CJD 63/6/2

file: CJD Incident Panel, Feb. 2001 meeting (63/6/2)

DH Department of Health

Skipton House
80 London Road
London
SE1 6LH

Tel: 020 7972 2000
Direct Line: GRO-C

To: All members and observers of the
CJD Incidents Panel

24th July 2001

Dear Colleague,

Re: Minutes of Meeting of CJD Incidents Panel, 22 – 23 February 2001

Please find enclosed for information the final, signed minutes of the meeting of the CJD Incidents Panel, held on 22nd – 23rd February 2001. Many thanks to all of those who attended the meeting, and provided comments on the draft minutes.

All those who attended the meeting of the Panel on the 4th June should have received a copy of the draft minutes of this meeting for comment. Please contact Claire Mills by the close of 31st July with any comments you may have on these minutes, if you have not already done so. A revised draft will be circulated at the next full meeting of the Panel for ratification.

I would like to take this opportunity to remind you that the next full meeting of the Panel will be held on Thursday 18th October 2001, from 10.00am to approximately 4.30pm, in Avonmouth House, 6 Avonmouth Street, London SE1. We look forward to seeing you there.

Please feel free to contact Claire or myself if you have any queries. Claire can be contacted by phone on GRO-C or alternatively by e-mail at: claire.mills@GRO-C.

Yours sincerely

GRO-C

pp

Dr Philippa Edwards
CJD Incidents Panel Secretariat

Note of Meeting of CJD Incidents Panel
22 – 23 February 2001, Hilton Bath City Hotel

Attendees

Chairman

Professor Michael Banner	Ethicist, Professor of Moral and Social Theology, Kings College, University of London

Members

Professor Don Jeffries	Vice Chairman, Virologist, St Bartholomew's Hospital (JWG)
Professor James Ironside	Neuropathologist, National CJD Surveillance Unit (JWG)
Dr Tim Wyatt	Consultant Microbiologist, Belfast (JWG)
Dr Geoff Ridgway	Consultant Microbiologist, London (JWG)
Dr Noel Gill	Public Health Laboratory Services, London
Dr Roland Salmon	Public Health Laboratory Services, Wales (JWG)
Ms Susan MacQueen	Infection Control Nurses Association
Professor Dame Lesley Southgate	Royal College of General Practitioners
Ms Diana Kloss	Law Faculty, University of Manchester
Ms Jean Gaffin	Lay Representative
Professor John O'Neill	Ethicist, Lancaster University
Professor Mike Bramble	British Society of Gastroenterologists
Professor Graham Smith	Royal College of Anaesthetists
Mr Andrew Tullo	Royal College of Ophthalmologists
Ms Kate Woodhead	National Association of Theatre Nurses
Dr Pat Hewitt	National Blood Authority
Mr Henry Marsh	Society of British Neurological Surgeons
Professor Ian Cooke	College of Obstetricians and Gynaecologists

Secretariat

Dr Pip Edwards	CJD/ BSE Policy Unit, DH
Dr Nicky Connor	CJD/ BSE Policy Unit, DH
Miss Claire Mills	CJD/ BSE Policy Unit, DH

DH Officials

Dr Mary O'Mahony	Communicable Disease Branch, DH
Mr Alan Harvey	CJD/ BSE Policy Unit, DH

Observers

Dr Glenda Mock	Department of Health, Social Services & Public Safety, Northern Ireland
Dr Mike Simmons	National Assembly of Wales
Ms Carole Fry	Communicable Diseases Branch, DH
Dr Martin Donaghy	Scottish Executive Health Directorate

Expert Advisors

Dr David Taylor	Sedecon 2000
Mr Charles Lister	Blood Policy Unit, DH
Mr John Barker	Institute of Sterile Service Management

Apologies

Members

Dr Mike Painter	Consultant in Communicable Disease Control, Manchester (JWG)
Mr Harry Cayton	Lay Representative, Alzheimer's Society
Professor John Lumley	Royal College of Surgeons
Dr Steve Deacon	Institute of Occupational Health and Safety
Dr Hester Ward	National CJD Surveillance Unit
Professor Peter Hutton	Royal College of Anaesthetists
Professor Len Doyal	Ethicist, Bartholomew's & Royal London School of Medicine & Dentistry
Mr Luke Gormally	Ethicist, Linacre Centre for Healthcare Ethics

DH Officials

Mr Peter Jones	CJD/ BSE Policy Unit, DH

Written comments were received from Dr Mike Painter (**CJDIP 2/32**), Professor Len Doyal (**CJDIP 2/35**) and Mr Luke Gormally (**CJDIP 2/34**).

