



Home Office

Guidance for Immigration Removal Centres (IRCs), Residential Short-Term Holding Facilities (RSTHFs) and escorts during the COVID-19 pandemic

Version 7.0

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About this guidance

This guidance tells Home Office staff and supplier staff in immigration removal centres (IRCs), residential short-term holding facilities (RSTHFs), pre-departure accommodation (PDA) and on escort about the principles for managing COVID-19 in places of immigration detention.

Contacts

If you have any questions about the guidance and your line manager or delivery manager cannot help you, or you think that the guidance has factual errors then please email DES DSO mailbox.

If you notice any formatting errors in this guidance (broken links, spelling mistakes and so on) or have any comments about the layout or navigability of the guidance then you can email the [Guidance Rules and Forms team](#).

Publication

Below is information on when this version of the guidance was published:

- version **7.0**
- published for Home Office staff on 14 September 2021 (**v1.0 first published for staff on 5 June 2020 (in force from 5 May 2020), v2.0 published on 7 July 2020, V3.0 published on 17 September 2020, V4.0 published on 30 November 2020, V5.0 published on 27 January 2021, V6.0 published on 19 July 2021.**

Related content

[Contents](#)

Instruction

Introduction

1. This guidance informs Home Office and supplier staff in IRCs, RSTHFs, PDA and on escort of the strategy for managing people in their care and particularly those who may be vulnerable or extremely vulnerable to the effects of COVID-19. The Home Office continue to take the welfare of those detained under immigration powers very seriously and will maintain our position of following relevant Government, Public Health England (PHE) and Public Health Scotland (PHS) guidance on this matter. Where this guidance refers to PHE guidance, in Scotland those references should be taken to mean the relevant PHE or PHS guidance.
2. All operational teams in the Home Office continue to consider PHE advice in relation to their operational activity. The Detention Gatekeeper will have considered PHE guidance in relation to those persons vulnerable to being more seriously affected by COVID-19, alongside Home Office detention policies, as part of any decision being made in relation to the use of immigration detention.
3. This guidance may be updated in line with the changing situation.

Who is clinically vulnerable?

4. For avoidance of doubt, the clinically vulnerable group is identified as per the factors noted in PHE guidance:

- aged 70 or older (regardless of medical conditions)
- under 70 with an underlying health condition listed below (that is anyone instructed to get a flu jab each year on medical grounds):
- chronic (long-term) mild to moderate respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis
- chronic heart disease, such as heart failure
- chronic kidney disease
- chronic liver disease, such as hepatitis
- chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS) or cerebral palsy
- diabetes
- a weakened immune system as the result of certain conditions or medicines they are taking (such as steroid tablets).
- being seriously overweight (a body mass index (BMI) of 40 or above)
- pregnant women

Who is clinically extremely vulnerable?

5. For the clinically extremely vulnerable group, this includes:

- a) Solid organ transplant recipients.
- b) People with specific cancers:
 - people with cancer who are undergoing active chemotherapy
 - people with lung cancer who are undergoing radical radiotherapy
 - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
 - people having immunotherapy or other continuing antibody treatments for cancer
 - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
 - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- c) People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD).

- d) People with rare diseases that significantly increase the risk of infections (such as such as severe combined immunodeficiency (SCID), homozygous sickle cell).
 - e) People on immunosuppression therapies sufficient to significantly increase risk of infection.
 - f) Women who are pregnant with significant heart disease, congenital or acquired.
 - g) Other people who have also been classed as clinically extremely vulnerable, based on clinical judgement and an assessment of their needs. GPs and hospital clinicians have been provided with guidance to support these decisions.
 - h) adults with Down's syndrome
 - i) adults on dialysis or with chronic kidney disease (Stage 5)
6. For the purposes of this guidance shielding and clinically vulnerable/extremely vulnerable refers to people who are at the most heightened risk of severe illness if they contract COVID-19, and who may require shielding for their own protection. Vulnerability is subject to clinical judgement in each case. In the community, shielding ceased from 1 April 2021. However, the opportunity to shield will remain available for vulnerable residents who wish to shield, and IRCs and RSTHFs must maintain the facilities for those with vulnerabilities who request shielding. Residents can shield within an individual room or on a designated unit, however, suppliers must maintain sufficient facilities to accommodate for increasing numbers of people shielding. Even if there are no individuals currently shielding, IRCs and RSTHFs must retain the ability to reintroduce shielding in the event of a localised outbreak, admission of a new individual requiring shielding or change of community guidelines.
7. We have also referred to relevant PHE and NHS guidance for ease in this document but please note this document is subject to change as government guidance evolves and it is strongly recommended that all staff always check and ensure they refer to the latest guidance on COVID-19 from the gov.uk website at: <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19#Clinically>.

