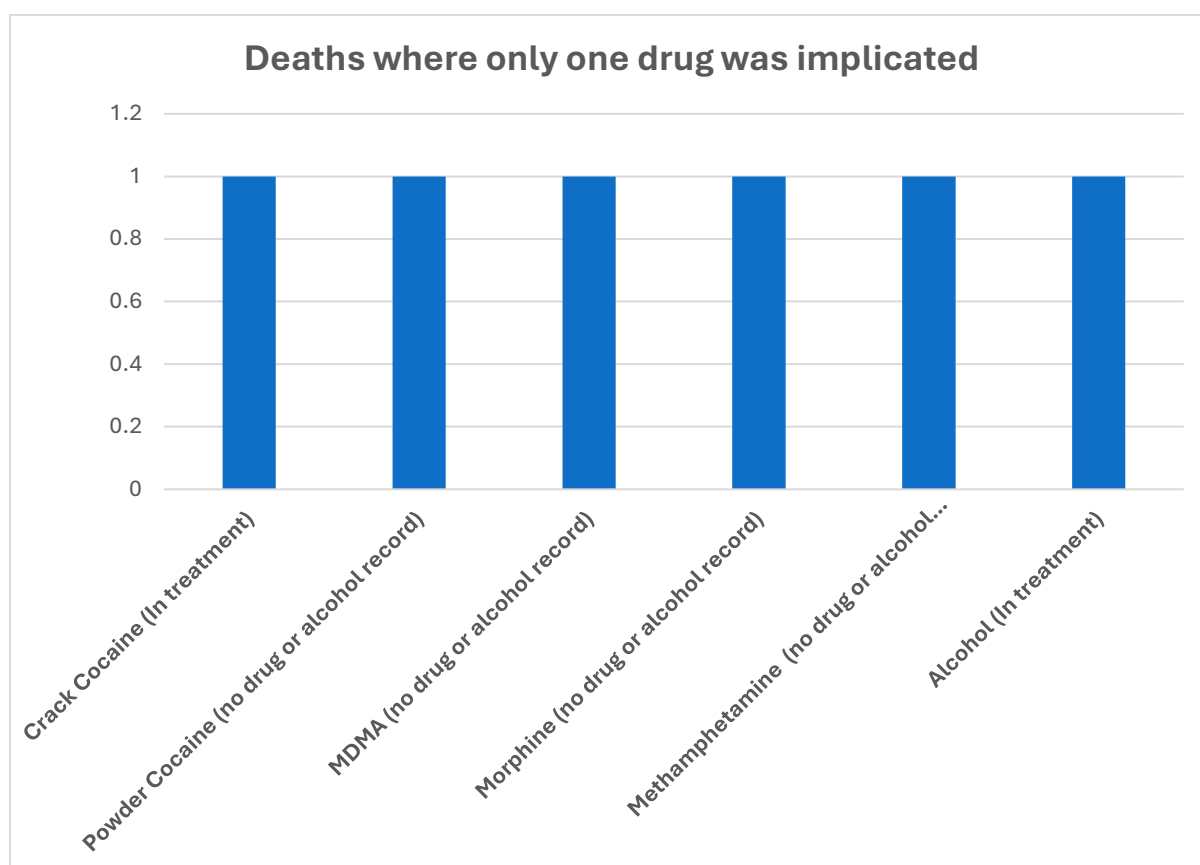
4.5 Drugs implicated in the deaths of those never known to treatment services



4.6 Drugs implicated in those that have left treatment services.



4.7 Deaths where only one drug was implicated



MDMA continues to feature in drug related deaths, particularly among young men. As an illicitly produced substance, pill strength and composition can vary significantly. Individuals who do not feel the expected effects may take additional tablets, increasing the risk of overdose and potentially fatal toxicity.

Methamphetamine use remains relatively uncommon in the UK; however, it is associated with some chemsex settings. As a potent stimulant, it can reduce inhibitions and increase risk-taking behaviours. Methamphetamine is reported to be more prevalent in countries such as Australia, where geographical factors and drug market dynamics have historically influenced patterns of stimulant use, in contrast to the UK where cocaine is more widely available.

In terms of the deaths where cocaine is implicated, one important factor to note is that the cocaine available in the UK is generally of higher purity than in previous years. Increased purity may lead individuals to consume doses that are stronger than anticipated, increasing the risk of acute toxicity, cardiovascular complications, overdose and death. This is particularly concerning for people who are unaware of the changes in potency or who combine cocaine with other substances, including alcohol and opioids. There was one death from acute alcohol intoxication.

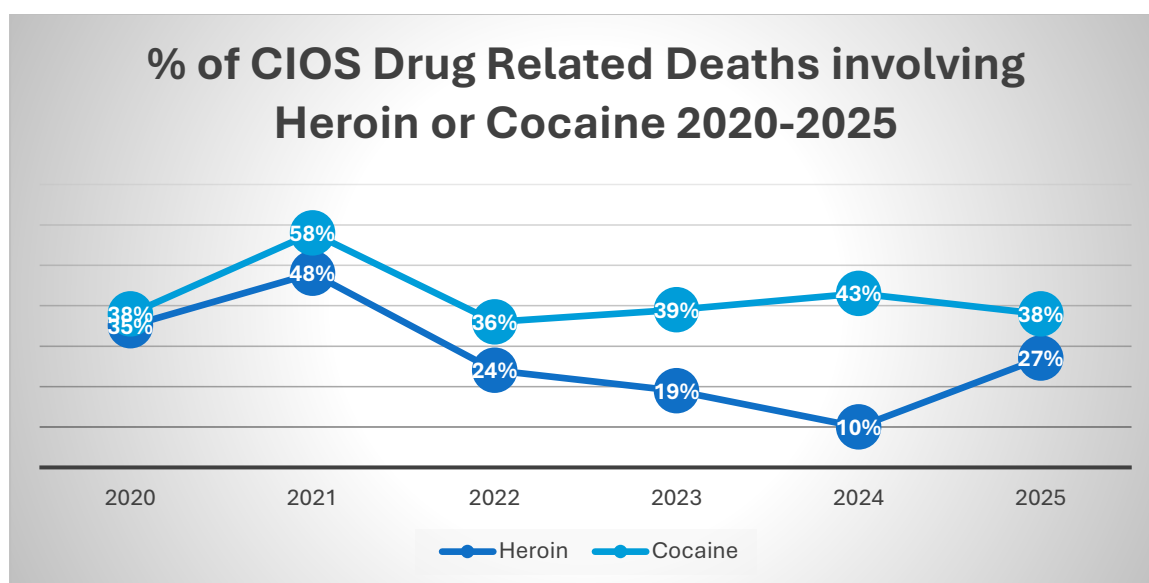
Of the deaths involving only one substance, 4 out of the 6 were not known to treatment.

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

87% of the DARDs involved between 2-12 different drugs. Alcohol was involved in 9 deaths (20%) (5 who were in treatment and 4 who were not). The charts at 4.4, 4.5 & 4.6 illustrate the wide range of drugs implicated.

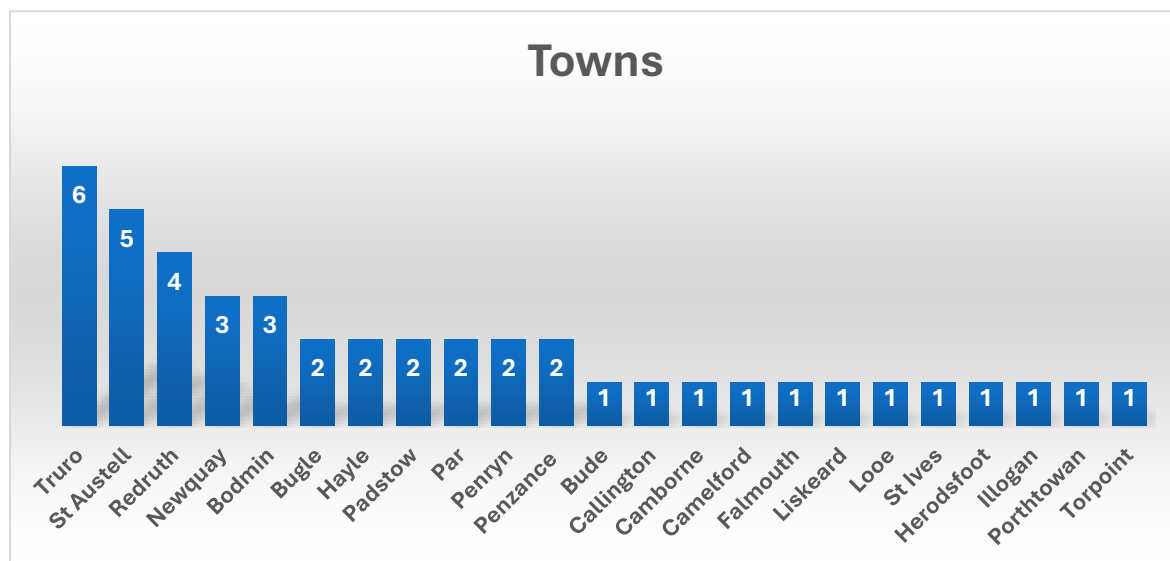
4.9 Whilst there continued to be more deaths involving cocaine*, deaths featuring heroin increased markedly to 12 deaths (27%), while deaths involving cocaine decreased slightly from 43% in 2024 to 38% in 2025 (17 deaths). Of the deaths involving cocaine, the evidence suggests seven involved powder cocaine and ten involved crack cocaine.

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

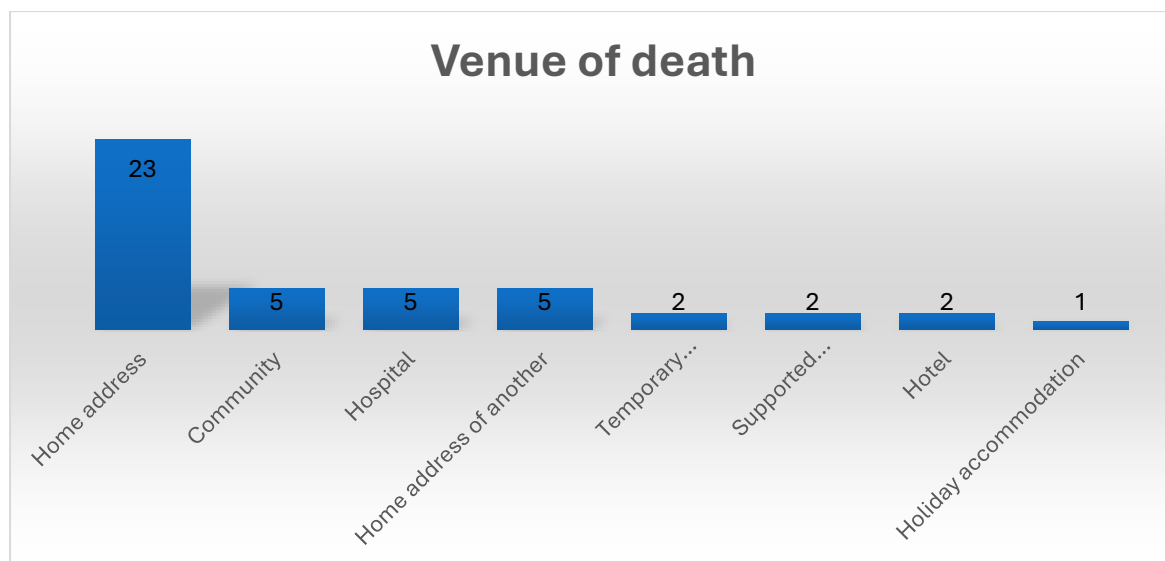


5. Circumstances of death

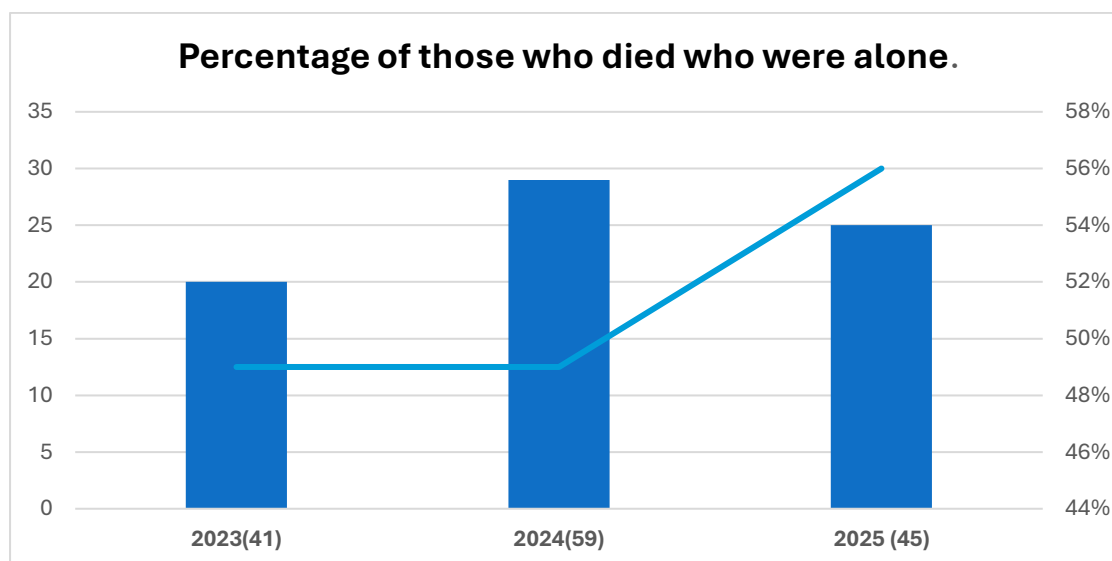
5.1 The map below illustrates the number of drug related deaths per town.



5.2 Where the deaths occurred. This presents a very similar picture to 2024.

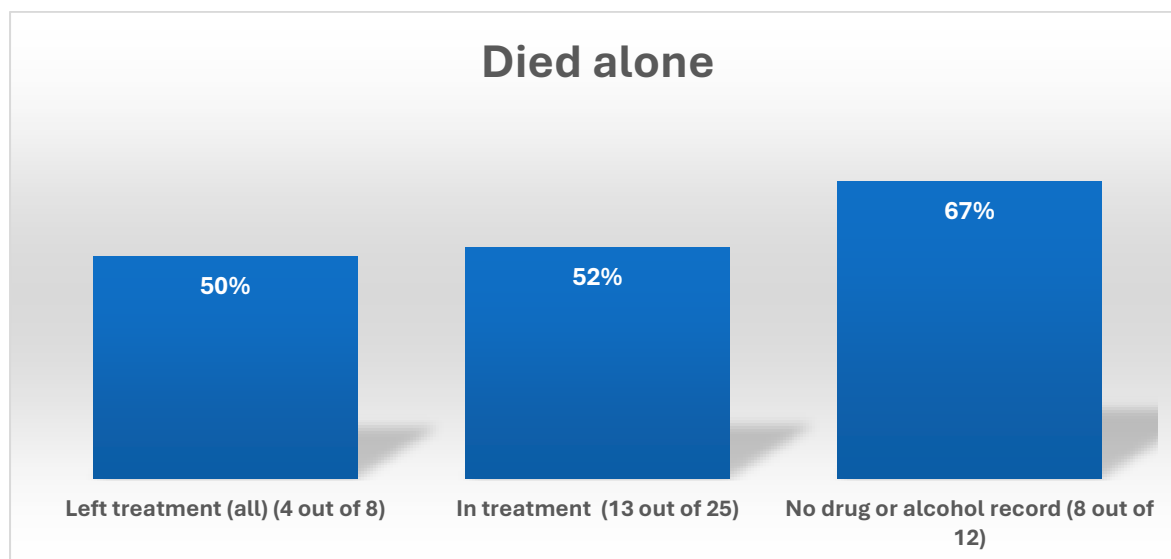


5.3 Died alone



25 out of 45 were alone when they died (56%) (49% in 2024, 49% in 2023). 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 such as With You's award winning [webchat service](#). The linked article highlights some of the broader issues that need to be tackled: [DDN April26 DDN Magazine April 2026](#).

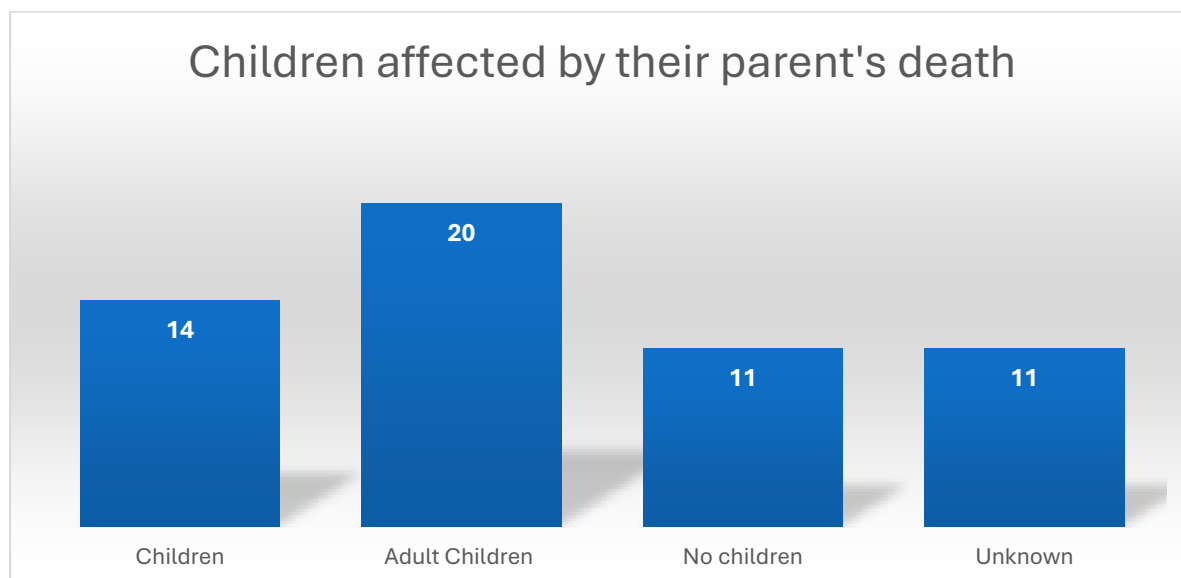
5.3.1 The chart below compares individuals who died alone by treatment status (in treatment, left treatment, or no recorded treatment). The highest proportion was observed among those with no recorded treatment history.



