1. Background

Sophie was a bright, intelligent and articulate women. Prior to becoming addicted to alcohol owned her own home and a senior role a project manager.

Whilst drunk one evening Sophie fell down and fractured her neck this led to continued chronic and debilitating pain.

2. Sophie's death

Sophie's death occurred following a four-day binge on alcohol. Local services including the police, ambulance crew and the hospital all had contact with her as she was found roaming the street half dressed, collapsed and incoherent.

Sophie would go to hospital and then discharge herself or leave. She was found deceased at her home one morning by her step mum.

3. Co-ordinated approach

Sophie was being supported by a number of services and individuals tried to communicate with one another however a multi-disciplinary team(MDT) meeting was not called to bring everyone together.

An MDT would have allowed for information and risk sharing to take place.

8. Brain/pain/drain

Sophie had mental health problems which she tried to manage by drinking, whilst drunk she fell and fractured her neck. This left her in pain. The pain killers didn't help so she drank more. The more she drank the worse her mental health became…….. The cycle continued.

You can read the full Safeguarding Adult Review here.

4. Alcohol Purchases

It was discovered after her death that Sophie was sourcing her alcohol from a local shop. It is possible that she would have been intoxicated at the time she was making her purchases.

If someone drinks alcohol to excess, and professionals know where they are sourcing their alcohol then the licencing team should be informed.

7. Housing

Sophie found herself having to live in temporary accommodation, for some of that time this worked well for her as she had no access to alcohol.

When she was moved into a town she quickly slipped into old habits and her drinking spiralled out of control again. She died less than a month into having her own tenancy.

6. Mental Health Act Section 13 (4)

On three occasions Sophie's family told professionals that they thought Sophie should be "sectioned". On no occasion was section 13(4) explained to them.

As Sophie's nearest relative her dad had the right to request for a Mental Health Act Assessment to be arranged. This request then has to be considered and a response provided.

5. Identifying family as carers

Sophie's family were heavily involved with supporting her and her complex needs, these included her physical disabilities as well as mental health needs and her addiction.

Sophie's family were not identified as carers and therefore were not offered a carers assessment or any other form of support as family members of someone with an addiction and complex needs.

Sophie

Safeguarding Adult Review

December 2024