Castle School
Together We Learn

Restrictive Interventions and Reasonable Force Policy

Autumn 2026

Key principle

Castle School prioritises the safety, dignity and wellbeing of all pupils, recognising that many have complex needs that may affect their behaviour and emotional regulation. Restrictive interventions will only be used when necessary, proportionate and reasonable to prevent harm and maintain a safe environment. We aim to understand the needs and triggers behind behaviour, use prevention and de-escalation wherever possible, and make reasonable adjustments. Any intervention will respect the pupil's rights, be properly recorded and reviewed, and form part of a wider plan to reduce future need. We work closely with pupils, families and professionals to ensure our approach is fair, consistent, safe and centred on the pupil's best interests.

Adapted from the Therapeutic Thinking model policy and incorporating April 2026 DfE guidance

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1 Policy purpose and status
2 Castle School commitment
3 Legal and guidance framework
4 Scope
5 Definitions
6 Non-restrictive intervention (physical intervention / appropriate physical contact)
7 Who may use reasonable force
8 When restrictive intervention may be used
9 Decision making
10 Prevention de escalation and least restriction
11 Individual assessment and planning
12 Planned and reactive intervention
13 Practice during an intervention
14 Unacceptable and high risk practice
15 Specific forms of restrictive intervention
16 Seclusion separation and removal
17 Searching pupils
18 Staff safety and emergency services
19 Medical support injury and safeguarding
20 Recording and reporting
21 Post incident support review and learning
22 Training competence and authorisation
23 Complaints allegations and whistleblowing
24 Monitoring governance and data
25 Policy communication and review
Appendix 1 Staff decision checklist
Appendix 2 Required incident record
Appendix 3 Written information for parents
Appendix 4 Governance monitoring framework
Appendix 5 Related documents and sources

1 Policy purpose and status

Castle School will use proactive support, communication, environmental adjustment, co-regulation and de-escalation to avoid restrictive intervention wherever possible. In a small number of circumstances, an intervention may be the only safe and lawful option. Any intervention must be necessary, proportionate, reasonable in the circumstances and used for the shortest possible time.

This is a standalone policy that sits alongside the Positive Support Policy. It applies across all school sites and whenever a member of staff or another authorised adult has lawful control or charge of a pupil, including educational visits, community learning, work related learning and school activities away from the premises.

The policy distinguishes legal requirements from Castle's higher internal recording standard. The statutory minimum covers each significant incident involving force and every incident of seclusion or restraint. Castle records and reports every restrictive intervention so that practice is transparent and patterns can be reduced.

2 Castle School commitment

Every pupil has the right to be treated with respect and dignity, to have their needs recognised and to receive the right support. Pupils with learning disabilities, autism, communication differences, physical disabilities, sensory needs, mental health needs and complex medical conditions may be at increased risk of restrictive intervention. Distress may be communicated through actions when a pupil cannot explain pain, fear, overload, confusion or need in another way.

Castle adopts the Therapeutic Thinking commitment to reduce and, wherever possible, eliminate restrictive intervention. The school recognises that restraint and seclusion remain contested practices and that pupils with learning disabilities, autism and other additional needs are disproportionately affected. Clear definitions, transparent decisions and co-produced planning

are essential because restrictive intervention must never become an ordinary response to distress or difficulty.

Restrictive intervention can be physically and psychologically harmful to the pupil, witnesses, staff and families. It may be experienced as frightening or traumatic even where the adult's actions were lawful and intended to protect.

Castle therefore uses the following hierarchy:

1. Understand the pupil and create conditions that support wellbeing and participation.
2. Plan proactively with the pupil, family and relevant professionals.
3. Recognise early signs and use communication, co-regulation and de-escalation.
4. Use the least restrictive safe response when risk cannot otherwise be managed.
5. Stop or reduce the intervention as soon as the immediate risk has reduced.
6. Record, report, support, review and learn from what happened.

The central question is what response is in the best interests of the pupil and those around them in view of the risks presented. This requires staff to compare the likely harm of intervening with the likely harm of not intervening. Parents and the wider school community may also be distressed or retraumatised by restrictive intervention, including where they did not witness it. Communication after an incident must therefore be factual, sensitive and open.

Restrictive intervention is an act of safety and care, not a behaviour sanction. It is never used to punish, humiliate, cause pain, force compliance or compensate for inadequate staffing, planning or provision.

3 Legal and guidance framework

The policy has been drafted with regard to the following principal legislation and guidance:

- ✓ Education and Inspections Act 2006 sections 93 and 93A
- ✓ Schools Recording and Reporting of Seclusion and Restraint No 2 England Regulations 2025
- ✓ DfE Restrictive interventions including use of reasonable force in schools effective from 1 April 2026
- ✓ Equality Act 2010
- ✓ Human Rights Act 1998
- ✓ Health and Safety at Work etc Act 1974 and associated regulations
- ✓ Children Act 1989 and Children Act 2004
- ✓ Children and Families Act 2014 and SEND Code of Practice 0 to 25 years
- ✓ DfE and DHSC Reducing the Need for Restraint and Restrictive Intervention current guidance
- ✓ DfE Keeping Children Safe in Education 2026
- ✓ DfE Searching Screening and Confiscation current guidance
- ✓ Cambridgeshire Therapeutic Thinking guidance and Therapeutic Thinking Principles of Restrictive Intervention training

Page 14 of the April 2026 DfE guidance contains statutory guidance issued under section 93A of the Education and Inspections Act 2006.

The Governing Body must have regard to it when establishing procedures for recording and reporting significant incidents involving force. The 2025 Regulations create separate legal duties for every seclusion and restraint incident, including restraint without direct physical contact.

