Australian Government
Department of Health

Communicable Diseases network AUSTRALIA

CDNA National Guidelines for COVID-19 Outbreaks in Correctional and Detention Facilities

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Revision history

Version	Date	Reason / Changes	Endorsed by
1.0	31/03/20	Initial Release	CDNA, AHPPC
2.0	10/06/20	Revision Update outbreak identification and management guidance	CDNA
3.0	24/07/20	Revision Update outbreak identification and management guidance Update infection prevention and control advice Update quarantine arrangements for new admissions to facilities from geographic areas of community transmission	CDNA, AHPPC
3.1	12/08/20	Revision Update for quarantine of inmates/detainees transferred from other facilities	CDNA
4.0	07/10/21	Guidelines revised incorporating vaccination and risks resulting from Delta variant	CDNA

The Communicable Diseases Network Australia (CDNA) developed this guideline. The Australian Health Protection Principal Committee (AHPPC) has endorsed it. It includes information from documents and guidelines from NSW Health and different international health authorities. This includes the Centers for Disease Control and Prevention USA, Public Health Agency of Canada and the Ministry of Justice and Public Health England.

This guideline provides best practice information to prevent and manage COVID-19 outbreaks in correctional and detention facilities to support:

- public health authorities
- managers and staff of correctional facilities
- health care workers

This guideline captures the knowledge of experienced professionals. It provides guidance on good practice based on the available evidence at the time of completion.

Readers should not rely on the information in this guideline alone. It is not a substitute for advice from other relevant sources including advice from a health professional. You may need to use clinical judgement and discretion in the interpretation and application of these guidelines. Correctional and detention facilities are responsible for making sure they comply with their jurisdictions outbreak management requirements, and the management of possible COVID-19 outbreaks.

The Commonwealth of Australia as represented by the Commonwealth Department of Health (the Department), CDNA and AHPPC membership do not warrant or represent that the details of this guideline are accurate or complete. CDNA, AHPPC and the department do not accept any legal liability or responsibility for any loss, damages, or costs incurred by using, reliance on, or interpretation of the details of this guideline.

Table of contents

1. Introduction

These guidelines apply to all correctional and detention facilities in Australia. This includes:

- prisons
- juvenile detention centres and youth justice centres
- community correctional centres
- onshore Australian immigration detention facilities.

More than 65,000 people enter and leave Australian prisons each year.[1] Aboriginal and Torres Strait Islander people are over-represented in custodial settings, representing more than one third of Australia's prison population.[1] This group also has a high prevalence of chronic disease. People in prison often come from disadvantaged backgrounds with complex health needs compared to the general population. Prisoners are less likely to have seen a doctor, five times as likely to smoke tobacco, and are more likely to have used illicit substances. Prisoners also have high rates of chronic physical conditions with 30% of prisoners reporting at least one chronic disease.[1]

There is a higher risk of transmission and severe disease if COVID-19 enters these facilities[2].

These guidelines support correctional and detention facilities to plan, prepare, detect, and respond to COVID-19 outbreaks. Each facility is unique and preparation to prevent and contain incursions of COVID-19 into the population needs local assessment. Contributions made to protect incarcerated populations include:

- establishment of partnerships
- early coordination of representatives from all aspects of correctional/detention systems
- limited access to the correctional/detention environment
- strict isolation of all new receptions[3].

The Centers for Disease Control and Prevention developed a COVID-19 Management Assessment and Response Tool (CMAR) for Correctional and Detention Facilities for PHUs. Public Health Units with correctional and detention facilities in their locality may wish to use it to develop localised plans for response to COVID-19 in a facility.

For case definitions and guidance on testing, management of contacts and management of cases, see the *CDNA COVID-19 National Guidelines for Public Health Units*.

1.1. COVID-19 risk

Incarcerated populations are more susceptible to outbreaks of respiratory illness. This is because people reside in groups, the turnover of inmates is often high and there is significant interaction with the community through for example court attendance etc. In addition, many inmates are at higher risk of severe disease following infection with SARS-CoV-2 as a result of chronic illness, including Aboriginal and Torres Strait Island people.

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[1] *Australian Institute of Health and Welfare, The health of Australia's prisoners 2018*

[2] *Braithwaite I, Edge C, Lewer D, Hard J. High COVID-19 death rates in prisons in England and Wales, and the need for early vaccination March 2021 https://www.thelancet.com/pdfs/journals/lanres/PIIS2213-2600(21)00137-5.pdf (accessed 15/8/2021)*

[3] *Blogg J, McGrath C, Galouzis J, Grant L, Hoey W. Lessons learned from keeping NSW's prisons COVID-free. Int J Prison Health. 2021 Mar 1;ahead-of-print(ahead-of-print). doi: 10.1108/IJPH-09-2020-0073. PMID: 33709638. (accessed 15/8/2021)*

It can be difficult to tell the difference between COVID-19, and a respiratory illness caused by other viruses based on symptoms alone. All individuals with symptoms congruent with COVID-19 should have a test to find a causative agent, including viral multiplex PCR for other respiratory viruses.

People who have clinical signs and symptoms consistent with COVID-19[2] **and** have epidemiological evidence for COVID-19[2] are 'suspect' cases[4]. For example, a close contact with a confirmed case, and people who have been in areas with recent local transmission of COVID-19. Individuals tested as part of broader testing (beyond suspect case definition) are 'potential' cases.

Under Australia's suppression strategy, a COVID-19 outbreak is defined as one case of COVID-19 in a high-risk setting which includes correctional and detention facilities (*CDNA COVID-19 National Guidelines for Public Health Units*.

Legal Framework

It is the responsibility of correctional and detention facilities to understand and comply with relevant legislation and regulations. Facilities must fulfil their legal responsibilities for infection prevention and control, by adopting standard precautions for health facilities in detention centres. Requirements are outlined in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021), and by state/territory public health authorities.

COVID-19 is a notifiable disease under the Australian National Notifiable Diseases List (NNDL).[5] This means that the relevant jurisdictional public health authority must be notified of a positive COVID-19 result. This is the responsibility of either the medical officer requesting the test and/or the laboratory performing the test, as per local legislative requirements.

1.2. Roles and Responsibilities

Facilities have responsibility for managing COVID-19 outbreaks under their requirements for inmate/detainee care, duty of care to staff, and infection prevention and control. All facilities should have in-house (or access to) infection prevention and control expertise and have outbreak management plans in place.

Facilities/Departments of corrective services/detention must:

- detect outbreaks (1 case) and notify state health departments/Public Health Units (PHUs)
- Collaborate closely with, and follow advice from, PHUs and state health department to manage outbreaks and consequences; confirm, declare, and manage outbreaks, including declaring when outbreaks are over.

1.2.1. The State/Territory Department of Health

The relevant state/territory department of health (or delegate) will assist facilities to detect, characterise and manage COVID-19 outbreaks. This work is done by the local Public Health

[4] See the CDNA National Guideline

[5] Australian National Notifiable Diseases List (NNDL) is available at: https://www.legislation.gov.au/Details/F2018L00450

Unit (PHU) in collaboration with state health department within the existing state emergency management framework.

This assistance includes:

- advise on confirming and declaring the outbreak
- co-ordinating testing and management of cases and contacts
- providing advice on infection prevention and control measures and use of PPE
- surveillance and reporting as the outbreak progresses
- contributing to national surveillance
- confirming and declaring when an outbreak is over
- advise and support vaccination response in outbreak setting.

1.3. Understanding COVID-19 Transmission

1.3.1. Incubation Period

People with COVID-19 may develop signs and symptoms, including mild respiratory symptoms and/or fever. This usually occurs 5-6 days after infection (mean incubation period 5-6 days, range 1-14 days). However, with new variants of the virus the incubation period can be much shorter (1-3 days). In a small number of cases, the incubation period may exceed 14 days.

1.3.2. Infectious period

People with COVID-19 are more likely to transmit the virus to others for about a week starting from a day or two before symptoms start. Some people never develop symptoms but may still be able to pass the virus onto others.

The PHU will confirm the infectious period for any cases. In most circumstances, this includes a 48-hour period before the onset of symptoms, as well as the days the person had symptoms and was in the facility. More conservative periods, up to 72 hours prior to symptom onset, may apply.[6]

For more details on the infectious period see the *CDNA COVID-19 National Guidelines for Public Health Units.*

1.3.3. Routes of Transmission

COVID-19 transmits through respiratory droplets, smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces. While the exact contributions of these routes remain unclear, **those who have been in close contact with a COVID-19 case are at highest risk**.

Aerosol and droplet transmission

Virus is present in respiratory secretions as people exhale. These may range from being large droplets to small aerosols, which may contribute to transmission of COVID-19. Behaviours, such as singing and shouting, can increase the force and range of spread of both large and small particles.

[6] See the CDNA National Guideline

In certain conditions, such as an indoor environment with a low air exchange rate (less movement of outside air replacing the air indoors), small particles that are normally dispersed may remain suspended or recirculate for longer periods.

The particles can move around by natural airflow, fans, or air conditioners. In these situations, airflow may play a role in transmission as others inhale the aerosol. In clinical care settings, take care during aerosol generating procedures (refer to Aerosol-generating procedures).

