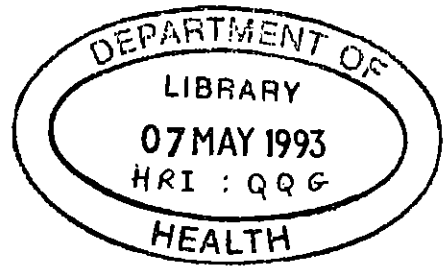
Report

of the

Advisory Committee

on

Communicable Diseases in Prison



January, 1993.

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INTRODUCTION

In 1990 the Minister for Justice announced the establishment of an Advisory Committee on Communicable Diseases in Prisons with the following terms of reference:-

> "To examine the problems posed by communicable diseases affecting offenders in prisons or places of detention, with particular reference to the problem of HIV/AIDS seropositivity, and, having regard to the welfare of offenders and staff and the interests of proper prison administration, to make such recommendations as are considered appropriate.
>
> To give priority to consideration of immediate needs relating to paraticular categories within the prison population who suffer from communicable disease and the formulation of recommendations designed to meet these needs".

The membership of the Committee is as follows:-

Mr. Thomas Lynch, Chairman	Principal, Department of Justice.
Dr. Owen Carey,	Medical Officer, Mountjoy Prison.
Dr. Enda Dooley,	Director Prison Medical Services.
Professor Irene B. Hillary,	Department of Medical Microbiology, U.C.D.
Mr. Thomas Hoare,	Deputy General Secretary, Prison Officers' Association.
Mr. Paul Murphy,	Psychologist, Department of Justice.
Mr. Raymond Murphy,	Prison Officers' Association.
Mr. Desmond O'Mahony,	Senior Psychologist, Department of Justice.
Mr. Bernard Power,	Prison Governor.
Mr. Martin Tansey,	Principal, Probation and Welfare Service.
Fr. Vincent Travers,	Catholic Chaplain, Mountjoy Prison.
Dr. James Walsh,	Department of Health.
Mr. James Woods,	Prison Governor.

In the course of its deliberations the Committee studied a wide range of litrature on the treatment and management of persons in prison who are HIV/AIDS seropositive. The Committee was also addressed by Ms. Alison Rowlands and Dr. Kevin Power of the Scottish Prison Service on developments in the management of HIV/AIDS seropositive prisoners in Scotland and the Committee wish to express their appreciation and thanks for the very valuable contributions which they made.

The Committee acknowledges that the primary function of the prison system is the secure and safe custody of persons committed there by the Courts and is conscious of the need to ensure that the operational requirements, necessary to ensure this principal objective, are not compromised. It accepts that persons sent to prison are sent there as punishment and not for punishment and that persons held in custody must be treated in a humane manner with the fundamental dignity of the human being, at all times and in all respects, being preserved. In this context, the Committee acknowledges the need for the provision of a level of medical service for prisoners commensurate with that provided in the community and sees such a provision as the shared responsibility of the health authorities and the prison service.

In considering the various communicable diseases the Committee drew a distinction between certain diseases, such as Tuberculosis, which can be transmitted through social contact or poor personal hygiene, Hepatitis B, which is mainly transmitted either through sexual contact or direct blood to blood contact and HIV which, while being transmitted in a broadly similar manner to Hepatitis B, poses particular management problems.

With regard to the first category of communicable diseases effective treatments exist and the prison service has had quite a degree of experience over the years in the management of such cases. The report therefore confines itself (Chapter I) to setting out protocols for the management of persons in

prison suffering from such diseases. With regard to Hepatitis B we are now fortunate that in recent years an effective vaccine has been developed for it also which is now routinely administered to all persons spending a length of time in prisons. Unfortunately there is no effective vaccine for HIV. Consequently the management of persons who are diagnosed as being HIV seropositive present unique problems for the Prison Service. Indeed, it could be said that HIV is one of the biggest issues for prison management today and the report concentrates mainly on this issue. It examines the present policy for the management of prisoners who are HIV seropositive and proposes the adoption of a policy which would have as its main pillars the guarantee of confidential testing and the phased elimination of segregation.

SIGNED

_____ Mr. T. Lynch, Chairman

_____ Dr. O. Carey _____ Dr. E. Dooley

_____ Professor I. Hillary _____ Mr. T. Hoare

_____ Mr. P. Murphy _____ Mr. R. Murphy

_____ Mr. D. O'Mahony _____ Mr. B. Power

_____ Mr. M. Tansey _____ Fr. V. Travers

_____ Dr. J. Walsh _____ Mr. J. Woods

CHAPTER I

Protocols for the Management of certain Communicable Diseases in Prison

1.1. A number of communicable diseases may be encountered more commonly in large institutional environments (including prisons) than in the general population. The following protocols provide advice on the organisational management of suspected (or confirmed) cases. They are not in any sense a detailed guide to medical practice. The precise medical steps taken may vary depending on the particular circumstances of any outbreak of illness. In relation to all of these conditions the advice of the doctor or other trained personnel should be sought without delay. As these conditions are notifiable to the Department of Health (via the local health authority or medical officer of health) various outside health agencies may be involved in providing advice in relation to their prevention, spread and appropriate screening. A list of currently notifiable diseases is given at Appendix I.

1.2. It should be stressed that a number of the following conditions are relatively uncommon but that outbreaks do tend to occur in environments (schools, army barracks, prisons, etc.) where people are living and working in close proximity to each other. The protocols deal only with conditions which may be spread by casual social contact or by lack of adequate hygiene procedures. Conditions such as HIV infection and Hepatitis B which require active intimate contact for spread (i.e. blood contact, sexual contact) rather than mere social contact, are discussed elsewhere in this report.

1.3. The main communicable diseases which may occur more easily in a confined environment such as prison are as follows:-

- Tuberculosis (TB).
- Food Poisoning (Salmonella).
- Bacterial Meningitis.
- Hepatitis A.

Tuberculosis

1.4. Tuberculosis (TB) is a bacterial disease which is common throughout the world. Though less common in this country than in the 1940's and 1950's there are still about 750 cases notified each year. The disease is spread by means of airborne droplets (this means by inhaling air expelled from an infected person by coughing, sneezing, spitting, etc.). It presents in a variety of ways but a combination of a chronic cough (especially coughing blood), profuse sweating particularly at night, and weight loss is highly suspicious.

1.5. The risk of infection and type of infection depends on a number of factors including age, previous exposure to TB, immune status, etc.

1.6. Where a case of TB is suspected in prison the following procedures should be followed:-

(a) Seek immediate appropriate medical advice.

(b) Isolate the suspect (i.e. in a single cell) pending confirmation of the diagnosis.

(c) When the diagnosis is medically confirmed arrange for transfer to a hospital or unit specialising in the treatment of TB. Though treatment may continue for a number of months a person is usually no longer infectious to others later than two weeks after treatment has commenced and consequently isolation is no longer warranted after this stage.

(d) Notify the local medical officer of health so that steps can be initiated to decide on appropriate screening of contacts and contact tracing, both within the prison and in the general community.

1.7 Because of the risk of T.B. infection the Committee recommends that all staff working regularly in prisons be screened for T.B. and that those requiring vaccination receive it. In future all new personnel recruited to the prison service should be screened on entry and vaccinated as appropriate.

Food Poisoning

1.8. The most common cause of food poisoning outbreaks in institutions is contamination of food, usually during the process of preparation, by one or more of a variety of strains of salmonella bacteria. It may arise, typically, when cooked and raw meats or dairy products are mixed or stored with inadequate refrigeration. Typically the patient or patients have eaten the same food and, between 12 and 48 hours after ingesting the organism, develop gastroenteritis with nausea, crampy abdominal pain, diarrhoea, fever, and sometimes vomiting. The disease is usually mild, lasting one to four days and treatment is symptomatic.

1.9. Where an outbreak of salmonella food poisoning is suspected the following procedures should be followed:-

(a) Seek immediate appropriate medical advice.

(b) Arrange for isolation with enteric precautions, (i.e. dispose of body waste and fluid spills (vomit) with appropriate hygiene precautions).

(c) The Medical Officer should notify the local public health authority so that appropriate steps can be taken to identify the source of the infection and take steps to ensure that high levels of hygiene are observed.

(d) Exclude recovered cases and symptomless excreters from work or occupation if the person concerned is a food handler whose work involves direct manual contact with food to be eaten without further cooking.

(e) Educate staff and prisoners in the prevention of food poisoning, and the maintenance of high standards of hygiene especially in areas where food is prepared.

Bacterial Meningitis

1.10. Bacterial meningitis may be caused by a wide variety of organisms. Outbreaks may occur in closed and semi-closed communities (e.g. prisons) where susceptible people congregate. Factors which lead to the development of the disease are not known but only a small proportion of people carrying the bacteria go on to develop the illness. The disease is spread by direct contact with respiratory secretions, i.e. by droplet spread as in the case of TB. The illness may vary in severity from a mild subclinical illness to an acute illness, requiring urgent treatment characterised by violent headache, vomiting, neck stiffness and pain.

1.11. In a case of supected meningitis within prison the following procedures should be followed:-

(a) Seek immediate appropriate medical assessment.

(b) Isolate the suspected case or cases and manage with respiratory precautions, (i.e. staff coming into contact should wear disposable masks, gloves, apron, etc.). Urgent transfer to hospital for confirmation of the diagnosis and continuation of appropriate treatment is indicated.

(c) Notify the local health authority of any outbreak so that appropriate preventive steps may be initiated.

(d) Undertake surveillance of intimate contacts of cases for 7 days after contact for any evidence of disease.

(e) Depending on the medical advice arrange for close contacts of a case (staff or prisoners) to have prophylactic (preventive) treatment for some days.

