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

Version 5

24 June 2022

# Revision history

| Version | Date | Reason / Changes | Endorsed by |
|---|---|---|---|
| 1.0 | 31/03/20 | Initial Release | CDNA, AHPPC |
| 2.0 | 10/06/20 | Revision<br>Update outbreak identification and management guidance | CDNA |
| 3.0 | 24/07/20 | Revision<br>Update outbreak identification and management guidance<br>Update infection prevention and control advice<br>Update quarantine arrangements for new admissions to facilities from geographic areas of community transmission | CDNA, AHPPC |
| 3.1 | 12/08/20 | Revision<br>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 |
| 5.0 | 24/06/22 | Revision<br>Updated to reflect changes in epidemiology and approach to management in the context of the Omicron variant and widespread community transmission.<br>Main changes:<br>• New overarching principles<br>• New outbreak definition<br>• New contact guidance | CDNA |

| | | <ul><li>New visitor guidance</li><li>Updated treatment guidance</li><li>Updated isolation, quarantine and cohorting guidance</li></ul> | |
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**Disclaimer**

The Communicable Diseases Network Australia (CDNA) developed this guidance. The Australian Health Protection Principal Committee (AHPPC) has endorsed it.

These guidelines provide best practice information to prevent and manage coronavirus disease 2019 (COVID-19) outbreaks in correctional and detention facilities to support the response of:

- public health authorities
- managers and staff of correctional facilities
- healthcare workers.

These guidelines capture the knowledge of experienced professionals and provide a best practice approach based on the available evidence at the time of completion.

Readers should not rely on the information in these guidelines alone. They are not a substitute for advice from other relevant sources including advice from a health professional. Clinical judgement and discretion may be needed in the interpretation and application of these guidelines. Correctional and detention facilities are responsible for the management of COVID-19 outbreaks and ensuring compliance with relevant jurisdictions outbreak management requirements.

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.

This document was developed by a CDNA working group coordinated by the Commonwealth Department of Health, with membership from each state and territory. It is informed by the *CDNA COVID-19 Series of National Guidelines*.

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# 1 Introduction

## 1.1 Overview

These guidelines outline Australia's national minimum guidance for correctional and detention facilities in planning and preparing for, detecting, and responding to COVID-19 outbreaks. The guidance reflects the need to maintain the normal functions of correctional and detention facilities, while protecting those at most risk of severe disease.

The guidelines aim to assist facilities to ensure their responses to COVID-19 outbreaks balance the risk of severe illness and high caseloads with the harms associated with prolonged isolation and quarantine. This includes harms resulting from restrictions on communication with family and friends, and the suspension of rehabilitation and other programs. Jurisdictions may adapt this guidance based on their local epidemiological context.

Guidance within this document reflects Australia's progress through the *National Plan to transition Australia's National COVID-19 Response* and the evolving COVID-19 situation in Australia.

For general guidance on COVID-19 transmission, case definitions and guidance on testing, management of contacts and cases, see the *CDNA COVID-19 Series of National Guidelines.*

For detailed guidance on infection prevention and control, refer to *Infection Control Expert Group (ICEG) endorsed infection prevention and control guidance*.

## 1.2 Key principles

In all facilities, the following key principles should apply:

- The aim of any COVID-19 control measures should be to protect detainee health and wellbeing, including physical and mental health.
- COVID-19 control measures should recognise the specific needs and vulnerabilities of people (detainees) in prison and detention.
- COVID-19 control measures should not be out of step with the approach in the wider community, other than as necessitated by the special needs and vulnerabilities of detainees, the challenges of the corrections setting, and the need to support safe operations for staff and prisoners.
- Collaboration between correctional facilities and public health units should be strong and ongoing, recognising that an effective response requires an effective partnership.

In situations where there is lower risk of severe illness, facilities may choose to implement less stringent controls, while in other situations (such as a new variant with higher risk of severe illness), more restrictive measures may be appropriate, developed in collaboration with local public health unit guidance.

Given the complexity of managing a pandemic virus in a correctional setting, it is important for facilities to be clear about the rationale for specific restrictions, which should be supported by clear record-keeping.

Lengthy and restrictive quarantine arrangements should be avoided as they have been shown to have unintended consequences, in that they discourage detainees to disclose themselves or others as close contacts.

