Waterborne Disease Outbreaks Associated with Drinking Water (N=32) by Year and Exposure State/Jurisdiction — Waterborne Disease and Outbreak Surveillance System, United States, 2011–2012.

Exposure Category and State/ Jurisdiction	Month	Year	Class*	Etiology (Confirmed/Suspected)	Predominant Illness†	No. cases	No. hospital-izations§	No. deaths¶	Water System**	Deficiency††	Water Source	Setting
Alaska	Jun	2012	3	*Blastocystis hominis* (S), *Giardia intestinalis* (C)	AGI	21	0	0	Transient Noncommunity	1, 2	Spring, Well, River/Stream§§	Camp/Cabin Setting
Arizona	Mar	2011	4	Unknown	AGI	7	0	0	Nontransient Noncommunity	2	Spring	Outdoor Place of Work
Colorado	Oct	2012	3	Propylene glycol (S)¶¶	AGI	26	0	0	Community	6	Lake/Reservoir/ Impoundment	Hospital/Health Care
Florida	Aug	2009***	3	*Legionella pneumophila* serogroup 1 (C)	ARI	10	4	1	Community	5a	Unknown	Hotel/Motel/Lodge/Inn
Florida	Jul	2011	3	*Shigella sonnei* subgroup D (C)	AGI	22	0	0	Commercially-Bottled	11c	Unknown	Indoor Workplace/Office
Florida	Mar	2012	4	Unknown†††	AGI	3	0	0	Commercially-Bottled	99b	Well	Indoor Workplace/Office
Idaho	May	2012	3	*Campylobacter* (C), *Giardia intestinalis* (C)	AGI	7	0	0	Community	6	River/Stream, Well	Community/Municipality
Illinois	Aug	2012	1	*Pantoea agglomerans* (C)§§§	Other	12	9	0	Community	99	Lake/Reservoir/ Impoundment	Hospital/Health Care
Maryland	May	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	7	6	1	Community	5a	Well	Hotel/Motel/Lodge/Inn
Maryland	May	2012	3	*Legionella pneumophila* serogroup 1 (C)	ARI	3	2	1	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
New Mexico	Jun	2011	3	Norovirus (C)	AGI	119	0	0	Transient Noncommunity	2	Spring¶¶¶	Camp/Cabin Setting
New York	Apr	2009****	1	*Legionella pneumophila* serogroup 1 ©	ARI	4	4	0	Community	5a	Lake/Reservoir/ Impoundment	Apartment/Condo
New York	Jun	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	2	2		Community	5a	River/Stream	Hospital/Health Care
New York	Sep	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	12	10	0	Community	5a	Lake/Reservoir/ Impoundment	Hotel/Motel/Lodge/Inn

New York	Sep	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	3		0	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
New York	Jan	2012	3	*Legionella pneumophila* serogroup 1 (C)	ARI	3			Community	5a	Lake/Reservoir/ Impoundment	Hotel/Motel/Lodge/Inn
New York	Mar	2012	4	*Legionella pneumophila* serogroup 1 (C)	ARI	2	1	0	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
New York	Apr	2012	3	*Legionella pneumophila* serogroup 1 (C)	ARI	2	2		Community	5a	Lake/Reservoir/ Impoundment	Apartment/Condo
New York	Oct	2012	3	*Legionella pneumophila* serogroup 1 (C)	ARI	2	1	0	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
New York	Nov	2012	3	*Legionella pneumophila* serogroup 1 (C)	ARI	2	2	0	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
Ohio	Jan	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	11	11	1	Community	5a	Well	Hospital/Health Care
Ohio	Mar	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	8	7	0	Community	5a	Lake/reservoir/impoundment	Hospital/Health Care
Ohio	Aug	2011	3	*Legionella pneumophila* (C)	ARI	10	4	2	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
Ohio	Nov	2012	4	*Legionella pneumophila* serogroup 1 (C)	ARI	2	2	0	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
Pennsylvania	Feb	2011	1	*Legionella pneumophila* serogroup 1 (C)	ARI	22	22	5	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care††††
Pennsylvania	May	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	2	2	0	Community	5a	Well	Long Term Care Facility
Pennsylvania	Aug	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	6	5	1	Community	5a	Well	Hospital/Health Care
Pennsylvania	Mar	2012	4	*Legionella pneumophila* (C)	ARI	2	2	1	Community	5a	Lake/Reservoir/ Impoundment	Hospital/Health Care
Pennsylvania	Nov	2012	4	*Legionella pneumophila* serogroup 1 (C)	ARI	4	4	1	Community	5a	River/Stream	Apartment/Condo

