DISCOVERY
Multi Academy Trust

PHYSICAL INTERVENTION POLICY

Summer 2025

POLICY DEVELOPMENT

This policy has been formulated with consideration of the following documents:

1. CPI Safety Intervention Trainer Guide
2. DfE Use of Reasonable Force July 2013
3. DfE Education Act 1996
4. Violence and aggression: short-term management in mental health, health and community settings May 2015

July 20	Policy adopted
Nov 21	Policy reviewed, no changes
Nov 22	Policy reviewed:
	New guidance updated
	Appropriate / Inappropriate touch updated
	Behaviour plan updated
Jun 25	Policy reviewed – minor amendments.

This policy should be read in conjunction with our Managing and Supporting Positive Behaviour Policy.

The Law

The use of corporal punishment is not allowed under any circumstances. The law forbids adults to use any degree of physical contact which is intended to deliberately punish a pupil, or which is primarily intended to cause pain, injury or humiliation (sections 548 to 550 of the 1996 act). The ban applies in all circumstances, and has applied since 1987.

Adults who are authorised by the CEO to have control or charge of pupils should only use physical intervention as is reasonable to manage a child displaying risk behaviour, presenting as an imminent or immediate risk to self or others. The provision applies when an adult is on the premises, and when he or she has lawful control or charge of the child's concerns elsewhere e.g. on a school trip or any authorised activity.

Authorised Staff

The Act allows all adults to use a reasonable physical intervention to control or restrain children. In normal practice only staff who have undergone specific training in the use of physical intervention will restrain pupils.

However, in self-defence or in the case of an emergency everyone has the right to defend themselves against an attack provided they do not use a disproportionate degree of physical intervention. In an emergency, for example, if a child was presenting as an imminent or immediate risk to self or others, any member of staff would be entitled to intervene as an emergency response.

Practical considerations

Before intervening physically, an adult should, wherever practical, employ the managing and supporting positive behaviour policy. Using de-escalation techniques, scripted interventions and appropriate consequences. The risk must be assessed before a decision is made bearing in mind the following key themes to aid lawful justification:

Duty of Care

Best interest

Reasonable and proportionate

Last resort and least restrictive

The risk of doing nothing versus the risk of doing something

Human Rights

Reduce use, prevent misuse and abuse.

Adults behaviour should be calm and consistent and children should be spoken to in this manner throughout the physical intervention.

The use of physical intervention should never be used as a substitute for good behaviour management, to gain compliance or enforce rules. It should be a last resort which is proportionate and the least restrictive.

Application of Physical Intervention

The type of physical intervention should always be the least restrictive therefore directly linked to the risk.

1. Block and Move
2. Disengagement
   -Hold and Stabilise
   Low Risk
   -Push and Pull
   Medium Risk
   - Lever
   High Risk
3. Holding
   Low Risk
   Medium Risk
   High Risk

It is vital to always reflect on professional and legal obligations and responsibilities and this can be done by ensuring any physical intervention is:

Safe

Effective

Acceptable and

Transferrable.

Staff should also always be looking to hold for the shortest period of time possible using the minimum amount of restriction on the basis of prevailing risk that the staff are attempting to manage therefore promoting early physical de-escalation. Where possible a physical restraint should never exceed 10 minutes (National Institute for Health and Care Excellence 2015).

The individual's safety and wellbeing must be monitored at all times therefore physical intervention should never happen in a 1:1 situation.

Positive/Safe Touch

We are aware that touch is sometimes necessary as well as therapeutic.

Touching a pupil might be proper or necessary:

- Holding the hand of the child at the front/back of the line when walking together around the setting;
- When comforting a distressed child;
- When a child is being congratulated or praised;
- To demonstrate how to use a musical instrument;
- Hand over hand, hand under hand or other such techniques to teach handwriting or fine motor skills;
- To demonstrate exercises or when teaching physical education e.g. how to hold a hockey stick;
- To give first aid.

Members of staff in a caring school recognise physical contact as an important part of child development and guidance. They understand that physical contact may be communication and they recognise the importance and significance of non-verbal communication and respond appropriately. This should always be done in a developmentally appropriate way and should a child shun the comfort offered through touch, the child's wishes will be respected by the member of staff dealing with the situation.

Therapeutic touch is used in situations where children are distressed. In these situations research has shown that it would be unkind or increase the child's distress if touch was not employed. When children are very distressed they often ignore information provided by their senses for example they may no longer see or no longer hear. When a child is distressed touch can be the only means of maintaining a connection with the child.

