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Guidance

# Monkeypox: prisons and places of detention

Public health advice for prisons and other prescribed places of detention.

From:
UK Health Security Agency (/government/organisations/uk-health-security-agency)

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↑ Contents

Contents



## Monkeypox: background

There has been a recent increase in cases of monkeypox in the UK as well as other parts of the world where it has not been seen before.

The symptoms of monkeypox (https://www.gov.uk/guidance/monkeypox#clinical-features) begin 5 to 21 days (average 6 to 16 days) after exposure.

Treatment for monkeypox is mainly supportive. The illness is usually mild and most of those infected will recover within a few weeks without treatment. Further information about the clinical features of monkeypox (https://www.gov.uk/guidance/monkeypox#clinical-features) is available.

See current case definitions for monkeypox (https://www.gov.uk/guidance/monkeypox-case-definitions).

The virus can spread if there is close contact between people and the risk to the UK population is low. Recent cases are predominantly in gay, bisexual and other men who have sex with men (GBMSM) aged 20 to 59 years. These groups are being advised to be alert to any unusual rashes or lesions on any part of their body, especially their genitalia, and to contact a sexual health service if they have concerns.

Cases meeting the case definition of the current outbreak are not classified as or managed as high consequence infectious disease (HCID) cases. This guidance only covers cases that are part of the current outbreak; it does not cover HCID cases. There is further information on the HCID status of monkeypox available (https://www.gov.uk/guidance/hcid-status-of-monkeypox).

## Notification of confirmed cases of monkeypox

↑ Contents

The Health Protection (Notification) Regulations 2010 (https://www.legislation.gov.uk/uksi/2010/659/contents/made) have been amended to include monkeypox as a notifiable disease in Schedule 1 and monkeypox virus as a notifiable causative agent in Schedule 2.

The National Health Service (Charges to Overseas Visitors) Regulations 2015 (https://www.legislation.gov.uk/uksi/2015/238/contents/made) have been amended to include monkeypox in Schedule 1.

## Identifying cases and contacts

Cases or contacts may be identified at reception into prisons and places of detention (PPDs), following presentation within the PPD setting itself or via contact tracing.

Cases or contacts may be concerned about presenting in the PPD setting due to potential stigma. Staff in PPDs settings should be sensitive to the circumstance and be supportive of those concerned.

### Reception screening

UK Health and Security Agency (UKHSA) health and justice advice is that new receptions into PPDs should be risk assessed (https://www.gov.uk/guidance/monkeypox-case-definitions) as part of the reception screen. Possible, probable, highly probable and confirmed monkeypox case definitions (https://www.gov.uk/guidance/monkeypox-case-definitions) are available. Highly probable cases (a person with an Orthopox virus positive result since 15 March 2022) are to be treated as confirmed cases. For those who do not currently have symptoms (https://www.gov.uk/guidance/monkeypox#clinical-features), it is recommended the following information is recorded in case future symptoms develop:

- do they have any history of travel in the last 21 days (and to where)
- do they think they may have had close contact (https://www.gov.uk/government/publications/monkeypox-contact-tracing) with a confirmed or possible monkeypox case

### Presentation with symptoms at reception or within the PPD

If a resident presents with symptoms, healthcare staff should wear appropriate personal protective equipment (PPE) (https://www.gov.uk/government/publications/principles-for-monkeypox-control-in-the-uk-4

↑ Contents

nations-consensus-statement/principles-for-monkeypox-control-in-the-uk-4-nations-consensus-statement) and clinically assess the patient according to monkeypox diagnostic testing (https://www.gov.uk/guidance/monkeypox-diagnostic-testing).

### Presentation within the PPD setting about concerns of close contact with a case

If an individual presents with concerns they have had contact with a monkeypox case then healthcare should undertake an initial risk assessment in regards to potential contact informed by the UKHSA contact classification matrix (https://www.gov.uk/government/publications/monkeypox-contact-tracing).

### Contact tracing

Contact tracing will be undertaken for suspected and confirmed cases. This should be conducted by the health resilience leads (HRL) in partnership with healthcare, and this information should be provided to the local UKHSA health protection teams (HPTs).

This should include information on contacts (https://www.gov.uk/government/publications/monkeypox-contact-tracing) within the infectious period (from date of symptom onset as per case definition) and nature of contact as per current contact risk classification – consider household, visitors (to household or households visited), sexual contacts, community settings (including shops and entertainment venues), healthcare exposures, public transport and so on.

## Reporting suspected cases and contacts

When cases and contacts are identified, the HPT should be informed and relevant case and contact management guidance followed.

Testing is advised for possible and probable (https://www.gov.uk/guidance/monkeypox-case-definitions) cases. Local UKHSA HPTs (https://www.gov.uk/health-protection-team) should be informed of confirmed, highly probable, probable and possible cases as soon as possible. Testing to be confirmed in line with locally agreed pathways.

