Ministry of Justice

HM Prison & Probation Service

Policy Name: HMPPS Control of Communicable Disease Policy Framework

Issue Date: 2 October 2025 **Implementation Date:** 2 October 2025

Replaces the following documents which are hereby cancelled:

- HMPPS Interim Pandemic Flu PF; and
- Interim Compartmentalisation & Isolation Policy Framework.

Introduces amendments to the following documents: N/A

Action required by:

☒	HMPPS HQ	☒	Governors
☒	Public Sector Prisons	☒	Heads of Group
☒	Contracted Prisons	☒	Youth Custody Estate
	The Probation Service	☒	Women's Estate

Mandatory Actions: All groups referenced above must adhere to the Requirements section of this Policy Framework, which contains all mandatory actions.

Governors, Directors and Managers must ensure that any new local policies that they develop because of this Policy Framework are compliant with relevant legislation, including the Public Sector Equality Duty (Equality Act, 2010).

This is an update to two earlier interim Policy Frameworks[1] and provides for a comprehensive guidance document for the management of communicable disease, informed by infection control and communicable disease outbreak management experts.

How this Policy Framework will be audited or monitored:

Compliance with this instruction will be monitored via;

- PGDs and governors who will monitor compliance with requirements set out within this policy framework at their sites.
- In contracted custodial settings, policy monitoring, audit and assurance will be via standard custodial contract management arrangements.

Resource Impact:

There will be minimal resource impact as sites already must have contingency plans in place for the management of communicable disease, reviewed annually.

[1] HMPPS Interim Pandemic Flu Policy and HMPPS Interim Compartmentalisation and Isolation Policy

Public Health guidance for communicable disease control and response in prisons and other prescribed places of detention is published at this link:

Public health in prisons and secure settings - GOV.UK

- **To note - guidance in Wales may differ from that being used in England. Further information for Wales can be found at:**

phw.nhs.wales/topics/the-communicable-disease-outbreak-plan-for-wales1/

Where not indicated, all references to Governors should be read as reference to Prison Governors and Directors of Contracted Prisons and YOIs.

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Approved by OPS for publication: Helen Judge, Chair, Operational Policy Sub-board, September 2025

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1. Purpose

1.1 The purpose of this policy is to support the safety and wellbeing of all people in prison including staff, visitors, and directly employed employees/contractors. It sets out measures which control the transmission of communicable diseases.

1.2 The policy further provides Governors, and Directors of contracted prisons, with an understanding of how to manage an outbreak of communicable disease and serves to cross reference guidance on infection control, Personal Protective Equipment (PPE), isolation and compartmentalisation, contact tracing, the need (where applicable) for testing requirements and the management of those who are immunosuppressed,[2] via Personal Management Plans.

2. Definitions

2.1 An **Outbreak Control Team (OCT)** or **Incident Management Team (IMT)** is a multi-agency team led by a public health professional and is established to investigate or manage a health incident or outbreak consistent with published public health guidance for prisons and places of detention.

2.2 **Reverse Cohorting** is the temporary separation of people newly received to prison from court/general population, to reduce the risk of the introduction of communicable disease and transmission risk to all the people present in an establishment. The length of any separation should be in accordance with HMPPS guidelines and public health advice. Prisoners may be reverse cohorted alone, or in a group with other prisoners.

2.3 **Protective Isolation** is the temporary isolation of people in prison who are symptomatic for and/or known to be infected with a communicable disease, and who present a risk of infecting others (which can be mitigated by isolating the person).

2.4 **Personal Management Plans** build on the concept of protecting those who are vulnerable and/or immunosuppressed and are therefore at heightened risk of serious illness were they to contract an infection. They take the form of a mutually agreed isolation and support plan, bespoke to the individual, based upon their medical needs and risks presented.

2.5 **Contact tracing** refers to the process of establishing all those who may have been in contact with a person who has contracted a communicable disease/illness and where applicable, can be followed up by testing and isolation/compartmentalisation. The definition of what constitutes a contact can vary depending on the disease in question and HMPPS will be guided by UKHSA/ Public Health Wales guidance/advice in this regard.

3. Scope of Application

3.1 The advice and range of measures contained and referenced in this policy are to be applied in the management of outbreaks of communicable disease/illness in conjunction with best practice issued by public health professionals, and where applicable, in conjunction with directed actions defined by Outbreak Control and Incident Management Teams.

[2] Having a weakened immune system. People who are **immunosuppressed** have a reduced ability to fight infections and other diseases.

Protective Isolation and Reverse Cohorting may be applied as a control measure for any communicable disease provided that:

- The communicable disease, or suspected disease, is transmissible by close contact between people and may present significant risk to human health and
- Public health guidance, or advice from a public health professional support isolation as an effective control measure to manage the suspected or confirmed disease and / or
- A healthcare professional advises isolation for an individual or group of people as an appropriate disease control measure.

