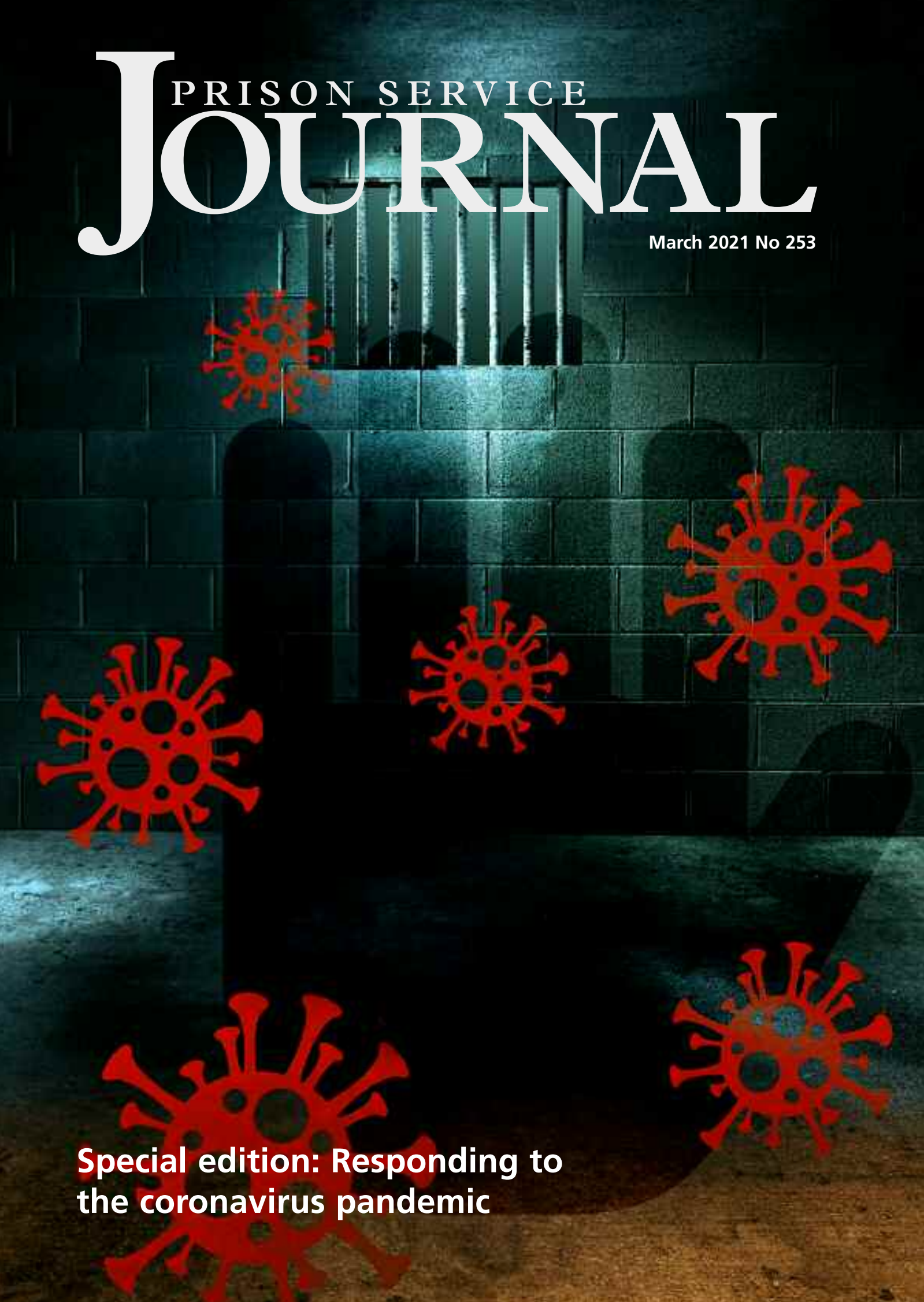

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Special edition: Responding to the coronavirus pandemic

Public health in English prisons

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Dr. Eamonn O'Moore is a consultant in public health. He has spent three decades as a physician specialising in infectious diseases and public health. He has a long-standing interest in prison health and health protection in prisons, advising policy makers and health agencies nationally and internationally. His current roles include National Lead for Health and Justice at Public Health England (PHE). PHE is an executive agency of the Department of Health and Social Care, and a distinct organisation with operational autonomy. PHE provides government, local government, the National Health Service (NHS), Parliament, industry and the public with evidence-based professional, scientific expertise and support. The aim of PHE is to protect and improve the nation's health and wellbeing, and reduce health inequalities. Dr. O'Moore is also the Director of the UK Collaborating Centre for the WHO Health in Prisons Programme (HIPP). HIPP was established in 1995 to support improvements in public health by addressing health and health care in prisons, and to facilitate the links between prison health and public health systems at both national and international levels.