Hepatitis A

1.12. Hepatitis A ("Yellow Jaundice") is a common. self-limiting infection, especially in areas of poor hygiene and sanitation. In common with other forms of hepatitis it presents as jaundice, with loss of appetite, nausea, mild fever, and occasional vomiting. It is spread by what is called the faecal-oral route. Essentially this means that food or water which are comtaminated by someone who is excreting the virus are ingested by someone else who then develops the condition (unlike hepatitis B which is spread by the sharing of intimate body fluids, e.g. blood, semen or vaginal secretions). Hepatitis A has an

incubation period from 15-40 days and a person is only infective to others for a few days before and after symptoms become apparent. There is no carrier state.

1.13. In a case of suspected Hepatitis A in prison the following procedures should be followed:-

(a) Seek immediate appropriate medical advice. (This is important as there are a number of other medical causes of jaundice).

(b) Isolate suspected cases and take enteric precautions (i.e. body waste should be disposed of observing appropriate hygiene precautions). Isolation is of only limited value in cases of Hepatitis A infection bearing in mind the long incubation period, the fact that the case is infective before any symptoms become apparent, and the fact that a case is only infective to others for a few days before and after the appearance of symptoms.

(c) Seek the advice of the local health authority in relation to identifying contacts and searching for missed cases as all forms of hepatitis are notifiable diseases.

(d) Consider providing immunoglobulin to intimate contacts of a case. (This protection is ineffective more than 2 weeks after exposure).

(e) Exclude cases of Hepatitis A from work or occupation for 7 days after the onset of jaundice, or until clinical recovery.

(f) Educate staff and prisoners in the maintenance of high standards of hygiene.

1.14. It is recommended that the protocols set out above for the management of these diseases be uniformly adopted in all prisons and places of detention and that all staff be made fully cognizant of the procedures to be applied in all such cases.

CHAPTER II

Development of Existing Policy in Relation to the Management of Offenders who are HIV Seropositive

2.1. From the mid 1980's the emergence of HIV seropositivity and other communicable conditions, among the prison population, presented problems and concerns for Prison Management. At the time there was little known about HIV/AIDS and international public reaction was one of lack of understanding and fear. Even among the medical and scientific disciplines there was little certain knowledge about the disease and much of what was known was very much open to differing interpretation. It was against this background that management in prisons were first confronted with the problem of managing prisoners who were identified as being HIV seropositive.

2.2. The first offender in the Irish Prison System was identified as being HIV positive in November, 1985. Quickly other positive results of HIV tests began to emerge among the prison population. Not surprisingly, the reaction of management, staff as well as prisoners themselves was confused and in character with the mood of the time which was one of fear and confusion. Medical opinion could provide no sound advice on how best such offenders might be treated; nor indeed was there available any definitive or

accepted indications on the full circumstances in which the virus might be contracted or the rate at which this population within prison might grow.

2.3. The first person identified as being HIV positive was released immediately. It was clear, however, that a policy of immediate release for all such prisoners could not be sustained without undermining the very purpose of imprisonment. The question to be decided, therefore was how such persons - for whom release could not be considered - could best be managed and cared for in a custodial environment. At the time staff and other prisoners had very understandable worries about contracting the virus and it was considered that their concerns would be minimised by a policy of separating such prisoners from the main prison population. Taking into account the medical advice available at the time and following extensive consultation with staff representatives, it was decided in 1985, for operational and security reasons, to segregate those diagnosed as being HIV seropositive.

2.4. In May 1986 a multi-disciplinary Departmental Working Group was established with the following terms of reference

" - to examine the situation in relation to AIDS in prisons and places of detention,

- to recommend standardisation and co-ordination of

procedures

and

- to make recommendations in relation to the future management of HIV offenders."

In its report the Group stated that they accepted that segregation would have to continue for the present but that the practice should not survive in the long term and that the needs and safety of segregated prisoners would best be served by their planned re-integration and the adoption of

- a policy of health education,

- a standard system of specimen handling

and

- a consistent practice in relation to blood spillage.

They recommended

- the introduction of pre and post test counselling,

- the provision of information booklets on HIV for all staff and prisoners,

and

- the establishment of a Steering Committee to oversee counselling, health education and the

standardisation of medical practices.

Finally, they recommended that the guidelines for managing HIV seropositive prisoners, which had earlier been agreed with the Prison Officers Association, be reviewed and subject to further negotiation.

2.5. A leaflet was issued to staff which gave the most up to date information then available on AIDS, those at risk, modes of transmission etc. Guidelines had been drawn up on prevention, protection, precautions to be taken in the event of an incident or accident and on the management of persons who had been diagnosed as antibody positive. The main guidelines issued at that time are at Appendix II.

2.6. To date it is still the practice to segregate (male) prisoners who are diagnosed as being HIV seropositive and the guidelines referred to are still in operation.

2.7. Male prisoners who are HIV seropositive are housed in two segregated units in Mountjoy Prison. However, for some considerable time now, female prisoners who are HIV seropositive are accommodated in the women's prison along with other prisoners and are not, therefore, subjected to any form of segregation.

2.8. Since 1985 the total number of persons who have tested positive within the prison system, or whose declared

positive status has been verified while in prison, is 200 approximately (85% male). However, there are good grounds for believing that the numbers coming forward for testing within the prison system do not give a true reflection of the numbers in custody who may in fact be HIV seropositive. In particular over the last 2 years the various disciplines working in prisons have indicated their awareness of a number of cases where there is reasonable suspicion that a prisoner is HIV seropositive but refuses to declare his or her status or undergo testing. There may be many reasons why people do not wish to undergo a test ranging from fear of learning the truth to fear of being segregated. However, there is evidence which indicates that fear of segregation is the primary deterrent in a number of instances.

CHAPTER III

Effectiveness of Current Policy of Segregation

3.1. When considering the positive and negative effects of a policy of segregating prisoners who are HIV seropositive one has to have regard to the practical management difficulties which this population of offenders present. There may, for example, be considerations which, from a strictly medical viewpoint, present as negative but from a security and prisons' operations point of view present as positive. In this Chapter we outline the negative and positive elements which have been experienced over the last 6 years of operating a policy of segregation.

3.2. Before dealing with the various effects of segregation it would first be appropriate to outline improvements in the medical knowledge about HIV which have taken place since the earlier years when the disease was first diagnosed. The fear, panic and confusion which then reigned centred around its natural progression, the mode of transmission of the disease, including, in particular, the practical risks for persons associating with persons who had the virus.

3.3. It is now well known that AIDS results from infection with a virus - the Human Immunodeficiency Virus (HIV). This virus attacks the body's immune system and makes it vulnerable to various infections. People infected with HIV do not

necessarily have AIDS. Often they are completely healthy. They are, however, infected for life. The virus gradually damages the immune system so that AIDS may eventually develop and infected persons can under certain circumstances, infect others.

3.4. It is important, in the first instance, that it be made clear how the infection <u>can</u> be passed on and how it <u>cannot</u> be passed on. It is known that the Human Immunodeficiency Virus can only live at dangerous levels in blood, semen and vaginal fluids and that there are four proven ways in which the virus can be passed from one person to another. These are:

- sharing needles/syringes with an infected person,

- sexual contact involving the exchange of body fluids with an infected person,

- injection or transfusion of blood or blood products taken from an infected person,

and

- from an infected pregnant mother to her baby.

Subject to these, it is also known that a person cannot become infected with the virus by

- sitting beside someone,

- hugging, kissing or shaking hands,

- sharing the same cutlery or crockery,

- using the same toilet facilities,

- using the same laundry facilities,

- using the same washing/swimming facilities,

- mouth to mouth resuscitation,

- insect or animal bites.

3.5. In considering these issues in the context of prisons it is important to understand that in a prison environment conflicts arise between prisoners themselves and between prisoners and prison officers which would not be as frequent in society at large. Such conflicts give rise to certain concerns in regard to the management of HIV seropositive prisoners and questions arise such as whether the virus can be contracted

- in the course of a fight,

- through injury from bites or from needles,

- through having urine and slops thrown over one,

- from being spat upon

or

- from coming into contact with blood spillage.

3.6. At present there is no known case of a person having contracted HIV as a result of fighting in prison, including no known cases of HIV infection as a result of bites. As has been pointed out the Human Immunodeficiency Virus lives mainly in blood, semen and vaginal fluids. While it has been found in urine and other body fluids it is present in such small quantities that infection is extremely unlikely - there are no known cases of HIV infection from having urine or slops thrown over a person or from being spat upon. The medical opinion is that there is no risk of transmission in such circumstances.

3.7. There is a degree of confusion regarding the overlap between Hepatitis B and HIV. This may be due to the fact that their method of spread is broadly similar. It is important to note that Hepatitis and HIV are two quite distinct diseases caused by quite separate agents and infection with Hepatitis B does not mean that a person also has HIV and visa versa. It is also important to note that an effective vaccine against Hepatitis B has become available. There are a number of forms of Hepatitis caused by infective agents (viruses). Hepatitis A, as we have already pointed out in Chapter I, is spread by the faecal-oral route. Hepatitis B and Delta

Hepatitis are different strains of virus and are spread by the same mechanisms as HIV (e.g. blood, sexual fluids). Non A Non B Hepatitis (mostly Hepatitis C) has two forms - one which resembles Hepatitis A and the other which resembles Hepatitis B.

3.8. It is in the context of this knowledge and having primary regard to the needs of the prisoners concerned that we now address the issues of the effect of current policy on persons who are HIV seropositive and the effectiveness of that policy.

3.9. Under present policy there is no compulsory testing of prisoners for HIV. However, prisoners wishing to take the test must first agree that the results of the test will be disclosed to prison management. They are aware that if they are tested positive they will be housed in one of the special segregation units in Mountjoy Prison. A question arises here as to the nature of the prisoners' consent. It is now freely accepted that for any patient, including patients who are prisoners, normally consent to any medical procedure should be free, informed, rational and unfettered. Clearly present policy poses difficulties in this regard because of the requirement that all such prisoners must, before being allowed the test, agree that the results be made available with the consequences outlined. This requirement poses medical ethics problems. These are fairly complex problems giving rise to a dilemma for Medical

Officers while at the same time raising serious issues in relation to the Governor's responsibility for and duty to prisoners. These issues are dealt with in a later Chapter.

