HM Prison &
Probation Service

HMPPS Cohorting & Compartmentalisation Strategy for prisons during COVID-19

Version 4

November 2020

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Introduction

Purpose

This is version 4 of the HMPPS Prison Cohorting Strategy. Since version 2.0 was issued in May, there have been a number of key changes. Iteration 2.1 was issued in August to remove areas that had become obsolete and reflect changes to isolation periods and shielding. Version 3.0 was issued at the beginning of September to build on this with further updates and changes to Reverse Cohorting and Protective Isolation, and also incorporate specific guidance on the cohorting requirements around ROTL.

Prisoner testing is central to the prevention and containment of outbreaks, and to protect prisoners and staff. The **purpose of version 4** is therefore to incorporate additional information on RCU prisoner testing into the guidance. This document does not provide guidance on testing which is contained in specific documents on this subject issued by the National Testing Lead. This version also provides updates on shielding arrangements and protective isolation of influenza cases.

As in previous iterations the first section defines key terms and concepts. The main section then comprises specifications for each aspect of cohorting/compartmentalisation. In previous versions we have referred to the model by its HMPPS name ‘cohorting’. However cohorting derives from a PHE model known as Compartmentalisation and to bring HMPPS into line with other agencies, we will adopt the term Compartmentalisation for this and future versions of the strategy.

We have also reworked the section on single cells. Prisoners who are self-isolating should be located in single cell accommodation wherever possible. However whilst single cell accommodation represents the best option, this is not always operationally deliverable and compartmentalisation can still be achieved in multi-occupancy accommodation where no other option exists though establishments must record all isolation decisions as outlined below.

Definitions and Key Concepts

Compartmentalisation - means the care of large numbers of people who are ill or who present heightened infection risk by gathering them together into one area (or multiple areas) and establishing effective barrier control between this group and the wider population. HMPPS launched a prison cohorting/compartmentalisation strategy on 31 March. It comprises three elements to protect those most vulnerable to disease, isolate the symptomatic and to hold newly received prisoners separated from the main population. The aim is to create separation between the symptomatic, those newly arriving, and those who are most vulnerable.

Name	Description
Reverse Cohorting	Process for the temporary separation of newly received prisoners; allowing the prison to verify that each individual does not present an infection risk before they are able to come in to contact with the general population.
Protective Isolation	Process for the temporary isolation of symptomatic prisoners for a period of at least 10 days.
Shielding	Process for the temporary isolation of prisoners within the clinically extremely vulnerable and vulnerable cohort. Prisons must continue to offer prisoners who are classed as extremely vulnerable the option to shield.

Unit – Previous versions have referenced cohorting ‘units’ or ‘areas’. We have moved away from this language as compartmentalisation is a series of processes which can take place in multiple locations. Establishments must design a model that fits their fabric and population. Reverse cohorting for example can take place across multiple locations. All models must be based on the specifications below. Prisons must ensure separation between groups. It is imperative that all prisons also fill to their operational capacity and do not declare spaces below that number on the basis of RCUs being full. Reverse cohorting must be provided at other locations in this scenario.

House-holding- HMPPS defines a household as a small number of prisoners who share a cell or dormitory equivalent to the community definition of a household. People are only a household where they are together in close proximity and cannot socially distance. A regime group (see below) is not the same as a household. If one member of the household becomes symptomatic, then all members of the household will be expected to isolate for 14 days as required in the community. If further symptomatic cases arise within the 14 day period this is indicative of a possible outbreak and advice from Public Health England / Public Health Wales must be sought.

Regime Group - Prisons have broadened households and assigned prisoners to a small group for regime. Regime groups take exercise and domestics periods together and as establishments begin to open up their regimes through EDMs, the management of regime groups will become more important. Members of a regime group must social distance at all times. If one member of the regime group becomes symptomatic, only members of the immediate household should automatically isolate. HMPPS Contact Tracing Guidance should then be followed to determine any other close contacts who may need to isolate.

