Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
FORENSIC – LOCKDOWN

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
2.0	*Feb 2020*	*New SOP format, amendments to ward names.*
3.0	*Feb 2023*	*Reviewed and updated with protocol changes and minor procedure changes. Approved at ODG (13 February 2023).*

Contents

1. INTRODUCTION

The Humber Centre, Pine View and South West Lodge are secure forensic services. These settings provide care for patients who are, have been or are at risk of contact with the criminal justice system. Security (relational, procedural and physical) in these settings is in place to support quality and safe care for patients who use the service. There may be occasions when there are concerns about one or more aspect of security that require the implementation of security measures above and beyond those required on a day-to-day basis. These situations are described as “lockdowns”.

A lockdown may be considered when an unusual security issue has arisen that has the potential to put the safety of patients, staff, visitors or the wider community, at risk. This might include equipment loss, failure of security equipment, attempted or actual escape, etc.

Such extraordinary security measures will impact on patients, staff and visitors and therefor is identified as a restrictive practice when used. This protocol is intended to guide decision making to ensure that effective security is maintained and that the consequences of those measures are both proportionate to the situation and effectively managed.

Forensic services in Humber NHS Foundation Trust are underpinned by the Clarity clinical model Clarity is a trauma-informed clinical care approach. Many service users have experienced trauma in their lives, and the team recognise that a trauma-informed way of working benefits all, even if they have not experienced specific trauma. At its core, trauma-informed working involves understanding that people’s life experiences impact on them in their current life and provides ways to support people with potential negative impacts of this. The model is underpinned by the five core-principles of trauma-informed care: Safety, Trustworthiness, Choice, Collaboration, and Empowerment.

2. SCOPE

This procedure is aimed at all staff working in the Forensic Service, but particularly those who may be involved in the initiation, co-ordination and ending of a lockdown.

3. PROTOCOL STATEMENT

Though not desirable or routine, the service will initiate lockdowns from time to time. The aim of a lockdown is to support safety and enable continued care to patients during unusual security situations. The lockdown approach achieves this by excluding or containing people, by preventing entry, exit or movement in all or part of the unit. A lockdown is usually achieved by means of physical security measures and the deployment of staff.

4. DUTIES AND RESPONSIBILITIES

All staff should be aware of this procedure. Staff initiating a lockdown should refer to it at the earliest opportunity. A copy will be retained in the co-ordinator’s log on the V drive.

5. PROCEDURES

5.1. Initiation of a lockdown

The decision to initiate a local ward or area lockdown will be taken as a matter of urgency, with the involvement of the Duty manager, security lead and senior staff that are available at the time. Initially, the lead role in the lockdown will be taken by the security lead, with the involvement of the manager of a particular ward/area, or co-ordinating manager where the former is not available.

A wider unit lockdown will involve the senior available manager, site manager or on-call manager together with the security lead if available and will remain until it is decided that the environment is safe to allow movement throughout the unit.

In all instances, the following will be informed:

- Patients (if appropriate)
- Staff teams (if appropriate)
- All ward shift leaders
- Reception staff (who can further communicate via the PAPU system)
- Service Manager (or on-call manager if out of hours)
- On-call psychiatrist
- Emergency planning team

Consideration will then be given to informing Trust on-call structures or the wider system as required:

- Escalation via on call to director on call
- Police or other emergency services where access and egress to the building is compromised
- NHSE/CQC (advice from manager re communication if a lockdown is sustained)

The following are offered as prompts for points to be considered:

- What is the impact on patient care/ safety?
- Does the lockdown need to apply to the entire building, or to limited areas? The aim is to ensure that any security response is proportionate to the situation and has the least restrictive impact on those being cared for in the service.
- Is there a requirement to apply secondary locks (E key Humber Centre, E Key Pine View) on key exit points? If so, it will be necessary to ensure that sufficient staff are carrying the appropriate keys to facilitate exit if necessary.
- Is there any need for support from emergency services?
- Is there any need to re-locate patients (or visitors who are already in the building)
- Can visitors remain in the building? Can they be allowed to leave?
- How are staff going to be informed of the situation? Is it necessary to issue hand-held radios? Should pager messages be used?
- If and how are patients going to be informed?
- Is it necessary to limit access / egress? If so, how will any parties be informed (NB informing planned visitors)?
- What considerations need to be made due to previous trauma patients have experienced?

5.2. Co-ordination/ongoing review

The Duty manager and security lead will take this role unless other senior staff are available and a handover of responsibility takes place. It is important that one individual (possibly with the support of others) has a lead role.

5.3. Ending of a lock down

The decision to end a lockdown does not necessarily require that the initial issue has been fully resolved, though this should ideally be the case. It may be that other measures have been put in place that can allow consideration of ending the lockdown.

In all instances, the following will be involved in the decision to end the lockdown:

- Co-ordinating manager
- Service manager (or on-call clinician if out of hours),
- On-call psychiatrist,
- All ward shift leaders,
- Any other individuals that have been involved in the ongoing process (including the emergency planning team).

5.4. Documentation/Review

A lockdown will, by definition, only occur as part of an ongoing adverse incident, and so will not require a further adverse incident form. However, the co-ordinator will include an account of the lockdown process as part of their recording of the incident.

All lockdowns will be reviewed within 24 hours, and this review will be further considered at the next senior meeting (there is a senior meeting each week) and at the next Security Committee. Lessons learned will be co-ordinated via the security team.

6. IMPLEMENTATION

All staff will maintain the least restrictive options to provide security and maintain individualised care wherever possible.

All new staff will be required to read the service protocols as part of their service security induction and security refresher.

7. MONITORING AND AUDIT

Awareness of the procedure is included in the security refresher each member of staff is required to attend on an annual basis.

Review of each implementation of the procedure by the security Committee to identify lessons learnt and changes to the procedure.

Annual review of the procedure.

8. DEFINITIONS

The term “lockdown” within this procedure refers to the physical and procedural control of an environment to manage a specific incident or problem. It is a term that is used within secure hospital services and prisons that is commonly understood. It does not refer to the use of the term lockdown in other trust policies or the use of the term in the wider NHS.