5.4 With Friends and Family

Where a friend or family member was present (42%), there appears to be a need for greater awareness of overdose prevention and recognition. In several cases, witnesses reported hearing the person snoring loudly but did not recognise this as a potential sign of overdose. Rather than calling emergency services, they often left the individual to sleep. In one case, the simple act of placing the person in the recovery position may have improved the outcome. [Understanding Overdose: Essential Information for Everyone - Safer Cornwall](#)

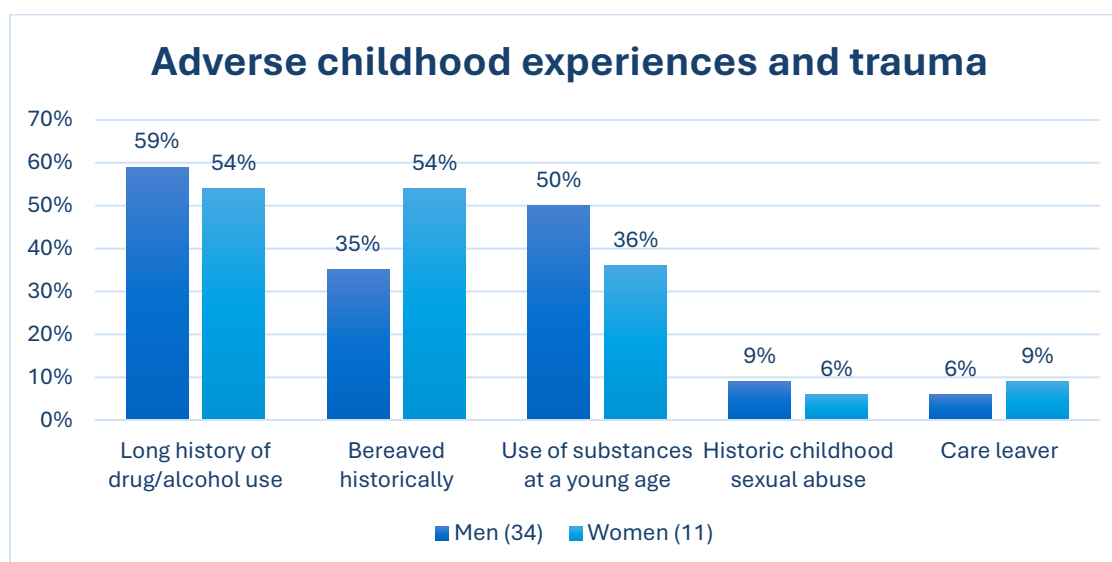
5.5 Children



For those people who died in 2025, and were parents, 14 children (under 18 years old) and approximately 20 adult children were affected. This is before we explore the range of partners and wider families affected. To ensure the 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 including [Home - Penhaligon's Friends](#). For the adult children, partners and affected others residing in Cornwall, the Cruse bereavement service is able to provide support for families and friends of those affected by a drug related death. [Home - Cruse Bereavement Support](#)

6. The Impact of Trauma.

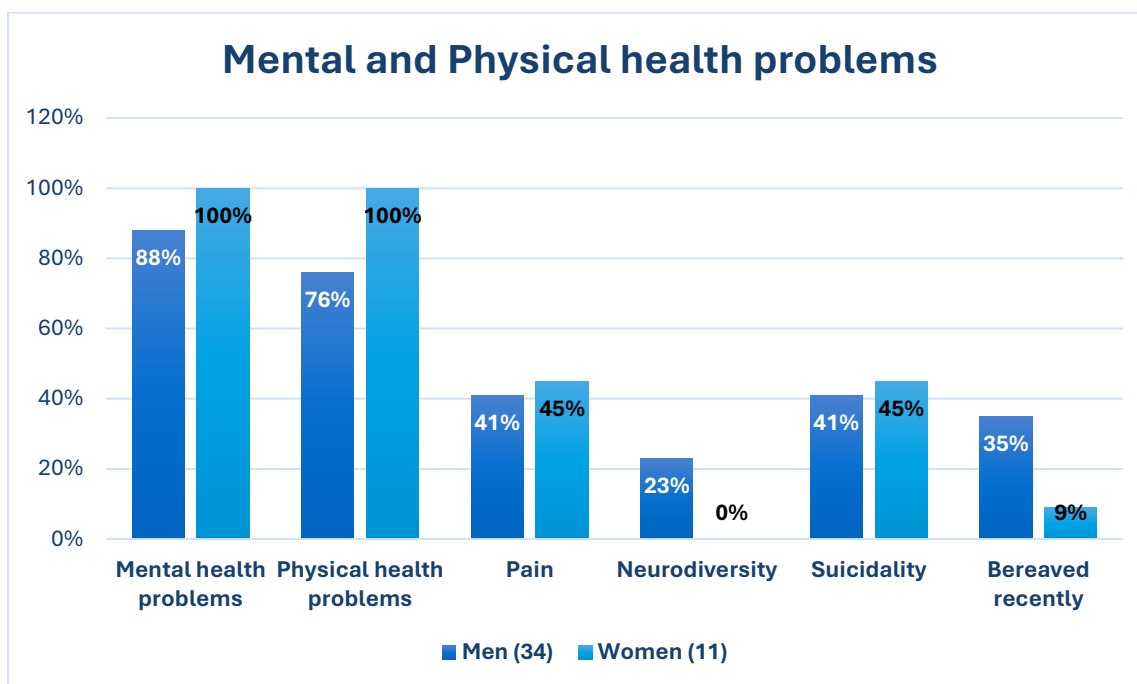
6.1 Drugs and alcohol are often used as a way of coping with, or attempting to numb, the emotional and psychological impact of adverse childhood experiences (ACEs). These experiences may include neglect, parental substance use, parental imprisonment, involvement in the care system, domestic or sexual abuse, and exposure to parental physical and/or mental health problems. ACEs can disrupt healthy emotional development, increase levels of toxic stress, and affect the brain systems involved in emotional regulation, reward, and coping. As a result, some individuals may turn to alcohol or drugs as a form of self-medication to manage anxiety, depression, trauma-related symptoms, low self-esteem, or feelings of loneliness and disconnection. Research consistently demonstrates a strong relationship, whereby individuals exposed to multiple ACEs are at significantly greater risk of developing substance use problems later in life. publichealthwales.nhs.wales/services-and-teams/policy-and-international-health-who-collaborating-centre-on-investment-for-health-well-being/publications-and-resources-bucket/adverse-childhood-experiences-and-their-impact-on-health-harming-behaviours-in-/



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](#). Three men (9%) (12% in 2024) and two women (6%) (6 % in 2024) experienced (or disclosed) childhood **sexual abuse**. Among individuals who died, a long history of drug and alcohol use was the commonly identified factor for both men (59%) and women (54%) together with early use of substances (50% & 36% respectively for men and women).

6.2 Mental and physical health problems.

Adverse Childhood Experiences (ACEs) and trauma can have lasting effects of poor physical and mental health, increasing the risk of anxiety, depression, substance use, chronic illness and poor wellbeing. Early adversity can disrupt healthy brain development and stress responses, but supportive relationships and timely interventions can help build resilience and improve outcomes.



Mental health problems are a significant factor for those dying from DARDs. 88% of men and 100% of women (79% and 87% in 2024 respectively). It is likely that improved data collection has contributed to the increase. These statistics highlight the need for our continued work on implementing the dual diagnosis approach across CIOS.

Physical health problems are another complicating factor in DARDs. 76% and 100% of women (68% and 69% respectively in 2024) experienced physical health problems. The increased risks associated with central nervous system depressants in individuals with respiratory disease, and stimulants such as cocaine in those with cardiovascular conditions, highlight comorbid physical health conditions as a significant risk factor.

Neurodiversity- 23% of men and 0% of women (24% and 25% respectively in 2024) are recorded as being neurodiverse. The lack of information for women, suggests the question is not being universally asked. 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.

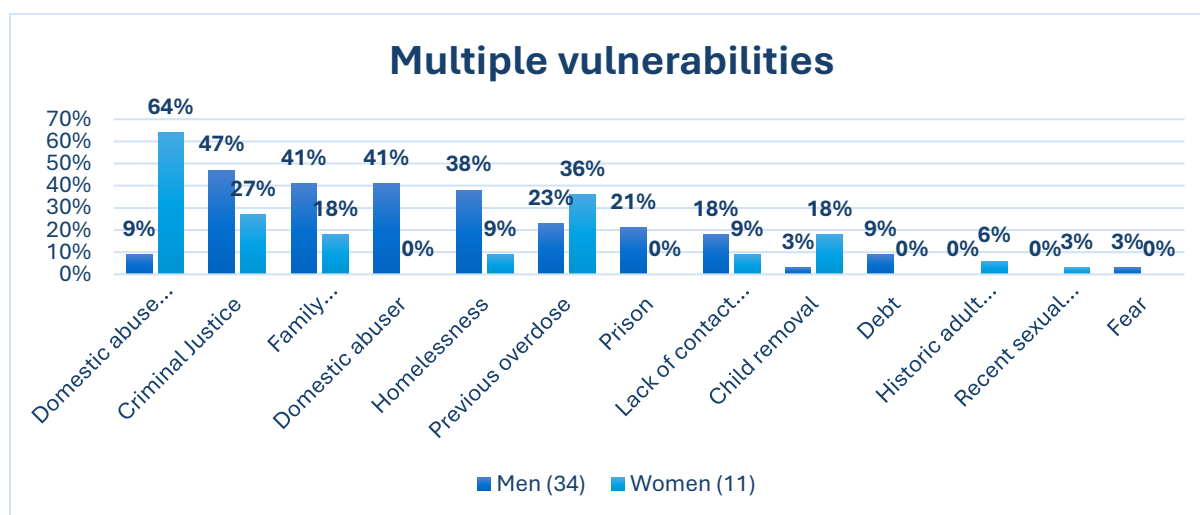
Suicidality was also prevalent across both groups.

6.3 Multiple Vulnerabilities

Adverse Childhood Experiences (ACEs) and trauma can have lasting effects on a person's physical and mental health affecting brain development, emotional wellbeing, stress responses and the ability to form healthy relationships. These impacts can continue into adulthood and contribute to a range of complex and interconnected challenges, often referred to as multiple vulnerabilities.

People affected by multiple vulnerabilities are more likely to experience poor mental and physical health, substance use, housing instability, unemployment, poverty and social exclusion. These factors can increase the risk of involvement in unhealthy or abusive relationships, both as victims and abusers of domestic abuse. They may also be more likely to become involved in the criminal justice system, publichealthwales.nhs.wales/files/aces/the-prisoner-ace-survey-infographic/, experience homelessness, family breakdown, child removal and financial difficulties. The stress,

trauma and isolation associated with these experiences can further compound existing vulnerabilities, creating cycles of disadvantage that are difficult to escape. For individuals who use drugs and/or alcohol, the combination of trauma, poor mental health, unstable housing and reduced social support can significantly increase the risk of overdose and drug-related death. [Premature mortality in people affected by co-occurring homelessness, justice involvement, opioid dependence, and psychosis: a retrospective cohort study using linked administrative data - The Lancet Public Health](#). A trauma informed approach recognises these links and seeks to address the underlying cause of vulnerability while building resilience, recovery and protective factors.



For the second year of recording men and women separately, we see that **domestic abuse** is the differentiating factor between men and women. 9 (64%) (62% in 2024) of the women are domestic abuse victims with 2 (6%) (44% in 2024) being high risk* victims of domestic abuse. One of the women was heard at Marac on 9 occasions. Three (9%) (5% in 2024) of the men were victims of domestic abuse but 14 (41%) (27% in 2024) of them were the abuser with 2 (6%) (12% in 2024) 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.

No men and 2 women (6%) (9% in 2024) experienced (or disclosed) historic adult sexual abuse, and 1 woman (3%) (6% in 2024) disclosed recent sexual abuse.

Men were more likely to have experienced criminal justice involvement, homelessness, recent bereavement and family relationship breakdown. Several deaths involved men who had been excluded from the family home following domestic abuse incidents, often resulting in a deterioration in their mental health, increased social isolation and a subsequent decline in their overall wellbeing.

Women were more likely to have experienced historical bereavement, previous overdose and child removal. Although child removal was identified in only one female death during the year, it remains a significant adverse life event with the potential to contribute to trauma and vulnerability.

These findings demonstrate the complex and cumulative relationship between adverse childhood experiences (ACEs), trauma, poor mental and physical health, substance use, social exclusion, and disrupted relationships. Exposure to ACEs can negatively affect mental health across the life course, increasing susceptibility to substance use, social disadvantage, and reduced engagement with support networks. The interaction of these factors reinforces the need for trauma-informed and gender-responsive prevention and

support services, as individuals experiencing multiple and overlapping vulnerabilities are at a substantially increased risk of drug and/or alcohol related death.

A number of deaths were concluded at inquest to be drug related deaths. However, they are not included in this report as they do not meet the inclusion criteria.

One case involved fluoxetine and propranolol toxicity, but these substances are not controlled drugs under the Misuse of Drugs Act 1971. Two cases involved alcohol and sertraline and one involved paracetamol toxicity (which may ultimately be concluded as suicide).

Two further cases were concluded as natural causes with death contributed to by chronic cocaine use and mixed drug toxicity respectively. These deaths have not been included in the dataset.

7. Priorities for Prevention 2026-2027

7.1 Trauma Recovery, Sustained Engagement and Responding to Emerging Risk Improve Trauma Recovery and Trauma-Informed Support

The DRD Review Group recommends strengthening trauma-informed practice across the local system, recognising the significant role that trauma and adverse childhood experiences play in problematic substance use, mental ill health and vulnerability to drug-related death. Priorities include improving access to trauma-specific interventions, expanding peer support, implementing trauma-informed workforce development, strengthening post-overdose and bereavement support, and ensuring that people with lived experience can access coordinated pathways that address both substance use and underlying trauma. This will support earlier intervention, improve engagement with services and contribute to reducing the risk of future drug-related deaths.

- 7.2** To strengthen trauma recovery as part of our Drug-Related Death (DRD) prevention work, the focus should move beyond trauma awareness and towards ensuring people can access effective trauma-informed support and recovery pathways. Evidence shows that trauma is highly prevalent among people who develop problematic drug use, and trauma-informed approaches can improve engagement, trust, safety and recovery outcomes.

Recommendations:

7.2.1: Improve Identification of Trauma

Introduce routine enquiry and assessment for trauma where appropriate, ensuring individuals are offered support pathways that address both substance use and underlying trauma.

7.2.2: Embed Trauma-Informed and Trauma-responsive Practice Across All Services

Ensure that all services working with people at risk of drug-related death adopt a trauma-informed approach, including substance use services, mental health providers, housing, criminal justice and emergency departments. This means recognising the impact of trauma, routine enquiry, responding compassionately, and actively avoiding re-traumatisation.

7.2.3: Improve Access to Trauma-Specific Interventions

Increase availability of evidence-based psychological therapies and specialist trauma services for people affected by adverse childhood experiences, abuse, violence, bereavement and other traumatic events. Long waiting times can undermine recovery and increase vulnerability.

7.2.4: Develop Peer-Led Trauma Recovery Support

Expand peer support networks and lived experience recovery roles. People with lived experience can help build trust, reduce stigma and support engagement with treatment and recovery services. Peer support is a recognised component of trauma-informed care.

7.2.5: Strengthen Post-Overdose and Bereavement Support

Provide timely trauma-informed outreach following a non-fatal overdose, and offer support to families, friends and communities affected by drug-related deaths. Trauma following overdose or bereavement can increase the risk of future substance use and poor mental health outcomes.

7.2.6: Train the Workforce

Deliver trauma-informed practice training across all agencies involved in DRD prevention, ensuring staff understand the links between trauma, substance use, mental health, self-harm and risk-taking behaviours.

7.2.7: Focus on Prevention and Early Intervention

Work with children, young people and families to address adverse childhood experiences (ACEs), family adversity and other risk factors that can contribute to both trauma and future substance use.

7.2.8: Recovery should be viewed as an ongoing process, with proactive follow-up and relapse prevention measures for individuals who disengage from services after reporting recovery, especially where there is known underlying trauma, including recognition of potential substitution between substances, such as transitioning from problematic drug use to alcohol use, or vice versa.

7.2.9: Services should recognise reduced engagement, non-attendance or disengagement from support as potential indicators of escalating risk rather than a lack of motivation to **engage. This is particularly important for individuals experiencing domestic abuse, where** non-attendance may reflect the impact of trauma, coercive control, ongoing safety concerns, or other barriers to accessing support. Cases should not be closed solely on the basis of non-attendance where significant vulnerabilities remain.

7.2.10: Assessment, treatment and review processes should actively explore changing patterns of substance use throughout the individual's treatment journey. Individuals engaged with services for alcohol dependency should not be assumed to be at lower risk of drug related harm. Services should routinely assess for polysubstance use, emerging drug use, underreported substance use and transitions between alcohol, prescribed medications and illicit drugs.

7.2.11: Regular opportunities for open, non-judgemental discussions about substance use should be embedded within care planning and review processes to support the early identification of changing risks. Particular consideration should be given to individuals whose visibility to services decreases following housing stabilisation, recovery, or changes in statutory involvement, as perceived stability may mask ongoing high clinical and psychosocial risks, including trauma, chronic pain, polypharmacy, neurodevelopmental conditions, and physical health problems.

7.2.12: Ensure that treatment and recovery pathways include ongoing assessment and support for underlying trauma, recognising that unresolved trauma, changing patterns of substance use, and reduced engagement with services may indicate increasing vulnerability and risk.

7.3 Prioritising Physical Health to Reduce Drug-Related Deaths

Recommendations:

7.3.1: Strengthen Physical Health Assessment within Risk Management

Ensure that physical health conditions are routinely assessed and incorporated into risk assessments, care planning, and safety planning for individuals who use drugs and/or alcohol. Physical health factors should be recognised as key contributors to vulnerability and drug-related harm, with assessment processes considering the impact of co-existing conditions on drug toxicity, overdose risk, medication effectiveness, and clinical presentation.

