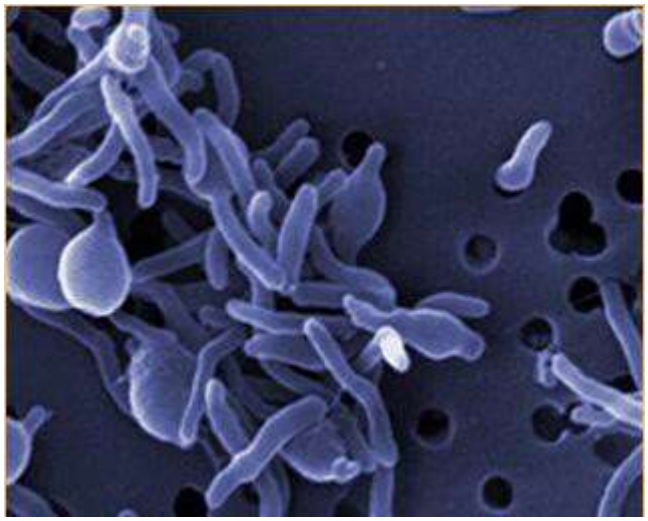
St Mary's University Twickenham London

Policy on Infectious Diseases

HSPG 12

(Version 4) – April 2017



St Mary's University
Waldegrave Road, Strawberry Hill,
Twickenham TW1 4SX
Switchboard 020 8240 4000 Fax 020 8240 4255
www.stmarys.ac.uk

Policy on Infectious Diseases

1. Statement of Policy

Employers are required by Health and Safety at Work etc. Act to do what is reasonably practicable to ensure the health and safety of staff and students. This includes taking steps to reduce the risk to staff and students from Infectious Diseases. There is also a requirement to report certain cases of disease under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (as amended 2013).
The University environment is one where many people have passing contact with others and there is potential for passing on infectious disease. This policy is designed to clarify the procedure by which the University should be made aware of infectious disease and the procedures which should follow from such notification.

The need to minimise embarrassment and further distress to those who are suffering or have suffered disease is recognised in this policy. The policy only covers diseases where there is a risk of other staff or students becoming infected. It does not cover minor ailments such as colds. Examples of diseases which should be notified to the University are given in appendix 1.

2. Organisation and Responsibilities

2.1 Health & Safety Officer

- will, in the case of life-threatening diseases or multiple cases of disease, inform the Vice-Chancellor.

2.2 Human Resources

- will pass on to the Health & Safety Officer any notifications of infectious diseases.

2.3 Tutors

- will inform the Health & Safety Officer of cases where it seems that students may be, or may have recently been, infected with a communicable disease.

2.4 Student Counsellors

- will offer counselling, advice and guidance, as appropriate to students infected with a communicable disease.

2.5 Health & Safety Officer

- will, on being informed of a case of infectious disease, consult with the medical staff and an occupational health consultant and in the case of a student the student counsellors.

- will discuss with the departmental manager (for staff) or the Student Union sabbatical officers (for students) the need for the infected person to refrain from entering University until non-infectious.

- in the case of a serious infectious disease the staff member or student may be asked to produce a certificate from their doctor to show that they are no longer infectious and may return to University. The Health & Safety Officer will receive this certificate and advise the line manager or SU official accordingly.

- will, if appropriate, supply information sheets to the close contacts (classmates, teachers, workmates, etc.) of the infected person and, if appropriate, will recommend that the contact consults their G.P. if worried.

- where an infectious disease is reportable to the Health and Safety Executive will make the report.

2.6 Occupational Health Consultant

- the advice of an Occupational Health Consultant will be sought on the medical and general aspects of infectious diseases and on University policy and procedures for dealing with cases of infectious disease.

2.7 All staff

- will, if they suspect they are or have recently been infected with a communicable disease, notify their departmental manager.

2.8 All students

- will, if they suspect they are or have recently been infected with a communicable disease, inform their tutor.

3. Arrangements

3.1 The following arrangements will apply

- staff will notify the Human Resources department in the event of the member of staff contracting an infectious disease. The Human Resources department will in turn notify the Health & Safety Officer;

- students will notify the medical centre if they suspects that they may have contracted an infectious disease (see appendix *I* for examples). The medical centre staff will notify the Health & Safety Officer;

- Alternatively, there is a sick book kept outside of student services, an entry should be made and a member of staff informed;

- the Health & Safety Officer will notify the occupational health consultant and in the case of a student the student counsellors;

- in the case of a life-threatening disease such as meningitis, or in the event of multiple cases of a less threatening disease, the Health & Safety Officer will notify the Vice-Chancellor.