3.10. There is evidence of prisoners refusing to undergo the HIV test because of fear of being segregated. The fact that segregation discourages certain prisoners from coming forward for assessment goes against all current health advice regarding the spread of the disease. Those who may be HIV seropositive are foregoing the most up-to-date treatment for the disease because they are unwilling to be segregated as they do not wish to undergo the social stigma and discrimination of having their HIV status known. All of these issues have been commented on in the report of the National Aids Strategy Committee (N.A.S.C.) and we fully endorse the views and comments contained in that report.

3.11. While the policy of segregation has been applied rigidly to male prisoners who have been diagnosed as being HIV positive there are indications, in practice, of a "hidden" HIV population which is not segregated. Information available suggests that some prisoners have tested positive before coming into prison but are not prepared to disclose their status because of fear of segregation. While hard statistics are not available on the actual numbers in the system who may be HIV seropositive, voluntary linked testing has shown that up to 200 have already passed through the system. Given the high incidence of drug abuse among

prisoners it is obvious that, at any one time, the numbers of prisoners throughout the entire system who have HIV far exceeds the numbers suggested. Since only about 40 are segregated this means that there are many prisoners in all institutions who are likely to have the virus but who are mixing freely with other prisoners.

3.12. Those who are segregated in the special units experience isolation from the rest of prisoners with feelings of discrimination and stigmatisation. The fact that they are housed together in a separate regime is in itself a daily reminder of their condition. Such prisoners may suffer deep depression which, from time to time, is characterised by general disruptive behaviour and self mutilation. The death of a former prisoner from AIDS, who had previously been held in custody in one of these units, causes an enormous amount of tension, grief and trauma among prisoners held there. Segregation intensifies and magnifies their difficult and tragic condition and they have no respite by way of mingling and associating with the main body of prisoners who might distract them from their own condition.

3.13. The fact that a segregation policy operates means that irrespective of the nature of the offence which has been committed all offenders identified as being HIV seropositive will be held in the special units in Mountjoy. This means that if such a prisoner, by virtue of the nature of his offence and previous criminal record, if any, were deemed

suitable for lower security containment or even for an open centre such an option would be denied him.

3.14. In addition, it is now clearly the case that there is no medical justification per se for segregating persons who are HIV seropositive and other countries in Western Europe do not as a matter of policy segregate on grounds of HIV positivity alone.

3.15. Nevertheless there is still an argument in favour of segregation for security and operational reasons. In the first place the better management of any prison is generally facilitated when different groupings of prisoners are kept apart. For example, a higher security regime appropriate to one group does not necessarily have to be applied to another group who do not need it. There is also the requirement to protect the more vulnerable from possible intimidation and even violence from other prisoners. Prisoners are always concerned about their own safety and welfare and could react in a situation where they felt themselves under threat from others, in this case prisoners identified as being HIV-positive. If they were to so react the ability of management and staff to counter such a reaction would be made all the more difficult in a non-segregated environment. Indeed, if it was unlikely that HIV prisoners would be accepted by the general prison population then it can be argued that segregation remains in their own interests.

3.16. The initial decision to segregate was, as we have said, taken at a time of fear, lack of understanding of the problem and the wish of staff and prisoners, because of fears for their own safety, not to have such persons mingle freely with the main body of prisoners. To-day, while there is a greater understanding of the problem, there is no evidence that the understanding is such as to guarantee the assimilation without difficulty of those who are seropositive into the main population. Indeed there is evidence to the contrary. Segregation of HIV prisoners has become the status quo and there will be considerable reaction to any change in this policy unless the opposition to their integration from both prisoners and staff can be overcome. This can only be achieved through careful education and the elimination of these fears.

3.17. One of the benefits which accrued from segregation was the ability of the prison service to provide an enhanced standard of medical, psychological, psychiatric, welfare, etc. services to this category of prisoner. Their accommodation in the one location allowed the concentration of all of the services in that area with a greater facility for monitoring their general health by all of the agencies concerned. In addition the fact that they have been accommodated in Dublin has also facilitated quick access to outside hospitals who have, to date, considerable experience in dealing with persons who have been diagnosed as being HIV seropositive. In Mountjoy Prison there is now a proven

capacity for dealing with the special needs of this population which is not yet available in other institutions. Consequently, in reviewing current policy the capacity of other institutions to cope from a medical, psychological, psychiatric and welfare point of view with this category of offender needs to be carefully addressed. In this context the comments of the National Aids Strategy Committee are worth noting particularly Paragraph 3.4. which states -

> "the indications are that the majority of people affected at present are from deprived urban areas and many have experienced social and economic disadvantage, unrelated to HIV and AIDS. For example, many women who are HIV positive are single parents, the majority are unemployed and live in local authority housing and many have had a history of drug misuse and consequently many members of the extended family network may be infected with HIV. Generic community services provided by the statutory authorities in deprived urban areas are under the greatest pressure. **It is proposed therefore that a strengthening of such services provided by the Health Boards in these areas would be an important initial step in developing a range of accessible and appropriate services".**

3.18. Finally, from the prisoners' point of view, the more

generous programmes of temporary release which are granted to persons housed in the segregation units are seen as a considerable benefit. While these offenders remain segregated it is possible to maintain this approach without seeming to be unfair to the rest of the prison population. However, once reintegrated it may be difficult to continue with this level of temporary release arrangements.

CHAPTER IV

Operational Issues for the Management of Seropositive Prisoners

4.1. It is universally accepted that communicable diseases pose special problems for prisons as do prisons pose certain problems for prisoners suffering from communicable diseases. With the emergence of HIV and AIDS among prison populations these problems have been exacerbated. It is therefore essential, in the formulation of policies for the management of these problems, to look carefully at the capacity of the prison service to deal with the problems particularly from an operational perspective.

4.2. Since the early days of dealing with prisoners who have been diagnosed as being HIV seropositive the Prison Service has provided, in a controlled setting, a high level of centralised services (including medical services) through the operation of a policy of segregation. In considering future policy, management should be guided by the practical operational needs of the prison service, the behaviourial patterns of prisoners, public health issues and medical requirements.

4.3. In view of current knowledge about HIV and its transmission, the Committee accepts that there is now no basis, from a medical point of view, for the segregation of persons who

are HIV seropositive. The question that needs to be addressed therefore is whether segregation can be ended without compromising essential operational requirements.

4.4. The general principles of security and the needs of the individual which underpin the good management of prisons are a given fact in relation to all prisoners irrespective of their status or condition. Those who are HIV positive fall into many categories. They may be young or old, literate or illiterate, high security risk or well behaved, mentally disordered or well adapted, hardened or disingenuous, destructive delinquents or social victims - the variation is extensive. These variations call for a special response. In determining the correct and most effective method of managing this population it is imperative that the multiplicity of characteristics be taken into account. It is not practical to have either a single response or a single regime for such a diverse population.

4.5. The operation of a policy of segregation in the present context implies a classification of prisoners by reference to one criterion only - s/he is HIV seropositive. Such an approach has obvious drawbacks for the effective and positive management of prisoners' sentences. The fact that prisoners are segregated on that basis alone means that persons with widely disparate characteristics and needs are housed in one area with a single regime. This can lead, for example, to highly volatile prisoners being housed with well

behaved prisoners. In normal circumstances they would be managed quite differently. It is also the case that irrespective of their HIV status they require different levels of medical treatment. It is clear, therefore, that different responses are required and the provision of a single response based on a single criteria is fraught with disadvantages

4.6. Another issue - which has already been referred to - is the evidence that many prisoners who are HIV seropositive are not coming forward within the prison system for testing because of the fear of segregation and stigmatisation. As a consequence there are a number of prisoners currently housed with the ordinary prison population who have the virus. While this has obvious drawbacks for their medical treatment there is the very serious consequence that staff (and prisoners generally) may suffer from the mistaken belief that only those who are segregated have the virus. This can lead to a false sense of security with the result that staff may not take the necessary precautions when dealing with prisoners who may be HIV seropositive.

4.7. Given the reluctance of prisoners to be tested, the very strong indications that there are prisoners who are HIV seropositive who are not segregated and the false sense of security which the current policy generates the Committee concludes that the classification of prisoners solely by reference to their medical condition no longer makes good

operational sense and can lead to the imposition of a regime which may be inappropriate in individual circumstances. While acknowledging that the medical condition of a prisoner is an important criterion, other criteria such as the nature of the offence, previous criminal record, behaviour while in prison, are factors which should be given the appropriate weighting when deciding the most appropriate regime to apply.

4.8. The Committee considers that there is no longer an advantage for the present policy of automatically segregating persons who are diagnosed as being HIV positive and the first step in moving away from this policy would be confidential testing for HIV. The Committee is aware that in a prison context persons, other than the medical officer, may become aware of the medical condition of individual prisoners. Consequently the Committee considers that the guarantee of confidential testing must go hand in hand with programmes for the better education of staff and prisoners in relation to HIV/AIDS. It is important, therefore, that education be accorded a top priority with the main process being completed within a period of 6 months.

4.9 The Committee, being of the view that an argument in favour of maintaining existing policy of segregation cannot be sustained, nevertheless is also conscious of the fact that to adopt a policy of desegregation or indeed a policy of not continuing to automatically segregate will require a

reassessment of the existing approach to the management of prisoners who are diagnosed as being HIV seropositive. In order to evolve a policy of non segregation the following critical areas of prisoner management require assessment

- confidentiality
- prisoner assessment/classification,
- education,
- medical services,
- contraband/visiting arrangements,
- environment
- organisational change

All of these issues are dealt with in subsequent chapters.