4 Scope

This policy covers physical and non-physical restrictive intervention, reasonable force, physical restraint, non-physical restraint, mechanical restraint, chemical restraint and seclusion. It also explains the boundary between restriction and non-restrictive intervention (physical intervention or

appropriate physical contact), personal care, therapy, moving and handling, medical treatment, removal and the use of a separation space.

It applies to all members of school staff. It also applies to another person whom the Headteacher has lawfully authorised to have control or charge of pupils for a particular purpose. Contractors, visitors and partner professionals remain accountable to their employer and professional framework as well as Castle's safeguarding and site procedures.

The policy does not replace clinical guidance, moving and handling plans, transport safety requirements, emergency medical procedures or safeguarding duties. Where more than one framework applies, staff follow the safest lawful course and record the reason for decisions.

5 Definitions

5.1 Therapeutic Thinking definitions

The definitions below use the terminology in the April 2026 Therapeutic Thinking model policy guidance. Castle School uses the same core definitions so that the language in policy, training and practice is consistent. Where a local operational clarification is needed, it is identified as a Castle note.

Term	Therapeutic Thinking definition
Child	Refers to all children and young people under the age of 18. Within the statutory elements of recording, the duty to record includes young people to the age of 20.
Parent	Used throughout this policy to refer 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, this also includes the local authority; it also includes a local authority providing accommodation for the child under section 20 of the Children Act 1989.
Governing body	A function of a maintained school. In relation to a school which is not a maintained school, the function of governance rests with the proprietor or trustees of an academy.

Term	Therapeutic Thinking definition
Disciplinary penalty	Actions, measures or proceedings intended as punishment or formal correction for misconduct. A penalty imposed on a pupil where their conduct falls below the standard which could reasonably be expected of them. **Therapeutic Thinking note:** Therapeutic Thinking is opposed to a methodology that includes punishments and sanctions and promotes responses based on reward and consequence rather than bribery and punishment.
Non-restrictive intervention (physical intervention or appropriate physical contact)	A planned or reactive use of touch to support a child's needs. A non-restrictive intervention has no intent to prevent, restrict or subdue movement of the body, or part of the body, through direct physical contact. There is no intent to immobilise a pupil or limit their movement.
Restrictive intervention	A planned or reactive act intending to prevent, restrict or subdue movement of the body, or part of the body, of a pupil. **Therapeutic Thinking note:** Restrictive intervention is the umbrella term for physical and non-physical actions intended to prevent, restrict or subdue movement. Use of restrictive intervention in any form triggers the relevant recording and reporting requirements.
Restraint	A non-disciplinary intervention which immobilises a pupil or limits their movement. This may or may not include direct physical contact. Holding a pupil's arms to their sides or removing a pupil's walking frame would both be considered forms of restraint.
Physical restraint	A restrictive intervention involving direct physical contact where the intention is to prevent, restrict or subdue movement of the body, or part of the body, of another person.
Non-physical restraint	Restricting a child or young person's independent actions by removing auxiliary aids, such as a walking frame, or disabling an electric wheelchair where the intention is to prevent, restrict or subdue movement of the body, or part of the body, through indirect actions.
Mechanical restraint	A non-disciplinary intervention which immobilises a pupil or limits their movement by enforcing the use of auxiliary aids such as belts, cuffs, multi-point harnesses or any other restrictive device not universally

Term	Therapeutic Thinking definition
	used for that purpose, with the intent to prevent, restrict or subdue movement of the body. **Castle note:** ordinary therapeutic, postural, transport or safety equipment is not mechanical restraint unless it is being used with the intent to prevent, restrict or subdue movement.
Chemical restraint	The use of medication to prevent, restrict or subdue movement of the body, or part of the body. **Castle note:** medication used to treat a diagnosed condition in accordance with clinical direction is not chemical restraint unless its purpose is to prevent, restrict or subdue movement.
Seclusion	A non-disciplinary intervention involving keeping a pupil confined to a place away from others to prevent, restrict or subdue movement of the body, or part of the body. Seclusion is preventing a child leaving that space by physical obstruction, blocking, or making them believe they will be punished if they try to leave.
Removal	Where a pupil, for disciplinary reasons, is required to spend a limited time out of the classroom at the instruction of a member of staff. The use of removal should allow for continuation of the pupil's education in a supervised setting.
Separation space	Where a pupil is taken out of the classroom to regulate their emotions because of identified sensory overload as part of a planned response. **Therapeutic Thinking note:** removal is reactive and separation space is proactive. If access to or use of a separation space is achieved through an action that meets the threshold for restrictive intervention, that restrictive element must be recorded and reported. **Castle note:** pupils and staff may also use the term regulation space operationally. The defining feature of a non-restrictive separation/regulation space is that the pupil is not prevented from leaving.
Challenging behaviour	Actions seen in individuals with learning disabilities or autism of such intensity, frequency or duration that they threaten the quality of life or safety of the person or others. **Therapeutic Thinking note:** challenging behaviour is a term rarely used within Therapeutic Thinking unless identified by other

Term	Therapeutic Thinking definition
	professionals. It is understood as communication arising from unmet need, communication difficulty, pain or distress, not as a diagnosis.
Difficult detrimental behaviour	Behaviour that a child or young person frequently displays that does not pose a risk of harm to self, others or property or is not recognised as a criminal offence. **Therapeutic Thinking note:** difficult behaviour never justifies the use of restrictive intervention. Disruption is categorised as difficult behaviour within this framework.

5.2 Additional terms used at Castle School

The terms below describe Castle School procedures or legal/operational concepts used alongside the Therapeutic Thinking definitions. They do not replace or alter the Therapeutic Thinking definitions above.

