## Prison Service Order

### Blood Borne and Related Communicable Diseases

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FOREWORD

The upsurge in hepatitis B in the ‘70s followed at the end of the decade by the emergence of HIV and AIDS sharply focused on the dangers of blood borne viral infections. In 1989, the identification of hepatitis C virus revealed yet another serious infection that is transmitted by the same route. The spread of HIV and hepatitis is a matter of concern for the whole community, but the ease with which they are transmitted by needle sharing, and in the case of HIV and hepatitis B by unprotected sex, has made them of particular importance in the prison environment.

The Prison Service has given a great deal of thought to the ways in which the spread of blood borne infections between inmates can best be prevented and of ensuring that staff are protected as effectively as possible. Information and advice regarding HIV/AIDS and hepatitis B has been issued at intervals and from time to time earlier advice has been revised as strategy has changed in the light of increased knowledge.

The ‘Review of HIV and AIDS in Prison’ (1995) by the AIDS Advisory Committee recommended that there should be a clearly articulated HIV/AIDS policy for staff. This Prison Service Order gathers together in one place all current policies and recommendations regarding HIV/AIDS, hepatitis B and hepatitis C, and shows in clear and comprehensive terms how they apply to staff.

The first chapter of the Order is concerned with the medical background. It provides information on the different ways in which the blood borne viral infections are spread and identifies the rare circumstances in which staff could be infected as a result of contact with inmates. There is a brief mention also of pulmonary tuberculosis because this condition spreads easily among people who are infected with HIV.

The second chapter of the Order offers advice on the management of risk situations, how to keep the risk of infection to the minimum, and what procedures to follow in dealing with risk situations.

The third chapter of the Order details the personnel policies in force within the Prison Service regarding the employment of people and job protection for staff who may be carrying a potentially infectious condition such as HIV and hepatitis B or C, whether it was acquired in the course of their duties or in their private lives. The responsibilities of management, staff and medical professionals are addressed.

Prison Service Trade Unions have been fully consulted on the content of this Order.

It is important that staff maintain a sense of perspective on the risks they run as result of their work. The chances of acquiring any serious infection are extremely small and adherence to recommended procedures will make them even smaller. It is however, in everybody’s interest - not only staff and inmates but also their families, relatives and friends - that everything possible should be done to prevent the spread of HIV,
pulmonary tuberculosis and blood borne hepatitis within the prisons and young offender institutions of England and Wales.
HIV / AIDS

1. **Key Points**

   - **HIV** stands for Human Immunodeficiency Virus. Over a period of years, it causes a gradual destruction of the immune system. It is the virus that can cause AIDS.

   - **AIDS** stands for Acquired Immune Deficiency Syndrome. This describes the state in which people have repeated infections, and sometimes tumours, as a result of destruction of the immune system by HIV.

   - **The HIV antibody test** detects the antibodies to the virus which first appear in the blood some weeks after infection. The test is the only way of knowing if someone is infected.

   - **HIV is spread in three ways:**

     I. **Blood spread.** In the United Kingdom this is now almost entirely limited to injecting drug abusers sharing unclean works;

     II. **Unprotected sexual intercourse.** This may be vaginal, anal and possibly oral;

     III. **From infected mother to baby.** This may occur in the womb, during the birth process or through breast milk. The risk is about 1 in 6, but falling.

   - **Spread among inmates** can occur from unprotected sex or the sharing of unclean works by injecting drug abusers.

   - **Spread from inmates to staff** will not occur in any ordinary circumstances. There is a risk of infection from being stuck with a contaminated needle, but even if this occurs the chances of infection are very low. There is also a theoretical risk from blood getting into a wound during a fight, but infection by this route is extremely rare.

   - **No vaccine is available** which will protect against HIV and there is not likely to be one for many years.

   Prisons in England and Wales have now been receiving inmates with HIV for more than ten years and over the whole of that time, no member of staff has been infected in the course of duty. There has been one documented case of a prisoner acquiring the virus while in custody.

2. **The basic facts about HIV and AIDS**
2.1 **HIV** stands for Human Immunodeficiency Virus. If this virus gets into someone’s body, it infects a particular type of cell, called the **CD4** cell, which is essential to the normal functioning of the immune system. When the virus has reduced the population of **CD4** cells to about a third or less of their original number, which usually takes many years, the immune system is no longer able to fend off certain diseases. The HIV infected person then begins to get ill with a variety of infections, and sometimes tumours, most of which are rarely, if ever, seen in people with normal immune systems. They are then said to have the Acquired Immune Deficiency Syndrome or AIDS.

2.2 Some people who catch HIV develop a mild illness a few weeks after infection consisting of fever, perhaps a few enlarged lymph nodes and a rash. This gets better without treatment and is followed by a long period during which the infected person looks and feels perfectly normal. All infected people produce antibodies to the virus, almost always within three months. It is the presence of these antibodies in the blood that is looked for when the HIV antibody test is done (see below).

2.3 The length of time before the first serious illness that calls for a diagnosis of AIDS varies greatly. A small number of people fall ill as little as two years after infection, and after ten years about half of an HIV infected population will have progressed to AIDS. It is thought likely that most of those who remain well at ten years will eventually fall ill, but perhaps a few will hold the virus in check indefinitely. From the time AIDS is diagnosed, people used to live on average about 20 - 30 months, but recent improvements in the treatment available have extended this period. Quality of life for people with HIV is variable but with appropriate treatment and management it can be good.

3. **The HIV antibody test**

3.1 The test is carried out on an ordinary blood sample and it shows whether or not the blood contains antibodies to the human immunodeficiency virus, HIV. If antibodies are present, it means that the virus is in the person’s body. When antibodies are found, we say that the person is ‘HIV antibody positive’, sometimes shortened to ‘HIV positive’ or ‘body positive’. It is important to note that the test does not detect the virus itself and it is not a test for AIDS.

3.2 The HIV antibody test is the only generally available way of checking if someone is infected with the virus and is, in consequence, infectious to others. Most people who test positive will be looking and feeling completely normal. There is, however, one difficulty: antibodies are not produced for some time after infection; it sometimes takes as long as three months, and just occasionally even longer. During the time between infection and the appearance of antibodies, known as the ‘window period’, the test is negative, but the person is highly infectious.

3.3 No-one who has run the risk of infection can be sure they are clear until they have had a negative test at least three months after the last occasion on which they could have contracted the virus. This has an important implication for staff. If anyone suffers a needle stick and there is a possibility that the needle was contaminated with HIV, it is
going to be three months before they know whether or not they have been infected. During that time, even though the risk of having caught the virus may be very small, they will have to behave as if they were infected and protect their partner by practising safer sex even if they are in a stable relationship.

3.4 Any member of staff who might be concerned about their own health should be aware that HIV testing is available through genito-urinary medicine (GUM) clinics where all proceedings are strictly confidential. GUM clinics are bound by law not to disclose information even to the patient’s general practitioner, without the express consent of the patient. General practitioners have to observe a professional standard of confidentiality, but they would be bound to disclose such information if, for example, the patient requested them to send a report for insurance purposes.

3.5 HIV antibody testing is available in confidence, by consultation with the Medical Officer, to any inmate who is concerned that he or she might be infected; the arrangements will vary between establishments and must be checked out locally. It is a national requirement that everyone being tested for HIV should be counselled to ensure that they understand both how the virus is spread and the implications of a positive test. There should be at least one person in every prison who has been trained to counsel people who ask for HIV testing.

4. How HIV is spread

4.1 HIV, the human immunodeficiency virus, is found in blood, semen and vaginal secretions. Infection occurs when a body fluid containing virus gets into the body of another person. There are only three known routes of infection:

- **Through blood.** In the early part of the 1980’s, there was a risk of catching HIV from blood transfusions, but fortunately, few potential donors in the UK were infected at the time. However, approximately half of all haemophiliacs in the UK contracted the virus from contamination of an imported blood product used in their treatment. All blood donations are now tested for the virus and blood products are heat treated so this source of infection has been virtually eliminated.

  Blood transmission now occurs only as a result of the sharing of unclean works by injecting drug abusers and, very rarely, as a result of needle sticks.

