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

SAFER CORNWALL
Kernow Salwa

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 2019 to 31st December 2019

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EXECUTIVE SUMMARY

Drug related deaths increased in 2019 by 3 deaths to 31 (+10.7% from 2018). Nationally, in the same timeframe, drug related deaths rose albeit not statistically significantly.

- Twenty-eight people (**90%**) died in 2019 from a death that involved **an opiate drug,** 2 more lives lost than the previous year.

- **Deaths involving heroin** specifically remained at the same level; 22 deaths or 71% of the total cases (-8% from 2018).

- **Cocaine** features in 20 of the deaths (64.5% of the total, +10.5% from 2018). This is the **third successive increase** since 2016 before which it rarely featured. **Cocaine is the only drug to feature in a death where no other drugs are present.**

- **52% of cases in 2019 involved the presence of heroin and cocaine** compared to 46% in 2018. The rise in the number of deaths where cocaine is present have been where it has been combined with heroin. This mirrors evidence that it is being marketed alongside heroin.

- **The highest rate of drug related deaths occurred in the 30 - 39 age group (12 deaths or 39%).** This represents a movement downwards in the average age from the previous two years where the 40 to 49 age group had the highest rate. It also runs against the national narrative that the increase in drug related deaths nationally is associated with an ageing group of users who are getting increasingly unwell.

- In 2018 an anti-depressant medicine was present in twenty-three cases (82%). Whilst mental health is still a significant factor in the drug related deaths for 2019, the number of cases where an **anti-depressant drug** has been found in toxicology **has more than halved to 10 (32%)**.

- Eighteen featured the presence of the **benzodiazepine drug Diazepam** (61% in 2018 with 17 cases). If all benzodiazepines are counted (lawful and illicit), then the number of cases for 2019 is 20 (64.5% and -10.5% from 2018).

- **Alprazolam** featured in 6 cases (21%) in 2018 but has **decreased to 2 cases** in 2019. It has, however, in part, been **replaced by 4**

cases of Etizolam where these two drugs appear to be interchangeable in their illicit use and desirability.

- **77% of cases do not have any alcohol present** within toxicology and this continues the downward trend since 2017.

- Thirty (97%) feature **more than one drug being present** and contributing to the death.

- **There were two more deaths in 2019 where Gabapentinoid drugs** such as Pregabalin featured (14 or 45%) All of these cases involve a combination with an opiate drug as they did in 2018.

- **Twenty people died whilst engaged in drug treatment** (64.5%) or within 6 months of leaving drug treatment and two whilst in alcohol treatment (6.5%) or within 6 months of leaving alcohol treatment (22 cases and **+ 6.7% from 2018)**.

- **No cases** involved a new psychoactive substance **(NPS)**

- There are an **increasing number** of people who have severe **pain issues** from physical conditions who have died from a combination of prescribed medicines and/or illicit medicines/ drugs.

- There are a growing number of cases where **domestic violence** is having an **effect upon women's successful engagement with drug/ alcohol treatment**.

- Some inquests have looked in depth at the possibility of the case being one of **suicide** but have **concluded that they are a drug related death**, there being evidence which falls just short of the legal level required to conclude a suicide.

- **Affected others**, carers of those with drug and alcohol issues and witnesses to drug related deaths **need more support after a drug related death has occurred**. The term 'postvention' has been adopted by those involved in suicide prevention but could equally apply to the prevention of drug related deaths. **Postvention** is a process that has the objective of alleviating the effects of this stress and helping survivors to cope with the loss they have just experienced.

- This report has identified four priorities that should focus preventative strategies going forward;

1. Improved joint working arrangements with regard to **pain management**, including pathways, communications between agencies involved and a drive to involve the patient in a multi-agency approach. Increased professional curiosity so as to identify people moving to the illicit market for pain management medicines.

2. Improved understanding of the interrelationship between **domestic abuse**, drugs and alcohol. Secure adequate understanding of the role of coercion and abuse in drug related deaths, domestic homicide reviews and suicide ensuring this information is included in the inquest process.

3. Greater clarity about and understanding of what is a **suicide** and what is a drug related death. Increased and comprehensive suicide prevention and review across our commissioned services.

4. Scope, identify and improve support systems via a range of options for **affected others**.

INTRODUCTION

1.1 This is the seventeenth annual Drug Related Deaths report for Cornwall and the Isles of Scilly, covering the calendar year 2019. It follows the guidance and requirements by the Department of Health and the Home Office for all Areas to have in place a system of recording and conducting confidential inquiries into drug related deaths within their specific areas.

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

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

1.4 Methodology

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

- Cornwall Drug Related Death Review Panel
- We Are With You Drug and Alcohol Service
- DAAT Clinical Governance Group
- Cornwall Controlled Drug Intelligence Network
- Devon and Cornwall Police and particularly the Drug Liaison Officers
- Cornwall Suicide Surveillance Group
- Office for National Statistics (Deaths Related to Drug poisoning in England and Wales 2019, published 14th October 2020)*. A copy of this report can be found **here**
- HM Coroner's Office
- Multi-Agency Suicide Prevention Group

1.5 Limitations

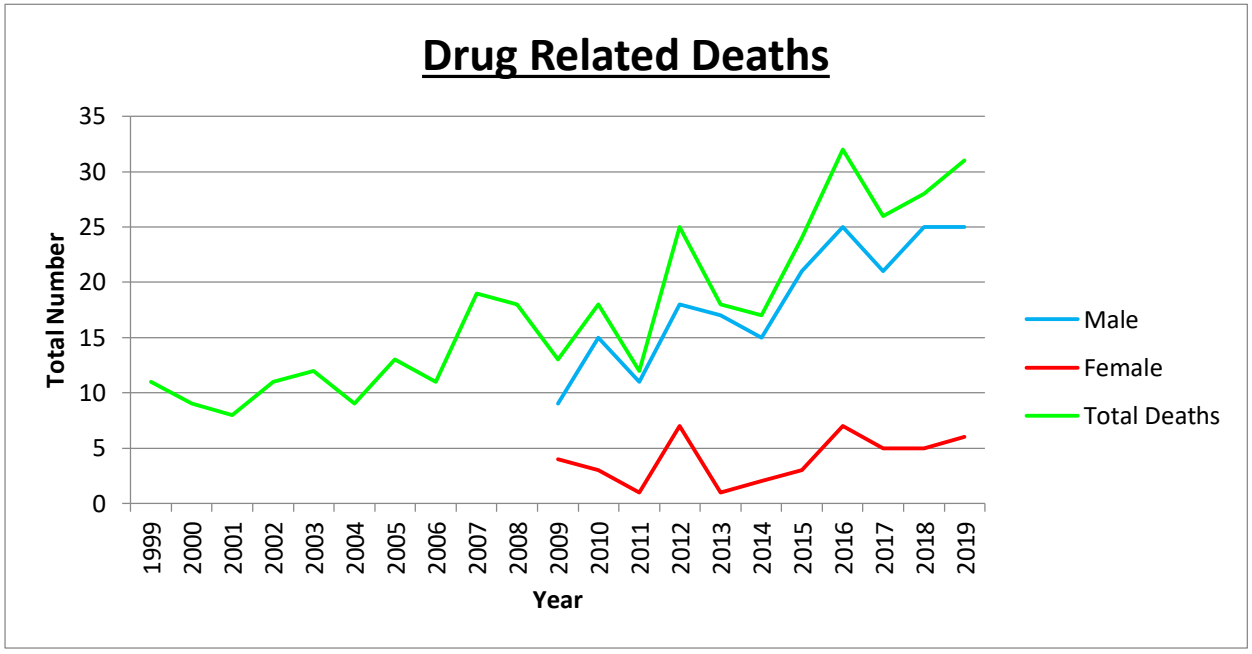
At the time of writing, 7 of the 31 deaths have yet to go to Inquest and to be officially concluded as a drug related death or otherwise. There is sufficient evidence at this stage such as toxicology and witness testimony to be reasonably certain, but status will be revised post Inquest. Certain evidence from GP's and the family may not be known prior to the inquest so there will be future information forthcoming which cannot at this stage be commented upon or be included.

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

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

2. Main Report 2019

2.1 The graph below illustrates drug related deaths in Cornwall from the beginning of 1999, when DAAT records commenced, up to the end of 2019 and shows an upward trend**.**



2.2 National Vs Local

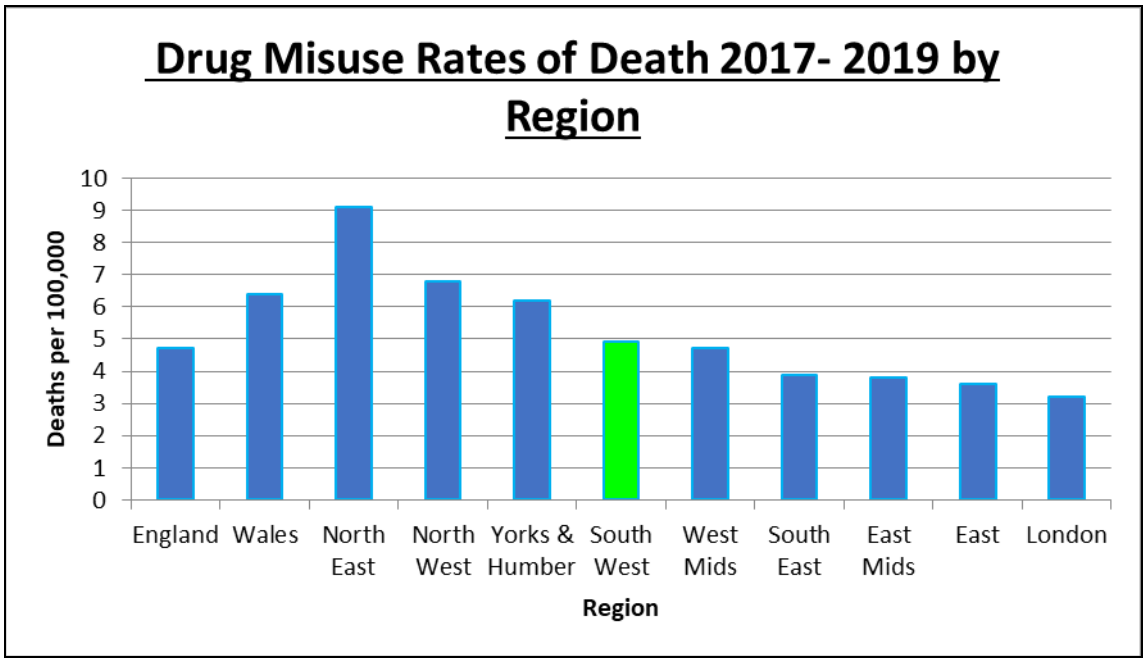
Comparison between ONS 2019 main national headlines and local CIOS data for 2019;