[Separate guidance specific to Scotland and Northern Ireland can be found here:](#)

- [Coronavirus \(COVID-19\): shielding advice and support - gov.scot \(www.gov.scot\)](#)
- [Coronavirus \(COVID-19\): guidance for 'clinically extremely vulnerable' and 'vulnerable' people | nidirect](#)

General principles for managing COVID-19 in an IRC and RSTHF

8. We continue to take proactive steps to support our immigration custodial establishments to monitor, manage and mitigate the threat of large numbers of staff and people in detention becoming infected with COVID-19 and to reduce the likelihood of the infection spreading.
9. This document is informed by published Government guidance on COVID-19 and more detailed PHE and NHS England (NHSE) guidance on the management of COVID-19 in places of detention:
<https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance/covid-19-prisons-and-other-prescribed-places-of-detention-guidance>).
10. Additional guidance, specific to Scotland and published by PHS, has also been used to inform the measures taken at Dungavel House IRC: [COVID-19: Information and Guidance for Social, Community and Residential Care Settings \(windows.net\)](#)

Escorting

11. The escort supplier must implement safer systems of work, which explain in clear terms how to reduce the risk of exposure to COVID-19 for both staff and the detained individuals while in transit. Escort staff must wear full PPE when disembarking the vehicle to collect or drop off a detained individual. Whilst on route there is no requirement for the escort staff to wear PPE. Once the escort vehicle is located in the security vehicle yard escort staff will be required to wear PPE. The number of detained people who may be transported by standard escort vehicle, coach or cellular vehicle will be dependent on the capacity of the vehicle and the number of officers required to fulfil escort duties. This must be risk assessed on a case by case basis, taking into account social distancing principles. Facemasks must be issued to detained individuals being moved, and if required they should be guided verbally on how to apply the facemask. Detained individuals under escort must have access to hand sanitiser where hand washing is not available.
12. If a detained individual being moved is displaying signs or symptoms of COVID-19 they must not be moved, and their case referred back to Detention and Escorting Population Management Unit (DEPMU). If an individual displays signs or symptoms of COVID-19 en route to an IRC/RSTHF or port of return the escort crew must return to the point of origin, or transfer the individual to hospital as appropriate (subject to healthcare considerations), contacting DEPMU as soon as possible.

13. If used, PPE for both staff members and detained individuals must be disposed of in designated areas as set out by the escort supplier and in line with PHE guidance. Escorting vehicles will be returned to the vehicle base and the vehicle must be taken off the road until a deep clean has been completed by our specialist contractor.

Partnership working between Immigration Enforcement, NHS England and PHE

14. There should be close working and liaison between the IRC supplier, IRC healthcare provider and Home Office staff and management, ensuring guidance and updates are regularly shared and any updates, or information about incidents or possible cases of COVID-19 are shared and jointly owned.

15. IRC healthcare teams must notify Home Office and local PHE, PHS or Public Health Northern Ireland health protection teams of any confirmed COVID-19 cases among detained individuals as soon as possible.

16. In addition, all parties must ensure PHE guidance is adhered to and PHE are notified immediately of any possible cases of concern and their advice is followed.

17. Health Protection Teams (HPT) will contact PHE's [National Health and Justice Team](#) and [Centre Health and Justice leads](#) in response to cases (possible and confirmed) in the immigration detention estate. The HPT and the National Health and Justice Team will decide whether to declare a formal incident and respond accordingly. This will support efforts across organisations to achieve infection prevention and control following the [national contingency plan for outbreaks in prisons and IRCs](#).