Indirect transmission

Respiratory droplets and secretions expelled by an infectious person can contaminate surfaces and objects. Indirect transmission via contact with contaminated surfaces and objects may be possible. However, indirect transmission does not present the same degree of risk as direct close contact with an infected person[7] . Live SARS-CoV-2 virus can survive on surfaces for several hours to a few days, depending on the surface type and environmental conditions. However, alcohol, household bleach, and other chemicals can inactivate the virus.

1.3.4. Quarantine and isolation

Both quarantine and isolation require people to stay away from others to prevent transmission.

By definition, well people potentially exposed to the virus, and who are at risk of infection, should quarantine away from others. Whereas people infected with the virus, whether they are unwell or not, should isolate away from others. Practical implementation of quarantine and isolation may be challenging in correctional and detention facility environments. Outbreak planning should incorporate strategies addressing these challenges (see below).

Quarantine periods and criteria for cases to be released from isolation are outlined in the *COVID-19 National Guidelines for Public Health Units*.

1.4. People at risk of moderate or severe COVID-19

Anyone who gets COVID-19 can develop severe disease. The likelihood of getting severe COVID-19 illness increases with age and presence of other diseases (a list is on the Department of Health website.)

1.4.1. Complications of severe COVID-19

Most people with COVID-19 have mild disease and will recover. Some people can develop severe illness with complications which may be life-threatening and can result in death.

Complications include:

- pneumonia (interstitial pneumonitis, secondary bacterial infection)
- respiratory failure
- septic shock
- multi-organ dysfunction/failure

[7] South Australian Health and Medical Research Institute August 2021

Inmates/detainees with COVID-19 who have pre-existing comorbidities may also experience a worsening of these chronic health problems. For example, congestive heart failure, asthma, and diabetes.

2. Preparedness and Prevention

2.1. Preparation

Facilities must ensure they prepare for outbreaks of COVID-19.

Effective response to COVID-19 relies on a well-functioning infection prevention and control program that works in conjunction with a well-functioning occupational health (OH) program. Facilities must also have strong governance structures to assess risk and implement mitigation strategies.

International experience includes development of specific accommodation, such as units to accommodate confirmed or probable cases and shielding units to protect the most vulnerable. If detainees arrive as a group, they may be cohorted together to quarantine for 14 days before entry into the general population[8].

Public health priorities identified in a review of COVID cases in prisons in the US[9] included:

- accelerated population reduction and support to re-enter the community and limit the need for re-incarceration
- improving prison ventilation systems
- limiting movements between facilities
- strengthened partnerships with public health departments
- maintaining effective occupational health programs
- providing emergency mental health support for inmates/detainees and staff
- ensuring appropriate mask use.

As any outbreak response involves contact tracing of both inmates and staff, administrative processes and procedures for accurate recording of staff rosters, inmate/detainee movements and visitors to the facility must be in place. These data should be readily available in an electronic format to give to public health authorities as required. Testing the process of extraction and provision is needed to ensure high quality and complete data are rapidly accessible.

It is essential for correctional and detention facilities to work with local and state/territory governments to ensure they can manage inmates/detainees with COVID-19 while maintaining the level of care required for all other inmates/detainees. This includes caring for inmates/detainees onsite if the policy is only to transfer cases to hospital if there is a clinical need for hospital care.

[8] Briefing paper- interim assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England. Prepared by: Dr. Éamonn O'Moore, National Lead for Health & Justice, PHE and Director UK Collaborating Centre, WHO Health in Prisons Programme (European Region). Date: April 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf (accessed 15/8/21)

[9] Elizabeth Barnert, Ada Kwan, Brie Williams, "Ten Urgent Priorities Based on Lessons Learned From More Than a Half Million Known COVID-19 Cases in US Prisons", *American Journal of Public Health* 111, no. 6 (June 1, 2021): pp. 1099-1105. https://doi.org/10.2105/AJPH.2021.306221

Facilities should consider identifying an infection prevention and control consultant who could be available if an outbreak occurs, to provide advice or join the Outbreak Management Team.

2.1.1. Staff Education and Training

Each correctional and detention facility is responsible for ensuring training of staff to be competent in all aspects of outbreak management prior to an outbreak. All staff (including prison/security officers, healthcare workers, and education staff) should know the signs and symptoms of COVID-19. This will help them to identify and respond quickly to a potential outbreak. Additionally, all staff need to understand the infection prevention and control guidelines and be competent in implementing these measures during an outbreak. All staff should be familiar with the Facility Outbreak Management Plan and know where to access it. This plan should be exercised in collaboration with the local PHU and state health department.

Topics for staff education and training should include:

- Symptoms and signs of COVID-19
- How to identify if a person with COVID-19 is deteriorating
- Exposure risk levels for COVID-19, including travel and contact with confirmed cases
- Vulnerable populations at higher risk of severe illness
- Personal hygiene, particularly hand hygiene, and sneeze and cough etiquette
- Appropriate use of PPE in an outbreak such as:
    - Gloves
    - Gowns
    - Eye protection (face shields, eye shields, goggles, or safety glasses)
    - Surgical masks and particulate filter respirators (PFRs) such as P2/N95 respirators
    - Training how to don and doff PPE correctly.
        - Note that training in use of particulate filter respirators requires fit testing well ahead of any outbreak
- Actions if experiencing symptoms of COVID-19 (do not work or visit a correctional or detention facility and seek testing for COVID-19)
- Handling and disposal of clinical waste
- Processing of reusable equipment
- Environmental cleaning
- Adequate cleaning of transport vehicles
- Safe laundering of linen
- Food handling and cleaning of used food utensils.

2.1.2. Consumable Stocks

Facilities with some clinical capacity should work with health care staff to ensure that they hold adequate stock levels of consumable materials required during an outbreak, including:

- PPE (gloves, gowns, surgical masks, and particulate filter respirators such as P2/N95 respirators, eyewear)
- hand hygiene products (alcohol based-hand rub, liquid soap, hand towel)
- cleaning supplies (detergent and effective disinfectant products).

Facilities should have an effective policy in place to obtain more stock from suppliers as needed. To monitor stock levels, facilities should:

- undertake regular stocktake (counting stock)
- use an outbreak kit/box

2.1.3. Prepare an Outbreak Management Plan

Preparing an outbreak management plan will help staff identify, respond to and assist in the management of a COVID-19 outbreak. It will protect the health of staff and inmates/detainees and reduce the severity and duration of outbreaks if they occur.

At a minimum, facilities must identify a dedicated outbreak coordinator or commander as well as an outbreak preparedness and response team. (See Appendix 5 Outbreak Management Team).

In the plan assume that:

- A resurgence in cases may mean local PHUs and other services have limited capacity **and may prioritise other settings depending on supply and demand dynamics.**
- Vaccination will protect most people against severe disease, but vaccinated individuals may continue to spread the virus to others.

Plan access to additional staff

Facilities may require surge workforce from outside the facility during an outbreak.

Facilities should have a staff contingency plan that can cover at least a 30 – 50% staff absentee rate. On occasion, facilities will need to furlough a larger proportion of the workforce. Staff may be absent for long periods if required to quarantine during a community outbreak.

Consider the potential impact of shortages of healthcare staff working in these facilities. Facilities should consider developing and maintaining a contact list of casual staff and working with relevant government departments to plan for a replacement workforce, if required.

Plan for wider testing

If a facility detects a case, all persons in the facility may require testing. Facilities should make plans for capability and locations to collect specimens and enable safe collection of deep nasal and throat swabs.

Plan to communicate

Facilities will need a communications plan as part of the Outbreak Management Plan. They should utilise multiple means of communication with inmates/detainees, staff, unions, professional services and inmate/detainees' families. External call centres can be pre-engaged to undertake communications on behalf of facilities. In addition, facilities should ensure adequate telecommunication facilities for teleconferences with multiple agencies.

Plan to enable physical distancing

Plans should include considerations of how to enable physical distancing in the facility. List possible physical distancing strategies as required at different stages of an outbreak. This may require more staff for supervision and management. Options include staggering mealtimes, removing every second chair in dining areas, and reducing group sizes in daily activities.

Inmates may need to lockdown in their cells for a period of time until the facility determines the extent of the outbreak.

Plan to enhance infection control

Facilities should procure, store and identify how to access additional PPE, including gloves, gowns, eye protection (face shields, eye shields, goggles or safety glasses), surgical masks and particulate filter respirators (PFRs) such as P2/N95 respirators.

Plan for how to deliver PPE to areas and dispose of the PPE safely.

- Facilities will require points for access, storage and disposal of PPE. This may involve use of large volumes of PPE.
- Disposal of PPE will generate large volumes of waste.

Prepare signs for PPE including how to put on and remove (don and doff) PPE and required infection prevention and control precautions. See Sequence for putting on and removing PPE in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021).

Cleaning AND disinfection should occur during COVID-19 outbreaks. Plan to use either a 2-step clean (use detergent first, then an effective disinfectant such as sodium hypochlorite diluted as per the manufacturer's instructions) or 2-in-1 step clean (use a combined detergent/disinfectant product (see Therapeutic Goods Administration (TGA) listed disinfectant with virucidal claims (kills viruses).

Develop lists to clean those frequently touched surfaces closest to the inmate/detainee, and those regularly touched by the hands of staff or inmates/detainees, more often.