Term	Castle School use
Reasonable force	The legal term for physical force used in limited circumstances. Reasonable means no more force than is necessary and proportionate in the circumstances as they appeared to the member of staff.
Significant incident involving force	An incident where force goes beyond ordinary non-restrictive intervention or appropriate physical contact between staff and pupils. This includes physical force used to implement a non-physical restrictive intervention.
Planned intervention	A restrictive intervention identified in an assessed individual plan because evidence shows a foreseeable risk that cannot reliably be managed through less restrictive means. It must use agreed approaches, be reviewed through assess-plan-do-review and have reduction or elimination as the long-term aim.
Reactive intervention (unplanned)	A response to an unforeseen emergency or a materially different immediate risk. Staff use dynamic risk assessment, taking account of the seriousness and immediacy of harm, available alternatives, their own competence, the environment and the pupil's individual needs.
Digital Passport	Castle School's pupil-specific working document summarising communication, sensory and regulation needs, known risks, preventative supports, helpful responses and key information staff

	need in everyday practice. It does not itself authorise restrictive intervention.
Risk Reduction Plan	An individual plan used where foreseeable risk requires additional assessment and planning. It identifies proactive and least-restrictive strategies, the circumstances and threshold for any planned restrictive intervention, how risk will be reduced, and the arrangements for review.

The purpose and effect of an action determine whether it is restrictive, not the label used by staff. An escort, guide, supportive hold, safety belt, separation space or piece of equipment may be non-restrictive in one situation and restrictive in another if the purpose or effect is to prevent, restrict or subdue movement. Where there is doubt, staff should seek advice from Positive Support/SLT and record transparently.

6 Non-restrictive intervention (physical intervention / appropriate physical contact)

Castle does not operate a no-touch policy. Non-restrictive intervention (physical intervention or appropriate physical contact) may be necessary for pupils' care, education, communication, health and inclusion. There must be no intention to prevent, restrict or subdue movement. Examples include:

- ✓ first aid and emergency medical care
- ✓ guiding or walking with a pupil, including holding a hand where appropriate
- ✓ comforting a distressed pupil where the pupil accepts the contact
- ✓ congratulating or praising a pupil in a way known to be welcome
- ✓ demonstrating a musical, physical or practical technique
- ✓ personal and intimate care in accordance with the pupil's plan
- ✓ feeding, dressing, changing and toileting support
- ✓ physiotherapy, occupational therapy, postural management and moving and handling

- ✓ on-body signing, support for visual impairment and other agreed communication
- ✓ supporting a pupil to a space they have chosen to use for regulation

Staff consider the pupil's age, understanding, communication, individual history, culture, sensory preferences, the purpose and duration of contact, the location and whether other adults are present. Wherever possible, staff seek assent before contact, observe signs of discomfort or refusal and stop or adapt. Known preferences and boundaries are recorded in the Digital Passport or relevant plan.

Staff also consider attachment and dependency. Regular touch must not become a habit that meets an adult's emotional needs or blurs the distinction between a professional relationship and the pupil's primary family relationships. Where a pupil has insecure attachments or seeks frequent physical reassurance, the team agrees consistent boundaries and alternative ways to provide connection and co-regulation.

Touch must be in the pupil's best interests and appropriate to the adult's professional role. It must not be sexualised, secretive, habitual for the adult's comfort, against the pupil's will without lawful safety justification, or used as punishment. Staff avoid unnecessary contact with intimate or sensitive areas and follow personal care and safer working procedures.

Non-restrictive touch must never be used to inflict pain or compel compliance. Staff must not make contact with the neck, breasts, abdomen, genital area or another sensitive body area except where necessary for agreed personal care, first aid, clinical treatment or immediate protection from harm. All corporal punishment is prohibited.

7 Who may use reasonable force

All members of school staff have the legal power to use reasonable force in the limited circumstances set out in section 93 of the Education and

Inspections Act 2006. The Headteacher may also authorise another person who has lawful control or charge of pupils for a specified purpose.

Staff who are likely to need to use reasonable force or another restrictive intervention receive Therapeutic Thinking Principles of Restrictive Intervention training appropriate to their role and the assessed needs of pupils. However, an untrained member of staff faced with an unforeseen emergency does not lose the legal power to act reasonably to prevent harm. They must use professional judgement, the minimum force necessary and summon trained assistance as soon as possible.

Parental consent is not required before reasonable force may be used lawfully. A parent cannot require the school to adopt a no-contact position. Parents and pupils should nevertheless be involved in proactive planning, and any planned intervention must be transparent and regularly reviewed.

8 When restrictive intervention may be used

The statutory power allows reasonable force to prevent or stop a pupil from causing injury to themselves or others, committing a criminal offence, damaging property or causing disorder among pupils. Castle's practice is more restrictive than the widest wording of the power. Force is not used for low-level disruption, refusal or non-compliance. Any intervention in response to disorder must be necessary to address a real safety risk or serious escalation and must meet the tests in this policy.

Restrictive intervention may be considered only as a last resort, where staff have reasonable grounds to believe it is needed and a less restrictive response is not likely to achieve a safe outcome in time. Examples may include preventing a pupil from entering immediate traffic danger, stopping a serious assault, preventing serious self-injury, separating pupils where there is an immediate risk of injury or preventing dangerous use of an object.

A restrictive intervention that may have been justified during immediate danger cannot continue after the risk has reduced and cannot be imposed

afterwards as a consequence. It is never used to force curriculum participation, personal care, medication, food, an apology, compliance with an instruction or movement to another place unless the separate legal and safety conditions for the intervention are met at that time.

9 Decision making

Before and throughout an intervention, staff consider three questions.

Question	What staff consider
Is it necessary	What harm is imminent or occurring, who or what needs protection, whether a non-restrictive option can work in time, and whether intervention is likely to reduce rather than increase risk.
Is it proportionate	The seriousness and likelihood of harm, the least restrictive effective option, the minimum force and shortest duration, and whether the response remains proportionate as circumstances change.
What is the effect on welfare	The pupil's medical conditions, communication, sensory needs, trauma, age, size, disability, understanding, dignity, emotional state and the impact on other pupils and staff.

