6 Advice on management of waterborne outbreaks of cryptosporidiosis

6.1 Introduction


6.1.2 Since that time an increased understanding of cryptosporidial infection has been gained, as too has experience in incident and outbreak investigations and management. IMTs and OCTs are seen as part of the overall arrangements by health authorities for the control of communicable disease and as such are very practical teams whose aim is the protection of public health by the prevention of infection. The teams are not collectors of evidence for legal purposes nor are they concerned with the maintenance of a commercial position by the water utility. The teams need to apply high standards of professional ethics and in particular ensure that patient confidentiality is maintained.

6.1.3 There are three components which underpin the management of waterborne outbreaks of cryptosporidiosis. The first is collaborative planning to develop response procedures, the second is recognising events which may put the population at risk and the third is early ascertainment by surveillance that there is an increase in human cases of cryptosporidiosis. The first of these requires advance collaborative planning; the second should trigger the convening of an IMT; the third should trigger the formal establishment of an OCT. In practice, the function and membership of both these teams is similar, to protect public health and return the situation to normal as soon as possible. The exact stage when an IMT will become an OCT will depend on each incident and local circumstances and could be early in the incident. This should be borne in mind in reading the following paragraphs. Relevant parts of the OCT checklist and meeting agenda in Appendix A3 will be useful equally to IMTs.

6.1.4 It is important to recognise however that there may be conflicting interests both within and outside the teams. The detail of information necessary to reach a conclusion for medical and public health needs may fail badly as legal evidence in a criminal prosecution and the resource required to collect different levels of evidence may vary considerably. It would be expected that, as the OCT is set up at the request of a Director of Public Health, it is primarily a team with a health objective. The Chair of the OCT should remind all team members of this at the outset.

Recommendation

6.1.5 The Group recommends that it is essential that Outbreak Control Teams are aware at the outset of the scope and purpose of their brief and that there is a clear understanding of the roles, responsibilities and standing of each member.
6.2 Incidents

6.2.1 Regulation 30(5) of the Water Quality (Water Supply) Regulations 1989 (SI No.1147) requires water utilities to inform district health authorities and local authorities as soon as possible of any event which gives rise to, or is likely to give rise to, a significant risk to health of persons residing in the authorities’ areas. In practice this means that Consultants in Communicable Disease Control or Consultants in Public Health Medicine (CCDCs/CPHMs) and Environmental Health Officers (EHOs) are being informed of incidents during treatment and supply of drinking water. On receipt of this information the CCDC/CPHM and the EHO will have to decide its importance in public health terms and act accordingly. Whereas waterborne outbreaks are relatively rare, incidents during water treatment and supply are not, but except in rare instances they are not likely to be a serious public health hazard. In order to assess the risk an Incident Management Team (IMT), similar to the Outbreak Control Team (OCT), may need to be formed.

Identifying an incident involving Cryptosporidium

6.2.2 An incident may be identified in a number of ways: by routine water sampling plus an increase in cryptosporidiosis in the community; sampling following operational work or repairs; by plant malfunction; or from consumer complaints. There is a legal requirement in the UK for public drinking water supplies to be monitored intensively by water utilities from source to tap. It must be done by bacteriological and chemical sampling, by visual inspection and organoleptic testing. Increasingly, continuous monitoring of treatment processes is carried out electronically at critical control points in the system. Despite this, circumstances can arise infrequently, where for short periods treatment of drinking water is not as effective as it should be.

6.2.3 Handling of water quality incidents is initially the responsibility of the water utility. Accordingly, utilities have internal procedures to deal with incidents. It is also likely that when serious incidents occur the local authority and the health authority will also become involved quickly. The key organisations likely to be involved in an incident should have written emergency procedures which can be put into action when an incident occurs.

6.2.4 An incident involving the breakthrough of Cryptosporidium oocysts through water treatment and into distribution may not be as obvious to identify as complete malfunctions such as disinfection or plant breakdown. This is covered in more detail in the section on advice to water utilities. It is possible that some water treatment plants may contribute to the background level of cryptosporidiosis in a community but usually the sources of background levels are not investigated or identified. The outcome of pre-outbreak assessments of potential problems, such as an increase in background numbers or presence of oocysts in water, should be explained when possible and the information disseminated to organisations likely to be represented on an OCT.

