DRUG & ALCOHOL ACTION TEAM
Cornwall and Isles of Scilly
Reducing Harm | Promoting Recovery

SAFER CORNWALL
Kernow Salwa

one and all onen hag oll
CORNWALL COUNCIL

DRUG RELATED DEATHS REPORT

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

1st January 2020 to 31st December 2020

CONTENTS

EXECUTIVE SUMMARY

Drug related deaths increased in 2020 by 9 deaths to 40 (+22.5% from 2019). This is the highest ever recorded number of drug related deaths for Cornwall and is the third successive annual increase. **In the same period nationally, the increase is 3.8%**

- Thirty-three people (**82.5%**) died in 2020 from a death that involved **an opiate drug,** 5 more lives lost than the previous year.
- **Deaths involving heroin decreased by 36%;** 22 deaths in 2019 to 14 in 2020.
- **Cocaine** featured in 15 of the deaths (37.5% of the total, **- 5 deaths and 27% from 2019**). After three successive annual increases since 2016 this is a notable decrease.
- **17.5% of cases in 2020 involved the presence of heroin and cocaine** compared to 52% in 2019 (**a reduction of 34.5%**). This is in line with marked decreases in the presence of heroin and cocaine in 2020 toxicology results.
- **Deaths involving methadone increased from 9 (29%) in 2019 to 15 (37.5%) in 2020**. Of these, the deaths where illicit methadone was a factor increased from 3 (9.7%) to 7 (17.5%)
- **9 deaths (22.5%) involve previously unseen illicit benzodiazepine drugs** which are much more potent than prescribed benzodiazepines. 22 cases involve diazepam and **27 (67.5%) feature any benzodiazepine being present**.
- **The highest rate of drug related deaths occurred in the 50- 59 age group** (11 deaths or 27.5%).
- **72.5% of cases do not have any alcohol present** within toxicology, slightly down from 77% in 2019, continuing the downward trend since 2017.
- Thirty-eight (95%) feature **more than one drug being present** and contributing to the death. **2 deaths (5%) feature only one drug** in toxicology and these were **cocaine and morphine**.
- **Deaths involving a gabapentinoid drug such as Pregabalin have reduced from 45% to 27.5%**- 3 less deaths for 2020

- **Twenty-two people died whilst engaged in drug treatment** (55%) or within 6 months of leaving drug treatment. 18 (45%) had no link to drug or alcohol treatment or had been out of treatment for over 6 months.

- **Two deaths** involved a synthetic cannabinoid receptor agonist (SCRA) such as the colloquially named 'spice' drug or **synthetic cannabis**. This has not been seen in Cornish drug related deaths previously.

Contributing Factors of Note

- Mental ill health (present in >75% of the deaths)
- Physical ill health/ Illness leading up to death (65%)
- Covid-19 (the collateral effects of the pandemic and not the actual infection by the virus).
- Pain (50%)
- Suicidality (>32%)
- Bereavement (22.5%)
- Family and relationship breakdown (>33%)
- Long history of drug use (>25%), early drug use by young persons (>22%) and adverse childhood experiences where a range of issues appear to have led to drug use (>30%)
- Criminal justice issues including imprisonment (>32%)
- Parental status/ children living elsewhere (>30%)

1. INTRODUCTION

1.1 This is the eighteenth annual Drug Related Deaths report for Cornwall and the Isles of Scilly, covering the calendar year 2020. It follows the guidance and requirements by the Department of Health and the Home Office for all Areas to have in place a system of recording and conducting confidential inquiries into drug related deaths within their specific areas.

1.2 The definition of a drug related death used is that of the Home Office, all 43 Police Forces within England and Wales, the Department of Health and Public Health England; '*deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, are involved'.*

1.3 Aims and Objectives of this report
This report examines issues that have arisen from the review of drug related deaths and associated learning, seeking to improve local understanding, practice and the lives of local residents and their families.

1.4 Methodology

This report has been compiled by drawing upon various expertise from partner agencies, data sharing and joint working. Below is a non-exhaustive list of contributions and guidance to this report.

- Cornwall Drug Related Death Review Panel
- With You Drug and Alcohol Service
- DAAT Clinical Governance Group
- Cornwall Controlled Drug Intelligence Network
- Devon and Cornwall Police and particularly the Drug Liaison Officers
- Cornwall Suicide Surveillance Group
- HM Coroner's Office
- Multi-Agency Suicide Prevention Group
- Office for National Statistics (Deaths Related to Drug poisoning in England and Wales 2020 Registrations, published 3rd August 2021)*. A copy of this report can be found **here**

1.5 Limitations

At the time of writing, 11 of the 40 deaths included (27.5%) have yet to go to inquest and to be officially concluded as a drug related death or otherwise. There is sufficient evidence at this stage such as toxicology and witness testimony to be reasonably certain that all cases mentioned herein are drug related deaths, but status will be revised post inquest as necessary. Certain evidence from GP's and the family may not be known

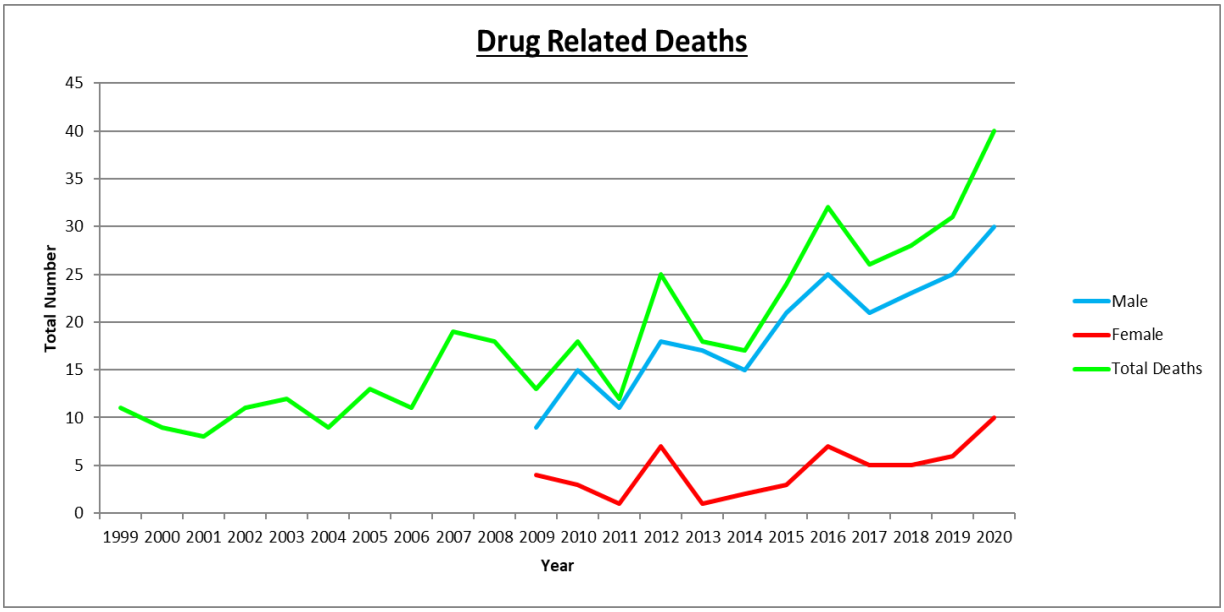
prior to the inquest so there will be future information forthcoming which cannot at this stage be commented upon or be included.

*ONS Statistics state: 'In England and Wales, almost all drug-related deaths are certified by a coroner following an inquest. The death **cannot be registered** until the inquest is completed, which can take many months or even years, and we are not notified that a death has occurred until it is registered. **This results in a discrepancy between local and national figures for a period of time**.

In common with most other mortality statistics, figures for drug-related deaths are presented for deaths registered in a particular calendar year, rather than deaths occurring each year.

2. Main Report 2020

2.1 The graph below illustrates drug related deaths in Cornwall from the beginning of 1999, when DAAT records commenced, up to the end of 2020 showing an upward trend and a sharp rise for 2020**.**



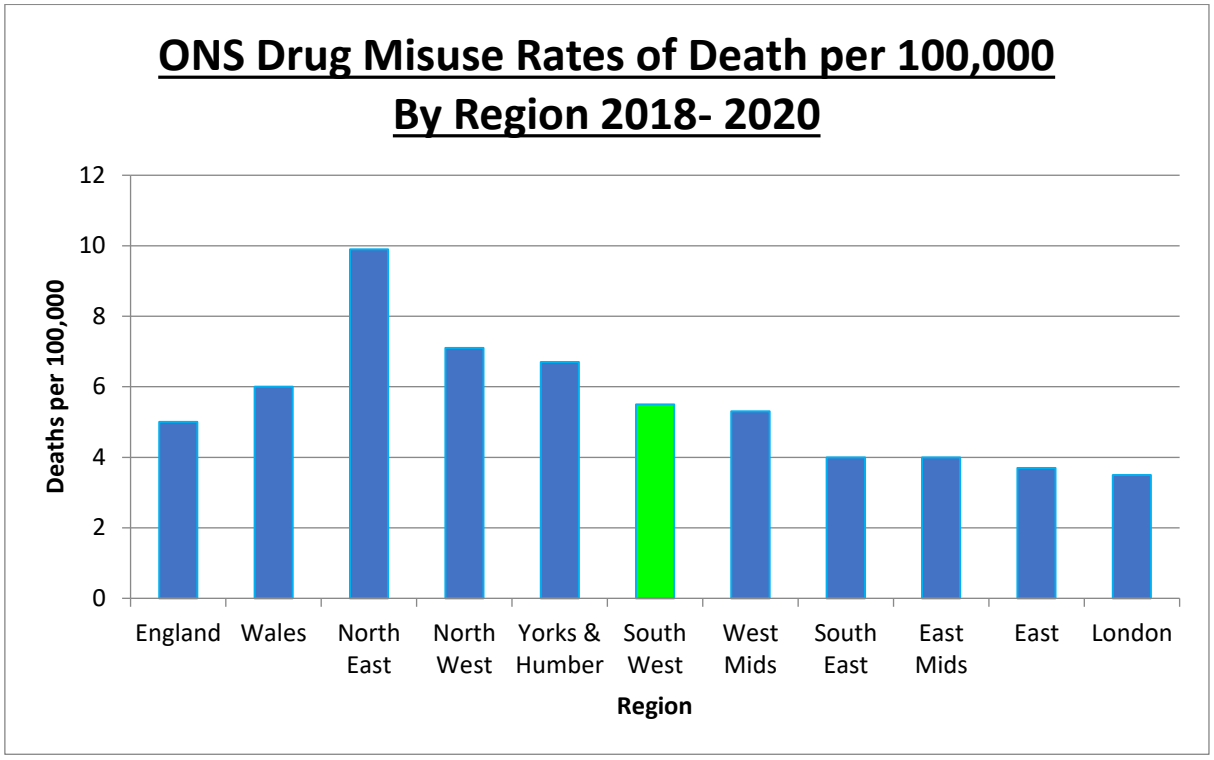
2.2 National Vs Local

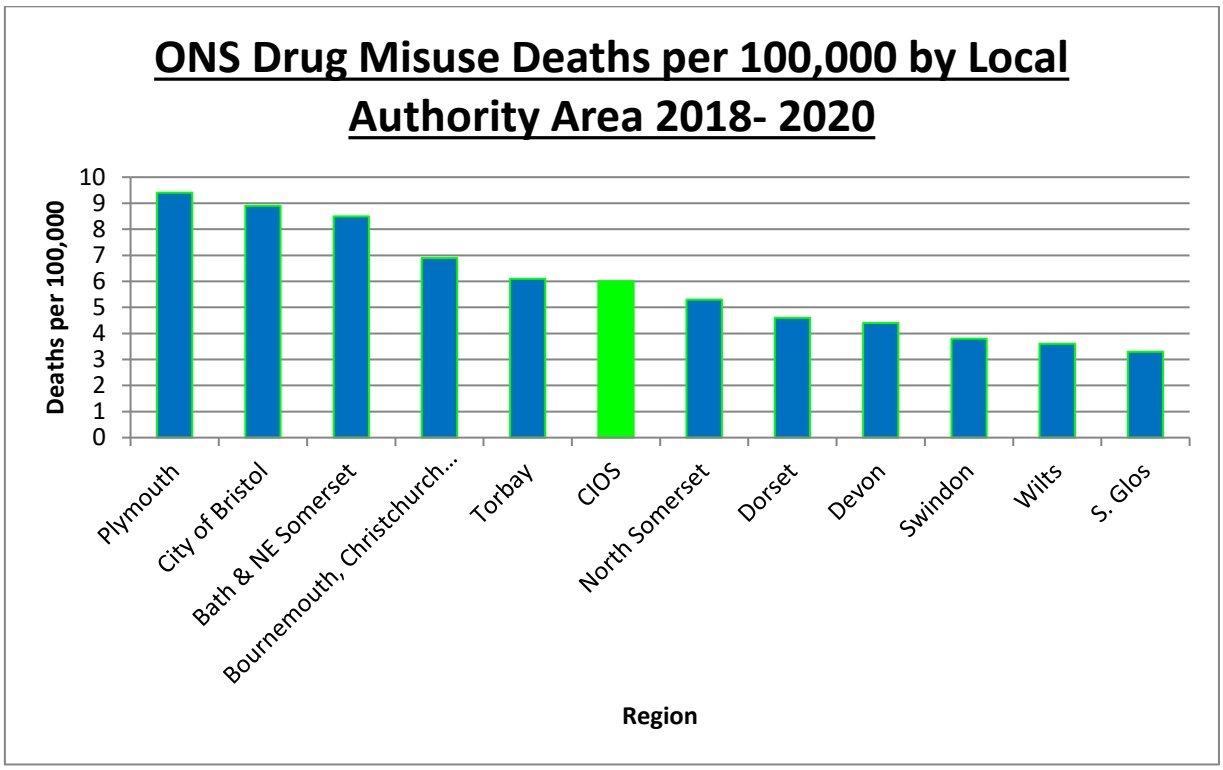
Comparison between the Office for National Statistics (ONS) 'Deaths related to drug poisoning in England and Wales: 2020 registrations' (published on 3rd August 2021) main national headlines and local CIOS data for 2020.

