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

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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 2021 to 31st December 2021

CONTENTS

EXECUTIVE SUMMARY

Drug related deaths for 2021 have decreased to 38 deaths from their previous record high in 2020 of 40.

- Thirty-two people (**84.2%**) died in 2021 from a death that involved **an opiate drug,** one less than in 2020 but a higher proportion of the total.

- **Cocaine** featured in 22 deaths (**57.9% of the total**, an increase of **7 deaths and +20.4% from 2020**). After the notable decrease in 2020, cocaine has returned but not to pre-covid levels.

- **Deaths involving heroin increased by 12.4%;** 14 deaths in 2020 to **18 in 2021 (47.4%)** after the notable decrease in 2020, but not to the same degree as cocaine and not to pre-covid levels.

- **Eleven (29%) of cases in 2021 involved the combined presence of heroin and cocaine** compared to 7 (17.5%) in 2020 (**an increase of 11.5%**).

- **Deaths involving methadone remained at 15 (37.5%) in 2020 and (39.5%) in 2021**. Of these, the deaths where illicit methadone was a factor decreased from 7 (17.5%) to 5 (13%)

- **12 deaths (31.6% and an increase of 9.1% from 2020) involve illicit benzodiazepine drugs** which are either new designer benzodiazepine drugs or drugs which are not available lawfully in the UK. 18 deaths (47.4%) involve diazepam and **25 (65.8%) feature any benzodiazepine being present**.

- **The highest rate of drug related deaths occurred in the 40- 49 age group** (14 deaths or 36.8%).

- 63% of cases do not have any alcohol present within toxicology, down from 72.5% in 2020 and 77% in 2019. Alcohol does, however, remain significant, featuring in 14 deaths.
- **Thirty-seven (97.4%)** feature **more than one drug being present** and contributing to the death. **The only death to feature a single drug being cocaine**

- **Deaths involving a gabapentinoid drug such as Pregabalin increased by two deaths to 13 (31.6%)**

- **Twenty-four people died whilst engaged in drug treatment** or within 6 months of leaving drug treatment (63.2%). 14 (36.8%) had no link to drug or alcohol treatment or had been out of treatment for over 6 months.

Contributing Factors of Note

- Mental ill health (>76.3% of the deaths; 75% in 2020)
- Physical ill health/ Illness leading up to death (>52.6%)
- Covid-19 (the collateral effects of the pandemic and not the actual infection by the virus).
- Pain as a result of a physical medical condition (>31.5%).
- Suicidality (>39.5%)
- Bereavement (29%)
- Family and relationship breakdown
- Long history of drug use
- Early drug use by young persons (>29%)
- Adverse childhood experiences where a range of issues appear to have led to drug use
- Criminal justice issues including imprisonment
- Parental status/ children living elsewhere

1. INTRODUCTION

1.1 This is the nineteenth annual Drug Related Deaths report for Cornwall and the Isles of Scilly, covering the calendar year 2021. It follows the guidance and requirements of 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'.*

An important differentiation between the above definition and the definition used by the Office for National Statistics is that of a drug poisoning; *Drug poisoning deaths involve a broad spectrum of substances, including controlled and non-controlled drugs, prescription medicines (either prescribed to the individual or obtained by other means) and over-the-counter medications. As well as deaths from drug abuse and dependence, figures include accidents and suicides involving drug poisonings and complications of drug abuse such as deep vein thrombosis or septicaemia from intravenous drug use.*

Some statistics are later compared in this report to illustrate the difference in definitions.

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 (Terms of Reference in Appendix 1)
- With You Drug and Alcohol Service
- DAAT Clinical Governance Group
- Cornwall Controlled Drug Intelligence Network
- Devon and Cornwall Police and particularly the Drug Expert Witnesses
- 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 2021 Registrations, published 3rd August 2022)*. A copy of this report can be found **here**

1.5 Limitations

At the time of writing, 13 of the 38 deaths included in this report (34%) 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.

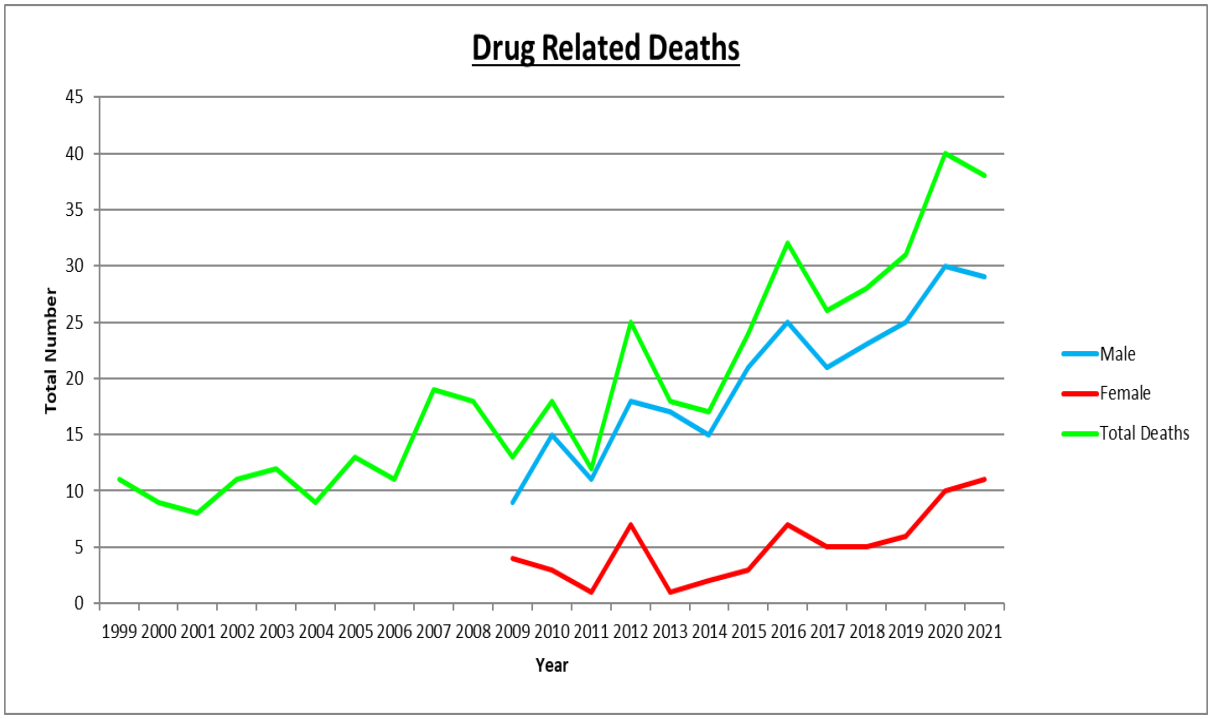
*ONS Statistics state: 'In England and Wales, almost all drug-related deaths are certified by a coroner following an inquest. The death **cannot be registered** until the inquest is completed, which can take many months or even years, and we are not notified that a death has occurred until it is registered. **This results in a discrepancy between local and national figures for a period of time, usually 6 months**.

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

This report presents figures for the year in which the death occurred, to maintain consistency in local monitoring of deaths and associated trends.

2. Main Report 2021

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 2021 showing an overall upward trend with slight a reduction overall in 2021 but a continued rise in female deaths.



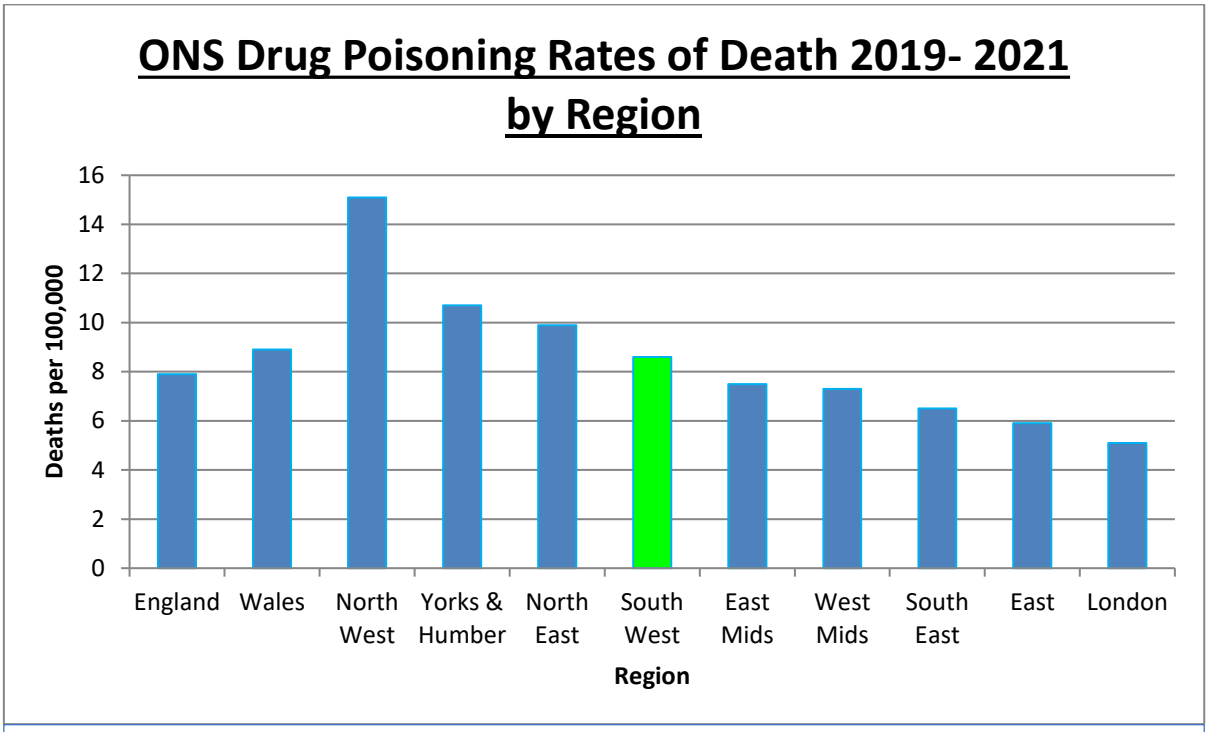
2.2 National Vs Local

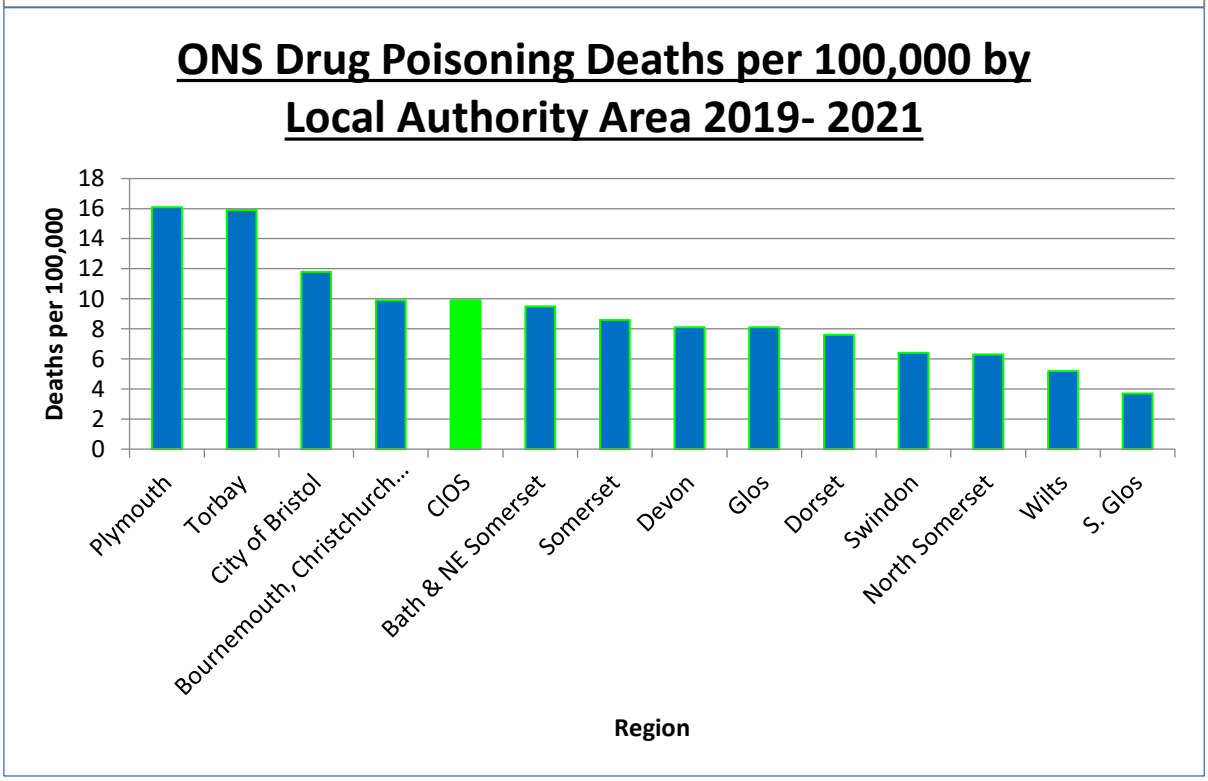
Comparison between the Office for National Statistics (ONS) 'Deaths related to drug poisoning in England and Wales: 2021 registrations' (published on 3rd August 2021) main national headlines and local CIOS data for 2021. NB- The ONS data presented here is for drug poisonings and drug misuse and indicated as such whereas the CIOS data is for drug misuse.

ONS	CIOS
The rate of death relating to drug misuse in 2021 was 53.2 deaths per million people. The male rate of drug misuse deaths was 77.5 deaths per million in 2021 (2,206 registered deaths) and the female	The rate of death relating to drug misuse in 2021 was 66.6 deaths per million people. The male rate of drug misuse deaths was 50.9 deaths per million in 2021 and the female rate was 15.8 deaths per

rate was 29.3 deaths per million (854 deaths).	million based on a static population of 570,300 (Census 2021)
Heroin and morphine continued to be the most frequently mentioned opiates with 1,213 drug poisoning deaths mentioning either one of these substances in 2021 (21.1 deaths per million people).	Heroin and morphine were also the most frequently mentioned opiate with 21 deaths mentioning either one of these substances (higher than national rate per million people - 36.8)
There were 258 deaths involving new psychoactive substances registered in 2021, which is 88.3% higher than the previous year (137 deaths) and a statistically significantly higher rate than the previous year (4.5 deaths per million people in 2021 compared with 2.4 in 2020). This rise was driven by an increase in the number of deaths involving benzodiazepine analogues (primarily flubromazolam and etizolam) from 62 deaths in 2020 to 171 deaths in 2021	There were 12 deaths involving new psychoactive substances registered in 2021 (14 actual instances of these drugs) which is proportionally 1.5% higher than the previous year (12 deaths also in 2020) and much higher than the national rate (21 deaths per million people in 2021 compared to 15.8 in 2020). Exclusively this rise was due to the number of deaths involving benzodiazepine analogues.
There have been increasing numbers of deaths involving benzodiazepines (a rise of 13.0% when compared with 2020, from 476 to 538 deaths), pregabalin (a rise of 18.9%, from 344 to 409 deaths) and gabapentin (a rise of 12.7%, from 118 to 133 deaths).	There have equally been increasing numbers of deaths involving any benzodiazepines in 2021 were 23 (65.8%) and a slight reduction from 2020 where there were 27 (67.5%). Pregabalin in DRD's remained at 11 deaths but a proportional rise of 1.4%, gabapentin rose by 100% but that was from no deaths in 2020 to one in 2021
There were 663 deaths involving methadone registered in 2021, which is 28.5% higher than the previous year (516 deaths) and a statistically significantly higher rate than the previous year (11.7 deaths per million in 2021 compared with 9.1 in 2020).	There were 15 deaths involving methadone in 2021, which is less of an increase locally than nationally, but still a much higher rate of the population than nationally - 2% higher than the previous but the same number of deaths (26.3 deaths per million in 2021)

Among males, there were 115.1 drug poisoning deaths registered per million in 2021 (3,275 deaths), compared with 54.1 deaths per million among females (1,584 deaths).	The ratio of men dying from a DRD against women is higher in Cornwall at 3.2:1 in 2021 (2.1:1 for England and Wales)
Rates of drug misuse death continue to be elevated among those born in the 1970s, often referred to as "Generation X", with the highest rate in those aged 45 to 49 years.	CIOS data concurs with the 'Generation X' finding with the highest rate amongst those aged 40-49 (14 deaths) followed by the 30-39 age group (11).
Approximately half of all drug poisoning deaths registered in 2021 involved an opiate (45.7%; 2,219 deaths).	A much higher proportion (84.2%) of deaths in Cornwall involved an opiate (32 deaths).
840 deaths involved cocaine, which is 8.1% more than 2020 and more than seven times the amount recorded a decade ago (112 deaths in 2011).	A higher rate of deaths locally (22) involved cocaine, which is 7 more than 2020 (proportionately 20.4% higher than 2020). There were no recorded cocaine related deaths in 2011. The involvement of cocaine started to be noticed in 2015 and has increased since then.
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	The majority of deaths locally indicate poly drug use. Only one death in 2021 involves a single agent in toxicology (cocaine).





