UK Health Security Agency

Serial number: BN2026/008 **18th March 2026**

Outbreak of invasive meningococcal disease, South East England

Notified by:	
Authorised by:	• *Merav Kliner, Incident Director* • *Will Welfare, Strategic Response Director* • *Emmanuel Okpo, Regional Deputy Director* • *Communications*
Contact:	Incident062.nrc@ukhsa.gov.uk
Incident Response Plan (IRP) Level	National Enhanced Incident
Incident Lead:	Merav Kliner, Trish Mannes, Emmanuel Okpo, Gayatri Amirthalingam
Distribution:	Please see page 6 for information with regards to the distribution instructions for this Briefing Note.

Summary:
Between 13 and 17 March 2026, UKHSA identified 20 cases of invasive meningococcal disease in the South East. Six cases have been confirmed as *Neisseria meningitidis* group B. Most cases are students from the University of Kent, Canterbury, and sixth form students from local secondary schools. At least 10 cases attended Club Chemistry in Canterbury on 5th, 6th or 7th March 2026. The illness has been severe with rapid deterioration, and two deaths have occurred.

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 Health Protection Teams (HPTs) are actively contact tracing to identify close contacts of all confirmed and probable cases and are communicating with them directly to give warn and inform advice and to coordinate antibiotic prophylaxis as per national guidance
- HPTs are also liaising closely with all educational and other community settings linked to cases to provide warn and inform information and advice.
- Antibiotic prophylaxis is being offered as a precautionary measure to a wider group as follows:
    a. Students who live on the Canterbury campus at the University of Kent
    b. Staff who live or work in affected halls of residence blocks on the Canterbury campus at the University of Kent
    c. Staff members working at Club Chemistry nightclub, Canterbury, and those individuals who attended the nightclub as visitors on 5th, 6th and 7th of March.

As the outbreak evolves, further groups may be identified that require antibiotic prophylaxis and will be communicated with directly.

Local clinics are offering chemoprophylaxis to contacts in the Canterbury area. If an eligible contact presents to a healthcare setting (primary or secondary care) and has not already received prophylaxis through UKHSA-coordinated clinics, this should be prescribed for them. Eligibility is defined in national UKHSA and NICE CKS guidance.

Given the severity of the outbreak, and as an additional precautionary measure, a targeted vaccination programme will begin, starting with students that are residents of the Canterbury Campus Halls of Residence at the University of Kent who will be contacted directly. Precise details of eligibility will be confirmed by UKHSA. UKHSA will continue to assess ongoing risk to other populations and the programme may be extended.

Where demand exceeds capacity, ICBs are responsible for ensuring timely access to postexposure prophylaxis and vaccination in line with NHS England commissioning guidance.

Implications and Recommendations for UKHSA Regions

Regional health protection teams are asked to add **CIMS Situation Record ID 201160306** for all reported cases of suspected IMD in young people with a link to Canterbury, with the same action for household contact records. Cases should be managed as per national guidance (UKHSA Meningococcal Public Health Guidance).

HPTs are reminded to complete 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
Clinicians are referred to the Urgent Public Health Message dated18/03/2026 **Outbreak of invasive meningococcal disease, South East England - GOV.UK**

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). Use appropriate PPE (including Level 2 PPE where clinically indicated) for assessment and management of suspected IMD.

- Clinical staff should apply standard respiratory hygiene and infection control measures in routine clinical settings
- Wear a fluid resistant surgical facemask for routine care of patients with suspected invasive meningococcal disease
- Wear an FFP3 mask or Hood for aerosol-generating procedures performed on patients with suspected invasive meningococcal disease

- Continue transmission-based precautions until the patient has been established on antibiotics for at least 24 hours
- No additional or enhanced IPC measures are required beyond those recommended in national guidance

- **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 aged 16-30 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. In acute settings, patients with sepsis should be managed according to local sepsis guidelines and immediate clinical management should focus on stabilisation (including fluid resuscitation as appropriate) and early engagement with ITU colleagues where necessary.

Information on antibiotic treatment indicated for suspected meningococcal infections is included in the outbreak Urgent Public Health Message and **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.

Implications and recommendations for Local Authorities:

Local authorities are asked to signpost local schools, colleges and universities to the resources and sources of information below. All children and young people should be encouraged to be up to date with their routine immunisations as per the childhood schedule (add link).

References or Sources of information:

Meningitis charities (Meningitis Research Foundation | CoMO, Meningitis Now | Meningitis charity | Research and awareness) do tremendous work supporting those affected by meningococcal disease and their families and their web pages have more information on vaccination and epidemiology.

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