

# Report of the Scrutiny Review of the E Coli 0157 Outbreak at Feltham Hill Infant and Nursery School

September 2010



London Borough  
of Hounslow

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## Foreword

Cllr Steve Curran  
Chair of Overview and Scrutiny Committee



It gives me great pleasure to write my first foreword to a scrutiny review. This review was planned to give members who were new to scrutiny after the elections in May 2010 on-the-job training in how scrutiny operates, as well as to give us new (and old) members the chance to understand better how various different parts of the council and partner agencies work.

It was soon apparent that members were less interested in training than in getting down to the job of carrying out scrutiny on behalf of the public who recently elected us to do just that. I want to thank my colleagues who approached this task with such enthusiasm.

Most importantly I want to place on record our thanks to officers and colleagues across different agencies and the schools concerned who came together quickly in a team to tackle this emergency. It is thanks to them that the outbreak was contained, there were no fatalities, and the school reopened very promptly after the spring half-term.

The stakeholders involved agree that there were lessons to be learned which can improve future responses to emergency situations. They have been pro-active in identifying lessons during the incident review meeting that took place after the school had re-opened. The lessons they identified along with the issues that were identified through discussion with witnesses involved in this review, are set out in the body of this report for members' consideration. As scrutiny members we hope we have added value by being outside the process and a neutral observer. We have made 28 recommendations. They are set out below.

I would like to thank all those who took part in this review: my elected member colleagues and co-opted members, parents, the scrutiny team, and the witnesses who gave up their evenings to answer our questions.

Recent research has found that organisations learn more effectively from failures than successes.<sup>1</sup> We hope this report can play a part in that learning and will be useful in informing agencies' response to any future such event – much as we hope this does not happen again!

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<sup>1</sup> The Academy of Management Journal, Volume 53, Number 3 June 2010: Failing to Learn? The Effects of Failure and Success on Organizational Learning in the Global Orbital Launch Vehicle Industry; Authors: Peter M. Madsen, Vinit M. Desai: "We find that organizations learn more effectively from failures than successes, that knowledge from failure depreciates more slowly than knowledge from success, and that prior stocks of experience and the magnitude of failure influence how effectively organizations can learn from various forms of experience."

# 1. Executive Summary and Recommendations

1. This review has turned out to have three roles. Firstly it was intended as a training exercise for new scrutiny members.
2. Secondly, it aimed to produce a comprehensive report into this incident and provide thereby an easy reference manual in the event of any similar outbreak of a communicable disease, whether in Hounslow or any other part of the country. (We are relying on our colleagues in the North West London Health Protection Unit (NWLHPU)<sup>2</sup> to publish this report through their usual channels.) Of the 28 recommendations contained in total in this report, 14 are lessons learned recommendations and do not therefore require a response. They are clearly indicated as such in the table of recommendations at page 29.
3. Thirdly, the review was a chance – as usually with a scrutiny review – to improve practice for the immediate future. The remaining 14 recommendations are of such a nature and require a response within the usual timescales for a response to a scrutiny report.
4. The lessons learned recommendations centre on leadership; communication; forward planning for potential escalation of the incident; engagement of GPs; and the arrangements for collecting and processing stool samples.
5. The issues that members feel should be addressed now are:
  - Whether it would be useful to align criteria for defining emergencies across different agencies.
  - Impressing on schools once again the importance of having an up-to-date contingency plan, with a copy held by the local authority.
  - Clarity on what information should be given to parents after a single case of E. coli O157 (also known as VTEC). NWLHPU has taken cognisance of the parents' expressed anxiety and has now adopted the policy into its practice guidelines of notifying parents after a single case of VTEC.
  - Recommending to other schools the use of a central texting system (i.e. Parent Mail) if they are not already using one as well as easy access to a website with up-to-date information.
  - Feltham Hill Infant and Nursery (FHI&N) School test the performance of their current central texting system.
  - Guidance be produced for schools on how to make their websites more visible on internet search engines.
  - Schools should ensure that their register of contact names, dates of birth, home addresses and parents' landline and mobile contact numbers are up-to-date.

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<sup>2</sup> Please note there is a glossary of abbreviations at p.52

- A further effort should be made to raise awareness of school governors' roles in emergencies – and their role in making sure their school has an emergency/contingency plan.
- The possibility of collaborating with neighbouring boroughs in London with regard to Environmental Health Officer (EHO) out of hours cover should be explored.
- The Council's Contingency Planning Unit (CPU) should investigate the possibility of developing a specification with local cleaning companies for any future deep clean of buildings.
- The Finance Directorate should look at the case for staff using corporate credit cards in limited cases, e.g. in emergency situations where suppliers demand immediate payment for urgent deliveries.

## 2. Terms of Reference

6. At their first meeting members agreed the following terms of reference for this scrutiny review:

*To investigate the arrangements for coordinated decision making and communication in respect of the E.Coli outbreak at FHI&N School and to identify lessons for best practice in respect of similar events in the future e.g. risk management and partner protocols.*

## 3. Methodology

7. This exercise was intended as a part training/part normal scrutiny review. Either way it was intended to be a short, sharp review. As a lessons learned exercise there was not extensive desktop research. The focus was intended to be on members being given the chance to test their questioning skills and get a feel for what a scrutiny review is like.
8. Preparatory meetings were held by officers in the scrutiny unit, briefings prepared and then three meetings were held for elected members with officers/witnesses:

14 June 2010	Leigh Farina – Contingency Planning Officer, LB Hounslow.
30 June 2010	Dr Margaret Meltzer – Consultant in Communicable Disease Control, NWLHPU. Dr Michael Robinson – Joint Director Public Health (DPH) for NHS Hounslow and LB Hounslow. Maggie Newbury – Head Teacher at FHI&N School Stuart Fleming – School Governor and Parent representative at FHI&N School
29 July 2010	Joseph McFarland – Head of Contingency Planning – LB Hounslow Juliet Isitt – Food Safety Manager – Environment – LB Hounslow Sheena Poley – Head of Business Services – Children’s Services & Lifelong Learning (CSLL) – LB Hounslow. (Dr Shaaz Mahboob from NHS Hounslow Public Health and Dr Margaret Meltzer – Consultant in Communicable Disease Control, NWLHPU were also in attendance.)

9. All elected members and statutory co-optees were invited to these meetings with a special focus on newly elected scrutiny members.

## 4. Steps in a scrutiny review

10. As members will be aware, this exercise was designed as a Scrutiny Member Induction, although it became a full scale review.
11. Scrutiny reviews characteristically follow a series of key stages, and it is worthwhile reflecting the stages that have been gone through:

<b>Pre-scoping phase</b>	The scrutiny unit received the initial referral from the Member, made initial enquiries, research, had informal discussions with colleagues from contingency planning, and informally raised the issue with key scrutiny chairs.
<b>Scoping Review Topic and Agreeing Terms of Reference</b>	Following a preliminary meeting with Leigh Farina – Contingency Planning Officer on 14 <sup>th</sup> June 2010, these were agreed by scrutiny members, with slight amendments, at the beginning of the 30 <sup>th</sup> June meeting.
<b>Gather Evidence and Information</b>	<p>Scrutiny members had interviews and discussions with a range of officers and representatives from LB Hounslow/PCT, NWLHPU, FHI&amp;N School, and propose to interview several more.</p> <p>In the preliminary meeting, guidance on questioning techniques was circulated and questioning exercises undertaken to help members with good interviewing techniques.</p>
<b>Evaluate Evidence and Draft Recommendations</b>	Members considered implications of what they have heard and identified some preliminary conclusions and recommendations.
<b>Agree Final Report and Recommendations</b>	The draft report was circulated to members and witnesses, then placed on the agenda of the Overview and Scrutiny Committee. Comments and suggested amendments from respondents were put to the Committee, who then agreed the final version to be sent to the Executive and the other agencies involved.

## 5. Context and Background

### What is e. coli O157?

(All information below taken from the Health Protection Agency (HPA) E. coli fact sheet.<sup>3</sup>)

12. Escherichia coli (commonly abbreviated E. coli): Most E. coli strains are harmless, but certain strains of E. coli known as verocytotoxin-producing E. coli (VTEC), produce a potent poison, or toxin, which causes illnesses ranging from mild diarrhoea through to very severe inflammation of the gut. Occasionally this can cause complications such as kidney failure, and anaemia. The most important toxin-producing strain associated with human illness is known as E. coli O157.
13. The bacteria can be passed on through:
  - eating infected food, mainly meat, unpasteurised milk and cheese.
  - contact with infected animals, such as at farms or animal sanctuaries.
  - contact with other people who have the illness, through inadequate hand washing after using the toilet, and/or before food-handling, particularly in households, nurseries and infant schools.
  - eating unwashed vegetables which may have been infected by manure from infected cattle.
  - drinking or swimming in infected water, such as river water, stream water or water from drinking wells.
14. People infected with E. coli O157 can have one, some, or all of the following symptoms: diarrhoea – about 50% of people also have blood in their stools; stomach cramps; fever. Some infected people may have mild diarrhoea or no symptoms at all. A very small number of patients may develop ‘haemolytic uraemic syndrome’ (HUS) which is associated with kidney failure, anaemia, and bleeding. Complications are more common in children under five years of age and the elderly. On average, it takes three to four days for symptoms to develop after swallowing an infectious dose of E. coli O157. Symptoms can last up to two weeks, except in cases with complications. Most people get rid of the bacteria after about one week although children may continue to carry it for longer periods.
15. As a reminder of the dangers of disease, in September 2009 93 people – mainly children – became ill after contracting e. coli O157 at Godstone Farm in Surrey. There were no fatalities but some of the children suffered what could prove to be permanent kidney damage.<sup>4</sup>

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<sup>3</sup> [http://www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1194947360190](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947360190)