2.3 Poly drug use and the often-associated synergistic interaction between drugs appears omnipresent within toxicology, with only one

death in 2021 involving a single drug (cocaine). All other deaths have involved at least 2 substances.

2.4 There were **18** (47.4%) **deaths from heroin toxicity or where heroin has been implicated in the death** in 2021. This is a proportional **increase of 12.4%** from 2020 (14/40). Whilst any increase in the number of deaths is of concern, the proportion of deaths related to heroin has not gone back to the 'pre-covid' level in 2019 of 71% and the even higher proportion in 2018 of 79%. The table at 2.9 below shows the fluctuating numbers and proportions of heroin and other substances over that last 7 years.

2.5 The proportion of deaths relating to the **presence of an opiate drug** has increased slightly in 2021 from 82.5% to 84.2% but is one **less death than 2020 (33 to 32 deaths)**. Of the opiate drugs present this year, heroin can be found in 18 deaths, methadone in 15, dihydrocodeine in 4, morphine in 3, tramadol, fentanyl*, buprenorphine, codeine and etonitazene** in 1 a piece with incidences of all of these drugs overlapping in the deaths and with other substances. 23 deaths (60.5%) involve opiates with any benzodiazepine.

*Fentanyl has been rumoured, anecdotally commented upon and actually identified in heroin in the UK and mentioned as being responsible for some heroin related deaths across the country in 2021 (also in 2020) where it is thought to have been mixed in with heroin. Forensic examination of police drug seizures and toxicology from deaths does not substantiate this in Cornwall and the one fentanyl-related death here is an illicit use of a fentanyl patch.

**Likewise, with the high potency opioid drug etonitazene and its related analogues, this chemical has featured in nationwide drug alerts in 2021 due to its presence in heroin samples as well as featuring in drug related deaths. The single death in Cornwall which features this drug, also featured the illicit benzodiazepine flualprazolam and the deceased had been engaged in drug treatment surrounding his use of illicit benzodiazepines, not opiates.

2.6 Cocaine featured in 22 of the deaths (57.9% of the total, **up 7 deaths or proportionally up 20.4% from 2020**). As with heroin, there was a notable decrease in the number of cocaine related deaths in 2020 compared to 2019**.** This has been explained in more detail in the 2020 annual report but, essentially, is thought to be a collateral effect of some of the measures taken during the Covid-19 pandemic such as lockdowns. Again, as with heroin, whilst cocaine related deaths have risen in a year, they have not gone back to the 'pre-covid' figures seen in 2019 (15 - 64.5%). **For the first time ever, cocaine related deaths have surpassed heroin related deaths** in Cornwall since records began in 1999

(11 deaths or 29% feature both drugs). This is seen as a significant change to the profile of a drug related death. As with previous years, the cocaine identified in toxicology is believed to be in the form of crack cocaine in the main, although, this cannot be ascertained exactly.

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, drug treatment records and personal disclosure, a more accurate picture can be gained about the role of crack cocaine in specific drug related deaths. The access to this information indicates strongly that crack cocaine use is now prolific and has been featuring since 2015 in Cornwall.

2.7 Deaths from **methadone toxicity** have **remained at 15 but a slightly higher proportion (up 2% to 39.5%) from the 15 deaths in 2020 from a total of 40.** Of those 15 incidences, 10 were in relation to prescribed methadone and 5 from an illicit source compared to 8 prescribed and 7 illicit in 2020. As with the data from 2020, there is suspected to be a higher number of methadone related deaths, in part, as a result of the covid-19 lockdowns and general supply routes being disrupted. The opiate market was partly satisfied by a greater amount of methadone being generally available but also by an increased supply of the new illicit benzodiazepine drugs.

2.8 This next table illustrates the most significant drugs and drug combinations in 2021

Type of Drug/drub combination	**Male**	**Female**	**Deaths (from the total of 40)**	**%**
Opiate drugs	24	8	32	84.2
Opiates and Benzodiazepines	17	6	23	60.5
Benzodiazepines	22	7	25	65.8
Cocaine	17	5	22	57.9
Methadone	13	3	15	39.5
Heroin	11	3	18	47.4
Illicit* benzodiazepines (included in the box above for all benzodiazepines)	11	1	12	31.6
Heroin and Cocaine	6	5	11**	29

***Illicit in this context means that they are not available on prescription in the UK or are unlawfully manufactured. Diverted prescribed benzodiazepines become illicit but are not part of this table.

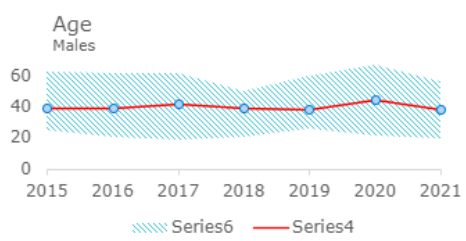
**Some toxicology is unable to ascertain if the morphine present is derived from illicit heroin or from another source such as morphine-based medicines. There are three deaths in 2021 where this is the case so, in any mention of heroin, there is the possibility that the number of heroin related deaths could be up to three more than stated.

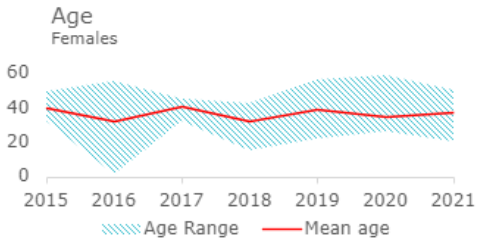
2.9 This table consolidates the previous graph at 2.1 and ensuing paragraphs for all years between 2015 and 2021.

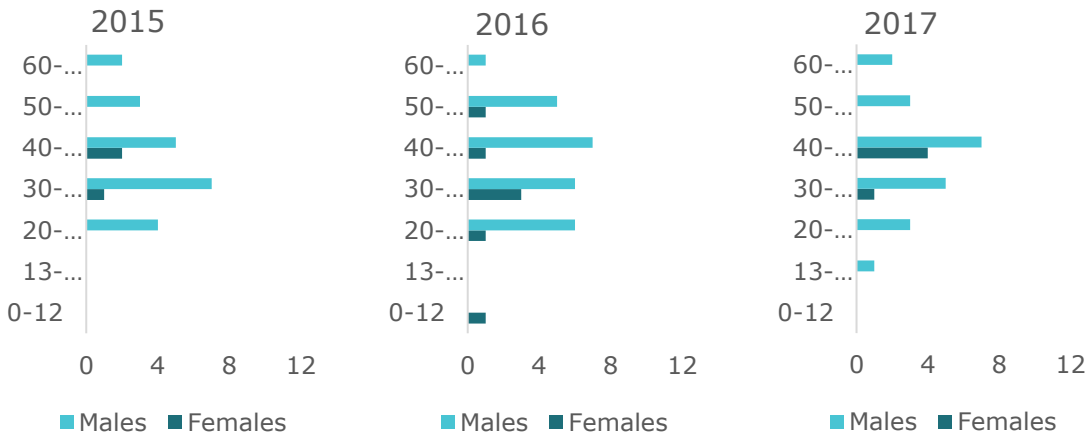
	2015	2016	2017	2018	2019	2020	**2021**
Total DRD's	24	32	26	28	31	40	**38**
% Change	+41%	+33%	-19%	+7.7%	+10.7%	+22.5%	**-5%**
Gender	21 M 3 F	25 M 7F	21 M 5F	23 M 5 F	25M 6F	30M 10F	**29M 9F**
Age group with highest rate of death	30-39 (33%)	30-39 (28%)	40-49 (42%)	40-49 (43%)	30-39 (39%)	50-59 (27.5%)	**40-49 (37%)**
Opiate drugs	18 (75%)	27 (84%)	22 (65%)	26 (93%)	28 (90%)	33 (82.5%)	**32 (84.2%)**
Heroin	12 (50%)	18 (56%)	15 (58%)	22 (79%)	22 (71%)	14 (35%)	**18 (47.4%)**
Methadone	5 (21%) (3 prescribed 2 illicit)	5 (15%) (4 prescribed 1 illicit)	13 (50%) (10 prescribed 3 illicit)	12 (43%) (10 prescribed 2 illicit)	9 (29%) (6 prescribed 3 illicit)	15 (37.5%) (8 prescribed 7 illicit)	**15 (39.5%) 10 prescribed 5 illicit)**
Cocaine	2 (8%)	11 (34%)	12 (46%)	15 (54%)	20 (64.5%)	15 (37.5%)	**22 (57.9%)**
Heroin & cocaine	2 (8%)	8 (25%)	7 (27%)	13 (46%)	16 (52%)	7 (17.5%)	**11 (29%)**
Benzo-Diazepines prescribed and illicit	8 (33%)	21 (65%)	15 (58%)	21 (75%)	20 (64.5%)	27 (67.5%)	**25 (65.8%)**
Opiate drugs and benzo-diazepines	8 (33%)	19 (59%)	16 61.5%)	20 (71%)	19 (61%)	27 (67.5%)	**23 (60.5%)**

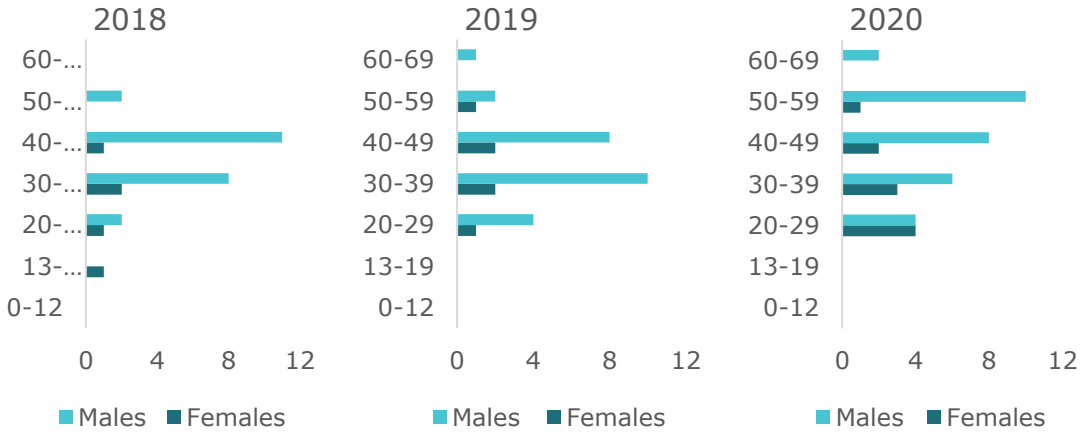
2.10 The highest rate of drug related deaths in Cornwall occurred in the **40-49 age group (14 deaths or 36.8%)** and is in line with the ONS findings for 2021 across England and Wales. The **average age of men and women** dying from a drug related death during 2021 is **38.5 40**. The

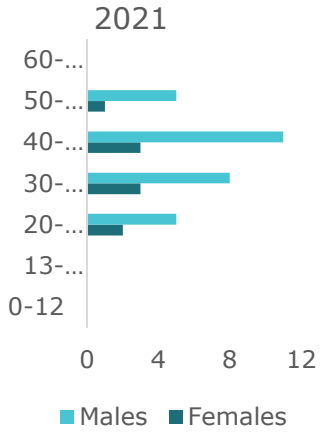
average age for men is back down to its' pre-covid figure in 2019 of 39. Men represent 76.3% (up 1.3% from 2020) of the total number of deaths (29 out of the total of 38). **Female deaths have decreased by one death to 9 for 2021** (23.7% of the total). The average age for women is 37.6 More detailed tables on this can be found at Appendix 2.











2.11 Toxicology further shows that **24 (63%) of deaths do not have any alcohol present** and represents a continued downward trend, (72.5% in 2020 and 77% in 2019) from when it was the most significant factor in 2019 to now featuring in less than 1/3 of deaths. However, it continues to be a significant factor over the lifespan of the individual, including early childhood use, heavy use throughout life and an underlying constant.

2.12 Drugs Present and/ Or Contributory to Death
The below table lists every substance that has been identified in toxicology over the last five years representing 163 deaths.

Substance	**2017**	**2018**	**2019**	**2020**	**2021**
Alcohol					
Alcohol present (includes post-mortem change)	7	5	6	9	**13**
Alcohol present/ significant (above 200 mg/ 100ml)	3	2	1	2	**1**
No alcohol present	16	21	24	29	**24**
Illicit drugs, Controlled Drugs and other substances					
Heroin	15	22	22	14	**18**
Cocaine	12	15	20	15	**22**
Diazepam	14	17	18	22	**18**
Methadone	13	12	9	15	**16**
Morphine	1	3	3	6	**3**
Phenazepam	0	0	0	6*	**0**
Cannabis	5	3	1	6	**12**
Alprazolam	3	6	2	3	**2**
Flubromazolam	0	0	0	2*	**3**

Flualprazolam	0	0	0	1*	**4**
Flubromazepam	0	0	0	0	**2**
Amphetamine	4	2	1	2	**4**
Synthetic cannabis	0	0	0	2*	**0**
MDMA/ MDA (Ecstasy)	3	3	1	0	**1**
Ketamine	1	0	2	1	**1**
Etizolam	0	1	4	1	**3**
Mephedrone	1	0	0	0	**0**
Gamma Hydroxybutyrate (GHB)	0	0	0	0	**1**
Volatile substance (gas)	1	0	0	0	**0**
Other drugs (medicines including those sourced illicitly)					
Amisulpride	1	0	0	1	**0**
Amitriptyline	1	3	2	10	**3**
Buprenorphine	0	1	1	0	**1**
Citalopram	3	4	2	3	**2**
Chlordiazepoxide	0	3	0	0	**1**
Chlorpromazine	0	0	0	0	**1**
Clonazepam	1	0	0	0	**0**
Clozapine	0	0	0	0	**2**
Codeine	1	0	0	3	**1**
Cyclizine	1	0	0	1	**0**
Dihydrocodeine	3	1	0	3	**4**
Fentanyl	1	1	1	1	**1**
Fluoxetine	0	2	2	2	**1**
Gabapentin	2	3	0	0	**1**
Hydrocodone	0	0	0	1	**0**
Lorazepam	0	0	0	1	**1**
Mirtazapine	3	6	5	9	**13**
Olanzapine	0	2	0	3	**0**
Oxycodone	0	0	0	0	**1**
Pregabalin	12	9	12	11	**12**
Procyclidine	1	0	0	1	**0**
Propranolol	1	0	0	3	**0**
Promethazine	1	0	0	2	**1**
Quetiapine	3	2	1	1	**3**
Sertraline	2	4	1	1	**5**
Temazepam	0	0	0	0	**1**
Tramadol	2	4	0	0	**1**
Trazodone	0	3	1	0	**1**
Venlafaxine	3	0	2	2	**1**
Zopiclone	5	1	1	4	**2**

2.13 Mental health. Whilst mental ill health is clearly linked to drug related deaths, the statistics for 2020 and 2021 have been alarming in the number of people that it has identified as having a mental health need and has been of significant importance in their drug taking. Some people have been identified as having a psychosis, but these numbers are eclipsed by those who do not have a psychosis and, instead experience psychological issues such as anxiety and depression. There is also evidence of a large amount of self-medication using alcohol and illicit substances where some people will use on top of their prescribed medication or not seek professional help at all and try to mitigate their symptoms alone.
With such a broad range of mental health conditions, indicators and needs represented amongst such a small number, it is very hard to make any conclusions apart from that mental ill health features in the majority of deaths (76%).