Recommendation

6.2.5 To facilitate recognition of an incident involving Cryptosporidium, the Group considers there is a need for local studies to identify background levels of cryptosporidiosis, and for local risk assessments to be conducted so that any increased incidence can be identified easily.
Recording and communicating the incident

6.2.6 All those involved at any stage of an incident should start a log-book immediately. This should include dates, times, key facts, summaries of telephone calls, and the actions taken by named staff. The need for systematic recording of events, particularly in the fast-moving early stages of an incident, should not be neglected as details will have an important role in the epidemiological study and in any subsequent review of lessons to be learned.

6.2.7 Communicating the incident is a key action. There is a statutory requirement to inform the local authority and health authority and the relevant Secretary of State (in practice DWI in England and Wales). Customers in the area affected should be advised as soon as possible and kept informed of progress. Circumstances will dictate who else needs to be informed. For example the fire brigade and the local renal dialysis coordinator must be told immediately of low water pressure or complete loss of supplies. Other outside organisations to be contacted may include the Environment Agency, the Ministry of Agriculture, Fisheries and Food, and the Ofwat regional customer services office. Important telephone messages to these organisations should be confirmed by facsimile transmission of the key points with the ‘messages sent’ output from these machines kept as objective evidence that a message was sent.

Recommendation

6.2.8 The Group recommends that all those involved at any stage of an incident should start a log-book immediately. This should include dates, times, key facts, summaries of telephone calls, and the actions taken by named staff.

Assessment and management of incidents

6.2.9 The next phase in managing an incident is the appointment of someone suitably senior at the water utility to act as Incident Manager to be in charge of taking remedial action to protect water supplies. The Incident Manager should check that sufficient human and equipment resources are available to cope, and that there are system drawings and road maps available in sufficient detail for the area affected. Key questions to be answered at this stage are who, and what, is at risk and from what kind of risk. Particular attention must be made to sensitive commercial and domestic water users and provision of alternative supplies may be needed, particularly for vulnerable groups such as nursing mothers, infants and the elderly and infirm.

6.2.10 The Incident Manager should consider the need to set up a local incident control room, appoint a duty officer and information officer, and assemble a support team. At the start of a major, or prolonged, incident it is common practice to draw up a shift system and if necessary send some of the team home immediately for rest before the first shift changeover.

6.2.11 The Incident Manager should regularly review the situation to ensure everything is under control. Evidence for this should be noted in the log-book. A local weather forecast can often help at this stage to see if actions planned for the next 72 hours will be affected. Resource requirements for the next 72 hours should be drawn up. Extra laboratory staff and work gangs may need to be placed on standby alert. Arrangements for out-of-hours working may need to be made.

6.2.12 External communications often become important at this phase of incident management. Dedicated telephone lines should be provided for use by the team dealing with the problem. Extra telephones and pagers should be provided if necessary: mobile phones can be invaluable during
an operational incident. This communication traffic must be kept separate from customer and press enquiries. Similarly, separate facsimile machine numbers should be dedicated for incoming and outgoing messages at the local incident room. Communications with outside organisations and customers, as well as other functions within the utility, should be dealt with by an information officer to allow the Incident Manager to concentrate on dealing with the situation.

6.2.13 The police force should be informed if it is likely that large numbers of water utility staff will be on the streets late at night either as part of the remedial action or delivering leaflets on ‘boil water advice’. It is wise to provide utility clothing (for example, fluorescent jackets with the utility logo) to these employees for safety and security reasons. Plans to use large numbers of water utility staff on the streets should include details of local communications, transportation, provision of food, drink and petty cash, and issue of torches, notebooks and maps. If a very large number of people is to be advised to boil water it is sensible to warn the electricity utility of the likely extra power demand.

6.2.14 When an incident occurs the actions taken by public health physicians in the health authority will be similar to those undertaken by the water utility such as keeping a log-book and managing communications. It is important for the CCDC/CPHM to note in the log-book the time and date when first informed of the incident, and by whom, as the water utility has a statutory duty to inform the district health authority and the relevant Secretary of State promptly of any incident which is likely to give rise to a significant risk to health. The DWI will wish to know if the water utility has complied with this regulation when it subsequently investigates the incident. What constitutes a significant risk to health should be agreed in advance with all concerned.

6.2.15 Depending on the seriousness of the incident an IMT may need to be set up. A check should be made to see if other district health authorities are involved; if so they should be included in the team, and a decision made on which district takes the lead. Similarly when more than one district is involved the health authority (or health authorities, as the case may be) should be informed so they can take a coordinating role, although the investigation and management of the incident is a matter for the CCDCs/CPHMs involved as they have executive responsibility. If the incident is considered to be serious or a potential public health risk involving a large number of the population and where advice to boil water has been given or where there has been or is likely to be much media attention, the Chief Medical Officer of the relevant Government department, should be informed. In practice this can be done by telephoning the Senior Medical Officer responsible for drinking water at the relevant Government health department. These telephone numbers should be readily available and up-to-date.