<sup>4</sup> <http://www.bbc.co.uk/news/10296061>

## Timeline of events

<p><b>Fri 29<sup>th</sup> Jan</b></p>	<p>The Senior Environmental Health Officer (EHO) from the Council's Food Safety Team receives a call from NWLHPU relating to a possible case of <i>E. coli</i> O157 at FHI&amp;N School.</p> <p>NWLHPU contact the school and ascertain that there were five children in the previous week with symptoms of diarrhoea.</p> <p>Attempts are made to contact the parents of the 5 children in order to question them and to obtain stool samples to exclude <i>E. coli</i> O157.</p>
<p><b>Sat 30<sup>th</sup> Jan</b></p>	<p>Following hospital laboratory tests the likelihood of the case of <i>E. coli</i> O157 increases and is sent to the reference laboratory for confirmation.</p>
<p><b>Mon 1<sup>st</sup> Feb</b></p>	<p>At 12.50 the NWLHPU formally report the first single case of confirmed VTEC to the local authority's CPU.</p> <p>Usual protocol requires cases to be reported to the Environmental Health Officer (EHO) at the Council, but due to an office move taking place on the same day, the unit was un-contactable so the report was routed through the Contingency Planning Unit (CPU)</p> <p>CPU informs the Corporate Communications Team (CCT) and the Business Support Team in CSLL.</p> <p>The NWL HPU convened a meeting to include the senior EHO and the school Head Teacher at 13.00 at the school.</p> <p>Initial report confirms one case of VTEC and four cases of diarrhoea.</p>
<p><b>Tues 2<sup>nd</sup> Feb</b></p>	<p>A second case of <i>VTEC associated with FHI&amp;N</i> is confirmed by the NWLHPU and an outbreak is declared. Again the CPU informs the CCT and Business Support in CSLL.</p> <p>At 14.30 an urgent teleconference is convened by the NWLHPU to form the Outbreak Control Team (OCT) consisting of representatives from NHS Hounslow, Children's Services, Corporate Communications, Environmental Health, Contingency Planning, Northwick Park Hospital laboratory, the Head Teacher of Feltham Hill and one of the school's governors and the Health Protection Agency (HPA) including South East London Health Protection Unit (SELHPU) (which had experience of managing two similar incidents).</p>

	<p>Based on expert advice from the HPA, the Head Teacher takes the decision to close the school. The CPU request the post incident report by SELHPU on the Surrey incident, (Godstone Farm outbreaks of <i>E. coli</i>.) to identify key steps to take when managing an outbreak of this nature.<sup>5</sup></p> <p>Information is prepared jointly by SELHPU and the school and provided to all parents by the school to inform them of the school closure, and the steps being taken. This is done through use of Parent Mail (which allows a text message alert to be sent out). The text directs parents to the school website and asks parents to attend school the next morning to collect stool sample pots and information sheets.</p>
<b>Wed 3<sup>rd</sup> Feb</b>	<p>Parents are sent the letter attached at appendix 4 which is also available via the school website. Both parents and staff who come to the school that morning are given sample pots and a questionnaire (to assist in identifying the outbreak source). They are told that all staff and children cannot return to school until they have submitted faecal samples which must test negative for <i>E. coli</i> O157.</p> <p>The outbreak is communicated to the local authority Chief Executive, Councillors and all schools in the borough.</p> <p>CPU sets up a recorded information line and provides cards with line number printed to school to distribute to parents. Daily Situation reports are issued by the CPU to senior staff within the council and local councillors.</p>
<b>Thurs 4<sup>th</sup> Feb</b>	<p>21 samples are taken from different areas around the school (including the kitchens and the toilets) by Environmental Health to exclude a source of the outbreak. All results come back negative.</p> <p>Sample pots distributed to parents are returned to the collection point set up at the school in sealed envelopes containing the sample pots; in addition the completed questionnaires, containing personal data of the children are returned to the school.</p> <p>The school staff collect the envelopes and inspect the samples to find that parents have not all submitted faeces and not all samples have been appropriately labelled with the children's names and dates of birth.</p>

<sup>5</sup> This report was still in preparation at the time and not due to be completed until June 2010.

	Samples are personally couriered each afternoon by an EHO to Northwick Park hospital laboratory for testing ( <i>this occurs on a daily basis from 3<sup>rd</sup> - 10<sup>th</sup> February</i> ).
<b>Mon Feb 8<sup>th</sup></b>	<p>CPU contacts a number of specialist cleaning contractors to source quotes for the school deep clean following which a contractor is appointed. CPU also seeks advice from Bromley Council where a similar outbreak in a school occurred previously.</p> <p>Due to press coverage and worried parents, CPU initiates a parents meeting which is held in the evening at 6pm with the following speakers:</p> <ul style="list-style-type: none"> <li>• Dr Margie Meltzer &amp; Dr. Claude Seng (NWLHPU)</li> <li>• Maggie Newbury (Head Teacher Feltham Infant and Nursery School)</li> <li>• Dr. Mike Robinson (Public Health Director, Joint Appointment NHS Hounslow and Hounslow Council)</li> <li>• Judith Pettersen (Director of CSLL, Hounslow Council)</li> <li>• Juliet Isitt (EHO, Hounslow Council).</li> </ul> <p>Parents, staff, school governors, councillors and press also attend the meeting.</p>
<b>Tues 9<sup>th</sup> Feb</b>	Staff finish clearing school ready for deep clean. All items touched by children are placed in one pile in each classroom for cleaning, or for discarding if un-washable. Anything not touched by children/not used that year stored separately as cleaning not required. PE kits and teddies (from a teddy bears picnic) left outside school for parents to collect and wash at home. Parents told to discard any school paper covered books taken home and school water bottles.
<b>Wed Feb 10<sup>th</sup></b>	School is “closed” to staff to allow deep clean to begin. All equipment and books cleaned either by dipping in solution or being wiped. Walls washed to the maximum height reachable by children. Staff and children are not to be re-admitted to the school until NWLHPU receive two negative stool samples from them.
<b>Wed 17<sup>th</sup> Feb</b>	NWLHPU receive negative samples from most teaching staff. Staff cleared microbiologically allowed access to school premises again to begin the recovery operation.
<b>Thurs 18<sup>th</sup> &amp; 19<sup>th</sup> Feb</b>	Staff, governors, parents and volunteers work to put the classrooms back together following the deep clean operation.
<b>Mon 22<sup>nd</sup> Feb</b>	School re-opens to pupils who have been cleared by the NWLHPU i.e. two negative samples. Assembly held for the pupils.
<b>Tues</b>	Parent’s meetings held to update parents. Press is invited to

<b>23<sup>rd</sup> Feb</b>	interview Head Teacher and to photograph the re-opening of the school. Low turnout.
<b>Fri 12<sup>th</sup> Mar</b>	Final daily situation report is issued
<b>24 Mar</b>	Multi-agency debrief/Incident review meeting with all stakeholders who had been involved.
<b>13 May</b>	<i>E. coli</i> O157 Outbreak Lessons Identified Report released.

### **Source of outbreak and subsequent health impact**

16. The source of the outbreak could not be identified. This is not unusual. The source of an outbreak of e-coli is seldom found. The mapping of the cases shows that there was an original cluster of 4-5 cases in one reception class. However, it is not clear whether there was a single point source for the initial cases or if a single individual introduced the infection which spread to others.
17. Two children were treated in hospital, one for a prolonged period of time.

### **Scrutiny referral**

18. In terms of scrutiny's involvement in this issue, Councillor John Cooper contacted the Scrutiny Unit on 11th February 2010 to say that he had attended the public meeting on Monday 8th February where the parents were particularly upset about the level of detail and the timings of notification of the incident.
19. He felt that it would be useful for the agencies involved to discuss and answer questions from scrutiny members and some of the parents in a constructive manner.

## 6. Main Findings

20. This chapter identifies key findings from the evidence witnesses provided to Members during this review. It is important to note that partners involved in co-ordinating the response to the outbreak were extremely proactive in ensuring they reviewed their actions and identified lessons learned. Some of the findings and recommendations set out here confirm what has previously been identified by stakeholders at the Council's internal debrief meeting and the findings from the multi-agency stakeholder debriefing.
21. All stakeholders involved in this review agreed that even if it led to repeating recommendations already made it would be useful if they were all brought together in this one report so that it provides a comprehensive and formalised record of issues arising from the co-ordination of the outbreak. Furthermore, it is an opportunity to ensure there is accountability in the ownership and implementation of identified recommendations.

### Leadership

22. During the evidence gathering sessions it appeared that there was a lack of overall leadership. Members noted the lack of what they termed a "chain of command" and a decision making structure. It is true that there was an Outbreak Control Team (OCT) but leadership within this group was not apparent.
23. In terms of formal responsibilities it is clear who should have led and in fact did lead on the management of the response: the NWLHPU. They led the investigation by inviting stakeholders from the various agencies to be part of the OCT and also chaired the OCT meetings. They themselves highlighted that each agency has its own role to perform so actions agreed were delegated to the appropriate agency at each meeting. The NWLHPU has said there was therefore "no one agency in charge".
24. However, other stakeholders have said this was a problem. It was not fully spelt out that the NWLHPU was the nominated lead. This is what seems to have confused the decision-making process. Even where the lead agency does not have the capacity or the knowledge to fulfil certain elements of the incident response e.g. press communications, public meeting with parents etc. the lead agency, in this case the NWLHPU, should retain the overall leadership role e.g. checking press releases, checking and signing off actions delegated to others.
25. Some of the confusion was perhaps down to the fact that Hounslow, as acknowledged by the NWLHPU, has a very effective Contingency Planning Unit, "one of the best in the sector", as the NWLHPU said.<sup>6</sup> This meant that the CPU took on a lot of co-ordination of the incident response. This is right and proper but Members feel there still needs to be clear

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<sup>6</sup> Meeting on 29 July 2010.

leadership which ultimately takes responsibility for overseeing the management of the entire response to the outbreak or incident.

26. An example of the effects of this perceived lack of leadership was seen during the conference calls held to co-ordinate the incident. Some stakeholders reported that they were difficult with colleagues talking over each other and some joining in half way through the call, that there was sometimes no agenda, or agenda items that were not relevant to many on the conference call. The NWLHPU chaired these calls. Having a clearly designated lead in place which was recognised by all partners could have helped things run smoother.

#### **Recommendation 1**

That it be clearly communicated to all stakeholders who the designated lead professional/agency is and that it be clear that they be responsible for chairing the Outbreak Control Team (OCT), having an overview and co-ordinating all aspects of inter-agency working (including ensuring clarity on the roles and responsibilities of each agency in terms of managing the outbreak.)

27. A key aspect of leadership in this situation would be to ensure that there is a clear and good communication between all partners and with those that are affected by the outbreak. It would normally be the responsibility of the lead agency, in this case the NWLHPU, to lead on communications. (This was recognised by the authority's communications team. See comments at para 69.)
28. Stakeholders involved in the response said that although there was satisfactory communication between different agencies and teams, it could have been better if there had been a communication plan in place.
29. Further aspects of communication are discussed in detail from page 14 onwards.

#### **Recommendation 2**

That the first Outbreak Control Team (OCT) meeting decide on the initial communication strategy and agree what the key messages are. There should also be agreement on a designated officer taking responsibility for taking forward the communication plan and monitoring it stays on track.