There are 23 mentions of an anti-depressant medicine (venlafaxine, sertraline, citalopram, fluoxetine, trazodone and mirtazapine) in toxicology (some appear in combination in a small number) and 6 anti-psychotic medicines are mentioned in 6 separate cases with 3 of them being in combination with anti-depressant medicines. Medicines such as amitriptyline appear in 3 of the drug related deaths but are not accounted for here in the anti-depressant figures as it can be prescribed for depression as well as nerve pain, headaches and migraine. Likewise, diazepam features in 18 of the deaths and a proportion of these deaths were where a person was being prescribed for anxiety and 'lower' level mental health issues. Other drugs present in toxicology such as pregabalin and zopiclone can be used where mental ill health is at play. All told, this underlines how significant mental ill health is in drug related deaths. **At least 29 DRD's in 2021 (76.3%) feature mental ill health with 6 people being prescribed for a diagnosed psychosis.** Mental health will be discussed further in Section 4 of this report.

2.14 Pain Management. This theme has continued to be featured since it was identified in the 2019 DRD annual review. Fifty per cent of deaths in 2020 involved chronic physical pain for a range of conditions. Whilst it is a slightly lower number in 2021 (29 deaths/ 31.5% of the total) it is still a factor. Whether we can identify it as such depends upon whether the person in question sought professional help for their pain or not.

Similar to mental ill health, there is a proportion of people who self-medicate and, in some way mitigate their pain this way. This often involves misuse of their own medicines, others' medicines or use of street illicit drugs/ medicines. An important factor that is evident in some of the deaths in 2021 is the role of emotional pain and how that can manifest in physical pain, in turn leading to self-medicating etc.

Emotional pain is more difficult to gauge but is evident from the information at inquest and investigations of life events. 11 deaths involved an overt element of personal bereavement where drug use escalated as a result. Pain, whatever its' physical or emotional origin, and mental ill health are two of the biggest drivers in drug related deaths which have been more evident during the last two years of the 'covid' period. Pain will be discussed further in Section 4 of this report.

2.15 Physical illness. 20 (52.6%) of the people who died in 2021 had notable physical illnesses. Some of these illnesses were brought about by and/ or exacerbated by drug use. These illnesses included epilepsy (4), seizures other than within epilepsy (3), liver disease, respiratory illnesses such as tuberculosis, emphysema, COPD and asthma also cancer, endocarditis, disorders relating to injecting. It is noted here that when someone experiences problematic drug use then their awareness and consideration of their personal care and health is often compromised.

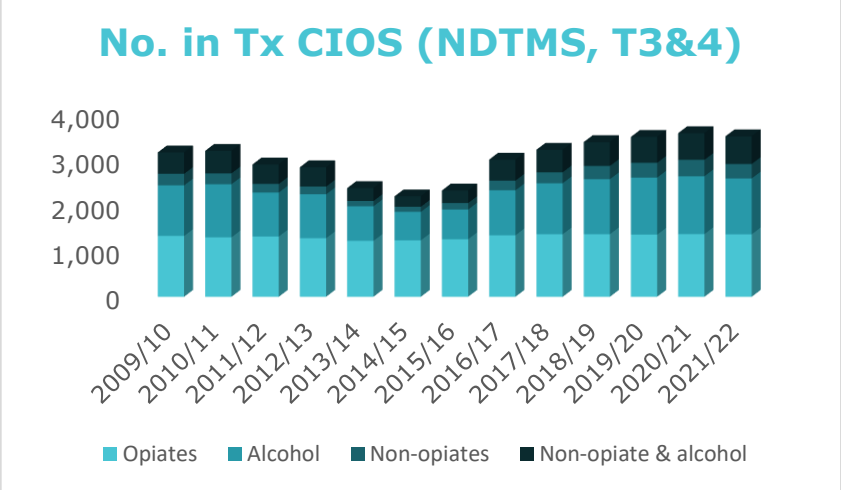
2.16 Pregabalin has featured in 31.6% of DRD's (12 deaths). Pregabalin is notable for its potentiating effect of heroin but, it has many medical uses in mental health treatment such as treating anxiety and in people suffering pain (particularly lower back pain) and epilepsy. The complexity of pregabalin prescribing for its' multiple medical uses and its' abuse potential makes assessing individual cases more difficult. Questions are raised such as; if someone is in pain and is self-medicating with street heroin, for example, would a proven neuropathic analgesic medicine like pregabalin assist with pain relief or would its' potentiating effect be a risk to the person? If no pain medicine is prescribed, will the person go on to use more illicit substances and risk their health/ life that way? For this and other reasons, pregabalin is a drug which is monitored.

2.17 Twelve deaths **(31.6%) involved illicit benzodiazepine drugs.** These benzodiazepines are much more potent than those available on prescription and are very dangerous in their own right, even more so when mixed with other drugs/ alcohol (which can potentiate the effects). These drugs were first reported on in the CIOS 2020 DRD annual report and were thought to be, in part, a reaction to the interrupted supply of opiates over the covid period. However, demand for these drugs and use of them remains high.
There were 14 instances of ingestion of these drugs in toxicology found in 12 deaths (The drugs found in toxicology were; Flubromazolam in 3 instances, etizolam 3, flualprazolam 4, alprazolam 2 and flubromazepam 2)

2.18
Drug Related Deaths and Numbers in Drug and Alcohol Treatment

	2015	2016	2017	2018	2019	2020	**2021**
Total drug related deaths (people in treatment or within 6 months of treatment and percentage of total)	24 (14-58%)	32 (15-47%)	26 (18-69%)	28 (18-64%)	31 (22-71%)	40 (22-55%)	**38 (23-60.5%)**
In current drug treatment (percentage of total number in any drug treatment)*	10 (1.4%)*	14 (1.6%)*	16 (1.2%)*	15 (1.3%)*	16 (1.4%)*	19 (1.7%)*	**20 (1.7%)***
Died within 6 months of leaving drug treatment	2	1	1	2	2	3	**1**
DRD and currently in alcohol treatment	1	0	1	1	4	0	**1**
Died a DRD within 6 months of leaving alcohol treatment	1	0	0	0	0	0	**1**
Not known to treatment	2	10	17	8*	10	9	**7**

*This percentage is an estimate based upon the NDTMS data that covers the financial year. In other words, for the calendar year of 2021, there were 38 DRDs. The NDTMS data covering most of that year is from April 2021 to March 2022. Year on year this gives an approximation of the percentage of those in drug treatment (opiate, non- opiate and non-opiate with alcohol) who die from a DRD.



The above graph shows the numbers in opiate, alcohol, non-opiate and non-opiate/ alcohol treatment over 12 years in Cornwall up to the end of March 2022. The graph shows that the numbers in opiate treatment have not changed significantly over the years, but that the other three categories have steadily increased since 2014/15. NB- once NDTMS have analysed the data from 2021/22, there will probably be a rise in the numbers which will bring this period in line with the previous two periods.

2.19 Accidental and deliberate overdose. At least **15 deaths (>39.5%) in 2021 featured suicidality** (thoughts about taking one's own life, suicide planning and suicide attempts). In any review of a drug related death where there is a history of suicidality, there may be no definitive agreement as to what was in the mind of the person immediately prior to death. There are seven deaths in 2021 which have been concluded as DRDs where there has been deliberation at inquest as to whether the death has been a deliberate consequence of the persons actions. But for the existence of a suicide note, for example, these deaths may well have been concluded as suicides but have instead been concluded as DRDs due to the mechanical means of the death being drug related. The large number of deaths where there has been suicidality as a possible contributory factor is of no surprise when considering that over ¾'s of the total number of deaths have involved people with a mental health need (as defined by NDTMS). **18 deaths (47%)** featured a history of **drug and/ or alcohol overdose**, accidental, deliberate or a combination of the two. Some of the people involved had many overdoses with a mixture of ambivalence, chaos and intent displayed. This is discussed further in Section 4 of this report.

2.20 As in previous years, there are many factors that could be contributing to a premature death that involves drugs. The case notes, inquest and general information surrounding each of these deaths informs us that people can use drugs and alcohol in an attempt to mitigate some of the negative effects of adverse childhood experiences, domestic abuse, family and relationship breakdown, children being removed from the family, unemployment, criminal justice issues, housing and many others. More often than not, it is never one issue but rather an accumulation.

2.21 Venues where deaths occurred (includes 3 deaths in hospital and two deaths where the person was on holiday or visiting Cornwall)

Venue	Number of DRD's
Home address	26
Home address of another	6
Supported accommodation	2
Car park	1
Shed	1
Park	1
Woodland	1

As in previous years, 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.

2.22 Area of Cornwall where deaths occurred linked geographically to the nearest town. No outstanding areas are identified.

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

3. BRIEF CIRCUMSTANCES/CASE STUDIES 2021

3.1 Drug Related Death 1

- 43-year-old female who was found by her ex-partner, cold to touch lying face up on the bed at his home address. Paramedics attended and confirmed her death.
- Cause of death given as 1a. Pulmonary tuberculosis 2. Diabetes and illicit drug use
- Issues of heroin dependence being treated with prescribed methadone, diabetes and tuberculosis. Hospital notes indicate that she was admitted on Christmas Day 2020 for a collapse. She was also in treatment for benzodiazepine use.
- Her toxicology revealed methadone and prescribed diazepam in therapeutic amounts, but pathology updated this with the drug/ medicine use being against a background of compromised physical health such as diabetes and a lowered respiratory system due to tuberculosis and COPD. Mental ill health due to anxiety, I.e., on-going anxiety drove her need for prescribed and illicit drugs.
- Other factors of note were relationship issues with her partner, mental ill health, access to her children who had been removed by Social Services and sporadic engagement with drug treatment services.
- Very early use of drugs; cannabis at around the age of ten, started using amphetamines in her teens and started using heroin at the age of 23. Link to childhood trauma.
- Drug use notably increased after her children were taken into care.
- A week before her death she was admitted to hospital after having collapsed and linked to her physical ill health exacerbated by drug use. She was discharged days before her death, but this discharge was not notified to the treatment service.

Findings and applying the learning

- Due to this woman's poor mental and physical health, she found it difficult to attend appointments and would often cancel them at short notice. Nevertheless, Recovery Workers were able to develop good therapeutic relationships and trust with her which enabled them to assist with many of the issues affecting her.
- In December 2020, the We Are With You Hospital Team was not able to work at the hospital following the Covid lockdown measures. With the added pressures of reduced staffing over the Christmas and New Year it appears that the usual processes were not followed by the hospital in notifying WAWY of the discharge. This has now been addressed and, although this appears to have not been repeated in other deaths reported upon here, how many potential similar situations that this may have

affected is not known. These rare set of circumstances have not repeated since. The early addressing of this, however, means that WAWY and those involved with hospital discharges have now prioritised.

3.3 **Drug Related Death 2**

- 41-year-old male who was found deceased in supported accommodation by one of the project workers. Evidence of drug paraphernalia in his room. Toxicology revealed heroin, cocaine (likely crack), and prescribed medicines for his mental health issues (PTSD and depression). Medical diagnoses of asthma and alcoholism.
- Cause of death given as 1a. Mixed drug toxicity/ overdose
- This man re-engaged with alcohol treatment, following relapse, after being sober for 11 years. His second alcohol treatment episode was from 2019 until death.
- Contributing factors – Bereavement. His mother died in 2012 and he lost his brother to suicide in 2017. He experienced alcohol related health issues as well as fluctuating suicidal intent and previous attempts on his own life. Disclosure of historic childhood abuse and trauma.
- Covid-19 lockdowns and associated limitation of movement further exacerbated his poor mental health. Naloxone was issued due to his contact with drug using peers and his latter disclosure of drug use with escalating issues linked to his mental health.
- A detox had been arranged and he was due for admission prior to death.
- Witnesses described his mood in the days before his death as being buoyant and chatty.

Findings and applying the learning

- Underpinning this man's use of alcohol and other drugs were his adverse childhood experiences and bereavement of close family members. The treatment record speaks of him being affected by more than one suicide amongst friends and family?
- This has contributed to establishing new workstreams looking at multiple overdoses and the work of the suicide prevention groups.

3.4 **Drug Related Death 3**

- 20-year-old male with a briefly history of cocaine use. He had a psychotic episode and collapsed at his home address, had a seizure and died.
- Cause of death given as 1a. Acute cocaine toxicity
- Cocaine levels in toxicology were over 8 times the lethal level.
- At inquest, the GP disclosed no other health concerns but when the patient disclosed use of cocaine and some presumably drug induced manifestations of hearing voices and seeing bright lights, the GP referred this man to local drug services. He died two days later.

- Likewise, evidence was heard from the man's father who knew of the cocaine use but it had been agreed that his son would seek help. Sadly, it was this man's father that found him in a state of distress, administered CPR and witnessed his death.
- A rare death where only one substance has been found in toxicology whereas the majority of drug related deaths involve poly drug use.
- He was also referred to CMHT for assessment 11 days before he died but he was not triaged in time for an appointment to be offered.

Findings and applying the learning

- Drug services are tasked to carry out an initial assessment within 5 working days. This man died 2 days following referral. The referral to CMHT was not marked up as urgent otherwise this man may have been prioritised for assessment. Some persistent and continued reinforcing messages to GPs may be required?
- Learning has been passed back via the inquest process about the need for urgency in some cases to be flagged up but also bearing in mind that the use of drugs in this case appears to have been very rapid in escalation in terms of time frame used and in large amounts.
- The prevalence of cocaine in drug related deaths for 2021 has surpassed that of heroin for the first time in Cornwall. This is the finding- what do we propose to do about it.