6.2.16 The assessment of public health risk should be made as a matter of urgency by the CCDC/CPHM after notification from the water utility. It will be important to know at what stage in the treatment process, from source to tap, the incident has occurred. Is the problem in the raw water storage, in the treatment, or in the distribution system, including, post-treatment storage in service reservoirs? It is important to get as much information from the water utility as possible because this will help to establish how much treatment the water has had and where the potentially contaminated water is in the distribution system. It is also important to
clarify terms. For example, it is important to determine whether the term 
‘reservoir’ relates to a raw water reservoir or a treated water, service 
reservoir.

6.2.17 It is also crucial to establish how long the problem had existed 
before its discovery and subsequent notification to the district health 
authority. Other questions to ask will include the possibility of mixing of 
the contaminated water with other sources, and the time it is likely to take 
for contaminated water to reach customers. Questions like these will 
enable the CCDC/CPHM to establish the degree of treatment the water has 
received – full, partial, or none at all – and for how long. The risk to health 
posed by the incident can then be assessed.

6.2.18 If the incident is sufficiently serious the CCDC/CPHM should set 
up an IMT, which should include the water utility, local authority and 
other relevant organisations such as the PHLS, CDSC, Environment 
Agency, Health and Safety Executive and the police. The members should 
either meet, or communicate frequently by telephone, to keep each other 
appraised of the situation. The use of pre-planned procedures for dealing 
with, for example, notification to customers of ‘advice to boil water’ is 
recommended. An important role of the IMT is to evaluate the possible 
outcomes of the incident, assess their impact on public health, and then 
plan for the best way to deal with each possible outcome. It may be 
necessary to seek the help and advice of others such as the regional 
edemiologist, the local Public Health Laboratory director and possibly 
the PHLS Communicable Disease Surveillance Centre (CDSC). Medical 
colleagues at the Department of Health also provide help and advice to 
CCDCs/CPHMs both in and out of office hours.

6.2.19 The Expert Group recognises that the decision on advice to boil 
normally rests with the water utility and that it is impossible to lay down 
precise recommendations on the information to be made available because 
this will differ with each incident and local circumstances. However, as 
part of the decision-making process, criteria for removing the notice 
should be considered.

6.2.20 The Group recognises that there is a need for uniformity in the 
wording of advice on boiling water to ensure that the water is 
microbiologically safe whilst avoiding confusion to consumers and 
potential dangers with overheating electric kettles. It is necessary only to 
bring the water to the boil to kill Cryptosporidium oocysts. Water should 
be allowed to cool before use.

Recommendation

6.2.21 The Expert Group recommends that all notices of advice to boil 
water issued to consumers should make it clear that it is only necessary 
to bring the water to the boil and then allow it to cool before use.

6.2.22 The IMT should consider the need for press notices and briefing. 
If the media are used then information should be channelled through one 
central point. It is essential that any information given should be accurate. 
The spokesperson for the IMT is most likely to be the CCDC/CPHM or a 
member of the health authority management team. With regards to 
informing the public, a practical point to be borne in mind is that the use 
of loudspeaker vans can create confusion, as the message may be heard by 
people living in an unaffected area. If loudspeaker vans are used, the area 
affected should be clearly stated. The IMT should also prepare a report at 
the end of the incident. The CCDC/CPHM should take the lead in the
report’s preparation and circulation to interested groups including the Chief Medical Officer of the relevant Government health department.

6.2.23 Other duties for the CCDC/CPHM will include checking that arrangements are in place for contact out-of-hours in case the situation deteriorates rapidly, or either the water utility or the local authority needs specialist advice. Checks should also be made to ensure that arrangements for hosting an IMT meeting are in place and that adequate communication links are available – if necessary at short notice.

6.2.24 If the response to the incident is to advise the potentially affected population to boil their drinking water, every effort must be made by the CCDC/CPHM to ensure that hospitals, residential institutions and vulnerable groups in the community, (for example, home dialysis patients) are informed as a matter of urgency. Arrangements for alternative water supplies may need to be made for these groups. Often the pre-planned ‘boil water’ procedures agreed between water companies, health authorities and local authorities will have set out arrangements for these tasks.

