Wolverdene Special School
Restrictive Physical Intervention Policy 2026

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This policy will be reviewed annually. The next review will be March 2027	

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1. Background

This policy is written in line with PRICE guidelines around the April 2026 legislative document ***Restrictive Interventions and the Use of Reasonable Force in Schools DfE Guidance: April 2026***

This is because PRICE is the body that trains, monitors and quality assures all Restrictive Physical Interventions within Wolverdene School.

We define restrictive physical intervention as follows:

Any physical contact undertaken by staff, with the intention to restrict or subdue movement of the body, (or part of the body) of the pupil. (DfE 2013b- Use of reasonable force in schools).

The school's approach to RPIs is grounded in five core principles from PRICE guidelines:

1.practising within a human rights and person-centred framework;

2. understanding the needs of those being supported;

3.prioritising primary, secondary, and non-restrictive strategies;

4. using approved practices only as a last resort; and

5. applying reflective practice to reduce reliance on restriction.

The principles below reflect how those values are applied in the specific context of schools and the DfE's April 2026 guidance.

- Protecting rights is fundamental. Every young person's right to safety, dignity, education, and freedom from unnecessary or disproportionate restriction.
- The rights of staff are of equal importance, including the right to a safe working environment, appropriate training and support, lawful professional judgement without fear of unfair censure, and a structured debrief following any significant incident.
- Prevention and early intervention come first. Restrictive interventions are not a behaviour management strategy and are never a substitute for good relational practice and proactive support.

This policy also reflects PRICE Training's interpretation of statutory guidance and supports the school's professional judgement in practice.

• Necessity is central. Force is used only where there is a real and immediate risk of harm and where less restrictive options are insufficient.

• Proportionality and least restrictiveness apply at all times. Force must be the minimum required, for the shortest time possible, and must reduce as risk reduces.

• Dignity, welfare, and safety are paramount. The physical and psychological welfare of the pupil remains a central consideration throughout any intervention.

• Professional judgement matters. PRICE Training supports dynamic, informed decision-making that recognises lawful responses depend on context, risk, and the individual.

• Reduction over reliance. Force must sit within a wider system of reflection, review, and learning aimed at reducing future reliance on restrictive interventions.

All staff within this setting aim to support children to identify the functions of behaviour and find alternative strategies to manage periods of dysregulation. We do this through a combination of approaches, which include:

- A relational approach, understanding the functions of behaviour and disseminating that knowledge to all staff.
- PACE (Playfulness, Acceptance, Curiosity, Empathy).
- Individual Keywork sessions.
- Targeted interventions.
- Restorative practice.

- Positive role modelling.
- Teaching an interesting, challenging and developmentally appropriate curriculum.
- Specific teaching around emotions, both in a group setting and on an individual basis
- Setting appropriate boundaries and expectations and providing supportive feedback.
- Monitoring and reviewing behaviour data to identify trends, enabling positive behaviour support planning.

More details about this and our general approach to promoting positive behaviour can be found in our Relationships and Positive Behaviour Policy. There are times when children's behaviour presents particular challenges that may require restrictive physical intervention.

This policy sets out our expectations for the use of such intervention. It is not intended to refer to the general use of physical contact which might be appropriate in a range of situations, such as:

- giving physical guidance to children (for example in practical activities and PE);
- offering sensory support under the direction of a qualified OT (Occupational Therapist)
- providing emotional support when a child is distressed; or
- providing physical care (such as first aid or toileting).

This policy is consistent with our Child Protection policy and duties under the Equality Act (2010), and with national and local guidance for schools on safeguarding children.

We exercise appropriate care when using physical contact (there is further guidance in our Safeguarding Policy); there are some children for whom physical contact would be inappropriate in the above situations (such as those with a history of physical or sexual abuse, or those from certain cultural/religious groups). We pay careful attention to issues of gender and privacy, and to any specific requirements of certain cultural/religious groups.

2. Principles for the use of restrictive physical Intervention

2.1 In the context of positive approaches

We only use restrictive physical intervention where the risks involved in using force are outweighed by the risks involved in not using force. It is not our preferred way of managing children's behaviour. Restrictive physical intervention may be used only in the context of a well-established and well implemented positive behaviour management framework with the exception of emergency situations. Any use of restrictive physical intervention will only be used if deemed to be in the best interests of the child. We describe our approach to promoting positive behaviour in our Relationships and Positive Behaviour Policy. We aim to do all we can in order to avoid using restrictive physical intervention. We would only use restrictive physical intervention where we judge that there is no reasonably practicable less intrusive alternative.