- **Through sexual intercourse.** HIV is transmitted by unprotected vaginal intercourse and, in the world wide epidemic, this has been by far the most common way in which it has been spread. Unprotected anal intercourse is even more dangerous.
Oral sex is thought to be less risky, but cannot be said to be entirely safe. Kissing, cuddling and any practices not involving exchange of blood, semen or vaginal secretions are safe.

- **From mother to baby.** If a woman who is infected with HIV becomes pregnant, there is a chance she will pass the virus on to her baby. This may occur in the womb, during the birth process or, possibly, through breast milk. Until recently, about 1 in 6 babies born to infected mothers in the UK have themselves been infected. It is now known, however, that the risk can be reduced further by treating the mother with an antiviral drug during pregnancy.

4.2 HIV cannot be spread by casual contact, shaking hands, sharing accommodation, sharing toilet facilities, sharing cups and plates or using someone else’s cutlery, even if they have not been washed. It is recommended, however, not to share razors or tooth brushes in view of the tiny risk that they will be contaminated with blood.

5. **The risk of spread of HIV within a prison**

5.1 **From inmates.** In 1996/7 the total number of positive HIV tests was 123, in a total population in excess of 60,000. There will, however, almost certainly have been others who were infected, but were not known. There is a risk of HIV spreading from inmate to inmate as a result of sexual intercourse, particularly unprotected anal intercourse, and also as a result of injecting drug abusers sharing works. It is not known to what extent spread has occurred as a result of sexual activity, but there has been one documented case of HIV infection in a prison in England and Wales as a result of sex between men. Transmission between drug injectors has been demonstrated at Glenochil Prison in Scotland where 14 users were found to be HIV positive, some of whom had certainly not been infected on admission.

5.2 The risk of a member of staff catching HIV from an inmate is very small. The only realistic hazard is from being stuck, accidentally or intentionally, by an infected needle; there has been one documented case in Australia of a prison officer being infected in this way. Even after a needle stick, the risk of transmission is quite low: in a large series of such accidents involving health workers, only 0.2% (2 in 1000) contracted the virus and infection was almost always associated with the more serious injuries. If, however, blood containing HIV was actually injected in the course of an assault, the risk of infection would be high. Blood spills as a result of fights and accidents carry hardly any risk of transmission of HIV. There is no risk from blood falling on the intact skin (though it is wise to wash it off promptly and thoroughly). A few cases have been reported in health care workers in which infection occurred as a result of blood getting into an open wound or an eye; infection is not known to have occurred in this way in any prison staff. Contamination by urine, faeces or saliva carries no risk of transmission of HIV.
5.3 From staff. Members of staff who may have acquired the virus in the

course of their private lives pose no threat at all either to colleagues or

inmates as they carry out their duties.

6. **Prevention of HIV infection**

6.1 There is no vaccine that can be used to immunise people against HIV.
It is proving very difficult to develop one and, even if a safe and effective vaccine is
eventually produced, it will be many years before it has gone through the
necessary tests and can be made generally available. For the foreseeable future, the prevention of HIV infection must depend entirely
on the avoidance of those activities that are known to spread the virus.

7. **Action that has been taken to minimise the risk of HIV transmission within prisons**

7.1 An extensive educational programme has been undertaken to ensure that staff and inmates are as fully informed as possible about HIV and AIDS and that they are aware of the dangers of unprotected sex and unclean works. Everything that anyone might need to know will be found in the revised video 'AIDS INSIDE AND OUT' (issued 1995) and its accompanying manual; this should be available in every establishment. Advice has been issued from time to time on the safest way of dealing with accidents such as needle sticks and blood spills; all that advice has now been updated as necessary and is gathered together in this Order (see The Management of Risk Situations, starting on page 14).

**TUBERCULOSIS**

Tuberculosis is caused not by a blood borne virus but a bacterium. It is referred to in this Order because people infected with HIV are very susceptible to the infection, and if they do develop the disease, it is likely to progress rapidly. It is therefore important that anyone with responsibilities in relation to HIV and AIDS is also well informed about tuberculosis.

8. **Key Points:**

- Pulmonary tuberculosis is an infection of the lungs by tubercle bacilli. If not arrested, it causes progressive destruction of the lungs with serious ill health and eventual death. It is at present an uncommon disease in the UK and is rarely seen among inmates.

- Transmission is by breathing in infected droplets that have got into the air as a result of someone with active disease coughing or sneezing. It can therefore be caught as a result of casual contact, particularly in confined and poorly ventilated places.

- Treatment depends on drugs and is, in general, very successful.
HIV infection makes people much more vulnerable to tuberculosis as the immune system has a vital role in controlling the tubercle bacillus.

Tubercle bacilli resistant to one or more of the drugs used in treatment have appeared widely and bacilli resistant to most or even all of the available drugs now pose a serious threat in places such as New York. Infection with resistant organisms is a very serious matter as there may then be no way to stop the relentless progression of the disease.

In the USA, both prisoners and prison staff have contracted pulmonary tuberculosis, sometimes involving multiple drug resistant organisms, in outbreaks occurring where large numbers of HIV positive inmates provided the opportunity for it to spread easily.

In the UK, there is not, at present, cause for serious concern as the prevalence of HIV among inmates is much lower than in places such as New York, and multi drug resistant strains are much less common. Nevertheless, everyone should be aware of the possibility of an upsurge in pulmonary tuberculosis if conditions here should change.

9. Some basic facts about tuberculosis

9.1 Tuberculosis is an infection caused by a germ named Mycobacterium tuberculosis. The organism is usually referred to as the tubercle bacillus and the illness itself is commonly known as ‘TB’.

9.2 Tuberculosis most often affects the lungs (pulmonary tuberculosis), but it can also attack other organs in the body, including lymph nodes, the kidneys, intestines, the membranes around the brain (meninges), bones and joints.

9.3 Tuberculosis of the lungs, pulmonary tuberculosis, is very easily spread from one person to another. The infection spreads through the air in the form of droplets laden with tubercle bacilli which are produced when the infected person coughs or sneezes. Transmission occurs most easily when there is prolonged contact in a confined and poorly ventilated place.

9.4 In the absence of treatment, the consequences of exposure of the tubercle bacillus depend on the effectiveness of the immune system. Many people have good natural immunity boosted by vaccination with BCG or a primary tuberculous infection in the past; they are able to resist the infection and do not become ill. Some people, however, are less able to deal with the infection; factors which may contribute to poor resistance include bad nutrition, alcoholism, diabetes and any condition which impairs the function of the immune system including infection with HIV.

10. BCG vaccination
10.1 BCG stands for Bacillus Calmette-Guérin which is a live, weakened strain of tubercle bacillus. Vaccination with BCG raises immunity in the same way as a natural primary infection that has been successfully overcome. From 1953 onwards, BCG was given to all 10 to 14 year olds in the UK. In recent years, however, vaccination has no longer been universal in all areas; in some districts, it has been restricted to children thought to be at increased risk. Many people born in the 1930’s or earlier will have had a primary tuberculous infection in childhood.

10.2 A person’s immune status can be determined by a skin test called tuberculin test. Staff who are tuberculin negative (ie show no evidence of immunity) are strongly advised to be vaccinated with BCG. It should be realised, however, that although BCG provides a useful degree of protection against the development of TB, it does not provide anything like complete immunity.

11. **The recent history of pulmonary tuberculosis**

11.1 Pulmonary tuberculosis was very common at the beginning of the century, but the prevalence fell steadily until the 1960’s by which time it had become almost a rarity. Over the last 20 years or so, however, there has been a modest increase in the disease in the UK.

11.2 Unfortunately, there is a possibility that tuberculosis could again become a problem in the UK. Two things have happened which have already resulted in pulmonary tuberculosis re-emerging as a major threat in some parts of the world. One event has been the worldwide spread of the human immunodeficiency virus, HIV. The other has been the appearance of strains of tubercle bacillus that are resistant to one or more of the drugs that are used to treat it.

11.3 HIV destroys just that part of the immune system that is required to combat tuberculosis. People with HIV infection are very vulnerable to infection with the tubercle bacillus and the disease has spread widely in parts of the world where there is a high prevalence of HIV.