ONS	CIOS
4,561 deaths related to drug poisoning were registered in England and Wales- 3.8% higher than 2019	The rate of increase (22.5%) was higher in Cornwall.
Among males, there were 3,108 registered deaths and 1,453 female deaths (Ratio of men to women is 2.14:1)	The ratio for men is higher in Cornwall at 3:1 in 2020 against 4:1 in 2019.
Rates of drug-misuse death continue to be elevated among	Highest rate amongst those aged 50-59 (11 deaths) closely followed

those born in the 1970s, with the highest rate in those aged 45 to 49 years.	by the 40-49 age group (10). There were 7 deaths in the 45-49 age group.
Approximately half of all drug poisoning deaths registered in 2020 involved an opiate (49.6%; 2,263 deaths); 777 deaths involved cocaine, which is 9.7% more than 2019, and more than five times the amount recorded a decade ago (144 deaths in 2010)	Over 4/5ths of deaths in Cornwall involved an opiate (82.5%; 33 deaths); 15 deaths involved cocaine, which is 27% less than 2019, but still significantly more than a decade ago where cocaine related deaths were rarely encountered.
Heroin and morphine continued to be the most frequently mentioned opiates with 1,337 drug poisoning deaths mentioning either one of these substances in 2020	Heroin and morphine were also the most frequently mentioned opiates with 20 deaths; 50% mentioning one of these substances.
There have been increasing numbers of deaths involving benzodiazepines in 2020 (a rise of 19.3% when compared with 2019; from 399 to 476 deaths), pregabalin (a rise of 41.0%; from 244 to 344 deaths), gabapentin (a rise of 32.6%; from 89 to 118 deaths) and zopiclone (a rise of 4.3%; from 140 to 146 deaths)	12 deaths (30%) involve previously unseen benzodiazepine drugs in Cornwall. 22 cases involve diazepam and 27 (67.5%) feature any benzodiazepine being present (a rise of 3% when compared to 2019). Pregabalin and Gabapentin deaths remain constant (no increase) whilst Zopiclone related deaths have increased by 400% (1 death to 4)
Over half of all drug poisoning deaths involve more than one drug, and it is not possible in those cases to tell which substance was primarily responsible for the death	95% of the deaths involve two or more drugs (this includes alcohol)

The below two graphs illustrate the rate of death per 100,000 population by region and local authority area respectively over a three-year period from 2018 to 2020.


ONS Drug Misuse Rates of Death per 100,000 By Region 2018- 2020
Deaths per 100,000
0
2
4
6
8
10
12
England
Wales
North East
North West
Yorks & Humber
South West
West Mids
South East
East Mids
East
London
Region


ONS Drug Misuse Deaths per 100,000 by Local Authority Area 2018- 2020
Deaths per 100,000
0
1
2
3
4
5
6
7
8
9
10
Plymouth
City of Bristol
Bath & NE Somerset
Bournemouth, Christchurch...
Torbay
CIOS
North Somerset
Dorset
Devon
Swindon
Wilts
S. Glos
Region

2.3 Poly drug use or synergistic interaction between drugs has again been one of the main findings within toxicology, with only two deaths in 2020 involving a single drug (cocaine and morphine). All other deaths have involved at least 2 substances.

2.4 There were **14** (35%) **deaths from heroin toxicity or where heroin has been implicated in the death** in 2020. This is a **decrease of 36%** from 2019 where there were 22 such deaths of the 31 in total. This is a significant decrease where previous years saw a steady rise in the prevalence of heroin related deaths culminating at 71% of the total deaths in 2019. This will be discussed later in the report at Section 4.

2.5 The proportion of deaths relating to the **presence of an opiate drug** has decreased in 2020 from 90% to 82.5% but still this translates to **5 more deaths in 2020 (28 to 33 deaths)**. Of the opiate drugs present this year, heroin can be found in 14 cases, methadone in 15, morphine in 6, codeine in 3, alfentanil and hydrocodone in 1 each with incidences of all of these drugs overlapping in the deaths. Apart from one death involving morphine as a sole agent in toxicology, opiate related deaths involve poly drug use.

2.6 Cocaine* featured in 15 of the deaths (37.5% of the total, **down 5 deaths or 27% from 2019**). **After three successive annual increases since 2016 this is a notable decrease.** As per previous years, the cocaine is believed to be in the form of crack cocaine in the main, although, as per the caveat asterisked below, this cannot be ascertained exactly. This will be discussed further in Section 4 of this report.

*Toxicology only indicates cocaine and its metabolites, so where a person has used crack cocaine, only cocaine metabolites are indicated. By adducing other evidence/ information such as criminal activity, witness testimony and personal disclosure a more accurate picture can be gained about the role of crack cocaine in drug related deaths. The access to this information indicates strongly that crack cocaine use is now fairly prolific and linked to the intelligence picture of organised crime drug distribution.

2.7 Deaths from **methadone toxicity,** or where it had been implicated in the death, had been decreasing for the previous two years but has **increased to being present in 15 (37.5%) of the deaths for 2020**. Of those 15 incidences, 8 were in relation to prescribed methadone and 7 from an illicit source. There is an associated rise in the proportion of deaths where illicit* methadone has been a factor from 9.7% (3 deaths) in 2019 to 17.5% (7 deaths) in 2020. Methadone has been one of the drugs where its' increased prevalence in 2020 deaths has in part addressed the balance when considering the reduction in the proportion of deaths related to

cocaine and heroin. Again, this will be explored more fully later in the report at Section 4.
* Illicit in this context refers to methadone that has been involved in the death and has not been prescribed to the deceased person.

2.8 This next table illustrates the most significant drugs and drug combinations with regard to their frequency in 2020 for male and female deaths.

Type of Drug/drub combination	**Male**	**Female**	**Deaths (from the total of 40)**
Opiate drugs	16	7	33
Opiates and Benzodiazepines	23	4	27
Benzodiazepines	22	5	27
Cocaine	11	4	15
Methadone	10	5	15
Heroin	11	3	14
Previously unseen illicit benzodiazepines (9) plus 3 gaining prominence in last three years (included in the box above for all benzodiazepines)	11	1	12
Heroin and Cocaine	5	2	7

2.9 This table consolidates the previous table and graph at 2.11 and 2.5 adding in gender and case numbers for all years between 2014 and 2020.

	2014	2015	2016	2017	2018	2019	**2020**
Total DRD's	17	24	32	26	28	31	**40**
% Change	-6%	+41%	+33%	-19%	+7.7%	+10.7%	**+22.5%**
Gender	15M 2F	21 M 3 F	25 M 7F	21 M 5F	23 M 5 F	25M 6F	**30M 10F**
Age group with highest rate of death	30-39 47%)	30-39 (33%)	30-39 (28%)	40-49 (42%)	40-49 (43%)	30-39 (39%)	**50-59 (27.5%)**
Opiate drugs	16 (94%)	18 (75%)	27 (84%)	22 (65%)	26 (93%)	28 (90%)	**33 (82.5%)**
Heroin	11 (65%)	12 (50%)	18 (56%)	15 (58%)	22 (79%)	22 (71%)	**14 (35%)**
Methadone	5 (29%)	5 (21%) (3 prescribed	5 (15%)	13 (50%) (10 prescribed	12 (43%) (10 prescribed	9 (29%) (6 prescribed 3 illicit)	**15 (37.5%) (8 prescribed 7 illicit)**

	(3 prescribed 2 illicit)	2 illicit)	(4 prescribed 1 illicit)	3 illicit)	2 illicit)		
Cocaine	0	2 (8%)	11 (34%)	12 (46%)	15 (54%)	20 (64.5%)	**15 (37.5%)**
Heroin & cocaine	0	2 (8%)	8 (25%)	7 (27%)	13 (46%)	16 (52%)	**7 (17.5%)**
Benzo-Diazepines prescribed and illicit	11 (65%)	8 (33%)	21 (65%)	15 (58%)	21 (75%)	20 (64.5%)	**27 (67.5%)**
Opiate drugs and benzo-diazepines	9 (53%)	8 (33%)	19 (59%)	16 61.5%)	20 (71%)	19 (61%)	**27 (67.5%)**

2.10 Male deaths 2014- 2020

	2014	2015	2016	2017	2018	2019	**2020**
Total Drug Related Deaths	17	24	32	26	28	31	**40**
Males	15 (88%)	21 (87%)	25 (78%)	21 (81%)	23 (82%)	25 (81%)	**30 (75%)**
Mean age	40	40	40	42	40	39	**45**
Youngest	27	2 x 25	21	19	2 x 21	26	**3 x 22**
Oldest	61	63	62	62	51	61	**68**
Spread of ages	20's- 2 30's- 6 40's- 5 50's- 1 60's- 1	20's- 4 30's- 7 40's- 5 50's- 3 60's- 2	20's- 6 30's- 6 40's- 7 50's- 5 60's- 1	teens 1 20's- 3 30's- 5 40's- 7 50's- 3 60's- 2	20's- 2 30's- 8 40's- 11 50's- 2	20's- 4 30's- 10 40's- 8 50's- 2 60's- 1	**20's- 4** **30's- 6** **40's- 8** **50's- 10** **60's- 2**

2.11 Female deaths 2014- 2020

	2014	2015	2016	2017	2018	2019	**2020**
Total Drug Related Deaths	15	24	32	26	28	31	**40**
Females	2 (12%)	3 (13%)	7 (22%)	5 (19%)	5 (18%)	6 (19%)	**10 (25%)**
Mean age	32	40	32	41	32	39	**35**
Youngest	30	32	15 months	32	15	22	**26**
Oldest	34	49	55	45	42	56	**59**

Spread of ages	2 x 30's	30's- 1 40's- 2	Child- 1 20's- 1 30's- 3 40's- 1 50's- 1	30's- 1 40's- 4	Teens- 1 20's- 1 30's- 2 40's- 1	20's- 1 30's- 2 40's- 2 50's- 1	**20'2- 4** **30's- 3** **40's- 2** **50's- 1**

2.12 The highest rate of drug related deaths in Cornwall occurred in the **50- 59 age group (11 deaths or 27.5%)**. This is the first time that this age group has seen the greatest number of deaths where previous years have seen it mainly being from the 40-49 age group apart from 2019 where the 30- 39 age group had the highest number. The **average age of men and women** dying from a drug related death during 2020 is **40**. The average age for men has increased to 45 from 39 due to the increased numbers of men dying in the 50 to 59-year-old group for 2020. Men represent 75% of the total number of deaths (30 out of the total of 40). **Female deaths have risen by 4 deaths to 10 for 2020** (25% of the total). The average age for women is 35, a decrease from 39 in 2019 where there were 4 less deaths of women.