Follow these principles:

- Clean inmate/detainee room/zone/bathroom/toilet every day if feasible
- Clean and disinfect frequently touched surfaces more often. These include:
    - bedside tables
    - light switches
    - remote controls
    - sinks
    - equipment close to inmates/detainees or staff
    - handrails and tabletops in facility communal areas
    - guard station counter tops.
- Cleaners should:
    - Use impermeable disposable gloves, gown or apron, eye protection or a face shield and the same respiratory protection as determined for other staff (surgical mask or particulate filter respirator)
    - adhere to the cleaning product manufacturer's recommended dilution instructions and contact time.
- Terminally clean the room when the COVID-19 positive inmate/detainee moves or is discharged.

Plan how to cohort/zone inmates/detainees in an outbreak

Cohorting/zoning refers to grouping individuals with the same status in the same location. Outbreak Management Plans should include floor-maps which have been colour coded and labelled with instructions for how to cohort/zone in response to infection patterns.

A clear priority in managing an outbreak is proactively limiting spread to unaffected staff and inmates/detainees. This requires removing ongoing risk of exposure to:

- Avoid proximity to and contact with COVID-19 cases.
- Avoid proximity to potentially contaminated areas, systems, equipment and surfaces such as in shared rooms, bathrooms and equipment.

Plan how to cohort/zone inmates/detainees together if possible, in a separate wing or building. In principle, when more than one inmate/detainee has confirmed COVID-19, the facility can provide care together in an area away from inmates/detainees who are not known cases, preferably in single rooms. If possible, identify areas that can be used for isolation.

Consider cohorting/zoning in planning and where feasible discuss with the PHU or other experts. However, some general principles are below.

Consider five zones:

Green zone	Individuals who have met the release from isolation criteria against COVID-19. Note: in the initial stages of an outbreak all inmates/detainees are usually considered close contacts and will be in quarantine.
Yellow zone	Unvaccinated individuals who have been released from quarantine following a risk assessment (includes those who are not close contacts). Fully vaccinated individuals who are not close contacts.
Amber zone	Individuals who have met the close contact or suspected case definition and are in quarantine. This may include new inmates/detainees when there is COVID-19 in the community.
Red zone	Individuals who have confirmed COVID-19.
Blue zone	Buffer areas between potentially contaminated and non-contaminated zones. For example, staff security points, corridors, staff lunchrooms, meeting rooms. Blue zones also include transition points from one zone to another where staff must don or doff PPE.

When setting up zones, facilities should consider:

- Amber and red zones should be
    - geographically separated
    - decluttered to make cleaning and decontamination easier
    - assigned dedicated staff
    - include single rooms/cells with their own bathroom.
- All zones should have
    - limited entry/access
    - sites for PPE and hand sanitiser
    - staff break areas, spacious to enable physical distancing to prevent spread
- Ideally implement zoning after the first round of testing is completed and be flexible to adjust zones as individuals recover. Anything that moves between zones such as food service or linen pathways should move from green to red zones i.e. from clean to contaminated.

2.2. Prevention

Correctional and detention facilities should prioritise prevention activities[10] (Box 1). It is essential that facilities avoid exposure to infection, by introduction of cases, which could spread quickly in the residential environment.

Box 1. Prevention and management[9]

A systematic review of published studies of infectious diseases in prisons identified consistent themes in relation of the importance of immunisation, screening new entrants, contact tracing and isolation of suspected cases.

Some unique challenges to prisons were also described, including high rates of movement between and within establishments, and the large number of potential contacts based on the high turnover in many prisons, regular visitors and regular association with prison staff. Epidemiological surveillance is therefore more important in these settings.

2.2.1. Education

Education for staff, inmates/detainees and visitors is vital to prevent introduction of COVID-19 and manage ongoing transmission in an outbreak setting. Information should include respiratory hygiene and cough etiquette, hand hygiene and restrictions on visitation.

Facilities should reinforce the underlying principle of staff and visitors staying away from the facility if they are unwell. Place signage at all entry points to the facility and by encouraging self-screening (refer 3.2.1).

2.2.2. Vaccination

COVID-19 vaccines are effective in preventing severe illness from COVID-19. Encourage staff and inmates/detainees to receive the vaccine when offered to them because of the higher risk of transmission of disease if it is introduced into a residential environment. Offer all new unvaccinated inmates COVID-19 vaccination on entry to the facility. In settings of community transmission or outbreaks in facilities, it may be appropriate to reduce the time between doses of AstraZeneca vaccine.

All facilities should document the vaccination status of inmates/detainees and staff.

In the event of an outbreak, redouble efforts to improve vaccination of both staff and inmates including reactive vaccination programs to prevent ongoing transmission in the facility and protect individuals.

2.2.3. Prevent Introduction into the Facility by Visitors and Staff

Facilities should comply with all Commonwealth, and state or territory directions on restrictions relating to visitors. This applies when visitors are unwell or when there is significant community transmission occurring.

- Visitors to the facility (including family members, legal support and official prison/detention visitors) can potentially transmit SARS-CoV-2 to inmates/detainees and should be **restricted** if there is local community transmission. Consider alternative means of family/legal contact such as audio-visual links.
- Facilities should advise (in relevant languages and culturally appropriate) all regular and non-regular visitors to be vigilant with hygiene measures including physical

[10] Beaudry G, Zhong S, Whiting D, *et al* Managing outbreaks of highly contagious diseases in prisons: a systematic review *BMJ Global Health* 2020;**5:**e003201. https://gh.bmj.com/content/5/11/e003201

distancing. Facilities should consider the introduction of signage and appropriate barriers.

- Instruct staff and visitors to stay away when unwell. **Staff must not come to work if symptomatic with an illness compatible with COVID-19**. Staff with symptoms should seek COVID-19 testing. Sick leave policies must enable employees to stay home if they have symptoms of respiratory infection or other infectious illness. They must notify the facility if they have been tested for COVID-19 or are a COVID-19 case.
- Consider screening for staff and visitors (including visiting workers)
    - Screening for symptoms or exposures
    - Use of check in apps for contact tracing
    - Frequently test staff if there is COVID-19 transmission in the community
    - Testing in reception centres and police cells.

Rapid Antigen Tests

Rapid Antigen Tests (RATs) are tests for SARS-CoV-2 antigen that are easy to conduct and get test results within 15 to 30 minutes. If there is a high prevalence of disease in the community, skilled health staff can conduct RAT on facility staff or visitors for **screening purposes.**

Facilities should **NOT** use RATs to confirm the diagnosis of SARS-CoV-2 infection. People who are symptomatic or known primary close contacts of a positive COVID-19 case should not get a RAT, instead they should isolate and have an RT-PCR test.

If a staff member or visitor receives a positive RAT result:

1. Immediately isolate the staff member. If a visitor is positive contact the PHU.
2. Notify the local PHU of the positive detection. The PHU will provide advice on control measures, repeat testing via RT-PCR and contact tracing;
3. **Do NOT initiate contact tracing separately from PHU advice. Facilities should keep any positive detection in strict confidence and only report to the PHU who will provide advice on the reliability of the result**

It is important to note that a negative result from a COVID-19 screening test does not negate the need for other appropriate interventions (such as mask-wearing and physical distancing).

For more information please see: Rapid Antigen Tests

2.2.4. Prevent Introduction by New Inmates/detainees

Lessons have been learnt from the UK about the importance of seeding of new cases into the population by incoming inmates/detainees[11] (See Box 2).

[11] Briefing paper- interim assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England. Prepared by: Dr. Éamonn O'Moore, National Lead for Health & Justice, PHE and Director UK Collaborating Centre, WHO Health in Prisons Programme (European Region). Date: April 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf (accessed 15/8/21)

High risk of introduction

Where there are *COVID-19 cases in the community*:

- Test all new inmates/detainees regardless of symptoms and provide quarantine for 14 days (see Box 3). Consider the anticipated length of stay (> 14 days)
- Facilities may consider some inmates/detainees lower risk, although located in areas with known community transmission. These include those who have been transferred directly from another facility and:
    - Where that facility has no suspect, probable or confirmed cases of COVID-19,
    - Where the inmate/detainee has only been in that facility within the preceding 14 days,
    - Where the inmate/detainee has screened for COVID-19 and is asymptomatic on entry.
    - Fully vaccinated individuals.

Box 2. Lessons from the UK

In an outbreak in Birmingham successful containment was achieved with control measures and compartmentalization led to successful containment.
However, subsequent newly diagnosed cases all came directly from new arrivals in reception.