Residential Short-Term Holding Facilities

18. Only non-symptomatic individuals should be accepted into RSTHFs. New arrivals are not routinely separated from the rest of the population although an 'isolation wing' is available should it be required. The full range of facilities usually provided in an RSTHF should be made available.

19. Preferably, detained individuals in RSTHFs should be housed in single occupancy rooms. Those held for short periods for initial asylum screening by UKVI may share rooms with a member of their travel 'bubble'. Room sharing is managed carefully, ensuring only those who have travelled together are sharing rooms. Irrespective of room sharing, social distancing measures must be in place, including distance marks on flooring, tables set apart and only one person seated per table in dining areas. All detained individuals should receive COVID-19 advice as part of their induction to the RSTHF, with requirements around social distancing measures and PPE being clearly explained to them.

Preventative measures to be undertaken

These measures apply to IRCs and, where applicable, to RSTHFs

20. Appropriate guidance must be prominently displayed to ensure staff, detained individuals and visitors frequently wash their hands using soap/hand sanitiser for at least 20 seconds and catch coughs and sneezes in tissues. This should include putting up copies of the Government isolation guidelines in prominent areas.
21. The IRC supplier must produce specific guidance for individuals in detention to explain in clear terms how to reduce the risk of an outbreak of COVID-19, including leaflets for new arrivals containing information regarding handwashing and PHE COVID-19 guidance. Detained individuals should be frequently reminded of the requirements to ensure thorough hand washing and hygiene. Appropriate guidance, translated into multiple languages where possible, must be prominently displayed (both posters and leaflets), and individuals reminded to immediately report any health or symptom concerns as per NHS guidance:

<https://www.nhs.uk/conditions/coronavirus-covid-19/>

22. All cleaning practices must be regularly reviewed by the IRC supplier to ensure they comply with PHE guidance. All IRC supplier staff must frequently clean and disinfect objects and surfaces that are touched regularly. PHE guidance is available at:

<https://www.gov.uk/government/publications/covid-19-decontamination-in-nonhealthcare-settings/covid-19-decontamination-in-non-healthcare-settings>

23. In addition to the standard cleaning processes, detained individuals should be provided on request with appropriate disinfectant cleaning materials for cleaning their bedrooms. IRC supplier staff should ensure that this cleaning takes place under supervision and that all such cleaning materials are safely returned and accounted for.

24. Ventilation in indoor spaces is an important consideration. [DSO 06/2018 \(Accommodation: lighting, heating and ventilation\)](#) sets out the measurable standards for the certification of rooms that can be applied consistently across IRCs, the PDA and RSTHFs. All suppliers will also continue to reference the relevant reports from the Chartered Institution of Building Services Engineers (CIBSE), as referenced in DSO 06/2018, and the extant guidance available when updating their local policies.

25. All IRC suppliers should seek to ensure that social distancing is maintained for areas where people can congregate, including IT rooms, library and classroom seating areas/chair and tables, as well as waiting and reception/discharge areas and appropriate signage should explain the importance of social distancing. Social distancing measures can be relaxed only for those residents who have passed through the 14-day reverse cohorting process and are part of the same bubble.

26. Two individuals not considered clinically vulnerable can share an en-suite room designed for two or more people. Other detained individuals will be placed in single

occupancy rooms with en-suite facilities and are strongly encouraged not to visit each other's rooms. Those held for short periods for initial asylum screening by UKVI may also share rooms with a member of their travel 'bubble'. In such cases, room sharing is managed carefully, ensuring only those who have travelled together are sharing rooms. Access to shared facilities is carefully managed and thorough cleaning regimes are in place.