2.13 Toxicology further shows that **29 or 72.5% of deaths do not have any alcohol present** and, although slightly down from 77% in 2019, tends to continue the downward trend since 2017 and includes some of the deaths where the deceased had been in drug and alcohol treatment. Only 2 deaths involved an amount of alcohol defined as significant for the purposes of this report (> 200mg of alcohol per 100ml of blood where the UK drink/ drive limit for comparison is 80mg/100ml). The remaining 9 deaths where alcohol is present could be considered as lower 'sociable' levels of alcohol fluctuating but close to either side of the 80mg/100ml level.

2.14 Mental health. People who had been experiencing mental ill health at death or where it had been an issue identified in their lives previously, featured in excess of 75% of the drug related deaths- this is a significant finding with 31 people affected in this way. Of this number, 5 had a diagnosed psychosis.

There are 15 mentions of an anti-depressant medicine (venlafaxine, sertraline, citalopram, fluoxetine and mirtazapine) in toxicology (some appear in combination in a small number of the deaths) and 4 anti-psychotic medicines are mentioned. Medicines such as amitriptyline appear in 10 of the drug related deaths but are not accounted for here in the anti-depressant figures. Amitriptyline can be prescribed for a number of conditions, including depression. Likewise, diazepam features in 22 of the deaths and a proportion of these deaths were where a person was being prescribed for anxiety and 'lower' level mental health issues. A total of 75% of the DRD's for 2020 feature mental ill health. Some were in mental health services treatment for these issues, others were identified whilst in drug

treatment and some will have not been to a GP or other health professional and will have described themselves as self-medicating.

2.15 Drugs Present and/ Or Contributory to Death

The below table lists every substance that has been identified in toxicology over the last four years representing 125 deaths.

Substance	2017	2018	2019	2020
Alcohol				
Alcohol present/ insignificant	7	5	6	**9**
Alcohol present/ significant (above 200 mg/ 100ml)	3	2	1	**2**
No alcohol present	16	21	24	**29**
Illicit drugs, Controlled Drugs and other substances				
Heroin	15	22	22	**14**
Cocaine	12	15	20	**15**
Diazepam	14	17	18	**22**
Methadone	13	12	9	**15**
Morphine	1	3	3	**6**
Phenazepam	0	0	0	**6***
Cannabis	5	3	1	**6**
Alprazolam	3	6	2	**3**
Flubromazolam	0	0	0	**2***
Amphetamine	4	2	1	**2**
Synthetic cannabis	0	0	0	**2***
Flualprazolam	0	0	0	**1***
MDMA/ MDA (Ecstasy)	3	3	1	**0**
Ketamine	1	0	2	**1**
Etizolam	0	1	4	**1**
Mephedrone	1	0	0	**0**
Buprenorphine	0	1	1	**0**
Volatile substance (gas)	1	0	0	**0**
Other drugs (medicines and illicit)				
Amisulpride	1	0	0	**1**
Amitriptyline	1	3	2	**10**
Citalopram	3	4	2	**3**
Chlordiazepoxide	0	3	0	**0**
Clonazepam	1	0	0	**0**
Codeine	1	0	0	**3**
Cyclizine	1	0	0	**1**
Dihydrocodeine	3	1	0	**3**

Fentanyl	1	1	1	**1**
Fluoxetine	0	2	2	**2**
Gabapentin	2	3	0	**0**
Hydrocodone	0	0	0	**1**
Lorazepam	0	0	0	**1**
Mirtazapine	3	6	5	**9**
Olanzapine	0	2	0	**3**
Pregabalin	12	9	12	**11**
Procyclidine	1	0	0	**1**
Propranolol	1	0	0	**3**
Promethazine	1	0	0	**2**
Quetiapine	3	2	1	**1**
Sertraline	2	4	1	**1**
Tramadol	2	4	0	**0**
Trazodone	0	3	1	**0**
Venlafaxine	3	0	2	**2**
Zopiclone	5	1	1	**4**

2.16 Pain Management. The 2019 annual report highlighted that certain drug combinations, self-medicating (especially in cases of pain management) and availability and accessibility of pain medicines warranted further investigation. This has since been addressed and will be discussed further in Section 4, but 2020 has continued to see this with **50% of the deaths involving those who have been enduring high levels of pain.**

2.17 Physical illness. 26 of the people who died in 2020 had notable physical illnesses. These illnesses were wide ranging but added to being vulnerable to a drug related death and were also detrimental to the person's mental well-being. Some of these physical illnesses overlap with the people who suffered high level pain. **13 deaths involved a person with liver disease which was predominantly brought about by their drug and/ or alcohol use**. A compromised liver will make it more difficult for the person to be able to metabolise such things as alcohol and drugs. There have been deaths in 2020 where it is clear from pathology and toxicology that levels of drugs have been higher in the bloodstream of the respective person due to a compromised liver and, therefore, the drugs have become more toxic to the person as a result.

2.18 Pregabalin has featured again, being present in 27.5% of them (11 deaths). Whilst this is one less than last year (11 by comparison with 12), Pregabalin is notable for a range of reasons, including its potentiating effect of heroin, it's legitimate use in mental health treatment such as anxiety and in people suffering pain and epilepsy. A more complex picture of drug/ medicine use has emerged in 2020 where factors such as mental ill health, pain management physical ill health, pleasure seeking and suicidality can all be involved.

2.19 Nine deaths **(22.5%) involved illicit benzodiazepine previously unseen in Cornwall. These benzodiazepines are much more potent than those available on prescription**. These have included Phenazepam (featured in 6 deaths), flubromazolam (2) and flualprazolam (1). There were a further 4 instances where 2 other illicit benzodiazepines featured, which have been seen in deaths over the past 3 years (alprazolam and etizolam). These are of similar strength.

Taking away the overlap in these drugs within toxicology with each other or with other drugs and **there are 12 deaths (30%) where high strength benzodiazepines have been significant in the post-mortem findings**. This increase in the use of alternative benzodiazepines is discussed further at Section 4 but one hypothesis is that this could be a legacy of 2020 lockdowns where other drugs may not have been so available. Nevertheless, supply and demand have increased.

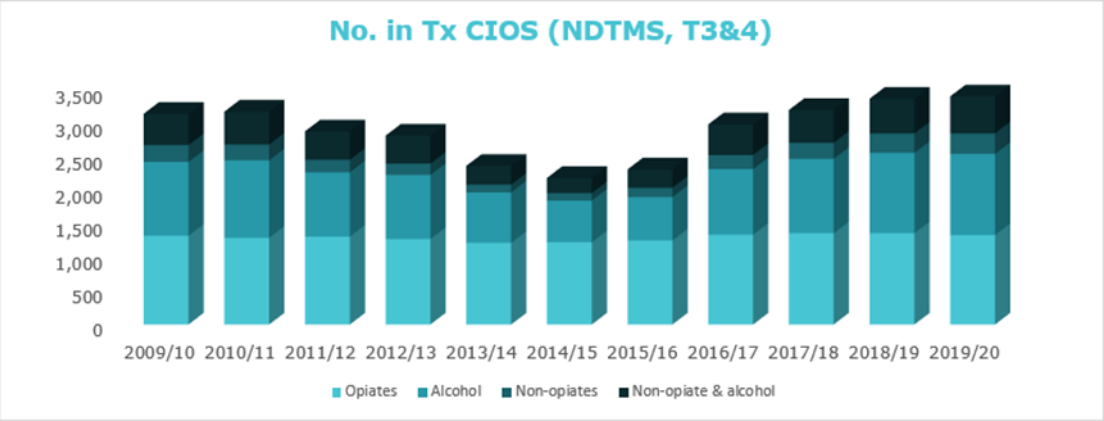
2.20
Drug Related Deaths and Numbers in Drug and Alcohol Treatment

	2014	2015	2016	2017	2018	2019	**2020**
Total drug related deaths (people in treatment or within 6 months of treatment and percentage of total)	17 (15-88%)	24 (14-58%)	32 (15-47%)	26 (18-69%)	28 (18-64%)	31 (22-71%)	**40 (22-55%)**
In current drug treatment (proportion of total number in treatment)	10 (0.7%)	10 (0.7%)	14 (0.9%)	16 (1%)	15 (0.9%)	16 (1%)	**19 (1%)***
Died within 6 months of leaving drug treatment	1	2	1	1	2	2	**3**
DRD and currently in alcohol treatment	3	1	0	1	1	4	**0**
Died a DRD within 6 months of leaving alcohol treatment	1	1	0	0	0	0	**0**
Not known to treatment	2	10	17	8*	10	9	**18**

*This data is an estimate based upon previous years. The equivalent data from NDTMS is not available as at the writing of this report.

The number of people who **died whilst being in treatment or within 6 months of leaving treatment has remained at 22 (71% reducing to**

55% as a proportion of the relative year's total). Of the 18 who appear in the 'not known to treatment' section, 2 males were out of treatment for over 4 years, one male for over 3 years, one male for over 2 years, one male for 14 months and one female for over a year.



The graph above shows the numbers in opiate, alcohol, non-opiate and non-opiate/ alcohol treatment over 10 years in Cornwall up to April 2020. The graph clearly shows that the numbers in opiate treatment have not changed significantly over the years, but the other three categories have steadily increased since 2014/15.

2.21 The term suicidality covers suicidal ideation (thoughts about taking one's own life), suicide plans and suicide attempts. **13 deaths in 2020 featured suicidality.** Some of these deaths involved a history of intentional overdoses using illicit or prescribed drugs or an ambivalence to the outcome of over-use. There are deaths described in Section 3 of this report (case summaries) where there is insufficient evidence to support HM Coroner concluding that the death was a suicide but that the context and some of the evidence pointed towards that conclusion. Where the inquest finds that a person deliberately took a certain drug(s) but did not intend to take their own life this will usually lead to a drug related death conclusion. The differences between conclusions can sometimes be blurred. In the absence of a suicide note, for example, intention can be difficult to ascertain, particularly if the deceased person has been alone prior to and/ or at death.

2.22 There are many other contributing factors that have been identified in the deaths from 2020. In each of the factors below, there was notable information pertaining to the way in which the deceased person reacted to the particular factor by increased drug use, for example, and where the drug use played a significant part in the lead up to their death. These include, expressed as a proportion of the total number of deaths;

- Bereavement (22.5%)
- Family and relationship breakdown (>33%)
- Long history of drug use (>25%), early drug use by young persons (>22%) and adverse childhood experiences where a range of issues appear to have led to drug use (>30%)Criminal justice issues including imprisonment (>32%)
- Parental status/ children living elsewhere (>30%)

2.23 Venues where deaths occurred (includes 4 deaths in hospital where the overdose occurred elsewhere)

Venue	Number of DRD's
Home address	29
Home address of another	4
Supported accommodation	4
Car park	1
Tent	1
Holiday caravan	1

2020 is no exception to previous years where the home address is the main venue where drug related deaths took place. The majority of those who died at home, died alone or were located alone.

2.24 Area of Cornwall where deaths occurred linked geographically to the nearest town.

Area	Number of DRD's
Camborne	**5**
Newquay	**5**
Penzance	**5**
Redruth	**5**
Falmouth	**4**
St Austell	**4**
Truro	**3**
Penryn	**2**
Bodmin	**1**
Bude	**1**
Hayle	**1**
Saltash	**1**
St Ives	**1**
St Keverne	**1**
Torpoint	**1**

3. BRIEF CIRCUMSTANCES/CASE STUDIES 2020

3.1 Drug Related Death 1

- 68-year-old male who was found by his friend at his home address, in bed, in a sleeping position, not conscious or breathing. The friend had seen the deceased the previous evening and stated that he was unwell.
- Cause of death given as 1a. Drug toxicity with 2. Ischaemic heart disease
- He had a past medical history of mental health issues, hernias, and various abdominal bleeds. No drug treatment record.
- The police found multiple empty blister packs of diazepam, propranolol and co-codamol and a nurse from his surgery stated that this man had been discussed in a meeting the morning of the death as there were concerns that he was a suicide risk.
- The levels of drugs present in toxicology do lend themselves to this concern of suicidality- 20 times the lower lethal level of codeine, 6 times the lower lethal level of paracetamol and nearly 3½ times the lower lethal level of cocaine.
- There was, however, insufficient evidence for HM Coroner to conclude that this was a suicide and, therefore, gave a conclusion of a drug related death.