Social Distancing is the UK Government's technique for minimising the risk of transmission between individuals. In all circumstances individuals (staff and prisoners) must remain at least two metres apart at all times. The recovery EDMs have outlined certain specific situations where establishments are able to move to a one metre plus rule with mitigations (e.g. in social visits where the fabric of the building makes it impossible to maintain 2m), however they must reinforce that two metres is the standard social distancing requirement.

Protective Isolation (PI) **means** isolating someone symptomatic or positive in Protective Isolation for 10 days subject to the requirements of the protective isolation specification contained in this document.

Shielding and Clinically Vulnerable/Extremely Vulnerable mean people at the most heightened risk of severe illness if they contract COVID-19, and who should be shielded for their own protection. In their latest guidance, PHE recognise two high risk groups; the clinically vulnerable and clinically extremely vulnerable.

Clinically Extremely Vulnerable individuals are defined as:

1. Solid organ transplant recipients.
2. 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
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD).
4. People with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell).
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. Women who are pregnant with significant heart disease, congenital or acquired.
7. Other people have also been classed as clinically extremely vulnerable, based on clinical judgment and an assessment of their needs. GPs and hospital clinicians have been provided with guidance to support these decisions.
8. Adults with Downs Syndrome.
9. Those with Kidney Disease at Stage 5.

Clinically Vulnerable individuals can be defined as people at risk because they:

1. Are 70 or older
2. Are pregnant
3. Have a lung condition that's not severe (such as asthma, COPD, emphysema or bronchitis)
4. Have heart disease (such as heart failure)
5. Have diabetes
6. Have chronic kidney disease
7. Have liver disease (such as hepatitis)

8. Have a condition affecting the brain or nerves (such as Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy)
9. Have a condition that means they have a high risk of getting infections
10. Are taking medicine that can affect the immune system (such as low doses of steroids)
11. Are very obese (a BMI of 40 or above)

This list is not definitive and vulnerability is subject to clinical judgement in each case. In the community, shielding has been paused since 1st August however the opportunity to shield will remain available for prisoners who wish to shield and establishments must maintain the facilities for those who request shielding. Prisoners can shield within an individual cell or on a designated unit however establishments must maintain sufficient facilities for numbers to increase. Even if there are no prisoners currently shielding prisons must retain the ability to reintroduce shielding in the event of a localised outbreak or change of community guidelines.

In line with specific guidance issued by the HMPPS HR department, staff who have previously been shielding must have an individual risk assessment completed prior to any return to work.

NOMIS and DPS Alerts**:** There are 4 alerts in Digital Prison Services and NOMIS to help you manage COVID Cohorts. Digital Prison Services and NOMIS to help you manage COVID Cohorts.

These alerts must be added to prisoners in each area. The alerts can be created under the alert type of ‘COVID unit management’ and are called:

- Reverse Cohorting Unit
- Protective Isolation Unit
- Shielding Unit
- Refusing to shield

The refusing to shield marker should still be used though shielding is suspended. Prisoners may still opt into shielding and prisons are advised to still record those who are shielding-eligible but choosing not to. The ‘Quarantined’ alert has now been removed and any prisoner who had this on their profile should have one of the new alerts added if relevant. Work is underway to allow establishments to see a list of all prisoners who are part of a COVID unit. There will also be some additional features which will help you manage these prisoners.

Specification 1: Reverse Cohorting

Purpose: Reverse Cohorting (RC) means the separation of a group of newly arrived prisoners from the rest of the population for a period of 14 days or until 2 negative test results are received within a period of at least 7 days in prisons with routine prisoner testing in place. The purpose is to ensure they are not carrying COVID-19 before they are integrated into the population. This includes prisoners received into an establishment and those moving back and forth for hospital or court.