27. All individuals entering immigration detention are carefully risk assessed and accommodated under the processes set out in [Detention Services Order \(DSO\) 03/2016 Consideration of Detainee Placement](#). In addition it is a legal requirement, following a European court ruling, that any person entering a custodial setting must have a room sharing risk assessment undertaken to consider both the needs of the individual being assessed and any risks around sharing with other residents. Guidance on this assessment process for the immigration detention estate is set out in [DSO 12/2012 Room Sharing Risk Assessment](#).
28. The dining areas and mealtime practices should ensure that adequate social distancing between staff and those in detention, and between detained individuals, can be maintained. This could include measures such as: increasing the number of sittings where there is communal dining; staggered opening of rooms over the different floors on residential units when collecting food; or eating in rooms only rather than at the communal benches/tables on the residential units.
29. Detained individuals are not required to wear face masks, but they should be encouraged to do so when not in their own room and when it is difficult to adhere to social distancing guidelines. This is especially important in reverse cohorting units, with detained individuals (temporarily) based there arriving from a range of different settings, including from the community and other custodial environments where social distancing may not have been possible. Detention notices should be placed in these areas to encourage residents to wear a mask, which should be proactively offered to residents by Detainee Custody Officers. Symptomatic detained individuals should be asked to wear a face mask when outside of their room or when being moved elsewhere in the centre. This is in addition to other measures in place, including for those individuals who are displaying symptoms, or who are at a heightened risk from the virus.

Initial healthcare screening

30. Following prioritisation of detained individuals who appear symptomatic, healthcare screenings of new arrivals must be prioritised in line with the Adults at Risk (AAR) level the individual holds (screenings of those at level 2 and 3 should be conducted first).
31. An initial healthcare screening of arriving individuals should take place on the escorting van by an IRC healthcare representative, using the full range of PPE available (mask, apron, goggles and gloves). Masks should be issued to the individuals being screened and, if required, they should be guided verbally on how to apply the mask. Where possible, the detained individual and staff member

should socially distance from each other, and the staff member must ensure that the detained individual understands what is happening and why at the start of the engagement and throughout.

32. The initial healthcare screening should look to identify people who have healthcare vulnerabilities or conditions that may heighten the risk of them becoming severely ill from COVID-19, in particular those with conditions covered in the lists included in PHE guidance, most recently updated on 14 September -(vulnerable) and 2 December - (extremely vulnerable) (and referenced above in this document):
<https://www.gov.uk/government/publications/staying-alert-and-safe-socialdistancing/staying-alert-and-safe-social-distancing>
<https://www.gov.uk/government/publications/guidance-on-shielding-andprotecting-extremely-vulnerable-persons-from-covid-19>
33. If someone is identified as vulnerable or extremely vulnerable, an IS91RA (Part C) must be completed by healthcare and forwarded via email to the relevant Detention Engagement Team (DET) and DEPMU without delay. The DET will then inform the responsible casework team, who should consider all circumstances around continued detention, including the person's (extreme) vulnerability, and complete a detention review.
34. The initial healthcare screening should also look to identify if any or all of the COVID-19 symptoms are present in the individual (a new, continuous cough and/or high temperature and/or a loss of, or change to, his/her sense of smell or taste). All new arrivals at an IRC will be asked to take a lateral-flow device (LFD) test, administered by the local healthcare team. If an individual does obtain a positive result, or receives a negative test but is displaying symptoms, then the individual will be placed in isolation and a confirmatory polymerase chain reaction (PCR) test will be arranged. In either event, an IS91RA (Part C) should be completed and forwarded via email to the respective DET and the DEPMU without delay. The DET will then inform the responsible casework team who should consider all circumstances around continued detention, including the presence of COVID-19 symptoms, and complete a detention review.
35. Anyone who has travelled with an individual who has tested positive will also be required to isolate, until a negative PCR test has been obtained, or until they have spent the required period in isolation.
36. The initial healthcare screening should ensure any vulnerable or extremely vulnerable individuals or symptomatic individuals are thoroughly assessed. Any concerns should result in individuals being accommodated overnight in separate isolation areas, as referred to later in the document, for examination as soon as practicable by a doctor and ongoing assessment of suitability to join the normal population within the centre. The detained individual should not be allowed to enter or return to normal population until a doctor has conducted this assessment. The person should wear a face mask while being transferred to an isolation room. It is noted that in RSTHFs GP access is not usually readily available. However, if a detained individual presents with COVID-19 symptoms, all efforts must be made to secure a doctor's attendance within 24 hours. If this is

not possible, the case should be escalated to the Head of Escorting Services or Head of Detention Operations. The individual must remain isolated until a decision on their future placement has been made.