Welcome and Introductions

1. The Chair welcomed all present and thanked them for attending. The apologies were announced as above. The group was informed that Professor John Collinge had resigned from the Panel due to the pressures of time. He had however agreed to provide advice if required.

2. The Chair explained that the primary purpose of the meeting was to discuss the main principles contained in the draft CJD Incident Guidance, which had been prepared by drafting groups prior to the meeting. The Guidance would then be redrafted and presented to the Panel at the next meeting in June. It would then be presented to the SEAC/ ACDP JWG before a wider consultation.

3. The Panel was also requested to advise on the management of the incidents involving blood and blood products from donors who later develop CJD.

Secretariat Provision to the Panel (CJDIP 2/26; CJDIP 2/33; CJDIP 2/34)

4. At the request of the Chairman the attending DH officials withdrew from the meeting for the discussion of this item. On their return, it was announced that the Chair would write to the CMO renewing the request for increased liaison and co-ordination between the various bodies, committees and panels that advised on CJD issues. It was also requested that the Panel be supported by a dedicated secretariat with help from other officials.

Ratification of Minutes of Last Meeting (CJDIP 2/01)

5. These were agreed subject to the following revisions:

- Minute 11. L.1: insert 'snapshot' between 'Estates' and 'survey'
- L. 6: replace 'would' with 'could'
- Minute 21. L. 5: delete from 'transfusions' to end of sentence.

Chairman's Initials:.. GRO-C ..... Date:..7..7....01.....

- L. 7: insert 'DH and the' between 'alert the' and 'NBA'
- L. 8: insert 'as appropriate' after 'NBA'

Matters Arising Not Covered on Main Agenda:

i) Revised Terms of Reference (CJDIP 2/ 02)

6. These were agreed subject to the following revisions:
   - Insert 'organs' after 'tissues'
   - Correct spelling of 'Creutzfeldt-Jakob'

ii) Indemnity

7. Members were reminded that they had been provided with an indemnity form to sign. Those members who had not yet returned the signed form to the secretariat were requested to do so.

iii) Revised Code of Practice (CJDIP 2/ 03)

8. It was requested that the document be amended to be appropriate for the whole of the UK.

Action: Secretariat

9. The group was informed that a Declaration of Interests form would be issued to members to complete and return to the secretariat.

Action: Members

General Introduction to CJD Incident Guidance (CJDIP 2/05, CJDIP 2/04)

10. This had not been written by the drafting groups and would need extensive further revision prior to consideration at the next meeting of the Panel. It was suggested that it could be amended to include an outline of the policy context in which the Panel was operating; this should include a clear explanation of the cost and other issues that prevented adoption of single-use instruments for all surgery.

11. The document should also outline the broad principles and reasoning behind decisions reached in the guidance. It should also be made clear that the document would be dynamic and would be revised as new knowledge emerged.

12. There was a need to clarify the relationship between CJD and other health issues (such as HIV), as well as the difference between variant CJD (vCJD) and sporadic CJD.

13. It was important that issues surrounding blood and blood products were not ignored due to the difficulty involved. There was also a need to recognise that decisions made on blood products would have international implications.

Chairman's Initials:... GRO-C ..... Date:... 7.7.01 .....

Discussion of Guidelines for CJD Incident Risk Assessment (CJDIP 2/05; CJDIP 2/27; CJDIP 2/28; CJDIP 2/29)

14. The group welcomed Dr David Taylor and Mr John Barker who were attending the meeting as expert advisors, and had been members of the CJD Incident Risk Assessment Drafting Group.

15. It was explained that the Risk Assessment Drafting Group, chaired by Dr Geoff Ridgway, had met twice to revise and expand on the original guidelines drafted by the CJD Incident Expert Group (which had been chaired by Professor Jeffries). The drafting group had also been asked to include assessment of the risk from blood and blood products.

16. A number of useful comments on the draft had been received from the Economics and Operational Research Unit of DH and these would be included in the revision.

