Byram House

SELF-INJURIUS BEHAVIOUR POLICY

Date: May 2026

SELF INJURIOUS BEHAVIOUR POLICY

Contents

1. Introduction to the Policy

This policy sets out the framework, principles, and procedures that **Byram House** follows to understand, manage, and reduce the risk of self-injurious behaviour (SIB) by children and young people in our care. The policy applies to all staff, agency workers, volunteers, and contractors working at Byram House, whether at 62 Deighton Road, 66 Deighton Road, or elsewhere.

The Home is Byram House, which comprises the two residences at 62 Deighton Road and 66 Deighton Road. This policy applies equally across both residences.

IMS Care LTD is committed to providing high-quality care in safe, friendly, supportive environments. We aim to do the best for each person we support. This policy focuses on effectively managing and reducing the risk of self-injury by developing an understanding of the reasons for the behaviour and implementing good professional practice.

There is not always a clear distinction between self-harm (which includes harmful behaviours such as substance misuse) and self-injury (direct destruction of body tissue without suicidal intent). The accompanying **Self-Harm Policy** may be more applicable for some individuals. Staff should discuss which policy applies in collaboration with clinical wellbeing teams and senior leaders.

The objectives of this policy are to:

- Ensure compliance with all relevant legislation, including the **Mental Health Act 1983 (as amended 2007)** , the **Mental Capacity Act 2005 (as amended)** , the **Human Rights Act 1998**, the **Children's Homes (England) Regulations 2015**, and **Working Together to Safeguard Children 2026**.
- Provide staff with a clear understanding of self-injurious behaviour, its causes, functions, and appropriate responses.
- Establish robust assessment, care planning, and risk management frameworks, including functional analysis and multidisciplinary team (MDT) involvement.
- Ensure the safety of children who self-injure, particularly those who engage in head banging or use ligatures.
- Support staff who witness or manage distressing incidents through supervision, debriefing, and access to counselling.

2. How this Policy Benefits the Home

This Self-Injurious Behaviour Policy benefits Byram House in the following ways:

- **Legal Compliance** – It meets duties under the **Mental Health Act 1983**, **Mental Capacity Act 2005**, **Human Rights Act 1998** (Article 3 – freedom from inhuman or degrading treatment; Article 8 – right to private life), **Children's Homes (England) Regulations 2015**, and **Working Together to Safeguard Children 2026**. It also aligns with **NICE guidance on self-harm** (CG133 and CG16, as updated).
- **Child Safety** – It provides clear guidance on immediate responses to self-injury (including ligature removal, head injury monitoring, and when to call 999), reducing the risk of serious harm or death.
- **Understanding Root Causes** – It emphasises functional analysis (sensory, pain attenuation, escape, attention, tangibles) rather than simply managing behaviour, promoting person-centred, trauma-informed, and neurodiversity-aware approaches.
- **Risk Reduction** – It lists preventative strategies (check for medical causes, review environment, provide sensory alternatives, use communication tools, reward positive behaviours, and consider medication under medical direction).
- **Staff Support** – It acknowledges the emotional impact on staff and commits to supervision, reflective practice, debriefs, and access to confidential counselling.
- **Inspection Readiness** – The **Social Care Common Inspection Framework (SCCIF) 2026** expects homes to demonstrate effective management of behaviour that challenges, including self-injury. This policy provides clear evidence.
- **Training Framework** – It sets out regular training for staff on recognising, responding to, and preventing self-injury, including head injury protocol and ligature cutter use.
- **Clinical Collaboration** – It defines the role of Clinical and Wellbeing Teams in assessment, care planning, and post-incident support, including the use of functional analysis tools (FAST, MAS, QABF, BBAT, Behaviour Chain Analysis).