6.2.25 CCDCs/CPHMs will be informed about most incidents as soon as they occur and, if prompt action is taken by the district health authority, local authority and the water utility, it is unlikely that any illness will result. However, the CCDC/CPHM should consider the need to heighten surveillance for several weeks after the incident with the help of local general practitioners and microbiologists within the National Health Service (NHS) and PHLS.

6.2.26 All reported incidents, involving water supplies in England and Wales will be investigated by the DWI. The Inspectorate will wish particularly to know whether the health authority was informed promptly by the water utility, and if any illness resulted from the incident and whether the health authority considers that water unfit for human consumption was supplied. Its enquiries are usually made by correspondence with the health authority, local authority, and water utility involved. Although the Inspectorate will have received a copy of the IMT report, an individual response from each party is always sought. Responses from a health authority to the Inspectorate may be used in support of a criminal prosecution of a water utility, or individuals in the utility, so all correspondence may need to be cleared by regional health authority lawyers.

6.2.27 CCDCs/CPHMs should periodically undertake desktop exercises to check the working of any pre-planned procedures, whether for incidents or outbreaks, between the health authority, local authority, and the water utility. This is a useful way to ensure that arrangements for communications, especially out-of-hours, are kept up to date. A recommendation is made in paragraph 6.3.7 below. Liaison meetings with the water utility and the local authority should take place regularly to review data and plans.

Role of local authorities when an incident occurs

6.2.28 It is also a requirement of the Water Quality (Water Supply) Regulations 1989 (Anon 1989) that a local authority makes arrangements with the water utility to receive notification of incidents which may pose a significant risk to health. Written emergency procedures should be developed so that roles and responsibilities are clear. In practice this will require EHOs in local authorities to establish a working relationship with
the relevant offices of the water utility and district health authority. It is essential that contact telephone and fax numbers are exchanged, and 24 hour contact is available.

6.2.29 There should be prior consultation between the local authority, the district health authority and the water utility to determine which incidents may constitute a significant risk to health. A good working relationship should allow the water utility to notify the local authority as well as the district health authority in the early stages of an incident to enable EHOs to prepare for any necessary action. If the incident then develops to the extent that formal notification is required, the local authority will be better prepared to act.

6.2.30 Once an incident has been notified, local authorities will need to have their own internal procedures for action. The local authority will, on the basis of the information received, need to act accordingly. In most incidents, especially of a microbiological nature, the EHO must advise the occupiers of certain high risk premises, such as schools and premises dealing with food and, in conjunction with the CCDC/CPHM, other institutions such as nursing and residential homes. Additionally the EHO should inform the ward councillors and other relevant council officials. These arrangements should be worked out in advance and contact points listed in an Emergency Telephone Directory. The Food Hazard Warning System can be utilised by EHOs in appropriate circumstances to alert food businesses. The district health authority will normally alert hospitals and general practitioners but this must be agreed with the CCDC/CPHM in advance.

6.2.31 EHOs in conjunction with the CCDC/CPHM will need to consider the advice to give to high risk premises based on the incident. If advice to boil water is issued then serious consideration must be given to advising food-based businesses to stop using tap water in food preparation if the final product is not cooked or heat treated.

6.2.32 For schools and other institutions, boiling and cooling water may be impractical. Water utilities are likely to be able to provide safe alternative supplies by tanker. However, the microbiological quality of tanker water cannot be guaranteed and it too should be boiled. The provision of a supply of bottled water may be another alternative course of action. Immunocompromised people should note the advice in Chapter 8 about boiling bottled water.

6.2.33 The EHO supervising the incident for the local authority should keep a detailed timed log of the events as they unfold, including any notifications, and subsequent investigations, of illness from within the affected areas, as this will be useful in preparing a report to the regulators once the incident is over.

6.2.34 If, in the unlikely event that the incident poses such a serious risk to health that the IMT decides to suspend supply, the local authority will have to consider, along with the water utility and district health authority, the provision of alternative supplies. At this point it may be necessary to implement the local authority’s overall emergency planning procedure. For further information on this topic see Dawson and West (1993).

Closing down an incident

6.2.35 The Incident Manager, in association with the IMT, should assemble the facts and establish the most probable explanation for the
incident. Alternative explanations should be considered but not eliminated until it is safe to do so, and then the reasons for their dismissal as possible causes recorded in the log-book.