3.5 **Drug Related Death 4**

- 37-year-old male was found collapsed and in cardiac arrest at home by his partner. She commenced CPR until the paramedics arrived and a spontaneous circulation was achieved after 37 minutes. He was transferred to hospital where he suffered fatal severe hypoxic brain injury
- Medical history of being hepatitis C positive and known to misuse alcohol and other drugs since mid-teens. He had a history of hospitalisations for overdose.
- The cause of death was given as 1a. Hypoxic brain injury and 2. Mixed drug overdose.
- Very long and thorough treatment journeys with drug services where every type of support was offered if not always taken up.
- Complex life which included adverse childhood experiences including drug and alcohol use from age 13, multiple terms of imprisonment, drug related violence against him, overdoses, multiple detoxes, parental alcohol use and 'falling in with the wrong crowd' when he went to secondary school with older peers encouraging him to commit crime with them and lifting him to access windows and steal for them. Later life where he became a prolific offender with the majority of criminality being related to his drug use.

- Wide range of drugs found in toxicology including heroin, cocaine (from anecdote, likely to be crack), methadone and flubromazolam .
- Last five years of his life found him either in prison, street homeless or 'sofa surfing'.

Findings

- From a young age he was exposed to a range of harms including break up of family, exploitation by older peers, sexual abuse and early paternity. In addition, he experienced problems related to auditory deficit and ADHD.
- He began to use substances as a maladaptive coping mechanism in his early teenage years as a means of dealing with trauma and exclusion and a life of prolific offending ensued, predominantly acquisitive crime to fund his increasingly expensive habit.

3.6 **Drug Related Death 5**

- 29-year-old female who was found off a footpath in cardiac arrest and police assistance was required due to two aggressive males at the scene. She received CPR and was transported to hospital where she died. She was known to have drug and alcohol-related problems since 2019 (aged 17) and had a history of attempted suicides. She had mental health issues; a previous diagnosis of Bi-Polar Disorder may have been mis-diagnosed and that perhaps a more fitting diagnosis was Emotionally Unstable Personality Disorder (EUPD). She was admitted to hospital for epigastric pain/ pancreatitis but she discharged herself the next day after being caught on the ward consuming wine and having been medicated with Librium.
- Cause of death given as 1a. Illicit drug use and 2. Alcoholic liver disease and chronic pancreatitis
- Toxicology identified heroin, cocaine, diazepam and anti-depressant medicine.
- The males at the scene asked the responding ambulance crew for Fentanyl and also removed cash from this woman's bra even as she was overdosing and being treated by the crew.
- On review, it was highlighted that she suffered from the bereavement of her father (from alcohol dependency) at the age of 14. She became depressed and was in treatment with the Child and Adolescent mental health service. She had a history of impulsive and deliberate overdoses in response to crises such as family conflicts and the break-up with a boyfriend.
- Drinking contributed significantly to her becoming suicidal. Other factors included back pain, anxiety, obsessive compulsive disorder, addiction to Tramadol, children removed and living with their respective fathers,

alcohol dependency, alcohol induced pancreatitis which, in turn, caused further pain.
- When children were removed, her alcohol use went 'off the scale' according to family. Her house became a 'drug den' and was in a very poor state.
- In treatment with We Are With You for 18 months up to her death where the initial self-referral for alcohol, on advice from her psychiatrist, quickly identified a need for drug treatment also.
- This woman embarked upon relationships with men who posed a significant risk and she moved accommodation a number of times fleeing from them.
- Much evidence of linked agency working in relation to physical and mental ill health, drug and alcohol treatment, family and housing issues etc. When this woman was at her most high risk, the communication between We Are With You, Social worker, First Light, Hospital Safeguarding Team, local Police Liaison Officer and Cornwall Housing meant that she had a support network and a safety net when she needed it the most

Findings and applying the learning

- This is yet another death that informs the work to be done in relation to non-fatal overdoses where this woman had multiple impulsive and deliberate overdoses resulting in hospitalisation. Furthermore, emotional and physical pain are very relevant here and inform the work being done in relation to identifying, triaging and dealing with pain in different ways.

3.7 **Drug Related Death 6**

- 57-year-old male who was found deceased at a friend's home. This man had a medical history of mental health issues which had worsened due to chronic pain. Two bottles of Oramorph (morphine) bottles were found in the bin. He had a medical history of spinal cord injury, spinal stimulator surgery, kidney cancer (2017), kidney removal (2016), type II diabetes and paranoia
- Cause of death given as 1a. Cocaine toxicity and 2. Ischaemic heart disease
- Other physical conditions included the loss of use of his right hand and was losing the use of his left hand and a heart condition related to cocaine use including heart attacks, neck pain relating to the spinal injury. On-going pain generally tended to underpin drug use.
- No drug treatment record.
- Change of GP due to retirement saw a different relationship between this man and the new GP. This was not a bad relationship but different due to the length of time that this man had been under the previous GP.

Findings and applying the learning

- As a result of this death the GP surgery are backing up all telephone calls that have not been responded to with a text to try to ensure vital appointment information, for example, reaches the patient.
- Although the communication latterly was not as efficient as it could be largely due to this man's worsening presentation, there was good use of his mother who acted as an intermediary, but she was only lawfully allowed certain information i.e., The GP was allowed to speak to his mother about prescribing issues but not matters of confidential medical interaction between patient and GP. This can largely be overcome by a power of attorney, but this was not in place in this case. The improvement in communication by text could offset this, for example, by letting the intermediary know that a phone call has not been answered and there may be outstanding matters to address.

3.8 **Drug Related Death 7**

- 40-year-old male who was found in respiratory arrest following a heroin overdose; he received ambulance treatment but declined to go to hospital. He was found later the same day by members of the public on his knees. Paramedics administered drugs and commenced CPR, but life was pronounced extinct shortly after. This man was a known drug user for 20 years. He was heroin dependent and had attempted to abstain, but this had resulted in increased alcohol consumption.
- Cause of death given as 1a. Illicit drug use against a background of ischaemic heart disease
- Toxicology identified heroin, cocaine, the relatively new designer benzodiazepine flubromazolam and other medicines all of which combined with an overall fatal effect.
- Teen use of cannabis and amphetamines with use of opiates starting in his early twenties
- A major factor on this man's mental ill health and drug taking was that this man had lost two brothers to a drug related death. There were no family or friends present at inquest to explore this further.
- Mental health team report identified worsening anxiety, paranoia and a drug induced psychosis with alcohol dependence.
- Dangerous alcohol use was addressed but he refused detox stating that he wasn't ready for that.

Findings

- It is probable that, had this man gone to hospital with the ambulance crew on the first of that day's interaction with them, he would have recovered fully from the overdose. The fact that he had the capacity and wherewithal to refuse was, in part, based upon a long history of using

drugs and being in similar situations where he had fully recovered without further medical attention.

- This man had difficulty engaging with the drug service due to his heavy alcohol use, his mental health and his transient life. A drug Outreach Worker was allocated to him so he could be assertively engaged in the community and followed around the county. This approach worked well and, on the occasions when he had forgotten he had appointments, for example, he was located and treated accordingly.
- Identified risks regarding his mental health were managed by close working relationship with the iCMHT; his self-neglect risks managed by joint work with his social worker.
- This man's relationship with his mother was seen as being a protective factor and the drug service had consent to share information with her from him which greatly assisted.

3.9 **Drug Related Death 8**

- 49-year-old female whose husband called the emergency services as he could not wake her. The paramedics attended and found the deceased to have a voice response and GCS 11 with good effort of breathing however, she suffered a cardiac arrest on arrival in ED and passed away. She had been complaining of feeling unwell; had weakness and lethargy for four days prior to passing away.
- Medical history of long COVID, pancreatitis, Raynaud's syndrome and she had been in a lot of pain according to the husband
- No drug or alcohol treatment history
- Cause of death given as 1a. Tramadol overdose and a drug related conclusion at inquest
- The toxicologist wrote; 'The tramadol is at a potentially fatal level. The history provided suggests there may have been a build up over several days rather than an acute excess, but this cannot be confirmed from the toxicology results. The metabolites of tramadol were 1.8 times the lethal leave and the only other drug present was paracetamol in a little over therapeutic levels.

Findings

- This is a death which was linked to on-going long covid and a tragic accidental overdose over a period of time of the opiate analgesic drug tramadol due to pain issues. This woman's ability to metabolise the painkiller was compromised.

3.10 **Drug Related Death 9**

- 21-year-old male whose family last saw him alive late evening when they retired to bed. The mother of deceased last heard him at around 0230.

She found him slumped in bed unresponsive next morning. Paramedics attended and pronounced death. An uncapped needle with unknown contents was found next to the bed. The deceased had a history of drug abuse and potentially drug induced seizures. He had a medical history of anxiety and depression

- Cause of death given as 1a. Acute heroin toxicity
- Whilst the level of heroin was high in this case, other drugs were identified indicating previous use of the benzodiazepine Etizolam and anti-depressant medicine.
- In treatment with We Are with You to address periods of excessive alcohol and street drug use including ketamine, cocaine, alcohol, crystal meth and benzodiazepines- three treatment episodes starting in 2018.
- Suicidality including suicide attempts, self-harm and previous overdose was apparent here.
- 2018/9 onset of seizures suspected to have been related to benzodiazepine withdrawal.
- Drug use increased over the covid period.

Findings

- Early use of some dangerous street drugs such as methamphetamine and ketamine (18) and high strength benzodiazepines (19); this after initial drug use at 15 of cannabis and tobacco.
- An example of a person who had drug related mental ill health which was not severe and enduring, therefore not qualifying for full mental health team treatment although there were appointments offered and taken up. These did not last as this man described his mental health as 'stable and manageable'.
- Good support from family and drug treatment.
- This man reported considerable remorse at his behaviour whilst intoxicated and its affect upon his family accepting his responsibility in the situation. He had insight into his issues and associated treatment.
- Another case that informs the current and future work around non-fatal overdoses.

3.11 **Drug Related Death 10**

- 47-year-old male who was found unresponsive in his home. He had been delirious for 3 days prior to death and had a history of intravenous drug use- this had resulted in a groin infection which had travelled to his heart. He had cardiac surgery for this but remained very ill up until his death.
- A 30-year history of using drugs with the last 21 of them being mainly by intravenous injection.
- Continuous treatment with We Are With You from 2014 but he frequently failed to attend both medical reviews with his prescriber and Recovery

Worker appointments, making it difficult to monitor his welfare at times and progress in treatment without placing sanctions on his prescribing to encourage attendance.
- Notable ambivalence towards drug treatment and his own physical health over a number of years. Multiple latter admissions to hospital where he would often self-discharge, on one occasion with a main line still inserted.
- Cause of death given as 1a. Acute suppurative pneumonitis with lung abscess formation, 1b. Intravenous drug misuse and 2. Methadone and heroin toxicity, cardiac sequelae (*a condition which is the consequence of a previous disease or injury),* complicating injection drug use associated endocarditis (post-surgical debridement).
- Evidence of cocaine, heroin and methadone use at some stage before death and part of the mechanism of death hand in hand with serious physical health conditions such as widespread infection and bacterial endocarditis as well an on-going heart related issues and those listed above in the cause of death.
- Anti-depressant medicines prescribed for long-term anxiety

Findings and applying the learning

- There was an opportunity for an ambulance to be called earlier than it was but, to some degree this man forbade that call being made until such time as he became delirious, and his wishes were over-ruled. It is arguable whether an early medical intervention would have saved this man's life.
- A holistic approach was taken to this man's care. He was often reluctant to address his use of street drugs and was aware of the significant risks that this raised for his health including the risk of death: in response to this, the treatment service provided a suitable opiate substitute prescription that reduced the risks of overdose and provided appropriate harm reduction advice and overdose awareness. He had experience of residential treatment services and was aware that he could access this more intensive level of support once more but opted not to do so.

3.12 **Drug Related Death 11**

- 43-year-old male who was found deceased by his friend and lodger at the home address.
- Cause of death given as 1a. Pulmonary embolism, 1b. Drug misuse and 2. Alcoholic liver disease
- Long history of alcohol use and began using cannabis aged 17 which triggered paranoia
- Drug use tapered off after he married at 23 but then escalated when 2 friends died in an incident. This man overdosed on methadone.
- Heavy use of temazepam and dihydrocodeine from illicit sources although heroin and crack were also used

- Main addiction was alcohol with evidence of one litre of vodka per day
- The metabolites of dihydrocodeine in toxicology were so high that suicide was a possibility although not concluded. He had a history of overdose both deliberate and accidental whereby a previous suicide attempt was by consuming dihydrocodeine.

Findings

- Alcohol dependence underpinned the physical and mental health problems that this man had which manifested in peripheral neuropathy which, in turn and in part, drove this man's use of opioids.
- No medical help was sought by this man in the last 12 months of his life.
- Whilst medical issues were obvious and frequent, there were no interactions with drug and alcohol services or mental health services.
- He died from the combined use of alcohol and his drug of choice, dihydrocodeine, in circumstances which may have been suicidal

3.13 **Drug Related Death 12**

- 48-year-old male who was found by the ambulance and fire responder in an armchair and in a state of slight decomposition. 4 bottles of methadone (2 empty) were found in the house. The deceased had a medical history of heroin addiction and mental health issues
- Cause of death given as 1a. Methadone and zopiclone toxicity
- Twenty-two-year history of opiate substitute treatment with methadone being prescribed up until his death; started smoking cannabis at the age of 12 and first used heroin at the age of 19.
- He reported that he struggled to deal with feelings arising from childhood abuse
- Suicide was explored at inquest as the level of methadone in toxicology was 11 times the therapeutic dose and 5 times the top end of the lethal range. Zopiclone was also in the toxic range. He had a history of overdose and attempt suicide, but other factors highlighted by family negated a suicide conclusion here. According to family, this man would often take all of his medicines in one go when they were dispensed to him and generally not adhere to safe taking of medicines as prescribed.
- GP record highlighted depression and long-term opiate addiction.

Findings

• One of seven deaths in this summary where there was some deliberation as to whether the death was a suicide but, due to the information available, concluded as a drug related death as the threshold of evidence to conclude suicide had not been met.
• Most recently the Methadone prescription was provided through Shared Care arrangements via a local GP with the support of a Recovery Worker

from We Are With You. The prescribing was set at 100mls methadone daily (1mg/ml) and collected on a weekly basis in line with guidance issued to reduce pressure on pharmacies during the COVD crisis. A risk assessment had been undertaken in order to consider this measure and appropriate prescribing reviews had taken place in February and April 2021 with the next review due in July 2021, a month after this man's death.

3.14 **Drug Related Death 13**

- 39-year-old female who was found deceased in bed by a friend. Lots of drugs and alcohol paraphernalia were found at the scene with signs of recent crack cocaine and heroin use.
- The cause of death was 1a. Combined drug intoxication
- Local drug treatment record but had been out of treatment for 15 months when she disengaged
- Potentially independently fatal levels of heroin and cocaine in the presence of mental health medicines such as quetiapine and mirtazapine which may have increased the risk of heart arrhythmia in combination with the cocaine
- Evidence of anxiety and depression with physical medical issues of polycystic ovaries. She had also been glassed in the head and had been blacking out as a result. Her health worsened considerably after this assault.
- Debts in relation to drugs.
- Evidence from the family that this woman would use heroin and crack regularly, whatever pills she could get her hands on and take as many drugs as she could particularly when she got her benefits paid to her. Consequently, her body was in a weak state, and she would vomit every morning. Open door policy where she lived and all and sundry frequented her house using drugs. It is apparent that the fatal administration of drugs could have been a combination of injected heroin and crack cocaine.

Findings

- A man admitted to injecting the combination of heroin and crack into this woman with her permission and then used the rest on himself. A full police investigation ensued but no charges were preferred.
- At inquest, a very poor picture was portrayed of the scene of this death together with the people who surrounded this woman both in life and at the time of her death. It would appear that this woman may have been deceased for two days before agencies were contacted and the inquest heard of social media footage that had been taken by a person where this woman lay. It appears that first aid or other assistance could have been administered earlier.

