

LYCÉE INTERNATIONAL DE LONDRES WINSTON CHURCHILL

("the School")

Policy #35: Physical Contact and Touch

This policy should be read in conjunction with our Safeguarding Children and Behaviour Management Policies.

Mission

Through a rigorous, bilingual programme and innovative methods, we educate students to become responsible, creative, and principled global citizens. We teach them to think critically and act ethically, to form and express their own opinions and respect those of others, to define their own life goals, and to make sense of and embrace change.

Our values are excellence, creativity, integrity, awareness and community.

In support of these aims and values we are committed to ensuring the following:

1. Aims and background

This policy follows the national guidelines for schools and sets out expectations for the use of physical handling for all adults in our school.

We recognise that there may be occasional times when a child's behaviour presents particular challenges that may require physical handling and when staff could breach their duty of care towards the students if they were not prepared to physically handle students.

Examples where touching or handling a student might be proper or necessary:

1. It is recognised that hugs and warm physical contact may be an appropriate and comfortable part of school life, particularly with younger children. Usually it is best for adults not to initiate such contact.

2. Reassurance may also be appropriately given, e.g. through a pat on the shoulder or arm.

3. Physical contact is often necessary in the Early Years Department: helping children to use the toilet, dressing, comfort and general care and is likely to occur in general play activities.
4. Physical contact is necessary when administering first aid.
5. Physical contact may be appropriate during craft activities to help and direct a child.
6. Young children and children with special educational needs may need staff to provide physical prompts or help.
7. Touching may also be appropriate if a child is in distress and needs comforting.
8. We also recognise that some children may be particularly sensitive to physical contact because of their cultural background, or because of abuse.
9. Holding the hand of a child at the front/back of the line when going to assembly or when walking together around the school or kindergarten.
10. Greeting, congratulating or praising a student.
11. Guiding a student, for example in demonstrating how to use a musical instrument or in the use of a paintbrush or woodwork tool.
12. Supporting a child in safely performing an exercise in games and physical education.
13. Tagging in chasing or territorial games where the teacher may be the chaser/tagger.
14. A child distressed by the fire alarm, may need to be carried or supported out of the building.

Some children, especially younger ones or those with Special Educational Needs may also need help with their personal care, for example: a) In changing clothes for games lessons. b) Changing clothing after outdoor play or gardening lessons. c) Toileting support.

2. Physical Contact:

We believe that good quality practice in Early Years encompasses a full understanding of child protection. However, Early Years practitioners are also responsible for promoting the development of young children, based on secure attachment and emotional security. The behaviour of all practitioners needs to support children as they grow as individuals and learn to value themselves.

Children need contact with familiar, consistent carers to ensure they can grow confidently, feeling self-assured. At times children need to be cuddled, encouraged, held and offered physical reassurance. Intimate care routines throughout the day are essential to children's basic needs (see below).

Physical Contact can be broken down into the following categories: Acceptable Comforting, Physical Contact in Play, Physical Handling in regards to Behaviour Management.

a. Acceptable Comforting: If a child requires comforting (following an accident, or on parents departure from playgroup) and if in the short term cuddles will help, these will be given.

- Occasionally, when separating a child from a parent/carer it is necessary to physically remove/transfer the child to a member of staff, with adult's consent.
- Sitting a child on an adult's knee is often a way of giving comfort or calming a child, this will be done on the child's request or with their consent.
- Occasionally there is no alternative to picking a child up, but for Health & Safety reasons this is a 'last resort'.
- Other activities, often instigated by the children themselves, we will explain are not appropriate. This includes any form of kissing on cheek, forehead or lips.

b. Physical Contact in Play: Tickling, catching a child as part of an agreed game, or holding a child around upper body, e.g. assisting them on bikes, stilts, helping them to jump, bounce, hop etc. are acceptable physical contacts that staff may from time to time engage in during play. Although such games and activities may be initiated by the child, there will be occasions when it may be adult-led. It is vital any contact must be on the child's terms and with their willing participation. The adult will always be sensitive to the child's feelings and body language as they may not always communicate verbally. All staff are trained and give due consideration to the EYFS, Safeguarding, First Aid and Physical Handling when assisting children in their play.

c. Physical Handling in regards to Behaviour Management: there are very occasional times when a child's behaviour presents particular challenges that may require physical handling. This guidance sets out expectations for the use of physical handling.

Positive handling: The positive use of touch is a normal part of human interaction. Touch might be appropriate in a range of situations:

- giving guidance to children (such as how to hold a paintbrush or when climbing)

- providing emotional support (such as placing an arm around a distressed child)
- physical care (such as first aid or toileting).

Staff must exercise appropriate care when using touch (please also refer to our Safeguarding Policy). There are some children for whom touch would be inappropriate such as those with a history of physical or sexual abuse, or those from certain cultural groups. The setting's policy is not intended to imply that staff should no longer touch children.