6.2.36 Closing an incident should be deferred until it is safe to do so and until it is clear the situation will not deteriorate or the problem recur. A cardinal issue here is whether water supplies are judged to be back to normal. Without such a guarantee, it is not possible to close an incident down. Depending on the severity of the incident, it may be necessary to discuss progress with the CCDC/CPHM in the district health authority, the local EHOs, or the DWI before finally closing down an incident.

6.2.37 The final action once an incident is closed is often the preparation of a post incident report by the water utility. An important component in this will be a review of lessons learnt in order to minimise the risk of a recurrence of the incident. An Incident Control Team Report similar to an Outbreak Control Team Report may also be prepared especially if illness has resulted in the community.

6.3 Outbreaks

6.3.1 The first Badenoch Report (Badenoch 1990) recommended that the CCDC/CPHM should inform both the water utility and the local authority if there is sufficient evidence to suspect an outbreak of waterborne illness. These three organisations should have prepared jointly an Outbreak Control Plan (OCP). A water utility often covers much larger areas than either the health authority or the local authority and at first it might appear sensible that it should take the lead in arranging outbreak control meetings. Nonetheless, in matters of public health, especially hazards to human health in the community, it is the health authority and in particular the CCDC/CPHM who will normally take the lead role.

6.3.2 The purpose of the OCT is to ensure coordinated investigation, management and control of an outbreak of waterborne illness in the community. It must define the tasks of the OCT members and any relevant public and private bodies. It should include statements on lines of communication, when to call the team together, management and organisation of the team, control measures which may need to be taken, and plans for any epidemiological investigations.

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<tr>
<th>Establishment of the Outbreak Control Team</th>
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<td>6.3.3 Events or occurrences which could trigger the DPH or CCDC/CPHM to call together the OCT include:</td>
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<tr>
<td>■ a greater number of cases of illness in a period of time than would normally be expected whether or not water-associated;</td>
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<td>■ the unexpected appearance of cases of cryptosporidiosis in more than one local authority district or more than one health authority district;</td>
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<td>■ a suspected, anticipated or actual major incident of drinking water contamination.</td>
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<tr>
<th>Terms of reference for the Outbreak Control Team</th>
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<td>6.3.4 The responsibilities laid down in the first Expert Group Report (Badenoch 1990) are still relevant. They are:</td>
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<td>■ to review the evidence for an outbreak by examination of the epidemiological, microbiological and other data;</td>
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to identify the population at risk to institute additional measures required to gather further relevant information;

to decide on measures to control the outbreak and to protect other members of the community at risk;

to make arrangements for the commitment of personnel and resources considered necessary;

to monitor the implementation and effectiveness of the measures taken;

to make arrangements for informing the public and media;

to decide on the point at which the outbreak can be considered of no further significance;

to prepare a report as soon as it is practicable on the outbreak and make recommendations for further action.

6.3.5 In general, most members of an OCT should know each other and the organisations represented before an outbreak occurs. The Group emphasises the importance of liaison and team work in managing an incident or outbreak involving Cryptosporidium in the drinking water supply. The organisations concerned should meet regularly to discuss procedures and these should be rehearsed regularly (see also section 5.5).

Recommendations

6.3.6 The Group recommends that all parties likely to be involved in an IMT or OCT should establish a working dialogue and trust, preferably prior to the emergency situation, so that when a major incident occurs it will be dealt with more effectively.

6.3.7 The Group also recommends that all parties regularly simulate incident and outbreak events to rehearse emergency procedures.

6.3.8 The OCT membership should be kept to as small a number as possible while providing the necessary expertise and relevant representation. The core members of the team will include the CCDC/CPHM and a consultant microbiologist from the NHS or PHLS, a Regional Epidemiologist (England and Wales), the Chief Environmental Health Officer from the local authority, and a Water Supply or Water Quality Manager from the water utility based on local circumstances. The OCT will normally be chaired by the CCDC/CPHM. Minutes of meetings should be taken by a person assigned specifically for this duty who will also be capable of following up action points.

6.3.9 Relevant representation on the OCT will be interpreted in many ways but frequently as requiring every health authority and local authority to be represented by at least one person. This may not enhance the work of the OCT and the objective may be better achieved by a liaison group of all those concerned, with two representatives only on the OCT. These should be a CCDC/CPHM and an EHO of sufficient seniority to take decisions and allocate resources. Other participants who could be invited or co-opted to work with the core OCT are:

- Hospital manager
- Public Health Laboratory Service/Scottish Parasite Diagnostic Laboratory staff
6.3.10 There is a strong argument for some members of the team being appointed on account of their experience in dealing with waterborne outbreaks previously or their knowledge of water treatment and distribution. This raises the question as to whether the management of outbreaks would be better served if there was a national panel of experts, members of which could take the lead role in outbreak investigation with the assistance of local health officials and the water company. Such a national panel could include epidemiologists, public health microbiologists and water engineers, all of whom have experience in the investigation of waterborne outbreaks of infection. A national panel of experts would supplement local knowledge, not replace it.

