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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 2022 - 31st December 2022

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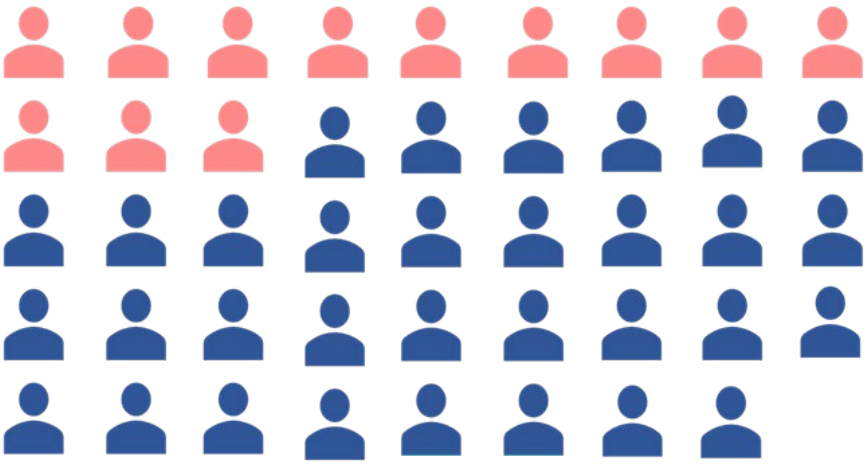
SUMMARY

2022 Drug Related Deaths- At A Glance

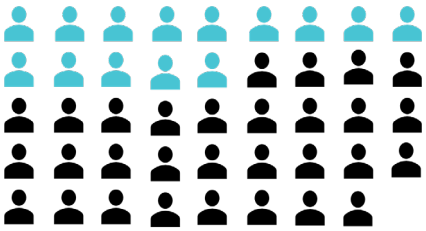
44 people died of a drug related death in 2022 in Cornwall and the Isles of Scilly.



32 males ♂ ♀ **12 females**

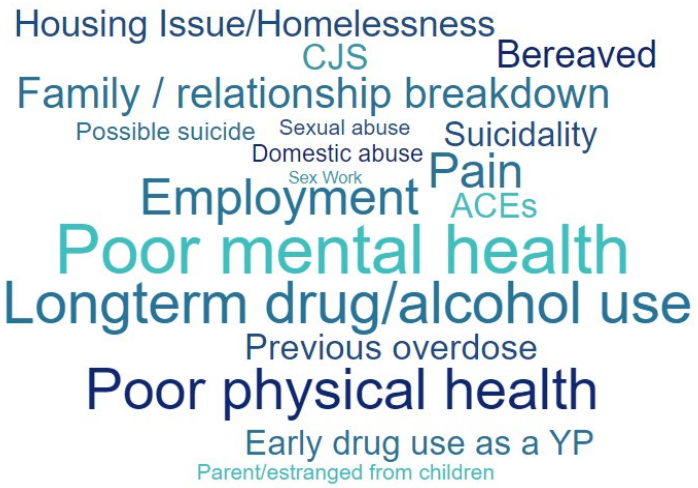
Average age of death was **43**.

14 of the 44 individuals had previously overdosed



26 people did not have an open drug or alcohol treatment case at time of death, 12 had never been referred for help in Cornwall in their lifetime.

Many of the individuals were affected by adversity and experienced multiple complex needs in their lifetime and at time of death.



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1. INTRODUCTION

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

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

a) Safer and better drug and alcohol treatment practice
b) Better local systems for drug intelligence and for learning from drug and alcohol related deaths
c) Improved toxicology and surveillance
d) Tackling the stigma experienced by people using drugs and alcohol
e) Addressing poly-drug and alcohol use

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

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

1.4 The definition of a drug related death used is '*deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, are involved'.*

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

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

1.7 This is the nineteenth annual Drug Related Deaths report for Cornwall and the Isles of Scilly, covering the calendar year 2022. This report will examine issues that have arisen from the review of drug related deaths recorded during 2022, reflect on local findings, make comparisons to previous years and national findings, identify associated learning, seek to improve local understanding and make recommendations for future preventative activity in relation to improving life chances of local residents and the prevention of drug related deaths in line with the strategy and action plan.

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

- Cornwall Drug Related Death Review Panel
- With You Drug and Alcohol Service
- Drug and Alcohol Clinical Governance Group
- Cornwall Controlled Drug Intelligence Network
- Devon and Cornwall Police and particularly the Drug Liaison/Expert Witness Officers

Information Classification: CONTROLLED

- 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 2022)

1.9 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.

1.10 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.

Information Classification: CONTROLLED

Progress against 2021 priorities

Increased coverage of naloxone

- Naloxone delivery continues to increase across a wide range of people and agencies, with 43 lives saved in 2022.
- Cover includes outreach workers and Supported Accommodation providers
- Security services commissioned by Cornwall Housing Options have now been trained, carry and have utilised nasal naloxone at Temporary Accommodation sites where there is an intensive housing management provision.

Pain Management

The Ten Footsteps approach to Living Well With Pain has been introduced, with 50 training spaces funded and delivered across relevant services and 5 to become trainers and rollout further training in future.

We are planning to build a Cornwall 'Live Well With Pain' training team which would be multi-disciplinary and is intended to increase awareness and improve implementation of drug screening across all relevant services, enabling earlier interventions for those experiencing pain.

However, broader communications to the general population about the risks in resorting to the illicit market for pain management to be considered, alongside amplification of the numbers who died through seeking pain medication through this route.

Broader approaches to pain are under exploration.

Co-occurring conditions

Whilst participants commend improvements in the joint support of people who are experiencing both mental health and drug and alcohol problems, there persists the exclusion of people from mental health services who continue to use drugs and alcohol.

In 2023-24, place-based workshops will seek to improve the joint practice for people affected.

Treatment staff are often better placed to support the more common mental health problems of anxiety, depression and sleep problems, and are being trained to do so.

Longer term Recovery Support needs to be able to address constructively should these problems arise once people leave structured treatment.

Initial rollout of a sleep management programme is showing early signs of success.

The employment of Experts by Experience has been key to improving local initiatives and will build upon this as they co-design local Recovery Communities.

Less progress has been made on introducing a process for keeping under review non-fatal overdoses and this remains a priority to be addressed via the non-fatal overdose focus group.

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2. Overview of Cornwall Drug Related Deaths in 2022

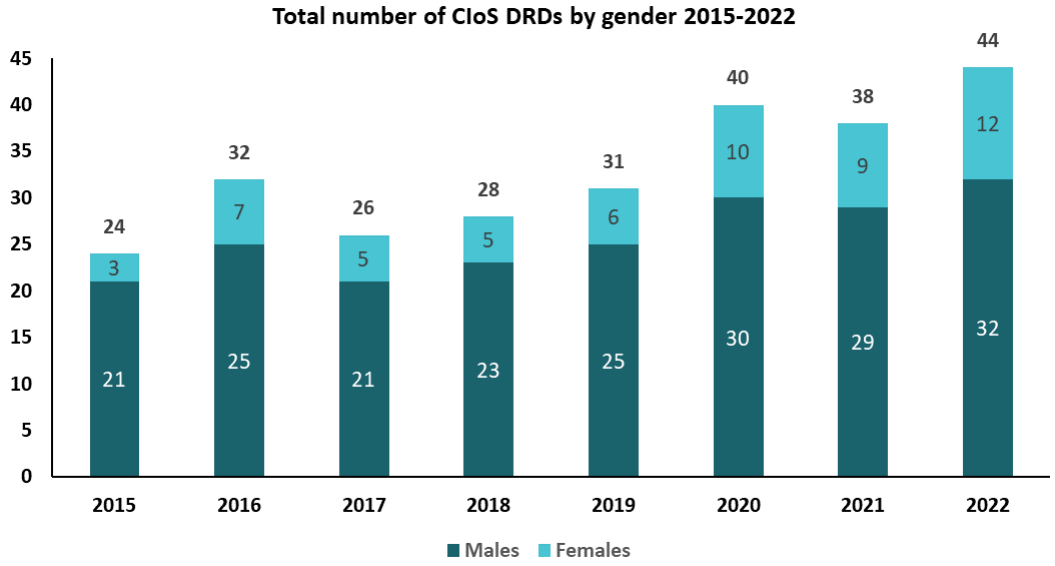
2.1 Between the period from 1st January 2022 and 31st December 2022, 44 deaths have been recorded as Drug Related Deaths in Cornwall and will form the basis of this report. There were no Drug Related Deaths recorded in the Isles of Scilly.

2.2 At the time of writing, 13 of the 44 deaths recorded as being potentially drug related (33%) 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. There may be more evidence provided at Inquest to inform future initiatives.

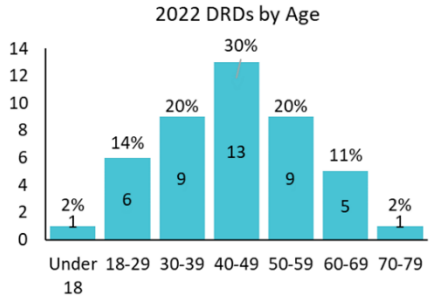
2.3 There was an increase in the number of drug related deaths from 38 in 2021 to 44 in 2022 (+16%).

2.4 The chart below illustrates the upward trend of drug related deaths in Cornwall from 2015 to 2022.

2.5 In 2022 there was an increase in drug related deaths in both males and females compared to previous years. Since 2015 there has been an increase in the proportion of female deaths, with women accounting for 27% of DRDs in 2022 compared to 13% in 2015.



2.6 The highest number of deaths was amongst people aged 40-49 (30%, n=13) with the next highest age brackets being 30-39 and 50-59. There was 1 drug related death of a 17-year-old, with has been subject to a Child Learning Review.



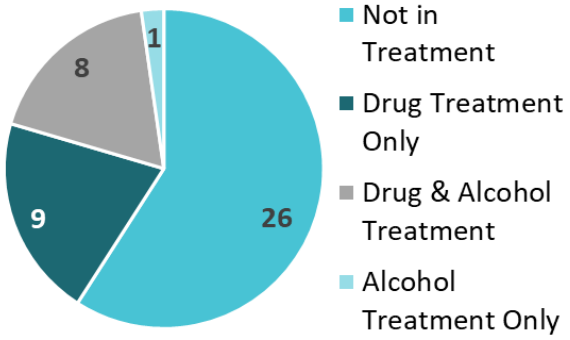
2.7 In 2022 there were 12 drug related deaths of people born in the 1970's of which were 10 males and 2 females. This generation has traditionally been one with a higher drug related death rate.

2.8 During 2022 there was an equal number of drug related deaths of people born in the 1970's and the 1980's. Of the 12 drug related deaths of people born in the 1980's, 6 were male and 6 were

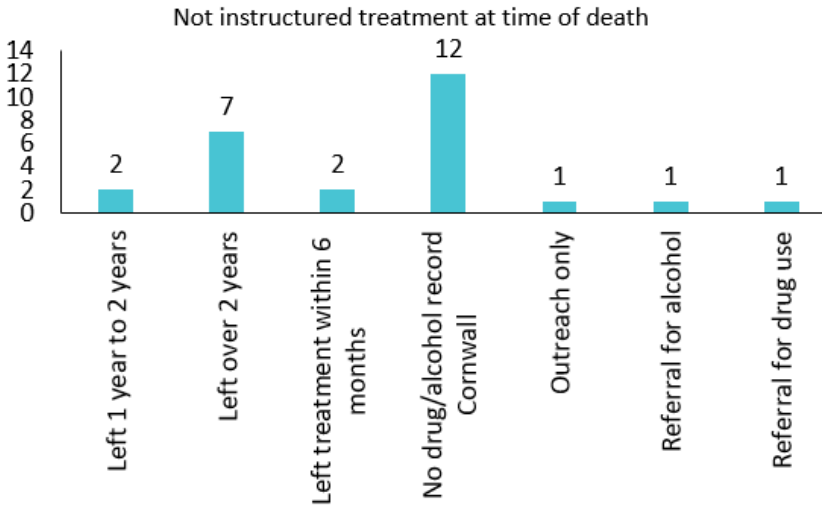
female. Whereas there were 4 drug related deaths of people born in the 1960's, all of which were male.

Contact with Specialist Drug and Alcohol Treatment Services

2.9 Of the 44 drug related deaths, 18 of them had an open case with Specialist Drug & Alcohol Treatment Services (pie chart), of which 2 were new referrals where the person had not yet been assessed.



2.10 The chart below shows whether these 26 individuals who were not open to treatment at time of death, were known to Specialist Drug & Alcohol Treatment Services in Cornwall over the course of their life. Of the 12 with no record, 5 had a long history of drug or alcohol use and never identified or referred.



2.11 There were 2 deaths where the cases had been closed to Specialist Drug and Alcohol Treatment Services within the last 6 months, both had used drugs and alcohol from a young age and both cases were closed due to non-engagement.

2.12 There were 2 deaths where the cases had been closed to Specialist Drug and Alcohol Treatment Services within the last 2 years, both had a long history of drug or alcohol use. One was not an open case because they had just come out of prison and had not yet been re-assessed, the other had stopped engaging.

2.13 There were 7 drug related deaths of people who had not had an open case with Drug and Alcohol Treatment services for over 2 years before they died. All of their cases were closed due to non-engagement / not wishing to continue with treatment.

2.14 Of the cases in treatment, 1 was in treatment for alcohol use only, however, the toxicology report for this individual indicated that they had also been using drugs.

Circumstances of death

2.16 The table below shows the venue of death and nearest town.

There were 3 deaths in hospital, all of these people had been in poor health as a result of their long-term drug and alcohol use and the cause of death was attributed to organ failure and infections.

	Community	Home address	Home address of another	Hospital	On holiday	Student Accommodation	Supported accommodation	TOTAL
Truro		3	1	3			3	**10**
Liskeard		4	1				1	**6**
St Austell		1	1	1			2	**4**
Newquay		2	1	1	1			**4**
Penzance		3					1	**4**
Camborne		3	1					**4**
Saltash	1	3						**4**
Bodmin		2					1	**3**
Falmouth		2				1		**3**
Hayle			1					**1**
St Ives		1						**1**
TOTAL	**1**	**24**	**6**	**3**	**1**	**1**	**8**	**44**

2.17 As in previous years, the majority of deaths occurred at the individuals home address (n=24 this year).

The number of deaths in hospital is the same as last year (n=3), but the number of deaths in Supported Accommodation is higher (n= 8 this year compared to 2 in 2021).

2.18 Seven people died whilst using on their own.

2.19 There were 6 drug related deaths at the address of another, of these, 2 were homeless and 'sofa surfing' with other known drug users, 2 had stayed overnight with people living in supported accommodation, 1 was staying with his mother following a relationship breakdown, 2 had been staying at a friend's home after spending the evening together. Finding somebody unresponsive and trying to save them would have caused significant trauma to the affected others, of these affected others, two of them also died a drug related death in 2022.

2.20 There was 1 death in student accommodation, which highlighted some gaps in prevention activity. This is being addressed through the Drug Partnership Young Persons Prevention, Education and Treatment Groups which will include Higher and Further Education.

2.22 There were 10 drug related deaths that happened in supported accommodation, 8 were people who lived there and 2 were visitors. In addition, one person who lived in supported accommodation died in hospital.

2.23 There were 5 drug related deaths where homelessness and frequent moves between short term emergency accommodation placements had made it difficult for specialist drug and alcohol treatment services to be provided.

2.24 There were 4 people who were being provided temporary accommodation by the Council under a statutory homeless duty when they died.

2.25 There was one person who died days after leaving residential treatment early and where the treatment pathway had not been followed correctly.

2.26 There was one person that died the day after they were released from prison, they were homeless and died at the address of another.

2.27 There were 2 people who died days after being involved in road accidents where they had been intoxicated.

Toxicology findings

2.29 Toxicology reports were available for 39 of the 44 deaths and detailed the drugs found in the body post death. The following analyses is based on the drugs which in conclusion are most likely to have contributed to death. Many substances appear in toxicology results that may not have contributed to acute death, for example substances taken in the days prior to death. This report does not detail all the substances used prior to death but focuses on those substances which are most likely to have led to a fatality as noted in the toxicology reports.

2.2 The table below shows that cocaine and methadone were the most frequently occurring substances present in toxicology. In all cocaine and methadone deaths, other drugs were present at levels likely to have contributed to death.