Restrictive Physical Intervention: This is when a member of staff uses physical force intentionally to restrict a child's movement against his or her will. This will be through the use of the adult's body rather than mechanical or environmental methods. This guidance refers to the use of restrictive bodily physical intervention and is based on national guidance. Our aim is to do all we can in order to avoid using restrictive physical intervention. However there are clearly rare situations of such extreme danger that create an immediate need for the use of restrictive physical intervention. Restrictive physical intervention in these circumstances can be used with other strategies such as saying "stop".

Duty of care: All staff have a duty of care towards the children in their setting. When children are in danger of hurting themselves, others or of causing significant damage to property, staff 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!" However, if it is judged as necessary, staff may use restrictive physical intervention.

Reasonable Minimal Force: When physical intervention is used, it is used within the principle of reasonable minimal force. Staff should use as little restrictive force as necessary in order to maintain safety. Staff should use this for as short a period as possible.

Who can use restrictive physical intervention? It is recommended that a member of staff who knows the child well be involved in a restrictive physical intervention. This person is most likely to be able to use other methods to support the child and keep them safe without using physical intervention. Preferably this will be the child's key worker, otherwise it will always be one of the permanent members of staff. Temporary staff, volunteers or students will not be allowed to use physical intervention except: In an emergency, anyone can use restrictive physical intervention as long as it is consistent with the setting's policy.

When can restrictive physical intervention be used?

Restrictive physical intervention can be justified when:

- someone is injuring themselves or others

- someone is damaging property
- there is suspicion that although injury or damage has not yet happened, it is at immediate risk of occurring.

Staff might have to use restrictive physical intervention if a child is trying to leave the site and it is judged that the child would be at risk. Staff should also use other protective measures, such as securing the site and ensuring adequate staffing levels. This duty of care also extends beyond the site boundaries: when staff have control or charge of children off site (e.g. on trips).

There may be times when restrictive physical intervention is justified but the situation might be made worse if restrictive physical intervention is used. If staff judge that restrictive physical intervention would make the situation worse, staff would not use it, but would do something else (like issue an instruction to stop, seek help, or make the area safe) consistent with their duty of care.

The aim in using restrictive physical intervention is to restore safety, both for the child and those around him or her. Restrictive physical intervention must never be used out of anger, as a punishment or as an alternative to measures which are less intrusive and which staff judge would be effective.

What type of restrictive physical intervention can and cannot be used?

Any use of physical intervention in a setting should be consistent with the principle of reasonable minimal force. Where it is judged that restrictive physical intervention is necessary, staff should follow the procedures below.

Procedure

Staff will: Use all reasonable efforts to avoid the use of physical intervention to manage children's behaviour. This includes issuing verbal instructions and a warning of an intention to intervene physically.

Physical intervention and restraint should be used as a last resort to support children and young people in times of crisis. Restraint should be avoided wherever possible. It is never a substitute for good behaviour management. Other methods (such as defusing conflict, non-physical calming, etc) of managing the situation should always be tried first, unless this is impractical.

Any incident of physical intervention and restraint should be recorded on CPOMS and the Head of School should be made aware of that incident. Parents should also be contacted.

A physical restraint record should show who was involved, the reason physical intervention was considered appropriate, how the child was held, when it happened and for how long. It should also include any subsequent injury or distress and what was done in relation to this.

The degree of force used should be the minimum needed to achieve the desired result. Physical restraint should only be considered an option if:

- Calming and defusing strategies have failed to de-escalate the situation
 - The response is in the paramount interests of the young person
 - Not intervening is likely to result in more dangerous consequences than intervening.
-
- Try to summon additional support before intervening. Such support may simply be present as an observer, or may be ready to give additional physical support as necessary.
 - aim for side-by-side contact with the child. Avoid positioning themselves in front (to reduce the risk of being kicked) or behind (to reduce the risk of allegations of sexual misconduct)
 - aim for no gap between the adult's and child's body, where they are side by side. This minimises the risk of impact and damage
 - aim to keep the adult's back as straight as possible beware in particular of head positioning, to avoid head butts from the child
 - hold children by "long" bones, i.e. avoid grasping at joints where pain and damage are most likely
 - ensure that there is no restriction to the child's ability to breathe. In particular, this means avoiding holding a child around the chest cavity or stomach.
 - avoid lifting children.
 - Keep talking to the child (for example, "When you stop kicking me, I will release my hold") unless it is judged that continuing communications is likely to make the situation worse.
 - Don't expect the child to apologise or show remorse as many young children do not understand the difference between accidental and deliberate hurt.
 - Use as little restrictive force as is necessary in order to maintain safety and for as short a period of time as possible.

In very extreme circumstances 2 members of staff might be necessary to ensure safety.

The school will identify and arrange access to appropriate staff training (e.g. Positive Approaches to Challenging Behaviour, Managing Behaviour in the Early Years).

1. Planning and Risk Assessment

After an emergency the situation is reviewed and plans for an appropriate future response are made. This will be based on a risk assessment which considers:

- the risks presented by the child's behaviour
- the potential targets of such risks
- preventative and responsive strategies to manage these risks.

