SPECIALIST EDUCATION SERVICES

Safeguarding and Child Protection Policy and Practice

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SES Avocet Ltd (4926028) and SES Turnstone Ltd (7972485)
are subsidiary companies of Specialist Education Services Holdings Ltd (7970185)

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1 INTRODUCTION

Specialist Education Services Safeguarding and Child Protection Policy and Guidance is based upon the principle that the interests and welfare of our young persons are of paramount importance and as such the primary focus of our work. **Any other organisational principles or philosophies must be secondary to child protection.**

This policy and procedure document takes into account current national guidance as of the date of its publication.

Our core safeguarding principles are:

- It is the company's responsibility to safeguard and promote the welfare of the children and young people it educates and cares for (commonly referred to as our Duty of Care)
- Children and young people who are and feel safe make more successful learners
- All Policies will be reviewed either annually or every two years depending upon their status in the review cycle and consequent to an incident or new legislation or guidance suggesting the need for an earlier date of review.
- All professionals should make sure their approach is child centered and consider, at al times, what is in the best interests of the child.

We recognise our moral and statutory responsibility to safeguard and promote the welfare of all children. We endeavour to provide a safe and welcoming environment where children are respected and valued. We are alert to the signs of abuse and neglect and follow our procedures to ensure that children receive effective support, protection and justice.

- Specialist Education Services will ensure that the welfare of children and young people is given paramount consideration when developing and delivering all activities
- All children, regardless of age, gender, ability, culture, race, language, religion or sexual identity, have equal rights to protection
- All adults have an equal responsibility to act on any suspicion or disclosure that may suggest a child is at risk of harm in accordance with the guidance indicated in this and other documentation referenced herein
- All children and adults involved in child protection issues will receive appropriate support from the senior management of the school who will follow policy guidance in doing so

Aims

- To provide all adults with the necessary information to enable them to meet their statutory responsibilities to promote and safeguard the wellbeing of children
- To ensure consistent good practice across the company
- To demonstrate the company's commitment with regard to safeguarding children

2 CONTEXT

As both Avocet House and Turnstone House are located within Norfolk and work within guidelines issued by the Local Safeguarding Children Board (LSCB), Specialist Education Services will give every assistance to agencies to enable them to carry out their statutory child protection responsibilities.

- We recognise that effective child protection is based upon agencies working together, the need for mutual understanding of aims, objectives and 'best practice'. This should always take into account the sensitive issues associated with gender, race, language, culture, disability and sexual orientation.

- Specialist Education Services will work closely with Norfolk LSCB to ensure that we maintain and emphasise shared responsibility, quick open communication, agreed procedures and follow an agreed course of action.

- Specialist Education Services work closely with the Designated Police Liaison Officer and implement the Safer Homes and Young People Protocol (SHAYPP) as part of an overall approach to safeguarding young people.

The Lead Designated Person for Child Protection (LDPCP) is the Registered Manager. In addition all Deputy Care Managers, Team Leaders, the Head of Care, the Deputy Head of Education, the Head of Education and Principal are trained as Designated Persons for Child Protection (DPCP). In addition the Principal, Registered Manager and Head of Education attend the Designated Professional Training for Safeguarding in Education.

This means there will be a reference point on site at all times for staff. A first port of call system is in place to ensure that a senior DPCP is available for advice at all times. All staff have in-house safeguarding and child protection training to at least the minimum requirement, in line with statutory guidance.

In the highly unlikely absence of all designated staff the Principal will assume responsibility for the co-ordination of child protection matters. However, if in very exceptional circumstances a situation arises where all designated staff and the Principal are unavailable concerns must be brought to the immediate attention of one or both Directors.

The role of the LDPCP is to co-ordinate and advise upon all child protection issues that arise, whilst ensuring all staff members are fully conversant with organisational policy and guidance. In addition the LDPCP will ensure policies and guidance pertaining to child protection matters remain current and are reviewed as necessary. *(See Appendix A for a full list of the LDPCP responsibilities).*

Specialist Education Services is committed to providing staff members with a level of training that will enable them to identify concerns, take preventative action and respond appropriately when faced with child protection issues. In addition there are comprehensive supervision and support structures for all staff members.

SES Ltd is committed to safeguarding and promoting the welfare of children and young people and expects all staff and volunteers to share this commitment.

3 DEFINITIONS OF ABUSE *(See also Appendix C for comprehensive detail)*

3.1 ABUSE

Abuse is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults or another child or children.

3.2 PHYSICAL ABUSE

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

3.2.1 Honour Based Violence

Honour Based Violence (HBV) is a term used to describe violence committed within the context of the extended family which are motivated by a perceived need to restore standing within the community, which is presumed to have been lost through the behaviour of the victim. Most victims of HBV are women or girls, although men may also be at risk. If there is any cause for concern in relation to HBV adults need to refer to the Safeguarding Policy and procedures.

3.3 EMOTIONAL ABUSE

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill treatment of another. It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

3.4 SEXUAL ABUSE

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

3.4.1 Child Sexual Exploitation (CSE)

Child Sexual Exploitation (CSE) is a type of sexual abuse in which children and young people receive something (such as food, accommodation, drugs, alcohol, cigarettes, affection, gifts, or money) as a result of performing, and/or others performing on them, sexual activities. Child sexual exploitation can occur through the use of the Internet or on mobile phones. In all cases, those exploiting the child or young person have power over them because of their age, gender, intellect, physical strength and/or resources. Sexual exploitation can be very difficult to identify. Warning signs can easily be mistaken for 'normal' teenage behaviour.

3.4.2 Female Genital Mutilation (FGM)

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death. The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman’s first pregnancy.

3.4.3 Sexting/Youth Produced Sexual Imagery

Sexting is considered by professionals as the “sending or posting of sexually suggestive images, including nude or semi-nude photographs, via mobiles or over the internet’. Young people interpret it as ‘writing and sharing explicit messages with people they know’. **Sexting in Schools and Colleges: Responding to incidents and safeguarding Young people Aug 2016** covers the sharing of sexual imagery by young people. On this basis the advice introduces the phrase ‘youth produced sexual imagery” and uses this instead of sexting’.

Any disclosure of this nature should be taken very seriously in line with the SES safeguarding reporting procedures.

(See also the SES Acceptable Use of Technology Policy and Practice document).

3.5 NEGLECT

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers);
- or ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

3.6 INSTITUTIONAL ABUSE

There are other forms of abuse and mistreatment which may need to be considered alongside the above, however in general, the above four categories are likely to cover the majority of concerns that arise. Institutional abuse, for example, whilst possibly reflecting a dysfunctional and abusive organisation and culture will relate to the abuse of individual children (and therefore will be covered by the four categories outlined above).

It is important to be aware that some groups of children may be more vulnerable to abuse for a variety of reasons. Vulnerable children includes disabled children; children living with parental adversity such as domestic violence, parental substance misuse or mental illness; unaccompanied asylum seeking children; children affected by gang activity or sexual exploitation; looked after children etc. Many of these children will have additional needs that require support and some may also be in need of protection.

We must be aware of the power we hold and our position of trust. This means maintaining appropriate professional boundaries so as to protect children from exploitation or harm, ensuring an unequal balance of power is not used for personal advantage or gratification.

4 ROLES AND PROCEDURES WHEN DEALING WITH DISCLOSURES AND CONCERNS

4.1 ALL STAFF

All staff working for SES because of their day-to-day contact with individual children are particularly well placed to observe signs of abuse or other safeguarding related concerns, e.g. self harm (see Appendix E). Alternatively a young person may

choose to make a disclosure to staff. In either situation, a concern or disclosure should be reported to a DPCP.

A Disclosure is information given by the child indicating that they have been or may be at risk of significant harm, or concerns raised that others may be at risk of significant harm. When a child discloses they must be taken seriously, believed and allowed to talk. The member of staff should not seek further information by asking leading questions as this may jeopardise any subsequent investigation.

Having listened to a Disclosure or registered a concern the member of staff must:

- Report it directly to the DPCP
- Follow any instruction given by the DPCP
- Complete a Disclosure form and pass it directly to the DPCP, ensuring that all original notes are included. All notes must be signed and dated. At this point a child protection timeline should be started to hold all information in one central place.
- Maintain confidentiality. Information disclosed or relating to child protection is shared on a 'need to know' basis that may be defined as follows; *"Information limited to those people whose dealings with the child might be jeopardised by withholding such information".* In practice disclosed information can only be shared with the DPCP and as directed by the Child Protection Team.
- Seek personal support from the LDPCP.

If at any time a staff member is in doubt as to whether a situation or circumstance falls within Child Protection they must discuss it with a DPCP without delay. The DPCP will be able to offer advice and assistance. If they themselves are in any doubt, they should contact the LDPCP to discuss the matter and gain advice upon what further action, if any, to take.

A further option is for the concern to be directly reported to the Norfolk LSCB and/or Multi Agency Safeguarding Hub (MASH) team. In such circumstances the person making the referral should have the following information available:

- Their own name, status and contact point
- The reason for their concern
- The full name, address and date of birth of the young person involved.
- Details of the placing authorities

Having made a direct referral staff should not make further enquiries; this could prejudice any subsequent investigation and prove to be counterproductive to the protection of the child. Once an external referral has been made the investigation becomes the responsibility of the Child Protection Team.