#### **Triggers for an emergency response**

30. For the NWLHPU, the outbreak constituted a major emergency as soon as two cases of VTEC were confirmed. This however does not fall within the Council's criteria for what constitutes a major emergency.

31. In the debrief/lessons learned exercise at the end of March 2010, colleagues agreed that the benefits of declaring this incident as an emergency for the Council would have been increased support from senior directors and a greater awareness across the authority of the impact of the outbreak. Colleagues also felt that although the outbreak did not fit the Council's emergency criteria, support and awareness for the Council's response could be raised by introducing a phased approach to emergencies. This would set out clearly defined trigger points, for actions required by each of the partners involved.
32. See appendix 8 for the current criteria used by LB Hounslow's Contingency Planning Unit for defining emergencies.

### **Recommendation 3**

That the agencies responding to this report come back with a view as to whether an alignment of criteria across organisations for emergencies would be helpful.

### **School Emergency Plan**

33. The school's emergency plan had been drawn up but copies had not been sent to the authority/CPU at the time of the incident.
34. Both Contingency Planning and CSLL identified that although OFSTED sometimes request to see plans, there is no statutory requirement on schools to have an emergency plan in place. CSLL do provide as much support as possible to encourage and help schools develop their plans i.e. through the use of a template. However it is the schools' responsibility to take ownership and responsibility for developing the plan. A piece of work is currently being initiated to go into all schools in the borough and work with staff to produce a plan where there isn't one. CSLL noted that in their experience, schools had been reactive to producing a plan i.e. one was usually formulated and put in place after an emergency.
35. Having an emergency plan in this case would have given CPU clarity of what the school's response structures were so that they could then co-ordinate a response within this rather than having to work "blind". CPU also said that it would have been useful to have had the contact details more quickly of linked nurseries and children's centres etc. which is what you would expect to see in a good emergency plan. In the view of the NWLHPU, the absence of a plan did not lead to any delays in stopping the outbreak.
36. Members would like reminders to be sent to all schools about the need to have an emergency plan and for it to be submitted to the local authority. Members have suggested that another reminder also be placed on HVEC

and the next Director's newsletter to governors, including suggesting to governors that they attend the training that the CPU offers.

**Recommendation 4**

That this report be circulated by CSLL to all borough schools, along with a reminder of the necessity of having an up-to-date contingency plan and submitting a copy to the authority's CPU, and that training for governors and school staff be advertised again in the Director's newsletter and on HVEC.

**Communicating to parents/public after single case of e. coli 0157**

37. At the public meeting parents stated strongly that they should have been informed after the first case, because as parents they had a right to information relating to the welfare of their child. They would wish to be informed after a single case of VTEC so that they could ensure enhanced hand hygiene for their children and be aware of symptoms to look for. The current HPA national guidelines suggest that parents are informed only after a second confirmed case, that there is an outbreak.
38. The DPH agreed that there needed to be more communication after a single case. However, this needed to be balanced with reacting proportionately to any case so as not to alarm parents unnecessarily. At the meeting for parents on Monday 8 February, Dr Seng from the Health Protection Agency also said that there needed to be a balance. He put this assertion into context by explaining that in the previous 12 months there had been some 300 reported single cases of e.coli 0157 nationally. There was a risk of over-reaction if after a single case all schools attended by these 300 infected children had been closed. The disruption and anxiety to parents would be disproportionate to the risk – there would also be a detrimental impact on attendance rates (as identified in para 95).
39. NWLHPU has taken cognisance of the parents' expressed anxiety and has now adopted the policy into its practice guidelines of notifying parents after a single case of VTEC.

**Recommendation 5**

That the NWLHPU confirm any changes to the national HPA guidelines as to whether parents are notified after a single case of E.coli 0157 (VTEC), or other serious communicable disease.

**Communication with/advice to parents in general**

40. The focal point for communicating with parents during the outbreak was the meeting held at the school. The NWLHPU said it suggested holding an

earlier public meeting on Wednesday 3<sup>rd</sup> February, but this offer was not taken up. The CPU contests this assertion and says that the Outbreak Control Team was set up on the 2<sup>nd</sup> February, and the meeting announced on the 5<sup>th</sup> February. The suggestion was not in the minutes of the previous three days. Either way it would appear to come back to an issue of communication and leadership mentioned above. One clear lesson from this is the need for public meetings as soon as possible after an outbreak has been confirmed in order to stem the potential for rumours and misinformation.

41. At the meeting, there were many parents who wanted to tell their individual story and seek reassurance/advice from the panel that they had followed the correct process/procedures. Questions and concerns were also raised about the risk to pupils at the junior school; what should parents do who had jobs in e.g. catering or childcare; why couldn't names of infected children be shared with the school or other parents.
42. Although there was criticism of the public meeting on 8 February and the chairing of the meeting, this would seem unfair. The problems occurred in the preparation; and not being clear about the 'key messages'; and not so much in the chairing of the meeting. There were also some allegations made in the meeting (particularly in relation to some GPs not being able to provide the necessary support) that could not be answered by HPA and PCT colleagues. This made chairing more difficult and led at moments to an antagonistic tone. The tone at the meeting was also determined by the communication that parents had received so far, which some felt was not complete.
43. The chair (who was only made aware he would be chairing on the day) did his best to manage the meeting, clarify points, ask colleagues to spell out any technical terms, and rephrased questions or points that had gone unanswered. It was simply that parents were extremely anxious and therefore less willing than otherwise to listen to more nuanced approaches that were being proposed by colleagues fielding questions. The chair could have been firmer but it was equally important to give worried parents the chance to 'vent'. The DVD of the meeting does not start at the very beginning so it is not possible to know if the chair formally said he was the chair and what ground rules he set out. Again the ground rules could have been set out on a large poster or projected on a screen.
44. It may have been advisable to have a clear flowchart at the meeting on a large poster or projector display and available for parents to take away explaining the process they needed to follow before their children could return to school. People absorb information in different ways – some are more visual than others and this could have helped. One of the witnesses said that there was too much written material. Particularly when it comes to parents whose first language is not English, information presented differently would have helped.

45. In terms of technical equipment there should have been more roving microphones and speakers should have been encouraged to only speak when they had the microphone. There should have been more staff at the meeting so that the chair did not have to walk around with the roving microphone.
46. It was suggested that a familiar face should have chaired the public meeting, and that a school governor could have been suitable for this role. (see also recommendation 17).
47. Members would wholeheartedly agree with the findings of the post-incident debrief that recommended for future public meetings:
  - A briefing should occur before the event to ensure the panel understand the key messages and arrangements throughout the meeting.
  - One person should control/chair the meeting. Only they should direct questions from the floor to the panel and the panel should not answer other questions.
  - Do not allow children from the affected school to attend, and make sure you have enough chairs.
48. At the meeting the head teacher reported that the school was now using a system called Parent Mail which could send text messages en masse. They had originally set it up as an opt-in service. They had changed that to an opt-out service. Members at the witness session heard how effective Parent Mail had been in getting regular information out. Members would welcome all schools adopting such a system if they do not already use one. It would be invaluable in handling information flows to parents/carers in emergency situations as well as having other uses in terms of getting information to parents/carers that might not make it through the filter of the pupil. However, one parent reported that it did not always function as it should. Sometimes his wife received a text, but not him. Sometimes the other way round. For example, he was not aware of the public meeting on 8 February.
49. Members also wanted to be reassured that parents/carers who don't use mobile phone/texts/internet would be communicated with by phone in the event of an emergency.
50. It was reported that parental use of social networking sites was not helpful and led to more confusion and misinformation. It will never be possible to prevent this happening. It is better that there is a consistent message from all partners through all possible media including Facebook etc.
51. There was good use of the school website (though it was apparently difficult to locate on internet search engines), and via the 24hr recorded message helpline. The question of an earlier face-to-face meeting with parents is discussed elsewhere in the report.

52. It should also be noted that the head teacher did undertake some house visits in some cases where there was a communication problem because parents had English as a second language. The possibility of using LinkLine (the NHS Hounslow interpretation service) was raised in discussion with Members – although it is not known if this would be practical in an emergency situation.
53. The most important aspect to communicating with parents, is clarity between all partners on what key messages are being put out so as to minimise confusion and avoid conflicting and contradictory advice from different partners (as happened at one point during the public meeting in relation to advice on when siblings at the junior school needed to be withdrawn).

**Recommendation 6**

That for any future incident a public meeting be held as soon as possible to enable parents to put their questions to professionals directly and that for the meeting planning and preparation, the lessons identified in the debrief meeting (bulleted in main report at para 47) are adhered to.

**Recommendation 7**

That CSLL when circulating this report (recommendation 4) also point out to schools the benefits of using a central texting service as a means of communicating with parents/carers. It has many uses but proved invaluable in this emergency.

**Recommendation 8**

That in the event of a future emergency when communicating with parents, the affected school makes robust arrangements to ensure that those parents who have English as a second language have equal access to information and advice being provided i.e. through use of interpreters.

**Recommendation 9**

That the communications strategy take into account that parents/carers are likely to use Facebook or other similar social networking sites and that this needs to be used to ensure messages get across.

**Recommendation 10**

That FHI&N School test the effectiveness of Parent Mail given the feedback from certain parents that texts might not always be delivered to all intended recipients.

**Recommendation 11**

That guidance be produced for schools as to how to make their website more visible on internet search engines.

**Recommendation 12**

That the following three recommendations from the earlier lessons learned exercise be noted (included here for completeness):

- A briefing should occur before the event to ensure the panel understand the key messages and arrangements throughout the meeting.
- One person should control/chair the meeting. Only they should direct questions from the floor to the panel and the panel should not answer other questions.
- Do not allow children from the affected school to attend, and make sure you have enough chairs.

**Communicating with other schools on same site**

54. A further lesson the NWLHPU said they had learned was the need to improve communication with other schools on the same site and therefore in close proximity to the potential source of the outbreak. There were cases of unauthorised absences of children at Feltham Hill Junior School (which shares a site with the Infant and Nursery School) as communication and advice to this and other schools was not effective as it could have been. The head teacher at the Junior school confirmed this at the public meeting. Partners, Members would fully endorse closer communication from an early stage where schools share a site.

**Recommendation 13**

That schools in close proximity/ sharing a common site be considered at risk by the HPU and be included in early communications with the affected school and have representation on the Outbreak Control Team (OCT).

**Communication with & impact on school staff**

55. Understanding of what was happening amongst all school staff (i.e. cleaners, catering, and breakfast club staff) was not fully confirmed. Due to the lack of communication staff were in a lot of distress.