Staff make decisions on the information reasonably available at the time. The school supports staff who make an honest, reasonable decision under pressure, while still reviewing the incident openly and taking action where practice needs to change.

Staff must be able to explain their professional judgement, including:

- ✓ how the action was in the pupil's best interests while taking account of the safety and rights of other people
- ✓ who or what required protection and the harm that was occurring or reasonably predicted
- ✓ why a non-restrictive response was not likely to achieve safety in time

- ✓ why the chosen form of intervention was less harmful than the available alternatives
- ✓ how the force, restriction, location and duration remained reasonable and proportionate
- ✓ how the pupil's communication, disability, medical needs, trauma, age, size and understanding were considered

A lawful power does not make every possible intervention defensible. The judgement may later be reviewed using the information available to staff at the time, the outcome, the quality of prior planning and whether staff followed this policy. Staff therefore record the reasoning, not only the name of a technique.

10 Prevention de escalation and least restriction

Prevention is a whole-school responsibility and is described fully in the Positive Support and Behaviour Policy. For pupils at increased risk, staff use the Digital Passport and individual plans to identify health factors, triggers, early signs, helpful communication, environmental changes, preferred adults, regulation strategies and approaches to avoid.

- ✓ Reduce noise, crowding, language, demand or sensory input where safe.
- ✓ Use the pupil's established communication and allow processing time.
- ✓ Offer time, space, choice, movement, a familiar activity or access to a voluntary regulation area.
- ✓ Use calm, non-threatening posture and avoid surrounding the pupil.
- ✓ Move other pupils and hazards rather than moving the distressed pupil where this is safer.
- ✓ Ask a familiar or better matched adult to take over where this is likely to reduce risk.
- ✓ Summon support early and allocate one adult to lead communication.
- ✓ Review the approach immediately if adult actions are increasing distress or danger.

A verbal warning that restrictive intervention may be used is given only when the pupil can understand it and the warning is likely to support safety rather than function as a threat.

Staff explain what is happening and how the intervention can end in the pupil's communication mode as far as circumstances allow.

Therapeutic Thinking prevention is based on analysis rather than a standard list of de-escalation scripts. Staff consider what the pupil has experienced, how the pupil may be feeling, the function or communication within the behaviour, and how adult responses may alter anxiety or dependency. Strategies that are helpful for one pupil may increase risk for another and must be tested through assess plan do review.

11 Individual assessment and planning

Where restrictive intervention is foreseeable, Castle completes a documented assessment and plan before it is needed wherever possible. This forms the specialist level of the graduated approach and the Digital Passport.

- ✓ Assess plan do review evidence and analysis of the behaviour, including health, pain, communication, sensory and environmental factors.
- ✓ A risk assessment identifying the behaviour, likely frequency and severity, people or property at risk and the risk of intervention and non-intervention.
- ✓ The pupil's views and communication, parent contribution and advice from health, therapy, social care or other professionals where relevant.
- ✓ Preventative adjustments, early indicators, regulation and de-escalation strategies, including strategies known to increase risk.
- ✓ The precise risk threshold at which intervention may be considered and the harm it is intended to prevent.

- ✓ The least restrictive planned techniques, transitions into and out of them, position and environment, maximum expected duration and criteria for release.
- ✓ Medical, respiratory, musculoskeletal, neurological, sensory, trauma and moving and handling considerations.
- ✓ Staff matching, number of staff, how to summon help, training needs and unresolved risks for leaders.
- ✓ Post-incident support, recording, parental reporting and the date and trigger for review.
- ✓ Where they are relevant to the pupil, Therapeutic Thinking analysis and planning includes:
- ✓ early prognosis and assess plan do review evidence
- ✓ a Therapeutic Tree linking experiences, feelings and behaviours
- ✓ analysis of subconscious dysregulation and conscious values or beliefs so that support can be differentiated
- ✓ anxiety analysis, including factors associated with over-anxiety or over-dependency
- ✓ a Predict Prevent Progress plan and a Risk Reduction Plan
- ✓ a risk calculator or equivalent recorded judgement of frequency, severity and who or what is at risk
- ✓ the pupil's physical characteristics, developmental profile, diagnosis, medical needs, sensory processing, communication and mobility
- ✓ the times, places, people, activities and environmental conditions associated with increased or reduced risk
- ✓ de-escalation approaches that have been effective and common approaches that have increased risk
- ✓ the pupil and adult shapes, environment, destination technique and transitions into and out of any planned physical intervention
- ✓ the social validity of the plan, including how the intervention may feel to the pupil and appear to others

- ✓ protective consequences that reduce immediate risk and educational consequences that teach safer internal discipline
- ✓ the pupil's or advocate's contribution, parental involvement and unresolved risks requiring leadership action

The plan identifies named staff who understand it, how additional support is summoned and how competence is assured. It is accessible to the staff who need it at the point of care. The plan is reviewed within its stated timescale and after every significant or reactive (unplanned) incident, change in presentation, injury, repeated use or evidence that the approach is ineffective.

A plan **does not** authorise intervention automatically. Staff must still assess necessity, proportionality and welfare in the actual circumstances. Conversely, the absence of a plan does not prevent a reasonable emergency action. Any reactive (unplanned) restrictive intervention triggers review and creation or revision of a plan where recurrence is foreseeable.

Mechanical equipment, medication and interventions affected by complex medical needs require advice from the relevant qualified clinician. The school does not design clinical restrictions or medication regimes independently.

12 Planned and reactive intervention

Planned intervention

A planned intervention is described in an assessed individual plan because evidence shows a foreseeable risk that cannot reliably be managed through less restrictive means. It uses trained and agreed approaches, is co-produced as far as possible and is reviewed through assess plan do review. Planning aims to eliminate or reduce the intervention over time.