4.2 DESIGNATED PERSON FOR CHILD PROTECTION (DPCP)

If the DPCP considers there to be grounds for referral they must inform the child's Social Worker, being clear that this is a Child Protection concern. If the child's Social Worker is not directly available the DPCP must inform the Placing Authority's Child Protection Team, initially by telephone. The child's own Social Worker or a member of the Child Protection Team will from then on provide advice and

assistance and will be responsible for coordinating the further conduct of the case. Therefore no further action should be taken without first consulting the Child Protection Team who must keep them informed of any further developments.

- The child's Placing Authority will take the lead. For Placement Authorities other than Norfolk, the Norfolk Child Protection Team and (MASH) must be informed at the same time. The two Placing Authorities are then responsible for their communication with each other; **SES staff should not act as a go between.**

- The DPCP must submit the full written report (Disclosure Form) and their own time line record of events to the Child Protection Team within 24 hours of the event.

- The details must then be entered on the internal Child protection timeline. Any updates must be added. These are kept in the child protection file.

- While all adults are responsible for the safety of all children at all times, in the event of a Child Protection referral it is the responsibility of the DPCP in particular to ensure the immediate safety of the child for whom the referral is being made.

- The DPCP is responsible for completing the online Ofsted Notification form within 24 hours of a child protection referral is taken up by Social Services. Copies of disclosures are not sent with a notification.

- If at any time the DPCP is unsure whether a referral is warranted they should contact the LDPCP and/or the LSCB/MASH to discuss the matter and gain advice upon what further action, if any, to take.

As stated above once a child protection referral has been made the investigation becomes the sole responsibility of the Child Protection Team with which all employees will cooperate fully. **The DPCP should not ring the police even if requested to do so by a Social Worker. It is the Child Protection Team's responsibility to take this step.** This is in line with Norfolk LSCB Safer Program Core Training guidance, issued in 2016

(See Appendix B for the DPCP checklist in the event of a disclosure/concern)

4.3 LEAD DESIGNATED PERSON FOR CHILD PROTECTION (LDPCP)

The LDPCP should be informed of all child protection related issues as soon as possible in order to offer advice and support and to ensure the policy and procedures are adhered to.

If the LDPCP is unsure as to whether a case should be formally referred, or has a general concern about a child's health or development, he or she can seek advice from the Norfolk LSCB or the child's Placing Authority.

- When referring a case of suspected or alleged abuse to the statutory agencies the LDPCP (or their designate) will ask to be informed of the timing of the subsequent Strategy Meeting. The strategy meeting involves representatives

from each of the statutory agencies and decides whether and how to investigate the allegation.

- The LDPCP (or their designate) should clarify with the investigating agencies when, how and by whom other agencies, parents or guardians of the child should be told a referral has been made.

- The Social Worker is responsible for providing a report of the outcomes of any related enquiry. The LDPCP (or their designate) should ensure receipt of this report as it enables the Case Coordinator to complete the Ofsted online Resolution form.

- The LDPCP can offer advice and support to any staff required to participate in strategy meetings or a Child Protection Case Conference.

- The LDPCP must be aware of all updates to confidential information in relation to child protection.

5 SUPPORT

There is a clear recognition that child protection work can be emotionally demanding and distressing. It is the responsibility of the LDPCP to ensure that due consideration is given to the affect on staff of any referrals, an opportunity to discuss this further should be provided as early as possible.

Specialist Education Services is committed to ensuring debriefing and/or counselling is available to staff who are, or have been, involved in Child Protection work.

The Registered Manager will give assistance and support to staff engaged in child protection work and will ensure they are available for all Child Protection Conferences.

6 RECORDING, RECORD KEEPING AND CONFIDENTIAL FILING

Having registered a concern or received a disclosure staff must:

- Complete the disclosure form promptly (e.g. within the hour), writing down in the young person's words, as exactly as possible, what was said or seen, putting the scene into context and giving the time and location.
- All hand written notes must be timed, dated, signed and kept, even if subsequently typed up or subsumed within a more formal report.
- It is important that all concerns, no matter how insignificant they may seem at the time, are recorded and conveyed to the LDPCP.
- The LDPCP must be made aware of all updates to confidential information.
- All records of a child protection nature must go directly to the child's confidential file. His case records will indicate that the separate file exists, but not its contents.

- Any timeline record kept by a DPCP in relation to a child protection referral is filed in the child's confidential file.
- Access to Child Protection records will be on a 'need to know' basis and the LDPCP will make specific decisions about access.
- If a child on the Child Protection register leaves for an alternative placement the LDPCP must inform the new placement immediately and arrange a separate handover of confidential information from other records. This handover should include signed evidence of paperwork transfer as specified in Keeping Children Safe in Education.
- The child should know that information is being recorded.

In addition records on all children should be constantly updated to ensure accuracy about:

- Who has parental/carer responsibility
- Any court orders that may be in force
- Any young person with a Children's Plan
- The young person's name at birth and any subsequent name changes
- Any other changes in home circumstances.

7 ALLEGATIONS AGAINST STAFF

All staff must read **"The Management of Allegations and Concerns Regarding the Professional Conduct of Adults in Relation to Child Protection: Policy and Practice".** This document gives a full and detailed explanation of policy and practice issues.

Allegations of abuse by members of staff must be investigated within the correct LSCB procedures, and when dealing with any allegation against staff, it is vital to keep the welfare of the child as the central concern. However, as with all child protection issues, a balance needs to be struck between supporting and protecting the child and keeping the effects of possibly false allegations to a minimum. Thus, urgent consideration should be given to the substance of the allegations.

On receiving an allegation the DPCP should proceed in line with recognised procedures, contacting the LDPCP who will liaise with the Principal. Investigations will be carried out by the appropriate agencies.
In certain circumstances, for example where the Principal is implicated in a child protection allegation, staff should make immediate direct contact with the LDPCP (if this is not possible their designate) who will inform a Co-Director and refer the case to the Norfolk LSCB Child Protection Team.

In dealing with any allegation the LDPCP needs to liaise with the LADO to decide:

- the risk of harm to the child or children
- the seriousness of the allegation
- possible contamination of evidence
- the welfare of the staff.

Suspension without prejudice of the member of staff may be considered where:

- there is cause to suspect a child is at risk of 'significant harm'
- the allegation warrants investigation by the police, or is so serious that grounds for dismissal are being considered. Suspension will not be automatic; consideration will be made as to whether the result that would by achieved by suspension could be obtained by alternative arrangements. The power to suspend is vested in the Principal.

Minutes of all past LADO meetings involving SES staff are stored centrally and confidentially in a single file that only is accessible by the Principal.

The decision to suspend should be carried out in line with Specialist Education Services' guidelines and can only be taken by the Principal after discussion with the LDPCP and/or outside agencies. Actioning this decision may be delegated to an appropriate senior manager.

8 CONFIDENTIALITY

In all child protection work the degree of confidentiality will be governed by the need to protect the child. Staff working with a child and his family must at all times make it clear that confidentiality may not be maintained if the withholding of information jeopardises the welfare of the child or young person.

Staff are expected to adhere to the following code of practice, or other practice guidelines provided by Specialist Education Services. This code of practice has been extracted from 'A Code of Ethics For Social Workers', adopted by the British Association of Social Workers, 1986.

"They will recognise that information clearly entrusted for one purpose should not be used for another purpose, without sanction. They will respect the privacy of clients and others with whom they come into contact, and confidential information gained in their relationship with them. They will divulge such information only with the consent of the client, except where there is clear evidence of serious danger to the client, worker or other person's or the community, or in other circumstances judged exceptional on the basis of professional consideration and consultation".

8.1 CONFIDENTIALITY: PRACTICE GUIDELINES

The following guidelines aim to provide staff with clear advice that will enable them to respond to issues of confidentiality with confidence.

All work with our children and young people and their families, must reflect respect for them. All practice must aim to uphold the highest possible professional standards in this area.

- Staff are required to inform a DPCP of any child protection disclosure or concern and act in keeping with the contents of this document

- Other than in the particular circumstances of child protection procedures children will be encouraged to talk to their parents and/or other significant adults.

- Staff will advise children of sources on confidential help, for example, the LAC team nurse, qualified and independent counsellor, GP, 'helpline' services or local young person's advice service.

- Staff must strive to develop open, honest relationships with our children through which trust may develop.

- Staff must never be drawn into accepting personal confidences, since confidentiality cannot be guaranteed. This should always be made clear.

- All records are kept in locked cabinets. Within each young person's main file a separate wallet is kept which holds all Child Protection information. Access to this information may only be obtained with the authorisation of the LDPCP.

9 SUPPORTING CHILDREN AND FAMILIES

- Children undergoing a child protection referral and investigation are likely to need a greater than normal level of support. This should be the focus of careful consideration as quickly as possible once a referral is actioned.
- The minimum we can offer is a safe environment in which the child feels valued and protected.
- We may offer support to the family of a child involved in a child protection investigation, but staff will need to remember the limits of confidentiality placed upon them, and that the welfare of the child is paramount.

