



**Bureau of Communicable Disease Prevention
Epidemiology Outbreak Report and Summary Template**

CHECK: WHAT FIELDS SHOULD YOU COMPLETE?

- ☐ Residential Facility outbreak that meets criteria below?
 - Norovirus (Etiology of norovirus infection is confirmed or probable)*
 - Influenza (Etiology of influenza infection is confirmed, probable, or suspect)*
 - Gastrointestinal illness, non-foodborne / non-waterborne; etiology unknown; "suspect" norovirus*
- ☐ Fewer than 5 cases in the outbreak?
- ☐ More than 5 cases investigated, but evidence of outbreak of associated cases weak ("suspect")?

IF ONE OF THE BOXES ARE CHECKED, COMPLETE ONLY FIELDS WITH BLACK AND BLUE FONT

IF NO BOXES ARE CHECKED, COMPLETE ONLY FIELDS WITH BLACK AND GREEN FONT

Outbreak #: 2022-076

Report Author: Cate Lewis and Andy Nutting

Agency: Southwest District Health Department

Disease / Condition: Enterotoxigenic E. Coli (ETEC)

If "Other", Describe:

Etiology status: *Confirmed*

Type of Outbreak: ☐ Animal contact ☐ Environmental contamination (other than food/water)

☒ Foodborne (NORS form required) ☐ Indeterminate/Unknown

☐ Other (specify below) ☐ Person to person

☐ Waterborne (NORS form required) ☐ Vectorborne

If "Other," Describe: Click here to enter text

INITIAL INFORMATION / INTRODUCTION

On what date did staff in your agency recognize this outbreak? 8/31/2022

How did staff in your agency detect this outbreak or, if it was reported to you, how were you notified about the outbreak from another source? Include any pertinent background.

[Example: On July 4, 2011, at 3:00 p.m., the manager of Long-term Care Facility A notified the Best Ever Public Health District by telephone of an outbreak of acute gastrointestinal illness among residents of the facility, which currently has 50 residents and 100 staff.]

On Aug 31, 2022, Southwest District Health (SWDH) Environmental Health received a phone call to notify them of a possible foodborne illness outbreak related to a wedding over the weekend. The caller was an attendee of the event that had heard of 40-50 persons being ill at that time with diarrhea being the most common symptom.

On what date did the outbreak BEGIN? 8/28/2022

Where did this outbreak occur (venue)? ☐ Assisted Living/LTCF or wing ☐ Community

☐ Daycare ☐ Healthcare facility (non-residential) ☐ Household ☒ Other (friends)

☐ Nursing Home/Skilled Nursing Facility or wing ☐ Prison/Jail ☐ Recreational Water

☐ Restaurant ☐ School



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If "Other," describe: A wedding

What event are you using to determine when the outbreak began? Please select the event from the dropdown: Onset of symptoms of the FIRST associated CASE. If "Other event", describe: [Click here to enter text.](#)

On what date was the outbreak declared over: 11/10/2022

Check the boxes below if other agencies or jurisdictions were involved (cases from these locations):

☒ Other Idaho PHD(s) (Please check all involved below)

☐ PHD 1 ☒ PHD 2 ☒ PHD 3 ☒ PHD 4 ☒ PHD 5 ☐ PHD 6 ☐ PHD 7

☒ Other State(s): Pennsylvania, Colorado, Utah, Washington, Wyoming, Illinois

☒ Other Country(ies): England

INVESTIGATION ACTIVITIES

Epidemiologic or other investigative methods employed should be described here. Examples include review of laboratory results, data collection and analyses (e.g., case-finding and case counting), site visits, interviews, and specimen collection.

[Example: On July 4, 2011, at 3:30 pm, a District epidemiologist contacted the manager of Facility A to discuss symptoms, request stool samples for norovirus detection and bacterial culture, and provide the Norovirus Detection and Outbreak Management Guidelines with templates for the daily log and initial and final outbreak reports.]