Drug	Number of deaths with drug present in toxicology
Cocaine	14
Methadone	14
Heroin	11
Codeine	10
Pregabalin	10
Diazepam	9
Morphine	9
Alcohol (includes Post-mortem change)	5
Dihydrocodeine	5
Alcohol (> 200mg / 100ml)	4
Bromazolam	4
Oxycodone	4
Mirtazapine	3
Tramadol	3
Alprazolam	2
Amitriptyline	2
Mephedrone	2
Flubromazepam	2
Flubromazolam	2
Quetiapine	2
Sertraline	2
Chlorpromazine	1
Gabapentin	1
Olanzapine	1

2.3 There were 6 deaths where both heroin and cocaine were present at levels likely to have caused death.

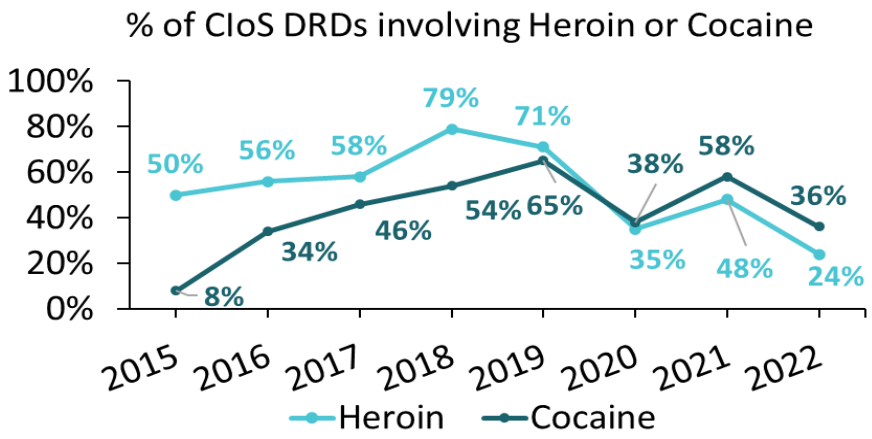
2.4 There were 14 deaths involving methadone and, in all instances, at least one other drug was present in toxicology at levels likely to have contributed to death. Nine of these were people in treatment receiving methadone as Opiate Substitute Therapy (OST). On average methadone was combined with 3 other substances at harmful levels. Methadone was most likely to have been combined with pregabalin (9 deaths). This points to the need to keep more firmly under review the use on top of OST in treatment at 3-month review periods as a minimum.

2.5 In 32 of the 39 toxicology reports, more than one drug was present at levels likely to have contributed to death. Hence polydrug use is a key factor in drug related deaths.

2.6 There were **22 deaths where more than one depressant drug was noted in toxicology as likely to have contributed to death**. This highlights the risk of overdosing when taking multiple depressants.

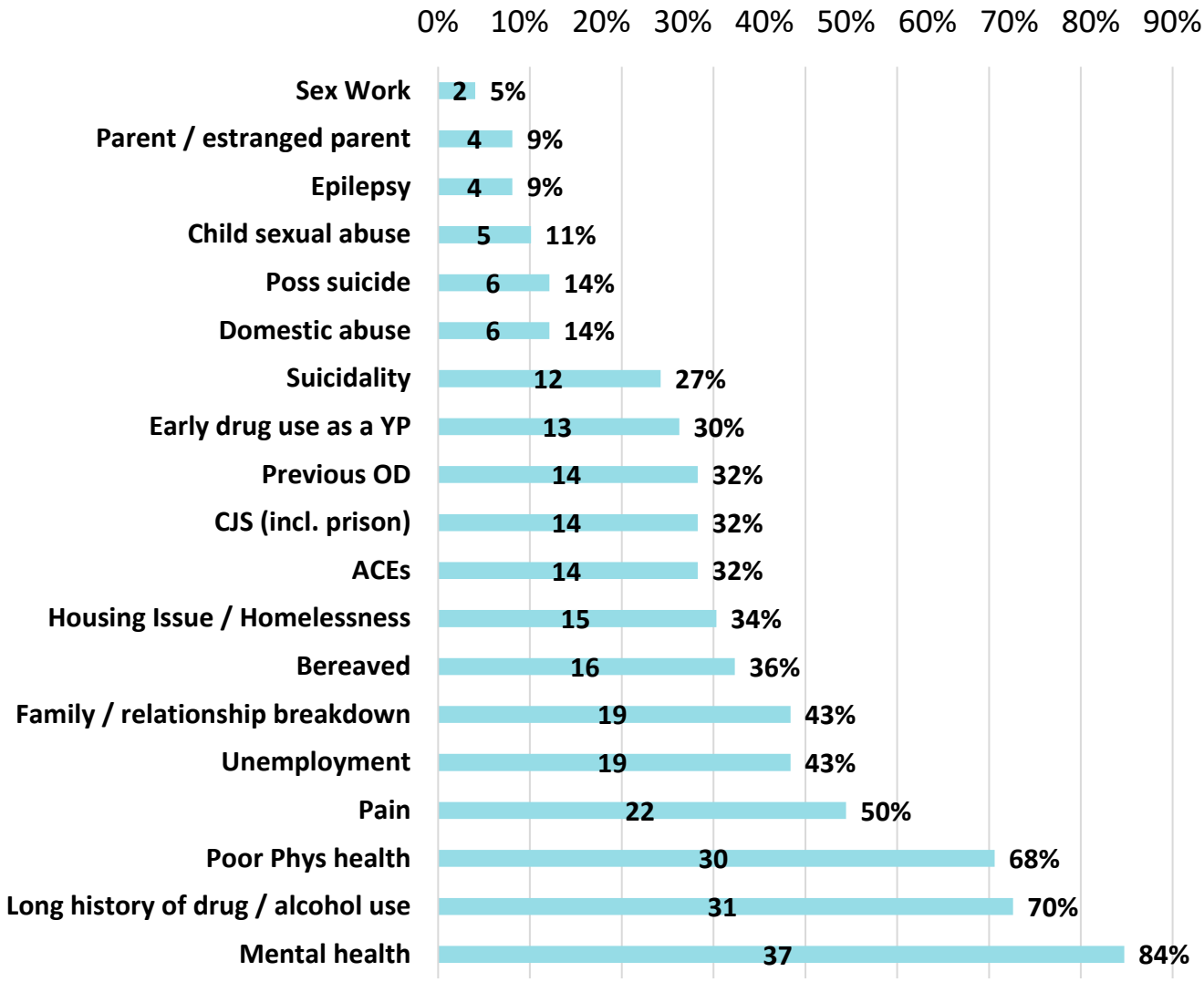
2.7 There were 12 deaths involving benzodiazepines at lethal levels. Many more individuals had lower levels of benzodiazepines present in toxicology due to prior use in the days leading up to death or through taking small amounts around the time of death.

2.8 There were a greater number of deaths where cocaine featured compared to heroin which is a continuation of a trend first seen in 2020 but both continue to reduce.



3. Contributing Factors

3.1 In line with previous reports, contributing factors have been recorded in relation to all drug related deaths[1]. The chart below illustrates the most frequently contributing factors. All 44 deaths had at least one of these factors identified, **the presence of 9 factors was most common, with an average of 6 identified factors present per DRD. The highest number of factors for a single case was 15.** [2]



3.2 37 drug related deaths where the person was experiencing **Mental Health** issues (84%) – a slight increase

3.3 22 drug related deaths where the person was experiencing **Pain** (50%) – a slight increase

3.4 There were 30 drug related deaths where the person was experiencing very **Poor Physical Health.**

[1] Factors are those that were able to be identified through the gathering of information from multiple agencies. Certain evidence may not be known especially for cases which have yet to go to Inquest.
[2] ACEs- Adverse Childhood Experiences- highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity.

3.5 There were 14 drug related deaths where the person had suffered significant **Adverse Childhood Experiences[2].**

3.6 There were 6 drug related deaths where the person was known to have experienced **domestic abuse** in their lifetime.

3.7 There were 5 drug related deaths where the person disclosed experiencing childhood **sexual abuse**

3.8 There were 2 drug related deaths where the person was involved in **Sex Work**.

3.9 **Suicidality** - there were 12 drug related deaths where the person had experienced suicidal thoughts or attempted suicide in the past.

3.10 A notable new number and factor this year is that there were 16 drug related deaths where the person was experiencing grief as a result of **Bereavement.**

3.11 **Housing Issue/Homelessness** was a factor in 15 of the 2022 drug related deaths. Of these:

- 2 were NFA
- 1 was not coping in general needs accommodation and had been referred for supported accommodation
- 1 was threatened with homelessness
- 8 were former rough sleepers
- 1 had spent time living in his car
- 1 was living in a hospital discharge bed space
- 1 was described as experiencing homelessness historically.

It has been widely recognised that rough sleepers are at more risk of dying earlier and that they are more likely to have multiple vulnerabilities, it is therefore particularly important that homelessness services complete drug and alcohol screening, offer support and complete referrals to services.

3.12 Of the 44 drug related deaths, 19 were recorded as being **unemployed**.

3.13 There were 19 drug related deaths where the person had experienced a **breakdown in a relationship** with a partner or their family.

3.15 There were 14 drug related deaths where the person had had involvement with the **Criminal Justice System**. One had died following discharge from prison.

3.16 Of the 44 drug related deaths, 14 of the people had experienced a **Previous Overdose**.

3.17 Of the 44 drug related deaths, 31 had a **Long History of Drug / Alcohol Use** (10 years plus).

3.18 There were 13 deaths where the person had commenced **Early Drug Use as a Young Person (under 15).**

3.19 Three people had **epilepsy**, and another individual was undergoing investigation for epilepsy, which was the first time this appeared and warrants further exploration in treatment. Gabapentin and pregabalin are used in the treatment of epilepsy. In one of the 4 deaths, pregabalin was

concluded in toxicology as having contributed to death but it was unknown whether this was obtained illicitly or through prescription.

3.20 There were 4 drug related deaths where the individual was a parent and where being **estranged from children** was a factor**.**

3.21 The chart below shows which factors occurred most frequently together in relation to deaths. The darker the colour the more deaths featured both those two particular factors. For example, poor mental health was most likely to be combined with poor physical health (n=25 deaths) and a long history of drug/alcohol use (n=25 deaths).

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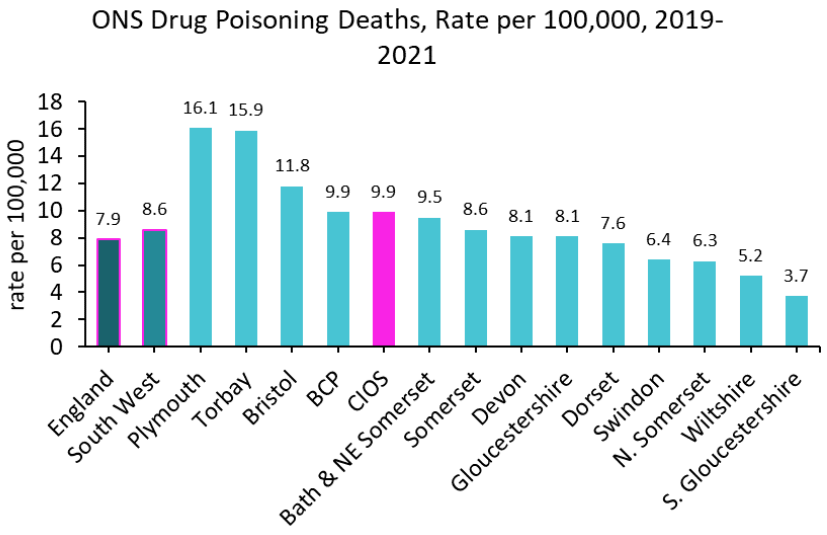
	Poor mental health	Pain	Poor physical health	ACEs	Domestic abuse	Sex Work	CSA	Suicidality	Bereaved	Housing Issue / Homelessness	Unemployed	Poss suicide	Family / relationship breakdown	CJS (incl. prison)	Previous OD	Long history of drug / alcohol use	Early drug use as a YP
Pain	20	-															
Poor Physical health	25	17	-														
ACEs	14	5	11	-													
Domestic abuse	6	2	6	5	-												
Sex Work	2	1	2	1	0	-											
CSA	5	2	5	4	2	2	-										
Suicidality	12	6	8	5	3	1	0	-									
Bereaved	15	8	11	5	1	2	0	6	-								
Housing Issue /Homelessness	13	8	11	4	2	1	0	3	7	-							
Unemployed	18	10	15	9	3	2	0	5	10	8	-						
Poss suicide	6	2	2	4	0	0	0	3	3	1	2	-					
Family / relationship breakdown	18	10	12	7	3	2	0	7	8	7	8	2	-				
CJS (incl. prison)	12	8	11	5	3	1	0	5	6	9	9	1	9	-			
Previous OD	13	8	9	7	4	1	0	10	8	6	7	4	8	8	-		
Long history of drug / alcohol use	25	15	23	11	4	2	0	8	14	14	17	2	14	13	11	-	
Early drug use as a YP	12	7	9	7	2	1	0	3	5	8	7	3	8	9	7	10	-
Parent / estranged parent	4	2	4	2	2	1	0	3	3	1	3	0	3	2	3	4	1

4. National Vs Local

4.1 Comparison between the Office for National Statistics (ONS) 'Deaths related to drug poisoning in England and Wales



5. Review and Learning from 2022 – Priorities for Attention in 2023-2024

5.1 Workforce Development

5.1.1 There remain clear gaps in key organisations with regards to drug awareness, identification screening and referral.

5.1.2 Drug and Alcohol training programme to be developed in collaboration with relevant services to ensure all staff have the skills to identify and refer as well as prevent harms associated to drugs and alcohol. In particular, Training / Guidance and support for Housing, Supported Accommodation providers and Adult Social Care including staff from other agencies who are involved in the provision of intensive housing management, floating support / tenancy sustainment.

5.1.3 Drug and Alcohol team to lead Learning sessions through all programmes being delivered (In Patient, Tier 4, Grant schemes, joint commissioning, trauma framework and implementation and contract reviews) with regard to findings from 2022 drug related deaths.

5.1.4 Continue to roll out Live Well With Pain training and focus on pain management. Initial evaluation of impact.

5.1.5 Dynamic risk assessment training and support to be delivered for people working with multiple vulnerabilities

5.2 Increased access to and engagement in treatment

5.2.1 Increasing screening and referrals from Health and Social Care, Probation and Housing - all services to screen, offer brief advice and support and actually refer to specialist treatment.

5.2.2 Overcoming non-engagement through monitoring and reviewing cases that drop out and implementation of a more persistent and assertive approach (supported by outreach and housing support).

5.2.3 Extend the remit of the Hospital Outreach Team to include drugs as well as alcohol-related frequent attenders.

5.3 Specialist Treatment

5.3.1 A more intensive focus on the first 6 months of treatment (cessation of use on top and injecting at 6-month point).

5.3.2 Ensuring 3-month reviews include DRD factors – including health review and prescribing review with GP. Audit in year of those in treatment 4 years+ for longer term health review.

5.3.3 Epilepsy and drugs awareness campaign

5.3.4 **Longer Term Aftercare and Recovery Support** - 3-6 months Aftercare via Structured Treatment provider which includes ongoing assessment of risk factors. Thereafter via Recovery Communities.

5.4 Support for families and affected others

5.4.1 Information about support available for families where a family member will not seek help

5.4.2 Specifying the offer for people in treatment suffering bereavement as well as those bereaved through a drug related death

5.4.3 Offer of naloxone to be extended for affected others.

5.5 Domestic Abuse and Sexual Violence (DASV)

5.5.1 Review implementation of the joint DASV/drug and alcohol protocol for reducing risk

5.5.2 Review referral rates to and from the SARC, and joint working arrangements.

5.5.3 Introduction of Healthy Relationships programme into treatment services

5.6 Dual Diagnosis

5.6.1 Rollout implementation via place-based workshops.

5.6.2 Joint review of drug related deaths which feature exclusion from help due to alcohol and/or drug use.

5.6.3 Staff in specialist treatment and recovery communities to be able to support common mental health problems such as anxiety, depression and sleep problems.

5.7 Housing pathways

5.7.1 Review the use of non-commissioned supported accommodation for this population with regard to this population

5.7.2 Increase in-reach into supported accommodation by drug and alcohol staff, through the Housing Support Grant, to support sustained engagement and joint working.

5.7.3 Joint review with Housing Options of pathways and processes for this population to improve sustained accommodation and reduce risk.

5.8 Introduction of Non-Fatal Overdose (NFO) Review process

To ensure information about non-fatal overdoses (NFO) is systematically kept under review.

5.8.1 That all NFOs of people in treatment are reported to treatment by the next available day.

5.8.2 That the Hospital Outreach Team attend all NFOs in hospital to seek to increase engagement and harm reduction.

5.9 Adult Safeguarding

5.9.1 Joint Adult Safeguarding review of emerging issues.

5.9.2 Implementation of the Blue Light programme for increasing engagement of people experiencing alcohol problems who do not engage with help/experience fluctuating capacity.

