



# ADAPTING TO COVID-19

Medical Isolation and Quarantine in Prison during a Pandemic

Special Issue

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## Welcome Message from the Chair

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Dear Members,

With the summer months behind us, we find ourselves confronted with what many had anticipated: a second wave of COVID-19. For people around the world this has required tremendous adjustment. As schools reopen, families are forced to determine how best to navigate this new reality while minimizing the risk of infection. For our network members, this stress is compounded by the additional imperative to protect one of society's most vulnerable populations – the imprisoned and justice-involved – from violations of human rights and dignity. In particular, we have witnessed how prison authorities around the globe scrambled to respond to the pandemic by implementing isolation and quarantine measures, which can be tantamount to solitary confinement.

It is for this reason that we decided to produce this second Special Issue of our network newsletter titled, “Medical Isolation and Quarantine in Prison during a Pandemic.”

I would like to thank the following authors for their excellent contributions to this issue:

- Robert Paterson, *International Committee of the Red Cross*.
- Johannes Flisnes Nilsen & Mari Dahl Schlanbusch, *Norwegian Parliamentary Ombudsman, National Preventative Mechanism*.
- Fiona Rafter, Emily Collett, & Anna McGilvery, *Inspector of Custodial Services, New South Wales, Australia*.
- Procuración Penitenciaria de la Nación, *Argentina*.

I would also like to thank our colleagues at [AMEND at the University of California San Francisco](#) (UCSF) for their tireless efforts in developing the infographics, which we have included at the end of this newsletter. The resources produced by AMEND continue to be invaluable in informing and reforming correctional practice, despite the ever-changing situation.

## WELCOME

Finally, I would like to extend a special thanks to Steven Caruana, Coordinator of the *Australia OPCAT Network*, and Emad Talisman, Policy and Research Analyst for Canada's *Office of the Correctional Investigator*, for their continued dedication to the work of this network. Their respective leadership and hard work make this newsletter possible.

I hope that you find this issue informative and helpful. Please feel free to share it with your colleagues and networks.

With Gratitude,

Ivan Zinger (J.D., Ph.D.), Correctional Investigator of Canada.

## Medical Isolation and Quarantine in Prisons<sup>1</sup> during COVID-19: An International Committee of the Red Cross Perspective

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# ICRC

**By Robert Paterson**

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Prison systems provide the ideal environment for a “perfect pandemic storm”, particularly with highly contagious respiratory pathogens such as SARS-CoV-2. In the absence of specific means of prevention or treatment, preventing COVID-19 entry into such a highly vulnerable setting is imperative. Unfortunately, this has proved difficult to accomplish, particularly in contexts where the virus has reached sustained community transmission. Prisons present numerous challenges to successful pandemic management, including limited capacity to implement rigorous quarantine and isolation measures. However, effective pandemic management in prisons is not only necessary to protect the health and lives of prisoners and prison staff, it is also necessary to global COVID-19 control.

### **Prisoners: A Highly Vulnerable Group**

People from underprivileged sectors of society are significantly over-represented in prison environments. Their access to health information and use of health services have generally been poor; they exhibit more behaviours associated with negative health outcomes and have a higher prevalence of both acute and chronic illnesses. Additionally, the proportion of older prisoners is increasing worldwide. Collectively, the demographic and epidemiological characteristics of prison populations closely match the key vulnerability criteria for the more severe forms and outcomes of COVID-19 disease.

### **Prisons: A Threatening Crucible**

Prisons are not healthy environments. The world continues to face rising incarceration rates without commensurate increases in prison system funding. Internationally

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<sup>1</sup> The terms “prisons” and “prisoners” will be used throughout this article as generic terms for all “places of detention” and all categories of “people deprived of their liberty”, respectively.

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recognised [minimum standards for acceptable conditions of detention and treatment of prisoners](#) are often not met: many prison systems are not able to assure the basic determinants of health, in terms of providing adequate food, water, housing, lighting, access to outdoors or even fresh air. Such environments preclude, or at least significantly impede, adherence to [WHO's](#) basic COVID-19 prevention measures: physical distancing, hand hygiene, respiratory hygiene, avoiding touching eyes, nose and mouth – let alone isolating oneself at home when sick. Accordingly, the prevalence of other respiratory illnesses such as tuberculosis are known to be higher, sometimes exponentially, in prisons than outside. Finally, despite their stated purpose of “separating and securing” certain groups of people from the rest of the community for the duration of their sentence, prisons – thankfully – are not perfectly sealed “closed environments”: visitors, staff and prisoners themselves can and do import and export pathogens between prisons and the community.

### **Prison Health Services: Still Insufficiently Connected to National Health Systems**

Despite clear guidance from relevant normative bodies, prison health services often remain insufficiently connected to their respective national health services. In many cases and most commonly in developing countries, prison health services are entirely resourced and managed by the detaining authority, with little if any collaboration or support from the national health authority. Aside from the myriad of challenges this creates in terms of access to quality health services and of assuring “equivalence of care with the community”, this disconnection constitutes a huge obstacle to successful outbreak control, which requires uniform application of common norms, standards, processes and protocols across the national territory. Inconsistencies create breaches in the national response to the pandemic which the virus can and will exploit: while prisoners are likely to suffer first, the unavoidable permeability of prison systems with their respective communities means that uncontrolled outbreaks in prisons will jeopardise their control in the whole country. Additionally, incomplete integration of prison epidemiological data with national health information systems precludes both complete analysis of health needs and global planning of required resources; in the case of a Public Health Emergency of International Concern, it also limits States' capacity to fulfill their reporting obligations under the [International Health Regulations](#).

### **Emergency Planning and Response: Often Weak and Overlooked**

Optimal responses to crises are contingent upon rigorous preparation including contingency planning, staff training, resource allocation, etc. The ICRC promotes crisis

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planning and contributes to emergency response in most of its operational contexts. However, it has frequently noted that preparedness efforts are negatively affected by the same constraints restricting prisons systems' capacity to assure optimal conditions of detention and treatment of detainees: insufficient funding, scarce public support and lack of political will. Established emergency planning and response programmes (EPRP) in prisons are uncommon; when present they are often mainly virtual and generally disconnected from national EPRPs. Their activation and implementation are often delayed and incomplete, and accordingly their impact can be insufficient.

### **A Focus on Prevention: Screening, Quarantine and Isolation**

As described above, prison environments favour the exponential spread of infectious diseases and particularly those spread by airborne-droplets. Furthermore, pre-existing vulnerability factors leading to more severe COVID-19 outcomes are over-represented in prisons. Also, the processes allowing early identification of cases and their safe and effective management are frequently weaker in prison settings, further exposing prisoners to adverse COVID-19 related health outcomes. Finally, timely access to hospitalization is a near universal problem for prisoners: timely access to referral centres offering suitable treatment to prisoners with severe or critical forms of the illness is likely to be even more difficult to assure. Prevention is therefore the most effective approach to addressing the COVID-19 outbreak in prisons. Accordingly, in close to 100 operational contexts, ICRC detention teams have been focusing their efforts on helping detaining authorities strengthen their capacity to prevent COVID-19 entry into the prison system. The ICRC has supported these authorities in providing technical and material support to set up effective screening, quarantine and isolation processes in prisons. In parallel, the ICRC has also supported authorities in their efforts to decongest prisons through executive, administrative and judicial measures reducing the inflow and increasing the outflow from the penal system, thus lowering prison overcrowding and subsequent vulnerability to COVID-19. It has concurrently reminded them of the need to prepare for the safe return of released detainees to the outside world, both in terms of protecting public health and negotiation of multiple restrictions on movement.

### **A Crucial Prison-Specific Process: Medical Examination on Admission**

The systematic medical examination of all newly admitted prisoners is a crucial prison-specific health process. Explicitly recommended in all relevant normative texts, its purposes are threefold: first, it allows the prompt identification of health needs, including



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those associated with age and/or disability, to assure timely access to the required treatments and/or continuity of care for pre-existing illnesses. Second, it allows the identification and subsequent separation of people with infectious diseases from the rest of the prison population, thus protecting other prisoners from contagion. Third, it allows the identification and documentation of physical and mental sequelae of ill-treatment, thereby contributing to the fight against this scourge. Accordingly, and in keeping with international standards, the ICRC urges prison authorities to assure the systematic and thorough medical examination of all newly admitted prisoners by qualified health professionals. Since the start of the pandemic, the ICRC has provided guidance, training and material support to promote implementation of effective medical screening processes for all people entering the prison (staff, family, lawyers, monitoring bodies, prisoners ...) to allow prompt identification and appropriate management of COVID-19 cases as per WHO standards and recommendations.