Outbreak Case Definition:

Outbreak Investigation Activities Summary:

METHODS

The methods section provides the elements to understand what was done to investigate larger outbreaks. Methods include clinical and environmental specimen collection and analysis (e.g., laboratory tests performed), epidemiologic methods employed, and environmental investigation.

- **Clinical specimen collection and analysis.** Describe how specimens were collected, what type of specimens were submitted, to whom they were submitted, and for what type of testing. Interpretation of results must be made in the context of what tests were requested.
- **Environmental laboratory testing.** Describe the location from which the specimen was obtained, the type of specimen collected, the volume or mass of specimen, and the type of testing. Transport time should be noted as some tests are compromised if samples do not reach the laboratory within a certain time, leading to potentially false-negative results or elevated bacterial counts.
- **Epidemiologic methods.** Describe any changes to case definition during investigation, case-finding and mode of data collection, study design (e.g., cohort studies, case-control studies) and data analysis methods.
 - Case investigation methods include case definitions, how subjects were identified, construction of the questionnaire, and how the questionnaire was delivered (e.g., telephone, in-person).
 - Cohort investigation methods include how the cohort was identified.
 - Case-control study methods include how the at-risk population was defined for the purposes of the investigation, how controls were selected, and how controls were recruited.
 - For matched studies, give matching criteria.
 - Statistical analysis includes methods, statistical tests used, and software used. It is suggested that questionnaires or other instruments used be attached as an appendix.
- **Environmental investigation.** Describe activities such as a site visit and inspection, review of pool maintenance records, collection of food samples, interview of food preparation practices, traceback or trace forward of food items, observing traffic flow, etc., and who conducted the activities.



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On Aug 30th, 2022, SWDH Environmental Health (EH) received a voicemail regarding possible food poisoning at a wedding. In this voicemail the father of the groom described that he spoke to individuals that got sick, around 15 people with diarrhea. Stated the food was catered by X Catering Co. The individual also left the phone number of the groom for them to call as he has more information. The groom was then called by EH to get additional information on 8/30. He was unaware that his father had contacted Southwest District Health (SWDH) and did not give any information at this time. On 8/31 EH spoke with the groom again and received more information. After this conversation EH notified Epi and we had a meeting to go over the situation and next steps. After this meeting the groom was then called by Epi and interviewed about the event, the food, activities on site and others known to be sick. While on the phone the first lab-confirmed case, a 23-year-old female who was a guest, was identified and reported to us by the groom. The individual had tested positive for ETEC on a PCR panel, labs confirmed in IHDE. All other pathogens on the GI panel were negative. The information gathered from the groom over the phone is as follows:

The wedding took place on August 27, 2022, dinner was held around 5pm. There were approximately 100-110 guests and at this time he noted around 50-70 suspected ill individuals. Guests came from all over, mainly Ada county, a few in Canyon county, a couple in Idaho county, some from Illinois, and just a few from Colorado, Pennsylvania, and England. Groom was also currently ill at that time and sx onset was 8/27 midnight-8/28 1am. Sx onset for others he heard from was mentioned to be around 8/28-8/29. Sx mentioned were abdominal cramping, chills and constant diarrhea. Other individuals mentioned similar symptoms, some with vomiting. The wedding occurred at X venue and was catered by X Catering Co. Other vendors were 2 bartenders who had a host bar with cans of beer, white claws and wine. Other drinks were cans of coke and bottled water. All were in a cooler with Ice from the venue. There was a cake to cut and pretzels on a dish as a snack while pictures were being taken. No games with food or drinks noted. Food catered at the wedding included Tri-tip (medium rare and well-done options), Garlic mashed potatoes, Gravy, Cauliflower cheese, salad (ranch and vinaigrette dressing options), huckleberry butter, bread, chicken strips and fries. The meal was set up as self-serve on a table with each dish having its own tongs and spoons, a heat cooler for well-done meat and a chef slicing the meat at the end of the table. At the time bride and groom did not have any leftovers as they threw them away after getting sick. Bride's father had leftovers at home. Testing of the leftovers was mentioned at this time. Groom was going to check with father-in-law. Told groom that we would have a survey put together so he could send it out to his guests to fill out about what foods they had eaten and if they were sick or not and what symptoms they were experiencing. Discussed getting others stool tested with IBL. Groom had already gotten tested through provider so waiting on his results. After phone call, emailed groom the survey investigation form created in Teams to distribute to their guests. This survey was made in collaboration with CDH as there are guests involved in the outbreak from their jurisdiction.