Facilities should aim for business-as-usual settings where possible outside the areas impacted by COVID-19 outbreaks.

Measures must be operationally achievable, giving consideration to the individual designs of correctional and detention facilities.

Guidance on detainee rights

The Australian Human Rights Commission's general guidance on the treatment of detainees[1] stipulates detainees should be able to communicate with their family and reputable friends at regular intervals, both by correspondence and by receiving visits. It reports that solitary confinement has exacerbated the symptoms of some prisoners with mental illness. And it notes that juvenile detainees are entitled to special protection, including the right to maintain contact with their family through correspondence and visits.

## 1.3 Understanding COVID-19

COVID-19 is an infectious disease caused by SARS-CoV-2, a novel coronavirus that was first identified in humans in December 2019. SARS-CoV-2 can be transmitted through respiratory droplets, smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces. More information about the disease, including infectious period, incubation period and clinical presentation is available in the *CDNA COVID-19 Series of National Guidelines*.

## 1.4 COVID-19 risk in correctional and detention facilities

Correctional and detention facilities are challenging environments and carry additional risk for COVID-19 seeding and transmission and outbreak management, compared with the wider community. This is due to the close living environment, the challenges of security requirements, the physical and mental-health vulnerabilities of detainees, and inflexible infrastructure.

- Aboriginal and Torres Strait Islander people are over-represented in custodial settings, representing 30% of the prison population (June 2021).[2] Almost half (49%) of 10-to-17-year-olds under youth justice supervision are Aboriginal or Torres Strait

[1] humanrights.gov.au/sites/default/files/content/letstalkaboutrights/downloads/HRA_prisoners.pdf
[2] www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release

Islander people (noting many people in this category are supervised in the community).[3]

- Detainee populations have a higher prevalence of health conditions associated with a greater risk of severe disease. These conditions include disability, mental health conditions, chronic physical disease, smoking, high-risk alcohol consumption and illicit drug use. Among the prison population:[4]
    - 75% are tobacco smokers (compared with a smoking rate of 12% in the general adult population[5]).
    - 65% have used illicit drugs in the previous year
    - about 40% report a diagnosis of a mental health condition
    - 30% have a chronic physical health condition, reporting at least one of: arthritis, asthma, cancer, cardiovascular disease, or diabetes
    - 22% have asthma.

It is essential for correctional and detention facilities to have risk mitigation measures in place to reduce the likelihood of COVID-19 outbreaks in the facility, minimise risk to detainees, staff and visitors, and effectively manage cases and contacts should an outbreak occur.

## 1.5 Roles and responsibilities

### 1.5.1 Correctional facilities

Facilities, in partnership with state and territory corrective services departments, have responsibility for managing COVID-19 outbreaks under their requirements for 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.

Correctional authorities are responsibility for the management, safety, good order and security of facilities.

### 1.5.2 State and territory departments of health

In managing outbreaks, facilities should seek guidance from the relevant state or territory department of health. This is usually done in collaboration with the local public health unit (PHU) and/or the jurisdiction's health department within the existing state or territory emergency management framework.

[3] www.aihw.gov.au/reports/youth-justice/youth-justice-in-australia-2020-21/contents/summary
[4] Data from: The health of Australia's prisoners 2018, Australian Institute of Health and Welfare www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/summary
[5] www.aihw.gov.au/reports/australias-health/tobacco-smoking

## 1.6 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 within detention centres. Requirements are outlined in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2021), and by state and territory public health authorities.

COVID-19 is a notifiable disease under the Australian National Notifiable Diseases List. This means that the relevant jurisdictional public health authority must be notified of a positive COVID-19 result, whether from rapid antigen or nucleic acid amplification testing.

# 2 Definitions

## 2.1 Case

See the *CDNA COVID-19 Series of National Guidelines* for current COVID-19 case definitions.

## 2.2 Close contacts

National guidance on the definition of a close contact can be found in the *CDNA COVID-19 Series of National Guidelines*.

When determining who is considered a close contact during an outbreak within correctional and detention facilities, consider factors such as ventilation, density of detainee numbers, and separation of wings and units.