### **A Work in Progress: Systematic and Safe Management of Prison Admissions**

Putting these recommendations into practice has not been straightforward, owing to the limitations on human, material and financial resources faced by most prison systems in ICRC operational contexts, often compounded by the previously mentioned disconnection with national health systems. Access to diagnostic testing remains insufficient and current tests, even when quality-assured and performed by trained personnel, are still not sufficiently reliable screening tools to determine prison admission given the heightened vulnerability of people in prison environments. Accordingly, given that most contexts are experiencing (or have experienced) sustained community transmission, the ICRC has recommended systematic quarantine for all new (asymptomatic) admissions, and medical isolation for those with symptoms consistent with WHO's COVID-19 suspect or confirmed case definitions. In the absence of effective and widely accessible preventive (vaccine) and curative (specific treatments) health interventions, there are no "safe" alternatives. And yet in most ICRC operational contexts, both of these essential public health measures have proved extremely difficult to apply.

### **A Critical Constraint: Space**

Even in those contexts where the necessary human and medical resources to ensure adequate medical care and infection prevention and control (IPC) are available, one of the key contributors to prison environments' vulnerability to COVID-19 also impedes diligent implementation of safe and effective quarantine and medical isolation: widespread and

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sometimes dramatic overcrowding. Establishing IPC-compliant areas to accommodate all COVID-19 contacts (quarantine) and cases (isolation) within an overcrowded prison is challenging enough; also, such areas encroach on the already insufficient space within an over-congested facility, thus further impeding adherence to basic prevention rules - and most obviously physical distancing - by prisoners, staff and visitors. Avoiding cross-contamination within and between such areas, and with the rest of the prison, and assuring adequate living conditions, symptom monitoring and medical management for all those held there, remains even more challenging.

### **Good Practices**

Many prison authorities have risen to the challenge, prioritised protecting prisoners' and staff health and wellbeing, and devised innovative approaches to prevent COVID-19 entry into their prisons.

To this end, variable degrees of "lock-down" were introduced, such as restricting family visits and transfers within the prison system, promoting virtual court hearings, etc. The ICRC has supported such initiatives, provided they were justified by public health imperatives, supported in law, that effective alternatives were put in place to respect prisoners' rights, wellbeing and dignity and that they were subjected to review. Efforts were made to strengthen/establish adapted contingency plans and to assure integration of prison systems within the national COVID-19 response.

Regarding quarantine, when sufficient space was not available to maintain all new admissions in individual cells for 14 consecutive days, prisoners were arranged into cohorts based on their day of arrival and kept separated from other cohorts - and from the rest of the prison - to prevent cross-contamination for the duration of their quarantine. In some prisons facing critical lack of space, arrivals from several consecutive days were put into one cohort; the number of days per cohort being determined by the number and size of available quarantine cells. Some States designated one or several prisons as "quarantine sites", temporarily relocating occupants to other prisons before admitting all newly sentenced (detained/committed/remanded) people there for their quarantine. Despite the associated security-related challenges, in certain contexts pre-existing public or private infrastructure was commandeered and designated to create new quarantine sites.

Regarding medical isolation and given the risk of rapid progression from mild symptoms to severe or even critical clinical status, the ICRC recommended that all symptomatic cases

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be triaged as they were identified, and either kept in the prison health facility (mild symptoms, no risk factors) or promptly referred to local IPC-compliant health facilities providing the required level of care. The ICRC supported strengthening both prison and referral health facilities according to their technical capacity through training, technical and material support as required. The ICRC also promoted formalising cooperation agreements between prisons and referral health facilities, to help assure timely transfers for life-saving care.

Such examples of good practice were generally seen in contexts where the COVID-19 response was coordinated by a dedicated crisis response “body” that included representatives from all involved government agencies with the required level of expertise, legitimacy and authority. In many contexts, prison authorities were actively involved – if not always from the outset.

### **Ongoing Challenges**

Some national authorities were unable to implement optimal COVID-19 prevention or outbreak management recommendations within their prison systems.

Global shortages of protective personal equipment (PPE) were major challenge particularly in the first half of the year, but available PPE stocks were also wasted through improper use by insufficiently trained staff; inadequate management/disposal of PPE also increased the risk of contagion.

In some contexts, the rigorous screening, quarantine and isolation processes applied in the community were declared “inapplicable” to prisons by authorities who seemed to expect that the virus would “change its spots” and become easier to manage inside prisons than outside. Simpler and “more realistic” procedures were favoured. In one context, all new admissions were kept in a single, poorly ventilated “quarantine cell” and remained there for 14 days, mixed with those admitted up to two weeks before and after them, before joining the general prison population. In others, all prisoners were made to wear reusable masks, despite being held in overcrowded prisons where basic hygiene – let alone safe management/disposal of masks – could not be assured. In yet another, a “prison-specific” COVID-19 prophylactic protocol, unsupported by any medical evidence, was administered to all prisoners and prison staff exposed to COVID-19, to declare them “COVID-19 free”. Such overly simplistic approaches are at best ineffective and wasteful, at worst dangerous, and always unacceptably discriminatory.

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Some national health authorities were unwilling to be involved in COVID-19 prevention and control in the prison system, stating that they were “overwhelmed” by cases in the community, thereby refusing access to lifesaving care for critically ill prisoners on the basis of their legal status rather than on medical criteria.

Finally, in some States, prison outbreaks were concealed to avoid adverse public reactions and/or political consequences, jeopardizing prisoners’ access to healthcare, national pandemic control and global COVID-19 monitoring and management.

Such examples of poor practice were typically seen in contexts where State institutions were already fragile before the pandemic, where inter-ministerial collaboration was difficult and where response-coordinating bodies lacked the necessary pan-governmental representation. Prisoner’s rights to health, and prisons’ critical role in pandemic control, were neither duly considered nor addressed.

### **The Way Forward**

As repeatedly stated by WHO since the start of the COVID-19 pandemic, gaining control of COVID-19 and thereby reducing its global morbidity and mortality requires unity and solidarity. This applies not only between countries, but just as importantly within them, and across all sectors of society – including people in prisons. Equity in terms of access to health care services is a basic human right, and in today’s globalized world, where a freak mutation and/or overspill event can spread to virtually every nation and result in close to 30 million cases and 1 million deaths in under a year, it is also necessary for our collective survival. The necessary resources required for effective COVID-19 prevention, response and control, including those needed to assure safe quarantine and medical isolation, must be available to all. Prison management of contacts and suspected or confirmed COVID-19 cases must be fully aligned with those of the national COVID-19 response, and close collaboration with, and support from, the national health authorities must be assured. Greater availability of quality diagnostic tools is needed. Better prevention and treatment options are eagerly awaited, and once developed and duly validated, their accessibility to all must be assured. Innovation is needed to devise processes that respect the key principles of outbreak control and case management, even in challenging environments such as prisons. In the meantime, ignoring prisons is not an option: the ICRC will continue to support prison and health authorities to promote the dignity and wellbeing of all people deprived of freedom.

## Use of Solitary Confinement to Prevent the Spread of COVID-19 in Norwegian Prisons

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***In the early days of the pandemic, the Parliamentary Ombudsman initiated an investigation into the safeguarding of inmates in Norwegian prisons following the outbreak of the COVID-19 pandemic. This article presents the key findings regarding the use of solitary confinement as a measure to prevent the spread of COVID-19 in prisons. It also discusses the balance between infection control and human rights.***

In Norway, a national pandemic response was put in place by the Government on March 12, which resulted in restrictions in the everyday lives of most citizens. In places of detention, such as prisons, the pandemic outbreak created particularly difficult challenges.

Inmates in prison generally have a higher morbidity rate than the rest of the population. This, in combination with other risk-factors, may present a risk of severe course of illness from the Coronavirus. Conditions in several prisons may also involve a higher risk of infection, due to e.g. poor sanitary facilities and overcrowded common areas. In addition, persons deprived of their liberty are especially at risk of having their human rights violated due to measures implemented to combat the pandemic.

