COVID-19 Guidance for Prison Settings
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Glossary

Resident
An individual who is in custody in prison, either on remand or sentenced.

Passman
A resident in custody who carries out duties such as cleaning of communal areas and assisting with other daily duties. The passman will normally have greater access to different residential areas and will work in areas outwith their household.

Staff
Staff in prison including prison officers (employed by the Scottish Prison Service or private prison provider); health care staff (employed by the NHS); contracted staff and other partners.

Admission quarantine
The process for the temporary separation of new admissions, ensuring that each prison resident does not present a COVID-19 risk before coming into contact with the general prison population.

Self-isolation
Isolation of individuals who are confirmed to be infected, are symptomatic or are at increased risk (such as a close contact of a case) of COVID-19.

Household
A small number of prison residents (maximum 8, subject to operational considerations) who share a cell or section of the prison. They are in close proximity and do not need to physically distance.

Regime Group
A group of prison residents who undertake activities such as exercise and domestic periods together. Members of a regime group must physically distance at all times.
Cohorting

A public health measure for the separation of prison residents into groups according to illness, clinical risk or work role, for the purpose of establishing an effective barrier control between them and the wider prison population.

Staff Cohorting

Allocation of staff to defined work groups e.g. different risk categories or regime groups, to minimise infection transmission and need for contact tracing.
1. Introduction

1.1 Scope

This guidance:

- Aims to provide a clear, concise and accessible overview of the public health measures that should be taken to prevent COVID-19 in Scottish prisons including both residential and healthcare settings.

- Covers all prisons including private prisons contracted to the Scottish Prison Service (SPS). It does not extend to other places of detention, such as police custody, immigration detention centre(s) or Children’s Secure Homes.

- Aims to support those working and living in the prison setting (staff and residents) as well as local Health Protection Teams (HPTs).

- Should be read alongside other relevant policy, guidance and legislation such as the Prison Rules and Directions and Healthcare Directions. NHS staff working within prison settings should follow the Scottish COVID-19 Community Health and Care Settings IPC Addendum and COVID-19 Guidance for Primary Care Settings.

- Is published by Public Health Scotland (PHS). Version 1.0 was co-produced with the SPS, the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland and the NHS Prison Health Care Operational Group Chair. For methods, see Appendix 2.

The SPS COVID-19 Pandemic Plan \(^1\) operationalises this and the above listed national guidance. Where the Pandemic Plan differs from national guidance, reasons for this would be documented.

\(^1\) Available from SPS on request
1.2 COVID-19 epidemiology

The disease COVID-19 is caused by a new strain of coronavirus (SARS-CoV-2) first identified in Wuhan City, China in December 2019. COVID-19 was declared a pandemic by the World Health Organisation (WHO) on 12 March 2020.

The definition of a possible case is a person presenting with recent onset of any of the following cardinal COVID-19 symptoms: new continuous cough OR fever / temperature ≥37.8°C OR loss of, or change in, sense of smell (anosmia) or taste (ageusia).

SARS-CoV-2 is spread through respiratory droplets when an infected person coughs or sneezes, although there is also emerging evidence of airborne transmission. ii Individuals may also acquire the infection through direct contact with an infected case or by contact with contaminated objects and surfaces. Viral shedding is highest early in the course of the disease, particularly within the first 3 days of symptom onset. On average, it takes 5–6 days from when someone is infected with the virus for symptoms to show, iii however this ranges from 2 to 14 days. iv Up to 1 in 3 cases can be asymptomatic, making detection of transmission challenging. Symptoms range from mild or moderate illness to pneumonia or acute respiratory infection requiring intensive hospital care. Case fatality rates average 2-3% worldwide but vary according to treatment access and risk factors of the population such as age, ethnicity and underlying co-morbidities. v

References:


1.3 The Prison Context

People in prison are disproportionately drawn from the most disadvantaged areas in Scotland. Many have poor health, with high prevalence of alcohol, drug and mental health problems. Overall mortality is three times higher than the general population. Many have experienced wider life adversity: 1 in 4 have been in care and nearly 1 in 5 have difficulty with literacy and numeracy. Imprisonment can compound poor health and wellbeing through, for example, loss of connectivity with family, employment or housing. See the Scottish Public Health Observatory (ScotPHO) Prison Population section for more information.

Scotland has one of the highest imprisonment rates in Western Europe. The average daily population (ADP) counts the number of individuals in prison at any one time. However, the number of individuals coming and leaving each year is much higher and given that an individual may have more than one episode per year, the number of admissions higher still. Pre-pandemic, the ADP in Scotland's prisons was on average 8200. In April 2021, the ADP count was approximately 800 fewer. This was due, in part, to measures such as facilitation of early release and reduced court activity.

The prison estate in Scotland consists of 15 prisons (2 are privately run and are contracted to the SPS). The prisons vary in design from modern 21st century buildings to those built in the Victorian era.

Healthcare in Scottish prisons is delivered by the NHS Health Boards through an enhanced primary care model. Pharmaceutical services are also the responsibility of NHS Health Boards and are delivered through a national contract. Other services such as dentistry and allied health professions are often delivered through an in-reach model from local Health Boards. Support for wider health and wellbeing, such as food, access to exercise and vigilance of poor mental health is delivered by prison staff. The safety of each individual prison environment and the wellbeing of residents is the responsibility of the Governor-in-charge.

The pandemic has brought serious challenges for those delivering care to residents in prison. As a closed and episodically overcrowded setting, the risk of transmission is high. This is in a population with a high prevalence of underlying co-morbidities, a recognised risk factor for adverse outcomes associated with COVID-19.
In response, initial mitigating steps were taken, such as reducing the prison population; restricting visits and transfers; restricting the prison regime and implementing various health protection measures. Some of these measures, such as physical distancing, can be challenging to organise, particularly in some of the older prison buildings.

**1.4 Rationale for prison guidance**

Despite the constraints of the pandemic, the considerable efforts of those working in prisons (both prison and healthcare staff) have meant that throughout 2020 there were relatively few infections, outbreaks, hospitalisations or deaths among residents and staff.

With the increase in community transmission from late 2020, driven in part by new variants, several prisons experienced large and sometimes sustained outbreaks. Learning has emerged from these outbreaks, from prison-based staff, local HPTs, national public health bodies and Scottish Government, and gaps in existing national guidance have been highlighted. As the courts resume, society opens up, movements and visits begin again, the risk of infection for the prison population will likely persist. Ongoing robust infection prevention and control measures (as for the community) such as physical distancing, hand and respiratory hygiene, and the use of face coverings should continue, while mitigating measures such as symptom vigilance, appropriate ventilation, vaccination and testing (of both staff and those in prison) are rolled out.

The need for bespoke prison COVID-19 guidance for Scotland is therefore clear.

**1.5 Underlying Principles**

**1.5.1 Human Rights**

The Human Rights Act came into force in the UK in October 2000. The Act sets out the human rights in a series of ‘Articles’. Each Article deals with a different right. These are all taken from the European Courts of Human Rights (ECHR) and are commonly known as ‘the Convention Rights’:
Article 2: Right to life

Article 3: Freedom from torture and inhuman or degrading treatment

Article 8: Respect for your private and family life, home and correspondence

The tension between Articles, 2, 3 and 8 in the current pandemic is fundamentally the difficulty of ensuring that transmission of the virus is minimised (Article 2) against the definition of ill treatment (Article 3), and the need to respect family life (Article 8).