ONS	CIOS
The rate of death relating to drug misuse in 2019 was 50.4 deaths	The rate of increase (10.7%) was

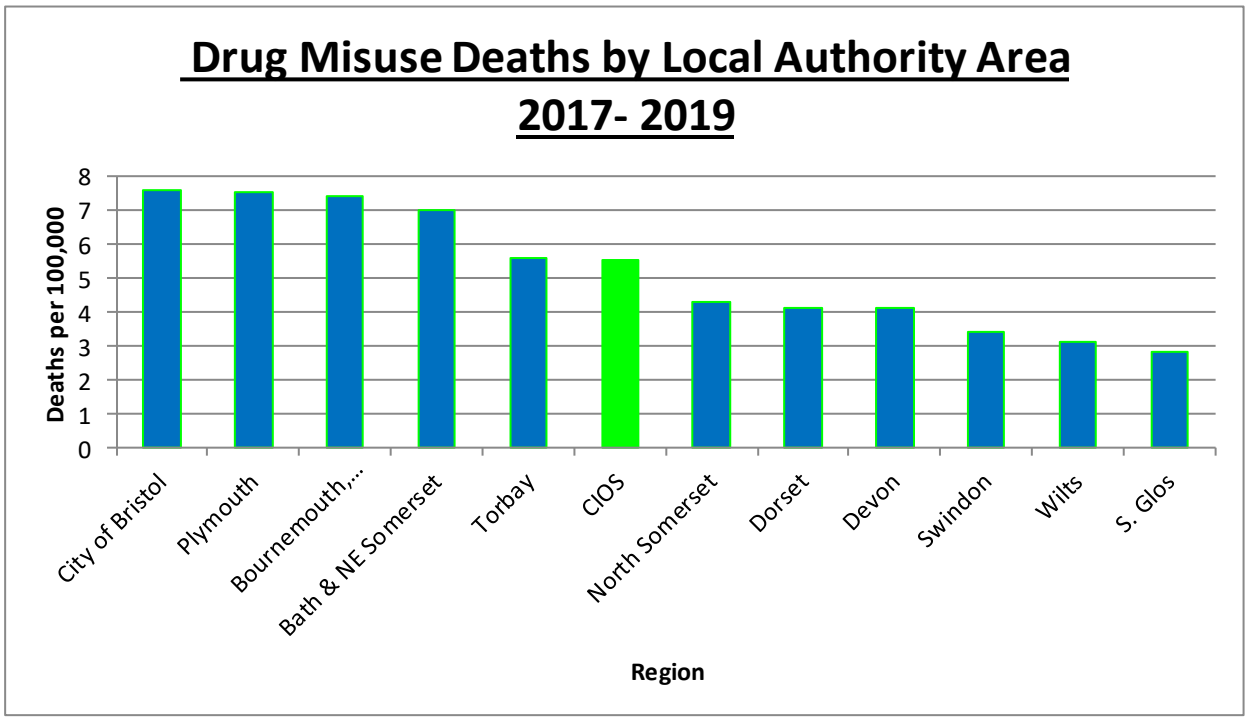
per million people, similar and not statistically different to 2018, where the rate was 50.9 deaths per million people.	higher in Cornwall.
The male rate of drug misuse decreased from 74.7 deaths per million in 2018 to 73.3 deaths per million in 2019. The female rate of drug misuse has steadily been increasing for several years and has now reached a new high of 27.7 deaths per million in 2019, up from 27.4 deaths per million in 2018. Neither change was statistically significant.	The rate and ratio for men is higher in Cornwall (81%), but not statistically different to the previous year locally. One more woman died in 2019, making a total of 6.
Since 2016, people aged between 40 and 49 years have had the highest age-specific drug misuse rate	In Cornwall, the age range has dropped with the 30 to 39 age group having had the highest rate of drug related deaths- 12 cases (39%). The 40 to 49-year-old group now follow with 9 deaths (29%).
Opiates are involved in just under half (49.2%) of drug poisonings registered in 2019, increasing to 62.4% when we exclude deaths that had no drug type recorded on the death certificate. As such, trends over time tend to resemble that of all drug poisonings.	28 people (90%) died in Cornwall in 2019 from a drug misuse death that involved an opiate drug-an increase of 7.7% on the previous year. Deaths involving heroin have stayed at 22. This represents 71% of the total and is down 8% from 2018.
Drug poisonings involving cocaine increased 26.5% for females and 7.7% for males between 2018 and 2019	Drug misuse deaths involving cocaine increased from 1 case to 3 for females and increased 21.4% for males (14 to 17)
Cocaine deaths rise for the eighth consecutive year to their highest level	Cocaine features in 20 of the deaths (64.5%) locally, an all-time high, +10.5% from 54% in 2018. This is the third successive annual increase. Cocaine is second only to heroin as the most prevalent drug in toxicology. Cases involving heroin in

	2019 are at 22, 20 for cocaine with 16 of these cases overlapping.
Fentanyl deaths have remained stable	1 death in 2019, the same as the two preceding years involving prescribed Fentanyl.
Deaths involving new NPS (new psychoactive substances) have remained stable	New psychoactive substances did not feature in any death.

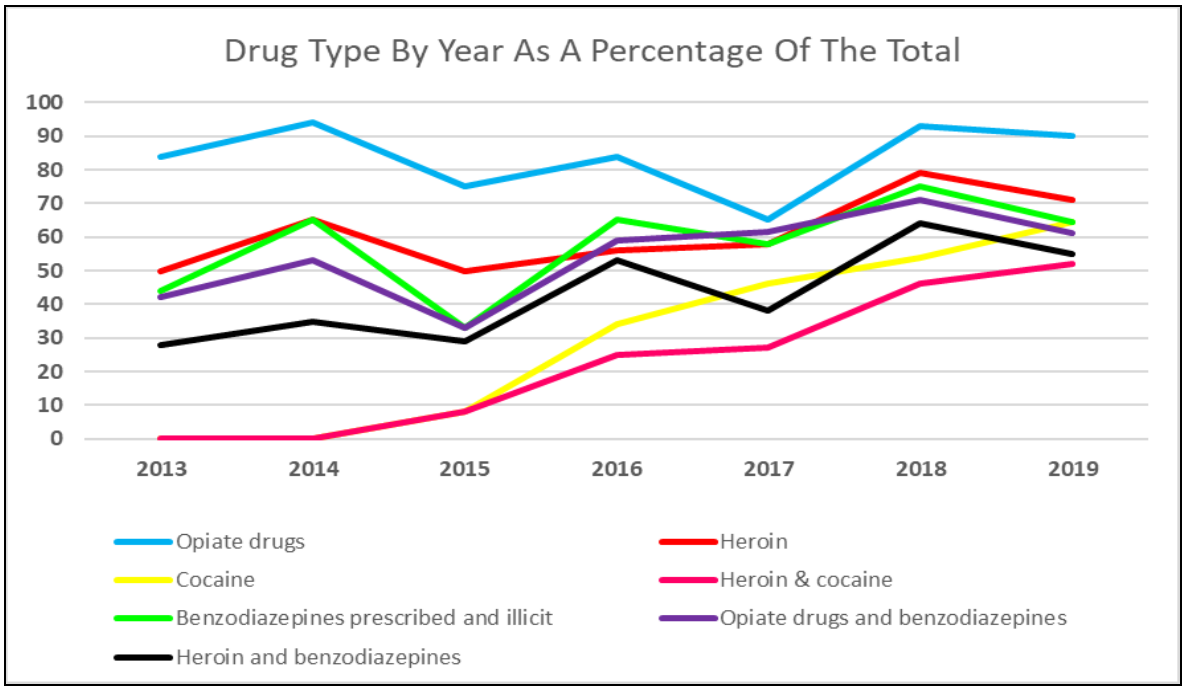
2.3 The graph below shows the South West region of England compared to England, Wales and other English regions over a rolling three-year time frame.



2.4 Further context can be seen below where Cornwall and the Isles of Scilly is compared to other local authority areas in the South West region of England over the same rolling three-year time frame.



2.5 The graph below shows the most commonly found drugs and drug combinations which have been significant in the deaths as a percentage of the total deaths for the respective year over the last seven years. This graph has been informed by the toxicology reports that have been completed for these 176 deaths.



2.6 Poly drug use or synergistic interaction between drugs has again been one of the main findings within toxicology, with only one death in 2019 involving a single drug (cocaine). All other deaths have involved at least 2 substances.

The tables and graphs show the drugs which significantly contribute to drug related deaths but **97% of the cases involve more than one drug**. There are often many complex drug interactions at play with any one case. Toxicology helpfully assists by sometimes being able to state that an individual drug is independently fatal. Where this is impossible to state, the **synergistic interaction between drugs is often the conclusion, particularly with depressant drugs, which potentiate each other.** For example, whether present lawfully or not, Pregabalin can potentiate the effects of heroin and cause premature death. The table at 2.19 shows the range of drugs found in toxicology over the last 3 years and the number of cases that the drug features in. It is entirely possible for a drug related death to feature heroin, for example, but likely that the person who has died has been poisoned by a range of other drugs and the heroin could be considered not as significant as one might ordinarily think. There are **many other factors to consider, however, such as drug purity, tolerance of the drug by the individual and drug interactions**.

2.7 There were 22 **deaths from heroin toxicity or where heroin has been implicated in the death** in 2019 (All these cases involved poly drug use to a greater or lesser extent. As can be seen from the graph at 2.5 and the table at 2.12, the trajectory of heroin in drug related deaths has been slowly climbing over the last 6 years as it has nationally.

2.8 Whilst the proportion of deaths relating to the **presence of an opiate drug** has decreased in 2019 from 93% to 90%, this translates to **2 more deaths in 2019 (26 to 28 deaths)**. Of the opiate drugs present this year, heroin can be found in 22 cases, methadone in 9, morphine and dihydrocodeine in 3, tramadol in 2, fentanyl and codeine in 1 with cases overlapping. As with heroin related deaths, opiate related deaths all involve poly pharmacy. Codeine is normally found in toxicology as a metabolite, indicative of heroin use but the case mentioned here involves a massive overdose of the drug in combination with fatal tramadol use.

