



## **Family Approach**

### **Case Study: PSAB 'YL' Safeguarding Adults Review**

#### **Who was YL?**

YL was a young woman in her early 20s. She was the mother of a two year old child. As a child she chose to live with her grandparents, and continued to live there as a young adult, though she still remained in contact with her mother and siblings. She had a history of trauma and had been the victim of domestic abuse, and she also experienced mental illness. Her family described her as an exceptionally pretty girl with a beautiful voice, who loved dancing. She was pursuing a career as a PE teacher.

#### **The facts of the case**

During the summer of 2019, YL started to present with regular and increasing self-harm behaviours, often accompanied by extreme emotional dysregulation. She frequently attended ED - either taken by ambulance or presenting there herself. She was diagnosed with Emotionally Unstable Personality Disorder (EUPD). She was supported by Mental Health services and had a number of inpatient admissions. Her self harm continued to increase and she began hearing command voices telling her to hurt herself and her family. Her behaviour became increasingly distressing to her grandparents and difficult for them to manage, and they became worried about the impact on YL's child.

Children's Services became involved when YL was admitted to hospital after taking an overdose. YL's behaviour was seen as a risk to her child and child contact conditions were put in place meaning YL could no longer sleep at her grandparent's house (her own home since childhood). This effectively made her homeless, and in October she was housed by the local authority in temporary hotel accommodation.

YL said that she found the hotel lonely and isolating. Her self harm behaviour began to escalate and she became less compliant with her medication. She also had problems with alcohol use. YL had a number of further inpatient admissions at this time, and was discharged to the hotel on Christmas Eve. YL tragically took her own life in her hotel room in early January 2020.

## **What was the learning from this case about the Family Approach?**

- The voice of the adult was overshadowed by a focus on child protection, not recognising that YL herself was only just into adulthood herself. There was no coherent and clearly articulated understanding of what YL wanted.
- The voice of the carer - YL's grandmother - was not heard. The role YL's grandmother played as carer to both YL (who was like a daughter to her) and her child, and the emotional impact of that, was not recognised. YL's grandmother was not offered a Carer's Assessment in line with the Care Act.
- Services did not have a good understanding of EUPD and how it differs from psychosis in its presentation and treatment. YL and her family were also not supported effectively to understand her diagnosis.
- Services did not understand and assess the whole family unit, including YL's mother and half siblings.
- Services did not work together and share information effectively. For example, discharge planning was not multi-agency and Children's Services were not involved. Agencies also did not always work well together to manage YL's fluctuating levels of risk.

### **More information**

To read the full SAR report and a learning summary for professionals, visit the [PSAB website](#).