8/31- 4 stool kits were sent out to multiple guests for stool testing. Survey was emailed to Groom, and it was sent out to guests. Received menu from Groom. Leftovers were picked up by EH. Leftovers included salad, tri-tip and cauliflower dish. EH attempted an onsite visit of the venue and the catering business- both were closed/out of town but spoke with owners of both to get details over the phone of the event and set up.

9/1- received 2 stool samples and were sent into IBL

9/2- EH performed on-site visit of venue. EH collected water sample from venue to test for E. Coli and TCS. This water was used to make the ice on site. Spoke with Groom and notified that IBL cannot test for ETEC so we plan to rule out STEC of the samples received. Received another stool sample and



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submitted to IBL.

9/6- EH performed on-site visit of catering business with and Epi from SWDH and State EIS officer. Epi notified those that submitted stool samples of their negative STEC results.

9/7- Spoke with IBL about food sample. Salad was unable to be tested, Cauliflower and tri-tip prepared and growing. Stated another week to grow and another week after that to isolate. Venue water results came back negative for E. Coli and TCS. Groom went to a medical provider to get stool culture and GI panel done since still symptomatic and original labs all came back negative, but ETEC was not on the GI panel tested. When spoke to groom asked additional questions- disposable plates and silverware used, no irrigation water on, each slice was not temped (precut pieces there when bride and groom first got there. They were first to go through the dinner line.), no hand wash station on site and no hand sanitizer noted near food. Desserts were there- chocolate covered pretzels, cake pops and choc chip cookies all from Albertsons. Some healthy individuals known about mentioned only eating tri-tip and salad, and another mentioned not eating dairy. Other vendors that ate on-site are now sick. 1 bartender, DJ, 2 venue employees, videographer all sick now.

9/8- spoke with groom, unable to provide a stool sample because feeling better now. Received photo and short video found of the food setup from the groom. Told groom that IBL is working on the food samples still and will likely take another week or two. Also told him that salad was untestable, and that water came back as negative.

9/14- IBL was able to see growth on both tri-tip and cauliflower plates. Total coliform bacteria and E. coli both saw growth. IBL plans to isolate and test further to find the specific sequence and type of E. coli that is growing on the food. This will take another 1-2 weeks. We do not have a written report yet as that will not come until it is complete. IBL staff stated that the growth is not something that is typically seen in food. Groom was notified of these results via phone call by Epi.

11/10- Epi was notified that the final report from IBL was complete. Shows PCR test was unable to detect ETEC DNA in the food cultures. Groom was notified that the results were in.

Suspect case: Guests/staff who attended the wedding that were told to groom to have symptoms who then groom told epi but did not fill out survey.

Probable case: Guests that attended the wedding or close contacts of guests with clinically compatible symptoms or a positive ETEC test within 2 weeks of a lab-confirmed case and filled out the survey

Confirmed case: Guests that attended wedding with lab confirmation of ETEC within 2 weeks of wedding

RESULTS/FINDINGS

Estimated number of persons exposed (it would be unusual for this to equal the number of cases identified): 100

4	SUSPECT cases identified
70	PROBABLE cases identified
1	CONFIRMED cases identified
75	TOTAL Cases identified (auto-sum by pressing F9 after placing cursor in text box for TOTAL)



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Date of onset of illness of last associated case: 9/5/2022

The other elements in this section should include: outbreak setting, age distribution among cases, sex distribution, geographic differences, vehicle (if applicable, suspected or confirmed), and other pertinent information (remember: person, place, and time). Use tables and figures (e.g., Epi curve) as needed to easily summarize.