Close contacts may extend beyond detainees that are housed together (cellmates) and may include detainees that have the following or similar contact with COVID-19 cases:

- Sharing meals and eating at the same time
- Smoking in enclosed environments
- Prolonged contact without the use of masks

## 2.3 Outbreak

In a correctional or detention facility, a COVID-19 outbreak may be defined as either:

- Two or more COVID-19 cases who were onsite in the same section and are epidemiologically linked; or
- Five or more COVID-19 cases among the wider correctional population within the past 7 days.

Notes:

  - The wider correctional population includes staff, visitors and detainees.
  - These definitions exclude cases who have been in solitary confinement or quarantine conditions during their infectious period.
  - A risk assessment may be conducted, in consultation with the jurisdictional health authority, to consider whether cases among staff wearing personal protective equipment (PPE) are included in the five cases that constitute an outbreak.

# 3 Outbreak management plan

Correctional and detention facilities are encouraged to prepare an outbreak management plan. This includes conducting practice exercises, outbreak reviews and incorporating lessons learned. It should include:

1. An identified outbreak coordinator outbreak management team.
    - Facilities should ensure a plan for resourcing to have dedicated staff for these roles.
    - The outbreak coordinator role is time consuming, and staff cannot give the role their full attention if they have other work commitments.
    - The outbreak coordinator needs to be clearly identified to all stakeholders and be the main point of contact. This will help reduce duplication and miscommunication.
2. Detailed procedures for the following (see below sections for full detail):
    - Communications, including plans for significant use of online meeting platforms, and documentation.
    - Education and training.
    - A redoubled vaccination effort.
    - Infection prevention and transmission control measures.
    - Staffing shortages.
    - Management of visitors, new arrivals and transfers.
    - Management of activities and programs.
    - Detecting and managing cases, including early identification and treatment for people at higher risk of serious illness.
    - Isolation of cases and quarantining of close contacts, including cohorting where possible.
    - Management of movement through the facility, including staff and detainees who may usually work across sections.
3. Recognition of the possibility that public health units and other services may have limited capacity to assist if community outbreaks surge.
4. Procedures to ensure accurate records of staff rosters and attendance, detainee movements and visitors.
    - Have these records available in an accessible electronic format to share with public health authorities as required.
    - Test the process for extracting and sharing data in advance.
5. Procedures to ensure adequate stocks of PPE (gloves, gowns, surgical masks and particulate filter respirators such as P2/N95 respirators, face shields, eye shields, goggles or safety glasses, hand hygiene products, and cleaning supplies.
    - Have a plan in place with suppliers to obtain more PPE if needed.
    - Plan how to access, store, distribute and dispose of the PPE safely, noting there may be large volumes of waste.

# 4 Prevention and control activities

Correctional and detention facilities should conduct the following prevention and control activities to minimise transmission risk and ensure they are prepared in the event of an outbreak.

## 4.1 Communication

COVID-19 is a notifiable disease. Correctional facilities must notify state and territory health departments/PHUs of COVID-19 cases and outbreaks and keep accurate records.

- Record all COVID-19 cases in the format preferred by the public health unit, which may request regular line lists, including details of any detainee hospital admissions.
- Contact details for state and territory health departments can be found on the Australian Government Department of Health website.

Use signage and other forms of communication, such as factsheets in relevant languages, to communicate COVID-19 risks and prevention measures.

Place signage at all entry points, bathrooms, kitchens and shared spaces. Standardised signs are available at the Australian Commission for Safety and Quality in Health Care website: www.safetyandquality.gov.au/our-work/healthcare-associated-infection/infection-control-signage

Communicate quickly and regularly with detainees, staff, unions, professional services and detainees' families. If required, consider using private call centres during an outbreak.

## 4.2 Education and training

Educate staff, detainees and visitors about the importance of preventing COVID-19 introduction to the facility and managing transmission in an outbreak setting. This should include the importance of mask-wearing, cough etiquette, hand hygiene and physical distancing.

Train all staff (including prison/security officers, healthcare workers and education staff, management and administrative staff) in outbreak management so they can respond quickly and effectively to a potential outbreak. This should include an understanding among relevant staff of:

- The disease
  - The symptoms and signs of COVID-19.
  - How to identify whether a person with COVID-19 is deteriorating.
  - Exposure risk factors for COVID-19 including contact with confirmed cases.
  - The vulnerable populations at higher risk of severe illness.
- Procedures
  - The outbreak management plan, including where to access it and whom to contact.