Reactive intervention (unplanned)

A reactive (unplanned) intervention responds to an unforeseen emergency or a materially different risk. Staff use a dynamic risk assessment, considering

the seriousness and immediacy of harm, available alternatives, their own competence, the environment and the pupil's needs. Trained staff should lead where they are available, but delay must not expose anyone to avoidable serious harm.

Following any reactive (unplanned) restrictive intervention, a senior leader reviews why it was not foreseen, whether the pupil's existing information was available, whether staffing and the environment were adequate, and what planning, training or provision must change.

13 Practice during an intervention

- ✓ One adult leads communication and uses the pupil's established communication wherever possible. They may use the prompt, "*one voice, and it's mine*" to remind staff of the need to reduce communication and support clarity of message.
- ✓ Staff state the safety reason for the intervention in simple language and explain what needs to change for it to reduce or stop.
- ✓ The intervention uses the minimum force and least restrictive position that can achieve safety.
- ✓ Staff continually monitor breathing, circulation, colour, responsiveness, distress, seizure activity and any known medical risk.
- ✓ A second adult summons help, protects other pupils, removes hazards and acts as a witness where possible.
- ✓ Staff avoid public exposure and protect privacy and dignity so far as immediate safety permits.
- ✓ The intervention is relaxed, reduced or stopped as soon as the immediate risk decreases.
- ✓ If the technique is ineffective or is escalating risk, staff reassess and change approach rather than increasing force automatically.
- ✓ Emergency medical help is requested immediately if there is breathing difficulty, collapse, altered consciousness, significant injury, prolonged distress or another medical concern.

The pupil is never left alone during restraint or seclusion. Staff do not conduct a detailed debrief while the pupil remains highly dysregulated. Immediate communication focuses on safety, reassurance and release.

Every effort is made to secure the presence of another member of staff who can assist, summon help and provide a witness account. Staff avoid escalating language or actions before, during and after intervention. Where a pupil is able to regain control, the intervention is relaxed and reduced in stages rather than maintained at its initial level.

14 Unacceptable and high risk practice

Force must never be used as punishment. Pupils must not be restrained in a way that affects the airway, breathing or circulation. Staff must not cover the mouth or nose, apply pressure to the neck, throat, chest or abdomen, use pain to obtain compliance or deliberately hold a pupil prone, supine or on their side on the ground.

The following practices are not authorised as planned Castle techniques and carry elevated risk:

- ☒ pressure to the neck, throat, chest or abdomen
- ☒ basket or wrap holds that compress the torso or restrict breathing
- ☒ hyperflexion or forcing the body forward
- ☒ holding a pupil by clothing where this may tighten around the neck or body
- ☒ joint locks, deliberate pain, twisting, forcing joints beyond their normal range or pulling by an outstretched arm
- ☒ deliberate ground restraint in any position
- ☒ forcing a pupil up or down stairs while restrained
- ☒ dragging a pupil from under furniture, a vehicle or another confined space

- ☒ lifting or carrying for behaviour control rather than an assessed moving and handling or immediate rescue need
- ☒ using belts, straps, furniture, doors or equipment to restrict movement without assessed lawful justification

If a pupil and staff unintentionally come to the ground, staff release or reposition to a safer alternative or standing position as quickly as possible. Where release creates an immediate greater danger, staff summon urgent assistance, continually monitor the pupil and use only the minimum action needed to reach a safer position.

15 Specific forms of restrictive intervention

Physical restraint

Physical restraint involves direct contact intended to immobilise or limit movement. Planned physical restraint uses only approaches taught through Castle's current accredited training and included in the pupil's assessed plan. In an unforeseen emergency, reasonable action may differ from a taught technique, but the member of staff must be able to explain why it was necessary and proportionate.

Non physical restraint

Non-physical restraint limits movement without direct contact. Removing a walking aid, blocking powered mobility or physically obstructing an exit may be restraint even if the pupil is not touched. Such actions require the same necessity, proportionality, welfare, recording and reporting considerations as physical restraint.

Mechanical restraint

Castle does not introduce mechanical restraint for behaviour control without documented clinical and multidisciplinary assessment, parental involvement, a clear legal basis and senior approval.

Equipment routinely used for postural support, transport safety, treatment, moving and handling or prevention of accidental injury is not mechanical restraint when that is its genuine purpose and it is used as prescribed. If equipment is used or altered with the intention of immobilising or limiting movement in response to behaviour, this policy applies.

Mechanical equipment intended to restrict movement must be recommended in writing by an appropriately qualified professional, normally an occupational therapist or another clinician. The written advice specifies its purpose, safe use, monitoring, review and recording. A parent request alone does not authorise the school to introduce restrictive equipment without professional assessment.

Chemical restraint

School staff do not use medication to punish, sedate for convenience or control movement. Medication is administered only in accordance with a lawful prescription, the school's medicines procedures and the pupil's healthcare plan. Any medication intended to manage acute distress or behaviour requires clinical direction, clear indications, monitoring and review. Staff record administration and any associated restrictive purpose or effect under the appropriate health and incident procedures.

Medication must remain in its original labelled container and be administered only as prescribed. Castle does not introduce a substance, supplement or restrictive diet intended to prevent or subdue movement without written clinical direction and the safeguards required by the Supporting Pupils with Medical Conditions procedures.

16 Seclusion separation and removal

Seclusion

Seclusion is not a disciplinary response and is not used as planned or routine behaviour management. In extremely limited circumstances, it may be used only as an emergency safety measure to prevent significant harm when a

pupil is experiencing a high level of dysregulation and less restrictive options cannot achieve safety in time. It must end as soon as the immediate risk has reduced.