3.2 When supported by advice, Protective Isolation and Reverse Cohorting controls may be applied by a Wing Manager or other suitable member of staff acting with the authority of the Governor, provided that the application is consistent with published or circulated public health guidance. If immediate advice is not available from a public health or healthcare professional, advice from a Health Protection Team or the UK Health Security Agency (UKHSA) / Public Health Wales should be sought straight away. **Governors should ensure that all senior leaders in the prison are familiar with the procedure for contacting the local UKHSA/Public Health Wales team for advice.**

3.3 Protective Isolation and Reverse Cohorting controls **must not** be applied for purposes other than communicable disease control. In other cases, PSO 1700 Segregation, Special Accommodation & Body Belts applies. Segregation: PSO 1700 - GOV.UK

3.4 The use of personal management plans for the immunosuppressed and those particularly vulnerable is strongly advised, particularly in the event of an outbreak of communicable disease.

3.5 Contact tracing and the use of testing will be undertaken largely on the recommendation of Public Health professionals and or OCTs and IMTs. Their use will also be governed by the type of illness/disease and its transmission route and capability for cross infection.

4. Outcomes

4.1 This policy provides Governors with:

- an understanding of procedures, processes and best practice to minimise onward transmission of disease, in support of operational guidance issued by HMPPS.
- Standardised processes to maximise appropriate isolation and protect wellbeing during isolation.
- Guidance on how to enable the best care for prisoners and staff who have become infected with communicable disease.
- Understanding of the principles to help manage and control an outbreak.
- Knowledge of how to align infection control practices with current guidance and best practice during an incident or outbreak of communicable disease.

5. Evidence

The Impact of communicable disease on Prisons

5.1 Prisons are vulnerable to the risk of significant and potentially serious outbreaks of communicable disease, in particular respiratory infections because:

- Large numbers of individuals live in close proximity, with a high degree of social mixing.
- The population is constantly turning over with admissions, discharges and transfers and unidentified risks may be brought into establishments.
- Prison populations have a higher prevalence of underlying medical conditions, including respiratory illness, than their peers in the wider community. For example asthma, immunosuppression (e.g. due to HIV infection) and other chronic illness, such as chronic liver disease due to Hepatitis C.
- It is therefore possible that many prisoners are likely to experience complications of infection from an outbreak of infectious communicable disease.
- It is important when managing communicable disease outbreaks that potential single cases and outbreaks are identified early so that immediate steps can be taken to prevent the spread of illness.
- It will not be possible to keep communicable diseases out of prisons if they are circulating in the wider community given the high turnover in the prison population and the movement of staff between community and prison settings. The strategy is therefore to mitigate the spread of disease and take steps to mitigate against severe outcomes.
- It is possible that the spread of seasonal outbreaks and even new pathogens will not be uniform throughout the prison estate, neither in caseload, nor in timeline. Therefore, at any specific time, some prisons could experience a high number of cases, whereas others could have few, or perhaps no, cases. It is also possible that at any one time, most, if not all, of the prisons in England & Wales could have cases and so, in extreme circumstances, the scope for moving people around the estate to avoid infection could become very limited, or require estate wide contingencies.

5.2 Governors should also be aware that there is extensive evidence[3] of an association between lower Time Out of Cell and time in Purposeful Activity and worse mental health outcomes and higher risk of suicide and therefore restrictions to prisoner location and activities need to be balanced based upon risk assessment. Where restrictions are necessary, in-cell activity should be provided.

6. Requirements

Planning and Preparedness

The Multi Agency Contingency Plan for the Management of Communicable Disease

6.1 All prisons are required to have a written Multi Agency Contingency Plan for the Management of Communicable Disease based on the UKHSA template which can be found at Management of incidents and outbreaks of communicable disease in secure settings in England - GOV.UK (www.gov.uk)

- The Multi Agency Contingency Plan (MACP) provides planners with useful guidance and templates for use in health surveillance/contact tracing.
- The MACP, once completed, should contain bespoke detail for the prison which should assist in identifying actions to manage their highest risk people.
- The MACP should also include detail for any business continuity requirement which might arise.
- Plan owners must ensure that their MACP clearly identifies the enablement of Infection control processes for example, maintaining stocks of bleach-based

[3] Prison Reform Trust report 2021, House of Commons Justice Committee Fifth report 2021 – 2022, Mental Health in Prisons

products and detergents, good hand hygiene practices including sanitisers and enhanced cleaning regimes (and plans for enablement).

- MACPs should also contain instruction on the effective deployment of suitable PPE compliant with and as directed by Public Health professionals

Routes of Transmission:

- MACPs should recognise the five primary routes of communicable disease transmission and allow for different approaches in infection control and PPE usage as advised by UKHSA (and by default) HMPPS Health and Safety guidance:
  1. Respiratory (including droplet and aerosol)
  2. Vector-borne (mosquitoes, ticks, sandflies and more)
  3. Contact (touch)
  4. Oral (food and water)
  5. Sexual or blood (including mother to child transmission)

- During an outbreak there may be indirect health and safety issues e.g. the redeployment of staff to unfamiliar tasks, caused by exceptional circumstances/staff shortages. MACPs and associated risk assessments must be used as a basis for ensuring the proper controls are in place in these circumstances. All decisions must conform to current Health & Safety Legislation.
- MACPs must include the name and contact details for the Local Resilience Forum (LRF) in their region and also for (LRF) emergency planning teams (out of hours contact details).
- MACPs must be self-sufficient, must not rely on prison staff assistance from outside the establishment during the outbreak and must be designed to meet the reasonable worst-case scenario (RWCS). Governors and Directors must plan for the possibility that there may be high levels of prisoners and staff becoming clinically ill over the period of the outbreak and (in extreme cases) for possible fatalities among prisoners and staff.