HPTs are likely to require the following information about cases:

- symptoms, including symptom onset date and symptom progression – ask about systemic influenza-like illness symptoms prior to onset of rash, to determine infectious period and epidemiological analysis

↑ Contents

# Management of cases in the PPD setting

### Isolation of cases

If a resident presents with symptoms, healthcare staff should wear appropriate PPE (https://www.england.nhs.uk/publication/national-infection-prevention-and-control/) and clinically assess the patient according to monkeypox guidance.

Possible and probable cases should be isolated in single cell accommodation while HPT advice and further clinical assessment (https://www.england.nhs.uk/ig/risk-stratification/) is arranged.

Arrangements for individual patients should be considered on a case-by-case basis. Confirmed and highly probable cases should isolate in a single cell and are able to end isolation once the de-isolation criteria (https://www.gov.uk/guidance/de-isolation-and-discharge-of-monkeypox-infected-patients-interim-guidance) are met.

Isolation within the PPD can be used for clinically well ambulatory suspected or confirmed cases for whom it is judged safe and clinically appropriate. They should be managed in a single room with separate toilet facilities where possible. If this cannot be arranged, this must be discussed with the HPT. Additional environmental cleaning should minimise the risk of possible transmission via surfaces.

### Infection prevention and control (IPC) measures for cases

For ambulatory well suspected or confirmed cases with limited lesions, covering lesions and wearing a face mask reduces the risk of onwards transmission.

If cases need to be transported to hospital, lesions should be covered and a face mask worn. If a possible case has extensive lesions that cannot be readily covered, then ambulance transport will be required.

Infection prevention and control (IPC) requirements for staff including those undertaking escort duties are detailed in the general IPC guidance section.

# Management of contacts

### Isolation of contacts

See definitions of contacts (https://www.gov.uk/government/publications/monkeypox-contact-tracing).

↑ Contents

Medium risk contacts (category 2) do not need exclusion or isolation provided they comply with passive monitoring, and should be given advice to avoid sexual or intimate contact and other activities involving skin-to-skin contact for 21 days from last exposure.

High risk (category 3) contacts should comply with passive monitoring, avoid contact with immunosuppressed people, pregnant women, and pre-school children where possible for 21 days from last exposure and be given advice to avoid sexual or intimate contact and other activities involving skin-to-skin contact for the same time period. Following risk assessment, high risk contacts may also be excluded from work for 21 days if work involves skin-to-skin contact with immunosuppressed people or pregnant women.

Decisions on contact isolation (including workplace high risk contact) will be advised by the HPT.

### IPC measures for contacts

When managing contacts, staff should follow general IPC guidance as outlined below.

### Vaccination

Some contacts may be given vaccination as post-exposure prophylaxis; this will be agreed with the HPT. See vaccination guidance (https://www.gov.uk/government/publications/monkeypox-vaccination). Pre-exposure prophylaxis maybe considered in an outbreak (https://www.gov.uk/government/publications/smallpox-and-vaccinia-the-green-book-chapter-29).

Vaccination must be accessed via out-reach to specific regional sites (which include NHS hospitals and specific sexual health centres). Residents in secure settings must travel to the site to be vaccinated as there is no provision for transporting or delivering vaccine elsewhere to the resident.

There are regional leads handling the access pathways for case management and treatment who will need to liaise with health and justice commissioners if vaccination is required. His Majesty’s Prison and Probation Service (HMPPS) will remain responsible for providing escort staff to accompany the resident to the vaccination site.

## General IPC guidance

↑ Contents

Staff should receive appropriate training and be competent in the required PPE donning and doffing procedures and hand hygiene. Staff should know their local procedures for reporting any PPE breach or other risk contact with a confirmed or highly probable case so that they can be assessed for follow-up and possible restrictions.

For suspected and confirmed clinically well cases managed in residential settings including PPDs, transmission risks should be based on a clinical risk assessment. For possible, probable, highly probable and confirmed cases, the minimum PPE is:

- gloves
- fluid repellent surgical facemask (FRSM) – an FRSM should be replaced with an FFP3 respirator and eye protection if the case presents with a lower respiratory tract infection with a cough and/or changes on their chest X-ray indicating lower respiratory tract infection
- apron
- eye protection (required if there is a risk of splash to the face and eyes, for example when taking diagnostic tests)
- the use of long-sleeved single-use disposable gowns may be considered where extensive manual handling, unavoidable skin-to-skin contact or contact with contaminated items such as used bedlinen, is anticipated
- the use of long-sleeved single-use disposable gowns should may be considered where extensive manual handling, unavoidable skin-to-skin contact or contact with contaminated items such as used bedlinen, is anticipated

HMPPS escort staff should also follow these PPE guidelines.