56. Staff at the school also gave up their half-term to work overtime without remuneration. This did have a knock-on effect in terms of staff sickness in the following period.

#### **Recommendation 14**

That the designated communication lead as determined by the critical/emergency incident lead (recommendation 1) ensures that the communication plan includes consideration of how full and early communication will be carried out with all staff (teaching and non-teaching).

#### **Communicating with GPs**

57. Early during the outbreak the NWLHPU requested NHS Hounslow to cascade advice to all GPs in Hounslow (plus GPs over the borough border in case there were Feltham patients attending their practices). NHS Hounslow initially decided to only send information to GPs in the locality affected. Subsequent events required GPs across the borough to be informed.
58. Despite being written to by NHS Hounslow it was reported by parents that some local GPs did not take parents' concerns seriously if their child was displaying symptoms of diarrhoea. Not all GPs were consistent in their advice to parents.
59. It was suggested at the public meeting on 8 February that parents/carers who were dissatisfied with their GP's response should write to NHS Hounslow. This however did not help address the immediate problem they had i.e. no access to medical advice/help from their GP. In future cases it would be helpful for it to be made clear to parents who/where they should go for help if they are not getting an adequate response from their GP/other professional who is their first point of designated contact for assistance.

#### **Recommendation 15**

That the Director of Public Health ensure that all GPs in the borough or over the borough boundary in proximity to the outbreak are notified of the incident; and that any communication to parents/carers sets out clear, easy steps as to how they can complain about any GP who does not take their child's illness seriously and who to contact to get the advice/treatment they need if their GP is not supportive.

### **Recommendation 16**

That the Director of Public Health ensure that all GPs are sent a copy of this report.

### **Role of School Governors in assisting with communication to parents**

60. The role of governors in communicating information to parents has already been mentioned in paragraph 46, with Members feeling that there would be benefit to a school governor, as a familiar face, chairing any public meeting with parents.
61. At both the second and third scrutiny panel meetings there was further discussion about the valuable role that governors could play in emergency situations. In particular it was felt that governors should be aware of their school's emergency plan and that they should be offered training on how to respond in an emergency situation. Members noted that CSLL had already offered such training and that the CPU are happy to run simulation exercises with school governors if helpful. The importance of involving the head teacher in any such training was acknowledged.

### **Recommendation 17**

That CSLL and CPU work with school governors to help raise awareness of the role they can play in responding to an emergency (including potentially chairing public meetings) as well as awareness of their school's emergency plan.

### **Communication between partners**

62. In terms of the conference calls chaired by NWLHPU (see para 26 for further details) it was felt that not all partners who needed to be part of the conversation were involved. NHS Hounslow was mentioned in this context – i.e. they did not attend every meeting. (This was recorded in the minutes of the Council's internal debrief meeting by CPU along with the related issue of GPs not knowing what was going on). The perception of both NHS Hounslow and NWLHPU is different and both feel that an appropriate level of engagement from NHS Hounslow did take place at the conference calls.

63. Members feel it is worth reiterating the importance of ensuring involvement of all relevant partners during a multi-agency response.

**Recommendation 18**

That a stakeholder analysis be carried out early on in the incident response to determine all relevant stakeholders and the level of involvement required from them.

64. During the emergency response by stakeholders, there was an incident which raised a safeguarding issue in relation to a vulnerable child. Although this issue is very specific and relates to an individual family, it is included in these findings because Members are acutely aware of the sensitivities around dealing with safeguarding children and the importance of ensuring that the Council deals with safeguarding issues in a way which does not bring any further inappropriate tension to what already is a difficult situation.
65. A social worker was deployed to visit a family after concerns raised by an EHO who had previously visited the family as part of her normal duties in responding to the outbreak. The EHO was not informed of the deployment of the social worker. In fact when the issue had been raised at the outbreak control meeting, there had been initial agreement that a health visitor should go to see the family. The social worker when visiting the family identified that concerns had been raised by the EHO. This put the EHO in an extremely difficult position and caused relationships to breakdown between the contact tracing team and the family.
66. The NWLHPU said in its response to the draft version of this report that they felt where the school (or others) are aware of child safeguarding issues then it is important that this is flagged up with the HPU at the outset so that due caution can be taken in communicating with the child's family.
67. Members would like to see wider learning extracted from this individual case and seek reassurance that there is a robust system of information sharing between different teams within the Council and external agencies (particularly where it is an external agency leading on the incident response) where a vulnerable family is concerned.

**Recommendation 19**

That CSLL respond with a view as to how in future children's safeguarding issues and information sharing about vulnerable families will be dealt with in an emergency situation.

## **Engagement with the local press**

68. The NWLHPU said in its response that it is usually the HPA communications office which leads. The HPA communications officer should always work with the PCT and LA communications officer so that any release to the media takes a consistent line and agencies do not contradict each other. Members agree with this and would refer to their earlier recommendation 2.
69. Hounslow's Corporate Communications Unit said they deferred to the Health Protection Agency as lead agency for media relations to avoid confusion and show the outbreak was being dealt with by the experts in the field. They requested being able to check information for the press before it was issued, but this didn't always happen, so their local knowledge was not used to address possible concerns that the information raised.
70. The Corporate Communications Unit felt local press were generally supportive, though they – perfectly understandably – ran stories about parents' concerns due to their individual circumstances as mentioned above.
71. Given the relatively high turnover of journalists at local newspapers, and the multi-agency approach necessary in responding to such incidents, it is unlikely that they will retain much institutional knowledge of how these things are managed. Once an incident begins, they need a single point of contact to avoid receiving conflicting messages (e.g. one agency issuing a new line before the others have it).
72. Members feel the above all links with recommendation 2 about having a clear communications strategy early on. They would like to be reassured that the council's Communications Unit's point about their local knowledge not being fully utilised is taken on board.

## **Support to Head Teacher**

73. Through discussion with partners at both the second and third scrutiny panel meetings it became apparent that the head teacher was receiving information from a number of different sources. This was reflective of the range of stakeholders involved in co-ordinating the response and the importance partners rightly placed on making sure that she was aware of everything that was going on. Partners acknowledged that she would have had an immense amount of information to absorb and keep up to date with.
74. The head teacher herself acknowledged that the support from the assistant head at Cranford Community College (provided for four days) had been really useful. Cranford Community College had been involved in responding to an outbreak of legionnaires previously.

75. Members felt that it was important to put in place support which would help ensure the Head was able to prioritise focus on the welfare of her students and staff. CPU suggested that it would have been helpful if she had someone she could have delegated some aspects of the response to. Members felt another option was to have a nominated person working alongside her who would co-ordinate the information and advice coming in from all agencies and have the overview of what was going on. Members strongly endorse that in future emergencies where a nominated person who could play this role should be identified.

#### **Recommendation 20**

That in any future incident the head teacher – particularly if it is a smaller school – be offered a CSLL staff member onsite to help co-ordinate the response if they so wish.

#### **Procedures for collecting stool samples**

76. The NWLHPU was full of praise for the authority's EHOs who helped with the collection of the stool samples.<sup>7</sup> It was a major exercise to collect two samples from all 360 pupils and approximately 50 staff as well as multiple samples from family and outside contacts of the confirmed cases. They dealt with over 1000 samples in total.
77. The DPH felt it was not appropriate that the teachers were used to collect and inspect stool samples and to check labels on samples. Some parents had felt embarrassed when handing over stool samples to teachers. He felt that in future, the Hounslow and Richmond Community Healthcare 0-16 community nursing service should be used.
78. The NWLHPU in its response to the draft version of this report said that they had come away with a different understanding from debrief discussions with partners that in future parents would be issued with pre-printed labels to attach to samples. Sample pots would be returned in a sealed safety pack.
79. Members would like clarity as to what has been agreed as to the procedure to be followed in future incidents.

#### **Recommendation 21**

That partners report back as to what has been agreed as to the procedures to be followed for stool sample collection in future incidents.

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<sup>7</sup> Stool is a common term normally used in reference to human faeces:  
[http://en.wikipedia.org/wiki/Stool\\_sample](http://en.wikipedia.org/wiki/Stool_sample)

80. The head reported that lots of stool samples had to be returned as they had been collected incorrectly. The fact that many parents had English as a second language may have contributed to this.
81. Environmental Health did ensure that there were translators present and translators had also been involved when necessary when visiting families in their homes. The NWLHPU felt there should have been greater availability of interpreters for parents/carers whose first language was not English. The head teacher felt that this aspect of communication had worked adequately. She did however share that many parents were unable to spell their own child's name correctly so names had to be double checked which took more time.
82. It has been a lesson learned that when collecting stool samples, access to up-to-date lists with names and addresses for all pupils in Hounslow schools is invaluable. They could be used in any future incident to provide labels e.g. for the stool samples.
83. Stakeholders felt that using the school as the collection point for stool samples was extremely effective and should be repeated in future.
84. There was discussion during the stakeholder debrief and scrutiny meetings of the decision to use Northwick Park laboratory to test stool samples instead of West Middlesex which obviously would have been much closer. The NWLHPU explained that Northwick Park laboratory is the designated public health laboratory for North West London and that this is not negotiable. It is likely that this will change in the future but the new designated hospital laboratory would be a large teaching hospital.
85. The debrief also identified one of the lessons learned was that although the need to conduct stool testing was urgent, it was not immediate. It would have been better to spend 24 hours making sure that processes and systems were set up properly as this would have reduced risks of confusion and subsequent delays. NWLHPU and Environmental Health said that due to poorly labelled containers they had to spend a significant amount of time on the phone matching results.

#### **Recommendation 22**

That the school be used as the collection point for stool samples in future as parents know where it is, rather than e.g. a health centre which parents do not know.

#### **Recommendation 23**

That the contacts database held by the school or the local authority be used to pre print electronic labels for all children (this is a relatively simple, quick and cheap task but one that would have significantly helped reduce sample labelling errors. Electronic lists should be made available to NWLHPU and the laboratory as necessary.

### **Environmental Health as the out of hours contact**

86. The Environmental Health Officer (EHO) rota providing emergency rota cover should have been discussed earlier as the EHOs felt that it was inappropriate to be the only source of emergency contact out of hours. The team does not normally have an EHO out of hours service in place so having to provide this from within available team resources was difficult.
87. Out of hours support from the EHO Team was necessary so that the NWLHPU could contact them to update on positive test results and so that they could undertake home visits to collect samples from affected families.
88. Since the incident, the NWLHPU confirmed that a letter had gone from the Unit Director to all borough Chief Executives making them aware of the importance of having out of hours arrangements in place.