The Compartmentalisation and Isolation Policy

6.2 All prisons and YOIs must have a local written isolation policy prepared and agreed with local healthcare service providers, (For England NHS England Commissioners, NHS Health and Justice Public Health regional leads and the local UKHSA and for Wales Public Health Wales and local NHS Health Boards). The Isolation Policy must be consistent with national guidance for infection control. Recognised Trade Unions should also be consulted.

6.3 The establishment Isolation Policy, procedures and processes should be reviewed at least annually as national public health guidance may vary dependent on prevalent diseases at the time. It should also be reviewed in response to any local public health incidents which may occur.

6.4 The establishment Isolation Policy must be applied consistently with this Policy and associated guidance on reverse cohorting, contact tracing and testing for communicable diseases, as directed by an IMT/OCT/Consultant in Public Health. The Isolation Policy should also include arrangements for the implementation of Personal Management Plans (PMPs) for managing the Immunosuppressed and those at clinical risk.

6.5 Governors and Directors of Contracted Prisons must nominate a local SPOC for communicable disease management, with contact details provided to Health@justice.gov.uk (and shared with Local Health Protection Teams and other Health & Justice Partners) Oversight of the role should be at SMT level.

6.6 Governors and Directors must prepare risk assessments to protect workers who encounter infectious micro-organisms, in the course of their duties. These preparations should also take account of the levels of PPE required for staff involved.

Data Management

6.7 Information on Communicable Disease cases and contacts (including staff) can be shared with Public Health Partners (in accordance with the Data Sharing Agreement between HMPPS, UKHSA and PH Wales (published 2024)). This should only include personal information that is essential for controlling the spread of disease, for example by contact tracing. Retention and control of said data must be strictly in accordance with standing instructions/policies relating to data sharing and security as stipulated in the agreement. Where requested by an OCT/IMT, potential contacts of an infectious disease case must be identified by the prison and shared with the OCT/IMT to reduce the risk of spread and to identify further potential cases.

6.8 The Governor retains overall responsibility for data protection within their establishment and must ensure data is managed throughout the contact tracing process in accordance with the Data Protection Act 2018, General Data Protection Regulation (GDPR) and HMPPS Data Sharing Agreement.

7. Response to an incident or outbreak

7.1 Where an incident or outbreak of communicable disease is suspected or confirmed, the Governor or Director of Private Prison should activate their Local Outbreak Management Plan. They should ensure that UKHSA local HPT are informed (at the earliest opportunity) who will arrange for an OCT/IMT to be held if appropriate. It is critically important that the Governor or nominated member of their Senior Management Team attend any OCT/IMT meeting called in response to an incident/outbreak of communicable disease.

The relevant sections within the Multi Agency Contingency Plan for the Management of Communicable Disease in Prisons and Places of Detention should be completed by the Governor and the UKHSA Consultant in Health Protection leading the OCT or IMT. This will provide key assessment information for the meeting discussion.

Guidance and relevant annexes can be found at:
Management of incidents and outbreaks of communicable disease in secure settings in England - GOV.UK

Wales guidance can be found at:
https://phw.nhs.wales/topics/the-communicable-disease-outbreak-plan-for-wales1/

7.2 During the outbreak, Governors/Directors must ensure that:

- All IMT and OCT meetings are attended by a member of their senior management team, or delegated senior manager
- Outbreak plans and roles and responsibilities are reviewed, to ensure they are resilient enough to reflect the risk identified, particularly in the case of widespread infection.

- Resources are made available to support every effort to contain the spread of the illness, including timely contact tracing of potential staff and prisoner cases as requested.
- They ensure sufficient resources are available (such as in cell activity) to support prisoners on ACCT or at risk of self-harm, on the basis that for many, the risk of self-inflicted injury could increase due to prolonged periods in cells.
- They agree and communicate a plan for how Family Contact Services will be maintained.
- Adjustment is made to meet the needs of those with protected characteristics under the Equality Act 2010, where there may be differential impacts for any of these groups (e.g. based on age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation).
- They must ensure infection control policies and protocols are implemented, as directed by an OCT/IMT.
- Staff and prisoner wellbeing is considered in all decisions made by the OCT/IMT

7.3 In extreme cases of communicable disease outbreak, unless directed otherwise, Governors/Directors must ensure that only those prisoners who are delivering a key essential service continue to go to work.