CHAPTER V

Confidentiality

5.1. The question of the doctor/patient relationship in the prisons context is a complicated one and the issue of medical confidentiality in that context needs to be examined with care and in a broader context. The essential difficulty for the doctor lies between his/her primary responsibility to the patient and his/her secondary responsibility to prison management and in particular the Governor of the prison.

5.2. Persons committed to prisons or places of detention are, by warrant of the Court, placed in the custody of the Governor of the institution. Legally the Governor has responsibility for the secure and safe containment of the person for the duration of his or her imprisonment and is directly accountable for any failure to discharge this responsibility. He must, therefore, ensure that all the necessary services, including medical services, are provided for the prisoner while in his custody and is obliged, in so far as is reasonably practicable, to make himself fully aware of the needs of the prisoner in order that he may discharge his responsibilities fully. Specifically with regard to the health of prisoners the Governor is required to make himself aware of the medical condition of all prisoners in his custody. In this context it is unclear

whether this duty relates to the overall health of the prisoner or whether it relates to detailed information about, for example, a specific disease.

5.3. The Medical Officer employed in each Prison or Place of Detention has specific responsibilities in relation to the support of the Governor and the Statutory Rules require that he/she support the Governor in the maintenance of discipline and order and the safe custody of the prisoners. The rules require that every prisoner be examined by the Medical Officer and that an account of the state of every sick prisoner must be entered in the Medical Journal. Where infectious or contagious diseases are concerned, the Medical Officer is required to report to the Governor in writing where he finds any prisoner who is suffering from such disease. Again it is unclear whether this notification relates to notification of the specific disease or whether it refers to reporting to the Governor that a prisoner is suffering from a notifiable disease and informing him of the appropriate action to take in the circumstances. It is understandable, therefore, that complex issues of ethics can arise for medical officers working in prisons.

5.4. The work of doctors depends on sincere and complete disclosures from their patients. They honour this candidness by confidentially safeguarding the information received. Breaching confidentiality may cause harm that is not commensurate with the possible benefits gained.

Confidentiality constitutes a guarantee of fairness in medical actions and where limitations or exceptions are put on it the patient tends to become suspicious, uncooperative and lacking in trust and the whole climate of the clinical encounter may suffer irreversible erosion. It is currently contended that, in a number of instances, this is the situation that pertains within our prisons, especially in relation to the HIV disease.

5.5. Medical confidentiality is clarified in a number of statements -

a) Declaration of Geneva (a modern statement of the Hippocratic Oath) as amended in Sydney (1968)

"I will respect the secrets which are confided in me, even after the patient has died".

b) International Code of Medical Ethics -

"A doctor shall preserve absolute secrecy on all he knows about his patients because of the confidence entrusted in him"

c) Declaration of Lisbon (World Medical Association, 1981)

- on the rights of the patient -

"The patient has the right to expect that his physician

will respect the confidential nature of all his medical and personal details."

d) Resolution on Medical Secrecy (World Medical Association, 1973)

" ...reaffirm(s) the vital importance of maintaining medical secrecy not as a privilege for the doctor, but to protect the privacy of the individual as the basis for the confidential relationship between the patient and his doctor; and to ask the United Nations, representing the people of the world, to give the medical profession the needed help and to show ways for securing this fundamental right for the individual human being."

While acknowledging the requirement that doctors maintain confidentiality in respect of disclosures made by a patient this is not absolute and there are a number of exceptions which are set out in the following paragraphs.

5.6. The fundamental exception to the over-riding rule of confidentiality is where the patient gives consent (bearing in mind that the information is the property of the patient, not the doctor) for disclosure. Included in this would be situations where other doctors or professional persons properly involved in the care of the patient have access to the information.

5.7. A second exception is where there is a legal statutory requirement for the notification of a medical condition to the appropriate authority (usually Dept. of Health) as in the case of notifiable infectious diseases, births and deaths, etc. HIV is not a notifiable disease in this country.

5.8. Thirdly, information may be disclosed to a third party (other than a relative) where it would be in the best interests of the patient to do so. In this situation the doctor is required to first make every reasonable effort to persuade the patient to allow the information to be disclosed. Only in exceptional circumstances will a doctor override any such refusal and s/he must be prepared to justify such action.

5.9. Fourthly, exception may be made where the doctor learns information about a serious matter during his professional relationship with a patient and feels obliged to disclose this in the public interest. An example would be where a patient discloses the intention to seriously harm somebody else and the doctor considers that this threat is likely to be carried out.

5.10. The other main exception to the rule of confidentiality is where a court orders the disclosure of information by the doctor (medical information is not governed by the rules of legal privilege). The doctor should only divulge

information when directed to do so by the judge or presiding officer of the court, or upon receipt of a formal sealed court order.

5.11. The doctor is a citizen as well as a healthcare professional and has obligations to protect other citizens. Essentially, a doctor must act according to a combination of what he believes to be the patient's best interests and the dictates of the practitioner's own conscience. The doctor would have to be prepared to justify any decision to breach confidentiality and the indications are that the courts would only condone a breach of confidentiality in extreme situations.

5.12. In discussing Medical Confidentiality in the prison context it must be emphasised that the doctor is bound by the same ethical rules as elsewhere. The development of a concept of patient's rights and the diminution of paternalistic medical practice has led to a greater demand from patients for adherence to medical secrecy in the absence of consent.

5.13. In some jurisdictions (Belgium, France, New Zealand) the right to medical confidence is enshrined in criminal law. Elsewhere, while not a legal right, it is considered to be part of the contract between doctor and patient and amenable to civil action for breach of contract. With the free movement of medical personnel within the EC it is likely that there will be greater pressure for stricter adherence

to this fundamental principal.

5.14. In relation to prisoners there is no derogation from the rules of confidentiality. This right of prisoners to medical confidentiality is increasingly being accepted administratively throughout Europe. The recent White Paper ("Custody, Care and Justice - the Way ahead for the Prison Service in England and Wales") from the English Home Office states (chap 6.23) -

> "Prisoners should expect the same standards of health care as those provided by the National Health Service."

As medical confidentiality is a basic tenet (and legal right) within the NHS this would appear to be an official acceptance of the same principle in relation to prisoners. In fact, medical confidentiality has been fully accepted and has not been the subject of debate for a considerable period in the U.K. prison system.

5.15. The published Standards for Health care of the Correctional Service of Canada state that -

> "The offender has the right to have medical information dealt with in a confidential manner. Standards of confidentiality shall be consistent with professional standards, Commissioner's Directives, the Privacy Acts and other federal legislation."

5.16. In providing advice the British Medical Association states ("Rights and Responsibilities of Doctors" BMA, 1988) that -

> "apart from not being able to choose their own doctor, prisoners have a right to the same medical attention as any other member of society, and a prison medical officer's responsibility to, and professional relationship with, his patients are the same as any doctor working outside prison."

5.17. In acknowledging the uniqueness of the prison environment the Committee accepts that it is necessary for Governors to be made aware of the general medical condition of prisoners in their charge. Accepting that the duty of confidentiality is not an absolute one the Committee is nevertheless conscious of the need to ensure that the doctor/patient relationship is not compromised. Consequently, it is considered imperative that the manner in which information, on prisoners' medical condition is handled and disseminated be clearly defined so as to ensure that the Governor may fully discharge his responsibilities and the doctor/patient relationship is not compromised. Because of the many complex issues involved it is recommended that discussions take place between Prisons management and the Medical Council to clarify the relationship between the medical officer and the Governor on this matter.

5.18 There are many aspects of the Rules for the Government of

Prisons, 1947, which do not outline precisely enough the respective roles of Governors and Medical Officers and which, in the view of many on the Committee, may indeed be interpreted as breaching medical ethics. It is understood that at the present time the Rules for the Government of Prisons are being redrafted and it is recommended that the role of medical officers be clearly and unambiguously set out in the revised rules, having due regard to the Governors' responsibilities and the doctor/patient relationship.

CHAPTER VI

Assessment/Classification of Prisoners

6.1. One of the most critical problems facing prison systems the world over today is prison overcrowding. Overpopulation, however, is not a problem that exists in isolation. Its consequences spill over into all areas of prison operations, arousing concern about such issues as the security of institutions and health and safety of staff and inmates.

6.2. The type of prison accommodation available at present can, broadly speaking, be categorised as high security institutions, secure institutions, semi-open and open institutions. The category of prisoner varies considerably from one institution to the next and the facilities and services of each type of institution also vary. In order to guarantee the secure and safe custody of prisoners, it is important to ensure that, as far as practicable, the security levels of the institutions match the security needs in relation to prisoners and that the range of facilities, etc. available are appropriate to prisoners' needs. We have already made reference to the fact that the segregation of HIV seropositive prisoners has resulted in prisoners with widely different characteristics and needs being housed in the one area with a single regime. As a result the needs of individuals, in areas other than medical, may not be fully catered for. We have therefore recommended that, in assessing

prisoners for the future, the broad range of characteristics should be taken into account in determining the manner in which they are to be treated. In this context the appropriateness of the present assessment and classification system is obviously one which needs to be addressed.

6.3. In determining the most efficient and effective use of limited resources and in order to ensure that prisoners sentences are positively managed the Committee is of the view that the assessment and classification of prisoners are essential components. At present the degree of classification of prisoners is limited with only certain offenders (e.g. sex offenders) being clearly categorised. In order to ensure the effective administration of sentences and management of prisoners it is recommended that the existing approach to assessment and classification be reviewed and that a more extensive and objective system be introduced.