5.10 Students / University

5.10.1 Review support arrangement and guidance through Drugs Partnership Young People Education, Prevention and treatment Subgroup

5.11 Communications and Awareness Campaigns

5.11.1 It is clear that both experienced drug users and the wider population are often unaware of the potentiating risks of multiple depressant use and of illicitly sourced drugs, specifically benzodiazepines and pain medication.

5.11.2 Further that a significant number of people died whilst using alone.

5.11.3 Communication and awareness campaigns should include a focus upon these issues in 2023-24.

6. Appendices

Appendix A Drug Related Deaths summaries 2022

Drug Related Death 2022/1

- 19-year-old man who died in his Falmouth University student accommodation. Toxicology showed high levels of dihydrocodeine and bromazolam (illicit benzodiazepine).
- He presented as a friendly, popular and energetic person. However, he had experienced childhood trauma. He had a diagnosis of ADHD and dyspraxia and suffered with considerable jaw pain.
- His mental health difficulties included depression, anxiety and self-harming behaviours. He had previously twice been placed in hospital under Section.
- He started using drugs from the age of 14; his drugs of choice were benzodiazepines, cannabis, cocaine and ketamine.
- He often purchased illicit drugs online. He was open about his drug use with the university but did not wish for them to refer him for help. At the time of his death, he was being supported by student services due to anxiety regarding his finances.
- A note was found that said “sorry I’m gone” and some other words that were illegible, but the Coroner did not feel there was enough evidence to state that this was a deliberate act to take his own life.

Learning going forward

- Universities are awaiting guidance/policy from the Office for Education regarding students with drug and/or alcohol difficulties.
- Since this death, Community treatment services have a dedicated worker who spends time at the University so that students can drop in or book appointments for advice, guidance or support.
- Community treatment and the university are also in talks about an overdose awareness campaign during Freshers Week.
- Further Safeguarding Adults awareness work to be undertaken with Falmouth university/Further Education.
- Widening pain management approaches to student population.

Drug Related Death 2022/2

- 50-year-old woman of no fixed abode found unconscious in her en-suite in a hospital discharge bed (supported accommodation). She was not found until 24 hours after her death despite her not answering the door. Welfare checks had not been completed because it was initially thought that she had gone out and not returned.
- A syringe was found under her, and toxicology confirmed recent use of heroin.
- History of deliberate and non-deliberate overdoses, including twice in the two months prior to her death, and had been a frequent hospital attender. The latter was often in relation to self-harming behaviours or accidents whilst under the influence of drugs and/or alcohol. These, in turn, appeared to be responses to adverse life events such as relationship breakdowns and becoming homeless. On this occasion, she had been admitted as the result of an assault where her arm was broken, and she had overdosed.
- Accommodated in a hospital discharge bed because the supported accommodation she inhabited previously would not accept her on return due to the risks associated with her.
- In structured drug treatment when she died and appeared to be achieving a relative level of stability and gaining additional support from residential support workers and monitoring via the pharmacy.
- Victim of county lines drug dealers who cuckooed her property in 2021; she was forced to leave her home and did not gain further secure housing by the time of her death.
- Subsequently given temporary accommodation in short-term placements in bed and breakfast type accommodation. This involved being moved around the county frequently

which made it difficult for her to feel safe and supported and difficult for her to sustain Opiate Substitute Therapy (OST) or to maintain contact with her daughter and grandchildren.

- Long history of substance use, mental and physical ill health. Started using drugs from the age of 22 and initially to cope with the death of her brother. Continued to do so to help with regulating her mood and dealing with life events. Her drug and alcohol use led to the breakdown of many of her close relationships.
- Chronic backpain, bowel disease and other illnesses.
- Diagnosed with paranoid schizophrenia in 1993 and had multiple admissions under the Mental Health Act until 1999.
- Previously completed a custodial sentence for possession of a firearm. Prison was a positive experience for her – she came out not using, but homeless and she remained abstinent for 12 months following release.

Learning going forward

This case highlights the need to consider suitability of temporary accommodation placements and to prioritise those with multiple vulnerabilities to not be frequently moved.

- Pathways for adults who are victims of cuckooing.
- Dual Diagnosis review
- To be included within the population who are the focus of the Housing Support Grant.
- Review of policies in supported accommodation provider.

Drug Related Death 2022/3

Confirmed Cause of Death: Overdose of prescription and illicit drugs against a background of chronic drug use.

- 41-year-old woman who had experienced clinical depression which was thought to have stemmed from traumatic events in her adolescence, multiple losses and bereavements.
- Youngest of five, at the age of 12 reported being injected by an older sister with amphetamines.
- At 13 she began working for a drug dealer to supply her brother who was then in prison. Whilst working for the drug dealer, she became addicted to heroin, and began sex working to fund this.
- At 17 she met a partner on a chat line and had a daughter, she subsequently gave this daughter up for adoption as she felt she was unable to cope. She then started to use crack cocaine. At 19, she met another partner, with whom she had two children, and these were both removed from her and left under his care.
- Several years later she met a third partner whilst sex working, who offered her accommodation and alcohol in exchange for sex. She had a daughter with this man, who was subsequently removed from her and left under his care.
- She suffered from nightmares and vivid flashbacks and was involved with CMHT and IAPT interventions. She maintained contact with her youngest daughter from the third partner, and frequently described this relationship as a protective factor in not acting upon her suicidal thoughts.
- She had Hepatitis C, which was successfully cleared, and hypothyroidism which caused her to struggle with a lack of energy and ongoing gastric issues.
- In 2018, she had attempted suicide, and was administered Naloxone and resuscitated.
- At the time of her death, she was maintained on low level opiate substitute therapy as she was also drinking dependently.
- In the six months prior to her death, she engaged positively in treatment, who remarked on her personal aspirations to be free of drugs, attend college and improve contact with her daughter. However, she also had a partner who was using. When he was taken to hospital following a suspected overdose, she had shared concerns about the impact of this on her recovery, self-care and mental wellbeing. She asked her partner to leave, and

safety plans were discussed. She remarked upon feeling exhausted and mentally drained following doing this. She also reported high levels of anxiety. It was the perspective of WY that her history of compound trauma and vulnerability to exploitation made life very challenging for her.

- Support from CMHT was regular, which WY report as her finding helpful and enabling her to feel more proactive.
- Nine days before her death, she reported a recent event to WY in which two people attended her property and attempted to coerce her into purchasing stolen goods and drugs. She disclosed to her Recovery Worker that she managed to get them to leave and take the heroin with them. She expressed she was happy about this and reported the incident to the police.
- Four days before her death, she reported feeling unwell, suffering from severe nausea and vomiting. Suspected food poisoning.
- She was found on 19th February 2022 by her neighbours who had gained access to the property via a locksmith. Police seized a large quantity of prescribed medication and illicit drugs from the property.
- Toxicology confirmed levels of Diazepam and Mirtazapine which were prescribed, but also levels of Alprazolam, Pregabalin and Amitriptyline which were illicit. Methadone was detected at a markedly elevated concentration sufficient to result in adverse effects on cardio-respiratory function in isolation.

Learning going forward

- Although a robust working relationship between Primary Care, CMHT, WAWY and Children's Social Services is referenced; it is possible that additional support within housing services may have helped further, potentially more wraparound support.
- A case of this complexity could have benefitted from a shared MDT and more intensive support, particularly at times of illness and adverse experiences.

Drug Related Death 2022/4

- 51-year-old man with historic episodes of poor mental health, self-harm, including symptoms of psychosis and at least one admission under section. Three days before his death, at the most recent Priority Prolific Offender (PPO) meeting, there were discussions documenting concerns about his worsening mental health, including anxiety, depression and also issues with a lack of sleep.
- He had Hepatitis C, suspected arthritis, some boxing related injuries and epilepsy.
- He started sniffing glue and smoking cannabis aged 14, had a fractious relationship with his family.
- There was a total of five known treatment episodes from November 2013 to January 2022 across community, outreach and criminal justice services.
- First recorded contact was in preparation for release from HMP Exeter, he was to return to the community on Opioid Substitution Treatment (OST) but did not engage. In November 2013, he was referred back into treatment, and at that time he had no fixed abode. OST commenced, a request for pregabalin prescribing was declined by GP at the time and this resulted in an aggressive response that led to him being identified as being of potential risk of harm to professionals, advice was to avoid lone working.
- Offending history was identified throughout treatment as being mainly acquisitive crime and drug offences. Records between 2013 and 2018 indicate there were numerous difficulties keeping him engaged in structured treatment, exacerbated by his transience and ongoing use of multiple substances, including illicit opiate substitutes, benzodiazepines, pregabalin and stimulants.
- In 2018, there was an acute episode of psychosis, reporting intrusive thoughts initially and then increasingly worrying symptoms of behaviour raised by professionals- including his housing provider at the time. Naloxone had been used during this period. A referral to CMHT was made and he was opened to the Home Treatment Team. Initially he was

detained under a section, then stabilised with medications, including via depo. Following this, he moved out of County.

- In August 2021, a referral was received by Streetlink who supported him to access temporary accommodation.
- Referral made to Community Treatment via his Probation Worker in October 2021. He was by then about to be NFA in the St Austell. Reason for referral was for use of Cannabis but was otherwise free of substances and keen to avoid relapse. Initially, he did not engage with treatment offers.
- Contact in November 2021 highlighted that he had been accommodated in Liskeard, but wished to remain open to his WY worker, advising he would prefer to be seen in St Austell as opposed to Liskeard. Despite this being his preference, he did not attend the next two offered appointments with his keyworker.
- He had accessed advice in the past regarding courses, diversionary activities and money management but does not appear to have stabilised in these provisions for long.
- In January 2022 accommodation staff contacted WY to express concerns about a return to substance use and instances of him being in a state of intoxication. It was agreed that he would be reallocated to a Liskeard Worker. Throughout this time, the record for this episode remained at referral/ triage stage, comprehensive assessment as still pending at the time of death.
- A Care Co-ordinator was allocated on 11 January 2022. Six days later, WY duty staff were informed that he had been found deceased in his room on 15th January 2022.
- The toxicology report found methadone, phenazepam and tramadol, which may have acted synergistically to enhance their toxic effects WY highlighted a need for partnership working with the Drug & Alcohol Outreach Service, with the aim of taking a more assertive approach and tracking him around the county to ensure continuity of care.

Learning going forward

- Developing a robust working relationship between stakeholders, in this case Accommodation and Community Services/ Workers may have led to more impactful, efficient and timely wraparound support.
- WY acknowledge that there was a verbal handover between the two teams; however, they consider it to be best practice for a written plan to be agreed and uploaded on to the client database. Following the death, this has been covered with both workers in supervision.
- We need to look more at improving the levels of social functioning with adults in treatment.

Drug Related Death 2022/5

- 24-year-old man died at his home where he lived alone. Friends had called an ambulance because they had gone to the property as previously arranged but could get no answer at the door. He was subsequently found deceased.
- Toxicology showed that he died of a mixed drug overdose due to the synergistic effects of methadone, tramadol, oxycodone, diazepam and promethazine. There was also evidence of recreational cocaine and cannabis use. He used lots of different types of drugs and was also a crack cocaine and heroin user, but at the time of his death, he was not in drug and alcohol treatment.
- Both his parents were drug users and he started taking drugs aged 12. He attempted suicide when he was 12 years old and left home when he was 15 years old.
- He was sectioned in 2016 under the Mental Health Act diagnosed with a drug induced psychosis. He subsequently developed endocarditis and had two strokes, so his physical mobility and health were poor.
- When he died, he was living in general needs temporary accommodation (Council owned flat) under a main homeless duty. He was the sole occupier.

- Noted in his housing records that there was a risk from others, risk of suicide, he was in poor health and that he required support to sustain a tenancy. He had experienced on-going homelessness throughout his adult life.
- Involvement with the criminal justice system for a range of different offences and was difficult to accommodate due to being at risk from others in some areas of the county due to drug debts and offences which were mainly drug related and included an assault on his mother.
- Known to drug and alcohol treatment services and did have an open case with them from 2013 to 2017 but he dropped out and does not appear to have either re-approached or been re-referred by any other agencies. There were no records of drug use by the Housing Team.
- There is evidence that whilst his case was open to them, WAWY worked flexibly and utilising other persons and agencies such as the Police, Probation and Homegroup to try and engage with him but he was difficult to engage, made worse by him being of no fixed abode for long periods of time. WY also referred him to adult safeguarding due to being a victim of emotional and physical abuse by his father and his uncle.

Learning

- Need for person centred risk assessments and suitability assessments before placing vulnerable people into temporary accommodation.
- Had there been drug and alcohol screening as part of the housing assessment and review process, it may have been more likely that he would have been re-referred to WY and more of a multi-agency approach may have been taken to safeguard him.
- Training in relation to drugs and alcohol and multi-agency working may be beneficial to Housing Options staff, specifically those co-ordinating placements, managing accommodation and supporting complex cases.
- This is now being looked at as part of new Housing Support Grant developments.

Drug Related Death 2022/6

- 36-year-old man found deceased in his own home. In life he had served an apprenticeship at a local garage with an interest in car mechanics. He also spoke of times when he used to enjoy riding a mountain bike. Over the years he lived in a variety of locations but said that he preferred to be closer to the Helston area where he had family.
- Mother died when he was 13 and he had used cannabis, alcohol, heroin and occasionally ecstasy and amphetamines since the age of 14 “to deal with the voices in his head”. He had had episodes as an inpatient on a psychiatric ward.
- Seven separate alcohol and drug treatment episodes since self-referring in 2014 at the age of 27 however he did not always engage.
- Two hospital detoxes were followed by a return to drinking and he subsequently declined any support.
- He was re-referred by CMHT in September 2021, as reported drinking 30 units of alcohol daily to alleviate boredom. Attempts were made to engage with him; however he missed all appointments.
- He was known to Adult Safeguarding and was an appointee. There were concerns in relation to self-neglect and about his ability to manage a tenancy and complete daily living tasks. In addition, there were, at times, further concerns about his vulnerability and ability to control who came to visit him at his home.

Learning going forward

- A more persistent, consistent and assertive approach with those who are finding it difficult to engage.
- Joint learning review across participating agencies.

Drug Related Death 2022/7

- 41-year-old woman died at home where she lived with her mother. She had been admitted to hospital 2 days earlier for an overdose of tablets. Her mother collected her, took her home and, In the morning, left her sleeping. When she went back later to wake her and was unable to, she called emergency services.
- Two drug treatment episodes, but at the time of death her case was closed. The second record dated 07/03/2022 was prompted by a copy of a letter sent to the GP from the Hospital Psychiatric Liaison Service in which it was stated that she had denied any recent use of alcohol or illicit substances but had been recently hospitalised following a cardiac arrest, secondary to a suspected overdose. It was apparent that an assessment from the mental health team was also being sought. She was contacted by a WY recovery worker who offered assistance, but no further contact was possible as when they called, her phone was answered by somebody who stated she was asleep and that they would pass a message on.
- It was reported at Inquest that she had experienced depression, paranoia, hallucinations and pain in her back that had "blighted her life".

Learning going forward

- A more persistent and assertive engagement of people who have had non-fatal overdoses

Drug Related Death 2022/8

- 36 years old woman who died at her home address where she lived alone. A neighbour went to check on her because she had not seen her for about 48 hours and saw that there were keys in the door. Her body was partially against the door which needed to be forced open for access.
- Toxicology report indicates that there was opiate toxicity and that the combination of methadone and morphine at the concentrations detected is likely to have resulted in fatal respiratory depression.
- Survived by her mother and brother, whom she was not close to, due to suspected childhood abuse by father.
- Diagnosed with developmental disorder as a child and moved schools because of her challenging behaviour and needs. Eventually moved to a 'special school'. Started self-harming, having underage sex, and increasing incidents of being in trouble.
- Friend was trying to protect her because she thought she may have been being 'groomed' by the milkman, who had her bank card and not letting her have access to money because she owed him money, and the friend believed he was forcing her to have sex with him. Her flat was used by other drug users, and she continued to self-harm, including via injecting.
- Suffered from obesity, epilepsy and had Hepatitis B and C. There had been a recent hospital admission due to seizures.
- In treatment with drug and alcohol services, stable on an opiate substitution programme since 2006. Also prescribed anti-depressant medication by GP. At times she struggled to engage.
- She had a phobia of gas and did not use the boiler and cooker.
- Homegroup closed her case 4 months prior to death due to non-engagement.

Learning

- A more persistent and assertive approach to engage those finding it difficult.
- Evidence of more trauma-focussed and developmental approaches required.

Drug Related Death 2022/9

- 42-year-old male with diagnosis of bi-polar disorder and in poor physical health due to ongoing substance use. Found on the living floor at his friend's home (supported accommodation) by his friend, who was also a drug user. The friend had gone out and

found him upon returning. Had been complaining of pain in his leg and abdomen that day. He had injected heroin the day before. Drug paraphernalia were found on the floor and according to the paramedics he had a drug-related cardiac arrest.

