Children's Services

REDUCING THE NEED FOR RESTRICTIVE INTERVENTIONS IN SCHOOLS

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Hertfordshire

FALCONER SCHOOL BUSHEY

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Restraint and restrictive intervention Policy

Falconer School

1. CONTEXT

This policy is written for schools or settings which have adopted Therapeutic Thinking Hertfordshire Steps, which is the local authority's preferred approach to supporting positive behaviour management in schools and settings. The Therapeutic Thinking Steps approach forms part of the authority's behaviour strategy. It has been agreed through the SEND Executive and forms part of Hertfordshire's Local Offer.

Policy Review

This policy will be reviewed in full by the Governing Body no less than every 2 years.

The policy was last reviewed and agreed by the Governing Body on 5th June 2024

It is due for review on 5th June 2026.

Signature ……. Date ……

Head Teacher

Signature ……. Date ……

Chair of Governors

2. INTRODUCTION

In Falconer school we believe that every child and young person has a right to be treated with respect and dignity, deserves to have their needs recognised and be given the right support. All school staff need to be able to safely manage behaviour and understand what a child (or young person) is seeking to communicate through difficult or dangerous behaviours.

Parents need to:

- know that their children are safe at school;
- be properly informed if their child is the subject of a restrictive intervention (including the nature of the intervention); and
- know why a restrictive intervention has been used.

This policy should be read in conjunction with:

- the behaviour policy;
- the staff behaviour policy (sometimes called a code of conduct);
- the child protection policy;
- the safeguarding response to children who go missing from education; and
- the role of the designated safeguarding lead (including the identity of the designated safeguarding lead and any deputies).

This policy is designed to reduce the incidents of, and the risks associated with restrictive interventions - and to eliminate unnecessary and inappropriate use of restraint.

National guidance

This policy is based on the principles set out in, and is prepared to supplement, Government guidance:

DfE: Guidance on Use of Reasonable Force July 2013:
https://www.gov.uk/government/publications/use-of-reasonable-force-in-schools

DfE and DHSC: Reducing the need for restraint and restrictive intervention, July 2019:
https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention

DfE: Keeping Children safe in Education, September 2023:
Keeping children safe in education - GOV.UK (www.gov.uk)

DfE: mental health and behaviour in schools November 2018:
https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2

DfE: Behaviour in Schools. Advice for head teachers and school staff, September 2022:
Behaviour in schools - GOV.UK (www.gov.uk)

The use of restrictive intervention will only be needed for a very small minority of children or young people. We know that the use of restraint and restrictive interventions are traumatising and this particularly so for children, who are still developing both physically and emotionally. We know that the use of restraint and restrictive interventions can be traumatic - and have long-term consequences on the health and wellbeing of children and young people. It can also have a negative impact on staff who carry out such interventions.

Children and young people with learning disabilities, autistic spectrum conditions or mental health difficulties may react to distressing or confusing situations by displaying behaviours which may be harmful to themselves and others and are at a heightened risk of restrictive interventions. Wherever possible, restrictive interventions should be avoided and proactive, preventative, non-restrictive approaches adopted.

Whenever considering restrictive interventions, the key question for everyone involved with children and young people whose behaviour is difficult or dangerous should be: -

"What is in the best interest of the child and/or those around them in view of the risks presented?"

"Is this a difficult behaviour or a behaviour that is dangerous to others or the child displaying the behaviour?"

A positive and proactive approach to behaviour

At Falconer, we operate a clear behaviour policy for meeting children and young people's individual needs, promoting positive relationships and emotional wellbeing and teaching that supports individuals to express their feelings using words and to develop independence in regulating their behaviours.

Behavioural difficulties may signal a need for support and it is essential to understand what the underlying causes are. For example, a child or young person may exhibit such behaviours as a result of a medical condition or sensory impairment, previous trauma or neglect, or be exacerbated by an unmet need or undiagnosed medical condition. Behavioural difficulties may also reflect the challenges of communication, or the frustrations faced by children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties - who may have little choice and control over their lives. Children and young people with behavioural difficulties need to be regarded as vulnerable rather than troublesome and we have a duty to explore this vulnerability and provide appropriate support.

Behaviour that escalates and becomes difficult or dangerous may result from the impact of a child or young person being exposed to challenging or overwhelming environments, which they do not understand, where positive social interactions are lacking, and / or personal choices are limited. Children and young people exhibiting difficult or dangerous behaviours need support and differentiation of teaching and

learning to have their needs met and to develop alternative ways of expressing themselves that achieve the same purpose but are more appropriate.

We use Hertfordshires Therapeutic Thinking to complete behaviour analyses to understand children and young people's needs and the causes of poor emotional wellbeing.