- ✓ The place must be safe, non-threatening, appropriately lit, ventilated and free from avoidable hazards.
- ✓ The pupil is supervised continuously by a named member of staff who can see and hear them and respond immediately.
- ✓ Doors are not locked. Any physical blocking or belief that the pupil cannot leave means the incident is seclusion and must be treated as such.
- ✓ Communication continues in a calm and accessible way without threats or punishment.
- ✓ The pupil is allowed to leave as soon as the immediate risk of harm has reduced.
- ✓ Duration is actively monitored and justified. Prolonged or repeated seclusion requires immediate senior review.
- ✓ Every incident is recorded and a copy of the written record is supplied to each parent as soon as practicable, with an endeavour to do so the same day, subject to the statutory exceptions.

Therapeutic Thinking recognises that seclusion may avoid the physical discomfort of restraint but may cause greater psychological harm through social isolation. Staff compare these risks for the individual pupil and record why seclusion was the least harmful available response. If physical restraint is used to achieve or maintain seclusion, both the restraint and the seclusion are recorded and reported. A pupil in seclusion receives direct staff support; observation from elsewhere is not treated as sufficient supervision.

Voluntary regulation and supportive separation

A pupil may choose or accept support to move to a quieter area and remain free to leave. This is not seclusion. Staff check that the pupil's apparent choice is genuine and that no physical obstruction, threat or learned belief

prevents leaving. If the pupil is prevented from leaving for safety, the status changes and the incident must be recorded and reported as restraint or seclusion.

Removal

Removal is a disciplinary arrangement under the Positive Support and Behaviour Policy. It is supervised, time limited and allows education to continue. It must not be used as a disguised form of seclusion and must be reasonable and adjusted for the pupil's SEND.

17 Searching pupils

The Headteacher and staff they authorise may search a pupil or possessions where the legal conditions are met. Reasonable force may be used only to search for items that legislation identifies as prohibited for this purpose, not merely for items banned under school rules. Staff follow current DfE searching guidance, consider safeguarding and SEND, preserve dignity and record any significant use of force under this policy.

Therapeutic Thinking identifies particular safeguarding risks where a search could become intimate, frightening or violating. Staff do not improvise a physical search technique. They pause where possible, obtain senior support, use the least intrusive lawful option, consider police involvement where an immediate weapon risk cannot be managed safely, and record the justification and outcome even where no item is found.

18 Staff safety and emergency services

Staff are not expected to put themselves at risk of serious harm. A duty of care does not require an adult to enter or remain in a situation where doing so is likely to create greater danger. Staff may move other pupils, withdraw to a safer position, use barriers or distance that do not unlawfully confine the pupil, summon trained colleagues, call emergency medical services or request police assistance.

The safest response may be observation from a safe distance while the area is cleared. Staff consider whether intervention would increase danger because of the pupil's size, a weapon, a confined space, stairs, traffic, water, fire, medical vulnerability or insufficient help. The reason for intervening or not intervening is recorded after a serious event.

Police are not called as a punishment or substitute for appropriate provision. They may be called where there is an immediate serious risk, a weapon, a serious suspected offence or a situation the school cannot safely contain. Staff share relevant communication, disability and medical information to support a proportionate response.

19 Medical support injury and safeguarding

After any restrictive intervention, staff check the pupil and adults for injury, breathing difficulty, pain, distress and changes in presentation. First aid or medical assessment is arranged promptly when indicated. Emergency services are called for any urgent concern. Known medical vulnerabilities in the pupil's plan are followed.

All injuries and adverse effects are included in the incident record and recorded under the school's accident and health and safety procedures. The school reports to the Health and Safety Executive where the legal reporting threshold is met. Damage to clothing, equipment or mobility aids is also recorded and addressed.

Any concern that force was excessive, punitive, unsafe, discriminatory or otherwise inappropriate is reported immediately to the Headteacher and Designated Safeguarding Lead. If the concern relates to the Headteacher, it is reported to the Chair of Governors. Allegations and low-level concerns follow Keeping Children Safe in Education and the Staff Code of Conduct, these can be reported verbally or via the school electronic system, Confide. The pupil's immediate safety and access to advocacy are prioritised.

20 Recording and reporting

Castle recording standard

Castle records every restrictive intervention on Arbor, including physical restraint, non-physical restraint, mechanical or chemical restraint used for a restrictive purpose, and seclusion. Ordinary non-restrictive intervention (appropriate physical contact) is not recorded under this procedure unless an injury, concern or other policy requires it.

The member or members of staff involved complete the written record as soon as practicable and endeavour to do so no later than the same day. If same-day completion is not possible, the reason is recorded. A senior leader reviews the record for completeness, immediate safeguarding or medical action, parental reporting and planning changes. The requirement applies even where the intervention was included in an agreed plan.

Significant incidents involving force

The Governing Body maintains a procedure under section 93A of the Education and Inspections Act 2006 for every significant incident in which a member of staff uses force. Parents are informed as soon as practicable, with an endeavour to do so no later than the same day, this is done first in person or via Telephone and then the required information is provided in writing.

Seclusion and restraint

The Governing Body maintains a procedure under the Schools Recording and Reporting of Seclusion and Restraint No 2 England Regulations 2025 for every seclusion or restraint incident, whether or not force or direct physical contact was used. Because Castle is a maintained school, a copy of the written record is supplied to each parent as soon as practicable and the school endeavours to do so no later than the same day.

Where a restraint incident is also a significant use of force, the school does not send duplicate accounts. It completes one full record that meets both sets of requirements and supplies the information required by law. Internal

sections containing unrelated third-party information are managed in accordance with data protection and safeguarding duties while the statutory parent record is supplied.