The pandemic created unprecedented challenges for the Prison Authorities. On the one hand, the state has a duty to implement measures to protect the lives and health of prison inmates. On the other hand, all measures that constitute an interference with the inmates'

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human rights, including infection control measures, must have a legal basis, and satisfy fundamental requirements of necessity and proportionality.

### **The Parliamentary Ombudsman's Investigation**



In the early phase of the pandemic, the Norwegian Correctional Services implemented several measures to prevent the spread of Covid-19 in prisons. The number of inmates was reduced by measures such as early release and suspended detention. This made it possible to avoid inmates sharing cells; it also made it easier to maintain physical distancing

and to safeguard hygiene requirements. This was most likely vital to the success of preventing major outbreaks of infection in prisons.

However, the Correctional Services also introduced severe restrictions on the daily lives of inmates as part of the effort to prevent the spread of the Coronavirus: activities, work and education programs were discontinued or reduced considerably, and all physical family visits were stopped. The most intrusive measure was a nationwide prison policy which entailed the use of solitary confinement for quarantine purposes. Shortly after the introduction of these measures, the Parliamentary Ombudsman initiated an investigation into the safeguarding of inmates following the pandemic outbreak.

### **An Adjusted Methodology Due to the Pandemic**

The Parliamentary Ombudsman's Office regularly visits places of detention in Norway, in order to fulfil its mandate as National Preventive Mechanism under the UN's *Optional Protocol to the Convention Against Torture*. As a result of the pandemic, the Ombudsman had suspended its in-person visits to avoid exposing anyone to the risk of infection. This made it necessary to base the investigation on other sources than observations, private interviews and on-site reviews of documents.

The revised methodology

included a survey to a selection of inmates in four prisons, written correspondence with the responsible Ministries and Directorates, phone interviews with prison management in

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ten prisons and the chairs of Norway's five Supervisory Boards of prisons, as well as written information obtained from Prison Healthcare Services in eight prisons. We also received input from members of the Parliamentary Ombudsman's Advisory Committee and other relevant stakeholders.

The investigation focused on the infection control measures that were implemented by the authorities, and the consequences of those for the inmates in a selection of prisons. The purpose of the investigation was to provide advice to the authorities to reduce the risk of inhuman and degrading treatment associated with the management of a potential new pandemic outbreak. The investigation is based on information obtained concerning the period between 12 March to 14 May 2020. The full report can be accessed [here](#).

### **Solitary Confinement as a Quarantine Measure in Prison**

On 3 April the Directorate of Norwegian Correctional Service issued a Circular that introduced a strict infection control regime for all prisons in Norway. The Directorate argued that the only way to implement the Health Authorities' general guidelines on quarantine and medical isolation in a prison setting was to "exclude" inmates from the company of others. The Ombudsman had serious concerns regarding the criteria for the use of quarantine and its manner of implementation.

According to the Directorate, the target group for quarantine included not only those inmates who would have been placed in quarantine at home if they had not been in prison, due to e.g. symptoms or travel to affected countries, but *all newly arrived inmates regardless of medical criteria*. Moreover, a quarantine would – as a rule – involve full exclusion from the company of others for 14 days. 'Full exclusion' means that the inmates would be subjected to solitary confinement, as they would be locked-up alone inside their cell for 23-hours (with 1-hour of outdoor exercise).

The Ombudsman's investigation indicated that a high number of inmates were subjected to this very intrusive form of quarantine. Statistics from the Correctional Service showed that, as of 30 April, more than 70% of all ongoing 'full exclusions' was due to COVID-19. A national count performed in late April by the Correctional Service found the highest number of inmates in solitary confinement since 2015. Among the 50 respondents to the Ombudsman's survey who stated that they had been in solitary confinement for infection control purposes, about 60% answered that they had been placed in quarantine upon arrival in prison.



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### **Lack of Legal Basis**

In the Circular, the Directorate referred to the Execution of Sentences Act Section 37, first paragraph (e) as the legal basis for implementing quarantine and medical isolation in connection with the pandemic. This provision allows correctional services to determine that an inmate should be wholly or partly excluded from the company of other inmates, if this is necessary in order to maintain “peace, order and security”. The Ombudsman concluded that the paragraph in question did not provide sufficient legal basis for solitary confinement justified by considerations of infection control. The legislature had intended that the provision only be used when it was based on an individual assessment of the inmates’ behaviour and not as a general measure of infection control.

At the same time, the Ombudsman recognised the importance of rules regulating when and how quarantine and medical isolation may be imposed in prisons. In the Ombudsman’s opinion, a legal basis for intrusive infection control measures in prison must be clarified by legislature. Given the intrusive nature of the measures, a Circular from the Directorate of the Norwegian Correctional Service is not a satisfactory legal basis. In the Ombudsman’s opinion, clarifications were needed to determine whether the Ministry of Justice and Public Security or the Ministry of Health and Care Services should have the primary responsibility for making changes to the rules concerning intrusive measures that are justified on the basis of infection control (in Norway, the Prison Health Care Services are imported from the municipalities, and organised independently of the Correctional Services).

### **Insufficient Evaluation of Less Intrusive Measures**

There was no doubt that the purpose of the quarantine, to protect the health of inmates, was legitimate. However, a basic prerequisite for measures such as solitary confinement to be considered necessary is the absence of less intrusive measures that could safeguard the same objective.

The Directorate of Norwegian Correctional Service established no clear guidelines on how to avoid solitary confinement for quarantined inmates, other than that “minimum human contact should be facilitated every day”. The lack of consideration of less intrusive measures appears to have resulted in widespread use of long-term solitary confinement.



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The Ombudsman found that this is not consistent with human rights requirements stating that measures amounting to solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible.

### **Health Screening and Testing as an Alternative to Solitary Confinement**

Both the UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) and the World Health Organisation (WHO) recommend avoiding infection control measures that involve solitary confinement, where the inmates spend more than 22-hours alone in their cells per day without meaningful human contact. A less intrusive infection control measure, which would be a relevant alternative to routine solitary confinement, is the implementation of health screening, combined with testing of inmates.

Even under normal circumstances, the health of new inmates should be assessed as soon as possible, through an intake interview and medical examination. In its [Interim Guidance on the Management of COVID-19 in Prisons](#), the WHO recommended that all inmates should be checked for fever and lower respiratory symptoms upon arrival in prison. Only if an inmate has symptoms of, or if they were previously diagnosed with COVID-19 and continue to experience symptoms, WHO recommends placing the inmate in medical isolation while awaiting a medical examination and testing.

The Ombudsman's investigation found that the Directorate of Norwegian Correctional Service requested the opportunity to test all new inmates to reduce the risk of infection and to avoid the use of routine solitary confinement in their dialogue with the Health Authorities. However, the Health Authorities would not prioritise testing of asymptomatic individuals beyond a few specifically defined groups, such as patients in nursing homes. The lack of testing opportunities was the main reason that the Directorate of Norwegian Correctional Service gave when it deemed it necessary to routinely subject all newly arrived inmates to solitary confinement.

However, the Ombudsman learned that the Directorate of Health upon request had advised against such a strict quarantine measure unless the inmate had symptoms of respiratory infection, or there were reasons to suspect that the inmate had otherwise been exposed to the Coronavirus. Instead, the Directorate of Health recommended that all inmates be screened upon arrival by the Prison Healthcare Services for symptoms, possible close contact, and travel.

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It was, therefore, the decision of the Directorate of Norwegian Correctional Service to routinely subject all newly arrived inmates to solitary confinement as a quarantine measure. This decision was a result of the Correctional Services' concern regarding the low capacity in the Prison Healthcare Services and lack of opportunities for systematic testing.

### **Insufficient Attention to the Harms of Solitary Confinement**

The Ombudsman found that the Prison authorities did not pay enough attention to the harms of solitary confinement.

When determining whether to implement intrusive infection control measures, it is necessary to balance the interests the measure is designed to protect, and the potential harm caused by the measure. While the imposition of routine long-term solitary confinement for all inmates upon arrival has likely contributed to the prevention of COVID-19 in prisons, it has also caused distress and other harmful health consequences for many inmates.

Of course, the measures imposed by the authorities must be seen in context of the acute nature of the pandemic and the lack of knowledge on symptoms, transmission and health-risks, at least in the very early phase of the pandemic.

Nevertheless, the implications of the Circular were that all new inmates had to spend more than 22-hours alone in their cells each day, without meaningful human contact. Long-term isolation, especially if lasting 14 days, involves a high risk of inhuman treatment. The Ombudsman pointed out that solitary confinement that extends for more than 15-days shall be prohibited by the Mandela rules.