3.15 **Drug Related Death 14**

- 46-year-old male who was reported as a high-risk missing person by his friends whilst on holiday in Cornwall with them. He had consumed a large amount of alcohol and class A drugs before he went missing at 0600am on the date of his death. The next day he was located in a wooded area where he was holidaying and pronounced dead at the scene. He was found face down and had numerous cans of alcohol and tobacco around him. An empty bottle of lidocaine with a broken bottle neck was also found nearby
- Going missing was described by family as 'out of character' and he left his mobile phone in the caravan where they were staying
- He was witnessed to consume 14 beers and 4 glasses of wine with a line of cocaine
- Cause of death given as 1a. Cocaine toxicity.
- Anxiety and depression for which he was prescribed anti-depressants. He was involved with the mental health team from where he lived outside of Cornwall and his children were very much protective factors. Previous overdose.
- Whilst an empty bottle of lidocaine was found and lidocaine was indicated in toxicology, the metabolites of cocaine were very high if not fatal in their own right

Findings and applying the learning

- All deaths for 2021 will be further investigated to see what, if any, links there are to suicide and cocaine use and this will be cross-referenced with the DAAT's working with Public Health, particularly with the Suicide Surveillance Group. There is an increasing number of deaths this year where the mechanism of death has been drug related with more than a suspicion that the deaths have been suicide.

3.16 **Drug Related Death 15**

- 40-year-old male who was found collapsed at home with multiple empty blister packs of medication. He had a medical history of depression, psychosis, personality disorder, epilepsy, previous self-harm, overdose, and opiate and benzodiazepine dependency
- Cause of death given as 1a. Mixed drug toxicity
- Toxicology revealed that this was another new benzodiazepine related death but in combination with prescribed methadone, diazepam and other medicines which would have added to the overall sedation and ultimate premature death.
- Ten-year drug treatment history
- Use of cannabis aged 12 and other drugs quickly followed

- Co-ordinated work between GP, Drug teams and mental health teams which included time on hospital mental wards and evidence of aftercare and planning his resettlement in the community.
- Much evidence of how various issues of mental ill health and drug use were being treated and how this man alleged problematic and on-going harassment from his neighbours. Whilst this latter point was addressed and plans made for alternative accommodation, this man did not want to move premises.
- Evidence of a relationship with a worker from a mental health support agency that was thought to be inappropriate with some blaming of the person by this man when he overdoses and was hospitalised. The worker was removed from the case, but this was also not to this man's satisfaction. This was dealt with by way of a safeguarding alert.
- This man died three days after being discharged from a mental health hospital but did have daily visits by the MH home treatment team as well as contact from a range of other agencies.

Findings

- Complex issues at play with dual diagnosis but agencies worked well together to the best of their ability with this man who did not always work positively with them, but the support was omnipresent.
- The matter of the hospital discharge close to death was investigated thoroughly and much evidence around it heard at inquest. It was muted that there was perhaps insufficient interim accommodation available in Cornwall between hospital discharge and the home address. HM Coroner reflected on this and heard detailed plans about resettling this man at his home despite the man's concerns about his neighbours. These concerns were thought to be part of the paranoia from which he suffered. The man was resolute that he did not want alternative accommodation so the agencies did all they can in the circumstances. Suicide was ruled out although suicidality was a feature of this man's presentation.

3.17 **Drug Related Death 16**

- 50-year-old male who was found dead by his neighbour after drinking throughout the afternoon/evening. He had a past medical history of heroin and alcohol use, depression, anxiety and falls.
- Cause of death given as 1a. Multiple drug toxicity (due to the cumulative effects of drugs and alcohol)
- Toxicology revealed the presence of alcohol, methadone, heroin, venlafaxine mirtazapine, diazepam, citalopram, paracetamol and pregabalin. The co-ingestion of these drugs led to fatal respiratory depression

- Open to drug treatment services since 2017 with 3 separate open records, most recently for 2 years and 4 months up until death including residential services
- Relevant factors included poly drug use including allowing peers to inject him with heroin and ketamine, heavy use of alcohol until be blacked out, intoxication fuelled overdoses and self-harm including suicidality and a plan to end his life. History of low mood and adverse childhood trauma
- Due to the pandemic, a number of services moved online, however We Are With You maintained a level of face-to-face work with this man due to concerns at times for his wellbeing
- On more than one occasion this man's drug worker was not available and alternative support was quickly provided, however, most recently there had been a 5-day delay in identifying an available worker, by which time sadly he had passed away.

Findings and applying the learning

- This man was at the stage where he wanted to address his childhood trauma. Whilst this was being addressed by agencies, he had not engaged yet prior to death and this is seen as a significant step in addressing his substance use which he sadly did not have time to see benefit from.
- Although We Are With You is not an emergency service, they aim to respond quickly to client's changing circumstances and during the last few days, there is not a record of the attempted contacts with this man that should have taken place whilst arranging for a worker to complete a further home visit. Appropriate learning has been passed back to the relevant staff but, equally there have been significant staff shortages that We Are With You have had to contend with over the last two years. This has also led to large caseloads for all workers. At the writing of this report, this situation of staffing is being addressed with multiple job vacancies advertised.

3.18 **Drug Related Death 17**

- 44-year-old male who was found deceased sitting in a chair by his partner. They had had an argument about his drug taking and she had seen him take approximately 30 white tablets with an 'M' printed on them and found a note in which he stated he was going to take his own life. She found him coughing up phlegm, but paramedics were not contacted, nor any help sought. She found him cold to touch and not breathing the next morning, she called her neighbour for help who contacted the paramedics.
- This man had a long history of drug taking and used methadone.
- Cause of death given as 1a. Mixed drugs overdose and 2. Coronary artery atherosclerosis and fatty liver disease

- The toxicology found that this man had used heroin and cocaine prior to death. Methadone was detected at a concentration within its quoted potentially toxic to lethal ranges and there was also evidence of previous benzodiazepine use including flualprazolam
- Three-year drug treatment history which ended 7 months before his death. At that time, he was in a very positive frame of mind, abstinent from drugs, looking to the future, volunteering and engaged in activities. He was aware that he could re-engage with drug services anytime he wanted to.

Findings

- Another death where there is evidence of heavy use of drugs linked to a potential suicide but, this case was concluded as a drug related death
- There appears to have been an earlier opportunity to have sought help with more of a chance of saving this man's life.

3.19 **Drug Related Death 18**

- 36-year-old male who was found deceased on his bedroom floor in a state of decomposition. A used needle and drugs paraphernalia were found in a jacket that was hanging on bed. He had a past medical history of opioid/drugs misuse and multiple previous overdoses
- The cause of death was given as 1a. Morphine toxicity (from heroin use)
- Multiple overdoses in supported accommodation where opiates were used and also the new benzodiazepines often resulting in hospitalisation. This man had been kept alive and monitored heavily during his stay in supported accommodation over the covid period and lockdowns. Eventually his disruption to the accommodation meant that he had to leave but only after many warnings and escalatory action.
- Risk factors of; Early use of drugs, adverse childhood experience, chronic spinal issues resulting in pain, stage 4 liver disease.
- Two detoxes where he then went into aftercare each time but was asked to leave due to him bringing drugs into the premises. The last of these detoxes and aftercare was two months before he died
- Mental health assessment flagged up this man as at high risk of accidental drug overdose
- Toxicology showed a fatal mixing of this man's methadone and other medicines with illicit heroin
- Drug treatment in Cornwall for two years up until his death after he relocated from outside of Cornwall. He came to Cornwall with chronic pain issues and liver disease so local drug teams were working with a man who had serious physical health issues from the outset. Evidence in the case records that this man received intensive treatment throughout his time in treatment from a multi-agency approach.

Findings

- Due to this man's propensity to overdose, he was regularly discussed between the DAAT and his supported accommodation providers as well as at Governance meetings where his case was flagged up due to the number of incidents reported where naloxone was used or there was clear indication that an overdose was because of the increasing risks generally from benzodiazepine use. For these and other reasons, there was an assurance that this man's care was being monitored constantly.
- In recognition of the increased risks this man faced having completed residential treatment and having been asked to leave, particular efforts were made to mitigate this by delaying his departure over the weekend so that additional support services would be available, providing overnight accommodation and transport to that accommodation and onward to gain housing support; something that unfortunately he did not take up. The Community Worker sought support from Outreach Workers in an attempt to locate and support him. There was as much monitoring and care given in the circumstances of this man having freedom to roam within the community setting.

3.20 **Drug Related Death 19**

- 37-year-old male who was seen to be acting strangely by his father during the day. He believed that the deceased had taken drugs. His father checked in on him throughout the night and at around 2am found him unresponsive so commenced CPR until the paramedics attended and confirmed death. The deceased had a history of drug misuse and there was evidence of drug use in the property with drug paraphernalia and numerous medications found
- Cause of death given as 1a. Multiple drug toxicity
- Toxicology revealed almost three times the lethal level of dihydrocodeine, illicit methadone, as this man was not in treatment and heroin use.
- Drug treatment ceased 18 months before death where the successful and mutual completion was written up in very positive terms. Not only was this man drug free at that time, but he was also volunteering with We Are With You and had other positive things going on. As is standard practice, this man was left in no doubt that he could return to treatment at any time should the need arise, but he did not re-present.
- There was evidence of a known man having dropped off 'something' to the deceased on the afternoon of the death which the family are strongly suspecting to be drugs. Whilst most of this evidence was redacted at inquest HM Coroner advised the family to speak to the police post inquest regarding their concerns.
- This man was a very keen gym goer with regular workouts and supervision of his friend's gym. Despite various drug issues in the period

that he was treated by We Are With You, there is much evidence of this man continuing his health promotion by going to the gym.

Findings

- There was a history of depression and suicide which was explored in the inquest due to the sheer number of drugs consumed. A historic suicide note was found under this man's bed which shows some suicidality. Without being able to prove it latterly though, this was concluded as a drug related death. A bereavement of a cousin and an overdose by a close family member did affect this man's mood. There was evidence from family that this man had endured years of abuse as a child which appears to have remained unaddressed and, therefore, a factor in the negative side of his life which manifested in drug use and self-harm and threats of suicide.

3.21 **Drug Related Death 20**

- 31-year-old man with a past medical history of minor injuries, anxiety with depression, intentional self-harm, overdose, asthma and gastritis
- Cause of death given as 1a. Toxic effects of cocaine
- No drug treatment record
- This death was originally suspected to be a murder as this man had been involved in an altercation in a pub during a night out which spilled out into public areas and involved him sustaining a head injury. To that end, a Home Office Pathologist was brought in to carry out the post-mortem.
- The injuries did not contribute to this man's death, but his level of cocaine use did, described as 'previous excess and/ or binge use'. He managed to get to an address where he was witnessed to be intoxicated, had seizures and died at the scene. The pathologist wrote; 'The description of his behaviour including agitation, hyperthermia and fitting is highly suggestive of Acute Behavioural Disturbance, which in the absence of any other finding is most likely attributed to the toxic effects of cocaine'.
- Evidence heard that this man had access to a substantial amount of cocaine

Findings

- Unable to establish any obvious learning from this death. This was a father of four who lived with his partner and family, had employment and was described as a social drinker and 'recreational' user of cocaine.
- There were other factors at play in this death that added to this man's overall agitation and CNS excitement. It could be said that the drugs potentiated his agitation/ excitement and vice versa.

3.22 **Drug Related Death 21**

- 50-year-old female who visited her partner at (16:00-18:00) with around £200 worth of crack cocaine which they both shared and finished by 22:00. The deceased then took out some Pregabalin capsules (200mg) which her partner states she had been prescribed but these were not in a blister pack. She gave four to her partner and she took some of unknown quantity. The partner of the deceased states that he fell asleep around 01:00hrs and woke at around 07:00 when he found her unresponsive. He called the ambulance and commenced CPR, but she died at scene.
- She had a history of seizures for which she was being investigated but had not been diagnosed and had a recent episode of pneumonia and shortness of breath which appeared to have been resolved. Factors of chronic back pain, anxiety and
- Cause of death given as 1a. Multiple drug toxicity and 2. Bronchopneumonia
- Toxicology included; Cocaine (potentially independently fatal) very high sertraline, chlorpromazine, very high illicit fentanyl, mirtazapine, kavain, pregabalin, and morphine
- This woman had been in drug treatment for 7.5 years but had last been discharged from treatment 5 years prior to death.
- Notable underlying factors of bereavement of her grandmother and her boyfriend and her children taken being taken into care.
- She had a plan in place to die by suicide by way of a heroin overdose. Long term suicidality and a mental health record that included anxiety, depression, emotional personality disorder, counselling for grief, hearing voices, PTSD

Findings

- It is rare to see unprescribed fentanyl in a medicinal preparation in toxicology and it is not known where this woman got the fentanyl patch although she was dipping the patch in her tea and telling her partner that it potentiated the drug, so the patch was present for its abuse potential. The use of kavain equally is rare in toxicology and its presence here is likely to be to potentiate other drugs.
- There is open evidence from the partner as to drug use and a shared endeavour. Equally so, there is evidence of this woman trying to get the most out of all of her drugs by potentiating them in different ways.
- Although pain was an issue, she was offered help via her GP, and she declined attendance at the hospital pain clinic.
- Notably, this woman had five years of what appears to have been high level drug use where she received no treatment for it and, in part, her associated pain and mental ill heath drove the use onwards.

3.23 **Drug Related Death 22**

- 25-year-old male who is believed to have taken Xanax (a benzodiazepine with alprazolam as the active ingredient) the previous night. His partner states that she slept on the sofa, and he went to bed, and she could hear him snoring. She woke at around 05:15 and could not hear the deceased snoring and found him not breathing with blue lips. She called the emergency services and commenced CPR.
- This man was known to use Xanax and heroin from the age of twenty and was in drug treatment in receipt of a methadone prescription with regard to his heroin dependency
- The cause of death was given as 1a. Drug toxicity
- Toxicology; 'Likely therapeutic concentrations of methadone, dihydrocodeine, pregabalin and morphine detected along with the presence of flubromazolam. Flubromazolam is a potent benzodiazepine drug which when taken in combination with the above drugs is likely to enhance the effects on cardio-respiratory function which may lead to a potentially fatal respiratory depression. Flubromazolam is likely present from counterfeit Xanax sourced online and was detected at a concentration previously associated with fatalities'
- Similar set of circumstances to DRD number 17 above where a partner has challenged their partner over his intended use of drugs, and he has subsequently died at the scene. Coincidentally, both cases feature illicit high strength benzodiazepine drugs. There was evidence of monitoring of the person taking the drugs in this instance albeit, it was not constant monitoring.
- One continuous drug treatment episode from October 2017 for support in management of opiate dependency. This man also continued to use illicit benzodiazepines, diazepam and cannabis throughout much of the time he was known to treatment services; initially, there was also occasional cocaine use.
- Evidence of this man having problems with the more restrictive movements because of covid and also how they impacted upon his access to his methadone prescription. An example of this was him not wanting to walk a mile to pick up his prescription as he had been moved with his partner into temporary holiday accommodation.

Findings

- The concern by the partner is evident none more so than she was expecting their first child when her partner died- she was very supportive of his drug treatment and assisted with communications.
- The covid change in access to prescription medicines was challenging but the drug team kept access to it open; this meant that this man had to make more of an effort which he wasn't happy doing. There is evidence that he was kept abreast of all changes and the reasoning for them.