Dr. O'Moore is the leading national advisor on public and prison health in England during the coronavirus pandemic. He played a central role in devising the strategic response and monitoring its impact.

This interview took place in October 2020.

JB: What drew you to work on infectious diseases in prisons? What has been your previous involvement in managing infectious diseases in prisons?

EOM: When I was in medical training at University College Dublin, I worked in one of the University hospitals which was across the road from the largest prison in Ireland at the time, Mountjoy. In the early part of my career I was working in HIV medicine and the population most affected in Ireland was those injecting drugs. As in many jurisdictions, this meant they were often imprisoned. When I was a Registrar in infectious diseases at the hospital, we would have people brought over the road from the prison for treatment, usually shackled in handcuffs. At that time HIV was a deadly infection and difficult to treat. Many of the people brought in from the prison were in the advanced stages of illness. There was something pretty wretched about these people who were emaciated, very obviously with advanced HIV infection, chained to often quite burly prison officers. That struck me at the time. I became more interested in prison health and curious about what went on in that building across the road from the hospital.

When I became more involved in public health, one of the issues that stuck me was that prison health was neglected speciality. Historically, the first pubic health system was established in prison in 1775, as it was recognised that 'jail fever' was a risk to the community as infection acquired in prison was being transmitted into the community. In the subsequent 200 years, the relationship between prison and community infection has become clearer. We've seen in many countries prisons becoming reservoirs of infection or amplifiers of infection. For example, in Russia a quarter of the tuberculosis cases for the whole country have been acquired in prison. That also means that interventions in prisons can be a means to access so-called 'hard to reach' populations. In my work I see that those people are not 'hard to reach' — they are locked in a cell for most of the day — what they are, in fact, is under-served.

I am pleased to say that I have seen an improvement during the years I have been involved with prison health. Particularly in the UK, which is world-leading in this area. That is why our work with the World Health Organization is so important to promote understanding not only of prison health, but of the 'community dividend', in other words the benefit to the whole of society, of working with people in prison to address underlying health needs. While there has been that progress, this pandemenic has shone a light on inequalities experienced by people in prison generally.

JB: What has been your role in this pandemic and in managing infectious diseases in prisons?

EOM: The Health and Justice team at PHE has a long standing role offering expert advice to the Prison

Service, the NHS, the Ministry of Justice and the Department of Health on preventing, responding to, and mitigating outbreaks of infectious diseases in prison settings.

When we started getting alerts about this novel coronavirus at the beginning of 2020, we were alert to the risk to the UK and specifically to people in prison. Our role was to work with partner organizations, the NHS and HM Prison and Probation Service (HMPPS) particularly, to understand what coronavirus outbreaks in prisons might mean for us. So very early on, I was involved in producing guidance and mitigations. Then as the situation evolved, we were clear about the escalating risk for prisons.

We were fortunate that there was a pre-existing partnership agreement between PHE, NHS and HMPPS, Ministry of Justice and Department of Health, which defined how we would work together. That well-established governance structure allowed us to quickly and effectively work together. That meant we could get our expert advice in to the people who needed to hear it, and I was very pleased with how responsive our colleagues in prisons and policy were to that advice.

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JB: How prepared were prisons and public health authorities for the coronavirus outbreak? Did you have contingency plans in place?

EOM: In 2009, I was working with what was then called the Health Protection Agency, working with prisons to respond to outbreaks of swine flu in prisons. We had that experience to draw upon and had also participated in a national pandemic exercise in 2016. That was the first such exercise where prisons were specifically included as a place where outbreaks may occur. Pandemic has been on the government risk register, sitting at a significant threat level, for a very long time.

Although we had been working on pandemics for a long time, the pandemic we had been thinking about was influenza. Nevertheless, many of the concerns and plans for pandemic influenza read across to coronavirus. We already had on the shelf a guide for pandemic in prisons, which helped us, but we had to adapt this to the situation we were seeing.

