



Public Health
England

Public Accountability Unit
Wellington House
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By email

Our ref: 28/07/jb/181

20 August 2014

Dear

Re: Tuberculosis

I refer to your email of 28 July 2014 in which you asked Public Health England (PHE) to provide a copy of a Serious Untoward Incident (SUI) report following an incident of tuberculosis at Kings College Hospital.

Your request has been considered under the Freedom of Information Act and in accordance with Section 1(1)(a) of the Act, PHE does not hold the information you have requested.

PHE does not hold a SUI report for this incident as it was not actually an SUI for the Health Protection Agency (a predecessor organisation of PHE), although it may have been one for the hospital. Upon receipt of your request and in the absence of the report you have requested, one of my colleagues has drafted a summary of what was done in response to the exposures and this is attached.

If you have any queries regarding the information that has been supplied to you, please refer them to me in the first instance. If you are dissatisfied with this response and would like to request an internal review, then please contact Mr George Stafford at the address above or by emailing internalreview@phe.gov.uk

Please note that you have the right to an independent review by the Information Commissioner's Office if a complaint cannot be resolved through the PHE complaints procedure. The Information Commissioner's Office can be contacted by writing to Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours sincerely

Freedom of Information Officer

Summary:

A case of *Mycobacterium tuberculosis* infection was diagnosed at King's College Hospital on 22nd July 2011. Onset of cough in the case was from 05/07/2011. Laboratory confirmation of MTB complex was received on Thursday 28th July 2011.

A risk assessment was undertaken by King's College Hospital and South East London Health Protection Team (SELHPT). This ascertained that exposure in the ward setting potentially occurred between 13/06/11 to 5/07/11 on the following wards:

- 1 - Fred Still
- 2 - Rays of Sunshine

Staff, patient and visitor contacts were identified for screening from the 1st May 2011. Those identified as having more than 8 hours cumulative contact (86 in total) were offered screening as well as parent/carer contacts. King's College Hospital was responsible for follow up of these individuals. IGRA testing was offered to all babies and Health Care Workers fulfilling the exposure criteria. All other contacts, including staff were sent inform and advise letters.

Chemoprophylaxis was offered and commenced for all children, including neonates and those aged 4 weeks and above who had significant contact with the case, as per NICE guidance, and after 6 or 12 weeks these individuals were screened again. If they were found to be positive treatment was continued and if negative they were offered BCG.

SEL HPT was responsible for organising screening for the out- of- area contacts identified by the hospital. These contacts were referred to relevant local Health Protection Teams (HPTs) for follow up. Ten children were offered IGRA testing only. 17 children were offered IGRA and Mantoux testing and the 17 parents of these individuals were sent letters requesting that they arrange clinic appointments with their local TB service.

SEL HPT out-of-area screening outcomes:

Of the 27 patients contacted, 21 agreed to screening, screened negative and were discharged with advice from their relevant TB Service. The remaining 6 were offered screening via their local HPT and no adverse outcomes were reported to SEL HPT.