The **Statement of Principles** relating to the treatment of persons deprived of their liberty in the context of the COVID-19 pandemic issued by the Council of Europe in March 2020 clearly states:

“While it is legitimate and reasonable to suspend non-essential activities, the fundamental rights of detained persons during the pandemic must be fully respected. This includes in particular the right to maintain adequate personal hygiene (including access to hot water and soap) and the right of daily access to the open air (of at least one hour). Further, any restrictions on contact with the outside world, including visits, should be compensated for by increased access to alternative means of communication (such as telephone or Voice-over-Internet-Protocol communication).”

Whilst there is a requirement for robust measures to halt or reduce transmission, particularly during an outbreak, these must be considered in balance with the protection of human rights of those in prison, particularly when experienced for prolonged periods.

**1.5.2 Equivalence**

People in prison should be afforded provision of or access to appropriate services or treatment which are at least consistent in range and quality with that available to the wider community, in order to achieve equitable outcomes. Further details can be found in the **Royal College of General Practitioners (RCGP) Position Statement**.

**1.5.3 Evidence informed guidance**

A full systematic review of the evidence was not possible in the timescales for production of this guidance. However, key documents of prison specific and general guidance were drawn
on, from Scotland, the rest of the UK (e.g. Public Health England) and internationally (e.g. WHO).

This guidance is based on what is currently known about COVID-19 and will be updated as required.

2. Admissions

2.1 Admission assessment

Wherever possible, COVID-19 triage questions should be undertaken prior to an arranged arrival at the prison facility (such as during court attendance or when in police custody). To enable early detection of possible or confirmed COVID-19, triage questions should be undertaken again on arrival at the facility. For unplanned arrivals, triage questions should be completed as soon as possible after arrival to the facility, as part of the reception process.

All staff must be vigilant for new onset of COVID-19 symptoms in residents and NHS staff should be notified immediately in these instances. Any resident who is known to have COVID-19, who is a possible case, or is a close contact of someone known to have COVID-19 prior to arrival at the facility, should enter the facility via agreed local processes and minimise contact with staff, other residents and environments as far as is possible.

Admissions to particular establishments may be suspended in certain circumstances such as under the advice of an Incident Management Team (IMT) during an outbreak or when there is operational instability (e.g. reduced staff numbers). SPS can invoke contingency court divert arrangements in this event and liaise with the IMT on viability of timescales where risks may be increased on those establishments receiving continued diverts.

2.2 Admission testing

Approval has been granted by the Scottish Government testing programme for the rollout of testing to all new admissions into prisons in line with the SG COVID-19 Testing Strategy. A plan to implement this is being formulated.
2.3 Risk categories on admission

Residents should be placed in a COVID-19 risk category by NHS staff determined by the criteria below. This ensures that the appropriate controls and where possible the appropriate segregation of residents is enabled. It will also determine the Personal Protective Equipment (PPE) and decontamination requirements for each category of residents. There must be local arrangements in place for risk category information to be shared with SPS operational staff to ensure new admissions are located in the most appropriate area, depending on local arrangements.

When deciding resident placement where symptoms are unknown – for example where the individual is unconscious, or individuals who have returned from a country on the quarantine list in the last 10 days (see travel regulations for full details), a full risk assessment should be carried out prior to placement in the high or medium risk category. vi This assessment should take account of risk to the resident (e.g. immunosuppression, fraility), clinical care needs and the wider prison population.

1. High-risk COVID-19 category:

A. Those with confirmed COVID-19.

B. Those who are symptomatic of COVID-19 (as determined by case definition or clinical assessment where there is a suspicion of COVID-19. COVID-19 may present differently in those with pre-existing conditions - see HPT guidance for more details. Staff should bear this in mind when making a clinical assessment.)

C. Those who are known to have had contact with someone with confirmed COVID-19 (close contacts) and are still within the minimum 10-day self-isolation period.

vi A low risk category only exists in acute hospital settings and is not applicable to prison settings
2. Medium-risk COVID-19 category

A. All other residents who have been triaged and who do not meet the criteria for the high-risk category and who do not have any symptoms of COVID-19.

B. Asymptomatic residents who refuse testing or for whom testing cannot be undertaken for any reason, unless identified as close contacts.

C. Those who are asymptomatic, have been tested and are awaiting results, unless identified as close contacts.

2.4 Managing resident placement on admission

For residents admitted in the high COVID-19 risk category, self-isolation should commence in their own cell immediately. These residents should not be placed in a multi occupancy cell until the self-isolation period is complete. Meals should be provided for residents in the high COVID-19 risk category within their cell, to avoid them entering any communal spaces.

Where all single occupancy cells are occupied and the cohorting of residents together in a double occupancy environment within the residential area is unavoidable, then it should be ensured that:

- Those with confirmed COVID-19 are placed together in double occupancy cells within the same residential area(s).

- Those with possible COVID-19 are not placed in the same double occupancy environment cells/residential areas as confirmed COVID-19 residents.

- Residents who are symptomatic but are still awaiting test results must not be cohorted together, as symptoms may be associated with another respiratory illness and cohorting increases the risk of onward transmission to others. These residents should be isolated in their own single cell facility and should not mix with others. If single cell occupancy is not possible, a risk assessment should be undertaken balancing the risk to the individual and the risk to the prison population.

- Residents who are identified as asymptomatic close contacts can share cells, but must be separated immediately if symptoms develop in any of them.
Residents who are at the **highest risk** from COVID-19 (those who have received a letter from the Chief Medical Officer (CMO) advising them that they are on the shielding list) and wish to follow precautionary measures, the option to not cohort with other residents should be considered.

Ideally, residents in both categories should have their own en-suite facilities within their cell. Where this is not available, it should be ensured that there are arrangements for residents in the high COVID-19 risk category to use showering facilities last in any rotation. In addition, it those in the high COVID-19 risk category should be provided with personal **linen** (such as towels) and toiletries and advised that items such as toothbrushes and razors must not be shared.

Only essential staff wearing appropriate **PPE** should enter the cells of residents in the high COVID-19 risk category. Any necessary care given by NHS staff should be carried out within the residents’ cell where possible, including medication dispensing under appropriate protocol. A local joint SPS/NHS risk assessment should be carried out for safe dispensing of controlled drugs.

If particular areas of the prison are assigned to high and medium COVID-19 risk category residents respectively, clear signage should be in place.

Any resident in the medium risk category who develops symptoms of COVID-19 should be isolated immediately in an individual cell pending testing by Polymerase Chain Reaction (PCR) for SARS-CoV-2. Unless identified as a close contact, they can be released from self-isolation if the test is negative.

Any resident who has shared a cell with a case during the symptomatic period from and including the 48 hours prior to onset of symptoms would be classified as a contact. Contacts should be transferred to their own individual cell and undertake a **minimum period of 10 days self-isolation**. Should they develop symptoms their period of 10-day self-isolation re-starts.

Individual prisons may decide to operate **households**. Thorough assessment of residents included in the same household (similar to cell sharing risk assessment) should take place. Consideration in particular is needed for residents who are at the **highest risk** from COVID-19. Dynamic risk assessments should assess those who are non-compliant with COVID-19 controls and those who mix with others more frequently. If one member of a household
becomes symptomatic, all members of the household must isolate from that time for a minimum of 10 days, as in the community. If the symptomatic case subsequently tests negative, isolation can be stopped for the whole household.