Several inmates who participated in the survey had experienced 14-days of solitary confinement upon arrival as distressing. Newly arrived inmates on remand are in a particularly vulnerable situation. They have an increased risk of suicide, which could be exacerbated by solitary confinement. Young age and mental disabilities may further worsen the harmful consequences. It is concerning that the Circular made no exceptions for inmates in situations of vulnerability.

The Committee on the Prevention of Torture (CPT) and SPT have recommended that necessary restrictions introduced as a result of COVID-19 must be compensated by measures to reduce the detrimental effects of isolation, partly by ensuring meaningful human contact for inmates, and other opportunities to maintain contact with family and

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friends. Furthermore, basic needs must be safeguarded, especially by ensuring inmates' daily outdoor time of at least one-hour and the opportunity to maintain personal hygiene.

Although the Directorate of Norwegian Correctional Service's Circular, to a certain extent, accommodated the recommendations of the committees through opportunities for video-calls and increased phone time, our findings suggest that compensatory measures were limited or were initiated late in the period covered by the survey. In our survey, only 58% and 50% of inmates who stated that they had been in solitary confinement answered 'yes' to the questions of whether they had been offered extra phone time or had access to video calls, respectively. Only a third of the inmates who had been in solitary confinement reported that they had been offered new or extra activities to compensate for the suspension of ordinary visits and other restrictions. Findings from the study also indicate that isolated inmates have had less access to compensatory measures, such as outdoor exercise, than other inmates.

### **Conclusion**

The Ombudsman's investigation found that the Prison Authorities lacked a legal basis for introducing solitary confinement as an infection control measure, at least beyond a brief transitional period. The Ombudsman further concluded that the imposition of solitary confinement as a quarantine measure for all newly arrived inmates did not comply with the requirements of necessity and proportionality.

In the Ombudsman's view, the responsible authorities have not adequately assessed whether less intrusive alternatives to solitary confinement could have attained the same objective. It was particularly concerning that solitary confinement was introduced despite advice to the contrary from the Health Authorities.

From 18 May, the Correctional Service eased the use of solitary confinement as a quarantine measure. The purpose was to avoid isolation that was not strictly necessary, and instead performed individual assessments based on medical criteria. This new practice is far more consistent with the human rights requirement of necessity.

Based on the findings, the Ombudsman called for rules for the implementation of infection control measures that would be better tailored to the situation of inmates in prison. This includes rules governing when measures such as quarantine and medical isolation can be implemented and how the measures should be executed in a prison.

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In this context, the Ombudsman stressed the need for a close cooperation between Correctional services and Health Authorities. This is important in order to ensure that the infection control measures, as used among the general population, are based on sound medical criteria and with appropriate legal safeguards. In particular, the regulations should ensure that infection control measures are in accordance with the human rights requirements of necessity and proportionality.

# A Delicate Balance: Monitoring Medical Isolation and Quarantine in New South Wales Custodial Centres

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**Inspector Fiona Rafter**

The Inspector of Custodial Services (ICS) provides independent scrutiny of the conditions, treatment and outcomes for adults and young people in custody. The [Inspector of Custodial Services Act 2012 \(NSW\)](#) outlines the functions of the Inspector and provides that the Inspector must inspect each custodial centre once every five years and every youth justice centre once every three years. The Inspector reports directly to the New South Wales (NSW) Parliament. The Inspector also oversees the Official Visitor Program in NSW.<sup>2</sup>

As of August 2020, the NSW custodial system consisted of 36 correctional centres and six youth justice centres, as well as a number of residential facilities, court cell complexes and transport vehicles, all of which fall within the jurisdiction of the Inspector. These custodial centres are located across rural, regional and metropolitan NSW.

At the time of writing, NSW authorities were working to control several small outbreaks of COVID-19 in the community. According to the [NSW Department of Health](#), on 14 September 2020 there were 149 active COVID-19 cases in NSW. Although there have been several cases of COVID-19 among staff who work in NSW custodial centres, these do not

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<sup>2</sup> There are 98 Official Visitor appointments to custodial facilities in NSW.

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appear to have led to an outbreak of COVID-19 within the custodial system. As of 14 September 2020, one prisoner tested positive for COVID-19 after entering custody in NSW.

Since March 2020, all prisoners, staff and visitors entering a custodial centre are screened by way of temperature checks and a questionnaire. Screening is particularly important in court cell locations as this is often a person's first point of contact with the custodial system. If a person is identified through screening as having any COVID-19 risk markers, a range of infection prevention and control measures are triggered to reduce the risk of transmission until any COVID-19 infection is confirmed. This screening process identified the above mentioned prisoner, who subsequently tested positive to COVID-19, as high risk despite not presenting with symptoms. The prisoner was isolated and additional personal protective equipment was used to reduce risks to other prisoners and staff.

### **Quarantine and Medical Isolation in NSW Custodial Centres**

Quarantine and medical isolation measures have been employed alongside screening since April 2020 to reduce the risk of COVID-19 transmission in custodial environments. All persons newly received into the custody of correctional authorities in NSW are subject to 14 days of quarantine in a designated area within their first correctional centre placement. In May 2020, NSW Health also introduced sentinel testing for all persons entering custody, which is administered during quarantine.<sup>3</sup>

The quarantine of newly received prisoners is managed and determined by custodial authorities. Persons subject to quarantine are effectively separated from the rest of the prisoner population. They are not permitted to mix outside of the cohort of people they were received with until the 14-day period has expired. In the busiest remand and reception centres, this can result in 14 (or potentially more) different quarantine cohorts. The relevant health provider provides daily review of prisoners and input on clearance of the prisoner for entry to the general population. While quarantined prisoners are held separately, they should be subject to the same routine with the same services and programs available as if they were not subject to quarantine. Currently 11 out of the 36 correctional centres in NSW are designated as reception sites and are operating this quarantine regime. During the 14-day quarantine, prisoners cannot be transferred to

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<sup>3</sup> Sentinel testing involves the systematic testing of persons, rather than targeted (and potentially biased) testing around geographical hotspots or in response to the presentation of symptoms. Sentinel testing of people coming into custody provides insight into community transmission rates while at the same time reducing risk of COVID-19 transmission in NSW custodial settings.

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another facility unless they test positive for COVID-19 and require transfer to a COVID-19 isolation hub or hospital.

The medical isolation of a person in NSW custody is a clinical decision that is triggered by the presence of key signs or symptoms of COVID-19 or by a positive match with specific criteria published by the correctional health authority. Until a clearance is confirmed by specialist population health staff, a prisoner remains in isolation. A test for COVID-19 is administered and a daily clinical review is conducted by health staff during isolation. Contact between the isolated prisoner and staff members is minimised and requires the employment of specific infection prevention and control measures. If a prisoner is confirmed to have COVID-19, they are transferred to a designated 'isolation hub' (located at 13 correctional centres around NSW) to be managed in medical isolation until clearance by population health clinicians.

### **ICS Focus on Quarantine and Medical Isolation**

The quarantine of newly received prisoners and the medical isolation of those suspected or confirmed as having COVID-19 are accepted as important measures to protect the health of prisoners and staff. It is well-established that there is an increased risk of transmission in environments like custodial centres where physical distancing is difficult to maintain. The prisoner population in NSW also consists of significant numbers of people at [higher risk](#) of developing serious illness due to COVID-19, which includes people aged 70 years and older; people with [chronic medical conditions](#), particularly those aged 65 years and over; people with compromised immune systems; and Aboriginal and Torres Strait Islander people aged 50 years and older with one or more chronic medical conditions. Reducing the opportunities for COVID-19 to enter the custodial environment minimises the risk of transmission and serious illness.

However, with these measures come curtailment of some rights and freedoms of individuals in custody. Prisoners in quarantine should have access to medical care and be able to have time out of their cell to mix with their quarantine cohort, exercise and maintain telephone contact with family or legal representatives. Although quarantined prisoners do not have access to programs, education and employment and other services until the end of the 14-day quarantine period, efforts should be made to keep prisoners occupied and mitigate mental health risks associated with loneliness.