By anticipating situations that may cause distress, and agreeing the steps to address them, whilst assessing, managing and reducing risk it is possible to reduce the use of restraint or restrictive intervention.

We aim to reduce restrictive practices by the proactive use of an early prognosis assessment which may lead to a thorough risk reduction plan drawn up with the involvement of the child(ren) (or young person) and their parents. Co-produced assessments and risk reduction plans aim to better understand the experiences of parents and children as well as to agree the steps that should be taken to avoid escalation and promote emotional wellbeing.

Our Behaviour policy sets out the steps we will take as a school to ensure that we comply with the provisions of the Equality Act 2010.

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3. DEFINITIONS

The term **child** refers to all children and young people under the age of 18.

The term **physical intervention** is used to describe contact between staff and a child (or children) where no force is involved. (e.g. comfort, affirmation, facilitation)

The terms **restrictive intervention** and **restraint** are used interchangeably in this policy to refer to:

- planned or reactive acts that restrict an individual's movement, liberty and/or freedom to act independently; and
- the sub-categories of restrictive intervention using force or restricting liberty of movement (or threatening to do so).

In this policy restrictive interventions and restraint can include, depending on the circumstances:

- Physical restraint: a restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

- Restricting a child or young person's independent actions, including removing auxiliary aids, such as a walking stick, or coercion, including threats involving use of restraint to curtail a child or young person's independent actions.
- Withdrawal: removing a child or young person involuntarily from a situation which causes anxiety or distress to themselves and/or others and taking them to a safer place where they have a better chance of composing themselves. We also refer to this concept below as Imposed Withdrawal.
- Forceable seclusion: supervised confinement and isolation of a child or young person, away from others, in an area from which they are prevented from leaving, where it is of immediate necessity for the containment of severely dangerous behaviour which poses a risk of harm to others.

Although it may not be necessary to make physical contact in cases of Withdrawal (Imposed Withdrawal) or Forceable seclusion, these are still regarded as forms of restrictive intervention.

The term **difficult** used throughout this policy refers to behaviour that a child or young person displays that does not cause harm or injury. Staff may find these behaviours challenging but they will not need physical intervention.

The term **dangerous** used throughout this policy refers to behaviours that cause evidenced injury to self or others, damage to property that will cause themselves or others harm, or committing a criminal offence.

The term **'parent'** used throughout this policy refers to all those with parental responsibility, including parents and those who care for the child (as defined in section 576 of the Education Act 1996). Where there is a Care Order in force (within the meaning of section 31 of the Children Act 1989), the local authority has the power to restrict the exercise by the child's parents of their parental responsibility, if the welfare of the child so requires.

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4. ACCEPTABLE FORMS OF PHYSICAL INTERVENTION

There are occasions when it is entirely appropriate and proper for staff to have contact or physical intervention with children or young people; however, it is crucial that this is appropriate to their professional role and in relation to the child's individual needs.

Occasions where staff may have cause to have physical intervention with a child may include:

- To comfort a child in distress (so long as this is appropriate to their age).
- For affirmation/praise.
- To gently direct a child or young person.
- For curricular reasons (for example in PE, Drama, etc).

- First aid and medical treatment.
- In an emergency to avert danger to the child.

Not all children feel comfortable with certain types of physical contact; this should be recognised and, wherever possible, adults should seek the child's permission before initiating contact and be sensitive to any signs that they may be uncomfortable or embarrassed.

Staff should acknowledge that some children are more comfortable with touch than others and/or may be more comfortable with touch from some adults than others. Staff should listen, observe and take note of the child's reaction or feelings and, so far as is possible, use a level of contact and/or form of communication which is acceptable to the child.

It is not possible to be specific about the appropriateness of each physical contact, since an action that is appropriate with a child, in one set of circumstances, may be inappropriate in another, or with a different child. In all situations where physical contact between staff and children takes place, staff must consider the following:

- The child's age and level of understanding.
- The child's individual characteristics and history.
- The duration of contact.
- The location where the contact takes place (it should not take place in private without others present).
- The purpose of the physical contact.

Children are encouraged to use socially acceptable touch, for example hand shakes and fist bumps and when to use them in contact.

Physical intervention must not become a habit between a member of staff and a child. Physical intervention should always be in the child's best interest and staff must have an awareness of children and young people who may not have secure primary attachments. Staff must have an awareness of the need to differentiate physical intervention to ensure that children or young people are able to distinguish and separate the attachment to staff (who are transient adults in their life) from the primary attachment to key adults such as parents and siblings.

Physical contact must never be used as a punishment, or to inflict pain. All forms of corporal punishment are prohibited. Physical contact **must not** be made with the child or young person's neck, breasts, abdomen, genital area, or any other sensitive body areas, or to put pressure on joints.