Findings

- This case has highlighted how useful it would be to have standing specialist mental health advice to the Drug Related Death Review Panel.
- It is acknowledged that there are in-depth reviews that take place within mental health services. This advice would be for reviews that did not meet the criteria for a Mental Health Review or where joint reviews require closer alignment.

3.3 Drug Related Death 2

- 42-year-old male who was found by the property's warden with a discharged syringe in the man's hand. The landlady attended the property as the deceased had not been seen for several days.
- Cause of death given as 1a. Heroin toxicity
- He had a past medical history of intravenous drug use, and a recent chest and skin infection
- Range of drugs in toxicology including cocaine, heroin and hydrocodone, the latter being a strong opiate drug that is no longer available in the UK. It has never appeared in toxicology in Cornwall before and it is likely to have been internet sourced or possibly left over from a time when this drug used to be used in pain treatment.

- In drug treatment for a heroin dependence between 21st October 2015 and 27th November 2018. He had been out of treatment for almost 14 months when he died.
- Upon discharge from drug treatment he was no longer using opiate drugs, rarely drank alcohol and was happy, requiring no further input from the local drugs team.

Findings and applying the learning

- This points to us needing to make clearer the aftercare offer for people and communications about help in sustaining progress.
- As this man had not been seen for several days it could suggest that he did not have a wide circle of close friend and/or family that were regularly in contact with him.

3.4 **Drug Related Death 3**

- 58-year-old female who was admitted to hospital the day before she died with an accidental overdose of medicines- predominantly pain medication in the form of the morphine medicine Oramorph
- Cause of death given as 1a. Polypharmacy drug misuse
- Out of alcohol treatment for 14 months but also had comorbid pain issues from osteoporosis and curvature of the spine as well as depression and stage 3 liver disease.
- Alcohol treatment and pain treatment episodes did not overlap so there was a communication issue not helped by this person not wanting either agency dealing to know about the issues. This led to her re-presenting to alcohol treatment without the treating agency being aware of her pain issues and overuse of pain medicines.
- Pain clinic were concerned about the overuse of pain medicines and tried to get her to scale her down her use, but she disengaged from their treatment.

Findings and applying the learning

- Had the drug treatment agency known about this person's pain issues and use of pain medicines, they would have offered her a different package of support which would also have included addressing issues with alcohol.
- Likewise, had the pain clinic been aware that this person had been in alcohol treatment, then some kind of communication to align services would have been made.
- Communication has been improved now with the inclusion of the drug treatment agency patient record software being made available to the RCHT pain clinic. This allows for rapid cross checking of databases to

ensure that the issues in this case do not happen again. This is safer for both patients and professionals.
- To further improve communications, correspondence that has routinely been forwarded to the GP of the respective pain clinic patient is to be copied to drug treatment services going forward.

3.5 **Drug Related Death 4**

- 53-year-old male who was found deceased on the sofa at home. He had a history of occasional drug use and emphysema
- The cause of death was given as 1a. Cardio-respiratory failure, 1b. Cocaine usage and 2. Pulmonary emphysema
- Whilst the level of cocaine use was not in itself deemed toxic, the emphysema and combined action of the cocaine were concluded as significant. The toxicologist noted that cocaine toxicity may manifest itself as myocardial infarction (heart attack), cardiomyopathy (heart muscle disease) or arrhythmia (abnormal heart rhythm).
- There was no history of drug treatment in this death and very little other information from other services.
- The main finding in this death was that this was a man with physical illnesses and combination of cocaine. There was no obvious learning as it appeared that his drug use had not been treated and, although occasional, was sufficient to fatally combine with other factors.

Findings and applying the learning

- This death highlights the need to continue to educate about the risks associated with cocaine use and particularly where there are other co-existing problems, such as physical illness, which that may make the person more vulnerable.

3.6 **Drug Related Death 5**

- 51-year-old man in drug treatment who died at his home address after texting a friend for help as the man feared he was having a seizure.
- Cause of death given as 1a. Acute heroin toxicity and 2. Methadone maintenance therapy with tolerance.
- 20-year history of using heroin with many illnesses. Treatment services didn't manage to engage him long enough to impact upon his chronic relapsing condition There was close working between GP and drug services and permission was given for this by the deceased.

Findings

- This man used street drugs and alcohol from an early age in order to regulate his mood and control both the physical and emotional pain that he experienced. The physical consequences of this drug and alcohol use resulted in serious illness and risks to his life that were discussed with him many times, however services never succeeded in helping him to stop.
- Risks identified and attempts to mitigate them were based around very robust joint working with Social Services, GP and District Nursing Team.

3.7 **Drug Related Death 6**

- 22-year-old male who was found at his home address by his friends in the morning after reportedly snorting the contents of a capsule
- Cause of death given as 1a. Poly drug toxicity
- He was known to take unprescribed medicines on top of prescribed ones and his toxicology showed nine different drugs ultimately leading to his premature death. These included illicit cocaine.
- At least one friend was at the premises and found this man deceased upon waking.
- Whilst the exact circumstances are not entirely clear is seems that drugs were consumed with more than this man present at the time of consumption. Sleep ensued and this man was found deceased when another awoke. The man had vomited at the scene so there was likely a window of opportunity to render first aid and call an ambulance.

Findings and applying the learning

- This highlights the need to work with all users to look after each other and monitor side effects and overdose potential. This is a focus of annual participation in the International Overdose Awareness Day and promoting other outreach events.

3.8 **Drug Related Death 7**

- 50-year-old male who was found deceased by friends having stayed the night at a friend's supporting accommodation room.
- This case is awaiting inquest at the writing of this report. The toxicology analysis, however, has ascertained that a number of drugs contributed to this death including alcohol, heroin, cocaine, diazepam, alprazolam, pregabalin and zopiclone.
- Money that this man had won through betting was used to buy heroin which was shared amongst friends at the supported accommodation.
- House rules were breached in so far as overnight guests are prohibited from staying in rooms.

- Staff at the supported accommodation were not alerted to the overdose/ death until paramedics attended as a result of a 999 call to them form a friend of the deceased. Had the staff been notified as soon as possible there would have been an opportunity to administer naloxone and save life.

Findings and applying the learning

- As above, naloxone was available at the premises and staff have saved lives here before by reversing opiate overdoses.
- All residents have been reminded of the protocols around using naloxone and informing staff as soon as possible that a situation was developing so that they may intervene at the earliest opportunity pending ambulance arrival. It was further reminded that overnight stays are prohibited for a number of reasons including the scenario in question.
- 999 call to ambulance and CPR was carried out by friends but it was too late. An element of intoxication here prevented all present to be aware fully of the gravity of the situation and ultimately delayed life-saving actions.
- A follow up will be made with the individuals involved about their experience and to ascertain levels of learning. This is a recommended course of action for a range of settings where naloxone is part of the toolkit.

3.9 **Drug Related Death 8**

- 31-year-old female who suffered a fatal overdose at her home address. On arrival of the ambulance they were informed that the patient had a 3-4 day history of Covid-19 symptoms (respiratory issues, fever, aches and pain). Paramedics found her in cardiac arrest and commenced CPR
- Cause of death given as 1a. Mixed drug overdose (heroin and cocaine) and bacterial septicaemia; gram positive cocci (staphylococcus species of bacteria was identified) 1b. Intravenous drug misuse
- It was confirmed that this was not covid related by later testing.
- Grossly elevated levels of morphine derived from heroin- 6 times the upper fatal level of morphine.
- Had been in drug treatment for heroin and crack cocaine issues but was discharged 2 months prior to her death due to non-engagement although she had not engaged with WAWY for the month prior to that. The treatment record was kept open until this woman was remanded in custody where the record was then closed with the offer made to her of return to treatment.
- She had previously attempted suicide by overdose.
- Started hearing voices in her head when she started using crack cocaine and, whilst she had previous involvement with mental health services,

she latterly declined an assessment in March 2020 as was not seen again by those services.

Findings

- This death was concluded at inquest as drug related but the sheer amount of heroin which was used before death could not rule out a determined action by the woman to take her own life by a means that was well known to her in life. There was insufficient evidence to conclude that this was a suicide.
- There is evidence of regular contact and liaison with the Probation Service and close working with the Offender Manager in order to offer support to Miss Ellis. Agreement to close the record was made in consultation with the Probation Service when this woman did not respond to attempted contacts

3.10 **Drug Related Death 9**

- 26-year-old woman who had died at her home address and had not been in treatment for drugs. She was found by family members with whom she lived.
- Cause of death given as 1a. multiple drug toxicity
- The level of anti-depressant medicine present in toxicology was potentially fatal in its' own right. Also present was higher than therapeutic levels of the anti-psychotic drug quetiapine as well as diazepam and cocaine being present. The alcohol level was almost three times the UK drink/ drive limit.
- Another death where there was insufficient evidence to conclude a suicide but there were elements of suicide present including previous attempts by overdose, arguing with partner prior to death, certain words said just prior to the fatal overdose and the magnitude of her drug consumption with alcohol. Said HM Coroner…"So I cannot find the balance of probabilities that X intended to take her own life. It's more likely that she was acting recklessly and impulsively without any specific intent."
- She did have a lot to live for also and was a dedicated mother to her young son.
- Her son had complex needs and, prior to the covid situation, she was able to work whilst he was cared for at school. During lockdown she had the added pressures of working from home and having her son being home schooled. Evidence at inquest that this put her under great strain.

Findings and applying the learning

- There is to be further review into this case and, in particular, whether mental health needs were recognised and acted upon.

3.11 **Drug Related Death 10**

- 43-year-old woman who was found deceased by police in her home address with multiple packs of medication present.
- She was 2½ years out of drug treatment and was discharged after her GP took over the pain medicine prescribing.
- Cause of death given as 1a. Multiple drug toxicity.
- She was an active competitor in bodybuilding between 1997 and 2013 and competed at the 2004 Ms Olympia relocating to the USA to train, returning to the UK in 2013.
- It is well documented that her intense training led to pain issues combined with pain from a road traffic accident and she began to self-medicate with opiate drugs which ultimately spiralled out of control with her toxicology showing a fatal combination of 9 drugs including illicit heroin and methadone.

Findings and applying the learning

- Whilst this woman received treatment for her pain and drugs use, she had been out of drug treatment for some time prior to death. She never overcame her pain issues and became locked in a spiral of drug use to ease her pain symptoms, but the drugs also caused her pain to increase and the cycle continued.
- In terms of completing treatment, if the pain management is not successful, we will no longer deem this a completion until the person is receiving adequate pain management support.

3.12 **Drug Related Death 11**

- 27-year-old male who was found by his best friend deceased in a caravan. The deceased had been drinking rum and vodka with friends and then took cocaine (around 1.5 grams). He returned to the caravan where he was staying and was not found until the following afternoon.
- Cause of death given as 1a. Acute cocaine toxicity
- This man had self-referred to local drug services but had not progressed beyond the referral stage. There was a two-week delay in offering the first appointment to this man. He self-referred as he felt that his cocaine habit had overtaken his life and he wanted to change things so that he could be a better father to his two young children.
- This death came in the early part of the first Lockdown when services were relocating to home addresses to work from and sort out appropriate information technology systems in support as well as trying to maintain contact with their clients and working in a different way with less physical contact in clinics
- Long history of depression and previous deliberate overdose of paracetamol. Low mood due to breakdown of relationship with the

mother of his children. Psychiatric services were unable to contact this man to offer an appointment.

Findings and applying the learning

- With regard to the delay in offering the first appointment, it appears that there was an administrative error when the initial referral was taken and that was not picked up until a checking process was undertaken by a Data Officer which located the record over 2 weeks later. Upon review systems were put in place in order to identify such errors. This was, in part, a by-product of the new working arrangements during the early stages of the pandemic.
- However, having reviewed all the evidence, it is unlikely that this administration error contributed to his premature death.

3.13 **Drug Related Death 12**

- 48-year-old male who was found deceased by his landlord and neighbour at his home address
- Cause of death given as 1a. Combined drug intoxication and 2. Coronary artery atherosclerosis.
- The deceased had a past history of alcohol dependence, substance misuse, anxiety, depression and chronic back pain. He was engaged in drug treatment for a continuous 11 years and died in treatment.
- This man had presented in his most recent episode of treatment as very stable and demonstrated abstinence from heroin use over his final 9 months via drug screens. This was an unexpected lapse back into drug use and subsequent death.
- The latter contact via telephone between treatment and the client was slightly erratic with phone sessions not being taken up by the man so well.

