REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Care Quality Commission** **2. Royal Institute of British Architects**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Wiltshire and Swindon
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 7th November 2017 an investigation into the death of Andrew Robert Frank Clegg was commenced. The investigation concluded at the end of the inquest on 28th March 2019. The conclusion of the inquest jury was that the deceased died from legionella pneumonia as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** The deceased, who was aged 56, was a vulnerable individual as a result of corticobasilar degeneration. He was resident in a recently constructed specialist care home. The care home had been constructed with little attention to water safety. There were long runs of pipes and with hot and cold-water pipes set in close parallel proximity, creating a potential for heat exchange. Over a period of time legionella bacteria colonised parts of the water system and the deceased was infected with a fatal outcome.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. Expert evidence suggested that architects designing care homes and healthcare premises, rarely take into account the need for water safety. In combating the risk of a proliferation of legionella bacteria, it is desirable, among other things, to design a water system with short pipe runs and with areas of maximum water usage established at the end of pipe runs to ensure a regular flushing of the pipework. Legionella bacteria, flourishing as it does at temperatures in excess of 20 degrees centigrade, precautions need to be taken to avoid heat exchange between hot and cold-water pipes, calling for cold-water pipes to be set at a distance from hot-water pipes rather than being run in parallel. 2. Care homes and other healthcare premises are regularly inspected by the Care Quality Commission. In recent years the inspection regime has included a duty on inspectors to check on water safety. Expert evidence at the inquest suggested that inspectors lacked training to help them identify risks relating to potential legionella infection.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your respective organisations have the power to take such action. Specifically, consideration might be given towards providing relevant education and training.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th May 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely the legal representatives of the family of the deceased and Sentinel Healthcare Ltd. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated 1st April 2019 SIGNED** **Assistant Coroner**