



# High secure building design guide

## Overarching principles

*for Ashworth, Broadmoor, Rampton Hospitals*

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# Contents

<b>Chapter 1</b>	Introduction	1
	Overarching principles	
	Introduction to security	
	Physical security	
	Procedural security	
	Relational security	
<b>Chapter 2</b>	High-level planning and design principles	3
	Introduction	
	Quality of environment	
	Life-cycle cost and maintenance	
	Staffing and layout	
	Flexibility	
	Minimising the potential for damage	
<b>Chapter 3</b>	Site-wide issues	5
	Introduction	
	Designing-in security	
	The secure perimeter and entrance building	
	Technological security	
	CCTV installation	
	Intervention time	
	Delay time	
	Security searching	
	Site layout planning	
	Categories of area usage in the hospital	
	Planning layout and access for security	
	Barriers	
<b>Chapter 4</b>	Building design	8
	Introduction	
	General	
	Enabling observation	
	Maintaining physical security	
	Staff and patient safety	
	Prevention of self-harm	
	Robustness of environment and materials	
	Infection control	
	Standard room specifications	
	Patient bedrooms	
	Seclusion room/suite	
	Treatment room/dispensary	
	Ward office	
	Patient bathroom	
	Ward kitchen	
	Patient WCs	
	Furniture and fittings	

<b>Chapter 5</b>	Building construction	10
	Introduction	
	Climbability	
	Roofs	
	Walls	
	Secure ducts and concealment of services	
	Apertures and penetrations	
	Floors and ceilings	
	Doors	
	Locks and keys	
	Windows	
	Sanitaryware/fittings	
	Finishes in patient areas	
	Fixings	
<b>Chapter 6</b>	Mechanical, drainage and electrical services	12
<b>Chapter 7</b>	Construction works	13
<b>Chapter 8</b>	Product testing	14
<b>References</b>		15

# 1 Introduction

- 1.1 This 'High secure building design guide' replaces the Physical Security Requirements document published by the Special Hospitals Service Authority in 1996.
- 1.2 The guide is in two parts – this 'Overarching principles' document and a 'Technical design guide' with associated drawings. The latter is held on a restricted basis by licensed provider organisations, and will be made available to design consultants under certain controls, which are set out in the 'Technical design guide'.

## Overarching principles

- 1.3 High security hospitals have twin security and therapeutic objectives. They provide a treatment environment for patients who are assessed as presenting a serious and immediate danger to others and who need treatment in a high secure hospital. The security provided should be such as to protect the privacy, dignity, health, well-being and spiritual requirements of patients and staff, and to prevent unauthorised access to the hospital and to make escape very difficult.
- 1.4 The environment provided by high secure hospitals is a crucial element in the delivery of therapeutic outcomes for patients, their safety and the safety of the wider community. Maintaining a high standard and continually improving the design of the environment will help to improve outcomes for patients. It should help to ensure the safety of patients, staff and the public, and provide comfortable, secure surroundings in which individuals may be detained for the duration of their treatment. Buildings are tools that should be used to enable the delivery of high-quality care. They can be used to assist the treatment model and facilitate care pathways, and to promote community engagement and recovery.
- 1.5 The security and therapeutic issues are closely integrated, and security should not be dealt with in isolation. Security provides a positive and supportive framework within which clinical care and therapy can be safely delivered. Maintaining high levels of security is the responsibility of all staff. Good security and therapy should be seen as integrated concepts rather than opposite ends of a spectrum.
- 1.6 High security hospitals provide a distinct and separate environment from prisons. Prisons and hospitals operate under different laws, are part of different larger organisations, and the workforce are from different professions with different training. It is not possible to transfer thinking and concepts in total from one organisation to another. This guide recognises these differences, and within this context physical security must be provided within the building and site layout design in a sensitive and balanced way.
- 1.7 The needs of patients within these environments vary and will depend on a number of factors including diagnosis, gender, age, forensic history and length of stay. Services should aim to meet individual needs and those of specific groups of patients, taking into account the experiences of current and former service users, carers, staff and other stakeholders, to consider how recovery and reduction of risk can be best achieved.
- 1.8 This guidance seeks to ensure that all elements such as the use of CCTV and the intrusion into patients' requirements for privacy and dignity are considered within the guiding principles of the Human Rights Act, and that the actions detailed have been considered to ensure they are lawful, legitimate and proportionate.
- 1.9 Where appropriate, this Guide has drawn on National Offender Management Service (NOMS) guidance.
- 1.10 The Clinical Secure Practice Forum is the change control mechanism for authorising change within security, and that includes this Guide.
- 1.11 This Guide is best practice and should be followed. Where there is a proposed variation, it should be supported by a risk assessment together with the

reasons for the variation. Derogations from standards within the Guide must be sought through the trust.