- Within the clinical record it is clear that the plan was to support this man to achieve a level of stabilisation with his prescription and once his child was born, to consider attending residential detox in order to gain abstinence from opiates
- The housing situation presented a challenge for him as he did not have transport. Following the COVID-19 lockdown, Cornwall Housing have had limited options available for people in similar circumstances. Support was provided by We Are With You and advice and guidance given in order to identify possible additional resources and mitigate the risks

3.24 **Drug Related Death 23**

- 21-year-old male. He had been recognised to demonstrate traits of autism that could lead him, on occasion, to be impatient. He was gaming with on-line friends into the early hours and complained of a sore throat and/or tooth ache. He took medication prescribed to his grandfather to ease his discomfort and when this did not appear to have an immediate effect, took more of it.
- HM Coroner concluded that this was an accidental death 'with no history of drugs, otherwise this would be a drug related death'.
- The cause of death was given as 1a. Mixed drug overdose
- The drugs used appear to have been co-codamol by the toxicology screen identifying high paracetamol and lethal levels of codeine. Zapain tablets (co-codamol) were left in a residential cabin in the garden from a late family member and this is where this man was able to use them when he took up temporary residence
- GP information of severe anxiety, moderate depression, autism and paranoia. Previous alcohol and medicines overdose.
- Information heard at inquest that autism tended to make this man frustrated when things did not work straight away so a theory was that he took tablets for pain and took more instead of waiting for them to have a positive effect on his pain.

Findings and applying the learning

- Another case where this could have been a suicide with very high levels of drugs in toxicology against a background of mental ill health. Other evidence tended to negate that although it will not be known for sure; This included recorded conversations that this man was having at the time when he played on the online gaming platform.
- There is learning here where out of date medicines or medicines not being required anymore by their prescribed owner are destroyed as soon as practicable as long as there is knowledge that the medicines were there. This man had been taken to hospital 2 years previously after having taken another family members medication.

3.25 **Drug Related Death 24**

- 45-year-old male who was found deceased on his sofa by a friend. Evidence of drug paraphernalia including empty methadone bottles and burnt tin foil was found along with various medications including pregabalin, methadone, mirtazapine and dihydrocodeine. The deceased was known to take unprescribed drugs, probably purchased on-line was last seen four days prior to being found
- The cause of death was given as 1a. Myocardial fibrosis due to 1b. Cocaine toxicity
- 15-year drug and alcohol treatment history up until death all within Cornwall
- Factors included depression and possibly bipolar symptoms, Drug/alcohol induced strokes in 2007/8, brain injury due to a road traffic collision, bereavement of close family member 6 months prior to death, asthma and other lung conditions, problematic long term alcohol use.
- History of seeking illicit diazepam and there was evidence of etizolam (illicit benzodiazepine) in the toxicology as well as methadone, cocaine and mirtazapine- the latter prescribed for the mental ill health.

Findings

- Good use of pharmacy staff to gauge this man's various presentations in the sometimes absence of him engaging with drug teams.
- Supportive family
- A long-term and good therapeutic relationship with the drug team with the evidence not pointing to any learning that may have changed the way this man was treated or would have elongated his life.

3.26 **Drug Related Death 25**

- 44-year-old female who was found unresponsive at another's address. History of domestic abuse from which she was fleeing- stayed one night with an ex-partner and they then stayed the next night together at a friend's flat. Ex-partner described her as admitting to having been on a week-long 'bender' of crack cocaine and heroin.
- The cause of death was given as 1a. Mixed drug toxicity
- Very long list of drugs found in toxicology including Pregabalin, Amphetamine, Methamphetamine, Temazepam, Paracetamol, Amitriptyline, Mirtazapine, Diazepam, Heroin, Cocaine, Zopiclone
- Two treatment episodes with We Are With You with differing presenting issues at point of self-referral (heroin and benzodiazepines). The treatment did not progress significantly beyond referral and initial assessment stages within either episode at her request top end treatment as she had ceased her use of heroin and benzodiazepines respectively.

- This woman stated that she suffered from anxiety and depression and had taken a deliberate overdose of Pregablin previously. It was confirmed that she was engaging with Outlook Southwest to address this area of need
- History of drug dependence since 1992 (intravenous use of heroin) with mental ill health (depression and anxiety)
- At the time of the triage assessment, she stated she 'needed to be seen to be seeking help' and advised the assessing duty worker that she was not allowed to see her youngest child until 'all this was sorted out'.

Findings

- It is the general opinion that this woman sought drug treatment only to placate other agencies who were dealing with her access to her children and that her short engagements that did not amount to actual treatment, were not serious attempts to address her drug issues.
- Unusual to find someone with such long-term use of heroin to have no local history of drug treatment.
- Whilst it appears that she was fleeing a situation in another area of Cornwall, she arrived at an address where there has been increased risk perhaps from drug use. The witnesses from the family described the scene of her death as horrendous, both in terms of the people around and the state of the flat.

3.27 **Drug Related Death 26**

- 40-year-old male whose friend found him deceased on his bed after a welfare call as he had not heard from him for a few days. There were obvious signs of drug misuse in the property. The father of the deceased stated that his son had been struggling to cope recently and that he had used drugs since the age of 20, more so lately because of the mother of his children dying recently due to an overdose
- The cause of death was given as 1a. Drug overdose
- Whilst this man had a record with We Are With You, he had effectively not engaged with them for 8 months prior to his death and was discharged from the service two months before his death.
- Toxicology showed that this man had used heroin and cannabis prior to death

Findings

- Whilst this man had not been seen for a few days, the date of death does seem to coincide with the date that his partner died four years previous. Suicide was not proven by evidence but could have been a factor. Bereavement is seen as a crucial factor.

- There was a pattern of this man disengaging with the drug service but persistence on their behalf and/ or this man re-referring would see him coming back to treatment. There is evidence of him trying to be contacted after the last disengagement, but this was hampered to some extent by the various Covid-19 restrictions.

3.28 **Drug Related Death 27**

- 20-year-old female who was found by her partner on cushions on the floor. The deceased had a history of drug and alcohol misuse and had taken an injection of heroin. The partner injected her with naloxone when he found her not breathing. A small amount of heroin and needles along with scales were found in the property. The deceased had a past medical history of cellulitis in her leg which she was given antibiotics.
- This death is still at the pre-inquest stage with two pre- inquest hearings having taken place. There are sub-judice issues including the supply aspect of the heroin. An official cause of death is awaited but the expected cause will be drug related in line with the comments from the toxicologist that excess sedation due to heroin and pregabalin in combination with cocaine and amphetamine possibly leading to arrhythmia, may prove fatal.
- Known to drug and alcohol treatment services since June 2015 with 5 separate treatment episodes on the record, three of them being with the young person's drug service Yzup. She reported a history of consuming excessive amounts of alcohol and varying street drug use that included heroin and crack cocaine
- Notable factors of suicidality including deliberate overdose and self-harming, reluctance to enter residential detox as she viewed this as being locked up, worsening of symptoms and situation with alcohol use. She was at times prescribed medication for her mental health but reported that she did not continue to take it. Her drug and alcohol use was reported to be a response to poor mental health: in effect she appeared to self-medicate using alcohol and street drugs. There is mention of significant anxiety and that she had experienced traumatic events that had a lasting effect on her mental well-being

Findings and applying the learning

- The latest risk assessment on record acknowledges the risks associated with the chaotic use of street drugs in combination with alcohol; the risk to self through frequent self-harm and suicide attempts; the concerns arising from the lack of stable housing; the risk from others as a result of her being street homeless and the vulnerabilities that arose from this including specific concerns about close relationships she developed at times that were of an abusive nature.

- Whilst mental health issues are noted in this woman's record it appears that there were on-going issues regarding treatment. It is noted in a safeguarding meeting 2 months prior to her death; 'All professionals felt that despite her alcohol misuse there is a role for CMHT given her poor mental health and overdoses. She has previously had extensive involvement from CAMHS due to childhood trauma. She is also wanting support from the CMHT'. This latter issue will be explored more at inquest and is likely something that can and will be fed back to the Dual Diagnosis Steering Group chaired by Mary Greener.

3.29 **Drug Related Death 28**

- 31-year-old male who was found on the living room floor by his neighbour unresponsive and not breathing. He called the emergency services, they attended and attempted resuscitation for 27 minutes before confirming life extinct. Medication for depression, Xanax and other unknown drugs were located in the property. This man was known to misuse diazepam and had a history of previous overdoses of Xanax (alprazolam); the last one being about 18 months ago.
- The cause of death is awaited as the inquest has not yet taken place.
- Likely DRD conclusion with toxicology stating; 'The results show the use of flualprazolam prior to death at a concentration that has previously been associated with toxicity / fatalities. There was also evidence of etonitazene use. Diazepam, zopiclone, promethazine and trazodone at therapeutic levels, and trace amounts of dihydrocodeine and paracetamol were also detected. CNS depressant drugs may act synergistically to enhance their toxic effects on the cardiorespiratory system'
- He had three episodes with We Are With You and the last episode was specifically to address this man's high benzodiazepine use- street high strength benzos. This episode lasted 44 days and he had only been using these drugs for 28 days before this episode started
- History of suicidal thoughts and in October 2019 had taken a deliberate overdose. At the time he described historically experiencing social and generalised anxiety from a young age. Prior to this there had been further admissions to the emergency department relating to his mental health.

Findings and applying the learning

- Drug alerts have been issued in relation to high potency synthetic opioids entering the heroin supply chain in the last year but, this is the only instance of etonitazene type compounds being in Cornwall by way of toxicology and/ or forensic testing done on behalf of the police. There is much rumour about these drugs and fentanyl being in heroin, but we have not seen it in Cornwall in either toxicology or forensic testing of drugs other than this isolated case.

- Joint working demonstrated between the drug team and GP in what is a relatively new field where high strength benzo's are now more commonplace in primary presentation- the key here being good communication all round in relation to the gradual lowering of drug use to prevent seizures etc
- There was learning for the drug team here where their review of this death revealed poor record keeping to contemporaneously record all meetings and interactions with this man. Likewise, liaison with the GP, who was coordinating mental health care, could have been better recorded. This learning point has been flagged up within WAWY and they have implemented an action learning process within team meetings to review cases such as this to recognise where practice can be improved.

3.30 **Drug Related Death 29**

- A 23-year-old man who had left his home address (parents address) at approximately 20:30hrs to see his girlfriend. He returned just before midnight as captured on the home CCTV where his demeanour did not suggest any intoxication or other concerns. The parents went into his room to check on him the following morning as his 08:00am alarm was sounding and found him face down on his bed non-responsive.
- Cause of death and conclusion are subject to inquest later in the year, but a DRD is expected with the toxicologist's conclusion being; '*There has been excess illicit use of MDMA (ecstasy), cocaine, ketamine and possibly buprenorphine (although this may be prescribed). The MDMA and cocaine will cause fatal cardiac arrhythmia. The ketamine is high enough to cause anaesthesia which, if not respiratory support will be fatal. The illicit alprazolam and use of pregabalin will increase the risk of sedation and possibly respiratory depression'.*
- This man was in tier 3 (structured) treatment to offer support regarding his use of street drugs including benzodiazepines and steroids. His engagement with We Are With You varied over time and appeared to reduce when his use of alcohol and substances increased. Communication was assisted with his supportive family and GP. When this mans' presentation deteriorated towards the end of his life, his drug treatment Recovery Worker responded by increasing contact with him and increased contact with his GP to help to manage his drug use and medications. The impact this was having on his physical health and mental wellbeing was notable and included seizures.
- Disclosure of historical deliberate overdoses and self-harming episodes. His anxiety and depressive symptoms increased when he was using drugs so was offered counselling to help him manage these symptoms. He was also made aware of other specialist services he could access for support around his mental wellbeing which he appears not to have taken up.

Findings and applying the learning

- This man placed importance on his physical appearance, and he worked out regularly. His use of steroids was discussed on a number of occasions with harm minimisation advice, safer injecting practices and information on needle exchange services being provided in line with the risk management plan. It was recognised in the review that the impact of his use of steroids was not recorded as being fully explored with him and this has highlighted a training need for some staff within With You. In response, With You have commissioned steroid training which is being cascaded to all staff to ensure that they increase their skills and knowledge on the subjects of Performance and Image Enhancing Drugs.
- DAAT provide basic drug awareness training. Although steroids are only Class C controlled drugs, some time is spent during this course discussing the particular problems that can arise from steroid use if someone has, for example, positive body image and yet harms themselves with steroid use.

3.31 **Drug Related Death 30**

- 31-year-old female who, the day before death, is said to have taken benzodiazepines, pregabalin, crack cocaine, and heroin. On the day of death, she is reported to have scored another £20 worth of heroin and taken another additional dose (0.2grams reported). This woman's partner then left the area where they were staying in a tent to buy some wine in town- they were homeless at the time of this incident. When he returned a short time later, he found his partner unresponsive. He administered 2 doses of naloxone, but she remained unresponsive. Ambulance were however they were unable to bring her back to life.
- The cause of death and conclusion will be ascertained at inquest later in the year.
- Toxicology confirms certain drugs and the expectation of a drug related death as a result*; 'heroin was used immediately prior to death at a concentration which is likely to have resulted in respiratory depression and death in isolation. Several other CNS depressant drugs were also present and may have enhanced the adverse effects on cardio-respiratory function including ethanol, amitriptyline, diazepam, etizolam and pregabalin. There is also evidence of cocaine use'.*
- She came to Cornwall in 2020 following the death of her then partner from a drug overdose and threats from local drug dealers. She came with the intention of turning her life around with the support of her grandmother and father who lived in the area of her death
- Relevant factors at death were homelessness, bereavement, HIV positive and was being treated with triple therapy: Norvir, Darunavir, and Emtricitabine, tested positive for Hepatitis C, covid-19 infection, longstanding anxiety and depression which she habitually used substances to cope with. Her mood was frequently low in relation to the

circumstances of her life and the loss of her child into care. She had also experienced episodes of drug induced psychosis. Both of her parents experienced substance misuse issues in their lives. She described her mother as being alcohol dependent and her father was in recovery from opiate use. Her past and current partners both had histories of opiate use. She stated that she first began drinking at the age of 18 as a means of fitting in and dealing with social anxiety. She had had a previous detox when living out of Cornwall. She had a past history of intravenous drug use (heroin) and also used crack cocaine. History of offending primarily acquisitive crime to fund her drug and alcohol use.

Findings and applying the learning

- Whilst lengthy, it is worth including here the summary of learning and review that With You submitted to HM Coroner for the inquest process;
- In many ways, this woman's journey in Cornwall illustrates the difficulties of working with people who find themselves homeless. In the course of a year and a half in treatment she moved about North and East Cornwall at times rough sleeping and at times housed in temporary accommodation in a variety of locations. Each time she moved she had to register with a new GP and have her prescriptions transferred to a local pharmacy this meant there were several breaks in treatment although attempts were made to deliver medication to her. This also interfered with her HIV medications. During their time in temporary homeless accommodation during lockdown, both she and her partner contracted COVID 19 so this further complicated matters making it difficult for them to be seen in person. In addition, she and her partner moved in and out of the county from Cornwall to Plymouth often on the spur of the moment making it difficult for the outreach teams to remain in contact. They both had issues with the Criminal Justice System and there were several warrants out for their arrests which may have explained their frequent moves in and out of the county. The structured, systemic approach to service provision simply does not take into account transience and homelessness and the difficulties that individuals in these circumstances have in gaining access in a timely manner to the services they require. Although housing did accommodate them in a series of temporary accommodations it does not appear that they took into consideration her physical health needs and the fact that she came into county to escape from threats in her own place of residence. We Are With You made many attempts to engage her in structured treatment, but this was hard to sustain due to prescriptions having to be continuously moved. Another consequence of the fluid lifestyle was that she had to continually relate her painful narrative to a host of different workers as she changed location. With regard to this, the introduction of the Drug and Alcohol Outreach Team within We Are with You means that workers can follow service users across the county minimising the necessity for repetitive narratives and re-traumatisation.