Findings and applying the learning

• All clients have a Disengagement Plan which is agreed with the service user at the beginning of treatment and periodically reviewed. This addresses how the service should proceed in the event that they are unable to make contact, or in the event that the service user does not attend appointments. Due to the length of time this man was in service, this protocol had not been followed and the plan had not been agreed. The keyworker had nonetheless continued to attempt contact with this man by phone. He was unable to arrange a home visit due to the Covid-19 restrictions at the time.
• The increased level of and requirement for telephone contact throughout the pandemic has highlighted that some clients do not respond as well as others to this. An increase in the ability of the service to outreach clients

now means that clients that do not respond to telephone contact now have another means of follow up to help with their continuity of treatment

3.14 **Drug Related Death 13**

- 37-year-old man who was in drug treatment when he died at the Royal Cornwall Hospital, Treliske
- The cause of death was 1a. Pulmonary embolism, 1b. Deep vein thrombosis and 2. Intravenous drug use
- HM Coroner concluded; This man died from a known complication of a necessary surgical procedure following illicit drug use.
- This man was working well with WAWY drug services, but he did have physical illnesses as a result of his use of intravenous drugs, particularly when he injected into his groin.
- 12 days before his death he injected heroin and the injection site became septic. He was averse to seeking help in relation to this as he did not want to go to hospital for fear of contracting covid-19. He eventually attended a minor injuries unit because the pain had become so severe. He was transferred immediately to RCHT where he was operated on for an acute femoral deep vein thrombosis, associated infection and an abscess was drained. He died at RCHT due to his deteriorating condition, hypoxia and an evident pulmonary embolism.

Findings

- The delay in this man receiving lifesaving treatment at hospital was delayed to such an extent that his life could not be saved. Whilst this was his decision to delay, his fear of contracting the virus was understandable and he risk assessed the situation wrongly as it transpired. It is very likely that his life could have been saved had the medical intervention been made sooner.
- Risks identified as moderate within his record include the risks associated with a history of intravenous heroin and cocaine use; the risks associated with heavy alcohol use and the risk of Deep Vein Thrombosis caused by past intravenous drug use. The risk management plan included regular harm reduction advice regarding alcohol use, especially if mixed with illicit or prescribed drugs. This man reported significantly reduced alcohol use from November 2019 onwards and due to this, as well as his good progress with opiate substitution treatment and stable housing, was considered to be at low risk overall
- This is the only drug related death in this report where this situation has become apparent.

3.15 **Drug Related Death 14**

- 38-year-old male who was found by his son, face down, unconscious on the kitchen floor of the home address
- Cause of death given as 1a. Mixed drug toxicity.
- This is the first of 6 deaths in 2020 where the benzodiazepine drug Phenazepam has been found in toxicology having never previously been encountered. The other 6 deaths are not obviously linked by drug supply network, the deceased's being known to each other or other factors and appear random in their occurrence.
- Phenazepam features here with nine other drugs including another high potency benzodiazepine drug, Alprazolam.
- This man-made good progress in treatment and produced negative urine screens towards the end of 2019. He self-detoxed from his Buprenorphine prescription and in Oct 2019 he requested that he be closed to treatment. His case was then closed with the proviso that he would be welcome to re-refer himself at any stage should he wish to do so.
- Used substances firstly heroin, then alcohol, then prescribed medication as a means of coping with his underlying anxiety and depression and as a maladaptive coping mechanism to deal with the emotional trauma of Social Services continued involvement with his children
- History of suicide attempts and self- harm which was sometimes as a reaction to his family issues and on-going child access etc.
- He was fully engaged with the mental health team and engaged in all treatment appointments offered as well as engaging with all interventions offered to him.

Findings and applying the learning

- This man was working with all services and open to all interventions, but his drug consumption continued despite all this.
- His combination of benzodiazepine drugs with a range of medicines including methadone led to a premature drug related death.
- It is unknown whether this man took the benzodiazepine drugs knowing them to be stronger than others or that he was mistaken somehow in thinking that they were something else.

3.16 **Drug Related Death 15**

- 54-year-old male whose neighbour raised concerns when a food parcel left on the doorstep to the flat was not picked up for two days. The police gained entry with the landlord's key and found the deceased slumped on a chair at his computer terminal
- Cause of death given as 1a. Methadone overdose and 2. Severe fatty liver disease

- Although this man was on a reducing prescription of methadone, the toxicology suggests that he was using more methadone than prescribed immediately prior to death by either stockpiling his own methadone and then using an increased amount in one go or using illicit methadone on top of his prescribed amount.
- Another factor here was that this man had impaired liver function and, therefore, his ability to metabolise methadone could have led to increased amounts able to remain in circulation and possibly poison him despite him using the prescribed amount.
- All other medicines were in therapeutic range, so this is a drug related death probably by virtue of his body being unable to process his medicines efficiently
- This death highlights the complexity involved with prescribing to a client who needs opiate substitute medication to stave off cravings and a possible relapse into heroin use set against a failing body through years of substance use. It was discussed at inquest that this man may have forgotten how much methadone he had taken or deliberately took too much due to his distress at being locked down during covid. This would not have been a suicide attempt but more of a coping with the situation action.
- This man's prescription of methadone was being lowered safely and he was making good progress towards his goal of becoming drug free. He had made good progress in lowering his methadone prescription with the assistance of liver testing via GP, hospital outpatient appointments and in-house liver scanning.

3.17 **Drug Related Death 16**

- 40-year-old female who was found by her partner, at their home address, unresponsive. Paramedics attended and she was administered adrenaline and naloxone and transported to hospital where she was taken to ICU for continuing treatment. Two days later, despite best efforts she was withdrawn from life sustaining treatment and died.
- Cause of death given as 1a. Liver necrosis and 1b. Drug toxicity
- This woman was on a methadone prescription as part of Opiate Substitute Treatment (OST) and she had a good working relationship with staff.
- Toxicology showed a small amount of cocaine but everything else was prescribed. The toxicologist and the pathologist agreed that this is a case where the cause of death, Liver necrosis (liver cell death), could have been caused by the methadone and paracetamol.

3.18 **Drug Related Death 17**

- 53-year-old male. The deceased and his friend both took heroin and pregabalin on an evening in the deceased's caravan. The following morning the friend found the man deceased on the bed.
- Cause of death given as 1a. Mixed drugs overdose and 2. Coronary artery atherosclerosis and fatty liver disease
- Long term drug treatment accompanied by a methadone prescription.
- Multiple factors in this life and death including bereavement, physical pain and illness, liver disease, previous overdoses and periods of homelessness.
- Latterly he was more stable when he co-habited with a friend in a caravan and they tended to look after each other and support each other in drug treatment.
- Whilst the witness evidence highlighted that these two friends bought and shared heroin together on the eve of the death, there is no other evidence to say how and when the deceased took other drugs such as Phenazepam. This is the second of 6 deaths this year where this drug has been found in toxicology.
- This man used illicit drugs on top of his methadone prescription despite being told many times of the risks. He was experienced in the use of illicit drugs although never sure of what the outcome might be when drugs are combined. This is no truer than not knowing the strength of illicit benzodiazepine tablets such as phenazepam.
- Over the course of his involvement with We Are With You there was close working with other services such as housing (including outreach workers), probation and supported living. Regular updates were provided to his GP / surgery where he also reported to be attending regularly.

Findings and applying the learning

- Whilst we have mounted several information campaigns about the risks associated with illicit benzodiazepines, we have learnt, from this death, that more information and teaching needs to be more comprehensively covered about specific risks of benzodiazepine use for those in OST.

3.19 **Drug Related Death 18**

- 39-year-old male was found deceased at his home address by a pharmacy dispenser. His medical history included hepatitis, alcoholism and poor mental health issues
- The cause of death was given as 1a. Methadone and phenazepam overdose
- This man was on a large dose of prescribed methadone, managed through supervised consumption, despite the challenges in providing this during the last year.

- During the last 6 months of this man's life, the way of working for We Are With You and other agencies had been impacted by the COVID-19 crisis. Face to face work was limited, with a greater emphasis on 'remote working' via phone and computer, however; open access services continued to be available. As this man did not often have access to a phone, reliance on his regular attendance at the pharmacy provided a link to the service and, due to his circumstances, the dispensing remained at daily supervised consumption
- This man's presentation and ability to engage with services appears to have been dependent upon his mental well-being. In more recent times, this appears to have improved and enabled more meaningful conversations to take place, but he struggled to accept the limitations of the opiate substitute prescription that could be provided. This led to him being upset with individual staff and the service in general
- An opiate substitute prescription of methadone was provided at a high level. Prescribing reviews took place on a regular basis, however, the aim was to provide this alongside psycho-social interventions such as motivational interviewing, but progress was limited due to the way he engaged with the service

Findings and applying the learning

- The third death of 6 from this year where phenazepam has featured. A trend which started in 2020 where opiate users and others started to use more street originated and never previously seen in Cornwall benzodiazepines.
- A lot of time and effort went into trying to treat this man and, whilst the covid situation did impact upon service delivery, he remained on a daily pick-up regime and was regularly contacted by phone to keep continuity of treatment.
- As above, this points to the needs for continued, sustained, specific targeted work with regard to the risks associated with illicit benzodiazepines.

3.20 **Drug Related Death 19**

- 34-year-old male who was a resident in supported accommodation
- Cause of death given as 1a. Mixed drugs overdose principally cocaine and heroin
- Diagnosis of paranoid schizophrenia with multiple mental health interventions and years of his life being hospitalised to treat his mental health issues interspersed with community treatment.
- Fluctuating balance of his mental health issues being exacerbated by or brought on by drug use. He often stated that he believed that he needed drugs to be well.

- A lot of talk in this inquest about where the most appropriate accommodation for this man was. His mother stated that he should not have been in a drug tolerant premises but he also had a history of breaking house rules at abstinent based supported accommodation.
- HM Coroner quoted as saying; '*I am unable to see how this (death) could have been avoided*'
- He was offered psychosocial interventions and also the possibility of substitute medication to take the place of heroin, but he stated that he was not dependent on heroin and did not wish to be prescribed any medication.

Findings and applying the learning

- Whilst his mental health would improve in mental institutions and/ or detox, he had at some stage have to be discharged and he went back to using drugs straight away.
- Helping him to have more insight into this pattern in a more assertive manner, through outreach may have assisted, as well as increased understanding of the underlying causes. This scenario will be referred to the Dual Diagnosis implementation Group to review for future provision.

3.21 **Drug Related Death 20**

- 38-year-old male who was found in his bed deceased. Drugs paraphernalia was found on the bed and the floor, including a loaded needle of suspected drugs located underneath him. A needle containing Naloxone was also located on the bed
- Cause of death given as 1a. Multiple drug toxicity
- This man was at the referral stage with We Are With You and had previously and successfully been discharged from their service with a cessation of alcohol use and misuse of various medicines.
- He had a 5-year abstinence from using heroin and only started using it again 6 weeks before his death. He had been issued with naloxone and had tragically been trying to use it on himself unsuccessfully to mitigate his heroin use on the day of his death.

Findings

- He did not want an opiate substitute medication for fear of getting addicted to it.
- This is the fourth death where the drug phenazepam has been found in toxicology and present with other drugs.
- As in previous deaths, this points to the needs for continued, sustained, specific targeted work with regard to the risks associated with illicit benzodiazepines.

3.22 **Drug Related Death 21**

- 34-year-old male who had been drinking alcohol with his friend most of the day. The friend of the deceased went to bed around 21:30 at which time the deceased was sleeping on the sofa and was heard to be snoring. The friend came back downstairs after about 2 hours and decided to check on the deceased and found him unresponsive, not breathing and cold to touch.
- Cause of death given as 1a. Aspiration and cardio-respiratory failure and 1b. Acute methadone and alcohol toxicity.
- This appears to a one-off tragic experimentation with methadone after having consumed alcohol with a friend at their shared accommodation.
- Family very upset by this death stating that their son was easily led and was 'influenced into a lifestyle'.

Findings and applying the learning

- Due to the fact that this man could not clear his own airway of vomit and likely had a reduced cough response due to the methadone, he died. There is a possibility that earlier intervention by the housemate could have cleared the airway and preserved life until the ambulance crew took over.
- It is not known whether there was any offer of methadone or whether this man independently chose to consume it.

