UK Health Security Agency

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Outbreak of invasive meningococcal disease, Dorset

Notified by:	
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Incident Response Plan (IRP) Level	National Standard Incident
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Distribution:	Please see page 5 for information with regards to the distribution instructions for this Briefing Note.

Summary:

UKHSA identified 3 cases of invasive meningococcal disease in Dorset with onset dates between 17 March and 12 April 2026. All 3 cases have been confirmed as *Neisseria meningitidis* group B with the outbreak strain subtype R1 P1.19, subtype VR2 P1.15. This is a different subtype to the recent outbreak in the South East and these cases are not linked to that outbreak.

The purpose of this briefing note is to detail the clinical and public health response.

Background and Interpretation

The meningococcus bacteria, *Neisseria meningitidis,* can cause meningitis and/or septicaemia (overwhelming blood infection). It is spread by close prolonged or intimate contact. The bacteria may be carried harmlessly at the back of the nose and throat and only rarely goes on to cause invasive disease. However, when invasive meningococcal disease does arise, it is very serious, progresses rapidly, and requires urgent medical treatment.

Meningococcal bacteria are classified by their outer capsule into different serogroups, of which MenB currently accounts for most disease in England. MenC, W and Y cases do also occur but have been reduced to exceptionally

low levels following the long-established MenC vaccination programme and the highly effective MenACWY teenage vaccination programme introduced in 2015.

Young people, in the age range of the cases in this current outbreak, would be too old to have been eligible for the national MenB vaccination programme that has been offered routinely to infants since September 2015. Licensed MenB vaccines offer direct protection against most, but not all, MenB strains causing disease in the UK. However, they do not prevent acquisition of carriage.

Response to date
The UKHSA are leading a multi-agency response and have declared a national enhanced incident. The response has initially focussed on advising those at highest risk of exposure to the infection:

- UKHSA South West Health Protection Team (HPT) has undertaken contact tracing to identify close contacts of all confirmed cases and has communicated with them directly to give warn and inform advice and to coordinate antibiotic prophylaxis as per national guidance
- Antibiotic prophylaxis and vaccination are being offered as a precautionary measure to a wider group as follows:
    a. Anyone who is a resident in Weymouth or Portland or Chickerell and is in current school years 7 to 13, or anyone not in full time education who would be in one of these year groups
    b. Anyone who attends a secondary school or further education college in the Weymouth, Portland or Chickerell area and is in current school years 7 to 13

Chemoprophylaxis and vaccination is being offered to the above eligible groups, through a combination of in-reach visits to school and local drop-in clinics.

Implications and Recommendations for UKHSA Regions

Regional health protection teams are asked to add **CIMS Situation Record ID 201202036** for all reported cases of suspected IMD in young people with a link to Weymouth, Portland or Chickerell, with the same action for household contact records. Cases should be managed as per national guidance (UKHSA Meningococcal Public Health Guidance) including completing the national Enhanced Surveillance form MENSV01 for all confirmed cases: Meningococcal disease: enhanced surveillance form - GOV.UK

Implications and Recommendations for UKHSA sites and services:
All meningococcal-positive clinical materials including isolates, PCR-positive clinical samples and/or DNA extracts) should be referred to the National Meningococcal Reference Unit, Manchester for confirmation, serogrouping and further characterisation.

Implications and Recommendations for NHS

NHS clinicians are reminded of the following:

- **Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE)**

For patients presenting with suspected meningococcal disease, standard infection prevention and control precautions should be followed in line with the National Infection Prevention and Control Manual for England (see Appendix 11).

- **Initial management of suspected IMD cases**

In a community setting, rapid admission to hospital is the highest priority when IMD is suspected. Patients with IMD may present with septicaemia and/or meningitis. Clinicians should have a high index of suspicion where a young person attends with consistent signs or symptoms.

Meningococcal sepsis should be considered in a rapidly deteriorating patient with sepsis even in the absence of a non-blanching rash, which is usually a late sign.

Information on antibiotic treatment indicated for suspected meningococcal infections is included **UKHSA Meningococcal Public Health Guidance**.