It may be deemed necessary as a result of the risk assessment to write an individual behaviour plan that is developed to support a child. If a behaviour plan includes restrictive physical intervention it will be just one part of a whole approach to supporting a child's behaviour. The behaviour plan should outline:

- an understanding of what the child is trying to achieve or communicate through their behaviour
- how the environment can be adapted to better meet the child's needs
- how the child can be encouraged to use new, more appropriate behaviours
- how the child can be rewarded when he or she makes progress
- how staff respond when the child's behaviour is challenging (responsive strategies). There are a range of approaches such as humour, distraction, relocation, and offering choices which are direct alternatives to using restrictive physical intervention.

2. Recording and Reporting

It is important that any use of restrictive physical intervention is recorded on **CPOMS**. The record will show: who was involved (child and staff, including observers), the reason physical intervention was considered appropriate, how the child was held, when it happened (date and time) and for how long, any subsequent injury or distress and what was done in relation to this. This should be done as soon as possible and within 24 hours of the incident. According to the

nature of the incident, it may be noted in other records, such as the accident book or child's individual record. The form should be signed by the parent/carer on collection of the child. Parents should be given a copy of the incident record form.

Complaints: The use of physical intervention can lead to allegations of inappropriate or excessive use. Where anyone (child, carer, staff member or visitor) has a concern, this should be dealt with through the school's usual complaints procedure.

3. Supporting and Reviewing

It is distressing to be involved in a restrictive physical intervention, whether as the person doing the holding, the child being held or someone observing or hearing about what has happened. After a restrictive physical intervention, support is given to the child so that they can understand why they were held. A record is kept about how the child felt about this where this is possible. Where appropriate, staff may have the same sort of conversations with other children who observed what happened. In all cases, staff should wait until the child has calmed down enough to be able to talk productively and understand this conversation. If necessary, an independent member of staff will check for injury and provide appropriate first aid. Support will also be given to the adults who were involved, either actively or as observers. The adults will be given the chance to talk through what has happened with the most appropriate person from the staff team. The key aim of after-incident support is to repair any potential strain to the relationship between the child and the adult that restrained him or her. The policy should emphasise that after a restrictive physical intervention, staff consider reviewing the individual behaviour plan so that the risk of needing to use restrictive physical intervention again is reduced.

4. Monitoring

The school's Board of Governors review this policy annually. The Head of Cycle and Head Teacher has the opportunity to seek support from the school's Wellbeing Leader where appropriate. Monitoring the use of restrictive physical intervention helps identify trends and therefore helps develop our setting's ability to meet the needs of our children without using restrictive physical intervention.

Policy created in 2022

Policy reviewed in:

- March 2023
- February 2023

Risk management

Any child who has needed to be restrained or who has challenging behaviour which might make this necessary should have a risk assessment and a behaviour plan specifying situations most likely to trigger difficult behaviour.

Intimate care:

All children have the right to be safe and to be treated with dignity and respect. Staff involved with intimate care of students need to be sensitive to individual needs. Staff also need to be aware that some adults may use intimate care as an opportunity to abuse children.

Intimate care can be defined as any care which involves washing, touching or carrying out a procedure to intimate personal areas which most people usually carry out themselves, but which some children are unable to do because of their young age, physical difficulties or other special needs.

See Nappy changing procedure [HERE](#)

Examples include care associated with continence and menstrual management as well as more ordinary tasks such as help with washing, toileting or dressing. It also includes supervision of children involved in intimate self-care. Intimate care is any care which involves one of the following:

- assisting a child to change his/her clothes
- changing or washing a child who has soiled him/herself
- assisting with toileting issues
- supervising a child involved in intimate self-care
- providing first aid assistance
- providing comfort to an upset or distressed child
- feeding a child
- providing oral care to a child
- assisting a child who requires a specific medical procedure and who is not able to carry this out unaided.

* * In the case of a specific procedure, only a person suitably trained and assessed as competent should undertake the procedure. Parents have the responsibility to advise the school of any known intimate care needs relating to their child.

Any child requiring specialist care will have an accompanying plan created in consultation and agreement with parents.

Staff will encourage each child to do as much for his/herself as possible

Techniques of physical restraint need to be learned from experienced professionals. Staff must also receive training and support in behaviour management.

Source for intimate care:

https://conductive-education.org.uk/wp-content/uploads/2017/10/NICE_Policy-for-Intimate-Care_Oct16_Proof-141016.pdf

Other sources of guidance:

<https://www.sjcs.co.uk/sites/default/files/styles/Policies/SJCS%20Physical%20Restraint%20and%20Use%20of%20Reasonable%20Force%20Policy.pdf>

[Minimising and managing physical restraint DfE 2015](#)

[Use of reasonable force in schools DfE 2013](#)

[Positive environments where children can flourish DfE 2021](#)

[Using rewards: encouraging good behaviour DfE 2014](#)