- the Health & Safety Officer will discuss with the departmental manager (for staff) or the unit leader (for students) the need for the infected person to refrain from entering University until non-infectious~

- in the case of a serious infectious disease the staff member or student may be asked to produce a certificate from their doctor to show that they are no longer infectious and may return to University;

- in cases where the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations require it, the Health & Safety Officer will report the case of disease;

- if appropriate the Health & Safety Officer will supply information sheets to the close contacts (classmates, teachers, workmates, etc.) of the infected person and, if appropriate, will recommend that the contact consults their G.P. if worried.

Appendix 1

Examples of infectious diseases which should be notified to the University

- meningitis (bacterial)
- hepatitis B
- measles
- mumps
- rubella
- pulmonary tuberculosis (TB)

INFECTIOUS DISEASES REPORT FORM AND CHECKLIST

Section 1 Your Details (Staff)

Name : _____ Date : _____
Telephone number: Work: Home: _____
Mobile: Fax number: _____

Section 2 The Student's Personal Details

Name: _____ Regnum _____
Department/Year/ Course: _____
Term time address

_____

_____

Phone Number: _____

Home Address: _____

_____

Phone Number: _____

Next of Kin: _____

Phone Number: _____

Description of Emergency: *(What is the student's condition? How was the case discovered? Who else is involved? Where is the student now?)*

		Date
Measles/Mumps/Rubella/Pulmonary Tuberculosis/Hepatitis B		
Meningitis suspected		
Meningitis confirmed	B	
	C	
	Viral *	
Student discharged		

If the student is in hospital or has returned home, please make a note below of the name and telephone number of the ward.

This form when completed should be passed to the Health & Safety Officer

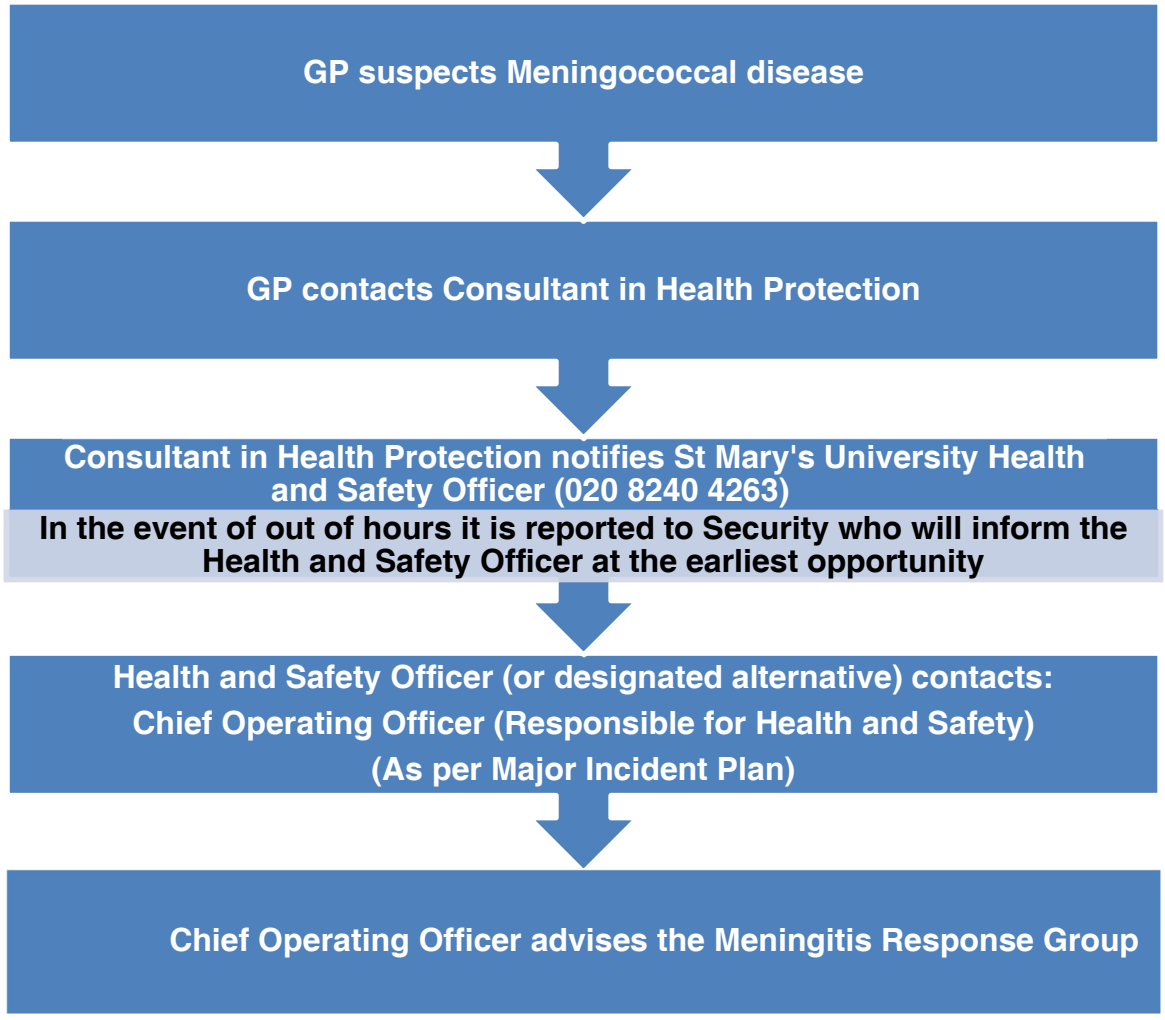
St Mary's University
Meningitis/Septicaemia Notification Procedure