Risk Assessment

17. The Panel proceeded to discuss the document section by section. The changes and clarifications proposed were noted by the secretariat and will be taken forward with the Risk Assessment Drafting Group.
18. (Note from the Secretariat: only the major issues are included in the minute)

19. It was noted that the group had been informed on infectivity levels of CJD by a number of experiments based on animal models. It was believed that tissue infectivity levels were different for vCJD and the sporadic form of the disease. Therefore the draft guidance separated the two diseases. The guidance should clearly indicate the quality of the data and the source of the evidence (e.g. animal models) on which conclusions were reached. The quality of evidence should be described in Table 1 on tissue infectivity.

20. The introduction should also consider the type of surgery performed on subsequent patients (para. 2.3)

21. The draft guidance assumed that the exposure leading to vCJD peaked in 1980 (see para. 2.9), as the disease was thought to be linked to exposure to BSE. The group was also informed that the incubation period figures quoted in the guidance were informed estimates, and did not take into account the possible role of genetic susceptibilty.

Route of Transmission

22. It was requested that the phrase 'experiments have shown' in this section be amended to 'experiments have suggested or indicated', as this phrase more accurately reflects the available knowledge. The wording of the document as a whole should be careful to reflect what is known and unknown.

Dentistry

23. Table 2 included information regarding the infectivity levels of dental tissues. A

Chairman's Initials GRO-C ..... Date: 7.7.01 .....

paper had been published which indicated that infectivity had been found in oral tissues in a hamster model. The drafting group had considered that dental operations involving the trigeminal ganglia and its nerve branches would have an equivalent risk of vCJD as CNS operations.

24. SEAC had considered possible dental tissue infectivity and had requested a Risk Assessment and further research

25. Dental tissues from vCJD patients were currently unavailable, as it was difficult to sample dental tissues at post mortem without disfiguring the face. Studies would be conducted when less invasive methods of tissue collection became available.

26. It was suggested that root canal work on vCJD patients should viewed as a clinical incident, which would have implications for the data gathering performed by the NCJDSU and for incident management. It was also suggested that experts were needed to advise on the infectivity of dental tissues. (See also minute 52)

Instruments

27. The guidance stressed that cleaning, rather than autoclaving, is the key component of decontaminating instruments to prevent transmission of CJD.

28. It was requested that this section of the guidance states that a major research programme is currently under way which could refine the figures quoted. Also, it should be stressed that disinfection techniques were not applicable to all appliances.

Cleaning

29. There was evidence to suggest that under ideal conditions, decontamination would produce a 10^8 reduction in contamination, rather than 10^5 as quoted. However, there was evidence from '*The Decontamination of Surgical Instruments and Other Medical Devices, SEHD*' (**CJDIP 2/29**) to suggest that current decontamination standards throughout the health service were poor. Therefore, the guidance was based on the more pessimistic estimate used in the Risk Assessment for Surgical Instruments. The Panel requested to see the evidence from the Decontamination review performed in England.

Action: Secretariat to seek permission to circulate the English Decontamination Review Survey to the Panel

Combined Effect of Decontamination

30. The Panel briefly discussed the 'contact theory' (paragraph 2.38), which suggested that contact alone with a contaminated instrument may be sufficient to result in infection. The Panel was informed that, whilst the experiment was still in progress, results to date did not support this theory. Therefore, the Panel agreed that the draft guidance need not take this hypothesis into account.

31. There was also evidence of a 'plateau effect', which assumed that at a certain point, decontamination does nothing at all to remove remaining material, which is

Chairman's Initials: GRO-C Date: 7.7.01

fixed to the instrument in a very low quantity. However, it was not known if it was stuck onto the instrument indefinitely, or if it might eventually come off when in contact with a patient. The graphs on page 9 of the draft guidance were scenarios based on mouse models with very pessimistic assumptions, and some of which took the plateau effect into account. The group agreed that the graphs should be included in the guidance, provided that they were fully explained. It was noted that the title on the 'Y' axis should be revised to 'likelihood of instrument being infective'.

32. It was noted that the risk assessments carried out by EOR and endorsed by SEAC were population based and these could not be directly interpreted as risks in individual incidents.

Endoscopes

33. The group turned to discuss flexible endoscopes, which were known to be particularly hard to decontaminate, as it was not possible to subject them to autoclaving. It was noted that autoclaving reduces the life expectancy of rigid scopes, and therefore some trusts decontaminated these instruments in glutaraldehye (which is believed to fix the abnormal prion to instruments). This caused concern amongst some members of the group, and needed addressing.