In order to reduce the risk of SARS-CoV-2 transmission following admission, individual prisons can consider admission quarantine for a minimum of 10 days (14 days where possible due to the incubation period of the virus) before joining the general population. Individual prisons should decide the length of admission quarantine based on operational conditions and restriction levels using a risk assessment approach. If space for allocation to an individual cell is constrained, residents can be grouped into a household by day of admission but physical distancing (subject to national guidance and local risk assessment) should be maintained during this period.

### 2.5 Staff cohorting for admission risk categories

Staff rotas should be planned in advance wherever possible, to take account of different COVID-19 risk categories and staff allocation, including contingency for staff illness or their own self-isolation requirements. There should be as much consistency in staff allocation as possible with the aim of reducing movement of staff; crossover of staff between resident risk categories should be the exception. Should staff groups need to go between COVID-19 risk categories as an exception, efforts should be made to see residents in the medium COVID-19 risk category first, then the high COVID-19 risk category. This should apply to all prison based staff including contracted staff (such as cleaning staff) and residents carrying out duties, such as passmen.

### 3. General measures to preventing the spread of infection in prison settings

In most instances, general public health measures such as hand and respiratory hygiene, adequate physical distancing, use of face coverings, appropriate ventilation, environmental cleaning, symptom vigilance and vaccination apply. See NHS inform for further details.
Additional information specific to the prison setting is outlined in respective sections below and in the SPS Pandemic Plan vii e.g. restriction of visiting and transfers.

### 3.1 Hand hygiene

Hand hygiene is considered to be one of the most important practices in preventing the onward transmission of any infectious agents including SARS-CoV-2.

Residents in prison should be provided with access to hand washing facilities using liquid soap and warm water ideally within their own cell to allow them to perform hand hygiene at appropriate times e.g. before and after eating, after using the toilet, and after contact with another individual.

Hand hygiene by staff must be performed before every episode of direct resident contact (touching or exposure to body fluids) and after any activity or contact that potentially results in hands becoming contaminated, including the removal of PPE, equipment decontamination, and waste handling. Hand washing should take place with sleeves rolled up to prevent contamination of clothing and should be extended to the forearms where possible. Staff working in prisons should carry a supply of Alcohol Based Hand Rub (ABHR) to enable them to perform hand hygiene at appropriate times.

Hand hygiene resources can be accessed at the links below from the National Infection Prevention and Control Manual (NIPCM):

- [How to wash hands – Appendix 1 - NIPCM](#)
- [How to use alcohol based hand rub – Appendix 2 - NIPCM](#)

### 3.2 Respiratory hygiene

Respiratory hygiene is designed to minimise the risk of cross transmission of respiratory pathogens including SARS-CoV-2. The principles of respiratory hygiene can be found in Section 1.3 of the NIPCM.

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vii Available from SPS on request
3.3 Physical distancing

All residents should maintain physical distancing at all times (unless in a household setting). Physical distancing should be based on national guidance and local risk assessment. For essential work, there may be exceptional circumstances where physical distancing cannot be followed; in those circumstances, a risk-based approach must be used, with appropriate PPE provided and mitigations in place to reduce the risk to acceptable levels, e.g. staggered timings / screens. Please refer to COVID-19 Guidance for Non-Healthcare Settings for further details.

All staff must maintain physical distancing wherever possible. This does not apply to the provision of direct care/support to any resident or during an intervention such as control and restraint, where appropriate PPE should be worn by staff unless delay could jeopardise an individual’s safety. There may be areas within prison settings where maintaining physical distancing is a challenge due to the physical layout of the facility and the nature of the work undertaken, and mitigations must be considered in these circumstances. SPS have local policies in place for physical distancing \(^{viii}\) and also wider use of mitigation measures where physical distancing cannot be maintained such as fluid resistant surgical masks (FRSMs) \(^{ix}\), staggered timings, screens, etc.

Staff must adhere to physical distancing as much as possible and should, for example:

- Stagger work breaks to reduce the number of staff in all recreational areas at any one time
- Maintain physical distancing when removing FRSMs to eat and drink.

SPS managers should maintain dynamic risk assessment in the observance of current physical distancing measures.

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\(^{viii}\) Available from SPS on request
\(^{ix}\) Available from SPS on request
3.4 Residents at highest risk from COVID-19

Advice for people at highest risk from COVID-19 (who may previously have been asked to shield) within the prison setting includes that they should be offered the option to follow more precautionary measures. Prisons must continue to offer this option to residents who are classed as being at highest risk from COVID-19. Those people will have received a letter from the Chief Medical Officer advising them that they are on the shielding list. NHS staff should ensure that those who chose not to take up the offer of precautionary measures and follow the same measures as the rest of the prison population are fully aware of the risks.

Precautionary measures may include residents at the highest risk from COVID-19 being:

- Accommodated in a single cell with en-suite showers where possible. A cell sharing risk assessment should reflect the health requirements and mitigation measure compliance of residents. NHS staff should be involved in this process.

- Provided with all meals and medication in the cell. A local joint SPS/NHS risk assessment should be carried out for safe dispensing of controlled drugs.

- Given access to communal showers where they do not have in cell facilities.

- Provided with a personal mobile phone if appropriate.

- Given access to the communal phone where use of a personal mobile is not possible.

- Given access to outside exercise.

In addition, those at highest risk from COVID-19 who choose to take up the offer to temporarily isolate should be supported to adhere to physical distancing wherever possible.

Staff providing care to these residents must:

- Wear PPE when delivering direct care to the resident.

- Undertake an individual risk assessment regarding direct interaction. Appropriate mitigating measures should be in place during interactions. However, staff should continue to engage with those who are at highest risk from COVID-19 to ensure that prolonged isolation is not negatively impacting on their mental health and wellbeing.
3.5 Vaccination

The Medicines & Healthcare products Regulatory Agency (MHRA) has given regulatory approval to a number of vaccines. Details and arrangements for the COVID-19 immunisation programme according to JCVI recommendations can be found on NHS inform.

Residents in prison are offered vaccination in line with the community but special efforts may be required to ensure as high uptake/coverage as possible. Prison resident vaccination uptake should be a particular point of focus for both SPS and the NHS Immunisation Coordinator of each health board with a prison.

As part of the NHS admission screening anyone entering prison should be assessed for vaccine status and offered vaccination if appropriate.

Further vaccination information can be found in COVID-19: Guidance for Health Protection Teams (HPTs).

3.6 Personal Protective Equipment (PPE) and Face Coverings

Face coverings are made of cloth or other textiles to cover the mouth and nose. Face coverings are largely intended to protect others, not the wearer, against the spread of infection because they cover the nose and mouth which are the main sources of transmission of SARS-CoV-2. Residents should wear a face covering at all times when out of their cell or household. The purpose of wearing these is to reduce contamination of the surrounding environment by those who may be asymptomatic cases of COVID-19. Physical distancing should also be maintained. Face coverings should be regularly laundered. Face coverings are not considered PPE.