11.4 A notable outbreak of pulmonary tuberculosis has been reported from New York State involving 19 prisons and two hospitals. A total of 41 inmates, all except one infected with HIV, developed multi-drug resistant tuberculosis; 36 of the inmates died, mostly within 4 weeks of diagnosis. Several health care workers were infected, and one prison officer, whose immune system was impaired as a result of radiation therapy for cancer, contracted tuberculosis and died.

12. **Pulmonary tuberculosis in UK prisons**

12.1 Tuberculosis is not at present a problem within the prisons of England and Wales. The number of inmates found to have active (not necessarily infectious) pulmonary tuberculosis in recent years and reported to DHC was 22 in 1995/6, but only 2 in 1996/7. No member of staff is known to have been infected by an inmate.
12.2 The important issue for prison staff, however, is that any inmate who has contracted pulmonary tuberculosis and who has tubercle bacilli in his or her sputum can pass that infection on by casual contact. It must be stressed, however, that the risk to staff is at present very small as the number of people within the system who are infectious, but unrecognised, is very small indeed. Furthermore, although the percentage of inmates of prisons in England and Wales who are infected with HIV is not known precisely, it is certainly very much lower than in the prisons in New York State. The conditions that made possible rapid spread of pulmonary tuberculosis in that prison system are therefore not at present to be found in the UK.

13. Recognition of pulmonary tuberculosis

13.1 It is important to be alert to the possibility of pulmonary tuberculosis in anyone with suspicious symptoms such as an unexplained cough that has continued for more than three weeks, weight loss or fever. Early detection is important both for the treatment of the infected person and for the protection of those who are in contact with them.

13.2 Staff must be particularly vigilant when dealing with groups who are at higher than average risk of tuberculosis. These include prisoners who:

- have been homeless
- come from exceptionally deprived backgrounds
- have a history of serious misuse of drugs or alcohol
- are HIV positive
- come from areas such as Asia, Africa and Latin America where there is a high prevalence of the disease.

13.3 When pulmonary tuberculosis is suspected, the patient must be treated as infectious to others until the sputum has been fully examined and shown not to contain tubercle bacilli. Detailed guidance on the procedures to be followed have been issued to medical officers.

13.4 Should a member of staff be a contact of an identified case, he or she is likely to be offered either a skin test to ascertain current immunity status and/or a chest X-ray by the community health team managing the situation. Staff may also wish to consult their own general practitioner, or the Prison Service Medical Adviser. Contact may be made through the establishment Personnel office or directly through Headquarters Personnel Business Link.

13.5 Establishments may find that the TB Liaison Nurse employed by their local Health Authority is also able to offer useful advice. Contact should be made through the Health Authority.

HEPATITIS B AND C

14. Key Points
Hepatitis B and C are viruses that cause acute hepatitis (inflammation of the liver), but can also cause serious liver disease such as cirrhosis many years after infection.

Diagnosis of hepatitis B infection is by detecting elements of the virus in the blood. The diagnosis of hepatitis C depends on detection of antibodies which can take a year or more to be produced.

Transmission occurs by blood spread for both viruses and there is a high risk when injecting drug abusers share uncleaned needles. Hepatitis B is also spread by sexual contact, but hepatitis C is not easily transmitted by this route. There is some risk for both viruses if saliva or blood come into contact with an open wound. Hepatitis B can be transmitted by contamination with urine, but it is not known if this is possible for hepatitis C.

Transmission from mother to baby occurs with hepatitis B, but is thought to be relatively uncommon with hepatitis C.

Spread among inmates. There is a high risk of spread for both viruses when injecting drug abusers share unclean works. Hepatitis B can be spread by unprotected sex or the exchange of saliva. The risk of transmission of Hepatitis C by these routes is thought to be much lower, although transmission by saliva and by a human bite has been recorded. This method of transmission is extremely rare.

Spread from inmates to staff should not occur in ordinary circumstances. Needle-sticks carry a significant risk if there is contamination with hepatitis B; the level of risk for hepatitis C is not yet clearly defined. Both viruses can be transmitted by bites, and there is a risk of infection if blood or saliva come into contact with an open wound or get into the eye. With routine precautions, however, the risk is very low.

Vaccination is available for hepatitis B, but not as yet, for hepatitis C. Short term protection against hepatitis B can be provided by giving specific immunoglobulin. All staff in contact with inmates are eligible for vaccination. All staff should be in possession of a Hepatitis B Action Card which details the steps to be taken after accidental exposure. See para 16.6 below.

15. **Basic facts about hepatitis**

15.1 Almost all cases of hepatitis (inflammation of the liver) are caused by one of three unrelated viruses called hepatitis A, B and C. Hepatitis A is the least serious and causes ordinary infective hepatitis; the virus is spread in contaminated food and water.

15.2 Hepatitis B and C can both cause much more serious forms of liver disease and both viruses are spread by blood. Hepatitis B is easily transmitted sexually, C is less easily so; both viruses can be
transmitted by infected blood or saliva getting into an open wound. Hepatitis B and C are very easily transmitted by sharing needles and they are therefore of particular importance in the prison environment.

16. **Hepatitis B**

16.1 This condition was first recognised in people who had been infected as a result of blood transfusion. This route of transmission is no longer a problem in the UK as all blood donations are tested for presence of the virus before they are released. The test looks for elements of the virus itself and does not depend on the production of antibodies. Nowadays, hepatitis B is most often transmitted by unprotected penetrative sex or by drug injectors sharing needles. Occasionally, it has been passed on by blood or saliva from an infected person coming into contact with open wounds and there is a possibility of infection by contamination with urine. It can also be passed from mother to baby, usually during birth or shortly after. Needle stick injuries involving needles contaminated with blood from a carrier of hepatitis B carry a substantial risk of infection.

16.2 About 4 out of every 10 people infected with the virus develop acute hepatitis with jaundice after an incubation period ranging from 2 to 6 months. The illness is often more severe then ordinary food borne hepatitis (hepatitis A), and about 1 person in every 100 dies. However, about 6 out of every 10 people infected with the virus do not have sufficient symptoms to seek medical advice.

16.3 A majority of people infected with hepatitis B succeed in ridding themselves of the virus; they develop antibodies which show that they have been infected, but they are no longer infectious to others. However, 6 or 7 out of every 100 people who are infected do not rid themselves of the virus. They become Hepatitis B carriers for long periods, sometimes for the rest of their lives. Carriers may develop serious liver disease, including, occasionally, after a very long latent period, liver cancer.

16.4 People who are chronically infected with hepatitis B will usually be looking and feeling entirely well and they are often completely unaware that they are infected. They cannot infect others by casual contact, but the virus is very easily passed on by unsafe sex or needle sharing.

16.5 People infected with hepatitis B virus are even more numerous than those with HIV; it is estimated that there are, world-wide, about 300 million people who are chronically infected.

16.6 Vaccination against hepatitis B is available to all Prison Service staff, and others such as Board of Visitors members and Education staff, who come into contact with inmates. Those wishing to take up this offer should submit a request in writing to the Health Care Manager who will make the necessary arrangements for supply. All eligible staff members are strongly encouraged to be immunised. Inmates are also eligible for vaccination and it is in everyone’s interest that there should
be a high uptake in both groups. For details of the immunisation course, see prophylaxis, page 12.

16.7 Short term protection against infection with hepatitis B can be provided after risky incidents by administration of specific immunoglobulin which contains a high concentration of antibodies (see page 12.) This procedure is highly effective in preventing infection provided it is administered within 48 hours of exposure. Any member of staff who thinks that he or she may have been exposed to infection must therefore report the matter immediately to the establishment’s medical officer. Immunoglobulin should be given after possible exposure even to staff who have been vaccinated since the immunity conferred cannot be assumed to be 100%. The Medical Officer must refer cases to their local Consultant for Communicable Disease Control (CCDC).

16.8 Hepatitis B Action Cards. All staff should be in possession of an Action Card which details the steps to be followed after exposure.

17. **Hepatitis C**

17.1 It had been known for a long time that some cases of hepatitis were not caused by either hepatitis A or hepatitis B virus. In 1989 a new virus, now called hepatitis C, was identified and this appears to be the cause of most cases of hepatitis not caused by hepatitis A or B.