Action: Secretariat to consider how to re-issue guidance regarding rigid endoscope decontamination

Type of Operation – Categorisation by possible risk

34. This section had been taken from '*The Risk Assessment for Transmission of vCJD via Surgical Instruments: A Modelling Approach and Numerical Scenarios*' **(CJDIP 2/15)**, which had been endorsed by SEAC. It was noted that the trigeminal nerves were cranial nerves and that tooth pulp contained trigeminal nerve branches.

35. It was suggested that this section should be amended to include laryngeal masks to category 2 when used during tonsillectomy, as these were subject to heavy contamination with potentially infective material. The group also believed that the ocular classifications needed further consideration.

36. The group noted that CSF had been defined as medium risk by the JWG and that lumber puncture instruments should be single-use.

37. Biopsy forceps used in the gastrointestinal tract could come into contact with risk material, and should therefore be given further consideration. It was noted that these might not be traceable, even though the endoscopes were. There were also some gynaecological instruments, such as canulae, which may be used on lymphoreticular tissue and which were difficult to decontaminate and would need further thought.

Chairman's Initials: GRO-C ..... Date: 7.7.01

38. The group agreed that the document as a whole should be amended to be more thorough regarding references, explanations and reasoning behind decisions made. A prose form setting out the broad principle points and the detailed arguments was needed.

Annex 1

39. It was agreed that the annexes should be amended to reflect the discussions outlined above regarding instrument decontamination, in consultation with specialists.

Annex 2

40. This section had been taken from **CJDIP 2/15**, which had been endorsed by SEAC. The Panel agreed that the current list could be used as a framework and altered if considered appropriate, following advice from specialists and experts in the relevant areas.

41. The Chairman indicated that there remained a lot of work to do on the guidance and that, although the Panel had no criticisms of the individuals comprising the current secretariat, insufficient resources had been provided to deliver the work required by June. The DH would need to address the issue of the secretariat and co-ordination as a matter of urgency

Action: DH officials to consider secretariat provision of Panel, and methods of increasing co-ordination of committees

Draft Guidance on CJD Incident Risk Management (CJDIP 2/06; CJDIP 2/30)

42. The risk management drafting group, chaired by Professor Dame Lesley Southgate, had met twice to revise the guidelines contained within the original guidance previously presented to the group. The drafting group had agreed the basic principles of incident management as:

- To provide the public with as much information as possible about the risk of CJD in the healthcare setting
- To aim to increase scientific understanding of the possible risks of transmitting CJD in the healthcare setting
- Minimise the possibility of doing harm to either society in general or to the individual
- Balance the individual's 'right to know' and 'right *not* to know' about possible exposure to risk.

43. The Panel suggested that the principles of the 'Public Awareness' should come forward to the beginning of this section.

Chairman's Initials: GRO-C ..... Date: 7.7.01 .....

44. Written comments had been received from Professor Doyal (**CJDIP 2/35**), who challenged the mechanisms outlined in the draft guidance, but did not disagree with the main principles.

Public Health Action

45. It was suggested that the word 'invasive' medical procedures in this section needed defining. Reviewing the wording developed for HIV incident management might be helpful in this.

Investigation, Step 1 – Identifying possible exposures to CJD in a healthcare setting

46. It was agreed that paragraph 3.6 needed rewording to clarify who was responsible for contacting the local Consultant in Communicable Disease Control (CCDC) with the details of an incident, as this responsibility did not fall within the remit of the National CJD Surveillance Unit (NCJDSU). It would also be beneficial to include a definition of a 'suspect' case of vCJD. Professor Will of the NCJDSU had recently written to the secretariat regarding this, and his letter would be circulated to the Panel.

Action: Secretariat to circulate Professor Will's letter

47. The mode of keeping the devolved administrations informed of every incident needed further consideration

Action: Chairman to meet with officials from devolved administration

Investigation, Step 2 – Initial information collection

48. The phrase 'medical devices' should be clarified (possibly by using the definition provided in the 'Microbiology Advisory Committee Manual').

Investigation, Step 3 – Initial appraisal and control measures

49. Paragraph 3.13 should be amended to clearly state that instruments should be identified and quarantined by a Trust as soon as a case of CJD is suspected. It was anticipated that in the future local teams could manage the early stage of an incident. The wording should reflect the evolving nature of the guidelines.