3. Definitions & Legislation

3.1 Definitions

Term	Definition
Home	Byram House, the children's home registered with Ofsted, comprising two residences at 62 Deighton Road and 66 Deighton Road.
Company	IMS Care LTD, the registered provider and legal entity responsible for operating Byram House.
Byram House	The name used throughout this policy to refer to the home and its staff.
Self-Injurious Behaviour (SIB)	The destruction or alteration of one's own body tissue without conscious suicidal intent. Examples include head banging, biting, hair pulling, eye gouging, skin picking, scratching, pinching, forceful head shaking, and inserting objects into the body.
Self-Harm	Any act of self-poisoning or self-injury, irrespective of motivation. In the Department of Health's definition, self-harm includes harmful behaviours such as drug misuse, excessive alcohol use, and smoking, whereas self-injury refers specifically to direct tissue damage without suicidal intent.
Functional Analysis	A process of identifying the underlying purpose or function of a behaviour (e.g., sensory stimulation, pain attenuation, escape, attention, tangibles).
Head Banging	A form of self-injury where a person strikes their head against a hard surface (floor, wall, furniture). May cause serious head injury or cumulative damage.

Ligature	Any item placed around the neck to restrict the airway, which may be used for self-injury. A ligature point is a fixed object to which a ligature can be tied.
Multi-Disciplinary Team (MDT)	A group of professionals from different disciplines (e.g., clinical psychologist, psychiatrist, social worker, registered manager, key worker) who work together to assess and plan support for a child.
NICE Guidance	National Institute for Health and Care Excellence guidelines on self-harm (CG133 – long-term management; CG16 – short-term management and prevention of recurrence).

3.2 Key Legislation and Statutory Guidance

Legislation / Guidance	Key Provisions	Relevance to this Policy
Mental Health Act 1983 (as amended 2007)	Provides for assessment, treatment, and detention of individuals with mental disorders. Code of Practice 2015 provides guidance on least restrictive options.	A child whose self-injurious behaviour is linked to a mental disorder may require assessment under the Act. Staff must know when to seek mental health crisis support.
Mental Capacity Act 2005 (as amended)	Presumes capacity unless assessed otherwise. Requires best interests decisions for those lacking capacity. Deprivation of Liberty Safeguards	Some children may lack capacity to make decisions about their self-injury. Interventions (including restraint) must be in their best

	(DoLS) for adults; for children, court authorisation may be needed.	interests and the least restrictive option.
Human Rights Act 1998	Article 3 – prohibition of torture and inhuman or degrading treatment. Article 8 – right to respect for private and family life. Article 2 – right to life.	The home has a positive duty to protect children from serious self-injury. Any restrictions must be lawful, necessary, and proportionate.
Children's Homes (England) Regulations 2015	Regulation 23 – health and wellbeing. Quality Standards – behaviour management, staff training, and safe care.	The home must have policies and trained staff to manage self-injury safely, and must notify Ofsted of serious injuries under Regulation 40.
Working Together to Safeguard Children 2026	Published March 2026. Strengthens multi-agency accountability and responses to extra-familial harms, including self-harm and mental health crises.	Self-injury is a safeguarding concern. The home must work with CAMHS, social care, and clinical teams.
NICE guideline CG133: Self-harm in over 8s – long-term management (2011, updated 2022)	Recommends individualised care plans, regular review, psychosocial assessment, and psychological interventions.	The home must develop care plans informed by functional analysis and reviewed at least every 12 months.

NICE guideline CG16: Self-harm in over 8s – short-term management and prevention of recurrence (2004, updated 2022)	Covers immediate management, risk assessment, and referral to mental health services.	Staff must know how to respond immediately to self-injury, assess physical harm, and when to call 999.
Social Care Common Inspection Framework (SCCIF) for Children's Homes 2026	Effective 1 April 2026. Focuses on children's lived experience, effective risk management, and staff competence.	Inspectors will evaluate how the home supports children who self-injure, the quality of care plans, and staff training.
Health and Safety at Work etc Act 1974	Duty to ensure health and safety of employees and others.	The home must protect staff from harm arising from managing self-injury (e.g., training in safe restraint, providing ligature cutters).

4. The Policy

4.1 What is Self-Injurious Behaviour?

Self-injurious behaviour is where a person physically hurts themselves. The National Autistic Society states that around half of autistic people engage in self-injurious behaviour at some point in their life. Child maltreatment and trauma are also known risk factors for non-suicidal self-injury.