In the event of a hospitalised patient requiring ongoing contact escort, enhanced PPE may be required for the attending staff and should be risk assessed with support from the HPT and trust IPC team.

### Hand hygiene

Hand hygiene is important and should be undertaken by the patient before leaving their room. Staff should follow best practice regarding hand hygiene when removing PPE. Alcohol-based hand sanitiser can be used as an alternative to soap and water for visibly clean, dry hands.

↑ Contents

It remains important to reduce the risk of transmission on surfaces. The risk can be substantially reduced by following agreed cleaning methods based on standard cleaning and disinfection using chlorine-based products.

If using reusable crockery and cutlery, use full PPE (FRSM, non-sterile disposable gloves, and a disposable apron) to collect crockery and cutlery, place in a plastic bag for transfer to a dishwasher, and then wash hands thoroughly after removing and disposing of the collection bag and PPE.

Increased cleaning is likely to reduce risk and is recommended. Anyone cleaning a contaminated area should wear full PPE, consisting of FRSM, non-sterile disposable gloves, and a disposable apron. Any used cloths and mop heads must be disposed of and should be put into waste bags.

Once the person is recovered (or left the cell or room) then a final clean should be undertaken while wearing full PPE (FRSM, non-sterile disposable gloves, and a disposable plastic apron). Using the standard cleaning detergent and disinfection products:

- remove all disposable items and dispose of in waste bags
- bag laundry packs and remove as described for contaminated laundry
- clean all hard surfaces and touch points including walls, floors, chairs, bed frame, mattress and ensuite facilities adhering to local policy of process including colour coding of mops and cloths
- any soft furnishings should be steam cleaned or vacuumed. If using a vacuum, use only a machine with HEPA filtration – full PPE to be worn when emptying vacuum into a waste bag

### Waste management

All waste produced by the case in isolation (whilst infectious) should be bagged in the cell or room. This bag should be placed into another waste bag outside the room for transport to the appropriate waste collection bin for usual domestic waste management in accordance with local policy.

Usual protective equipment should be worn by people handling waste and hands washed on disposal of PPE.

Waste generated by healthcare should be disposed of as healthcare waste according to the National infection prevention and control manual (https://www.england.nhs.uk/publication/national-infection-prevention-and-control/).

↑ Contents

Monkeypox can be spread via contact with clothing or linens (such as bedding or towels) used by an infected person therefore handling should be minimised. Linens and bedding should be carefully lifted and rolled to prevent dispersion of infectious particles from lesions and body fluids. Any such linen should be bagged (preferably in a water-soluble bag) in cell or room, ideally by the infected person. This bag should be placed into a plastic bag outside the cell or room and transported to laundry.

Where possible, wash laundry items separate from the rest of the residential accommodation's laundry using the normal detergent, following the manufacturer's instructions.

Where a residence has off-site laundry facilities, each premise should discuss the requirements for safe pre-laundering storage, transfer and processing of contaminated laundry.

Ideally, laundry should be washed at temperatures above 65°C and dried. Usual protective equipment should be worn by people handling used laundry and hands washed after disposing of PPE.

If prison staff handle monkeypox contaminated laundry, they should wear full PPE – specifically FRSM, non-sterile disposable gloves, and a disposable apron. The use of long-sleeved single-use disposable gowns should be worn where skin contact with contaminated laundry is anticipated.

Where laundry is processed off site, no additional decontamination steps are required for disinfected linens to be returned for re-use providing the laundry processor has validated disinfection processes as part of their BS EN 14065 procedures.

### Reducing contact with clinically vulnerable people

Where possible, pregnant women and severely immunosuppressed individuals (as outlined in the Green Book (https://www.gov.uk/government/publications/contraindications-and-special-considerations-the-green-book-chapter-6)) should not assess or care for individuals with suspected or confirmed monkeypox. This will be reassessed as evidence emerges.

+ show all updates

↑ Contents

De-isolation and discharge of monkeypox-infected patients: interim guidance (/guidance/de-isolation-and-discharge-of-monkeypox-infected-patients-interim-guidance)

Monkeypox: diagnostic testing (/guidance/monkeypox-diagnostic-testing)

Monkeypox: reducing risk of transmission at vaccination clinics (/guidance/monkeypox-reducing-risk-of-transmission-at-vaccination-clinics)

HCID status of monkeypox (/guidance/hcid-status-of-monkeypox)

Monkeypox: planning events and mass gatherings (/guidance/monkeypox-planning-events-and-mass-gatherings)

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Collection

**Monkeypox: guidance (/government/collections/monkeypox-guidance)**

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**Infectious diseases (/health-and-social-care/health-protection-infectious-diseases)**

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↑ Contents