- Had been released from prison on the Friday with no accommodation to go to. Had scheduled appointments with relevant services for the following Monday but died on the Saturday. As he died the day after he was released from prison, the death is being treated as a death in custody.
- Known to WY for many years with his first record dating back to October 2011 and reported being heroin dependent since his 20's.
- Many physical health problems due to his long-term injecting including an Embolism, 2 DVT's, septicaemia, Hepatitis C and ulcerated legs.
- Multiple detox referrals, but he struggled to complete these episodes and quickly relapsed.
- Last treatment episode was closed in July 2021 when his suspended sentence was activated, and he went to prison. WY were informed of his pending release, and it was noted that he was at high risk of overdose upon release.
- Homeless prior to going to prison as he had been found Intentionally Homeless in May 2021. This was following an inspection of his emergency accommodation whilst he was away which identified he was breaching the terms and conditions of the provision of accommodation by having and it is assumed using illegal drugs on the premises (drug paraphernalia found).
- Due to logistic difficulties within the prison, there was only limited contact with clients, so the priority was given to Harbour Housing under the Accommodation for Ex Offenders (AfEO) project. An offer of accommodation was made to him by Harbour Housing via the project, but he declined it as he did not want to live in the area where the accommodation was. An offer of temporary accommodation was not made because he had not yet been reassessed to determine whether there was a statutory duty to accommodate.

Learning going forward

- Drug use to not be used as a rationale for being assessed as Intentionally Homeless.
- New Prison Continuity of Care arrangements (no releases on Fridays) to be audited in January 2025, to assess whether they are impacting positively on discharge arrangements.
- AfEO to be reviewed for vulnerability assessments.
- Non commissioned services where drug use is cause for eviction, not to be utilised for this population.
- Increasing awareness amongst drug users of the potentiating effects and unknown strengths of illicit benzodiazepines and other central nervous system depressants.
- **Joint work with co-occurring conditions.** This 67-year-old man died at home in retirement housing (Sanctuary Housing).

Drug Related Death 2022/10

- 46-year-old man died in temporary accommodation on the Cabin site at New County Hall, Truro.
- Post-mortem toxicology revealed the presence of a high level of methadone together with a number of compounds, including illicit benzodiazepines (flubromazolam, bromazolam and flubromazepam), along with high levels of pregabalin.
- tarted using drugs at 12 and first used heroin aged 15. The use of diazepam helped him function more effectively and opiates relieved physical and to some extent, emotional pain.
- Had been experiencing homelessness for 10 years.
- Previously worked for 14 years as a labourer, but his drug use had impacted on his ability to sustain work and housing. Also became involved in criminal justice system.

- Self-referred to treatment in November 2020 and was being supported at time of his death with heroin, crack cocaine and benzodiazepine dependency.
- History of unintentional overdoses as a result of benzodiazepine and opiate use, one of which was three weeks before he died. However, he was believed to have stabilised and at the latest appointment, he had discussed the possibility of a more secure tenancy and requested further support to explore options in relation to education, training and employment. Further to this, he had been attending the Eden project once a week, completing horticultural activities.
- He was receiving treatment for his mental health problems. He had a diagnosis of bi-polar disorder and had previously psychotic episodes.
- Had experienced recent grief, with his mother and father dying within 9 months of one another. Was building back relationships with his family daughter and siblings) locally.
- Physical health difficulties and pain due to Chronic Obstructive Pulmonary Disease (COPD), deep vein thrombosis (DVT), emphysema, lung damage (from pneumonia in 2020) and a faceplate from a hammer attack 11 years previously. The combination of these limited his physical activity. In addition, his use of illicit substances led to changes in his behaviour which resulted in problems securing a tenancy.

Learning to take forward:

- Increasing awareness amongst drug users of the potentiating effects and unknown strengths of illicit benzodiazepines and other central nervous system depressants.
- Joint work with co-occurring conditions.

Drug Related Death 2022/11

- 67-year-old man died at home in retirement housing (Sanctuary Housing). Found in the hallway in following the attendance of the building warden due to a leak coming from his apartment to the apartment below. There were 22 empty whisky bottles of various sizes located in the kitchen at the address.

- He was not known to drug and alcohol treatment services, but it was heard at inquest that he had been affected by his wife dying in 2012 and made a suicide attempt in 2016. The GP had described him as being alcohol dependent and in poor health, suffering from COPD, Arthritis, back pain, basal cell carcinoma 1987, lumbar disk degeneration, urinary issues, black outs from coughing and depression.

Learning

- Alcohol screening and referral from primary care could have led to engagement in treatment, that could have also enabled him to access support to deal with pain and bereavement. Similarly, picking up on alcohol dependence as part of assessment and mental health planning following attempts at suicide.

Drug Related Death 2022/12

- 26-year-old man died alone in his own home found by his landlord.
- Empty blister packs found around flat for Clonazepam and Dihydrocodeine. In addition, there were several empty bottles of beer, tobacco, 50ml bottle of what was suspected to be a potent THC Vape Cartridge.
- There was a notepad full of mostly repeated passages, handwriting not legible.
- Past medical history of experiencing anxiety and insomnia and was referred by his GP to WY in 2019 with regard to excessive drinking.
- Following a breakup from his girlfriend, his GP prescribed him a sedating antihistamine (Promethazine). When he asked to increase the dose, his GP referred him to a Social Prescriber.
- Having been homeless and then living in his car, he was accommodated by the Council as part of the Everyone In Covid Response from 02/04/20 – 09/06/20. It was noted in his housing application that he was a drinker and smoked cannabis but had given up both for

a couple of years and was worried that if he is placed near other drinkers and users he would relapse. It was also noted that he suffered from anxiety and depression, but he was not on medication for this as he would prefer counselling. No support needs or risks were identified.

- May 2020, he reported he was not happy in the new accommodation and stated he had been to GP and got prescription for Diazepam and Citalopram, he was accommodated in a caravan park and the site manager reported concerns that he was drinking heavily and possibly dealing, pestering other guests for their prescription medication and offering herbal cannabis in exchange. He moved from there into accommodation in June 2020. He reported to Housing Options that he had found somewhere else to live and against advice that it would not be affordable, left his temporary accommodation so his case was closed, and Housing Options had no further contact with him.
- March 2021, he requested a card stating that it was in his medical interest to smoke cannabis but this was refused.

Learning going forward

- Focus upon increasing the use of screening tools and more proactive engagement of people who are not in alcohol/drug treatment.
- Checking understanding of risks associated with poly substance use.
- Joint reviews to cover the combined risks between his prescribed medication, illicit use and drinking risks (depressants potentiating each other).

Drug Related Death 2022/13

- 61-year-old man was a regular drinker who died in his own home. He had been in the kitchen making dinner when he suddenly collapsed. Family heard him fall and found him on the floor and he was not breathing effectively. Emergency services were called but despite best efforts, it was not possible to save him.
- The post-mortem toxicology revealed a high level of alcohol in the blood as well as a very high potentially fatal codeine levels. This was said to have increased risk of choking due to their sedative effect. Chronic (presumed alcohol-related) liver cirrhosis was also a contributing factor.
- He was not known to drug and alcohol treatment services and family stated that he had had a history of cardiac issues and had a prescription for this and that he had not drank any more than usual that day.

Learning

- This death highlights the unknown risks to people drinking at higher levels of harm and the lack of awareness amongst people who are not dependent upon drugs and alcohol of the potentiating effects of depressant drugs, in this care alcohol and codeine.

Drug Related Death 2022/14

- 30-year-old woman died in her home (supported accommodation) of an accidental overdose of methadone and other prescribed and illicit drugs against a background of historic and long-term drug use. She is survived by her partner and father whom she was close to.
- She had been in structured treatment regarding her use of alcohol and street drugs and was in receipt of an opiate substitute prescription. She had been known to services since 2012 (aged 20) and reported that she first drank at the age of 11 years, took ecstasy tablets and cocaine aged 13 and smoked cannabis throughout her teenage years. At age 17 she used Mephedrone. At age 18 she reported that alcohol became problematic and at this time she occasionally smoked street heroin. Aged 20-21 she became dependent on street heroin and at times was injected by others. She also used other illicit opiates including non-prescribed Subutex (buprenorphine) and Methadone. As a result of her alcohol and illicit drug use, she resorted to crime in order to fund her drug and alcohol use.

- History of probation orders. She expressed an interest in doing courses on health and beauty as a longer-term goal.
- When under the influence of street drugs, she could be vulnerable to abuse and had a history of abusive relationships and exploitation. She struggled to maintain her accommodation and was provided with various temporary housing, resulting in her living at a number of locations both within and outside of Cornwall.
- Frequent changes in accommodation created a challenge to provide consistent support from the treatment service, however positive professional relationships developed with a number of workers and there is evidence of multidisciplinary working. Residential treatment had been discussed with her, but this did not progress due to frequent relocations.
- Recent accidental drug overdose of heroin, diazepam and seizure medication took place 12 days before she died.
- Referred to the Crown Court for sentencing on 9th June 2022 and she reported needing more drugs due to anxiety over this as she was very concerned that she may be sent to prison.
- Long history of mental ill health, being diagnosed with depression, anxiety, bipolar and PTSD and was sectioned in 2016. She also had a hearing impairment, poor dental health and back pain and had sustained a head injury in 2020.
- Was in foster care from age 15 -16. Her mother suffered with bipolar disorder and tried to drown her in the bath when she was a small child.
- Previously provided sex for money and had a history of unhealthy relationships and had been referred to Adult Safeguarding and gained support from domestic abuse services.

Learning

- We have a number of women with very similar life experiences with whom risk is not being reduced significantly and social functioning is not being supported to improve. This requires a more intensive joint approach.
- Non-fatal overdose process is required to assure a more consistent approach to follow up and engagement.

Drug Related Death 2022/15

- 37 year old man was found deceased at home, by a friend two nights after they had been out drinking together. His friend had become concerned as he had not heard from him, could get no answer from the door so used a spare key to enter the property.
- Post-mortem indicates that there was a history of drug use. Toxicology showed heroin use, low ethanol and possibly Sildenafil (a vasodilator used for the treatment of erectile dysfunction). Not known to treatment so there is limited information regarding his background and personal circumstances.

Learning going forward

- Communications about risks of combining central nervous system depressants to be targeted at wider population and not just people who are dependent upon drugs.

Drug Related Death 2022/16

- This man died in hospital at the age of 42 from sepsis and secondary bilateral pneumonia as a result of long-term drug use.
- He had been living in supported accommodation that was not commissioned by the Council where residents had significant issues with alcohol and substances. The culture there has been described as one of adverse support with drugs being exchanged for sexual favours and benefit money being pooled for alcohol and substances.
- Reported first tasting alcohol at the age of four and by the age of fifteen he was drinking and smoking cannabis daily. There were also episodes of binge drinking whilst at school. At 16 he secured a job in a local bar and was subsequently intoxicated most nights.

- Had a series of occupations including bar work, labouring and farm work. One son who lived with his ex-partner. He secured long term work and accommodation on a farm but lost this as a result of relationship breakdown. He was also employed intermittently in the building trade but as a result of a serious injury to his foot found it difficult to hold down work. He subsequently engaged in transactional sex for money and substances.
- Known to treatment for nine years. Most recently he used alcohol and heroin which he smoked and injected as well as occasionally using crack cocaine. At times he also used cannabis, ketamine, and powder cocaine.
- Drugged and raped at 19. He had significant physical and mental health problems and had a history of deliberate overdoses, was nutritionally compromised, and had back and abdominal pain. He was a victim of multiple assaults from drug dealers and through sex work. His friend who had just been released from prison and was staying with him died of an overdose in his home which triggered an episode of depression.
- Recovery Workers offered him many opportunities for detox and rehabilitation, but he found himself unable to access them due to his lack of self-esteem and heavy reliance on substances to cope with his mental health and historic trauma. He lost all faith in Mental Health Services who on three separate occasions declined to take him due to his substance use.
- In the lead up to his death, his interest in life and ability to look after himself was severely compromised and safeguarding referrals were submitted. He was unable to eat though continued to use heroin and drink alcohol occasionally.

Learning going forward

- WY now has an Outreach Nurse who accompanies staff to visit service users who are reluctant to engage with Primary and Secondary Health Care and advocates on their behalf with GP services. The Nurse is supported by Health Peer Advocates.
- A more focused approach to people engaged in sex work.
- A trauma pathway for people who are still using drugs/alcohol is required.
- Follow up on safeguarding referrals and actions. Importance of dual diagnosis and joint working agreements.
- It is not clear what happened as a result of the safeguarding referrals.
- He struggled to attend hospital appointments as was unable to travel to the testing site for a COVID swab.
- His script for methadone was started but he was too fragile to pick up the script and reverted back into heroin use. Buvidal may have helped with this.
- Oversight of non-commissioned accommodation providers is lacking.

Drug Related Death 2022/17

- Woman who died aged 32. Started to use alcohol and illicit drugs aged 13 when she also stopped attending school regularly and would go missing.
- Diagnosis of depression and self-harmed. Reached out to her GP on a number of occasions who referred her for a mental health assessment, but she often did not fulfil the criteria for further help, as her emotional stability fluctuated, and she was not always displaying her symptoms of distress. On one occasion, she was sectioned under the Mental Health Act.
- Would often drink to excess and blackout and would use opiates such as codeine and oramorph.
- Self-referred to drug treatment in 2013 (aged 23) but never engaged; there were no further referrals or contact.
- Had a close and loving relationship with parents who were a protective factor to her feelings of suicidality. In the lead up to her death, she was struggling in her relationship with an unfaithful partner and was being evicted from her flat and her parents were moving out of Cornwall.

- Found deceased by partner after previous evening drinking and had consumed oramorph. She died due to the toxic effects of a high level of morphine and evidence of cocaine use in her body in combination with pneumonia. Her mental ill health did not meet the criteria for CMHT. However, she was not offered alternatives, which would be more available today.
- She had been given one off advice by Housing Options that the eviction notice was not valid and that she should contact again when she had received a valid 2-month notice, but she did not re-approach.

Learning going forward

- A more persistent and assertive joint approach to engagement.
- Feeding back to GPs about lack of engagement and joint approach to increase in future.

Drug Related Death 2022/18

- 29-year-old woman, survived by parents, sisters, partner and five children.
- Suffering extreme dental pain, had taken cocaine.
- Partner found her in the bedroom, attempting to pull her teeth out of her mouth. Police arrived and she died under restraint. Due to this, a Home Office pathologist completed the post-mortem. He concluded that she died of acute behavioural disturbance following cocaine use which could have led to sudden death. It was also noted in the Post-mortem report that she was in the early stages of pregnancy (estimated 5-6 weeks). She was not known to treatment.
- Reports provided to the Coroner outlined that in the days leading up to her death, she had been complaining of severe toothache and she was waiting to go to a dental appointment. The ambulance was delayed in their arrival as this emergency had a category 2 response. Family members had been led to believe that she had visited her GP in the April before her death and discussed symptoms of anxiety, for which she was referred to counselling and given anti-depressants.
- Family remarked that she had been losing weight and had been having investigations at hospital to identify any thyroid issues or possible Multiple Sclerosis.
- Not known to any services apart from GP, and there were no recent records of inpatient, outpatient, or emergency appointments at RCHT. The GP was not aware of any drug use.
- Whilst it is rare and unusual, cocaine use can give rise to a syndrome of acute behavioural disturbance, where an individual can experience bizarre or paranoid behaviour, agitation, acute distress and sudden death. There is often hyperthermia. The behaviour of the individual may well trigger involvement of emergency services (police, paramedics and/or medics) and when considering deaths as a result of this syndrome, restraint of individuals exhibiting acute behavioural disturbance – either for the protection of the individual or to maintain the security of others – followed by a sudden collapse is a common feature. As in this case, it is not unusual for no anatomic cause of death to be apparent at post-mortem and levels of stimulant drugs, such as cocaine, may not be excessively high.

Learning to take forward

- Support for the families impacted, particularly the children.
- Support and education for the professionals impacted.

Drug Related Death 2022/19

- 17-year-old who had a difficult and unstable childhood, characterised by witnessing historic and current domestic abuse, being a victim of domestic abuse and perpetrating domestic abuse within his family home. Also reported parental substance/alcohol use, poor parental mental health and poor physical health of his mother.