7.3.2: Improve Identification and Monitoring of High-Risk Physical Health Conditions

Develop a systematic approach to identifying and monitoring physical health conditions associated with an increased risk of drug-related death. Particular attention should be given to liver disease, respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease, thyroid dysfunction, and other conditions that may increase susceptibility to overdose, respiratory depression, or adverse drug interactions.

7.3.3: Promote Integrated Physical and Mental Health Care for Women with Multiple Vulnerabilities

Ensure that women experiencing co-occurring substance use and domestic abuse receive holistic assessments that include regular monitoring of physical health. Services should work collaboratively to ensure that physical health deterioration is identified and addressed promptly and is not overshadowed by safeguarding, housing, or social care concerns.

7.3.4: Improve Recognition and Support for Acquired Brain Injury and Head Trauma

Undertake a multi-agency review of the prevalence and impact of head injuries and acquired brain injury among people experiencing drug and/or alcohol dependency, homelessness, and multiple disadvantage. The review should inform the development of a clear pathway for identification, assessment, treatment, and ongoing support, recognising the potential contribution of cognitive impairment to substance-related harm and mortality.

7.3.5: Reduce Barriers to Accessing Physical Healthcare

Work across health, substance use, housing, and emergency care services to identify and address barriers that prevent people who use drugs and/or alcohol from accessing timely physical healthcare. This should include reviewing factors such as self-discharge

from hospital, missed appointments, stigma, and potential inequalities in healthcare responses to ensure equitable access to assessment, treatment, and follow-up care.

7.3.6: Strengthen Multidisciplinary Working Around Complex Physical Health Needs

Promote multidisciplinary case review and coordinated care for individuals with complex physical health conditions and substance use needs. This should include effective information sharing between primary care, acute hospitals, mental health services, drug and alcohol services, and other relevant partners to ensure risks are understood and managed collectively.

Expected Outcome:

A greater focus on physical health within substance use services and multi-agency risk management arrangements will improve the identification of individuals at heightened risk, support earlier intervention, reduce preventable complications, and contribute to a reduction in drug-related deaths.

7.4 Improving Accessibility and Inclusion in Treatment Services

Recommendations

7.4.1: Deliver Tailored and Inclusive Treatment Pathways

Treatment providers should continue to develop and deliver tailored, person-centred support for women, LGBTQ+ individuals, and neurodivergent people. Service models should recognise that traditional approaches, including group-based interventions, may not be appropriate or effective for everyone, and should offer flexible alternatives that respond to individual needs, preferences, and experiences.

7.4.2: Strengthen Workforce Competence in Equality, Diversity and Inclusion

Ensure all staff are trained and supported to use open, inclusive and non-judgemental approaches when engaging with people accessing treatment. This should include avoiding assumptions, confidently discussing identity and protected characteristics, and accurately recording relevant information to support comprehensive assessment, effective care planning, and improved service outcomes.

7.4.3: Reduce Barriers to Engagement for Underserved Groups

Services should routinely consider how factors such as gender, sexual orientation, gender identity, neurodiversity, disability, trauma, culture, and lived experience may affect access to treatment, engagement, and recovery outcomes. Providers should implement flexible approaches that reduce barriers, improve accessibility, and promote sustained engagement in treatment and recovery support.

7.4.4: Monitor Equity of Access and Outcomes

Regularly review treatment access, retention, completion rates, and outcomes across different population groups to identify and address inequalities. Findings should be used to inform service improvements and ensure that individuals from marginalised or underrepresented groups receive equitable opportunities to engage with treatment and recovery services.

Expected Outcome:

More inclusive and accessible treatment services will improve engagement, retention, and recovery outcomes for individuals who may experience barriers within traditional service models, helping to reduce inequalities and the risk of drug-related deaths among vulnerable and underserved populations.

7.5 Preventing Drug Related Death Through Harm Reduction, Overdose Awareness and Emergency Response.

Recommendations:

7.5.1: Strengthen Identification of People at High Risk of Overdose

Services should strengthen efforts to identify and proactively support individuals at increased risk of overdose and drug-related death. Given that 57% of individuals who died from a drug-related death in 2025 were alone at the time of death, risk assessments, care planning, and harm reduction interventions should routinely explore patterns of solitary substance use and incorporate actions to reduce associated risks.

7.5.2 Increased awareness and monitoring of prescribed polydrug use, recognising that the synergistic effects of multiple medications are frequently identified as a contributing factor in drug-related deaths. Services should ensure regular medication reviews and robust prescribing oversight to minimise preventable risk.

7.5.3: Expand Access to Naloxone and Overdose Prevention Technologies Increase the availability, accessibility, and promotion of naloxone across treatment services, healthcare settings, housing providers, criminal justice services, and community organisations. Opportunities to utilise welfare check-in arrangements, webchat, overdose alert technologies, and other innovative approaches to support people who use substances alone should be explored and implemented where appropriate.

7.5.4: Reduce Social Isolation and Improve Connection to Support Ensure that individuals are aware of and supported to access local harm reduction, recovery, and peer support services. Particular attention should be given to people who are socially isolated, recently disengaged from services, living alone, or experiencing significant life events or periods of instability that may increase the likelihood of using substances alone and the risk of fatal overdose.

7.5.5: Enhance Overdose Awareness Across Communities and Services Strengthen overdose awareness and harm reduction education across treatment services, healthcare providers, community organisations, families, carers, and wider communities. Training and information should improve understanding of overdose risk factors, signs of overdose, and the importance of early intervention.

7.5.6: Improve Recognition of Medical Emergencies and Emergency Responses Overdose prevention training should emphasise that heavy snoring, gurgling, choking sounds, or unusual breathing may be signs of a life-threatening overdose and should never be assumed to indicate that someone is simply "sleeping it off". Individuals should

be encouraged to call emergency services whenever there is uncertainty about a person's condition and be supported to place the person in the recovery position while awaiting medical assistance.

7.5.7: Extend Harm Reduction Messaging Beyond Opioid Use

Ensure overdose prevention and harm reduction education is delivered to wider substance using populations and not solely focused on opioid use. This should reflect the increasing risks associated with polysubstance use, synthetic opioids, and contamination of non-opioid drug supplies, which can significantly increase the likelihood of overdose and death.

7.5.8: Equip Families, Carers and Communities to Respond to Overdose

Information campaigns and training programmes should ensure that service users, families, carers, peers, and community members can recognise the signs of overdose, respond confidently and appropriately in an emergency, and access harm reduction resources, including naloxone where appropriate. A whole-system approach to overdose prevention will increase the likelihood of timely intervention and save lives.

Expected Outcome:

Improved access to harm reduction interventions, increased overdose awareness, wider naloxone distribution, stronger emergency responses, and targeted support for people who use substances alone will reduce preventable drug-related deaths and strengthen community capacity to respond effectively to overdose incidents.

7.6 Strengthening the Multi-Agency Response to Exploitation and Cuckooing

Recommendations:

7.6.1: Develop a County-Wide Multi-Agency Framework for Identifying and Responding to Exploitation

Develop and implement a robust, county-wide, multi-agency approach to identifying and responding to exploitation affecting people who use drugs and/or alcohol. This should include cuckooing, criminal exploitation, coercion, control, and situations where individuals are being exploited by friends, associates, or others within their own homes. The framework should include clear referral, assessment, and support pathways for individuals who do not meet formal safeguarding or police thresholds but remain vulnerable to significant harm.

7.6.2: Strengthen Support for Individuals Unable or Unwilling to Report Exploitation

Services should establish alternative mechanisms for identifying and responding to exploitation where individuals are unwilling or unable to report concerns to the police due to fear, intimidation, coercion, dependency, or potential repercussions. Responses should focus on building trust, reducing harm, and increasing safety while respecting the individual's wishes and circumstances.

7.6.3: Improve Recognition of Repeated Patterns of Exploitation

All partner agencies should be supported to recognise and respond to recurring indicators of exploitation, including repeated reports of unwanted visitors, financial exploitation, drug dealing from a person's home, intimidation, violence, and frequent episodes of crisis or homelessness. Services should maintain therapeutic relationships while ensuring that escalating risks are identified, recorded, and acted upon through coordinated multi-agency interventions.

7.6.4: Utilise the Multi-Agency "Team Around Me" Approach

Implement a structured multi-agency case coordination model, such as a "My Team Around Me" approach, for individuals at high risk of exploitation. This should enable coordinated risk management, information sharing, safeguarding activity, and support planning across substance use services, housing providers, social care, healthcare, mental health services, community safety partnerships, and law enforcement agencies.

7.6.5: Develop a Dedicated Pathway for Adults Experiencing Cuckooing and Home-Based Exploitation

Consider the development of a dedicated pathway, aligned to established domestic abuse approaches, for individuals whose homes are being occupied, controlled, or used by others against their wishes. The pathway should provide consistent assessment of risk, coordinated multi-agency support, safety planning, advocacy, and access to appropriate housing and safeguarding interventions.

7.6.6: Recognise Exploitation as a Risk Factor for Drug-Related Deaths

Ensure that exploitation and cuckooing are routinely considered during risk assessments, safeguarding discussions, and drug-related death prevention activity. Where exploitation is identified, services should recognise the increased risks associated with violence, overdose, homelessness, mental ill health, treatment disengagement, and social isolation, and implement enhanced support accordingly.

Expected Outcome:

A coordinated and proactive multi-agency response will improve the identification of exploitation, strengthen safeguarding arrangements, reduce vulnerability to harm, and provide earlier intervention for individuals at heightened risk. By addressing exploitation as a contributing factor to substance-related harm, the system can better protect vulnerable adults and help prevent future drug-related deaths.

7.7 Recognising Housing Instability Following Domestic Abuse as a Risk Factor for Drug-Related Death

Recommendations:

7.7.1: Recognise Housing Instability Following Domestic Abuse as a Significant Risk Factor

Partners should recognise homelessness, housing instability, and exclusion from the family home following domestic abuse as significant risk factors for deteriorating mental

health, substance-related harm, social isolation, and drug-related death. This should be reflected within local risk assessment processes, pathways, and strategic planning.

7.7.2: Strengthen Multi-Agency Responses Through the DAT/DASV Protocol

The DAT/DASV Protocol should include clear arrangements for identifying and responding to individuals whose housing circumstances have changed as a result of domestic abuse. This should ensure that risks associated with homelessness, sofa-surfing, temporary accommodation, social isolation, disengagement from services, and escalating substance use are recognised and addressed through coordinated multi-agency support.

7.7.3: Identify and Respond to Deterioration Following Loss of Accommodation

Services should be alert to the increased vulnerability of individuals who experience a loss of stable accommodation following domestic abuse. The Drug-Related Death Review Panel identified a recurring pattern whereby individuals with a history of trauma who were required to leave the family home following the perpetration of domestic abuse subsequently experienced a decline in their mental health, physical wellbeing, social support networks, and engagement with services. Early intervention should be provided where indicators of deterioration are identified.

7.7.4: Ensure Coordinated, Trauma-Informed Support for All Individuals Affected by Domestic Abuse

Services should ensure that individuals affected by domestic abuse, including both victims and those responsible for abusive behaviours, have access to coordinated, trauma-informed support that addresses immediate housing needs alongside wider health, mental health, substance use, safeguarding, and social support requirements. Support should be proportionate to identified risks and aimed at reducing vulnerability, preventing crisis, and improving engagement with services.

7.7.5: Integrate Housing Risk into Drug-Related Death Prevention Activity

Housing instability, homelessness, and accommodation-related vulnerabilities should be routinely considered within drug-related death prevention initiatives, risk assessments, and multi-agency case discussions. Where housing-related risks are identified, agencies should work collaboratively to prevent escalation and provide timely access to appropriate accommodation and support services.

Expected Outcome:

Earlier identification of housing-related vulnerability following domestic abuse, combined with coordinated multi-agency intervention, will reduce social isolation, improve engagement with support services, strengthen protective factors, and help prevent drug-related deaths among individuals experiencing significant life disruption and trauma.

Appendix A

Drug and Alcohol related death 1

- 27-year-old man who was discovered unresponsive by a social worker in a friend's hotel room.
- Cause of death: 1a) Acute Opiate and Alcohol Toxicity 11 Chronic Alcohol Related Liver Disease.
- He was in treatment for his alcohol use only. He reported that his drinking became problematic during the COVID lockdown.
- He disclosed childhood bullying and having experienced a same-sex abusive relationship.
- He had some physical health challenges.
- He was diagnosed as autistic and expressed suicide ideation on several occasions with many admissions to Longreach House. He was not under secondary mental health services at the time of death, despite repeated contact with liaison, safeguarding, and crisis pathways. This highlights the challenge of continuity and thresholds for care.
- He wished to access detox but felt the group work was a barrier for him. Short emergency department stays with detox medication were not equivalent to structured inpatient detox, which may have led to misunderstandings about the level of support he received.
- Intersection of autism, alcohol use, trauma (including alleged assaults), sexuality, and isolation created a multi-layered vulnerability. His queer identity and autism diagnosis may have made mainstream group therapies feel inaccessible, underlining the importance of tailored services.
- Safeguarding: Multiple referrals noted, but follow-up sometimes unclear or fragmented, especially around domestic abuse disclosures.
- His father and grandmother died in the years prior to his death.

Learning and actions

- This death highlights the need to improve accessibility and inclusion in Treatment Services. Service models should recognise that traditional approaches, including group-based interventions, may not be appropriate or effective for everyone, and should offer flexible alternatives that respond to individual needs, preferences, and experiences.
- Assessment, treatment and review processes should actively explore changing patterns of substance use throughout the individual's treatment journey. Individuals engaged with services for alcohol dependency should not be assumed to be at lower risk of drug related harm. Services should routinely assess for polysubstance use, emerging drug use, underreported substance use and transitions between alcohol, prescribed medications and illicit drugs.
- To strengthen trauma recovery as part of our Drug-Related Death (DRD) prevention work, the focus should move beyond trauma awareness and towards ensuring people can access effective trauma-informed support and recovery pathways. Evidence shows that trauma is highly prevalent among people who use drugs, and trauma-informed approaches can improve engagement, trust, safety and recovery outcomes.

Drug related death 2

- 75-year-old woman who was discovered unresponsive by her husband.
- Cause of death: 1 a) Morphine toxicity

- She had hypertension, Type 2 diabetes, depression, arthritis and osteoarthritis. In March 2024 was open to the memory assessment team.
- On the date of her death, she was unwell in bed, and her carer had been in to assist and had given her paracetamol to manage her pain. Her husband checked on her throughout the day and gave her a teaspoon of his prescribed oramorph.
- The bottle was left within her reach, and it appears she drank more of it throughout the day.
- Later that evening, he discovered her unresponsive and called for an ambulance.

Learning and actions

- Awareness raising on the risk associated with prescribed opiates and in particular, the dangers of taking medication prescribed for someone else.
- Highlights the importance of safe storage of opiate medication particularly when individuals have impaired memory issues and/or are experiencing severe pain as both of these may drive unintentional overuse.

Drug related death 3

- 54-year-old man who was discovered unresponsive in bed by paramedics. An unknown individual had raised the alarm by calling 999.
- Cause of death: 1a) Myocardial fibrosis 1b) Cocaine toxicity.
- He had experienced significant childhood trauma including sexual abuse whilst at boarding school which was never adequately addressed. Pathways for historic sexual abuse survivors, particularly men, remain unclear and underdeveloped.
- He began using drugs from a very early age and hence had been using substances for a long time.
- He was estranged from his children.
- He was open to treatment at the time of his death.
- He experienced homelessness and at the time of his death, his living conditions were described as very poor.
- In terms of physical health, he suffered from ulcerated wounds caused by his IV injecting with abscesses and infections dating back years, showing chronic neglect of physical health needs.
- He felt he was on the ADHD spectrum and was dyslexic and felt amphetamines helped him self-medicate. He also suffered from depression and panic attacks and feelings of suicide. However, there were no referrals to secondary mental health services. His neurodivergence appeared to complicate his coping strategies and increase his vulnerability.

Learning and actions

- **Improve Access to Trauma-Specific Interventions-** Increase availability of evidence-based psychological therapies and specialist trauma services for people affected by adverse childhood experiences, abuse, violence, bereavement and other traumatic events. Long waiting times can undermine recovery and increase vulnerability.
- **Strengthen Physical Health Assessment within Risk Management-** Ensure that physical health conditions are routinely assessed and incorporated into risk assessments, care planning, and safety planning for individuals who use drugs and/or alcohol. Physical health factors should be recognised as key contributors to vulnerability and drug-related harm, with assessment processes considering the impact of co-existing conditions on drug toxicity, overdose risk, medication effectiveness, and clinical presentation.
- **Reduce Barriers to Engagement for Underserved Groups-** Services should routinely consider how factors such as gender, sexual orientation, gender

identity, neurodiversity, disability, trauma, culture, and lived experience may affect access to treatment, engagement, and recovery outcomes. Providers should implement flexible approaches that reduce barriers, improve accessibility, and promote sustained engagement in treatment and recovery support.

Drug related death 4

- 57-year-old man who was discovered by the coastguard.
- The cause of death is 1a) Methamphetamine Toxicity 2 Hypertensive Heart Disease
- There is limited information available regarding this death, as the individual was not engaged in or known to treatment and the inquest has been adjourned.
- The use of methamphetamine remains relatively uncommon in the UK; however, it is associated with the chemsex scene (although in this case, no evidence to suggest). Methamphetamine is reportedly more prevalent in countries such as Australia, where access to cocaine is more restricted compared to the UK.

Learning and actions

- This death highlights the importance of extending prevention efforts beyond those already known to services. Continued focus on harm reduction messaging, awareness raising, and improving access to support for hidden or underserved populations remains a key priority.