Prisoner and staff compartmentalisation and isolation

7.4 In order to mitigate risk and ensure that all are kept as safe as possible, prisoners who are assessed as being at risk of infecting others with a communicable disease (which can be mitigated by isolating the prisoner) should be isolated from others, as directed by an OCT/IMT, in accordance with public health or clinical advice. In the event of a prisoner being unwilling to isolate, it is appropriate for HMPPS to enforce isolation.

7.5 This Policy Framework provides for the application of “Reverse Cohorting” and “Protective Isolation”. The application of Reverse Cohorting can be either made nationally, or at an establishment level based upon risk.

7.6 Protective Isolation requirements must be applied on the advice of a qualified healthcare professional, or public health specialist, for individuals with suspected or confirmed infection with communicable diseases, the spread of which can be mitigated by isolating the prisoner. It should be noted that this requirement may also be applied in exceptional circumstances, strictly on the advice received from UKHSA/ PH Wales for those who are immuno-suppressed.

7.7 Reverse Cohorting requirements may be applied only if:

- The measure is advised by a public health specialist (Health Protection Teams/UKHSA) and
- The measure is guided to be applied by HMPPS Headquarters or
- The measure is agreed to be applied by a Governor or Prison Group Director on a risk-based approach, provided that decision making on application has been delegated from Headquarters.

7.8 Recovery – Outbreak Management Plans must outline strategies and process for restoring staffing levels, associated regime delivery and recovery of normal operations.

8. Communicable Disease Contact Tracing

8.1 It is the role of the OCT/IMT/UKHSA HPT to decide whether contact tracing is required, to define what constitutes a contact specific to that incident, how this will be assessed, and to advise what actions need to be taken once a contact is identified.

8.2 Responsibility for identifying contacts will depend on the contact definition and which organisation holds, or is able to obtain, the relevant information. In circumstances in which the contact definition is based on time spent in a shared space, the Governor or Director will have lead responsibility for identifying contacts within the setting.

8.3 Settings should keep accurate records about shared accommodation (for example, cells, bedrooms or dorms) and opportunities for close contact (for example, work, religious activities, social activities and visiting) in order to enable effective contact tracing. This should also include information regarding potential staff contacts.

8.4 Where identification of a contact requires information best obtained by other organisations, they would take lead responsibility (for example, healthcare staff are likely to be best placed to identify sexual contacts).

8.5 The timeframe for completing contact tracing will vary by infection to ensure preventative measures can be delivered in time, for example post exposure prophylaxis or immunisation. The HPT will advise Governors or Directors of the exact timeframe required. **To support preparedness, Governors should be confident they can stand up and undertake contact tracing within 48 hours when devising local plans.**

8.6 Responsibility for the actions taken once a contact is identified will depend on the action required. The Governor or Director will be responsible for implementing actions within their remit (for example, isolating contacts or restricting movements) and healthcare will be responsible for implementing actions within its remit (for example, vaccination or provision of post-exposure prophylaxis for prisoners).

Guidance on contact tracing can be found in the UKHSA and Public Health Wales documents.

Management of incidents and outbreaks of communicable disease in secure settings in England - GOV.UK (www.gov.uk)

phw.nhs.wales/topics/the-communicable-disease-outbreak-plan-for-wales1/

9. Testing

9.1 For isolated cases, initial testing will be conducted by the commissioned Healthcare Service Provider' on identification of patient symptoms. In an outbreak situation, it is the role of the IMT/OCT to decide whether wider scale testing is required, specific to the disease identified[4].

[4] Revised guidance for Covid 19 Testing was issued April 2024 COVID-19: testing from 1 April 2024 - GOV.UK

Infection Prevention and Control (IPC) Measures/Actions

10. Prisoner and staff compartmentalisation and isolation

10.1 Prisoners may be isolated in any available accommodation including the cell or room occupied before isolation. Healthcare and public health professionals may determine that isolation in the existing cell location is the most appropriate option. In these cases, appropriate risk assessments must be in place to manage any risk of transmission in accordance with PSI 37/2015 (Health and Safety Arrangements for Risk Assessment).

10.2 If numbers requiring isolation are (or may become) large, a dedicated unit may be established. Any area or accommodation used for the isolation of prisoners in such a unit and all activities therein, must be fully risk assessed in accordance with PSI 37/2015 (Health and Safety Arrangements for Risk Assessment) following consultation with healthcare and public health professionals and recognised trade unions/staff associations (for which reasonable facility time should be provided) and be compliant with all HMPPS SOPs in place at the time.

10.3 Isolation of any individual must always be for the minimum period of time consistent with public health or clinical advice and guidance and **must not exceed 14 days duration** for any individual episode of isolation (unless a longer isolation period is required by an HMPPS Public Health Notice)

10.4 If advice is received to extend isolation of an individual beyond 14 days, or if isolation is expected to last beyond 14 days from the outset, then procedures and safeguards for separation must be followed as set out in PSO 1700 (Segregation, Special Accommodation and Body Belts). The only exception to this is where a HMPPS Public Health Notice requires isolation for longer than 14 days. In these cases:

- The isolation must be reviewed by a Governor on day 14 and
- The procedures and safeguards for separation must be followed as set out in PSO 1700 Segregation, Special Accommodation & Body Belts if isolation is to last beyond the period authorised by an HMPPS Public Health Notice.