    - What to do if a staff member is a close contact or experiences symptoms.
- Infection prevention and control protocols (see Section 4.5 Infection prevention and control)

## 4.3 Vaccination

COVID-19 vaccines are effective in preventing severe illness.[6]

- Ensure detainees have access to advice and information on vaccination.
- Offer COVID-19 vaccination to all incoming detainees who are not up to date.
- Encourage staff to remain up to date with vaccination, including booster doses. Some jurisdictions may require mandatory vaccination for staff.
- Where possible, document the vaccination status of detainees and staff.
- Offer vaccination at regular and frequent intervals; during an outbreak redouble efforts to improve vaccination rates among staff and detainees.

For more information, refer to the *CDNA COVID-19 Series of National Guidelines* and the *Australian Technical Advisory Group on Immunisation's statement on up-to-date vaccination*.

## 4.4 Detainees at risk of severe illness

Identify detainees who may be at risk of severe illness ahead of any outbreak. Ensure clinicians have considered their suitability for antiviral medications in the event of infection, in light of underlying health conditions and other medications. Suitability should be noted in medical records, allowing the administration of antivirals to begin without delay in the event of infection.

## 4.5 Infection control

Measures such as mask-wearing, physical distancing, hand hygiene and cleaning reduce transmission risk and assist outbreak managements. Consider:

- Personal hygiene, particularly hand hygiene, and sneeze and cough etiquette.
- Handling and disposal of clinical waste.
- Processing of reusable equipment, and safe laundering of linen.
- Environmental cleaning and cleaning of transport vehicles.

### 4.5.1 Masks and PPE

Masks are effective at preventing transmission[7].

- Detainees should be encouraged to wear masks during an outbreak.
- Staff should wear masks at all times.

[6] COVID-19 vaccine information | Australian Government Department of Health

[7] Infection prevention and control in the context of coronavirus disease (COVID-19): A living guideline (who.int)

For more information on the use of face masks, see *The use of face masks and respirators in the context of COVID-19*.

Train staff in PPE use, including fit testing; see *Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021)* for more information.

#### 4.5.2 Hygiene

Ensure adequate hand-washing supplies, tissues and lined disposal receptacles in all parts of the facility.

Ensure regular sanitising of shared spaces, including surfaces, handles, taps and bathrooms.

For guidance on cleaning, refer to the *Coronavirus (COVID-19) Environmental cleaning and disinfection principles for health and residential care facilities*. For information on cleaning and disinfection of protective eyewear, see the *ICEG guidelines on cleaning and disinfection of protective eyewear in health and residential care facilities*. For information on disinfectants for COVID-19, see *Disinfectants for use against COVID-19 in the ARTG for legal supply in Australia*. For guidance on handwashing and standard signage, see www1.health.gov.au/internet/main/publishing.nsf/Content/how-to-wash-and-dry-hands.

## 4.6 Physical distancing

Implement physical distancing measures to reduce transmission:[8]

- Separate seats in dining areas; during outbreaks stagger mealtimes.
- Use floor markings to indicate safe distancing.
- Install barriers where possible in group spaces.
- Ventilate spaces to the extent possible.
- Use outdoor space where possible for meals, visits and group activities.
- Use PPE when transferring detainees where close contact is unavoidable.
- Reduce group sizes in activities.

## 4.7 Visitors

Visitors should:

- Not enter the facility if they:
  - have respiratory symptoms, irrespective of their vaccination status, or
  - are a close contact
- Be aware that they can spread COVID-19 even if they do not have symptoms.
- Wear masks, practice physical distancing and wash or sanitise hands.
- Test, if required by facility management.

[8] Social Distancing Evidence Summary 2019 (health.gov.au)

Facilities should:

- Provide advice (in relevant languages and a culturally appropriate manner) to all visitors and staff about hygiene measures and physical distancing, including through signage.
- Ensure hand sanitiser and masks are available at entry points.
- Install barriers where possible in visiting and group spaces.
- Use ventilation where possible in visiting areas, and consider outdoor space.
- Consider implementing the following public health measures for visitors (including visiting workers):
  - Testing on arrival
  - Using a questionnaire to check for symptoms and potential exposures
  - Using government-approved check-in apps
  - Encouraging vaccination

During an outbreak, visits by family, friends and professional workers should continue subject to the following guidance:

- For detainees who are COVID-19 cases, in-person visits should be replaced by regular electronic (video and phone) contact with family, friends and professional supports.
- For detainees who are close contacts, electronic visits are preferred, however in-person visits may be continued depending on the risk.[9] Consider the role of infection control measures, vaccination and frequent rapid antigen testing, and mental health impacts of restricting visitors.
- For all other detainees, in-person visits should continue, subject to compliance with testing, mask wearing, distancing and other prevention requirements by both visitor and detainee. These requirements may include the use of RATs.
- In-person visits must be facilitated for detainees in juvenile facilities.
- Specialist support, including cultural support for Aboriginal and Torres Strait Islander detainees, social workers and other support, should continue uninterrupted for all detainees during an outbreak, if necessary via electronic means.
- Any visitor restrictions should take account of the mental health impact of extended periods of isolation.

## 4.8 New intake and transfer restrictions

- All detainees (new or transferred) arriving at a facility should be:
  - tested on arrival

[9] Kirby Institute modelling has found that family visits are a low risk for starting outbreaks. The modelling indicates that under Delta settings, even if an infected family visitor entered a prison each day, it is highly unlikely for an outbreak to occur if 80% of detainees are vaccinated. This risk is likely to be still lower if PPE and social distancing measures are in place and the family visitor is fully vaccinated.

    - quarantined for the period specified by the state or territory authority
        - asymptomatic arrivals who test negative may be quarantined together
    - tested before release from quarantine
- Where possible, limit new admissions or transfers during an outbreak.
    - Experience suggests that outbreaks in remand centres can seed outbreaks in receiving prisons.

# 5 Testing

## 5.1 Types of tests

Nucleic acid amplification testing (NAAT) (for example, using reverse transcription polymerase chain reaction, RT-PCR) is the gold standard for diagnosing acute symptomatic SARS-CoV-2 infection. For guidance, see the *Public Health Laboratory Network (PHLN) guidance on laboratory testing for SARS-CoV-2*.

Rapid antigen tests (RATs) are an alternative, providing fast results. The sensitivity of RATs is lower than NAAT/PCR and performance varies from test to test. For guidance, see the *PHLN and CDNA joint statement on SARS-CoV-2 rapid antigen test*.

## 5.2 Who to test

Symptoms that should trigger testing for SARS-CoV-2 and possibly other respiratory pathogens (e.g. through multiplex PCR) include:

- Acute respiratory symptoms (e.g. cough, breathing difficulty, or sore throat, runny nose/nasal congestion), with or without other symptoms, or
- Fever (≥37.5°C) or history of fever (e.g. night sweats, chills), or
- Loss of smell or loss of taste.

For detainees or staff with symptoms compatible with COVID-19, promptly isolate and test.

- If a test is positive, follow the guidance in Isolation of COVID-19 cases.
- If a test is negative, maintain isolation until acute symptoms resolve.

For detainees who are close contacts, follow jurisdictional requirements for testing of close contacts in high-risk settings, noting:

- Where close contacts are quarantined together, they should be tested frequently, daily if possible, to identify cases early.
- Any close contact that develops symptoms or returns a positive test should be removed from cohorted quarantine promptly.

For new arrivals and transfers, test as advised in New intake and transfer restrictions.

## 5.3 Routine testing

Routine testing may be considered for early detection and surveillance purposes. Consider:

- Testing staff on arrival, especially those involved in transfers between facilities.
- Testing detainees at frequent intervals (e.g. two times a week[10]).
- Testing visitors before entry.

Some jurisdictions may use wastewater testing as a surveillance method; refer to jurisdictional guidance for more information.

Symptom screening during daily detainee musters may be considered.

For guidance on recommended testing in high-risk settings, including detention and correctional facilities, see the *Testing Framework for COVID-19 in Australia*.

[10] Doherty Institute modelling related to schools maybe a useful reference on the efficacy of surveillance testing: www.doherty.edu.au/uploads/content_doc/Synthesis_DohertyModelling_FinalReport___NatCab05Nov.pdf

# 6 How to manage COVID-19 cases and close contacts

## 6.1 Quarantine and isolation

Quarantine and isolation strategies help prevent transmission by keeping people who may be infected away from others.