## Introduction to security

- 1.12 The Review of Security in High Security Hospitals by Sir Richard Tilt (2000) set the security requirements for the perimeters and entrances of high secure hospitals. The perimeter standard is equivalent to category B in the prison service.
- 1.13 Security is a concept of three interdependent dimensions – relational, procedural and physical security. Physical security alone does not provide security and cannot operate without appropriate relational and procedural security. Physical surroundings, including décor and furniture, have an impact on security.

## Physical security

- 1.14 The physical security requirements for the design of a high secure hospital are largely determined by the need to prevent a patient from being able to break through the fabric of the building, to attempt or achieve a breach of the secure perimeter, including the passing of contraband, and from being able to gain uncontrolled access to other rooms or areas without authorisation.

## Procedural security

- 1.15 Procedural security relates to the proper application of a set of procedures, routines and checking.
- 1.16 Establishing a comprehensive range of effective procedures across the service anchors the application of therapeutic activity to structure and routine. This ensures that staff are able to effectively establish clear boundaries across the service.
- 1.17 The routine application of procedures also enables safe practices to be embedded in practice and applied consistently. Staff should be trained to adopt these procedures and to understand their context and purpose for the individual.

## Relational security

- 1.18 Relational security is the formation of a therapeutic alliance between staff and patients. This is centred in continuing risk assessment and detailed knowledge of the patient and the use of personal and professional skills by each member of staff to ensure they support and offer appropriate treatment for patients.
- 1.19 The building design should allow staff to develop good-quality relationships with patients that motivate and encourage them to use the therapeutic environment and to understand the constraints upon them.



## 2 High-level planning and design principles

### Introduction

- 2.1 This section outlines high-level planning and design principles that are particularly pertinent to the high secure service. The ‘Technical design guide’ provides more detailed guidance on how these are to be taken into account throughout the design, construction and commissioning stages.

### Quality of environment

- 2.2 A good-quality environment can impact on people’s lifestyles, attitudes and behaviour. Matters such as design of buildings, rooms, ward areas, space, light, access to fresh air, gardens, colours and furnishings all play a part in creating a good-quality hospital environment. These same issues also play a part in the security of the hospital. Patients need to feel they are in a hospital environment if they are to develop cooperation and see their treatment as helpful and supportive.
- 2.3 The design of systems, products and materials should be robust, tried and tested, and evidence-based. When considering new products and systems, the Home Office Scientific Development Branch (HOSDB; <http://scienceandresearch.homeoffice.gov.uk/hosdb>) should, where appropriate, be consulted.

### Life-cycle cost and maintenance

- 2.4 Life-cycle cost analysis is an integral part of any project, and the approach to it is detailed in a number of DH publications. In designing any building, room, fixture or fitting, careful consideration should be given to its whole-life cost. For high secure hospitals, this should also take into account the future security cost as well as the traditional issues regarding maintenance. Any standardisation of specification at each site will take into consideration full life-cycle costs, including a robust, sustainable balance between capital and revenue expenditure. In the planning stage of any development, adequate allowance should be made

for the revenue to support the capital investment made.

### Staffing and layout

- 2.5 Design of the site and internal building layouts can have a significant impact on staffing levels and personal safety. Careful consideration should be given, from inception to completion, to the layout of the site and individual buildings, to avoid the requirement for additional staffing or technological systems.
- 2.6 The following are examples of issues which should be taken into account:
- dead ends, blind corners and long distances should be minimised;
  - good sightlines should be provided;
  - the adjacencies and proximity of buildings and services should be considered.