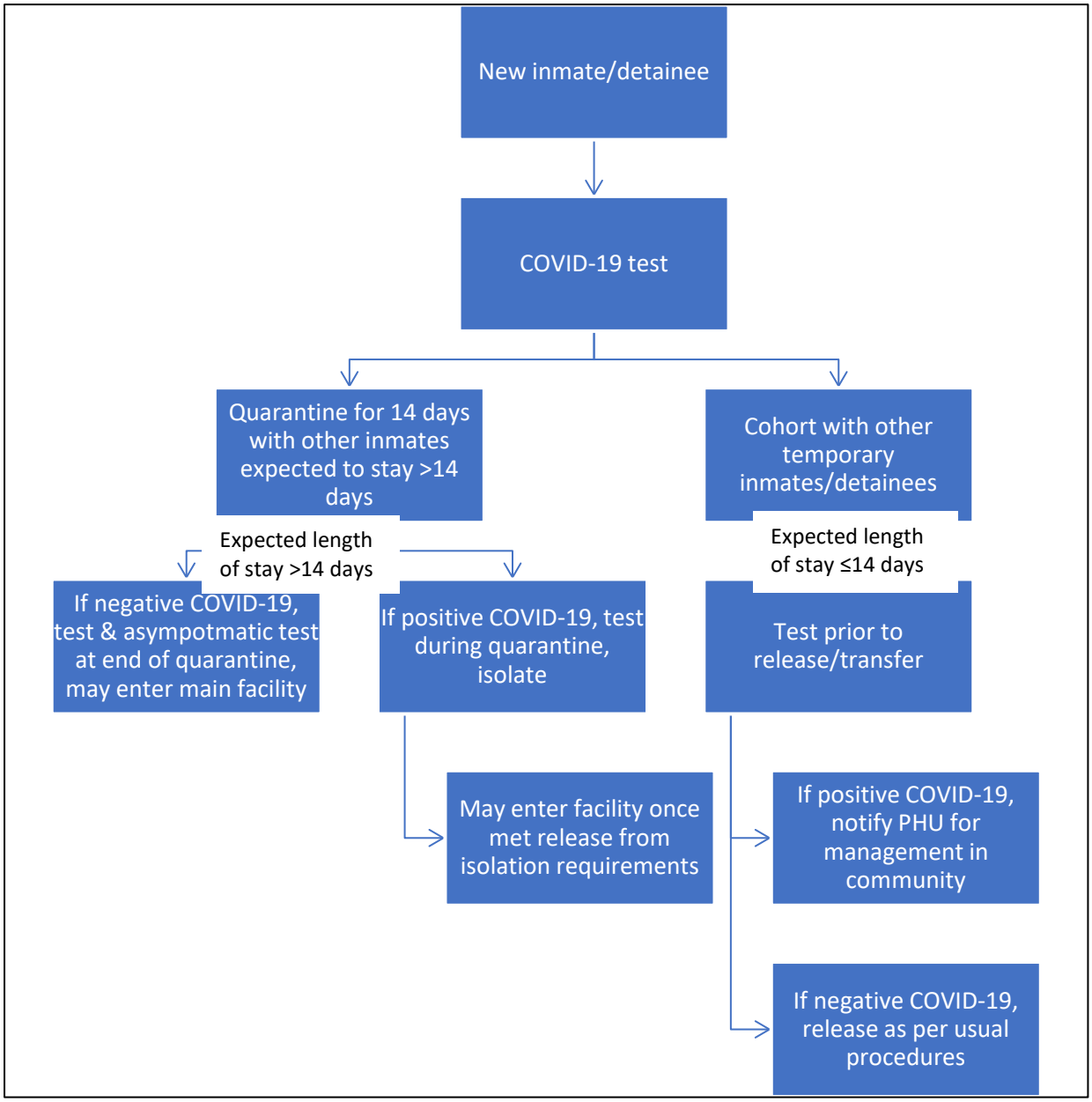
Highly effective reception screening protocols need to be in place to identify symptomatic patients as well as to enable effective quarantine for 14 days before being admitted to the general population.

Public Health England National Health and Justice Team[10]

Box 3. Quarantine options

1. *Individual - in a single cell with access to private toileting facilities.*
2. *In cohorts (separated group in the same area of the facility)*
   a) those staying less than 14 days (test prior to exit)
   b) those staying > 14 days but arrive in groups or on the same day. Note that, if a case emerges in this group, individual quarantine will be required for all members for 14 days after the onset of illness in the case.

Figure 1. Flow of inmates/detainees when there is COVID-19 in the community



Lower risk of introduction

When there are no community cases of COVID-19

If there are *no COVID-19 cases in the community*, screen individuals for COVID-19 symptoms in the watch house or at reception, prior to transfer to the facility.

Test all incoming inmates/detainees who are unwell and place them in isolation.

2.2.5. Prevent Spread Between Facilities

Test all inmates/detainees who are being transferred from another facility (unless there has been no COVID-19 in the state/territory). Where there is COVID-19 in the community, reduce movement between facilities to minimise exposure to transport staff. If transfers are required, ensure staff wear full PPE.

2.2.6. Prevent exposure within the facility

Prevention requires vigilant implementation of effective infection prevention and control procedures. Facilities should use risk assessments to ensure the risks of a COVID-19 outbreak are as low as possible. This can involve examining:

- the layout and the environment,
- equipment,
- workforce training,
- processes or practices affecting any aspect of inmate/detainee management and delivery of personal and clinical care.

Ensure signage and other forms of communication (i.e. information and fact sheets) in relevant languages convey key messages including what actions the facility is taking to protect them and explaining what they can do to protect themselves. Support personal protection measures including respiratory hygiene, cough etiquette, and hand hygiene.

Facilities must ensure adequate hand washing supplies, as well as tissues and lined disposal receptacles are available for inmates/detainees to use; in common areas, in the visitor area and in where possible each inmate/detainee's room.

NOTE: The implementation and use of alcohol-based hand hygiene products should be undertaken in a safe manner within facilities that ensures appropriate access for visitors and inmates/detainees, without compromising safety or enabling unauthorised access.

3. COVID-19 Case and Outbreak Management

3.1. Detecting and managing a case of COVID-19

Establish systems to monitor staff and inmates/detainees for COVID-19. These should have a high level of vigilance and have a low threshold for COVID-19 testing. If local transmission of COVID-19 is occurring, effective surveillance will:

- enable early identification of symptoms in staff and inmates/detainees
- assist to recognise and manage cases early.

Promptly restrict and test any people who have acute respiratory infection or fever. Place unwell inmates/detainees in single rooms in a dedicated wing or unit. This will ensure that staff can provide care without moving or being allocated to work in other areas throughout the facility. If unwell inmates/detainees must leave their room to attend the infirmary or health centre, they should wear a surgical mask (if tolerated). Treat the person as a suspected COVID-19 case while waiting for their result.

The CDNA National Guideline provides the current case definition for COVID-19. The guidance provides advice on definitions of a confirmed case or suspect case and primary or secondary close contacts.

3.2. Notification – State/Territory Department of Health

Immediately notify the local state/territory Public Health Unit of any suspected or confirmed cases[12]. See sample reporting template available at Appendix 3.

If the case is a staff member, exclude them from work (refer to guidance here) until they meet the release from isolation criteria outlined in the CDNA National Guideline. The correctional or detention facility must notify the PHU of the case. The PHU will determine if the case was infectious while at the facility and advise on appropriate action.

The PHU will provide the facility with a preferred case list (also called a 'line list') template to use during an outbreak. The facility should send the line list to the PHU each day with note of any inmate/detainee hospital admissions.

State/Territory Public Health Unit Contact details

State	Contact Details
Australian Capital Territory	Business Hours: 02 5124 9213 | After Hours: 02 9962 4155
New South Wales	1300 066 055
Northern Territory	08 8922 8044
Queensland	13 432 584 (13 HEALTH)
South Australia	1300 232 272
Tasmania	1800 671 738
Victoria	1800 675 398
Western Australia Public Health Emergency Operations Centre	9222 0221

Up to date local State and Territory health department contact details are available on the Australian Government Department of Health website.

Public Health Unit staff may wish to explore a model of SARS-CoV-2 transmission within prison settings developed by researchers at The Kirby Institute.

3.3. Activate the Outbreak Management Plan

The definition of a COVID-19 outbreak is:

> **A single confirmed case of COVID-19 in an inmate/detainee, staff member or attendee of a correctional or detention facility.**

This definition includes any confirmed case who attends a correctional or detention facility during their infectious period. The State/Territory PHU will assist the correctional or detention facility to decide whether to declare an outbreak.

3.3.1. Call a meeting of the Outbreak Management Team

Activate the outbreak management plan and meet with the Outbreak Management Team as soon as possible. Many health care staff will fill the required roles in the OMT. However,

[12] Laboratory confirmed COVID-19 is a notifiable disease in all Australian states and territories. The requesting medical officer and/or the testing laboratory must notify the infection to the jurisdictional communicable disease authority, depending on local legislative requirements. This notification is confidential.

other prison/detention staff, particularly management, should lead and actively manage the response. (see Appendix 5).

The OMT needs to consider engaging an infection prevention and control consultant or discuss other support requirements with their PHU. Surge staffing from other agencies may need to be requested if feasible to assist correctional and detention facility staff and avoid transfer of inmates/detainees to hospital.

3.3.2. Test

Once an outbreak is declared, the PHU will assist to coordinate testing in the facility

The PHU will assist the facility OMT to test all members in the exposed region of the facility (including staff), as required. The CDNA National Guideline outlines recommended COVID-19 tests and methods of sampling.

If a medical officer requests a test, an appropriately trained health professional should collect the required respiratory samples with the proper use of PPE. Inmates/detainees do not need to transfer to a hospital to get COVID-19 testing. Testing must occur in an appropriate location.

The PHU may advise the OMT to implement additional actions while waiting for test results in order to minimise transmission.

The PHU will advise on the need to screen individuals who test negative and, where feasible, implement a program of repeat tests [13].

3.3.3. Isolate and cohort

Immediately isolate ill inmates/detainees (or cohort) and minimise their interaction with other inmates/detainees.

Ensure that there is no movement of inmates/detainees across different regions in the facility; for example, 'sweepers' who may usually have additional rights to move across the facility.

Establish the green to red zones as identified in the plan. Note: Do not cohort confirmed cases with suspect cases.

The PHU will help with contact tracing outside of the facility and will provide advice for isolation of cases and quarantine of contacts, whether inmates/detainees or staff. The PHU will also determine when cases can come out of isolation. Ideally these processes should be exercised with the local PHU as part of preparation.