Information Classification: CONTROLLED

- He and his brother were removed from his parent's care when he was a child and he went to live with his paternal grandmother, until the age of 12 when he chose to return to his parents.
- Had four treatment episodes with YZUP, with referrals coming from social work, GP, a Youth Rehabilitation Order and out of court disposal process. He was reluctant to engage with professionals regarding his drug use and agreed only to do so if Court ordered. He felt that he had too many professionals in his life. He was not receiving support from YZUP at the time of his death.
- Main drug of choice was benzodiazepines/sedative drugs which he purchased illicitly, in person and online.
- Records show that he had a seizure in May 2021 and there were investigations for epilepsy through University Hospital Trust Plymouth (Derriford) at the time of his death.
- Had a diagnosis of ADHD, engaged in offending behaviour and experienced poor mental health. He started using drugs aged 11 in order to self-medicate his low mood using illicit drugs and his mother's prescription.
- Self-harming behaviours, intrusive thoughts and hallucinations.
- Periods when he would drink alcohol to excess as well.
- Whilst in treatment with YZUP he had CAMHS and Autistic Spectrum Disorder assessments, CAMHS support and ongoing therapy and had agreed to a referral to explore his exposure to domestic violence. Throughout his treatment the majority of the work done was substance education, targeted harm reduction and working on the impacts of being an affected other and YZUP liaised with other agencies to promote engagement with him.
- In 2021 he disclosed to YZUP that he had been the victim of violence from drug dealers and that he was being affected by criminal exploitation and had been involved in gang type behaviour.
- It is also noted that in 2021 his girlfriend had taken an overdose and he was angry because he was being blamed for this. Days later he was sent home for the remainder of the school year with work to complete remotely due to his risks to other students. His parents had disengaged with Adult WY services at that time as there had been a series of incidents in the family home and they believed professionals breached confidentiality by contacting the Police due to concerns around his and his father's wellbeing.
- In July the same year there were a number of incidents including being arrested for being drunk and disorderly, assault/criminal damage and him stealing his parents' car and crashing it. He later disclosed that his father had assaulted him and that he did not want to go home so alternative accommodation was sought. At this time Social Care, Youth Offending Service, YZUP and CAMHS were involved, but he did not engage well and spend a lot of time either working or sleeping and parents were not overly supportive in helping him to engage with appointments.
- In October 2021 he was placed in emergency accommodation specifically for 16/17-year-olds. Concerns had been raised that some of his social media posts hinted that he may end his life and that he may be carrying a weapon. Approximately 2 weeks later he moved to Foyer accommodation and from that point forward he began to further disengage. Accommodation is not clear from that point forward, but he reported to YZUP that he had moved around and kept getting evicted and he was moving between places including his parents and his grandmother's addresses. A few weeks before his death he was resident at a dry house in Devon, however, he was evicted 6 days before his death because he had been found taking Valium. He died at the parental home.
- When completing the Reframe intervention (criminal justice diversion scheme), he seemed to understand and be reflective of the impact the misuse was having.
- He had one previous deliberate overdose of paracetamol in 2021 and his mother stated that the day before he died, he had told her that he was fed up and she thought on reflection he was implying that he was ready to die.

- He died from mixed drug toxicity, with a low to medium level of illicit methadone, which he was not tolerant to, and bromazolam.

- This death has been subject to a Safeguarding Childrens Learning Review.

Learning

- It is a rare occurrence for a child to be placed in a residential drug/alcohol unit. There is no evidence that the criteria for such a placement were followed. All residential placements (including for young people) should go through the Drugs and Alcohol Tier 4 panel and should include adequate preparation, an Aftercare Plan and a Contingency Plan for an unplanned discharge.

Drug Related Death 2022/20

- A former marine who died at his home address aged 49 years. Having not seen him for four days his friends decided to do a welfare check on him and found him deceased with IV drug paraphernalia around him. There was also evidence of hoarding.
- Joined the Marines after completing his schooling and following his discharge from the Marines he was employed as a boat builder for several years and remembered that this was the happiest time of his life.
- Had experienced physical abuse from his father as a child and his mother left the family when he was three years old.
- Estranged from his daughter and granddaughter due to his substance use, but he had been in recent contact with his brother.
- Had been in treatment for 9 years for heroin dependency, although he also used other drugs and drank alcohol to excess. There were some periods of non-engagement during this time. He was due to collect his prescription on the date of his death but did not do so.
- Self-reported mental health and drug problems for 20 years. Suffered with a severe anxiety disorder, mood affective disorder and depression and was referred to the Community Mental Health Team but his continuing substance use proved a barrier, although he reported self-medicating to manage his mood fluctuations.
- Offered referrals to detox and rehab but felt ambivalent to this. Throughout his time in treatment, he continued to use other illicit drugs on top of his prescription and to drink alcohol.
- He suffered with pain from a historic back fracture and had prolapsed discs, was asthmatic, had COPD and cardiac issues. Due to his medication and alcohol use, he became overweight which resulted in vascular disease.
- Mobility issues and walked with a stick and sustained further damage when he was knocked down by a car sustaining fractured ribs and a punctured lung for which he was hospitalised.

Learning going forward

- Direct relationship between drug use, poor mental health and physical pain management and how to support and manage these concurrently.
- There appears to have been little joined up practice between services.
- Joint care management can make a critical difference in cases such as this. There are now practices (and escalation processes) in place to ensure escalation of concerning mental health and physical ill health.
- Drug and alcohol treatment staff now trained in the Ten Footsteps to Live Well With Pain and utilising tools from this training in their work with opiate users, but clear joint working is required in such cases.

Drug Related Death 2022/21

- 53-year-old man died at his home address due to the toxic effects of a combination of prescription drugs and alcohol. He lived alone and was found by his landlord and a workman as they were completing routine alarm checks and had used a master key to enter the flat because they could get no answer at the door. The landlord had last seen him 4 days before.
- Conclusion drawn from the post mortem and Toxicology report was that benzodiazepines, methadone, pregabalin and alcohol had all been present. Whilst none were individually thought to be at fatal levels, the combination of multiple drugs and alcohol was likely to have resulted in respiratory depression and death.
- Known to drug and alcohol treatment services and had first presented to them in 2006, requesting support for illicit opiate dependency. He was in continuous treatment throughout this time. Additionally, he consumed alcohol at low but regular intervals, most recently reporting to be drinking 4 units daily, usually beer. The risks of combined drug toxicity had been discussed with him in the past and he was trained in the use of Naloxone.
- Suffered from sustained generalised anxiety disorder and periods of low mood throughout his recorded treatment history and was also described as having a degree of social phobia, which presented him with significant difficulty in terms of feeling able to access talking therapies.
- There were periods of time where he felt hampered socially by his anxiety; he found going out quite difficult to manage at times. However, he also felt very close to his mother and was able to enjoy family visits, trips to Liverpool to visit family and friends, and had a few close friends locally.
- Attendance at appointments was generally regular historically but had been less so more recently. He declined referrals to CMHT and psychological therapies when offered.
- Physical health includes a recorded period of diaphoresis (abnormal sweating) which was addressed with GP prescribed medications, and periods of back pain. However, he considered his physical health to be generally quite good, he was able to care for himself and fulfil his basic needs and described himself as eating well.
- He had not wanted to engage in employment or training opportunities historically or more recently. He had a stable tenancy but did express a wish for more suitable housing and had recently registered on Home choice for this purpose.
- No criminal activity disclosed or identified during his time in treatment aside from the possession and use of illicit drugs.

Learning to take forward:

- A more intensive focus upon cessation of injecting and use on top by the 6-month milestone in treatment to be reinvigorated.
- All treatment staff to be competent and confident in supporting Anxiety Management within treatment.

Drug Related Death 2022/22

- 35-year-old man died in Temporary Accommodation where he lived alone in a self-contained flat under a daily licence provided by the Council under a main homeless duty. He was a single person who had been rough sleeping following a relationship breakdown. He was considered to be priority need due to poor physical and mental health and it was noted that he had been in prison in the past and was at the time of approach prescribed tramadol for pain in his shoulder and a list of other medication.
- Temporary Accommodation Officer described him as a pleasant man who regularly picked his son up from school, and had a good relationship with his ex. His flat was kept clean and tidy.
- Accommodation Officer never discovered any evidence of drugs or alcohol and had no safeguarding concerns.

Information Classification: CONTROLLED

- Diagnosed with depression, anxiety and sleep disorders and schizophrenia, and had made suicide attempts previously, which resulted in hospitalisation
- Had a past medical history of addiction to prescription drugs for pain management, following motorbike accident and was also prone to fits as a result.
- Involved in a road traffic accident whilst driving a moped the day before he died. A witness describes him weaving left to right, before hitting the kerb, falling from his bike and hitting his head twice. After the police were notified of this incident and his ex-partner requested a welfare check due to no contact, the police located him deceased at his home address. Toxicology states that there had been prior ethanol, cocaine and illicit benzodiazepine use (bromazolam and flubromazepam).

Learning going forward

- Ten Footsteps to Live Well With Pain would also be appropriate and should be more widely promoted.
- No one identified that he was using illicit substances and was therefore having problems. This death highlights the need for drug and alcohol screening and brief advice to be completed by all agencies.

Drug Related Death 2022/23

- 53-year-old man who was a trained motorbike engineer with a passion for motorbikes and motor racing and a keen darts player. Divorced and survived by two adult sons with whom he maintained contact on a regular basis. Subsequently in a long-term relationship where he and his partner supported each other in times of difficulty.
- Had been looking after his partner who had had a hip replacement and he reported being happy that his older son was getting married, and his younger son had commenced a roofing apprenticeship.
- Had self-referred to drug and alcohol treatment in May 2013 and remained in treatment until his death. First used substances aged 17 and experimented with heroin at 20, becoming dependent. Commenced opiate substitute therapy at 30 and experienced significant issues with polysubstance use for most of his adult life. Although options for detox were discussed, it was not an option he felt he could commit to as he did not have a safe environment to live in. He was often known by treatment services to be homeless and sleeping rough or sofa surfing and he did not think he would be able to focus on recovery without a stable home.
- Local Housing Options Team have no record of ever receiving any rough sleeper alerts regarding him or housing applications by him.
- Although he did not meet the criteria for serious mental illness, he had ongoing mental health issues including severe anxiety, paranoia and sleep disorder along with episodes of self-harm. Had been followed home and robbed in 2017 and attacked with a hammer in his home in 2020, as a result suffered from PTSD and agoraphobia and had been referred for counselling. Reported ideas of suicide at times, he stated that he would not put his family and friends through the trauma of ending his own life.
- Ongoing problems with osteomyelitis, sciatica and septic arthritis which caused pain which he self-medicated with opiates. As a result of a depressed immune system experienced persistent infections to his skin and throat and ongoing sores on his ankles exacerbated by intravenous drug use. Hospitalised for Deep Vein Thrombosis (DVT). Ongoing use of stimulants affected his appetite. Nutritionally compromised and suffered from chronic fatigue.
- On 21 July he spoke with his Recovery Worker on the telephone and stated he didn't want a prescription anymore, he wanted to focus on housing and not be involved with other drug users, he was able to stay with friends and his mental health was poor.
- Died at his friend's home less than a week later. The friend states that this was his second overdose that week and on this occasion the two of them had both taken some Valium and then an injection of Heroin that was bought from the same dealer, nobody else was

present, they both passed out on the living room floor and when the friend woke up he tried to wake him and it was not possible, so the friend administered a full Naloxone pen and gave chest compressions until paramedics arrived and pronounced him deceased.

- The friend was 21 years younger than him, the paramedics reported that the friend was very much in a drug induced state. The friend's home was in a poor state of tidiness and cleanliness with badly soiled and damaged furniture, there were a lot of empty beer bottles and uncapped needles around the property and there was no electricity.
- The friend died 2 weeks later and has also been listed as a drug related death.

Learning

- No referrals made to Housing Options under 'duty to refer' despite homelessness and vulnerability.
- He was not picked up in any rough sleeper counts and was effectively experiencing 'hidden homelessness'.
- Detox had been discussed but homelessness had been considered a barrier.
- Specialist treatment not being informed about clients experiencing non-fatal overdoses, so increased risks were not recognised or addressed. Non-fatal overdose reporting may have also led to risk being reassessed and a different approach being taken.

Drug Related Death 2022/24

- 76 year old woman died in her own home, and was found by a support worker. The Coroner's report states the cause of death as codeine toxicity, alcoholic liver disease ad pyelonephritis (a kidney infection caused by bacteria in the bladder).
- Alcohol dependent, drinking a litre of brandy and approximately four bottles of wine per day in the weeks before their death, but was not known to drug and alcohol treatment services.
- Suffered with health issues including oesophageal varices, gastrointestinal haemorrhage and hypertension due to alcoholism and was engaged with the Supported Living Team. Concerns were raised by the team to social services three times; however it was deemed that she had capacity.
- Concerns around self-neglect and a heightened risk of falling, she suffered a fall earlier in the year (July) and obtained injuries to her face. Her confidence levels then reduced, and she would no longer go to the shops for herself, a social worker then advised the supported living team it was appropriate for them to go and buy alcohol for her.
- She was able to call the GP herself but would not pass information to the supported living team. The week before she died, she was diagnosed with cellulitis and given antibiotics for this.
- She developed an addiction to prescription medication of Zapain and codeine for which she was supported to wean herself off by the supported living team in the week before she died.
- Prior to this she had been going to the shops and buying co-codamol plus taking paracetamol and taking this in addition. Once this was realised by the supported living team, they had her prescription changed to just codeine, so she then wasn't taking dangerous amounts of paracetamol which is in co-codamol.
- There are no records that indicate the individual was referred to or being supported by WAWY for her alcohol or drug problems.

Learning

- Need to introduce screening within services and undertake further exploration of fluctuating capacity within this population.

Drug Related Death 2022/25

Information Classification: CONTROLLED

- 48 year old woman died days after she abruptly left rehab, at the home of a person she had only met that week, who was a known drug user living in supported accommodation. She died from an overdose of illicit and prescription drugs. She is survived by her mother and her two teenaged children.
- Experienced issues with drugs and alcohol for more than twenty-five years and reported a familial history of substance use with her father experiencing alcohol dependence. She had commenced substance use at an early age progressing to intravenous heroin and crack use around the age of 23. She also used cannabis and Benzodiazepines, but no problematic alcohol use reported.
- Experienced childhood sexual abuse and was witness to domestic abuse. This was followed by exhibiting anti-social behaviour, acquisitive crime and association with offenders and the Police had warning markers on her records for firearms, mental health, being suicidal and for drug use.
- Diagnosed with COPD and was in the throes of dealing with the menopause which exacerbated her anxiety.
- Also diagnosed with ADHD which contributed to her impulsive decision making and inability to concentrate for long periods of time.
- Experienced intrusive thoughts of suicide and, prior to her admission to rehab, had taken an overdose of benzodiazepines in an attempt to end her life.
- Before going into rehab, she had a prolonged hospital detox following the overdose. She appeared to settle well into the structure of Chy Colom but had reported feeling homesick.
- Whilst in Chy Colom there was an outbreak of Covid which meant that groups were run online. She tested positive for covid and found the isolation very difficult to cope with and she was also expressing anxiety about a court case relating to her daughter that was due to take place imminently.
- She was asked to leave Chy Colom following a disclosure from a fellow resident that she had been asking peers to divert their medication (pregabalin) to her.
- On the date of her death her mother had created a concern for welfare log with the Police as she had not had contact from her daughter for a couple of days which was out of character and the last time she had spoken to her daughter she had asked her to transfer money to the new friend and she was concerned for her welfare and that she may have started using drugs again.

Learning going forward

- The Contingency Plan for unplanned discharge was not activated. There is nothing to indicate that Chy Colom tried to contact her after she left the final time to discuss collection or disposal of her belongings or that they tried to contact her, her social worker or anybody else to check that she had reached her destination.
- Since the death Chy Colom staff have reviewed their discharge policy and have taken on board the learning opportunities provided.

Drug Related Death 2022/26

- 32 year old man first used alcohol and substances as a teenager and quickly progressed from smoking to injecting. He had six adverse childhood experiences including being abused when he was 7 years old and being left in the care of his alcohol dependent father by his mother. He had conflicting relationships with his parents and sister due to his experiences with them as a child and latterly because his father was in recovery and struggled to see him still using.
- Vulnerable to others and found it difficult to protect himself, he had recently been in a few fights and had his wallet stolen twice.
- Whilst there were no offences pending at the time of death, he did have a criminal record for drug/alcohol related offences including being drunk and disorderly, assaulting a Police Officer and breaking and entering, attempted armed robbery and he was detained in prison in 2016-2017.

