

BOHS November 2025

Update from the HSE

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HSE Legionella Technical Lead

- Brief update on Legionella inspection campaign
- Summary of recent Legionella-based prosecutions

Legionella Campaign Update

Legionella Intervention Campaign Update

In 24/25 work year we carried out an inspection campaign on the management of legionella risks in the plastic injection moulding sector.

We targeted 100 plastic injection moulding sites with registered cooling towers, with roughly 65 of these sites being visited by HSE throughout GB.

Roughly 35 of the sites had either ceased operation or were no longer operating a cooling tower.

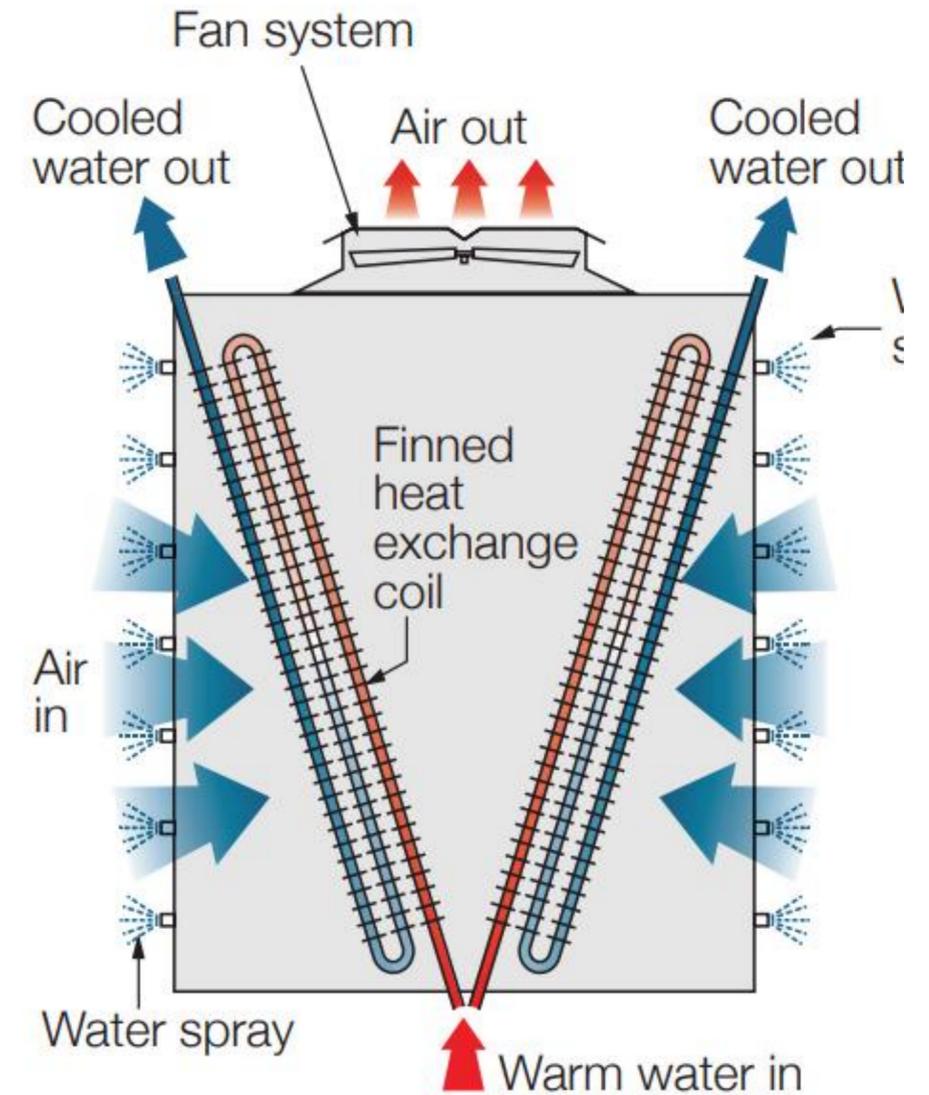


Legionella Intervention Campaign Update

Of the sites no longer operating cooling towers, most had failed to update the LA register.