2.9 Cocaine* in drug related deaths has **increased for the fifth consecutive year with 20 out of the 31 cases** showing its presence (64.5% and +10.5% from 2018). This is **mainly in the form of crack cocaine** and continues to align with the local intelligence picture surrounding crack cocaine. All services are seeing a greater impact from the effects of crack cocaine in circulation. This includes organised crime supply methods, a changing landscape for vulnerable people being drawn into

criminality and exploitation as well as a cohort of heroin users who now also use crack cocaine. Following the trend of increased presence of cocaine, the combination of **heroin and cocaine** in drug related deaths has also seen **a fifth successive rise from 13 to 16 cases (52% which is +6%).** At the writing of this report, 23 toxicology reports have been received thus far for the drug related deaths of 2020. Of these, 48% show the presence of cocaine.

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

2.10 Deaths from **methadone toxicity,** or where it had been implicated in the death, **decreased for the second successive year** in 2019 to 9 deaths from 12 the previous year. Of those 9, 6 were cases where methadone has been present due to having been lawfully prescribed, the remaining3 involved illicitly sourced methadone. The availability and accessibility of other opiates and particularly heroin, has meant that illicit demand for methadone has not appeared to be as high as previous years.

In 2012, there was an international shortage of heroin, so methadone use and related deaths increased. There has been no such shortage since.

2.11 This next table illustrates the most significant drugs and drug combinations with regard to their frequency in 2019 for male and female deaths.

Type of Drug/Total Number of Drug Related Deaths	**Male (25 deaths)**	**Female (6 deaths)**	**Total Deaths**
Opiate drugs	23	5	28
Heroin	19	3	22
Cocaine	17	3	20
Heroin and Cocaine	14	2	16
Benzodiazepines	17	3	20
Opiates and Benzodiazepines	16	3	19
Heroin and Benzodiazepines	16	1	17

2.12 This table consolidates the previous table and graph at 2.11 and 2.5 adding in gender and case numbers for all years between 2013 and 2019.

	2013	2014	2015	2016	2017	2018	**2019**
Total DRD's	18	17	24	32	26	28	**31**
% Change	+28%	-6%	+41%	+33%	-19%	+7.7%	**+10.7%**
Gender	17M 1 F	15M 2F	21 M 3 F	25 M 7F	21 M 5F	23 M 5 F	**25M 6F**
Age group with highest rate of death	30-39 (39%)	30-39 47%)	30-39 (33%)	30-39 (28%)	40-49 (42%)	40-49 (43%)	**30-39 (39%)**
Opiate drugs	16 (84%)	16 (94%)	18 (75%)	27 (84%)	22 (65%)	26 (93%)	**28 (90%)**
Heroin	9 (50%)	11 (65%)	12 (50%)	18 (56%)	15 (58%)	22 (79%)	**22 (71%)**
Methadone	5 (28%) (all illicit)	5 (29%) (3 prescribed 2 illicit)	5 (21%) (3 prescribed 2 illicit)	5 (15%) (4 prescribed 1 illicit)	13 (50%) (10 prescribed 3 illicit)	12 (43%) (10 prescribed 2 illicit)	**9 (29%) (6 prescribed 3 illicit)**
Cocaine	0	0	2 (8%)	11 (34%)	12 (46%)	15 (54%)	**20 (64.5%)**
Heroin & cocaine	0	0	2 (8%)	8 (25%)	7 (27%)	13 (46%)	**16 (52%)**
Benzo-Diazepines prescribed and illicit	8 (44%)	11 (65%)	8 (33%)	21 (65%)	15 (58%)	21 (75%)	**20 (64.5%)**
Opiate drugs and benzo-diazepines	8 (42%)	9 (53%)	8 (33%)	19 (59%)	16 61.5%)	20 (71%)	**19 (61%)**
Heroin and benzo-diazepines	5 (28%)	6 (35%)	7 (29%)	17 (53%)	10 (38%)	18 (64%)	**17 (55%)**

2.13 Male deaths 2013- 2019

	2013	2014	2015	2016	2017	2018	2019
Total Drug Related Deaths	18	17	24	32	26	28	**31**
Males	17 (94%)	15 (88%)	21 (87%)	25 (78%)	21 (81%)	23 (82%)	**25 (81%)**
Mean age	35	40	40	40	42	40	**39**
Youngest	2 x 21	27	2 x 25	21	19	2 x 21	**26**
Oldest	58	61	63	62	62	51	**61**
Spread of ages	20's- 5 30's- 7 40's- 2 50's- 3	20's- 2 30's- 6 40's- 5 50's- 1 60's- 1	20's- 4 30's- 7 40's- 5 50's- 3 60's- 2	20's- 6 30's- 6 40's- 7 50's- 5 60's- 1	teens 1 20's- 3 30's- 5 40's- 7 50's- 3 60's- 2	20's- 2 30's- 8 40's- 11 50's- 2	**20's- 4** **30's- 10** **40's- 7** **50's- 2** **60's- 1**

2.14 Female deaths 2013- 2019

	2013	2014	2015	2016	2017	2018	**2019**
Total Drug Related Deaths	18	15	24	32	26	28	**31**
Females	1 (6%)	2 (12%)	3 (13%)	7 (22%)	5 (19%)	5 (18%)	**6 (19%)**
Mean age	58	32	40	32	41	32	**39**
Youngest	58	30	32	15 months	32	15	**22**
Oldest	58	34	49	55	45	42	**56**
Spread of ages	1 x 58	2 x 30's	30's- 1 40's- 2	Child- 1 20's- 1 30's- 3 40's- 1 50's- 1	30's- 1 40's- 4	Teens- 1 20's- 1 30's- 2 40's- 1	**20's- 1** **30's- 2** **40's- 2** **50's- 1**

2.15 The **average age of men and women** dying from a drug related death during 2019 is **39**. The age for men has decreased for the second year running but is not statistically significant with the 7-year average being just over 39. Men represent 81% of the total number of deaths (25 out of the total of 31) almost mirroring exactly the proportion of male deaths for the previous 2 years. **Female deaths have risen by 1 death to 6 for 2019** (19% of the total) with the percentage of the total deaths being almost the same for the previous 2 years. **The rate of male deaths is consistently higher in Cornwall compared to the rate for England and Wales**.

2.16 The **highest rate** of drug related deaths in Cornwall has been in the **30 to 39 age group**. Twelve were in this age range (39%). The average age in the last 7 years has not significantly changed, hovering between the higher end of the 30-39-year group and lower end of the 40-49-year group.

2.17 Twenty-four (77%) people did not have any alcohol present. This continues the downward trend since 2017. Alcohol used to be a major factor in drug related deaths.

The remeaning7, where alcohol was present (only 1 where the level is considered significant in its own right) was where it was combined it with central nervous system depressants or stimulant drugs such as cocaine. Four deaths involved a person who was in alcohol treatment and subsequently died of a drug related death. Further detail of these can be found at paragraph 2.23 below.

2.18 2018 saw a considerable number of deaths (23 – 82%) where an anti-depressant medicine was present. Whilst mental health is still a significant and no less a factor in drug related deaths, the number of deaths in 2019 where an **anti-depressant drug** has been found in toxicology has **decreased to 10 (32%)**. Four involve an anti-psychotic medicine and 5 feature a lower level sleeping tablet. Table 2.19 below.

2.19 Drugs Present and/ Or Contributory to Death

The below table lists every substance that has been identified in toxicology over the last three years representing 85 deaths.

Figures in **black** are for **2019**, **red** for **2018** and **blue** for **2017**

Substance	Number of cases for last 3 years
Alcohol	
Alcohol present/ insignificant	**6** **5** **7**
Alcohol present/ significant (above 200 mg/ 100ml)	**1** **2** **3**
No alcohol present	**24** **21** **16**
Illicit drugs, Controlled Drugs and other substances	
Heroin	**22** **22** **15**
Cocaine	**20** **15** **12**
Diazepam	**18** **17** **14**
Methadone	**9** **12** **13**
Etizolam	**4** **1** **0**
Morphine	**3** **3** **1**
Alprazolam	**2** **6** **3**

Cannabis	1 3 5
Amphetamine	1 2 4
MDMA/ MDA (Ecstasy)	1 3 3
Ketamine	2 0 1
Mephedrone	0 0 1
Buprenorphine	1 1 0
Volatile substance (gas)	0 0 1
Other drugs (medicines and illicit)	
Amisulpride	1 0 0
Amitriptyline	1 3 2
Citalopram	3 4 2
Chlordiazepoxide	0 3 0
Clonazepam	1 0 0
Codeine	1 0 0
Cyclizine	1 0 0
Dihydrocodeine	3 1 0
Fentanyl	1 1 1
Fluoxetine	0 2 2
Gabapentin	2 3 0
Mirtazapine	3 6 5
Olanzapine	0 2 0
Pregabalin	12 9 12
Procyclidine	1 0 0
Propranolol	1 0 0
Promethazine	1 0 0
Quetiapine	3 2 1
Sertraline	2 4 1
Tramadol	2 4 0
Trazodone	0 3 1
Venlafaxine	3 0 2
Zopiclone	5 1 1

2.20 Deaths in 2019have highlighted that certain drug combinations, self-medicating (especially in cases of pain management) and availability and accessibility of pain medicines warrant further investigation. Person 22 is an example where the role played by a specific anti- psychotic drug and its pain potentiating effects suggests further investigation.

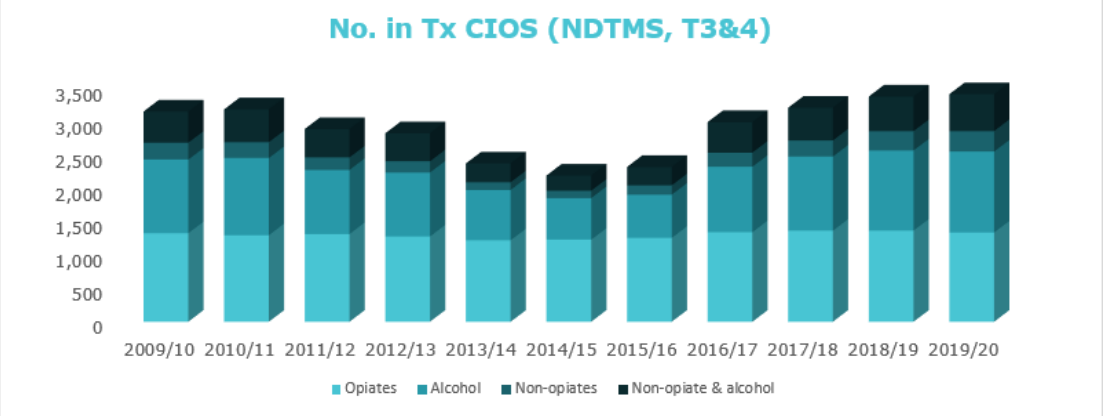
2.21 Gabapentinoid drugs, particularly Pregabalin have become more prominent in toxicology in 2019.Of the 12 deaths where pregabalin has been present, 9 of them also involve heroin with the remainder involving another opiate drug. Whilst Pregabalin can be sought for its potentiating effects with opiate drugs, it is also sought for its standalone impact on pain and mental health issues such as anxiety.