However, there may be situations of such concern where we judge that we would need to use restrictive physical intervention immediately. We would use restrictive physical intervention at the same time as using other approaches, such as saying, "Stop!" and giving a warning of

what might happen next. Safety is always of paramount concern and staff are not advised to use restrictive physical intervention if it is likely to put themselves at risk. We will make parents/guardians aware of our Restrictive Physical Intervention Policy alongside other policies when their child joins the School.

2.2 Duty of care

We all have a duty of care towards all of the children in our setting. This duty of care applies as much to what we don't do as what we do. When children are in danger of hurting themselves or others, or of causing significant damage to property, we have a responsibility to intervene. In most cases, this involves an attempt to divert the child to another activity or a simple instruction to "Stop!" along with a warning of what might happen next. However, if we judge that it is necessary, we may use restrictive physical intervention.

2.3 Reasonable force

When we need to use restrictive physical intervention, we use it within the principle of reasonable force. This means using an amount of force in proportion to the circumstances. We use as little force as is necessary in order to maintain safety, and we use this for as short a period as possible. Minimum bruising and slight marks may be present after physical intervention, should this happen staff will notify SLT and inform parents/carers as well as having that discussion with the child.

3. When can restrictive physical intervention be used?

The use of restrictive physical intervention may be justified where a pupil is:

- committing an offence (or, for a pupil under the age of criminal responsibility, what would be considered an offence for an older pupil);
- causing personal injury to, or significant damage to the property of, any person (including the pupil him/herself); or
- Prejudicing the maintenance of good order and discipline at the school or among any pupils receiving education at the school, whether during a teaching session or otherwise. (NB – The justification of 'maintenance of good order and discipline' does not apply to residential settings. Therefore, once a child is in The Lodge at the end of the school day 'maintenance of good order' ceases to be justification for the use of restrictive physical intervention).

Restrictive physical intervention may also be appropriate where, although none of the above have yet happened, they are judged as highly likely to be about to happen. Restrictive intervention may also be used where the child is showing signs of dysregulation and the staff judge that early intervention is in the best interests of the child. This is to prevent them from becoming too dysregulated and therefore requiring significant physical intervention. However, this method of working will need to be agreed by the Senior Leadership Team and recorded in the child's Positive Behaviour Support Plan.

We are very cautious about using restrictive physical intervention where there are no immediate concerns about possible injury or exceptional damage to property.

The main aim of restrictive physical intervention is usually to reduce risk in order to restore safety. We acknowledge that there may be times when restrictive physical intervention may be justified as a reasonable and proportional response to prevent damage to property or to maintain good order and discipline at the school. However, we would be particularly careful to consider all other options available before using restrictive physical intervention to achieve either of these goals. In all cases, we remember that, even if the aim is to re-establish good order, restrictive physical intervention may actually escalate the difficulty.

If we judge that restrictive physical intervention would make the situation worse, we would not use it, but would do something else (like go to seek help, make the area safe or warn about what might happen next and issue an instruction to stop) consistent with our duty of care. Our duty of care means that we might use a restrictive physical intervention if a child is trying to leave our site and we judged that they would place themselves at unacceptable risk. This duty of care also extends beyond our site boundaries: there may also be situations where we need to use restrictive physical intervention when we have charge of children off site (e.g. on trips).

We never use restrictive physical intervention out of anger or frustration or as a punishment.

4. Who can use restrictive physical intervention?

If the use of restrictive physical intervention is appropriate, and is part of a positive behaviour management framework, a member of staff has received PRICE training, should be involved where possible. We recognise that there will be very rare occasions of immediate and extreme risk when a member of staff without training may need to intervene in a limited way to de-escalate a situation.

However, in an emergency, any of the following may be able to use reasonable force:

- Any teacher who works at the school; and
- Any other person whom the Headteacher has authorised to have control or charge of pupils, including:
- Support staff whose job normally includes supervising pupils such as teaching assistants, learning support assistants, residential care staff, learning mentors and lunchtime supervisors; and
- People to whom the Headteacher has given temporary authorisation to have control or charge of pupils such as paid members of staff whose job does not normally involve supervising pupils (for example catering or premises-related staff) .