50. It was suggested that in order to fully implement the actions outlined in the draft management guidelines, there should be 24-hour access to the Panel secretariat and that further thought should be given to this possibility. It was suggested that the Communicable Disease Surveillance Centre had an appropriate set up for 24 hour on call medical cover.

Investigation, Step 4 – Further information to characterise risk

51. It was anticipated that a proforma would be issued for each incident. The NHS should be made fully aware of the issues and be prepared to manage an incident if necessary.

Chairman's Initials: GRO-C ..... Date: 7.7.01 .....

52. It was noted that dentistry remained an area of expertise lacking on the Panel, and it was suggested that a representative from the British Dental Association be included as a member. The BDA were currently working on CJD guidance, and it was important that all guidance on this issue should be consistent. (See also minute 26).

Action: Secretariat to request CMO to appoint a representative of British Dental Association to the Panel

Investigation, Step 5 – Risk assessment

53. Neurological endoscopes were recognised as an area of concern, as they were in contact with high risk tissues, were difficult to decontaminate effectively and were often not traceable. The DH policy on tracing endoscopes needed clarifying and included in the guidance.

54. It was proposed that quarantined instruments could be used (with informed patient consent) in some emergency situations. This issue caused concern amongst some members of the Panel and needed further discussion.

55. An explanation of why it was not acceptable to subject instruments to further decontamination cycles and then return them to use was also required.

Public Health Management

56. Following careful consideration of the balance between the pursuit of knowledge and individual patient care, the group had suggested that a database of cohort patients could be devised, the existence of which could be placed in the public domain. The database would contain details of patients who were considered to have possibly been exposed to a risk of CJD. Data could be gathered on these patients in order to gain knowledge about the risks from medical interventions.

57. The Panel agreed that the scientific justification underlying the general principle of establishing a database of cohorts required explanation. This would be helpful in the future for defining the perimeters of risk associated with the disease.

58. Where any of those patients was considered by the Panel to have been placed at a significant/ high risk of exposure, they would be actively contacted. They would be informed of their possible risk of exposure in order to advise them against donating blood/ organs, and to advise on precautions to be taken if they were to undergo surgery, as they might pose a risk to others. It was acknowledged that this would be a burden of information to the individual, but this was considered as justifiable on general public health protection grounds.

59. Some members of the Panel expressed concern over actively informing any patient. It was agreed that this would require further discussion.

Chairman's Initials:... GRO-C ..... Date:...7.7.01.....

Instruments

60. The group agreed that the number of decontamination cycles that would render an instrument fit for re-use would require further thought and discussion, and should be seen together with the risk assessment guidance. It should be emphasised that these rules should be seen as guidelines and that instrument complexity should be taken into account when reaching decisions.

61. It was suggested that it would be helpful to include a representative of the Institute of Sterile Service Management (ISSM) as a member of the Panel, who could help to advise on this issue.

Action: Secretariat to request CMO to appoint a representative of the Institute of Sterile Service Management to the Panel

62. It was suggested that views of the public on the guidance could be helpful, e.g. by a 'citizen's panel'. This should be further considered at the next meeting of the Panel in June.

Locus of Responsibility for Incident Follow-up (CJDIP 2/07; CJDIP 2/07A)

63. This paper had been requested by Panel members and clinicians in order to clarify who is responsible for ensuring that appropriate action is taken regarding CJD Incidents. It was explained that the hospital Trust/ primary care provider was responsible for taking action suggested by the Panel. The Health Authority has responsibility for ensuring that suitable measures are taken to protect public health. Panel advice should therefore be provided to the Trust or primary care unit involved, but copied to the governing Health Authority (or Health Board).

Report to the SEAC/ ACDP JWG (CJDIP 2/08)

64. The framework document was agreed as satisfactory and the Secretariat was requested to proceed with the drafting of the report on this basis. Members were requested to send any comments in writing to the Secretariat.

PI 17 (CJDIP 2/09)

65. The group was informed that this case involved an appendicectomy on a vCJD patient. The instruments were not traceable and therefore the cohort of patients was large and ill defined. In the light of this information, the Panel agreed that there would be no possibility of a useful follow-up. However, the Panel reserved the right to consider whether the cohort of patients should be included on the database proposed in the draft Panel Guidance Document.