2.22 Alprazolam featured in 6 deaths (21%) in 2018 but **decreased to 2 in 2019**. It has, however, in part been **replaced by 4 instances where Etizolam was present. with** these two drugs appearing to be

interchangeable in their illicit use and desirability. At the writing of this report there has been considerable activity surrounding a range of benzodiazepine drugs on the illicit market in 2020 which have contributed to deaths and many overdoses. Whilst they will be reported upon in next year's report, it is showing that the change from alprazolam, to etizolam and other benzodiazepine drugs is a fluid one driven by demand for illicit benzodiazepines as much as supplier/ dealer tactics.

2.23
Drug Related Deaths and Numbers in Drug and Alcohol Treatment

	2013	2014	2015	2016	2017	2018	2019
Total drug related deaths (people in treatment or within 6 months of treatment and percentage of total)	8 of 18 (44%)	15 of 17 (88%)	14 of 24 (58%)	15 of 32 (47%)	18 of 26 (69%)	18 of 28 (64%)	**22 of 31 (71%)**
In current drug treatment (proportion of total number in treatment)	6 (0.4%)	10 (0.7%)	10 (0.7%)	14 (0.9%)	16 (1%)	15 (0.9%)	**16 (1%)**
Died within 6 months of leaving drug treatment	2	1	2	1	1	2	**2**
DRD and currently in alcohol treatment	0	3	1	0	1	1	**4**
Died a DRD within 6 months of leaving alcohol treatment	0	1	1	0	0	0	**0**
Not known to treatment	10	2	10	17	8*	10	**9**



As can be seen from the table above, the number of people who died whilst being in treatment or within 6 months of leaving treatment has risen from 18 to 22 (64% to 71% as a proportion of the relative year's total). Of the nine who appear in the 'not known to treatment' section, one person was out of treatment for over a year, another for over 3½ years and another had been in treatment elsewhere and moved to Cornwall but had not accessed treatment services.

The graph above shows the numbers in opiate, alcohol, non-opiate and non-opiate/ alcohol treatment over the last 10 financial years in Cornwall. The graph clearly shows that the numbers in opiate treatment have not changed significantly over the years, but the other three categories have steadily increased since 2014/15. This tends to agree with the increasing number of cocaine related deaths since 2015 and cocaine's increased availability. The number of people who have died from a drug related death whilst being in alcohol treatment is slightly up at 4 deaths in 2019. These cases can be examined further in section 3 below; 'Brief Circumstances/ Case Studies 2019'. **The case numbers are 2, 12, 16 and 20**.

2.24 Affected others, carers of those with drug and alcohol issues and witnesses to drug related deaths **need more support after a drug related death** has occurred. The term '**postvention**' has been adopted in suicide prevention and could equally apply to drug related deaths. Postvention is a process that has the objective of alleviating the effects of this stress and helping survivors to cope with the loss they have just experienced. This has been evident in inquests where relatives have expressed being left out of the discussions concerning their loved ones, having a range of concerns that sometimes only get expressed at an inquest and feeling let down by systems and processes. The inquest process is there to assist in the prevention of future deaths and by the very nature of there being an inquest, it does highlight those who are potentially more vulnerable to future mental and physical pain, especially if their issues are not resolved.

2.25 Preventable deaths include those where there is an overt domestic violence aspect to them. Some of the **cases in 2019 include domestic violence** where it has impacted upon the person's ability to properly engage with drug services, for example. It has been highlighted that there needs to be more investigative work done with domestic violence services going forward and incorporate them more into the reporting of cases to HM Coroner. By extension there will be more learning coming from these lives and deaths. **Case 7 below is an example of this**.

2.26 Similar to 2018, **people with multiple problems and vulnerabilities taking their own lives** continues to be a serious issue that requires a multi-agency approach. These deaths are not counted in this

report but often the overlap is very clear. We sit on the Cornwall Suicide Surveillance Group (SSG) and the Multi-Agency Suicide Prevention Group (MSPG). The blurring of the boundaries between what is a drug related death and a suicide, however, can sometimes be difficult to assess. If the evidence does not meet the threshold- on the balance of probabilities- then a suicide conclusion will not be given. If a suspected suicide has involved the subject taking their own life with the use of drugs but the evidence threshold has not been met, then the case will inevitably be concluded a drug related one. Person**16 below is an example of this**.

2.27 Venues where deaths occurred

Venue	Number of DRD's
Home address	11
Home address of another	6
Hospital after an overdose elsewhere	4
Supported accommodation	4
Street, field	3
Licensed premises	2
Squat	1

2019 is no exception to previous years where the home address is the main venue where drug related deaths are occurring. Supported accommodation can be considered for the time being a home address for the purposes of this report. The majority of those who died at home, died alone or were located alone.

2.28 Area of Cornwall where deaths occurred linked geographically to the nearest town;

Area	Number of DRD's
Newquay	**2** (6 in 2018)
Penzance	**4**
Truro	**4**
Camborne	**4**
Redruth	**1**
St Austell	**7** (2 in 2018)*
Bodmin	**2**
Falmouth	**2**
Launceston	**1**
Liskeard	**2**
Callington	**1**

3. BRIEF CIRCUMSTANCES/CASE STUDIES 2019

3.1 Seven of the 31 suspected drug related deaths in 2019 are awaiting inquest hearing by H.M. Coroner for Cornwall. Apart from these seven inquests, all others have been concluded as drug related deaths. Requests have been made following previous DAAT annual reports to include brief details of the individual circumstances regarding places of death, levels of care, treatment of the deceased and the combination of drugs and other substances or other material considered to have caused death. There follows a brief summary of all 31 deaths with any lessons learned;

3.2 **Drug Related Death 1 – Jan 2019**

- 35-year-old man in drug treatment who died at the home address of another
- Cause of death given as 1a. Polypharmacy drug misuse
- Located with a friend who in turn was temporarily residing with his sister in her supported accommodation for those with physical disabilities. Staff were not aware.
- Having taken heroin and pregabalin and, in this man's own words; 'He didn't want to go home as he didn't want his girlfriend to see him in this state'
- The drug treatment risk assessments identified that he was at risk of low tolerance, but these were not reflected in his risk management plan. This was addressed in supervision with the relevant staff.
- Overall this man received good drug treatment, but he did the bare minimum in order to get his medication.

Findings and applying the learning

- Staff at the supported accommodation were made aware of the room's use and they dealt with the situation of the room only being allowed for the use of the lady in question going forward. The venue had a change of practices to ensure that the right people were staying in the premises which included security checks.
- Two people witnessed this man's medical condition worsen and they called the ambulance to assist. The air ambulance in fact attended but he died on scene.
- Many different types of interventions were offered to this man, but he only wanted opiate substitute medication, so he did not engage with most of what was of offer. It is probable that his treatment would have been more effective had he done so.

3.3 **Drug Related Death 2 – Jan 2019**

- 61-year-old man in alcohol treatment who died at his home address

- Cause of death given as 1a. Synergistic central nervous system depressant effects of several drugs
- Alcohol client who died of a drug related death by virtue of high levels of Fentanyl. This was prescribed to him, but the levels are debatable and was put down to a drug related death due to Fentanyl's interaction with a small amount of alcohol and other prescribed medicines in therapeutic amounts
- This was definitely an accidental overdose as this man was being lined up for an alcohol detox that he was looking forward to.

Findings and applying the learning

- This man's GP was gradually lowering the amount of Fentanyl available to him as the GP was aware of the alcohol issues with good liaison between GP and other services.

3.4 **Drug Related Death 3 – Jan 2019**

- 29-year-old man in drug treatment who died in a licensed premises.
- Cause of death given as 1a. Polypharmacy drug misuse
- Body located in a toilet cubicle having been there overnight and found the following morning by the cleaner. Whilst it was usual practice for the staff to check all areas prior to closing for the night, it did not happen on this occasion.

Findings and applying the learning

- Staff at the licensed premises were reminded of their duties accordingly by management.
- In part due to this case, drug and alcohol services began to work toward an 'opt out' culture with regards to Naloxone (a drug used to reverse the effects of opiate drugs), rather than 'opt in'. Evidence has shown that by using this approach, service users are more willing to accept Naloxone, and this has resulted in a significant increase in Naloxone being dispensed across the county, which is hoped will reduce the number of fatal overdoses

3.5 **Drug Related Death 4 – Feb 2019**

- 38-year-old man who was not in drug and alcohol treatment was found deceased at a motel.
- The inquest is awaited but toxicology reveals that this man was poisoned by a fatal amount of cocaine; 4x the lethal amount. This is the only case this year where only one drug has been present in toxicology and been solely responsible for the death

Findings and applying the learning

- As this man was not known to local services and had recently temporarily moved to the area it is anticipated that more information will become available at inquest.

3.6 **Drug Related Death 5 – Feb 2019**

- 43-year-old man in drug treatment who died at his home address
- Cause of death given as 1a. Multiple drug toxicity
- This man had probably been dead for several days, his flat was filthy and full of rubbish, used needles and prescription drugs
- In continuous drug treatment from November 2013 until the time of his death

Findings and applying the learning

- This man had 4 different recovery workers in 2 years. A lot of staff during that period either relocated or moved jobs in the North and East section of Addaction. The North and East locality is now more stabilised with staffing and any transfers of service users to a new recovery worker are far more efficient with recommendation that the old and the new workers are involved in joint meetings with the client.
- Urine screening was not as regular as it should have been in this case and this was addressed in keyworker learning and supervision. From this case forward urine screening and drug testing is to be covered in routine staff supervision adhering strictly to drug treatment recommended time frames on testing.
- Whilst the lack of engagement in the psychosocial elements of treatment was sustained, there were appropriate responses documented to missed appointments and failed medication collections throughout his treatment history including follow ups to check on welfare by letter, phone and text, which was how concerns were raised to locate this man on this occasion, unfortunately with the outcome of him being discovered deceased.
- It was noted that there was no prescribed treatment agreement on the man's drug treatment record which would be a good way to revisit the expectations of treatment and highlight the importance of engagement in all elements of treatment.

3.7 **Drug Related Death 6 – Feb 2019**

- 33-year-old man in drug treatment who died in supported accommodation
- Cause of death given as 1a. Toxicity of multiple drugs
- Heroin was used alone in this man's room despite him regularly being made aware of the risks involved with this.