5. Planning around an individual and risk assessment

In an emergency, staff do their best, using reasonable force within their duty of care.

All children have a Positive Behaviour Support plan, which includes the use of restrictive physical intervention. We ensure that such staff receive appropriate training and support in

positive behaviour management as well as restrictive physical intervention. We consider staff and children's physical and emotional health when we make these plans and consult with the child's parents/guardians.

In most situations, our use of restrictive physical intervention is in the context of a prior risk assessment which considers:

- what the risks are;
- who is at risk and how; and
- what we can do to manage the risk (this may include the possible use of restrictive physical intervention).

The risk assessment process informs the practice that we develop to support the child. If the PBS (Positive Behaviour Support) Plan includes restrictive physical intervention it will be as just one part of a whole approach to supporting the child's behaviour. The PBS plan outlines:

- our understanding of what the child is trying to achieve or communicate through his/her behaviour;
- how we adapt our environment to better meet the child's needs;
- how we teach and encourage the child to use new, more appropriate behaviours;
- how we recognise when a child makes progress; and
- how we respond when the child's behaviour is challenging (responsive strategies).
- consideration of the impact of applying restrictive physical intervention will have on the child whilst being mindful of previous experiences and trauma and reviewing how this may cause further trauma for the child.
- how strategies can reduce the need for physical intervention.

We pay particular attention to responsive strategies. We use a range of approaches through applying PACE principles (including humour, distraction, relocation, and offering choices) as direct alternatives to using restrictive physical intervention. We choose these responsive strategies in the light of our risk assessment. We draw from as many different viewpoints as possible when we anticipate that an individual child's behaviour may require some form of restrictive physical intervention. In particular, we include the child's perspective. We also involve the child's parents (or those with parental responsibility), staff from our school who work with the child, and any visiting support staff (such as educational psychologists, speech and language therapists, social workers and colleagues from the Child and Adolescent Mental Health Services (CAMHS).

We recognise that there may be some children within our school who find physical contact in general particularly unwelcome as a consequence of their culture/religious group or disability. There may be others for whom such contact is troubling as a result of their personal history, in particular of abuse. We have systems to alert staff discreetly to such issues so that we can plan accordingly to meet individual children's needs. Staff will do all they can in this situation to avoid a restrictive physical intervention, but this may not always be possible if the safety of the child or others is at risk.

6. What type of restrictive physical intervention can be used?

Any use of restrictive physical intervention by our staff should be consistent with the principle of reasonable force. In all cases, staff should be guided in their choices of action by the principles in Section 2 above.

In line with April 2026 guidance, PRICE are supporting schools to think about RPIs in the following ways in order to support consistent recording, as practical guidance rather than prescriptive categories, but as a shared language to help articulate proportionality and necessity in records, training, and review.

- Levels of force: Low-level (light contact, minimal effort, no significant resistance);
- Medium level (deliberate and sustained contact, moderate effort, active resistance);
- High-level (significant and sustained contact, significant and sustained physical effort, significant and ongoing resistance).

These descriptors apply across all levels of the PRICE Training framework. Contact at every level sits within an approved and structured approach. A low or medium-level response is not an improvised reaction but a deliberate, trained, and proportionate one.

Degrees of restriction:

- Minimum (lightest limitation, significant freedom of movement retained);
- Moderate (more substantial containment, multiple contact points, movement significantly impaired but not fully controlled);
- Rigorous (high degree of containment, movement substantially or fully controlled, highest welfare risk, most rigorous review required).

Staff should not act in ways that might reasonably be expected to cause injury, for example by:

- holding a child around the neck or collar or in any other way that might restrict the child's ability to breathe;
- slapping, punching or kicking a child;
- twisting or forcing limbs against a joint;
- tripping a child; or
- holding a child by the hair or ear.

Such actions are considered inappropriate.

We do not plan for and do not allow, except in emergency situations, staff to use seclusion. Seclusion is where a young person is forced to spend time alone in a confined space against their will. We may, however, use withdrawal or time-out in a planned way. We define these as follows:

Withdrawal involves taking a young person, with their agreement, away from a situation that has caused anxiety or distress, to a place where they can be observed continuously and supported until they are ready to resume their usual activities.