10.5 People showing symptoms of disease should be isolated in a single cell wherever possible. If a single cell is not available, where necessary, cases confirmed to have the same illness/disease may share a cell.

10.6 Protective Isolation may also be required for individuals who are identified contacts of a person known, or suspected, to have a communicable disease. Public health advice and associated HMPPS guidance will set out details of the application of protective isolation for contacts, how contacts are identified and any testing arrangements which may mediate the requirement for isolation.

10.7 Open establishments and/or those with shared accommodation who are unable to physically restrict access, may wish to restrict movement through a local rule or compact. However, if an individual does not consent to isolation, the authorisation processes that apply in closed establishments as set out in the HMPPS Cohorting & Compartmentalisation Guidance must be applied – further details and templates can be found at:
https://assets.publishing.service.gov.uk/media/62a1ca8fe90e070395bb3e94/compartmentalisation-guidance.pdf
compartmentalisation-guidance.pdf

Authority to isolate prisoners

10.8 Under Prison Rule 45 and YOI Rule 49 Governors can remove prisoners/young people from association with other prisoners/young people where doing so is desirable for the maintenance of good order or discipline, or in their own interests. The initial period of removal can be up to 72 hours. Removal for more than 72 hours may be authorised by Governors in writing, who may then authorise a further period of removal up to 14 days if required. Where isolation is required for more than 14 days by a Public Health Notice, a review must take place and removal for more than 14 days must be authorised by governors in writing. Leave of the Secretary of State in writing is required to authorise removal for a total period of more than 42 days. In deciding whether to authorise removal for more than 72 hours, the governor must fully consider any recommendation from a healthcare professional for the prisoner to resume association.

10.9 In the context of communicable diseases, Prison Rule 45 and YOI Rule 49, give powers to remove people in prison from association where doing so is desirable to prevent the spread of disease, given that the spread of disease in prison undermines good order and discipline. Removal from association means that the prisoner or young person has no association with other prisoners/young people. This may occur in protective isolation or reverse cohorting.

10.10 In the application of this policy, the Governor's authority is constrained by the requirement to seek and give due regard to the advice of a qualified public health professional or a healthcare professional. Where such advice is not immediately available the Governor has the authority to remove people in prison from association in line with published or circulated public health guidance, but professional advice from a Health Protection Team or the UKHSA / Public Health Wales should be sought straight away.

Isolation for Reverse Cohorting and Protective Isolation – general principles

10.11 Where a prisoner is already segregated under PSO 1700 at the time that protective isolation/reverse cohorting is required, their segregation should continue under PSO 1700 but the health and safety requirements as set out under this policy should be applied to ensure that any risk of transmission is managed and the segregation review documents should be updated to reflect the new reasons for segregation.

10.12 The requirement to apply isolations on the advice of public health or healthcare professionals should include consideration of the proportionality of the measure and the holistic welfare of the individuals.

10.13 The requirements in paragraphs 11.8 to 11.18 below are minimum expectations that should be delivered in all cases of isolation. Establishments must continue to adhere to all Infection Control Procedures in accordance with UKHSA/PH Wales advice when delivering regime to isolated prisoners.

10.14 The safety and welfare of the person being isolated must be maintained. If a healthcare professional advises that isolation may present significant risks to a person's safety or wellbeing, Governors may decide not to isolate that person, or to maintain isolation for a shorter period, but must seek and give due regard to advice from a public health or healthcare professional on other mitigations which may contribute to infection control.

10.15 Governors must ensure that welfare and wellbeing checks are provided at least daily (preferably more frequently) and are recorded. Regular meals and any medications must be provided. A wellbeing check is a conversation enabling the well-being of an

individual to be gauged and typically involves asking questions that would facilitate a prisoner to raise issues and ask for assistance.

10.16 All isolating individuals must have a further wellbeing check at the 72-hour point of isolation - for prisoners under both Protective Isolation and Reverse Cohorting. This 72-hour check must be undertaken by either the Wing Manager or other suitable member of staff and must be attended also by a qualified healthcare professional to comply with Prison Rule 45. The details of the 72-hour wellbeing check must be recorded as case notes on NOMIS/SystmOne and relevant isolation forms (as provided in the supporting HMPPS Isolation and Compartmentalisation Operational Guidance) must be completed to authorise isolation for more than 72 hours. The review will determine whether it is desirable to continue isolating the individual taking into account both the health risks posed by the individual and any risks that isolation poses to them.

10.17 Any isolation for more than 72 hours must be authorised by prison staff acting on the authority of the Governor. This authorisation must be given to the prisoner in writing and must set out the reason for isolation and the expected duration of isolation.

10.18 All isolations must again be reviewed by Wing Manager or other suitable member of prison staff and a qualified healthcare professional after 7 days.

10.19 Establishments must ensure that contingency plans are in place in the event of evacuation. For example, where an isolating individual is on a Personal Emergency Evacuation Plan (PEEP).