Appropriate and inappropriate touch

Our policy rests on the belief that every member of staff needs to appreciate the difference between appropriate and inappropriate touch. Hence all staff members need to demonstrate a clear understanding of the difference. They need to show themselves to be highly aware of both the damaging and unnecessary uses of touch in an educational context. Touch is not to be used as an ill-thought out or impulsive act of futile reassurance/gratification. If a member of staff was concerned about touch being used inappropriate then the safeguarding policy should be followed and the DSL should be told immediately.

Behaviour plan (Appendix A, B and C)

If a child has needed physical intervention or has come from a setting where it has been used previously a behaviour plan should be put in place to identify any specific reason why physical intervention should not take place but also to allow for appropriate methods of de-escalation.

A risk assessment highlighting physical hazards and control measures should also be completed and shared with parents.

Recording Incidents

It is important that there is a detailed written report of any occasion where physical intervention is used on BehaviourWatch. This should be completed immediately following the incident and the Head of School/Nursery manager and CEO will be informed.

This should include –

The name(s) of the child and adult(s) involved

The age

Where the incident took place, were there any witnesses?

The reason that the physical intervention was necessary (identify triggers)

How the incident began and progressed including what parts of the behaviour policy had been employed

The degree of physical intervention (name) and duration

The outcome of the incident

Time and date when parents/carers are informed

Details of any injuries sustained to adult, pupil and property.

This must be shared with the Head of School/nursery manager and CEO.

Parents should be informed as soon as possible but always on the same day as the intervention took place. The time and date this information was shared with parents needs to also be logged on BehaviourWatch.

Monitoring and Review

The Head of School, Trust Inclusion Lead and the CEO should monitor the numbers of physical interventions regularly and changes to the managing and supporting positive behaviour policy should be put in place to minimise these as part of a wider restraint-reduction strategy to minimise avoidable restraint.

Individual Behaviour Plan

(Please change roles to fit with specific setting)

Name		**Date**		**Version**	
Senco		**Date of Birth**		**SEN stage**	

Behaviours witnessed	**Staff approach**
1 Anxiety (Where we are starting to notice a change in behaviour)	**1 Supportive** (We manage this by being supportive)
2 Defensive (Where he / she is beginning to lose control – believes there is a threat)	**2 Directive** (We manage this by being directive)
	Scripted Intervention *Limit Setting*
3 Risk Behaviour (This is where we are experiencing behaviours which pose an imminent risk to self or others)	**3 Physical Intervention** (This may result in physical intervention)
	Least restrictive- proportionate to the risk being presented. Only if imminent or immediate harm to self or others.
4 Tension Reduction (Where he / she are beginning to regain control)	**4 Therapeutic Rapport**

Things of interest:

Relationships with adults:
Triggers:

Staff must follow the Discovery MAT Managing and Supporting Positive Behaviour Policy 2025 and Physical Intervention Policy 2025.

Notification (copy of the plan to)
SLT **SENCO** **Parents/Guardians**
Relevant staff

Names: **Signatures:**
[Parent] **.....**
.....
[SENCO] **.....**
.....

[Pupil] **.....**
.....
[Teacher] **.....**
.....
[Teacher] **.....**
.....
[HLTA] **.....**
.....
[TA] **.....**
.....
Senior Manager:

.....
Head of School

APPENDIX B Behaviour Plan Example

Individual Behaviour Plan

Name of child	Joe Brown	**Date plan was written**	21/12/18	**Version**	1
Senco	S. Smith	**Date of Birth**	12/6/2011	**SEN stage**	SS

Behaviours witnessed	**Staff approach**
1 Anxiety	**1 Supportive**
Rocking in chair Tapping pencil Reluctant to start work	Quiet conversation with trusted adult. Support in starting work. Small steps, broken down task, now and next.
2 Defensive	**2 Directive**
Refusal Asking challenging questions	*Scripted Intervention – Interrupt, redirect, reinforce* Joe I have noticed you are yet to start your work. I'll give you a few seconds to begin the first step, Thank you for listening. *Limit Setting* - Joe first focus on the first step then I will come back to check you are ok. Joe if you begin your work then you can stay in the classroom.
3 Risk Behaviour	**3 Physical Intervention**
Violence to staff – throwing classroom objects directly at them	*Least restrictive- proportionate to the risk being presented. Only if imminent or immediate harm to self or others.*
4 Tension Reduction	**4 Therapeutic Rapport**
Hiding in an enclosed space	Restorative conversation once Joe has calmed

Staff must follow the DIscovery MAT Behaviour Policy 2019 and Physical Intervention Policy 2019.