- Two other residents of the supported accommodation were aware of this man using heroin alone in his room, but they did not check up on him.

Findings and applying the learning

- All residents were alerted to making sure that they check on those who might be using heroin and reminded of initial first aid and naloxone interventions. This particular premises and their staff and residents are well known for having a robust policy in relation to naloxone availability and administration of it. They have saved many lives as a result of their openness and forward thinking so when an incident such as this happens, the entirety of the project feels the effects.
- Although this man had given up his buprenorphine prescription, he was being assessed and tested days before his death to return to a regular opiate substitution treatment prescription.

3.8 **Drug Related Death 7 – Feb 2019**

- 41-year-old woman in drug treatment who died in hospital after a drug overdose in the street.
- Cause of death given as 1a. Bronchopneumonia and hypoxic brain injury 1b. Cardiac arrest secondary to poly drug toxicity
- Fatal overdose of drugs taken with another person in a car witnessing the overdose- that person appears to have decamped the scene. Taxi driver attempted CPR before ambulance arrived.
- This woman experienced domestic violence and was subjected to coercive behaviour. She disclosed this to her drug treatment workers, and it was witnessed that her partner would lurk in the background when she sometimes had treatment sessions. She wanted to recover and had recently got a new job, so the partners involvement was detrimental to this recovery.
- There was evidence of a good working relationship between drug services and domestic violence services

Findings and applying the learning

- It is recommended that the DAAT review the domestic violence and sexual abuse treatment more thoroughly going forward in line with how the drug treatment is reviewed and incorporate this with the reporting to HM Coroner thereby increasing the potential for learning.
- The above point has already commenced with a notable increase in cases during 2020 that crossover between drug related death and domestic violence. The DAAT now being part of the same team as the DA/SV services will allow for a more in-depth analysis of future cases. DAAT and Public Health are to assist a domestic homicide review starting in late 2020 where part of the learning will focus on a joint approach to

investigating deaths where suicide, mental health, drugs and alcohol and domestic abuse/ sexual violence have been at play.

3.9 **Drug Related Death 8 – Mar 2019**

- 46-year-old man who had been extensively in drug treatment out of county died at the home address of his parents where he was seeking to detox himself with parental support
- Cause of death given as 1a. Toxicity due to multiple drugs
- 16-year history of heroin use and this death was as a result of a combination of heroin and cocaine.
- Very supportive family but through no fault of their own this man was able to overdose on one occasion 3 to 4 weeks before he died and the fatally in March 2019.
- When he had opportunity and was alone in the house, he travelled to Bristol to buy drugs and returned to Cornwall to use them.
- Likelihood of reduced tolerance due to less usage of drugs whilst he was with his parents and abiding by the self-imposed but informal drugs detoxification

Findings and applying the learning

- This well-intentioned family were doing their best to keep their son safe and trying to get him off of drugs. They were not able to be with him every minute and he was able to purchase drugs. In hindsight, a better way would have been to refer him to local drug services in Cornwall so that he and the family had support and expert guidance.

3.10 **Drug Related Death 9 – Mar 2019**

- 39-year-old woman who had been out of drug treatment for over 3½ years died at the home address of another
- Inquest awaited
- Visited a friend for an evening of drinking, fell asleep in a chair and was discovered the following morning unresponsive
- Evidence from the witness at the scene has yet to be seen and tested at coroner's court so at this stage it is difficult to assess what the learning is.
- What we do know is that this woman died of a fatal combination of heroin, cocaine, ketamine, illicit methadone and other medicines. She did not have alcohol present in her post-mortem toxicological screen.

Findings and applying the learning

- Inquest and evidence/ information coming from it is awaited.

3.11 **Drug Related Death 10 – Mar 2019**

- 30-year-old man in drug treatment who died in hospital after an overdose at a friend house where he was staying for the night
- Cause of death given as 1a. Polydrug toxicity 2. Bronchopneumonia.
- This man had recently been referred to drug treatment and had received only one treatment session before his death.
- Staying with a friend after a domestic dispute with his partner. He was found by his workmate in bed not breathing; CPR started and continued on paramedic arrival.
- Self-referred for cocaine use but decided on his first treatment session that he no longer needed help
- Many drugs present in his toxicology including heroin, cocaine, illicit methadone and other medicines.
- Lack of tolerance to opiates likely to have been an issue

Findings and applying the learning

- Addaction (now known as We Are With You) were unable to work with this man as he decided that he no longer needed support after only one session of treatment. They were, however, surprised at this death not least that this man did not disclose any use of opiate drugs nor any other drug other than cocaine to them.
- The rise in crack cocaine use since 2016 has in part led to crack cocaine training being laid on by WAWY for their staff with invites to DAAT, Bosence Farm staff, police and other agencies. This quality training was given by Kfx training facilitated by Kevin Flemen. Good networking opportunities with wide range of topics such as current organised crime group methods, cocaine and the county lines situation.

3.12 **Drug Related Death 11 – Apr 2019**

- 49-year-old man who was not in drug and alcohol treatment and died in a field.
- Cause of death given as 1a. Myocardial fibrosis and 2. Cocaine use
- Despite a medical history of a drugs overdose, alcohol and drug abuse including intravenous heroin use, crack cocaine, diazepam and pregabalin, he was not known to local drug services.
- Last seen alive on 21/4/19, reported missing 24/4/19 and found deceased 27/4/19.
- Reportedly overdosed 6 days before he went missing on illicit methadone.
- This is another of the increasing number of combined heroin and cocaine related deaths

Findings and applying the learning

- Little detail coming from the inquest with no obvious learning. The condition of this man's heart, however, showed that he was not in good health even before worsening his situation with a wide range of drugs. It is likely that the cocaine was significant in this death due to his heart condition although synergy of drugs also played a part.

3.13 **Drug Related Death 12 – Apr 2019**

- 35-year-old man who was in alcohol treatment died at his home address
- Cause of death given as 1a. Etizolam overdose and ethanol toxicity
- This man used the social media platform Snapchat two days before he died to say that he was to take his own life, but this apparently happened a lot, so he was not taken seriously.
- High alcohol with cocaine and etizolam death.
- Only with WAWY for 3 months and he self-referred for alcohol only with no mention of drug use. No assessments were made, and he was going to be discharged from treatment.
- Relationship breakdown prompted his self-referral.

Findings and applying the learning

- Identified that there was a lack of drug treatment staff at the time in the Bodmin area but not thought to be related to this death. Minor learning point that WAWY staff should always offer a full range of access options and fully evidence this in the HALO notes.
- WAWY were unaware of this man's use of the potent benzodiazepine drug etizolam and cocaine which were present in toxicology. To that end they could not start to support him in his use or offer harm reduction.

3.14 **Drug Related Death 13 – May 2019**

- 32-year-old man who had been out of drug treatment for over 12 months and died at his home address
- The cause of death was 1a. Heroin poisoning
- Initial report to police was that this man was an ex-heroin user. With a 12 months period of him being out of drug treatment there is insufficient information to paste together what might have caused this fatal relapse in his drug use.
- Male lived at home with his parents. He was last known to be alive at 2300 on the night before he died when he spoke to a neighbour on the phone. Next of kin heard him snoring at 0700 the following morning and attempted to enter his room but felt resistance; they assumed that the door was locked and went about their daily activities. At about 1100 they went to check on him again and found him lifeless on his bed.

Findings and applying the learning

- There is a fine line between what could be construed as a 'normal' snore and one which is indicative of a person having problems breathing. It will never be known at what point this man was when he was heard snoring at 0700 but he died within 4 hours of that point. Previous outreach events and awareness training generally have been carried out in Cornwall and continue with WAWY's drug treatment where snoring is flagged up as a possible warning sign when people use opiate drugs. This is on-going and this case is a tragic reminder of its importance as an indicator of someone needing help.

3.15 **Drug Related Death 14 – May 2019**

- 37-year-old woman who was in drug treatment and died at her home address
- Cause of death given as 1a. Multiple drug intoxication.
- Died 6 days after the inquest of her husband's inquest who also died of a DRD.
- Friend of this woman was at the scene and both injected heroin together.
- Very good outreach and persistence from WAWY staff who maintained this woman in treatment as she would regularly not attend meetings and interventions. She had informed drug treatment staff that she was mistrustful of services as she did not want her son taken away from her with whom she had a good relationship.
- This woman did not speak of her drug use which hampered treatment somewhat. Multiple services involved not least because of her son who has now lost both parents to a drug related death.

Findings and applying the learning

- Son was identified as a young carer and he received support from the young person's service offered by WAWY to this end.
- Despite mistrust issues, this woman developed an effective working relationship with her recovery worker and the family worker, and this was acknowledged within the record whereby she felt able to ask for help, discussed matters that were of concern to her and maintained regular contact. The family worker had a close working relationship with the school, and they were in regular contact regarding the son's welfare.
- A graphic case of the ripple effects emanating from a drug related death(s) and affected others.

3.16 **Drug Related Death 15 – May 2019**

- 47-year-old man who was in drug treatment and died in hospital after an overdose in his hometown
- Cause of death given as 1a. Morphine (heroin) intoxication
- Heroin and diazepam death.
- In treatment from 2002 until his death so a long history with Addaction (WAWY) and previous Cornwall Drug and Alcohol Team (NHS).
- Early trauma- his mum left home when he was aged 10, is dad was abusive towards him and he left home to live with a friend at 14. His friend fell overboard whilst working as fisherman and died. This man's drug use drugs then escalated at that point after his early use of drugs and alcohol.

Findings and applying the learning

- Very long and continuous drug treatment history which saw this man being offered a wide range of services.
- This man benefitted from treatment at Bosence Farm completing work within the 12 steps programme up until end of April 2019 and then was discharged successfully. He continued to attend daily either Narcotic Anonymous or Alcohol Anonymous groups.
- Furthermore, he continued to receive 'After Care' support from Bosence Farm with sessions attended at the end of April and three sessions in May.

3.17 **Drug Related Death 16- May 2019**

- 28-year-old man who was in alcohol treatment and died at his home address
- Cause of death given as 1a. Morphine overdose
- Alcohol service user who died of an accidental morphine overdose after having tried to self-medicate due to a couple of days of diarrhoea and vomiting.
- Comprehensive range of treatments offered to this man during treatment for alcohol issues.
- Emotionally unstable personality disorder, PTSD from childhood experiences, obesity, low mood from alcohol dependency. Self- harm and overdose history.
- Died on the anniversary of the breakup of his marriage.