### Flexibility

- 2.7 The service requirements will change, at a macro and a micro level, and the following issues should be taken into account in the design:
- buildings and mechanical and electrical services should be designed to ensure that as far as practicable they can be changed internally when the need arises. For example, there should be the minimum number of internal structural walls (as opposed to solid walls) so that the internal layout can be modified without affecting the structure of the building;
  - all buildings and internal layout of wards should be designed to ensure that, as far as reasonably practicable, they can be used by all patient groups;
  - wherever it is safe to do so without compromising the required integrity of the building, construction should be in the form of stud walls rather than solid block or brickwork.

## Minimising the potential for damage

- 2.8 Inevitably damage will occur, therefore careful consideration should be given to the selection and detailing of products and components to ensure that they are suitably robust. They should also be capable of being maintained and repaired by the trust's maintenance team, and should require minimum support from external specialists.
- 2.9 Within a high secure hospital, there may be a need for a more regular redecoration or refurbishing than in other hospitals. Furnishings may suffer more frequent damage, and damaged and broken furniture presents a security risk and should be removed and replaced. If an item is damaged or removed, it should not provide the opportunity to be used for self-harm or as a weapon against others.

## 3 Site-wide issues

### Introduction

- 3.1 The safety of the public, patients and staff is a fundamental feature to be addressed within the physical security measures in high secure hospitals.

### Designing-in security

- 3.2 Although the effectiveness of relational security measures will largely be determined by operational staff, the design of buildings and the nature of the site layout can contribute in a significant way, both to help staff and to promote the efficacy of these measures.
- 3.3 Physical security measures are an integral part of the design and specification, and should be considered at inception and throughout the design process.
- Patient-accessible buildings must be designed so that they provide a safe, secure and therapeutic environment.
  - The buildings and site layout should be designed to deliver optimal safety conditions by being planned with good sightlines and by avoiding blind corners, hidden recesses, dead-ends, isolated and dark areas, and spaces that are difficult to observe and supervise.
  - The various parts of buildings and the furniture and fittings (including external landscaping) must be designed and constructed so that they cannot be easily broken, removed, or used for concealment or as a weapon (see 'Delay time', paragraph 3.16 below).
  - The design should also allow for part of the building or buildings to be isolated without unduly affecting the whole.
  - Locking is an integral component in the provision of a safe and secure environment.
  - Patients receive social visits, and these will take place in a specially designed visits complex, located inside the secure perimeter.

- 3.4 Physical security includes the use of physical and structural measures and technological measures. The aim should be to use physical security measures primarily as far as is practicable and, where required, technological measures should be self-sufficient and supported by an emergency power supply.

### The secure perimeter and entrance building

- 3.5 The perimeter and entry building are to be designed in accordance with Category B prison standards, produced by the National Offender Management Service (NOMS).
- 3.6 The **secure perimeter system** should make it very difficult for patients to escape, or for intruders to gain access from the outside without detection. The requirements are as indicated in the NOMS 'Physical and Special Security Guide No 4 – Perimeter security'. Note: Guide No 4 is only to be applied for the secure perimeter, which includes the secure barrier system, sterile area, patient-free areas and associated CCTV, alarm and lighting systems.
- 3.7 The **secure entrance** should be made through an "entry building" that is constructed to the same standards as the secure perimeter to which it will be connected. The entry building must be designed to prevent unauthorised access to the roof either from inside or from outside the hospital. It will be planned and equipped so that all movements "in" and "out" of the hospital are strictly controlled. The physical security requirements for an entry building are as indicated in the NOMS 'Physical and Special Security Guide No 2 – Entry building'.
- 3.8 Where there is a need for internal secure zonal fences and barriers to control and restrict outdoor movements, the requirements are detailed in the 'Technical design guide'.

### Technological security

- 3.9 Technological security includes:
- access control systems;

- perimeter security lighting;
- external lighting within the secure perimeter;
- closed circuit television (CCTV);
- perimeter intrusion detection systems (PIDS);
- communication systems;
- staff attack alarm (SAA) systems.