37. Healthcare teams should identify and share generalised details of any individual who may have healthcare vulnerabilities or conditions that may cause concern, in particular those with conditions covered in the lists included in PHE social distancing guidance.

<https://www.gov.uk/government/publications/staying-alert-and-safe-socialdistancing> <https://www.gov.uk/government/publications/guidance-on-shielding-andprotecting-extremely-vulnerable-persons-from-covid-19>

38. If healthcare staff deem the individual to be asymptomatic with no healthcare vulnerabilities or conditions that may heighten the risk of them becoming severely ill from COVID-19, business as usual screening should take place by the IRC supplier staff, without the use of PPE as long as the personal distancing guidelines can be maintained at this point.

39. If used, PPE for both staff member and detained individual must be disposed of in designated areas as set out by the Supplier and in line with PHE guidance.

40. Healthcare appointments associated with the possible completion of Rule 35 reports should continue to be conducted in person wherever it is possible to do so. If, however, it is not possible to conduct a face to face appointment because of logistical or other difficulties due to the impact of COVID-19, the reasons for this must be clearly detailed within any ensuing Rule 35 report that may be produced, which should be completed to the best of the healthcare professional's ability to do so. A follow up 'in person' appointment should then be arranged as soon as the reason for being unable to conduct a face to face assessment has been resolved.

Ongoing Monitoring and Reporting of cases

41. The Home Office has established a single, comprehensive COVID-19 vulnerable individual spreadsheet that is used and updated weekly with regard to those cases that remain in detention, including those who are detained in prison as Immigration Cases either awaiting transfer to the detention estate or who are considered not suitable for Immigration detention, and who fall into the COVID-19 PHE risk categories.

42. All IRC supplier and Healthcare staff should record the presence of any vulnerability factors, as set out in PHE's guidance, which are likely to influence a change in the individual's Adult at Risk (AAR) rating in the form of an IS91RA (Part C), which should be completed and forwarded via email to the relevant DET and DEPMU teams without delay. The DET will then inform the responsible casework team who should consider all circumstances, including the supplementary AAR guidance which refers to PHE guidance around continued detention (<https://www.gov.uk/government/publications/adults-at-risk-inimmigration-detention>), and complete a detention review.

43. All new cases who fall into COVID -19 PHE risk categories should be submitted to respective DET who will forward to the relevant Detained Casework Teams. In addition, the DET team will liaise with the DET SPOC to ensure the details are included in the weekly central return.
44. If the individual remains in detention, they should be placed into isolation as a protective measure and this is detailed later in the guidance.
45. Where healthcare staff identify any person, who has healthcare vulnerabilities or conditions that may cause concern, particularly those with conditions covered in the lists included in the latest PHE social distancing guidance, then an IS91RA (Part C) should be produced. Where the individual's vulnerability is considered high DET will inform the responsible casework team and continued detention will be reviewed, as referenced in DSO 08/2016 (management of adults at risk in detention). All those falling within either of the PHE vulnerabilities lists should be considered as being AAR Level 3 cases for the purposes of assessing detention.
46. If an individual who is identified as having a COVID-19 vulnerability (clinically vulnerable or clinically extremely vulnerable) is not to be released, or if they are being detained pending such a release, appropriate steps must be taken to reduce contact between that person and others (staff and other detained individuals) in accordance with the PHE guidance. This should include ensuring that these individuals are accommodated in single occupancy rooms as set out below. These detained individuals should be given a face mask to wear and should be encouraged to wear it when out of their room.
47. As part of preparations for release the DET should ensure that people returning to the community understand the actions required of them once in the community to reduce risks from COVID-19, including knowledge of [social distancing](#) and self-isolation measures to take if they are in a [clinically extremely vulnerable group](#). Where individuals are being released to asylum accommodation it is imperative that information in relation to COVID 19 is passed to UKVI and the accommodation provider by the local Home Office team responsible to ensure that they are aware of any isolation requirements and are able to provide the correct guidance to individuals.
48. Where applicable, the local HPT must be made aware of any cases or close contacts of known cases that are being released into the community (particularly those with no fixed abode) before completing a full period of protective isolation upon release, for example at least 10 days for cases or 10 days for close contacts. The relevant Local Authority must be made aware of any cases or close contacts of known cases with no fixed abode by the local healthcare team.
49. Where appropriate, probation services and approved premises/hostels should also be advised by the DET and/or caseworker to facilitate appropriate self-isolation if the person is symptomatic or has had a positive test for COVID-19, or has had contact with a confirmed case.