Findings and applying the learning

- WAWY recommended in hindsight that this man could have benefitted from more proactive outreach as he was ambivalent and sometimes erratic in engagement. That said, he was in alcohol treatment and this

accidental overdose by trying to self-medicate could not have been foreseen.
- This case was very nearly a suicide conclusion and perhaps was a suicide but there was insufficient evidence to conclude this ultimately. This man previously had been found on an overbridge threatening suicide and the death being on an anniversary are both evidence of his state of mind.

3.18 **Drug Related Death 17- June 2019**

- 42-year-old man who was in drug treatment and died in supported accommodation
- Cause of death given as 1a. Multiple drug toxicity
- This man developed sepsis and had long lasting effects from this. He had reported bleeding from orifices for a long period of time due to organ damage caused by the sepsis.
- He had openly talked about his drug misuse stating that the combination of his alcohol use and intravenous heroin use placed him at continuous risk of overdose.
- He had presented as intoxicated at his last keyworker appointment two days before he died and talked about how much he loved taking drugs and that he did not intend to stop using them. He added that returning to work may increase his drug use as it would provide him with a bigger income.
- He came into compensation monies paid just five days before his death.

Findings and applying the learning

- This man's drug treatment keyworkers took a multi-agency approach to his care, working closely with his GP and housing support staff in order to reduce risks. The compensation payment shortly prior to his death significantly increased his drug use and associated risks which in turn fatally impacted upon his life.
- Ironically, the drug treatment team were fighting against this man's unwillingness to give up using drugs but were very aware of his situation due to his openness so could employ tactics to try and keep him safe to a point.

3.19 **Drug Related Death 18- July 2019**

- 54-year-old man who was in drug treatment and died at his home address
- The cause of death was given as 1a. Upper gastrointestinal haemorrhage 1b. Ruptured oesophageal varices but this case did not go to inquest with HM Coroner finding that this was a natural cause death.
- This man used heroin at his flat with others. They witnessed him react badly to the heroin which they mistook for alcohol withdrawal, but they

did administer naloxone and CPR. Ambulance called who also administered naloxone.
- He did not work well with an appointments system and was in and out of homelessness. He only contacted WAWY on an absolute needs basis, for example when he needed funding for housing or benefit support and was not good at keeping appointments or adhering to various treatment options.

Findings and applying the learning

- Regular home and outreach visits were completed as a way of trying to keep this man engaged in treatment and is accepted as best practice.
- Despite high levels of heroin and cocaine being present in toxicology this was concluded to be a natural cause death. This case was carefully considered by the CIOS Drug Related Death Review Panel and it was decided that this case should still be a drug related death despite the inquest conclusion as it still fit within the definition of a drug related death (see paragraph two of the executive summary in this report).

3.20 **Drug Related Death 19- July 2019**

- 45-year-old man who was in drug treatment and died in supported accommodation
- Cause of death given as 1a. Mixed drug intoxication and 2. Pneumonia
- Early drug use included starting to use cannabis age 14; began combining heroin and amphetamine around age 17; stopped amphetamine use age 21 but continued with heroin use. Interspersed with heavy consumption of alcohol. Long term use led to many illnesses and related issues.
- Housemates found this man collapsed during the evening in the communal kitchen and helped him to his room where he said he was fine. Later his neighbour heard a bang and went into the room and found him slumped forward on a table. There was evidence of drug use and the man was conscious and breathing so was helped to bed. He was found deceased the next morning in his room.
- There does not seem to be follow up care where his condition and possible use of drugs were known to others in the building with opportunities missed to prevent him overdosing.
- This man had a number of physical health complications, vascular, cardiovascular and pulmonary, relating to long term intravenous drug use which were treated on a number of occasions in a primary healthcare setting. This included being treated for pneumonia in the critical care wards of RCHT. He was discharged from RCHT and collapsed 5 days later after poly substance misuse including using 4 opiate drugs. It is presumed that his opiate tolerance was low at death due to his stay in hospital.

Findings and applying the learning

- This man was regularly given advice regarding the risks relating to a continuation of intravenous drug use by his non-medical prescriber and keyworkers. He attempted to address this by smoking rather than injecting illicit heroin but this in turn caused his COPD to worsen.
- The recent hospitalisation shortly before death made this man even more vulnerable to the negative effects of opiate drugs
- In completing a comprehensive review of the treatment records for this man, appropriate care and support were provided by the drug treatment team both in terms of psychosocial interventions and opiate substitute treatment prescribing. He attended regular prescribing reviews, was tested for BBV's, given Naloxone training and provided with take home Naloxone. He was offered and accepted detox, referred to Intuitive Recovery and signposted to NA meetings. Risk assessments and care plans were updated every 3 months and changes in client presentation were noted with a risk management plan in place to manage this.

3.21 **Drug Related Death 20- July 2019**

- 36-year-old man who was in alcohol treatment and died at his home address
- Inquest awaited
- Oramorph availability is the main issue with this case with the question of an alcohol service user having access to a large amount of liquid morphine.
- This man was able to drink 2 bottles of Oramorph before his girlfriend was able to take another bottle away from him.
- Oramorph prescribed for back pain.
- Inquest adjourned for call this man's registered GP and a locum to inquest.
- Evidence of a previous deliberate overdose.

Findings and applying the learning

- As this case is at the pre-inquest stage, the information has yet to be fully heard in front of HM Coroner in which case all issues are subject to testing and confirmation at this writing of this report but the case has been deemed serious enough for HM Coroner to insist that two GP's attend inquest to be cross examined about the availability of morphine.

3.22 **Drug Related Death 21- July 2019**

- 56-year-old woman who was in drug treatment and died at the home address of another

- Inquest awaited
- Cause of death given as 1a. Myocardial Fibrosis and 1b. Cocaine Abuse.
- Not a conclusive tox screen but there is the presence of Ibogaine where this woman was apparently trying to self- detox from heroin.

Findings and applying the learning

- The scientific evidence (toxicology and pathology) has yet to be heard and cross examined but a key part of this will be the role played by a drug called Ibogaine.
- Ibogaine is a naturally occurring psychoactive substance found in plants in the family Apocynaceae. It is a psychedelic drug with dissociative properties

3.23 **Drug Related Death 22- Aug 2019**

- 41-year-old woman who was not in drug or alcohol treatment who died at her home address
- The cause of death was given as 1a. Drug overdose 2. Bronchopneumonia
- Issues of long-term pain and feeding issues due to bariatric surgery.
- Long-term use of non-prescribed medicines which she would buy from anywhere.
- Latter evidence of social media platform WhatsApp purchases of drugs from men around the country- Oramorph liquid, MST tabs, Severedol and other non-prescribed medicines found at the scene.
- Pain clinic deemed her not suitable for further pain clinic work which GP tried to overturn.
- Many issues including physical and mental health, looking after an autistic child. Psychosis of emotionally unstable personality disorder. Overweight person who went into underweight quite quickly.
- Family reiterated that she would abuse prescription and non-prescribed medicines over long periods of time.

Findings and applying the learning

- Psychiatrist questioned the role of the anti- psychotic drug Quetiapine due to the possibility of it leading to further abdominal pain. As she had lots of pain issues anyway this is to be brought to the CIOS drug related death review panel to assess this. Inquest was heard at the end of October 2020, so elements of her treatment record had not been heard up to this point. DAAT will engage with the RCHT Pain Clinic and Psychiatric Liaison to see what the learning is here and will form part of the recommendations in this report.

3.24 **Drug Related Death 23- Aug 2019**

- 49-year-old man who was in drug treatment died at his home address
- The cause of death was given as 1a. Mixed drug overdose with synergistic pathological effect 2. Hypertensive and obesity related cardiomyopathy with a BMI of 33 and fatty liver change
- Lots of opiates used by this man for back pain.
- Childhood sexual abuse, social anxiety, heart condition and chronic back pain.
- Lots of evidence for good inter-agency working between CMHT, GP and WAWY.
- At the time of death this man had an open record with local drug treatment services but had not been seen in person and an assessment had not been undertaken. Over the course of the three times that he was open to them, on each occasion he did not progress to a stage where he engaged with an agreed course of structured treatment. All three episodes were brief.

Findings and applying the learning

- This is one in a growing number of cases where the issue of physical pain has been the driver in the person seeking medication from lawful medical sources and illicit. This is continuing through some of the cases already seen in 2020. This needs to be a focus for the future. The inclusion of the pain consultant from RCHT at drug related death review meetings over the last couple of years has been enormously helpful and he will be invaluable going forward in identifying what progress can be made in alleviating pain in cases such as this.

3.25 **Drug Related Death 24- Aug 2019**

- 37-year-old man who was in drug treatment and died at the home address of another
- The cause of death was given as 1a. Mixed drug overdose 2. Bronchopneumonia
- This was a person who was difficult to manage as he was in and out of prison and prone to behavioural issues that included violence against those looking after him. Housing therefore was a perennial problem for him.
- He was with another when he died and they both used heroin together. Naloxone was used by a third party but too late as this man was not monitored after using heroin. Witness who also used heroin stated that it was strong heroin.
- Out of prison for 2 months before he died but housing issues were being seriously looked at

- April 2019 he was admitted to RCHT with an attempt on his life by poly pharmacy overdose with a suicide note left.

Findings and applying the learning

- With Housing First now able to work more intensely with clients such as RD it is hoped that fast tracking to accommodation may help to offset issues such as are highlighted in this case
- Many referrals to Outlook SW too address his mental health were made including one after the suicide attempt but there was no engagement by him
- Lots of work done with him by a number of agencies but he was prone to scuppering help with his behaviour.

3.26 **Drug Related Death 25- Aug 2019**

- 22-year-old woman who was not in drug or alcohol treatment and died at her home address
- The cause of death was given as 1a. Mixed drug overdose
- Massive levels of Tramadol and codeine both being potentially fatal independently
- Dr attended inquest due to family concern about the amount of codeine available to their daughter. Fatal tramadol amounts were from illicit sources.
- This woman was in regular receipt of a prescription for 100 codeine tablets at a time and the GP stated that her medical record was regularly reviewed. All prescribing was reviewed by the GP to be within guidelines and recommendations.
- Baseline tox levels were probably very high with high tolerance to codeine but the level in toxicology was four times the lethal level.
- She could have sourced online extra codeine as well as she did with tramadol.
- MH with emotionally unstable personality issues.

Findings and applying the learning

- Mental health appointments were sent to the wrong address but were backed up with text messages to the correct mobile phone.
- Family were concerned about their daughter's drug use from prescriptions and felt let down.
- Hospital were doing tests and bloods for on-going leg pain. Process of elimination as to why the pain persisted. Hospital only issued 7 days' worth of codeine.
- GP stated all meds were in keeping with legislation, appropriateness/ guidelines for her reported pain issues.