FRSM and other PPE provide the wearer with a degree of protection against exposure to infection risks associated with the task being undertaken. FRSM are surgical or other medical grade masks that are used in certain health and social care settings to protect the wearers against hazards and risks. FRSMs can be considered PPE when worn by staff who are suitably trained and supervised in their use. FRSMs worn by staff moving around the prison outside the delivery of direct resident interaction without physical distancing are for the purposes of source control in line with face coverings rather than PPE, but will also provide a degree of protection should staff have to intervene with a resident unexpectedly.
A resident may be required to wear a FRSM when working in a situation where PPE is required to be worn or leaving an establishment under escort. If a resident is considered for an exemption from wearing a face covering, a local risk assessment must be completed and other mitigations must be considered such as change in work role.

PPE requirements for staff during the COVID-19 pandemic are determined by the risk associated with the COVID-19 risk categories detailed in Table 1. Any PPE used during ‘business as usual’ for risks such as chemical/substance exposure should continue but are separate to PPE use for viral transmission control.

3.6.1 Use of PPE by staff determined by COVID-19 risk category

The PPE worn by staff for direct care differs depending on the COVID-19 risk category and the task being undertaken.

Table 1 details the PPE which should be worn by staff when interaction takes place within 2 metres of a resident in each of the COVID-19 risk categories.

FRSMs should be worn by staff for all interactions within 2 metres regardless of the COVID-19 risk category. This is an IPC measure which has been implemented alongside physical distancing specifically for the COVID-19 pandemic. FRSMs should be changed if wet, damaged or soiled. Manufacturers of FRSMs may stipulate a ‘maximum wear time’. However, it is worth noting that it is unlikely that an individual will wear an FRSM for more than 4 hours without removing it to eat or drink, in which case it should be disposed of and a new one put on.

PPE should be stored to prevent contamination in a clean/dry area until required for use (expiry dates must be adhered to). When removed, PPE should be disposed of in the clinical waste stream and hand hygiene performed.
Table 1: PPE for direct resident care determined by risk category

<table>
<thead>
<tr>
<th>Medium COVID-19 Risk Category</th>
<th>Gloves</th>
<th>Apron</th>
<th>Face mask</th>
<th>Eye face protection</th>
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<tr>
<td>Risk assessment – wear if contact with blood or bodily fluids is anticipated</td>
<td>Risk assessment – wear if direct contact with patient, their environment or blood or bodily fluids is anticipated (gown if extensive splashing anticipated)</td>
<td>Always within 2 metres of an individual - FRSM</td>
<td>If splashing or spraying, including coughing/sneezing anticipated Single use or reusable following decontamination</td>
<td></td>
</tr>
<tr>
<td>Single use</td>
<td>Single use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High COVID-19 Risk Category</td>
<td>Worn for all direct resident care</td>
<td>Always within 2 metres of an individual</td>
<td>Always within 2 metres of an individual Single Use</td>
<td>Always within 2 metres of an individual Single use, sessional or reusable following decontamination</td>
</tr>
<tr>
<td>Single use</td>
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3.6.2 PPE – Putting on (Donning) and Removing (Doffing)

It is important to don (put on) and doff (remove) PPE appropriately to prevent contamination of the user. The poster from the NIPCM describes the safe methods for donning and doffing PPE. Regular PPE and IPC refresher training is required and is available to SPS staff. Note: there is no requirement for the use of gowns in prison settings unless by healthcare staff undertaking an aerosol generating procedure (AGP) or if extensive splashing of blood or bodily fluids is anticipated.

3.6.3 Sessional use of PPE

During the peak of the pandemic, some PPE was used on a sessional basis. This meant that these same items of PPE could be used for a longer period of time moving between individuals and for a period of time where a staff member was undertaking duties in an environment where there was exposure to SARS-CoV-2.

Sessional use of PPE is no longer required or recommended with the exception of wearing a visor/eye protection in a communal area where residents in the high COVID-19 risk category are. FRSMs can be worn sessionally. FRSMs should be changed if wet, damaged, soiled or
uncomfortable and must be changed when leaving high-risk category. Sessional use of
gloves and aprons may be associated with transmission of infection and must not occur.
ABHR should never be applied to gloves. Gloves are only required when there is exposure
to blood and/or body fluids, otherwise adequate hand hygiene will suffice.

3.7 Additional staff measures

Staff and their prison managers must be vigilant for COVID-19 symptoms amongst the
workforce. Daily reminders or triage processes should be in place with easy access to
testing for all. Managers must ensure that any staff who have confirmed or possible COVID-
19 or are identified as close contacts of a case by Test and Protect do not attend physically
for work. Regular COVID-19 screening of prison staff is being rolled out across the Scottish
prison estate.

3.7.1 At risk staff

Staff with underlying health conditions that place them at increased risk from COVID-19
should discuss this with their line manager in the first instance. They may then be referred to
the Occupational Health service. The COVID-19 Occupational Risk Assessment
Guidance can be used to support an individual occupational risk assessment.

3.7.2 Uniforms

Uniforms can be safely laundered at home. Further general information on management and
laundering of uniforms can be found in the NIPCM COVID-19 Community Health and Care
Settings Addendum.

3.7.3 Travel to work

Staff should follow the Scottish Government guidance on travel and transport, in particular
in the section on car-sharing.

If staff have COVID-19 symptoms, have been diagnosed with COVID-19 or are self-isolating,
they must not travel and should follow the ‘stay at home’ advice.
When staff are using public transport or private/commercial vehicles they should aim to maintain physical distance from other people whenever possible and use face coverings.

If use of private/commercial vehicles is necessary and it not possible to maintain physical distancing with individuals who are non-household members, it is important to limit the number of passengers and space out as much as possible. Car-sharing should be avoided or, if essential, mitigations should be maximised.

3.7.4 Training and education

All prison staff (including those in private prisons) should undergo the mandatory SPS COVID-19 Prevention Awareness training which includes PPE training and has been quality-assured by NHS Education for Scotland. Each prison should maintain a record of PPE training for their staff.

4. Prison environment

4.1.1 Safe management of linen

Linen used for individuals who are in the high risk category (confirmed or possible case of COVID-19 or a close contact) should be treated as being infectious (known or suspected infectious pathogen or contamination with blood or body fluids). Information on the handling of infectious linen can be found in the NIPCM. Linen used for individuals who are in the medium risk category can be handled as per normal.

Prison settings with their own in-house laundries may also refer to National guidance for safe management of linen in NHS Scotland.

Please also refer to the section on staff uniforms within this guidance.

4.1.2 Safe management of blood and body fluid spillages

General advice for the safe management of blood and body fluid spillages recommended for prison settings can be found in Appendix 9 of the NIPCM.
4.1.3 Safe disposal of waste (including sharps)

Waste should be handled in accordance with guidance contained within the NIPCM. Waste generated from residents’ cells who are in the high risk category (confirmed or possible case of COVID-19 or a close contact) should be disposed of as clinical waste where clinical waste contracts are in place.

If the prison setting does not have a clinical waste contract, it should be ensured that all waste items that have been in contact with a resident who is a confirmed or possible case of COVID-19 (e.g. used tissues and disposable cleaning cloths) are disposed of securely within disposable bags. When full, the plastic bag should be placed in a second bin bag and tied. These bags should be stored in a secure location for 72 hours before being put out for collection.

4.1.4 Cleaning of prison equipment

Clutter and excess storage items should be removed from all areas to facilitate effective cleaning and minimise the potential for contamination.