These procedures apply whether the student is resident in hall, living off-campus locally or living at home.

Please Note: In the event of a student being admitted to hospital with suspected Meningococcal disease or Septicaemia, **it is the responsibility of the Doctor looking after the patient** to notify the case.

The Doctor will notify by telephone the Consultant in Health Protection Medicine for the appropriate area.

To facilitate procedures at St Mary's University, the Consultant in Health Protection Medicine will then notify the Health and Safety Officer, who in turn holds contact telephone numbers of all relevant staff.



Appendix 2

MENINGOCOCCAL OUTBREAKS

POLICY & PROCEDURES

INTRODUCTION

1. The notification rate of meningococcal disease rose in the mid 1980s and has remained high during the 1990's. Recent media attention has raised public awareness of meningococcal meningitis following the outbreaks at Cardiff University in 1996 and the University of Southampton in 1997.

2. Statistically, a university the size of St. Mary's can expect at least one case of meningococcal disease each year, probably in the winter months. (Less now that most students are vaccinated against type C meningitis.)

3. In the interests of the well-being of the University community, there is a need for a policy to be in place at St. Mary's for dealing with meningococcal outbreaks.

MENINGITIS RESPONSE GROUP

4. The University has established a standing Meningitis Response Group (MRG) with the following membership and remit:

Chief Operating Officer & Clerk to the Board of
Governors CCDC (Consultant in Communicable
Disease Control) Health and Safety Officer
Medical Advisers
Student Services Manager
Vice-Chancellor
Press Officer
Student Accommodation
President, SU
Chaplain
Domestic Services

Remit

a) to keep a watching brief on developments nationally
b) to work closely with the Kingston & Richmond Health Authority through the Consultant in Communicable Disease Control (CCDC).
c) to maintain contact with the Meningitis Research Foundation and the National Meningitis Trust
d) to ensure that relevant staff members take appropriate steps routinely throughout the year and especially during the Autumn semester to raise awareness on campus to the symptoms of meningococcal disease and the ways of minimising risk.
e) to manage the University's response to an outbreak of meningococcal disease (on campus) paying particular regard to support for those affected directly or indirectly, communication liaison, information management, public relations, positive and proactive media relations, the allaying of

understandable community anxiety following an outbreak, and the provision, coordination and deployment of resources.

f) Nursing staff to offer meningitis C vaccination to all Students who have not previously received it.

THE ROLE OF THE CONSULTANT IN COMMUNICABLE DISEASE CONTROL (CCDC)

5. The CCDC is legally responsible on behalf of the Health Authority for the management and control of notifiable infections such as meningococcal disease and septicemia. At the date of drafting these procedures, the CCDC is Dr Barry WALSH at the Health Protection Unit, Wilson Hospital, Cranmer Road, Mitcham
Surrey, CR4 4TP.