Safer working practice

To reduce the risk of allegations, all staff should be aware of safer working practice and should be familiar with the guidance contained in the staff handbook / school code of conduct / staff behaviour policy and Safer Recruitment Consortium document, **Guidance for safer working practice for those working with children and young people in education settings (September 2019)** **http://www.thegrid.org.uk/info/welfare/child_protection/allegations/safe.shtml**

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5. RESTRAINT OR RESTRICTIVE INTERVENTIONS

Restraint or restrictive interventions may be used when all other strategies have failed, and therefore only as a **last resort**. All staff should focus on promoting a positive and proactive approach to behaviour and emotional wellbeing, including de-escalation techniques (appropriate to the child), to minimise the likelihood of, and avoid the need to use, restraint.

There will, however, be times when the only realistic response to a situation will be a planned restraint or restrictive intervention

Before implementing a planned restraint or restrictive intervention it is necessary to undertake a careful risk assessment. This will need to include a record of the child's needs (including their vulnerabilities, learning disabilities, medical conditions and impairments), evidence of the risks to self and others and the extent to which a restrictive intervention would be in the child's best interests. A risk calculator (ANNEX 4) will be carried out.

If it is necessary to undertake a restrictive intervention, then staff should employ the planned and agreed approaches/techniques as set out in the child's individualised risk reduction plan (Annex 5 – Therapeutic Plan / Risk Reduction Plan).

The planned intervention will be based on the following principles: -

- The assessment of risk to safeguard the individual or others i.e. restraint will only be used where it is necessary to prevent the risk of serious harm, including injury to the child, other children, staff or the or the school community (as opposed to if no intervention or a less restrictive intervention was undertaken).
- An intervention will be in the best interests of the child - balanced against respecting the safety and dignity of all concerned.
- Restraint will never be used to force compliance or with the intention of: inflicting pain, suffering or humiliation.
- If restraint is appropriate then techniques used will be reasonable and proportionate (see Appendix) to the specific circumstances and risk of seriousness of harm; they will be applied with the minimum force needed, for no longer than necessary, by appropriately trained staff.

- When planning support and reviewing any type of planning document that references restraint or restrictive interventions (such as risk reduction plans) children, parents and where appropriate (for example, where the child or parent/carer wants it) advocates should be involved.
- In an emergency, such as a child running into a road, or a child attacking a member of staff and refusing to stop when asked, then reasonable force may be necessary. This would be an unplanned intervention which: -
- requires professional judgement to be exercised in difficult situations, often requiring split-second decisions in response to unforeseen events or incidents where trained staff may not be on hand.
- will include judgements about the capacity of the child at that moment to make themselves safe.
- requires responses which are reasonable and proportionate and use the minimum force necessary in order to achieve the aim of the decision to restrain.

An unplanned intervention should trigger a multidisciplinary discussion to look at what support is needed to reduce the risk of future incidents. Staff should update and/or implement a new risk reduction plan depending on the circumstances of the unplanned incident.

Staff should not be expected to put themselves in danger and that removing other children and themselves from escalating situations may be the right thing to do. We value staff efforts to rectify what can be very difficult situations and in which they exercise their duty of care for all children or young persons.

The circumstances when reasonable force may be used will need to meet the following criteria: -

- To prevent a child from committing a criminal offence (this applies even if they are below the age of criminal responsibility)
- To prevent a child from injuring themselves or others
- To prevent or stop a child or young person from causing serious damage to property that would lead to harming self or others(including their own property)

Legal defence for the use of force is based on evidence that the action taken was:

- Reasonable, proportionate and necessary

Staff should have reasonable grounds for believing that restraint is necessary to justify its use. They should only use restraint where they consider it is necessary to prevent serious harm, including risk of injury to the child or young person or others. Staff should use their professional judgement to decide if restraint is necessary, reasonable and proportionate.

Since children are developing both physically and psychologically this makes them particularly vulnerable to harm. The potentially serious impact of restraint on their

development requires that the child's best interests is the paramount consideration when reaching a decision on whether to, and how to, restrain a child. However, this does not mean that the child's best interests automatically take precedence over other considerations such as other people's rights, but they must be given due weight in the decision.

Deprivation of liberty or segregation

Deprivation of liberty is unlawful – unless sanctioned by process of law (Mental Health Act 1983, Mental Capacity Act 2005 – Deprivation of Liberty Safeguards) and / or by way of court order (inherent jurisdiction – or s16 Mental Capacity Act Order); Mental Capacity Act Code of Practice:

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

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6. ASSESSING AND MANAGING RISKS

Staff will use the minimum force needed to gain safe outcomes.

Restrictive intervention which have any of the following 3 effects are wholly inappropriate:

- If there is a negative impact on the process of breathing
- The child feels pain as a direct result of the technique
- The child feels a sense of violation.