- Quarantine is the separation from others of a person who is well but may have been exposed to COVID-19.
- Isolation is the separation from others of a person who has tested positive on a RAT or PCR (NAA) test, and thus is considered a confirmed (NAA) or probable (RAT) case of COVID-19. People who have symptoms compatible with COVID-19 who are waiting for test results should also isolate.

## 6.2 Mental health during quarantine and isolation

Detainees in isolation and quarantine face risks to their mental health. Corrections staff should be aware of this risk, with heightened awareness for Aboriginal and Torres Strait Island detainees and detainees with underlying mental health conditions. Systems should be in place to report any mental-health concerns.

Ensure detainees subject to quarantine or isolation have access to families and support networks through telephone and video contact. Ensure access for mental health and social support services. Ensure appropriate cultural support for Aboriginal and Torres Strait Islander detainees, and for people from culturally and linguistically diverse backgrounds.

## 6.3 Isolation of COVID-19 cases

Isolate COVID-19 cases for 7 days from the day they took their positive test; if acute respiratory symptoms persist after 7 days, continue isolation until they resolve. Refer to the *CDNA COVID-19 Series of National Guidelines* for additional information on release from isolation.

Subject to consent and feasibility, detainees with COVID-19 may be housed in cohorts with other COVID-19 cases within the facility. See Cohorting.

Providing capacity exists within a correctional facility and locality, it is not recommended that detainees who are COVID-19 cases be transferred to a different correctional facility or external setting, other than hospital, for isolation purposes. This guidance is designed to minimise any clinical and transmission risks that may be associated with transfer.

If court cases are deemed essential to proceed, appearances should be undertaken in a manner that does not impede isolation arrangements, for example, through audio-visual link.

## 6.4 Monitoring and clinical care of COVID-19 cases

Detainees with COVID-19 should be managed by healthcare staff. Early assessment by healthcare staff is important to identify those people at high risk of progression to severe disease who may benefit from COVID-19 treatments. Consideration of treatments is a clinical decision. It is important to consider supply and access to treatments such as antivirals, to ensure they are available early in the disease course (within five days of symptom onset).

The health of COVID-19 patients can deteriorate quickly. Monitor all detainees with COVID-19 closely, including health assessments at least once per shift. Have in place arrangements to alert healthcare staff to any deterioration between assessments.

Ensure correctional staff supervising unwell detainees are able to recognise deterioration in a COVID-19 patient and know when to seek medical intervention. The *RACGP Home-care guidelines for adult patients with mild COVID-19* provide advice on escalating care.

When transferring COVID-19 cases to hospital, notify the ambulance service and receiving hospital of the COVID status of the detainee and follow their advice.

Usual escorts and accompanying healthcare staff, preferably those who are fully vaccinated, can escort detainees. Appropriate PPE and cleaning protocols should be used.

## 6.5 Quarantine for close contacts

Quarantine close contacts of COVID-19 cases for 7 days after the day the primary case took their first positive test.[11]

Quarantine in cohorts may be considered, taking into account:

- Vaccination: Detainees with up-to-date vaccinations are at much-reduced risk of severe illness.
- The negative impacts of isolation: Extended periods of isolation can result in distress and deteriorating mental health.
- Comorbidities: Cohorting may not be safe for detainees with high-risk comorbidities, including advanced age or illness.
- Safety and security of detainees to be cohorted.

Promptly remove close contacts who develop symptoms from quarantine with other close contacts into individual isolation.

Close contacts should be tested according to the protocols outlined in Section 5.2 Who to test.

[11] Close contacts who are recently recovered COVID-19 cases do not need to be quarantined if it is within 12 weeks since they were released from isolation.

## 6.6 Cohorting

Some facilities may find it helpful to implement cohorting, recognising this is not always feasible.

A possible zoning system is suggested here:

| Zone | Description |
| --- | --- |
| Cases in isolation | Zone for COVID-19 cases<br>Isolation in rooms should be limited to the shortest time possible for reducing transmission risk. COVID-19 cases may mix with other COVID-19 cases in isolation. |
| Close contacts in quarantine | Zone for close contacts<br>Consider vaccination status, comorbidities and mental health when making decisions about whether close contacts are quarantined alone or in cohorts.<br>If close contacts are cohorted together, repeated testing should be undertaken to identify cases early and limit potential for further transmission within the cohorted group. |
| Business as usual | Zone for:<br>- recovered cases who have been released from isolation<br>- close contacts who have completed quarantine<br>- the general detainee population not impacted by the outbreak |

- All zones should have sites for PPE and hand sanitiser, and staff break areas that enable physical distancing.
- Anything that moves between zones, such as food service or linen pathways, should move from green to red zones – i.e. from clean zones to contaminated, and not the reverse.
- Yellow and red zones should:
  - Be geographically separated from the green zone.
  - Be decluttered to make cleaning and decontamination easier.
  - Be assigned dedicated staff where possible.
  - Include single rooms/cells with their own bathroom where possible, taking account of the needs of vulnerable individuals.