Exceptions

The statutory exception applies where the pupil is aged 20 or over or where the staff member considers that reporting to a parent would be likely to result in serious harm to the pupil. In the latter case, the incident is reported to any parent to whom it can be reported without serious harm or, if there is none, to the local authority where the pupil ordinarily resides. The Designated Safeguarding Lead oversees and records this decision. Castle pupils are normally under 20, but the wording is retained so staff understand the full duty.

Parent communication

A face to face or telephone conversation may provide immediate reassurance and context but does not replace the written report. The written communication includes the date, time, location and approximate duration, why intervention was necessary, the type and degree of force where relevant, and any physical injury. For seclusion or restraint, the parent receives the statutory written record. Parents are invited to a follow-up discussion where appropriate.

The follow-up discussion considers known or emerging triggers, whether the Education Health and Care Plan and individual plans were followed, the effectiveness of de-escalation, the impact on the pupil and what should change. Parent involvement supports review but does not replace the school's duty to reach and record its own lawful professional judgement.

Other records

Injury, first aid, medical treatment, safeguarding concerns, absence, police involvement and health and safety matters are also recorded in the relevant school systems. The restrictive intervention record does not replace those

duties. Records are factual, secure, accessible only to those with a legitimate need and retained under the school's records retention schedule.

21 Post incident support review and learning

Immediate recovery takes priority over a pressured debrief. The pupil is offered a safe environment, familiar communication, regulation support, food, drink, personal care, first aid and medical assessment as appropriate. Staff and pupil wellbeing continue to be monitored, including delayed signs of pain, injury or distress. Pupils who witnessed the event are supported where needed.

Separate reflections are obtained from the pupil and staff involved when they are ready. The pupil's account is sought through their usual communication and may include observation, symbols, AAC, advocacy or family support. Reflection should ideally be facilitated by a person who was not directly involved. It is not used to secure agreement with the adult account or a forced apology.

The review considers:

- ✓ what happened before, during and after the incident and what the pupil may have been communicating
- ✓ whether pain, health, sensory, communication, trauma, staffing, environment or curriculum contributed
- ✓ whether the pupil's Education Health and Care Plan and agreed support were delivered
- ✓ whether the plan was accessible, followed and effective
- ✓ what de-escalation was attempted and whether adult actions affected escalation
- ✓ whether the intervention was necessary, proportionate, reasonable and stopped promptly
- ✓ the physical and emotional impact on the pupil, staff and witnesses
- ✓ what must change in support, staffing, training, environment, clinical advice or planning

- ✓ whether safeguarding, health and safety, employment or external notification action is required
- ✓ The relevant Digital Passport, Positive Support Plan, Risk Reduction Plan and risk assessment are updated following a significant incident and whenever evidence shows that a strategy is ineffective. Repeated use without meaningful review is unacceptable.

Where appropriate, a restorative conversation supports reflection, emotional recovery and repair of relationships. It takes place only when the pupil is ready, uses the pupil's communication system and is not framed as a demand for apology or acceptance of the adult account. Staff and pupil support may include further conversations, family involvement, clinical advice, occupational health, counselling or other agreed resources.

22 Training competence and authorisation

All staff receive training in Therapeutic Thinking relational practice, Castle's positive support approach, communication, prevention, de-escalation, this policy and the statutory recording and reporting duties. Training is tailored to the pupils and roles involved. Staff likely to use physical restraint receive current Therapeutic Thinking Principles of Restrictive Intervention training, including restraint reduction and elimination, safe practical application and legal decision-making.

Training records include the course, provider, content, date, expiry or refresher date and staff attendance.

- ✓ Practical competence is not assumed solely from attendance. Leaders observe practice, provide coaching and address gaps.
- ✓ Pupil-specific briefings cover plans, medical risks, communication, transitions and the precise circumstances in which a planned intervention may be considered.
- ✓ Agency, temporary and new staff receive a clear induction and are deployed in accordance with their verified competence and the assessed risk.

- ✓ Only trained staff use planned restrictive techniques. Emergency statutory powers remain available to all staff acting reasonably.
- ✓ Training content and individual plans are reviewed after serious or repeated incidents and when guidance or pupil need changes.

23 Complaints allegations and whistleblowing

Parents and pupils may raise concerns through the school's complaints procedure. The school provides accessible support for pupils to communicate a concern and explains advocacy options where appropriate. A complaint does not prevent immediate safeguarding action or referral to another agency.

An allegation that a member of staff used inappropriate force or another restrictive intervention is managed under Keeping Children Safe in Education. Staff report concerns about colleagues to the Headteacher. Concerns about the Headteacher are reported to the Chair of Governors. Low level concerns and conduct issues follow the Staff Code of Conduct. Staff and volunteers may use the whistleblowing procedure and must not face detriment for raising a genuine safeguarding concern.

The existence of an injury does not by itself prove that force was unreasonable, and the absence of injury does not prove that practice was appropriate. The school considers the full evidence, including necessity, proportionality, welfare, communication, training, records and accounts from the pupil, staff and witnesses.

24 Monitoring governance and data

The Headteacher is accountable for implementation. The Assistant Headteacher for Positive Support oversees operational quality, Arbor record completion, individual review, training and analysis. The Designated Safeguarding Lead reviews safeguarding concerns and exceptions to parental reporting. The Safeguarding Governor provides focused oversight and reports assurance to the Governing Body.

The Governing Body takes all reasonable steps to ensure recording and reporting procedures are followed. It regularly reviews anonymised and appropriately aggregated information to:

- ✓ identify repeated patterns, triggers and pupils or provisions requiring additional support
- ✓ test whether plans and interventions reduce risk over time
- ✓ identify training, staffing, environmental or resource needs
- ✓ identify possible disproportionate use relating to SEND, vulnerability or protected characteristics
- ✓ review injury, duration, seclusion, reactive (unplanned) intervention, police involvement and delayed reporting, and assure itself that pupils, parents and staff receive post-incident support and that learning is acted upon

Governors consider the limits of the data and avoid drawing firm conclusions from very small groups. Individual case detail is shared only where necessary for governance, safeguarding or legal accountability.