Clearly the use of a restraint technique that negatively impacts on a child's breathing presents a real risk of causing serious harm

The following interventions have elevated risks and can result in a sense of violation, pain or restricted breathing and **must be avoided**:

- The use of clothing or belts to restrict movement
- Holding a person lying on their chest or back
- Pushing on the neck, chest or abdomen
- Hyperflexion or basket type holds
- Extending or flexing of joints (pulling and dragging)

The following can result in significant injury and must also be avoided:

- Forcing a child or young person up or down stairs
- Dragging a child or young person from a confined space

- Lifting and carrying
- Seclusion, where a person is forced to spend time alone against their will (requires a court order except in an emergency)

The principles relating to Restrictive Intervention are as follows: -

- Restrictive intervention will only be used in circumstances when one or more of the legal criteria for its use are met.
- Restraint or restrictive intervention is an act of care and control, not punishment. It is never used to force compliance with staff instructions.
- Staff will take steps in advance to avoid the need for restrictive intervention through dialogue and diversion.
- The child will be warned, at their level of understanding, that restrictive intervention will be used unless they stop the dangerous behaviour.
- Staff will use the minimum force necessary to ensure safe outcomes.
- Staff will only use force when there are good grounds for believing that immediate action is necessary and that it is necessary for staff to intervene physically to avoid harm to the child or another child or staff member.
- Staff will be able to evidence that the intervention used was a reasonable response to the incident.
- Every effort will be made to secure the presence of other staff, and these staff may act as assistants and/or witnesses. However, staff will also ensure other children are removed from the area to help de-escalate the situation.
- As soon as it is safe, the restrictive intervention will be relaxed to allow the child to regain self-control.
- Escalation will be avoided at all costs.
- The age, understanding, and competence of the individual child will always be considered.
- In developing a risk reduction plan, consideration will be given to approaches appropriate to each child or young person’s circumstance.
- Procedures are in place, through the pastoral system of the school, for supporting and debriefing children or young persons and staff after every incident of restrictive intervention, as it is essential to safeguard the emotional well-being of all involved at these times.

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7. DEVELOPING A RISK REDUCTION PLAN IN FALCONER SCHOOL

If a child is identified as presenting a risk that restraint or restrictive intervention may be required, a risk reduction plan will be completed. This plan will help the child and staff to avoid situations that escalate through understanding the factors that influence the behaviour and identifying the early warning signs in an effort to manage and reduce risk.

The plan will include: -

- "Therapeutic tree" (also known as "Roots and fruits") to explore the link between experiences, feeling and behaviours (Annex 1)
- Anxiety analysis to understand the factors that underlie or influence the behaviour as well as the triggers for it (e.g. staff, peers, activity, location etc. Annex 2)
- Analysis of both conscious and subconscious behaviour with solutions and differentiation of environment or teaching and learning
- An understanding of the wider causes of behaviours - such as those that stem from medical conditions, sensory issues and unmet need or undiagnosed conditions.
- Recognition of the early warning signs that indicate that poor emotional wellbeing is beginning to emerge.
- Alternatives to restraint, including effective techniques to de-escalate a situation and avoid restrictive interventions.
- Details of the safe implementation of restraint, including how to minimise associated risks, particularly taking into account the growth and development of children and young people.
- Details of a communication plan with the children including for those who are non-verbal (including those with speech, language and communication needs).
- Co-produced with parents/carers and the child to ensure their views and experiences are considered.
- A dynamic risk assessment to ensure staff and others act reasonably, consider the risks, and learn from what happens.
- Explanation of how to record any planned or unplanned interventions.
- How to find the record in school of risk reduction options that have been examined and discounted, as well as those used (Annex 5).
- A clear description stating at which point a restrictive intervention will be used
- Identification of key staff who know exactly what is expected and how to build positive relationships
- A system to summon additional support if needed
- Identification of training needs or unresolved risk factors

*[*We may also need to take medical advice about the safest way to hold a child or young person with specific medical needs.]*

Please refer to the Annex for a risk reduction plan format.

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8. TRAINING AND DEVELOPMENT OF STAFF

Guidance and training are essential in this area. We adopt the best possible practice in Falconer school and provide training for all staff at several levels including: -

- Awareness of issues for governors, staff and parents
- Positive behaviour management - all staff x 1 day every year
- Emotional well-being and trauma informed practices - all staff
- Managing conflict in difficult situations - all staff

Training and development play a crucial role in promoting positive behaviour and supporting those whose poor emotional wellbeing has the risk of becoming difficult or dangerous. Settings have a statutory responsibility to enable staff to develop the understanding and skills to support children and young people and help parents to secure consistent approaches.