The Reverse Cohorting specification has been expanded to incorporate specific guidance for prisons operating ROTL. Closed establishments who do not operate ROTL should simply refer to the first table below. Closed prisons who operate ROTL should also consider the guidance contained in the second table. Category D prisons should read the guidance on ROTL or accompanied ROTL as a direct replacement for the sections on escorts. There are some inconsistencies between reverse cohorting following escorts and reverse cohorting in relation to ROTL, hence it is important that prisons consider the right tables for their functional area.

Outcomes	Delivery
All establishments must develop a **local 14 day reverse cohorting model**	Reverse cohorting will be required in the following three circumstances: - Reception prisons must RC every new arrival immediately. - Prisons who receive prisoners on IPT must RC any prisoner who is transferring from a 'red' or 'amber' site' - All prisons must RC any prisoner who has been out of the establishment for longer than a single day on a continuous escort unless they are released on ROTL when different requirements apply (Refer to the ROTL Specific Cohorting Requirements Section 7). - Prisons must be able to identify those prisoners who are reverse cohorting and their locations within the site. The NOMIS alert must be used in all cases. Establishments can determine their local operating model for reverse cohorting. The local model may be one of three models: 1) **Hold new prisoners on a designated RC Unit (RCU)** 2) **Hold new prisoners in regular residential units** 3) **Develop a hybrid model** where part of the 14 day period is spent on an RCU and part is at a secondary location. As above any delivery in a secondary location must achieve the same level of regime and separation as RCU. The cross-deployment of staff should be minimised between RCU and other locations as much as possible. Single cells should be used where available. Where this is not possible, prisoners should only share with prisoners they came through Reception with as these prisoners are already part of the same household.

All reception prisons who are operating RCU prisoner testing must amend their reverse cohorting model	Establishments which are now operating prisoner RCU testing can reduce the duration that prisoners spend reverse cohorting. Where a new prisoner has spent **at least 7 days** reverse cohorting **AND** has received **2 negative COVID-19 test results** they are able to progress from reverse cohorting into standard location prior to the standard 14 days. Both tests must be confirmed negative. Void or inconclusive tests do not count as negative tests. Governors must ensure that the proposed RCU prisoner testing arrangements have been approved by the Regime Recovery Testing (RRT) team before testing begins. Prisons should contact HMPPSCOVID19RegimeRecoveryTesting@justice.gov.uk for further information.
All prisons **receiving a prisoner on IPT** only need to reverse cohort those arriving from a 'red' or 'amber' site.	The default position is that reverse cohorting is not required before or after an IPT, provided the prisoner has been through RCU once on arrival into the reception prison. There is no requirement to re-reverse cohort prisoners who have been in continuous custody at the point they are transferred. A new Transfer Risk Assessment process has been introduced whereby PMU will consult the heat map showing the live outbreak status at every site. Prisons must also consult this and reverse cohort every prisoner received from a red or amber site for 14 days. RC arrangements will be dependent on the status of the sending site as follows: • Transfer from a green site to any other site – no RC required • Transfer from an Amber/Red site to any other site – RC at receiving establishment and receiving establishment must be given prior notice of RC requirement and number of cells needed. All relevant Safe Operating Procedures must be adhered to during transfers, including the cleaning and disinfecting of transport as per guidance. A script to support reception staff in explaining the need for prisoners to reverse cohort is available in Appendix A of this document.
Establishments must develop a local strategy for managing **prisoners going to court.**	A prisoner does not need to routinely go onto RCU from a court escort of one day. If the escort continues over more than one continuous day, the prisoner should complete a 14 day RC period at the end of the escort. Where a prisoner has completed a 14 day reverse cohorting period at one establishment and then goes to court and is required to move back and forth for more than a day prior to being located at a secondary prison, a second 14 day reverse cohorting period must be completed. RC can be facilitated in the prisoner's own cell on return from court rather than on an RCU provided the same regime is provided for that prisoner. In the event that a prisoner is required to attend court during their initial 14 day reverse cohorting period, and then returns from court to a different prison then a secondary 14 day reverse cohorting period must be re-started as the original period was not completed.