10 POSITIVE PERSONAL CONTACT BETWEEN CHILDREN AND STAFF

At both Avocet House and Turnstone House there is clear and unequivocal expression of normal, positive, physical contact between adults and between adults and children. This is not physical contact that in any way seeks to establish authority over a child, but that which expresses 'parental' affection, to provide comfort, ease distress and signal care as would be expected between good parents and their children.

To deny this would be tantamount to emotional deprivation and we believe that normal adult/child physical contact is a critical therapeutic factor in children's care plans to a greater or lesser degree.

Our policy on positive personal contact has been affirmed by the very latest research and knowledge of neurobiology, and as illustrated by the writings of Dr Margot Sunderland. Particularly important is the clear connection between the production of positive neurochemicals of oxytocin and opioids, and warm parental physical contact and affirmation. Many if not all the children will have experienced the opposite of this where their brain chemistry has been swamped by repeated high levels of cortisol, adrenaline and noradreniline created by stressful situations.

Nevertheless every adult needs to appreciate the difference between appropriate and inappropriate touch, and to be aware of touch which poses as therapeutic, but

which is actually being used to satisfy the practitioner's need for contact rather than that of the child's. Naturally adults have to be fully cognisant of touch that is invasive or which could be confusing, re-traumatising, or experienced as stimulating in any way whatsoever. Should any such touch be used, it would be deemed as the most serious breach of professional boundaries warranting disciplinary action.

Bearing in mind the specific context, the following guiding principles should apply:

- Specific programmes involving therapeutic physical contact will be considered through the PAN (Portfolio of Achievement and Need) process
- Given that a high proportion of children with emotional and behavioural problems may have experienced sexual and/or physical abuse, staff need to ensure that any physical contact is not misinterpreted.
- If at any time a child demonstrates verbally or otherwise that he is not comfortable with physical contact staff should respond immediately by ceasing that contact.
- There should be no general expectations of privacy for the physical expression of affection or comfort, although this may be appropriate in exceptional circumstances (e.g. bereavement)
- Staff need to be aware that different cultural factors may apply
- Age and maturity are factors to be considered in deciding appropriate physical contact
- Where a member of staff feels that it would be inappropriate to respond to a child seeking physical comfort, the reasons for denying this should be clearly explained to the child. The child should be comforted verbally as necessary.
- Children should be counselled with regard to socially appropriate/inappropriate times/places/situations to seek physical comfort
- Appropriate physical contact should be a focus of discussions with parents/carers and placing authorities through Personal Tutor (and Case Coordinator where necessary).
- If an embrace takes place, care should be taken to make it a 'sideways' cuddle wherever possible, sensitively and tactfully handled.
- The issue of Personal Contact in general should be raised in interviews and induction training for staff and discussed in staff development and supervision.
- Physical contact of any kind initiated by staff should be no more than is necessary to fulfil its purpose. For example, in comforting a young person in distress, such physical comfort should be the minimum necessary to assist the young person to regain composure and calm.

10.1 PERSONAL CARE

There may be occasions when staff are involved in the intimate care of young people either because of the young person's age or level of functioning. For example it may be necessary for staff to supervise the running of a bath with particular regard to temperature and safety. If a young person asks for help when bathing this should take the form of verbal instruction, prior to the young person going into the shower or bath.

Some young people may ask for help in washing their hair and this is acceptable providing that it is done over a sink or bath side. Any other bodily contact is not appropriate. Staff should never have any contact with a young person that may

compromise them and allow misinterpretation of their intentions. If staff are in any doubt about the appropriateness of their actions they should seek advice from a senior colleague

The following are examples of physical contact, which are unacceptable:

- Play fighting between staff and young persons,
- Over affectionate cuddles,
- Kissing, and
- Any contact likely to be interpreted as sexual in nature,

The kind of physical contacts likely to be acceptable include:

- Planned physical contact which is part of a bespoke therapeutic intervention
- Holding a hand in situations which might present fear or anxiety,
- Putting an arm around the shoulder of a young person in distress,
- Patting a young person on the back to display approval, and
- Reinforcing a verbal request to calm down with a physical prompt such as a hand on a shoulder.

(The list is intended to be illustrative and not exhaustive)

The following areas of activity have been identified as situations in which staff and young persons could be vulnerable:

- Being alone with a young person,
- Examining a young person in case of injury or illness,
- Physical contact arising out of social interactions with SEN young people,
- Touching with the intent of providing comfort, and
- Physical contact initiated by a young person.

In order to minimise the risks in these sensitive areas, the following procedures should be adopted:

- All reasonable measures should be taken to avoid being alone with a young person. However, there are many circumstances where this will not be possible. In such circumstances, ensure that a colleague knows your whereabouts and the proposed duration of your 1:1 work.
- Physical examinations of young people are a sensitive area. Some young people may understandably not want an 'audience' of more than one adult and would prefer such examinations, (e.g. a rash on the upper part of the thigh), to happen in private with an adult they know and trust. Adults should base their approach on their previous knowledge of the child and safeguard themselves by alerting other adults to when such examinations are taking place. Intimate examinations should, under no circumstances, be carried out by members of staff, but should be done by medical practitioners.
- In the case of a distressed young person seeking physical contact this should be kept to the minimum necessary to fulfil the purpose of the young person regaining composure and calm.
- When inappropriate physical contact is initiated by a young person staff should seek to disengage from the situation as soon as is possible. In seeking to

disengage, staff may need to signal their disapproval of the inappropriate contact. This should be done consistently, i.e. irrespective of which young person has initiated it and on *all* occasions of inappropriateness. It is possible to disengage from such physical contact without signalling rejection of the young person or their affectionate intentions.

There may be some young people for whom any physical contact is particularly unwelcome. For example, some young people may be particularly sensitive to physical contact because of their cultural background or because they have been abused. It is important that all staff have an awareness of these young people. Staff should bear in mind that even innocent and well-intentioned physical contact could be misconstrued. If staff believe their intentions have been misconstrued they should immediately seek to discuss this with a senior colleague.

10.2 CARE AND CONTROL

Detailed advice concerning positive management of behaviour, physical intervention and restrictive physical intervention is contained in other comprehensive policy and practice documentation and is a substantial component of staff induction and training.

To this end the Team Teach Approach is used for staff training purposes. This training complies with statutory guidance and has been awarded a National Training Award. It is affiliated to The General Services Association and has been accredited by the British Institute of Learning Disabilities (in 2006, 2009 and 2012) and more recently The Institute of Conflict Management in 2015.

SES has intermediate and advanced instructors available on both sites.

(See also the "Positive Management of Behaviour Policy and Practice" document)

10.3 1:1 WORKING

Another area that has been identified as where both adults and young persons could be potentially vulnerable is that of being alone in a 1:1 situation. To ensure a naturalised domestic living situation one to one working is not only in reality unavoidable, it is also necessary to meet the complex needs of young people who have suffered a level of deprivation in respect of quality of attention and care from adults. We believe that a huge amount of invaluable work goes on in informal and planned 1:1 situations. Eliminating vulnerability for adult and child then becomes a matter of clarity of policy and professional practice.

The overriding principle is that wherever possible the child should feel that there is an appropriate naturalness about any situation unless there is a need through assessed risk to behave otherwise. Therefore, for example, virtually all internal room doors have fire doors with automatic closers fixed to them. Propping doors open will not only contravene fire safety regulations but also signals an institutionalism and lack of trust. A decision to prop a door open in this context must be temporary, risk related and explained to the child. Many community areas are open and easily observable.

All other precautions listed below should still be in place and observed.

These situations may fall into the following categories:

- natural, domestic living arrangements (e.g. watching TV with 2 children when one child leaves the room; cooking food in the kitchen, being invited to play a computer game by a child)
- planned 1:1 working required by casework (e.g. counselling re: family visit; talking a child through a behaviour programme, bespoke therapy, settle time, etc)
- Travelling to appointments, Doctors, Dentist, meetings, etc
- Accessing community or leisure facilities
- During the night

10.3.1 On Site: Natural Domestic Living

Due to the number of adults around at any one time, coupled with the open aspect of much of the house and site, it is highly likely that there will always be a at least a second adult in proximity, however there are circumstances where this might not be the case.

In such circumstances, staff are to ensure that a colleague knows the location and the proposed duration of any 1:1 time. Staff should always work in such a way that others know their whereabouts.

Particular note should be made of the individual child's Risk Assessment and advice can and should be sought from the duty DCM or Head of Education if staff are unsure of policy and practice.

10.3.2 Planned 1:1 Working Agreed As A Part of Casework

This type of working can only take place when a casework decision has been made via a PAN Meeting to offer or instigate 1:1 work, e.g. a bespoke therapy session. 1:1 time may be agreed as part of a wider behavioural programme, e.g. as part of assisting a settle routine where dedicated adult attention (as illustrated by story reading) is required. Any decisions of this kind are taken by a group of adults usually with consultant support. They will be clearly planned and time related with a review procedure built in.