Cohorting the IRC to reduce the risk of COVID-19 spreading through IRC establishments and to minimise the risk of new receptions bringing COVID-19 into the IRC estate, all IRC suppliers are to follow a reverse cohorting process outlined below.

50. IRCs operate a 'reverse cohorting' process to mitigate the risk of COVID-19 spreading through other IRC establishments. This is comparable to that operated by Her Majesty's Prison Service. This means that after initial health screening newly detained people are housed in a dedicated area or wing with other new arrivals where they remain for 14 days without contact with the rest of the population. After this period, they are then relocated to other parts of the IRC. Should anyone within this cohort become symptomatic they will be isolated pending testing and no new arrivals will be admitted to that unit and all relevant PHE guidance is followed.
51. Should COVID-19 infection occur in these cohorts either during the week of arrivals, or in the following week, that group will need to be further isolated and the infection dealt with in line with PHE handling advice, with the symptomatic individual placed in isolation for 10 days. This may be deemed an outbreak and could trigger a formal outbreak response, which will be decided by PHE or PHS, in consultation with the Home Office, supplier and local healthcare team.
52. Transfers between centres will be kept to a necessary minimum, in the interest of risk reduction. Any proposed exceptions in instances of need, must be agreed in advance by the Head of Detention Operations.
53. Those individuals arriving in an IRC from residential STHFs should be included within the above reverse cohorting arrangements. Northern Ireland prison moves will continue to go into Larne STHF before being transferred to Dungavel IRC. Manchester STHF will continue to operate as normal, with transfers from there to go to the rotating IRC that is taking receptions.
54. Any receptions from locations other than prison should be included within the reverse cohorting process. However, thorough risk assessment by the IRC supplier on reception should seek to identify any issues of concern that such an individual may experience living within that group. If that assessment indicates that such an individual would be uncomfortable within this group, the IRC should identify alternative arrangements which are consistent with the reverse cohorting principles.

55. Each IRC should create designated areas/units for the protection of specific cohorts within their population. We therefore instruct all to utilise the following cohorting guidance:

Name	Description
Reverse Cohort Unit (RCU)	<p>Unit for the temporary separation of newly received individuals for 14 days each; allowing the IRC to verify that each individual does not present an infection risk.</p> <p>If a detained individual shows symptoms during this time, they should be moved to isolation for 10 days. This should be in a discrete unit/wing/area and there should be a limited on-wing regime with social distancing rules applied. If detained individuals are unable or unwilling to maintain social distancing, then removal from association (under rule 40) should be considered.</p>
Protective Isolation Unit (PIU)	Unit or area for the temporary isolation of symptomatic individuals for up to 10 days.
Shielding Unit (SU)	Unit or area for the temporary isolation of those individuals within the PHE extremely vulnerable or, as per para 6, vulnerable persons cohort, reducing the likelihood of these susceptible groups contracting the virus.

56. The locations of these units are local decisions and it is essential that the healthcare provider at each IRC takes the lead in decisions relating to each individual case in terms of referral and discharge of these detained individuals to and from the units.