Establishments must develop a local strategy for managing **prisoners going to hospital**	A prisoner does not need to routinely go onto RCU from a hospital escort of one day. If the escort continues over more than one day, the prisoner should complete a 14 day RC period at the end of the escort. RC can be facilitated in the prisoners own cell on return from hospital rather than RCU provided the same regime is provided as they would receive on the RCU. Establishments should refer to the ROTL Specific Cohorting Requirements Section of this document for information on prisoners going to Hospital on ROTL. The use of term 'single day' is applicable to any escort that takes place within a 24 hour period. For example, if a prisoner is discharged to hospital overnight, then if they were returned to the establishments within the 24 hour period, they would not normally require reverse cohorting. Prisoners with a serious underlying medical condition who are regularly attending hospital (i.e. Dialysis, chemotherapy) should already be located on a shielding regime and do not need to be reverse cohorted on return from hospital or relocated to the RCU.

ROTL Specific Reverse Cohorting Requirements

The guidance below does not counter or undermine the ROTL EDMs or PSI. Instead its purpose is to clarify cohorting requirements to support ROTL and outworker schemes. Guidance refers only to the cohorting arrangements that must be developed alongside ROTL. Closed establishments operating ROTL must note the differences between cohorting after ROTL and cohorting after escort as different rules apply.

Outcomes	Delivery
Establishments must develop a local strategy for the management of prisoners on **workplace ROTL**.	Establishments must develop a model of regime-groups or house-holding for prisoners on external work placements. Whilst we recognise the limitations of the physical fabric in the Cat D estate and that establishments cannot return all prisoners to an RCU, prisons are required to operate a form of reverse cohorting by grouping prisoners into regime groups where possible. This means that establishments must co-locate prisoners who are out of the prison on outwork placements regularly where possible. We recognise that the population cannot be continually moved around to create new daily regime groups therefore establishments will need to group prisoners once into households or regime groups based on their placement days and locations. Governors are required to implement steps to separate external workers from non-external workers and group those working together as much as possible.

	Establishments should also ensure that they assess placements before approving and monitor them to ensure they are not breaching localised lockdown. Before approving a placement Governors need to satisfy themselves that a location is COVID secure and during monitoring of the placement must satisfy themselves that prisoners are not breaching regional restrictions by continuing to work in the area.
Establishments must develop a local strategy for the management of prisoners who leave the establishment on **Resettlement Day Release (RDR)** for purposes other than outwork.	PHE has confirmed that prisoners who are leaving an establishment on RDR do not need to be reverse cohorted on an RCU on return provided the establishment operates the model of regime groups or households and takes reasonable steps to minimise contact between prisoners from different groups. Establishments are also advised to develop procedures for informally monitoring prisoners who have been out on a single day RDR where possible. This is the Category D model of reverse cohorting. This includes RDR for purposes other than work, either during stage 3 (to public areas and buildings) or in stage 2 which adds domestic ROTL to family homes (subject to compliance with community guidance issued by the Government).
Establishments must develop a local strategy for the management of prisoners who leave the establishment on **Resettlement Overnight Release (ROR)** for purposes other than outwork.	PHE has confirmed that prisoners who are leaving an establishment on ROR do not need to be reverse cohorted on an RCU on return provided the establishment operates the model of regime groups or households and takes reasonable steps to minimise contact between prisoners from different groups. Establishments are also advised to develop procedures for informally monitoring prisoners who have been out on a single day ROR where possible. This is the Category D model of reverse cohorting. This includes ROR for purposes other than work, either during stage 3 (to public areas and buildings) or in stage 2 which adds domestic ROTL to family homes (subject to compliance with community guidance issued by the Government).
Establishments must develop a plan for the management of prisoners who return from ROTL and present as symptomatic.	In the event that a prisoner returns from RDR or ROR and becomes symptomatic or tests positive for COVID-19 then 'protective isolation guidelines' should be followed and health protection teams informed. If a prisoner becomes symptomatic and is employed at a workplace that employs multiple prisoners or there is an outbreak at a workplace, a local review must be undertaken to assess the appropriateness of their work placements continuing. Establishments must ensure that Test and Trace procedures are followed in adherence with HMPPS Contact Tracing Guidance

Specification 2: Protective Isolation

Purpose: Protective isolation is designed to isolate prisoners who are symptomatic for a minimum period of 10 days and until it can be verified that they are symptom-free. Any contact of a symptomatic or confirmed COVID case must isolate for 14 days as this is current Government guidance on the length of time over which symptoms can develop.