### CCTV installation

- 3.10 The use of CCTV in patient areas is supported by the Tilt Report in association with certain principles, which are described in Chapter 6 of the ‘Technical design guide’.
- 3.11 A CCTV system can be used to enhance observation, act as a deterrent to criminal acts, aid investigations, detect crime, apprehend and prosecute offenders and generally enhance patient, staff and visitor safety. However, any installation should take into account any restriction placed upon the system through the Human Rights Act (1998) and Data Protection Act (1998), including guidance issued by the Information Commissioners Office regarding the use of CCTV.
- 3.12 The use of the system in patient-accessible areas should be in accordance with trust policy and supported by local procedures. It is an additional resource to observation and supervision. It does not replace the need for appropriate levels of staff/patient observation and interaction, nor should it require more staff to realise its benefits.
- 3.13 These measures should be centrally managed, monitored and recorded from the hospital control room. Local monitoring and review systems may be required.
- 3.14 The systems should be designed to monitor, detect and ensure an effective response to any incident, to record all incidents for later analysis and to engender a sense of confidence and safety.

### Intervention time

- 3.15 The layout of the hospital, the access and circulation arrangements, and the alarm and monitoring systems in place should be such that the maximum time needed for staff intervention, within the secure perimeter area, should not exceed the period set down in the “Technical design guide”.

### Delay time

- 3.16 The minimum delay or resistance time required from elements of the building or from other elements of construction are set out in the ‘Technical design guide’ and form the basis of the suggested solutions in that guide. Other building solutions may be utilised, providing they achieve those delay times (see the NOMS Guide 2, page 11).

### Security searching

- 3.17 Each hospital has a policy detailing the requirements for how and when security searches are to be carried out. The key issues to be taken into account in designing, constructing and commissioning are: avoiding opportunities for concealment of items and, depending on the category of patient area, inclusion/exclusion of access panels for maintenance, and exposed versus seamless fixings.

### Site layout planning

#### Categories of area usage in the hospital

- 3.18 The accommodation within the secure perimeter is categorised as follows:
- a. patient continually observed areas (for example ward dayrooms, therapy areas and education areas);
  - b. patient periodically observed areas (for example bedrooms and toilets);
  - c. staff-only areas;
  - d. estates and facilities staff-only areas;
  - e. external areas, including ground access/privilege areas and landscaping.
- 3.19 The ‘Technical design guide’ takes into consideration the level of risk presented in these different areas.

#### Planning layout and access for security

- 3.20 When designing the layout of the buildings and their geographical location on site, patients’ privacy and dignity needs will be a key consideration. In addition, the following principles should be taken into account:
- a. Good sightlines are required to enable effective observation and to minimise the number of cameras required for CCTV coverage.

- b. External areas should be planned and laid out so that they are as easy as possible to observe and search and do not provide areas for hiding or concealment.
- c. Access to engineering spaces (for example housing plant and equipment) should, wherever possible, be from non-patient areas.
- d. Primary pedestrian access to every patient-accessible building will be via the main entrance to the building.
- e. Safe routes should be provided between different areas to enable patients to move around unescorted.
- f. The route from the entrance building to the child/patient visiting centre should not pass through a patient-accessible area or any area where a child can be seen by a patient.
- g. The aim is that vehicular movement will be minimised, with the majority of vehicles accessing buildings via the service entrances.
- h. Sufficient turning space and access for vehicles should be allowed at the main entrance and all service entrances to buildings.
- j. The only vehicular access via patient-accessible areas, with the exception of emergency vehicles, will be patient transport.
- k. Local policy should determine the arrangements for routes shared between pedestrians and vehicles.
- m. Deliveries and collections to and from all patient-accessible buildings should be enabled via a secure arrangement which maintains, wherever possible, separation between the patient and the service provider.

### Barriers

- 3.21 Where opaque barriers (for example hedges, solid fences/walls etc) are used, they may restrict visibility. If used, they should be sited so that they do not impede effective observation.
- 3.22 Internal fences may be used to facilitate unescorted patient movement by separating patient and non-patient areas. Where internal fences join with the secure perimeter they need to meet perimeter standards.
- 3.23 Where barriers are introduced with the sole function of controlling the manner of movement – for example within patient areas to separate different recreational uses – a “dash fence” or other agreed barrier (for example shrubbery) may be used to a maximum height to be agreed at design stage.

## 4 Building design

### Introduction

4.1 The hospital should provide a safe and secure environment for patients, staff and visitors that is compliant with all statutory requirements. This chapter covers the key objectives of the building design such as enabling observation, maintaining physical security, preventing self-harm, robustness of materials, and maintaining infection control. The ‘Technical design guide’ includes specific guidance on ways of achieving these objectives. There are specific requirements for core room spaces in high secure hospitals; again, the key objectives are outlined here and the design descriptions are included in the ‘Technical design guide’.