If the numbers of cases in a facility increase in an outbreak situation, isolation resources may come under pressure. If a single room is not available, follow these principles to guide inmate/detainee placement:

- solitary confinement rooms may be appropriate if alternative single room accommodation is not available.

[13] See Section 11, Outbreak investigation and management in high-risk settings, in the CDNA National Guideline for additional information about repeat testing in the context of an outbreak.

- inmates/detainees with excessive cough and sputum production or other risk factors for transmission should have highest priority to a single room.
- inmates/detainees who are COVID-19 cases can stay together in the same room (cohort), if feasible.
    - Staff must ensure they change their PPE and perform good hand hygiene when moving between inmates/detainees cohorted in the same room.

If these options are not available and an inmate/detainee needs to isolate, staff should contact the local PHU to seek advice on the best alternative.

Once isolation or cohorting measures are in place, to further reduce the risk of transmission, allocate specific correctional and detention facility staff (including specific healthcare staff and specific guards/security staff) to the care of inmates/detainees in isolation.

Maintain a register of staff members caring for patients with COVID-19. The facility must ensure that staff members:

- do not move between their allocated room/section and other areas of the facility, or care for other inmates/detainees.
- monitor themselves for signs and symptoms of acute respiratory illness and do not attend work if unwell.
- do not work in other facilities even if asymptomatic, until the PHU declares the outbreak is over.

Separate unaffected vulnerable inmates/detainees who are at risk of severe COVID-19 disease from those who may have been exposed to COVID-19. Consider other measures to protect vulnerable inmates/detainees including early release or alternative accommodation. This particularly applies to inmates/detainees considered suitable for early release including youth.

Release from isolation

The local PHU will work with the facility to determine when the case may be released from isolation. The minimum standard for release from isolation criteria can be found in the COVID-19 CDNA National Guidelines for Public Health Units.

3.3.4. Enhance physical distancing

Follow the facilities plan to enable spacing between inmates/detainees. Reduce gatherings of inmates/detainees such as by staggering mealtimes. Suspend unnecessary group activities. If there are zones with no disease in the facility, determine if small group activities can occur. Small group activities should maintain physical distancing.

3.3.5. Provide clinical care including mental health support

Most people who acquire COVID-19 do not suffer from severe disease. Inmates/detainees may be anxious and concerned about what will happen to them. Ensure that you provide reassurance, information and clinical care.

Monitoring of confirmed cases for deterioration

If cases are receiving care in the facility, health care staff should monitor patients frequently, or at least once per shift. Facilities should have a way to alert officials and health care providers if there is any deterioration in the prisoner's/detainee's state of health.

Train correctional staff supervising unwell inmates/detainees in recognising a deteriorating patient. Monitor patients with COVID-19 for indications that their condition is getting worse including worsening shortness of breath, blue lips or face, pain or pressure in the chest, clammy or pale and mottled skin, confusion, fainting or coughing up blood. The following RACGP Homecare guidelines may be helpful.

Mental Health

Both cases in isolation and contacts in quarantine may face emotional challenges when separated from the rest of the population. Processes for monitoring detainees, and early detection of mental health concerns, should be enhanced with heightened awareness for Aboriginal and Torres Strait Island detainees.

Transfers

If you need to transfer a COVID-19 case to hospital, ensure that you notify the ambulance service and receiving hospital of the outbreak/suspected outbreak verbally. You will also need to complete a transfer advice form (see Appendix 4).

Usual escorts and accompanying health care staff, preferably those who are fully vaccinated, can escort inmates/detainees. All escorts, irrespective of vaccination status, should adhere to appropriate PPE requirements (on the advice of health care staff) during transfer. Vehicles used for transport must be appropriately cleaned after transfer of the patient.

A transfer of any person to another custodial facility is unwise during an outbreak. Identify alternative presentation for Court appearances such as video links.

3.3.6. Enhance infection prevention and control

In an outbreak everyone in the facility should wear a surgical mask as a minimum.

All workers who work within the zone for individuals with suspected or confirmed COVID-19 should have access to P2/N95 respirators.

To identify the appropriate personal protective equipment to use in different zones or when performing tasks, a risk assessment should be undertaken see Box 4. See Appendix 6 for further information on infection prevention and control.

If there is a low of risk of SARS-CoV-2 transmission

PPE may include the use of a surgical mask, gloves, gown and eye protection, depending on the indications for use.

Undertake a risk assessment to inform the use of PPE
Risk assessment will inform determination of the appropriate of PPE for different circumstances. This should occur within a standardised risk management framework, which includes higher order controls already in place at an organisational and state and territory level. Risk assessment should consider:

a) Inmate/detainee's likelihood of COVID-19, this is higher if the person:
- has COVID-19
- has symptoms consistent with COVID-19
- is a close contact of a case.

b) Inmate/detainee's factors for higher risk include:
- potential for behaviours that increase the risk of SARS-CoV-2 transmission (e.g. exhibiting challenging behaviours, coughing, shouting or increased work of breathing)
- inability of the inmate/detainee to wear a surgical mask.

c) Nature of the contact episode
This risk is higher with longer duration and close proximity of contact between worker and individual

d) Physical location
This risk is higher with
- The presence of multiple individuals with suspected/confirmed COVID-19 in an enclosed space

If there is a high risk of SARS-CoV-2 transmission

PPE may include the use of a P2/N95 particulate filter respirator, gloves, gown and eye protection, depending on the indications for use.

Particulate filter respirators

Wear PFRs such as P2/N95 respirators instead of a surgical mask if the risk assessment suggests a likely high risk of transmission.

If a risk assessment is not possible, staff should use P2/N95 respirators in place of surgical masks.

Train staff who use P2/N95 respirators in their correct use. Staff should complete fit testing before first use, ideally during the preparation phase. This allows selection of the most suitable P2/N95 respirators. Each time staff use P2/N95 respirators they should perform a fit (seal) check.

It is important to use P2/N95 respirators correctly to provide protection against airborne pathogen transmission. Develop a respiratory protection program to guide the selection, testing and use of P2/N95 respirators.

In situations where facilities have not carried out fit testing, and a P2/N95 respirator is recommended, the facility should prefer a fit-checked P2/N95 respirator over a surgical mask.

Staff providing direct care or working within the zone for individuals where risk assessment suggests a risk of transmission, should use PPE for standard, contact and droplet precautions as specified COVID-19 Infection Control Expert Group and in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021).

Protective eyewear

The eye is a potential route of transmission for SARS-CoV-2. Protective eyewear can protect the eye from contamination with particles and body fluids that may contain SARS-CoV-2 and prevent people from touching their eyes and face and spreading virus from their hands to their face and eyes.

Use protective eyewear (in addition to other required PPE) when working within the zone with individuals with confirmed, or suspected COVID-19.

Standard Precautions apply in all risk levels (high and low) and eyewear is recommended where facilities anticipate risk of exposure (splash) from blood or body fluids.

3.3.7. Clean and disinfect

Follow the plan for cleaning and disinfection at section 2.7.

Minimise equipment and items in areas with cases. Only use reusable inmate/detainee care equipment for the individual inmate/detainee. For equipment that must be shared, clean and disinfect between each inmate/detainee use.

Wash and sanitise linen using hot water (>65 degrees Celsius for 10 minutes). Use a standard laundry detergent. Dry linen in a dryer on a hot setting. Implement standard operational procedures for the safe laundering of used linen within the facility, such that there is no need to separate the linen for use by ill inmates/detainees from the linen used by other inmates/detainees. Use appropriate safe work practices including the use of PPE when handling soiled linen.

Standard safe operating procedures, including the use of PPE where applicable, applies for the use, cleaning and sanitising of crockery and cutlery in a hot dishwasher. If a dishwasher is not available, wash by hand using hot water and detergent. Rinse in hot water and dry. There is no need to separate the crockery and cutlery for use by ill inmates/detainees from that of other inmates/detainees.

See the Australian Government Department of Health website for more information on environmental cleaning and disinfection. This is available in ICEG guidance see ICEG recommendations .

3.3.8.Communicate

Make sure to activate a communication plan. This is important because many individuals, services and stakeholders will be seeking information.

3.3.9. Signage

Place signs at the entrances and other strategic locations within the facility to inform of the infection prevention control requirements in the facility. Ensure you place PPE precautions sign/s in appropriate language/s outside symptomatic inmate/detainees' rooms to alert staff to follow transmission-based precautions.

Standardised signs are available at the Australian Commission for Safety and Quality in Health Care website: https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/infection-control-signage

3.3.10. Visitors

During a COVID-19 outbreak, suspend visitor access into and within the facility. Facilities should postpone visits from non-essential external providers.

3.3.11. Management of staff

Only designated, preferably fully vaccinated, staff should care for patients with potential or confirmed COVID-19.