PI 26 & 28 (CJDIP 2/10)

66. These incidents involved the same patient, who had undergone procedures in two hospitals. The incident investigating team comprised members from both

Chairman's Initials: GRO-C Date: 7.7.01

hospitals, and had provided a detailed analysis of the incidents to the Panel. A sub group of the Panel had met to discuss the case, but outstanding questions remained regarding the identification of any 'at risk' groups and if instruments still in quarantine should be returned to use.

67. The group agreed that there were no patients who would be classified as being in a 'high risk of being exposed' group. However, the Panel reserved the right to consider whether the cohort of patients should be included on the database proposed in the draft Panel Guidance Document. Therefore, a publicity campaign may need to be undertaken.

68. The Walsham forceps should be destroyed as an extra-precautionary measure, as these had been exposed to a 'medium' risk of possible contamination with lymphoreticular tissue, were rather difficult to clean and the Panel were not confident that they could be guaranteed to have undergone at least 10 decontamination cycles. It was agreed that all remaining instruments could be classified as 'low risk' and could be returned to use.

PI 37 (CJDIP 2/11)

69. The group had been provided with tabled paper **CJDIP 2/11**, and welcomed Mr Charles Lister from the Blood Policy Unit in DH, who was attending the meeting as an official.

70. The incident involved pooled blood products derived from plasma, which included plasma donated in 1996 and 1997 by a person who later developed vCJD. The possible size of the cohort could be up to 40, 000 patients. Other parts of the donor's blood may have been used in labile blood components. However, the NBA was not currently in a position to confirm this as yet.

71. The incident was reported in December 2000. The MCA had instructed the product manufacturers, Bio Products Laboratory, to inform hospitals of the implicated batch numbers. No recall was necessary, as all products were beyond their expiry date. In January, the Haemophilia Society and the Primary Immunodeficiency Association had notified their members of the incident and the UK Haemophilia Doctors Organisation had written to Haemophilia Centre Directors advising them on how to handle enquires from patients. Specific guidance in relation to other patients had not been issued. A draft paper from the Deputy Chief Medical Officer was provided for comment (tabled paper **CJDIP 2/11**) and Panel advice was requested regarding what information should be provided to other patients regarding the risk of transmission.

72. The Panel was informed that there was some experimental animal evidence to suggest vCJD infectivity in blood and that this should be noted in the letter. To date there is no epidemiological evidence in humans to support this, but it is too early in the course of the epidemic to confirm whether infectivity is present or not.

Chairman's Initials:...GRO-C..... Date:...7.7.01.....

73. The Panel had agreed that the risk assessment in the Panel guidance document **(CJDIP 2/05)** indicated that haemophiliac recipients of the implicated plasma-derived products, would not pose a significant risk to others. Therefore special precautions would not be recommended if they were to undergo surgery. It was noted that one recipient had already had surgery delayed because of concerns over the risk to subsequent patients from surgical instruments. It was noted that the actions of the Haemophilia Society had resulted in directly informing patients without allowing for a right "not to know". However, it was recognised that haemophiliacs represented a special group of patients who receive particular care from their clinicians and who had already experienced the threat of infection from products. The Panel expressed concern over a number of points in the draft letter but considered it was not possible to cover all these in detail at the meeting. It was pointed out that the term 'counselling' was used inappropriately in places. It was suggested that the Panel use the same definition as provided in *'Human Fertilisation and Embryology Authority Code of Practice'*.

74. The Panel recognised the importance of providing advice on this matter in a timely manner. It was agreed that a subgroup of relevant experts on the Panel would meet as soon as possible to further discuss this incident and report back to Mr Lister and the NBA with their advice. The Deputy Chief Medical Officer and the DH were free to provide advice in the meantime without the Panel's comment, but this would not receive the support of the Panel.

75. It was noted that this was the third incident involving blood products and it may be necessary to return to the Panel for advice on the two earlier incidents.

PI 13 (CJDIP 2/12)

76. This incident involved thoracic surgery on a vCJD patient. The instruments had been traceable, and the hospital had made the decision to destroy them. It was understood that the hospital would be able to identify the cohort, including the patient immediately following the index case. A small subgroup of the panel had met with the incident team and requested further information to be collated on the operations performed on subsequent patients. The team were in the process of doing this.