- Changed from co-codamol as GP was worried about how much paracetamol this woman was consuming with her codeine.
- This inquest led to a discussion with the Controlled Drugs Accountable Officer (CDAO), and Medication Safety Officer NHS England & NHS Improvement (South West) whereby this and other recent cases in 2020 have involved morphine medicines at highly elevated levels and prescribing. The CDAO will be kept appraised of these cases particularly when they go to inquest so that he may attend inquest to hear the evidence. There will be more of a dynamic feed to the SW Controlled Drug Intelligence Network this way and will allow for another form of expertise to hear the evidence and disseminate the learning.
- On-going work in relation to the appropriateness of opiate medicines and chronic pain.
- There does not appear to have been a consideration for this woman to be referred to drug services for her overuse of painkillers. Perhaps professional curiosity might have considered another approach to her pain management. This case highlights the number of people that have pain issues that get out of control and yet have no access to treatment that looks into issues around their pain over and above the level of pain.

3.27 **Drug Related Death 26- Sept 2019**

- 50-year-old man who was in drug treatment and died in supported accommodation
- The cause of death was given as 1a. Methadone toxicity
- Ante mortem serum tox, hypoxic brain injury.
- Two overdoses in his room in July which were successfully intervened by project staff. This man admitted to purchasing and using illicit medication which included high strength benzodiazepine drugs in both of these overdoses.
- Even though the cause of death was given as methadone toxicity this man was on a 60ml methadone per day prescription and the toxicological metabolites reflected comparable use of this prescription. Metabolites of other medicines and illicit drugs were also indicated.
- Diabetes, asthma, hep C, alcoholic cirrhosis, nerve compression in back, paracetamol overdoses, heart disease.
- Surrounded himself with friends who, in his own words to treatment staff, 'engaged in self- destructive behaviours'.

Findings and applying the learning

- Pain issues very much in evidence again in this case with a wide range of ill health evident.
- Father of the man made the point that this supported housing did not employ the same level of support at evenings and weekends, so residents did not have the same level of support perhaps when they need it. This

premises used to have all night support, but it was very underused and financial cutbacks meant that this facility had to be removed. In its place, however, came all night security with certain training to support residents including first aid and awareness/ use of naloxone. The views from the father will be fed to an up-coming contract review meeting where staff will be asked their opinions as to the support offered to residents. This information from the father was only brought to the attention of the DAAT at the inquest in late October.

- This man was a well-liked resident whose death shook the staff even though they were fully aware of his chaotic lifestyle and how they had to save his life on previous occasions.

3.28 **Drug Related Death 27- Sept 2019**

- 26-year-old man who had been drug treatment the previous 6 months and died in public toilets.
- The cause of death was given as 1a. Morphine toxicity
- This man had a friend outside of the toilets who raised the alarm when he found his friend collapsed
- Toxicology revealed the presence of alcohol, heroin, cocaine and other medicines
- This man presented with significant issues of past trauma and bereavement which were linked with his substance use; he suffered further trauma and loss within his time within the service
- This man began to disengage with his drug treatment with part of the reason given that his ex-partner had died out of county. Despite many various attempts to re-engage him including via his mother his record was closed. A new keyworker continued with the attempts to re-engage him to no avail.

Findings and applying the learning

- Transience presented a challenge to regular contact and attendance at appointments, as well as to establishing his whereabouts and welfare at any given time. This also presented challenges to supporting wider elements of treatment and recovery, including his initial stated desire to retrain in trades other than his background as a chef
- This man's mother is recorded as a consistent source of support to him in both re-engaging him in treatment, attempting to provide a safe and stable place for him to reside and also in terms of working with treatment staff to contact him.
- The case underlines the need for support to affected others and is an area where the DAAT drug related death prevention co-ordinator is keen to re-enter as soon as the restrictions on movement due to Covid-19 are relieved. Online forums are a short-term way forward with this, however.

3.29 **Drug Related Death 28- Oct 2019**

- 32-year-old man who was not in drug or alcohol treatment and died at his home address
- The inquest is awaited
- It appears that, subject to coronial finding, this man was addicted to painkillers and would supplement his prescribed medicines with over the counter medicines for pain. He was being treated for back pain.
- Another example of someone becoming dependent upon painkillers through pain becoming an overwhelming part of their life.

Findings and applying the learning

- Due to there not being full knowledge of the facts as yet in this case due to it being pre-inquest any learning is not known at the writing of this report. It is yet another case, however, which underlines a need for pain management to be focussed upon where possible and a multi-agency approach to it. This will be one of the cases which informs that focus.

3.30 **Drug Related Death 29- Nov 2019**

- 28-year-old man who had been out of drug treatment for 3 months and died in hospital after an incident at his home address
- The inquest is awaited
- Heroin and crack related death according to toxicology
- He was evicted from his supported accommodation for drug possession and then he was attempted to be re-engaged by We Are With You but he said that he was doing well and did not need treatment at that time. There followed a 3-month period prior to his death where it is not known what exactly was happening to him in relation to his drug use and related issues.
- Early indication that this man was found by a friend after injecting a 'brown drug'.

Findings and applying the learning

- As per other awaited inquests there is learning that is yet to come from hearing the full evidence in this case.

3.31 **Drug Related Death 30- Nov 2019**

- 30year old man who was in drug treatment and died at the home address of another
- The cause of death was given as 1a. Heroin and cocaine overdose

- Two brief periods on treatment totalling 113 days. Self-referred both times so was motivated but disengaged early both times when he thought that he'd become abstinent.
- Ex- Parachute Regiment and French Foreign Legionnaire who was medically discharged from the Parachute Regiment with an injured back, the pain issues appear to have stemmed from this time.
- Main problem was that he took control of the treatment in that he determined when he was cured/ recovered. He needed far more time in therapy after his two occasions of achieving abstinence.
- Started using heroin for pain and somewhere along the line he was introduced to crack cocaine. Anxious person on anxiety medicine whose anxiety was worsened by crack use. His use of heroin increased also.
- WAWY report tallies with GP report so this man was being open and constant with all who were trying to help him.

Findings and applying the learning

- As above, this man decided on two occasions that he was abstinent and therefore, recovered. He was informed that abstinence was a good first step but that there was a lot more to be worked upon to reinforce his abstinence. He did not go with this advice and relapsed after his periods of abstinence. He was easy to work with and disciplined, presumably due to his military background.
- This case does highlight that there are often many intertwined issues that lead to drug use and just taking the drugs away from the situation does not necessarily solve those issues. This man needed far more drug treatment in order for him to recover and that treatment was on offer.

3.32 **Drug Related Death 31- Nov 2019**

- 33-year-old man who was not in drug or alcohol treatment who was of no fixed abode and died in a squat
- The cause of death was given as 1a. Heroin and cocaine overdose
- 5 squatters were in a room when this man used heroin. The other squatters stated that they did not know him well and it is believed that he was relatively new to the area. Two of them went out leaving the other two to sit with him. They claim that he was snoring before they left the room for a while and returned 30 minutes later finding him not breathing. 999 called and CPR commenced by the occupants as well as administering naloxone but to no avail.

Findings and applying the learning

- The WAWY outreach team had been newly formed in October 2019 and they attended the premises the next day to engage with the four people who had witnessed this incident. Of those four, two are now in

accommodation and being treated for their own issues. The outreach team confirmed that very little was known about the deceased person by those present. The squat has been closed down.

- The winter cold weather provision and, in particular, the Covid-19 provision of accommodation for homeless people throughout 2020 has tended to keep the majority of homeless people from the street. Outreach workers are not aware of overt squats around Cornwall although they do probably still exist. Any information that updates this situation, however, will be acted upon and the occupants engaged with a view to assisting them with immediate issues such as better accommodation, physical/ mental health and drug and alcohol issues.
- At the writing of this report England is just about to enter another lockdown and services are waiting to see exactly what that means for further provision of accommodation. There appears to be two main pockets of homeless people in numbers at the moment; Penzance and Moorfield, Truro. These locations are receiving attention.

4. Review and Learning From 2019

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

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

The learning from this Group is fed into the inquest process via reports from the Chair (the author). The Group also informs an approves the content of this report.

4.2 **Specific issues.** The deaths reviewed highlight specific learning and have informed priorities going forward.

- **Pain medicine, management and mental health**
  Both the youngest person who died, aged 22 and the oldest who died at 61 years suffered from severe pain. Many others in between also suffered the same problems. Some were treated for this; some were not and there is a mix of those who were treated and yet sought other medication to deal with the pain.
  There is evidence that communication could have been better between patient/ client and clinician as well as between those agencies and staff caring for the patient/ client. When pain continues and the person in pain is not receiving treatment or what they think is the right treatment, illicit drugs and overuse of prescriptions can occur sometimes resulting in overdose and death. Concerns have been expressed by families and treatment workers to the scale of some prescriptions and access to medicines.
- Drug combinations, self-medicating and availability and accessibility of pain medicines warrant further investigation, including the potentiating effects of certain antipsychotic medicines, Pregabalin, the treatment of depression, epilepsy and neuropathic pain and the interrelationship with illicitly obtained opiates. A Task and Finish Group has been drawn together to review, consisting of Specialist substance treatment, , shared care, GP pain lead, lead pharmacists, SW Controlled Drugs Accountable Officer and Medicines Safety Officer, NHS Kernow Head of Prescribing and Medicines Optimisation, RCHT Pain Consultant, Local Medical Council Lead GP and DAAT Senior Primary Care Development Manager.
- **Universal coverage of naloxone. Specialist drug service has moved to an** 'opt out 'approach to issuing Naloxone (an opiate antagonist which reverses the effects of opiate drugs), rather than 'opt in'. In adopting this approach, service users have been more willing to accept Naloxone, which has resulted in a significant increase in distribution and coverage. During 2019-20 there has been an increase in services getting involved in the programme and an increase in distribution of naloxone to be used by street and community outreach services in addition to supported housing residential services.

Complex Needs Accommodation Providers continue to train their staff, residents and volunteers or access training through WAWY colleagues and Ethypharm, the naloxone supplier. In addition, WAWY train their service users and supply them directly with their own personal supply.

The full naloxone report for April 2016 to April 2020 broken down by financial year can be found at Appendix 1.

- **Domestic abuse** has been a factor in a number of deaths, having a negative impact upon a person seeking and receiving treatment. This

review identified that there could be more improved joint working in this area specifically.