### General

#### Enabling observation

- 4.2 To enable good observation and control of the environment, obstruction-free sightlines should be achieved for all patient areas.
- 4.3 Hidden areas and recesses, blind corners, out-of-sight and overlong corridors, and cul-de-sacs should all be avoided wherever possible to prevent the over-reliance on CCTV. CCTV may be employed as a supplement to aid observation.
- 4.4 The observation requirements for individual rooms are covered in the ‘Technical design guide’.

#### Maintaining physical security

- 4.5 The physical security requirements for buildings in the secure area are largely determined by the need for buildings that can physically prevent a patient from being able to break through the fabric of the building, to attempt or achieve a breach of the secure perimeter, or from being able to gain uncontrolled access to other rooms or areas, including roof areas.
- 4.6 There will be a need to maintain a continuous secure line around the building envelope, through

the appropriate design of doors, windows and other openings. It is necessary to maintain continuation of the secure line internally within the buildings to protect sensitive areas.

#### Staff, patient and visitor safety

- 4.7 All rooms should be planned to minimise the possibility that staff, patients or visitors could become isolated, be taken hostage or be barricaded in.

#### Prevention of self-harm

- 4.8 Patient-accessible buildings should be designed to make the act of suicide or self-harm as difficult as possible. WCs, bathrooms, patients’ bedrooms and any areas where patients may be periodically observed, even for a short time, are all high-risk areas.
- 4.9 Building interiors, fittings and furniture in high-risk areas should be designed to ensure that they minimise the possibility of use for self-harm, as a ligature, as a weapon or for barricading. See ‘Robustness of environment and materials’ below.
- 4.10 The suicide prevention strategy should be guided by the National Suicide Prevention Strategy for England (DH, 2002) and consultation with the risk department.

#### Robustness of environment and materials

- 4.11 Materials should be specified that are robust and resistant to sustained attack. All building components, furniture and fittings in patient-accessible areas will be specified, designed, fitted and fixed with the prescribed security fixings to ensure that they cannot be dismantled, removed or used by patients for self-harm, as a ligature, weapon, missile or escape aid, for barricading or for any other illicit purpose.
- 4.12 All components and elements should be designed and installed to minimise opportunities to conceal any contraband, weapons or small items. Details

should be uncomplicated, making them easy to see, to search and to reach.

- 4.13 Protective or preventive measures should be incorporated into the building fabric or setting as sensitively as possible and so that the living environment is therapeutic.

### Infection control

- 4.14 The healthcare environment is a secondary reservoir for pathogenic organisms. In order to reduce the risk of healthcare-associated infection, it is vital that infection prevention and control requirements are designed in at the planning stage of all facilities.

### Standard room specifications

- 4.15 Standard room specifications will be determined by the functionality and perceived risk of the room as indicated in paragraphs 4.16–4.25, that is, what the room is going to be used for, the levels of observation and the risks associated with that use.

### Patient bedrooms

- 4.16 Each bedroom should provide facilities for the sleeping, personal, living and sanitary needs of patients.
- 4.17 A patient bedroom should be a minimum of 12 m<sup>2</sup> and in addition be provided with an en-suite sanitary facility. The layout should be arranged so that the entire room and en-suite can be observed from outside the room when necessary.
- 4.18 The layout of the room, fixed furniture and equipment should be such that it would be extremely difficult for a patient to commit suicide or to harm themselves or others. It should also ensure that the patient is not provided with vantage points from which to attack or conceal themselves from staff entering the room.

### Seclusion room/suite

- 4.19 A seclusion facility is a place of safety which should be designed to afford maximum privacy and dignity for the patient without compromising security, and should assist in minimising antagonism between secluded and non-secluded patients.
- 4.20 The Mental Health Act Code of Practice (Chapter 15.60, 2008) states that: “The room used for seclusion should: provide privacy from other

patients, but enable staff to observe the patient at all times; be safe and secure and should not contain anything which could cause harm to the patient or others; be adequately furnished, heated, lit and ventilated; and be quiet but not soundproofed and should have some means of calling for attention (operation of which should be explained to the patient).”