Prisoners in medical isolation face increased restrictions on access to family contact and social interaction with staff and other prisoners in custody, withdrawal from programs,

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education and employment, potential stigma associated with the illness, anxiety associated with their ill health, reduced access (if any) to time outside of their cells. Medical isolation should be for a period required to confirm whether an individual is positive for COVID-19. At the time of writing this was generally taking around one to two days in NSW. Extended periods of medical isolation may occur if an individual tests positive to COVID-19 and measures will need to be implemented to mitigate any deleterious effects of this experience.

Accordingly, a primary focus of the ICS since the introduction of these measures has been to monitor the effectiveness of their operation and to scrutinise the conditions for those subject to the regimes.

Initial work was undertaken to develop best practice guidance on the elements of effective quarantine and medical isolation frameworks that mitigate the risks of COVID-19 in a custodial system as well as the risks of collateral harms arising from restrictive isolation regimes. We scanned and collated expertise from a range of resources published by the [World Health Organisation](#), the [Communicable Diseases Network Australia](#), the [European Centre for Disease Prevention and Control](#), and the [Centers for Disease Control and Prevention](#). We compared these against the policies, procedures and protocols that NSW correctional and correctional health authorities shared with us and were able to offer targeted guidance, particularly around gaps and potential risks of harms concerning prisoner treatment and conditions.

We have established regular communication channels with both adult and youth correctional and health authorities that have enabled us to remain abreast of any changes in custodial settings. At the same time we have continued to engage with people in custody by maintaining the Official Visitor Program, introducing a dedicated free call line to ICS from custodial centres and via a program of on-site monitoring visits to locations operating quarantine and medical isolation regimes. This work is continuing.

### **Challenges of Quarantine and Medical Isolation**

As there is considerable variability in the facilities, locations and prisoner populations across the custodial system, achieving consistency can be challenging, particularly with respect to the range of measures for quarantine and medical isolation that have demanded prompt implementation.



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Addressing the threat of COVID-19 in custodial environments and the implementation of quarantine and medical isolation measures has required capacity building among staff. COVID-19 is a new disease and research regarding its spread and symptoms is rapidly evolving. For non-medical staff, as for most of us who are not medical professionals, this pandemic has required us to learn about infection prevention and control strategies and the proper use of personal protective equipment. Creating this staff capacity however is only part of the challenge. Ensuring consistency and vigilance in relation to screening, quarantine and medical isolation and related processes will continue to be of critical importance as one infected person can quickly become many.

In NSW, health services in custodial settings are not provided by custodial authorities, but by a separate state health service or a community provider in privately operated custodial centres. This has created an imperative for increased collaboration and communication to ensure accessible, actionable and current advice about COVID-19 and the associated measures, including those that require a different approach to custodial processes for health and custodial staff, and those that encroach on the conditions and wellbeing of people in custody.

In an oversight role, we have considered whether people in custody who are subject to quarantine and isolation regimes are provided with a clear and transparent explanation about the criteria for these regimes, the conditions for management under these regimes and how they will progress out of them. We have also been monitoring the understanding of staff about the clinical need for these restrictive regimes, and the implementation of associated infection prevention and control measures in the management of these regimes.

The rapid introduction of a suite of new protocols around personal hygiene, environmental cleaning and the use of personal protective equipment has presented challenges for consistent implementation across a large custodial system. The local implementation of these measures has been a focus of our monitoring since April, and we have been able to provide feedback and guidance about operational practices at particular sites that require attention and support to better protect the safety and wellbeing of people in custody and staff in custodial settings. In particular, following a period of heightened awareness between March and May 2020, we observed some 'COVID-19 fatigue' within parts of the system. This appears to have been addressed but requires ongoing vigilance and monitoring by custodial authorities and ICS.

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One of the most significant challenges we have observed across the system is managing the quarantine cohorts in a way that does not lead to individuals being effectively isolated for 14-days. Prisoners requiring protection or with association issues who cannot safely interact with prisoners in their quarantine cohort may only have limited contact with other people during quarantine. This can result in reduced time out of cell for all quarantined prisoners as facilities try to manage the needs of multiple groups that need to be separated. This requires careful planning to maximise the number of separate areas that can be used by different cohorts and ongoing monitoring of time out of cell to reduce the impact on prisoner mental health. The availability of quality mental health and psychosocial support is an important feature of any custodial environment, but for those subject to quarantine or medical isolation where the regime can significantly exacerbate anxiety and distress, it is vital.

The style of custodial facilities greatly varies across the NSW custodial system and this can be a challenge for ensuring prisoners in quarantine and medical isolation are held in suitable accommodation. Different infrastructure can impact the level of amenity for prisoners in quarantine or medical isolation. For example, some cells built in the 1800s are small, poorly ventilated and do not have showers. By way of contrast, the quarantine areas at Parklea, Clarence and Mid-North Coast Correctional Centres are new contemporary correctional facilities opened in 2020.

Hunter Correctional Centre is not a designated quarantine or isolation hub. It is one of two dormitory-style prisons in NSW and holds a large proportion of prisoners considered to be at higher risk of developing serious illness due to COVID-19. Consequently, it was identified as a high-risk location for an outbreak of COVID-19 and the decision was made to protect prisoners in high risk groups by separating them from other prisoners except for those held in the same dormitory. Up to 100 prisoners identified as vulnerable were moved into the same block consisting of four dormitories, each of which can hold up to 25 people. Each dormitory includes two telephones, eight private bathrooms, and a kitchenette. Each prisoner has a cubicle containing a single bed, television, desk and storage. Prisoners can access exercise yards adjoining the dormitories from around 6am to 10pm.

Strategies were put in place to minimise their face-to-face contact with staff by using the Public Address (PA) and intercom systems for communicating where possible, and electronic surveillance for monitoring prisoner safety. Attempts were also made to separate the custodial staff working on this block from other staff as much as possible.

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Where a prisoner in this block needs to attend the health clinic, they are given priority and no other prisoners are allowed in the health centre at that time. Additional art and craft materials, books and games were provided in the dormitories and exclusive access to social visits via Audio Visual Link (AVL) on Sundays to reduce the potential for outside contact. This arrangement for separating these particularly vulnerable prisoners would not have been tolerable without measures aimed to mitigate the impacts and maintain a level of prisoner amenity and wellbeing.

The increased use of AVL and the introduction of tablets for visiting families and friends has been welcomed across the NSW custodial system and has allowed prisoners greater access to families located abroad, interstate or in other parts of NSW. This is an important development and we support the continued use and expansion of this technology to facilitate family contact and reintegration, as well as the reintroduction of in-person visits as soon as it is safe to do so, and use of compassionate in-person visits in the interim.

While preventing and containing the spread of COVID-19 in custodial facilities is of the utmost importance, this needs to be done in a way that respects the human rights, needs and dignity of prisoners. Where these concerns come into competition, such as in relation to the suspension of in-person visits from family and friends, finding a workable compromise is a delicate balancing act that requires continual refinement as circumstances change. However, without a vaccine for COVID-19 strategies for preventing and containing its spread in custodial facilities will need to remain in place and, therefore, must be sustainable and humane.

## Solitary Confinement and COVID-19 in Argentine Prisons

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**By Procuración Penitenciaria de la Nación Argentina.**

*Prisoners Ombudsman's Office, Argentina.*

*Note: This article was translated from Spanish. We extend our sincerest gratitude to Dr. Leticia Gutierrez for volunteering her time to conduct this translation. For the original, please email: [Emad.Talisman@OCI-BEC.gc.ca](mailto:Emad.Talisman@OCI-BEC.gc.ca)*

In July of this year, the Inter-American Commission on Human Rights (IACHR); the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Nils Melzer (herein referred to as, Special Rapporteur on Torture); the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras (herein referred to as, Special Rapporteur on the Right to Health); and the Regional Representative for the Office of the UN High Commissioner for Human Rights (herein referred to as, Regional Representative), asked the Argentine State to account for the serious situation denounced by Procuración Penitenciaria de la Nación (PPN) regarding prisoners subjected to a prolonged and indefinite isolation regime by reason of COVID-19.

At the same time that PPN was promptly issuing its warning, the Federal Oral Criminal Court No. 5 of San Martín (hereinafter, TOF 5) rejected the requests of detainees belonging to the group at-risk of contracting COVID-19 for house arrest, and ordered compulsory isolation measures in solitary confinement for an indefinite period of time for those same detainees. Said isolation ordered by TOF 5 was not identified in the health regulations issued by the national government or in the protocols on COVID implemented by the Federal Penitentiary Service (SPF), much less for the conditions and long periods of isolation that were permitted. These detainees were being held in solitary confinement in individual cells for 23-hours per day. They were under such conditions between 60 to 95 days. Likewise, TOF 5 ordered that this solitary confinement be implemented indefinitely: during the “period that the pandemic crisis lasts”.