17.2 Blood transfusion was an important route for transmission of hepatitis C in the UK before routine testing of donations began in September 1991. The test depends on the detection of antibodies, however, and even now not all infected blood can be identified. The virus has also been spread by infected blood products such as the Factor 8 needed by haemophiliacs. Hepatitis C is very easily transmitted by needle sharing and it has spread widely among drug injectors. Transmission by saliva and by a human bite has been recorded.

17.3 Unlike hepatitis B (and HIV), hepatitis C is not easily transmitted sexually, but spread by this route does occur. The virus can be passed from a mother to her baby, but it is probable that this is relatively uncommon. It is unlikely that the virus would be passed on by ordinary day to day contact as, for example, between prison staff and inmates. As with hepatitis B, needlestick injuries are the only events that carry a significant risk of transmission to staff, but the level of risk has not yet been clearly defined.

17.4 Having been infected with hepatitis C virus, some people develop acute hepatitis with jaundice, which is usually mild, after a delay of one to three months or more; there may also be other symptoms such as arthritis and rashes. Many people, however, do not become obviously ill. Antibodies to the virus (on which a definite diagnosis depends) may appear in the blood during the initial illness, but it can be a year or more before they are produced.

17.5 The worrying aspects of hepatitis C lies not in its short term effects, which are not usually very severe, but in its ability to cause long continued mild hepatitis that goes on indefinitely without healing.
Chronic hepatitis of this type occurs in as many 50-75% of infected people. The condition does not usually cause serious ill health, but there is a danger that over a long period of time (10-20 years or more) more serious forms of liver disease, such as cirrhosis, may develop.

17.6 People who have continuing disease caused by the hepatitis C virus have the virus in their blood and are highly infectious to anyone who share needles or works. They may be looking and feeling entirely well and be completely unaware that they are infected.

17.7 It has been estimated that there may be as many as 250,000 people infected with hepatitis C in the UK.

17.8 Treatment for chronic infection with hepatitis C is being developed, but is, as yet, only effective in a minority of patients. There is no vaccine and no immediate prospect of one being produced.

18. **PROPHYLACTIC TREATMENT**

18.1 This refers to any immunisation or other treatment that is given to healthy people to prevent them falling ill with some specific disease in the future. Prophylaxis is available for hepatitis B and also for pulmonary tuberculosis. No vaccines exist for HIV or hepatitis C.

19. **Hepatitis B vaccine**

19.1 This vaccine is prepared from one element of the hepatitis B virus and contains no live infective material. It is necessary to give a course of three doses over six months; the second dose is given one month after the first and the third five months after that. Completion of a full course of the vaccine confers a reasonable degree of protection which is thought to last from 3-5 years. Indirect exposure to a carrier is unlikely to lead to infection in vaccinated persons, but injection of infected blood, as in an accidental needle stick, may still do so. It is important, therefore, that staff who have received the vaccine are aware that they do not have 100% protection against catching Hepatitis B and they must be no less vigilant than before in avoiding exposure.

19.2 Hepatitis B vaccine is not available to the population generally, but is made available to people considered to be at higher than normal risk. As with workers in the NHS, all prison staff who come into regular contact with inmates are eligible for the vaccine. Any staff who have not already received the vaccine are strongly encouraged to do so, and it is also important that those previously vaccinated receive booster doses at appropriate intervals.

19.2.1 **Establishments which do not already comply with existing Prison Service policy that all staff (and others such as BOV members) in regular contact with prisoners are offered the vaccine must make adequate arrangements to ensure that this is now put into place.**

19.2.2 Where suitable occupational health services are available the vaccine may be administered on site. Where this is not the case the member of staff may be given the vaccine, with advice on storage, for
administration by their general practitioner. Where a charge is made by the GP the cost must be met by the establishment.

19.3 A blood test must be carried out on staff after completion of the full course of injections to ensure that antibodies have been produced and immunisation is therefore effective.

19.4 It is clearly in the best interests of staff that there should be a high level of immunisation among inmates as this will reduce the number of carriers within the system. Immunisation against hepatitis B should be offered to every prisoner on reception and given within one week of reception (DDL 2/1996).

19.5 Immunoglobulin in prevention of hepatitis B. Specific hepatitis B immunoglobulin is prepared from the plasma of people who have recently recovered from the natural disease or have been immunised. It is treated to ensure that it cannot transmit hepatitis B virus or any other blood borne infection. Immunoglobulin provides immediate, but short term, protection against infection with hepatitis B. It is very effective provided it is given within 48 hours of exposure. It should be given after needle sticks or other accidental exposure and must be followed by a booster dose of hepatitis B vaccine, or a full course as necessary. All staff should be in possession of an Action Card which tells them what to do if they think they may have been exposed to hepatitis B.

20. Tuberculosis vaccination - BCG (Bacillus Calmette-Guérin).

20.1 This vaccine increases resistance to tuberculosis. It was in the past given to all schoolchildren unless there was a specific contra-indication, but it is no longer administered universally in all areas. Staff who have not previously been given BCG and who show, when tested, a negative reaction to tuberculin (indicating no past tuberculous infection) are advised to receive the vaccine.

Chapter 2
The management of risk situations

1. Procedures to minimise risk

1.1 Some aspects of Prison Service work may expose staff to communicable diseases. This part of the Order gives instructions on how to keep the risk of infection to a minimum and details the recommended procedures for dealing with risk situations.

1.2 Under the Management of Health and Safety at Work Regulations governors in prison establishments must ensure that assessments are carried out to determine the level of risk associated with work activities, and decide if any additional precautions are required. The Control of Substances Hazardous to Health Regulations 1994, which cover micro-biological agents, will also apply to these situations. The
procedures which are detailed below will form an integral part of the control measures required under both these sets of Regulations.

1.3 The confidentiality of prisoners known to be infected with HIV or Hepatitis must be protected. Staff must also recognise that there will be other instances where a prisoner is unaware of their own medical status. In all risk situations, therefore, staff should proceed on the assumption that any body fluids may be infectious and consequently universal routine precautions should always be taken.

1.4 A description of routine precautions is given in the section ‘Guidelines For Cleaning Up Blood And Body Fluid Spillages’. All incidents involving the spillage of blood and body fluids (including saliva, vomit and urine) must be treated with care because of the possible risk from blood-borne infections including Hepatitis B and C and HIV. Routine precautions are simple and sensible. They assume that all body fluids from all friends, relatives, colleagues, clients, and inmates could be infectious.

1.5 The main operational risk to prison staff occurs if blood from an infected person comes into contact with an open wound, rash or sore, or if the skin is punctured by a contaminated needle or other sharp object. (please see the section on Dealing with Needles and Syringes, page 16). This is most likely to occur during searching, whilst dealing with violent or self-harming prisoners, or in incidents involving major blood and body fluid spillages, for example suicide attempts or bloody fights.

2. Searching Procedures

2.1 Searching a prisoner or prison buildings can produce surprising and sometimes unpleasant or dangerous results. Objects which have been found on prisoners or on prison property include:

- Razor blades, sewn into lapels, glued under tables, concealed in bars of soap or in the spines of books.
- Pins or needles concealed in lapels.
- Injecting equipment, hidden inside ballpoint pens, inside tubes etc.
- Tattooing equipment. Professional tattooing is thought to be safe because the equipment is sterilised between customers. However, tattooing inside a prison is considered unsafe because sterilisation is unlikely to take place. Equipment found in a search may contain traces of blood.

2.2 In searching, the main risk of infection is in the member of staff being stuck with a needle or other sharp object, and getting body fluids such as blood, saliva etc. into an open wound or a break in the skin. When searching is to take place, staff must:
- Cover all cuts, grazes or abrasions with a waterproof plaster.
- Wear leather gloves where there is a risk of the skin being pierced during a search.
- Wear disposable gloves where there is a possibility of contact with another person's blood or other body fluid.
- Use the eyes and not the hands - whenever possible look rather than touch. If there is an object taped beneath a table, for example, it should be clearly visible.
- Take great care and feel garments gently, to ensure that they do not contain objects such as syringes, needles or razor blades. Where possible, get the prisoner to empty his or her own pockets and reveal the lining. If possible, make the prisoner's fingers do the searching. He or she should know if there is anything sharp to be careful with.
- When searching is completed, dispose of any contaminated objects such as gloves in the yellow plastic bags provided for use in infection control. (Please see the section: ‘Guidelines for clearing up blood and body fluid spillages’ starting on page 18).