#### **Recommendation 24**

That the potential for having collaborative arrangements for the provision of out of hours emergency EHO cover with neighbouring boroughs is investigated.

### **Clarity about deep cleaning**

89. The cleaning company was sourced by CPU. There was a considerable degree of confusion as to what deep cleaning entailed. The company chosen to carry it out was far stricter in what it said was necessary than the advice provided by the Health Protection Agency. The cleaning company worked from precedent i.e. previous clean up operations they had been involved in. CPU recognised that there was ambiguity on advice around items such as soft toys and lunch boxes. Some of these items were destroyed.
90. There was a feeling that this led to resources being thrown away that did not need to be. And this is even though Environmental Health swabbed the entire school and found no evidence of the bacteria, even in the toilets or drinking fountains. All the school's Key Stage 1 books were destroyed and would have to be replaced. Materials and equipment worth £8000 were disposed of.
91. Members during their discussion felt that a pre agreed detailed cleaning specification (with advice and input from HPA) for such situations would be helpful. They also felt that it was worth considering putting a framework agreement in place with a number of cleaning companies so in an emergency situation, you already are aware of which cleaning companies provide the service that you need and there is clarity about what exactly

the deep clean will involve. NWLHPU did comment that they have since asked national guidelines to be developed around this area.

#### **Recommendation 25**

That CPU investigates the potential of putting in place a pre-agreed specification with local cleaning companies which can be used in emergencies to carry out a deep clean. This specification should be put together with advice from HPA.

#### **Recommendation 26**

That in an emergency advice be sought from the NWLHPU/Environmental Health before commissioning any deep clean of a building.

#### **Dealing with confidentiality issues**

92. During the public meeting, parents raised the issue of sharing confidential information. To what extent can or should local health agencies share information about which children/adults have been infected with parents and the school?
93. The school was very interested in knowing which pupils had been excluded as this had a bearing on whether an absence was authorised or not. This was during and subsequent to the outbreak. The school would also have liked to give an opportunity to support those children that were in hospital. The HPU expressed the view that support to the children/their families was the responsibility of the GP.
94. Under Health Protection (Local Authority Powers) Regulations 2010 the Local Authority, from April 2010, Environment Health has powers that may be used to serve a notice on a parent to exclude a child with an infection/contamination and to exclude the child from school for up to 28 days; Environmental Health may also inform the head teacher of the contents of the notice served on the parent. These powers would be used on a discretionary basis.

#### **Recommendation 27**

That schools and other agencies note the new powers available to Environmental Health to serve a notice on a parent to exclude a child with an infection/contamination and to exclude the child from school for up to 28 days; Environmental Health may also inform the head teacher of the contents of the notice served on the parent. (These powers would be used on a discretionary basis.)

### **Attendance and attainments statistics**

95. The head teacher has said she was concerned about the impact of this incident on the school's attendance and attainment figures. Children who were not in school would be formally recorded as having an unauthorised absence. Attendance and attainment targets are very important for a school's reputation and the bald figures do not allow for the story behind them to be told. A month after the school had reopened there were still children who were off school because of the outbreak.
96. There were also unauthorised absences of children at Feltham Hill Junior School (which shares a site with the Infant and Nursery School).
97. Guidance on restrictions to school attendance would have been helpful so there was clarity for parents about when they needed to pull their children out of school and when they could continue to attend as they posed no threat to other students. Members believe this guidance should be part of the key messages that are communicated to parents (see recommendation 2).

### **Financial implications**

98. The costs which have to be borne by the local authority came to some £21k as set out in appendix 1. The costs for the books that were destroyed (unnecessarily as it turned out) had to be borne by the school.
99. There is the question regarding the payment for further stool sample pots. They could only be delivered once payment had been received i.e. a credit card payment was needed. As the finance department was unable to find any resolution to this situation, staff on more than one occasion had to use their personal credit cards to purchase the pots. Members felt that this was completely inappropriate.
100. In their discussions members wished to widen this point to recommend – if this is not already possible – that a range of options be available for the authority, or schools via the authority, to pay creditors through e.g. procurement cards. Members would like an update on flexible payment methods for creditors.

#### **Recommendation 28**

That the Finance Directorate determine how to make significant speedy payments in such situations so that staff do not have to use their personal credit cards etc; and that Finance provide an update to members on the range of options available to pay creditors e.g. with procurement cards.

## 7. Conclusions

101. As stated at the outset of this report, the purpose of this work was two-fold:
- to provide a training case study for new and existing Members, giving them an opportunity to practice their scrutiny skills and build knowledge of the agencies and teams involved in co-ordinating the response to the outbreak
  - to ensure there is a clear set of recorded recommendations, which have the support of the agencies involved and capture lessons learned to inform management of future outbreaks.
102. What was strongly apparent to Members was the proactive approach taken by all agencies involved to ensure that they carried out a review and debrief exercise after the incident to identify lessons learned. This demonstrates the good working relationships there were between all agencies involved. They came together quickly and effectively in what were obviously difficult circumstances.
103. Given the need for a multi-agency response, Members feel there needs to be greater clarity from the outset as to the agency/team that takes leadership responsibility in managing future incidents and is essentially responsible for overseeing how the response is co-ordinated. This role would include involving all relevant partners, ensuring there is a communication plan in place and ensuring that all aspects of interagency working run smoothly.
104. A significant part of the main findings talk about communication - whether it is to parents at the school, to those involved in responding to the outbreak, or between partners. This is reflective of the need in any emergency, to prioritise who is responsible for communicating, what is being communicated and the way in which it is being communicated. For Members having a communication plan in place between all the agencies at an early stage is essential to help ensure there is a consistency in messages that are being sent out and that the message reaches all those who need to be informed.
- Member feedback on the format of the training**
105. Members have fed back that they found the sessions very useful. One of them said that they “understood scrutiny for the first time”. Another said how valuable it was for new Members.
106. One Member felt that “Greater explanation of where the scrutiny panel’s conclusions were leading e.g. report to Executive, being adopted at once by the relevant department would have been helpful. This Member also stated “I am not sure whether the people ‘invited’ to attend for questioning are actually “obliged” to do so”.
107. Future training sessions should provide more clarity on both these points.

## 8. Table of recommendations

No.	Recommendation	Response required?
1.	That it be clearly communicated to all stakeholders who the designated lead professional/agency is and that it be clear that they be responsible for chairing the Outbreak Control Team (OCT), having an overview and co-ordinating all aspects of inter-agency working (including ensuring clarity on the roles and responsibilities of each agency in terms of managing the outbreak.)	No response required. Lessons learned recommendation
2.	That the first Outbreak Control Team (OCT) meeting decide on the initial communication strategy and agree what the key messages are. There should also be agreement on a designated officer taking responsibility for taking forward the communication plan and monitoring it stays on track.	No response required. Lessons learned recommendation
3.	<b>That the agencies responding to this report come back with a view as to whether an alignment of criteria across organisations for emergencies would be helpful.</b>	<b>Response required.</b>
4.	<b>That this report be circulated by CSLL to all borough schools, along with a reminder of the necessity of having an up-to-date contingency plan and submitting a copy to the authority's CPU, and that training for governors and school staff be advertised again in the Director's newsletter and on HVEC.</b>	<b>Response required.</b>
5.	<b>That the NWLHPU confirm any changes to the national HPA guidelines as to whether parents are notified after a single case of E.coli 0157 (VTEC), or other serious communicable disease.</b>	<b>Response required.</b>
6.	That for any future incident a public meeting be held as soon as possible to enable parents to put their questions to professionals directly and that for the meeting planning and preparation, the lessons identified in the debrief meeting (bulleted in main report at para 47) are adhered to.	No response required. Lessons learned recommendation
7.	<b>That CSLL when circulating this report (recommendation 4) also point out to schools the benefits of using a central texting service as a</b>	<b>Response required.</b>

No.	Recommendation	Response required?
	<b>means of communicating with parents/carers. It has many uses but proved invaluable in this emergency.</b>	
8.	That in the event of a future emergency when communicating with parents, the affected school makes robust arrangements to ensure that those parents who have English as a second language have equal access to information and advice being provided i.e. through use of interpreters.	No response required. Lessons learned recommendation
9.	That the communications strategy take into account that parents/carers are likely to use Facebook or other similar social networking sites and that this needs to be used to ensure messages get across.	No response required. Lessons learned recommendation
10.	<b>That FHI&amp;N School test the effectiveness of Parent Mail given the feedback from certain parents that texts might not always be delivered to all intended recipients.</b>	<b>Response required.</b>
11.	<b>That guidance be produced for schools as to how to make their website more visible on internet search engines.</b>	<b>Response required.</b>
12.	That the following three recommendations from the earlier lessons learned exercise be noted. (Included here for completeness): <ul style="list-style-type: none"> <li>• A briefing should occur before the event to ensure the panel understand the key messages and arrangements throughout the meeting.</li> <li>• One person should control/chair the meeting. Only they should direct questions from the floor to the panel and the panel should not answer other questions.</li> <li>• Do not allow children from the affected school to attend, and make sure you have enough chairs.</li> </ul>	No response required. Lessons learned recommendation
13.	That schools in close proximity/ sharing a common site be considered at risk by the HPU and be included in early communications with the affected school and have representation on the Outbreak Control Team (OCT).	No response required. Lessons learned recommendation

No.	Recommendation	Response required?
14.	That the designated communication lead as determined by the critical/emergency incident lead (recommendation 1) ensures that the communication plan includes consideration of how full and early communication will be carried out by all staff (teaching and non-teaching).	No response required. Lessons learned recommendation
15.	That the Director of Public Health ensure that all GPs in the borough or over the borough boundary in proximity to the outbreak are notified of the incident; and that any communication to parents/carers sets out clear, easy steps as to how they can complain about any GP who does not take their child's illness seriously and who to contact to get the advice/treatment they need if there GP is not supportive.	No response required. Lessons learned recommendation
16.	<b>That the Director of Public Health ensure that all GPs are sent a copy of this report.</b>	<b>Response required.</b>
17.	<b>That CSLL and CPU work with school governors to help raise awareness of the role they can play in responding to an emergency (including potentially chairing public meetings) as well as awareness of their school's emergency plan.</b>	<b>Response required.</b>
18.	That a stakeholder analysis be carried out early on in the incident response to determine all relevant stakeholders and what level of involvement is required from them.	No response required. Lessons learned recommendation
19.	<b>That CSLL respond with a view as to how in future children's safeguarding issues and information sharing about vulnerable families will be dealt with in an emergency situation.</b>	<b>Response required.</b>
20.	That in any future incident the head teacher – particularly if it is a smaller school – be offered a CSLL staff member onsite to help co-ordinate the response if they so wish.	No response required. Lessons learned recommendation
21.	<b>That partners report back as to what has been agreed as to the procedures to be followed for stool sample collection in future incidents.</b>	<b>Response required.</b>
22.	That the school be used as the collection point for stool samples in future as parents know where it is, rather than e.g. a health centre which parents do not know, and where staff are not prepared/trained to deal with the task.	No response required. Lessons learned recommendation