6.4. While the Committee does not see itself being competent in the area of drawing up criterion to be followed in the classification of prisoners, it considers that the objective of any system of classification should be directed towards ensuring that

- prisoners are housed in the least restrictive secure facilities for which they are suited,

- the prisoner population is kept in reasonable balance

throughout the prison system,

- the medical, psychological, psychiatric, welfare educational and vocational needs of prisoners are met,

- the best use is made of resources and that the resources of the institution meet the prisoners' needs.

It is essential that the broadest possible criteria are used and that no single criteria, such as a prisoner's medical condition, should be the sole determining factor. The Committee is conscious of the fact that the development of an effective classification system can, of necessity, be a lengthy process.

6.5. On the question of assessment it is important that all persons be fully assessed on committal. In this context the Committee notes the recommendation of the Advisory Group on Prison deaths which states that -

> "Given the critical nature of the early stages of imprisonment the Group is satisfied that new arrangements should be made for prisoners being received into prison. These arrangements should include the setting aside of a special building or at least an area in the prison as a Centre that would be devoted solely to dealing with offenders in the initial days of their imprisonment"

That Group went on to recommend

> "that a Committal Assessment Centre be established in Dublin in which all newly-committed offenders would be accommodated and assessed during the initial days in prison and that arrangements be made in Cork, Limerick and Portlaoise prisons to ensure that committals to those prisons would receive a service on a par with that in the Dublin Centre in the initial days of their imprisonment."

6.6. Because of overcrowding in some institutions it is necessary in certain instances to accommodate more than one prisoner per cell. In such circumstances the danger of spreading disease is increased. It is important, therefore, that on first committal all persons are housed in single cell accommodation until such time as they have been fully assessed. Consequently, the Committee fully supports the recommendation of the Advisory Group on Prison Deaths for the provision of a committal centre. The Committee recognise, as did the Advisory Group, that the provision of such a centre will involve either major expenditure and/or major reorganisation which can only be achieved in the long-term. It is recommended that in the interim the present committal arrangements be reviewed in order to improve assessment of prisoners on committal.

CHAPTER VII

Education/Prevention

7.1. The terms education and prevention in relation to communicable diseases are frequently, but mistakenly, used synonymously. Prevention demands a reduction and hopefully, in time, elimination of high risk behaviours that lead to the transmission of HIV. Achieving behaviourial change is difficult. Education is just one important aspect of this process.

7.2. The National Research Council, in their recent volume **AIDS: Sexual Behaviour and Intravenous Drug Use, (Turner, Miller and Moses 1989, Washington D.C., National Academy Press)**, comprehensively reviewed the available literature on facilitating change in health behaviours and identified four broad aspects to any programme likely to alter an individuals risk associated behaviours.

a) Education

b) Motivating and sustaining behavioural change.

c) Social factors that can support or hinder change in individual behaviour.

d) Evaluation

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Press Release

The Minister for Justice has authorised the publication of the Report of the Advisory Committee on Communicable Diseases in Prison which was set up by the Minister for Justice in 1990.

She would first like to take the opportunity of thanking the Committee for its valuable work and for its Recommendations set out for the better management of communicable diseases in the prisons.

The Minister is accepting in principle all 33 of the Recommendations set out in Chapter XII. Many of these relate to practice and procedures and there will be no undue delay in implementing them. She is glad to note, and accepts, the Recommendation of the Committee for the phasing out of the policy of segregating prisoners who are HIV-positive. She intends to set up immediately the two Committees recommended by the Group, i.e. an Education Committee to oversee education programmes in prisons to prepare the way for de-segregation and a HIV Steering Committee to oversee the future management of HIV-prisoners and related matters.

Some of the Recommendations call for special comment i.e.

(a) **Assessment, Classification and Committal Centre (Recommendations 5,8,9,10).**

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Overcrowding of prison accommodation inhibits proper assessment and classification measures, and makes it difficult to spare an institution specifically for a Committal Centre. Nevertheless the Minister will take account of the Group's Recommendations in this area when assessing policy for prisons for the future and the provision of additional prison spaces. The Group itself acknowledged that the provision of a Committal Centre is a longer term objective.

(b) **Hygiene, sanitation.**

The Report recommends that arrangements be made within the next 7 years under which all prisoners would have in-cell sanitation or access to toilets at all times. The Minister is at present considering a building programme for the prisons for the years 1993-1997 and the Recommendation in the Report will be taken into account when the programme is being finalised.

(c) **New Health Care Unit, Mountjoy Prison.**

The Minister accepts the Recommendations in the Report for the use of the New Unit. The Unit will be ready for occupation shortly and the Minister proposes to transfer into it all HIV-positive prisoners who are at present segregated, along with other prisoners who

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need enhanced primary medical care. As segregation is phased out the Unit will cater for any prisoners requiring closer medical supervision, including those with AIDS-related complications, but who do not require treatment of a kind provided in outside hospitals.

3 May, 1993.

7.3. Providing accurate and appropriate information is the first step in attempting to alter risk behaviours. Besides playing a role in facilitating behavioural change, education can help to allay unnecessary fears and reduce discrimination. Information must be targeted to the needs of specific groups and delivered in a manner and through a medium that is comprehensible and relevant to the audience it is intended to reach. It must also be sufficiently frank and explicit, particularly in the area of sexuality, so as to avoid any possible misunderstandings.

7.4. Once the appropriate information has been successfully communicated to the target population, the problem is to get them to act on it. Numerous factors will play a part in this, including how the individual perceives the risk, whether he has the appropriate skills and resources to respond to the perceived threat and how the required changes are perceived within the individual's peer culture. Thus for an individual to be motivated to take action in relation to HIV, the disease must be perceived as a personal risk with serious consequences. He must also believe he has the ability and opportunity to do something constructive about the threat, ideally the opportunity to choose from a variety of alternate behaviours. While it is difficult to get across to people the risks associated with HIV, it is even more difficult to get

people to initiate and maintain new behaviours which demand a long term effort.

7.5. Conscious of the urgent need to make information available to staff and prisoners on HIV the Committee made an interim recommendation to the Minister for Justice for the production of appropriate information booklets. Following the Minister's acceptance of the recommendation the Education Sub-Committee of the Advisory Committee on Communicable Disease, in association with a group of consultants, produced information leaflets which have already been circulated to all prison staff and prisoners. These information booklets are seen by the Committee as an important first phase in the education process and it is recommended that an HIV Education Committee be established on an on-going basis to evaluate the educational requirements and to continue the process of providing the necessary educational aids. The formal approach to education in this area can best be determined following a full evaluation, by the HIV Education Committee, of the education/information needs. The Education Committee should comprise persons from the medical, psychological, welfare and educational disciplines together with the chaplaincy service, prison management and staff representatives. The Committee also considers that the education programme to be adopted should, together with the use of information leaflets and books, include, as appropriate, seminars for staff and prisoners together with the use of videos/films on the subject of HIV prevention. The Committee is of the view that the main

educational process should be completed within a period of six months with further continuous education programmes also being put in place. Should the delivery of the programme necessitate the assignment of a person specifically to ensure that the work is carried through effectively it is recommended that this be done.

7.6. It has become increasingly clear that the social environment in which an individual functions can have a powerful impact in either supporting or hindering changes in individual behaviour. Certainly people are less likely to behave in ways that will incur the disapproval of others in their social group. There is no doubt that the behavioural change reported by homosexual men particularly in the epicentres of the disease, has been hugely facilitated by changes in the accepted standards and expectations for sexual behaviour in this group. Achieving comparable shifts in the group norms of prisoners in terms of their injecting and sexual behaviour and of prison officers in terms of their work practices would be a powerful aid to prevention. A broader social issue concerns society's general tolerance of such things as the use of explicit sexual language in educational material, the sale and use of condoms, needle exchange etc. If the public good is served by individuals altering their sexual and injecting behaviour, those individuals will at least need ready access to the means of effecting this change.

7.7. On the general question of altering sexual practices and

injecting behaviour the Committee considered the question of making available condoms to prisoners and the operation of a needle exchange scheme. On the question of making condoms available to prisoners the Committee, bearing in mind the legal position and the lack of evidence that anal intercourse between prisoners is common in prisons, considered it inappropriate to make condoms available to prisoners while in prison. However, the Committee is of the view that condoms should be available to prisoners on their release. The question of the introduction of a needle exchange programme is dealt with in a later chapter.

CHAPTER VIII

Medical Services

8.1. The provision of Health Care Services to the community is in the first instance the responsibility of the health authorities. The prison service only provides primary health care services and the more specialised services must continue to be provided by the health authorities.

8.2. It is accepted that persons who may be diagnosed as being HIV positive may indeed be perfectly healthy requiring no more than routine medical care with intermittent monitoring. Some may require special medication while others, as they progress to the later stages of the virus, may require very specialised care. In the earlier years, when information on the disease was limited, one of the perceived advantages of segregation was the possibility of providing an enhanced medical service by the concentration of the full range of services in one area in Mountjoy Prison.

8.3. There is no doubt but that the concentration of medical services has resulted in the provision of an adequate level of service both within the segregation unit and also a high level of service in hospitals, who provide the specialised service for such prisoners in the Dublin area. However, it must be acknowledged that while existing medical services in other institutions and other health board areas may be sufficient to

cope with persons at the earlier stages of the disease they may not be adequate, in certain circumstances, to cater for prisoners at the later stages. It is important that the appropriate level of medical service be available in all institutions and by the various health authorities who provide the services to those institutions. It is recommended, therefore, that the Director of Prisons Medical Services should, in association with local prison management and the Health Boards in whose areas the institutions are located, develop the medical service available to each institution to enable the provision of appropriate medical care for HIV seropositive prisoners. In this regard it should be noted that the National Aids Strategy Committee made the following comments

"a) HIV positive prisoners should be able to avail of medical and paramedical services of an equivalent standard to those available to similarly infected people in the community.

b) To facilitate continuity of care between the prison and the general community the overall integrating of facilities between these two locations for this group should be encouraged. This may involve more formal linkage or liaison between care facilities in the communities and those within the prison.

c) Prison regimes should be structured, as far as

possible, to facilitate the diagnosis, medical treatment, and on-going care of HIV positive individuals

d) As far as practicable primary-care and consultant-based out-patient services should be provided within the prison. Where a prisoner requires specialist in-patient medical treatment this should be provided within the health service on the same basis as to any other citizen."