Notification (copy of the plan to...)
SLT **SENCO** **Parents/Guardians** **Relevant staff**

Names:	Signatures:
[Parent]	.....
[SENCO]	.....
[Pupil]	.....
[Staff]	.....
[Staff]	.....
[Staff]	.....
[Staff]	.....

Senior Manager:
.....

Date: .....
Review date:.....

Appendix C Risk Assessment

REF NO:

ACADEMY NAME: Discovery MAT **DATED:**

YOUNG PERSONS RISK ASSESSMENT

Risk Assessment for:		Additional Information:	
Date of Birth			
Most likely risk behaviour (Please highlight)	Run, bite, spit, hide, climb, physical, pulling, pushing, hitting, kicking, head butting, self harm, throwing of objects, barricading		
Prevention			

Physical Hazards	Risk (H/M/L)	Current Control Measures	Additional controls for the young person to make sure the risk is adequately controlled	Additional Control Measures in place: Y/N		Assessor Comments
				In Place	Adequate	

Summary of significant risks:	Control measures to be implemented

Signed:

Assessor:..... Support person/s: .....

.....

.....

Review Date: Plan to be reviewed daily by HoS and adjusted for safety.

A COPY OF THE COMPLETED ASSESSMENT SHOULD BE SHARED WITH THE PARENTS AND YOUNG PERSON AND COPY STORED WITH HOS/SENCO

RESIDUAL RISK RATING	ACTION REQUIRED
VERY HIGH (VH) Strong likelihood of fatality/Serious Injury	**The activity must not take place at all. You must identify further controls to reduce the risk rating.**
HIGH (H) Possibility of fatality/serious injury occurring	**You must identify further controls to reduce the risk rating. Seek further advice, e.g. from your H&S Team.**
MEDIUM (M) Possibility of significant injury or over 3 day absence occurring.	**If it is not possible to lower risk further, you will need to consider the risk against the benefit. Monitor risk assessments at this rating more regularly and closely.**
LOW (L) Possibility of minor injury only	No further action required.

Appendix D

FIGURE 3: BEST-PRACTICE INDICATORS

- Restrictive interventions should be used within an organisation as part of a wider restraint-reduction strategy to minimise avoidable restraint.
- As part of a restraint-reduction strategy, restrictive interventions should be used only when all other non-restrictive interventions have failed to manage the prevailing risk. Restrictive interventions should never be used as a punishment, to force control, gain compliance, or enforce rules.
- People who are likely to be subject to the use of restrictive interventions should have an individual risk assessment completed in order to identify any specific contraindications associated with the person, including any known vulnerabilities that may increase the likelihood of an adverse consequence. Where possible, specific medical advice should be sought in order to fully assess the impact restrictive interventions may have on those individuals who are known to be in vulnerable groups.
- All restrictive interventions should be authorised and approved by the organisation and written into an individual management plan. Where restrictive interventions are used reactively to manage an unforeseen risk, an individual assessment and management plan should be undertaken as soon as is reasonable and practical.
- Only staff who have received training should use restrictive intervention skills.
- Prolonged physical restraint increases the risk of restraint-related death. Whenever possible, all reasonable and alternative non-restrictive interventions should be used if the duration of a physical restraint exceeds 10 minutes (NICE, 2015).
- Staff using restrictive interventions must be fully aware of the risk associated with each intervention. They must monitor the individual's safety and well-being at all times, be able to identify signs of distress, and know how to respond to medical emergencies. (See Figure 5.)
- In order to maximise the *Care, Welfare, Safety, and Security*[SM] of everyone, restrictive interventions should be used within the context of the *Opt-Out Sequence*[SM] in order to promote early physical de-escalation.
- Staff who use restrictive interventions should also be trained in emergency first aid so they can respond to medical emergencies should they occur as a result of restraint.
- Restrictive interventions should be used only for the minimum amount of time, using the minimum amount of restriction on the basis of prevailing risk that staff are attempting to manage.
- In any emergency where an individual is held on the floor, a supine (face up) position should be used (Barnett et al, 2013; 2016).