Time-out is where a response to a young person's inappropriate behaviour includes a specific period of time with no positive reinforcement as part of an overall intervention plan. More details on our response to seclusion can be found in our Relationships and Positive Behaviour Policy.

Where staff need specific training in the use of restrictive physical intervention, we arrange that they should receive PRICE (Protecting Rights in a Caring Environment) training.

Further, we actively work to ensure general training is accessed by our staff in the following areas:

- relating to legal issues policy and risk assessment
- in addition to behaviour management strategies such as positive approaches to behaviour management;
- training relating in developing a therapeutic culture, attachment theory and P.A.C.E to allow the staff to maintain positive relationships with the children whilst ensuring they are able to meet the child's attachment needs;
- restorative practice
- the use of Safe Spaces
- de-escalation techniques; and
- a record of such training is kept and monitored.

7. Recording and reporting

We record any use of restrictive physical intervention using the online reporting system CPOMS. We do this as soon as possible and in any event within 24 hours of the incident. Regular reviews of the physical interventions are carried out by the SLT, PBS manager, the governing body and external professionals.

According to the nature of the incident, we may also note it in other records, such as HCC's Health and Safety documents or RIDDOR.

Further, our Governing Body ensures that procedures are in place for recording significant incidents and then reporting these incidents as soon as possible to pupil's parents.

After using restrictive physical intervention, we ensure that the Headteacher and / or other members of the Senior Leadership Team is informed in the daily debrief at the end of each day. We also inform parents by phone (or by letter or note home with the child if this is not possible) each and every time a RPI has occurred.

In rare cases, we might need to inform the police, such as in incidents that involve the possession of weapons. This would be in line with our general practice, informed by the joint DfE/Home Office (1999) publication 'School Security: Dealing with trouble makers – protecting pupils and staff and Section 45 of the Violent Crime Reduction Act 2006'.

8. Supporting and reviewing

We recognise that it can be distressing to be involved in a physical intervention, for the child and or any members of staff involved in or observing. We also recognise that it can be distressing for parents and carers to be informed that their child has been involved in a restrictive physical intervention.

After a restrictive physical intervention, we will use our knowledge of the child to support them and prevent re-escalation. We will use restorative practices to discuss the incident and give support to the child so that they can understand why the physical intervention was necessary. As part of the support and repair process the child's views will be sought and these will be recorded on the online log. The debrief process is different for every child and take into account their emotional literacy levels. In some cases, there are children that are not emotionally able to debrief after an incident without retriggering a further incident. This may be due to a number of contributing factors, where it is judged this is the case the staff team will record this in the PBS Plans, and an alternative method of debrief will be explored. Where it is appropriate, we may have similar conversations with other children who observed what happened.

In all cases, we will wait until the child is emotionally regulated enough to be able to engage with the repair process. If necessary, the child will be asked whether he or she has been injured so that appropriate first aid can be given. This also gives the child an opportunity to talk with another member of staff unconnected to the incident and if required they will be made aware of the complaint's procedure.

We also support adults who were involved, either actively or as observers, by giving them the chance to talk through what has happened with the most appropriate person from the staff team. Staff receive regular clinical supervision where they are encouraged to reflect on incidents and the impact it has had on them. Staff will also be made aware of the confidential help that can be given by the Employee Support Line.

A key aim of our after-incident support is to repair any potential strain to the relationship between the child and the people that were involved in the restrictive physical intervention. This does require the child to be ready to reflect on the incident.

After a restrictive physical intervention, we consider whether the PBS plan needs to be reviewed so that we can reduce the risk of needing to use restrictive physical intervention again.

9. Training & Monitoring

We monitor the use of restrictive physical intervention in our school. Assistant Headteachers are responsible for reviewing the records on a termly basis, and more often if the need arises, so that appropriate action can be taken. The information is shared with the governing body during safeguarding reviews. The Assistant Headteacher responsible for behaviour and attitudes, along with the PBS Manager, will review these daily and refer reports back if we feel more information is needed. Both of these members of staff are PRICE trainers and they are responsible for the training

of all staff, and challenging any use of an RPI that is not in line with the PRICE guidelines. All staff within the school, with the exception of admin and site staff are trained in PRICE.