<table>
<tr><th>Outcomes</th><th>Delivery</th></tr>
<tr><td>All establishments must develop a local isolation plan for each confirmed COVID case.</td><td>
It is generally recommended that COVID-19 positive and/or symptomatic prisoners are isolated in their existing cell or to a dedicated Protective Isolation Unit (PIU). Establishments must determine locally whether a designated PIU is required in conjunction with their respective Health Protection Team (HPT). Wherever possible symptomatic prisoners should be isolated in a single cell. However we recognise this will not always be possible. Therefore the following guidance should be followed:

Known positive cases can stay together, e.g. cellmates tested together who get their results together and both come back positive.
Someone who is sharing a cell with a symptomatic or positive person should be advised and moved to a separate cell wherever possible.
Where prisoner refuses or there are no single cells available, this prisoner can stay in the cell and should be under heightened monitoring to provide additional, appropriate support.

The principles of Protective Isolation must be implemented as standard wherever a symptomatic/COVID-19 positive prisoner is located. This includes:

Effective barrier control
Separation between Cohorts of prisoners
Regimented cleaning in line with relevant SOPs.
Prison staff should be able to identify those prisoners who are protectively isolating.
Ensure that prison healthcare provide daily/regular checks on those in protective isolation

Establishments must refer to the isolation decision checklist in annex B and the acknowledgment in annex C for further guidance on making isolation decisions. The checklist should be used to record isolation location decisions where a prisoner becomes symptomatic. In circumstances where cell-mates to COVID-19 cases are asked to leave a cell and refuse, the document at annex C should be used to record their refusal.
</td></tr>
</table>

All establishments must maintain separation between COVID-19 positive prisoners and other symptomatic prisoners to contribute to control of influenza and other respiratory infections	All symptomatic prisoners must remain in protective isolation for at least 10 days from the date of symptom onset, even if they test negative for COVID-19. If a prisoner is diagnosed with influenza or another respiratory illness it is important to retain absolute separation of these cases from any other symptomatic or known COVID-19 positive cases in the prison. Infection control procedures for COVID-19 should be followed for all suspected or confirmed cases of influenza.
Any local model of protective isolation **must achieve the nationally agreed principles**	The principles of Protective Isolation must be implemented as standard wherever a symptomatic/COVID-19 positive prisoner is located. This includes: • Effective barrier control • Separation between Cohorts of prisoners • Regimented cleaning in line with relevant SOPs • Daily/ regular health and wellbeing checks

Specification 3: Shielding

Purpose: Shielding is designed to isolate prisoners who are classed as vulnerable to COVID-19. In the community, shielding has been paused since 1st August. In the prison estate the opportunity to shield will continue to be available for any prisoner who wishes to opt in and establishments must therefore maintain the facilities and services for those who wish to shield, even if there are no prisoners currently shielding in case the community guidelines change or there is a localised outbreak and to provide for the escalation of the national outbreak in autumn / winter 2020/21.