Utah	Aug	2011	4	Shiga toxin-producing *E. coli* O121 (C), Shiga toxin-producing *E. coli* O157:H7 (C)	AGI[§§§§]	56	2	0	Transient noncommunity	2	Spring	Camp/Cabin Setting
Utah	Jul	2012	3	*Legionella pneumophila* serogroup 1 (C)	ARI	3	3	0	Community	5a	Lake/Reservoir/ Impoundment	Hotel/Motel/Lodge/Inn
Utah	Aug	2012	3	*Giardia intestinalis* (C)	AGI	28	0	0	Community	4	Well	Subdivision/neighborhood
Washington	Jan	2011	3	*Legionella pneumophila* serogroup 1 (C)	ARI	3	3	1	Community	5a	Well	Hospital/Health Care
Wisconsin	Aug	2012	1	Norovirus Genogroup I GI_2 (C)	AGI	19	0	0	Transient noncommunity	2	Well[¶¶¶¶]	Hall/Meeting Facility

Abbreviations: AGI = acute gastrointestinal illness; ARI = acute respiratory illness; Other = undefined, illnesses, conditions, or symptoms that cannot be categorized as gastrointestinal, respiratory, ear-related, eye-related, skin-related, neurological, hepatitis or caused by leptospirosis.

* Strength-of-evidence class determined on the basis of epidemiologic, clinical laboratory, and environmental data (e.g., water quality data) provided to CDC. Class descriptions available at http://www.cdc.gov/healthywater/surveillance/outbreak-classifications.html

[†]The category of illness reported by ≥50% of ill respondents. All legionellosis outbreaks were categorized as ARI.

[§]Value was set to missing in reports where zero hospitalizations were reported and the number of people for whom information was available was also zero.

[¶]Value was set to missing in reports where zero deaths were reported and the number of people for whom information was available was also zero.

**Community and noncommunity water systems are public water systems that have ≥15 service connections or serve an average of ≥25 residents for ≥60 days/year. A community water system serves year-round residents of a community, subdivision, or mobile home park. A noncommunity water system serves an institution, industry, camp, park, hotel, or business and can be nontransient or transient. Nontransient systems serve ≥25 of the same persons for ≥6 months of the year but not year-round (e.g., factories and schools) whereas transient systems provide water to places in which persons do not remain for long periods of time (e.g., restaurants, highway rest stations, and parks). Individual water systems are small systems not owned or operated by a water utility that have <15 connections or serve <25 persons. Water systems in this table include community, noncommunity and bottled water.

[††] Deficiency classification assigned to all outbreaks associated with drinking water. Class descriptions available at http://www.cdc.gov/healthywater/surveillance/deficiency-classification.html

[§§]Spring water source contaminated during temporary connection with contaminated surface water source (stream).

[¶¶]Skin and eye symptoms in addition to AGI; other possible chemical exposures from cross contamination between drinking water and boiler water.

***The first case of illness in this outbreak occurred prior to 2011-2012, but the outbreak was reported later and not previously described in a surveillance report.

[†††]Chemical contamination suspected due to short incubation period; three bottled water samples tested, no chemical contamination detected.

[§§§]Outbreak of *Pantoea agglomerans* bloodstream infection in a healthcare facility linked to drinking water. Oncology clinic patients received infusions contaminated with *P. agglomerans* via central line, and environmental samples from the clinic and pharmacy where infusions were prepared shared the PFGE pattern found in patient blood samples. *P. agglomerans* was isolated from the pharmacy sink where the infusates were prepared, as well as from the oncology clinic ice maker. This is the first report of a *Pantoea* infection outbreak in a healthcare facility, and in a drinking water-associated outbreak surveillance report.

[¶¶¶]Outbreak occurred at the same venue with same etiology and water source as an outbreak previously reported in 1999. Contamination by surface water was suspected, based on the 1999 investigation.

****The first ill cases were identified in 2009, and were linked by molecular subtyping in 2012 to additional ill individuals living in the same apartment complex with onset dates in 2011 and 2012.

[††††]Hospital had a copper/silver ionization system in place to control Legionella at the time of the outbreak; copper and silver ion concentrations were at manufacturer-recommended levels..

[§§§§]Zero outbreak-associated cases of hemolytic uremic syndrom (HUS) were reported.

[¶¶¶¶]Setting was a meeting facility. The facility owner was not aware that the facility had a septic system, and was not maintaining this system. The outbreak occurred after the septic system overflowed and contaminated the well.