Trend of substitution of cooling towers for dry systems. Dry systems are lower risk, and this is seen as a positive move for the industry.

Plans to gather data from these sites to see if there is valuable information on substitution that can be presented to the industry.



Legionella Intervention Campaign Update

From the plastic site inspections, there was roughly a 35% material breach rate.

Material breaches range from minor to major and include items such as:

- Inadequate risk assessment
- Inadequate written control scheme
- Inadequate management of risk

Risk gap is lower than previous campaigns.



Legionella Intervention Campaign Update

Additional campaign in 2025/26 work year to include inspection at 50 Food & Beverage sites.

These inspections are underway, with initial findings indicating a lower material breach rate when compared to plastics sector.

Expect Q4 completion for the intervention.



Recent Prosecutions

**Prosecution:
Amey Community Ltd**

ACL – Background

HMP Lincoln is a prison estate consisting of five main accommodation wings (A-E).

Amey Community Ltd are a facilities management business who were contracted to manage the facilities at the HMP Lincoln. This included the hot and cold-water system on the estate.

In 2017, a prisoner living in E wing contracted and subsequently died from Legionnaires' Disease.



ACL – Background

An investigation undertaken following the incident discovered the same species of legionella bacteria in the prisoner's cell and nearby shower block on E wing, as was isolated from the patient during diagnosis.

HSE were involved with investigating the incident, and a prosecution was deemed appropriate due to the extent of the failings.



ACL – What Went Wrong

Failed to act on a Legionella Risk Assessment carried out in 2016.

A risk assessment will detail what actions are required to reduce the risk from legionella bacteria, **so far as reasonably practicable.**

In the months and years following the prisoner's death, extensive works were carried out to act on the recommendations of the legionella risk assessment.



ACL – What Went Wrong

Failed to act on a Legionella Risk Assessment carried out in 2016.

It was concluded that ACL had failed to take all reasonably practicable measures in acting on the recommendations of the 2016 Legionella Risk Assessment.

ACL – What Went Wrong

Failed to put in place a written scheme for preventing and controlling legionella risks.

The ACOP L8 states that, where there is a reasonably foreseeable risk of exposure to legionella bacteria, there should be a Written Scheme detailing how the risk will be controlled.

This Written Scheme should be properly implemented and managed.



ACL – What Went Wrong

Failed to put in place a written scheme for preventing and controlling legionella risks.

At the time of the prisoner's death, ACL did not have a Legionella Written Control Scheme in place.

ACL – What Went Wrong

Failed to ensure that appropriate water temperatures were maintained.

Temperature control is a strategy for reducing the risk of legionella growth in domestic water systems. HSG274 guidance states that monthly temperature checks should be carried out to validate control.

In October and November 2017, the months preceding the prisoner's death, ACL failed to carry out temperature checks on E Wing.



ACL – What Went Wrong

Failed to ensure that appropriate water temperatures were maintained.