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According to the standards of international human rights law, prolonged and indefinite isolation of prisoners amounts to an act of torture or, at the very least, to cruel, inhuman or degrading treatment or punishment.

Given the seriousness of the situation forewarned by the PPN, from that moment on, multiple interventions were made before the Argentine Justice in order to reverse the measures established by the TOF 5. However, the claims in favor of these people were disregarded by the Argentine Justice. Under these conditions, the PPN decided to report the situation to the IACHR and the UN.

**The Mandela Rules<sup>4</sup> prohibit the indefinite and prolonged isolation of persons deprived of their liberty.** Isolation is understood to be confinement for 22-hours a day without meaningful human contact. Likewise, “solitary confinement for a time period in excess of 15 consecutive days” is considered prolonged (Rules 43, 44 and 45). Indefinite isolation is one that lacks a specified period of duration (“while the pandemic lasts”). The former Special Rapporteur on Torture, Juan Mendez, pointed out that **being subjected to a prolonged or indefinite isolation regime amounts to cruel, inhuman or degrading treatment or punishment, or may even constitute a case of torture.** In this sense, the former Rapporteur on Torture specified:

“Individuals subjected to either of these practices [of prolonged or indefinite isolation] are in a sense in a prison within a prison and thus suffer an extreme form of anxiety and exclusion, which clearly supersede normal imprisonment. Owing to their isolation, prisoners held in prolonged or indefinite solitary confinement can easily slip out of sight of justice, and safeguarding their rights is therefore often difficult, even in States where there is a strong adherence to rule of law.”<sup>5</sup>

The former Rapporteur on Torture adds that:

“Long periods of isolation do not aid the A/66/268 11-44570 21 rehabilitation or re-socialization of detainees (E/CN.4/2006/6/Add.4, para. 48). **The adverse acute and latent psychological and physiological effects of prolonged solitary confinement constitute severe mental pain or suffering.** Thus the **Special**

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<sup>4</sup> UN, "Standard Minimum Rules for the Treatment of Prisoners" of 1955, revised and updated through the approval of the "Mandela Rules" (UN Resolution 70/175, of December 17, 2015).

<sup>5</sup> [UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 5 Aug. 2011, A/66/268. Page 16-17, paragraph 57.](#) Accessed: 25 September 2020.

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**Rapporteur concurs with the position taken by the Committee against Torture in its General Comment No. 20 that prolonged solitary confinement amounts to acts prohibited by article 7 of the Covenant, and consequently to an act as defined in article 1 or article 16 of the Convention. For these reasons, the Special Rapporteur reiterates that, in his view, any imposition of solitary confinement beyond 15 days constitutes torture or cruel, inhuman or degrading treatment or punishment, depending on the circumstances. He calls on the international community to agree to such a standard and to impose an absolute prohibition on solitary confinement exceeding 15 consecutive days.”<sup>6</sup> (Emphasis added).**

The prohibition of torture has a special status in international law, as it is considered a *jus cogens* rule; that is, an “imperative norm” of general international law<sup>7</sup>. This prohibition is absolute because it is imposed anywhere and at all times, both in times of peace and in times of war. No circumstance, no matter how exceptional it may be, or a state of war, internal political instability, or any other state of emergency, can ever serve as justification for mistreating detainees.

Likewise, the Committee against Torture considers the obligation to prevent torture in article 2 of the Convention Against Torture to be “wide-ranging.” The Committee states:

“The obligations to prevent torture and other cruel, inhuman or degrading treatment or punishment ... under article 16, paragraph 1, are indivisible, interdependent and interrelated.”<sup>8</sup>

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<sup>6</sup> *Ibid*, page 20, paragraph 76.

<sup>7</sup> Cf. Human Rights Committee, General Comment 24 (52), [General Comment on issues related to the reservations made on the occasion of the ratification of the Agreement or its Optional Protocols, or of accession to them, or in relation to the Declarations made in accordance with article 41 of the Covenant, UN Doc. CCPR/C/21/Rev.1/Add.6 \(1994\), paragraph 10](#). See also, International Criminal Tribunal for the former Yugoslavia, Prosecutor against Delalic and Others, Case IT-96-21-T, Judgment of November 16, 1998, para. 452, 454; Prosecutor against Furundzija, Case IT-95-17 / 1-T, Judgment of December 10, 1998, paragraphs 139 and 143; Prosecutor against Kunarac and Others, Case IT-96-23-T & IT-96-23 / I-T, paragraph 466.

<sup>8</sup> Committee against Torture, [General Comment No. 2. Application of article 2 by States parties. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, January 24, 2008, CAT/C/GC/2, paragraph 3](#). Accessed: 27 September 2020.

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**The absolute and imperative nature of the prohibition of torture and ill-treatment prevents any State from invoking exceptional circumstances, such as the Coronavirus pandemic (COVID 19) or any other public emergency, to justify acts of this nature in the territory that is under its jurisdiction<sup>9</sup>. On the contrary, once this situation has been verified, the State must immediately cease such practices, whatever the context in which they are carried out.**

On July 8, 2020, the Regional Representative sent a note to the Minister of Justice and Human Rights of the Nation, expressing his concern about the case reported by the PPN. In particular, Mr. Jan Jařab requested *“the adoption of the necessary measures of an urgent nature to guarantee the personal, physical and mental integrity, the dignified treatment and the health of the people deprived of their liberty who are under an isolation regime, ensure that the conditions in which these people are currently detained conform to international human rights standards and are immediately provided with adequate conditions of detention, food, recreation, contact with their families and advocates, and medical care in accordance with the pathologies from which they suffer”*. Likewise, the Regional Representative requested a meeting with the Minister of Justice to personally discuss the matter. This meeting was held Tuesday July 21.

As of the aforementioned mediation of the Regional Representative, on July 15, 2020, the Inspector of the National Directorate of the Federal Penitentiary Service, María Laura Garrigos, asked the TOF 5 judges to order *“the cessation of the measure [isolation] ordered in a timely manner, and that the authorities of the aforementioned complexes [of Ezeiza and Marcos Paz] reassign the accommodation of the aforementioned inmates in the corresponding sectors according to their personal characteristics, criminological profile, risks and needs”*. In this note, the FPS Inspector stressed that *“the measure ordered would imply a potential worsening of the detention conditions of the aforementioned inmates, a circumstance that cannot be maintained over time.”*

Faced with the inexplicable lack of response from the TOF 5 judges, on July 17, Inspector Garrigos sent new communication to that court informing it that, in relation to what was stated by the Regional Representative, Jan Jarab, *“and based on the constitutional mandates of respect for the fundamental rights of all persons deprived of their liberty within the framework of the international norms in the matter that guarantees the [FPS], it is*

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<sup>9</sup> *Ibid*, paragraph 5.



## MEDICAL ISOLATION DURING COVID-19

*impossible to prolong the isolation beyond the necessary periods. Due to the issues at hand, it was determined to relocate the inmates to other wards, preserving the health measures”.*

From that moment and during the following days, the FPS was implementing the cessation of isolation arbitrarily provided by TOF 5. This FPS measure not only benefited the eight detainees covered by the urgent appeal requested by the PPN but also other detainees who were in the same situation, also by order of the TOF 5.

On July 29, 2020, the Special Rapporteur on Torture and the Special Rapporteur on the Right to Health sent a joint communication to the Argentine State requesting urgent attention to the complaint presented by PPN. In said communication, both rapporteurs stated:

“We express our greatest concern over the aforementioned allegations that order indefinite solitary confinement as an emergency measure in response to the COVID-19 pandemic, since prolonged or indefinite solitary confinement goes against the absolute prohibition of torture and other cruel, inhuman or degrading treatment or punishment (A/66/268)”.

Moreover, the special rapporteurs emphasized that *“measures to combat the pandemic in places of deprivation of liberty must be taken in full knowledge of the principles of ‘do no harm’ and ‘equivalence of care’, in light of the prohibition of torture and ill-treatment, and the right to enjoy the highest possible level of physical and mental health provided for in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)”.*

In addition to requesting updated information on the events denounced by the PPN, both rapporteurs urged the Argentine State, *“to adopt all the necessary measures to protect the rights and freedoms of the aforementioned persons and to investigate, prosecute and impose appropriate sanctions on any person responsible for the alleged violations”.* They also urged the Argentine State, *“to take effective measures to prevent such events, if they occurred, from being repeated.”*

On July 30, 2020, the IACHR sent a note to the Argentine State for the purpose of submitting information regarding the situation denounced by the PPN, and within the framework of the request the PPN made for precautionary measures.