Hertfordshire Steps is the foundation of our thinking and the umbrella that all other training sits within. Hertfordshire Steps training covers two distinct developmental areas:

“Therapeutic Thinking” (previously known as “Step On”) – **(De-escalation training)** All teachers, Teaching Assistants and Behaviour Mentors complete this de-escalation training. ‘Therapeutic Thinking’ / ‘Step On’ is a therapeutic approach to behaviour management, with an emphasis on consistency, on teaching internal discipline rather than imposing external discipline and on care and control, not punishment. It uses techniques to de-escalate a situation before a crisis occurs and, where a crisis does occur, it adopts techniques to reduce the risk of harm.

“Principles of Restrictive Physical Intervention” (previously known as “Step Up”) – **(Restrictive intervention training)** This provides training on elements of restrictive intervention (restraint) and personal safety. This training can only be provided within services where staff have already completed ‘Therapeutic Thinking’ / ‘Step On’ training and are still within certification. Seven members of staff at Falconer have this level of training namely:

- Jeff Fisher
- Alex Noot
- Chris Jones
- Carmel Fox
- Dave Cline

- Kanwal Ajmal

Additional training is tailored to take account of the needs of the children and young people being taught and/or cared for and the role of the specific tasks that staff will be undertaking.

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9. RECORDING AND REPORTING

The use of a restraint or restrictive intervention, whether planned or unplanned (emergency), must always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident, in a book with numbered pages. The written record should include:

- the names of the staff and child or young persons involved;
- the type of restrictive intervention employed;
- the reason for using a restrictive intervention (rather than non-restrictive strategies);
- how the incident began and progressed, including details of the child 's behaviour, what was said by all those involved, and the steps taken to defuse or calm the situation;
- the degree of force used, how that was applied, and for how long;
- the date and the duration of the whole intervention;
- whether the child or young person or anyone else experienced injury or distress and, if they did, what action was taken.

All records should be open and transparent and enable consideration to be given to the appropriateness of the use of restraint.

Governing bodies and proprietors must ensure that they comply with their duties under legislation. They must also have regard to this guidance to ensure that the policies, procedures and training in their schools or colleges are always effective and comply with the law.

The nominated governor is:
Ross MacDonald

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10. COMPLAINTS

All staff and volunteers should feel able to raise concerns about poor or unsafe practice and potential failures in the school or education setting's safeguarding arrangements.

Appropriate whistleblowing procedures, which are suitably reflected in staff training and staff behaviour policies, should be in place for such concerns to be raised with the school or college's senior leadership team.

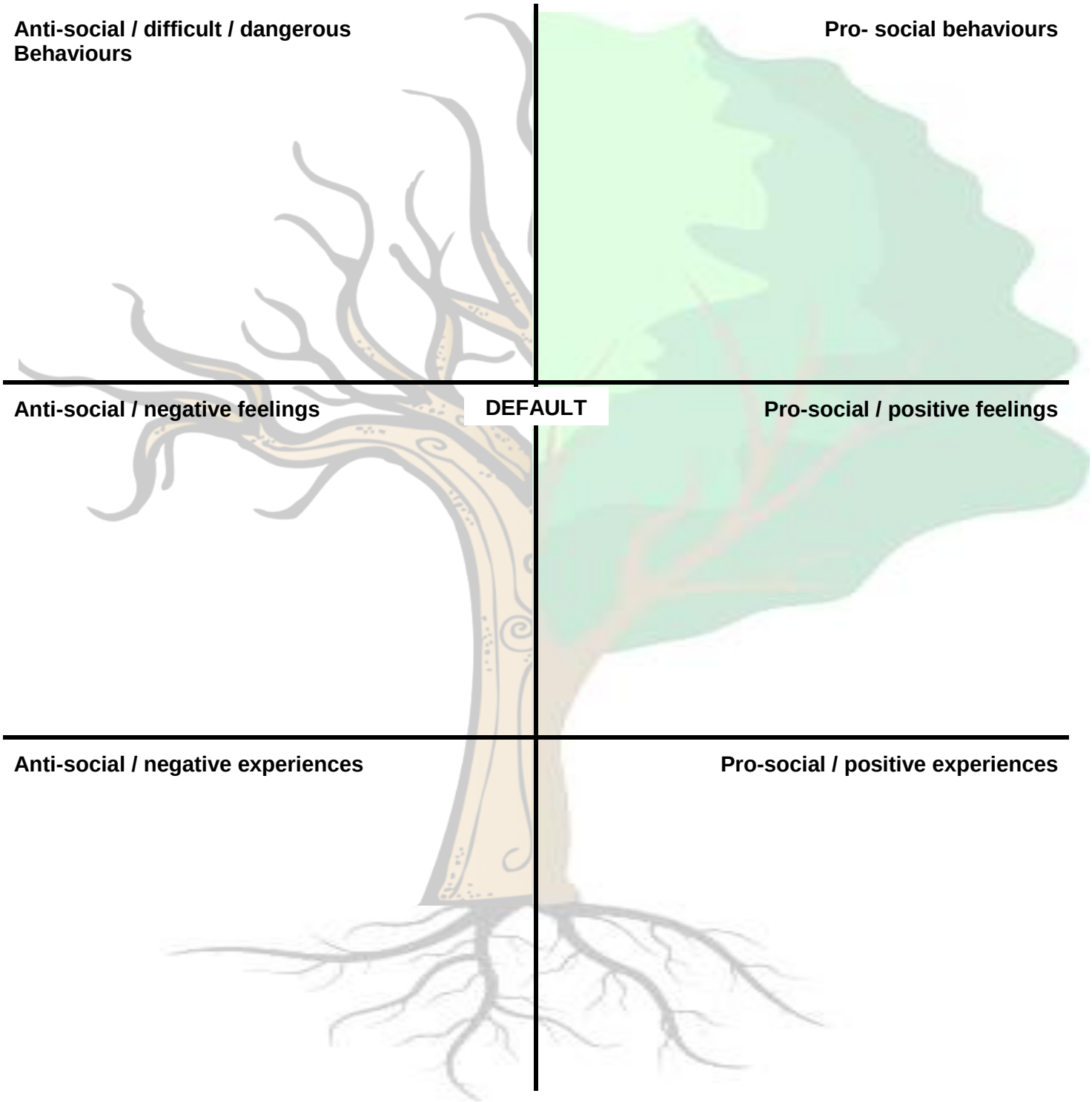
If staff members have concerns about another staff member then this should be referred to the Head Teacher or Principal. Where there are concerns about the Head Teacher or Principal, this should be referred to the Chair of Governors/ Chair of the Management Committee/Proprietor as appropriate. Where the head teacher is also the sole proprietor of an independent school, allegations should be reported directly to the designated officer(s) at the local authority. Staff may consider discussing any concerns with the school's designated safeguarding lead and make any referral via them.