No.	Recommendation	Response required?
23.	That the contacts database held by the school or the local authority be used to pre print electronic labels for all children (this is a relatively simple, quick and cheap task but one that would have significantly helped reduce sample labelling errors. Electronic lists should be made available to NWLHPU and the laboratory as necessary.	No response required. Lessons learned recommendation
24.	<b>That the potential for having collaborative arrangements for the provision of out of hours emergency EHO cover with neighbouring boroughs is investigated.</b>	<b>Response required.</b>
25.	<b>That CPU investigates the potential of putting in place a pre-agreed specification with local cleaning companies which can be used in emergencies to carry out a deep clean. This specification should be put together with advice from HPA.</b>	<b>Response required.</b>
26.	That in an emergency advice be sought from the NWLHPU/Environmental Health before commissioning any deep clean of a building.	No response required. Lessons learned recommendation
27.	<b>That schools and other agencies note the new powers available to Environmental Health to serve a notice on a parent to exclude a child with an infection/contamination and to exclude the child from school for up to 28 days; Environmental Health may also inform the head teacher of the contents of the notice served on the parent. (These powers would be used on a discretionary basis.)</b>	<b>Response required.</b>
28.	<b>That the Finance Directorate determine how to make significant speedy payments in such situations so that staff do not have to use their personal credit cards etc; and that Finance provide an update to members on the range of options available to pay creditors e.g. with procurement cards.</b>	<b>Response required.</b>

## Appendix 1 – Costs of dealing with outbreak

Financing of the incident recovery is the responsibility of the Council. The table below gives a breakdown of costs:

<b>Officer time/activity</b>	<b>Cost</b>
EHO: time spent at the school, meetings and teleconferences.	<b>£1990</b> (£20ph)
Taking sample pots Northwick Park	<b>£1036</b> (unit cost £64.75, 16 trips required in total) <ul style="list-style-type: none"> <li>• 2 hours officer time</li> <li>• 30 miles @ 72.5p a mile.</li> <li>• £3 parking</li> </ul>
EHO Officer time and mileage delivering and collecting pots from patients/contacts	<b>£1008</b>
Safeboxes	<b>£815</b> (unit cost £3.40)
Communications Team: media management costs	<b>£300</b> (£30ph)
Alcohol hand gel	<b>£145</b>
School cleaning costs (met by LA)	<b>£11,737.08</b>
Contingency Planning Officer	<b>£3990</b> (£33ph)
On-going costs to school to replace equipment following the clean up operation.	<b>£9,000</b>
<b>Total Cost</b>	<b>£30,021.08</b>

## Appendix 2 – Roles and responsibilities of stakeholders involved

Those involved in co-ordinating a response were asked to provide a brief description of what they believed their roles and responsibilities were. Information provided is re-produced below.

### *CPU (Hounslow Council)*

The Contingency Planning Unit ensure the Council and its departments maintain plans to allow them to effectively respond to incidents such as an outbreak of disease, flood, fire or any other emergency. They respond to outbreaks by coordinating the activities that take place within the local authority and by liaising with external agencies. They also identify good practice examples from similar outbreaks, assist in sourcing contractors, and conduct debriefs.<sup>8</sup>

### *CCT (Hounslow Council)*

In this case, corporate communications worked with the school and NWLHPU on media relations, and offered advice on wider communications activities such as the public meeting. With all the interest in the school, we acted as a conduit for the press so the head could focus on the more pressing matter of dealing with the issue. As NWLHPU led on these matters, we liaised with them to make sure they were hearing concerns 'from the ground' and made sure the local press understood who was in charge of the multi-agency response.<sup>9</sup>

### *Environmental Health Food Safety Team (Hounslow Council)*

GPs and the NWLHPU are statutorily required to notify the local authority of cases of infectious disease. Our role is to investigate the source and recommend control measures to prevent the spread of disease. We co-ordinate the collection of microbiological samples from patients and contacts and act alongside the HPU to limit the spread of an outbreak. We also have powers to exclude persons from work or close and/or disinfect premises.<sup>10</sup>

### *CSLL*

There were a number of officers in different teams in Children's services that were involved as set out below:

The Business Support Officer is the Departmental Co-ordinator for CSLL and is the first point of contact when schools need guidance and support

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<sup>8</sup> Leigh Farina, Contingency Planning Officer, Contingency Planning Unit, Hounslow Council, Monday 7<sup>th</sup> June.

<sup>9</sup> Philip Sutcliff, Corporate Communications Officer, Hounslow Council, 8<sup>th</sup> June.

<sup>10</sup> Juliet Isitt, Food Safety Manager, Hounslow Council, 9<sup>th</sup> June.

with emergencies. She acts as the liaison between the schools, council and other agencies taking advice from the CPU. This role has responsibility for the monitoring of absences, attending daily conference calls and supporting the school with their recovery plan.

The Information Services officer is responsible for the communication channels between the council and the press/media. Liaison takes place between the CPU and CCT to ensure that communications are consistent and have been regularly updated this would include advice to schools about how to communicate with parents e.g. keeping the telephone voicemail up to date and the school website.

The Director ensures that the department responds to any requests for actions that need to be taken. The Director made contact with the Head Teacher and Chair of Governors to assess what other support was required and attended parent/public meetings.

The Head of Finance was responsible for identifying the contingency funding to support the school with the deep cleaning exercise.

The Head of Access and Inclusion was responsible for producing specific guidance to the school for parents about how absence/ non-attendance was to be recorded.

Staff from Business Services were asked to support the school with collecting samples for the Health Protection Agency and getting the school ready to re-open.<sup>11</sup>

### *NWLHPU*

The work of the NWLHPU was to undertake investigations to determine the source of the outbreak, to offer advice to control the outbreak and to prevent further cases. The NWLHPU also offered advice to parents, the public and GPs. They worked collaboratively with the laboratory to monitor results, worked closely with the school, especially on communications and with environmental health. The NWLHPU analysed questionnaires on all staff and children attending the school; however no source was found.<sup>12</sup>

### *NHS Hounslow*

In this outbreak, the role of NHS Hounslow was to act as a link between the NWLHPU and GPs, and to provide health advice to the public. In general, NHS Hounslow has overall responsibility for protecting the health of its residents but this is discharged through a memorandum of understanding with the NWLHPU.<sup>13</sup>

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<sup>11</sup> Sheena Poley, Head of Business Services, CSL, Hounslow Council, 8<sup>th</sup> June.

<sup>12</sup> Dr Margaret Meltzer, Consultant in Communicable Disease Control, NWLHPU, 8<sup>th</sup> June.

<sup>13</sup> Mike Robinson, Director of Public Health, Hounslow NHS, Tuesday 8<sup>th</sup> June.

*Feltham Hill Infant & Nursery School*

As the Head Teacher at the school my key role in this outbreak was to safeguard the wellbeing of children and staff in the school. I followed advice from Health agencies in order to make effective decisions specifically about school closure. I organised (with local authority support) staffing arrangements, deep cleaning and managed the incident. I was involved in daily teleconferences which enabled all professionals to share information. From this I was able to update my staff and my school website to share information with parents. I communicated with parents by text, website and parent mail and a formal meeting. From the very first phone call I kept detailed notes and recorded each part of the process.<sup>14</sup>

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<sup>14</sup> Maggie Newbury, Head Teacher, Feltham Hill, Infant and Nursery School, Thursday 10<sup>th</sup> June.

## **Appendix 3 – Details of discussions with witnesses**

### Stuart Fleming – School Governor and Parent Representative

Stuart Fleming gave members a briefing of his involvement.

He found out on the Tuesday evening from the school, when he got a telephone call at 7pm from the school administrator saying to keep the information confidential. His phone and that of his wife's kept ringing with calls and texts from concerned parents and friends. Texts then went out to all parents the next day Wednesday.

Maggie Newbury informed members that texts were done using a new system called Parent Mail which can send messages en masse, and this was trialled during the snow closures and was seen to work and be effective. Although not every parent was on the system, as at the time of the incident, it was an opt-in service, and since the incident this has been changed to an opt-out system.

Stuart was surprised that staff were involved in taking stool samples.

It was time consuming getting the stool samples.

The school coped well.

The public meeting could have been better organised. It was organised and chaired by the Contingency Planning Unit. A film of the meeting is available.

A lot of people didn't take the time to educate themselves about the information.

There was too much written information.

### Questions

A member expressed concern that teaching staff were collecting stool samples.

Maggie Newbury said staff had to collect 2 samples, 48hrs apart, and that initially the school coped well, in putting together information packs etc, but she accepts the public meeting could have been better organised.

Cllr. Steve Curran asked who had organised the meeting.

Maggie Newbury said it was planned by CPU but in her name ('allegedly' by her), and letters were sent to parents in her name. There was daily liaison through tele-conferencing by all the professionals involved.

Cllr. Steve Curran asked who chaired the public meeting.

Maggie Newbury said it was chaired by Joseph McFarland Head of CPU.

Dr Margaret Meltzer said she felt, if the meeting had taken place on the Wednesday, as she had suggested, a lot of issues would have been addressed at an early stage.

In response to a question if she was supported by any senior officer from the CSLL, Maggie Newbury said she did receive a telephone call offering assistance,

but this was done in the midst of other issues, hence her support for calls for a protocol/ guidance. She was able to put together packs for parents that included a letter to each parent, e-coli O157 factsheet and a health questionnaire.

Maggie Newbury said she was in acceptance with Dr Margaret Meltzer on the 24hr issue, as this was important, as well as the fact that the floor was not well controlled during the public meeting (see Dr Margaret Meltzer's comments in appendix 3 re: paragraph 6.8 of the preliminary report).

Cllr. John Cooper commented that CPU chaired the public meeting, and during the meeting it was hard to hear the chair as the microphone was not working properly, the meeting was not well coordinated, but he wanted members to bear in mind that parents at the meeting were clearly agitated and passionate about the welfare of their children. Hence a lot of them were talking without listening to the chair and chairing the meeting became even more difficult to manage.