## Technical Briefing on the Use of Medical Isolation in Federal Prisons during COVID-19: The Canadian Experience

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**By Dr. Ivan Zinger (JD, PhD)**

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**Emad Talisman (MA)**

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In mid-July 2020, in the midst of the global COVID-19 pandemic, Canada’s federal prison service provisionally issued policy instruction on Medical Isolation and Modified Routine *before* consulting with stakeholders. Upon review of this provisional policy, the Office of the Correctional Investigator (OCI) raised a significant issue: the way in which the Correctional Service of Canada (CSC) defined and operationalized the term “Medical Isolation” had the potential to violate basic human rights standards, such as the right to be free from arbitrary or unlawful deprivation of liberty.

In summary, CSC’s operational definition for Medical Isolation appears to extend this practice to all individuals entering prison facilities, regardless of whether they are symptomatic or not. Case in point, at the time of writing this article (September 22, 2020), there were 376 federal inmates in Medical Isolation despite the fact that federal prisons are currently reporting no active cases. As reported in [its second COVID-19 update on June 19, 2020](#), the OCI has reason to be concerned about the conditions of confinement (e.g., reports of near total cellular confinement and the denial of fresh air exercise) imposed on both symptomatic and asymptomatic individuals in federal prisons.

The issues surrounding the use of Medical Isolation were anticipated by the Office in its [first COVID-19 update during the early days](#) of the pandemic. In response to the implementation of these extraordinary policy measures, the OCI referenced a recent briefing prepared by medical professionals from AMEND at the University of California,

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San Francisco, titled [\*The Ethical Use of Medical Isolation – Not Solitary Confinement – to Reduce COVID-19 Transmission in Correctional Settings\*](#) (Cloud, Augustine, Ahalt, & Williams, 2020). In this briefing, the authors provide the following definitions (*emphasis added*):

- **Quarantine:** the practice of separating and restricting the movement of people who *may have been exposed* to a contagious disease until results of a laboratory test confirm whether or not they have contracted the disease. These individuals may have been exposed to COVID19, for example, by spending prolonged time in close proximity to someone who has tested positive, or they may have early symptoms of a potential COVID-19 infection.
- **Medical Isolation:** the practice of isolating incarcerated people from the rest of the prison population *when they show signs or test positive for COVID-19* in order to stem the risk of COVID-19 transmission throughout the prison.

The Centers for Disease Control and Prevention (CDC) in the United States employ [similar definitions](#).

The OCI assessed the measures and criteria for making the decision to medically isolate individuals entering federal prisons as contrary to the above definitions, and a potential breach of the statutory requirement to use the least restrictive measure. The criteria in question are:

- a. An inmate admitted with a new warrant of committal or being returned to custody following suspension or revocation;
- b. An inmate who has symptoms of COVID-19;
- c. An inmate who is diagnosed with COVID-19 (laboratory or clinical diagnosis);
- d. An inmate who has been in close contact with other persons that have symptoms of, or a diagnosis of, COVID-19;
- e. An inmate transferring from an outbreak institution;
- f. An inmate transferring from an institution in an area with elevated community transmission; and,
- g. An inmate interregionally transferring to a province with a mandated medical isolation for those travelling from out of province.

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Unless the correctional service intended on using the term “medical isolation” synonymously with “quarantine” and/or “self-isolation”, the Office was of the view that this practice is far too restrictive for uniform application across all intended categories.

In fact, subsection (g) of the listed criteria suggests that the term Medical Isolation is being used interchangeably with self-isolation. However, Canadian provinces have not implemented a requirement for Medical Isolation for those travelling from out of province. Some provinces (for example, those in Atlantic Canada’s “Bubble”) require that travellers entering the province *self-isolate* for 14-days, regardless of whether the traveller is a potential vector of transmission or not. This is, strictly speaking, not the same as Medical Isolation.

Based on this information, the Office recommended that both policy and practice be revised to distinguish between Medical Isolation, which should apply only to those who test positive or show signs for COVID-19, and Quarantine, which applies to persons who *may have been* exposed to COVID-19. In both cases, the OCI recommended prompt laboratory testing, and for prisoners to enter the general inmate population *as soon as they received* medical clearance.

The Office understands the need for temporary restrictive cellular confinement until laboratory results (or medical clearance) has been received. However, the application of these measures must not violate standards that emerged from recent Supreme Court of Canada decisions that effectively abolished the use of solitary confinement in federal penitentiaries as defined by the United Nations *Mandela Rules*; specifically, minimum out of cell time, regular health checks, meaningful human contact, external oversight and review, and access to programs/services.

Furthermore, to categorically lump individuals *without* symptoms, a diagnosis, or known/potential exposure to COVID-19 together with those *who have* symptoms or are diagnosed with COVID-19, seems to run contrary to the least restrictive principle. It may even aggravate the risk for further transmissions if these individuals are housed together on the same ranges, houses, or other living units.

In light of these concerns, the OCI recommended that the policy guidance include:

- Definitions to clearly distinguish between the practice of Medical Isolation and Quarantine, including clinically relevant criteria where appropriate;

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- Service standards (e.g., time restrictions, response times) for medical clearance and the institutional head's authorization to discontinue medical isolation and quarantine;
- Time restrictions for quarantine and medical isolation, with clear guidelines to allow for the extension of restrictions as per the advice of health care;
- A requirement that any stays in medical isolation beyond 14-days be flagged in the offender management system (OMS), and be subject to the same level of review and oversight as those in place for Structured Intervention Units<sup>10</sup>; and,
- Basic expectations for conditions of confinement including out-of-cell/yard/shower time, access to video visitation, health care visits, and access to outside yard.

This exercise demonstrates the need for procedural safeguards and clear operational definitions when devising measures to stem the transmission of COVID-19 in prisons. Specifically, Medical Isolation must be clearly defined and distinguished from other public health practices such as Quarantine, and neither should ever devolve into solitary confinement.

As prison oversight bodies around the world learn to adapt to the instability and uncertainty created by the COVID-19 pandemic, it is critical that we do not become complacent in our commitment to safeguarding the rights of prisoners. It is all too easy to overlook the importance of liberty, autonomy, and dignity when faced with existential threats. However, as the above analysis demonstrates, we must ensure that the measures implemented by prison authorities over the course of this pandemic do not inadvertently violate human rights standards and/or statutory obligations to provide humane and rehabilitative custody.

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<sup>10</sup> In 2019, the practice of administrative segregation (i.e., solitary confinement) was eliminated from the *Corrections and Conditional Release Act* (CCRA) and replaced with the new system of Structured Intervention Units (SIUs). The purpose of SIUs according to section 32 of the CCRA is to “(a) provide an appropriate living environment for an inmate who cannot be maintained in the mainstream inmate population for security or other reasons; and (b) provide the inmate with an opportunity for meaningful human contact and an opportunity to participate in programs and to have access to services that respond to the inmate’s specific needs and the risks posed by the inmate.”

## RESOURCES

### Resources

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#### **From AMEND at University California San Francisco (UCSF)<sup>11</sup>**

The infographics below were taken directly from [this webpage](#) published by our colleagues at AMEND at UCSF. Readers are also encouraged to read, "[Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19](#)" (Cloud, Ahalt, Augustine, Sears, & Williams, 2020).

Click here for [more COVID-19 Guidance and Resources](#) from AMEND.

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#### **From the Australia OPCAT Network Coordinator, Steven Caruana**

On the 7<sup>th</sup> and 8<sup>th</sup> of September, 2020 (depending on your time zone), our colleagues in Australia hosted an online presentation titled, "COVID-19 and North American Corrections: Learnings for Australia."

COVID-19 has had a serious impact in Canada and the United States, and much has been learned regarding the transmission and control of the virus in congregate living environments such as prisons, long term care homes, and detention centres. With Australia facing its second wave of COVID-19 infections, this time having a greater impact on corrections and immigration detention centres, it seemed only prudent for our two hemispheres to have a conversation.