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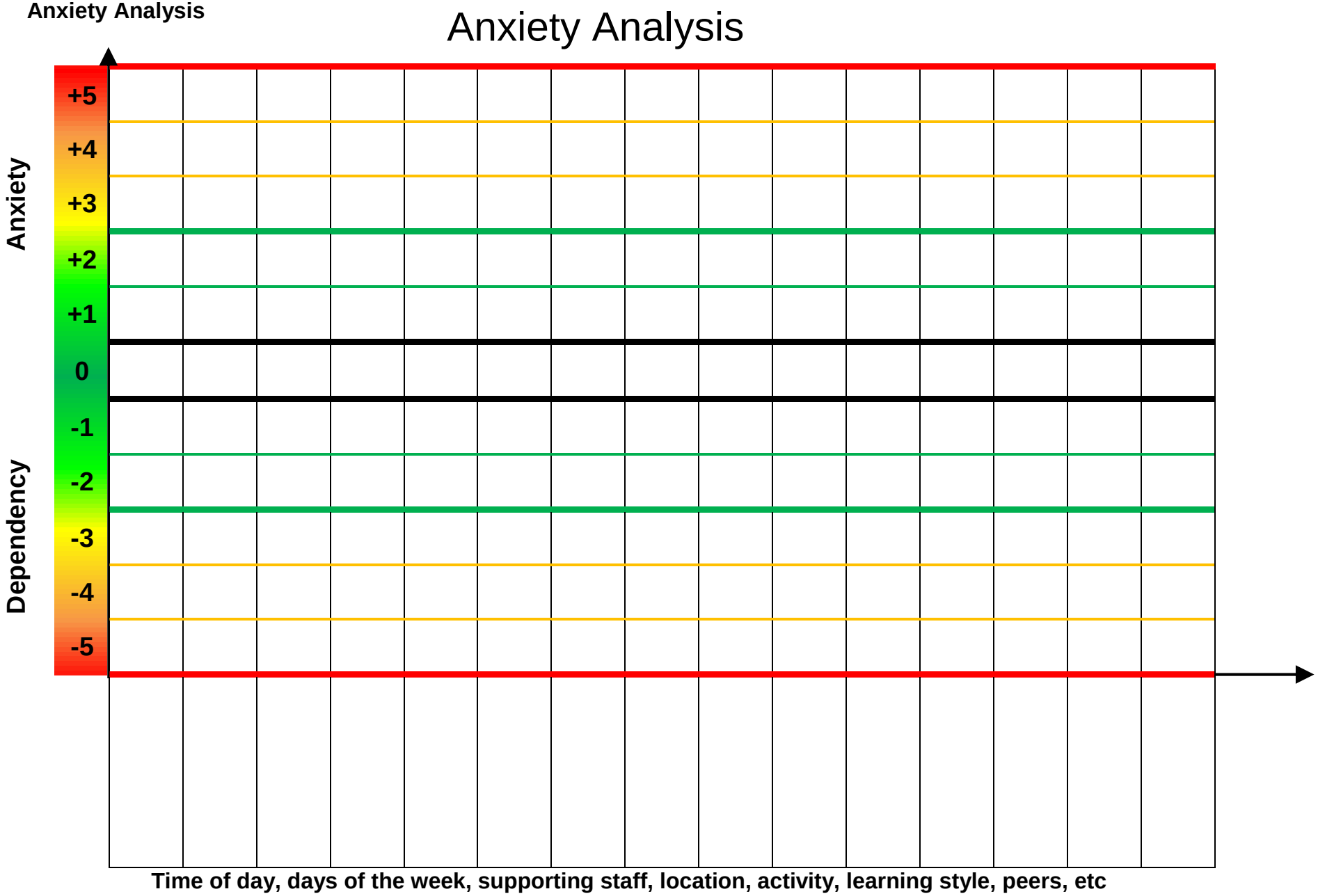
ANNEX. 1. Therapeutic tree (Roots and fruits)
Analysis tool to explore behaviours, feelings and experiences