Drug related death 5

- 55-year-old woman who died in hospital having been discovered by her brother drowsy and behaving strangely.
- Cause of death: 1a) Pneumonia 1b) Amphetamine and gabapentin toxicity 2 Frailty.
- She had experienced significant childhood trauma and as an adult sexual violence.
- She began using substances at an early age and was in treatment at the time of her death.
- Prior to her death, she had been the sole carer for her father who died shortly before her death. This led to significant isolation. Following his death, she is described as experiencing "overwhelming grief".
- She suffered with poor mental health including self-harm, anorexia, anxiety, panic attacks, low mood, paranoia and auditory hallucinations and long-standing suicide ideation.
- In terms of physical health, she had osteoporosis, a low BMI (body mass index), aortic regurgitation and a back injury which had led to an addiction to pain medication.
- She was engaged with With You for 10 years with her support managed by one recovery worker for the most part.

Learning and action

- Critical care referral and safeguarding were both attempted late, when her health had already deteriorated. The recommendation is that we **improve Identification and Monitoring of High-Risk Physical Health Conditions**. Develop a systematic approach to identifying and monitoring physical health conditions associated with an increased risk of drug-related death. Particular attention should be given to liver disease, respiratory conditions such as Chronic

Obstructive Pulmonary Disease (COPD), cardiovascular disease, thyroid dysfunction, and other conditions that may increase susceptibility to overdose such as in this case her low body weight, respiratory depression, or adverse drug interactions.

- Adult social care has introduced a waiting well service since this death to ensure those individuals waiting to be assessed receive support in the interim.
- Similarly, the eating disorder clinic has recruited extra staff including a lead psychologist to ensure those waiting for integrated mental health support are routinely offered regular wellbeing calls.
- Bereavement –Cruse is providing a generic bereavement service within Cornwall including those who have been affected by a drug and/or alcohol related death.

Drug related death 6

- 59-year-old male who was found deceased at his home after family members attended due to concerns for his welfare.
- The cause of death is 1a) Acute Opiate toxicity (having taken 12 different drugs).
- He had a past medical history of hypothyroidism, left ventricular hypertrophy, high cholesterol, depression, anxiety, bipolar disorder and post-traumatic stress disorder and previous suicidal ideation for which he was prescribed a large number of medications.
- He was significantly impacted by his mother's terminal illness and the death of his sister.
- He was not known to drug and alcohol treatment services.

Learning and actions

- **Increase awareness and monitoring of prescribed polydrug use,** recognising that the synergistic effects of multiple medications are frequently identified as a contributing factor in drug-related deaths. Services should ensure regular medication reviews and robust prescribing oversight to minimise preventable risk.
- **Strengthen Multidisciplinary Working Around Complex Physical Health Needs.** Promote multidisciplinary case review and coordinated care for individuals with complex physical health conditions and substance use needs. This should include effective information sharing between primary care, acute hospitals, mental health services, drug and alcohol services, and other relevant partners to ensure risks are understood and managed collectively.

Drug and Alcohol Related Death 7

- 57-year-old woman who died in interim nightly accommodation. Police attended after a concern for welfare was logged.
- Cause of death: 1 a) Alcohol and illicit drug misuse 2). Liver cirrhosis and diabetes
- She had experienced significant childhood trauma which led to her first using alcohol aged 7 years old.
- She moved to Cornwall in 2020 having fled a high-risk domestic abuse relationship.
- She had multiple complex health conditions, including Type 2 Diabetes, Irritable bowel syndrome (IBS), COPD and Post traumatic stress disorder (PTSD). She experienced oedematous legs, recurrent gastric bleeding with melena,

alcohol-related seizures, Alcoholic Liver Disease and decompensated cirrhosis with ascites, managed by the Hepatology Team at the Royal Cornwall Hospital. She also had peripheral neuropathy affecting mobility, erosive duodenitis, and a history of right ventricular failure (December 2022).

- She had complex mental health needs, including complex PTSD linked to severe childhood abuse and later sexual exploitation and assault. She experienced longstanding reactive depression, emotional instability, and had post-natal depression after both of her children were born. She was prescribed Venlafaxine and had a history of self-harm and multiple suicide attempts. There was also evidence of alcohol-related brain injury (ARBI).
- At the time of her death, she was supported by a number of agencies, and a significant number of multi-agency meetings were taking place.

Learning and actions.

- Women with a history of severe trauma and substance use issues need safe, secure accommodation.
- **Promote Integrated Physical and Mental Health Care for Women with Multiple Vulnerabilities** Ensure that women experiencing co-occurring substance use and domestic abuse receive holistic assessments that include regular monitoring of physical health. Services should work collaboratively to ensure that physical health deterioration is identified and addressed promptly and is not overshadowed by safeguarding, housing, or social care concerns.
- **Improve Recognition and Support for Acquired Brain Injury and Head Trauma** Undertake a multi-agency review of the prevalence and impact of head injuries and acquired brain injury among people experiencing drug and/or alcohol dependency, homelessness, and multiple disadvantage. The review should inform the development of a clear pathway for identification, assessment, treatment, and ongoing support, recognising the potential contribution of cognitive impairment to substance-related harm and mortality.
- **Improve Access to Trauma-Specific Interventions.** Increase availability of evidence-based psychological therapies and specialist trauma services for people affected by adverse childhood experiences, abuse, violence, bereavement and other traumatic events. Long waiting times can undermine recovery and increase vulnerability.

Drug related death 8

- 42-year-old male who was discovered unresponsive by workers in his accommodation.
- The cause of death is: 1a). Acute cocaine toxicity.
- Adverse Childhood Experiences: He lived with his mother and stepfather and reported ongoing physical and emotional abuse towards both him and his mother. By age 16, he felt forced to leave the family home and was living on the streets.
- Early Drug Use: Started cannabis and alcohol at 11 (daily by 14–15), added LSD, pills, and amphetamines at 13; increased use after dealing cannabis at 14. Heroin use began at 29 after earlier experimentation.

- Homelessness: Long-term substance use contributed to 20 years with no fixed abode, mostly street homelessness despite periods in supported, shared, and council housing (including Housing First).
- Mental Health and Abuse: Abused during detention for drug-induced psychosis in his teens; ongoing secondary mental health needs with service involvement. He had a dual diagnosis and when he stopped using, he struggled to cope with his mental health.
- Bereavement and child removal- Experienced significant trauma following his ex-wife's suicide, with their daughter previously taken into Local Authority care due to substance use.
- Criminal Justice: History of short custodial sentences for offences including drunk and disorderly, theft, shoplifting, and ABH; more recently linked to anti-social behaviour involving verbal aggression towards the public.
- Long term unemployment-due to his mental and physical health issues, he was unable to work.
- He was in treatment services in the county for over 10 years including at the time of his death. He felt safe in the office of the treatment provider often dropping in for a chat.

Learning and actions

- Dual Diagnosis: Ensuring everyone who has a co-occurring mental health and substance use need receives the appropriate support for both conditions at the right time.
- Trauma-Informed Practice: Provide trauma stabilisation training for professionals supporting individuals with multiple vulnerabilities, recognising that trauma is often a long-term, enduring factor in their lives.
- Criminal Justice/Support Needs: He was recently charged with an offence he misunderstood to be registerable under the sex offender register, highlighting the need for enhanced support for individuals facing offences associated with shame and stigma.

Drug related death 9

- 36-year-old man who was found unresponsive in bed following a welfare check when he had not attended work.
- Cause of death: 1a) Mixed drug toxicity
- Toxicology test has revealed the presence of synthetic opioids. Some of the tablets were identified as OP80 oxycodone these tablets contained N-pyrrolidino isotonitazene which concurs with the toxicological findings.
- He was living in Cornwall due to his work.
- He was not known to any services in Cornwall and was not known to use drugs and/or alcohol.
- It is understood he was mid-way between dental treatment.
- No local GP registration or hospital attendances suggests limited healthcare engagement in Cornwall. His hometown GP confirmed little engagement with their service due to being a fit and healthy young man.
- Nitazenes were identified post-mortem, underscoring the risks that synthetic opioids pose to both occasional and experienced drug users.

- Delayed toxicology results complicate timely linkage between seized drugs and cause of death.

Learning and actions

- This appears to have been a tragic accident whereby a young man has taken an illicit tablet not knowing it was contaminated with synthetic opioids. We will continue to raise awareness of the risks posed by synthetic opioids. [You searched for synthetic opioids - Safer Cornwall](#)

Drug Related Death 10

- 37-year-old woman who had a friend staying over. He reports they had been drinking the previous evening and fell asleep on the sofa. He found her unresponsive the following morning.
- Cause of death: 1a) Mixed Drug Toxicity 11) Alcoholic Liver Disease and Myocardial Fibrosis.
- She experienced childhood trauma and was a victim of domestic abuse.
- She reported ongoing physical pain that had initially arisen from a hip displacement, and she developed a dependence on opiate-based medication, initially prescribed for this, leading to her referral into drug and alcohol treatment.
- She experienced high levels of anxiety, depression and reported an eating disorder.
- Her children were removed from her care due to ongoing child protection proceedings, and this increased her anxiety. Having been told there was a high chance that they would not be returned to her, left her with feelings of hopelessness.
- Services often struggled to engage her.

Learning and actions

- Continue the MTAM approach for those with complex vulnerabilities but strengthen the approach for complex women.
- The Fern (Child removal pilot) is aiming to improve outcomes for those who have their children removed from their care.
- Non-engagement is often a symptom of trauma and coercive control, not a lack of motivation. Closing cases due to non-attendance risks losing individuals at the highest level of vulnerability. **Services should recognise reduced engagement, non-attendance or disengagement from support as potential indicators of escalating risk** rather than a lack of motivation to engage. **This is particularly important for individuals experiencing domestic abuse, where** non-attendance may reflect the impact of trauma, coercive control, ongoing safety concerns, or other barriers to accessing support. Cases should not be closed solely on the basis of non-attendance where significant vulnerabilities remain.
- Trauma was present but not stabilised. Ensure workers supporting women with multiple vulnerabilities are able to offer trauma stabilisation.
- Ensure that women experiencing co-occurring substance use and domestic abuse receive holistic assessments that include regular monitoring of physical health. Services should work collaboratively to ensure that physical health deterioration is identified and addressed promptly and is not overshadowed by safeguarding, housing, or social care concerns.

Drug Related Death 11

- 52-year-old man who was discovered unresponsive by his mother with whom he lived. He was taken to hospital where he died a few days later.
- Cause of death: 1a) Multiple Drug Toxicity.
- He had experienced significant loss over recent years with several family members dying between 2021 and 2023.
- He had a past medical history of psoriatic arthritis, osteoarthritis of his hip joints with a right sided total hip replacement in 2023. He had high blood pressure and mixed anxiety and depression noted in 2020. An accidental poisoning by drugs was noted in his GP records in 2022. Medication was prescribed but he does not appear to have been referred for support with his drug use despite disclosing illicit drug use.

Learning and actions

- Bereavement has been a recurring theme within drug related deaths for a number of years. As of 2026, a generic bereavement service has been launched which may assist those struggling with grief. [Home - Cruse Bereavement Support](#)
- Similarly, pain management has been an increasingly concerning issue within the drug related deaths with individuals sourcing medications online. Work on a pain management pathway is a priority for 2026.
- He was not in treatment for drugs and alcohol at the time of his death. There is a need for improved screening and identification and referrals into treatment by GPs. Work is being undertaken to improve referrals and dispel myths about referral criteria.

Drug related death 12

- 45-year-old man who was at a friend's house. The friend believed he had taken drugs and been drinking and she reports hearing him snoring loudly during the evening. The next morning another friend discovered him unresponsive.
- Cause of death: 1a) Dihydrocodeine toxicity.
- He experienced long term problematic alcohol use which progressed to drug use, and he was not engaged with treatment since 2016
- Domestic abuse- early notes (2014) detail an assault on his wife which led to separation, increased alcohol use and homelessness.
- He had a past medical history of drug use, Crohn's, chronic asthma, tuberculosis, obstructive sleep apnoea, diverticular disease and back pain.
- He had a history of depression and historically had attempted to end his life.
- He had attended A&E on multiple occasions, yet no referrals to drug and alcohol services. It is unclear whether: he hid his substance use or presented with medical issues where substance use was not suspected.
- Many people re-refer to drug and alcohol treatment during crises, but some do not. The reasons for this may include -past negative experiences, stigma or shame, feeling "not bad enough" to seek help, not recognising risk.
- The snoring referred to, likely indicated respiratory depression, a known sign of overdose, particularly with opiates like dihydrocodeine. This is a repeated theme across drug related deaths: peers place people "on their backs" or "to bed," misreading snoring as harmless sleep.

Learning and actions

- Need for consistent screening in A&E (e.g. alcohol and drug brief interventions).
- Consider outreach models for formerly known service users. Explore whether a “light touch” re-engagement offer or periodic check-ins might capture those who deteriorate without asking for help and reflect on accessibility and perceived openness of services.
- Strong need for targeted education for service users and wider communities: that snoring could indicate a potential overdose (not “sleeping it off”). Encourage calling emergency services when unsure. Safe positioning (recovery position) and monitoring. Need to extend overdose/harm-reduction education to non opiate-using populations due to the risk of contamination with synthetic opioids.

Drug related death 13

- 40-year-old man whose father raised a concern for welfare when his son did not turn up at their agreed time. His father had seen him a few days earlier when he had reported not feeling very well and having injured his ankle.
- Cause of death: 1a) Mixed Drug Toxicity & Coronary Artery Atherosclerosis.
- Childhood trauma-his mother struggled with alcohol dependency and his father spent time in prison. Consequently, he lived with this grandmother.
- Early and long-term use of substances- he began smoking cannabis at eight years of age. He then began using heroin at 16 and heavy drinking at age 19.
- Revolving prison door- he went to prison multiple times.
- He was diagnosed with attention deficit hyperactivity disorder (ADHD) and suffered from depression and anxiety.
- He suffered chronic knee pain as a result of an old fracture to his kneecap, and he had poor dentition. In later years, he experienced gastric issues related to his alcohol consumption. He was diagnosed via dry blood spot testing with Hepatitis C, which was promptly treated.
- His father was supportive but there were a number of domestic abuse referrals from son to father.

Learning and actions

- Once housed, visibility dropped and multi-agency contact reduced (no probation, less contact with treatment or other services). There was a perceived stability which masked ongoing high clinical risk (polypharmacy, cardiac disease, trauma, ADHD and, chronic pain). It is imperative that services sustain long term support for those with multiple vulnerabilities.
- Trauma, neurodiversity, and pain were under-addressed. Integrate trauma-informed, ADHD-informed, and pain-informed care pathways into substance use treatment (not as add-ons).

Drug Related Death 14

- 41-year-old female whose mother found her unwell. She then became unconscious and a friend advised calling an ambulance. The friend tried unsuccessfully to locate naloxone within the property.
- Cause of death: 1(a) Mixed drug overdose & intravenous drug use related fulminant infective endocarditis of the aortic valve II Chronic pancreatitis.
- She had multiple long-term health conditions worsened by drug and alcohol use, including asthma, pancreatitis, hypertension, anaemia, liver cirrhosis and heart failure. She also experienced DVT, pneumonia, recurrent chest infections and

significant weight loss. She frequently attended hospital for domestic-violence-related injuries and substance-related complications, including liver issues, anaemia, seizures, appendicitis, pancreatitis, overdoses, hypertension, and most recently sepsis and infective endocarditis in September 2024.

- She used drugs and alcohol to self-medicate difficult emotions and low self-esteem. Her last reported self-harm was in December 2022, involving superficial cuts and cigarette burns. She also experienced periods of suicidal thoughts, most recently in August 2023, but protective factors—particularly her family—prevented escalation. She was diagnosed with anxiety, depression and agoraphobia, with associated panic attacks and poor sleep. She received various mental-health medications from her GP and had previously engaged in CBT and domestic-violence counselling. A 2017 CMHT assessment concluded she was unable to engage with support due to her ongoing substance use.
- Lack of employment/confidence- left school at 15 and felt she lacked confidence due to this. She did not report any employment during her treatment journeys. She had wanted to volunteer in order to help others, but due to her ongoing health, substance use and social challenges this plan was not progressed.
- Early and long-term drug use- she smoked cannabis as a teenager and was introduced to heroin aged 20 by a boyfriend. She reported opioid and alcohol dependency from the age of 21.
- Domestic abuse- victim in number of relationships where she experienced domestic violence and she sustained significant physical and psychological harm.
- Potential financial and sexual exploitation from men who were accessing her home.

Learning and actions

- Continue the MTAM approach for those with complex vulnerabilities but strengthen the approach for complex women.
- Neurodivergence, in women (in particular) is often under-identified complicating communication, tolerance of waiting rooms and adherence. Improve the trauma informed response to and identification of those with neurodiversity.
- A dual diagnosis pathway may have benefitted this woman. Continued work on dual diagnosis across the county.
- Exploration of a “passport” type system, to avoid individuals having to retell their history and to explain triggers, what helps, physical conditions and named contacts.
- More staff trained in trauma stabilisation to support individuals with complex vulnerabilities.
- **Improve Identification and Monitoring of High-Risk Physical Health Conditions**-Develop a systematic approach to identifying and monitoring physical health conditions associated with an increased risk of drug-related death. Particular attention should be given to liver disease, respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease, thyroid dysfunction, and other conditions that may increase susceptibility to overdose, respiratory depression, or adverse drug interactions.

Drug related death 15

- 54-year-old male whose friends discovered him unresponsive when the conducted a welfare check on him. He was taken to hospital but died the following day.
- The cause of death is 1a) Cerebral infarction 1b) Cocaine toxicity.
- He experienced a traumatic childhood marked by ongoing physical and sexual abuse, contributing to later substance use as a coping mechanism.
- He had a past medical history of Major Depressive Disorder, PTSD, emotionally unstable personality disorder, alcohol dependence, poly substances use and Epilepsy. He self-harmed and experienced suicide ideation and had made previous attempts on his life.
- Bereaved by the death of his mother in 2000, with whom he had limited contact.
- He had two sons but experienced estrangement and no ongoing relationship.
- He endured repeated periods of homelessness, residing in emergency and temporary accommodation, although he was in stable housing at the time of death.
- He had spent time street homeless and periods in prison leading to relationship breakdown.
- He had been violently attacked and his assailant sent to prison. Head injuries are common among people experiencing drug/alcohol dependency and homelessness. There are concerns these injuries are not adequately treated, due both to individuals self-discharging and to professionals not responding with the same level of care as they would for non-drug-using populations.
- Fear of exploitation-others in his house. Believed he was being cuckooed. He was very vulnerable and when hospital care workers called an unknown male answered the door.
- There was a package of care in place to support his drug and alcohol dependency and mental health, and he received regular medication reviews and psychosocial interventions. There was additional support in place to support his physical health and manage his debts.