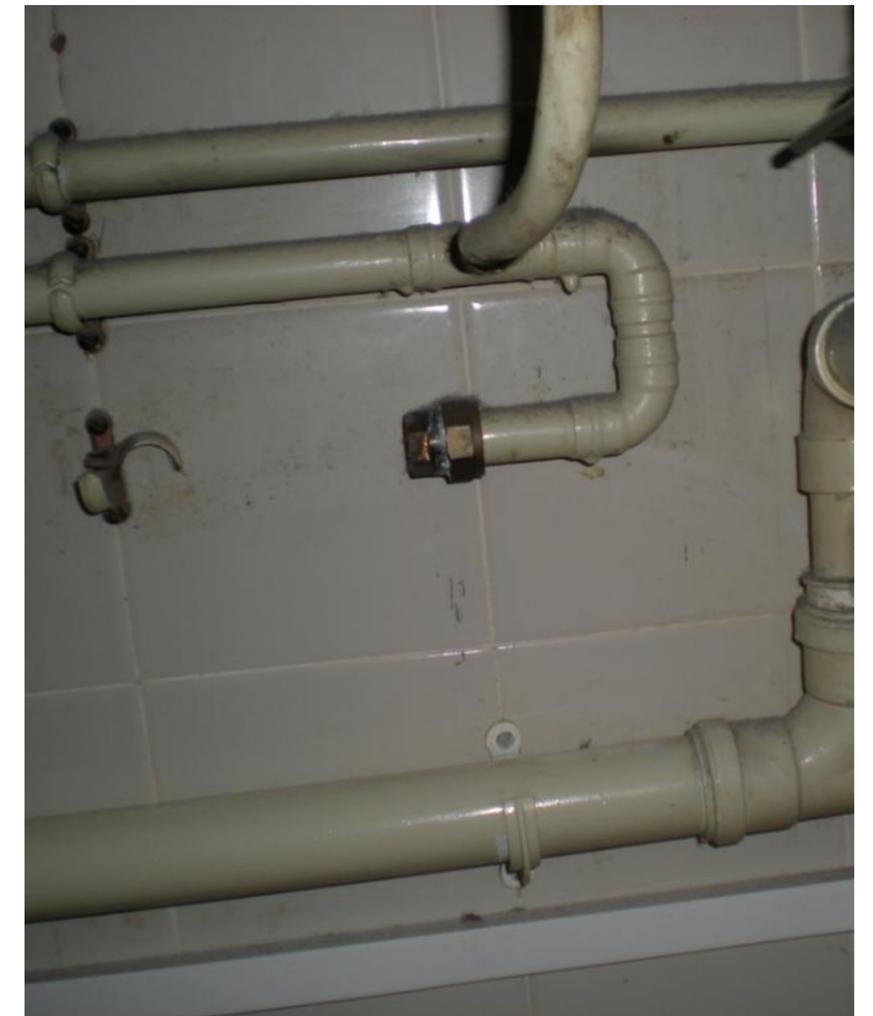
It was concluded that this failure meant that legionella risk was not discovered until it was too late.

ACL – What Went Wrong

Failed to carry out action in relation to little used outlets, dead legs and dead ends.

Stagnation is a key risk factor when considering growth of legionella bacteria. Dead legs, dead ends, little used outlets can all create areas that encourage biofilm formation and therefore legionella growth.

While some flushing was taking place, there was no up-to-date list of little used outlets, dead legs or blind ends.



ACL – What Went Wrong

Failed to carry out action in relation to little used outlets, dead legs and dead ends.

It was concluded that ACL failed to take reasonably practicable action in relation to *some* of the identified dead legs or ends.

ACL – Prosecution

Amey Community Limited pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974.



ACL Sentencing

Judge Concluded:

- Medium Culpability with Harm Level A (death) but medium risk of harm
- Starting point after sentence £1.2m
- Reduced to £900k after mitigation
- Further reduced to £600K for early guilty plea



ACL Sentencing

Judge Concluded:

£600k fine
+ legal fees of £15K

Amey Community Ltd - Prosecution

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HSE Health and Safety Executive

Company fined £600k after prisoner dies

Firm fined £600k over prisoner legionnaires' death



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Company failed to manage legionella risk as prisoner dies

3rd December 2024 | [News](#) | [Press release](#) | [Prosecution](#)

A company has been fined after it failed to manage the risk of legionella bacteria in the hot and cold water systems at HMP Lincoln.

The Health and Safety Executive (HSE) investigation followed the death of an inmate.

Amey Community Limited has now been fined £600,000 after pleading guilty to a health and safety offence.