10.3.3 Attending Meetings/Appointment with a Young Person

There may be occasions when staff will be asked to take a young person to a meeting or an appointment. Staff should make sure they are aware of the following:

- Carry a mobile phone with a contact number for colleagues if needed

- Ensure you are aware of Risk Assessments and any current contextual information from the duty DCM or Head of Education

- Follow the procedures for using the home's vehicle/own vehicle for transporting young people

10.3.4 Accessing Learning, Community or Leisure Activities

In order to address issues of institutionalisation it is good practice for young people to access learning, community and leisure facilities either individually or in small groups. In order to minimise risks the following guidance should be observed.

- Carry a mobile phone making sure you have a contact number for a colleague, in case you require assistance whilst out

- Ensure you have fully informed colleagues (e.g. duty DCM or Head of Education) where you are going, who you have taken out, what time you left and your expected return time, and follow signing out procedures

- Ensure you have the necessary knowledge, skills and where appropriate qualifications to safely participate in the activity

- All staff should ensure that appropriate planning documentation and risk assessments (if applicable) are completed prior to the activity taking place.

- Follow the procedures for using the home's vehicle/own vehicle for transporting young people

10.3.5 During the Night

It is already clear in policy guidance that adults should ensure the home is settled before retiring for the night themselves.

Each young person's bedroom door is alarmed, with the primary purpose of ensuring they can be adequately nurtured and cared for should they require support in the night. Additionally, the alarm system ensures young people are safeguarded at all times when in their bedrooms, allowing staff to know their specific whereabouts.

It would appear heavy handed and signal a lack of trust if an adult awoken by a bedroom door alarm were to have to alert a second adult just to safeguard a child going to the toilet and returning to bed. However there are three adults on site (two at Turnstone House) all linked by telephone, who can be alerted where the need for mutual support, or the risk assessment, require their presence.

At times of heightened and demonstrable need, arrangements can be in place to raise two adults, or in extreme cases of having a waking watch in addition to a sleeper-over.

A Nightime Disturbance Log is used to record issues arising outside the normal settle times i.e. once children have gone to sleep, approximately after

1100 and before 0600 when adults rise. This log is completed to give key details of, and reasons for, the disturbance.

11 CODE OF PROFESSIONAL PRACTICE

11.1 INTRODUCTION

There is a statutory responsibility on all schools and colleges. **"Keeping children safe in education: Statutory guidance for schools and colleges" (Commencing September 2016) clearly states:**

Safeguarding policies should include,

"…..a staff behaviour policy (sometimes called the code of conduct) which should amongst other things include - acceptable use of technologies, staff/pupil relationships and communications including the use of social media."

"These policies, along with Part one of this guidance (Keeping children safe in education) and information regarding the role of the designated safeguarding lead, should be provided to all staff on induction. Governing bodies and proprietors should take a proportional risk based approach to the level of information that is provided to temporary staff and volunteers."

This clearly relates to all adults not just care workers:

Seven International Ethical Principles for People Working with Children and Young People *(The International Child and Youth Care Network)*

It is the professional responsibility of each childcare worker to:

1. Value and respect each child or young person as an individual in his/her own right, in his/her role as a member of his/her family, and in his/her role as a member of the community s/he lives in;

2. Respect the relationship of the child or young person to his/her parents, his/her siblings, other members of his/her family and other significant persons, taking account of his/her natural ties and interdependent rights and responsibilities;

3. Facilitate the optimal growth and development of each individual child or young person to achieve his or her potential in all aspects of functioning;

4. Help each child or young person for whom he or she bears responsibility by preventing problems where possible, by offering protection where necessary, and by providing care and rehabilitation to counteract or resolve the problems faced;

5. Use information appropriately, respecting the privacy of children and young people, maintaining confidentiality where necessary, respecting the right of children and young people to be informed of matters concerning themselves,

and avoiding the misuse of personal information;

6. Oppose at all times any form of discrimination, oppression or exploitation of children and young people, and preserve their rights;

7. Maintain personal and professional integrity, develop skills and knowledge in order to work with competence, work co-operatively with colleagues, monitor the quality of services, and contribute to the development of the service and of policy and thinking in the field of childcare.

All other standards expected of workers with children stem from these seven clauses.

11.2 SES EXPECTATIONS OF ADULTS

There are specific references to the expectations of adults working for SES throughout a range of policy and practice documents. Below are examples of where they are to be found. However these are not exclusive as virtually all policy and practice documents refer either directly or indirectly to operational and professional practice expectations.

11.2.1 From the core standards, again applying to all adults irrespective of role:

Personal and Professional Conduct

1 To role model and maintain professionally high standards of ethics and behaviour, within and outside Avocet and Turnstone House
2 Treat young people with dignity, building relationships rooted in mutual respect, and at all times observing proper boundaries appropriate to a professional position
3 To implement at all times the safeguarding of young people in accordance with their risk assessments and the companies policies and procedures
4 Showing tolerance of and respect for the rights of others
5 Not undermining fundamental values, policies and practice of the company
6 Demonstrate mutual respect and tolerance of those with different faiths, beliefs and orientations in accordance with equal opportunities
7 Ensuring that personal beliefs are not expressed in ways which exploit young people's vulnerability or might lead them to break the law
8 Adults must have proper and professional regard for the ethos, policies and practices of SES, maintaining high standards in their own attendance and punctuality
9 Adults must have an understanding of, and always act within, the statutory frameworks which set out their professional duties and responsibilities

11.2.2 From the "Acceptable use of Technology Policy and Practice" document

Section 6.1: Unacceptable Behaviour

Section 6.3: Electronic Communication Between Staff and Students

11.2.3 From the "Leadership and Management in the Deputy Care Manager Role" document

Section 2.6: DCM Code of Conduct

11.2.4 From the "Management of Allegations and Concerns Regarding the Professional Conduct of Adults in Relation to Child Protection: Policy and Practice" document

Appendix B: What is Acceptable Behaviour by Adults Towards Children

As part of staff induction, SES also expects all adults to understand the 'Guidance for safer working practice for those working with children and young people in education settings, October 2015'. The content of this guidance is discussed in the context of SES policy and practice, with any specific differences highlighted in the training.

12 CONTACT WITH UNAUTHORISED PERSONS

The very nature of the young people, all of whom have special educational needs often characterised by learning difficulties, poorly developed social skills, emotional vulnerability and impulsivity which can lead to poor decision making, places our children at particular risk. There is a delicate balance between protecting children and promoting independent and self-help skills. Staff need to consider carefully the risks involved and the level of supervision and support required in activities where young people engage with members of the public both in person and also electronically via the Internet or telephone. Staff must always be vigilant for those who may seek to take advantage of or exploit the young people in their care.

Any contact by unauthorised persons should always be reported immediately to the duty DCM, who will decide what, if any, action is required. Reports should always be taken seriously and investigated.

13 RISK ASSESSMENT

- In addition to individual risk assessments on each child, the physical premises and site undergo a similar scrutiny in light of potential risk and supervision.
- In the case of child protection risk assessment will identify areas where supervision is difficult, where unauthorised visitors may access the premises, and times when young people may be more vulnerable.
- The assessments will also consider identifying areas where staff may become vulnerable to allegation, e.g. being alone with children.

14 CREATING AND MAINTAINING A 'SAFE' ENVIRONMENT

At all times staff should, through good professional practice, seek to:

- create a listening environment
- create a 'no secrets' environment
- become a 'telling' environment
- create an environment where there is respect and care demonstrated to others
- help young people to feel confident to ask for help when they need it.

14.1 THE PORTFOLIO OF ACHIEVEMENT AND NEED

The Portfolio of Achievement and Need (PAN) refers to the process of overall planning to support a child's learning and development at each establishment. In all aspects of the PAN process staff will have regard to specific learning opportunities which may help young people to protect themselves and each other from abuse, and from becoming abusers themselves.
All staff have a collegiate responsibility to enable young people to:

- gain an understanding of human development and relationships
- help promote good parenting through discussing issues about child development and childcare
- build up self-esteem by experiencing a positive learning environment where they are encouraged and offered opportunities to succeed
- learn to solve problems and deal with a range of challenging situations
- develop in a supportive environment where everyone is valued and respected
- express emotions and feelings, and deal respectfully with the emotions and feelings of others.

14.2 ENSURING E-SAFETY AND SECURITY *(Internet Use and Laptops)*

Each house has a remote E-Safety monitoring system as well as the standard in house filtering and monitoring systems regarding appropriate use and safety.

- All children have Risk Assessments, which incorporate specific detail of how to safeguard individuals in line with recent published E-safety guidelines.
- All children's machines will undergo regular monitoring to ensure appropriate internet use
- Social Networking sites will be assessed for appropriateness on a site by site basis. Monitoring of social networking usage will be part of the regular monitoring process.
- Staff will check that the sites selected for student use are appropriate to the age and maturity of students;
- The Principal will monitor the overall effectiveness of Internet access strategies. This will be achieved through a combination of a commercial remote monitoring system and in house systematic monitoring.

- Personal Tutors and Link Tutors will be trained in systematic monthly checking of the young people's computers and other items that have Internet capability or the provision to transfer information and/or pictures. It is ultimately the Personal Tutor's responsibility to ensure the monitoring is carried out.
- Monitoring may move to a more infrequent sample monitoring for individuals with an extended track record of responsible use.
- Access levels will be reviewed as students' Internet use expands and their ability to retrieve information develops;
- The ICT co-ordinator/system administrator will ensure that regular checks are made on files to monitor compliance with the Internet Access Policy
- E-Safety will be an integral aspect of the curriculum for all young people as education around E-Safety is one of the most effective safeguards for vulnerability that may arise from internet use.