Outcomes	Level of local autonomy (total, partial, limited)
Establishments must offer all prisoners classified as clinically vulnerable by NHS / HMG guidance the opportunity to shield	Though shielding has been suspended in the community, establishments must still offer shielding facilities for those who wish to "opt in" and continue to shield. Prisoners must be supported to make an informed decision on whether or not to shield, or other steps to mitigate infection risk, taking into account local risk which will vary from time to time. Establishments can either: 1. Create a designated Shielding Unit large enough to accommodate prisoners who wish to opt in. 2. Create a separated shielding regime for prisoners wishing to opt in that can be provided to their individual cell location. Prisons adopting this model must consider how they will ensure that shielding applies to all aspects of regime, including meals, showers and exercise. Establishments should not de-commission their shielding units if prisoners wish to continue to shield and should retain sufficient capacity to shield larger numbers should more prisoners wish or be advised to commence shielding in the future. Prison staff and healthcare should continue to engage with shielding eligible prisoners. All prisoners in this cohort should have received a letter in June/July from NHS colleagues informing them that they still have the opportunity to shield. Establishments should make sure all prisoners have been offered the opportunity to "opt in" and all prisoners should have their decision to waive this right recorded. They should be supported to make an informed decision and should be able to shield in that is their preference. The HMPPS disclaimer should be completed and stored, the prisoner decision not to shield should also be recorded on NOMIS case notes. Prisoners should be reminded that the opportunity to shield will be available for anyone who wants this to take up at any time, and they should alert staff if they change their mind about shielding at any time. Patients who are children will be supported by healthcare professionals on a case by case basis to understand the best approach to managing infection risk in their individual

	circumstances. Establishments should provide a consistent staffing group, where possible to reduce contact for those who are shielding.
Establishments should continue to engage with individuals who are classed as **extremely clinically vulnerable**.	As part of the November lockdown in England, the Government advice for clinically extremely individuals has changed. Prisoners who meet the clinically extremely vulnerable criteria should be ***strongly advised*** to shield until government advice changes.
Establishments should recognise the extra isolation that a person shielding may experience.	All prisoners who are shielding must be offered the opportunity to exercise in the open air daily & to be offered support within the regime group if possible; other support mechanisms must be made available to the prisoners through Healthcare, Safety team, Chaplaincy and the Education teams.

Appendix A: Template Script for Reception

Template Script for Reception Staff: Explanation of the need to Reverse Cohort

Hello, this is ***PRISON NAME.*** I am sure you are aware that there is currently a virus called the Coronavirus in circulation. This means that there are a number of extra precautions in place to keep you safe whilst you are here. One of these measures is that we are keeping everyone who is new into prison, or has transferred from a prison that is a higher risk of Coronavirus separate from the rest of the prison for 14 days to make sure that you are not carrying the virus before you move into the main residential area of the prison. You will be located in a cell in ***INSERT RCU AREA NAME (e.g A Wing)*** for your first 14 days here, and then moved to the main area of the prison.

This winter there is also a risk of influenza (or 'flu) circulating. Reverse Cohort arrangements will also help to keep everyone safe from 'flu.

Whilst in this area, you will still receive your regime such as access to showers and exercise, but your access to other activities in the prison might be limited. You should speak to the staff on the wing about what you will be able to access during this time.

Please make sure that you follow social distancing rules as much as possible with everyone except for your cell mate (If applicable). This means that you must try and stay 2 metres apart from other people at all times. This is to protect yourself, and others as much as possible.

If you are due to be attending court or any other escort such as to hospital within your first 14 days, you may be required to restart the 14 day period on your return. This will depend on how long the escort is for. You should speak to your wing staff if you think this may affect you.

If you have any other questions about cohorting, or being in prison during Coronavirus in general, please ask the staff on your wing who will do their best to help you. We appreciate your co-operation on this, helping to keep us all safe.

Appendix B: Isolation Decision Making Checklist

In making decisions about prisoner isolation during COVID-19, it is important that all decisions are made defensibly and are recorded in the establishment defensible decision log. Establishments should wish to use the below checklist when making such decisions, and may wish to keep a copy of this in their log to support their decisions.