HMP Lincoln, Greetwell Road (Image: Jack Flintham/Lincolnshire Echo)

to manage the risk of legionella bacteria in the hot and cold water systems

after contracting Legionnaires' disease while serving a prison sentence

whereby shower blocks tested positive for legionella days after the 71-

by Executive (HSE) Inspector Aaron Rashad, found Amey Community Services at HMP Lincoln, failed to act on a risk assessment carried out to prevent and control legionella risks, failed to ensure that the company failed to monitor water temperatures in the water system in order to prevent legionella bacteria to multiply rapidly.

under Section 3(1) of the Health and Safety at Work etc. Act 1974. The company was fined £15,186.85 in costs at Lincoln Magistrates' Court on 3 December



Prosecution: Sanctuary Housing

Sanctuary Housing – Background

Sanctuary Housing Group is the Landlord and dutyholder for a sheltered housing complex at Vincent Naughton Court in Birkenhead.

The complex consists of flats supplied by a hot and cold domestic water system, of which Sanctuary Housing is responsible for ensuring the risk arising from Legionella bacteria are sufficiently managed.



Sanctuary Housing – Background

HSE were made aware of some concerns around legionella positive sample results and residents being rehoused at this premises.

This triggered some initial site enquiries, and a subsequent site visit to establish whether risk was being managed.

HSE inspectors found that the systems in place to manage the legionella risk were significantly below the expected standard.

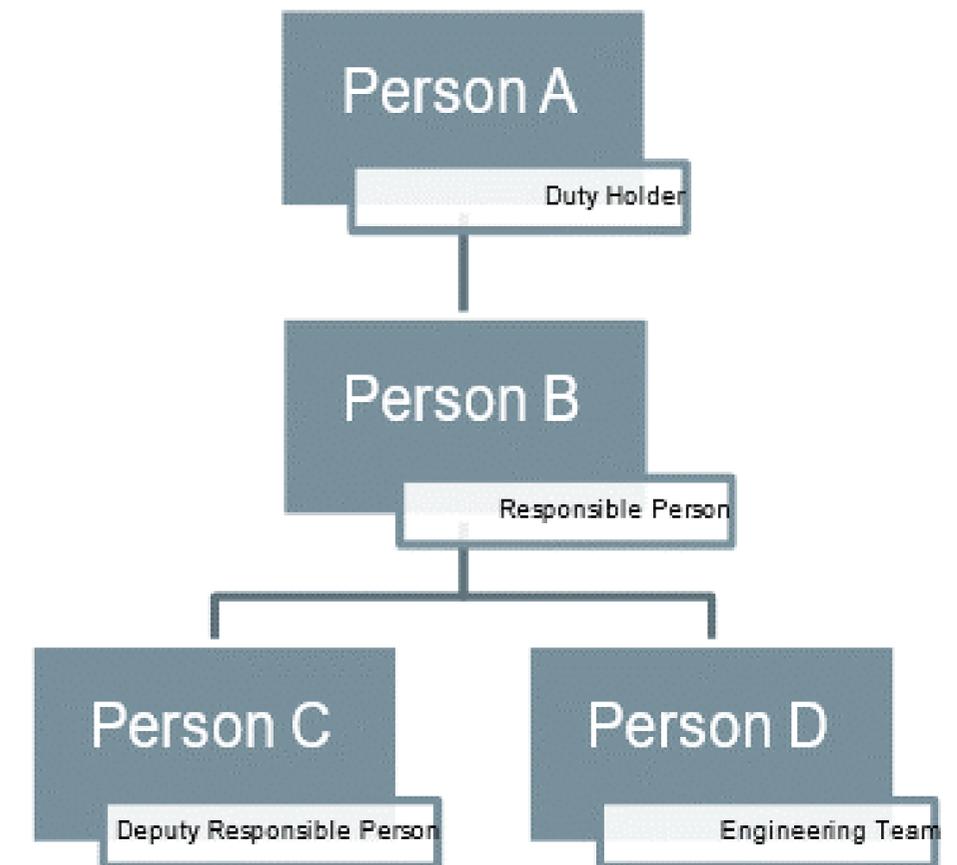


Sanctuary Housing – What Went Wrong

No trained and competent Responsible Person appointed

The ACOP L8 states that the dutyholder should appoint a Responsible Person(s) to oversee management of legionella risk.