### Treatment room/dispensary

- 4.21 A treatment room/dispensary should be provided on each ward for the examination and treatment of patients in an emergency or as a routine procedure. A dispensary is a non-patient area and will be located separately but adjacent to the treatment room with a connecting door.

### Ward office

- 4.22 A ward office should be provided to act as a staff base for the management of the ward; this is a staff-only area.

### Patient bathroom

- 4.23 While each bedroom is provided with a shower and en-suite facilities (appropriate quantity to be independent wheelchair-accessible), each ward should have in addition an independent wheelchair-accessible bathroom for patients' use.

### Ward kitchen

- 4.24 A ward kitchen should be provided to enable the serving of food. Patients may be allowed access, under supervision if required, to prepare snacks or hot drinks.

### Patient WCs

- 4.25 WCs for patients' are to be provided which are accessible from patient communal and activity areas.

### Furniture and fittings

- 4.26 The design and specification of all furniture and fittings to be used in patient-accessible areas will be carried out in liaison with the hospital's supplies, facilities and security departments.
- 4.27 Furniture and fittings should be robust, anti-ligature, prevent opportunities for concealment, meet infection control requirements (see paragraphs 4.8–4.14) and be in accordance with the purchasing strategy of the hospital.

## 5 Building construction

### Introduction

- 5.1 The construction standard for buildings within the secure perimeter is a key component in the overall security system of the hospital. The patient's bedroom is the first secure constraint, followed by the secure envelope of the building (see paragraph 4.6) and the secure perimeter and entry building.

### Climbability

- 5.2 Walls and external façades should make wall scaling as difficult as possible.

### Roofs

- 5.3 Roofs must be constructed in a manner so as not to be easily accessible, dismantled, penetrated, nor to provide access to materials that can be used as a weapon or for self-harm.

### Walls

- 5.4 The external walls form part of the continuous secure line around the building envelope, and any form of construction needs to be resistant to break-through.
- 5.5 Internal walls in patient-accessible areas must be of specific construction; those in non-patient accessible areas can be of standard construction.

### Secure ducts and concealment of services

- 5.6 All pipes, ventilation ducts and cabling in patient-accessible buildings or areas should be concealed.
- 5.7 Access for maintenance and servicing should, where possible, be from non-patient areas, through secure locked doors or panels.

### Apertures and penetrations

- 5.8 Apertures in walls should comply with the specific dimensions set out in the 'Technical design guide'. Where they exceed these dimensions, they need to

be protected as specified in the 'Technical design guide'.

### Floors and ceilings

- 5.9 Floors and ceilings will form part of the internal secure line in a building and will provide protection to the roof zone and the plant and equipment which that space may contain.

### Doors

- 5.10 Doors that are required on the internal secure line should be designed as internal secure doors.
- 5.11 Doors that occur in the secure line of the external envelope of the building must be designed as external secure doors.
- 5.12 All internal and external secure doors must be provided with a lock in accordance with the locking strategy.
- 5.13 Careful consideration should be given to the design of doors, frames and associated furniture to ensure that, individually and collectively, they minimise the opportunity for ligation risk and the means to barricade or prevent the door from being opened.

### Locks and keys

- 5.14 The locking strategy in the clinical security framework extends and develops the recommendations contained within the Tilt Report and is compliant with the current NOMS guidance. The overarching aim is to ensure that locks are utilised in such a way as to maximise security.

### Windows

- 5.15 The windows in patient-accessible areas will form part of the secure line, and careful consideration needs to be given to the design of the window structure, the way it is fixed to the building structure, and all fixtures and fittings.



- 5.16 Where there are non-patient areas within patient-accessible buildings which are within the external secure line, they are to be designed to form part of the secure line.
- 5.17 Where there are areas non-accessible to patients which are entirely separated by an inner secure line from patient-accessible areas, but which are within the same building envelope, the windows can be of a proprietary design. They should not, however, compromise the principles described in paragraphs 3.2–3.8. The windows must not provide foot/hand holds to enable patients to gain access to a roof.

### Sanitaryware/fittings

- 5.18 Sanitaryware in patient-accessible areas should not be of a domestic construction and should be as specified in the 'Technical design guide'.

### Finishes in patient areas

- 5.19 It should not be possible to remove the paint finish from walls or ceilings for use as a weapon or for self-harm.
- 5.20 Floor finishes should be durable and hard-wearing.