(See also the "Acceptable Use Of Technology Policy and Practice" document)

14.3 PEER ON PEER ABUSE

Through induction training all staff are made aware of the safeguarding issues that can manifest themselves via peer on peer abuse, such as bullying, cyber bullying, gender based violence, sexual assaults and sexting. In order to respond to concerns of peer on peer abuse, adults will need to refer to the Anti-bullying Policy and Practice document, the Positive Management of Behaviour Policy and Practice document, and the Appropriate Use of Technology Policy and Practice document, depending on the nature of abuse.

In a situation where child abuse is alleged to have been carried out by another child, the child protection procedures should be adhered to for both the victim and the alleged abuser; that is, it should be considered a child-care and protection issue for both children.

15 STAFF RECRUITMENT AND SELECTION

SES has in place a series of systems and checks that assist in the safe recruitment and selection of staff. All staff are subject to a Disclosure and Barring Service check at the enhanced with barred list level. Candidates must provide proof of identity through official documents and qualifications and references are checked for authenticity.

All staff must provide a full employment history with any gaps fully explained and all appointments will be subject to references having being received and checked. Referees will be reminded that references must not contain any material mis-statement or omission relevant to the suitability of the applicant.

Even the most careful selection process cannot guarantee the suitability of candidates and all new appointments will be subject to a probationary period. On commencement of duties all staff participate in the Staff Support and Development Programme, which provides regular, planned and supportive supervision, guidance and development opportunities.

Directors, Principals, Registered Managers, Heads of Education, Heads of Care all attend the local authority Safer Recruitment Training. Deputy Care Managers are offered this training as part of their professional development at an agreed timescale, although this is not deemed mandatory.

Specialist Education Services holds a Single Central Record (SCR) for those employed or engaged with the establishment. This document forms an integral part of the recruitment and selection policy and forms part of the overall safeguarding measures. This is maintained in line with the Keeping Children Safe in Education 2016 statutory guidance.

[See also the "Recruitment and Selection Policy and Practice (Incorporating the Policy Statement on the Secure Storage, Handling, Use, Retention and Disposal of Disclosures and Disclosure Information)" document]

16 SAFEGUARDING AND CHILD PROTECTION TRAINING

Specialist Education Services is committed to the training and updating of designated staff as a priority, with refreshers at 2 yearly intervals, overseen by the LDPCP. All staff (full-time and part-time) will have access to basic safeguarding training as part of their induction process and will undertake suitable refresher training annually in line with the Keeping Children Safe in Education guidelines. As part of the induction training it is important that all risk areas are considered with regards to keeping Young People safe; this covers a comprehensive range of areas:

- What is Child Protection? A brief look at SES Safeguarding Policy
- Role of Local Safeguarding Children's Board (LCSB) and the Multi Agency Safeguarding Hub (MASH)
- Signs and Symptoms of Abuse
- Recognising responding to a disclosure
- The Role of the Designated Person
- Whistleblowing procedures and policy
- Child Sexual Exploitation & Teenage Pregnancy
- Honour Based Violence & Female Genital Mutilation
- Child Trafficking
- Radicalisation & Prevent Duty
- E-Safety
- Peer on Peer Abuse
- Essential Government Safeguarding Documents

The primary aim of this training is to raise awareness amongst all staff in relation to child abuse in order to equip them with relevant knowledge and skills which will enable them to recognise and respond to child protection issues, and enable them to implement this policy. They must also be able to recognise how this training is implemented to protect Young People on a daily basis through the care planning process.

Personal Development happens through opportunities to:

- examine the values and attitudes underlying concerns about child abuse
- identify personal values and attitudes to child abuse, e.g. Am I aware of my personal prejudices? Will I transfer them to the child or young person? Will this affect my ability to function effectively in this situation?
- explore personal feelings about cases of abuse.

Adults have a responsibility to ensure young people are taught about safeguarding, including online, through teaching and structured learning opportunities. This may include covering relevant issues through a range of means, including, PSHEE, SRE, tutorials, personalised planning (such as specific twenty four hour curriculum) and sharing views on individual risk assessment and personal progress.

17 PORTFOLIO OF OTHER POLICY AND PRACTICE DOCUMENTATION THAT CONTRIBUTE TO THE SAFEGUARDING PROCESS

In a high quality organisation there will be a wide range of policy documents and practice issues that underpin the holistic safeguarding process. No one of these documents and associated practice and procedures can in themselves illustrate the complete picture.

Some of these policies and guidance has been signposted throughout this document. Each policy referenced in the text above or the list below can be seen in detail on the establishment's internal network and every staff member has their own personal copy on their laptop.

- Children Missing from Care and Education Policy and Practice Document
- Access and Visitors Policy and Practice Document
- Anti Bullying Policy and Practice Document
- Policy and Practice For The Disclosure Of Information In The Public Interest (Whistle Blowing)
- Complaints and Representations Policy and Practice
- Grievance, Capability and Disciplinary Procedures
- Health and Safety Policy and Practice Document
- Regulation 44 and 45 Procedures and Supporting Guidance
- Notification Of Significant Events Policy and Practice
- Critical Incident Policy and Practice
- Personal, Social, Health and Economic Education Policy and Practice
- Educational, Social and Leisure Visits and Activities Policy and Practice
- The Management of Allegations and Concerns Regarding the Professional Conduct of Adults in Relation to Child Protection: Policy and Practice
- Appropriate and Suitable Location Review for Avocet House

The following national guidance should also be read in conjunction with this policy:

- What to do if you're worried a child is being abused: Advice for practitioners March 2015
- Working Together to Safeguard Children March 2015
- PREVENT Strategy HM Government July 2015

- Keeping children safe in education: Information for all school and college staff September 2016
- Keeping Children Safe in Education September 2016

All staff have a responsibility for monitoring its effectiveness. All designated members of staff have a particular responsibility, (and the Lead Designated Person a specific responsibility), for monitoring and evaluating our use of child protection procedures and the degree to which each house is safe, welcoming, supporting and a listening and telling environment.

APPENDIX A

Lead Designated Person for Child Protection (LDPCP)

Referrals/Working with others

- Refer cases of suspected abuse or allegations to the relevant investigating agencies.
- Act as a source of support, advice and expertise within the establishment when deciding whether to make a referral by liaising with relevant agencies.
- Liaise with Principal to inform him/her of any issues and ongoing investigations and ensure there is always cover for this role.
- Refer cases to the Channel programme where there is a radicalisation concern as required

Training

- To recognise how to identify signs of abuse and when it is appropriate to make a referral.
- Have a working knowledge of how LSCB's operate, the conduct of a child protection case conference and be able to attend and contribute to these effectively when required to do so.
- Ensure each member of staff has access to and understands the safeguarding and child protection policy especially new or part time staff.
- Ensure all staff have induction training covering safeguarding and child protection and are able to recognise and report any concerns immediately they arise.
- Plan and implement annual safeguarding and child protection training for the establishment
- Be able to keep detailed accurate secure written records of referrals/concerns.
- Obtain access to resources and attend any relevant or refresher training courses at least every two years.
- The LDPCP should undertake Prevent awareness training, understand and support the requirements with regards to the duty and provide advice and support to staff on protecting young people from the risk of radicalisation.
- Facilitate a culture of listening to young people and take into account their wishes, and consider the feelings amongst staff in any measures that the establishment may put in place to protect them.

Raising Awareness

- Ensure the establishment's safeguarding policy is updated and reviewed annually and work with the Principal regarding this.
- Ensure parents receive and understand the child protection policy, which alerts them to the fact that referrals may be made and the role of the establishment in this to avoid conflict later.
- Where children leave the establishment ensure their child protection file is copied for new establishment as soon as possible but transferred separately from the main file.

APPENDIX B

DPCP Checklist In The Event Of A Disclosure/Concern

- Listen to the concern being expressed

- If necessary instruct the member of staff expressing the concern to complete a Disclosure form clearly outlining the disclosure or the concerns and reasons for them. This must be dated and signed.

- Ensure the immediate safety of the child or young person.

- Consult with the Registered Manager (LDPCP); if for any reason this is not immediately possible proceed as designate to the Principal.

- Inform the Local Area Safeguarding Children Board's Child Protection Team and MASH (if required) initially by telephone. They will from then on provide advice and assistance and will be responsible for co-ordinating the further conduct of the case.

- If the alleged abuse or staff's concerns are directly linked with the young person's home life, then Norfolk Social Services Child Protection Team will pass the case over to the Child Protection Team in the child or young person's home area.

- Take no further action without first consulting the Child Protection Team. Keep them informed of any further developments.

- It is the responsibility of the Lead Designated Person (or their designate) to inform the appropriate responsible officer for the child's home district without delay. If the child or young person's home district is within Norfolk, the relevant responsible officer should be notified of the circumstances of the case.