# 7 Additional outbreak guidance

## 7.1 Detainees who are not COVID-19 cases or close contacts

For detainees who are not COVID-19 cases or contacts:

- Make every effort to continue business-as-usual interactions during an outbreak, subject to compliance with testing, mask wearing and other prevention requirements.
- Ensure detainees who are not COVID-19 cases or close contacts are separated from zones of infection or potential infection.
- Ensure detainees who may usually have additional rights to move across the facility, for example those employed in the facility, do not move from zones housing COVID-19 cases or close contacts to zones housing unimpacted detainees.
- If solitary isolation is considered necessary for an individual detainee for reasons of COVID-19 health risk or mental health, and is not available, contact the state or territory public health unit for advice.
- Consider early release or alternative accommodation for detainees who are vulnerable, suitable for early release, or in youth detention.

## 7.2 Guidance for staff

- Staff with acute respiratory symptoms should stay at home when sick to help prevent the spread of all respiratory viruses, including COVID-19.
    - Except for medical care or other urgent reasons, people with acute respiratory symptoms should stay at home:
        - until at least 24 hours has elapsed since their last fever episode (without the use of fever-reducing medications)
        - until there is significant improvement in their acute respiratory symptoms
        - if they have a pending COVID-19 test result
        - if they receive a positive COVID-19 test result.
- Staff members who are COVID-19 cases should be excluded from work until they meet the release from isolation criteria outlined in the *COVID-19 CDNA National Guidelines for Public Health Units*.
- Staff members identified as close contacts should follow jurisdictional guidance for close contacts. Restrictions may include:
    - Isolating and get tested if COVID-19 symptoms develop.
    - Not attending high-risk settings, including correctional and detention facilities for 7 days.
    - Wearing a particulate filter mask during the following 7 days.

    - Testing at frequent intervals.
- The facility may consider allowing asymptomatic staff who are close contacts to return to work during their quarantine period. This should only be done in accordance with jurisdictional requirements.
- Maintain a register of staff members caring for patients with COVID-19.
- Maintain a contact list of casual staff and explore options for a surge workforce, factoring in the potential for significant shortages in healthcare staff.

# 8 Release from detention

Detainees with COVID-19 should not be kept in correctional facilities beyond their release date for reasons related to the disease.

When releasing a detainee with COVID-19, ensure safe transportation to accommodation suitable for isolation and maintenance of ongoing care and monitoring. Accommodation should be provided for detainees who are homeless for at least the duration of the isolation period. In relation to Aboriginal and Torres Strait Islander detainees in particular, attention should be given to ensuring that overcrowding and other factors will not compromise their ability to remain isolated.

When releasing a detainee who is a close contact, ensure ongoing support and advice, including access to testing, if required.

# 9 Declaring an outbreak over

Correctional facilities should refer to jurisdictional advice on when an outbreak can be considered ended. Factors to take into account may include:

- Source of infection and transmission is understood within the facility, and there is no further risk of transmission.
- No detainee cases identified within 7 days from when the last case was effectively isolated.
    - Note, additional precautions may be required for days 8 to 14.
- Where residents identified as a case or close contact are able to effectively isolate and there is no ongoing risk.

# 10 Review of outbreak response

Correctional facilities and public health units should review all outbreaks to reflect on what worked well during the outbreak, and which of their specific policies, practices or procedures need revision to improve their responses for future outbreaks.