Recommendation 6.3.11 The Expert Group recommends that a list of national experts who can be contacted in the event of an outbreak, be compiled. Consideration should be given to how the list should be compiled but it could include epidemiologists, public health microbiologists and water engineers with experience in the investigation of waterborne outbreaks of infection. Such experts would supplement local knowledge but not replace it.

6.3.12 Circumstances will dictate how an outbreak may be recognised and there is always difficulty in deciding when to declare a genuine waterborne outbreak. The CCDC/CPHM is responsible on behalf of the district health authority for formal declaration of a waterborne outbreak after discussion with the local authority and water utility members of the OCT. Having made this difficult decision, the implementation of the previously agreed plan should follow automatically. Early consideration should be given to the criteria that will be required before the outbreak can be declared over. From the public relations standpoint it is important to inform the community that the outbreak is over as soon as this information is available.

6.3.13 It is normal for the CCDC/CPHM to prepare a final report on the outbreak with the help of the other members of the Team. An outline model for a report is given in Appendix A3. In addition to the report, the lessons learnt and how future outbreaks could be better managed must be
identified and recorded. This report should then be sent to key people in each organisation represented on the OCT. The Group recognises that the statutory powers for the investigation and control of communicable disease rests within the health authorities and the local authorities. However, it considers that OCT reports should be formally received and recommendations commented upon by the Drinking Water Inspectorate or its regulatory equivalents to ensure consistency and that any lessons learnt are communicated widely.

**Recommendation**

6.3.14 The Group recommends that OCT reports on waterborne outbreaks should be formally received and recommendations commented upon by the Drinking Water Inspectorate or its regulatory equivalents.

6.4 Press relations in management of an incident or outbreak

6.4.1 The media can play a valuable public information role during the course of an incident. Television and radio can be expected to issue announcements to back up the direct sources of information to consumers. However, at a fairly early stage there will also be investigative journalism which will have different objectives. It is important to distinguish between these two facets to ensure that necessary clear messages to consumers are not clouded by the premature conclusions of reporters.

6.4.2 Information for the public and media during an outbreak should be controlled from one location to be agreed by the Outbreak Control Team. However, it is becoming increasingly important for public health professionals to have a working knowledge of how the press operate and how to liaise with them, especially now that the general public are increasingly aware of medical issues through the media, whether it be newspaper, magazine, radio, television or the Internet.

6.4.3 Good relations should be established with the local press well before any incident or outbreak. This may be accomplished by inviting journalists to meet key members of staff at their place of work, taking the opportunity of explaining the nature of their work, including how they collaborate with other local agencies and departments in safeguarding the public health.

6.4.4 It is prudent that they place themselves in a position of being able to play an active part in setting any news story about water ‘problems’ in its correct context. However, a cautious approach should be adopted when providing journalists with information regarding a potential problem, to ensure that this is not misrepresented.

6.4.5 An initial enquiry by journalists is often best handled by obtaining the essential information being sought, and the background to the article or programme, and then for the relevant officer to inform them that expert advice will be taken after which the press will be contacted again.

6.4.6 It is prudent for the officers to make every effort to gain a breathing space to sort out their thoughts on the topic before giving permission to be quoted. The nature of the information being sought should be identified; ask whether anybody else is being approached about the topic; identify any deadlines and set an agreed time for a further interview.
6.5 Draft meeting agenda, checklist and outline report for Outbreak Control Teams

6.5.1 OCTs are unlikely to be convened often and it is possible that the Chairman and members will have little experience of dealing with any emergency. To help the team and to try to ensure a consistency of approach, the Group has drawn up a draft agenda for OCT meetings, a checklist as an aide mémoire for the OCT chairman and the outline of an OCT report. These are given in Appendix A3.

6.6 Questions asked frequently during an outbreak

6.6.1 Experience during outbreaks has shown that there are a number of questions asked frequently by members of the public of Outbreak Control Teams. To help the team the Group has drawn up a list of the most frequently asked questions together with some suggestions for briefing those dealing with the public. These are also given in Appendix A3.

References