This person(s) should have sufficient authority, competence, and knowledge of the system to adequately carry out their role.



Sanctuary Housing – What Went Wrong

No trained and competent Responsible Person appointed

It was concluded that Sanctuary had failed to appoint a trained and competent Responsible Person to manage the legionella risk at Vincent Naughton Court.

Sanctuary Housing – What Went Wrong

The lack of a suitable and sufficient legionella risk assessment.

The ACOP L8 states that a suitable and sufficient assessment must be carried out to identify and assess the risk of exposure to legionella bacteria.

The ACOP states that, as part of the risk assessment, take into account the individual nature of each site.



Sanctuary Housing – What Went Wrong

The lack of a suitable and sufficient legionella risk assessment.

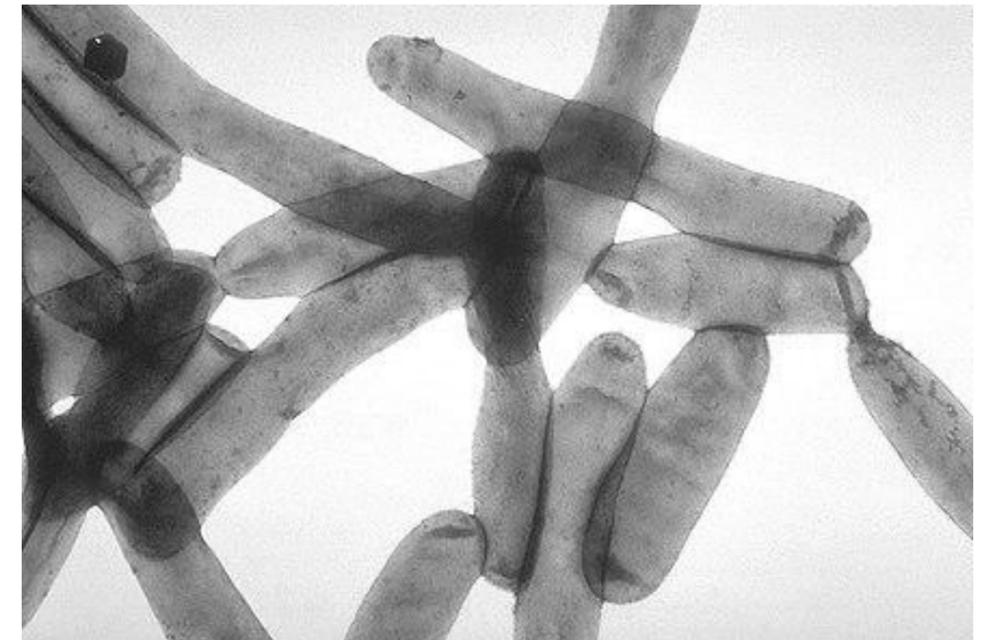
It was concluded that Sanctuary had failed to carry out a suitable and sufficient legionella risk assessment for the water system at Vincent Naughton Court.

Sanctuary Housing – What Went Wrong

The lack of adequate legionella control scheme.

The ACOP L8 states the risk from exposure should be controlled by measures which do not allow the growth of legionella bacteria in the system.

Controls include avoiding temperatures that encourage growth, avoiding stagnation, and taking action to ensure correct and safe operation of the water system etc.



Sanctuary Housing – What Went Wrong

The lack of adequate legionella control scheme.

It was concluded that Sanctuary had poorly managed the risk of legionella growth in the water system of Vincent Naughton Court.

Sanctuary Housing – What Went Wrong

Exposing vulnerable residents to contaminated aerosols.

The residents were a particularly vulnerable group due to their age and health issues, putting them at a higher risk of contracting Legionnaires' disease.

The HSE investigation found that legionella was detected in July, and a letter was sent to residents by Sanctuary Housing which stated that the tap water could be stored in sinks and boiled in kettles.

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Sanctuary Housing – What Went Wrong

Exposing vulnerable residents to contaminated aerosols.

More importantly, the letter failed to inform residents that they should avoid using their showers.