New Cases

57. Outside of the process in place for new arrivals, those with a new, continuous cough and/or a high temperature and/or loss of, or change to, his/her sense of smell or taste should be placed in protective isolation for 10 days; housed on a separate wing or separated area with no contact with the general population. Individuals displaying symptoms will be asked to take a PCR test, as will any resident they may have been in contact with. If a negative result be obtained an individual can return to normal association, before the ten-day isolation period ends (with the approval of the local healthcare team). For RSTHFs, where detained individuals cannot be accommodated for over 5 days (unless removal directions are set) and an individual is identified as being within this group, the case is to be escalated to the Head of Detention Operations for potential transfer to an IRC for isolation or next steps.

58. Even though shielding in the community is currently paused, those in detention with healthcare vulnerabilities or conditions that may heighten the risk of them becoming severely ill from COVID-19 may be isolated if possible and practicable. IRC suppliers should explain to detained individuals why they are being asked to relocate, be encouraged to do so for their own safety and be advised that, if they refuse, they can change their mind at any time. Suppliers should seek signatures on disclaimers from people in the vulnerable groups that refuse to comply with the request to relocate for shielding purposes. This will need to evidence that the option of shielding was offered and fully record where individuals do not wish to take up this offer and for what reason.
59. Regular assessment should be made by healthcare staff and any individuals continuing to deteriorate or show substantial COVID-related symptoms should be kept as separate as possible from those considered only mildly affected or seemingly improving.
60. If necessary, separate areas should be used for this. Additionally, care should be taken not to house new cases with those that have already been separated for some days and are not showing ongoing signs as set out in PHE guidance to further mitigate the spread of COVID-19.
61. Those in detention who have a new, continuous cough or a high temperature or loss of, or change to, their sense of smell or taste but are clinically well enough to remain in the IRC following thorough assessments by Healthcare staff do not need to be transferred to hospital.
62. Staff should wear specified PPE for activities requiring sustained close contact with symptomatic cases. Staff should practise social distancing and everyone in the IRC should be routinely reminded of the importance of this. Suppliers should, where possible, avoid cross deploying staff between areas in which separate cohorts are accommodated.
63. IRC suppliers must draw up plans in partnership with local health teams to (wherever possible) minimise contact between symptomatic people with underlying conditions and those who are symptomatic but without underlying conditions. This could include the use of different landings or areas of a unit.
64. IRC suppliers, with input from local Home Office managers, should consider removal from association of those individuals who ignore advice and either recklessly or deliberately endanger other individuals in detention and staff. Any such action must be taken in accordance with DSO 02/2017 on Rule 40/42. For the avoidance of doubt, removal from association would only be justified/needed if the level of non-compliance warrants it. For example, an individual in isolation who refuses to see Healthcare staff and makes it clear verbally that he/she does not want to stay in their room but takes no other action in that respect would not be providing grounds to be considered for removal from association. Alternatively, an individual who actively resists their continued isolation, attempts to push out of the

door whenever it is opened, tries to assault staff or causes damage to the room should be considered for removal from association.

Short Term Holding Facilities

65. STHFs should only accept non-symptomatic individuals. New arrivals will not be routinely separated from the rest of the population, although an 'isolation wing' should be made available if required (for people developing symptoms or arriving from facility with confirmed COVID-19 outbreak). Should an individual become symptomatic while at the STHF they should either be taken to hospital or their case should be discussed with the Head of Detention Operations for a potential move to an IRC, as appropriate in the particular circumstances of the case concerned.

Regime for detained people in isolation or shielding units

66. Those in detention identified for accommodation in the isolation unit should not have access to the IRC's general regime. Access to an on-unit regime should be provided instead, to the extent that this is practicable. Outreach services from welfare and World Faith should be offered by telephone and / or by skype, where practicable. Those individuals who are shielding should have comparable regime access to individuals detained in normal accommodation.

67. Those detained in isolation or shielding units should be offered the option of requesting DVDs, books, and console games from normal regimes.

68. In terms of shop access, shop purchases should be offered to people on these units. This can be completed on a shop order which IRC supplier staff can collect on behalf of the detained individual.

69. All IRC suppliers are asked to ensure that they undertake an Equality Impact Assessment (EIA) for each substantial regime change that is approved by the onsite Home Office Delivery Managers. This is part of the Public Sector Equality Duty (PSED) introduced by the Equality Act 2010.