- Immediately notify Ofsted of a Child Protection referral by completing an Online Notification of Significant Events form. Print the completed Notification of significant events form for the child's file. Ofsted is informed of the instigation and outcome of any child protection enquiry.

- Make an entry in the Notification of Significant Events book.

- Following the resolution of a CP referral an online **Resolution Form** must be completed by the Case Co-Ordinator and will automatically be sent to Ofsted.

- Log all contacts and updates on the internal Child Protection timeline.

- If there is an allegation made against a member of staff, this must be referred directly and immediately to the Lead Designated Person who will involve the Principal.

APPENDIX C

SIGNS AND SYMPTOMS OF ABUSE

The following is a list of signs and symptoms as it appears in the current LSCB procedures. Staff should familiarise themselves with these and be aware of them.

This appendix is intended to help staff that come into contact with child abuse. It should not be considered as a comprehensive or definitive list, nor does the presence of one or more factors give proof that child abuse has occurred. It may however, indicate that careful investigation should take place.

1 PRESENTATION OF AN INJURY

There are certain parental responses, which are known, by research and experience, to suggest a cause for concern. These include:

1.1 An unexplained delay in seeking treatment that is obviously needed, or it is sought at an inappropriate time;

1.2 A lack of awareness or denial of any injury;

1.3 Incompatible explanations are offered

or;

The child is said to have acted in a way that is not appropriate to its age and development

or;

Several different explanations are offered:
(N.B. The child and/or other members of the family may support the explanations, however improbable)

- A reluctance to give information, or failure to mention previous injuries known to have occurred. Conversely, some parents are over-compliant in their response to questioning;
- The family has attended Accident and Emergency departments, unusually frequently, with appropriate and inappropriate requests for attention;
- A constant presentation of minor injuries, which may represent ‘a cry for help’, which, if ignored, may lead to more serious injury. Attention may be sought for other problems unrelated to the injury, which may not even be mentioned;

- Unrealistic expectations of the child, or constant complaints about the child. Parents may show a violent reaction to a child's naughty behaviour;
- Consent for further medical investigation is refused;
- The parents are drunk or under the influence of drugs or cannot be found;
- The parents ask for the child to be removed from home or indicate difficulties coping with the child.

2 PHYSICAL INJURY

This part is of particular relevance to doctors but also offers a lay person's guide to the more common injuries found in cases of child abuse. Some injuries may seem insignificant by themselves, but repeated injuries, even of a very minor nature, especially in a baby or young child, may be symptomatic of child abuse and, if no action is taken, the child may be injured more seriously.

2.1 BRUISES

- Petechial haemorrhage (pin-point haemorrhage of the face and neck can indicate a serious shaking injury).
- Multiple subungual haematomas (haemorrhages under fingernails).
- Black eyes- particularly suspicious if both eyes are black (most accidents cause only one), if the lids are swollen and tender and if there is no bruising to the forehead or nose. Black eyes can also be caused by blood seeping down from an injury above, e.g. a skull fracture - in these cases, there will be little lid swelling.
- Bruising in or around the mouth (especially in small babies where it can indicate force-feeding).
- Grasp marks on the arms, or chest, of a small child.
- Finger marks (e.g. three or four small bruises may be seen on one side of the face and one on the other.
- Symmetrical bruising on the ears – sometimes on the back of the ear.
- A direct impression or outline bruising (e.g. belt marks, handprints).
- Linear bruising (particularly on the buttocks or back).
- Bruising on soft tissue with no obvious explanation.
- Different age bruising.

N.B. most falls, or accidents, produce one bruise on a single surface, usually on a bony protuberance. A child who falls downstairs generally has only one or two bruises. Bruising in accidents is usually on the front of the body, as children generally fall forwards. In addition, there may be marks on their hands if they have tried to break their fall.

N.B. The following are uncommon sites for accidental bruising:

- Back, back of legs, buttocks (exception, occasionally, along the bony protuberances of the spine);
- Mouth, cheeks, behind the ear;
- Stomach, chest;

- Under the arm;
- Genital, rectal area (but ask if the child is learning to ride a bicycle);
- Neck.

N.B. Harmless "Mongolian blue spot" may be mistaken for fresh bruises in African or Asian children.

2.2 FRACTURES

- Any fracture which does not have a clearly accidental history.
- A vague history of "must have hit his/her head on the cot bars" or maybe "falling downstairs" will be suspect.
- Additional, unsuspected fractures of the ribs, long bones and skull may be revealed on x-ray.

Fractures should be suspected if there is pain, swelling and discolouration over a bone or joint. The most common non-accidental fractures are to the long bones (i.e. arms, legs, ribs). It is very rare for a child under one year to sustain a fracture accidentally. Fractures normally cause pain and it is difficult for a parent to be unaware that a child has been hurt.

2.3 JOINTS

A tender, swollen joint with a normal x-ray may require a further x-ray in two weeks, to reveal fracture of bleeding under the periosteum (lining of the bone).

Radiological signs which should arouse suspicion:

- Any fracture in a young child.
- Spinal fracture in a young child.
- Multiple fractures.
- Various stages of healing.
- Epiphyseal displacement.
- Metaphyseal fracture or fragmentation (chip fractures).
- Double contour lines of periosteum.
- Massive cortical thickening – this is a late sign.
- Avulsion of provisional zone of clarification.

2.4 MOUTH

Tear to the fraenulum often indicates force-feeding of a baby. There is often finger bruising on the cheeks or in and around the mouth. In addition, there may be linear grazing on the palate.

2.5 EYES AND BRAIN

- Retinal haemorrhage from chest compression or shaking.
- Bleeding into the anterior chamber of the eye.
- Subdural haemorrhage – suspect when presenting signs are vomiting; irritability; failure to thrive and/or minor weakness of arm and leg on one side – in the

chronic case. Tense fontanelle, hypertonia, fits or pallor – in the acute case, these would present as very sick children.

2.6 VISCERA

Injuries to a solid or hollow viscous in a child may present as an acute abdomen with vomiting or with signs of shock, the child may show signs of acute abdominal tenderness, or of peritonitis.

2.7 POISONING

Ingestion of tablets, medicines, or domestic poisoning may not always be due to accidental carelessness. The child may present as being drowsy. Be particularly cautious of the parents are known to, or appear to, abuse drugs or alcohol.

2.8 HYPERNATRAEMIC

This can result from parents making over concentrated feeds out of ignorance, or malicious intent, or from withholding fluid from a child, or by the addition of salt to feeds. Hypernatraemic dehydration can arise accidentally, however, and this should be excluded.

2.9 BITES

These can leave clear impressions of marks of individual teeth, or sometimes a more general crescent-shaped mark. Human bites are oval or crescent shaped. If the distance is more than 3 cm across, they must have been caused by an adult or older child, with permanent teeth.

2.10 BURNS AND SCALDS

It can be very difficult to distinguish between accidental and non-accidental burns, but as a general rule, burns or scalds with clear outlines are suspicious, e.g. a gloves and socks effect. So are burns of uniform depth over a large area. Also, splash marks about the main scald area (caused by hot liquid being thrown).

Remember also:

- A responsible adult checks the temperature of the bath before a child gets in.
- A child is unlikely to sit down, voluntarily, in too hot a bath and cannot scald its bottom accidentally without also scalding its feet.
- A child getting into too hot water of its own accord will struggle to get out again and there will be splash marks.
- Small round burns may be cigarette burns (but may be friction burns and accidental, if along the bony protuberances of the spine). It is sometimes felt difficult to differentiate between impetigo and cigarette burns – but generally impetigo is multiple and increases even during early stages of treatment. Cigarette burns also tend to have a characteristically dark, thick base.

2.11 SCARS

All children have scars, but notice should be taken if an exceptionally large number, particularly if of different ages and if accompanied by current bruising. Unusually shaped scars (e.g. old cigarette burns), or large scars (indicating burns that did not receive treatment), should be viewed suspiciously.

2.12 HONOUR BASED VIOLENCE

Honour Based Violence (HBV) is a term used to describe violence committed within the context of the extended family which are motivated by a perceived need to restore standing within the community, which is presumed to have been lost through the behaviour of the victim. Most victims of HBV are women or girls, although men may also be at risk. If there is any cause for concern in relation to HBV adults need to refer to the Safeguarding Policy and procedures.

3 NEGLECT AND FAILURE TO THRIVE

A child's growth and development may suffer when he/she receives insufficient food, love, warmth, care and concern, praise and encouragement or stimulation. Such children, when placed in a different environment, e.g. a hospital or a foster home, sometimes show rapid and dramatic improvement, but occasionally improvement may be slow owing to the child's inability to adjust to a regular diet. Neglect and failure to thrive will need a medical diagnosis but warning signs, apart from perhaps the child's neglected appearance, may include:

- A child who is short in stature and under-weight for his/her chronological age;
- A cold skin mottled with pink or purple;
- Swollen limbs with pitted sores which are slow to heal;
- The child's skin condition is poor, especially in the nappy area;
- Diarrhoea – caused by poor, or inappropriate, diet, irregular meals and tension;
- Abnormally voracious appetite (e.g. at school or nursery);
- Dry sparse hair;
- General physical disability;
- Unresponsiveness in the child, or indiscrimination in their relationships with adults – often seeking attention, or affection, from anyone;
- A child who stays frozen in one position for an unnaturally long time.