The results section includes the findings that lead to your conclusions. Results should be consistent with the methods and remain factual and neutral. The results section should not include explanations or discussions that are best placed in the discussion section.

- **Clinical laboratory investigation results.** Clinical laboratory results should be documented with the detail provided by the test. For example, species should be reported if provided on the laboratory report. Molecular and genotyping results should be included.
- **Environmental laboratory results.** See note on clinical laboratory results above.
- **Epidemiologic investigation results.** The first major area is descriptive epidemiology. Start with clinical and laboratory aspects first. Next, orient the reader to the time, place, and person of the investigation. This is the logical place to show an epidemic curve, if appropriate. Pertinent negative findings should be presented. Then guide the reader to how the descriptive findings led to a hypothesis. Analytic epidemiology (e.g., comparisons of cases and controls, or exposed and not exposed) follows. Analytical results should be reported from general to particular, from univariate, to bivariable to multivariable (stratification and then regression) analysis.
 - Number of responses and participation rate (in total, and by cases and non-cases/controls)
 - Number of cases (i.e., met case definition) identified and overall attack proportion (for cohort study)
 - Illness characteristics
 - Symptoms of illness (table of symptoms and frequency in cases and non-cases)
 - Duration of illness (median, range)
 - Severity or outcomes of illnesses: hospitalizations, deaths, lasting effects.
 - Laboratory findings in relation to cases
 - Demographics among cases and non-cases/controls: age (median, range, and by age group), sex, status (e.g., guests/staff, etc.), ethnicity (if relevant). Might best be expressed in tables.
 - Incubation period (including median and range). It is usually useful to graph the epidemic curve.
 - Relationship of exposures to illnesses: table showing attack proportions, measures of association (e.g., risk ratios, odds ratios, as appropriate to study design), confidence intervals, and p-values.

[For specific examples, see Section 8 "Stand-alone Documents" in the Investigative Guidelines (OUTBREAK REPORT GUIDANCE DOCUMENT)]

Survey sent to groom to send to guests. 71 responses received from the survey.

Ill persons based on survey results: Male- 28, Female- 43

4 individuals that were staff are suspect cases- bartender, 2 venue staff and DJ - were sick and told groom but did not fill out survey.

2 individuals that groom mentioned were not sick. States that 1 only ate tri-tip and salad and the other only ate non-dairy items. These individuals also did not fill out the survey.

71 persons ill out of approx. 100 guests. 4 persons ill of 7 on site working staff.

Symptoms experienced: Diarrhea- 70, vomiting- 10, fever- 10, chills- 19, abdominal cramps- 63, other- 7

1 hospitalized



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Foods eaten: Tri-tip- 68, Garlic Mashed potatoes- 57, Cauliflower and cheese- 64, Salas- 61, Bread- 54,

Chicken strips- 12, Fries- 9, Huckleberry butter- 32, other-3, ranch dressing- 29, vinaigrette dressing- 25, other-

2

1 confirmed case- ETEC PCR positive on GI panel

1 probable case that submitted stool sample came back negative for GI panel but ETEC was not on this GI panel. Only STEC, Campy, Shigella,

3 probable cases that submitted stool samples to SWDH then to IBL were negative for STEC