All parents will be notified either through a phone call or email to talk through the incident and use of an RPI, and offered the CPOMS report should the parent request this. This is in line with DfE April 2026 guidance: Restrictive interventions, including use of reasonable force, in schools (April 2026).

Our analysis considers equalities issues such as age, gender, disability, culture and religion issues in order to make sure that there is no potential discrimination; we also consider potential child protection issues. We look for any trends in the relative use of restrictive physical intervention across different staff members and across different times of day or settings. Our aims are to protect children, to avoid discrimination and to develop our ability to meet the needs of children without using restrictive physical intervention. We report this analysis back to the Governing Body so that appropriate further action can be taken and monitored.

10. Concerns and complaints

The use of restrictive physical intervention can be distressing to all involved and can lead to concerns, allegations or complaints of inappropriate or excessive use. In particular, a child might complain about the use of restrictive physical intervention in the heat of the moment but on further reflection might better understand why it happened. In other situations, further reflection might lead the child to feel strongly that the use of restrictive physical intervention was inappropriate. This is why we are careful to ensure all children have a chance to review the incident after they have returned to an emotionally regulated state.

If a child or parent has a concern about the way restrictive physical intervention has been used, our School's complaints procedure explains how to take the matter further and how long we will take to respond to these concerns.

Where there is an allegation of assault or abusive behaviour, we ensure that the Headteacher is immediately informed and they will follow the procedures as set out in our Allegations of Abuse Policy. We would also follow our child protection procedures. In the absence of the Headteacher we ensure that the Assistant Headteachers are informed. If the concern, complaint or allegation concerns the Headteacher, the Chair of Governors must be informed.

If parents/carers are not satisfied with the way the complaint has been handled, they have the right to take the matter further as set out in our complaint's procedure.

The results and procedures used in dealing with complaints are monitored by the Governing Body.

11. List of Approved PRICE techniques

Table of approved RPI techniques			
P.R.I.C.E.	Description	Purpose	Effectiveness
Phase 1 (one person)			
Walk and Talk	This is not a hold, it is a non-restrictive technique to maintain safety and balance, enabling staff to engage positively and assess risk whilst walking and talking. Please note: The technique becomes restrictive if in the context of preventing the person from moving towards a source of risk or potential danger.	For use when responding and engaging with a person we support. It is an initial response whilst dynamically assessing risk.	Low-level response when responding to a low to medium level of arousal (when dynamically risk assessing the situation).
Single embrace	One-person technique Standing and walking. Can also be seated.	Low-level response to a low-level arousal. Moves the person away from the potential risk.	Low to Medium. Requires a degree of positive response from the person you are supporting (this will be reliant on the knowledge of the child and how they react).
Adapted Embrace	One-person technique. Standing and walking. For use when you have previous knowledge of a child you are supporting who hasn't responded positively to a single embrace. Can also be seated.	Low-level intervention, in response to a low-level arousal, however, can easily be raised to a medium level response to a medium level of arousal. It is used to move the person away from a potential risk with support as appropriate.	Low to medium. Requires a degree of positive response from the person you are supporting (this will be reliant on the knowledge of the child and how they react).
Side hug	One-person technique. An immediate response to a high-risk situation (for example if a person was running towards a road). Standing hold. Static technique.	Medium level response to a high-level situation. It can ensure the person's immediate safety.	Medium to high. Allows staff to make a dynamic risk assessment on the course of action.
Adapted side hug	One-person technique. An immediate or planned response to a high-risk situation (for example if a	Medium-level response to a high-level situation. To move a person away from risk or danger –	Medium to high effectiveness to a medium to high level of arousal.