2.3 The Security Manual gives additional guidance on searching and these procedures must be followed.

3. **Precautions to be employed during a violent incident**

3.1 In a violent incident, the main risk of infection is from being struck, spat at, bitten, stuck with a needle or sharp object, or from being drenched with urine. It is important to remember that, although risk of infection with HIV from a needle stick injury or a bloody fight may be low, it is not non-existent. There is a risk of Hepatitis B and C from contact with contaminated saliva or blood. It is known that Hepatitis B can be transmitted by urine, but it is not known whether the same is true for Hepatitis C.

3.2 **It is vital that staff dealing with a violent incident or attempting to search a violent prisoner protect themselves by using these precautions:**

- Make an assessment of the risks.
- Get help
- Employ Control and Restraint techniques, augmented by Health and Safety advice, and get the incident under control.
- Officers taking part should, as far as possible, avoid the risk of contact with blood and body fluids, for the reasons described above.
3.3 In the event of an incident where there has been contact with blood or body fluids, staff must take action outlined in para 3.5, and seek medical advice and counselling as soon as possible, or as soon as the incident is brought under control. Sources of advice and counselling include:

- The nearest hospital GUM clinic, where advice and counselling are completely confidential
- A counsellor from the prison HIV counselling team - also a confidential service

3.4 Examples of incidents requiring medical advice:

- Where the skin has been punctured by a sharp object, such as a razor or a syringe
- Where blood has splashed into the eyes, mouth, or any part of the body with exposed cuts and grazes
- If biting has resulted in a break in the skin
- An incident involving a great deal of blood, such as a suicide or suicide attempt.

3.5 Until medical help is available, officers involved in incidents such as these must take the following steps as appropriate:

- If a ‘needle stick injury’ (skin puncture) has occurred, squeeze the surrounding area to encourage a little bleeding
- Wash or shower the affected area with soap and water, and thoroughly rinse eyes and mouth with plain water
- If required, the sharp object could be placed in a plastic bag and retained in a safe place to be tested
- Staff who believe that they may have been exposed to HIV infection must abstain from unprotected penetrative sexual intercourse, or from giving blood, until they have had professional advice.

3.6 It is important to remember that the risk of HIV infection from an injury is very low, especially compared to that of hepatitis. Staff who believe that they have been exposed to HIV during the course of their duties may respond by wishing to have a test for HIV antibodies. This is a complex matter, and is fully discussed in the section ‘THE HIV ANTIBODY TEST’, which must be referred to before the decision to have such a test is made.

3.7 If routine precautions are observed, the risk of hepatitis being transmitted during an incident of a violent nature is still low. As stated in the section ‘Hepatitis B and C’, all staff must be in possession of a
Hepatitis B Action Card which details the steps to be taken after accidental exposure.

4. **Dealing with needles and syringes**

4.1 There are several scenarios where Prison Service staff may come into contact with used needles and syringes in the course of their duty:

- As a matter of routine in the health care centre.
- Illicit injecting equipment being handed in.
- Illicit injecting equipment being found during a search.
- Injecting equipment being used as a weapon by a prisoner.
- An accidental needlestick injury sustained during an incident involving staff and an inmate.

4.2 In each case it is important to dispose of the used equipment safely, as it may be contaminated with blood infected with HIV, hepatitis, or other infections.

*The procedure for disposal is as follows. Gloves must be worn wherever possible*

- **Pick up the needle and syringe carefully, with the sharp end pointing away from you. Make sure you do not walk into anyone else.**

- **Do not attempt to resheath the needle if the plastic cover is still with it. This manoeuvre is a common cause of accidental injury, and accounts for about 40% of needlestick injuries worldwide.**

- **Place it in a ‘sharps’ box, if available. This is a specially designed yellow plastic box, available from the Health Care Centre.**

- **If a sharps box is not available, place the used needle and syringe in an empty drinks can and tape over the opening. Alternatively, place the equipment in a jar and close the lid.**

- **On no account open or interfere with the sharps box or other receptacle used to store used injecting equipment. Keep the sharps box or receptacle locked away until it has been collected for safe disposal.**

- **Contact the appropriate officer for collecting and disposal. All prisons should have a contract with a professional agency for the disposal of clinical waste including sharps.**
• It is extremely important that routine precautions are observed at all times, and this must be re-emphasised when dealing with used needles and syringes.

• ‘Routine precautions’ means simply that blood and body fluids must be treated with absolute caution. The object is to avoid contact with these fluids, no matter where they originate - from a used syringe or needle, or from a wounded colleague, friend, relative, or inmate.

Please refer to the section ‘Guidelines for clearing up blood and body fluid spillages’ starting on page 18.

4.3 If a member of staff has an accident with or is attacked with used injecting equipment, or a sharp instrument which may be contaminated with blood, he or she may be at risk of infection with hepatitis B or C, or possibly HIV. Because of this risk, the following actions must be taken:

• Encourage the wound to bleed by applying pressure.

• Wash thoroughly with soap and hot running water.

• Seek medical advice. Your doctor or medical adviser will advise on the necessity for a tetanus or hepatitis B inoculation, and will also need to see you because there has been a risk of HIV infection, however slight. If the wound is bleeding or needs attention, a qualified first-aider will administer first aid.

• Report all injuries in the Accident Book.

• Save the equipment in a sealed container if you feel that it should be tested for HIV, which can be done via the Public Health Laboratory Service. The issues surrounding testing are complex, so read the section on testing before taking this action.

• See an HIV counsellor. The names of the counselling team at your establishment are available from the Multi-disciplinary AIDS Management Team, from the prison health care centre, or are in some cases advertised on posters throughout the prison.

Remember that only a very small number of people have become infected with HIV from needlestick injuries. Of health care workers who have suffered punctures from contaminated needles, only 0.2% (2 in 1000) were infected with HIV. The low rate of HIV infection through this possible route of transmission is because the quantity of blood passed on from a needlestick injury is likely to be much smaller than that from an injection of blood when sharing injecting equipment.

HIV is much less infectious than hepatitis B or C, which are, like HIV, transmitted through blood.

The consequences of HIV infection are very serious, so it is of great importance to follow the rules of routine precautions to avoid infection.
4.4 A note on confidentiality: When staff injuries are recorded in an 'accident book' it is important not to include any detail relating to the known possible viral infections that may be affecting any participant in an incident. Confidentiality must be adhered to in all medical matters.

5. Guidelines for clearing up blood and body fluid spillages.

5.1 It is likely that, whilst at work, prison staff will come into contact with blood and body fluid spillage. It is always important to take sensible precautions when there is a spillage of this nature, and to treat all such fluids as if they were infected, whether they are from a colleague, relative, friend or inmate. Observing these precautions, known in this document as 'routine precautions', will help safeguard against infections which are carried in the blood or other body fluids.

Routine Precautions - Procedures to prevent infection from blood borne viruses that might be present in any spill of blood or other body fluid.

5.2 General Rules - The main aim of these simple rules known as ‘routine precautions’ is to prevent other peoples' blood and other body fluids such as urine, saliva, etc from coming into contact with the person clearing up. This is important if the occupational spread of blood borne viruses such as HIV, hepatitis B and hepatitis C, and the bacterium which causes tuberculosis, is to be prevented. (Please refer to the medical section for summaries of the routes of transmission of these diseases).

5.3 It must be noted that hepatitis B can be transmitted by urine, although it is not yet known if this is possible in the case of hepatitis C. Staff involved in handling containers for urine samples during the compulsory drug testing, as set down in the Prison Service Drug Strategy, must wear disposable gloves.

5.4 The rules are:

- Keep wounds and grazes covered with waterproof dressings. If you have a skin infection, seek medical advice.