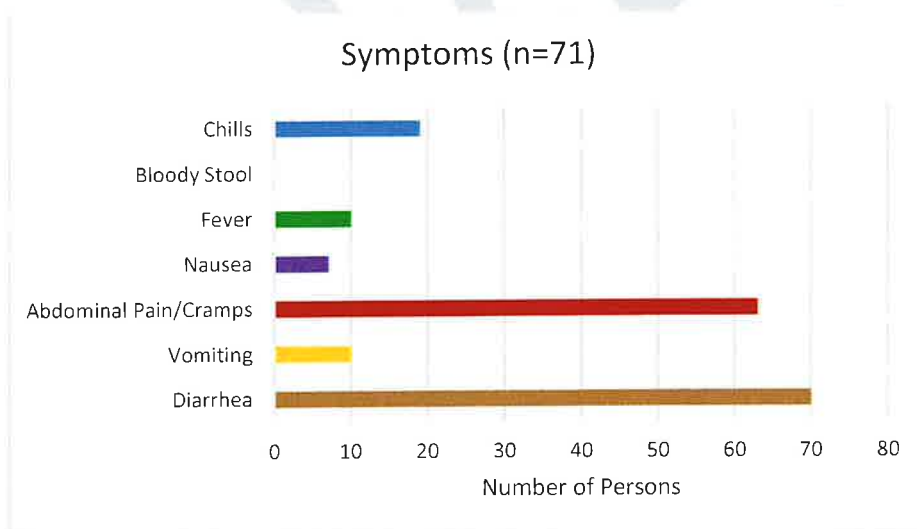
Sx duration approx. 1.5 weeks

Water sample from venue tested for total coliforms and E. coli- negative- 9/7

Food samples from leftovers tested for total coliforms and E. coli- both grew on the plates- IBL to isolate further for confirmation- 9/14

ETEC PCR test showed no DNA detected from the cultures of the food samples- 11/10

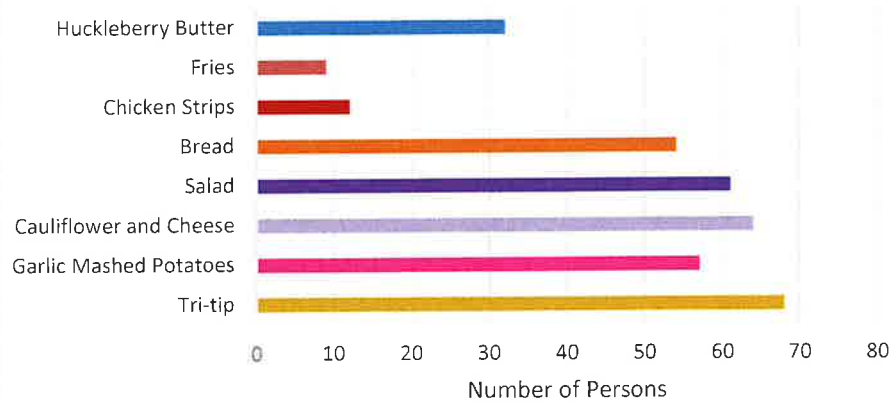
Below are the data charts displaying survey data:



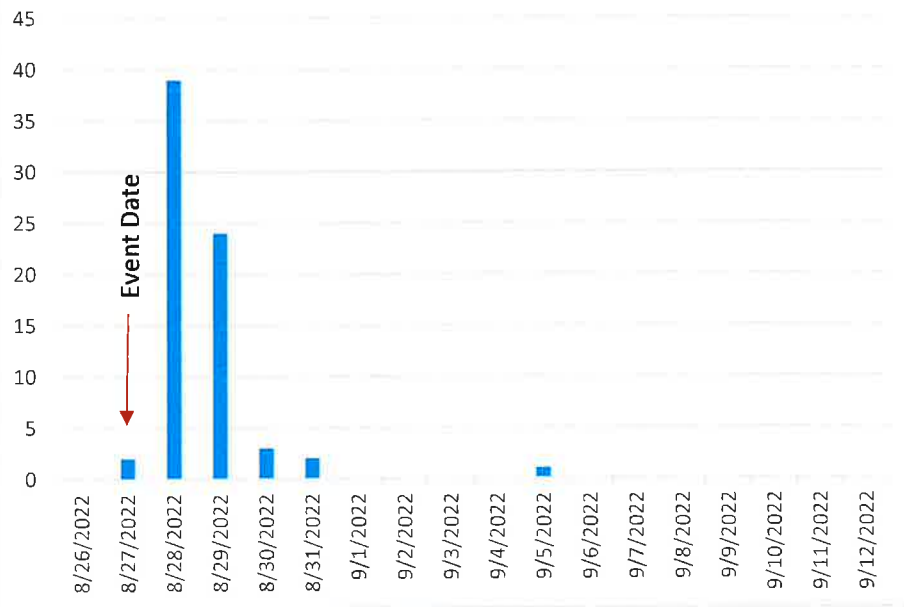


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Foods Eaten at Wedding (n=71)



Epi Curve: Case Counts by Day (n=71)



INTERVENTIONS

The intervention section should include specific control measures or other interventions that were recommended for controlling the spread of disease or preventing future outbreaks. Examples of interventions include press releases; health education/counseling provided to ill persons and contacts; referral for diagnosis, treatment, or other preventive service; work, school, or daycare exclusions or restrictions; isolation; notification of worksite, daycares; recommended testing of water supply; recommended disinfection of environment or contaminated articles.

[Example: Best Ever Public Health District provided the assisted-living facility with Idaho's Norovirus Outbreak Detection and Management Guidelines. We educated the facility administration about norovirus symptoms, transmission, infection control recommendations, and prevention. The findings from the kitchen inspection by the Environmental Health Specialist were also discussed with facility administration and kitchen staff. Best Ever Public Health District followed up on a regular basis with the assisted living center point of contact to identify new cases and assess progress in implementing norovirus outbreak control recommendations.]



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Conclusions/Recommendations.

This section should include a written discussion of the results of the investigation, including interpretation of statistical analyses, public health action taken, follow-up, and measures to prevent future outbreaks. Discussion includes whether or not the observed association could be due to chance, bias (e.g., selection, information), confounding, or effect modification (interaction). Recommendations should specify what should be done to control the current outbreak, prevent future outbreaks, improve management of future outbreaks, and improve methods in future investigation. Recommendations should be short and concise, state who should do what, and should be realistic given available resources and acceptability.

[For specific examples, see Section 8 "Standalone Documents" in the Investigative Guidelines - OUTBREAK REPORT GUIDANCE DOCUMENT]

Data discussion:

The epidemic curve suggests this to be a point source outbreak with no secondary spread that was identified. Ill persons recovered approximately 1.5 weeks after initial onset of illness. All cases attended the wedding on August 27, 2022. No specific food item appears to be the source as it looks like ill persons ate a wide range of food and no food item stood out from the survey results. It is also hard to determine if there is one food source since no healthy persons filled out the survey to compare against.

Public health action:

A survey was sent to the groom of the wedding who then sent it to the guests to fill out. The survey was created in collaboration with CDH since guests were known to be from their jurisdiction. They allowed SWDH to take the lead on the outbreak since the implicated businesses were in our jurisdiction. After the survey results were completed, it was noted that the majority of cases were residents of CDH's jurisdiction. CDH had access to the survey results/line list so they could do any further investigation or work with their residents. The survey had public health recommendations regarding how to prevent further spread of the illness and who to reach out to if they had questions or needs.