11. Isolation Safeguards

Safety

11.1 Where an individual is identified to be at risk of self- harm or suicide per the HMPPS Prison Safety Policy Framework, an ACCT must be put in place. For prisoners on an open ACCT, it is critical that the necessary observations and conversations take place and that case reviews are held as required. Staff must be alert to the risk that isolation may exacerbate existing mental health issues and may increase risk of suicide and self-harm. For individuals managed under ACCT who are isolated under this policy, consideration should be given to informing Next of Kin.

11.2 Individuals subject to Basic Regime status under the Incentives Policy Framework should normally (and as an exception to normal practice for Basic Regime prisoners) be provided with a television for the period of isolation, unless there is an over-riding safety reason not to make this provision.

11.3 Any isolation decision must take account of the specific needs of the individual, particularly those with social care needs, those at greater risk of severe illness, and that support for pregnant women and babies in Mother and Baby Units in the Women's Prison Estate is provided. The decision should take account of maintaining the wellbeing of the individual whilst in isolation (for example this could be the provision of in-cell activity (e.g. education and exercise, or other therapeutic activity)) This should be viewed in addition to the regime activity provision referenced in section 11.9.

11.4 Any isolation decision must also take account of, and meet the need for, both physically and cognitively disabled prisoners.

11.5 Any decision to isolate a person must be non-discriminatory and take account of, and make adjustment for, the needs of those with other protected characteristics under the

Equality Act 2010 where there may be differential impacts for any of these groups (based on age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation).

11.6 Early days and induction processes including risk identification must be followed and fully delivered for all prisoners new to custody.

11.7 Provided it is safe to do so, contact and access arrangements for Probation staff should be maintained wherever possible, in particular if the isolated person is approaching a Parole hearing or preparing for release. All arrangements should maintain infection control arrangements as advised and directed by health professionals.

11.8 If an isolated person were to become due for release during the expected period of isolation, advice from a public health professional should be sought on arrangements for the safe movement of the person and arrangements for their release to, and management in, the wider community. Isolation of individuals under this policy must not prevent their release. It is best practice for establishments to facilitate ongoing key worker contact during this period.

Regime Requirement

11.9 Newly arrived prisoners, if isolated, must receive the same induction information as they would do if they were not isolated (under PSI 07/2015 (Early Days in Custody)).

11.10 If implemented, all prisoners in Protective Isolation and Reverse Cohorting must be provided at least a minimum level of regime entitlement/access during the isolation period in line with PSI 75/2011 Residential Services and the Prison Rules 1999/YOI Rules 2000 unless their illness makes it infeasible. This includes:

- A minimum of 30 minutes of time in the open air daily.
- Regular access to a telephone to maintain contact with family, friends, and legal representatives (Prison Rules 4 and 38/YOI Rules 42 and 16)
- Access to a shower at least weekly & facilities for in-cell ablutions (Prison Rule 28(2)/YOI Rule 24(2)).

11.11 Attention should be paid to how access to showers and time outdoors may support recovery from illness. Establishments should seek to provide regime activities beyond minimum requirements wherever possible.

11.12 Wherever possible, cells used for isolation should have in-cell sanitation.

11.13 Corporate worship and pastoral care are an important part of prison life. Where corporate worship is suspended for those in isolation Governors must agree arrangements with their chaplaincy team to support prisoners with their faith/belief needs during this period. The arrangements must be clearly communicated to both staff and prisoners.

11.14 For those isolated under Reverse Cohorting arrangements, Governors should encourage as much association, exercise, domestic and faith/belief engagement as possible, where appropriate and safe to do so as set out in associated guidance.

11.15 In the event of public health advice on outbreak management or a local risk assessment (that includes engagement with recognised trade union partners, for which reasonable facility time should be provided) assesses that an element of minimum regime provision is unsafe to operate, all relevant decisions must be recorded in the

local defensible decision log. This must include where the requirement for time in the open air cannot be met and anyone receiving regime entitlement beneath the standard.

11.16 Pay for isolating prisoners must continue to be paid at their relevant rate of unemployed, employed or standard pay (see PSO 4460). Prisoners not eligible for pay remain without pay. Governors retain the ability to defer social visits by the accumulation of visiting orders in line with PSI 16/2011, where this is necessary and proportionate on public health grounds under Prison Rule 34, if someone is in protective isolation/reverse cohorting.

11.17 The decision to stop a prisoner receiving visits must be documented in the local defensible decision log and these individuals must be prioritised for secure social video calls and access to telephones, if none are available in-cell, during the isolation period.

11.18 If there is an exceptional reason for a prisoner to be granted a face-to-face social visit whilst they are in protective isolation/reverse cohorting this may be facilitated at the Governors discretion with appropriate controls.

11.19 Legal visits cannot be withheld, but Governors should also consider the use of digital or telephone access, which should be prioritised.

Exceptional Provisions

11.20 In exceptional circumstances Governors can take a decision not to apply reverse cohorting for some or all people received, for example if operational capacity pressures present a risk of lockouts into police custody occurring. A decision not to apply reverse cohorting should be recorded in the defensible decision log and IMT/OCT minutes as required.