During an outbreak of COVID-19:

- ensure staff (health care workers and corrections staff) do not move between wings or units of the facility where possible
- ensure staff do not attend work if they are a contact or have been directed into quarantine
- ensure staff do not work at another facility or high risk setting until the PHU declares the outbreak is over

3.3.12. Mental health and emotional and social wellbeing

Extended periods of isolation can result in distress and deteriorating mental health. Facilities should ensure inmates/detainees continue to have access to their families and support networks through telephone and video contact. Facilities should ensure mental health and social support services are able to access and support inmates/detainees while in isolation or quarantine. Cultural support should be available for Aboriginal and Torres Strait Islander inmates/detainees. Researchers in prison health have written:

> *'Prisoners are a vulnerable group, with multiple complex health needs and worse health outcomes relative to the general population worldwide. To date, little focus has been given to the effects of the COVID-19 pandemic on the mental health of prisoners; an area of concern given their high rates of pre-existing mental disorders, suicide, and self-harm, and the links between poor mental health, suicide, and self-harm, and reoffending behaviour.*
>
> *COVID-19 presents substantial challenges to offender populations. Measures have been, and should continue to be, implemented to reduce disease transmission within prisons; however, these measures are not cost free and their consequences to mental health should be decreased wherever possible.*

The importance of acts of kindness in promoting positive mental wellbeing should not be underestimated.' Hewson, Shepherd, Hard and Shaw 2020[14]

'Opportunities for contactless social engagement and periods spent outdoors need to be integrated into COVID-19 quarantining practices in custodial settings.' Stewart, Cossar, Stoove 2020[15]

All staff members should self-monitor for signs and symptoms of COVID-19. If they are unwell, staff should not attend work, and should self-exclude, even if they have used appropriate PPE.

3.3.13. Admissions

It is unwise to accept new admissions to a correctional and detention facility during an outbreak. However, if cohorting is in place and admission must occur, facilities may admit new inmates/detainees to an unaffected unit during an outbreak.

The re-admission of inmates/detainees who were in hospital for COVID-19, may occur if the person has met the Release from Isolation requirements see CDNA National Guideline.

If transfer must happen before meeting release from isolation requirements, provide appropriate accommodation along with infection prevention and control requirements and dedicated experienced staff.

3.3.14. Transfers

Transfers of people unaffected (tested negative, asymptomatic and having quarantined) may be possible in **exceptional circumstances**. Refer to the Public Health Unit before considering this. If a transfer occurs, tell the receiving facility that the inmate/detainee may have been exposed to COVID-19 and is at risk of developing disease.

Release from detention

If facilities release an inmate/detainee from detention, notify the PHU implement/consider the following measures, as required:

- If the inmate/detainee is a confirmed case, ensure safe transportation to accommodation suitable for isolation and maintenance of ongoing care and monitoring.
- If the inmate/detainee is a close contact, ensure transportation to accommodation suitable for quarantine for the length of time required. Ensure ongoing support and advice, including access to testing, if required.
- If the inmate/detainee is not a close contact, advise them to self-monitor for any symptoms and seek testing urgently if symptoms develop.

If a known COVID-19 case is due for release, the relevant PHU should make an assessment on the adequacy of the likely place of isolation and the willingness and ability of the inmate/detainee to comply with isolation. Provide accommodation for inmates/detainees who are homeless for at least the duration of the isolation period. In relation to Aboriginal

[14] Hewson, T., Shepherd, A., Hard, J. and Shaw, J. Lancet Psychiatry. 2020 Jul; 7(7): 568–570 "Effects of the COVID-19 pandemic on the mental health of prisoners"

[15] Stewart, A., Cossar, R. and Stoove, M. (2020), "The response to COVID-19 in prisons must consider the broader mental health impacts for people and in prison", Aust NZ J Psychiatry. June 2020

and Torres Strait Islander inmates/detainees in particular, you need to be sure that overcrowding and other factors will not compromise their ability to remain isolated.

3.3.15. Monitoring Outbreak Progress

During outbreak management, it is important to observe all inmates/detainees for signs and symptoms of COVID-19. Facilities should be able to monitor inmates/detainees and staff for signs and symptoms of COVID-19 every day.

Testing (including repeat testing) and ongoing actions for individuals in the defined setting should follow the CDNA National Guideline. This includes:

- isolate and treat individuals who test positive.
- quarantine, as best as possible, and monitor symptoms, for individuals who test negative.
- where possible, begin a program of repeat testing of people who are asymptomatic for those in quarantine.[16]

Update the information in the line list through daily meetings of the OMT, or more frequently if major changes occur. Provide the line list to the PHU each day (or as arranged) until the PHU declares the outbreak is over.

The PHU will review updated information for:

- evidence of ongoing transmission
- effectiveness of control measures and prophylaxis.

The PHU will work with the correctional or detention facility OMT and tell them if any outbreak control measures need to change. The OMT should also continue to engage with infection prevention and control practitioners.

The OMT should review all control measures and consider seeking further advice from PHU if:

- the outbreak comprises more cases than the facility can manage.
- the rate of new cases is not decreasing.
- three (3) or more inmates/detainees are in hospital related to COVID-19, OR
- a COVID-19-related death has occurred. Telephone to notify the PHU of this.

4. Declaring the Outbreak Over

The time from the onset of symptoms of the last case until the PHU declares the outbreak is over can vary. In most circumstances PHU can declare a COVID-19 outbreak is over if no new cases occur within 14 days (maximum incubation period) following the date of isolation of the last case. However, the PHU may require a longer period before declaring the outbreak over. Once the outbreak is over, provide reports to relevant stakeholders and ensure that data are appropriately summarised.

The OMT may make decisions about ongoing facility surveillance after declaring the outbreak over, considering the following needs:

[16] Repeat testing should be undertaken in line with the CDNA National Guideline.

- Maintain general infection prevention and control measures.
- Monitor the status of ill inmates/detainees and communicate with the public health authority if their status changes.
- Notify any late, COVID-19-related deaths to the PHU.
- Alert the PHU to any new cases, signalling either re-introduction of infection or previously undetected ongoing transmission.
- Advise relevant state/territory/national agencies of the outbreak in a correctional or detention facility, if applicable.

5. Review

After a declaration that an outbreak is over, it is important that all parties reflect on:

- what worked well during the outbreak
- which policies, practices or procedures need revision to improve responses for future outbreaks.

The OMT should consult with the local PHU to consider a debrief for any outbreak. A debrief provides the opportunity to:

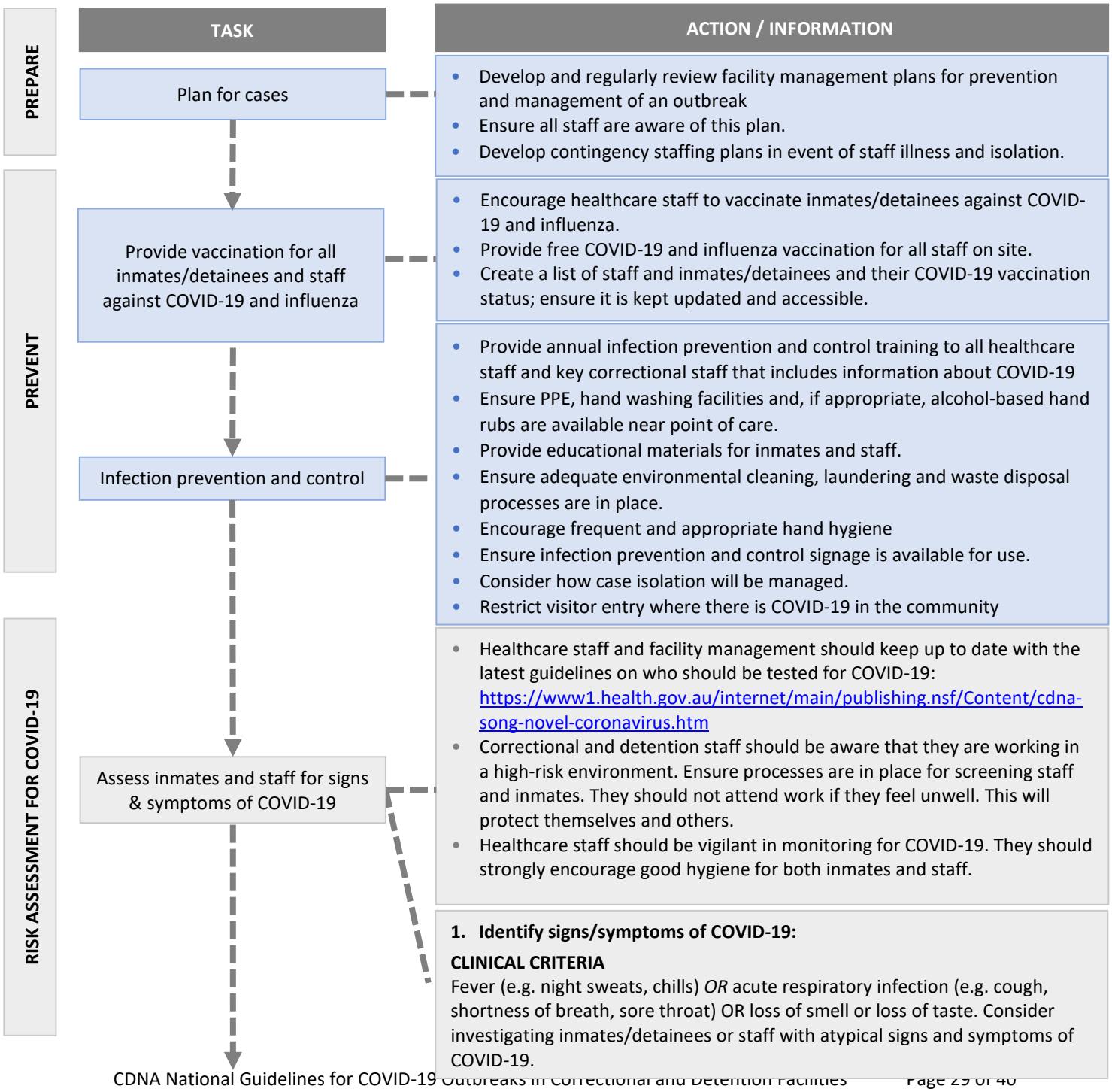
- identify strengths and weaknesses in outbreak response and investigation processes
- provide information to help improve the management of future outbreaks
- involve all members of the OMT and any others who participated in the response to the outbreak.