This failure would lead to residents being exposed to the risk of Legionnaires' disease.

Sanctuary Housing – Prosecution

Sanctuary Housing Association pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974.



Sanctuary Housing - Sentencing

Judge Concluded:

- High Culpability and Harm Level A (death) but Low risk of harm
- Starting point substantially increased within bucket due to numbers at risk and as a Very Large Organisation
- Fine starting point of £1.2m



Sanctuary Housing - Sentencing

Judge Concluded:

£900k fine
+ legal fees of £11K

Inspector's Comments

“Sanctuary Housing failed to protect vulnerable residents living at Vincent Naughton Court through its mismanagement of the site's water system.

Sanctuary Housing - Prosecution

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Sanctuary Housing residents put at risk after

Company vulnerable deadly disease

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Residents put at risk of deadly disease as company fined £900k

The company fined at 22nd October 2024







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A company has been fined following an outbreak of legionella at its sheltered housing accommodation in Birkenhead, putting vulnerable residents at risk of contracting Legionnaires' disease.

Sanctuary Housing has been fined after an outbreak of legionella at its sheltered housing in Birkenhead, which endangered vulnerable residents.

... handed a massive fine
... Legionnaire's Disease in

Back to Barrow-in-Furness

Back to Barrow – How Key Findings are Still Relevant after 20 years

One of the most high-profile outbreaks of Legionnaires' Disease in the UK is the August 2002 Barrow-in-Furness incident.

Battle to contain worst-ever Legionnaires' outbreak

130 VICTIMS OF KILLER BUG

BRITAIN was on the brink of its biggest ever outbreak of Legionnaires' disease last night.

A man of 89 has already died of the killer bug, 18 other cases have been confirmed, and another 11 suspected victims have been identified.

And experts are warning that up to 130 could be struck down by the pneumonia-like illness.

Urgent investigations are under way to identify the source of the outbreak in Barrow-in-Furness, Cumbria.

Last night the Forum 28 arts complex, in the busy town centre, emerged as the most likely culprit.

Police cordoned off the building and were standing guard outside.

The complex, the only town centre building with the type of water-cooled air-conditioning system associated with Legionnaires', has up to 1,000 visitors a day. Tests are being

By **Jenny Hope**
Medical Correspondent

carried out on water samples from the system and if it proves to be the source then anyone who has passed through the centre of Barrow recently could be at risk.

Legionnaires', which has an incubation period of ten days and is a particular threat to the elderly and unfit, is carried by water droplets which are pumped out by air-conditioning systems.

On average the disease can kill up to 15 per cent of its victims, although an outbreak in Stafford in 1985 affected 68, of whom 23 died.

Dr Nigel Calvert, a consultant in communicable disease control, who is in charge of tracking down the source, said: 'This is the largest outbreak I am aware of.'

Anyone who has visited Barrow since July 1 could have contracted the disease and if they display any

Turn to Page 4, Col. 1



On guard: Police outside the building at the centre of the outbreak

Back to Barrow – How Key Findings are Still Relevant after 20 years

7 deaths and 180 cases of Legionnaires' Disease.

In the years following the outbreak, a report was produced which detailed the key findings and failings.

When looking at both Amey and Sanctuary, these key findings remain relevant today.

Report of the public meetings into the legionella outbreak in Barrow-in-Furness, August 2002



Back to Barrow – Key Findings

- Poor lines of communication and unclear lines of responsibility
- Failure to act on advice and concerns raised
- Failure to carry out risk assessments
- Poor management of contractors and contract documentation
- Inadequate training and resources

Back to Barrow – Key Findings

Poor lines of communication and unclear lines of responsibility

Good lines of communication and clear allocation of responsibilities is an important aspect in managing the risks from Legionella bacteria.

They help to detail what needs to be done, who it will be done by, and when it will be done.

The Barrow investigation identified basic corporate failings, such as a lack of general leadership and poor communication channels, which ultimately resulted in the risks from Legionella bacteria not being appropriately controlled.