8.4. In the context of considering medical facilities the Committee considered the use which should be made of the special unit in Mountjoy Prison. Bearing in mind that, within a prison setting, there are limits to the level of medical service which can reasonably be provided and the contribution which the health authorities must continue to provide, the Committee recommends that the new unit should have the following functions

- where a prisoner required medical care or supervision of a degree that could not be provided in his original location, but not of such a degree to warrant transfer or admission to outside hospital, he should be transferred to this unit for as long as required and return to his original location when well enough. The intention would be to provide a <u>good first-line medical facility</u> but in no way attempting to replicate the range of services or

facilities available in a general hospital. In this way appropriate levels of care could be provided to the following groups:

(a) HIV positive prisoners who needed specific medical supervision;

(b) other communicable diseases which might merit periods of isolation (e.g. TB cases on treatment or awaiting transfer);

(c) psychiatric cases (including those considered at risk of suicide); and

(d) cases returning from outside hospital following operations, etc. who require a period of convalescence.

As recommended in the NASC report various out-patient and consultative services that are used (e.g. specialist HIV services, dermatology services, etc.) should be brought-in and the unit should serve as a suitable location for such services. With suitable staffing it should be possible to undertake much of the routine minor work, e.g. suturing lacerations, dressings, blood samples, which currently require referral to outside hospitals.

8.5. In the provision of this service the Committee are of the view that fully trained medical staff should be provided. While

acknowledging the excellent contribution which prison officer medical orderlies provide it recommends that qualified nurses should be employed. This can be done by either training existing medical orderlies or by employing nurses.

CHAPTER IX

Visiting Arrangements/Contraband

9.1. The Committee is conscious of the fact that the majority of prisoners who have been diagnosed as being HIV seropositive are also drug abusers and that there is drug abuse in prisons. The committee accepts that such abuse is possible only to the extent that drugs can be brought into the prisons illegally. The quantities so imported can be very small and this gives rise to major difficulties in detection. It also recognises that measures could be taken, such as the erection of barriers between visitors and prisoners and the strip searching of all persons including visitors entering the prison which would virtually eliminate the problem. However such an approach would result in an unacceptably inhumane visiting regime.

9.2. While acknowledging that the most effective deterrent is staff vigilance the committee is conscious of the fact that there is no screening of visitors entering most institutions and that certain visiting facilities have serious limitations.

9.3. In order to prevent, insofar as is reasonably practicable, the smuggling of any form of contraband into prisons the committee recommends that

- existing visiting facilities which are inadequate be enhanced,

- all visitors to the principal closed institutions be liable to be screened,

- persons found passing contraband be prosecuted by the Gardai and barred from future visits,

- video equipment in all visiting areas should be enhanced where necessary,

- video evidence should be used, where possible, in the course of prosecutions,

- all visitors should be prevented from bringing any goods into the visiting areas, and

- all prisoners caught in possession of contraband should be put on restricted visits for a period and prosecution should be considered.

9.4. The Committee is conscious of the fact that whatever efforts are made to prevent contraband coming into prisons certain quantities of illicit drugs and injecting equipment will filter through and that such injecting equipment will continue to be shared among prisoners. In this context the Committee considered the question of the appropriateness of making available clean disposable injecting equipment to prisoners in an effort to prevent the transmission of disease. While

acknowledging that clinically supervised needle exchange schemes may operate in the community it was considered that such an approach would be inappropriate in the context of the safety and security of the prison. The Committee is of the view, therefore, that efforts should be concentrated instead on the prevention of contraband entering prisons and on the education of prisoners against sharing needles.

CHAPTER X

Environment

10.1. Irrespective of medical advances it has long been accepted that among the essentials in preventing the spread of communicable disease are

- good standards of hygiene,
- adequate sanitary facilities

  and
- adequate living space

At the present time a number of institutions face problems in these areas due to the age of the housing stock, poor sanitary facilities and an overcrowded population.

10.2. It is accepted that the standards of hygiene in prisons should be coextensive, as far as practicable, with standards within the general community. The European Prison Rules provide that

"the accommodation provided for offenders...shall meet the requirements of health and hygiene due regard being paid to climatic conditions".

It is recommended that the Department issue a circular to all Governors outlining its objectives for compliance with this rule, making provision for periodic reporting by each Governor

on the general standard of hygiene within the institution with particular reference to inmate accommodation, sanitation facilities, bath areas, laundry, reception, visiting areas, workshops, education units, kitchens and food preparation areas.

10.3. At the present time a senior officer in each institution has been assigned the duty of Health and Safety Co-ordinator. It is recommended that a senior officer also be assigned responsibility for the maintenance of a high standard of hygiene within the institution.

10.4. It is recommended that the present cleaning practices and methods be reviewed.

10.5. It is appreciated that current policy envisages the installation of in-cell sanitation in all new buildings and in the course of the refurbishment of existing buildings. It is recommended that this programme be proceeded with as quickly as possible.

10.6. It has been mentioned earlier that poor sanitation and overcrowding have long been acknowledged as contributing to the spread of disease. This is particularly the case in relation to the diseases mentioned in Chapter I. The issues of sanitation and overcrowding were also referred to in the report of the Advisory Group on Prison Deaths which stated that

> "Many of our prisons do not have in-cell toilet or washing facilities. The consequences of this is that prisoners have to use a chamber pot during much of the time for which they are locked up at night. In the morning when the prisoners are unlocked they have to carry the pot, containing the urine and/or excreta, to an area where they empty it down the drains and wash the pot.....The group regards this practice.....as demeaning and degrading to prisoners".

The Group goes on to recommend that this practice be eliminated and

> "that access to toilet and wash-up facilities be made available to all prisoners on a twenty four hour basis as soon as possible".

The Group also pointed out that all during the 1980's the prison population continued to grow and despite major additions to the housing stock overcrowding in prisons and places of detention became a problem which resulted in the doubling up of prisoners in cells designed for one person. They went on to recommend that

> "the number of offenders in any prison be limited to the number that would ensure one prisoner per single cell but allowing for doubling up where that is done for

acceptable reasons".

10.7 At the present time there are very specific conditions for and arrangements whereby prisoners take showers and receive changes of clothing. It is recommended that current procedures be reviewed with a view to increasing the frequency of showering for prisoners and the frequency with which changes of clothing are allowed.

10.8. In the context of preventing the spread of communicable diseases it is imperative that both the issues of sanitation and overcrowding be addressed and the Committee fully supports the recommendations of the Advisory Group on Prison Deaths in this regard. The Committee sees the implementation of these recommendations within a realistic timeframe as one of the more significant ways in which the spread of communicable diseases can be combatted.

10.9. While recognising that there are financial resource implications the Committee is of the view that a firm programme should be drawn up with the aim of ensuring that in-cell sanitation/24 hour access to toilets is provided for all prisoners by the year 2000. In the overall planning for improvements in prisons, account should also be taken of the need to provide adequate showering and wash up facilities for staff.

CHAPTER XI

Organisational Change

11.1. The Committee in recommending the evolution of a policy aimed at the elimination of automatic segregation of prisoners who are HIV seropositive are conscious of the fact that some of those currently segregated may require to be kept segregated for reasons other than their medical condition. It is important therefore that great care is taken in the transition.

11.2. Organisations are complex systems and like individuals are commonly resistant to change. Segregation of HIV prisoners has become standard practice and there will inevitably be some reluctance to changing this. How strong this will be is difficult to estimate. Certainly in light of the developments that have taken place since 1985, some adjustment to the reality of HIV will have taken place, particularly in those institutions that have been dealing with HIV on an on-going basis. Resistance to change is likely to be strongest in institutions that perceive themselves to be psychologically and physically distant from the problem. Obviously the aim of any strategy to reintegrate HIV seropositive prisoners should be to minimise resistance and encourage support for the logic of the new policy. In attempting to achieve this a number of important points need to be kept in mind.

11.3. Successful change is going to require a consistent co-ordinated approach. Any inconsistencies will undermine the change process. A serious potential problem is that while educating for reintegration, confusing and contradictory messages continue to be given by maintaining the practice of segregation. The only meaningful resolution of this will be achieved by making explicit to everyone including staff, inmates and management that education is taking place in the context of a policy that has its ultimate goal the reintegration of HIV seropositive prisoners. Ideally there should be a specific time frame to this. The effect of this will be to make comprehensible to everyone what is going on and in so doing prepare the whole prison culture for reintegration.

11.4. With an issue as sensitive as HIV it is very important in pursuing reintegration that change should be organised in a gradual way. Conversely anything that might be perceived as dramatic or threatening needs to be avoided. Without the support of staff, inmates and management any operational targets in this area will be difficult, if not impossible, to achieve. Thus intermediate steps on the road to reintegration need to be established. From the onset it should be recognised that the first target has nothing to do with reintegration per se, but with ending the input to the segregation areas by initiating confidential testing for HIV in all prisons. This is doing no more than making explicit what is already implicitly accepted i.e. that HIV prisoners

are present throughout the prison system. The next step would be to slowly reintegrate those individuals in the segregated areas who by their behaviour warrant an opportunity to avail of the full range of facilities available to other prisoners. By stopping input to the segregation areas and facilitating gradual reintegration, the actual numbers segregated will quickly reduce. There may well remain a hard core group that for operational and security reasons will require long term segregation irrespective of their status.