Definition of self-injury (Department of Health's Self-Harm Expert Reference Group):
The destruction or alteration of one's own body tissue without conscious suicidal intent. This distinguishes it from self-harm (which includes drug use, excessive alcohol, smoking) and from socially accepted body modification.

Examples of self-injurious behaviour include:

- Head banging (on floors, walls, or other surfaces)
- Hand/arm or other body part biting
- Hair pulling
- Eye gouging
- Face or head slapping
- Skin picking, scratching or pinching
- Forceful head shaking
- Inserting objects into the body or under the skin
- Use of ligatures (see also Ligature Policy)

Staff must be aware that self-injury can range from mild (superficial scratches) to severe (serious head injury, life-threatening ligature use).

4.2 Understanding Self-Injurious Behaviour – Functions and Causes

Self-injurious behaviour is often a means of communication or expression where the individual cannot express their needs in words. It may be a way to get needs met (hunger, thirst, pain, fear, displeasure, anxiety) or to relieve emotional or physical numbness.

Functions of behaviour (reasons why it continues):

Function	Description	Example
Sensory Stimulation	Provides an internal sensation that pleases or removes an unpleasant sensation.	Rocking or head shaking that becomes head banging.
Pain Attenuation	Alleviates physical or emotional pain (e.g., ear infection, headache, gastrointestinal pain, or emotional distress from trauma).	An autistic child with undiagnosed acid reflux bangs head to distract from internal pain.
Escape or Avoidance	Gets away from an undesired situation, demand, or environment.	Self-injury in a busy supermarket to communicate "I want to leave."
Attention	Gains attention or a reaction from others. For children who have experienced neglect, this may be attachment seeking.	Self-injury after feeling ignored; staff response (even negative) meets need.

Function	Description	Example
Tangibles or Activities	Obtains a desired item or access to a preferred activity.	Self-injury to be taken to a quiet room or to spend time with a specific staff member.

Multiple functions – a behaviour may serve more than one function (e.g., escape and attention). The function may also change over time or vary between incidents. Staff must assess each incident individually and avoid assumptions based on past history.

4.3 Methods of Self-Injury (including Head Banging and Ligatures)

Head banging:

- Can cause significant and serious head injuries, including fractures, brain injury, and cumulative damage.
- Staff must place a softer object (e.g., pillow, crash mat) between the child's head and the hard surface, where this is set out in the child's Support Plan and risk assessed.
- After any head-banging incident, staff must follow the **Head Injury Protocol** (Appendix C) and complete the **Staff Checklist** (Appendix D). This includes monitoring for 24 hours and seeking medical advice (111) or calling 999 for serious symptoms (unconsciousness, clear fluid from ears/nose, seizure, bleeding from ears, numbness, prolonged dizziness).

Ligature use:

- Some individuals use ligatures to inflict injury on themselves. Ligatures can be fixed (tied to a secure point) or non-fixed. Points do not have to be high – ligatures can be used when kneeling or sitting.
- On every occasion when a person ties a ligature, staff must **remove the ligature as quickly as possible** using trained techniques and ligature cutters (see Ligature Policy).

- For individuals who regularly use ligatures, management strategies must be agreed with the MDT and Clinical and Wellbeing Team, detailed in the Support Plan and risk assessment.
- Staff (including bank and agency) in services where a ligature risk has been identified will receive annual training on ligature awareness and use of ligature cutters.

4.4 Physical Intervention and Restraint

Some self-injurious behaviour may require staff to physically intervene using **Proactive Team Teach** or other authorised positive behaviour support (PBS) methods.

Key principles:

- Physical intervention is a last resort, used only to prevent immediate, significant harm.
- Interventions must be proportionate, lawful, and in the child's best interests (under the Mental Capacity Act 2005 where applicable).
- All physical interventions must be recorded on the home's electronic recording system (Access) within **24 hours**.
- A **debrief** must be held with all staff involved and, where appropriate, with the child (when calm and able to engage).
- The MDT must be informed and regularly review the child's Support Plan following any incident involving restraint.