3.23 **Drug Related Death 22**

- 53-year-old male who was found deceased in a caravan which was his home address.
- The cause of death was given as 1a. Drug toxicity
- No drug treatment records.
- The toxicology screen was to be expected apart from the standout high level of methadone- this was not prescribed to him and was the property of a friend. There was no explanation at inquest as to how the methadone got there or what the circumstances were behind the deceased consuming it.
- Family witnesses' initial thoughts were that this man had overdosed because he had bouts of manic depression.
- Mental health services have an account that this man had previously impulsively overdosed on the opiate drug Tramadol.
- Bereavement in the family whereby two of his siblings had died by way of a drug related death. This death is linked by a brother dying of a drug related death albeit a month after this death. In total this family has lost 4 children to a drug related death.
- This man would routinely take a range of medicines with the family saying,' If they were prescribed (to anyone) then they were OK to take'.

- Being made unemployed due to the covid situation may have had a bearing on his mood.

Findings and applying the learning

- Information regarding the methadone was fed back to the drug treatment team to take up with the friend of the deceased as he is still in treatment.

3.24 **Drug Related Death 23**

- 28-year-old female who was found deceased in bed by her partner. The deceased's partner stated that she had spent the day in bed having taken crack cocaine and cannabis the previous evening.
- The cause of death was given as 1a. Methadone and phenazepam toxicity
- This woman's death was brought about by a lethal cocktail of cocaine, illicit methadone and is the fifth recorded death this year to include the illicit benzodiazepine drug Phenazepam. As with previous deaths, there was no evidence to suggest that this woman took this benzodiazepine knowing it to be the drug Phenazepam or whether she thought she was taking another drug such as Diazepam.
- No drugs treatment record but she was being treated by the Community Mental Health Team for anxiety. She was referred to We Are With You by RCHT following a hospitalised opiate overdose but she did not engage with WAWY.
- This woman was unwell and being sick at the home address before her partner left her for the evening and, upon returning later that evening, found her unresponsive. There was knowledge that she had taken illicit drugs so a monitoring of her health would have been advisable in these circumstances.

Findings and applying the learning

- This and other deaths highlighted the need to widely alert a range of agencies and service users about the risks associated with these new benzodiazepine drugs. This was done via the cascade alert system and other agencies and supported accommodation premises did likewise. There have been good joint conversations had around this subject including better liaison with RCHT emergency department and a police-led operation into fake, high strength and mislabelled benzodiazepines. This work is on-going in partnership with many agencies.
- Another death where it could have been possibly avoided by earlier first aid and medical intervention.

3.25 **Drug Related Death 24**

- 49-year-old male who was found deceased with two empty bottles of methadone in the bin in his room.
- The cause of death was given as 1a. Ill effects of multiple drugs
- Long term drug treatment service user who was on a methadone prescription, but the level of toxicological metabolites suggest that he overused it before death. Other drugs present were derived from prescribed medicines that were in therapeutic range.
- Reported to have stopped using heroin 5 years before death.
- Engaged well in treatment but had many competing issues that added to his anxiety including assault by family member, financial debts, long history of depression, use of illicit benzodiazepine drugs and covid lockdown.
- Despite the issues above his daughter said that he was doing well of late and his death came as a complete shock bearing in mind his long history of drug use where previous years had seen him in a much worse place.

Findings and applying the learning

- This has been recorded as a drug related death by virtue of the pathology and toxicology but all drugs present could be accounted for from a lawful prescription.
- This man was at the top end of the age range that has been the most prevalent age range in Cornwall for the last 3 years for someone to die from a drug related death. There is a distinct possibility that the excess of methadone tipped this man's long-term use of drug abused body over the edge with co-morbid left lower lobe pneumonia affecting his ability to breathe efficiently.
- All issues were being dealt with by a range of agencies to resolve those individual issues and reduce his anxiety.

3.26 **Drug Related Death 25**

- 27-year-old pregnant female who was found unresponsive at home with her children. It is reported that she had been unwell all day and had been taking co-codamol and solpadeine for back ache. Paramedics suspected co-codamol overdose. She was taken to hospital with a weak pulse and had a fatal cardiac arrest in ED.
- The cause of death was given as 1a. Excess poly drug consumption
- No drug treatment history although this woman had been self-medicating for years due to enduring back and pelvic pain. The current pregnancy added to the pain that she was suffering.
- Tragically her unborn 27-week child also died in hospital.

- Family evidence heard that this woman was 'addicted' to pain killers and would 'eat them like sweets'. They further stated that she was stubbornly refusing to get herself some help from the hospital
- Paracetamol induced liver necrosis was evident which further impaired this woman's ability to metabolise the amounts of pain killers being consumed.
- GP was treating her latterly for the pain and the pain was as before with previous pregnancies. This prompted a comment from HM Coroner at the end of the inquest; 'How do you treat a pregnant mother's pain?'

Findings

- A death which continues to underline the significance of pain as a factor and why some people overuse pain relief medicines and/ or illicit drugs to try and manage their pain.

3.27 **Drug Related Death 26**

- 49-year-old male who was found by his support worker, lying on his front, on top of the bed with significant decay obvious.
- The cause of death was given as 1a. Methadone toxicity
- Methadone fund in toxicology and this man had recently started a methadone script (15 days before he died) with local drug services.
- Dual diagnosis issues which were being treated although covid lockdown had a bearing on this man's treatment from all services.
- Another inquest that adduced that this was a drug related death but there were also indications that this could have been a suicide. These included the door to his flat being wedged shut from the inside by a step ladder, a history of suicidality and the recent death of his mother who he was caring for as he did with his late father. His mother was terminally ill and his access to her was limited due to the covid lockdown- this hit him hard and his drug and alcohol use went up as a reaction to this.
- Due to the decomposed state of this man, toxicology could only be done with liver samples which are not as accurate as blood, for example. To this end it is impossible to extrapolate that the toxicology represents this man's methadone prescription or excess use of it.

Findings

- This death squarely sits between a drug related death and suicide and it will never be satisfactorily decided either way based on the evidence available so the safer conclusion is a drug related one.
- By far the biggest trigger here towards a DRD or a suicide was the recent death of his mother who he was very close to. He was latterly advised to not go to see her due to the possibility of transferring the covid virus to her and yet, she was dying, so he was tormented by this situation.

- A tragic death of a man who had been engaging with services, was open in his presentation but found the combination of bereavement and lockdown overwhelming.
- Lockdown had an effect of monitoring this man on a new methadone prescription.
- The issue of bereavement leading to an increased use of drugs and/ or change in presentation to treatment agencies is being addressed.

3.28 **Drug Related Death 27**

- 38-year-old female who was found by her parents, in a kneeling position - her forehead on the floor, her hands were under her and palms facing upwards - on the 1st floor landing of her home address
- The deceased, a young mother, was able to procure fatal amounts of prescribed medication from a number of on-line pharmacies despite having been convicted of forging prescriptions in her work as a Practice Nurse, for which she had been struck off the Nursing Register.
- The cause of death was given as 1a. Excess consumption of codeine
- History of overdoses and was going through particularly traumatic divorce with her partner. She was engaged in the court process for access to and in order to have her children back in her care.
- Mother of the deceased did not think she intentionally took her own life, 'perhaps a cry for help'.
- Evidence at the scene may have been indicative of a deliberate overdose and suicide attempt but this was insufficient for a suicide conclusion. There was other evidence that tipped the balance that this was a tragic accidental overdose.

Findings and applying the learning

- Another example of the fine line between some drug related deaths and suicide.
- HM Coroner issued a Preventing Future Deaths Notice to the CQC and Minister of State in relation to the ease that this woman was able to obtain medicines from online pharmacies. The ensuing investigation and response to HM Coroner recognised the current legislative framework is inadequate and enforcement action is being considered against a number of the pharmacies identified.
- This case was closely scrutinised by the SW Lead Controlled Drugs Accountable Officer, and Medication Safety Officer Medical Directorate, NHS England & NHS Improvement who is also the chair of the Cornwall Controlled Drugs Local Intelligence Network (CDLIN) which the DAAT attend. This link between the specialism of the chair and DAAT has been strengthened partly as a result of this case and others linked to the issue of pain in DRD's. There is closer liaison now pre-inquest as well as further

anticipated attendance at inquest by the chair who will pick up upon issues. The chair assisted in the investigation by HM Coroner.
- Changes to the law and/or guidance as to online pharmacies is awaited.

3.29 **Drug Related Death 28**

- 47-year-old male, who after consuming an entire bottle of vodka, placed the needle of a charged heroin syringe directly into the top of his skull and pushed down, injecting the heroin. His associate administered naloxone twice, started CPR and called the ambulance but this man died at the scene.
- The cause of death was given as 1a. Combined heroin and ethanol toxicity and 2. Sever fatty liver disease and ischaemic cardiomyopathy
- This incident was witnessed by a group of friends who this man would often play to in behaviour which was characteristic of the way he lived his life, ambivalent to the risks of drug use and resistant to change although he was often in drug and alcohol treatment. Poly drug use which included a previously unseen in Cornwall benzodiazepine drug.
- Many services were engaged with this man, but he was very difficult to treat due to his lifestyle.
- Several bereavements in his life including 3 siblings, the last of whom died from a drug related death less than two months previous.
- Yet another example of a broken family relationship, early drug use, physical and mental illness exacerbated by often excessive drug and alcohol use.
- Recent long-term partner relationship breakdown.

Findings

- There was a lot of work done with this man over years in various agency treatments but this was largely ineffectual due to his reluctance to contemplate change.
- The manner of his death was described at inquest as almost in keeping with him being the 'showman', centre of attention and liked by all who knew him.
- One close relative stated after the funeral of his brother;' He's off to self-destruct now'.
- This man's drug use was not thought to be driven by suicidal ideation but was a tragic step too far in his career of using all manner of intoxicants for a wide number of reasons.

3.30 **Drug Related Death 29**

- 51-year-old male who was found deceased by his friend. The friend of the deceased stated that they had taken a synthetic cannabinoid called

'spice' during the evening in his bedroom. The friend called the emergency services and commenced CPR
- The cause of death was given as 1a. Mixed drug toxicity including synthetic cannabinoid and amphetamine with coronary atherosclerosis and fatty liver changes.
- Long history of chronic back pain, medicine seeking behaviour, PTSD, poor attendance at mental health appointments.
- Over 4 years out of drug and alcohol treatment
- Family gave evidence at inquest that this man's drug use and overall situation worsened when a certain person moved in with him- this led to different drugs being tried such as the 'spice'.
- Diagnosed with schizophrenia, stopped taking his medication and self-medicated with alcohol, cocaine and amphetamine.

Findings and applying the learning

- His underlying health conditions of fatty liver disease and atherosclerosis were worsened by the use of illicit drugs. His combination of drugs such as cocaine, amphetamine and spice were dangerous individually and in combination as they all would tend to cause a disruption to the normal working of the heart.
- This man needed drug treatment and he did not engage well with mental health services.
- This case is to be reviewed by the pain management focus group and the Dual Diagnosis Implementation Group to prevent this set of circumstances concluding in a fatality in future.

3.31 **Drug Related Death 30**

- 47-year-old male who was found by his friend, collapsed, cold and not breathing in the car park outside an industrial unit. He called the emergency services. On their arrival, paramedics found him cold to touch, unresponsive, lying supine on the floor between 2 vehicles with no respiratory effort and no cardiac output
- The cause of death was given as 1a. Acute cocaine and amphetamine toxicity
- This man was referred to local drug services 4½ years before he died but he did not engage with the service. There are no other drug service records.
- Mental health issues that were being treated but the Covid lockdown did affect his interaction with the mental health team. Despite that, he did engage to the extent that he was showing them positive signs such as creating a safe space for himself and he got a pet which was a protective factor.
- His death came about after he was helping at an industrial unit with gardening etc. The inquest evidence heard that he had a 'binge' of

stimulant drugs whilst working which ultimately killed him. There was evidence of him sweating profusely before his unwitnessed collapse, but he was working hard so it did not register as a warning sign for any witness. He was working alone when he collapsed so there was no chance of first aid or an ambulance being called.

Findings

- Long history of drug use but no related treatment apart from his mental health being treated. A parent whose child was taken into care in part due to his inability to look after the child with drug use seeming to dominate his thoughts.
- A total shock to his immediate peers and friends but one member of the family said that they thought that it would be drugs that killed him ultimately.