6. The CCDC will advise the MRG on:

- the close contact (or wider) target group to be traced
- the requirement for antibiotic prophylaxis
- the requirement for vaccination

7. The MRG will liaise with the CCDC over information dissemination, communication and public relations

ROUTINE AWARENESS TRAINING

8. All members (staff/students) of the University need to be on the alert for signs and symptoms of meningococcal disease, particularly amongst freshers in the autumn semester.

9. MRG has responsibility for ensuring that appropriate information about meningitis is made generally available to the community at appropriate times throughout the year.

10. Routine information will usually include:

- information leaflets supplied to individual students at Registration
- information posters on all residence and prominent University notice boards (replenished as necessary during the year)
- symptom and Helpline posters by all residence telephones
- information for students using the University's Accommodation Service private rented sector database
- update information included on Web sites and in the Student Handbook and Students' Union information
- leaflets and posters in the Student Services Centre

11. A meeting of the MRG will be convened each October to disseminate information and good practice and generally flag up the need for vigilance in this area.

CONFIDENTIALITY

12. Of necessity, those immediately responsible for responding to an outbreak will be aware of the personal details of the student(s)/staff affected by the disease.

13. This information is confidential and release of such information will be determined by the Vice-Chancellor or Chief Operating Officer acting on behalf of the student(s)/staff and family (ies) involved.

RESPONSIBILITY

14. The management of the University's response to an outbreak of meningococcal disease on campus rests with the MRG, advised by the CCDC and University Medical Officers.

15. MRG will pay particular regard to support for those affected directly or indirectly liaison, communication, information management, public relations, positive and proactive media relations the allaying of understandable community anxiety following an outbreak and the provision, coordination and deployment of resources.

16. All University staff has a responsibility to pass on any information relating to any relevant unconfirmed or confirmed cases to the Vice-Chancellor as a matter of urgency.

PROCEDURES

17. Unconfirmed case

A possible case: a possible case is a clinical diagnosis of meningococcal meningitis or septicemia where the clinician and public health doctor consider that a diagnosis other than meningococcal disease is as likely. No public health measures are necessary and contacts do not need preventive antibiotics unless or until further evidence emerges that changes the diagnostic category.

A probable case: a probable case is a clinical diagnosis without microbiological confirmation where the clinician and public health doctor judge that meningococcal disease is the most likely diagnosis.

17.1 The Vice-Chancellor's Office becomes aware of possible or probable case:

a) confirms details
b) MRG informed

c) Consults CCDC
d) Letter 1 is issued same day via notice boards and email to students in same Hall if relevant, and by the next day at the latest, to students on same programme
e) if student is resident in Halls, local general practices alerted.
f) The Vice-Chancellor considers support needs of student(s) staff concerned and their family and friends. If possible case subsequently diagnosed as not due to meningococcal disease, this information issued as soon as possible to reduce concern.

18. Isolated confirmed case

A confirmed case is a clinical diagnosis of meningococcal meningitis or septicemia, which has been confirmed microbiologically.

18.1 Initial Report

Any GP/Hospital, CCDC/other reports should be forwarded by their authors immediately to the Chief Operating Officer, including:

a) possible/probable/confirmed case
b) when and where person became ill
c) time of admission to hospital
d) confidential details of case (name, school, residence)
e) whether family have been notified
f) provisional likely close contact group
h) advice of CCDC on likely/definite action required by him/her and timing of such action.
h) advice on appropriateness of hospital visit by the Chaplain (bearing in mind possible arrival of parents/family in a severe case)
i) what action has been taken so far?
j) advice on the need for immediate meeting of MRG (particularly if report is outside normal office hours)

18.2 Meningitis Alert

Vice-Chancellor triggers Meningitis Alert by:

briefing members of MRG and arranging a meeting as a matter of priority

Briefing the following additional key people that an alert is under way:
Chief Operating Officer
Human Resources Manager
Student Services Manager
Estates Director/Site Operations Managers

c)Chief Operating Officer to brief other relevant parties

18.3 Initial Meeting of MRG

MRG meets to agree immediate action:

Standing Agenda

a) Briefing from CCDC -confidential details of case status of case (individual's condition, type and strain of meningitis if known etc.) progress on tracing close contact group action taken so far advice from CCDC
b) Immediate action re identification of close contact group communication with close contact group treatment of close contact group establishment of University help line
c) Need to brief National Helplines
d) Need for additional resources (nurses, accommodation, etc.)
e) Community publicity (posters, door drops, Web site entry)
f) Need for group meetings of students/staff other than close contacts
g) Need for any special briefing of residences (or other) staff
h) Media matters -press, radio and TV – appoint a University "Press Officer"
i) Support for the student(s)/staff member and those close to them who are affected (e.g. family, friends)
j) Arrangements for updating information
k) Issue Letter 2 to relevant people
l) AOB
m) Time of next meeting

18.4 Further Meetings of MRG

MRG will meet as often as necessary during the alert to stay on top of the situation.

18.5 The Roles of Individual Members of MRG

While a meningitis alert remains in force, individual members of MRG have the following individual responsibilities:

Chief Operating Officer	Liaison with CCDC University Medical Officer(s) / Nursing Staff Community well-being Updating Senior Officers / Press Officer Liaison with the Students' Association Inform and advise Hall Managers Ensure information is issued speedily to students, as appropriate

	Coordinating support for anxious students and parents Convening meetings of MIRG as necessary Initiating standard procedure for a student death
Chaplain	Providing welfare support for student case and family
CCDC	Briefing MRG on case developments Liaising with local general practices as and when necessary. Providing medical advice to MRG Drafting letter to close contact group for MRG approval Talking to close contact group and wider groups Providing medical advice on community bulletins etc. Specifying antibiotic -vaccination required Advising when to stand down from a Meningitis alert
University CCDC, Public Press Officer	Press contact in association with Vice-Chancellor and relations Compiling community publicity (bulletins etc.) Web communication, email briefings Drafting and circulating of notes of MRG meetings
SU President	Maintaining link between MRG and Union Feedback to MRG on student mood on campus Organising urgent bulletin/leaflet distribution

18.6 In addition to the notes of MIRG meetings kept by the University Press Officer, each member of MRG will maintain written notes (dated and timed) of individual management actions taken during a meningitis alert.

19. Outbreak of two or more confirmed cases

19.1 Unrelated cases of meningococcal disease will normally be deemed unrelated if any of the following circumstances apply:

a) two confirmed or probable cases occur in different academic terms.

b) two confirmed cases due to different strains, whatever the interval between them

c) two confined or probable cases with no evidence of any common links i.e. social contact, different halls of residence

d) two possible cases, or one possible and one confirmed/probable case, whatever the interval or link between them.

19.2 Related cases will normally be deemed related and an outbreak declared if two

confirmed or probable cases of meningococcal disease occur at the same University within a four week period in the same term which are, or could be, caused by the same serogroup, serotype and sero subtype and with a common link (same social network, same hall of residence) can be determined.

Meningitis Maximum Alert -Outbreak Control Committee

Terms of Reference

i) To review evidence and decide whether there really is an outbreak.
ii) To develop a strategy to deal with the outbreak and allocate
iii) responsibilities for initiating action.
iv) To arrange for the necessary interviews and other investigations, with the use of laboratory and epidemiological expertise, to identify the nature, vehicle and source of infection.
v) To undertake action to seek to prevent further cases by controlling the source of the outbreak, or dealing with the cause.
vi) To undertake action to seek to prevent further cases elsewhere by communicating findings to national health agencies.
vii) To undertake action to seek to prevent secondary spread of the infection by controlling or isolating cases, by monitoring contacts of cases and identifying and monitoring other persons “at risk”.
viii) To provide an accurate and responsible source of information for other professionals, the media and the public.
ix) To develop systems and procedures to prevent the future occurrence of similar episodes.

Additional Representation for the MRG
(Through CCDC)

Consultant Microbiologist
Pharmacy Department of Kingston Hospital representative
Health Authority Press Officer
Head of Nursing of Community Trust.