Dr Michael Robinson said members should have the opportunity to watch a video that was done of the public meeting event. In retrospect he assumed that the Head of CPU was experienced in handling such difficult meetings, but he also feels he did the best he could. Next time he said he would check if the person chairing such meetings had any experience.

Cllr Peta Vaught said an experienced chair was definitely needed.

Dr Margaret Meltzer said the NWLHPU came away with a valuable lesson i.e. parents asking why they were not alerted after the 1<sup>st</sup> case was confirmed. She discussed this with colleagues at the HPA and this is being considered for future cases, i.e. alerting parents at a school after a single confirmed/suspected case of e-coli O157.

Cllr John Cooper felt he should remind members that around the time of the incident, the winter vomiting bug was also doing the rounds.

Dr Margaret Meltzer said she felt the school coped very well, and another issue that was faced was parents complaining about access to their GP's and the advice given.

Dr Margaret Meltzer said another issue was that of schools on a shared site, and in future letters to go to both head teachers.

## Maggie Newbury – Head Teacher

Maggie Newbury said samples were collected from all 360 children 50 staff approx and all gave 2 samples each.

Maggie talked about her accountability as Head Teacher – she took advice from HPA and was well supported by the Children’s Director at the Council (who put her in touch with the Community College who have had many difficult incidents to deal with).

She said she felt well supported professionally and Judith Pettersen (CSLL Director) contacted her and put her in touch with Cranford Community College who have had interesting issues to deal with. She then set up a recovery team to put the school back to order. She has had to deal with a lot of fallout from this case including attendance issues, unauthorised absences etc as well as having to maintain her targets.

Maggie had a lot to do – this was on top of managing the school and staff and keeping things going and still having other targets to manage in the context of the outbreak i.e. attendance targets that were obviously detrimentally affected.

There was the issue of when an absence became unauthorised (the fact that HPA couldn’t share names of children did not help). This had an affect on the school as an organisation.

As there is no clear guidance on how to deal with these issues, this has had a huge impact on the business of the school, but she is proud of her staff and the way they worked. The school governors, some Hounslow staff and her staff helped with the deep clean.

The deep clean had a big impact. The staff worked through the school holidays to get school ready for the children to return on time after half term. Local authority staff also helped. Have had to manage the financial costs but it is the emotional well being of the staff that has been a key factor too – there are ongoing considerations. Still need to meet curriculum standards - are not given any lee way with this because of the outbreak.

She went on to say the school was closed for 8 school days because of the half term holidays. The school closed on Friday of half term and opened on Monday with everything in place.

## Questions

Councillor Steve Curran – asked about any on costs.

Maggie said she was still negotiating about the costs, but was grateful she inherited a healthy budget. It was the emotional cost to staff that was unquantifiable. Her KS 1 children’s books were all destroyed as part of control measures and she has been referring and reminding her staff to use the Employee Counselling Service at the CC.

She was asked how she was able to deal with the issue of the press?

Press intrusion was an issue. Maggie communicated with CPU, HPA and education during this time there was no one link to the school. Maggie said the Communications Team at the civic dealt with the press issues, but on the last day she invited the press to the school. She was aware though that some parents were using social networking sites to discuss the case. There is a need to educate parents about this.

CPU did a lot of the running around in terms of organising logistics i.e. if boxes were needed to pack away things.

Cllr. John Todd asked what was the e-coli link to the school?

Following the first incident, clinicians identified the school the child went to and investigation went on from there. Investigation had to be based on evidence from clinicians.

Dr Margaret Meltzer said they had 13 confirmed cases within 6 families all linked to the school. EHO's took 21 environmental samples from different areas of the school; all the swabs tested at the HPA Food Water and Environment Laboratory were negative. Neither the environmental nor the epidemiological studies found source of the VTEC outbreak.

Were you given contradictory information?

Yes. Example of this was deep cleaning contractors. They were appointed by CPU and paid for by the LA. Definition of cleaning not identified and the school was not given a specification of what the deep cleaning would involve. Cross advice from different cleaning agencies. Some said it was safe to keep books, others said they needed to be destroyed.

Dr Margaret Meltzer said that the email shared with her of the intended action by the cleaning company seemed an over the top reaction. The NWLHPU had therefore sought the view of a national expert on infection control. The HPA view was that the destruction of inanimate objects such as books was probably excessive as they do not harbour E.coli O157 bacteria and the bacteria do not survive long on surfaces where there is no organic matter.

Maggie said she received contradictory information, and the deep clean contractor was appointed and paid for by CPU. She said the deep clean was not a deep clean in the literal sense of the word.

Cllr. Peta Vaught said the name should be changed to disinfecting and not deep clean.

Dr Margaret Meltzer said the EHOs worked extremely hard, and were a major partner in collecting and delivering the stool pots and samples. She said the EHOs had run out of stool sample pots, and faced difficulties in obtaining funding from the council for new pots which were urgently required.

She also felt that GP's should have better supported families the affected. Anecdotal reports to the HPU suggested that the families did not receive that support.

The deep clean for her was an over kill, and she does not know how the contractors were contacted as her departmental advisor (Dr Hoffman) was not in approval of the procedure and measures adopted by the contractor.

Maggie said the cleaning companies contacted all gave conflicting information.

Cllr. Mindu Bains raised the subject of having a do's and don'ts list or learning video for children and parents.

Maggie said they used NWLHPU documents and advice on hand washing.

Issue of GP role in supporting the family.

The HPU and environmental health continued to take and test samples from families into April 2010. Some children required exclusion from school/nursery for up to 6 weeks.

Dr Michael Robinson – Joint Director Public Health for NHS Hounslow and LB Hounslow

Dr Michael Robinson reminded members of the Godstone Farm e-coli O157 outbreak where a child had died, and so it was very important this was handled appropriately. He said e-coli O157 was something the HPA was still learning about and national guidance was now being rewritten in light of all the new cases. He felt it was very difficult to control e-coli as there were cases daily in London, but not leading to an outbreak.

He described his role as to coordinate and to monitor. He was also able to assist the HPA with access to and cooperation from GP's and community nurses, and to speak and reassure the public.

He said he felt the parties involved all worked well together, an inheritance from their work on swine flu.

There is an issue in terms of judgement - balancing between informing parents and scaring them. School nurses in future could be involved.

(Maggie Newbury confirmed that she does have a good relationship now with the school nurse – didn't really know nurse when incident happened).

He said the agenda had changed slightly as the cases developed. There was also the challenge of having two schools on the same site.

He was also surprised that some GP's did not know how serious this case was. Next time he would write a slightly different letter to GP's.

He was in favour of parents being informed after a single case, and not to use teachers ever again in collecting samples but to use the 0-16 service of community nurses.

Questions

Cllr. John Cooper said he felt it might be helpful if the GP was not being cooperative, to provide parents with another number they could contact.

Maggie said this was a good idea and would also think of offering telephone support line.

Parents should be advised, if your GP is not helpful/behaving in the appropriate manner, then call this number.

Cllr John Todd touched on the confidentiality issue and the matter of the Local Authority through the schools acting in loco parentis.

Members were concerned with the rigid approach taken to confidentiality. It jeopardises common sense approach.

Dr Michael Robinson said next time he would tell GP's they can tell schools if parents were in agreement of their child having suspected e-coli.

Cllr. Elizabeth Hughes said it might also assist if there was a unique code in all correspondence to parents that could be quoted to the GP or practice nurse so they would know the severity of the case.

Dr Michael Robinson should ask parents to tell school – this advice can be formalised.

Members raised possibility that parents could quote the code to receptionist (given to them in communication letter by school?) when they call up in instances like this, so there is clarity about advice/process for dealing with these kind of complaints amongst staff at practices.

Dr Michael Robinson said this was a good idea.

Maggie Newbury said a 24hr contact line was set up by the CPU and on the website.

Cllr Steve Curran asked if a senior officer from the department had been available to assist MN on a daily basis for the duration of this incident would have helped her?

Maggie Newbury said it would have to some extent, and the Business Support Officer Sheena Poley did ring her as stated before, but MN was in the midst of doing other things.

Cllr. Steve Curran said more was needed and not just a telephone call, as Maggie Newbury had her mind on a lot of other issues,

There needs to be clarity around the support offered to the head teacher – a support protocol should be drafted.

Cllr Liz Mammatt enquired whether the handling of the Press had been a problem as she had been quoted several times.

Officers said they would seek a response from the Corporate Communications Unit.

## Appendix 4 – Letter to parents from HPU



North West London  
Health Protection Unit

61 Colindale Avenue  
London  
NW9 5EQ

[www.hpa.org.uk](http://www.hpa.org.uk)

**HPU ref: S101262**

Wednesday, 03 February 2010

Dear Parent/Guardian

### **Precautionary school closure due to E coli 0157 infection**

I am writing to you to inform you that a child who attends the Feltham Hill Infant and Nursery school was identified with E coli 0157 infection. A second child associated with the school has been identified as a case. In view of these developments, we recommended that the school should be closed as a precaution.

Although E coli 0157 infection in most people resolves in a few days, it can sometimes be more serious.

All children and staff who attend that school will have to provide two stool specimens that have been shown to be clear of infection before being able to come back to school. The reason for this is that some people can carry and spread the germ that causes the illness without becoming ill themselves. The samples should be taken at least 48 hours apart.

When the school will reopen depends on a number of factors including how long it takes to get clear samples from staff and pupils. We anticipate that this will be after the February half term holiday on 22 February 2010.

The Children's Centre, the Breakfast Club, the After-school club and Once Upon a Time day centre for under fives will not admit any children who attend Feltham Hill Infant and Nursery School. However children who attend Feltham Hill Junior school will be admitted.

**If you are worried about any symptoms in you or your child then you should seek your GP's advice or contact the out of hours service**

Yours faithfully

A handwritten signature in blue ink that reads 'M. Meltzer'.

Dr Margaret Meltzer  
GMC No. 2242833  
Consultant in Communicable Disease Control  
North West London Health Protection Unit

## Appendix 5 – Newspaper article after school meeting

### Feltham parents vent anger over E coli school closure at packed public meeting

12:46pm Tuesday 9th February 2010

**By Paul Teed**

**Five diagnosed with E coli  
Tests on seven more expected to be positive  
GPs criticised for turning away 'sick' children  
Cuddly toys and books to be destroyed in clean-up**

Doctors have been criticised for turning away children with E coli symptoms from their surgeries following an outbreak at a primary school.

Parents of pupils at Feltham Hill Infant and Nursery School in Bedfont Road, Feltham, complained that GPs told them they were not responsible for dealing with the infection.

