



PHYSICAL INTERVENTION POLICY

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1. Core Principles and Justification

Physical intervention is a last resort and should only be used when necessary to prevent a participant from:

1. Harming themselves.
2. Harming others (other participants, staff, or visitors).
3. Causing serious damage to property that could lead to injury.

A. Legal Context and De-escalation

All staff actions are guided by common law duties and Section 93 of the Education and Inspections Act 2006 (England).

- De-escalation First: The primary strategy for managing challenging behaviour is always verbal de-escalation and the use of preventative environmental and relational strategies. Our Self-Regulation and Trust values are essential for building the rapport needed to manage conflict non-physically.
- Prohibited Use: Physical intervention must never be used as a punishment, to enforce compliance, to inflict pain, or as a routine response to frustration or non-cooperation.

B. Training and Authorisation

Only staff who have successfully completed accredited training in safe, non-harmful physical intervention techniques (e.g., Team Teach, MAPA) are authorised to use restraint. This training is regularly refreshed and focuses heavily on understanding the emotional drivers behind challenging behaviour.

2. Types of Physical Intervention

A. Non-Restrictive Intervention

These techniques are low-level, non-contact, or minimally restrictive and are designed to guide or prompt a participant safely.

- Positive Touching: A hand on the shoulder or back to guide a participant from one activity to another (if accepted by the participant).
- Blocking/Shielding: Placing oneself between two participants who are arguing or standing between a participant and potential danger.
- Removal of Objects: Safely taking an object from a participant that could be used to harm themselves or others.

B. Restrictive Physical Intervention (Restraint)

This involves direct physical contact where the primary purpose is to prevent movement or restrict the liberty of a participant. Restraint must only be used if there is immediate danger and other techniques have failed or are clearly inadequate.

- Safe Holding: Use of trained, approved holds to restrict a participant's movement temporarily until the immediate danger has passed and they are calm and safe.

- Duration: The hold must be maintained for the minimum duration required to restore safety and must cease immediately if the risk subsides or if the participant shows signs of distress (e.g., struggling to breathe).

3. Intervention for Participants with SEND

We recognise that participants with SEND (including those with SEMH, ASD, or learning disabilities) may present challenging behaviour for reasons related to their communication difficulties, sensory needs, or anxiety.

A. Individualised Risk Assessment

For any participant known to present a risk of requiring restrictive intervention, a detailed Individual Behaviour Support Plan (IBSP) and Risk Assessment must be in place. This plan must specify:

1. Triggers: Known factors that lead to escalation (e.g., loud noises, specific people).
2. De-escalation Strategies: Specific, person-centred methods to calm the individual (e.g., use of quiet space, visual aids, preferred activity).
3. Sensory Needs: Any sensory issues that could affect the hold (e.g., sensitivity to touch, joint hypermobility).

B. Restraint of Children with SEND

When physical intervention is necessary for a child with SEND:

- The intervention must be carried out with heightened sensitivity to the child's sensory, communication, and pain thresholds.
- The child's EHC Plan or ISP must be consulted to understand any specific risk related to position or medical vulnerability before any hold is used.
- The intervention must be clearly justifiable as a necessary preventative action for safety, not a response to their disability-related behaviour.

4. Post-Intervention Procedures

A. Immediate Welfare and Review

Once the physical intervention has ended:

1. Immediate Care: Attend to the immediate physical and emotional needs of the participant and any affected parties. This includes medical checks if necessary.
2. Debrief (Participant): Once calm, the participant must be offered a restorative conversation to discuss the events, understand why the hold was necessary, and plan how they can use their Self-Regulation skills next time to prevent a recurrence.
3. Debrief (Staff): All staff involved must debrief to ensure professional practice was maintained and to identify any learning points or injury concerns.

B. Reporting and Recording

A full, detailed record of the incident must be completed by the staff member(s) involved within 24 hours. The record must include:

- The time, date, and location.

- The specific risk or harm being prevented (the justification).
- Details of de-escalation strategies attempted.
- The type of hold used and the exact duration.
- Any injuries sustained by any party.
- Whether the participant has SEND and if their IBSP was followed.

The Programme Lead must review the report and inform parents/carers and the commissioning body/school of the incident on the same day the intervention occurred. These records are subject to regular internal review to monitor patterns and reduce the use of restraint.