Prisoner Name/Prison Number:		
Date:		
Member of Staff Making Isolation Decision:		
Consideration	**Yes/ No**	**Comments**
1. Has the prisoner been confirmed by healthcare partners as being positive and/or symptomatic for COVID-19?		
2. Have healthcare/the OCT (if engaged) been involved to determine the isolation plan?		
3. Have healthcare/the OCT (if engaged) been involved to determine the isolation plan?		
4. Has the affected prisoner been moved to the prison PIU/isolated in their existing cell location?		
5. Has the decision about where to isolate them been communicated to the prisoner?		
6. Does the affected prisoner share a cell?		
7. Have any affected cell sharers been updated on the situation and informed that it is recommended they move?		
8. Have any affected cell mates moved cells? (If they have refused to move cell, establishments should refer to appendix C).		
9. Any other relevant considerations:		

Appendix C: Prisoner Acknowledgment

Throughout the COVID period, Public Health England (PHE) advice and guidance from Outbreak Control Teams (OCT) has been that prisoners who have a confirmed COVID-19 diagnosis should isolate either in the Protective Isolation Unit (PIU) or their own cell and that their cell-mate (known as their Household for COVID purposes) can remain in cell and isolate alongside them. However guidance received from PHE in October 2020 has changed. Over winter the risk of an individual sharing a cell with a prisoner who has COVID-19 is much greater due to winter flu. If a cell-mate has winter flu and then contracts COVID-19 there is a much greater risk to them. Therefore over winter it is much more important that we isolate COVID-19 prisoners away from other prisoners wherever possible.

Establishments can either:

1. Remove the non-symptomatic prisoner from the cell and take them to another single cell where they will be required to isolate for period of a minimum of 14 days; and isolate the symptomatic or positive prisoner in their current cell. They re-located prisoner should be treated as if they are symptomatic for the period of the 14 days as there is a possibility that they have been infected with the virus. The symptomatic or positive prisoner should be isolated for a period of 10 days.
2. Remove the symptomatic or positive prisoner from the cell and re-locate them to another cell for a period of a minimum of 10 days. Their cell-mate will then be required to isolate in the original cell for a period of a minimum of 14 days.

Establishments may encounter situations where prisoners do refuse to move cell, despite being cell mates with an individual who has COVID-19. In these situations, it is important that establishments very clearly explain to prisoners the following:

- That PHE advise is that they are more vulnerable to COVID-19 if they also have winter flu therefore the PHE guidance is that households should not isolate together during winter.
- Prisoners can choose not to move away from a cell-mate who has COVID however they realise that this is placing them at heightened risk.

Following identification of a symptomatic/positive prisoner case, staff should initiate conversation with any cell mates and explain to them that it is recommended that they move cells to protect them from COVID-19. The risk of transmission of COVID-19 is greatly increased if they live in the same cell as someone with symptoms/confirmed positive, and therefore it is in their best interest to move cells.

Staff must record the conversation with the prisoner on NOMIS case notes and retain this form in the prisoner IMR. The **purpose** of this document is to provide an aide memoir to staff conducting these conversations, and a template acknowledgment for prisoners to sign and formalise their decision. Staff must offer prisoners the chance to move and get prisoners to record that they have had this conversation by signing the form attached.

Overleaf is a template acknowledgment form that establishments should utilise in cases where a prisoner refuses to move out of a cell with a symptomatic/positive person. This must be completed in all cases and the refusal must be documented on NOMIS, system-One and in the establishment defensible decision log for COVID-19.

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ACKNOWLEDGMENT FORM

Name:

Prison number:

Cell location:

Establishment:

Summary of conversation

____________ (name of staff member) has been to see me on ______________ (enter date) and we have discussed the fact that someone in my cell has tested positive/is symptomatic for COVID-19. They have explained:

- That it is recommended that I move cell away from this individual and move in to a single cell temporarily.
- That staff have explained to me that during winter the risk of my contracting COVID from my cell mate is higher due to winter flu and the advice is for them to isolate alone.
- That I understand this and still do not want to move from the cell.

I……………………………………..…………..………………………………………..……………
……………………………………… (name; surname; prison number) choose to **not** follow this advice)

Any other comments I wish to make:

Signature________________________Print_________________________Date_____________

Staff signature ___________________ Print __________________Date___________________