Learning and actions.

- This death highlights the risk of stroke from cocaine use and its serious impact on heart health.
- Police are getting better at recognising cuckooing and exploitation and utilising partial closure notices. This means the resident can stay in the property but no one else can stay there otherwise the tenant will lose their tenancy. However, there needs to be a system wide approach to exploitation when an individual is reluctant to report the issue to the police.
- Recent research on drug related intimidation shows how widespread the issue is: [Drug Related Intimidation in Northern Ireland: Nature, support needs and how to respond | A Summary Report](#)

Drug related death 16

- 46-year-old male who collapsed at a friend's house.
- The cause of death is 1a) Poly-drug toxicity.
- He experienced a traumatic childhood due to his father's alcohol dependency.
- Bereavement-he reported struggling with the death of his father and friends.
- An accident several years before this death cast a long shadow over his life. He was unable to work which led to the breakdown of his relationship.

- He was in a lot of pain -due to his spine and having pancreatitis. He reported that his inability to control this pain led to an increase in illicit drug and alcohol use.
- He suffered with PTSD and suicide ideation.
- Homelessness- At the time of his death, he was living in unsupported interim nightly accommodation.
- He received treatment for heroin and alcohol use, with occasional cocaine and benzodiazepine use. Support included psychosocial interventions, harm reduction, housing, and life skills/employability assistance. His worker maintained close liaison with probation and followed up referrals to mental health and housing services.
- He was vulnerable to exploitation by others.
- He was blamed by others for a woman's death and struggled to cope with the resulting shame and stigma.
- He was physically unwell, with COPD and liver cirrhosis, reducing his ability to metabolise drugs.

Learning and actions

- Supported housing is being redesigned to deliver trauma-responsive support for vulnerable individuals. Its effectiveness for those with the most complex needs remains to be seen.
- Work is underway to develop a pain management pathway for individuals relying on prescribed and illicit drugs.
- **Improve Identification and Monitoring of High-Risk Physical Health Conditions**-Develop a systematic approach to identifying and monitoring physical health conditions associated with an increased risk of drug-related death. Particular attention should be given to liver disease, respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease, thyroid dysfunction, and other conditions that may increase susceptibility to overdose, respiratory depression, or adverse drug interactions.
- **Embed Trauma-Informed Practice Across All Services**-Ensure that all services working with people at risk of drug-related death adopt a trauma-informed approach, including substance use services, mental health providers, housing, criminal justice and emergency departments. This means recognising the impact of trauma, responding compassionately, and actively avoiding re-traumatisation.
- **Develop a County-Wide Multi-Agency Framework for Identifying and Responding to Exploitation**-Develop and implement a robust, county-wide, multi-agency approach to identifying and responding to exploitation affecting people who use drugs and/or alcohol. This should include cuckooing, criminal exploitation, coercion, control, and situations where individuals are being exploited by friends, associates, or others within their own homes. The framework should include clear referral, assessment, and support pathways for individuals who do not meet formal safeguarding or police thresholds but remain vulnerable to significant harm.

Drug related death 17

- 42-year-old male who had been drinking cider and whisky and taken illicit or unprescribed medication the previous evening. His partner noticed him snoring heavier than usual, when she left for work in the morning and returned to find him unresponsive.
- The cause of death is 1a) Mixed Drug Toxicity.
- He had a past medical history of Tourette's, borderline personality disorder, anxiety, and depression and was known to drink 4-6 cans of cider every day.
- He was not known to drug and alcohol treatment services.

Learning and actions

- Improved screening by GPs for those with problematic drug and alcohol use. Ongoing alcohol screening training is being delivered to primary care practitioners to strengthen early identification of alcohol-related harm, contributing to a significant increase in referrals into alcohol treatment and enabling earlier intervention for those at risk.
- Enhance overdose awareness training, emphasising that heavy snoring can indicate an overdose, as it is often misinterpreted by family and friends, leading to delayed intervention.
- **Deliver Tailored and Inclusive Treatment Pathways**-Treatment providers should continue to develop and deliver tailored, person-centred support for women, LGBTQ+ individuals, and neurodivergent people. Service models should recognise that traditional approaches, including group-based interventions, may not be appropriate or effective for everyone, and should offer flexible alternatives that respond to individual needs, preferences, and experiences.

Drug related death 18

- 63-year-old female who was discovered unresponsive by her family.
- The cause of death is 1a) multiple drug toxicity 2) Chronic obstructive pulmonary disease.
- She had a history of erratic analgesic use, including obtaining excess medication. In addition to chronic pain, she also had type 2 diabetes and chronic obstructive pulmonary disease (COPD)
- She had been dependent on alcohol when she was younger but by the time of her death, her alcohol use was no longer problematic. However, professionals became concerned about possible opioid dependence and her return to smoking.
- There had been a rapid decline in her health over the last 3 years.
- The inquest heard that the drugs acted synergistically, and her underlying COPD meant she already had a degree of respiratory depression.

Learning and actions

- Overuse of both prescribed and illicit medication to manage pain remains a significant concern in drug-related deaths. In Cornwall, work is underway to develop a pain management pathway to enable individuals with chronic pain to access effective alternatives to medication.

- The synergistic effects of polydrug use are frequently observed as a contributing factor in drug-related deaths. In this case her COPD made her especially vulnerable to overdose. **Improve Identification and Monitoring of High-Risk Physical Health Conditions**-Develop a systematic approach to identifying and monitoring physical health conditions associated with an increased risk of drug-related death. Particular attention should be given to liver disease, respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease, thyroid dysfunction, and other conditions that may increase susceptibility to overdose, respiratory depression, or adverse drug interactions.
- Historically she had difficulties accessing mental health support due to her alcohol dependency highlighting the need to embed a dual diagnosis approach across the system.
- The review panel highlighted concerns that pain management and wider support needs may sometimes be under-recognised in older adults, particularly women.
- Continued implementation of the Drink Wise, Age Well approach in Cornwall.

Drug related death 19

- 65-year-old female whose husband heard a thud when she fell out of bed. He called for an ambulance, but it was not possible to save her.
- The cause of death is 1a) Drug and Alcohol Toxicity II) Hypertensive and Valvular Heart Disease, Fatty Liver Disease and Chronic Renal Disease.
- She had a traumatic childhood.
- She experienced high risk domestic abuse as a young woman which ultimately led to the removal and adoption of her child.
- She had a diagnosis of complex emotional difficulties in conjunction with anxiety and depression and a history of self-harming.
- She had a history of oesophageal cancer and suffered from severe global arthritis and osteoporosis.
- She had been dependent on alcohol for many years.
- She self-referred to treatment 3 years prior to her death.

Learning and actions

- Women with histories of childhood trauma, high-risk domestic abuse, child removal, mental ill health, and substance use are disproportionately represented in drug and alcohol-related deaths. In response, the treatment provider established a dedicated women's service in March 2025 to support those with multiple vulnerabilities, with a focus on addressing the shame and stigma that often act as barriers to engagement and recovery. Continued work on gender responsive, trauma informed support for women with multiple vulnerabilities.
- Earlier screening and referral could have facilitated more timely access to appropriate support services. Ongoing alcohol screening training is being delivered to primary care practitioners to strengthen early identification of alcohol-related harm, contributing to a significant increase in referrals into alcohol treatment and enabling earlier intervention for those at risk.

Drug related death 20

- 31-year-old male visiting Cornwall on a camping trip with friends. On arrival, he appeared under the influence of drugs and was manic and erratic, but this was not unusual for him. Around 1 pm, friends found him asleep on a sofa and placed him on his side. He was found unresponsive the following afternoon.
- The cause of death is 1a) Drug misuse.
- He had taken a mixture of prescribed and illicit drugs.
- He had long term mental health issues and was bi-polar.
- He started using drugs problematically whilst at university.
- Three months prior to his death, he had been mugged and hit his head.

Learning and actions

- Placing someone to sleep—even in the recovery position—when they are overdosing is a common occurrence in drug-related deaths. Despite past campaigns, ongoing awareness-raising remains necessary, highlighting the importance of calling an ambulance.
- **Improve Recognition and Support for Acquired Brain Injury and Head Trauma**—Undertake a multi-agency review of the prevalence and impact of head injuries and acquired brain injury among people experiencing drug and/or alcohol dependency, homelessness, and multiple disadvantage. The review should inform the development of a clear pathway for identification, assessment, treatment, and ongoing support, recognising the potential contribution of cognitive impairment to substance-related harm and mortality.

Drug related death 21

- 50-year-old male who was discovered unresponsive by his housing support worker.
- The cause of death is 1a) Pneumonia and Mixed Drug Toxicity.
- As a former veteran, alcohol use may have been culturally normalised and reinforced within the working environment.
- Bereavement appears to have been a significant factor, with his father's death in 2019 identified as a potential point at which his alcohol use became problematic. He also disclosed a family history of alcohol-related difficulties.
- His alcohol use led to the loss of his wife, his job and his home.
- A safeguarding referral was submitted in March 2023 due a suicide attempt and escalating alcohol consumption but was not progressed.
- He was referred to With You by Outlook southwest, GP, wife and Cornwall housing.
- He had numerous presentations at the emergency department in the weeks and days prior to his death

Learning and actions

- There have been a number of drug-related deaths involving individuals who were referred to treatment for alcohol use but subsequently died from a drug overdose.
Assessment, treatment and review processes should actively explore

changing patterns of substance use throughout the individual's treatment journey.

Individuals engaged with services for alcohol dependency should not be assumed to be at lower risk of drug related harm. Services should routinely assess for polysubstance use, emerging drug use, underreported substance use and transitions between alcohol, prescribed medications and illicit drugs.

- Improved recognition of the risks facing men (particularly veterans) following loss of relationships, housing, and social status may strengthen safety planning and targeted support.
- It is unclear if any multi agency working was undertaken in response to his overdoses. A "My Team around Me" approach would have been beneficial in this case.

Drug related death 22

- 52-year-old male whose friends raised a concern for welfare when they hadn't heard from him.
- The cause of death is: 1a) Multiple drug toxicity.
- He struggled with depression and anxiety and also experienced symptoms of obsessive-compulsive disorder (OCD).
- He suffered significant facial injuries including a fractured jaw and eye sockets following an unprovoked attack in 2015 and experienced significant anxiety when the perpetrator was due to be released from prison.
- He was HIV positive from his time working as a bin man.
- He had held down a career until his drinking became problematic.
- He had been introduced to drugs when prescribed dihydrocodeine for chicken pox in his early 20s.
- Long term drug use- he started using drugs at an early age.
- Bereavement -partner died (2014), mother died (2015), brother-in-law (2020), stepdaughter died (May 2024)
- Suicide ideation – early 2021

Learning and actions

- The amitriptyline and methadone contributed to his death- amitriptyline is dangerous in overdose. The reported toxic effects of amitriptyline include hypotension, syncope, hypertension, tachycardia, metabolic acidosis, myocardial infarction, arrhythmias, heart block, stroke, respiratory depression, convulsions and coma.
- He was stable on a methadone script but missed two appointments prior to his death.
- **Embed Trauma-Informed Practice Across All Services**-Ensure that all services working with people at risk of drug-related death adopt a trauma-informed approach, including substance use services, mental health providers, housing, criminal justice and emergency departments. This means recognising the impact of trauma, responding compassionately, and actively avoiding re-traumatisation.

Drug related death 23

- 22-year-old male discovered unresponsive by a member of the public on the Southwest coastal path.

- The cause of death is 1a) 3,4-Methylenedioxymethamphetamine toxicity.
- There is limited information available regarding this death, as the individual was not engaged in treatment.
- The inquest concluded that he took the MDMA recreationally leading to an accidental overdose.
- A key risk factor with MDMA use is the unpredictability of dosage and potency. Users may take an initial dose and, if the expected effects are not felt within approximately 20–30 minutes, may consume additional tablets or increase the dose. Variability in purity and strength between tablets can result in unintentional overconsumption and increased risk of overdose. He had an extremely high toxicological reading for MDMA.

Learning and actions

- Awareness raising of the risk of the unpredictability and risk associated with the dosage and potency of MDMA to younger recreational users. There is potentially a lack of understanding by users of the risk of serious harm and/or death from MDMA.

Drug related death 24

- 41-year-old male, living with his parents, was found unresponsive by them.
- The cause of death is 1a) Drug Misuse.
- The toxicology discovered etonitazene -a potent synthetic opioid.
- He reported a traumatic childhood.
- He had a long history of drug use.
- He had a long history of suicidality and self-harm
- His ongoing drug use led to the loss of his home, his relationship, his job and his self-esteem.
- Following the onset of seizures, he began taking Pregabalin, initially prescribed by Neurology and later withdrawn, after which he sourced it illicitly.
- In later years he experienced frequent opportunistic infections and chronic pain from a longstanding foot injury.
- He provided palliative care for his father who later died.
- The pharmacist noted increasing intoxication and unsteadiness, possibly due to higher use or reduced drug metabolism due to his liver damage.

Learning and actions

- As a result of this death, the treatment provider Pharmacist has engaged with the Clinical Director to develop protocols for the use and misuse of pregabalin, with a policy currently in progress. The service is also exploring pregabalin's role in drug-related deaths and emergency presentations, with the aim of establishing improved care pathways across primary and secondary services.
- The treatment provider has reintroduced drug testing strips capable of detecting synthetic opioids in substances like heroin; the new strips are more reliable than previous versions.
- **Improve Identification and Monitoring of High-Risk Physical Health Conditions**-Develop a systematic approach to identifying and monitoring physical health conditions associated with an increased risk of drug-related death. Particular attention should be given to liver disease, respiratory conditions such

as Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease, thyroid dysfunction, and other conditions that may increase susceptibility to overdose, respiratory depression, or adverse drug interactions.

Drug related death 25

- 56-year-old male who was discovered unresponsive in his van.
- The cause of death is 1a Acute Alcohol and Cocaine Toxicity II Ischaemic Heart Disease.
- He had a personality disorder and experienced suicide ideation.
- He was known as engaging in domestic behaviour in 2022 when he was referred to drug and alcohol treatment services for his alcohol use following the breach of a domestic violence protection order (against him). It was not possible for the treatment service to engage him in support.
- The domestic abuse resulted in the loss of his home and relationship and prevented him having contact with his children.
- The domestic abuse seems to have escalated to a high-risk situation in 2024

Learning and actions

- An ageing cohort of individuals continuing to use alcohol and cocaine, with associated impacts on cardiovascular health, has been identified as an ongoing concern in recent years. A targeted awareness campaign aimed at pub settings is planned for 2026 to help address this issue.
- Improved support for individuals exhibiting abusive behaviours. The DRD review panel identified a recurring pattern where eviction from the family home due to domestic abuse contributed to a downward spiral in the individual's wellbeing.

Ensure Coordinated, Trauma-Informed Support for All Individuals

Affected by Domestic Abuse-Services should ensure that individuals affected by domestic abuse, including both victims and those responsible for abusive behaviours, have access to coordinated, trauma-informed support that addresses immediate housing needs alongside wider health, mental health, substance use, safeguarding, and social support requirements. Support should be proportionate to identified risks and aimed at reducing vulnerability, preventing crisis, and improving engagement with services.

Drug related death 26

- 42-year-old male who collapsed at his mother's address. Emergency services were called for but it was not possible to save him.
- The cause of death is 1a) Amphetamine Toxicity, 2) Oesophagitis.
- He reported having a challenging childhood due to his father's alcohol dependency.
- Homelessness: He struggled to maintain stable accommodation during treatment, at times living with his mother and stepfather, and ultimately hoped to live independently with his brother. Housing instability negatively affected his emotional wellbeing and contributed to increased alcohol use, which reduced during periods of stable employment and rose when he was unemployed.

- He had previous convictions for violent offending behaviour related to his alcohol use. He recognised that it affected his thinking skills and led to poor decision making.
- Early use of alcohol- He started drinking at the age of 17 and said that he started because that was the "thing to do" and that he very quickly became a regular weekend user.
- He presented with low mood, depression, isolation, low self-esteem and insomnia.
- He experienced insomnia and may have used amphetamines to manage work demands, often working 2–3 jobs when employed.

Learning and actions

He was referred to With You due to his involvement in the criminal justice system. He was referred to With You in relation to his alcohol use but died from a drug related death. He may have been reluctant to disclose his drug use for fear the information would be shared with probation. **Assessment, treatment and review processes should actively explore changing patterns of substance use throughout the individual's treatment journey.** Individuals engaged with services for alcohol dependency should not be assumed to be at lower risk of drug related harm. Services should routinely assess for polysubstance use, emerging drug use, underreported substance use and transitions between alcohol, prescribed medications and illicit drugs.

Drug related death 27

- 35-year-old male found unresponsive after smoking heroin at a friend's house. He was discovered in cardiac arrest. Emergency services provided advanced life support and administered naloxone, but resuscitation was unsuccessful.
- The cause of death is 1a) Multiple drug toxicity.
- He had a past medical history of ADHD, alcohol and drug dependency (including heroin and ketamine), previous suicidal ideation and attempts, and convulsions. He had been prescribed Elvanse for ADHD but had difficulty accessing it.
- Domestic violence protection order (made against him) led to the loss of his home and relationship.
- Homelessness- At the time of his death, he was unemployed and of no fixed abode, having been living at a friend's house.
- He fell through the gaps in accessing support due to moving between Wales and Cornwall.
- He went to detox and rehabilitation twice in his treatment journey.

Learning and actions

- **Embed Trauma-Informed Practice Across All Services**-Ensure that all services working with people at risk of drug-related death adopt a trauma-informed approach, including substance use services, mental health providers, housing, criminal justice and emergency departments. This means recognising the impact of trauma, responding compassionately, and actively avoiding re-traumatisation.
- Improved support for individuals exhibiting abusive behaviours. The DRD review panel identified a recurring pattern where eviction from the family home due to domestic abuse contributed to a downward spiral in the individual's wellbeing.