Having the established way of working and having done that thinking in advance, it gave us a jump start on what we needed to do. Compared to other jurisdictions, we were more prepared, but we do have one of the largest prison systems in Europe, a very complex system, so we weren't in any way complacent. We realised we were facing the greatest challenge of our professional careers and it was going to be a bumpy ride. At the beginning, we weren't sure of what we would face. There were a lot of uncertainties.

JB: Were there any forecasts of potential impact in prisons? What was the situation you thought you would be facing?

EOM: The biggest risk we identified in prisons was what we call 'explosive outbreaks'. Prisons are closed settings that bring together people in close quarters, often with underlying medical vulnerabilities, and often with challenges around access to diagnostic and therapeutic services. You can then think then about the numbers potentially requiring hospitalization, the numbers requiring care and then mortality rates. In our reasonable worst case scenarios, we were looking at significant numbers of deaths. Ministry of Justice published the interim analysis, which showed without action being taken, estimates were that around 2,700 people may have died in prison. This was based on various assumptions about the rate of infection and fatality rate. Of course that level of infection would also present a significant risk to those who worked in prisons and those that visited prisons.

JB: What are the particular vulnerabilities of the prison population that have an impact upon the risk?

EOM: For a variety of reasons, people in prison generally have complex physical and mental health needs. One particular study discussed 'prison age' as being physiologically ten years older than their chronological age. In other words if you are a man of fifty who has significant prison experience, you will have the same level of illness as someone who is sixty. That is a reflection of some of the social factors that lead people to be in prison as well as the lifestyle issues such as higher levels of smoking. People in prison have a higher prevalence of respiratory illness, immunosuppression (for example due to HIV infection) and other chronic illnesses such as cardiovascular

disease, diabetes or liver disease. Recent years have also seen a growth in the older prisoner population, which is defined as people over fifty years of age, and they are a group with greater vulnerabilities. In the context of coronavirus, people from minority ethnic groups have been more adversely affected, and in prisons, there is a disproportionately high number of Black, Asian and minority ethnic people.

JB: What action did PHE or you missing should be taken in order to manage the risk of infection spreading?

EOM: The first measure was to increase social distancing, reducing the interactions between people and so mitigate the risk of transmission. In prisons, the confined space means that they can be crowded and claustrophobic space with choke points and bottlenecks. People are often in close quarters when moving through the physical space. Interactions in work or education were also a risk. We worked closely with HMPPS to think pragmatically of ways that social distancing could be achieved. Interventions included sequential and limited unlocks so that there were only a certain number of people in the spaces at any time and distance could be maintained. That had significant implications for how people accessed food, showers and other necessities of life. We also had to work with staff to ensure that they understood and maintained social distancing themselves. There are many different people who come into prisons to provide services, so we had to limit that to what was necessary. Together this meant that there were significant restrictions on the regime and activities in prisons. This really impacted on every aspect of daily life for those who lived and worked in prisons. We were, however, very conscious of our duty of care so were clear that we should maintain access to outdoor space, showers and other facilities.

The second major strategy was known as 'compartmentalisation'. I would compare this to a submarine, where a system of bulkheads enable the separation into compartments. This is a means of control that can prevent infection quickly spreading through the whole institution. There were three compartments that prisons were required to create. The first was Protective Isolation Units (PIUs), to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation. The second was Shielding Units (SUs), to protect the most vulnerable. Third, was Reverse Cohorting Units (RCUs), to accommodate new receptions or transfers in for a period of 14 days to detect any infectious cases before entering general population.

Creating these units was very challenging in prisons and took time and significant effort to make it happen.

JB: Was reducing the prison population a necessary part of the strategy?

EOM: Our initial position was that we should aim for a system where there was single accommodation. That was the most effective way to reduce infection risk. That, however, would have required a significant reduction in the prison population. In parallel, one of the impacts of the pandemic was that court and police activity was affected. This meant that the flow of people into prisons was slowed and the population reduced. There was also an early release scheme implemented, but this only led to relatively small numbers of people being released. As time went on, we reviewed and refined our assessment of risk and were confident that the effectiveness of the other measures taken, including social distancing and compartmentalization meant that there was less need to reduce the prison population further in order to manage the risks.

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JB: How would prisons and public health experts respond to outbreaks in individual prisons?