4 EMOTIONAL ABUSE

a) Emotional abuse can exist in the absence of physical ill treatment. A child's need for love, security, encouragement, praise and stimulation when unmet, can have a serious and sometimes irreparable effect on the child's development. Parents may be hostile, rejecting, indifferent, or, perhaps worst of all, inconsistent and unpredictable in their response to their child.
b) In some families, one particular child may be singled out for such treatment and even siblings encouraged to scapegoat their abused brother or sister. Some children may become household drudges, having to carry the burden of many tasks in the home, inappropriate to their age and status.

c) Some parents emotionally abuse their children by being seriously over-protective and possessive to the extent of preventing normal social contact and activity with friends. This may extend to refusing to allow their children to attend school, or reluctance on the part of the child to attend.
d) An environment in which domestic violence exists is highly abusive to all its victims and children in particular can be hurt and abused without being touched.
e) Emotional abuse is generally difficult to evaluate, and where it is suspected, it is advantageous to obtain psychological and psychiatric opinion as part of the child abuse assessment.

5 COMMON FAMILY CHARACTERISTICS

Certain family and social characteristics have been frequently noted in cases of child abuse. Again, their presence does not prove that an injury was non-accidental, nor does the absence of any of these characteristics mean there will be no cause for concern. The presence of a number of the following factors, however, will almost certainly indicate that the family is under great stress and in need of help, whether an injury has occurred or not.

The following are indicators for the need to be alert.

5.1 THE PARENTS.

- The parent's own childhood was deprived and they were subjected to abuse and often had a turbulent adolescence.
- They had a youthful marriage and mother had her first baby before she was twenty years old. There was poor preparation for parenthood and poor or non-existent antenatal care.
- The parents are young and immature.
- They are socially isolated and often mobile. Often they are antagonistic to authority figures and very sensitive to use of the support services.
- There is marital instability, trouble, or violence. A typical family structures are over-represented in research studies and one partner is likely not to be the parent of all the children.
- Father figures are often aggressive and rigid. Mothers often show depressive illness.
- Parental needs come before children's needs. Parents may show jealousy and rivalry towards the child. There may be unrealistic expectations of the child and ignorance of normal child development, leading to conflict in such areas as feeding, toilet training etc. They complain that the child cries a lot.
- The excessive use of alcohol, drug/substance abuse and a level of general criminality may be evident.
- The carer may have a history of mental health problems and non-compliance with treatment.

5.2 THE CHILD.

- The child was born prematurely, or was a delicate baby requiring extra attention. This may have led to the separation of mother and baby following the birth.
- The child was a result of an unwanted pregnancy.

- The child is seen realistically, or unrealistically, as a problem (difficult feeder, slow toilet trainer, control problems, learning problems, etc.).
- The child cries a lot.
- The child shows apprehension of a parent(s) or other adults. In extreme cases, young children may exhibit frozen awareness whereby they seek to avoid provoking any negative reaction from an adult. Conversely, an older child may look after the parent, or brother and/or sisters, in order to head off stress. This can deceive professionals into thinking that the parent-child relationship is sound.
- The child is often dirty and unkempt.
- Older abused children may demonstrate what is happening in the family by difficult, anti-social behaviour.

5.3 FAMILY CIRCUMSTANCES.

- Environmental stress, such as poor housing, together with financial difficulties, perhaps stemming from unemployment, can contribute to causing child abuse.
- The family may lack support from extended family and neighbours.
- They may have moved several times and have no local roots.
- There have been a number of children in quick succession, with a history of general concern about their care.
- A child's arrival, whether the first or later child, will have an effect on the family and may be a source of stress.

6 SEXUAL ABUSE

a. Sexual abuse is now known to be more common than has been generally recognised. Boys and girls of all ages can be victims but the majority are girls. The perpetrators are usually adults known to the children involved e.g. fathers, stepfathers, relatives, neighbours, family, friends etc. Abuse within a family is rarely an isolated event; it sometimes lasts for months and years and involves more than one child. Abuse usually escalates from caressing and fondling, which the child may welcome initially, to mutual masturbation and penetration.

Victims may disclose their situation to adults in whom they have confidence. It is now known that children rarely fantasise, or make up stories of sexual abuse. Children's allegations should, therefore, always be taken seriously and thoroughly investigated.

b. Often, there are no physical signs to indicate sexual abuse, although concern should be felt and a forensic medical examination undertaken, when the following are present:

- Some injuries in the genital/anal area e.g. bruising, tearing of the vaginal wall, rectal damage;
- Infections, or abnormal discharge, in the genital/anal/oral area e.g. venereal disease, thrush, cystitis, unexplained bleeding, presence of semen, or foreign bodies in genitalia;

- Pregnancy, especially where the child is under sixteen and/or identity of father is a secret or vague;
- Abnormal dilation of the urethra, anus or vaginal opening.

c. Young people who are being sexually exploited (CSE) maybe:

- involved in abusive relationships, intimidated and fearful of certain people or situations
- hang out with groups of older people, or antisocial groups, or with other vulnerable peers
- associate with other young people involved in sexual exploitation
- get involved in gangs, gang fights, gang membership
- have older boyfriends or girlfriends
- spend time at places of concern, such as hotels or known brothels
- not know where they are, because they have been moved around the country
- go missing from home, care or education.

d. The psychological indicators sometimes linked to child sexual abuse include:

- Sexually precocious behaviour; e.g. inappropriate contact with adults;
- Sexualise drawings and play;
- Sudden, poor performance at schools;
- Regressive patterns; soiling, wetting;
- Poor self-esteem; “Cinderella” Syndrome;
- Psychosomatic symptoms; headaches, abdominal pain;
- Suicidal gestures; overdosing, etc;
- Self-mutilation;
- Identification with the aggressor, leading to the abuse of other children;
- A confusion of ordinary affectionate contact with abuse;
- Promiscuity;
- Anorexia nervosa;
- Sleep disturbance, e.g. nightmares, hyper-alertness, vivid dreams with veiled sexual content;
- Withdrawal and depression;
- Running away.

N.B. Many of these symptoms are also associated with other forms of childhood disturbance and in themselves should not be seen as diagnostic.

e. The patterns of behaviour in particular children will depend on the age, sex and stage of development of the child.

- Pre-school children are more likely to show direct physical responses, sexualisation of behaviour and regressive signs and symptoms;
- School age children may show unexpected decline in school performance, loss of self-esteem patterns, running away, reluctance to return home at the end of a school day, may be resistant to PE, undressing at school, medicals etc;

- Adolescents may overdose, run away, self-mutilate, become promiscuous, develop anorexia, abuse drugs or alcohol, or have hysterical attacks;
- Boys are more likely to identify with the aggressor.

N.B. Many of these symptoms are also associated with other forms of childhood disturbance and should not in themselves be seen as diagnostic.

f. The following are some possible characteristics (from research and experience) of families where sexual abuse has taken place. (This is not necessarily a comprehensive list):

- Sexual abuse is seen by some as a symptom of the family's overall dysfunction. Sexual abuse is seen as a means of avoiding overt conflict and thus a means of preventing disintegration of the family, but at the expenses of the abused child. Sexually abused children are made to comply by the adult's abuse of their power.
- Families are often somewhat isolated and have difficulty cultivating relationships outside the family circle. Roles and boundaries within the family can be confused and daughters may not only take on the sexual role but other maternal responsibilities as well. Research shows that parents often have a history of abusive, or deprived, experiences in childhood.
- There may be inappropriate displays of affection between fathers and daughters, or mothers and sons.
- Severe marital conflict is often present but usually suppressed. Stepfathers and cohabitees are over-represented in research studies.
- A degree of collusion is often evident between family members. The non-abusing parent sometimes colludes in either an overt, or covert, way. Poor mother-daughter relationships are common. Sexual abuse becomes the family secret. The child is often made to keep the secret through favours, punishments, fears of parent being sent to prison, or the family disintegrating.
- All socio-economic groups are represented and, contrary to popular myths, the offender is often a respectable member of the community, of average intelligence and a decent provider.
- The recent occurrence of stressful events is often associated with the onset of the abuse, e.g., bereavement, separation. The opportunity for the abuse to occur may be created by the absence of mother for some reason and where the father figure is left alone with the child for long periods of time.
- A few sexually abusing families are totally disorganised, chaotic and promiscuous. Sexual attitudes in these families are very poorly defined and almost any kind of sexual behaviour is permitted.
- Many perpetrators abuse alcohol frequently.

g. <u>Sexting/Youth Produced Sexual Imagery</u>

All incidents involving youth produced sexual imagery should be responded to in line with SES safeguarding reporting procedures. Adults should follow the following guidelines:

- The incident should be referred to a LDPCP
- The LDPCP should hold an initial review meeting with appropriate adults
- There should be subsequent interviews with Young People involved if appropriate
- At any point of the process if there is a concern a Young person has been harmed or is at risk of harm a referral should be made to children's services and or the police immediately.

"Sexting in Schools and colleges: Responding to incidents and safeguarding young people 2016" should be read in conjunction with this policy.