- Elvanse 50mg (lisdexamfetamine) prescribed for ADHD; potential difficulties accessing prescriptions via GP or ADHD services. Limited access to specialist prescribing may create barriers, increasing risk of self-medication, particularly when moving between areas. Workers to remain alert to and factor into risk assessments.

Drug related death 28

- 59-year-old male whose neighbour raised a concern for welfare when his post hadn't been collected for several days. The police attended and found him deceased.
- The cause of death is 1 a) Opiate (methadone) and benzodiazepine toxicity II. Hypertension.
- A large amount of medication was found at his property- all of which was prescribed to him.
- Bereavement - His father died in 2018, and he witnessed a friend die when he was a teenager.
- He said he was adopted as a child and struggled to feel like he belonged in his teens.
- He made references to suffering from childhood sexual abuse from a male neighbour.
- He began using substances in adolescence, initially alcohol, progressing to heroin use at age 15 during a period of street homelessness and following the traumatic death of a close friend.
- He demonstrated good engagement with treatment since 2003, with sessions largely focused on mental health support, particularly while stable on Opiate Substitute Therapy (OST).
- He had secured local authority housing and was in receipt of benefits.
- He had ceased using alcohol since 2014 due to liver and kidney issues.
- A safeguarding referral had been made and there was evidence of good multi-agency working prior to his death.

Learning and actions

- He had stockpiled a lot of the drugs prescribed to him including his methadone tablets. Given that methadone is the drug most frequently implicated in deaths among people in treatment, a review will be undertaken to identify patterns of use, prescription diversion, and opportunities to strengthen safeguards for individuals receiving OST and those using illicit methadone.
- Increased pharmacy input within the treatment provider enables improved oversight of prescribed medications across both GP and treatment services, supported by shared access to clinical systems. This has strengthened the ability to identify and assess potential drug interactions and polypharmacy risks. There are plans to further develop this approach to enhance client awareness and understanding of medication-related risks.
- Pre-existing liver and kidney conditions may have impaired drug metabolism, potentially increasing the risk of accumulation and adverse effects. **Strengthen Physical Health Assessment within Risk Management**-Ensure that physical health conditions are routinely assessed and incorporated into risk assessments, care planning, and safety planning for individuals who use drugs and/or alcohol.

Physical health factors should be recognised as key contributors to vulnerability and drug-related harm, with assessment processes considering the impact of co-existing conditions on drug toxicity, overdose risk, medication effectiveness, and clinical presentation.

Drug related death 29

- 31-year-old male who was discovered by hotel staff when he failed to check out of his room.
- The cause of death is 1a) Mixed Drug Overdose.
- His past medical history included heroin dependence, depression, and asthma. He had a documented history of heroin misuse since 2017 and experienced an overdose in July 2021 but was not known to treatment services in Cornwall. He was diagnosed with depression and prescribed antidepressants and pain medication.
- An unused naloxone and drug paraphernalia was discovered in his hotel room which suggests he was accessing the needle exchange or had friends who were.
- There is very little information which suggests he might be from out of county.

Learning and action

- This death highlights the importance of extending prevention efforts beyond those already known to services. Continued focus on harm reduction messaging, awareness raising, and improving access to support for hidden or underserved populations remains a key priority.

Drug related death 30

- 38-year-old man who was acting erratically after taking cocaine and drinking an excess of alcohol. His friends left him to calm down and discovered him unresponsive and called for an ambulance.
- The cause of death is 1a) Cocaine Overdose & Alcohol Intoxication.
- He was not known to drug and alcohol treatment services.
- His medical history included bipolar disorder and recent self-harm requiring hospital treatment.
- He was struggling with his mental health following the breakdown of his relationship.

Learning and actions

- The DRD review panel felt that he had made a spur of the moment decision to take an excess of alcohol and cocaine possibly due to his poor mental health.
- It was highlighted at the review panel that cocaine purity has increased in recent years, potentially elevating the risk of harm and overdose.
- He was employed in the construction industry, where cocaine use was noted to be prevalent. An employer was reported as stating, "If I started testing, I would have to sack the whole of the workforce," highlighting the extent of substance use within the sector.

Drug related death 31

- 36-year-old male who was discovered unresponsive by his friend at his home address.
- The cause of death is 1a) Mixed drug toxicity.
- His childhood was marked by trauma, including the death of his sister.
- He sustained multiple physical injuries while intoxicated, including fractures to his shoulder and ankle. He was also the victim of several assaults resulting in facial and head injuries and experienced an episode of gastric bleeding.
- He had a history of detention under the Mental Health Act and reported episodes of paranoia, which may have been indicative of drug-induced psychosis. He found it difficult to adhere to prescribed medication, refusing depot injections due to adverse effects. He was also diagnosed with PTSD and experienced vivid, distressing dreams.
- He was vulnerable to exploitation; he had been cuckooed in the year prior to his death and may have been the victim of cuckooing immediately preceding his death.

Learning and actions

- Adopt a more robust multi-agency approach for individuals experiencing repeated exploitation, including cuckooing. This should incorporate a “My Team Around Me” model and establish a clear, structured pathway—aligned with those used in domestic abuse responses—for individuals whose homes are being occupied by friends or associates against their wishes.
- The need to raise awareness of overdose risk and appropriate emergency responses, including recognising the signs of overdose and placing individuals in the recovery position while awaiting medical assistance.

Drug related death 32

- 50-year-old male who was discovered unresponsive by his carer in his supported accommodation.
- The cause of death is 1a) Drug induced seizure.
- He had engaged in treatment for many years and successfully stopped his use of opiates and alcohol.
- He was the victim of childhood sexual abuse when he was in care, and this was subject to an ongoing investigation which affected his mental health.
- He had paranoid schizophrenia which he believed was caused by his childhood trauma.
- He had pancreatitis, COPD, Type 2 diabetes and had a colostomy. He also suffered from foot pain and seizures.
- His brother died in 2019, and he struggled for a long time to come to terms with this.
- He experienced 3 non-fatal overdoses in the months prior to his death.
- He reported using illicit pregabalin.

Learning and actions

- Encourage clinicians to explore whether illicit substance use is serving a self-medication function, particularly where individuals report benefits relating to anxiety, psychosis, trauma symptoms, sleep disturbance, or intrusive thoughts.
- Reinforce awareness among prescribers of the risks associated with pregabalin use, diversion, dependence, overdose, and exploitation.
- Strengthen pathways that enable individuals with co-occurring conditions to access coordinated support rather than receiving separate or fragmented interventions.
- Share learning regarding the high prevalence of pregabalin use within substance-using populations and the importance of assessing ongoing need, effectiveness, and potential alternatives where appropriate. With You are currently working on a pregabalin use protocol.
- A high-risk protocol relating to the overdoses may have helped although there was evidence of good multi agency working via MDTs.

Drug related death 33

- 53-year-old male who was found unresponsive at his home by family members after they had been unable to contact him for several days; an ambulance was subsequently called.
- The cause of death is 1a) Methadone Toxicity.
- His life was marked by significant emotional trauma, including witnessing his mother's death, which he frequently cited as a driver for his substance use.
- Long-standing substance dependence and repeated relapses adversely affected his physical health, including the development of hypertension, a gastric ulcer, liver damage, and ascites.
- He experienced mental health difficulties, including anxiety, depression, and suicidal ideation.
- The loss of his relationship and home due to domestic abuse (he was the abuser) led to a downward spiral. Prior to that he had been a high functioning drug user able to maintain a job and home.
- Following the breakdown of his relationship, he was placed in a house of multiple occupation where his health declined significantly. He had trench foot due to self-neglect, limited mobility and experienced loneliness and isolation.
- He had been stable on a buprenorphine prescription, but this had lapsed. He was then subsequently prescribed methadone by health for homeless.
- He had been fast tracked for detox and rehabilitation but sadly died prior to admittance.
- Following his relapse in late 2024, a multidisciplinary approach was initiated, including referral to weekly Multi-Agency Partnership meetings to prepare for residential detox.

Learning and actions

- A more safety-focused approach to mental health—particularly in response to the client's frequent suicidal ideation—integrated into treatment planning alongside detoxification and rehabilitation, may have better supported the identification and management of unmet needs.

- Improved support for individuals exhibiting abusive behaviours. The DRD review panel identified a recurring pattern where eviction from the family home due to domestic abuse contributed to a downward spiral in the individual's wellbeing.

Recognise Housing Instability Following Domestic Abuse as a Significant Risk Factor-Partners should recognise homelessness, housing instability, and exclusion from the family home following domestic abuse as significant risk factors for deteriorating mental health, substance-related harm, social isolation, and drug-related death. This should be reflected within local risk assessment processes, pathways, and strategic planning.

Drug related death 34

- 57-year-old man who was discovered unresponsive by his carers. He was transferred to hospital where he subsequently died.
- The cause of death is 1a). Hypoxic brain injury following cardiorespiratory collapse 1b). Illicit drug use 2) Brain abscesses, chronic kidney disease.
- He was known to buy weapons and keep them at his home and had a criminal record.
- He was known to purchase drugs online.
- He suffered with poor mental health and was known to self-harm.
- He struggled with social isolation.
- He was verbally and physically abusive to his carers.

Learning and actions

- Despite being known to services as a problematic drug user, there is no clear evidence of referral into structured treatment. This highlights the need for improved screening processes and more consistent referral pathways for individuals identified as using drugs and alcohol problematically.

Drug and Alcohol related death 35

- 48-year-old male who was found unresponsive by his wife
- The cause of death is 1a) Acute Alcohol Intoxication with use of Opiates II) Decompensated Liver Failure in Alcoholic Cirrhosis.
- Early onset substance use, with alcohol and amphetamines used from approximately age 14
- His mother died in February 2020.
- Complex and chronic physical health conditions, predominantly linked to alcohol use, including decompensated alcoholic liver disease complicated by acute kidney injury and suspected COPD. He experienced recurrent respiratory issues, with multiple hospital admissions for pneumonia and breathing difficulties. In the months prior to his death, he was hospitalised following a collapse associated with hepatic encephalopathy (ammonia on the brain). He also lived with ongoing chronic pain related to historical injuries, including fractured ribs, a clavicle fracture, and upper body nerve damage.
- Mental health needs, including significant anxiety described as social anxiety and difficulties adjusting to life changes following a work-related injury. He also

reported symptoms consistent with post-traumatic stress, which he associated with his time in prison.

- Occupational impact and loss of employment, having worked as a professional fisherman for many years before being unable to continue due to workplace injuries. He remained out of paid employment for several years thereafter and frequently expressed distress about his inability to work and provide for his family, which he identified as a key trigger for both alcohol use and low mood.

Learning and actions

- Substance use for pain management has been a recurring theme in drug-related deaths over recent years. In response, a dedicated pain management pathway is currently being developed within Cornwall.
- Deteriorating physical health and continued substance use significantly reduced his body's ability to metabolise alcohol and opiates effectively. Earlier screening and referral to drug treatment services may have been beneficial, as his health was already in advanced decline by the time he first engaged with treatment.
- Underlying trauma and emotional distress may have been significant barriers to recovery. Periods of vulnerability and tearfulness suggest unresolved psychological difficulties that may have contributed to continued alcohol use and difficulties engaging with treatment.
- Substance use may function as a coping mechanism for underlying trauma, mental ill health, or adverse life experiences. Removing alcohol without adequately addressing underlying psychological needs can leave individuals struggling to manage distress, increasing the risk of relapse and disengagement.
- This case highlights the importance of trauma-informed approaches within substance use treatment. Understanding the role alcohol played in managing emotional distress may be as important as addressing the alcohol use itself.

Drug related death 36

- 52-year-old female who was found unresponsive at home
- The cause of death is 1a) Multiple drug toxicity 2) Right lung lobar pneumonia.
- She had a long history of drug use having used substances from a very early age. At 17, she used ecstasy, amphetamines, and cocaine on weekends with friends. At 18, she entered a relationship with a 29-year-old who smoked heroin and this led her to smoke heroin herself.
- She suffered with anxiety and depression, PTSD and self-harmed.
- Her physical health was impacted significantly following an accident which resulted in her having chronic pain, multiple hip replacements and pelvic fractures.
- She had experienced significant trauma including being raped when she was a young person.
- She maintained periods of abstinence when pregnant.
- The death of her mother caused her to relapse.
- She may not have been using illicit substances for several years prior to her death but relapsed three weeks prior possibly due to ill health. If so, her tolerance would have been reduced.

Learning and actions

- Recovery should be viewed as an ongoing process, with proactive follow-up and relapse prevention measures for individuals who disengage from services after reporting recovery, especially where there is known underlying trauma, including recognition of potential substitution between substances, such as transitioning from drug use to alcohol use, or vice versa.
- Mental health needs may not have been fully addressed alongside substance use treatment. Although the individual disclosed PTSD, anxiety, self-harm, and requested a mental health referral, there is limited evidence that specialist psychological support was successfully accessed or sustained.
- Multiple agencies were aware of aspects of the individual's needs, but responsibility for onward referral may have been unclear. Substance use services, primary care, and other professionals all had opportunities to explore and facilitate access to mental health support.
- Recovery from substance use can uncover underlying psychological difficulties. Periods of reduced substance use may have increased the visibility of unresolved trauma, mental health difficulties, and emotional distress, highlighting the importance of integrated treatment approaches.
- Requests for support create important intervention opportunities. When individuals express a desire for help, such as requesting a mental health referral, timely action is critical as motivation and engagement can fluctuate.
- Fear of professional intervention can affect honesty and engagement. Where children are involved, individuals may minimise substance use, mental health difficulties, or safeguarding concerns due to fears about potential child protection consequences.
- Therapeutic relationships play a vital role in engagement and recovery. Consistent, trusting relationships can provide a critical source of psychological safety for individuals with histories of trauma and instability.

Drug related death 37

- 37-year-old male discovered unresponsive by a support worker in the doorway of a property.
- The cause of death is 1a) Fatal Cardiac Arrhythmia 1b) Cocaine Toxicity.
- He was homeless at the time of this death
- He described multiple childhood traumas that he believes contributed to his substance use, including witnessing his mother's death, experiencing domestic abuse from a parent, and losing relatives in a house fire.
- He began using cannabis and alcohol at age 11, with early progression to dependent alcohol use and binge use of other substances. He started using opiates, including heroin, at 17, becoming a daily user by 23. He began injecting heroin in his late 20s, having injected amphetamines since adolescence.
- He reported no longstanding health conditions but had been treated for several issues linked to poor self-care and neglect, including trench foot, respiratory illness, and dental problems.

- He reported anxiety and PTSD from childhood trauma, with sleep disturbance and flashbacks. He showed paranoia, distrust of services, and declined mental health support. Substance use was seen as a coping mechanism despite worsening symptoms, including occasional hallucinations.
- He had an extensive history of involvement with the criminal justice system.

Learning and actions

- Individuals who are homeless, experiencing poor mental health, and involved in the criminal justice system may struggle to engage with traditional service models. This individual demonstrated repeated disengagement from services and appeared to have significant distrust of mental health support, resulting in limited opportunities for sustained therapeutic intervention.
- Non-engagement should be viewed as an indicator of vulnerability rather than reduced need. The case highlights how some of the most vulnerable individuals may be the least likely to access or maintain contact with services, particularly where there are trauma, severe mental ill health, homelessness, substance use, and previous negative experiences of statutory agencies.
- Assertive outreach approaches are particularly important for high-risk individuals. Traditional appointment-based models may not be effective for individuals who are homeless, distrustful of services, or experiencing significant psychosocial difficulties.
- Trusting relationships are often the key to engagement. The discussion identified that progress with regard to mental health difficulties may be more likely when interventions are delivered through practitioners with whom individuals have an established relationship and sense of psychological safety whereby the practitioner access the mental health professional advice line for guidance and support.
- Homelessness can both result from and exacerbate multiple vulnerabilities. Ongoing rough sleeping, poor physical health, trench foot, substance use, and mental ill health collectively illustrate the cumulative impact of social exclusion on health and wellbeing.
- Behaviours associated with trauma, mental ill health, and substance use can create barriers to housing stability. Repeated tenancy breakdowns and difficulties sustaining accommodation may be manifestations of wider unmet needs rather than solely issues of compliance or behaviour.
- Fear that information will be shared with criminal justice agencies may act as a barrier to disclosure. Individuals subject to probation requirements or criminal justice interventions may be reluctant to openly discuss substance use or mental health difficulties if they perceive this could affect their legal circumstances.

Drug related death 38

- 38-year-old female who collapsed after taking drugs. Naloxone was administered by a friend, and she was transferred to hospital where she later died.
- The cause of death is I(a) Mixed drug overdose.
- She was not known to drug and alcohol treatment services.

- She had been a victim of domestic abuse and sexual violence, and her abuser was known to use drugs and alcohol problematically.
- She held down a job in a health role and family reported she led a regular life.
- She was prescribed mirtazapine and there was mention of her being addicted to painkillers.

Learning and actions

- Hidden substance use can go unrecognised in professionally employed individuals. Employment in a responsible professional role may have contributed to assumptions that the individual was functioning well, potentially reducing professional curiosity regarding substance use or other vulnerabilities.
- Stigma and fear of professional consequences may act as barriers to disclosure and engagement. Concerns about reputation, confidentiality, and potential impacts on employment may discourage healthcare professionals and other employed individuals from seeking support for substance use.
- Opportunities for identification may have been present within healthcare settings. Contact with primary care, hospital services, and the prescribing of mirtazapine suggest points where substance use screening, brief interventions, or further assessment could have been considered.
- Routine screening is important where risk factors are identified. Reports of painkiller addiction, prescribed medication, and healthcare contacts highlight the value of using validated screening tools to identify substance use issues that may otherwise remain hidden.
- Substance use patterns may not fit stereotypical presentations. Sporadic or intermittent drug use can still present a significant overdose risk, particularly where tolerance fluctuates, and individuals may not present as dependent or in obvious crisis.
- Domestic abuse may provide an opportunity to identify substance use risks. Where domestic abuse involves a perpetrator with known drug or alcohol use, consideration should be given to how partner agencies identify and respond to associated substance use risks for victims and family members.