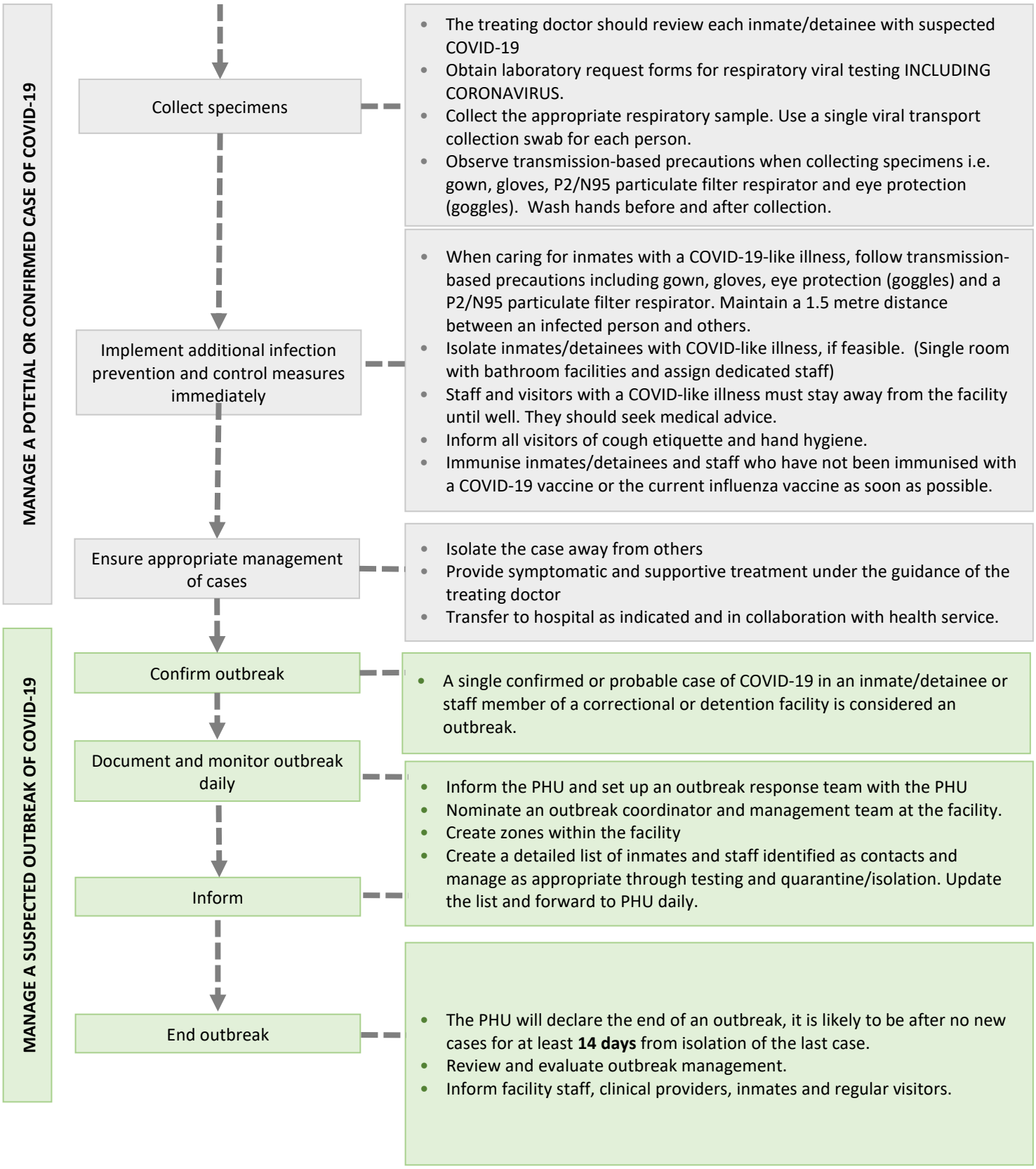
6. Appendices

Appendix 1. Prevention and Management of COVID-19 in Correctional and Detention Facilities

Flowchart for COVID-19 Management in Correctional and Detention Facilities in Australia

This guideline is for use by correctional and detention facilities in Australia. It has been adapted from Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units.
https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
Note: the case definition may change over time




MANAGE A POTETIAL OR CONFIRMED CASE OF COVID-19
Collect specimens
The treating doctor should review each inmate/detainee with suspected COVID-19
Obtain laboratory request forms for respiratory viral testing INCLUDING CORONAVIRUS.
Collect the appropriate respiratory sample. Use a single viral transport collection swab for each person.
Observe transmission-based precautions when collecting specimens i.e. gown, gloves, P2/N95 particulate filter respirator and eye protection (goggles). Wash hands before and after collection.
Implement additional infection prevention and control measures immediately
When caring for inmates with a COVID-19-like illness, follow transmission-based precautions including gown, gloves, eye protection (goggles) and a P2/N95 particulate filter respirator. Maintain a 1.5 metre distance between an infected person and others.
Isolate inmates/detainees with COVID-like illness, if feasible. (Single room with bathroom facilities and assign dedicated staff)
Staff and visitors with a COVID-like illness must stay away from the facility until well. They should seek medical advice.
Inform all visitors of cough etiquette and hand hygiene.
Immunise inmates/detainees and staff who have not been immunised with a COVID-19 vaccine or the current influenza vaccine as soon as possible.
Ensure appropriate management of cases
Isolate the case away from others
Provide symptomatic and supportive treatment under the guidance of the treating doctor
Transfer to hospital as indicated and in collaboration with health service.
MANAGE A SUSPECTED OUTBREAK OF COVID-19
Confirm outbreak
A single confirmed or probable case of COVID-19 in an inmate/detainee or staff member of a correctional or detention facility is considered an outbreak.
Document and monitor outbreak daily
Inform the PHU and set up an outbreak response team with the PHU
Nominate an outbreak coordinator and management team at the facility.
Create zones within the facility
Create a detailed list of inmates and staff identified as contacts and manage as appropriate through testing and quarantine/isolation. Update the list and forward to PHU daily.
Inform
End outbreak
The PHU will declare the end of an outbreak, it is likely to be after no new cases for at least 14 days from isolation of the last case.
Review and evaluate outbreak management.
Inform facility staff, clinical providers, inmates and regular visitors.

Appendix 2. Checklists

Checklist for Public Health Units		✓
Declare an outbreak	According to the CDNA guidelines	
Identify infectious period and exposure locations		
Investigate for downstream contacts and upstream source	Assist Outbreak Management Team from the facility to identify close and casual contacts. Include staff who may have worked at the facility during the infectious period	
Manage contacts outside of the facility	Trace, test, isolate and quarantine persons who have been at the facility and exposed	
Arrange testing for COVID-19 for all persons in the facility and recent visitors	Test and plan repeat test program	
Obtain records of COVID vaccinations	Identify fully vaccinated staff and detainees for management according to the CDNA guidelines	
Review results	Provide preferred line list format to the OMT for daily reports. Immediate review of positive test results with location of the inmate/detainee	
Advise the Facility Outbreak Management Team on		
Cohorting zones	Identifying zones, assigning staff, reviewing movements	
Quarantine and isolation periods	Advise on period of quarantine, release from isolation as identified in the SONG (this may include reference to fully vaccinated persons)	
Enhance infection prevention and control	Assist with identifying an IPC practitioner. Review disinfection and cleaning. Assist in risk assessment to inform the use of PPE.	
Managing staff	Staff screening program Identify staff who are close contacts who will need to be furloughed Recommend preferably fully vaccinated staff should care for patients with suspected or confirmed COVID-19.	
Release from detention facility	Ensure PHU is aware of any prisoner movements out of the facility	
Declare the outbreak over **According to the CDNA guidelines**		
Reflect on operations	Document and share lessons	

