Committee on the Inquiry into the E.coli outbreak in Wales

E.Coli(2) 01-05(p3)

Meeting date: 07 November 2005

Meeting time: 2:30pm

Meeting venue: Committee Room 3, National Assembly for Wales

RESPONSES FROM OTHER CONSULTEES RECEIVED TO DATE

Two other submissions have been received to date:

National Public Health Service Wales recommend the following terms of reference should be considered:

- The circumstances that led to an outbreak of E coli O157 in the South Wales valleys in September 2005, particularly the identification of:

  deficiencies in the current legislative and enforcement framework that might have contributed to its occurrence;

  how changes in the current regulations, inspection processes and enforcement measures in relation to farming practice, the meat industry and food producers might prevent such an outbreak occurring again;

  improvements that might be made in relation to local authority food procurement policies that would reduce the risk of its recurrence;

- The effectiveness of the measures taken to control the outbreak;
- The overall management of the outbreak, including the:

  resources available to deal with it, and

  co-ordination of the multi-agency response;

- The provision of any recommendations that would strengthen the capacity in Wales to

respond to future major outbreaks of infectious disease;
- The roles and responsibilities of health and education professionals, politicians, government and the media, particularly public service broadcasters, in providing information to the public in ways that effectively convey an understanding of risk, promote health and prevent the spread of infection;
- The response of NHS trusts in relation to the management of patients requiring in-patient care;
- The provision of infection control advice to families of affected individuals.

The UK e.Coli Support Group (Haemolytic Uraemic Syndrome Help) have written to the Committee as follows

"We would encourage the remit of the Inquiry to be as wide as possible as we believe this is the only way to establish all the facts relating to this outbreak and could help prevent similar outbreaks and cases in the future.

Whether the recommendations made in the 2001 Scottish Task Force on E.coli O157 have been implemented and acted upon, and if so, how this outbreak could have occurred when the Task Force looked into areas of food borne transmission and health; just to name a few of the topics they covered in the work and report.

Whether other similar reports such as the Advisory Committee on the Microbiological Safety of Food [ACMSF] Report on VTEC in 1995 could have helped to prevent this outbreak and or reduced the number of cases.

Given that person-to-person spread appears to have been a contributory factor to the number of cases in this outbreak, what lessons can be learned and should have been learned from previous outbreaks. In relation to this, we would be particularly interested in the Scottish Task Force Recommendations in 2001. One of these recommendations states, "Hygiene for families, groups affected by E.coli O157 should be promoted by available literature". Was this the case in this outbreak?

In addition what other form of advice was given immediately by the relevant authorities including GP’s, Health Care Professionals etc.

Due to the known long term health problems of sufferers of HUS, we would like the Inquiry to investigate the possibilities of long term follow -up studies of these patients, providing they, and their families, would be agreeable to it, as so much could be learned to help others in the future.

We believe, in view of the spread of the outbreak, the question of whether the closure of schools would have been appropriate and should be addressed by the Inquiry.

Committee Service

November 2005