Drug related death 39

- 48-year-old woman who became unresponsive after taking drugs with a friend. He called for an ambulance but left before it arrived.
- The cause of death is 1a). Pneumonia 1b) Chronic obstructive pulmonary disease and drug toxicity.
- In terms of her physical health, she had COPD, Emphysema and Asthma.
- In terms of her mental health, she experienced depression and anxiety.
- She had a history of domestic abuse and had previously been heard at Marac as victim at risk of serious harm or death. One of the abusers ensured she was isolated from her family. She was referred to the domestic abuse service in October 2025, but they deemed it an inappropriate referral.
- A referral to Adult social care was made in 2025 but not progressed.
- She developed a very good therapeutic relationship with her drug worker over the years.
- Family members died in 2021 and 2022.
- She was in receipt of a methadone prescription at the time of her death, but the postmortem suggests there were up to 7 different drugs taken prior to her death.

Learning and actions

- Bereavement support Cruse is providing a generic bereavement service within Cornwall including those who have been affected by a drug and/or alcohol related death. This may improve outcomes for those using substances to manage their grief.
- Continued awareness raising of the heightened risk of overdose for those with respiratory diseases.
- Threshold-based decision making can potentially overlook cumulative risk. While individual incidents may not meet statutory safeguarding criteria, the combination of reported fear, vulnerability, substance use, exploitation concerns, poor physical health, and previous domestic abuse indicators may warrant broader multi-agency consideration.
- There may have been opportunities for greater professional curiosity and exploration of exploitation risks. Practitioners identified concerns regarding vulnerability and possible coercion; however, there is evidence that these concerns may not have been fully explored through a trauma-informed and contextual safeguarding lens.
- Domestic abuse, exploitation and substance use are often closely interconnected. This case reinforces the importance of viewing these issues collectively rather than as separate presenting concerns, particularly for women experiencing multiple vulnerabilities. System flags on DASV and D&A services.
- Information sharing and record review are important when assessing risk. Historical information, including previous referrals and incidents, may provide a broader picture of risk than is apparent from a single referral episode.
- Poor housing conditions can compound existing vulnerabilities. Living in damp and unsuitable accommodation may have exacerbated significant respiratory conditions including COPD, emphysema, and asthma, contributing to overall health deterioration.

Drug related death 40

- 34-year-old male found unresponsive at home after a friend became concerned for his welfare and attended the address.
- The cause of death is 1 a) Poly-drug toxicity.
- He had a past medical history of alcohol dependency, smoking, substance use, calcium deposits on the brain, fractured vertebrae, intracranial calcification, malnutrition, oesophagitis, right upper quadrant pain (sphincter of Oddi spasm), seizures, traumatic musculoskeletal neck pain, and vulnerable adult status.
- He experienced anxiety, depression, suicidal ideation and his neck pain was caused by a suicide attempt two months prior to his death.
- Friends and family reported he had been assaulted a month prior to his death, sustaining head and neck injuries with loss of consciousness, after which he reported seizures and feeling unwell.
- He was not known to drug and alcohol services.

Learning and actions

- He was not referred to treatment despite a history of both alcohol dependency and substance use. Improved screening and identification by GPs and hospital staff.
- Head injuries are common among individuals with drug and/or alcohol dependency, raising questions about whether services are failing to identify risk or whether individuals are not seeking appropriate medical care following an assault although in this instance, there was evidence of appropriate follow up care. Improve Recognition and Support for Acquired Brain Injury and Head Trauma-Undertake a multi-agency review of the prevalence and impact of head injuries and acquired brain injury among people experiencing drug and/or alcohol dependency, homelessness, and multiple disadvantage. The review should inform the development of a clear pathway for identification, assessment, treatment, and ongoing support, recognising the potential contribution of cognitive impairment to substance-related harm and mortality.
- Information sharing across health systems remains a challenge. The case highlights the difficulties that arise when individuals access services across different healthcare systems and geographical areas (Derriford hospital in Plymouth). Information relating to hospital admissions, mental health assessments, safeguarding concerns, and follow-up actions are not readily visible to professionals in Cornwall.

Drug related death 41

- 57-year-old male whose friend discovered him unresponsive.
- The cause of death is: 1a) Multiple drug toxicity (Methadone, Morphine and Diazepam).
- He began using heroin at the age 20. There were no periods of abstinence unless he was in prison. He used a variety of substances, including heroin which he injected and smoked, crack cocaine, and benzodiazepines.
- He had COPD and had damaged his hips and ribs following an accident in 2020.
- He had a history of abscesses and infections, including a groin abscess and injection site inflammation. In May 2022, a missed injection in his right leg caused an infection requiring antibiotics, after which he stopped IV use.
- He presented as extremely malnourished with a low body weight.
- He experienced low mood, anxiety and stress.
- Six weeks prior to his death, his long-term partner passed away, and he had lost his parents during the COVID pandemic.
- He was in receipt of a methadone prescription at the time of his death under the GP shared care system.
- He reported unwanted associates staying with him and exploiting him prior to his death

Learning and actions

- Bereavement as a theme in drug related deaths has been seen for several years. In response to this, a new generic bereavement service has been commissioned with a particular remit to include those affected by a drug related death.
- The need for greater professional curiosity regarding the factors contributing to the individual's weight loss and whether these may indicate wider safeguarding concerns.

- The need for a robust, county-wide approach to supporting individuals who may be experiencing exploitation by friends or associates, where concerns do not meet the threshold for, or are not formally identified as, cuckooing and where there are concerns about potential repercussions from reporting to the police. This would support practitioners to safeguard individuals effectively while maintaining therapeutic relationships.

Drug related death 42

- 42-year-old male who was discovered deceased by his landlord.
- The cause of death is: 1a Cardiac Fibrosis 1b Chronic Drug Toxicity.
- He was violently attacked as a youth and sustained long term injuries including chronic back pain and mental health problems including sleep disturbance, nightmares, chronic pain, and emotional distress
- He dealt with the trauma by using opiates which had first been prescribed to him for his injuries.
- He was referred into drug and alcohol treatment by his GP where he was stabilised on an Opiate substitution therapy (OST). He then decided he could manage without the OST and disengaged from the support
- He relapsed into drinking alcohol but self-referred back into treatment for support with this.
- He then managed to stop drinking and again disengaged from support.
- He appears to have relapsed back into using opiates as indicated by the toxicology report.
- He was employed.

Learning and actions

- Bereavement- support in relation to the loss of his mother may have been beneficial.
- Underlying trauma may have contributed to substance use transitions. While the individual appeared to have made progress in addressing alcohol use, there is evidence that underlying trauma, mental health difficulties, sleep disturbance, nightmares, chronic pain, and emotional distress remained unresolved. This may have increased vulnerability to the use of other substances.
- Recovery from one substance does not necessarily reduce overall risk. The case demonstrates that improvements in alcohol use may be accompanied by increased use of prescribed or illicit drugs if underlying causes of distress are not addressed.
- Individuals may disengage from services despite clear evidence of need. Leaving before assessments can be completed is common among people experiencing multiple disadvantages. Services must therefore consider how support can be offered proactively rather than relying solely on attendance and ongoing engagement.
- Stigma and fear of professional consequences may influence help-seeking behaviour. The individual appeared motivated to maintain employment despite significant personal difficulties. Concerns regarding disclosure, professional identity, and the impact on employment may have influenced engagement with support services.

Drug related death 43

- 53-year-old female whose daughter was concerned for her welfare as she wasn't replying to her messages. She asked her brother to check on their mother and he discovered her unresponsive.
- The cause of death is 1a) Morphine and Pregabalin Toxicity 2) coronary artery disease.
- She was referred to treatment services in July 2023 by her GP for help with her alcohol use, but they were not able to engage her.
- She broke her back in February 2025 and on discharge, she had ceased her alcohol use but started self-medicating with a combination of prescribed and illicit drugs. She also suffered from coronary artery disease and Peripheral Neuropathy.
- She experienced stress and depression.
- Her mother and sisters died in tragic circumstances which led to problematic alcohol use.

Learning and actions

- Continue to promote trauma-informed, non-judgemental approaches that encourage honest conversations about substance use.
- Strengthen efforts to identify and support people experiencing grief, loss, chronic pain, and declining physical health at an earlier stage.
- Reinforce awareness among professionals of the overdose risks associated with multiple prescribed and non-prescribed depressant medications
- Continue implementing recommendations from previous reviews regarding reducing stigma and improving access to support services.

Drug related death 44

- 43-year-old male was found unresponsive by his parents with whom he was residing.
- The cause of death is 1 a) Drug Misuse.
- He had chronic back pain and recurrent sciatica. He was also prone to chest infections and had iron-deficiency anaemia. Later in life, he developed chronic, infected leg ulcers that required hospitalisation and regular district nurse visits for dressing and compression bandaging.
- He experienced long-standing depression and anxiety and occasional suicidal thoughts. He suspected he might have bipolar disorder, but this was never confirmed. His mental health was managed by his GP.
- He had a long history of using substances and had first tried detox when he was 17.
- Bereavement- He had lost his younger brother and a number of friends including his partner.
- He had a history of involvement within the criminal justice system.
- Prior to his death, he was prescribed an opiate substitution prescription of 90 ml of methadone.

Learning and actions

- Reduced engagement with services should be viewed as a potential indicator of escalating risk and increased vulnerability, with flexible and proactive

approaches, including planned home visits, used to maintain contact and support.

- Bereavement and other significant life events should be routinely explored and considered within substance use and mental health risk assessments.
- Overuse of both prescribed and illicit medication to manage pain remains a significant concern in drug-related deaths. In Cornwall, work is underway to develop a pain management pathway to enable individuals with chronic pain to access effective alternatives to medication.

Alcohol Related death 45

- 23-year-old male who was discovered unresponsive by his friend.
- Cause of death: Acute alcohol intoxication and a face down position.
- He was in treatment at the time of his death for his problematic alcohol use.
- He was diagnosed with ADHD as a child.
- He suffered with severe mental health problems and was criminalised for self-harming behaviour carried out in a public place.
- He had a very supportive family.
- Co-occurring alcohol dependence and severe mental ill-health significantly increased risk. He was experiencing severe mental health difficulties, including suicidal ideation, self-harm, mania, sleep deprivation and social isolation, while drinking at extremely high levels.
- Good partnership working was evident, particularly between probation, alcohol treatment services and mental health services, with evidence of risk assessment, treatment requirements and attempts to coordinate care.

Learning and actions

- Young adults with neurodivergence and complex needs may require adapted engagement approaches. His history of ADHD, difficulties attending appointments, and challenges with conventional service engagement highlight the need for flexible, trauma-informed and neurodiversity-aware interventions.
- Potential trauma and adverse childhood experiences require ongoing professional curiosity. Although there were references to traumatic experiences, it was unclear how fully these had been explored or recorded. Services should continue to enquire sensitively and ensure appropriate specialist referrals where trauma is identified.
- Recording and information sharing remain important learning points. Discussions highlighted that interventions may have taken place but were not always clearly documented. Improved recording systems and expectations for staff to review historical records should strengthen continuity of care.
- Criminalisation of individuals during mental health crises may create additional barriers to support. The review prompted reflection on how behaviours arising from severe mental distress can sometimes be treated through a criminal justice lens rather than a therapeutic one.
- Alcohol intoxication at extreme levels can rapidly become fatal. The combination of acute alcohol intoxication and positional asphyxia (face-down position) emphasises the risks associated with very heavy drinking episodes.

Appendix B Drug Related Death Action Plan 2025-2026

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> • Strong, safe, vibrant communities with more decent, affordable homes • A resilient economy creating good growth and jobs • A caring place for families where children build a bright future • Supporting people to live healthy and dignified lives <u>Safer Cornwall:</u> Our specialist services protect and support the most vulnerable and reduce harm.	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	• 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?	
Raise awareness of substance-specific risks to the general public, especially recreational users and young adults, by highlighting the increased risk of heart attack and stroke from cocaine use, and the dangers of MDMA and ketamine—including contamination and toxicity. Consider risks to people in treatment including -Methadone (OST): Mitigate overdose risk through 3–6-month	The wider public including those who use drugs recreationally and young people will be better informed of the risks they are exposed to. Those in treatment will be better monitored and reviewed thereby reducing risk.	-Awareness raising initiatives of the dangers of cocaine, MDMA and ketamine. -Improvement of the LDIS system so we have improved access to warn those who use drugs recreationally when there is potential contamination of substances. -Shared access to case management systems by GPs and treatment providers and improved communication. -Alternatives to methadone as an OST.	September 2026	

prescription reviews, balancing flexible access with supervised consumption or safer alternatives. Pregabalin, Diazepam, Mirtazapine: Conduct regular reviews to detect prescribed and illicit use. Ensure joint reviews and communication between prescribers when prescribed externally (by GPs or mental health services). For illicit use, treatment plans must include strategies for stabilisation, reduction, and alternatives.		-Regular reviews and better understanding as to why individuals are taking pregabalin, diazepam and mirtazapine.	
Update: The Drug and Alcohol team has developed a Summer Communications Plan for 2026 to strengthen harm reduction, overdose prevention and drug-related death messaging across Cornwall. A key focus is partnership work with Boardmasters Festival, where evidence-based harm reduction messages will be promoted through festival communications, welfare services and social media, including advice on staying hydrated, looking after friends, understanding the risk associated with ketamine and MDMA, avoiding the mixing of drugs and alcohol, being aware on contaminated vaping products and knowing how to access welfare and medical support. We will also be targeting communications to publican and taxi drivers via their newsletter asking for their help (by displaying posters and cards) in highlighting the cardiovascular risks of long-term cocaine use, particularly when mixed with alcohol use. A targeted review of gabapentinoid use was undertaken by the treatment provider, resulting in several recommendations. These included improving awareness of gabapentinoid related risks and strengthening treatment pathways through coordinated multi-agency working. Greater multidisciplinary collaboration between GPs, With You, pain services and mental health teams was identified as an opportunity to provide additional support. The review also highlighted the importance of prioritising psychosocial interventions (PSI) to support self-reduction, engagement and risk reduction. Routine use of urine drug screening (UDS) and Wedinos testing was recommended to improve understanding of substances being used. Regular GP summary records could provide a clearer picture of prescribed and illicit use, including the involvement of multiple gabapentinoids. The review noted that there is currently limited evidence to support substitute prescribing for gabapentinoid dependence; therefore, self-reduction supported through psychosocial interventions remains the primary treatment approach. Inpatient detoxification may be appropriate in some cases, although access and availability can be limiting factors. Regular prescribing reviews continue to be identified as a key learning point from drug related death reviews. Methadone remains the substance most frequently implicated in deaths among individuals in treatment, reflecting the pattern seen in 2024. Further work is planned during 2026 to better understand the factors contributing to this trend and identify opportunities for improvement in clinical practice and risk management.			

Pain Management: Safer Prescribing to Prevent Dependency and Overdose. Published Pain Management Pathway Detailing how pain is managed in treatment and recovery covering both pharmacological and psychosocial interventions Collaborative Prescribing: Treatment providers, GPs, and hospitals must jointly manage opioid prescribing for pain and post-operative care in those with substance use histories. Integrated Reviews: Strengthen joint reviews and information sharing (including case notes) to manage risks from combined prescribed and illicit drug use. Holistic Pain Strategies: Enhance collaboration with pain specialists to support safe medication use and promote non-pharmacological pain management options through all treatment and recovery services.	Individuals who take prescription medication for pain management and those taking combinations of prescribed and illicit drugs will be kept safer.	-Mapping of pain management initiatives within Cornwall and the Isles of Scilly including With You’s approach, Royal Cornwall Hospital Trust and the VSE sector. -Introduction of pain café within Safe and Well hubs and Bosence (to be confirmed). -Assessment of suitability of pain cafés for those using drugs and alcohol.	December 2026
Update: The planned work to investigate pain management and strengthen the evidence base for preventing dependency and supporting recovery aimed to reduce the number of residents becoming dependent on pain mediation (or sourcing illicitly), improve treatment outcomes for those affected by pain and establish clear pathways to effective pain had made steady progress during 2025. Discussions with existing pain cafés highlighted inconsistent provision across Cornwall and challenges in implementing a similar model within the Safe and Well Hubs. Pain remains a priority, with pain identified as a contributing factor in drug related deaths for several years. During 2025, work focused on improving prescribing practices, strengthening joint working between treatment providers, GPs and hospital services, auditing existing pain management provision and developing alternative pain management support within the Safe and Well Hub in Penzance and Bosence. Imagine If (who deliver some of the pain cafés across Cornwall) has secured funding to run a pilot café in Penzance supporting those with former drug and/or alcohol dependency who are struggling with pain. Similarly, a monthly group is being held at Bosence exploring the issue of pain in people’s recovery journey. Both projects utilise the Live Well with pain model. Home - Live Well with Pain. With You has also undertaken work on raising awareness on the issues associated with Gabapentinoid use and how best to support people who are reliant on Gabapentinoids.			