3.32 **Drug Related Death 31**

- 22-year-old male who was found unresponsive in a tent with no pulse by a woman who was possibly his girlfriend. A bystander performed CPR compressions until the paramedics arrived and transferred him to hospital. Despite maximum care and management the deceased became more hypotensive and hypoxic and given the probability of devastating brain injury as a result of prolonged CPR and the decision was made in conjunction with his family to withdraw organ support.
- The inquest is awaited where a cause of death will be agreed and the inquest concluded. The previous inquest was adjourned in order to get the main witness to attend.
- Toxicology shows a death linked to ingestion of methadone which is likely to have come from the woman with him in the tent. Furthermore, it is likely that this will become a drug related death by conclusion.
- A contentious issue here is the origin of the methadone and how he came to ingest it and the family have serious concerns to be addressed at inquest.

Findings

- Inquest awaited as above with the highlighted issues to be resolved.

3.33 Drug Related Death 32

- 31-year-old woman who was found showing no signs of life by her partner at her home address. Ambulance staff completed 2 hours of advanced life support to no avail.
- The cause of death is awaited as is the inquest but the toxicology indicates that this woman consumed alcohol, diazepam, morphine and

methadone prior to death. She had been discharged from drug treatment so it is unknown at this stage whether the methadone was illicit or was left over from her time in treatment. If it was left over from treatment then it was still consumed out of a therapeutic setting and advice.

- At the time of death this woman was no longer in treatment with We Are With You; the element of structured treatment having ended 3 months prior to her death with ongoing recovery support in place until the record was closed with mutual agreement 2 months before her death.
- This woman met with her WAWY Recovery Worker and agreed that the record should be closed as she no longer needed support regarding use of illicit drugs or alcohol and that she had in place on-going support from the Positive People Team, Womens Aid, was attending groups and was about to return to college. She was reminded that she could return for additional support if required at any point.
- Long standing domestic abuse issues that were being looked after by a range of services but there was tangible positive outlook and trajectory including a plan to return to studying at college.

Findings and applying the learning

- This death has yet to be heard at inquest where it will become clearer as to the mechanism of death and the contribution that medicines/ drugs made to this death.
- Police enquiries initially flagged up a domestic abuse situation and the full facts of this will also be heard at inquest so the learning is not clear at this time.

3.34 Drug Related Death 33

- 53-year-old male who was found at his home address, cold to the touch and in a state of rigor mortis. An ambulance was waved down by a respiratory care nurse who had been unable to gain entry to the deceased's property. They could see him through the window, slumped on the floor. His daughter stated that the deceased had not been administering his medications correctly and had been using drugs. He was last seen alive 48 hours prior. He had a past medical history of end-stage heart failure, COPD, liver disease, receiving methadone replacement, drug misuse, hepatitis B and C positive, and impaired mobility
- The cause of death is awaited and will be agreed when the inquest goes ahead.
- This was referred into the We Are With You service asking for help to reduce his use of illicit street drugs. He was reluctant to stop his use of opiate drugs and reported that they helped him manage pain. He supplemented prescribed medication with street heroin and benzodiazepines and this is something he continued to do throughout the

time he was known to treatment services: in particular occasionally he reported that he had been sick shortly after taking his methadone and then resorted to use of street drugs.
- Although ambivalent about changing his opiate use, he did attend appointments and engaged with the service sufficiently in order to maintain the opiate substitute prescription. Regular assessments and reviews were undertaken. Appointments were arranged with We Are With You aiming at 4 to 6 weekly contacts. He was aware that additional support was available and at times he did seek this and the drug treatment service responded accordingly.

Findings

- At the time of writing and awaiting the inquest, it is not a forgone conclusion that this will be recorded as a drug related death as the only components of the toxicology are methadone and diazepam, both of which were prescribed. Provisionally the methadone metabolites appear in line with his prescribe dose.

3.35 Drug Related Death 34

- 22-year-old man who died in hospital after a suspected drug overdose at his home address.
- The inquest is awaited and the bulk of the evidence has not been seen pre-inquest- some evidence is of a sensitive nature so it is not being commented upon further here. The toxicology, however, points towards a poly drug fatal overdose. The circumstances and train of events will have to be awaited until the inquest is held.

Findings and applying the learning

- As above, this will be more fully reported upon in the next annual report once the full evidence has been heard including the origin of various drugs/ medicines.

3.36 Drug Related Death 35

- 57-year-old male who was found unresponsive at his friend's house, with foam around his mouth. The friend called his mother and the emergency services and commenced CPR. Attending paramedics confirmed him life extinct. The friend stated that they spent the night consuming alcohol, and whilst he had taken drugs, he had not seen the deceased take any, though he had a bruise on his arm consistent with an injection
- The cause of death has provisionally been given as 1a. Morphine toxicity although that is likely to change as heroin, cocaine and flubromazolam

were identified in toxicology. Flubromazolam is a new illicit benzodiazepine that has first been seen this year in Cornwall toxicology.
- Inquest awaited to ascertain cause of death and hear the full evidence.
- It appears that this man was making good headway with his drug issues until one of his brothers died in February of this year.
- Previously had been in drug treatment with Addaction and dropped out of the last treatment episode 3½ years ago as well as recent bereavement of a sibling.

3.37 Drug Related Death 36

- 29-year-old woman who, on the day of her death, was complaining of back pain so her partner applied deep heat into her back. After a short while the woman started curling her fingers and toes in a suspected seizure. She then went rigid and unresponsive, dying at the scene (home address).
- Hospitalised 4 days before death following vomiting and low potassium. It is believed that she self-discharged before she could have the treatment of IV Potassium. Partner reports that she was being sick this morning and couldn't keep food or drink down and this is a regular occurrence when her potassium is low
- Inquest and cause of death awaited.
- The main area of toxicological concern was the identification of a synthetic cannabinoid but this could be a combined physical illness with illicit drug use.
- This woman was referred to WAWY drug services 2½ years before her death with regard to her use of synthetic cannabinoids. She disclosed that there was a history of eating disorders, childhood sexual abuse and mental health problems

Findings and applying the learning

- This woman was a service user for 20 months in the last 3 years of her life. There were two treatment episodes, but in the second she did not engage at all despite the attempts by her recovery worker. Ordinarily, a home visit would have been completed but this intervention had been more restricted due to the covid pandemic.
- Complex needs relating to mental health, eating disorders which were impacting on her physical health and substance misuse issues and frequently presented as "in crisis". The Treatment service approached MH services as this woman could not be contacted; it emerged that the Community Mental Health Team had discharged her as they also had been unable to contact her. This situation to be reviewed by the Dual Diagnosis Implementation Group to improve pathways, communication and joint care.

3.38 Drug Related Death 37

- 47-year-old male who was found on the bedroom floor, by his partner. A neighbour attended the address and after they realised that the deceased was not breathing, they called the emergency services and commenced CPR. Attending paramedics confirmed him life extinct. It is believed that he had taken valium the previous evening and a glass of gin was found on the bedside table. The deceased's partner stated that it was not unusual for him to fall out of bed and for her to leave him on the floor sleeping. He had a past medical history of epilepsy and IV drug misuse.
- The cause of death and inquest is awaited.
- Toxicology shows a range of drugs being present including cocaine, diazepam, methadone, heroin and a new benzodiazepine drug that has not been seen in previous years in Cornwall called flubromazolam.
- Local drug treatment was current at death. Risks identified as high in the record included the risk of mixing depressant drugs such as benzodiazepines, alcohol and opiates. This risk was mitigated with harm reduction advice regarding mixing depressant drugs and he was well aware of these risks. He was offered naloxone to reverse opiate overdose and trained in the use of this since April 2014. Another risk identified as high was the risk to his health from epilepsy. He was encouraged to seek regular reviews from his GP regarding this although he did often say that he found the side effects of the medication difficult to cope with so didn't always comply with taking it.

Findings

- There is no obvious learning as yet as this man's relationship with both his partner and his extended family was seen as being a protective factor and he was considered to have good insight into his own situation regarding his drug and alcohol use.

3.39 Drug Related Death 38

- 46-year-old male who was found by his support worker, sat deceased in a chair at his home address. A crack pipe, tin foil and three empty bottles of methadone were found in close proximity to the deceased. A number of prescription drugs were also found in the property
- Inquest and agreed cause of death awaited but it stands at 'unascertained' pre-inquest.
- Due to decomposition, liver samples were taken for toxicology which are not as accurate as fluid samples. Cocaine, methadone, alcohol and heroin were found to be present. This and other evidence have yet to be interpreted for an inquest conclusion but it appears to be drug related as at writing this report.

- He ended his relationship with his long-term partner so that he could address his drug use and rebuild links with his family and in particular his son.
- Three factors increased his social isolation: his physical injury that led to reduced mobility, this in turn led to significant pain at times; his use of street drugs had restricted his contacts to those who also used substances and when this stopped, he recognised the importance of staying separate from these people; Covid-19 restrictions.

Findings

- Over time the use of illicit drugs varied. With the support of With You Cornwall and his Probation Officer, backed by a Court Order, he successfully managed to stabilise on an opiate substitute prescription and cease street drug use.
- Plans to address these issues were in place and included a cautious approach to building trust with his family and seeking to fulfil the role as father to his son. He also was keen to seek face to face group support once this became available.
- Although still in receipt of an opiate substitute prescription at time of death, this man had sought to reduce this in a sustained and realistically gradual fashion and had developed a good professional relationship with his Recovery worker. When the worker was not able to contact his client, he recognised this as out of character and took appropriate steps to establish the situation and it was through this process that he sadly found that his client had died.

3.40 Drug Related Death 39

- 53-year-old male. His support worker detected laboured breathing when talking him on the phone and alerted 111 who sent an ambulance. Paramedics carried out an ECG which was clear, but the deceased refused to go to hospital for a check-up. On a security check a couple of days later, he was found unresponsive with evidence of rigor mortis. He had a medical history of pulmonary hypertension, post-traumatic stress disorder, psychosis, back injury with ongoing sciatica, abscess on the lung and was pre-diabetic. He had last seen his GP with a seven-day history of headaches and migraines. He had a long history of opiates and intravenous drug use.
- Long term morbid obesity made later life difficult especially when he took illicit drugs.
- Thew cause of death is to be ascertained at inquest.
- In drug treatment with WAWY for the last 7 years of his life and with Cornwall NHS Community Drug Team prior to that. At the time of his transfer he was receiving opioid substitution therapy which WAWY continued.

Findings

- This man had sporadic attendance throughout his treatment but this stabilised somewhat in the final three years when he was resident in Harbour Housing supported housing projects. He seemed to have developed a sound therapeutic relationship with his WAWY recovery worker which seems to have been a positive influence in his periods of abstinence. He was in a position to be considering independent living and making plans for this in the last months.
- WAWY were working with a physically ill man who was a long-term drug user and showed little sign that he would ever give up using drugs. Despite this, he lived until 53 years of age which, although a premature death, was above the average age for a man who uses drugs in Cornwall with the average age being 45 for 2020- in previous years it has been 40.

3.41 Drug Related Death 40

- 66-year-old male who was admitted to hospital after being found collapsed and unresponsive at home. He was surrounded by five empty bottles of vodka and an empty bottle of Oramorph (morphine).
- Paramedics had attended the deceased's address 2 days previously however he refused to go to hospital. He had a past medical history of alcohol dependency, atrial fibrillation, congestive cardiac failure, chronic self-neglect, chronic cellulitis and type II diabetes mellitus.
- The cause of death will be ascertained at inquest.
- The toxicology indicated that this man had consumed an excessive amount of morphine prior to death but no alcohol was found. There appears no apparent reason for this pre-inquest
- He had two previous treatment episodes with WAWY for alcohol issues.

4. Review and Learning from 2020

4.1 The Cornwall DAAT Drug Related Deaths Review Group is a standing multi-agency panel of local experts who provide advice and support for the investigation and prevention of drug related deaths in Cornwall & isles of Scilly.

The Group reviews all potential drug related deaths, through reports from treatment, clinicians, prescribing, toxicology, and pathology, as well as patient records. Membership spans Consultants in pain medicine at Royal Cornwall Hospital Treliske, psychiatry, psychology and mental health services, Police, Shared Care General Practice, specialist drug and alcohol treatment (We Are With You), Head of Prescribing and Medicines Optimisation at NHS Kernow and from the Cornwall Partnership NHS Foundation Trust. This group and its findings help to inform the reports to HM Coroner and to improve services and life chances for residents.

The learning from this Group is fed into the inquest process via reports from the Chair (the author). The Group also informs an approves the content of this report and explore and identify any themes and learning to improve prevention in the future.

In 2021-22, this group will include Experts by Experience recruited from alcohol and drug treatment.

4.2 **Summary of specific issues**.