19.3 In the event of two or more cases over a four week period:

a) Each additional case will be dealt with as above.

b) MRG will trigger a Maximum Alert status which will involve additional

consideration of:

i) the need to extend single case risk contact group(s) to wider group(s)
ii) the possible need for a local Help line and Help Desk
iii) the need for daily press briefings
iv) the need for clear and unambiguous procedures for a hospital admissions to ensure prompt treatment
v) the possibility of urgent mass briefings of students and staff
vi) the need for students/staff to remain on the appropriate site while control measures are implemented
vii) the possibility of mass prophylactic treatment/immunisation
viii) the need for the closure of facilities such as bars/ENTS because of their potential as the focus for the spread of meningococcal infection
ix) the need for daily/twice daily residence room checks to be carried out by personal visits by Hall's staff to each student's room in all or specified risk locations.
x) the issue of updated information daily via a central University bulletin board, the Web and email.
xi) the possibility of calling upon the National Meningitis Trust Mobile Awareness Vehicle (MAVIS) to give assistance in disseminating information
xii) the need for a public health team to be available on campus

c) the CCDC will be asked formally to join MRG at its meetings.
Letter 3/Letter 4 will be sent to relevant people depending upon
d) medical advice as to whether this was a cluster or not.

20. Alert Stand Down

20.1 MRG will declare a stand down from a meningitis alert when appropriate, in consultation with the CCDC.

20.2 The Vice-Chancellor and University Press Officer will ensure that the ending of the alert is made known to the community in general and to those who have played key individual roles during the alert.

21. After Care Plan

Once all media attention and student/staff concern has been allayed, the Vice- Vice-Chancellor In consultation with the Chaplain and Student Services personnel will be responsible for putting into operation an after care plan to ensure that contacts of the case and the cases themselves are given appropriate emotional support and help with their academic studies, finances, accommodation etc.

22. Post-outbreak Review

Following the stand down, the Chief Operating Officer will convene a final meeting of MRG in order:

a) to review the adequacy of the University's response to the outbreak
b) to identify any weaknesses/failures in procedures
c) to amend procedures accordingly
d) to consider, in the light of experience, amendments to be made to the Group's routine awareness procedures.

23. Control of Information

Whenever an alert for a possible or actual meningitis outbreak occurs there should be a constant flow of accurate information from one source only, either the Vice-Chancellor or Vice Vice-Chancellor on his behalf this source should be recognised by all those interested parties as the only authorised source of information. Information must be regularly updated and disseminated throughout the incident and even after stand down,

Rumours should be discounted quickly and those seeking accurate information should be referred to the one source.

Appendix 1

General Background

1.1 Meningitis means inflammation of the meninges, the brain lining. It can be caused by a variety of organisms of which *Neisseria Meningiddes* is the most important, causing disease in children and young adults. The meningococcal bacteria lives in the nose and throat.

1.2 Viral Meningitis

This is the most common type. Symptoms are usually mild and most cases do not require admission to hospital. Recovery is normally complete without any specific treatment, but headaches, tiredness and depression may persist. No public health action is usually needed.

1.3 Bacterial Meningitis

There are two main forms: pneumococcal and meningococcal. Both bacteria can cause disease elsewhere in the body.

1.4 Meningococcal Disease

The meningococcal bacteria causes two main types of illness: meningitis and septicaemia (blood poisoning). The disease requires prompt treatment with antibiotics and carries a significant mortality and morbidity. Septicemia is the more serious form of illness and can occur on its own or in combination with meningitis. Meningococcal disease is fatal in about one in ten cases. Meningococcal disease may occur m outbreaks and epidemics, particularly in institutions such as Halls of Residence and military camps.

Eliciting a social contact network can be difficult. The following methods are suggested:

a) identify all students who share an accommodation sub-unit, e.g. shared kitchen and bathroom facilities
b) identify closest friends
c) compile a social diary of the student's movements in the week before illness.

a) and b) should allow identification of students who share a household setting for prophylaxis. c) is useful as a cross-check on close contacts and as a means of identifying links between cases if further cases should occur. The student should be asked specifically about recent kissing contacts. Students would not normally be offered prophylaxis unless they fall into the close contact group.

The bacteria can spread from person to person in circumstances where there is prolonged, intimate contact such as kissing, coughing and sneezing. Infection is usually acquired from a healthy carrier (see below) rather than from a person with the disease. Public health action is always required to identify and provide preventive measures to close contacts of a case of meningococcal disease.