Soft furnishings which cannot be cleaned appropriately should be avoided where possible, such as fabric chairs and carpets.

Re-useable shared items passed/shared between residents or staff such as phones, electronic items, food trays and wheelchairs must be cleaned between individuals as per below. This cleaning should be determined by risk category.

- Medium risk category: General purpose detergent for routine cleaning. See Appendix 7 of the NIPCM for cleaning of equipment contaminated with blood or body fluids or where an item has been used by a resident with a known or suspected infectious pathogen.

- High risk category: Combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine.

Manufacturer’s instructions should be referred to for cleaning electronic products.
4.1.5 Cleaning of the prison environment

Environmental Cleaning should be undertaken as per frequency detailed below using the stipulated products depending on the risk category.

- Medium risk pathway: cleaning at least daily using general purpose detergent

- High risk pathway: cleaning at least twice daily with combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine.
  - First clean: full clean
  - Second clean: touch surfaces within individual cells / communal areas

**Resident cells**

Resident cells should, where possible, be cleaned by the occupants who should be provided with the appropriate tools and products to do so. In the high risk category occupants should be encouraged to clean their cell daily, paying particular attention to high touch areas such as door handles, table tops and light switches.

**General areas**

Within prisons, cleaning may be carried out by contracted cleaning staff, Industrial Cleaners or passmen. SPS should ensure that any in-house cleaners are trained to undertake cleaning to the same standard as cleaning contractors. It is the responsibility of the Governor-in-charge to ensure that the prison environment is safe (this includes environmental cleanliness/maintenance). The person in charge must act if this is deficient.

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x Cleaning in the medium risk category should be carried out with chlorine based detergent for rooms where individuals are known or suspected to have an infectious illness such as norovirus or symptoms such as loose stools, vomiting, etc.

xi High risk touch surfaces as a minimum should include door handles/push pads, taps, light switches, lift buttons. Where an area has not been occupied by any staff or individuals since the first daily clean was undertaken, a second daily clean is not required.
The prison environment should be:

- Visibly clean and free from non-essential items and equipment to facilitate effective cleaning
- Well maintained and in a good state of repair

**Cleaning practice points:**

The following good practice points apply:

- Disposable cloths/paper roll/disposable mop heads should be used to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings
- Re-usable parts of cleaning equipment, such as mop handles, should be cleaned, dried and stored
- For carpeted floors that cannot withstand chlorine-releasing agents, manufacturer's instructions should be consulted for a suitable alternative to use following, or combined with, detergent cleaning
- Decontamination of soft furnishings may require to be discussed with the local HPT/Infection Control Team (ICT). Heavily contaminated soft furnishings may have to be discarded. If it is safe to clean with standard detergent and disinfectant alone then the appropriate procedure should be followed
- If an item cannot withstand chlorine releasing agents staff are advised to consult the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning
- Manufacturer's instructions should be followed for dilution, application and contact times for all detergents and disinfectants

**When an organisation adopts practices that differ from those recommended in this guidance with regards to cleaning agents, the individual organisation, as always, is fully responsible for ensuring safe systems of work, including the completion of local risk assessment(s) approved and documented through local governance procedures.**
4.1.6 Ventilation

Ventilation of indoor space is important for reducing the risk of transmission of SARS-CoV-2. Ventilation should be used alongside other control measures, such as physical distancing, cleaning, and use of face coverings. The amount of fresh air entering a space should be maximised at all times wherever possible. The number of individuals in a room; the degree to which they are infectious; the type of activity; the ventilation rate and the length of time individuals are in the room may all impact on the potential for transmission. Activities such as singing, loud speech and vigorous exercise may generate high levels of contaminated air.

A risk assessment should be undertaken to identify areas where there may be poor ventilation. Mechanical ventilation systems should be operated as advised by specialists and set to maximise fresh air intake and minimise recirculation of air from room to room or within a room.

Further ventilation guidance is available from the Health and Safety Executive (HSE) and Scottish Government. These additional resources also contain practical considerations on how to achieve good ventilation.

4.1.7 Built environment

Prison settings should apply administrative controls to establish separation to minimise contact between COVID-19 risk categories. Due to the wide variation in establishment configurations and structure across the prison estate it is not possible to be descriptive in exactly how these should be applied and full assessment should be undertaken locally. Guidance contained within the NIPCM COVID-19 Community Health and Care Settings Addendum describes some suggested measures which may apply to prison settings also.
5. Case Management

5.1 Case definition of COVID-19

Definition of a possible COVID-19 case (clinical criteria)

A person presenting with recent onset of any of the following cardinal COVID-19 symptoms:

- New continuous cough OR
- Fever / temperature ≥37.8°C OR
- Loss of, or change in, sense of smell (anosmia) or taste (ageusia).

Please refer to Section 3 of the PHS COVID-19 Contact Tracing Guidance for a list of additional symptoms considered to be associated with COVID-19.

Definition of a confirmed case


5.2 Case testing, contact tracing and isolation

Any resident who develops any symptoms suggesting possible COVID-19 must be clinically assessed. If the individual's condition suggests COVID-19, a PCR test should be carried out by the prison-based NHS staff and the resident put into isolation separately from their household for a minimum of 10 days from symptom onset and any close contacts identified for household or self-isolation. If test results are negative for the individual resident and the individual is well and has not had a fever for 48 hours, isolation can be discontinued - see NHS Inform for more information on ending isolation. Further detail on follow up of cases is outlined in the PHS COVID-19 Contact Tracing Guidance.

Staff with symptoms of COVID-19 should not attend work, should self-isolate for 10 days, and should arrange to be tested as soon as possible. Further detail on how to arrange a test is available on NHS inform or using a local agreed protocol where this is in place.
When there is a single new case with symptoms, either in staff or residents, consistent with COVID-19 arising within the establishment, the local Health Board HPT should be informed. The HPT (in conjunction with Test and Protect) will lead on Contact Tracing. Please see Appendix 1 for contact details of local HPTs

5.3 Contact testing and isolation

Any identified close contacts of a case (resident or staff) must self-isolate for a minimum of 10 days and have a PCR test. For residents, this will be carried out by prison based NHS staff. For staff, guidance on booking a test can be found on NHS inform or by way of local agreed protocol, where this is in place. A decision can be made with the support of the local HPT to isolate close contacts as a cohort, depending on the circumstances. Further details on follow up of contacts can be found in PHS COVID-19 Contact Tracing Guidance.

All members of a household with a case are close contacts and must isolate for a minimum of 10 days. If a further household member becomes symptomatic, that person’s clock will be re-set for a further 10 days from date of symptom onset (if they subsequently test PCR negative there should be clinical assessment to determine isolation period). See PHS COVID-19 Contact Tracing Guidance for more details. A second confirmed case in a household would require a risk assessment by the HPT or IMT.

5.4 Staff close contact with a case

Staff should minimise any non-essential contact with symptomatic or confirmed COVID-19 cases. The local HPT will provide IPC advice to staff who work directly with residents with symptoms of COVID-19 or confirmed infection. For activities requiring close contact with a symptomatic but as yet unconfirmed case, PPE information can be found in Table 1. Risk assessment by the HPT is required to consider whether PPE, if used, was adequate to reduce exposure risk so that isolation is not required.
5.5 Stepping down IPC Control Measures for confirmed COVID-19 cases

Before IPC control measures are stepped down (discontinued) for an individual with COVID-19, it should be considered whether there are any other infection control reasons for ongoing isolation e.g. suspected norovirus or measles.