Therapeutic Tree (Roots and fruits)

Name	
Supporting Staff	
Date	
Review Date	



ANNEX 2 Anxiety Analysis



Annex 3: Evidence of Differentiation

	Score	**Predict** Staff/Location/Activity/Peers/Time	**Prevent** Adaptations (including protective consequences)	**Progress** Adaptations (including educational consequences)
Increased Anxiety	+3 - +5	Unable to cope with: 1. 2. 3. 4. 5.	What will manage the over-anxiety: 1. 2. 3. 4. 5.	How will we teach and monitor the management of over-anxiety: 1. 2. 3. 4. 5.
	+2	Vulnerable to being unable to cope with: 1. 2. 3.	Monitoring needed: 1. 2. 3.	Adaptation or contingency needed: 1. 2. 3.
	0			
Increased	-2	Vulnerable to being unable to cope without: 1. 2. 3.	Monitoring needed: 1. 2. 3.	Adaptation or contingency needed: 1. 2. 3.

	- 3 - - 5	Unable to cope without: 1. 2. 3. 4.	What will manage the over-dependency: 1. 2. 3. 4.	How will we teach and monitor the reduction of over-dependency: 1. 2. 3.

ANNEX 4 **Risk Assessment Calculator**

For assessing and managing foreseeable risks for child or young persons who are likely to need Restrictive Intervention

Name	
DOB	
Date of Assessment	

Harm/Behaviour	Opinion Evidenced O/E	Conscious Sub-conscious C/S	Seriousness Of Harm A 1/2/3/4	Probability Of Harm B 1/2/3/4	Severity Risk Score A x B
Harm to self					
Harm to peers					
Harm to staff					
Damage to property					
Harm from disruption					
Criminal offence					
Harm from absconding					

Seriousness	
1	Evidence of upset or disruption.
2	Evidence of needing support internally from our school resources – e.g first aid, nurture, budget allocation.
3	Evidence of needing intervention from external agencies outside of school resources – e.g. hospital, professional counselling or group work, insurance claim.
4	Evidence of harm that cannot be resolved e.g. disability, sectioned mental health, loss through arson.
Probability	
1	Yearly or less. No identified triggers remain. There is evidence of historical risk and no evidence of current risk.
2	Monthly or less. The risk is reducing but remains relevant, the context has changed to make a reoccurrence less likely.
3	Weekly or less. The risk of harm is more likely than not to occur again.
4	Daily or constantly. The risk of harm is persistent.

*Risks which score **6** or more (probability x seriousness) should have strategies listed on the plan.*

Annex 5: Individual Therapeutic Plan / Risk Reduction Plan

Name	DOB	Date	Review Date

Photo	Risk reduction measures and differentiated measures (to respond to triggers)

Pro social / positive behaviour	Strategies to respond
Anxiety / DIFFICULT behaviours	Strategies to respond
Crisis / DANGEROUS behaviours	Strategies to respond
Post incident recovery and debrief measures	

Signature of Plan Co-ordinator…… Date ……..