4.5 Assessments (Functional Analysis and Risk Assessment)

Initial assessment:
The Initial Assessment Tool must include details of any previous self-injury, including previous management or support. Where possible, the MDT will engage family members to gain their views.

Functional analysis tools:
For any child who has self-injured, at least one of the following functional analysis tools must be completed:

- Functional Assessment Screening Tool (FAST)
- Motivation Assessment Scale (MAS)
- Questions About Behavioural Function (QABF)
- Brief Behavioural Assessment Tool (BBAT) – Expanded
- Behaviour Chain Analysis

These tools help identify the underlying function(s) of the behaviour and inform the risk assessment.

Risk assessment:
A detailed risk assessment must be completed and regularly reviewed by the MDT (including Clinical and Wellbeing Team). The risk assessment should identify:

- Preferred methods of managing self-injurious behaviour.
- De-escalation strategies.
- Post-incident support for the child and staff.
- Environmental modifications (e.g., removal of ligature points, padding of hard surfaces).
- When to involve emergency services.

4.6 Care and Support Planning

For any child assessed as at risk of self-injurious behaviour, there must be an agreed plan in the child's **Support Plan / Care Plan** that sets out:

- Short-term and long-term management strategies.
- Functions of behaviour identified.
- Preventative measures (see section 4.7).
- Staff protocols for responding to SIB (including use of barriers, redirection, distraction, and when to call 999).
- Post-incident support (debrief, medical checks, emotional support).

- Review schedule (at least every 12 months, or more frequently if behaviour escalates or changes).

The care plan must be developed with the child (where age and understanding allow), the MDT, and, where appropriate, family members.

4.7 Reducing the Risk of Self-Injury – Preventative Strategies

The following strategies can reduce the likelihood of self-injury. They should be considered and, where appropriate, incorporated into the child's Support Plan.

Area	Action
Medical causes	Contact GP and/or dentist. Describe behaviour (time, situation, frequency, when started, duration). Check for pain (ear infection, reflux, headache, dental issues).
Mental health causes	Check for changes in wellbeing (sleep, appetite, mood). Seek advice from Clinical and Wellbeing Team.
Staffing ratios	Consider increasing from 1:1 to 2:1 where risk assessment indicates.
Environment	Check for changes (noise, light, crowding, restrictive features). Ensure tidy, organised, and calm. Reduce sensory overload (ear defenders, low lighting).
Structure and routine	Make daily schedule predictable. Increase supervision at times when SIB usually occurs.
Sensory alternatives	Provide alternative sensory experiences (fidget toys, weighted blankets, sensory rooms, exercise).
Communication tools	Use visual supports, pictures of body parts, symptom symbols, or regulation zone cards (e.g., "red zone" card for when urges are high).

Positive reinforcement	Reward periods without SIB and, importantly, reward alternative coping behaviours (e.g., seeking staff support instead of self-injury).
Medication	Only under the direction of a medical practitioner (e.g., psychiatrist, GP) and in agreement with the MDT. Used only for severe or persistent SIB where other strategies have failed.

4.8 What Staff Must Do When Self-Injurious Behaviour Occurs

Immediate response:

1. **Respond quickly and consistently** – never ignore self-injurious behaviour, even if you believe it is attention-seeking.
2. **Keep responses low key** – limit verbal comments, facial expressions, and displays of emotion. Speak calmly, neutrally, and clearly.
3. **Reduce demands** – if the behaviour is triggered by a task, step back. Return to the task later when the child is calmer.
4. **Remove physical and sensory discomforts** – unpleasant smells, loud noises, uncomfortable clothing. Move the child to a quieter area if needed.
5. **Redirect** – tell the child what to do instead (e.g., "hands down"). Use visual cues. Redirect to an alternative activity that requires both hands.
6. **Use distraction** – offer a preferred activity (physical, creative, comforting, constructive, fun, with others, or inspiring – see examples in section 4.8 of original policy).
7. **Use barriers** – where agreed in the Support Plan, place a barrier (crash mat, pillow) between the child and the hard surface.
8. **Physical restraint** – only where there is risk of severe injury, and only if authorised in the Support Plan and risk assessment, and within best interests under the Mental Capacity Act.