An environmental health inspection was performed at the catering business to evaluate food storage and handling practices, employee health protocols and ask about any ill workers. Preparation of food items, correct storage and cooking were not able to be observed since catering was only on weekends, so a walk-through of the day's events was discussed/demonstrated with staff. It was noted that the setup of the wedding was buffet style with a meat carver at the end. The meat carver was also the only catering person on site that day and did all the transportation, set-up, serving and cleanup for the meal at the venue, no help from venue staff. It was noted to SWDH EH that the meat slices were individually temped, which would contradict what the groom stated about not observing this action. There was also no handwash station observed by the groom or seen in pictures of the meal, which was in the loft of the venue, away from the rest of the day's events. The closest handwash station at the venue was noted to be 30-40 feet away. A picture of the meal and a short video clip was provided to SWDH from the groom to get a better visual and idea of the layout. Catering staff did note that they washed hands, used hand sanitizer, and wore gloves as needed. The entire process for the day was approx. 3.5 hours from time done cooking to time catering left the event. Fridge temp logs on site were reviewed, and storage and cleaning practices were reviewed as well. Staff were knowledgeable about proper food handling techniques and



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excluding ill employees. Environmental Health specialists and Epidemiologists wondered if an unidentified ill food handler, improper hand washing, or cross-contamination could have been possible. It was noted that the guests ordered medium rare steak as an option. Medium rare steak was cooked to 130 degrees Fahrenheit which according to EH is not a high enough temp to kill all pathogens including E. coli. 145 degrees Fahrenheit is the recommended temp for steak to reach. The possibility that cross-contamination of food products occurred from the not fully cooked meat is a suspicion as well. No violations were noted during SWDH's inspection, and no ill employees or food handlers were identified. Also of note, the catering business served multiple other weddings on the same weekend and no other event was noted to have ill guests. This outbreak appears to be an isolated incident. The venue provided water and ice during the event so water samples were taken and tested at IBL and determined not to contain E. coli or total coliforms. Both catering and venue businesses were allowed to continue to operate since no violations were found on inspection and no additional cases were identified from other events of theirs.

Cultures for E. coli and total coliforms saw growth for two food items, tri-tip steak and cheesy cauliflower, submitted for testing at IBL. This was verbally confirmed. ETEC specific PCR testing was negative for the specific samples tested. Due to growth being seen on multiple food items cross-contamination is suspected and multiple food items may be the vehicle for transmission which would explain why no one food stood out from the survey results. E. coli, specifically ETEC, was identified in one stool sample of an ill guest who was seen by medical personnel. E. coli is the suspected pathogen as it was identified in a stool sample of an ill guest, grew on samples from food and matches the symptomology and incubation period captured in the survey results. It is still unsure exactly where ETEC originated from but the information we have collected has led us to suspect that the food was the vehicle for transmission at the wedding.

A press release was not issued since the outbreak was limited and not ongoing.

This outbreak is declared over as of 11/10/2022 once we received final results on the food testing. This is approx. 11 weeks after the initial point-source exposure.

Recommendations for future investigations:

Building up local capacity to do enhanced environmental sampling of a facility implicated in an outbreak.

Date outbreak report was finalized:

Date NORS forms submitted to State (food or waterborne outbreak):

Trip tip, mashed potato, cauliflower cooked cheese sauce -

Salad – mixed greens, candied bacon, granola, onion, holumi cheese

Bread – huckleberry butter

Saturday – All cooked day of

Employees working on it – 5 in the warehouse and 1 person at the event,

All different temps for the tri tips – medium to well – brought all their own equipment

Ranch and vinegarette dressing*

All produce comes from Charlie's Produce

Tri tip/ ball tip Shamrock Foods – Mostly purchased a few days – working condition

Cash and Carry if there was extras

The party kept the food

Nothing abnormal – there were 3 other events – had potatoes at this other event only difference was the califlouwer and the ball tip steaks – 4 different weddings

No sores was wearing gloves had access to a handwashing – meat is carved – All the meat is cooked on site –

Temperature logs are kept for every event

Not for salads

Quat dispenser – every week

Company came out within last month

No other complaints from the other weddings

No desert service, bar service, or appetizer from them

Missed questions – consumer advisory, how it actually got cooked meat trailer, layout of the venue

Venue does not have a commercial kitchen – have a fridge there is a sink upstairs – 2 employees were working the day of the event – served upstairs with a hand sink there – private well there is ice was tested – bacteria all testing done last year –