Facility Checklist for COVID-19 outbreak in a detention or correctional facility

Correctional/ Detention Facility Checklist		
Outbreak management	**Details**	✓
Isolate a person suspected of having COVID while arranging testing	Immediately isolate unwell inmates/ and cases in a single room with their own bathroom facilities, if possible, while waiting for a diagnosis.	
Inform the Public Health Unit	Inform the PHU. This includes a positive result from a rapid antigen screening test. Isolate the person. The PHU will assist the facility to decide whether to declare an outbreak and immediate actions.	
Activate the Outbreak Management Plan		
Call a meeting of the Outbreak Management Team	Arrange for the team to meet as soon as possible (within the day). The purpose of the team is to direct, monitor and oversee the outbreak and liaise with others. Clearly define roles and responsibilities.	
COVID-19 testing	All persons in the facility and staff - as coordinated by PHU	
Clinical management of cases	Cases should be regularly reviewed by healthcare workers. If a case requires transfer to hospital, advise the hospital in advance.	
Isolate and quarantine cohorts	The PHU will assist in identifying zones for management of those who may exposure and of cases of disease. Facilities should not cohort confirmed cases with suspected cases.	
Enhance infection prevention and control	Appoint an IPC advisor/contractor. Minimise equipment and items in areas with case. Enhance cleaning AND disinfection. Undertake a risk assessment to inform the use of PPE.	
Communicate	Activate communication plan	
Signage	Place signs at entrances and other strategic locations within the facility to inform infection protection control requirements.	
Visitors	Restrict access to facility to only essential external providers.	
Mental health and emotional and social wellbeing	Ensure continued access for inmates/detainees to family and support networks through telephone and video contact. Facilitate mental health and social support services. Ensure cultural support is available for Aboriginal and Torres Strait Island people.	
Management of staff	Restrict staff movement between units or zones of the facility. Assign vaccinated to care for COVID-19 patients Screen staff (symptoms and or tests – PHU will advise) Staff should not attend work if they are unwell. Staff should not work at another facility until the PHU declares the outbreak is over.	
New admissions	Avoid accepting new admissions during the outbreak if possible.	
Release from detention	If an inmate/detainee is due for release detention, notify the PHU prior to departure. Ensure close contacts are not released into the community.	
Monitor outbreak progress		
Observation of all inmates/ detainees	Increase observation for signs and symptoms of COVID-19	
Testing	As recommended by PHU	
OMT review of control measures	The Outbreak Management Team should continue to review control measures in place and seek further advice from the PHU as required	
Declaring an outbreak over is the role of the PHU.		
Reviewing outbreak management	After the PHU declares the outbreak is over, all parties should reflect on: What worked well during the outbreak Which policies, practices or procedures need to be modified to improve responses for future outbreaks.	

Appendix 3. Initial facility report to a PHU – COVID-19 Outbreak

Date/time: _____ Public Health Officer:_____

Contact details:

Person notifying outbreak: _____ Position: _____

Telephone number: _____ Email: _____

Facility details:

Name of Facility_____

Address: _____

Facility Manager / Director: _____

Telephone number: _____ Fax number: _____

Email address: _____

Description of facility:

Attach a floorplan, highlight units/wings

Description of the facility population:

Age range of detainees _____

Number who identify as an Aboriginal or Torres Strait Island person _____

Summary of the population and number unwell

	Number
Total inmates/detainees in the facility	
Inmates/detainees with COVID-19 symptoms	
Total staff working at the facility (see below)	
Staff with COVID-19 symptoms	

Staff:

Staff type	No. of staff	No. casual staff
Management		
Administrator		
Guard		
Healthcare staff		
Other (specify)		

List for those who have symptoms:

Inmate / staff identification name/ number	Location in the facility	Date of onset of symptoms	Date test was collected	Additional details (test result, transfer to hospital,

Appendix 4. Transfer Advice Form

[Facility Letterhead]

Date: ……/……/……

To: [Admitting Officer, Facility Name]

Please be advised that: [Inmate/detainee Name]

is being transferred from a facility where there is a cluster/outbreak of **COVID-19**. At this stage the outbreak is:

☐ suspected

☐ confirmed

Please ensure that **appropriate infection prevention and control precautions** are followed with this inmate/detainee.

At the time of transfer:

☐ **does not have** an acute respiratory illness

☐ **has** an acute respiratory illness

☐ is a **suspected case of COVID-19**

☐ is **confirmed case of COVID-19**

☐ is believed to have had **close contact with a confirmed case of COVID-19**

Inmate/detainee details: _____ _____

Given name Surname

Date of birth:

Name of originating facility:

Name of contact person:

Phone number:

Appendix 5. Forming a facility based an Outbreak Management Team (OMT)

The outbreak management team (OMT covers) several critical functions. Some people may perform more than one role.

The OMT should first meet within hours of case identification and then daily to:

- direct and oversee management of the outbreak
- monitor the outbreak progress and begin changes in response, as required
- liaise with GPs and the state/territory Department of Health, as arranged.

The OMT should include the following roles and functions:

Role	Function
Chairperson (facility Director, Manager or Senior Clinical/Medical Officer)	The chairperson coordinates outbreak control meetings. This includes setting meeting times and agenda, and delegating tasks.
Secretary	The secretary organises OMT meetings and communicates any changes to team members. They also record and share meeting minutes.
Outbreak Coordinator (Nurse, Infection Prevention and Control Practitioner or Doctor)	The coordinator carries out the infection prevention and control decisions of the OMT. They also coordinate activities required to contain and investigate the outbreak. This role is often given to an Infection Prevention and Control Practitioner (ICP) or delegate.
Media Spokesperson (facility Director, Manager, Nursing Manager or Senior Medical Officer)	Media interest in outbreaks that happen in correctional and detention facilities is common. Media interest occurs especially if there are adverse outcomes. The department can assist facilities to manage media interest. The department recommends facilities to liaise with them before making media statements.
Visiting/Contracted General Practitioners or Medical Directors	Some GPs may be available to take part in the OMT. Identify their role during the planning process. It is valuable to choose a clinical lead amongst those GPs who attend a facility. During an outbreak, this person is important to assess and manage ill inmates/detainees. GPs can work with correctional and detention facilities and the department to put control strategies in place.
Public Health Officers	During the first OMT meeting, the OMT should confirm and understand how PHUs can help and their role/responsibility.

Appendix 6. Infection prevention and control

Standard Precautions

Standard precautions are a group of infection prevention and control practices always used for the care of all persons and at all times regardless of a known or perceived infectious disease risk. Practise the principles of standard precautions in correctional and detention facilities and for interactions with a potential or confirmed COVID-19 case.

Health care staff and general correctional and detention staff must abide by the recommended precautions to protect themselves and others if an inmate/detainee is unwell or suspected to have an infectious illness including COVID-19. Staff should follow standard and transmission-based precautions as described in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021). Risk assessment should inform the choice of PPE appropriate for each circumstance.

Hand hygiene

COVID-19 can be spread by contaminated hands. It is important to use frequent hand hygiene. Hand hygiene refers to any action of hand cleansing, such as:

- hand washing with soap and water or
- hand rubbing with an alcohol-based hand sanitiser (gels or rubs).

Washing with soap and water is preferable but alcohol-based hand gels and rubs are suitable when hands are not visibly soiled. If hands are visibly soiled or have had direct contact with body fluids, they should be:

- washed with soap and running water
- then dried thoroughly with disposable paper towel.

Online hand hygiene courses are available at National Hand Hygiene Initiative. Encourage staff, in particular healthcare staff, to complete refresher training. Staff, inmates/detainees and visitors must have ready access to hand hygiene stations. These might be alcohol-based hand rub/gel or hand basins with liquid soap, water and paper towel. Make sure you adequately stock and maintain these. Where possible, have hand basins that are hands-free (for example, elbow operated). This facilitates hand hygiene practices and prevents re-contaminating hands when turning taps off. However, where hands free taps are not available, people can turn the taps of using paper towel used to dry hands. Ensure staff and inmates/detainees are aware of the proper hand hygiene technique and why it's important.

Encourage inmates/detainees and visitors to use good hand hygiene. This is very important to prevent transmission of infectious organisms. Teach inmates/detainees how to practice good hand hygiene and wash their hands:

- after toileting
- coughing, sneezing
- blowing their nose
- before and after eating
- when leaving their room.

Remind visitors to perform hand hygiene when they enter and leave the facility.

Facilities should never consider the use of gloves as an alternative to hand hygiene. Hand hygiene must occur before putting on gloves and immediately after removing them.

Personal protective equipment (PPE)

Staff must wear appropriate PPE when caring for infected inmates/detainees needing contact and transmission-based precautions. Staff may require a gown, eye protection, surgical mask or PFR, and gloves depending on the level of precautions necessary.

Train correctional and detention facility health staff and ensure they are competent in the proper use of PPE. This includes donning and doffing procedures. New staff must complete training and all existing health staff, including non-clinical support staff, should complete refresher training. Staff must remove PPE in a way that prevents contamination of the HCW's clothing, hands and the environment. Staff should:

- immediately discard PPE into appropriate waste bins
- always perform hand hygiene before putting on PPE and immediately after removing PPE.

Facility health staff must change their PPE and perform hand hygiene after every contact with a suspected or confirmed case of COVID-19 or when in contact with an ill inmate/detainee. Staff should not wear PPE when moving from one room to another.

Respiratory etiquette

Respiratory etiquette tries to reduce the spread of virus by droplets produced when someone coughs or sneezes. Encourage inmates/detainees, staff and visitors to practice good respiratory etiquette. This includes:

- coughing or sneezing into the elbow or a tissue
- disposing of the tissue
- performing good hand hygiene.

Remind and give specific advice to any inmate/detainee with an acute respiratory illness.

Cough and Sneeze Etiquette

- When coughing or sneezing, use a tissue to cover your nose and mouth
- Dispose of the tissue afterwards
- If you don't have a tissue, cough or sneeze into your elbow

- After coughing, sneezing or blowing your nose, wash your hands with soap and water
- Use an alcohol-based hand cleanser if you do not have access to soap and water

Remember:

Hand hygiene is the single most effective way to reduce the spread of germs that cause respiratory disease!

Anyone with signs and symptoms of respiratory infection:

- should be instructed to cover their nose/mouth when coughing or sneezing;
- use tissues to contain respiratory secretions;
- dispose of tissues in the nearest waste receptacle after use; and
- wash or cleanse their hands afterwards.