- Approached the Council Housing Options department in January 2022 for advice and assistance about his housing circumstances stating that he was in accommodation that he secured via the Lighthouse Project but he was being asked to leave because he was unable to remain sober and he was looking at a house of multiple occupation as an alternative. His housing case was closed because the Prevention & Engagement Officer had neither been able to contact the landlord or him to progress the application.
- Known to WY since 2013 with 9 separate treatment episodes. Self-referred seeking support and recovery with alcohol, heroin and crack cocaine and hoped to achieve abstinence, settle down, meet somebody and secure employment. Attended community recovery groups and had a number of detoxes, although experienced many relapses and periods of non-engagement. He wanted to be totally drug free including from prescribed substitutes, which often saw him self-detoxing or engaging in rapid reduction and subsequently relapsing.
- Outcome of a mental health assessment concluded that he suffered with generalised anxiety / panic disorder / agoraphobia and depression and his case was then closed by the CMHT. He was prescribed antidepressants by his GP at various stages of his life and often experienced low mood and suicidal thoughts. He had a non-fatal overdose less than a month before he died and had attempted an overdose on New Years Eve. Interventions from WY included providing crisis numbers for CMHT, referrals to CMHT and welfare checks.
- Two weeks prior to his death, a friend died from a drug related death in his home. This bereavement had a significant negative impact on his mental health and led to him making active suicide threats. He made a suicide attempt (by sitting on a bridge) 2 days after this friend died and Police and With You talked him down.
- A week before his death he was referred to supported accommodation. A referral for detox and rehab had also been made and accepted five days before he died, he was due a telephone assessment to discuss stabilisation before going in.
- Due to be re-assessed by mental health and Pentreath on 10 August 2022. It has been recorded that all of these services and his recovery worker had been trying unsuccessfully to contact him and had also tried to contact his parents to check on his welfare but had no responses.
- Found deceased by the Police approximately 6 days after he died after a neighbour reported a smell in the communal area of the property where he had been living.
- In the month prior to his death, it is evident that there was a serious decline in his mental health, but it is unclear what steps were taken at this point, to increase or vary the support offered to him.

Learning to take forward

- Process for working with hard to reach people to be reviewed.
- A need to promote dynamic risk assessment.
- Consideration could be made to having a clear policy, detailing the rapid response of WY to any service user who becomes an ‘affected other’. This could include an invitation to the affected other support group, a one-off rapid counselling/de-brief (perhaps through the WY counsellors), the offer of increased support worker sessions, and providing bereavement helpline numbers.

Drug Related Death 2022/27

- Man died aged 41, at his mother’s address, where he had been staying after a recent break up with his partner. Relationship had broken down as they were both heavy drinkers and he believed that the relationship was becoming unhealthy. A history of illicit drug use and dependent drinking and is survived by four children. None of his children lived with him.
- Self-referred to drug and alcohol treatment service in 2018. Employed at the time and drinking 10 plus units per day but had managed to stop drinking for the prior ten days and

was seeking help to remain abstinent. Appointments were offered but he did not attend them. In custody for allegation of threats to commit criminal damage and was seen by a treatment Criminal Justice Team worker in a cell. He continued to not engage, and the case was subsequently closed, the discharge summary 02/11/2018 states 'treatment commencement declined by client'.

- Went to bed after having a drink and reportedly being settled for the night at 7:30pm, his mother though she was leaving him to sleep the next morning, however, when she tried to wake him, she realised he may have died and called emergency services who confirmed that he had died.
- Toxicology report states ethanol, morphine and amitriptyline were detected, although levels were not markedly elevated, it is probable that it was the combined effect that led to death in combination to the post mortem identifying an enlarged fatty liver with microscopic evidence of steatohepatitis and early damage to the liver parenchyma in keeping with the combined evidence of chronic alcohol and drug misuse which would carry a risk of sudden cardiac death.

Learning going forward

- Process for prompting ahead of appointments and dealing with missed appointments has been introduced
- Blue Light approach to people not engaging in treatment.

Drug Related Death 2022/28

- 33 year old chef died at his home address. History of alcohol dependency and recreational drug use.
- Known to drug and alcohol treatment but his case was closed because he did not engage.
- Had previously made suicide attempts by overdose in 2019 and self-harmed. Two days before his death, his father had taken him to hospital due to his poor mental health which has been described as depression and anxiety.

Drug Related Death 2022/29

- 58 year old man died at home alone. Found by a friend who went to check on him.
- At the time of his death, he had been in treatment for heroin dependency.
- He had been using drugs for 25 years and had kept this hidden from his family.
- Stated on several occasions that his main trigger for substance use was boredom as he had an interesting and eventful life in the past and the provision of a tablet from the treatment service broadened his horizons allowing him to connect with fellow music enthusiasts across the world. He also enjoyed listening to Radio 4 and debating current issues via the internet.
- Experienced anxiety and low mood and had agoraphobic tendencies. These mental health difficulties were heightened by the Covid-19 lockdown.
- Suffered from 'crippling' headaches and chronic pain from a knee injury. Prone to a range of opportunistic infections including regular chest infections, scabies and gastroenteritis.
- October 2019 engaged in a Drug Rehabilitation Requirement (DRR) order which saw him remain free from heroin use. However, he was a vulnerable person who had his property broken into and was assaulted a number of times.
- Despite being difficult to engage due to his distrust of any establishment, WY persevered and were able to help him stop intravenous use and then heroin all together. The WY worker was able to build up a good relationship with him when he was on the DRR but they were unable to get him to seek support from his GP regarding chronic chest problems.
- He had many issues related to lack of finances including rent arrears. In the winter months prior to his death he reported having no money to heat his flat

Learning

- The risks associated with untreated pneumonia were not sufficiently addressed
- Flexing the capacity in treatment to promote engagement in wider health services.

Drug Related Death 2022/30

- 53 year old man who had been in treatment for 11 years.
- First started drinking and smoking marijuana when he was 14 years old. He progressed to using heroin in his mid-20's which he both injected and smoked over a period of many years. Not a dependent drinker. Laterally also used cocaine, amphetamines and illicit benzodiazepines.
- Worked as a deep-sea fisherman for a long period of time until his drug use and physical health both contributed to him being unable to work in this any longer. He strongly believed work was good for his mental health and continued to make attempts to find employment.
- Suffered from low mood due to the changed circumstances of his life and his own perceived powerlessness to change his pattern of drug use. He was deeply affected when his wife met a new partner and relationships with his daughters became strained as a result of his continuing substance use. In the course of his treatment, he experienced several family bereavements including the death of his father.
- Following an assault in 2020 he suffered from raised anxiety and at times struggled to get out of the house. He was referred to Valued Lives and to Outlook South West for additional support both of which he found useful. Though discussions were had with regard to a referral to the Community Mental Health Team he was reluctant for this to happen. Towards the end of his life, he self-harmed by cutting to his arms.
- A number of physical health problems. Following an old injury to his knee he suffered ongoing pain and discomfort and later arthritis developed. He also had a history of deep vein thrombosis related to his intravenous drug use and varicose veins which bled on occasion.
- Used substances to deal with physical pain, psychological distress and the boredom that ensued when he was not at work. His is a narrative of steady decline with little evidence of him reaching a point of desistance. He was offered a referral to detox and rehabilitation but did not choose to pursue this option.
- The GP reported to WY after he had died that in his most recent appointment which had been on 20 June 2022, he had told the GP about his new grandchild and talked positively about his family. He stated that he was happy on his prescription and that his cocaine use was more of a problem than his heroin use. He also noted during the GP appointment that he had been cuckooed on a few occasions and said that there was at that time somebody in his flat that owed him money.
- This man lived in social housing and the WY records indicate that in January 2022 he had told his Key worker that he had got involved with a drugs ring but had stepped away from it and on a later contact he stated that and he was trying to register for Home Swap and that he was upset because he felt people thought he was dealing (he stated he was not dealing). The Coastline Housing Officer for Redruth stated that there had been no tenancy issues and no information had been received by Coastline in relation to cuckooing.
- Nearer to his death he had requested an increase in his methadone and a medical review had been requested. He did not collect his prescribed methadone 05 October, but no services received a missed dosage notification.

Learning to take forward

- This man functioned best when he was working and stated himself that he believed it was good for both his mental health and substance use. An IPS referral (for employment for people in treatment)may have been helpful here to support this man into work.
- Communication between services involved was poor. It appears that this man may have been vulnerable to others but nothing had happened to alert partners in his care to any safeguarding issues, specifically cuckooing risk. Increased awareness of safeguarding risks would be aided by wider awareness and understanding of cuckooing.
- He was self-harming by 2022 and his mental health deteriorated, at this stage making his mental health a priority and trying to encourage a referral to mental health services could possibly have been a path to explore with his GP and WY. The losses he experienced in every aspect of his life affected him profoundly.

Drug Related Death 2022/31

- 51 year old man died in hospital. Had been seen by the Police in the early hours of the morning but when they tried to speak with him, he told them to go away. Police returned to the place where he had been seen before and found him in a collapsed state, so ambulance was called. Resuscitation efforts commenced by the Police and then the ambulance crew but this was ceased on the grounds of futility. He was taken to the Emergency Department in cardiac arrest. Extensive attempts were made in hospital but were unsuccessful.
- Toxicology identifies high presence of both diazepam and morphine along with oxycodone and low level of methadone and pregabalin which would have been likely to have led to excess sedation and respiratory depression. It was also noted that there may have been previous exposure to cocaine, but it was not at a toxic concentration prior to death.
- The post mortem detailed that there were signs of IV drug use (scarred groin sinuses) and acute lung infection/sepsis and with the toxicology findings it is expected that this will be confirmed as a drug related death.
- He had been living in supported accommodation and was known to drug and alcohol services but his case had been closed late 2021.
- Whilst in treatment it is noted that he had not dealt with past trauma including a friend dying of an overdose, various assaults and becoming street homeless and that he had periods of depression. It was also noted that he had secured supported accommodation, was working with Pentreath, he had made his own guitar and having this made him happy, he had also developed air brushing skills and had aspirations of starting a business customising surf boards. However, over time his behaviour was often very challenging, and he was referred to the Adult Social Care High Risk Behaviour Panel, but there is no record of any subsequent actions.

Learning to take forward:

- More intensive involvement of drug and alcohol treatment with supported accommodation to increase engagement and joint working**.**

Drug Related Death 2022/32

- This 49 year old man died from an acute infection in his lungs against a background of heroin use and recent withdrawal.
- Not known to drug and alcohol treatment services, but his family stated that he was a known heroin user, previously intravenously but more recently smoked.
- In the lead up to his death he had been particularly unwell for six days; vomiting and having difficulties breathing. As he was getting progressively worse and had begun to vomit blood an ambulance was called and attended but he refused to be taken to hospital and he died a few hours later.
- The inquest revealed that:

Information Classification: CONTROLLED

- He did not know his father and had a difficult relationship with his mother and stepfather and lived with his aunt.
- He was in a relationship with a heroin user and had a good relationship with his daughter and stepson.
- He never asked for help with his mental health or substance use.
- He presented with behavioural issues as child and was diagnosed with Asperger's and Obsessive Compulsive Disorder (OCD) and was considered to be a hoarder.
- He had experienced chronic pain due to knee issues.
- He had been in prison a few times and the last time he was released in 2018 his physical health was declining
- He was no longer motivated to work or leave the house and refused to see a GP.
- At time of death, he had a cough, was thin and found it difficult to climb stairs.
- Not picked up by any services, including within prison.

Learning to take forward

- Information for families where a family member will not engage.
- Exploring how his heroin use and mental health problems were not picked up by Probation or prisons

Drug Related Death 2022/33

- Sixty three year old man died at his social housing home address aged 63 and is survived by his son and daughter.
- Unemployed and was a long-term dependent drinker and heroin user. Not in drug and alcohol treatment when he died. Engaged with drug and alcohol treatment services in three different episodes, twice in 2015, when he felt suicidal, and once in 2016 which lasted until 2018. Had managed eleven years of being abstinent previously.
- Experienced childhood sexual abuse by a family friend and had been diagnosed as having PTSD. Engaged with CMHT.
- History of rough sleeping and committing crimes to fund his habit at that time.
- He re-engaged in treatment in 2016,but declined Opiate Substitute Therapy and was at In 'significant risk of overdose of heroin and mixing'. He was closed in October 2018 due to non-engagement after he missed 3 appointments and didn't respond to follow up enquiries.
- Although he had not been in drug or alcohol treatment for over four years when he died, he was still known to the Police as being a drug user and dependent upon alcohol and five days before his death he had had a heroin overdose and was admitted to RCH Treliske but discharged himself. His son was aware of the ongoing problem and of him attending hospital.
- Police were called on Wednesday 23 November by a concerned friend as they hadn't been able to make contact with him after numerous attempts of trying.
- Toxicology reports Dihydrocodeine detected at a concentration within its quoted potentially toxic range, Methadone detected at a concentration within its therapeutic to potentially toxic ranges. Previous medical records indicate there was some spinal damage causing physical pain for which he was prescribed Gabapentin 6 x 300mg daily & Co Codamol up to 8 per day, 30mg of codeine.

Learning going forward

- It is not clear what, if any, pain management for the spinal injury the individual received.
- There is no evidence to show that risk / information was shared between GP prescriber and drug treatment.
- It is not clear what notification process was completed for the non-fatal overdose that happened on the 18th November (died 5 days later).

- Assessments and case reviews to include pain management updates.
- There is a need to develop more proactive re-engagement of people who drop out, perhaps through outreach and for workers to find the individual to identify the barriers to their engagement
- There is a need to identify how we can act upon risk assessments in a long-term sense. This could be by identifying those at risk from mixed drug overdoses and offering learning about the dangers of mixing drugs. A medicines review could have assisted.

Drug Related Death 2022/34

- 59-year-old electrician was found at home by neighbours after they received concerning text messages.
- He had previously attempted suicide and stated he would like to end his life before he was 60. He said would use 'the same method as King George 5th with a cocaine and heroin overdose', (his 60th birthday would have been in 2 days' time). His daughter said he had stopped taking his heart medications in the summer as he did not want to reach his next birthday. He died from drug toxicity and congestive cardiac failure.

Drug Related Death 2022/35

- 43 year old man died at his friends home from an overdose of prescription and illicit drugs contributed to by severe heart disease against a background of chronic pain.
- He had previously had many surgeries including bowel surgery on multiple occasions. In addition to this he had been diagnosed with a degenerative spinal condition which he was medicated for.
- He had self-referred to WAWY in 2019 for support with alcohol and cocaine use.
- He was known to Housing Options and approached 6 times between January 2019 and June 2020, but his case was closed. It is detailed in his housing application that he was not threatened with homelessness, but he was seeking assistance because he had had operations on his spine, neck and throat and he was requesting assistance finding more suitable accommodation. He was signposted to Adult Social Care for an Occupational Therapy (OT) assessment for aids or adaptions by way of exploring ways to prevent him having to move out. Records show that the outcome of an OT visit was that adaptations were recommended but the landlord was not keen to allow them, so a housing case was re-opened but later closed as he did not engage.
- A week before his death, on 02/12/22 he had crashed a car into an island and the airbags had been deployed, the Single Vehicle Road Traffic Collision Log stated "possible drink driver conveyed to hospital – possible injuries to trachea, blood coming from mouth, complaining of back pain. Possible spinal injury - lumbar spine fracture - possible Life changing injuries". A full scan in hospital found a small spinal fracture but no other injuries, so he was discharged from hospital on 05/12/22 with a back brace and medication.
- The night before his death he had been out drinking with his friend to celebrate his friend's birthday and gone back to the friends where they shared approximately 1 gram of cocaine. His friend reports that he helped him get comfortable on the sofa and then went upstairs to bed and the next day found him deceased on the sofa.

Learning to take forward:

- Chronic pain management**.**

Drug Related Death 2022/36

- This person died aged 28, emergency services were called when he was found unresponsive in bed by friends at the friend's home, paramedics pronounced dead at the scene.
- He is survived by his parents and brother and young son.