- Avoid direct contact with blood and body fluids. When dealing with these fluids, wear disposable gloves and apron. Use disposable towels and tissues, and other equipment where appropriate.

- Wash off any blood, urine, vomit or saliva which is splashed onto the skin, mouth or eyes as soon as possible.

- Wear uniform leather gloves if there is a risk of being cut or pierced. If there is heavy bleeding or a large spillage, wear disposable gloves underneath leather gloves, so that hands will not be contaminated if gloves become sodden.
- Wash or shower with hot, soapy water at the first opportunity after any contact with another person’s blood or body fluids, whether or not protective clothing has been worn. Body fluids other than blood - saliva for example - may contain virus such as hepatitis B or C.

- Dispose of all waste and contaminated material in yellow plastic bags, to be collected in accordance with local arrangements.

5.5 **The procedures for dealing with relatively small spills are:**

- **Disinfect the spillage.** Use bleach diluted with hot water (10% solution is adequate). Wearing disposable gloves, wipe up the spillage with paper tissues or towels, after leaving the bleach/water solution in place for fifteen minutes. Wipe again with bleach/water solution.

- **Alternatively, place disposable towels over the area of the spill, and pour diluted bleach over them.** Leave for fifteen minutes, clear the towels away, and wipe clean, again with diluted bleach.

- **It is important to dispose of soiled towels and other waste safely.** Waste matter, including soiled gloves and apron, should be sealed in a yellow plastic bag of the sort used in clinical waste, and disposed of in accordance with the guidelines set down.

- **Circumstances will dictate whether a change of uniform is necessary.** Clothing which has come into contact with spilt blood or other body fluids can be dry cleaned or washed in the hot cycle of a washing machine.

5.6 **The procedures for dealing with large spills are:**

- When dealing with the large amount of blood associated with suicide or serious self injury by ‘slashing’, more elaborate safety measures must be taken. Staff dealing with this type of spillage must first seal off the area, which must be closed to all but essential personnel.

- Employing the principles of routine precautions, staff must attempt to avoid contact with spilt fluids, and wear protective clothing.

- To clear up the bulk of the spill, it may be necessary to use a sealed tank water vacuum cleaner such as an Aqua-Vac, which can be part filled with the recommended solution of bleach.

- After the area affected by the fluid spill has been covered by bleach solution, it must be left for 15 minutes, so that the virus-killing constituent found in bleach (sodium hypochlorite) has time to do its work.
- A footbath containing bleach solution placed at the threshold of the contaminated area will help to stop waste matter from being spread elsewhere on footwear.

- Contaminated clothing and other waste must be sealed into yellow plastic bags and collected for safe disposal.

- In the case of a very large spill, where waste material or fluid has contaminated a very large area, or where an establishment does not have access to the correct equipment, a specialist cleaning contractor must be brought in.

5.7 Although most staff will be concerned about contracting HIV through contact with a blood or body fluid spill, it is rarely passed on in this way. HIV is not air borne, unlike tuberculosis, which is passed on by breathing in infected droplets produced by an infected person coughing or sneezing. Hepatitis B and C can both be transmitted via blood and saliva, and hepatitis B can be transmitted by contamination with urine.

5.8 It is of vital importance to minimise any risks of any occupational infections to staff, and routine precautions must be observed at all times. They are more than adequate for avoiding infection with HIV, and will also be helpful in the prevention of hepatitis B and C, and TB.

6. **Resuscitation**

6.1 The theoretical risk of transmission of HIV from mouth to mouth resuscitation is extremely low, and there has been no known example of transmission via this route. There is some risk from transmission of hepatitis B and hepatitis C, both of which can be passed on through saliva. Common sense tells us that tuberculosis, where it is present in sputum, can be passed on through casual contact.

6.2 Existing standards of good practice are designed to protect both the giver and receiver of resuscitation. It would be unethical to refuse resuscitation to anyone on the grounds that they may be infected with HIV, hepatitis B or C, or tuberculosis, and the best precaution against infection is to follow procedures correctly.

6.3 Prison health care staff must be trained in the use of resuscitation aids for use in mouth-to-mouth resuscitation, as must any staff who carry them. Brookes airways or similar resuscitation aids are included in first aid packs widely available in all establishments, but must only be used by those trained to do so.

7. **Testing for HIV antibodies**

7.1 The HIV antibody test is a procedure which detects the presence of antibodies to HIV in the blood. Antibodies to HIV infection are formed by the body to destroy the infectious agent.

7.2 Some staff may feel that they should be tested for HIV antibodies because of a work-related event, and may want a blood test at the time
of event, or if there has been an accident with used injecting equipment may wish to reserve the equipment for testing. (Please see the section ‘Dealing with needles and syringes’. It is important to consider these issues before having this test:

7.3 **How does the test work?** - A small sample of blood is taken and checked for ‘antibodies’ to see if there has been a reaction to HIV. It is not a test for AIDS.

7.4 **The limits of the test** - the window period. Once there are sufficient antibodies present in blood, this test is very accurate. However, it can take up to three months after the risky event for enough antibodies to develop to make an accurate test. Therefore it is necessary to wait three months after the HIV risk incident to have the test for infection resulting from that incident. This three-month interval is often referred to as the ‘window period’, during which time the person must assume they could be infected and are capable of infecting others through the routes of transmission described on page 3. Generally the results of a blood test are available fairly quickly but it can sometimes take up to two weeks for a test result to come through. Occasionally the test will have to be repeated because the result is equivocal.

7.5 **What does a positive test result mean?**

- There are HIV antibodies in the blood. The person has an HIV infection, but this result does not mean that he or she has AIDS. The hospital/clinic will carry out further tests to determine the state of health of the individual infected and whether any treatment is required.

- The test does not show how long the person has been infected, and does not tell us when or if he or she may become ill.

7.6 **What does a negative result mean?**

- There are no HIV antibodies in the blood, or not enough to show positive. It is only certain that the person is not infected with HIV if there has been no risky event, or risky behaviour, in the preceding three months.

- If this is not the case, the test must be repeated a minimum of three months after the last risky event.

- A negative result DOES NOT mean that a person is immune to HIV.

7.7 **Testing and confidentiality** - Testing can be done either at a local Genito-urinary or GUM clinic (also known as ‘special’, STD, or VD clinic), or by a GP. GUM clinics are bound by law to maintain confidentiality and do not report the result of a test to a client’s GP without their express consent (see Section 1 Paragraph 3.4.).
7.8 **Counselling issues** - It is very important for a person who thinks that he or she requires a test for HIV antibodies to see an HIV counsellor first. A counsellor will help the client to fully understand all the points discussed in this section, and will give clear information to enable the client to make up his or her mind whether to be tested. The counsellor will help the client to assess the chance of infection. HIV counsellors offer support before and after the test, and can refer on to a support group.

7.9 **Issues for staff who may have been exposed to HIV infection** - There are additional issues which must be considered if a person thinks that he or she may have been occupationally exposed to HIV infection. These are listed below:

- If the person who may have been exposed to infection decides after advice that he or she wants to be tested for HIV antibodies, it will be necessary to have blood taken immediately. This is to confirm the absence of prior infection, in the event of any later claim for industrial injury.

- This blood sample, taken immediately, need not be tested straight away. It can be stored, and will only need to be checked if the sample taken after the ‘window period’ of three months is found to be positive.

- If the first test shows negative and the second positive, it is likely that the risk incident was the cause of HIV infection provided that there were no further risk incidents (personal or professional) during the intervening period.

- If both tests show positive then it is certain that the individual was infected prior to the HIV risk incident which initiated the process.

7.10 For these reasons staff need clear, independent HIV counselling before deciding whether or not to have HIV testing and to understand fully all the implications for them and their family or partner.

8. **Management of Outbreaks**

8.1 An outbreak of an infectious disease can be considered to have occurred if more than one inmate or member of staff has acquired the infection and there is evidence that transmission took place within the establishment.