Key notes which should be referred to in conjunction with Table 2 below:

- **Completing the isolation period**: residents should complete a period of a minimum of 10 days’ isolation. Those recently discharged from hospital (within the self-isolation period) must complete a total of 14 days’ isolation. This is because in general those with COVID-19 who are admitted to hospital will have more severe disease than those who remain in the prison or community setting, especially if they require critical care.

- Staff identified as a COVID-19 case or contact should complete a minimum of 10 days’ self-isolation in line with PHS Contact Tracing guidance. All other individuals should follow 'stay at home’ guidance on NHS inform.

- **COVID-19 clinical requirements for stepdown**:
  - Clinical improvement with at least some respiratory recovery
  - Absence of fever (>37.8°C) for 48 hours without use of antipyretics
  - A cough or a loss of/change in normal sense of smell or taste may persist in some people, and is not an indication of ongoing infection when other symptoms have resolved

- **Testing required for stepdown**:
  - No testing is required routinely to stepdown IPC precautions in prison settings.
  - For severely immunocompromised individuals or those at extremely high risk of severe illness, negative tests may be required where ongoing care is required as an outpatient in a healthcare setting. This would be determined by the hospital-based clinician.
Table 2: Stepdown requirements in Prison Settings

<table>
<thead>
<tr>
<th></th>
<th>Number of isolation days required</th>
<th>COVID-19 Clinical requirement for stepdown</th>
<th>Testing required for stepdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident cases in prisons</td>
<td>10 days from symptom onset (or first positive test if symptom onset undetermined)</td>
<td>Absence of fever for 48 hours without use of antipyretics &amp; at least some respiratory recovery</td>
<td>Not routinely required</td>
</tr>
<tr>
<td>Cases discharged from hospital</td>
<td>14 days from symptom onset (or first positive test if symptom onset undetermined)</td>
<td>Absence of fever for 48 hours without use of antipyretics &amp; at least some respiratory recovery</td>
<td>Not routinely required</td>
</tr>
</tbody>
</table>

5.5.1.1 Transferring between COVID-19 risk categories on stepdown

Residents should be managed in the high COVID-19 risk category for any healthcare requirements in prison or essential outpatient visits or during any external healthcare appointments that cannot be re-scheduled, e.g. urgent dental care, until criteria described in Table 2 are met. Residents can then be transferred back to the medium COVID-19 risk category. Symptom vigilance should be maintained.

5.6 Maintaining Health and Wellbeing during Isolation

Those in isolation will continue to have access to health and care including prescribed medication. Symptom vigilance must be maintained including for signs of mental health problems and any concerns acted on.

For those not in a cell with en-suite facilities, access to hot water and showers should be ensured for personal hygiene. Access to outdoor exercise should be given whilst maintaining physical distancing and wearing of a face covering. The frequency and duration that a resident is out of their cell should be determined by a local risk assessment which must consider staffing levels, PPE, and ability to maintain physical distancing. This is usually determined with the support of the HPT leading and IMT.
Residents entering isolation should be offered the option to inform a family member/next of kin. Access to a telephone should be given.

5.7 Death

The IPC measures described for management of a resident with confirmed or possible COVID-19 continue to apply whilst the resident who has died remains in the prison environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living individuals.

There is no requirement for a body bag. Viewing, hygienic preparations, post-mortem and embalming are all permitted. Body bags may be used for other practical reasons such as maintaining dignity or preventing leakage of body fluids.

All deaths in prison, including COVID-19 related deaths, must be reported to Police Scotland immediately and the scene preserved until released by the police in attendance.

6. Outbreak Management

6.1 Outbreak definition

On identification of a new possible or confirmed COVID-19 case, the prison must immediately contact the local HPT who will undertake an assessment of the situation.

An outbreak is defined as two or more linked cases of disease within a defined setting over a period of 14 days.

Detailed information on outbreak management is available in Management of Public Health Incidents: Guidance on the roles and responsibilities of NHS led incident management teams.
6.2 Setting up an Incident Management Team (IMT)

Following notification to the local Health Board HPT, the Consultant in Public Health (Medicine) (CPH(M)) may choose to convene a Problem Assessment Group (PAG) to undertake an initial assessment and determine if an IMT is required. PHS can provide expertise and support.

The IMT is an independent, multi-disciplinary, multi-agency group with responsibility for investigating and managing the outbreak. It provides a framework, response and resources to enable the NHS Health Board and other statutory agencies to fulfil their remits. These include taking action to minimise the number of cases by identifying and controlling the source of infection; communicating necessary information to those affected, relevant organisations/agencies, the public and the media; and collating learning that will assist in preventing/managing further outbreaks. The IMT should work in partnership with affected establishments to aid understanding of individual regimes, constraints and geographies.

A suggested list of IMT membership can be found in section 6.5 of the Management of Public Health Incidents Guidance. A template agenda and IPC outbreak checklist are also available, which can be adapted as necessary.

The Chair of the IMT should ensure that arrangements are in place to record the minutes of each meeting. These should be circulated among all members of the IMT before the next meeting and their accuracy agreed before finalising. Due to the possible confidential nature of the content, all respective organisations should ensure they are both used and stored in compliance with the Data Protection Act 2018. The minutes are subject to Freedom of Information (FOI), with redaction of Personal Identifiable Information.

6.3 Management of Cases and Contacts

Please refer to Section 5 for the management of cases and contacts. Identification of others (both staff and residents) who might also be close contacts will be co-ordinated by the local HPT who will liaise with Test and Protect services. This can be carried out in partnership with prison services utilising, for example, staff rotas, and is important to carry out in a timely manner and on an individual and confidential basis.
6.4 Cohorting

During an outbreak case numbers can rise rapidly. Cohorting may be considered in the event that there is insufficient accommodation to allow cases to isolate in single cells. Those who are confirmed cases can be cohorted together for isolation. Those who are close contacts can also be cohorted together for isolation with physical distancing in place where possible but should not be cohorted with confirmed cases. If cohorts are large, consideration may be given to forming smaller groups within the cohort that can progress through isolation without the introduction of new members. This minimises the risk of repeated periods of isolation due to subsequent members becoming symptomatic. Those at highest risk from COVID-19 should not be cohorted with others.

6.5 Regime groups

Residents can be assigned to a regime group which can take exercise and domestic periods together. Regime groups should not consist of individuals from different cohorts, where possible. This may be constrained by factors such as staff capacity in the context of an outbreak. Regime groups must maintain physical distancing and wearing of face coverings. If one member of a regime group becomes symptomatic, only members of their immediate household may require isolation and testing but this will be risk assessed by the HPT.

6.6 Staff cohorting

During an outbreak, efforts should be made as far as possible to dedicate assigned teams of staff to care for residents in different cohorts. There should be as much consistency in staff allocation as possible, reducing movement of staff between cohorts of residents and risk of transmission. Rotas should be planned in advance wherever possible to take account of different COVID-19 risk categories and staff allocation. For staff groups who, exceptionally, need to go between COVID-19 risk categories, efforts should be made to see non-COVID residents first. Face masks should be changed between COVID-19 risk categories and other preventative measures such as hand hygiene should also be carried out.
6.7 Control measures

Control measures in place to manage transmission should be reviewed by the IMT. Part of the review can include a visit to the prison setting by the local Health Board IPC team and other partners such as Environmental Health.