11.5. Conscious of the fact that an abrupt ending of segregation would give rise to serious operational problems the Committee recommends that segregation as it currently exists should continue for the time being. It recommends the introduction of confidential testing and the adoption of a policy whereby in future those diagnosed as being HIV seropositive are no longer automatically segregated. The Committee also recommends that prisoners who are currently segregated be carefully monitored and their reintegration should proceed on a case by case basis with only those who seek reintegration and whose behaviour warrants it, being reintegrated.

11.6. Testing for HIV should be freely available to all inmates throughout the prison system. This is particularly important in the light of the recent medical thinking on HIV that stresses the importance of early diagnosis and early intervention. Once an individual has made a formal request to the Medical Officer for the test, he should be referred for

pre-test counselling. This should be carried out by an appropriately trained person and should be as uniform as possible across institutions. Where the individual consents to the test written consent should be obtained. Individuals presenting for repeated HIV tests should be obliged to go through the same counselling procedures on each occasion. Whether the result of the test is negative or positive, the individual should receive post-test counselling. Where the result is positive this should be on-going.

11.7. It is important with the evolution of this new policy to ensure that it is carefully managed. Accordingly the Committee recommends the establishment of a HIV Steering Committee in the Department of Justice which should comprise senior management in the Department of Justice with responsibility for prisons, the Director of Prison Medical Services, Prison Management, the Probation and Welfare Service, the Psychology Service, Education/Work and Training Services and staff representatives. This Management Committee should

- monitor the HIV situation in prisons and liaise with each institution,

- ensure that confidential testing for HIV is available in all prisons along with appropriate counselling services,

- standardise infectious disease control practices in operation throughout all penal institutions for inmates and staff,

- draw up guidelines for prison staff to minimise any risks involved in operational procedures that carry a potential risk of HIV transmission e.g. searches,

- liaise and co-ordinate with outside services e.g. medical services, voluntary and statutory agencies involved in the treatment and prevention of HIV,

- oversee the formulation and implementation of an on-going education campaign for both prison inmates and prison officers,

- oversee the provision of appropriate training for specialist groups as required e.g. Medical Officers, Medical Orderlies, Probation and Welfare Officers, Psychologists etc.

11.8. The Steering Committee should be backed up by local multi-disciplinary committees established in each penal institution whose responsibility it would be to see that policy with regard to HIV and related matters is implemented in their institutions. The Steering Committee should act as a source of advice, support and practical help to the local teams in carrying out their work, but local teams should be encouraged

to develop their own responses to meet the particular needs of their institution. Good communication and co-ordination between headquarters and institutions is essential in ensuring that consistency prevails across institutions.

11.9. It is important that prisoners who are diagnosed as being HIV seropositive are managed properly in all institutions. They should be kept on normal location and have full access to all the occupational options available in a particular institution. Any restrictions to this should only take place on the advice of the Medical Officer charged with the clinical management of the inmate, as is the case with any other inmate. Primary health care and counselling for the individual and his family should be dealt with by a multi-disciplinary team. Particular attention should be paid to informing HIV positive inmates about harm minimisation techniques and about the resources available in the community to facilitate the adoption of these practices. Where an individual's health requires it, he should be referred for consultation to the appropriate community based hospital.

11.10. All confirmed (i.e. either blood tests taken in prison or positive HIV status confirmed in writing by an outside agency) cases of HIV seropositivity should be reported in an unlinked anonymous way to the Medical Director to facilitate monitoring of prevalence and pattern of HIV infection throughout the prison system. This is crucial from the point of view of planning future strategy and allocating resources.

11.11. Inmates with a history of injecting drugs run a high risk of returning to drugs as soon as they are released from prison. In the case of individuals who are HIV seropositive this presents particular problems, in terms of the risk to their own health and because of the potential spread of HIV through the continued use of shared needles and syringes. There is also the risk of spreading the virus through unprotected sexual intercourse. Thus carefully planned releases are essential. The multi-disciplinary team should have responsibility for seeing that the release of HIV positive individuals from prison is carefully planned and supervised. Particular attention should be paid to

- addressing the practical needs of HIV seropositive prisoners for medical services (including medical cards), accommodation and social welfare entitlements

- linking individuals and their families into community based HIV agencies. If possible this should start while the individual is still in prison. Prisons are part of the community and imprisonment presents an ideal opportunity for many agencies offering services in the HIV field to establish contact with clients often difficult to engage outside of prison.

11.12. Finally the Committee is conscious of the fact that HIV/AIDS is not simply a prisons issue but is an issue for the whole community. While a certain amount of care and attention may

be give to persons in custody it is equally important that the aftercare services are put in place which will ensure that there is adequate support for the prisoner on release.

APPENDIX I

LIST OF NOTIFIABLE DISEASES

INFECTIOUS DISEASES	SEXUALLY TRANSMISSIBLE DISEASES
Acute Anterior Poliomyelitis	Ano-Genital Warts
Acute Encephalitis	Candidiasis
Acute Viral Meningitis	Chancroid
Anthrax	Chlamydia Trachomatis
Bacillary Dysentery	Genital Herpes Simplex
Bacterial Meningitis (including meningococcal septicaemia)	Gonorrhoea
Brucellosis	Granuloma Inguinale
Cholera	Infectious Hepatitis B
Diphtheria	Lymphogranuloma Venereum
Food Poisoning (bacterial other than salmonella)	Molluscum Contagiosum
Gastro Enteritis (when contracted by children under 2 years of age)	Non-specific Urethritis
Infectious Mononucleosis	Pediculosis Pubis
Infectious Parotitis (mumps)	Syphilis
Influenzal Pneumonia	Trichomoniasis
Legionnaires Disease	
Leptospirosis	

INFECTIOUS DISEASES

SEXUALLY TRANSMISSIBLE DISEASES

Malaria

Measles

Ornithosis

Plague

Rabies

Rubella

Salmonellosis (other than typhoid or paratyphoid)

Tetanus

Tuberculosis

Typhoid & Paratyphoid

Typhus

Viral Haemorrhagic Diseases

Viral Hepatitis Type A

Viral Hepatitis Type B

Viral Hepatitis Unspecified

Whooping Cough

Yellow Fever

CHAPTER XII

Summary of Conclusions and Recommendations

12.1. It is recommended that all staff working regularly in prisons be screened for T.B. and that those requiring vaccination receive it. (Paragraph 1.7).

12.2. It is recommended that specific protocols for the management of communicable diseases more commonly encountered in institutional environments be uniformly adopted throughout all prisons and places of detention and that staff be made fully aware of the procedures to be applied in such cases. (Paragraph 1.13).

12.3. The Committee considers that there is no longer an advantage from either a medical or operations viewpoint for the present policy of automatically segregating persons who are diagnosed as being H.I.V. positive and the first step in moving away from this policy would be confidential testing for H.I.V. (Paragraph 4.8).

12.4. The Committee considers that the guarantee of confidential testing must go hand in hand with programmes for the better education of staff and prisoners in relation to H.I.V./AIDS. It is important therefore that education be accorded a top priority with the main process being completed within a period of 6 months. (Paragraph 4.8).

12.5. The Committee is conscious of the fact that to adopt a policy of desegregation or indeed a policy of not continuing to automatically segregate HIV seropositive prisoners requires a reassessment of the existing approach to the management of such prisoners. (Paragraph 4.9).

12.6. The Committee accepts that it is necessary for Governors to be made aware of the general medical conditions of prisoners in their institutions and is also conscious of the need to ensure that the doctor/patient relationship is not compromised. It considers it imperative therefore that the handling and dissemination of information on prisoners' medical conditions be clearly defined and recommend, because of the complex issues involved, that discussions take place between Prison Management and the Medical Council to clarify the relationship between medical officers and Governors. (Paragraph 5.17).

12.7. The Committee considers that under the existing Rules for the Government of Prisons the role of the Medical Officer viz a viz the Governor is imprecise. It is recommmended therefore that in the course of redrafting the rules the role of the medical officer be clearly defined having regard to the Governors' reponsibilities and the doctor/patient relationship. (Paragraph 5.18).

12.8. The Committee recommends that, in assessing prisoners for the future, the broad range of characteristics should be taken into account in determining the manner in which they are to be treated. (Paragraph 6.2).

12.9. In order to ensure the effective administration of sentences and management of prisoners, the Committee recommends that the existing approach to assessment and classification be reviewed and that a more extensive and objective system be introduced. (Paragraph 6.3).

12.10. The Committee fully supports the recommendation of the Advisory Group on Prison Deaths for the provision of a committal centre. The Committee recognise, as did the Advisory Group, that the provision of

such a centre will involve either major expenditure and/or major reorganisation which can only be achieved in the long-term. It is recommended that in the interim the present committal arrangements be reviewed in order to improve assessment of prisoners on committal. (Paragraph 6.6).

12.11. The Committee acknowledges that education in relation to HIV/AIDS is one of the important factors in the reduction of the incidence of high risk behaviour that leads to the transmission of HIV. It recommends therefore that a HIV Education Committee be established to evaluate the educational requirements and information needs of prison staff and prisoners on HIV/AIDS. (Paragraph 7.5).

12.12. The Committee recommends that the HIV Education Committee should comprise persons from the medical, psychological and welfare disciplines together with the chaplaincy service, prison management and staff representatives. (Paragraph 7.5).

12.13. The Committee considers that while the formal approach to education should be formulated by the HIV Education Committee the programme should include seminars for staff and prisoners and the use of videos/films on the subject of HIV prevention. The Committee is of the view that the main education process should be completed within 6 months and recommends that should it be deemed necessary to assign a person to carry through the programme effectively that this should be done. (Paragraph 7.5).

12.14. Bearing in mind the legal position and the lack of evidence that anal intercourse between prisoners in prison is common, the Committee considers it inappropriate to make condoms available to prisoners while

in prison. However, it considers that condoms should be available to prisoners on their release. (Paragraph 7.7).