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

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Certificate of Analysis

Workorder: E220900073

Report To: Southwest District Health -
Environmental
13307 Miami Lane
Caldwell, ID 83607

Client: Southwest District Health Department -
Caldwell
Profile: BT Emergency Response

Bacterial test results are reported separately from water chemistry testing

Chemistry samples are disposed of after 60 days and records are destroyed after 5 years unless the laboratory is notified by the client

Sample Summary

Lab ID	Sample ID	Matrix	Method	Date Collected	Date Received	Analytes Reported
E220900073-001	2022076-001	FV	BAM 4A	08/31/2022 15:32	09/01/2022 16:39	1
Collector: Rehl, Rhianna						
E220900073-002	2022076-002	FV	BAM 4A	08/31/2022 15:32	09/01/2022 16:39	1
Collector: Rehl, Rhianna						
E220900073-003	2022076-003	FV	BAM 4A	08/31/2022 15:32	09/01/2022 16:39	1
Collector: Rehl, Rhianna						

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Certificate of Analysis

Workorder: E220900073

Analytical Results

Lab ID: E220900073-001		Date Collected: 08/31/2022 15:32				Matrix: Food / Vegetation			
Sample ID: 2022076-001		Date Received: 09/01/2022 16:39				Location:			
Parameter	Results	Units	RDL	MDL	MCL	DF	Analyzed	By	Qual
BAM 4A									
Shiga-Toxin Producing E. coli	See comments below					1	10/15/2022 12:30	ZS	*

Analysis Results Comments

Shiga-Toxin Producing E. coli

Sample tested for ETEC presence. No ETEC DNA detected through PCR analysis of cultures from food samples.

RDL: Reporting Detection Limit - Lowest limit the lab reports data

MDL: Method Detection Limit - A calculated minimum concentration that can be measured with 99% confidence that the result is greater than zero

MCL: Maximum Contaminant Level is the highest level of a contaminant that is allowed in drinking water under the Safe Drinking Water Act

DF: Dilution Factor - Factor used to calculate analyte concentration

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Certificate of Analysis

Workorder: E220900073

Analytical Results

Lab ID: E220900073-002		Date Collected: 08/31/2022 15:32				Matrix: Food / Vegetation			
Sample ID: 2022076-002		Date Received: 09/01/2022 16:39				Location:			
Parameter	Results	Units	RDL	MDL	MCL	DF	Analyzed	By	Qual
BAM 4A									
Shiga-Toxin Producing E. coli	Unsatisfactory specimen, see comments					1	10/15/2022 12:30	ZS	*

Analysis Results Comments

Shiga-Toxin Producing E. coli

Salad mix was too deteriorated to submit through the testing process.

RDL: Reporting Detection Limit - Lowest limit the lab reports data

MDL: Method Detection Limit - A calculated minimum concentration that can be measured with 99% confidence that the result is greater than zero

MCL: Maximum Contaminant Level is the highest level of a contaminant that is allowed in drinking water under the Safe Drinking Water Act

DF: Dilution Factor - Factor used to calculate analyte concentration

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Certificate of Analysis

Workorder: E220900073

Analytical Results

Lab ID: E220900073-003		Date Collected: 08/31/2022 15:32		Matrix: Food / Vegetation					
Sample ID: 2022076-003		Date Received: 09/01/2022 16:39		Location:					
Parameter	Results	Units	RDL	MDL	MCL	DF	Analyzed	By	Qual
BAM 4A									
Shiga-Toxin Producing E. coli	See comments below					1	10/15/2022 12:30	ZS	*

Analysis Results Comments

Shiga-Toxin Producing E. coli

Sample tested for ETEC presence. No ETEC DNA detected through PCR analysis of cultures from food samples.

RDL: Reporting Detection Limit - Lowest limit the lab reports data

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