Work is ongoing in creating integrated pain pathways for individuals dependent on prescribed or illicit drugs to manage their pain, establishing a ketamine specific pathway linked to urology services, improving information sharing through shared case management system access. Collectively, these actions aim to reduce dependency on prescribed or illicit pain medication, lower overdose risk, improve access to holistic pain management support and embed pain management as a core component of treatment and recovery pathways.			
Strengthening Early Intervention and Prevention - Promote validated screening tools (e.g. Assyt-LITE) across all frontline services. - Increase awareness and visibility of support services for individuals and families. - Audit the use of routine ACEs enquiry under the Compassionate Cornwall All Age Framework.	Those using drugs and alcohol in a harmful way will be assessed and referred for support sooner. Families affected by loved one’s drug and alcohol use will know where to access support. Professionals will be equipped to understand and enquire about trauma.	Assyst-Lite rolled out across Health, Housing and Social Care. Probation screening tool implemented. Rates of referrals from these sources are monitored. Awareness raising of the treatment provider’s family service and affected others group. The data on the use of ACEs enquiry will be analysed and an audit with frontline staff as to the barriers/benefits of asking and training on the same as required.	September 2026
Update: Primary Care Alcohol Screening Training The DAT delivered alcohol screening training to 100 primary care practitioners from St Austell Healthcare as part of ICB-funded work to strengthen alcohol harm prevention across Cornwall and the Isles of Scilly. The programme incorporates system-wide learning, incorporating learning from thematic reviews, Alcohol Related Brain Damage, homelessness and social isolation, to support earlier identification of risk. Since December, this work has contributed to a 50% increase in referrals from primary care into community treatment, demonstrating improved identification and earlier intervention. With You continue to improve their offer for families affected by drugs and alcohol use. Their affected others group work has been established for a number of years and offers a wide range of support to families impacted by their loved one’s substance use. Their walk and talk offer has recently been opened up to the affected others as this area of work continues to grow. In terms of the audit of the routine use of ACEs enquiry-this work ties in with the Safer Cornwall thematic review into the lived of four women who did during 2021-2024 all of whom were care leavers. The review recommends “The introduction of sensitive and skilled routine adversity and trauma enquiry and PTSD screening for all services working to support parents with a key focus early in the system”. This is part of an approach looking to address the intergenerational implications for trauma and to address the same. Linking in with this wider ambition for Cornwall will be ongoing through 2026.			

Ensure consistent, compassionate care for those with multiple vulnerabilities. - Expand the “My Team Around Me” multiagency model. - Train more staff in trauma stabilisation techniques. - Use assertive referrals to With You instead of passive signposting to ensure those with multiple vulnerabilities can access support. - Offer flexible engagement: joint visits, outreach, and creative problem-solving. - Support continuity by overlapping outgoing and incoming keyworkers.	A cultural shift will take place to deepen understanding of how trauma and multiple vulnerabilities can affect engagement with services. Professionals will be trained to go beyond traditional approaches—meeting individuals with empathy, patience, and unwavering compassion to build trust and foster meaningful connection.	Professionals are aware they can refer clients into treatment without the need for a self-referral. Mandatory training for staff on how to engage individuals and changing the narrative from “won’t engage”, “we haven’t found the right way to engage the client”. All agencies will understand the “My Team Around Me” approach. More agencies will be trained in trauma stabilisation. Professionals trained in trauma stabilisation will feel empowered to do their job.	50% of the professionals working with multiple complex needs will understand and be using the MTAM approach. - We will monitor the number of referrals to With You to ensure the cultural shift is working.
Update: My team around me There have been 76 people attending MTAM Level 2 training (up to the last session on 20th June) from across 15 organisations. The Complex Needs team are running monthly MTAM Level 2 training sessions up to December 2026: these are in-person half-day session offered at Pydar House or Polkyth House. (MTAM Level 1 training is currently offered via a self-accessed webinar.) At such time as the MTAM Guidance Document and the new Complex Needs Advisory Panel become the adopted way of working (implementation of which is scheduled for early October 2026), we will revise the training offer to reflect those changes. MTAM training is also expected to offer some additional topic-focused ‘lunch & learn’ sessions (e.g. on psychologically informed and trauma-informed environments; and on cuckooing & multiple vulnerability). Trauma stabilisation training The Trauma Stabilisation Learning Programme (TSLP) is delivered as a four-day experiential training programme across Cornwall, Devon, Plymouth and Torbay, creating a consistent trauma-informed approach across the Peninsula. The model combines clinical and systems expertise, with each cohort co-facilitated by a Clinically Experienced Trainer and a Systems Experienced Trainer from sectors such as domestic abuse, homelessness and substance misuse. Delegates receive practical tools, worksheets and ongoing resources to help them support people			

experiencing trauma symptoms, improve emotional regulation, and safely "hold" individuals while they await specialist therapeutic interventions.

Currently 423 people have been trained across Devon and Cornwall with another 89 delegates to be trained. This includes 188 practitioners from a wide range of statutory and voluntary sector organisations in Cornwall that have either completed or are booked onto the programme, with a further 2 programmes being delivered to approx. 40 delegates this financial year. The programme has also developed a growing trainer network across the Peninsula, including clinically experienced and systems-based trainers who are supported through a train-the-trainer and co-delivery model.

Success indicators include consistently improved pre and post-training confidence and capability scores, increased practitioner confidence in managing trauma presentations, enhanced de-escalation skills, better client emotional regulation, colleagues better able to identify and protect themselves against vicarious trauma and overwhelmingly positive feedback from delegates, many of whom describe TSLP as the most impactful training they have attended and report lasting improvements in their day-to-day practice.

Assertive outreach and flexible support (meeting people where they are)

With you has a dedicated outreach team able to reach out to clients with multiple vulnerabilities who find it harder to engage with traditional service models. This message is being echoed within the GP screening training, the My Team around me training, the dual diagnosis awareness training and the Blue light approach which is being launched within Cornwall.

Appendix C 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: <i>by the end of 2024/2025 prevent nearly 1000 deaths.</i> OHID Drug Related Death Prevention Action Plan 5 Priorities: 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. 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’. 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. Tackling the stigma experienced by people using drugs and alcohol. People have a better understanding of who develops problems and why. 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 ✓ Target met but improvement work ongoing.
Update: Between 2023 and 2026, the drug related death (DRD) review process has undergone significant improvement, evolving from a limited quarterly review model with a substantial backlog, low review coverage and incomplete data collection to a more robust, structured and responsive system. Following the publication of the OHID guidance in 2024, governance arrangements were strengthened through revised Terms of Reference and panel membership, while the introduction of a dedicated DRD sub-group in 2025 increased review coverage and helped address historical backlogs. By May 2026, the implementation of a real-time surveillance model further enhanced the timeliness of reviews, improved multi-agency engagement and information sharing and supported a more comprehensive approach to identifying learning and informing prevention, with ongoing work focused on achieving a full review coverage and sustaining continuous improvement. Local Drug information system (LDIS) update: During 2025, LDIS piloted an out of hours rota involving the drug and alcohol team, with time off in lieu provided for on-call duties. Following evaluation, this approach was found to be resource-intensive relative to the volume of intelligence reports received. As a result, out of hours provision continues but is managed by managers within their existing roles. LDIS activity remained largely business as usual throughout the year; however, LDIS panels were convened in response to concerns about clusters of overdoses. Subsequent drug testing identified no unusual substances or trends, and no public alerts were required. LDIS also strengthened engagement with the night-time economy through a successful awareness campaign featured in a licensing newsletter distributed to publicans and taxi drivers. The campaign promoted the LDIS reporting pathway and highlighted the role of naloxone in preventing overdose deaths, resulting in increased uptake of naloxone training amongst local taxi drivers. Synthetic Opioid 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). Information on synthetic opioids and an easy read version of the Synthetic opioid preparedness plan has been published on the Safer Cornwall website: Synthetic Opioids - Safer Cornwall			
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 2025 ✓ Target met but improvement work ongoing.

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 (NFO) referral pathway was implemented in partnership with South Western Ambulance Service Foundation Trust (SWASFT) in April 2025 to improve access to support following overdose incidents. A dedicated multi-agency sub-group was established to oversee implementation and review progress. Key developments during the year included learning from North Somerset’s, the North West and West Midlands pathway models, strengthening links with Integrated Neighbourhood Teams, issuing communication to raise awareness, gaining access to ambulance naloxone administration data and improving collaboration with police and ambulance services. Analysis of referral data identified two individuals who were not previously known to treatment services and who are now engaging with With You. However, referral numbers remained low compared to ambulance callouts, highlighting challenges including limited awareness amongst ambulance crews, gaps in information sharing and the inability to cross-reference anonymous NDTMS data. Priorities for 2026 include further comms to SWASFT staff by means of a short informative video, increasing referrals into treatment, developing a high-risk NFO response protocol for all NFOs and improving access to overdose data across Cornwall to enable timely follow up and intervention.			
Improve screening and service integration.	- Good cross service protocols - Earlier interventions	- Tackle comorbid mental and physical health issues -reduce drug related deaths	December 2025 ✓ Target met but improvement work ongoing.
Update: Primary Care Alcohol Screening Training The DAT delivered alcohol screening training to 100 primary care practitioners from St Austell Healthcare as part of ICB-funded work to strengthen alcohol harm prevention across Cornwall and the Isles of Scilly. The programme incorporates system-wide learning, incorporating learning from thematic reviews, Alcohol Related Brain Damage, homelessness and social isolation, to support earlier identification of risk. Since December, this work has contributed to a 50% increase in referrals from primary care into community treatment, demonstrating improved identification and earlier intervention.			
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 ✓ Target met but improvement work ongoing.

Update: Since August 2025 steady progress has been made in developing support for those affected by drug and/or alcohol related deaths through a multi-agency working group. A survey of individuals with lived and professional experience highlighted widespread bereavement, inadequate and inconsistent support, significant stigma and a strong preference for compassionate, non-religious remembrance opportunities in natural settings. Four respondents have expressed an interest in helping shape this work moving forward. Findings identified bereavement support as a significant unmet need, with many respondents relying on peer support, workplace supervision or mutual aid services rather than formal support pathways. Respondents emphasised the need for greater public education, trauma informed approaches and efforts to reduce stigma surrounding substance use and drug related deaths. In response, plans are being developed for a community remembrance event in Spring 2027, potentially incorporating a tree planting ceremony. Progress has also been made through the launch of a specialist Cruse bereavement service, informed by people with lived experience and a new pilot programme of Hope Walks delivered by MIND for those affected by drug and/or alcohol related deaths. The group has additionally established links with researchers at the University of Bath who are developing a Bereavement Support and Coronial Process Toolkit, helping to inform future service development and best practice.			
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 ✓ Target met but improvement work ongoing.
Update: Between 2021 and 2025, Cornwall’s supported housing and complex needs services continued to strengthen their response to drug related harm, reporting 91 overdose recoveries, the majority involving naloxone administration. The highest level of activity was recorded in 2023, reflecting both increased risk and improved reporting practices. Since naloxone was introduced across supported housing in 2009, a total of 178 lives has been saved, with over half (91) occurring during the last five years, demonstrating the impact of expanded distribution and workforce training. Naloxone training has also increased significantly, rising from 110 participants in 2023 to 215 in 2025, with delivery extending across housing, outreach, probation, domestic abuse services, local authorities, security providers and community organisations. Progress against the Drug related death action plan has included streamlined training and reporting processes, wider access to naloxone and the adoption of nasal naloxone by Devon and Cornwall police, contributing to a more resilient, system-wide approach to overdose prevention. The priority for 2026 is the implementation of a peer-to-peer naloxone distribution model.			
Investigate pain management	- Evidence based learning	- Implement alternative approach to pain management	December 2025 ✓ Target met but improvement work ongoing.

Update: The planned work to investigate pain management and strengthen the evidence base for preventing dependency and supporting recovery aimed to reduce the number of residents becoming dependent on pain mediation (or sourcing illicitly), improve treatment outcomes for those affected by pain and establish clear pathways to effective pain had made steady progress during 2025. Discussions with existing pain cafés highlighted inconsistent provision across Cornwall and challenges in implementing a similar model within the Safe and Well Hubs. Pain remains a priority, with pain identified as a contributing factor in drug related deaths for several years. During 2025, work focused on improving prescribing practices, strengthening joint working between treatment providers, GPs and hospital services, auditing existing pain management provision and developing alternative pain management support within the Safe and Well Hub in Penzance and Bosence. Imagine If (who deliver some of the pain cafés across Cornwall) has secured funding to run a pilot café in Penzance supporting those with former drug and/or alcohol dependency who are struggling with pain. Similarly, a monthly group is being held at Bosence exploring the issue of pain in people’s recovery journey. Both projects utilise the Live Well with pain model. Home - Live Well with Pain. With You has also undertaken work on raising awareness on the issues associated with Gabapentinoid use and how best to support people who are reliant on Gabapentinoids. Work is ongoing in creating integrated pain pathways for individuals dependent on prescribed or illicit drugs to manage their pain, establishing a ketamine specific pathway linked to urology services, improving information sharing through shared case management system access. Collectively, these actions aim to reduce dependency on prescribed or illicit pain medication, lower overdose risk, improve access to holistic pain management support and embed pain management as a core component of treatment and recovery pathways.			
Partnership work to enable better Housing Pathways -	- Suitable accommodation options available	- Homelessness prevention - Harm reduction	December 2025
Update: Partnership work to improve housing pathways remains ongoing through collaboration with housing partners via the Cornwall Homeless Partnership Board and its associated sub-groups. This board reports to the Safer Cornwall Partnership Board.			
Awareness Campaigns	- Increased awareness - Reduce stigma -Risk of using alone	- Increased access to services - Harm reduction - Reduce drug related deaths	December 2025
Update: The Drug and Alcohol team has developed a Summer Communications Plan for 2026 to strengthen harm reduction, overdose prevention and drug-related death messaging across Cornwall. A key focus is partnership work with Boardmasters Festival, where evidence-based harm reduction messages will be promoted through festival communications, welfare services and social media, including advice on staying hydrated, looking after friends, understanding the risk associated with ketamine and MDMA, avoiding the mixing of drugs and alcohol, being aware on contaminated vaping products and knowing how to access welfare and medical support. Additional activity includes an International Overdose Awareness Day campaign focused on overdose recognition and naloxone awareness, targeted communications to publican and taxi drivers asking for their help (by displaying posters and cards) in highlighting the cardiovascular risks of long term cocaine use, particularly			

when mixed with alcohol use. The plan includes the launch of Cornwall Council's naloxone policy close to International Overdose Awareness Day. The plan utilises established community, partner and internal communication channels to increase awareness, encourage safer behaviour, promote naloxone training and support a coordinated approach to reducing drug related harm.			
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 DAT/DASV partnership has continued to strengthen its collaborative response to individuals experiencing both substance use and domestic abuse. Following review and approval in 2023, a series of multi-agency workshops identified key priorities, including improving understanding of services and referral pathways, enhancing partnership working, and developing a Healthy Relationships Train the Trainer programme. These priorities have informed subsequent activity, including the delivery of health relationships training to With You and Bosence Farm staff and bespoke training from Barnardos focused on identifying primary abusers, coercive control and professional manipulation. Learning from the 2024 DRD report further highlighted the significant impact of domestic abuse, particularly among women, with 62% of women who died from drug related causes identified as domestic abuse victims. In response, regular DAT/DASV working groups were established throughout 2025 to drive improvements in referral pathways, workforce development, partnership working and implementation of the DAT/DASV protocol. The DRD lead and Marac chair, who lead this work, are also members of a national learning network examining the relationship between domestic abuse and alcohol use. Researchers who are part of this group have reviewed Domestic Homicide Reviews where alcohol was identified as a contributing factor and will be presenting their findings through a national webinar. Locally, Cornwall will build on this learning by delivering a multi-agency webinar in autumn 2026 to showcase good practice when working with individuals affected by both domestic abuse and substance use. Priorities for 2026 include analysing agency self-audit findings, evaluation the impact of training delivered to date, strengthening referral pathways and joint working arrangements, expanding reflective practice opportunities and maintaining oversight through regular performance monitoring, service reviews and governance updates to both domestic abuse and drug related death partnership structures.			
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: December 2025 saw the long-awaited publication of a national ‘Delivery Framework’ for Dual Diagnosis/ Co-Occurring Conditions, jointly developed by NHSE and the DHSC. The recommendations from this framework will shape implementation around learning, development and practice across 2026-2027, and into the future. Initially, our priorities are around strategic leadership and service design. By the end of March 2027, we are aiming to:

- Have facilitated a pilot for the use of the ASSIST-Lite screening tool for substances and alcohol in at least one mental health team at CPFT
- Have an operational Joint Working Forum for mental health and treatment services to provide specialist consultation and work to overcome system blockers in real time
- Have carried out a system audit for Cornwall, to determine our position against the national guidance, and utilise this to inform an action plan
- Utilise our learning, and our action plan, to develop updated county-wide guidance/ a strategy for Dual Diagnosis
- Have a clearer pathway for people wishing to access Tier 4 treatment (inpatient and residential treatment) with co-occurring mental health difficulties

Although we can evidence more effective joint working between mental health and treatment services, and the recent development of an Intensive Assertive Treatment offer for people experiencing complex psychosis; there are still pockets of resistance and lacking knowledge across Cornwall. We are yet to achieve a truly ‘no wrong door’ approach within our systems, and even whilst practice, attitudes and engagement with awareness training have continually developed, unhelpful barriers to care and support persist.

Throughout implementation, we do not expect to see a reduction in escalating mental health issues, but earlier intervention, and an increase in people experiencing these co-occurring conditions benefitting from shared care planning, more effective information sharing and coordinated interventions.

Review of the process prior to detox and rehab	-Individuals will be adequately prepared for detox and rehab. -Individuals will be aware of the risks of bingeing on drugs and alcohol prior to detox	-reduction in drug related deaths for those about to enter detox and rehab	December 2025
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Update:
A review of the detox and residential rehabilitation referral process has confirmed that adequate preparation is routinely considered as a core component of referral decision making. Individuals are supported to ensure they are appropriately prepared for detox and rehab, including receiving information and advice on treatment expectations, readiness for change, and the risks associated with continued substance use. This process will be monitored through contract review meetings, with treatment provider reports on service leavers used to enable learning as to whether there was effective preparation for detox and rehabilitation prior to admission.

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: Fear and debt were identified as themes in the 2023 DRD report. The Life Skills team at With You continues to support clients in addressing debt-related issues. Concerns relating to fear and intimidation were also highlighted in the Northern Ireland report “Drug Related Intimidation in Northern Ireland: Nature, Support Needs and How to Respond (October 2025) Drug Related Intimidation in Northern Ireland: Nature, support needs and how to respond A Summary Report , which identified these factors as significant barriers to seeking support. From our review of the 2025 drug related deaths, we see a similar theme emerging in relation to unwanted friends and associates staying with vulnerable adults and their reluctance to report the situation. This theme is reflected within the priorities for 2026-2027.			

Appendix D

Glossary of terms

Acute -severe and sudden onset.

Amphetamine- are central nervous system stimulants.

Arrhythmia-an irregular heartbeat.

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

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

Cardiac arrhythmia-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 overdose 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 rise 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 Fentanyl 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.