### Fixings

- 5.21 The fixing of building components is an important element of physical security, and the following considerations need to be taken into account:
- a. at times, fixings may need to withstand considerable physical force;
  - b. attempts may be made to dismantle components, therefore the fixings should be specified so as to make these attempts very difficult;
  - c. fixings should be specified to minimise the opportunity for vandalism and breakage.

## 6 Mechanical, drainage and electrical services

- 6.1 A high standard of installation should be maintained to meet the requirements of high secure hospitals, as well as meeting those of all relevant regulatory bodies.
- 6.2 In designing any patient-accessible facility, it is important that proper consideration is given to the future maintenance of the installation and plant, particularly with respect to the limitations on access in patient areas.
- 6.3 Engineering plant and equipment should, wherever possible, be located in a secure duct or room and be accessible from a non-patient area.

## 7 CCTV installation

- 7.1 The use of CCTV in patient areas is supported by the Tilt Report in association with certain principles, which are described in the 'Technical design guide'.
- 7.2 A CCTV system can be used to enhance observation, act as a deterrent to criminal acts, aid investigations, detect crime, apprehend and prosecute offenders, and generally enhance patient, staff and visitor safety. However, any installation should take into account any restriction placed upon the system through the Human Rights Act (1998) and Data Protection Act (1998), including guidance issued by the Information Commissioners Office regarding the use of CCTV.
- 7.3 The use of the system in patient-accessible areas should be in accordance with trust policy and be supported by local procedures. It is an additional resource to observation and supervision. It does not replace the need for appropriate levels of staff/patient observation and interaction, nor should it require more staff in order to realise its benefits.

## 8 Construction works

- 8.1 Any works within or adjacent to the secure perimeter will create security risks from increased vehicle movement, the contractors' staff and the materials, plant and equipment used.
- 8.2 In determining the approach to managing these risks, consideration should be given to whether the construction site needs to be isolated within the secure perimeter, or whether, in the case of major projects, a separate penetration of the secure perimeter should be provided to access the site.
- 8.3 Consideration also needs to be given to the risks associated with construction plant remaining within the secure perimeter when not in use. Risk assessments should be carried out by the security department whenever construction equipment is required to remain within the secure perimeter, and an outline of the approach to be taken is detailed in the 'Technical design guide'.

## 9 Product testing

- 9.1 The 'Technical design guide' identifies the criteria for testing requirements for all aspects of patient-accessible buildings. Any items which have been tested by the three high secure hospitals are approved for use in each of them if they are proposed for use in the same environment and are from the same supplier.
- 9.2 Tests should be carried out in conjunction with representatives from security, estates and internal stakeholders, recorded by video and/or photographs, and a written report produced.
- 9.3 Each hospital should retain records of all testing undertaken and make it available to other high secure hospitals on request.
- 9.4 Each hospital should ensure that the life-cycle integrity of materials and components is considered, and should retain records on the long-term performance and deterioration of components and materials.

## References

**Data Protection Act 1998.**

[www.opsi.gov.uk/Acts/Acts1998/ukpga\\_19980029\\_en\\_1](http://www.opsi.gov.uk/Acts/Acts1998/ukpga_19980029_en_1)

**Human Rights Act 1998.**

[www.opsi.gov.uk/ACTS/acts1998/ukpga\\_19980042\\_en\\_1](http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980042_en_1)

**The National Suicide Prevention Strategy for England.**  
DH, 2002.

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009474](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009474)

**NOMS Physical and Special Security Guide No 2 –  
Entry building**

**NOMS Physical and Special Security Guide No 4  
– Perimeter security**

[NOMS guides can be obtained from a nominated administrator on each site.]

**Safety and Security Directions for High Secure  
Psychiatric Services** (The Safety and Security in  
Ashworth, Broadmoor and Rampton Hospital Directions  
2000, as amended by the Ashworth, Broadmoor and  
Rampton Directions 2003 (no 2) and 2002 (and as may  
be further amended from time to time)).  
[www.dh.gov.uk/en/Healthcare/Mentalhealth/Policy/  
Mentalhealthsecureservices/index.htm](http://www.dh.gov.uk/en/Healthcare/Mentalhealth/Policy/Mentalhealthsecureservices/index.htm)