	person was running towards a road). Can move/walk and engage in dialogue while holding. Can be seated. This may require an additional trained adult to use "rainbow leg support" to support the child's legs.	either as an immediate response or planned response when held in a Side Hug.	Very flexible technique – can be adapted to the environment you are in.
Phase 2 (two person)			
Standing double embrace	Two-person technique. STANDING ONLY. Can be static or walking. Need to ensure you are familiar with the summary risk assessment for variables including size, health conditions and appropriateness of the hold.	For use when attempting to apply a Phase Two hold on a person who demonstrates behaviour that may challenge when the difference in height between the person and staff makes a Cupped Hand unsafe to use.	Medium to high effectiveness in response to a medium to high level of arousal. Very effective if the person you are supporting is known to bite. Very good for phasing up or down, particularly good for phasing down to Figure of Four or Single Embrace.
Figure of four	Two-person technique. Static or moving. Can be seated. This may require an additional trained adult to use "rainbow leg support" to support the child's legs.	A two-person technique used to support a person when a Phase One hold is not effective.	Medium effectiveness to a medium level of arousal. Useful as it is transitional (can be phased up or down) depending on the arousal levels of the person you are supporting.
Cupped hand	Two person technique. Static or walking. Useful response when supporting a person who may bite, scratch or pinch or where a Figure of Four has been proven to be ineffective. This may require an additional trained adult to use "rainbow leg support" to support the child's legs	For use where a person you are supporting is unable to be held safely in a Figure or Four as they are too strong or are attempting to bite towards the hand, chest or shoulders of the staff member. A useful transitional hold.	Medium to high effectiveness to a medium to high level of arousal in the person you are supporting. Effective as it can be phased up or down as circumstances dictate.

Safe location to knees	Two-person technique. Static. Level 1 and Level 2 techniques can be used depending upon the size and previous knowledge of the person you are supporting.	For use when the person is being held in a Cupped Hand or Standing Double Embrace and they drop to their knees and attempt to maintain the high arousal behaviour that is challenging. It allows the staff to respond to the imbalance of a drop of body weight by the person (when they are in a heightened state of arousal). It allows staff to dynamically assess the next transitional action to maintain their own and the person's safety).	Medium to high effectiveness to a medium to high level of arousal in the person being supported. Allows staff to phase up and phase down through dynamic risk assessment.
Scoop from the floor	Two person technique. Standing and standing/walking hold. Subject to careful risk assessment for suitability. Very dynamic/responsive.	For use when the person you are supporting is sitting in a straddled position sitting on another person and they have not responded to a verbal request to move from the position.	This is a medium to high impact technique used in response to a medium to high level of arousal in the person you are supporting.
Scoop from the front	Two person hold. Standing and standing/walking hold. Subject to careful risk assessment for suitability.	Very dynamic/responsive. For use when the person you are supporting is moving towards staff member, with the intention to attack them or another from the front.	This is a highly effective response to a high arousal situation.
Straight arm transition – Level 1	Two person transitional technique. Standing or seated. Static hold.	For use when the person we are supporting pushed their hands forward out of a Figure of Four technique – to allow the staff to dynamically risk assess and transition the hold up or down.	Medium to high effectiveness in response to a medium to high level of arousal in the person we are supporting (more towards the high arousal level).
Small Person techniques			
Comfort embrace	One-person technique. Suitable for use with KS1 & 2.	To offer physical emotional containment when a child is distressed.	Low to medium level technique for use when a child is in a low to medium level of arousal

			and able to respond positively.
Seated comfort embrace	One or two person technique. Suitable for use with KS1 & 2.	To offer physical emotional containment when a child is distressed in a seated position (in line with soft chair policy).	Low to medium: o 1 person low o 2 persons medium
Floor support	One-person technique. Suitable for use with KS1 & 2.	To support child who is distressed and is voluntarily on the floor.	Medium level of response to a medium level of arousal in the child.
Rainbow leg support	One-person technique. Suitable for use with KS1 & 2. This is usually used in combination with 2 person techniques as above	To support a child who has taken themselves to the floor and is kicking with their legs.	Medium to high level of effectiveness to medium/high level of behaviour.
Up and Go	One-person technique. Suitable for use with KS1 & 2.	To move a child away from danger i.e. if they need to be lowered from a table or chair or are emotionally distressed.	Low-level response to a low level of arousal. Very effective (as per example above). Low to medium effectiveness.
Prevention and Breakaways			
T Stance / Safety stance	This is not a hold, it is a technique to maintain safety and balance, enabling staff to engage positively and assess risk	For use when responding to a potential confrontation and/or engaging with a person we support. It is an initial response whilst dynamically assessing risk.	Low level response when responding to a low to medium level of arousal (when dynamically risk assessing the situation).
Defensive Stance	Can be static or moving. This is not a hold. It is a technique that helps maintain the member of staff's safety.	It is used to maintain the safety of the member of staff. It allows a dynamic risk assessment when safely approaching a person we are supporting who may be in need of physical support.	Low to medium level response to all levels of arousal/intervention.
Arrow head formation	This is a two-person formation that is used when you have dynamically risk assessed that a Phase 2 technique is an appropriate response to the level of arousal. Planned intervention	It is for use in a planned intervention following a dynamic risk assessment that a phase two technique or other technique/appropriate response to the level of arousal.	Medium to high level response from the support worker to a medium to high level of arousal Very effective response