- Certain deaths have been concluded as drug related where there has been insufficient evidence to conclude **suicide**, due to the threshold for evidence having not quite been met. A greater focus upon suicide awareness and prevention, therefore, and specifically into the coronial reporting for inquest would assist the Coroner.
- **Consistency of urine screening in Opiate Substitute Therapy (OST).** The review of one death highlighted an insufficient use of urine screening which, had it been undertaken, may have better informed the treatment team and plan. This now more formally routinised through supervision, monitoring and reporting on an exception basis.
- **People in treatment for alcohol dependence** to be made more aware of the full range of We Are With You services, even if they do not disclose any drug use, due to drug related deaths occurring in this treatment population.
- **The role Outreach plays in Prevention.** Some of the deaths in this year from 2019 and previous years have informed the decision to increase delivery of outreach to more proactively engage people who are hard to reach and/ or who might need to be worked with in a more flexible fashion.
- Two deaths involved a licensed premise. The review of these and deaths from previous years has prompted a review of the information sharing and briefing of those involved with Licensing. Historically, training and support have focussed upon these venues, but there has been a hiatus in 2020. As processes gear up again, training and work with Officers will feed in learning from this Review.

4.3 Other Prevention initiatives

4.4 International Overdose Awareness Day 2019

On Friday 30th August 2019 Cornwall DAAT and partners held an awareness and training day.

This was the third successive event in Cornwall to raise awareness of drug overdose, first aid and many related issues. The event this year was held at the White River Centre, St Austell and included:

- first aid training and Basic Life Support (resuscitation, placing someone in the recovery position) and administering Naloxone. Breaking down the stereotypes, letting people know the facts and myth busting was very much a part of the day. Leaflets and other information were available together with experienced staff and service users from Cosgarne Hall, Freshstart, Addaction and the DAAT.

4.5 Reducing Drug Related Deaths Conference

The ninth annual Drug Related Death Conference took place on Friday 6th September 2019 at The China Fleet Club, Saltash. Once again kind donations from, Public Health Devon, Devon and Cornwall Police and sponsorship from companies associated with drug treatment/ harm reduction allowed this conference to be provided free to delegates

This has always been a popular conference with guest speakers and agencies coming together to share best practice, learning from drug related deaths and preventative strategies. This year was no exception with an eclectic mix of plenaries being delivered;

- Selective Serotonin Reuptake Inhibitor drugs interaction with MDMA (Ecstasy) and other drug interactions (having featured in the death of a young person)
- Lung health, spirometry, smoking cessation
- Help for Homeless Lead GP to cover his work and alternative approaches to treatment
- Public Health Devon- web based portal for drugs identification
- Police- Partnership Agency Information Sharing portal and form & inter agency working
- Psychologically Informed Environments and trauma led approaches for those in supported housing
- Invasive Group A Streptococcus infection and preventative measures
- Drug and alcohol workers- a perspective from the frontline focussing on when a service user dies and the impact upon the worker etc.
- Tuberculosis screening within the homeless community and a successful Public Health pilot

The subjects were chosen in part having reviewed the drug related deaths leading up to the conference where learning and identification of preventative measures are used as a framework for the conference.
This year saw the number of places available for the conference far outnumbered by the demand making this was the biggest conference in the 9 years of it being held.

Feedback was very positive with the variety of topics and speakers being appreciated by the attendees.

5. Conclusion and Priorities

Despite our very best collective efforts, numbers of drug related deaths of residents in Cornwall continued to increase in 2019, as it has done nationally.

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

Priority 1 Improved joint working arrangements with regard to **pain management**, including pathways, communications between agencies involved and a drive to involve the patient in a multi-agency approach. Increased professional curiosity so as to identify people moving to the illicit market for pain management medicines.

Priority 2; Improved understanding of the interrelationship between **domestic abuse**, drugs and alcohol. Secure adequate understanding of the role of coercion and abuse in drug related deaths, domestic homicide reviews and suicide ensuring this information is included in the inquest process.

Priority 3; Greater clarity about and understanding of what is a **suicide** and what is a drug related death.
Increased and comprehensive suicide prevention and review across our commissioned services.

Priority 4; Scope, identify and improve support systems via a range of options for affected others.

Affected others, carers of those with drug and alcohol problems and witnesses to drug related deaths need more support after a drug related death has occurred on a parity with some of the work now being carried out with postvention after a suicide. Early intervention and support after a drug related death can help to offset mental and physical manifestations of grief and a range of emotions which, in turn, can lead to high risk behaviour.

Work has commenced on the recommendations from this report and it is hoped that they will be implemented at the earliest opportunity and that the 31 people who have tragically and prematurely died in 2019 from a drug

related death, will have, as part of their legacy, contributed towards the future safety and well- being of others.

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

APPENDIX 1

Naloxone Report 2016-20

The following report highlights drug related incidents, naloxone use, naloxone supply and naloxone training delivered across Complex Needs services since the naloxone programme was introduced in 2009.

More detailed reports were produced from 2016, when all complex needs supported housing settings became part of the naloxone programme and agreed to have naloxone on site should they be required to save a life in an emergency.

1. Drug Related Incidents

2019-20

Provider	Recovered from overdose	With Naloxone	No Naloxone	Deceased	Not an overdose situation	
Coastline	2	1	1		2	
Harbour (Cosgarne)	13	13		1		
LiveWest (DCH)	6	5	1	2		
Total Incidents	**21**	**19**	**2**	**3**	2	**26**

In 2019-20 we are starting to see and record more overdoses of non-opiate drugs where naloxone is not used and would be ineffective. Providers continue to be as proactive in their response and as effective in their outcomes despite not having an antidote to these illicit pills and capsules.

2018-19

Provider	Recovered from overdose	Deceased (naloxone administered)	Deceased (no naloxone administered	Not an overdose situation	
Coastline	3				
Harbour	11	1		1	
LiveWest (DCH)	1				
Saha - FreshStart					
Homegroup			1 (alcohol use)		
St Petrocs (Outreach)	1				
St Petrocs (Day Centre, Truro)	1				
Total Incidents	**17**	**1**	**1**	**1**	**20**

2017-18

Provider	Recovered from overdose	Deceased (naloxone administered)	Deceased (no naloxone administered	Not an overdose situation	
Coastline	2				
Harbour	7		1	1	
LiveWest (DCH)					
Saha - FreshStart					
Homegroup	1			1	
St Petrocs (Outreach)	1				
Total Incidents	**11**		**1**	**2**	**14**

2016-17

Provider	Recovered from overdose	Deceased (naloxone administered)	Deceased (no naloxone administered	Not an overdose situation	
Coastline	2				
Harbour	7			4	
LiveWest	2				
Saha FreshStart	1				
Homegroup	1	1	2		
St Petrocs				1	
Total Incidents	13	1	2	5	**21**

2016 – 2020

Provider	Recovered from overdose	Deceased	Not an overdose situation	
Coastline	9		2	
Harbour	38	3	6	
LiveWest	9	2		
Saha - FreshStart	1			
Homegroup	2	4	1	
St Petrocs	3		1	
Total Incidents	**62**	**9**	**10**	**81**

Since December 2009 and the start of this project in April 2016, there were **25** lives saved in supported housing projects using naloxone. 19 of these were at Cosgarne Hall (Now Harbour Housing); 4 at Coastline Housing; 1 at FreshStart (now Saha – FreshStart) and another 1 at a Homegroup service. The numbers saved across services can be seen at the table below.

2009 – 2020

Provider	Recovered from overdose	Deceased	Not an overdose situation	
Coastline	13		2	
Harbour	57	3	6	
LiveWest	9	2		
Saha - FreshStart	2			
Homegroup	3	4	1	
St Petrocs	3		1	
Total Incidents	**87**	9	**10**	**106**

Summary of all lives saved following overdose since the introduction of naloxone in complex needs services in 2009

Dates	2009 - 2016	2016-17	2017-18	2018-19	2019-20	TOTAL
Lives Saved	25	13	11	17	21	**87**

2. Naloxone distributed

Naloxone continues to be supplied by We Are With You (WAWY) to Complex Needs Providers as per the agreement in the Naloxone Guidance for Complex Needs providers document.

During 2019-20 there has been an increase in services getting involved in the programme and an increase in distribution of naloxone to be used by street and community outreach services in addition to supported housing residential services

Number of kits distributed					
Provider	**2016/17**	**2017/18**	**2018/2019**	**2019/2020**	**Total**
Coastline	14	3	9	12	38
Harbour	22	15	22	23	82
LiveWest	10	5	0	0	15
Saha - FreshStart	8	0	2	5	15
Glen Carne	4	3	1	1	9
Homegroup	28	2	0	0	30
St Petrocs	15	0	1	2	18
CHL				12	12
Konnect				13	13
Grand Total	**101**	**28**	**35**	**68**	**232**

3. Naloxone training delivered

Complex Needs Providers continue to train their staff residents and volunteers or access training through WAWY colleagues and Ethypharm, the naloxone supplier. In addition, WAWY train their service users and supply them directly with their own personal supply.

	NUMBERS TRAINED				
Training delivered	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**Total**
Residents	147	63	148	104	462
Staff	98	43	96	83	320
Student placement	2	2	0		4
Volunteer	8	27	29	19	83
Work placement	3	0	0		3
Grand Total	**258**	**135**	**273**	**206**	**872**

In Cosgarne (Now Harbour Housing), **114 people** were trained (18 staff; 3 volunteers; 84 residents and 9 external agency staff) prior to 2016 when the naloxone project was rolled out more widely. Some other complex needs providers had also undertaken training prior to this time.

Summary of total numbers trained since the introduction of naloxone in complex needs services in 2009

Year	2009 - 2016	2016-17	2017-18	2018-19	2019-20	TOTAL
Numbers Trained	114	258	135	273	206	**986**

The Annual breakdown of numbers trained across Providers

2016/17

Agency	Numbers
Saha - FreshStart	20
Coastline	85
Glen Carne	16
Harbour	61
Homegroup	39
LiveWest	24
St Petrocs	13
Grand Total	**258**

2017/18

Agency	Numbers
Saha - FreshStart	14
Coastline	56
Harbour	44
Homegroup	13
LiveWest	7
Grand Total	**134**

2018-19

Agency	Numbers
Saha - FreshStart	45
Coastline	81
Harbour	125
Homegroup	11
LiveWest	11
Grand Total	**273**

2019/20

Agency	Resident	Staff	Volunteer	Total
Saha - FreshStart	9	4		13
CHL		12		12
Coastline	49	32	12	93
Harbour	44	29	7	80
Homegroup		5		5
LiveWest		3		3
Grand Total	**102**	**85**	**19**	**206**