

# HUSH NEWSLETTER

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## OUTBREAK UPDATES:

### ◆ South Wales—2005

An outbreak of *E.coli* O157 during the end of 2005 resulted in over 150 cases, including one fatality, and affected 42 schools in South Wales. Twenty-eight children and five adults were treated in hospital.

Joint investigations were carried out by the South Wales Police and a number of local authorities in the area. Earlier this year the police issued a statement saying that following their investigation there was insufficient evidence to provide a realistic prospect of a conviction in respect of an offence of manslaughter. It was also concluded that a prosecution under the Health and Safety Act 1974 was not appropriate.

A combined prosecution for 13 food hygiene offences has been commenced by Bridgend CBC, Caerphilly CBC and Rhondda Cynon Taff CBC. A committal hearing took place in March 2007, committed to trial in April and the next preliminary hearing scheduled for 4th June at Cardiff Crown Court.

The National Assembly for Wales has established an independent Public Inquiry under the chairmanship of Prof Hugh Pennington. The preliminary hearing of the Inquiry was held in June 2006 and the timing of further stages, including its oral hearings and the appearances of witnesses, will be published in due course.

### ◆ Dunfermline—2006

During May 2006 an outbreak of *E. coli* O157 occurred in Fife, centred on the Careshare Nursery in Dunfermline. There were 14 confirmed cases, 7 of whom were children at the nursery. The other 7 confirmed cases were close relatives of some of the nursery cases.

The Incident Control Team (ICT) Report was published last week and concludes that it is not possible to say what the source of this outbreak was, but the most likely scenario is a single introduction into the nursery followed by person to person spread. The report identifies both areas of good practice in handling the outbreak and things that could be improved for the future, and makes 29 recommendations for action.

Because of the unusual nature of the strain of *E. coli* O157 involved and the significant media and public interest that the outbreak attracted, NHS Fife identified the need for a post-outbreak review beyond that of the usual review carried out by the ICT. It therefore commissioned Dr Malcolm McWhirter, then DPH of NHS Forth Valley, supported by Health Protection Scotland, to undertake a review of NHS Fife's response to the outbreak. The external review concluded that "*The Outbreak Control Team responded rapidly and appropriately to the outbreak of E. coli O157 centred on the Careshare nursery. The standard of this response is at or above that which would be expected in any other NHS Board.*" The review identified a number of areas that should be discussed and addressed to improve the working and resilience of the NHS Fife ICT in the event of any future significant communicable disease outbreak or major incident.

## THANKS TO GAIL & NEWS INTERNATIONAL ...

HUSH was delighted when member, Gail Cobley, contacted us to say her employers, News International Limited, had agreed to donate £875 so we could purchase 5 more fluorescent light boxes. These will be ordered and distributed as required to various locations across the country—if you know of a group or organisation that could make good use of a lightbox, then please let our co-ordinator know by calling Freephone: 0800 731 4679 or e-mailing [hush@ecoli-uk.com](mailto:hush@ecoli-uk.com).

Gail tells us on the following page, of the family's awful experience in 2005 when Alice suffered HUS.

# Alice's Story

One Sunday at the end of April 2005 my daughter Alice (who was almost 2 years old) received an invitation to a birthday party. While I accompanied her my husband, David, took our 4 year old daughter, Phoebe, to the local City Farm. A week later, just days after her second birthday, Alice woke up with vomiting and diarrhoea. For the whole of that Sunday and the Bank Holiday Monday she was unable to keep anything down and became more and more listless. There was blood in her nappies, which we assumed was due to the trauma caused to her insides.

Tuesday—David took Alice to the GP, who referred her to our local hospital due to the bloody nappies. She was admitted and put on a drip to rehydrate her. David and I spent the next few days doing shifts between Alice, Phoebe and work.

Friday— In the morning the doctor told us that the Thursday's blood test results showed some worrying signs. Her platelet count had dropped significantly, as had her haemoglobin. Her creatinine and urea levels had risen, indicating the start of kidney failure. All the signs were pointing to a condition called HUS, Haemolytic Uraemic Syndrome, which causes a toxin to be produced which attacks the blood, causing the breakdown of the clotting system and stopping the kidneys from working effectively. On the other hand, as this usually follows from E.coli and none had been found in Alice's system, the doctors were somewhat puzzled. At lunchtime, the morning's blood test results came back and showed a worsening of Alice's condition. HUS was confirmed, despite the lack of E.coli confirmation.

Saturday—We were transferred to Guy's by ambulance for specialist treatment. Alice was less flat out than she had been previously, but still hadn't eaten anything for a week. We arrived at the paediatric renal ward, which was scary but reassuring at the same time. The consultant was wonderful – very calm and put our fears at rest. Alice apparently was at 2-3 on a scale of 1-10. There is no treatment for the condition, just an alleviation of symptoms. At this point her kidney function was at 50% so dialysis was not necessary. However, she was given a blood transfusion straight away to help her feel better. Blood tests showed that the infection was still going and that things were getting worse rather than better.

Monday – Another blood transfusion. Platelets down to 7 – should have been over 150. Transfusions are standard until they reach 100 so she was given plasma as well.

Tuesday – The worst day yet. Alice woke at 5.00 am with a massive nosebleed. The place was a bloodbath and for the first time the staff appear out of their depth. Luckily both David and I are nosebleed veterans so we took control. An emergency blood test was taken and we moved onto the open ward from our room to await treatment. The ENT doctor told us he couldn't do anything to help. Platelets were confirmed at 6 and Alice had an emergency platelet transfusion which eventually stopped the nosebleed at 11.00 am. All 3 of us were covered in blood after some spectacular bloody vomiting. I didn't manage to calm Alice down enough to clean her up until 8.00 pm that day. After the platelets she had a blood transfusion and then a plasma transfusion. The blood test that night showed platelets up to 96 so no further transfusion was required for the time being, although it remained to be seen whether this was just because of the transfusions rather than her body fighting back. We were very concerned that Alice had eaten nothing since the previous Sunday and had only drunk apple juice. The consultant ruled out a feeding tube as that would need to go into her nose and could potentially cause another nose bleed. The nutritionist gave us a high calorie drink to hide in the apple juice and told us that junk food was the best thing to give Alice! E.coli was finally confirmed and Public Health started calling.

Wednesday - Relief at last. The platelet count had risen to over 100 overnight which meant that Alice was finally starting to fight the infection. Another blood transfusion. Alice finally started to eat – a few chips with ketchup.

Thursday – Blood test showed that platelets have hit 150 and that finally the creatinine and urea levels were falling. Kidney function was at 60%. My parents-in-law came to visit with Phoebe—the first time I had seen her for a week. We are all able to go out for lunch because no treatment is necessary. Another blood test will be taken on Saturday and if the improvement continues we should be able to go home. Alice was eating more and more, mainly Quavers and chocolate buttons!

Saturday – Everyone was tense as the blood test was taken at 7.00 am and had to wait until 1.30 pm during the ward rounds to get the results. Eventually we were told that all was well and we could finally go home. It was a huge relief, firstly that Alice had made such a good recovery and secondly because it was a real strain on all of us, particularly as I was 7 months pregnant at the time.

A week later it was confirmed that Phoebe was an E.coli carrier but exhibited none of the symptoms. From this we concluded that Phoebe must have caught E.coli on her visit to the farm and passed it on to Alice.



*Alice (centre) with her sisters Phoebe (right) and Victoria (left)*

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