11.21 If for any operational reason the minimum regime access requirement for those in Reverse Cohorting or Protective Isolation is not safely achievable, this must be kept to an absolute minimum duration and Governors must ensure that there is a defensible audit trail and decision log completed for every prisoner, available for inspection on request.

11.22 Decision logs must be retained for six years as evidence for any potential legal claim which may arise.

Recording of Safeguards and Compartmentalisation Regime

11.23 Governors must ensure that when isolating people in prison for either Protective Isolation or Reverse Cohorting, the decision to isolate them and rationale (for the purposes of Health protection), the healthcare considerations for and against isolation and the level of regime access being received by those individuals, during the isolation period, is recorded. This should be noted on relevant Prison and Health case management systems

11.24 Governors must ensure that a record of those in isolation is made in the establishment's defensible decision log and that this is kept under review. The records for those held in isolation under this policy should be made available to the establishment's Independent Monitoring Board on request.

11.25 Governors are encouraged to keep local records to monitor potential equalities impacts of isolation and reverse cohorting, to determine whether any groups with protected characteristics are impacted by the need to isolate and the potential reasons why this

may occur. Records should include any decisions and actions implemented by the Governor to mitigate any negative impacts realised.

11.26 Wing managers and Governors must be aware of the locations of those who are isolating (and the number of those who have been isolated for more than 72 hours) and the level of regime access being offered to them.

11.27 In all cases, prisoners must be clearly informed about why they are in isolation or are having their regime access delivered in a small regime group.

11.28 For isolating prisoners Governors must ensure for those where English is not their first language, or have other communication issues, that suitable translation or assistive support is given, to allow the prisoner to understand what is happening.

11.29 Governors must ensure that a record of the safeguards in place to protect those individuals in isolation be kept and maintained. This should include:

- The number of people being isolated in the establishment and the reason for the isolation.
- The cellular location of those being isolated.
- The level of regime activity being delivered to those in isolation and whether this is being delivered as part of a regime group or individually. If this is individually, the reasons why group participation is not possible must be recorded.
- Any protected characteristics of those in isolation.
- Written authorisation by staff acting with the authority of the Governor for isolation for more than 72 hours.
- Recommendations from healthcare staff as to whether isolation should continue or cease.

11.30 Prison Group Directors should assure the implementation of this policy within the establishments in their groups.

12. Youth Custody Service

12.1 All references to prisoners or individuals subject to isolation within this Framework includes children and young people located at under-18 YOIs and Secure Training Centres (STCs) Guidance for The Children and Young People Secure Estate (CYPSE) including Secure Children's Homes can be found at compartmentalisation-youth-guidance.pdf

12.2 Separation or isolation of children and young people in the CYPSE should only take place as a last resort and only when it is a justified, appropriate, proportionate and necessary response when alternative interventions have been exhausted.

12.3 Children and young people in the CYPSE have been identified as having experienced high levels of trauma and high prevalence of speech, language and communication needs and other conditions which may affect their behaviour, response and understanding of what may be happening to them. Given the potential impact of being confined to their rooms, the management of any instance of separation or isolation, including Protective Isolation or Reverse Cohorting, which involves children or young people must take account of their individual needs and vulnerabilities.

12.4 When children and young people in the CYPSE are subject to Protective Isolation or Reverse Cohorting, the principles and requirements set out in the Framework on separation and isolation of children and young people – Minimising and Managing Use

of Separation and Isolation in the Children and Young People Secure Estate - should be followed. This Framework may be accessed via the following link:

Minimising and Managing Use of Separation and Isolation in the Children and Young People Secure Estate - GOV.UK (www.gov.uk)

12.5 Each separated child must have their needs met in a planned way and have access to a bespoke regime, regardless of how long the case of separation may be.

13. Resources

13.1 In most situations there will be no or very limited resource implications from adhering to this isolation section of this policy. Where extensive isolation or reverse cohorting is required, there may, in some instances, be additional resource requirements to maintain stability and meet the needs of those isolated. In these cases, Governors should raise this with Prison Group Directors in the first instance (for the Contracted Estate, escalation would be via their organisational structures and related HMPPS contract managers).

14. Guidance

14.1 The Outbreak Control Team

For detailed guidance on OCT/IMT structure, membership and function, Governors should refer to the UKHSA and PHW documents:

Management of incidents and outbreaks of communicable disease in secure settings in England - GOV.UK (www.gov.uk)

phw.nhs.wales/topics/the-communicable-disease-outbreak-plan-for-wales1/

A representative of the Health Protection Team (HPT) will usually chair the meetings of the IMT. The attending governor or director (or nominated representative) will advise on all the operational issues pertaining to the effective functioning of the setting while the consultant in health protection (CHP) will lead on the expert management of the specific incident or outbreak.

14.2 It is the duty of the chair to ensure that the OCT/IMT is managed properly and in a professional manner. The UKHSA/Public Health Wales Health Protection Team (HPT) is usually responsible for ensuring that all meetings have a written agenda, minutes (with decisions) and clearly assigned action points.