# Appendix 1: Facility COVID-19 Checklist

Correctional and detention facility checklist:

| In the event of COVID cases or outbreaks | Details | ✓ |
|---|---|---|
| Isolate all COVID-19 cases | Immediately isolate COVID-19 cases for 7 days, or longer when acute respiratory symptoms have not resolved. COVID-19 cases may be isolated together. | |
| Isolate and test anyone with symptoms | Immediately isolate symptomatic detainees until acute respiratory symptoms resolve. | |
| Inform the public health unit | All positive tests, including from rapid antigen and nucleic acid amplification (PCR) tests, must be reported promptly to the public health unit. | |
| Outbreak settings (see Section 2.3 for outbreak definition) | | |
| Convene the outbreak management team and activate the outbreak management plan, Section 3 | This team should meet as soon as possible (within the day). Its purpose is to direct the response, monitor and oversee the outbreak and liaise with others. Ensure roles and responsibilities are clearly defined. | |
| Identify close contacts, Section 2.2 | Definitions will vary depending on the nature of contact and the physical characteristics of each facility. | |
| Test for COVID-19, Section 5 | Test anyone with symptoms.<br>Test all close contacts frequently, including detainees and staff.<br>Consider routine surveillance testing throughout the facility to assess spread. | |
| Clinical management of cases, Section 6.4 | Cases should be managed by healthcare workers. They should be assessed promptly for treatment eligibility. If a case requires transfer to hospital, advise the hospital in advance. | |
| Isolate and quarantine cohorts, Section 6 and Section 7.1 | Separate COVID-19 cases, close contacts and unimpacted detainees.<br>Maintain isolation for cases for 7 days or longer where acute respiratory symptoms persist.<br>Consider the mental health impacts of isolation; house detainees in cohorts where possible and appropriate.<br>Make arrangements to protect detainees at higher risk of severe disease.<br>For close contacts housed in cohorts, test frequently to identify and isolate cases early.<br>Avoid transmission between groups by avoiding the movement of staff and detainees across cohorts.<br>Continue business as usual for unimpacted areas of the facility. | |

| In the event of COVID cases or outbreaks | Details | ✓ |
|---|---|---|
| Enhance infection prevention and control | Enhance cleaning and disinfection.<br>Undertake a risk assessment to inform the use of PPE. | |
| Activate communication plan | Communication channels are required with the public health unit, the families of detainees, staff networks, personal visitors, and professional and support workers who interact with detainees. | |
| Signage | Place signs at entrances and other locations to inform infection protection control requirements. | |
| Mental health and emotional and social wellbeing, Section 4.7 and Section 6.2 | Ensure detainees have continued access to family and support networks through ongoing visits. Where a detainee has COVID-19, facilitate telephone and video contact as an alternative to in-person visits. Where a detainee is a close contact, consider in-person or electronic visits, depending on a risk assessment. In-person visits must be facilitated for detainees in juvenile facilities.<br>Facilitate mental health and social support services.<br>Ensure cultural support is available for Aboriginal and Torres Strait Islander people, and detainees from culturally and linguistically diverse backgrounds. | |
| Management of staff, Section 7.2 | Restrict staff movement between units or zones of the facility. Assign vaccinated staff to care for COVID-19 patients.<br>Consider screening staff for symptoms and through regular testing.<br>Staff should not attend work if they are symptomatic. | |
| New admissions, Section 4.8 | Test and quarantine all new admissions.<br>Asymptomatic arrivals who test negative may be quarantined together.<br>Test before release from quarantine. | |
| Release from detention, Section 8 | Detainees should be released at their due date regardless of COVID-19 status.<br>Ensure detainees with COVID-19 or close contacts have the appropriate advice and care on release. | |

## Appendix 2: Outbreak Management Team

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

The outbreak management team should meet within hours of identifying the outbreak 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 or territory Department of Health and public health unit, as arranged.

The team should include the following roles and functions:

| Role | Function |
| --- | --- |
| Chairperson (facility director, manager or senior clinical/medical officer) | To coordinate outbreak control meetings and delegate takes. |
| Secretary | To organises and record meetings and communicate outcomes to team members. |
| Outbreak coordinator (nurse, infection prevention and control practitioner or doctor) | To carry out the infection prevention and control decisions, coordinate investigation and management activities.<br>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) | To respond to media inquiries, according to state and territory protocols. |
| Visiting/contracted general practitioners or medical directors | To assess and manage unwell detainees and assist in control strategies.<br>It is valuable to choose a clinical lead among GPs who attend a facility. |
| Public health officers at public health units | The role of public health units should be established at the first meeting of the outbreak management team |
| Staff representation | As liaison and to raise relevant issues. |