- He started using polysubstance from the age of 13. He was referred to children's drug and alcohol treatment service when he was 17 years old by a Community Nurse after he was found unconscious in a local park having drunk a litre of vodka, the referral also stated that he was using cannabis daily along with MDMA and amphetamines recreationally with friends. He did not engage with YZUP.
- He was later referred to Adult drug and alcohol treatment services We Are With You (WAWY) several times but did not engage.
- He suffered childhood asthma which continued into adulthood. This was exacerbated by smoking cannabis and crack cocaine and although this was explained to him, he did not accept that the drug use was impacting on his respiration.
- He also suffered with low mood linked to his cocaine and crack cocaine use and unresolved bereavements. His main drugs of choice were crack cocaine and alcohol. He was referred to mental health services but did not receive support as it was stated that he needed to address his substance use first.
- In 2017 he called in to WY asking to go into detox because his crack cocaine use had significantly escalated, appointments were offered but he did not attend.
- He was always seeking employment as he believed that having responsibilities and his own financial income would give him purpose. He had several jobs in factories and the building trade but consistently his employment was interrupted by his compulsion to use substances.
- He had an offending history and periods in prison which included acquisitive crime to fund his substance use, criminal damage, drink driving, possession of Class C drugs and possession of a bladed article.
- In 2018 he was referred to WAWY by the Liaison and Diversion Service who had reviewed him in custody following an arrest for drink driving and possession of cannabis, but he did not attend the offered appointment.
- He also had a history of binging on substances following stressful situations, and although he had indicated that he wished to create his own family, his ability to control his emotions and behaviour when intoxicated lead to him having unstable relationships and experiencing relationship breakdowns.
- He self-referred to WAWY in 2019 with his motivation being that he had an eleven month old son with his ex-partner and he wanted to be a better father. However, he was recalled to prison after having an altercation with his partner and ripping off his electronic tag.
- He was released from HMP Channings Wood in November 2020 and was collected by his father and taken to live with his parents. He self-referred to WY in January 2021 and was referred to WAWY's Who Dare Works project for support with access to employment, his use did reduce over the following months, and he worked intermittently on various jobs for his brother.
- There was an instance in April 2020 when he binged on substances for two days, but other than that he reported that he was not using substances over a period of months. His case was closed in June 2022 because he had stopped engaging.

Learning to take forward:

- Suffered from paranoid ideation and drug induced psychosis but mental health services felt unable to work with him due to his use of substances.
- The treatment services offered may not have been appropriate for his substances of choice. He may have benefited from daily check ins, short serial appointments and a timetable of activities.
- Diversion as an intervention was not successful.
- This death highlights the importance of dual diagnosis and joint working agreements.
- It is recognised that individuals who use cocaine do not easily fit into structured treatment and that it is imperative that when individuals do present seeking support that they are offered intensive treatment and more proactive engagement until the period of "come

down" is alleviated. We are With You is implementing a Crack Plan and rolling out a strategy for harm reduction with crack users.

Drug Related Death 2022/37

- 65 year old man was a retired builder who went to the pub every day, where he would sit outside and ask others to go in and get him a drink with his money. He was known to be alcohol dependent. He had arrived around 3pm on the day of his death and was found collapsed on his way between the beer garden and the toilets at around 8.30pm by a member of the public. CPR was commenced by first responder and two members of the public until paramedics arrived 40 minutes later. He was pronounced dead at the scene by the paramedics.
- When he died, he was in poor health and reported heart, kidney and liver problems as well as having arthritis in his hands. The GP confirmed that he had early stage lung cancer, had radiotherapy in July 2021 and this was stabilised. He was seen by the GP in June and it was noted that his weight was going up, his mobility was reducing and he had an ongoing cough, he had inhalers for COPD and was not on any other medication other than Amlodipine. He was referred for swimming lessons.
- He had received structured treatment in relation to his alcohol consumption during 2013-2014. His records showed that he had used heroin in the past but was alcohol only at that time. He had experienced an overdose in 2005 when a girl injected him with more than he was used to taking. His case had been closed since April 2014, as he had reduced his alcohol intake and stated he did not want to continue with treatment.

Learning to take forward:

- Relationship between physical healthcare services, alcohol screening and subsequent proactive engagement should have occurred through the hospital Outreach and alcohol care teams, as well as through GP.
- Longer term aftercare and recovery support for people leaving treatment

Drug Related Death 2022/38

- 50 year old man who died in hospital. He was the carer for his mother who had Parkinson's Disease, though on the date of his death, his mother was in Bodmin Hospital.
- Concerns that he may have been using codeine prescribed for his mother and safeguarding referrals had been submitted for both of them as there were concerns that his alcohol dependency meant that he was neither fit to look after himself or his mother.
- Ambulance Crew attended his home on the date of death and recorded signs of jaundice and self-neglect; they also observed signs of hoarding and evidence of rats.
- Hospital records indicate that he had been dehydrated and was experiencing generalised weakness, reduced mobility and weight loss.
- Although the toxicology report showed low levels of alcohol when he died, he had been alcohol dependent for many years and the hospital admission was on a background of cirrhosis of the liver and acute chronic liver failure which was likely sepsis induced. Despite being given IV antibiotics and being within a supportive care setting, he collapsed on the ward and died despite several attempts to resuscitate.
- The findings of the toxicology report were that there were very high levels of codeine. Alcohol may have increased the risk, but the codeine toxicity alone would have been fatal.
- Between 2016 to 2019, three self-referrals were made to alcohol treatment, during all episodes, attempts to engage with him were unsuccessful. A month before his death, he was referred to alcohol treatment services by the Hospital Alcohol Liaison Team at RCH Treliske where the client had been admitted with jaundice and advance cirrhosis of the liver. Attempts to contact him were made but it was not possible to speak to him, so an appointment letter was sent, however, he did not attend this so another appointment letter was sent.

- WAWY offered psychosocial and motivational interventions a total of four times since his initial referral in 2015, however these were declined. In 2017, two key working sessions were attended and well received as the individual had a positive response to engagement and stated a lowered consumption of alcohol, however then disengaged.

Learning going forward

- It is possible that if an outreach worker had completed a visit in the early referrals, self-neglect could have been identified then and safeguarding referrals made at an earlier stage
- It is not clear whether hospital staff were aware that there was a belief that the individual was taking his mother's codeine, had they have known they may have considered a different course of treatment.

Drug Related Death 2022/39

- 35 year old woman died at a Women's Refuge dispersed unit. She is survived by her three children and friends.
- She had spoken to her support worker 2 days before she died and was seen by a nurse the day before to change dressings on her legs which happened daily.
- She was not known to drug and alcohol treatment services.
- There had been hospital admittances in the weeks leading up to her death on 11 August 2022 with complaints of chest pain and leg soreness and on 29 August 2022 for possible sepsis and respiratory failure and was discharged on 02 September 2022 with medication to manage the pain.
- She had a high BMI (71) and multiple health conditions, including chronic type II respiratory failure, cellulitis, asthma, sleep apnoea, urinary retention, pulmonary embolism and Meniere's disease. She also was diagnosed with post-traumatic stress disorder and emotionally unstable personality disorder.
- She had a history of sexual assault, stalking, suffering from coercive control and had had her children taken away.

Learning going forward

- As there had been recent hospital presentations it is likely that her support needs may have changed but it is not clear what safety measures were in place in relation to her taking her medication.
- She was not known to drug and alcohol treatment services and may have benefited from e social prescribing in relation to the pain and her weight.
- The dispersed units are specifically for people with multiple vulnerabilities and, as such, her care plan should have included a risk assessment and involvement of health services, including alcohol and drug treatment to engage. This to be picked up through the joint drugs, alcohol and DASV pathway.
- It is important to ensure that person centred risk assessments are completed at the commencement of a placement and that these are regularly reviewed and updated appropriately.

Drug Related Death 2022/40

- 68 year old man not known to Drug & Alcohol Treatment Services died alone in his own home. An academic Doctor, research scientist who described himself as a workaholic. Career had been hampered by his poor mental health (diagnosis of Bipolar condition) and in his lifetime had a number of episodes that required hospitalisation. He was under the supervision of the Community Mental Health Team; his next monthly depot injection was due around the date of his death. He was taking prescription drugs for heart and lung conditions. He smoked and had no desire to stop smoking

- He had been the carer for his late wife who died of a terminal illness and his mental health had deteriorated significantly since she died three years earlier. He had neglected the home, threw little out and there were signs of a rodent infestation.
- He had become excluded from the community due to his alternative lifestyle and his mental health, depressive episodes became very problematic, neighbours frequently called emergency services because they were concerned for his welfare.
- During the last 6 months of his life, he had lost his driving licence and become more reclusive, relying on supermarket home delivery and avoided seeing of speaking to those closest to him, stating that he was unwell. He had been asked whether he would like to be referred for bereavement services but had declined, stating he was supported by friends and family.
- He had an adult son who lived in Scotland who maintained regular contact with him and who had recently informed him that he was to become a grandfather. His son had invited him to move in with them so that he could be cared for and see the grandchild more easily.
- A friend of both him and his late wife had been regularly seeing him, as he had not been in contact to confirm a pre-arranged meeting, she attended the property and found him deceased. A small notebook was found in the property that contained an entry that could have indicated suicidality, but as he had experienced a number of depressive episodes in recent years it was not possible to determine when this was written. As he had not been prescribed morphine, it is not clear whether this was obtained illicitly or if it was leftover from when either he or his late wife had been prescribed it.
- The only professionals involved had been the GP and the CPN who had been in monthly contact. During appointments they had not been concerned about any increased risks as his mental health was managed by medication and he was in regular contact with a friend and family member for emotional support.
- The son indicated at inquest, that on reflection he may have overlooked signs that his father may be going into a depressive episode as it was difficult to judge over the telephone.
- Cause of death: Fatal level of morphine against a background of Pneumonia and Heart Disease. As he had not been prescribed morphine, it is not clear whether this was obtained illicitly or if it was leftover from when either he or his late wife had been prescribed it.

Drug Related Death 2022/41

- This 44 year old man died at home. He lived with his mother, she seen him around 10am before she went out, but when she returned home in the afternoon, she found him to be unresponsive in bed.
- Toxicology report confirmed the cause of death was overdose of prescription drugs contributed to by cardiovascular disease, against a background of chronic drug abuse.
- Had epilepsy and had experienced 3 convulsions over the past week. The last convulsion that she was aware of had been the day before and lasted for 25 minutes before self-resolving. Medical attention had not been sought and she said that he had 2-3 fits a week.
- Known to WAWY and had one continuous treatment episode from February 2020 until the time of his death in November 2022. He transferred from Buckinghamshire when he relocated to Cornwall to live with his mother. He was on a methadone script but continued to use heroin on top, he had a history of problematic alcohol use as well but this was not current.
- Reported to WAWY that he had been using heroin since the age of 13 and both he and his mother were trained in the use of Naloxone. He was provided with regular needle exchange and harm reduction advice.
- Described himself as being extremely socially anxious; a significant history of childhood trauma and sexual abuse, his Adverse Childhood Experiences score was 9. He also described ongoing PTSD and anxiety, as well as a history of psychosis, including being sectioned under the Mental Health Act in 2016 for 4 weeks.

Information Classification: CONTROLLED

- Referred by WAWY to CLEAR and details of First Light DV Service were given. He was also referred to CMHT but the referral was not accepted, they signposted him to sources of therapy for his past trauma and recommended that he engage with WAWY.
- It was also recorded that he was in poor physical health, including recurrent DVT, COPD and epilepsy for which he was in receipt of interventions from primary care.

Drug Related Death 2022/42

- 19 year old woman was found deceased by her neighbours at her home address.
- Not in drug and alcohol treatment when she died.
- Oldest of 3 children but began showing behavioural and learning difficulties once she started school. In her teens she regularly truanted from school, shoplifted and was also known to self-harm. In order to distance her from bad influences her mum sent her to live with her grandma when she was 14 but following an incident where she ran away, she was placed in foster care.
- Former child in care, referred to children's drug and alcohol treatment service YZUP by the Children's Social Worker in 2017 when she was 15 years old due to being both an affected other and a substance user. She attended only one appointment where she was adamant that she neither needed or wanted to engage with the service, she was given harm reduction advice and how to make contact should she change her mind and the case was closed.
- History of anxiety, depression and self harming. During adolescence she was involved with CAMHS until discharge in October 2019 due to reaching adult age.
- Friends described her as either very happy or very down. When she was happy, she was very lively and positive, a kind, uplifting, positive person and a great friend who made everyone happy.
- Previously had a long-term relationship which when it ended had a serious impact on her emotionally. Once when she had been very down, she had asked a friend sit with her 'in case I die'.
- Also disclosed to a friend that she self-harmed and said that if she ever were to take her life, she would leave a window open to release her spirit.
- In 2021, she started a new relationship with a man in his 30s and appeared very in love. After a while this relationship started to deteriorate and a week before her death police were called to an incident where her partner was restraining her due to a mental health episode and her threatening to harm herself. She was verbally aggressive with police and refused to engage. During the incident 2 friends arrived and agreed to look after her and stay with her to ensure she was safe. She also stated to police that she had no intention to cause herself harm. Police completed a VIST which was graded as amber.
- Toxicology report shows Oxycodone was present at a concentration that has previously been associated with fatalities and there was also evidence of recent cocaine use which is known to exhibit significant cardiotoxicity in a person of that age. The only prescribed medications were anti-depressants; the Oxycodone was obtained illicitly along with cocaine.
- The coroner stated that there was insufficient evidence to say it is more likely than not a suicide due to her known habits around use of cocaine and oxycodone, as this leaves it open to speculation that it could have been an accidental overdose. Although the amount of oxycodone implies this was deliberate, suicide could not be confirmed so the death would be recorded as a drug related death.

Learning

- No involvement with MH services following discharge from CAMHS – follow ups and transitions to adult MH services

Drug Related Death 2022/43

- 43 year old man died in hospital having been admitted days before due to general poor health.

- Had become mal nourished as the drug use had led to him either not eating or not being able to absorb the nutrients, was admitted due to his poor health and overall rapid clinical deterioration. It was apparent that he had been significantly unwell due to infections for an extended period relating to long term IV illicit drug use.

- Medical records indicated that there had been a long list of presentations to health services where he had become infected in varying locations as a result of the IV drug use, treatment was always given and even on the final hospital admittance aggressive treatment was given to try and fight the infections but at that time it proved that bacteria had gone too far by the time he sought medical assistance and it was no longer possible for this to be treated and recovered from.

- Primary cause of death was therefore the habitual drug misuse causing infections in multiple areas leading to sepsis and organ failure.

- GP reported that it was recorded in his notes that he was openly using illicit drugs intravenously over an extended period in addition to prescribed drug. Engaging him with medical care was always difficult, there were regular instances where he attended health services when had got infections from IV use, but he regularly failed to attend follow up appointments.

- Prior to his death, he was living in temporary accommodation provided by the Council under a main homeless duty for the past 2 years. It was noted in his housing application that he had medium to high support needs. Referrals had been sent to supported accommodation but he failed to respond to them trying to contact him to organise an assessment. Housing had nothing recorded in the risk assessment to indicate drug use but it was noted that he had fled to Cornwall from Liverpool and he had stated he had been asked to sell drugs in January 2019 and refused - he went to the Police about it but he did not believe they pursued it as they advised him to move away. The risk assessment indicated that on this basis he was at risk of being exploited by others.
- Despite being a long term IV user and frequent attender in hospital, he was not known to or referred to treatment.

Learning to take forward:

- Improve screening and referral processes across services
- Assertive engagement

Drug Related Death 2022/44

- 42 year old woman died in Nottingham where she had gone for the Christmas period. She was originally from Nottingham but moved to Cornwall in 2019 fleeing domestic abuse.
- In treatment with WY and was recorded as having a dual diagnosis. She had been admitted to hospital under Section in 2021. She had been on OST and had taken two weeks supply of medication with her having requested a holiday prescription to be dispensed.
- Had been living in temporary accommodation under a main homeless duty having fled domestic abuse from a partner who had been a drug dealer. She had not told her Housing Officer or the Accommodation provider that she was going away, and they subsequently reported her as a missing person.
- Prior to going into temporary accommodation, she had been accommodated in a Women's Refuge, but they asked her to leave because of her problematic drug use. She

Information Classification: CONTROLLED

had 8 short-term emergency accommodation placements before moving into the final placement at time of death.