Serious injury or risk of serious injury: Call 999 immediately.

Following the incident:

- **Assess physical harm** – follow Head Injury Protocol (Appendix C) for head banging. Check for bleeding, bruising, fractures, loss of consciousness.
- **Seek medical attention** – call 111 for advice (non-emergency) or 999 for emergencies.
- **Record the incident** – on the home's electronic recording system (Access / Sleuth) within the same shift.
- **Inform the MDT** – including the Clinical and Wellbeing Team, social worker, and Registered Manager.
- **Debrief** – with staff involved and, where appropriate, with the child (when calm). Focus on learning, support, and updating the Support Plan.

4.9 Supporting Staff After Incidents

Observing and managing self-injury can be distressing and traumatic. The home is committed to supporting staff.

Support measures include:

- Regular supervision (at least monthly) where SIB incidents can be discussed.
- Reflective practice sessions (group or individual) facilitated by the Clinical and Wellbeing Team or external provider.
- Post-incident debriefs within 48 hours, focusing on emotional wellbeing and learning.
- Access to a confidential Employee Assistance Programme (EAP) or counselling service.
- Time off if needed after a particularly traumatic incident, in line with the home's sickness policy.

The Registered Manager must ensure that staff are aware of these support options and are encouraged to use them without fear of stigma.

4.10 Reporting and Recording

All incidents of self-injurious behaviour must be:

- Recorded in the child's daily notes and incident log.
- Reported in weekly reports and on the home's electronic recording system (Access / Sleuth).
- Notified to the Registered Manager and the Clinical and Wellbeing Team within agreed timescales (to be decided per service or per individual, but no longer than one working day for serious incidents).
- For serious injuries (e.g., head injury requiring hospital admission, ligature use requiring cutting), a **Regulation 40 notification** to Ofsted must be made without delay.
- For work-related injuries to staff, a **RIDDOR report** may be required.

4.11 Support from Clinical and Wellbeing Teams

The Clinical and Wellbeing Team must be involved:

- Before a child is admitted, to assess their risk of self-injury.
- When a child who has not previously self-injured starts to do so.
- When an individual's self-injury increases in frequency, intensity, duration, or method changes (immediate notification, not waiting for the next MDT meeting).
- At regular MDT or Clinical/Wellbeing meetings (monthly or quarterly) to review all occurrences of self-injury.

Roles of the Clinical and Wellbeing Team:

- Review the child's SIB plan, staff protocol, and risk assessment.
- Provide additional support to the child (e.g., psychological intervention).
- Facilitate staff reflective practice.
- Recommend specialist interventions (e.g., behavioural, sensory, trauma-focused).

For services with no in-house clinical team, see Appendix A. For services with an in-house clinical team, see Appendix B.

4.12 Head Injury Protocol (Appendix Material)

Appendix C – Head Injury Protocol (adapted from original) includes:

- If a child hits their head, staff must monitor for **24 hours** for symptoms of head injury / concussion:
    - Difficulties staying awake or keeping eyes open.
    - Vomiting.
    - Headache not relieved by pain relief.
    - Dizziness or balance difficulties.
    - Change in behaviour (e.g., more irritable).
    - Signs of confusion.
    - Re-opening of an old wound.
    - Problems understanding or speaking.
    - Problems with eyesight.
- Call **999** immediately if:
    - Unconsciousness.
    - Clear fluid coming from ears or nose.
    - Seizure activity.
    - Bleeding from ears or bruising behind ears.
    - Numbness or weakness in part of body.
    - Prolonged signs of dizziness/unsteadiness.

Appendix D – Staff Checklist after head-banging/hitting incident (to be completed and kept on the child's file).

5. How the Home Trains its Staff About this Policy

Byram House provides structured training to ensure all staff understand and can implement this Self-Injurious Behaviour Policy effectively.