77. The Panel agreed that some patients could be in an 'at risk' group, as there was a possibility of contact with lymphoreticular tissue. It was suggested that a subgroup of the Panel should meet to discuss the case once the incident team had collated the requested information. It was also suggested that the incident team be asked to identify the first few patients to have undergone procedures using the implicated instruments. The details of the criteria on which the 'at risk' group would be identified was to be decided.

78. The Panel agreed that as further public health action may need to be taken (i.e. informing patients), the process of information gathering should be expedited.

Chairman's Initials: GRO-C ..... Date: 7.7.01

PI 21 (CJDIP 2/13)

79. The incident involved sporadic CJD and re-useable prisms (which are non-autoclavable) in contact with the cornea. The prisms were no longer in use and were not traceable.

80. The Panel agreed that it is not possible to exclude the likelihood that corneal epithelial cells may have contaminated the tonometer, which might therefore raise the possibility of contamination with a transmissible agent. However, tonometry has not been a recognised risk factor for sporadic CJD, and the amount of tissue which would be likely to contaminate the tonometer head would be very small indeed and may well be removed by washing. The risk was also reduced, as the surgery was 10 years prior to the onset of symptoms, at which time infectivity levels in the eye were expected to be considerably lower than the maximum value for this tissue. However, the Panel reserved the right to consider whether the cohort of patients should be included on the database proposed in the draft Panel Guidance document.

    (Note added after meeting: See 'Matters Arising' in the Minutes of the meeting of the CJD Incident Panel in June 2001.)

81. This incident highlighted the need for additional guidance on the issue of ocular tissue infectivity. It was agreed that the Secretariat would write to the Chair of the JWG requesting advice.

Action: Secretariat to write to Chair of JWG

PI 34 (CJDIP 24)

82. The Panel agreed that this case would need careful consideration and discussion. The group was informed that work was in progress regarding the safety and risks posed from dialysis machines. It was agreed that a working party would look at this issue at a later date. The Secretariat would write to the Chair of the JWG requesting that a working party look at this issue and provide advice.

Action: Secretariat to approach Chair of JWG

Letters Issued from the Panel Since November 2000 (CJDIP 2/19, CJDIP 2/19A)

83. Members were content with the contents of the letters issued to clinicians since the last meeting of the Panel in November. The Secretariat agreed to write to any outstanding cases to inform them of the main decisions that had been reached in the meeting.

Action: Secretariat

Database of Incidents (CJDIP 2/14)

84. This item was not discussed at the meeting due to lack of time.

Chairman's Initials: GRO-C ..... Date: 7.7.01 .....

Any Other Business

85. It was suggested that the minutes of the meeting eventually be made available to the public. It was requested that names should be removed from minutes in this event.

Date of Next Meeting

86. It was anticipated that the next meeting of the full Panel would be held in June 2001. The secretariat would inform members of the details once a date had been arranged.

Summary of Action Points

- The minutes of the meeting of November 2000 to be amended as requested by Panel members
- The secretariat to redraft guidance in consultation with drafting groups and re-circulate to the Panel for discussion in June.
- A sub-group of the Panel to meet to further discuss case PI 37.
- Permission to be sought to provide a copy of the NHS Estates Decontamination Review to Panel members.
- Secretariat to request CMO to appoint a representative from ISSM and BDA to the Panel
- Chairman of Panel to meet with devolved administrations
- Secretariat to contact the Chair of the JWG, requesting advice regarding ocular tissue infectivity and dialysis machines.

Papers provided for information:

- CJD Instrument Risk Assessment Summary (**CJDIP 2/15**)
- BSE Inquiry Summary (**CJDIP 2/16**)
- Revised membership list (**CJDIP 2/17**)
- Updated CJD Incident List (**CJDIP 2/18 & CJDIP 2/18A**)
- Meeting attendees and apologies (**CJDIP 2/23**)
- Letter from Dr Will Patterson (**CJDIP 2/25**)
- Extract from Guardian, 19/01/01: "CJD risk 'Right to Know' plan" (**CJDIP 2/20**)
- Paper: Iatrogenic Creutzfeldt-Jakob Disease at the millennium' (**CJDIP 2/22**)
- Letter to CMO regarding donating endoscopes to developing countries (**CJDIP 2/31**)

Chairman's Signature:... GRO-C .....

Date:.....7.7.01.....