If not already in place, the IMT will consider measures to minimise entry into the prison, including temporary closure to new admissions, and pausing of visiting and normal daily activities or services (e.g. education, hairdressing etc.). In an outbreak situation, consideration of 14 days of self-isolation for close contacts should be made by the IMT. Cases only require isolation for 10 days from symptom onset (or from test date if asymptomatic). It is important to note that the 10-day isolation period is a minimum and careful consideration must be given to extending this to 14 days in a prison context, especially during an outbreak. This is due to the viral incubation period being 14 days and the remaining days could lead to a period of risk, should incubating symptoms arise when the individual is back in the general population.

Staff and residents should be vigilant for development of symptoms consistent with COVID-19 and encouraged to report these immediately so that necessary isolation and testing measures can be initiated. There should be awareness that there may be perceived barriers to reporting symptoms such as desire to avoid isolation for self and close contacts.

6.8 Mass Testing

Testing can play a part in outbreak management in addition to testing to confirm a case; testing of close contacts; and testing of new admissions. This asymptomatic mass testing can be of the whole population or targeted to specific groups of concern often according to the layout of the prison. This should be based on a risk assessment by the IMT and PCR testing is strongly advised. Consideration should be given regarding the need to inform local microbiology laboratory services where it is anticipated there will be a large volume of samples received.

Staff or residents have the right to decline testing. In this instance the public health benefits of asymptomatic testing should be reinforced. During an outbreak any symptomatic resident
or resident who is a close contact and who declines testing should be isolated for a minimum of 10 days.

**6.9 Monitoring of outbreaks**

The monitoring of outbreaks is led by the local HPT who will chair the incident management team meetings. It is important for prison services to share information requested by the HPT promptly, including the names and personal contact details of residents and staff as required. The frequency of IMT meetings will be determined as appropriate dependent on the course of the outbreak. A recovery plan can also be considered.

**6.10 Communication Plan**

In any outbreak, clear communication is important. Health Boards and SPS should use their locally developed communications plans which indicate how they will provide information about the outbreak and its control to the key agencies involved in the outbreak including clinical colleagues, the local authority, PHS and Scottish Government, the general public and in particular the residents and staff in the establishment affected.

Actively engaging with the media and providing accurate and timely information may prevent inaccurate reporting and provide reassurance that the necessary control measures have been implemented. It is usually the HPT that leads on external communications via the IMT.

**6.11 Declaring the outbreak over**

As the number of new cases declines a cautious approach to declaring the outbreak over should be taken. There should be no new possible or confirmed COVID-19 cases for a minimum period of at least 14 days from last possible exposure to a case in a resident or staff member. The HPT must also be satisfied that existing cases have been isolated/cohorted effectively and symptoms should be resolving and that IPC measures are being applied appropriately. The IMT should decide when the public health response to an incident is over and, if it is appropriate, make a statement to this effect for release to the general public and other interested parties. This would come following formal assessment and report that there is no longer a significantly increased risk to public health.
6.12 Outbreak reports/shared learning

It is good public health practice to share learning from experience of outbreak management. A debrief on the management of the outbreak should take place as soon as possible after the incident (termed a ‘hot’ debrief). This should: summarise the outbreak; consider the effectiveness of the investigation and control measures taken; and make recommendations aimed at minimising the risk of further outbreaks and improving their management. The chair of the IMT will make a decision on the requirement and appropriate format for a full outbreak report during the pandemic. The content of this should be agreed by all members of the IMT or acknowledge areas of disagreement. The NHS Health Board should provide a response to the recommendations made in the outbreak report.

In addition to an IMT report all outbreaks should be summarised in an appropriate standard summary form for submission in timely fashion to PHS for the purposes of incident surveillance.

7. Transfers, visits and liberations

7.1 Inter prison transfer

To date during the pandemic inter prison transfers (IPTs) have been kept to a minimum. Some transfers and movements will be necessary as part of population management and progression; this should be informed by a risk assessment.

In certain situations, such as an ongoing outbreak, transfers to and from the prison with the outbreak may be curtailed or stopped. Any resident who is a possible or confirmed case of COVID-19 or a close contact is unlikely to be eligible for transfer to another setting, with the exception of hospital for medical care or during an operational emergency.

7.2 Court attendance

Those who have confirmed or possible COVID-19 or are close contacts should not attend court. The court should be informed as soon as possible if a resident is a possible COVID-19 case or has confirmed COVID-19. It is the responsibility of the prison establishment to inform
any impacted court(s) of a declared COVID-19 outbreak. SPS Operations Directorate must also brief and update Scottish Courts and Tribunals Service liaison team of the outbreak being declared and progress of any subsequent PAG/IMT.

Any court transfer must follow safe escort and transfer protocols. The measures of physical distancing, hand hygiene and use of face masks should be followed. Virtual attendance of court proceedings is advised whenever possible. A risk assessment may be necessary for any court attendance where a breach in the above measures has occurred to determine whether isolation or testing are required on return to prison. Contact tracing of a resident or staff case must include any court contacts and escorts.

7.3 Escorting

Escorting of residents to courts, other prisons, and hospital is routinely carried out by an escort contractor who will follow their own COVID-19 guidance, which must be aligned with this guidance and in accordance with SPS contractual arrangements. In some instances, such as a medical emergency, prison staff may escort a resident to hospital from prison.

All escorting staff should follow general measures such as physical distancing where possible and hand hygiene. Where staff are required to share transport for escort purposes, staff and residents must wear a FRSM. A risk assessment must be completed prior to the journey commencing. Escorting staff should follow PPE guidance as per Table 1 and adhere to SPS operational policy. xi

Any vehicle used to transport a possible or confirmed case (high COVID-19 risk category) must be cleaned and disinfected using methods outlined for environmental cleaning following a possible case as soon as possible before being brought back into service.

xi Available from SPS on request
7.4 Hospital attendance

Ambulance staff should be notified of a possible or confirmed COVID-19 case prior to transfer.

Operational escorting staff should wear PPE in line with Table 1 depending on the resident COVID-19 risk category. In certain circumstances and settings in hospital, such as intensive care or where AGPs are performed, escort staff may be advised by hospital staff to wear additional PPE e.g. an FFP3 mask (suitably fitted) and a sleeved gown. Escorting staff should take a second set of PPE.

Escorting staff must follow hospital IPC procedures as advised by hospital staff in attendance. If they are asked to locate in an area away from the prison resident, they must inform the prison Duty Manager who will risk assess and advise as required.

Individuals transferring back from hospital who are confirmed COVID-19 cases should be clinically assessed and as a minimum meet the stepdown requirements as described in Table 2 and associated notes in Section 5.5. Depending on the circumstances, they may be required to complete their self-isolation period upon return to prison.

Those attending hospital as an inpatient or for an outpatient appointment that is not COVID-19 related are not required to isolate on return if infection control measures are followed throughout the visit.