70. The HO Delivery Managers are to then share all PES documents with the Head of Detention Operations.

Visitors

71. The provision for social visits to take place has been reintroduced in a carefully controlled and risk-assessed way. However, social visits may be curtailed in the event of an escalation in control measures at a local, regional or national level. Where visits take place, they will follow wider PHE guidance for prisons and places of detention including social distancing measures and regulations around the use of PPE/face coverings:

[Preventing and controlling outbreaks of COVID-19 in prisons and places of detention - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/guidance/preventing-and-controlling-outbreaks-of-covid-19-in-prisons-and-places-of-detention)

72. All staff and visitors to IRCs and STHFs will be required to wear a face mask, at all times, when undertaking direct contact with those detained and when in the main centre. These are in addition to other protective measures already in place. If a visitor cannot wear a mask for health reasons, they can still be permitted access to the main centre or holding facility but only to areas where they can reasonably be expected to socially distance.
73. Testing arrangements are now in place for all visitors to IRCs, who will be asked to take an LFD test on arrival and obtain a negative result before being granted entry into the main facility.
74. Legal visits can continue alongside other means of contact (video conferencing, telephone and email). Suppliers must have safe systems of work in place for face to face legal visits.
75. Detained individuals can request an additional £10 phone credit each week and continue to have access to the internet, mobile phone services and video calling facilities to ensure individuals are able to contact legal representatives and family.
76. Arrangements for external medical practitioners to attend IRCs for the purpose of conducting medico-legal, or other formal medical examinations will be permitted. Requests should be made in writing to the relevant IRC. Visiting medical professionals will be required to observe, for the purposes of consultation and examination, all reasonable precautions to prevent COVID-19 infection.
77. Handwashing facilities should be available for **all** visitors and they should be advised of the requirements to wash their hands and maintain social distancing as per PHE guidance and relevant safe systems of working. Where practicable, all visitors should be asked to have their temperature checked as part of the process of being granted access to the IRC/RSTHF.

Staff

78. Staff should be conscientious when attending work and if they are unwell, with a new continuous cough, a high temperature or loss of, or change to their sense of smell or taste, they should not travel to work and self-isolate in line with Government guidance for the general population.
79. Regular staff testing arrangements are in place at all IRCs and RSTHFs, which involves staff taking an LFD test and obtaining a negative result before being granted entry to the main facility, and PCR testing.
80. COVID-19 vaccinations are at the centre of the Government's plan to ensure life can return to normal as soon as possible. The [COVID-19 vaccination programme](#) is being delivered to all adults in England and staff and residents across the estate (including Scotland) are encouraged to get fully vaccinated, with on-site provision available for residents in our IRCs for this purpose. Vaccinations

in IRCs are administered by the NHS, or other commissioned healthcare service providers.

81. If a member of staff becomes unwell on site with a new, continuous cough or a high temperature or loss of, or change to, his/her sense of smell or taste, they should go home and self-isolate in line with Government guidance for the general population.
82. Any member of staff who lives in a household where someone is unwell with symptoms (see paragraph 84 below), should be sent home and they should arrange to have a [test](#) and follow the [Stay at home guidance](#).
83. All staff and visitors in IRCs and STHFs will be required to wear a face mask, at all times, when undertaking direct contact duties with those detained and when in the main centre or holding facility. These masks must be at the Type IIR (FRSM) standard. These are in addition to other protective measures already in place.
84. Staff forums and notices to staff should remind staff to be vigilant and to immediately engage healthcare should any detained individual show symptoms or complain of feeling unwell.
85. Non-operational staff should work in separate areas from detained individuals.
86. Testing for COVID-19 is now available and staff should use the gov.uk self-referral portal <https://self-referral.test-for-coronavirus.service.gov.uk/>

when they meet the below criteria:

- you have a high temperature
- you have a new, continuous cough
- you've lost your sense of smell or taste or it's changed
- you've been asked to by a local council
- you're taking part in a government pilot project

You can also get a test for someone you live with if they have symptoms.

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