- The risks noted in the risk assessment were:
  - Incidents of violence to public
  - Known suicide attempts, known self-harm
  - Incidents of being abused/exploited
  - Substance /alcohol abuse

Appendix 2: Glossary of drugs

Name of Drug (pharmaceutical and brands)	Type of drug	Prescribed in UK?	Type of drug/use of in medicine i.e., depressant Antipsychotic, antihistamine also used for sleep problems	Risks
Alcohol	Depressant	No	Depressant.	
Alprazolam (Xanax)	Benzodiazepine	Yes- private prescription only, not NHS	Depressant. Used to treat anxiety and insomnia. 10 times stronger than diazepam.	
Amitriptyline (Elavil, Endep, Vanatrip)	Antidepressant	Yes	Depressant. Used to treat nerve pain and help prevent migraines. Higher doses given to treat depression.	
Bromazolam	Benzodiazepine	No- Class C	Depressant. 'Designer' benzodiazepine.	
Chlorpromazine (Largactil)	Antipsychotic	Yes	Depressant. Used for schizophrenia and other psychoses and short-term management of severe anxiety. Sometimes prescribed for chronic hiccups. Used in adults to treat nausea and vomiting and anxiety before surgery.	Longterm use can cause serious movement disorders.
Cocaine	Stimulant	No- Class A		Increases risk of heart strain and respiratory arrest.
Codeine	Opioid	Yes	Depressant. Used to treat pain after an operation or injury or on-going pain when lower strength painkillers have not worked. Also used to treat diarrhoea.	
Diazepam (Valium)	Benzodiazepine	Yes	Depressant. Used to treat anxiety, muscle spasms and seizures or fits. Also, in hospital, to reduce alcohol withdrawal symptoms.	Available illicitly, but no means of knowing what the actual ingredients are.
Dihydrocodeine (DHC Continus, DF118 Forte)	Opioid	Yes	Depressant . Used to treat moderate to severe pain. Also used for long-term pain if weaker painkillers, such as paracetamol, have not worked.	
Flubromazepam	Benzodiazepine	No- Class C	Depressant. 'Designer' benzodiazepine.	
Flubromazolam	Benzodiazepine	No- Class C	Depressant. 'Designer' benzodiazepine. Heavy hypnotic	

			and sedative effects, long-lasting amnesiac effects.	
Gabapentin (Neurontin)	Gabapentinoids	Yes	Depressant. Used to treat epilepsy and nerve pain.	
Heroin	Opiate	No- Class A	Depressant	
Mephedrone	Empathogen-Stimulant	No- Class B	New Psychoactive Substance. Used as part of chemsex.	
Methadone	Opioid	Yes	Depressant. Prescribed as an opiate substitute.	
Mirtazapine	Antidepressant	Yes	Depressant. Used to treat depression, obsessive compulsive disorder (OCD) and anxiety. Drowsiness is a common side effect.	
Morphine (MST, Zomorph, Sevredol, Morphgesic, MXL, Oramorph)	Opioid	Yes	Depressant. Used to treat severe pain e.g., after an operation, serious injury, heart attack or cancer treatment.	
Olanzapine (Zyprexa, Zentiva)	Antipsychotic	Yes	Depressant. Used to treat schizophrenia and bipolar disorder.	
Oxycodone (Oxycontin, Oxypro, Longtec, Reltebon, Zomestine)	Opioid	Yes	Depressant. Used to treat severe pain. Also used for long-term pain if weaker painkillers have not worked.	
Phenazepam	Benzodiazepine	No- Class C	Depressant. Sedative effects and can be used to reduce symptoms of anxiety.	
Pregabalin (Alzain, Axalid, Lyrica)	Gabapentinoids	Yes	Depressant. Used to treat epilepsy, anxiety and nerve pain.	
Quetiapine (Atrolak, Biquelle, Seroquel, Sondate, Zaluron)	Antipsychotic	Yes	Depressant. Used to treat schizophrenia, bipolar disorder and only used for depression alongside other medicines.	
Sertraline (Lustral)	Antidepressant	Yes	Used to treat depression, and sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).	Increases risk of bleeding.
Tramadol (Maxitram, Marol, Zydol, Zamadol, Tramulief, Tramquel)	Opioid	Yes	Depressant. Used to treat moderate to severe pain. Also used for long-term pain if weaker painkillers have not worked.	

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Appendix 3: CIOS Local Drug Information System (LDIS) Update

Cornwall and Isles of Scilly Local Drug Information System Standard Operating Procedure (LDIS SOP) 2023 Update

Introduction

The purpose of this document is to prevent or reduce harm to people of all ages (including young people) who use, or are at risk of using, illicit or illegal drugs.

It describes:

• How urgent or emerging information on new, novel, potent, adulterated or contaminated drugs (or an emerging mode of ingestion) is disseminated with appropriate audiences across Cornwall & Isles of Scilly. This also includes other associated threats to health and drug use such as iGAS (Invasive group A streptococci), Botulism, Hepatitis B, Hepatitis C and Tuberculosis.

• How intelligence will be gathered and assessed to reach decisions about whether and how to disseminate information to appropriate audiences in the Area, as well as South West regional centre. It is important to note that the purpose of this LDIS SOP is not to collect general information. This process is reserved to reduce harm around emerging, dangerous or urgent practice or substances. The LDIS Co-ordinator will ensure this principle is maintained.

Scope of the protocol

This LDIS SOP is based on published PHE guidance for local authority areas on drug alerts and local drug information systems available here: https://www.gov.uk/government/publications/issuing-public-health-alerts-about-drugs

This LDIS SOP has been designed to support and interact with LDIS protocols in other local authority areas, as well as that operated by the South West OHID regional centre. The LDIS SOP is the responsibility of the designated LDIS Co-ordinator to operationalise.

A flow diagram representing the steps within the CIOS LDIS is at Appendix 1.

• A distribution list for stakeholders to the LDIS, relevant to each stage, is at Appendix 2. This includes the name and contact details of the LDIS Co-ordinator and the LDIS Panel.

Protocol

The LDIS SOP process consists of three clear stages:

1. Receiving intelligence (through telephone calls to 07483338752 or DAAT@cornwall.gov.uk)

2. Managing and assessing the intelligence received

3. Responding to assessed intelligence appropriately.

Stage 1: Receiving Intelligence

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Any organisation, person or team that has intelligence about a substance (or mode of ingestion) that meets any of the following criteria is encouraged to report this as soon as possible to the LDIS Co-ordinator:

• Substances causing acute medical, social or emotional harm, particularly new or novel substances • Substances that people say are having uncommon side effects that aren't normally associated with the substance

• Substances that appear to have a spike in purity or strength of their active ingredient/s

• Substances that appear to be branded in such a way so as to mislead the user as to the ingredients • Contaminated substances or substances adulterated with dangerous agents

• An emerging trend of mixing substances or ingesting them in a way that is particularly hazardous to health. Any organisation, person or team that has any intelligence characterised by the above is encouraged to inform the LDIS Co-ordinator immediately, providing as much detail as possible.

An electronic form to do this is at
https://safercornwall.co.uk/download/5900/?tmstv=1688132354

In the event that intelligence is received by other means (e.g. telephone call or email to the local public health team), the LDIS Co-ordinator will provide support to complete the electronic form. Intelligence received by the LDIS Co-ordinator will be subject to a brief initial check. This check rules out any 'hoax' information that the LDIS Co-ordinator identifies.

The LDIS Co-ordinator will then email stakeholders to stage 1 so as to corroborate, confirm or otherwise establish the validity of the intelligence to hand. The email will contain a link to the electronic LDIS tool for the submission of further linked intelligence. The LDIS Co-ordinator will give a brief description of the intelligence received so far, including relevant geographical area involved, and ask for additional relevant information as a matter of urgency. Responses to this stage 1 request are requested within 48 hours. This time frame may be shortened at the discretion of the LDIS Co-ordinator. Emails asking for stage 1 responses will be clearly entitled, "REQUEST FOR DRUG-RELATED INFORMATION - FOR URGENT RESPONSE PLEASE WITHIN 48 HOURS"

An example email communication that is sent:

We have received information from (source) to suggest that (name of substance) has been (sold/used/located/confiscated) in (area of CIOS or South West region). At this stage we are wanting to establish whether there is any additional intelligence from partners in the system to validate the information we have received. Please complete the Reporting Form within (48hrs) with details of any intelligence known by your service

Intelligence received by the LDIS Co-ordinator where there is an already-established evidence base, such as forensic analysis or other confirmed laboratory results, will proceed directly to stage 2 of the protocol for the LDIS Panel to analyse the information and design an alert, if appropriate.

Stage 2: Managing and assessing the intelligence received

Responses made on the electronic form populates a spreadsheet which helps the LDIS Co-ordinator to analyse the intelligence. The grading of the intelligence will be assessed

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against this matrix. The LDIS Co-ordinator will make a recommendation to members of LDIS panel based on the grading process using the matrix. For a decision to be made a minimum of 2 LDIS panel members will be required to make a decision.

Names, job titles and contact details of the LDIS Panel are set out at Appendix 2.

Stage 3: Responding to assessed intelligence appropriately

The LDIS Panel will use the information received to reach a decision about how to respond to the intelligence. It is important to consider both children and adult safeguarding issues as part of the drug alert process.

Possible responses include:

- No further action
- Share for Information Only with certain audiences, but not as a formal drug alert
- Issue a formal drug alert to specific local audiences
- Copy neighbouring local authorities into the information/alert
- Notify OHID South West Centre (because of the regional scope of the alert).

It should be noted that some information warrants sharing with other strategic agencies. These include:

- Novel psychoactive substances should be shared with OHID
- Reportable infections should be shared with OHID
- Information with regional or national connotations should be shared with OHID at the conclusion of stage 2.

Time periods of alerts

Each alert will ordinarily be 'live' for 12 weeks.

Stakeholders to stage 3 of this LDIS SOP will be informed of the date each alert will close, when the alert is issued. However, at the discretion of the LDIS Panel, the life of an alert may be extended if further intelligence warrants.

After 12 weeks, the alert will be classed as 'closed'. If further similar information is received after the 12-week period, the whole process beginning at stage 1 will be put into action. After each alert, a record of any lessons learnt will be made and a note of any onward mitigating actions will be made on the Assessment and Responses sheet to help inform future practise.

Governance of this LDIS SOP

Themes of the alerts and information bulletins resulting from the operation of this SOP will be reviewed on a regular basis by: Cornwall Local Drugs Partnership and Clinical Governance Group.

This SOP will be reviewed after 2 years, or earlier if new national guidance is issued.

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Drug Intelligence and Alerts Process Appendix A

Stage 1 – Reporting

The Local drug information reporting form should be completed and sent to **DAAT@cornwall.gov.uk**.

Stage 2 - Assess and Verify the Information

Any drugs intelligence will be rapidly assessed usually within 24 hours *(see attached flow chart)* but will need to be more rapid if users are dying or there is risk of significant harm. It can also be left until normal business hours if the impact is minimal e.g. an Information Only circulation.

- The intelligence will be assessed using the current PHE national matrix (Appendix B), which includes the following criteria:
- **Local Relevance** (What geographic area is affected? Does the problem seem likely to spread? If very localised and likely to remain so, it will be unlikely to merit wider circulation)
- **Anecdotal report** (Is this supported by other sources)
- **Source of evidence** (Is this a credible source, supported by sound evidence)
- **Forensic evidence** (Is there forensic or other evidence of the drug, potency or contamination involved? If no (or poor) evidence, it will be harder to justify wider circulation of the information)
- **Confirmed Harm** (Are users of the drug being hospitalised or dying? How many? If just a small number of people are feeling unwell, without consistent signs and symptoms, and recovering without any lasting harm, circulating the information may not be warranted)
- **Media focus** (Is the media reporting the story and is it prompting concerns among services and their users? If the media is all over a story and services/users are voicing concerns, it might be more appropriate to circulate the information or consider issuing a harm reduction warning)
- **Potential impact of alert/warning** (Is a warning going to be specific and helpful enough that people can avoid the problem?
- If the information is going to be so vague that it can't really change people's behaviour, or reduce risk, it won't be helpful to circulate it or issue a warning.

Stage 3 – Responding to assessed intelligence appropriately

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Information will be graded according to the information received this will be assessed according to the evidence and graded as follows:

- Weak evidence – Do not consider an alert
- Medium evidence – Only consider if supported by multiple criteria.
- Strong evidence – consider an alert
- Exceptional circumstance – consider an alert.

The full matrix is available in Appendix B.

Possible responses include:

- No further action
- Share information "for information only" but not as a formal drug alert
- Issue a formal drug alert
- Report to the regional and national Public Health team for consideration as a national alert.

Depending on the drug alert, we will aim to supply additional information on the actual drug and the risks to key agencies, such as schools.

The CIOS Drug and Alcohol Action Team will work closely with partners to ensure any necessary support services are in place to manage any actions that result from the alert.

After each alert, any lessons learnt will be recorded and a note of any onward mitigating actions will be made to help inform future practice.

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Drug Alert Process Map

The local drug information reporting form is completed and returned to:
DAAT@cornwall.gov.uk

The intelligence is graded by the panel using the grading and efficiencies matrix. See appendix B.

If an alert is warranted the local drug information reporting form will be disseminated by the LDIS Co-ordinator.
The team will also ensure support is in place if required.

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Appendix A

Local drug information reporting form

Please complete as much of the form as possible and return to **DAAT@cornwall.gov.uk**

Your contact details: if appropriate role and service		
Click here to enter text.		
Location where incident occurred: geographical area and location if known (ie, home, street, nightclub, hostel, hospital)		
Click here to enter text.		
Name of drug: if known, indicate if brand name on packet, street name, chemical name etc.		
Click here to enter text.		
Route of administration: how was the drug taken? (Tick if known)		
Smoked ☐ Swallowed ☐ Sniffed ☐ Injected ☐	(If injected) IV ☐ IM ☐ Skin pop ☐	Other ☐ (please specify) Click here to enter text.
Effect of drug: the effect of drug as described to you		
Click here to enter text.		
How was this effect different from what expected? (eg, lasted longer, was more potent)		
Click here to enter text.		
Polydrug use? Was the drug used with any other drugs or alcohol?		
No ☐ Yes ☐ Unknown ☐	If yes, please list others: Click here to enter text.	
Dosage: how much was taken; if more than one type of drug please list amount for each		
Click here to enter text.		
Cost: please specify if price is for weight, per bag, pill etc.	**Appearance of drug:** (ie, white powder, pill) If available, please attach photograph (next to coin for scale)	
Click here to enter text.	Click here to enter text.	
Concern: please indicate concern (ie, adverse effect, altered behaviour, violence, overdose)		
Click here to enter text.		
Did the incident involve a hospital admission?		
No ☐ Yes ☐ Unknown ☐	If known please specify which hospital, when this occurred, whether still ongoing? Click here to enter text.	
Did the incident result in death or other serious harm? (Give details if known)		
Click here to enter text.		
Where was the drug purchased? (Please tick if known)		
Internet ☐ Shop ☐ Dealer ☐ Friend ☐	Other (describe): Click here to enter text.	
Has this issue or concern been raised by other service users? (How many times?)		
No ☐ Yes ☐	If yes, roughly how many times: Click here to enter text.	
If known, please indicate drug experience of person concerned		
Experienced drug user ☐ Recreational drug user ☐ Naive drug user ☐	Other relevant background information, ie, vulnerable adult, young person (age): Click here	
Any other information		
Click here to enter text.		

Thank you for your co-operation

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Grading and Efficacy matrices

Appendix B
Grading of information received

Grading criteria	Weak evidence Do not consider an alert	Medium evidence Only consider if supported by multiple criteria	Strong evidence Consider an alert	Exceptional circumstance
1. Local relevance	Not locally relevant	Maybe relevant	Locally relevant	Exceptional circumstances
Tick one box	☐	☐	☐	☐
2. Anecdotal report	Anecdotal without support	Anecdotal supported by multiple reports	Anecdotal supported by multiple sources and other criteria	Exceptional circumstances
Tick one box	☐	☐	☐	☐
3. Source of evidence	Unreliable or unknown source, no other evidence	Unreliable but multiple sources or supported by other evidence	Reliable source and specific enough to be of use	Exceptional circumstances
Tick one box	☐	☐	☐	☐
4.Forensic evidence	No forensic evidence	No forensic evidence but other compelling evidence	Forensic evidence	Exceptional circumstances
Tick one box	☐	☐	☐	☐
5.Confirmed harm	No confirmed harm	Potential serious harm or death	Serious harm or death confirmed	Exceptional circumstances
Tick one box	☐	☐	☐	☐
	Boxes ticked in this column are a good indication that an alert **is not** warranted	Boxes ticked in this column are neutral and should be supported by other strong evidence to warrant an alert	Boxes ticked in this column are a good indication that an alert **is** warranted	Exceptional circumstances for one criteria, may make an alert more likely or even justify an alert by itself
Result of grading matrix (no. of ticks)	☐	☐	☐	☐

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Initial decision	☐ **Do not alert** ☐ **Undecided** ☐ **Alert or other actions considered**

Efficacy of alert

Efficacy questions	Do not consider an alert	Efficacy neutral	An alert is more likely	Exceptional circumstance
Information is in the public domain	An alert is unwarranted and press reporting is not causing concern	An alert is unwarranted but press reports are causing concern	As alert is being considered and press reports are causing public concern	An alert is more likely because of intense media and public attention
Tick one box	☐	☐	☐	☐
Will an alert enable avoidance or risk reduction?	An alert would not be specific enough to enable avoidance or risk reduction	An alert would not be specific but generic harm reduction advice is applicable	An alert would enable a drug avoidance or harm reduction response	An alert would not be not specific but other exceptional concerns override
Tick one box	☐	☐	☐	☐
Will an alert be counterproductive ?	An alert is likely to be counterproductive	An alert may be counterproductive but harm reduction message suitable	An alert is unlikely to be counterproductive	An alert is warranted despite the risk of it being counterproductive
Tick one box	☐	☐	☐	☐

Use the answers to the efficacy questions to review the decision and arrive at a final decision recorded below.

Final decision

Final decision	Click here to enter text.

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