8.2 Responsibility for advising on the medical aspects of an outbreak of HIV, hepatitis B or C or pulmonary tuberculosis will lie with the Head of Health Care. With all outbreaks of communicable diseases, there is a statutory obligation on the Head of Health Care to liaise with the Centre of Disease Control (CDSC) and notify the Health Authority’s Consultant for Communicable Disease Control (CCDC). In the case of the blood borne viruses, he will need to liaise with the Multidisciplinary
Communicable Disease Management Team. Points that may need to be considered are highlighted below:

- How the infection got in to the prison?. Was it through a new admission, a member of staff, a visitor?

- How the infection is being spread? In the case of HIV and the blood borne hepatitis viruses, the most likely cause of outbreaks is needle sharing by intravenous drug users, but for HIV and hepatitis B sexual transmission must also be considered.

- How many people are affected? Screening will be required to detect people who are not ill but are carrying the infection. This will call for informed consent and it will be necessary to mount an urgent educational programme to explain the situation to inmates and to provide counselling facilities. The co-operation, not only of inmates, but also of staff would be called for in the unlikely event of an outbreak of pulmonary tuberculosis.

- How further spread can be prevented? In the face of an outbreak caused by needle sharing, it would be necessary to reinforce the education inmates should have already received concerning the risks of this practice. Groups of a suitable size should be shown the video 'AIDS Inside & Out' and/or the drugs module of 'Talking about AIDS' and encouraged to discuss the implications in the light of the outbreak that had occurred. Information should be made available on the cleaning of works for those who still persist in sharing. In some establishments sterilising tablets are provided for this.

- If sexual transmission has been occurring, the risks of unsafe sex would need to be emphasised followed by information on safer sex techniques. Condoms may be prescribed if in the clinical judgment of the doctor there is a risk of HIV or STD transmission.

- Consideration should be given as to whether there is any action that could be taken to reduce the risk of similar outbreaks in the future. The outbreak may have revealed that there is a poor understanding among inmates of the risks of needle sharing or unprotected sex and a lack of information on the best ways of reducing risk. This may need to be addressed by improving the standard of training on these subjects.
Chapter 3

Employment and job protection policies

1. **Introduction**

1.1 This section of the Order attempts to apply the knowledge about blood borne viral diseases and how to manage risk situations, contained in the first part, to the employment of people within the prison environment. Whilst everyone has a duty to be aware of the dangers of such diseases and adopt the recommended safe working practices, specific responsibilities apply to various groups.

1.2 Both the Prison Service and its employees have responsibilities which are enhanced by the Prison Service Value of commitment by our staff and to our staff, with a prime concern being their safety and well-being. These responsibilities and values should be reflected in the conditions of employment, the most important of which in this respect is equal opportunities and elimination of discrimination.

2. **Discrimination and Equal Opportunities**

2.1 Discrimination covers any form of arbitrary distinction, exclusion or restriction affecting a person by virtue of a personal characteristic, in this case infection with HIV or similar blood-borne virus. Discrimination against persons with HIV is prohibited by the provisions on human rights in various national and international texts, such as the European Convention on Human Rights.

2.2 According to protocol drawn up by the World Health Organisation (WHO), discrimination can only be justified if a difference is legitimate. For example it is legitimate to impose an AIDS screening test on blood donations or to exclude people exhibiting ‘risk behaviour’ from blood donation, but it is not legitimate to impose general screening at recruitment for work. A measure is arbitrary if it seriously infringes the rights of the individual or is not necessary to protect the health of others.

2.3 Discrimination may be found at three levels:

- legislation
- internal regulations of organisations
- practice

It is essential that discrimination should not only be identified and addressed in written texts and policies but also in working practices.

2.4 Equality of opportunity is one of the core values of the Prison Service. Selection for employment is on the basis of merit. The criteria for advancement in the Service are the individual’s ability, qualifications and suitability for the work, regardless of race, nationality, or ethnic origin, religion, gender, sexual orientation, marital status, disability or any other irrelevant factor.
2.5 If any member of staff feels that they have been the subject of harassment or victimisation they should follow the Equal Opportunities Complaints Procedure, which is set out in the Staff Handbook, and supplemented by additional guidance.

3. **The responsibilities of the Prison Service as an Employer.**

3.1 The Prison Service has a duty under the Health and Safety at Work Act 1974 to ensure, so far as it is reasonably practicable, the health, safety and welfare at work of its employees. One of the principal tools in monitoring health and safety is the process of risk assessment, as all risks arising from the Service’s activities and environment must be assessed.

3.2 The Service’s duty extends to the protection of employees, infected with the hepatitis viruses or HIV, from harassment, discrimination or victimisation, and ensuring that any such action is appropriately addressed.

3.3 The Prison Service has a responsibility to ensure that employees receive adequate training and education on health and safety procedures with special regard to blood-borne diseases, and that staff are able to participate in any vaccination programme that may be available, such as that for hepatitis B.

3.4 The Prison Service must ensure that members of staff are not financially disadvantaged after possible exposure to a blood-borne virus through an accident at work. The normal arrangements for compensation for accidents at work that lead to loss of earnings or ill health will apply. Staff can also be reimbursed for any additionally costs incurred on insurance policies which have been imposed either because a blood test is HIV positive or because a blood test was taken, irrespective of the result. Details were given in Notice to Staff 59/1990.

3.5 If a Governor or Head of Group or Service becomes aware that a member of staff is infected with a blood-borne virus, the member of staff must be reassured that the information will be treated as confidential and passed on only in accordance with these guidelines (see para.9). The utmost importance must be attached to safeguarding an individual’s rights as an employee so far as practicable.

3.6 The Prison Service is not legally entitled to disclose that an employee is infected with HIV etc except when the employee consents, subject to the provisions below. The decision to disclose without consent is for the Director General, but may be delegated, normally to the Director of Health Care. Any such decision will be considered most carefully and would only occur in the most exceptional circumstances. It would be based upon the demonstrable need to protect others from harm.

3.7 If the member of staff is not a health care worker who has been or will be carrying out any invasive procedures, then he or she must be allowed to continue in his or her current post, provided the governor is satisfied that the member of staff has obtained and is following expert
occupational advice. When such advice has not been obtained, this must be arranged as soon as possible, and special leave granted when appropriate until the date of the appointment.

3.8 Governors or Heads of Groups or Services must ensure that all existing and new health care workers, including agency staff and independent contractors, are given a copy of the appropriate guidance from the Professional Regulatory body on the ethical responsibilities and occupational guidance for AIDS/HIV Infected Health Care Workers. It must be ensured that the health care worker signs to confirm that he or she has read and understood the statement and that written confirmation should be kept on the health care worker's personal file.

3.9 When an infected health care worker has undertaken invasive procedures, the Governor or Head of Group or Service must ensure that such activities cease immediately and notify the Director of Health Care on a strictly confidential basis. It must be arranged wherever possible for the health care worker to be transferred to suitable alternative work within the establishment. When this is not possible, the Head of Personnel Services must be told, in strict confidence, to make appropriate alternative arrangements.

3.10 When a decision has to be made about suitable work or early retirement, it is essential that the member of staff is consulted.

If, following the procedures outlined in Section 4, he or she does not agree with the decision, the member of staff must be told the reasons and informed of the appeals process. Trade union assistance is available and members of staff have the right to approach a trade union representative.


4.1 If the health of the infected member of staff starts to deteriorate, this must be managed in accordance with the normal sick absence procedures. See the guidance in ' Managing Sick Absence', and consult Personnel Business Link in Headquarters where necessary.

4.2 Line management needs to demonstrate to all staff that their attendance and well-being is of active concern to management, and will therefore wish to know whether there is any serious underlying medical condition which explains the absences from work. A G.P. may be asked, with the member of staff's permission, if there is such a condition, but any confidential medical information must only be obtained by the appointed Medical Adviser via Prison Service HQ as set out in 4.4 below.

4.3 At an early stage, no-one, even including the member of staff, may be aware that he or she, for example, has an HIV related illness. However once the disease has been identified, that medical information must be treated as confidential.
4.4 Where a member of staff has been off sick for more than 2 months or where prolonged absence over 2 months has been indicated by the GP, the case should be referred to Personnel Business Link for further action, including the possibility of early retirement on medical grounds.