Signature of Parent / Carer…… Date ……

Signature of Young Person……Date……

ANNEX 5 – Restrictive Intervention Record Form

Student Name:	
D.O.B:	
Reporting Member of Staff:	

Location of Incident:
Time and Date of Incident:

Justification for physical intervention (tick all that apply):		**Predicted harm prevented by physical intervention with predicted levels (see Individual Plan)** e.g. bruising to peers, lacerations, destruction of computer, 20 mins of geography lost for 15 child or young person's etc.)
To prevent harm to self	☐	
To prevent harm to other children	☐	
To prevent harm to adults	☐	
To prevent damage to property	☐	
To prevent loss of learning (see plan)	☐	

Incident Form/Book Complete	Y/N
Medical Treatment / Injuries	Y/N
Damage to Property	Y/N

Name(s) of additional staff witness:	**Name(s) of additional student witness:**

Unresolved Harm/ Details of damage to property (costs and details of harm to property and people including medical intervention:

Triggers:
Additional factors:

Management:	**Comments:**	
How was the incident resolved?		
What were the Consequences? Protective and Educational		
Has student reparation/ de-brief taken place?	**Y/N**	
Has staff de-brief taken place?	**Y/N**	
Has the Risk Management plan been reviewed or updated?	**Y/N**	
Was there Police involvement?	**Y/N**	
Has there been Internal Exclusion / FTEX / PEX?	**Y/N**	

Primary de-escalation techniques used
(please state order in which they were used)

Verbal advice and support		Offering services of other staff	
Calm talking		Informing of consequences	
Distraction		Taking non-threatening body position	
Reassurance		De-escalation script	
Humour		Clear instruction / warning	
Negotiation		Withdrawal from activity	
Offering choices and options		Diversion	

Number	Description of how technique was employed
1	
2	
3	
4	
5	

Restraint techniques including sequence of techniques, time and staff involved:

Time	Technique	Shape	Staff name
Duration of restraint:		**Duration of incident:**	

Is there any physical mark or harm caused by the use of restraint?	**Y/N**	Details:
Has the student indicated that this was caused by the use of physical intervention?	**Y/N**	Actions: • •

Incident reporting and monitoring	
Incident reported to: Head Teacher by:	
Parents / Carer informed by:	@
Student wellbeing verified by:	@
Staff wellbeing verified by:	@
Incident form completed by:	@

Verification of account of incident:		
Staff name	**Staff signature**	**Date**

Reporting staff name: _____ Signature: _____

Incident form coordinator check signature: _____ Date: _____

ANNEX 6 – Physical Intervention in Use at Falconer

Types of Restraint Techniques



Technique 1 – Figure of Four

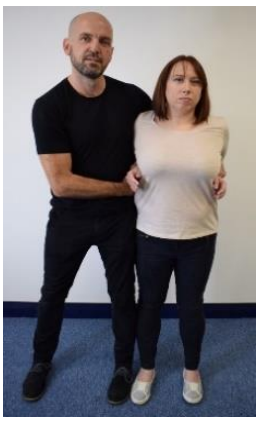
Secure guiding and prevention of exaggerated movement or grabbing

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Technique 2- Elbow Tuck - Additional safety support, especially with elevated risk

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Technique 3: Elbow Tuck Lone Worker

Allows safe control when staff is alone



Technique 4: Fix and Stabilise- contain without escalation, promote calm and stability



Supportive Touch Options

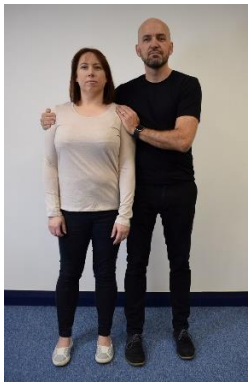
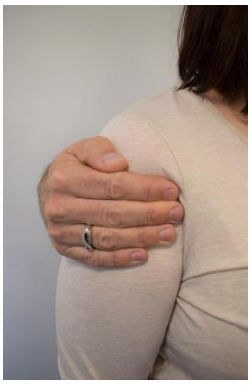
- **Offering an Arm**
    - Presenting your arm for the student to hold or lean on voluntarily.



- **Supportive Hug**
    - A brief, gentle hug given with consent to provide comfort and reassurance.



- **Supportive Arm**
    - Light touch or gentle placement of your hand/arm on the student's arm to offer grounding or reassurance.

- **Supportive Arm (Paired)**
    - A two-person approach where staff members each offer supportive touch (e.g. one on each side) to guide or reassure.



- **Open Mitten Guides**
    - Using open hands with fingers together ("mitten" shape) to gently guide movement, e.g. at the elbow.



- **Open Mitten Guides (Paired)**

- Two staff members using open mitten hands together to guide the student (e.g. during transitions or when moving through busy spaces).
-  

- **Open Mitten Escort**
  - Light physical guidance using one or both open mitten hands to walk alongside or slightly behind a student, offering direction and support.



Technique

- Figure of 4

Secure guiding, prevent exaggerated movement or grabbing

- Elbow Tuck – Braced

Additional safety support, especially with elevated risk

- Elbow Tuck – Lone Worker

Allow safe control when staff is alone

- Fix and Stabilise

Support and contain without escalation, promote calm and stability