In this presentation, we heard from leading experts about the situation in the United States and Canada and the potential implications for correctional facilities and detention centres in Australia.

The entirety of the online presentation (2.5 hours) was uploaded to YouTube for your viewing pleasure. Please feel free to share and promote the video!

[COVID-19 and North American Corrections: Learnings for Australia. \[YOUTUBE LINK\]](#)

The PowerPoints from the presenters can also be found here:

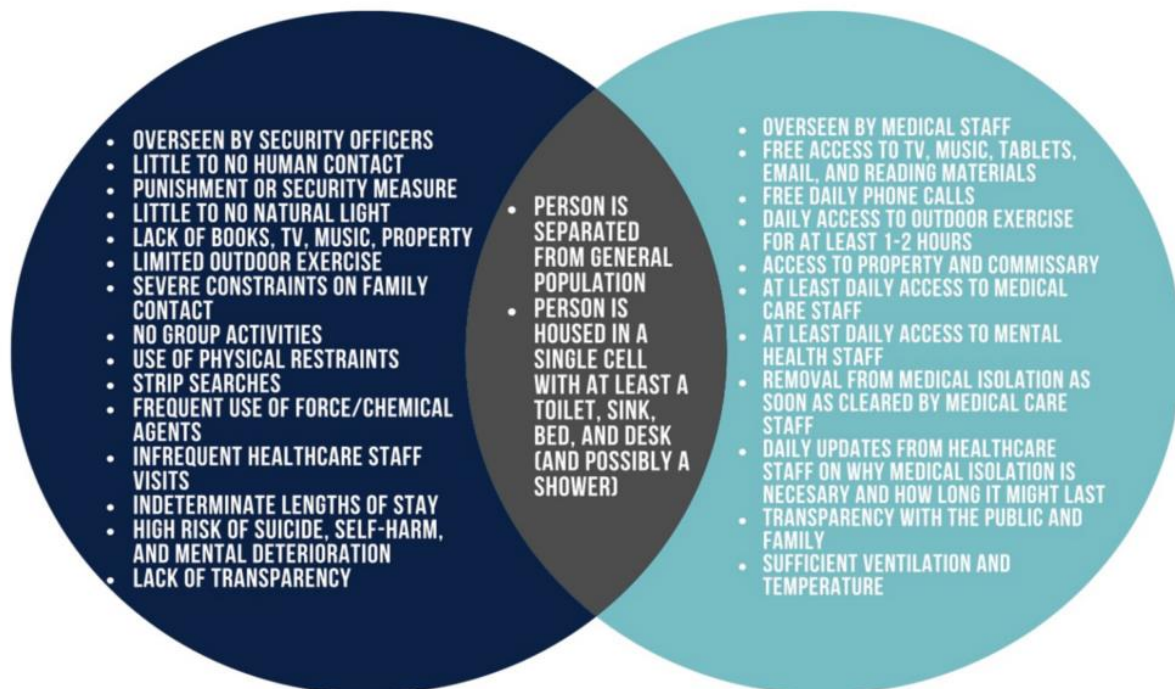
[PowerPoint Presentations from Webcast](#)

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<sup>11</sup> *Disclaimer:* The guidance in these resources reflect current clinical best practices and do not constitute medical advice.








INFOGRAPHICS FROM AMEND AT UCSF

# SOLITARY CONFINEMENT VERSUS MEDICAL ISOLATION

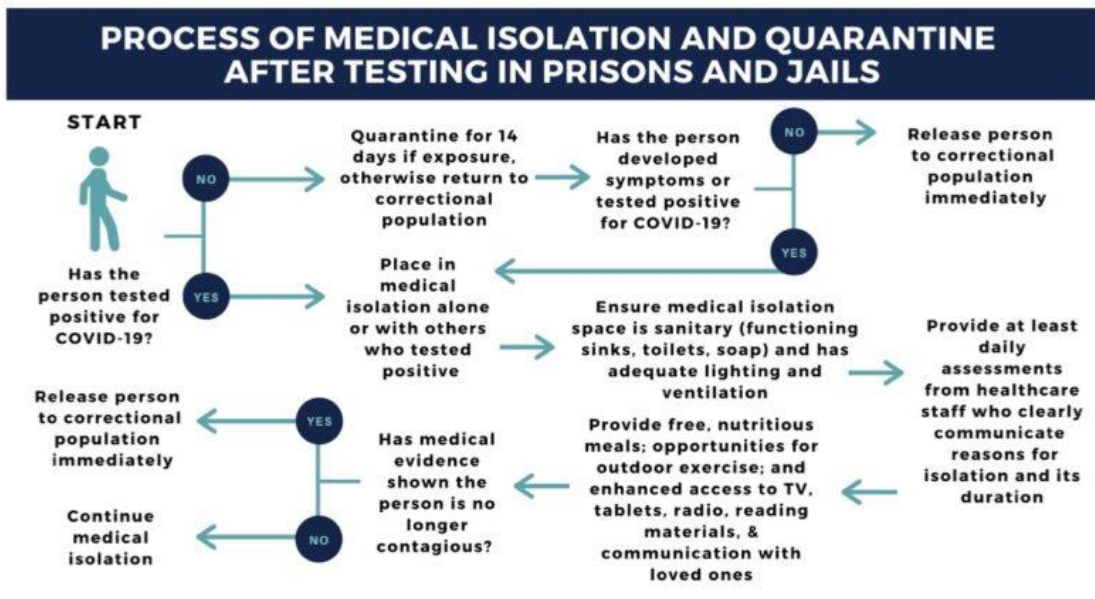




# RESOURCES

<b>ETHICAL MEDICAL ISOLATION (MI) &amp; QUARANTINE (Q)</b>		<b>SOLITARY CONFINEMENT</b>
<p>MI: Separating people with a confirmed or suspected contagious disease until no longer contagious</p> <p>Q: Separating asymptomatic people who have been exposed to a contagious disease until it is known if they will become infected</p>	 <b>DEFINITION</b>	<p>Isolating people from the rest of correctional population while imposing major restrictions on visitors, phone calls, recreation, and property</p>
<p>Reduce the spread of disease</p>	 <b>PURPOSE</b>	<p>Punishment</p>
<p>MI: Ends when medical evidence shows person is no longer contagious</p> <p>Q: Ends when person is found to have infection (moves to MI) or found to be free from infection (back to gen pop)</p>	 <b>LENGTH</b>	<p>Determined by security staff, often indeterminate</p>
<p>Medical Staff</p>	 <b>SUPERVISING STAFF</b>	<p>Security Staff</p>
<p>Sanitary (functional toilet, sink, soap), adequate light and ventilation, comfortable temperature</p>	 <b>CONDITIONS</b>	<p>Often little to no natural light, unsanitary, poor temperature regulation, frequent use of force or chemical agents</p>
<p>Free and enhanced access to TV, tablets, radio, reading materials, and canteen; access to nutritious meals; opportunities for going outdoors</p>	 <b>AMENITIES</b>	<p>Major restrictions or complete bans on most recreation, personal property, TV, tablets, radio, reading materials, canteen</p>
<p>Free and enhanced access to phone calls, video calls, or email with loved ones</p>	 <b>HUMAN CONTACT</b>	<p>Major restrictions or complete bans on family contact, visitors, phone calls, email</p>





## WHAT SHOULD BE DONE?

- 1** Clearly communicate with residents and staff about use of medical isolation and quarantine, how they are different from solitary confinement, and when they will end.
- 2** Ensure medical isolation and quarantine housing units are sanitary and optimize available amenities.
- 3** Public health agencies should provide Departments of Corrections with testing kits if needed; DOCs should track and report cases and use of medical isolation and quarantine to assist communities with surge planning.
- 4** If adequate facilities are not available, DOCs should partner with hospitals and other community settings to house patients from jails/prisons in need of medical isolation or quarantine.
- 5** To mitigate spread of COVID-19, DOCs, health agencies, policy makers, and advocates should work together to achieve depopulation and ethical use of medical isolation and quarantine.

## RELEASING AS MANY PEOPLE AS POSSIBLE IS THE BEST WAY TO COMBAT COVID-19

-  Mitigates coronavirus transmission to prevent illness and save lives of incarcerated people and correctional workforce
-  Necessary to optimize physical distancing in prisons/jails
-  Enables empty housing units to be converted to medical isolation and quarantine spaces
-  Relieves strains on over-stretched correctional healthcare systems