25 Policy communication and review

The policy is available to all staff, pupils and parents. Staff confirm that they have read and understood it and receive practical briefing on the school's recording and reporting procedure. Pupils are given accessible information about how adults may keep people safe and how to raise a concern. Parents receive information about the policy and individual planning where relevant.

The policy is reviewed annually and earlier after a change in law or guidance, a serious incident, safeguarding review, complaint, emerging pattern, material change in training or evidence that practice is ineffective or disproportionate. The review includes consultation with pupils, parents, staff, relevant professionals and governors.

Appendix 1 Staff decision checklist

Stage	Questions
Before	What is the immediate or imminent harm. Can communication, time, distance, environmental change or another adult achieve safety. What does the pupil's plan say. What medical or sensory risks are relevant.
Decision	Is intervention necessary. Is it proportionate to the harm. Is it the least restrictive effective option. How will the pupil's welfare and dignity be protected.
During	Is the intervention working. Is breathing and circulation unaffected. Can force or restriction be reduced. Has the risk decreased. Is medical help needed.
End	Release or reduce as soon as the immediate risk has reduced. Support regulation. Check for injury and seek medical help where indicated.
After	Record the same day where practicable. Ensure written parent reporting. Obtain separate reflections. Review safeguarding, health and safety, the plan and lessons for future support.

Appendix 2 Required incident record

The school's approved record must capture the statutory minimum and Castle's additional learning information. It should include:

- ✓ pupil name, date of birth, age, gender, ethnicity, SEND status code and relevant needs or circumstances
- ✓ names and roles of staff directly involved and adult and pupil witnesses
- ✓ date, time, location, context, approximate duration of the incident and duration of restriction
- ✓ what happened before the incident, known or possible triggers and the observable behaviour
- ✓ preventative and de-escalation strategies used, in order, and their effect
- ✓ the harm that was occurring or predicted and who or what required protection
- ✓ why intervention was necessary and why a less restrictive response was insufficient
- ✓ the type of intervention, technique or action, position, transitions, degree of force and sequence
- ✓ how the pupil was monitored and how and why the intervention was reduced or ended
- ✓ injury, pain, distress, property damage, first aid, medical treatment and other adverse impact
- ✓ pupil account, staff account and witness information, recorded separately where practicable
- ✓ post-incident support for the pupil, staff and witnesses
- ✓ safeguarding, police, health and safety or other external agency action
- ✓ time, date, method and recipient of parent contact and written reporting
- ✓ reason if recording or parental reporting was not achieved on the same day

- ✓ review of the Digital Passport, Positive Support Plan, Risk Reduction Plan, risk assessment and Education Health and Care Plan delivery
- ✓ senior leader review, required actions, owners and review date

Appendix 3 Written information for parents

For every Castle restrictive intervention, parents receive written information as soon as practicable and the school endeavours to send it on the same day.

The parent-facing record includes at least:

- ✓ the pupil's name and the date, time, location and approximate duration
- ✓ a brief factual account of what occurred and why intervention was assessed as necessary
- ✓ the type of intervention and, where force was used, the degree of force
- ✓ the duration of restraint or seclusion and how it ended
- ✓ any physical injury or identified adverse effect and medical or first aid action
- ✓ the immediate support provided and the proposed follow-up discussion or review
- ✓ a named contact for questions or concerns and information about the complaints procedure

For seclusion or restraint, each parent receives a copy of the written statutory record. If the incident is also a significant use of force, one report may satisfy both duties provided it contains the required information. Parent agreement to a planned intervention does not remove the duty to report an incident.

Appendix 4 Governance monitoring framework

Area	Suggested assurance information
Frequency and type	Number of incidents, pupils involved, physical and non-physical restraint, seclusion, planned and unplanned intervention and significant use of force.
Duration and harm	Duration bands, injury or medical treatment, staff injury, pupil distress, property damage and emergency service involvement.
Timeliness	Same-day recording and written parent reporting, delayed cases and reasons, completion of senior review.
Patterns	Time, location, activity, staffing, triggers, repeat incidents and whether individual plans reduced frequency or severity.
Equality	Proportionate review by protected characteristic, SEND, age, pathway and vulnerability, with caution for small groups.
Learning	Plan changes, environmental action, clinical advice, staff training, complaints, safeguarding concerns and evidence that actions were completed.

Appendix 5 Related documents and Sources

- ✓ Positive Support and Behaviour Policy
- ✓ Child Protection and Safeguarding Policy
- ✓ Staff Code of Conduct
- ✓ Health and Safety Policy and accident reporting procedures
- ✓ First Aid and Supporting Pupils with Medical Conditions procedures
- ✓ Moving and Handling procedures and individual plans
- ✓ Complaints Policy Low Level Concerns procedures and Whistleblowing Policy
- ✓ Educational Visits Policy and transport risk assessments
- ✓ Data Protection Policy and records retention schedule

National and local sources

- ✓ DfE Restrictive interventions including use of reasonable force in schools April 2026
- ✓ Schools Recording and Reporting of Seclusion and Restraint No 2 England Regulations 2025
- ✓ DfE and DHSC Reducing the Need for Restraint and Restrictive Intervention current guidance
- ✓ DfE Behaviour in Schools advice for headteachers and school staff 2024
- ✓ DfE Keeping Children Safe in Education 2026
- ✓ Cambridgeshire Therapeutic Thinking Model Policy Guidance Reducing the Need for Restrictive Interventions in Schools
- ✓ Safer Recruitment Consortium Guidance for Safer Working Practice for those working with children and young people in education settings current edition