Establishment of the OCT/IMT

14.3 Responsibility for managing outbreaks or incidents is shared by all of the organisations who are members of the OCT/IMT. This responsibility includes the provision of sufficient financial and other resources necessary to bring the outbreak/incident to a successful conclusion.

14.4 Core OCT/IMT members are responsible for ensuring that all relevant organisations are co-opted on to the OCT/IMT. Others can make a request to join the OCT/IMT if there is a case to do so, but the final decision on membership resides with the chair.

14.5 Responsibility for operational management of the outbreak must be given to the OCT/IMT by the prison. The representatives must be of sufficient seniority (for example,

normally a member of the Governor's SMT) to make and implement decisions and to ensure that adequate resources are available to undertake outbreak management.

14.6 The OCT/IMT will provide practical advice on infection control and outbreak management taking into consideration all factors surrounding the outbreak in a coordinated and multi-disciplinary way. It will also advise on strategies to avoid or minimise feeding and seeding outbreaks (bringing in and exporting out prisoners and staff infected with communicable disease).

Surveillance

14.7 During the management of the outbreak, it is essential that the right information is made available to health protection teams and epidemiologists to enable them to undertake accurate "surveillance". HMPPS has engaged with UKHSA and PH Wales to ensure the correct protocols and agreements are in place.

14.8 Surveillance can be split into four distinct components:

- Early detection and investigation.
- Comprehensive early assessment.
- Monitoring.
- Rapid investigation of the effectiveness and impact of countermeasures (e.g. containment measures (isolation and cohorting) and including the safety of pharmaceutical countermeasures) in achieving mitigation.

14.9 Information and data should be collected on the number of infected prisoners, those experiencing more severe symptoms of infection, related hospitalisation, and related deaths. It must be noted, however, that this information would be "patient in confidence" and would by default belong to the participating Prison's contracted healthcare service provider/healthcare manager and would need to be 'shared' with relevant parties in accordance with recommendations made by the OCT. **It is, however, essential that information is shared promptly, managed according to data protection requirements and provided without impediment.**

14.10 Surveillance information gained should be used to inform OCT/IMT meetings.

15. Regime Delivery

15.1 In their planning for managing outbreaks of communicable disease, which may well be seasonal, Governors/Directors should also put in place contingency arrangements for the RWCS of widespread outbreak and potentially high levels of staff sickness, above the regular norm. Plans should outline regime delivery outcomes achievable with reduced staffing, with graduations upwards until normal staffing levels are achieved.

In the case of widespread outbreak of communicable disease Governors/Directors must outline plans for delivery of four essential regime priorities during the outbreak period:

- Meals
- Medication
- Prisoner safety and welfare
- Family Contact

Although unlikely to be needed for the management of annual/ seasonal illness, when managing more widespread outbreaks of illness within their sites, Governors and Directors of Private prisons should also include, within their planning, recovery contingencies outlining staged return from the RWCS as directed by the nature of the disease/illness and prevailing conditions/national advice.

15.2 Governors and Directors of Private prisons must ensure that all regimes outlined within their plans comply with the Prison Act 1952, the Prison Rules 1999, YOI Rules 2000, the Human Rights Act 1998, the Health and Safety at Work Act and the wider legal framework.

15.3 In their outbreak management planning it is essential that Governors and Directors of Private ensure that recognised trade unions are meaningfully engaged and consulted in the design process. It is important to note that partner providers are equally engaged, as key stakeholders and to ensure shared planning.

15.4 In their planning, Governors/Directors/ should plan for the likelihood that during wider outbreaks of communicable disease that there may be heightened risk of prisoner control issues relating to limited regime availability. implementation

Curtailment of Visits

15.5 The protection of health can provide a justification for restrictions on social visits under Rule 34 or Rule 73 and this policy sets out procedures and safeguards so that restrictions may be considered necessary and proportionate.

15.6 For more severe outbreaks/pandemics, the OCT may advise that visits are reduced / closed, and the prison reduces its regime to reduce the spread. Although rare, governors should be mindful of this potential and have outline plans in place for this.

15.7 Members of the IMB, Justices of the Peace and legal advisers cannot be prohibited from visiting a prison.

15.8 Prisons must put in place procedures to arrange alternatives to face-to-face legal visits, particularly telephone contact. Where governors conclude there is no suitable alternative, they may facilitate face to face visits by exception and only where other infection control measures can be implemented.

15.9 The decision to stop a prisoner receiving visits must be documented in the local defensible decision log and these individuals must be prioritised for secure social video calls and access to telephones if none are available in-cell during the isolation period.

15.10 If there is an exceptional reason for a prisoner to be granted a face-to-face social visit whilst they are in protective isolation/reverse cohorting this may be facilitated at the Governors discretion with appropriate controls.

16. Communication of important information to staff and prisoners

16.1 HMPPS in conjunction with public health professionals and Health & Justice partners will maintain concise communications with staff and prisoners in relation to communicable disease and will ensure that advice and guidance is current and accessible to all staff, prisoners and visitors as required.