2. Facts about Meningococcal Disease

2.1 How is the diagnosis made?

Laboratory tests are required to confirm the diagnosis. Public health action is taken as soon as there is strong suspicion that a person is suffering from meningococcal disease, and often before the diagnosis is confirmed.

There are several strains of meningococcal of bacteria of which Group B (60-85% of cases), and Group C *(35-40%* of cases) are the commonest m the UK. Group C infection is relatively more common in young adults and more likely to cause disease outbreaks.

2.2 How is meningococcal infection acquired?

Meningococcal bacteria are carried at the back of the throat or nose by 10% of the general population (and up to *25%* of young people). Only rarely does infection give rise to disease. Illness usually occurs within 7 days of acquiring the bacteria, but symptom less carriage can persist for many months. It is not known why some people become ill and others remain healthy carriers. The bacteria does not survive for long outside the body and most people acquire infection from prolonged, intimate contact with a symptom less carrier.

2.3 What action can be taken to prevent spread?

Antibiotics - preventive oral antibiotics are recommended for close contact of a case of meningococcal disease in order to clear the nose and throat of meningococcal carriage, and to prevent further spread of infection. Those used are either:

a) a very short course of rifampicin, 600mg every 12 hours for two days

OR

b) a single dose of ciprofloxacin, *500*mg

The antibiotics do not prevent meningococcal disease from developing. If only one case has occurred, antibiotic prophylaxis is recommended only for those who have had prolonged, intimate contact with the case. As the infection does not easily spread from person to person, there is generally no need for wide-seale preventive measures.

Immunisation - there is an effective vaccine against Group C disease but not against Group B. Immunisation is recommended for close contacts of individual Group C cases and to define high risk populations in outbreaks of Group C disease. It takes five to seven days to produce an immune response. It offers long term protection.

3. Guidelines for dealing with meningococcal disease

Guidance on the control of meningococcal disease has been published by the PILLS Meningococcus Working Group:

Control of Meningococcal Disease guidance for consultants in communicable disease control.

Communicable Disease Report DCR Rev. (1995) ~S 189-95

Management of Clusters of meningococcal disease. Communicable Disease Report DCR Rev. 1997 73-4

Managing Meningitis in Higher Education Institutions. CVCP and National Meningitis Trust. ISBN 1 84036 012 7. June 1998.

Document title	**Infectious Diseases – HSPG 12**
Version	4
Person responsible	Estates/ Facilities/ HSO
Author	Terry Docherty
Document date	March 2008
Last amended	April 2012
Effective from	April 2010
Review date	Sept 2027
Impact Assessment date	TBC
History (where discussed / who circulated to / committees considered	HSC

Appendix 2

General Notification

CASE OF MENINGITIS

As you may already know, a student at St. Mary's University, Twickenham was admitted to *(hospital name) today/yesterday (date)* believed to be suffering from bacterial meningitis. We
very much hope that this student will make a full recovery and will be able to return to University as soon as possible.

The purpose of this letter is to inform the University community of action already taken as regards the contacts of this particular student, to reassure those who are concerned, and to reiterate the symptoms of meningitis of which everyone should be aware.

The University, working closely with the Consultant in Communicable Disease Control (CCDC), *has already identified/is currently identifying* the small number of students/and others who have had close physical contact with the patient over the last seven days. The germs that cause bacterial meningitis are present in some *15%* of people's throats and are spread between people by coughing, sneezing and kissing. However, since they cannot survive outside the body for long, they cannot be spread through water supplies, swimming pools or buildings. Therefore, it is only the very close domestic contacts of the patient who are at a small increased risk of contracting the disease. This group *has been (is* currently being contacted and special arrangements *have been made/are being made* for them to be appropriately treated by the local CCDC. Vaccination of members of the University community is unlikely to be required, but the CCDC will inform us if this becomes necessary.

If you have not had close domestic contact with the patient, you are not at an increased risk of contracting the disease. Therefore, fellow students, those who live or work in the same Hall of Residence, or casual contacts, are unlikely to be at higher risk and do not require special treatment or investigation. This advice may change in exceptional circumstances, in which case you will be notified by the University Medical Centre.

However, everyone should be aware of the early symptoms of meningitis and, if you feel unwell, you should seek medical advice from your local GP. The symptoms include:

- violent or severe headaches
- high temperature / fever
- vomiting
- stiff neck
- dislike of bright lights
- drowsiness/lethargy
- joint pains
- rash of red/purple spots which look like bruising under the skin.