The sector has for some years now been developing a Dual Diagnosis Strategy in an attempt to facilitate more joined up practice for those with mental ill health and substance use; it would appear also that there is work to be done with our primary and secondary health care providers for those service users who have progressive health conditions or terminal illness. In essence there are lessons to be learned for all the agencies involved in the care of this woman as the numbers of rough sleepers and those in emergency or temporary accommodation continue to increase in Cornwall.

- In part recognition of the issues raised by this death, With You have now re-assigned a Registered General Nurse from their nurse prescribing team to full time outreach (as of April 2022). This nurse works with the Outreach Team and delivers clinical care, unblocks a range of issues and breaches the gap between primary care and the likes of drug and alcohol providers. This gap is sometimes just a matter of using the professional language of an agency and, therefore, expediting things. Nevertheless, it would be recommended that the clinical outreach abilities of With You are explored further especially in light of the With You review and the potential for more cases such as this one.

3.32 Drug Related Death 31

- 34-year-old female with a history of IV drug misuse. In 2015, she required a mitral valve replacement after developing endocarditis and related to drug use. She was able to stop using drugs and remained abstinent for a few years. She began using again and was admitted to Royal Cornwall Hospital on several occasions in 2021 with suspected infection at the site of the prosthetic valve. She self-discharged contrary to medical advice. She was last admitted In October 2021with sepsis, deteriorated acutely and died in the hospital the next day.
- The cause of death was given as 1a. Infective endocarditis and 1b Mechanical mitral valve.
- No toxicology was required due to the medical history and expected cause of death. This is a drug related death as it fits with the definition (*underlying cause is poisoning, drug abuse or drug dependence)*
- Whilst this woman had a history of treatment with We Are With You, she had last been discharged five years before her death.
- Multiple admissions to the cardiology ward at hospital with many of her stays at hospital being cut short due to her self-discharging early against advice.
- Evidence of mental ill health with depression.
- Criminal justice issues with supply of Class A drugs

Findings and applying the learning

- An overwhelming drive by this woman to use drugs dangerously and when significant harm was befalling her as a result. This is another death informing the non-fatal overdose work.

3.33 Drug Related Death 32

- 35-year-old male who was found in an empty bath and whose body was decomposing. He had a past medical history of a brain stem haemorrhage and alcohol misuse
- 1a) Spontaneous Brainstem Haemorrhage 2 Decompensated Alcoholic Liver Disease, Drug Misuse with a drug related death concluded
- There was no drug and alcohol treatment episodes to review in this case but there is a lot of evidence of offers to refer this man to primarily alcohol treatment to which he declined every time. The mainstay of this man's substance use was alcohol and the metabolites in toxicology were 4½ times the UK legal drink drive limit and arguably fatal in a non-dependent alcohol user. This man, however, was dependent and had many medical issues related to it. Cocaine was also found in toxicology.
- Evidence of multiple admissions to hospital for alcohol related conditions such as; acute renal failure, grand mal seizures, gastro-intestinal haemorrhages, ascites which latterly had to be drained weekly.
- Depression since 2013 and worsened by alcohol use. In 2013, this man's father had to travel to Thailand to bring his son back to England as he had been working there but had become very sick due to his use of alcohol.
- Supportive partner and step-children who adored him and supportive father.

Findings

- There is every likelihood that this man's life would have been elongated, if not completely changed for the better, had he taken up the offers of alcohol treatment. He did use drugs intermittently latterly, but the mainstay of his ill health issues was alcohol use. He had a supportive network around him to have been able to accept alcohol treatment with ease it is felt.

3.34 Drug Related Death 33

- 53-year-old male who got home at approximately 1800 hours on after being out in Newquay area with people unknown. This man's wife says that she feels that he may have been smoking something. He went to sleep at approximately 2100 hours and woke up the next morning at approximately 0900 hours went to the bathroom around 1045am and collapsed on his way out into the hallway. The ambulance was called, and

he was pronounced dead at 1135 by a paramedic. From SWAST reports: this man was known to smoke heroin.
- The cause of death is awaited and will be agreed when the inquest goes ahead early next year
- A DRD is expected here as the toxicologist found that methadone was detected at a concentration within its quoted potentially toxic to lethal ranges and sufficient to result in a potentially fatal respiratory depression with concomitant morphine, pregabalin, mirtazapine and cocaine use, all of which are likely to have enhanced the adverse effects on cardio-respiratory function
- History of anxiety and depression and in receipt of pregabalin for this
- Notable close bond between this man and his wife
- History of homelessness and drug/ alcohol use but he had been in stable accommodation for the last couple of years of his life.
- Back pain
- This man approached With You in relation to his use of street heroin and occasional crack cocaine. Once settled onto an opiate substitute prescription, he continued with further occasional use of both substances, however, it does not seem to have been problematic and was limited. He remained in treatment for nearly three years up to death. This man's partner was also being supported for her opiate use so there was a level of insight and knowledge between them

Findings

- It is clear that the mutually supportive relationship that this man had with his wife was of utmost importance to him. Once they settled into their flat, it appeared that life was more settled for them and there were longer term plans for gradual change as the stability that brought benefitted them. In the meantime, it appeared that this man was content to be living a quiet life continuing with support from the treatment provided.
- The level of methadone metabolites were high compared to what one would expect from this man's prescription. It appears that his self-confessed occasional use of crack cocaine and heroin with increased levels of methadone has combined and proved fatal.
- Support, communication and progress was all in evidence when reviewing this death.

3.35 Drug Related Death 34

- 51-year-old male who was found deceased sat on a chair in the living room. He had not been heard from for 4 days.
- The inquest is set for later in the year to ascertain cause of death and a conclusion.

- An expected DRD with the toxicologist commenting that; *'The presence of 6-monoacetylmorphine likely indicates use of illicit heroin as the likely cause for morphine being present. The concentration of morphine is potentially fatal. There are therapeutic levels of oxycodone, diazepam and pregabalin present which will have increased the risk of death but not cause death alone'*
- Bereavement- This man found it difficult to come to terms with the death of family members, his mum in 2006, his dad in 2008 and in particular his younger brother's death in 2010.
- This man experienced pain following a serious leg injury and at times his mobility was affected. Previous alcoholic fatty liver and asthma. He frequently stated that he had been sick and complained of pain from his stomach
- Mental health- Bipolar Affective Disorder (diagnosed 2002 in HMP Channings Wood), Adult ADHD diagnosed by Addaction psychiatrist circa 2012, significant personality difficulties and mood lability – CMHT psychiatrist 2011
- He reported that he had found previous support from CMHT beneficial, and his GP continued to monitor and support him regarding his mental wellbeing. He also found that medication to address his ADHD to be beneficial, but it appears that he did not always take the medication.

Findings and applying the learning

- Good evidence of multi-agency working for physical health issues, mental health and drug/ alcohol treatment.
- A review did flag up that a latter drug/ alcohol treatment episode should have been closed earlier and this was due to this man's non-engagement at the time. That said, and as the treatment record had not been closed, another contact was made with this man, and he did engage again albeit not fully. Furthermore, when this man re-engaged, he informed the treatment worker that he had been abstinent from drugs and alcohol- this was accepted and not confirmed with the man's GP which is best practice. Both points have now been addressed in supervision sessions acknowledging that the worker did have a good therapeutic relationship.
- Another death where a longstanding alcohol use issue was the mainstay.

3.36 <u>Drug Related Death 35</u>

- 48-year-old male from out of county who had been visiting a friend for the last 5 weeks. The friend had gone to bed, awoke 4 hours later and went to check on her friend where she found him slumped in a chair in the living room deceased. They had been supporting each other with deaths of their friends and to help each other day to day with their mental health needs as both have issues.

- He had a past medical history of mental health issues including bi-polar disorder, paranoia, and psychosis and was recovering from heroin and alcohol dependence.
- The cause of death will be agreed at an inquest later in the year, but toxicology has indicated that this is drug related by virtue of the presence of amphetamine at a potentially lethal level in combination with diazepam, methadone and pregabalin which were all found at levels consistent with therapeutic use
- The methadone came from this man's prescription from out of county where he had been in treatment.

Findings

- This man had been complaining of breathlessness a few days prior to death and the scene of the death did not show obvious signs of drug use. The cause of death will be agreed at inquest but, irrespective of any medical condition that may be reported, the toxicology clearly shows that this is not a natural death.
- Likewise, prior to the inquest, information from drug treatment out of county is not available to comment upon. Anything coming from the disclosure of the full evidence, including that of the drug team from out of county, that can assist the learning will be disseminated to local teams.

3.37 Drug Related Death 36

- 34-year-old male who was found by his friend next to his bed, face down in the state of rigor mortis with blood coming out of his nose. There was evidence of drug paraphernalia around the room and a used needle found on the floor near the body. This room happened to be a shed where the deceased had been staying for the last three weeks with a friend.
- Inquest and cause of death awaited towards the latter part of the year.
- Information from this man's family was that his mental health had been really bad recently prior to death. He had been using drugs for some while, but this became more serious of late suggesting that he was recently taking methadone, heroin and valium.
- One continuous treatment episode with We Are With You for a year running up to his death after a GP referral
- He reported to have been "snorting" heroin, with no injecting use, for the six months prior to referral and wished to commence on an opiate substitute prescription (OST) in order to reduce and stop his use. He stated he had used cannabis from the age of 14 and a mixture of stimulant drugs in his later teenage years.
- He described a history of depression and anxiety of long duration and was prescribed Citalopram and Propranolol by his GP to alleviate his

symptoms. Diazepam had also been prescribed at times of heightened anxiety.
- Detox offered but declined as it interfered with his employment- he worked 6 days a week
-

Findings and applying the learning

- In review, two main factors are evident in impacting this man's treatment journey with We Are With You. One of a personal nature and the other more global in scope.
- From the onset of his treatment this man was working six days a week and often out of hours. This made it difficult to provide a regular service to him and there were resultant gaps in communication and contact
- Coupled with this, the global pandemic meant that face to face meetings and opportunities for regular drug testing were limited. Although regular prescribing reviews were carried out by telephone, this did not really give the opportunity for a robust therapeutic relationship to be developed or the chance for either his Recovery Worker or prescriber to corroborate his narrative by means of observation and dissonance. This form of contact would have been replicated with his GP.
- What is evident throughout the record is that this man had a strong desire for recovery but found himself in a position from which it was very difficult to move forward
- Going forward, this man would have probably benefitted from a monthly depot injection of a drug known as Buvidal. This would have allowed him to maintain his work schedule and not have to attend prescribing/ dispensing appointments as regularly. Buvidal was not available when this man was in treatment.
- A point of learning which With You have taken up is to approach appropriate employers, with the client's permission, to see if appointments can take place within work time.

3.38 <u>Drug Related Death 37</u>

- 51-year-old male who was found deceased behind his sofa by a letting agent; he called paramedics who confirmed death.
- He had a past medical history of alcohol use.
- Inquest awaited and listed for later this year where cause of death will be determined.
- Toxicology indicates that this is drug related; '*Pregabalin was detected at a significantly elevated concentration which is highly likely to have resulted in significant adverse effects on cardio-respiratory function which are likely to have been enhanced by the presence of highly potent benzodiazepine drugs, flubromazolam and flubromazepam. Quetiapine,*

which is also a CNS depressant drug, was detected at a concentration within its quoted potentially toxic range'

- This man began using alcohol at the age of 13 in an attempt to deal with issues that were occurring in the home environment where he was the recipient of abuse and the witness to problems in his parent's relationship. On leaving school he began a university degree in Psychology and Philosophy, but he did not complete the course due to relationship breakdown and concomitant escalating substance use. At the age of 20 he left the family home and, seeking a surrogate family unit joined a New Age Travelling Group. Within the community there was a culture of substance use, and he was regularly using a mixture of cannabis, ecstasy, cocaine and amphetamines in conjunction with regular alcohol use. At the age of 34 he reports beginning to smoke heroin on a regular basis.
- Much evidence of pain and physical ill health, had a diagnosis of Bi-Polar Affective Disorder with hypomanic episodes and throughout his treatment journey with We Are With You he was involved with Community Mental Health Services, Pentreath Recovery College and CLEAR emotional and trauma therapy specialists

Findings

- Ambivalence was a key feature in this man's inability to recover from drug use. Whilst on the one hand he continually aspired to be abstinent from all substances, the relief that opiates in particular gave him mitigated against this desire. He believed for much of his life that he was in control of his substance use and that it assisted him in dealing with his psychological distress and the fluctuating affects caused by his bi-polar disorder. In the final months of his life his ability to remain in control of his substance use and to comply with medication regimes diminished greatly and increased his anxiety and ability to cope.
- Throughout his treatment, this man was well supported by both statutory and voluntary mental health services and, whilst there potentially could have been more joined up working between professionals from mental health and drug/ alcohol services around more robust safety planning, they were heavily impacted by the covid situation. This man's second attempt at detox, for example, was heavily delayed due to a covid-19 breakout, but that was not able to be worked around.
- His therapeutic relationship with his WAWY worker was sustained and positive and seen as a major asset in attempts to help him recover.

3.39 <u>Drug Related Death 38</u>

- 31-year-old male who was found lying on his bed not breathing and cold to touch by staff at a homeless pod site. A half-consumed bottle of methadone was found in the pod which was prescribed to another person

who was in drug treatment with With You- this person was also a resident on site at that time but in a different pod unit.
- He had a past medical history of anxiety, depression, binge drinking and cannabis use
- Inquest listed for later in the year where a cause of death will be determined. Whilst previous use, but unmeasurable in toxicology, of cocaine and cannabis was mentioned, the outstanding toxicological feature of this death is the presence of methadone, and this was not prescribed to this man albeit he had a current link to local drug and alcohol treatment, a complex history of alcohol dependency and substance use. He was using a range of different substances including crack cocaine and alcohol and had a past history of substance use including cocaine, MDMA, heroin, benzodiazepines and cannabis.

Findings

- It is clear from the drug and alcohol treatment record that this man did want support to enable him to change his life and regain contact with his children. His anxiety and lack of self-esteem mitigated strongly against this. He was also apparently unable to engage in a therapeutic relationship with those working with him which made it difficult to progress forwards. Just before his death he began discussing the possibility of detox and rehabilitation. Although perhaps the structure could have been more flexible in the management of his case, a home visit was carried out and he was regularly contacted with the With You Outreach Service who did access him accommodation. Paradoxically, his use of substances as a maladaptive coping strategy for dealing with his anxiety and depression compounded those issues and he frequently reported thoughts of suicide. He continued to be supported by his family particularly his sister for whom he felt a deep affection.
- More of the detail from the consumption of methadone will become apparent at inquest.

4. Review and Learning from 2021

4.1 The Cornwall DAAT Drug Related Deaths Review Panel is a long-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 the Consultant 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. This is not an exhaustive list, and a range of agencies can be co-opted on to the panel to assist.

The learning from this panel is fed into the inquest process via reports from the Chair and he also attends all inquests that are suspected to have been drug related; this will include suicides on occasion. The learning is fed back, in part, to the members of the panel. The panel also informs and approves the content of this report and explores and identifies any themes and learning to improve prevention in the future. The terms of reference for this group can be found in appendix 1.