Training Element	Frequency	Method / Content
Induction	Upon appointment	Face-to-face training covering: definition of self-injury vs self-harm, functions of behaviour (sensory, pain, escape, attention, tangibles), methods (head banging, ligature, biting etc.), immediate response protocols, head injury protocol, ligature cutter use (where relevant), recording, and the dual-site operation (62 & 66 Deighton Road).
Annual refresher	Every 12 months	Classroom or virtual session covering updates to legislation (NICE guidance, SCCIF 2026, Working Together 2026), case studies, functional analysis tools, and refresher on head injury protocol.
Functional analysis training	At induction and biennially	Training on using FAST, MAS, QABF, BBAT, and Behaviour Chain Analysis to identify functions of self-injury.

Training Element	Frequency	Method / Content
Positive behaviour support (PBS) / de-escalation	Annually	Training on proactive strategies to reduce SIB, redirection, distraction, and low-key responses.
Ligature awareness and cutter use	Annually (for relevant placements)	Practical training on safe removal of ligatures, use of cutters, and post-incident preservation of evidence.
Head injury and first aid	At induction and biennially	Training on recognising concussion, using the head injury protocol, when to call 111/999, and basic first aid.
Staff support and self-care	Annually	Training on recognising vicarious trauma, debrief procedures, and accessing counselling.

Staff are required to:

- Read and sign this policy annually.
- Complete all mandatory training sessions.
- Know the location of head injury protocol checklists and ligature cutters (where applicable).
- Immediately report any new or escalating self-injury to the Registered Manager and Clinical Team.

6. Related Policies and Guidance

This policy must be read in conjunction with:

- Safeguarding Policy
- Self-Harm Policy (accompanying policy)
- Ligature Policy
- Physical Intervention Policy
- Behaviour Management Policy
- Health and Safety Policy
- Accident and Incident Reporting Policy (including RIDDOR and Regulation 40)
- Data Protection Policy
- Children's Homes (England) Regulations 2015
- Working Together to Safeguard Children 2026
- Social Care Common Inspection Framework (SCCIF) for Children's Homes 2026
- NICE guideline CG133 (long-term management of self-harm)
- NICE guideline CG16 (short-term management and prevention of recurrence)

7. Appendices

Appendix A – Guidance for Services with No In-House Clinical Team

- For services without a dedicated in-house clinical team, staff must rely on external clinical support (e.g., CAMHS, community learning disability team, or commissioned psychology services).
- The Registered Manager must ensure contracts or service level agreements are in place for access to functional analysis and clinical oversight.
- All functional analysis tools (FAST, MAS, etc.) must be completed by a suitably trained professional (e.g., behaviour analyst, psychologist) either employed or contracted.
- MDT meetings must include external clinical professionals as required.

Appendix B – Guidance for Services with an In-House Clinical Team

- In-house clinical teams (e.g., psychologists, behaviour analysts) are responsible for completing functional analysis, risk assessments, and developing SIB care plans in collaboration with the MDT.
- Clinical team members should attend regular team meetings, provide reflective practice, and offer training to care staff.
- The clinical team must be notified immediately of any new or escalating SIB.

Appendix C – Head Injury Protocol

(As set out in section 4.12, to be printed and displayed in the home, and included in individual care plans where a child is at risk of head banging.)

Appendix D – Staff Checklist After Head-Banging/Hitting Incident

Check	Completed (Y/N)	Notes
Child assessed for immediate injury (bleeding, loss of consciousness, seizures)		
999 called (if any red flag symptoms)		
111 called for advice (if no red flags but concerns)		
Head injury monitoring log started (24-hour observation)		
Child's Support Plan and risk assessment updated		
Incident recorded on electronic system (Access)		
Registered Manager and Clinical Team notified		
Debrief with staff involved completed		
(If ligature used) Police notified and ligature preserved		

8. Policy Approval and Review Details

Byram House

Policy Name	Self-Injurious Behaviour Policy	
Home	Byram House	
Reviewed by	Danyaal Iqbal / Mustafa Amin	Deputy Manager / Registered Manager
Approved by	Stacey Wagstaffe	Responsible Individual
Date	May 2026	