Early diagnosis and treatment greatly increase the chances of a full recovery.
A case of meningitis always attracts very rapid coverage in the local and national media. Therefore, we recommend that you contact your parents or close relatives immediately to reassure them that you are well and that you have received appropriate advice from the University.

This notice has been issued with the approval of the CCDC.

Chief
Operating
Officer
(DATE)

Letter 1

DATE

Dear Student

Meningitis and Septicemia

A *(year of study)* year student living in *(Hall of Residence/at home/private rented accommodation)* was admitted to hospital on *(date).* It is possible that s/he may have meningitis/septicemia.

The cause of the illness is *not/considered unlikely to be* meningococcal disease. Other students and staff are not considered at any risk from this incident, even if they were in close contact with the case.

We have been advised by the Consultant in Communicable Disease Control for Richmond and Twickenham Primary Care Trust, that preventive antibiotics will not be necessary for contacts of the student concerned.

If we receive any urgent information or instructions we will contact you immediately, otherwise please pay attention to notice boards and your email where we will post any subsequent non-essential information that we obtain.

Yours sincerely

Chief Operating Officer

Letter 2

DATE

Dear Student

Meningitis and Septicemia

A *(year of study)* year *(study subject)* living in *(Hall of Residence/at home/private rented accommodation)* was admitted to hospital on *(date)* with confirmed/probable meningococcal meningitis/septicemia.

The meningococcal bacteria lives in the nose and throat and is only passed on by prolonged intimate contact such as kissing, coughing and sneezing. The health authority's Department of Public Health is issuing preventive antibiotics to only the intimate contacts of the student concerned.

Whether or not you have been in contact with the case, you are advised to be especially vigilant over the next few days. The important thing to know is that the disease can develop very rapidly, sometimes within a matter of hours. Early symptoms may be similar to those you get with a flu or hangover:

- feeling feverish
- vomiting
- severe headache
- stiff neck, back and joint pains

If you feel unwell, ask a friend to help you and to visit regularly. If these symptoms are not relieved by paracetamol or aspirin, you must consult a doctor.

If any of the following symptoms develop get medical help urgently as early treatment saves lives:

- rash of tiny red bruises that doesn't fade under pressure
- severe dislike of light
- disorientation or drowsiness

Yours sincerely

Chief Operating Officer

Letter 3

DATE

Dear Student

Meningitis and Septicemia

Two students from St. Mary's University have recently been admitted to hospital believed to be suffering from meningococcal meningitis/septicemia.

One was *(year of study and study subject)* student living in *(Hall of Residence/at home/private rented accommodation)* The other was a *(year of study and study subject)* student living in *(Hall of Residence/at home/private rented accommodation)*

We have been advised by the health authority's Department of Public Health that these cases are not considered to be connected, because

- they were due to two different strains of the meningococcal bacteria
- they occurred more than four weeks apart
-they were not known to each other and had no common links

As there is no evidence of a link between the two cases, wider use of antibiotics or vaccine is not being recommended. Preventive antibiotics have been issued to intimate contacts of both students, as is routine policy.

I enclose some general information on meningitis *(enclose Meningitis Trust leaflet).* If you need any further advice or information you can contact the following groups who offer 24 hour helplines:

National Meningitis Trust - *01453* 768000
Meningitis Research Foundation - 0808 800 3344

Yours sincerely

Chief Operating Officer

Letter 4

DATE

Dear

A bespoke letter with more detailed wording will be drafted by the CCDC and agreed with the Vice-Chancellor

The letter will contain the following information:

- *Background information to date*
- *What action is being proposed*
  - *antibiotics +/- vaccine*
  - *whom- defined communities at risk*
- *Clinical advice re: meningitis, including the need to react to any fever and non-specific flu-like symptoms by consulting a doctor.*

PLUS

Helpline numbers and information leaflets.

Contact List

Chief Operating Officer
Student Services Manager
Vice-Chancellor's
Secretary Health and
Safety Officer President,
Students' Union
Vice-Chancellor
Press Officer
Human Resources Manager
Student Accommodation
Telecommunications Manager
Chaplain
International Office
University Sister
University Medical Officer

Chief Operating Officer's office and Vice-Chancellor's office to retain a list of emergency contact numbers for relevant staff.