Five people associated with the school - among them two children - have been diagnosed with the bug, and tests on seven more are expected to come back positive. The school has been closed since last Wednesday.

About 200 concerned parents packed Feltham Hill Junior School hall for an urgent meeting last night.

Dr Mike Robinson, director of public health at NHS Hounslow, told the audience: "I've written to all the GPs in the Feltham area to tell them that any concerns that are expressed then they need to take them seriously, and they should not be brushing you away."

Dr Margie Meltzer, a consultant at the Health Protection Agency (HPA), said youngsters who had been ill were "improving".

Children's cuddly toys and books will be destroyed when specialist cleaners enter the school on Thursday. Mums and dads reacted angrily after learning the HPA confirmed the first pupil with E coli on Saturday, January 30 - three days before alerting parents.

The agency contacted the school that weekend and discovered four more children had symptoms.

One mum said: "We should have been told on Monday there was a confirmed case of E coli at the school - my daughter had signs on Saturday.

"I sent my daughter to school on Monday because I thought she just had a bit of diarrhoea."

A grandmother added: "You took a choice away from all these parents by not giving them all the information so they can make an informed and educated decision."

Dr Robinson said: "It's a question of balancing up with the disruption and anxiety caused, versus as you say the common sense, so parents have a right to know so they can take the precautions."

Hounslow Council's environmental health team has taken swabs inside the school, excluding the outdoor drinking fountains, and has not found the source of the bug.

Juliet Isitt, environmental health officer at Hounslow Council, told parents they could be reassured the catering was safe, adding: "Even areas like the toilets where we might have expected to find it were all clean."

Dr Meltzer said: "We think it has been transferred from person to person once in the school, we don't think there's an ongoing source in the school."

Head teacher Maggie Newbury said she hoped to re-open on Monday, February 22.

For more information call NHS Direct on 0845 46 47.

## Appendix 6 – Report from professionals on lessons learned debrief

Report: *E. coli* Outbreak Lessons Identified

Author: Leigh Farina

Contact: 020 8583 5111

Date Released: 13MAY10

- 1.1 This report details the lessons identified during an outbreak of *E. coli* O157 in an Infant and Nursery school in the London Borough of Hounslow.
  - 1.2 The outbreak occurred at the beginning of February and eventually affected 18 people. The source of infection was never found despite extensive investigation by the NW Health Protection Unit (NWHPU) and Environmental Health Officers. The school was closed for a total of 3 weeks, underwent a deep clean and all pupils and staff had to submit 2 stool samples in order to return to the school.
  - 1.3 Further detail relating to the outbreak can be obtained in debrief reports by contacting the Contingency Planning Unit at the London Borough of Hounslow. A background section is included as an appendix.
- 
- 2.1 Lesson 1: The decision to close the school was made on the first day of the outbreak; this was then relayed to parents through the successful use of a school messaging system – Parent Mail. The ability to contact parents quickly stops the spread of rumours and leaves the school able to manage the incident rather than phoning parents.
  - 2.2 Lesson 2: The Outbreak Control Team<sup>15</sup> decided that all pupils and staff would have to submit 2 stool samples for testing. The need to start this was progressed urgently, but in hindsight this did not have to be started immediately and an extra day could have been given to organise the logistics of this. This process requires sample pots, arrangements to get samples to a laboratory, a place for samples to be dropped off, a rota for all staff involved and transport.
  - 2.3 Lesson 3: School staff received sample pots from parents and staff and this may not be the most appropriate group of people for this role. The advantage is parents and teachers saw a familiar face during the incident, but had to hand over a personal sample to someone they knew. The decision of who should receive the samples should consider health sector staff who are used to this type of role. The school was the best location to receive the samples.
  - 2.4 Lesson 4: This type of incident involves multiple services from across the Local Authority (Environmental Health, Emergency Planning, Children's Services and Communications) and an emergency was not declared. The benefits of declaring this as an emergency would have been increased support from senior directors and a greater awareness across the authority of

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<sup>15</sup> Outbreak Control Team consisted of representatives from the Health Protection Agency, *E. coli* testing laboratory, Epidemiology team, Environmental Health, Contingency Planning Unit, School, Children's Services department, Primary Care Trust, and Communications teams.

the impact. The reason for not declaring an emergency was that it did not fit the title as defined in the Major Emergency Plan. This could be overcome with a phased approach to emergencies, with clearly defined trigger points and actions.

- 2.5 Lesson 5: The Outbreak Control Team quickly needed to identify if there were links between pupils at the school and with other establishments such as nurseries, breakfast clubs and children's centres. The school had no emergency plan and therefore the team were reliant on the knowledge of school staff, and this caused delays in stopping the spread of the outbreak.
- 2.6 Lesson 6: The parents of children at the school and a junior school on the same site were very concerned about the outbreak spreading to the junior school. This was not considered a risk by the NWHPU and this decision was based on clinical evidence, which whilst correct did not take in to consideration public perception. Decisions made during emergency response should take in to account not just the evidence but also how the decision might be perceived.
- 2.7 Lesson 7: Information sharing was difficult between the school and the health authorities, although worked well between the EHOs and NWHPU. The school were unable to show their support for children in hospital as the NWHPU could not release the names. The debrief identified this could be overcome by making it clear medical information would not be released, but parents could inform the school if they wished.
- 2.8 Lesson 8: The NWHPU changed their definition of who was at risk which caused a change in the advice given to parents. This caused confusion and worried parents that the outbreak was not being controlled. In common with Lesson 2, time should have been taken to set definitions and properly assess the risk.
- 2.9 Lesson 9: Representatives from establishments that share a site with another that is affected by an outbreak should be included in the outbreak control team.
- 2.10 Lesson 10: Sample pots should be issued with labels – the school would need to submit an electronic line list with students full details and GP to the HPU, and this made in to labels. This would enable GPs to receive the results from the laboratory and would mean the school would not have to check each sample as it is submitted.
- 2.11 Lesson 11: Costs involved – these amounted to **£21,021.08**, here is a breakdown: Environmental Health Officer time spent at the school, at meetings and teleconferences (at £20 per hour, average planned overtime rate) = £1990  
Taking pots to Northwick Park unit cost £64.75 (= 2hours officer time + 30 miles/72.5p/mile + £3 parking) x 16 trips = £1036  
Officer time and mileage delivering and collecting pots from patients/contacts = £1008  
5x 48 boxes of Safeboxes = £815  
Media Management Costs (£30 per hour) = £300  
Alcohol Hand Gel = £145  
School cleaning costs = £11737.08  
Contingency Planning Officer Time (at £33 per hour) = £3990

- 2.12 Lesson 12: During the incident, the outbreak control team did not strategically consider the steps to be taken should the incident escalate – such as the source of the outbreak found to be in the school meals, or *E. coli* spread to other schools. Escalation at an early point should be considered in all incidents.
- 2.13 Lesson 13: The following key points should be considered if a public meeting is convened.
- A briefing should occur before the event to ensure the panel understand the key messages and arrangements throughout the meeting.
  - One person should control/chair the meeting. Only they should direct questions from the floor to the panel and the panel should not answer other questions.
  - Do not allow children from the affected school to attend, and make sure you have enough chairs.

## Appendix 7 – Attendance by members at review meetings

Date of review meeting	Members present
14 June 2010	Cllr Mindu Bains, Cllr Colin Botterill, Cllr Peter Carey, Cllr John Cooper, Cllr Ajmer Dhillon, Cllr Liz Mammatt, Cllr Shantanu Rajawat, Cllr Balvir Sond, Cllr Rebecca Stewart
30 June 2010	Cllr Steve Curran (Chair), Cllr Mindu Bains, Cllr Peter Carey, Cllr John Cooper, Cllr Elizabeth Hughes, Cllr Liz Mammatt, Cllr Shantanu Rajawat, Cllr John Todd, Cllr Peta Vaught, Jacqui Corley (co-opted member, CYP Scrutiny Panel)
29 July 2010	Cllr Steve Curran (Chair), Cllr Colin Botterill, Cllr Ajmer Grewal, Cllr Liz Mammatt, Cllr Shantanu Rajawat, Cllr Peta Vaught, Cllr Allan Wilson, Jacqui Corley (co-opted member, CYP Scrutiny Panel)

## **Appendix 8 – LB Hounslow criteria for defining emergencies**

(Received from CPU 23 August 2010)

The definition of a Major emergency is:

Any event or circumstance (happening with or without warning) that causes or threatens death or injury, disruption to the community, or damage to property or to the environment on such a scale that the effects cannot be dealt with by the emergency services, local authorities and other organisations as part of their normal day-to-day activities.

The Council's Major Emergency Plan (MEP) will be invoked

- When the response to an emergency involves more than two departments, and when it becomes necessary to co-ordinate the Council's response. However, the MEP will never take the place of departmental arrangements for dealing with 'routine' minor emergencies.
- Declaration by the emergency services
- If notified by the Chief Executive or Deputy
- If a severe weather or flood warning is received

We have 3 tiers of activation:

1. Normal Business
2. Alert (an event that has either a warning or period of low level activity that is likely to escalate to an emergency)
3. Major Emergency (moving to the recovery phase and back to normal business post incident)

This arrangement is relatively new and actions are as yet not defined.

## Glossary

<b>CCT</b>	Corporate Communications Team
<b>CPU</b>	Contingency Planning Unit
<b>CSLL</b>	Children's Services & Life long Learning
<b>DPH</b>	Director for Public Health
<b>EHO</b>	Environmental Health Officer
<b>EOC</b>	Emergency Operating Centre
<b>FHI&amp;N</b>	Feltham Hill Infant & Nursery School
<b>GPs</b>	General Practitioners
<b>HPA</b>	Health Protection Agency
<b>NWLHPU</b>	North West London Health Protection Unit
<b>OCT</b>	Outbreak Control Team
<b>OFSTED</b>	Office for Standards in Education
<b>PCT</b>	Primary Care Trust
<b>SELHPU</b>	South East London Health Protection Unit
<b>VTEC</b>	Vero cytotoxin-producing Escherichia coli (name/abbreviation often used by health professionals to describe E. coli/E.coli 0157)

Sunita Sharma Head of Scrutiny & Performance  
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Alan Weaver	Scrutiny Officer
Jonathan Hill-Brown	Scrutiny Officer
Deepa Patel	Scrutiny Officer
Ben Osifo	Scrutiny Officer
Nadia Awan	PA to Head of Scrutiny & Performance

[www.hounslow.gov.uk](http://www.hounslow.gov.uk)

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अनुवाद की मुफ्त सेवा उर नमै दी भइत सेवा



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