7.5 Visiting

The following measures are good public health practice to minimise COVID-19 risk to the prison population as a whole. Implementation of these measures will need to be balanced with the wellbeing of individual residents, regarding visiting from friends and family. SPS may choose to operationalise these measures according to local restriction circumstances and risk assessment. Visiting still carries a risk that transmission of the virus could occur. Local visiting arrangements would need to be reviewed if a case or cases arise.
Prisons should:

- Ensure that all visitors are informed on arrival of IPC measures
- Ask visitors on arrival if they have any symptoms of COVID-19. See triage questions for a suggested approach
- Maintain a list with visitor details for Test and Protect purposes in line with data protection requirements
- Ensure that visiting areas are well ventilated where possible
- Ensure that visiting areas are cleaned between visits
- Provide alternative measures of communication including telephone or video call where visiting is not possible should be considered

Visitors should:

- Not visit if they have possible or confirmed COVID-19, if they have any of the cardinal symptoms of COVID-19, or if they have been advised to self-isolate for any reason
- Perform hand hygiene on entry to the facility and again on leaving the facility
- Wear a face covering on entering the facility (under 5s exempt) in line with current Scottish Government guidance
- Not touch their face or face covering once in place, wherever possible
- Observe physical distancing (under 12's exempt)
- Avoid eating and drinking whilst visiting wherever possible. If this should occur, visitors should do so whilst physically distanced from any other individuals to allow for removal of face covering. Hand hygiene should be performed before and after consumption of food or drinks.
- Remain in areas demarcated for visiting
7.6 Home leave

Home leave pertains to one prison only. SPS and the local HPT will liaise and develop suitable processes to be put in place.

Two points are highlighted here:

The physical distancing and face covering guidance on NHS Inform must be followed during home leave as for the general public.

Should a resident be identified as a close contact whilst on leave or become symptomatic or COVID-19 positive they must return to the prison and self-isolate as required. SPS will arrange transport for this process.

7.7 Liberations

The SPS has no legal authority to hold an individual past their liberation date. Preparations for release, including with key partners, should be made in advance.

For those who are not a COVID-19 case or close contact standard pre-release planning should be followed.

For those who are a COVID-19 case or close contact and still in isolation, or where there is an outbreak, liaison with key partners and any household setting to which the resident is being released is essential with consent of the resident to disclose such information. Advice should be sought from the local HPT and local authority partners e.g. through convening a case conference.
## Appendices

### Appendix 1 – Contact details for local Health Protection Teams

<table>
<thead>
<tr>
<th>Health board</th>
<th>Office Hours Telephone Number</th>
<th>Out of Hours Telephone Number Ask for Public Health On Call</th>
<th>Health Protection Team Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>01292 885858</td>
<td>01563 521 133 Crosshouse Hospital switchboard</td>
<td><a href="mailto:hpteam@aapct.scot.nhs.uk">hpteam@aapct.scot.nhs.uk</a></td>
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<tr>
<td>Borders</td>
<td>01896 825560</td>
<td>01896 826 000 Borders General switchboard</td>
<td><a href="mailto:Healthprotection@borders.scot.nhs.uk">Healthprotection@borders.scot.nhs.uk</a></td>
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<tr>
<td>Dumfries and Galloway</td>
<td>01387 272 724</td>
<td>01387 246 246</td>
<td><a href="mailto:dg.hpt@nhs.scot">dg.hpt@nhs.scot</a></td>
</tr>
<tr>
<td>Fife</td>
<td>01592 226435</td>
<td>01592 643355 Victoria Hospital switchboard</td>
<td><a href="mailto:fife.hpt@nhs.scot">fife.hpt@nhs.scot</a></td>
</tr>
<tr>
<td>Forth Valley</td>
<td>01786 457 283 Ask for CPHM on call</td>
<td>01324 566000 Ask for CPHM on call</td>
<td><a href="mailto:Fv.healthprotectionteam@nhs.scot">Fv.healthprotectionteam@nhs.scot</a></td>
</tr>
<tr>
<td>Grampian</td>
<td>01224 558520</td>
<td>0345 456 6000</td>
<td><a href="mailto:gram.healthprotection@nhs.scot">gram.healthprotection@nhs.scot</a></td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>0141 201 4917</td>
<td>0141 211 3600 Gartnavel switchboard</td>
<td><a href="mailto:php@ggc.scot.nhs.uk">php@ggc.scot.nhs.uk</a></td>
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<tr>
<td>Highland</td>
<td>01463 704886</td>
<td>01463 704 000 Raigmore switchboard</td>
<td><a href="mailto:hpt.highland@nhs.scot">hpt.highland@nhs.scot</a></td>
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<td>Lanarkshire</td>
<td>01698 858232 / 858228</td>
<td>01236 748 748 Monklands switchboard</td>
<td><a href="mailto:healthprotection@lanarkshire.scot.nhs.uk">healthprotection@lanarkshire.scot.nhs.uk</a></td>
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<td>Lothian</td>
<td>0131 465 5420/5422</td>
<td>0131 242 1000 Edinburgh Royal switchboard</td>
<td><a href="mailto:health.protection@nhslothian.scot.nhs.uk">health.protection@nhslothian.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Health board</td>
<td>Office Hours Telephone Number</td>
<td>Out of Hours Telephone Number Ask for Public Health On Call</td>
<td>Health Protection Team Email</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>Orkney</td>
<td>01856 888034</td>
<td>01856 888 000 Balfour Hospital switchboard</td>
<td><a href="mailto:ORK.publichealth@nhs.scot">ORK.publichealth@nhs.scot</a></td>
</tr>
<tr>
<td>Shetland</td>
<td>01595 743340 (answer phone only) 01595 743060 (Board HQ who will pass on to appropriate PH person)</td>
<td>01595 743000 Gilbert Bain switchboard</td>
<td><a href="mailto:shet.publichealthshetland@nhs.scot">shet.publichealthshetland@nhs.scot</a></td>
</tr>
<tr>
<td>Tayside</td>
<td>01382 596 976/987</td>
<td>01382 660111 Ninewells switchboard</td>
<td><a href="mailto:tay.healthprotectionteam@nhs.scot">tay.healthprotectionteam@nhs.scot</a></td>
</tr>
<tr>
<td>Western Isles</td>
<td>01851 708 033</td>
<td>01851 704 704</td>
<td><a href="mailto:wi.healthprotection@nhs.scot">wi.healthprotection@nhs.scot</a></td>
</tr>
</tbody>
</table>
Appendix 2: Methods

Version 1.0 of this guidance was developed in collaboration with the Scottish Prison Service and NHS health centre managers (via the Prison Care Network/Healthcare Operational Group) through regular guidance working group meetings. During guidance production the working group engaged, via presentations and discussions, with key stakeholders including relevant clinical problem assessment groups (CPAGs), HMIPS, Healthcare Improvement Scotland, SG, HPTs, PHS COVID Response Cell Leads and the Prison Care Network.

Additionally, a ‘lessons learned’ exercise was conducted to assimilate information from documentation collated by PHS in relation to COVID-19 outbreaks in prisons, including minutes of PAG and IMT meetings, reflections of stakeholders involved in these and other relevant correspondence between SPS, SG, HPTs, ARHAI and PHS. This ensured that important learning was considered and key gaps identified when developing this guidance.

Acknowledgements

Public Health Scotland, Scottish Prisons Service, NHS Prison Care Network Healthcare Operational Group, ARHAI Scotland and NHS external peer reviewers.