Initial Review Meeting

The initial review meeting should consider the evidence and aim to establish:

- Whether there is immediate risk to a young person or young people
- If a referral should be made to the Police or Social Services
- If it is necessary to view the imagery in order to safeguard the Young person. In most cases the imagery should not be viewed
- What further information is required to decide the best response
- Whether the imagery has been shared widely
- Whether immediate action should be taken to delete or remove images from devices or online services
- Any relevant facts about the young people involved which would influence risk assessment

An immediate referral to police and social services should be made at the initial stage if:

- The incident involves an adult
- There is reason to believe that the young person has been coerced, blackmailed or groomed
- What you know about the imagery suggests the content depicts sexual acts which are unusual for the Young persons developmental age, or are violent
- The imagery involves sexual acts and any young person in the imagery is under 13
- You have reason to believe any young people are at immediate risk of harm owing to the sharing of the imagery.

If none of the above apply then SES may decide to respond to the incident without involving other agencies. This decision would be made in cases where the LDPCP is confident that they have enough information to asses the risks to the young people involved and the risks can be managed within the establishments support and behaviour management procedures.

6.1 FEMALE GENITAL MUTILATION

It is believed that FGM may happen in the UK as well as overseas. Girls of school age who are subjected to FGM overseas are likely to be taken abroad (often to the family's country of origin) at the start of the school holidays, particularly in the summer, in order for there to be sufficient time for her to recover before returning to school.

There are a number of factors in addition to a girl's or woman's community, country of origin and family history that could indicate she is at risk of being subjected to FGM.

Potential risk factors may include:

- Families that believe FGM is integral to cultural or religious identity.
- a girl/family has limited level of integration within UK community.
- a girl confides to a professional that she is to have a 'special procedure' or to attend a special occasion to 'become a woman';
- a girl talks about a long holiday to her country of origin or another country where the practice is prevalent or parents state that they or a relative will take the girl out of the country for a prolonged period.
- a parent or family member expresses concern that FGM may be carried out on the girl.
- a family is not engaging with professionals (health, education or other) or is already known to social care in relation to other safeguarding

There are a number of indications that a girl or woman has already been subjected to FGM are similar to the Risk factors, other signs and symptoms may include:

- a girl or woman has difficulty walking, sitting or standing or looks uncomfortable;
- a girl or woman finds it hard to sit still for long periods of time, and this was not a problem previously;
- a girl or woman spends longer than normal in the bathroom or toilet due to difficulties urinating;
- a girl spends long periods of time away from a classroom during the day with bladder or menstrual problems;
- a girl or woman has frequent urinary, menstrual or stomach problems;
- a girl avoids physical exercise or requires to be excused from physical education (PE) lessons without a GP's letter;
- there are prolonged or repeated absences from school or college (see 2015 guidance on children missing education
- increased emotional and psychological needs, for example withdrawal or depression, or significant change in behaviour;
- a girl or woman is reluctant to undergo any medical examinations;
- a girl or woman asks for help, but is not be explicit about the problem; and/or
- a girl talks about pain or discomfort between her legs.

Remember: this is not an exhaustive list of indicators.

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers to make a report to the police. This must be completed as soon as possible, ideally by the end of the next working

day. If unsure what action to take, professionals should discuss with their named/designated safeguarding lead.

The following resources are available for further information and detailed guidance and can be found easily via a Google search:

- GOV.UK information on FGM (gov.uk)
- Female Genital Mutilation: resource pack (gov.uk)
- NSPCC's FGM website
- FGM Teachers Resources (various on Google)
- Multi-Agency Practice Guidelines: Female Genital Mutilation (gov.uk)
- Metropolitan Police Project Azure: Guidance for Schools (on Google)

6.2 CHILD TRAFFICKING

Child trafficking is where children are recruited, moved or transported and then exploited, forced to work or sold. Children are trafficked for CSE, benefit fraud, forced marriage, domestic servitude, forced labour and criminal activity. Child trafficking is a hidden crime. Child trafficking requires a network of people who recruit, transport and exploit children and young people. Each group or individual has a different role or task.

Staff should report any trafficking concerns, to the DPCP. Contact will be made to the Child Trafficking Advice Centre (CTAC) who will co-ordinate a mutil-agency responses, focused on protecting the child.

Due to the success of the family work conducted at SES establishments, some young people, where appropriate, can travel oversees unsupported with members of their immediate family.

APPENDIX D

RADICALISATION AND EXTREMISM

Every adult recognises that safeguarding against radicalisation and extremism is no different to safeguarding against any other vulnerability in today's society. To this end we have an **SES Preventing Extremism and Radicalisation Policy and Practice** document which covers this issue in detail.

It sets out our beliefs, strategies and procedures to protect vulnerable individuals from being radicalised or exposed to extremist views, by identifying who they are and promptly providing them with support.

It provides a framework for dealing with issues relating to vulnerability, radicalisation and exposure to extreme views. We recognise that we are well placed to be able to identify safeguarding issues and this section clearly sets out how SES will deal with such incidents and identifies how the curriculum and ethos underpins our actions.

The main aim of this policy is to ensure that adults are fully engaged in being vigilant about radicalisation; that they overcome professional disbelief that such

issues will not happen here and ensure that we work alongside other professional bodies and agencies to ensure that our children are safe from harm.

We believe that it is possible to intervene to protect people who are vulnerable. Early intervention is vital and adults must be aware of the established processes to refer concerns about individuals through designated routes. We must have the confidence to challenge, the confidence to intervene and ensure tdhat we have strong safeguarding practices based on the most up-to-date guidance and best practice.

APPENDIX E

SELF HARM

Introduction

Self-harm is when somebody intentionally damages or injures their body. It's usually a way of coping with or expressing overwhelming emotional distress.

Sometimes when people self-harm, they may feel on some level that they intend to die. Over half of people who die by suicide have a history of self-harm.

However, the intention is more often to punish themselves, express their distress or relieve unbearable tension. Sometimes the reason is a mixture of both.

Self-harm can also be a cry for help. It should always be taken seriously.

Types of self-harm

There are many different ways people can intentionally harm themselves, such as:

- cutting, burning, bruising, scratching their skin
- hair pulling
- punching or hitting themselves
- poisoning themselves with tablets or toxic chemicals
- misusing alcohol or drugs
- deliberately starving themselves (anorexia nervosa) or binge eating (bulimia nervosa)
- excessively exercising

People often try to keep self-harm a secret because of shame or fear of discovery. For example, if they're cutting themselves, they may cover up their skin and avoid discussing the problem.

Signs of self-harm

The following may be signs of self-harming:

- unexplained cuts, bruises or cigarette burns, usually on their wrists, arms, thighs and chest
- keeping themselves fully covered at all times, even in hot weather

- signs of depression such as low mood, tearfulness or a lack of motivation or interest in anything
- self-loathing and expressing a wish to punish themselves
- not wanting to go on and wishing to end it all
- becoming very withdrawn and not speaking to others
- changes in eating habits or being secretive about eating, and any unusual weight loss or weight gain
- signs of low self-esteem, such as blaming themselves for any problems or thinking they're not good enough for something
- signs they have been pulling out their hair
- signs of alcohol or drugs misuse

Why people self-harm.

There are many reasons why children and young people try to hurt themselves. And once they start, it can become a compulsion. The exact reasons aren't always easy to work out. In fact, they might not even know why they do it.

Self-harm is more common than many people realise, especially among younger people. It's estimated around 10% of young people self-harm at some point, but people of all ages do. This figure is also likely to be an underestimate, as not everyone seeks help.

In most cases, people who self-harm do it to help them cope with overwhelming emotional issues, which may be caused by:

- social problems – such as being bullied having difficulties at work or school, having difficult relationships with friends or family, coming to terms with their sexuality if they think they might be gay or bisexual, or coping with cultural expectations, such as an arranged marriage
- trauma – such as physical or sexual abuse, the death of a close family member or friend
- psychological causes – such as having repeated thoughts or voices telling them to self-harm, disassociating (losing touch with who they are and with their surroundings), or borderline personality disorder

These issues can lead to a build-up of intense feelings of anger, guilt, hopelessness and self-hatred. The person may not know who to turn to for help and self-harming may become a way to release these pent-up feelings.

Self-harm is linked to anxiety and depression. These mental health conditions can affect people of any age. Self-harm can also occur alongside antisocial behaviour, such as misbehaving at school or getting into trouble with the police.

Although some people who self-harm are at a high risk of suicide many people who self-harm don't want to end their lives. In fact, the self-harm may help them cope with emotional distress, so they don't feel the need to kill themselves.

The feelings that these issues bring up can include:

- low self-esteem and low confidence

- loneliness
- sadness
- anger
- numbness
- lack of control over their lives

The self-harm cycle

Self-harm is often used as a coping mechanism. The physical pain of self-harm might feel easier to deal with than the emotional pain that's behind it. Sometimes it can be a way for someone to punish themselves for something they've done. It can also make them feel they're in control of something in their life.
When a person self-harms, chemicals are released into the brain which can become addictive very quickly. The person may feel an instant relief of pressure and 'bad feelings'. This relief is short lived and is often replaced by feelings of guilt and immediate pressure. And this is how the cycle continues.