5. **Responsibilities of the employee**

5.1 *All members of staff must minimise the risk of infection by following the established health guidelines and adopting the safe working practices set out in their training, in this Order, and other instructions.*

5.2 *Infected members of staff must seek expert occupational health advice and follow the recommended safe working practices. However they are not required to reveal the infection to management nor undergo any kind of test.*

5.3 No employee, whatever their position within the Prison Service, can refuse to work alongside another employee who is infected with hepatitis virus or HIV (or, indeed, any disease), provided that person has been declared fit for work by a qualified medical practitioner. Any such refusal may be grounds for disciplinary action or redeployment, given that clear information, advice, counselling and safe practice guidelines have been provided beforehand.

5.4 *All employees must give full support to the Prison Service’s commitment to the elimination of all forms of discrimination, harassment and victimisation. In particular, if they are aware that a member of staff, or indeed a prisoner, is HIV positive, then they must not divulge that information to anyone else.*

6. **Responsibilities of the Health Care Worker.**

6.1 All health care workers in the Prison Service have an overriding ethical duty to protect the health and safety of their patients.

6.2 The General Medical Council, General Dental Council and the UK Central Council for Nursing, Midwifery and Health Visiting have issued statements to their professional members on HIV and AIDS which refer to the ethical responsibilities of health care workers. Health care workers are required to sign written confirmation that they have read and understood the appropriate statement, which is provided by the Governor.

6.3 Provided general infection control measures are followed scrupulously, the circumstances in which HIV and the hepatitis viruses could be transmitted from a health care worker to a patient and vice versa are restricted to invasive medical treatment. Such procedures must not be performed by a health care worker who is HIV+ or is carrying the hepatitis B or C virus.

6.4 All health care workers who believe that they may have been exposed to infection in whatever circumstances must seek medical
advice. Members of staff who may have been exposed to the hepatitis B virus must follow the procedures outlined earlier in this Order.

7. **Responsibilities of the Infected Employee.**

7.1 There is no legal obligation for a prospective or current employee to declare if they are HIV positive or suffer from a blood-borne viral disease. However if ill health related to the infection results in inefficiencies or absences from work, infected employees are encouraged to confide in their line manager to ensure a concerned and considered approach in dealing with the matter. The Staff Care and Welfare Service may also be approached for advice. Trade union assistance is also available.

7.2 An employee who knows that they are infected must adopt the recommended safe working practices and minimise the risk of transmission. Failure to do so may lead to possible disciplinary action.

7.3 An infected health care worker who has never undertaken any procedure that carries a risk of transmission (invasive procedures) is not required to inform the Governor provided the health care worker has obtained and is following expert occupational advice regarding future clinical practices.

7.4 An infected health care worker who has undertaken invasive procedures must cease these activities immediately upon being diagnosed. That person, or his or her occupational or medical adviser, must inform the Governor on a strictly confidential basis.

7.5 Infected health care workers' employment status and rights will be safeguarded so far as is practicable. The Prison Service will make every effort to arrange suitable alternative work and retraining opportunities or, where appropriate, early retirement.

7.6 These guidelines apply in the same way to independent health care contractors, including general medical practitioners, dentists, agency staff, students, and other health care staff working for the Prison Service in a capacity other than an employee.

7.7 Infected independent contractors employed by FSHAs, self-employed health care workers who are not part of a line management structure and anyone else who is not clear to whom to report should notify the local Consultant in Communicable Disease Control if they have performed exposure prone invasive procedures.

8. **Responsibilities of the G.P. or Occupational Health Physician.**

8.1 All concerned staff are encouraged to seek advice and support in relation to their work and fear of infection by approaching their own G.P. or the appointed Prison Service Medical Adviser either through their local Personnel Office or through Headquarters Personnel Business Link. All members of staff have a duty to maintain the employee’s confidentiality.
8.2 Physicians or occupational health practitioners who are aware that infected health care workers under their care have not sought or followed advice to modify their practice and/or are continuing to perform exposure prone procedures, are required under Department of Health Guidelines (1994) to notify the appropriate regulatory body and the Prison Service as employing authority.

8.3 Occupational health physicians have a key role to play in ensuring that infected employees receive the same rights of confidentiality as any patient seeking or receiving medical care. They are able to act as an advocate for the employee and advisor to the employing authority.

8.4 Physicians are ethically and professionally obliged not to release medical records or information without the consent of the individual. However there may be occasions when it may be necessary in the public interest for the employer to have access to confidential information. In such circumstances the employee should be counselled about the implications of this disclosure.

9. **Confidentiality.**

9.1 Governors, Medical Officers and line managers have a responsibility for ensuring that all reasonable steps are taken to protect individual confidentiality. Disclosure of confidential information without consent may amount to fundamental breach of contract on the part of the Prison Service, and will be considered a disciplinary offense.

9.2 Disclosure without consent can only be justified in very exceptional circumstances (see para 3.6). The fact that an infected employee may have died, or have been identified publicly, does not mean that the duty of confidentiality is at an end.

9.3 Under the Data Protection Act, employees have the right to formally request access to any information held about them on computer. Advice on procedure can be obtained from the Data Protection Liaison Officer.

**WHERE TO GET FURTHER HELP : USEFUL ADDRESSES AND TELEPHONE NUMBERS**

**HM Prison Service**
Directorate of Health Care
Cleland House
Page Street
London SW1P 4LN
Telephone: 0171 217 3000 Office hours

**The National AIDS Helpline**
0800 567 123 24 hour free service

**The National Drugs Helpline**
0800 776 600 24 hour free service
London Lesbian and Gay Switchboard
0171 837 7324  24 hour service

Bisexual Phoneline
0131 557 3620  7.30-9.30 Thursdays
Edinburgh
0181 569 7500  7.30-9.30 Tues/Wed

Body Positive
51 Philbeach Gardens
London SW5 9EB
(a self-help group)
Helpline: 0171 373 9124  7pm-10pm  Mon-Fri
Administration 0171 835 1045  4pm-10pm Weekends
Office hours

Body and Soul
(a self-help group for families and children)
0171 833 4929  11am-6pm  Mon-Fri

Positively Women
0171 713 0222  10am-5pm  Mon-Fri

Mainliners
0171 582 5226  Office hours

Blackliners
0171 738 5274  10am-6pm  Mon-Fri

The Terrence Higgins Trust
0171 242 1010  12noon-10pm Daily

The National AIDS and Prisons Forum
0171 582 6500  Office hours
Admin only

The British Liver Trust
Central House
Central Avenue
Ransomes Europark
Ipswich IP3 9QG
Helpline 01473 276 328 2pm-5.30pm Mon-Fri
Administration 01473 276 326 Office hours

USEFUL PUBLICATIONS

Protection against bloodborn infections in the workplace: HIV and Hepatitis, the Advisory Committee on Dangerous Pathogens, HMSO, 1995

Control and prevention of Tuberculosis in the United Kingdom: Code of Practice 1994, the Joint Tuberculosis Committee of the British Thoracic Society, original article in Thorax: reprint requests to:
Dr C Skinner
Birmingham Heartlands Hospital
Bordesley Green East
Birmingham B9 5SS
Guidance on Tuberculosis control, the Interdepartmental Working Group on Tuberculosis, the Department of Health and Welsh Office, June 1996

BCG and Tuberculosis, the Health Education Authority, 1995

Hepatitis information for general practitioners, the British Liver Trust, 1995

Intravenous drug use and hepatitis C... what you need to know, the British Liver Trust, 1995


HIV and Custody: risk reduction and health promotion in custodial settings, Di Robertson and Silvia Casale, Health Education Authority

AIDS and drug misuse update, report by the Advisory Council on the Misuse of Drugs, HMSO, 1993

AIDS: HIV infected health care workers, HMSO, 1994

Decontamination of equipment, linen, and other surfaces contaminated with hepatitis B and/or HIV, Department of Health, 1993

Protection against infection with HIV and Hepatitis virus: guidance for clinical health care workers, HMSO 1990

The Health and Safety at Work Act, 1974 HMSO

Management of Health and Safety at Work Regulations, 1992 HMSO

The Companies Act Business Charter, the National AIDS Trust, 1992

AIDS and the workplace: a guide for employers, the Department of Employment and the Health and Safety Executive

The national AIDS reference manual, employment section, NAM Publications, 1995