- **Notifying cases to UKHSA**

Inform your UKHSA local health protection team of all suspected cases as soon as possible and without waiting for laboratory confirmation, so they can swiftly provide advice to household and other close contacts in the community and manage indicated public health measures: (Contacts: UKHSA health protection teams - GOV.UK)

- **Diagnostics**

The following samples should be taken where possible:
1) blood for culture (before 1st dose of antibiotics)
2) blood for PCR (ideally EDTA or, alternatively other unclotted blood specimen)
3) CSF where possible, and where there is no contraindication to lumbar puncture (within 4 days of commencing antibiotics)
4) throat (nasopharyngeal) swab for culture (within 24 hrs of antibiotics)
These should be cultured locally and any isolates sent to the Meningococcal Reference Unit. All meningococcal-positive clinical materials (including isolates, PCR-positive clinical samples and/or DNA extracts, also lysate extracted from Biofire loading syringes) should be referred to the National Meningococcal Reference Unit, Manchester for confirmation, serogrouping and further characterisation.

- **Post-exposure prophylaxis for healthcare staff**

Post-exposure prophylaxis is recommended for healthcare workers who have not worn appropriate PPE including a fluid resistant surgical facemask as part

of droplet protection, and who have been involved in airway care of suspected or confirmed patients during the time when index case had not been on appropriate antibiotics (e.g. ceftriaxone) or had been on it for less than 24 hours. Further information is included here **UKHSA Meningococcal Public Health Guidance**.

Implications and recommendations for Local Authorities:

Local authorities are asked to be aware of the variety of materials that are available to support awareness of meningitis and septicaemia and to make appropriate use of those resources and sources of information below in their routine work. All children and young people should be encouraged to be up to date with their routine immunisations as per the childhood schedule.

References or Sources of information:

Meningitis charities (www.meningitis.org, www.meningitisnow.org) do tremendous work supporting those affected by meningococcal disease and their families and their web pages have more information on vaccination and epidemiology.

UKHSA rolling news story
UKHSA blog
University vaccine communications toolkit
MenACWY vaccine: information for young people
Meningitis: signs and symptoms leaflet and poster - GOV.UK
Meningitis and septicaemia: information for students - GOV.UK
Meningitis and septicaemia: poster for new university entrants - GOV.UK

Instructions for Cascade:

Briefing Notes are routinely cascaded to the below groups:

- UKHSA Private Office Groups who cascade onwards within Groups
- UKHSA Health Protection in Regions:
  UKHSA Field Services
  UKHSA Health Protection Teams including UKHSA Regional Deputy Directors
  Deputy Directors in Regions Directorate
- UKHSA Lab Management Teams
- UKHSA Regional Communications
- Generic inbox for each of the Devolved Administrations
- Inboxes for each of the Crown Dependencies
- DHSC CMO
- OHID Regional Directors of Public Health
- National NHSE Emergency Preparedness, Resilience and Response (EPRR)
- NHSE National Operations Centre

- **Devolved Administrations** to cascade to Medical Directors and other DA teams as appropriate to their local arrangements.
- **Crown Dependencies** to cascade to teams as appropriate to local arrangements.
- **Regional Deputy Directors** to cascade to Directors of Public Health
- **UKHSA microbiologists** to cascade to non-UKHSA labs (NHS labs and private)
- **UKHSA microbiologists** to cascade to NHS Trust infection leads
- **NHS labs/NHS infection leads/NHS microbiologists/NHS infectious disease specialists** to onwards cascade to NHS labs/NHS infection leads/NHS microbiologists/NHS infectious disease specialists to onwards cascade to infectious disease specialists, microbiologists, emergency departments, acute medicine, paediatrics and intensive care units
- **NHSE National Operations Centre** to cascade to ICBs, acute trusts and relevant providers

- Royal College of Emergency Medicine
- Royal College of General Practitioners
- Faculty of Intensive Care Medicine
- Royal College of Paediatrics and Child Health
- Royal College of Pathologists
- Faculty of Pharmaceutical Medicine
- Royal College of Physicians
- Faculty of Public Health
- NHS Immunisation Team