EOM: Cornonavirus, as well as other communicable diseases, are notifiable illnesses that have to be reported to PHE. Where cases are reported in a prison, PHE will undertake a risk assessment and decide whether to convene an outbreak control team (OCT), a multi-agency group involving a public health consultant in communicable disease control, prison health providers, prison management, local authority public health teams and relevant experts from the NHS. The OCT would collect the data and co-ordinate a local plan to respond to the outbreak. This may include advice on restrictions, access to testing, advice to cease transfers of people in and out of the prison. The local team also report this to the national Health and Justice team, for surveillance purposes so as to build up a picture of the totality of the position across the country. The national team would also offer expert advice due to our experience in the prison context. The OCT may

meet every day or every few days depending upon the circumstances. Their role will be to continue to monitor the situation, understand how the outbreak is moving and take action to reduce the impact. The OCT will not only focus on the outbreak amongst prisoners but will also consider staff and visitors.

The OCT process is a well-established intervention and is a well-oiled machine. It is led by public health experts but also draws upon a wide range of expertise including those who run the prison.

JB: What was the impact of coronavirus within the prison system? How did it compare to the forecasts?

EOM: In wave one of the pandemic, it did appear to be successful. We didn't see those large outbreaks we had been concerned about, we didn't see high levels of morbidity and mortality that we had feared and the prison service, with modifications, continued to function and to serve the courts.

I would say that the response is still going on. We are now seeing rising levels of infection and what might be described as a second wave. This is happening at a time of year when we would normally see a rise in seasonal flu and other respiratory illnesses. This means that the winter may be a challenging time. We are now applying the lessons we have learned from the first wave and building on the strong partnership working that has been established. Given the success of the response to the first wave, we can go into this next phase with confidence in the knowledge that we have protected people in prisons and saved lives.

JB: What were the collateral costs of these measures on prisoners, prison staff and their families?

EOM: The success in containing the infection in wave one did come at a cost. In particular on the daily lives of those in prison, including their ability to see those they love and their ability to engage in education and work. At the beginning there was a national lockdown in the community, so everyone was experiencing some restrictions. This gave a synchronicity between prison and the community. As the pandemic wave evolved over the summer, there was then a growing dissonance between what was being experienced in prison and what was happening in the community. At that time, we had to start to re-normalize prison regimes while at the same time being alert to the risk of new infections.

The duration of the restrictions meant that they became increasingly hard to tolerate. We were also mindful that there were pre-existing problems in the prison system, including the prevalence of mental ill-health, self-harm, suicide and violence. That had to be balanced with the imperative to save life.

JB: Is there likely to be a need to maintain some of these mitigation strategies and restrictions on everyday life in prisons for a protracted period?

EOM: My early assessment in April 2020 was that some control and restriction were likely to be required until at least March 2021. At the time people felt that was a long period to be thinking about restrictions. As time has gone on, that prediction has been consolidated. We have an ongoing epidemic wave, the vaccine remains under development and we are entering the time of year when respiratory illnesses emerge. We are therefore likely to see social distancing and compartmentalization remaining a feature of prison management as the virus develops in the community. The more infection there is in the community, the greater the risk of importation into the closed prison environment and the potential for explosive outbreaks.

With flu, we often have in prisons what is called a long tail, so there are outbreaks in the latter part of the flu season. We had outbreaks of flu in prisons in 2019 right up to April. Dealing with this requires effective management at a local level, responding to specific circumstances. The risk profile of prisons requires both longer and more agile management than other environments.

JB: What are you most proud of in the response to the pandemic?

EOM: The courage, dedication and commitment of staff who work in prisons has been very evident and they have worked to try to make prisons as safe as they can be. Whether custodial or health staff, they have put themselves in harm's way on the frontline to deliver the job they have been tasked with. They have done this selflessly and professionally and are amongst the best public servants.

I am also very proud of the response of the people we look after. There has been a high degree of buy-in from prisoners' themselves. There is no doubt we need to do more to mitigate some of the impacts of long periods of isolation.

As a country we have long and well-established excellence in public health practice. We are one of the few jurisdictions in Europe that has a team within a national health protection agency that focusses specifically on the needs of people in the prison system. I am proud to lead that team. The team has played a critical role in the successful response. They have been able to build over many years a good understanding of the prison system and the needs of the people within it. At the beginning of the year when the World Health Organization started to think about these issues, they turned to us to inform their guidance on responding to coronavirus in prisons. That international leadership is something we should be rightly proud of.