		It allows staff members to adhere to the fundamental concepts of team work, communication and timing.	
Hair grab: front	One-person technique. Use hair grab release when a person you support has grabbed the front of your hair or hood but has not taken a secure hold.	To break away from unwanted physical contact and ensure the safety of the staff member and afford the person we support the opportunity to self-regulate.	Medium effectiveness.
Hair grab: rear	One-person technique. For use when a person we support grabs your hair from the rear.	To break away from unwanted physical contact and ensure the safety of the support worker and afford the person we support the opportunity to self-regulate.	Medium effectiveness.
Bite prevention wave	One-person technique. Used to keep the member of staff safe and minimise the risk of being bitten (predominantly on the arm as this is most common).	To break away from unwanted physical contact and ensure the safety of the staff member and afford the person we support the opportunity to self-regulate.	Medium effectiveness. Requires a degree of positive response from the person we are supporting.
Pony tail/nape of neck grab	One person technique. Used to keep ourselves safe when the hair (pony tail or nape of neck) has been grabbed from behind.	To break away from unwanted physical contact and ensure the safety of the staff member and afford the person we support the opportunity to self-regulate.	Medium effectiveness.
Sleeve grab: single handed	One person technique. Used to keep ourselves safe when being grabbed on one sleeve by a person we are supporting. In terms of context the scenario could potentially be in relation to a person attempting grab both sleeves to pull a staff member to the floor or head butt.	To break away from unwanted physical contact and ensure the safety of the support worker and afford the person we support the opportunity to self-regulate.	Medium effectiveness
Wrist grab: scissor release	One person technique.	To break away from unwanted physical	Medium effectiveness.

	Used to keep ourselves safe from a single wrist grab with thumbs underneath. In terms of context, the person that we are supporting may attempt to drag the staff member.	contact and ensure the safety of the staff member and afford the person we support the opportunity to self-regulate.	
Wrist grab: arch release	One person technique. Response to a single handed grab (where the person is not pulling/dragging you), this technique can be used as an alternative to the 'Scissor Release'. Static position.	To break away from unwanted physical contact and ensure the safety of the staff member and afford the person we support the opportunity to self-regulate.	Medium effectiveness.
Wrist grab: Single hand	One person technique. Used to keep ourselves safe when a person we support takes hold of our wrist with a single hand (with their thumb on top).	To break away from unwanted physical contact and ensure the safety of the staff member and afford the person we support the opportunity to self-regulate.	Medium effectiveness.
Wrist grab: Two handed	One person technique. Used to keep ourselves safe when a person we support takes hold of your wrist/arm with two hands.	To break away from unwanted physical contact and ensure the safety of the staff member and afford the person we support the opportunity to self-regulate.	Medium effectiveness.
Wipeaway	One person technique. Breakaway/preventative technique, used to keep yourself safe from unwanted physical contact. In response to a person attempting to strike or grab hold of the support worker.	To break away from unwanted physical contact and ensure the safety of the staff member and afford the person we are supporting the opportunity to release the grab/avoid striking the support worker.	Medium effectiveness.

12. Equalities, Safeguarding and Equal Opportunities Statement

Wolverdene, in all policies and procedures, will promote equality of opportunity for students and staff from all social, cultural and economic backgrounds and ensure freedom from discrimination on the basis of membership of any group including gender, sexual orientation, family circumstance, ethnic or national origin, disability (physical or mental) religious or political beliefs.

As part of our commitment to meet the Public Sector Equality Duty (PSED), Wolverdene school aims to:

- Provide opportunity to all
- Foster good relations, and create effective partnership with all sections of the community
- Only take actions which do not discriminate unlawfully in service delivery, commissioning and employment
- Provide an environment free from fear and discrimination, where diversity, respect and dignity are valued
- Demonstrate zero tolerance to any form of bullying, harassment or abuse.