- **Heroin and cocaine use significantly less in drug related deaths than previous years**

With heroin related deaths being down 36% and cocaine related deaths being down 27% for 2020 in Cornwall, this is a noticeable difference from the national picture where both drugs have shown another increase. It was initially thought that the Covid-19 lockdown periods would have curtailed the ability of drug traffickers to move drugs around the UK and hence, account for the lower prevalence of these drugs in drug related death toxicology. Whilst logistically that is true to a certain extent, the below graph shows that drug trafficking offences have steadily risen in Cornwall over the whole of the Covid-19 period. The lockdown and associated death figures do not appear to form any pattern. Police and Border Force activity, however, has been high and could account for the increased number of trafficking offences being detected, for example, with the decrease in transport over swathes of the last 18 months leading to dealers being potentially more easily identifiable on transport systems.

- **Methadone related deaths have increased** which has been an indicator in previous years that there has been an actual or perceived shortage of heroin. Morphine related deaths have increased and the same argument can be used that where heroin is in short supply, heroin users may seek out other opiates such as methadone and morphine. With You have been aware of the risk of prescribing methadone over longer periods during the Covid-19 period and they have risk assessed every person in receipt of a methadone prescription at an early stage to mitigate this risk. Nevertheless, increased amounts of methadone in the community can lead to diversion of it but this has had to be weighed against the risks of Covid-19 transmission.

- **Increased benzodiazepine use**

One of the main findings from the review of deaths in 2020 has been that 12 deaths (30%) involve previously unseen illicit benzodiazepine drugs in Cornwall which are much more potent than prescribed benzodiazepines. 22 cases involve diazepam and 27 (67.5%) feature any benzodiazepine being present. This has a large part to play in the increased number of deaths.

The increased availability of Phenazepam and Flubromazolam, for example, have been so widely used in the last year and have been responsible for so many overdoses, that we have issued a series of drug alerts through our cascade system. Furthermore, the seriousness of the situation has led to a Police-led Peninsular operation to share intelligence and map the extent of the relevant drugs impact. This has operated within the near complete absence of any functional national drugs alert system. Further, the significant and increasing delay in forensic testing information renders it useless in any meaningful prevention of drug related deaths.
Treatment providers such as With You have been jointly working with GP Practices, hospital departments and others to look at how treatment and post-treatment services can adapt to the increased workload and change in some service user drug use profiles. **It is widely believed that part of the Covid-19 legacy will be future increased benzodiazepine use** with new examples of the drugs continuing to appear. Close partnership working will continue to monitor this rapidly changing situation where it is known that organised crime groups have already realised the potential of exploiting this market. We have been working closely with supported accommodation providers to help mitigate the risk of these new drugs. The reporting process designed for the reporting of incidents where naloxone has been used in cases of suspected opiate overdose has now been amended to include all incidents irrespective of naloxone deployment (i.e. not only opiate overdoses). This has been an effective tool to monitor trends and ensure relevant intelligence is shared.

- **Domestic Abuse**

Drugs and alcohol problems do not exist in isolation. One of the priorities stemming from the findings of the 2019 Drug Related Death Annual Report was to improve understanding of the interrelationship between domestic abuse, drugs and alcohol and to secure adequate understanding of the role of coercion and abuse in drug related deaths, domestic homicide and suicide ensuring that this information is included in the inquest process.

The Drug Related Death Prevention Lead has now been on two domestic homicide reviews (DHR) as a panel member and has led a focus group on the suicide of a woman who is currently subject of a DHR. The Domestic Abuse Co-ordinator has been involved in the newly formed drugs and alcohol Affected Others Group as well as the Multi Agency Suicide Prevention Group where her input and insight has proved invaluable. This is helping to develop identification of common themes to address.

Three new posts within the Council Domestic Abuse and Sexual Violence Team are working closely with the Drug and Alcohol Team on co-exiting issues. The roles are a Peninsula Behaviour Change Coordinator, a Cornwall and a Peninsula Domestic Abuse Implementation lead.
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The main areas for cross-theme work include, but are not limited to:

- Mapping of current safe accommodation and associated support service provision; and identifying gaps in provision across the Peninsula area.
- Development of pathways and referral protocols, workforce development and communication programme, ensuring consistency in data collection and monitoring, identifying other potential areas for collaboration in order to deliver a Whole Housing Approach and sharing best practice to reduce avoidable deaths.

Similarly, the Cornwall DA Implementation lead is responsible for leading and co-ordinating activity to secure high-quality implementation of domestic abuse projects across Cornwall and the Isles of Scilly. This role has particular focus on the Domestic Abuse Act 2021 and associated statutory duties, and the implementation of Domestic Homicide Review (DHR) recommendations and associated project work. The main areas of work include, but are not limited to:

- Working with partners to implement the DA Bill and associated Statutory duties, leading a workforce development and communication programme for the DA bill
- Identifying potential to deliver a Whole Housing Approach, sharing best practice, identifying potential risks and escalating to the DASV Strategic Group, monitoring the implementation of DHR recommendations

- A specific Older people DASV project
- DASV communications.

Community Safety Partnerships have a Statutory Duty to conduct DHRs and implement the lessons learnt. This role will support the implementation of recommendations across the partnership, and lead on key projects associated with the learning.

Similarly, in response to the Domestic Abuse Act and associated statutory duties, the Cornwall DA Implementation role has been created to review and improve Safe Accommodation related service provision for those impacted by domestic abuse across Cornwall and IoS. The post will deliver an implementation plan to ensure successful delivery of the Act. This includes:
Supporting the creation of an approach that meets the needs of clients and their children requiring Safe Accommodation support; Development of a more efficient system through a collaborative model of support that reduces duplication and delivers an improved experience with more positive outcomes for clients and their children; Partnership working and agreed understand of responsibilities under the DA bill and associated duties through supporting a comprehensive workforce development and communications plan. The post will also lead on the implementation and management of DHR recommendations across CIoS and this includes management of recommendations and action plans; Liaising with key agencies to ensure implementation and feedback; Developing briefings to inform partners of key learning following DHRs; Leading on key projects that implement the recommendations – such as the Older peoples DASV pilot.

- **Mental Health and Complex Needs**

Mental ill health has been present in over 75% of the deaths reviewed (31 deaths) with 5 of these featuring a diagnosed psychosis. Some of these people will have been in (and out) of mental health treatment whilst others will have been self-medicating between, during or instead of structured treatment. Mental health issues and the partnership working between agencies has been flagged up at previous inquests where drug related deaths and/ or suicides have been the conclusions. For this and other reasons we have introduced a Complex Needs Team to improve the lives of people experiencing multiple vulnerabilities.
The overlap between drug and alcohol use and mental health means that the team are working with colleagues in Mental Health to incorporate the Dual Diagnosis Strategy into the Complex Needs framework.

Underpinning everything that the team are doing is the concept of transformative co-production whereby there is the involvement of Experts by Experience in everything we do, and we will be looking at how this can improve our prevention work.

One of the Complex Needs Strategy Coordinators is the lead on liaison between the drug related death and suicide work so there is now a work trajectory that is more aligned with the new innovations and changes.

- **Suicide**

Another priority from the 2019 DRD report was; 'Greater clarity about and understanding of what is a suicide and what is a drug related death. Increased and comprehensive suicide prevention and review across our commissioned services'.

We have continued to develop work with the suicide prevention and surveillance initiatives being coordinated by Public Health but also to adduce information from the inquests to assist in this process**, as suicidality features in a third of the drug related deaths**.

Public Health are working ever closer towards a real time suicide surveillance model and, to that end, have been in regular contact with the DAAT who have been involved in real time surveillance of drug related deaths since 1999.

The Psychiatric Liaison service piloted a project using a brief psychological suicide prevention intervention (Collaborative Assessment and Management of Suicide, CAMS) with people presenting through the Psychiatric Liaison Service at the Royal Cornwall Hospitals Trust who have self-harmed or made a suicide attempt. This cohort included people who use drugs and alcohol. DAAT maintain close links with the Psychiatric Liaison Service via the Drug Related Death Review Panel. Between March 2019 and April 2020 there was a reduction in suicidal behaviour, improved well-being and enhanced joint working between mental health, the third sector and GP's. Recent learning coming from a domestic homicide review (suicide) has pointed towards an improved framework between mental health and GP's.

Following the successful pilot of this project, the Suicide Prevention Steering Group elected to fund a training role to ensure the CAMS pathway is rolled out more widely across CFT services as a way of implementing the approach in triage and decision-making processes. This role is due to start in August 2021.

Timely notifications of suspected suicides in order to ensure that postvention support can be offered to the bereaved is jointly being looked

at and there have been a series of joint meetings for a more collaborative approach to this. This links in also with the Affected Others work facilitated by the DAAT.

- **Bereavement**

Recent bereavement was a factor in 22.5% of the drug related deaths (9 deaths). Work has already commenced to scope a prevention initiative with the Registration Service for early recognition of those who could be affected. This approach is in tandem with Public Health regarding similar findings of bereavement being a factor in why a person may complete suicide.

- **Pain and physical ill health**

People suffering from physical pain issues featured in 50% of the deaths. As with mental health, some of the people were in treatment for the pain or they were between treatment episodes or not ever in treatment and self-medicated with a range of medicines/ drugs. The recommendation from 2019 to convene a pain management group was implemented and continues in its work programme. Teams within RCHT (Pharmacy, Safeguarding and the Pain clinic now all have read only access to the alcohol and drug treatment electronic case management system, to facilitate information sharing and a joint care approach.

- **Affected Others Focus Group and the Art of Grief project**

This group was set up as a result of one of the four priorities from the 2019 DRD annual report in recognition of the numbers of people who are affected by a drug related death. On average, 135 people will be affected to some degree by every death; Thus, for 40 drug related deaths for 2020, that means that up to 5,400 people could be affected ranging from immediate family, friends, work colleagues to emergency services, landlords and more. Of those 5,400 affected, 20% can be affected to such a degree that they are at increased risk, for example through harmful behaviours directed at themselves and towards others. **This could mean that up to 1,080 people need additional, specific support. This is not delivered in a comprehensive fashion at present.**

The Art of Grief pilot aims to break down some of the many taboos surrounding drug related deaths and to overcome some of the stigma associated with it, resulting in feelings of isolation and disconnection by the people affected. This project aims to look at different ways of engaging with bereaved families to help break some of the isolation and loneliness experienced, allowing a family to have a voice and to share that with the

wider community which, in itself, be a healing opportunity. The first artefacts from this project will be used in future prevention work.

- **Covid-19 from March 2020 to the present**

The effects of the pandemic have been worse for those who were already vulnerable or in need of support and, as can be seen from the case summaries in section 3 of this report, their multiple issues worsened in the main for reasons such as increased isolation and reduced healthcare and support. **There is no evidence that points to any of the 40 deaths having also been as a result of Covid-19 infection**

- **Universal Coverage of Naloxone**

2020/21 has seen further increases in services getting involved in holding naloxone for target groups and to widen their ability to save lives. Training in the use of naloxone has been carried out via online teaching by Ethypharm during the pandemic. Local service level agreements previously held by supported accommodation premises/ agencies in Cornwall have been updated.

5. Conclusion and Priorities

Despite our very best collective efforts, numbers of drug related deaths of residents in Cornwall continued to increase in 2020 and was notably more than the national increase.

We have approached the review of the death of each individual with a commitment to identify anything we can to improve our ability to prevent future deaths and to recognise the suffering of the individuals involved and impact upon their families and friends.

Priority 1 Reducing the harm related to **illicit benzodiazepine use**, particularly for those in treatment.

Priority 2 Continue to improve joint working arrangements between drug and alcohol treatment and **pain management**, including pathways, communications between agencies involved and a drive to involve the patient in a multi-agency approach. Further, to identify those at risk of turning to the illicit market for help.

Priority 3 Continue to improve our understanding of the interrelationship between **domestic abuse, drugs and alcohol**. Secure adequate understanding of the role of coercion and abuse in drug related

deaths, domestic homicide reviews and suicide ensuring this information is included in the inquest process, and that services are aware of, confident and competent to address.

Priority 4 To co-produce our approach to Prevention with Experts by Experience, to see if we can identify ways of further improving our collective approach and understanding.

Priority 5 Increase the outlets and availability of naloxone in areas identified which could play and greater role in prevention.

Priority 6 Suicide Prevention-Increasing suicide prevention within alcohol and drug treatment and postvention support for those impacted.

Priority 7 Improve support for affected others.

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