The inclusion of experts by experience is still an ambition of this panel and is imminently to take place pending final sign off of terms of employment.

New for the autumn of 2022 will be a smaller review group which will basically include the chair of this panel with We Are with You representatives (medical and clinical lead, services manager and complex needs lead). This smaller group will focus on those that have died from a DRD and who were in treatment with WAWY. This smaller group will allow a more in-depth analysis specifically focussed on the nuances, challenges and more often found complexity within clients. This will also be fed by WAWY internal reporting.

4.2 **Summary of specific issues**.

- **Heroin and cocaine prevalence in DRD's has increased from 2020 but, not to pre-covid levels. Illicit benzodiazepine drugs not seen pre-covid are remaining a significant risk to health**

Heroin related deaths being down by 36% and cocaine related deaths being down 27% for 2020 from 2019 in Cornwall was a significant change to all previous years apart from 2012 when there was a heroin shortage, albeit for different reasons.

There were **18** (47.4%) **deaths from heroin toxicity or where heroin has been implicated in the death** in 2021. This is a proportional **increase of 12.4%** from 2020 where there were 14 such deaths of the 40 in total. Whilst any increase in the number of deaths is of concern, the proportion of deaths related to heroin has not gone back to the 'pre-covid' level in 2019 of 71% and the even higher proportion in 2018 of 79%. **Cocaine featured in 22 of the deaths** (57.9% of the total, **up 7 deaths or proportionally up 20.4% from 2020**). As with heroin, there was a

notable decrease in the number of cocaine related deaths in 2020 compared to 2019**.** This has been explained in more detail in the 2020 annual report but, essentially is thought to be a collateral effect of some of the measures taken during the Covid-19 pandemic such as lockdowns. Again, as with heroin, whilst cocaine related deaths have risen dramatically in a year, they have not gone back to the 'pre-covid' figures seen in 2019 of 64.5%. **For the first time ever, cocaine related deaths have surpassed heroin related deaths** in Cornwall since records began in 1999 (11 deaths or 29% feature both drugs). This is seen as a significant change to the profile of a drug related death. As with previous years, the cocaine identified in toxicology is believed to be in the form of crack cocaine in the main, although, this cannot be ascertained exactly with toxicology only identifying cocaine and not crack cocaine.

Whilst Covid-19 and all its derivatives are likely to be around for years to come, 'traditional' drugs trafficking methods will likely not be curtailed again to the same degree as they were in the first two years of covid. The temporary hiatus in heroin and cocaine trafficking allowed another market to grow (benzodiazepines) in Cornwall, as well as nationally, and this appears to be staying for now. The added level of increased benzodiazepine use in Cornwall is a consideration that treatment agencies, supported accommodation and the like have taken seriously. Presentation of some clients has changed and the treatment available has also had to change to accommodate this. There is now increased emphasis on benzodiazepines within drug training that DAAT facilitate. Naloxone training and the need to incorporate incident reporting has also changed to include benzodiazepine incidents. There is good communication between a wide range of agencies on the subject of benzodiazepines in Cornwall.

- **Non-fatal overdoses**

Approximately 50% of the deaths in 2021 were preceded by a history of overdose with some cases involving multiple overdoses with or without medical attention. Alcohol was more significant overall in the overdoses ante mortem than in the actual death but, as a precursor symptom, it is an important one to track.
The 50% figure is a conservative estimate with evidence of overdose in 47% of the deaths by virtue of clinical notes and other information from the inquest bundles.

There are notable pilot schemes in Scotland that have shown a marked decrease in drug related deaths, non-fatal overdoses and other benefits by adopting an early intervention program aimed at those people who overdose, even if that overdose is the only one that they have had. The basic idea is that police, ambulance and hospital teams have set up a way of dynamically collating daily overdoses with named individuals, and being

able to provide and early intervention, mainly in the form of outreach from a drug and alcohol service initially.

Certain factors are important here such as the police deeming the person who has had the overdose to be vulnerable per se and will submit forms to relay that concern of vulnerability. This will allow early communications between a range of agencies that would not have been possible had the person not been deemed vulnerable. Furthermore, named individuals from ambulance and hospital services are discussed so that an outreach arrangement can be made despite that person not initially wanting further contact. Statistics have shown that this way forward saves lives and gets people into treatment that much faster.

It is the intention and aim of the DAAT to replicate this process in Cornwall. A small steering group has been set up to look at some of the information governance hurdles and other issues, but this group will be assisted by colleagues in Scotland who have already been down this route. If this is to succeed then communication between agencies is of paramount importance and changes in process will need to be negotiated after the initial stage of scaling the issue; the scaling of issue is in progress between DAAT, police and the NHS.

- **Mental Health and Complex Needs**

Mental ill health has been present in 76.3% of the deaths reviewed (29 deaths). The DAAT affiliated complex needs team has been in existence since April 2021 and has been influential in moving forward the agenda on dual diagnosis, for example.

The complex needs teams' mantra is that everything that the team are doing is within the concept of transformative co-production whereby there is the involvement of Experts by Experience in everything they do. This has translated into objectives that are set each year for each member of the DAAT team and affiliated team members (domestic abuse and complex needs).
Examples of this are and will be incorporation of experts by experience in the DRD review panel, assisting with the planning and involvement in various events such as the Service of Remembrance for those that have died from a DRD and the DRD conference.

An escalation process which was commenced as a result of an inquest involving dual diagnosis matters in 2018, is now routinely used as part of the escalation process between drug and alcohol services and mental health services. This is in evidence at every Dual Diagnosis Steering Group meeting now where cases are discussed. This steering group is one of four

groups that DAAT members are present at where mental health is the focus but overlaps so many other issues.

- **Suicide**

With at least 7 of the deaths included in this report being suspected to be suicide due to, for example, a history of suicidality, the need to continually cross-reference the drug related death work with suicide work has never been more important. As can been seen by some of the case summaries, they could as easily have been concluded at inquest as a suicide save for the absence of a suicide note. A copy of the Cornwall and Isles of Scilly Annual Suicide Report 2021 by Public Health, Cornwall Council will be hyperlinked to this report when it is available (expected imminently) Again, there is heavy overlap here with the large number of those experiencing mental ill-health, this links in with the next bullet point.

The DAAT continue to play an active part in the various forums that address suicide and mental health including Suicide Surveillance Group, Multi Agency Suicide Prevention Group, Mental Health and Suicide Prevention Innovation Collaborative and the Dual Diagnosis Steering Group.

This collaboration and partnership working will be further drawn upon and is essential in the successful setting up of a non-fatal overdose group.

- **Pain deriving from physical and mental ill health (emotional pain)**

The number of people succumbing to a drug related death and also experiencing high levels of pain remains high. Both physical (at least 31.5% in 2021) and mental ill health can generate considerable levels of pain and that pain can be enduring. Whilst the physical pain is probably easier to quantify, there is evidence in this year's deaths of pain attached to emotional trauma in its many forms. This is probably linked to the very high numbers of people who have experienced mental ill health (over ¾ of the deaths for 2021). Drivers of this emotional pain can be bereavement (29% in 2021) and unresolved trauma such as adverse childhood experiences.

One of the key pieces of work going forward is to introduce a new approach to pain and how a range of agencies can help with this. The My Live Well with Pain website https://my.livewellwithpain.co.uk/about/ states;

'My Live Well with Pain has been created by a group of clinicians who specialise in working with people with persistent pain.
After many years of working with people with pain, they have recognised that one of the keys to living well with pain is self-management.

When people self-manage their pain, their quality of life improves. Eventually it stops dominating their day and they begin to get more out of life. Managing your pain is not automatic – but it is something that can be learnt. That's where this website comes in……'

With the realisation that just treating people in pain with drugs can be counter-productive, in fact, drugs can cause pain, a newer narrative involving deprescribing of pain medicines has emerged. This is where My Live Well With Pain comes in. It has developed what is known as the Ten Footsteps approach, more details of which can be found here

In 2022, staff from We Are With You, Bosence Farm detox and Rehab unit and various others will be trained in the Ten Footsteps approach so that clients can be triaged in a more comprehensive way in relation to their pain. Thereafter, alternative approaches will be considered such as social prescribing. This will attempt to divert people away from a potential circle of life and pain, away from relying purely on medicines, potentially closing the need for some to self-medicate with illicit drugs. If the pain is reduced or removed from the person's psyche, then so too might the need to use drugs.

- **Universal Coverage of Naloxone**

2021/22 has seen another further increase in naloxone availability. Training and issue of this life-saving drug to a wide range of people and agencies is on-going. There has also been a roll-out of Nyxoid (nasal route of administration) to security personnel who look after the various homeless pod sites in Cornwall. This started in 2021 and resulted in training to all personnel. Four lives have been saved by these personnel since June 2022. The roll-out of nasal naloxone in tandem with the already widely available injectable form (Prenoxad) has proved its' worth in a short space of time and gives further scope to lifesaving as these personnel also look after a wide range of venues.
When personnel are trained in the use of naloxone and issued supplies, they are required to report on any usage of it together with the circumstances and action taken. This information is collated by the DAAT and regularly reported upon at the Clinical Governance Meeting. Trends, issues, blockages and the like are quickly flagged up this way. The naloxone reporting form also now includes reporting across the range of drug use when in an overdose situation, for example. This is valuable intelligence as well as not allowing issues to be overlooked.

5. Conclusion and Priorities

Any decrease in the number of annual drug related deaths is to be welcomed but, 38 deaths is still a very high figure. The knock-on effect of

these deaths is of no small concern and the cumulative impact of them has profound effects upon the communities within Cornwall.

Thirty-eight deaths translate to 5,130 affected others on average with 1,026 people on average from those affected, going on to potentially experience things like self-harm, harm of others, use alcohol and other drugs and experience suicidality. This is a lot for services to pick up upon in one year alone in one county.

The review of the death of each individual comes 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. The below-listed priorities build upon previous annual report findings and also utilise new initiatives to tackle some of the larger issues within drug related deaths.

Priority 1 Non-fatal overdose. To scope and introduce a dynamic assessment of those who overdose and offer timely interventions via outreach

Priority 2 Pain. Introduce the Ten Footsteps' approach to triaging pain with We Are With You and other services

Priority 3 Mental health including the effects of bereavement. DAAT to continue engagement with a variety of forums focussing on suicide, mental health and the overlapping factors

Priority 4 To co-produce our approach to Prevention with Experts by Experience (EBE's).

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

Sid Willett
Drug Related Death Prevention Coordinator
Cornwall & Isles of Scilly Drugs and Alcohol Action Team
August 2022

Appendix 1

Cornwall Drug Related Death Review Panel Terms of Reference

SAFER CORNWALL
Kernow Salwa

Cornwall & Isles of Scilly Drug Related Deaths Review Panel

Terms of Reference

1. Purpose

All Areas should have in place a system of monitoring and surveillance of all drug related deaths and all such deaths should be subject of formal review.

The Drug Related Death Review Panel exists to review the circumstances of each drug related death that occurs within Cornwall & the Isles of Scilly, in accordance with rules of sub-judice and disclosure, to identify, where appropriate, action or recommendations that may prevent similar fatalities in future.

2. Authority and Accountability

The Panel reports to the Safer Cornwall Partnership and The Community Safety Strategic Board.

3. Membership

The Panel membership shall be approved by the Community Safety Strategic Board. The core membership will be formed from the below named individual positions or representatives from named agencies.

- Drug and Alcohol Strategy Lead/Manager.
- CIOS Drug Related Deaths Prevention Co-ordinator
- Police Drug Liaison Officer(s)
- Alcohol and drug treatment service managers
- Cornwall Foundation Trust (NHS) mental health representatives

- Risk Managers from commissioning organisations
- HM Coroner's Officer
- G.P with Special Interest Substance Misuse
- South West Ambulance Service Trust
- Accident and Emergency Department
- Carers

The circumstances surrounding individual deaths may call for additional representatives to be co-opted to the panel and these may include, Adult and Social Care, Children's Services, Housing and the Probation Service together with others as necessary.

4. Quorum

There shall be five members present in order for a meeting to be declared quorate.

5. Frequency

Meetings shall be held at least three times a year. The Chair of the Drug Related Deaths Review Panel may request additional meetings if necessary.

6. Secretariat

Secretariat will be provided by the Drug and Alcohol Team.

7. Duties

The duties of the panel can be categorised as follows:

- To establish a formal intelligence network between strategy leads, commissioners, and treatment providers and support agencies working with people with alcohol and/or drug problems.
- To develop a system of monitoring and surveillance of all suspected drug related deaths.

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- To collate all intelligence concerning drug related deaths and formally review the circumstances surrounding each individual death having regard to sub-judice rules and rules of disclosure.
- To correlate with any findings through Domestic Homicide and Suicide Reviews.
- To make recommendations and disseminate learning points identified at drug death reviews to prevent similar fatalities.
- To keep under review progress against recommendations until completion.
- To maintain a library of evidence for actions taken as a result of reviews.
- To prepare reports for the information of HM Coroner for Cornwall.
- To respond to any directions and orders from HM Coroner regarding drug related deaths.
- To prepare an Annual Report for the attention of the Community Safety Strategic Board.
- To coordinate and implement drug related deaths prevention campaigns and overdose prevention initiatives.

8. Administration

It shall be the responsibility of the Chair to arrange for:

- Publication of an annual list with the dates, time and venue of each meeting.
- Arrange for the agenda and relevant papers to be distributed to the Panel no later than 5 working days prior to the meeting.
- A record of any action points to be made and for this to be distributed to the Panel no later than 14 days following the meeting.
- Ensuring that action points carried forward to future meetings are followed up.
- Provide commentary and / or minutes for the Community Safety Strategic Board as necessary.

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9. Reporting

The Panel shall report to the Community Safety Management Group and the Community Safety Strategic Board, the Director of Public health and HM Coroner for Cornwall as may be directed.

The Drug and Alcohol Team will also liaise with the Suicide Surveillance Group, Multi Agency Suicide Prevention Group, the Clinical Governance Group and the Controlled Drugs Local Intelligence Network to keep under review emergent issues, disseminate findings and learning.

10. Review

The Terms of Reference shall be reviewed every 3 years, or at the direction of the Community Safety Board or Manager, when compliance with them will be monitored against the minutes of the meetings held in the previous 36-month period.

Scheduled review – April 2024

Appendix 2

Male deaths 2015- 2021

	2015	2016	2017	2018	2019	2020	**2021**
Total Drug Related Deaths	24	32	26	28	31	40	**38**
Males	21 (87%)	25 (78%)	21 (81%)	23 (82%)	25 (81%)	30 (75%)	**29 (76.3%)**
Mean age	40	40	42	40	39	45	**39**
Youngest	2 x 25	21	19	2 x 21	26	3 x 22	**20**
Oldest	63	62	62	51	61	68	**57**
Spread of ages	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	**20's- 5** **30's- 8** **40's- 11** **50's- 5**

2.11 Female deaths 2015- 2021

	2015	2016	2017	2018	2019	2020	**2021**
Total Drug Related Deaths	24	32	26	28	31	40	**38**
Females	3 (13%)	7 (22%)	5 (19%)	5 (18%)	6 (19%)	10 (25%)	**9 (23.7%)**
Mean age	40	32	41	32	39	35	**37.5**
Youngest	32	15 months	32	15	22	26	**20**
Oldest	49	55	45	42	56	59	**50**
Spread of ages	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	**20's- 2** **30's- 3** **40's- 3** **50's- 1**