12.15. The Committee considers that, following a change in the current policy of segregation, the level of medical service now available to HIV seropositive prisoners in the segregated areas in Mountjoy Prison should be provided in all institutions for prisoners who are HIV seropositive. It recommends that the Director of Prison Medical Services should, in association with local prison management and the Health Boards in whose areas the institutions are located, develop the medical services available to each institution. (Paragraph 8.3).

12.16. The Committee, having regard to the limit which must be placed on the level of medical service which should be provided within a prison setting and the contribution which the health authorities must continue to provide, recommends that the special unit currently under construction in Mountjoy Prison be used to provide a good first-line medical facility but in no way should attempts be made to replicate the range of services or facilities available in a general hospital. (Paragraph 8.4).

12.17. The Committee endorses the recommendation of the National Aids Strategy Committee that specific out-patient and consultative services that are provided to the prison service should be brought in and that routine minor work which currently requires referral to outside hospitals should be undertaken in the special unit. (Paragraph 8.4).

12.18. The Committee are of the view that medical services should be provided by fully trained medical staff and recommends that qualified nurses be employed. This can be done by either training existing medical orderlies or by employing nurses. (Paragraph 8.5).

12.19. In order to prevent, insofar as is reasonably practicable, the smuggling of any form of contrabrand into prisons the Committee recommends that

- existing visiting facilities which are inadequate be enhanced,
- all visitors to the principal closed institutions be liable to be screened,
- persons found passing contrabrand be prosecuted by the Gardai and barred from future visits,
- video equipment in all institutions should be enhanced where necessary,
- video evidence should be used, where possible, in the course of prosecutions,
- all visitors should be prevented from bringing goods into the visiting areas.
- all prisoners caught in possession of contraband should be put on restricted visits for a period and prosecution should be considered. (Paragraph 9.3).

12.20. The Committee considered the question of the appropriateness of making available clean disposable injecting equipment to prisoners in an effort to prevent the transmission of disease. While acknowledging that clinically supervised needle exchange schemes may operate successfully in the community it was considered that such an

approach would be inappropriate in a prison context. The Committee is of the view therefore that every effort should be concentrated on the prevention of contraband entering prisons and on the education of prisoners against sharing needles. (Paragraph 9.4).

12.21. The Committee recommends that a senior officer be assigned responsibility for the maintenance of a high stadard of hygiene within each institution. (Paragraph 10.3).

12.22. The Committee recommends that the present cleaning practices and methods be reviewed. (Paragraph 10.4).

12.23. It is recommended that the current practices and procedures for showering and clothing changes be reviewed. (Paragraph 10.7).

12.24. In the context of preventing the spread of communicable diseases it is imperative that both the issues of sanitation and overcrowding be addressed and the Committee fully supports the recommendations of the Advisory Group on Prison Deaths in this regard. The Committee sees the implementation of these recommendations within a realistic timeframe as one of the more significant ways in which the spread of communicable diseases can be combatted. (Paragraph 10.8).

12.25. While recognising that there are financial resource implications the committee is of the view that a firm programme should be drawn up with the aim of ensuring that in-cell sanitation/24 hour access to toilets is provided for all prisoners by the year 2000. In the overall planning for improvements in prisons, account should also be taken of the need to provide adequate showering and wash up facilities for staff. (Paragraph 10.9).

12.26. The Committee recommends that the Department of Justice evolve a policy aimed at the elimination of automatic segregation of prisoners who are HIV seropositive. (Paragraph 11.1).

12.27. Conscious of the fact that an abrupt ending of segregation would give rise to serious operational problems the Committee recommends that segregation, as it currently exists, should continue for the time being. It recommends the introduction of confidential testing and the adoption of a policy whereby in future those diagnosed as being HIV seropositive are no longer automatically segregated. The Committee also recommends that prisoners who are currently segregrated be carefully monitored and their reintegration should proceed on a case by case basis with only those who seek reintegration and whose behaviour warrants it, being reintegrated. (Paragraph 11.5).

12.28. The Committee recommends that testing for HIV should be freely available to all inmates throughout the prison system. Once an individual has made a formal request to the Medical Officer for the test, he should be referred for pre-testing counselling. This should be carried out by an appropriately trained person and should be as uniform as possible across institutions. Where the individual consents to the test written consent should be obtained. Individuals presenting for repeated HIV tests should be obliged to go through the same counselling procedures on each occasion. Whether the result of the test is negative or positive, the individual should receive post-testing counselling. Where the result is positive this should be on-going. (Paragraph 11.6).

12.29. The Committee recommends the establishment of a HIV Steering Committee comprising of Senior Management in the Department of Justice, Prison

Management, Probation Service, Psychology Service, Education/Work and Training Services and Staff Representatives. (Paragraph 11.7).

12.30. The Committee recommends that the HIV Steering Committee should be backed up by local multi-disciplinary committees established in each institution whose responsibility it would be to see that policy with regard to HIV and related matters is implemented in their institutions. (Paragraph 11.8).

12.31. It is important that prisoners who are diagnosed as being HIV seropositive are managed properly in all institutions. They should be kept on normal location and have full access to all the occupational options available. Any restriction to this should only take place on the advice of the Medical Officer charged with the clinical management of the prisoner. Primary health care and counselling for the individual and his family should be dealt with by a multi-disciplinary team. Particular attention should be paid to informing HIV positive inmates about harm minimisation techniques and about the resources available in the community to facilitate the adoption of these practices. Where an individual's health requires, s/he should be referred for consultation to the appropriate community based hospital. (Paragraph 11.9).

12.32. The Committee recommend that all confirmed cases of HIV seropositivity should be reported in an unlinked anonymous way to the Medical Director to facilitate monitoring of prevalence and pattern of HIV infection throughout the prison system. (Paragraph 11.10).

12.33. The Committee recommends that the multi-disciplinary team in each institution should have responsibility for seeing that the release of

HIV positive individuals from prison is carefully planned and supervised. Particular attention should be paid to

- addressing the practical needs of HIV positive offenders for medical services (including medical cards), accommodation and social welfare entitlements,

- linking individuals and their families into community based agencies,

- meeting the needs of HIV positive offenders serving short sentences. It is clear that the release of HIV positive offenders serving longer sentences are in the main carefully planned. However, the release of short term prisoners often takes place without planning. Special procedures should be put in place to ensure that the on-going practice of unplanned releases of these offenders ceases. (Paragraph 11.11).

APPENDIX II

Main Guidelines for the Management of HIV/AID Seropositive Prisoners

- A prisoner who is antibody positive, at other pre-AIDS stages or who is a confirmed AIDS sufferer but who has no symptoms or signs of illness, may be placed on ordinary location in a single cell or accommodation shared with other inmates who are antibody positive but clinically well, subject to the following restrictions.

  . Use of own utensils including a toothbrush and disposable razor.

  . As much control as practicable over the disposal of all body waste.

  . A strict understanding of, and adherence to, the rules of personal hygiene with particular emphasis on procedure in the event of accidents involving spillage of blood, semen and faeces. In such circumstances:-

  (i) the medical orderly to be informed immediately;

  (ii) all cleaning up to be done under the supervision of a medical orderly; and

(iii) disposal of all dressings by the medical orderly.

Obviously it is desirable that such accidents are dealt with quickly; so in the absence of the medical orderly cleaning up should be done by an officer familiar with the relevant procedures.

- No work which involves a reasonable risk of blood spillage or electrocution.

- No games, such as football, which carry a reasonable risk of blood spillage.

- An understanding by the prisoner of the possible modes of communication of the disease and an undertaking to take every precaution to prevent any such communication.

- Symptoms or signs of illness in such a prisoner should be brought to the attention of the Medical Officer immediately.

- A confirmed AIDS sufferer who is ill should be transferred to a hospital. Pending transfer he should be held in isolation in a single cell.

Having regard to current information, the following measures are recommended relevant to the protection of

Medical Orderlies and officers in contact with antibody positive prisoners.

- Waterproof dressings should be worn on cuts on exposed surfaces.

- Special care should be exercised in the use of sharp instruments and needles to avoid self-inoculation.

- Gloves and/or protective clothing must be worn whenever contact with possibly contaminated material is unavoidable.

- All instruments, non-disposable objects and surfaces possibly contaminated with infectious material should be decontaminated using effective disinfectant solutions.

- Disposable contaminated items or waste should be made safe as far as practicable - e.g. by sterilising - before final disposal.

- If a prisoner is found to have antibodies to the virus or to have AIDS itself, staff who have frequent dealings with the prisoner should be informed accordingly.

The following precautions are desirable if an incident or

accident causes contact with the blood or any other body

- fluid of a prisoner. In that event the affected area of skin should be washed with ordinary soap and water, or simply with plenty of tap water. Mucus membranes, lips, mouth, tongue or eyes should be washed with clean cold tap water as soon as possible after the incident.

- In all cases where there is contact with the body fluid of an antibody positive prisoner or of an AIDS sufferer medical advice should be sought as soon as possible.

- Anyone who has an abrasion or cut should ensure that it is covered by a waterproof dressing when there is contact with an antibody positive prisoner or an AIDS sufferer.

- All blood or body fluid should be mopped up wearing gloves and a plastic apron and using paper towels and a sodium hypochlorite solution. The paper towels, gloves and apron used should be double bagged marked with an appropriate warning label and disposed of by incineration in accordance with proper medical practice.

- Clothing contaminated with blood, semen or faeces worn by such prisoners should be handled with

gloves. A plastic apron should be worn. The clothing should be double bagged (the inner bag alginate and the outer plastic), marked with an appropriate warning label, sealed and disposed of by incineration in accordance with proper medical practice.

. Should an antibody positive prisoner or an AIDS sufferer become incontinent or develop bleeding then disposable materials such as sheets, etc., should be used wherever possible.