Back to Barrow – Key Findings

Poor lines of communication and unclear lines of responsibility

Sanctuary had no trained and competent Responsible Person appointed who could oversee the management of legionella risk on site.

Amey failed to produce a written control scheme, a document that should detail clear lines of communication and roles and responsibilities with regards to legionella control tasks.

Back to Barrow – Key Findings

Failure to act on advice and concerns raised

Where competent advice has raised concerns around the risk from Legionella bacteria, it is important that dutyholders act on this advice so far as reasonably practicable.

The corporate failings previously mentioned in the Barrow outbreak were further compounded by individual failings in not acting on concerns that had been raised.

For example, before the outbreak, a contractor had expressed his concerns to a senior officer at Barrow Borough Council about the lack of water treatment for the cooling towers. However, there was a failure to take any effective remedial action.

Back to Barrow – Key Findings

Failure to act on advice and concerns raised

Sanctuary failed to act on some of the advice given by their water treatment contractor, such as when concerns were raised to the dutyholder regarding the lack of monthly temperature checks being carried out on the building's water system.

Amey failed to act on the recommendations of this risk assessment, so far as reasonably practicable, with a large portion of remedial actions only being completed after the prisoner had contracted Legionnaires' Disease.

Back to Barrow – Key Findings

Failure to carry out risk assessments

Up until the outbreak in 2002, Barrow Borough Council had failed to properly assess the risks from legionella bacteria at the arts and leisure facility.

Lack of resource resulted in a backlog of uncompleted risk assessments and, consequently, a suitable control scheme for legionella was not drawn up.

A fully trained and competent person should have assessed the risk of legionella and prepared a written scheme detailing exactly how the risk of legionella would be managed.

Back to Barrow – Key Findings

Failure to carry out risk assessments

Sanctuary failed to carry out a suitable and sufficient legionella risk assessment for the system at Vincent Naughton Court.

The risk assessment that was in place at the time of the HSE investigation was not representative of the water system due to it omitting key risk items such as dead legs in the form of hose reels connected to the domestic water system, and combination water heaters without a maintenance or management programme in place.

Back to Barrow – Key Findings

Poor management of contractors and contract documentation

The failure by Barrow Borough Council to properly manage contractors was a significant factor in the cause of the outbreak in 2002.

For example, the council did not properly check whether the contractor had carried out the specified work in relation to legionella control tasks they had been contracted to do.

Back to Barrow – Key Findings

Poor management of contractors and contract documentation

Sanctuary, as the dutyholder, failed to check the adequacy of the risk assessment produced by their contractor to ensure that it was suitable and sufficient for the system at Vincent Naughton Court.

Amey's contractual documentation was unclear and left ambiguity between who was responsible for certain parts of the water system.

Back to Barrow – Key Findings

Inadequate training and resources

Adequate training, competency, and resources allows those involved with legionella control activities to understand their responsibilities, identify risk gaps, and arrange remedial works where they are required.

In 2002, the investigation into the Barrow-in-Furness outbreak concluded that staff training was lacking.

The report stated that those responsible for the management of the control of legionella should have received training to ensure they were competent to carry out the work they were assigned to do.

Back to Barrow – Key Findings

Inadequate training and resources

Sanctuary failed to adequately train the staff involved with legionella control activities at Vincent Naughton Court.

Amey had inadequate resource to carry out their contractual obligations, such as the October and November 2017 temperature monitoring tasks.

HSE Enforcement

HSE enforce on the RISK, not on whether there is Legionella Bacteria in the system or because someone has contracted Legionnaires' Disease.

In Sanctuary's case at Vincent Naughton Court, no one came to harm, and no one was diagnosed with Legionnaires' Disease.

HOWEVER, prosecution was pursued due to the severity of dutyholder's failure to manage the RISK of exposure to legionella bacteria within their water system.

Final Thoughts

Legionnaires' Disease is foreseeable and preventable, and no one should contract it from a well-managed water system. However, it is clear that there are still lessons to learn from the Barrow-in-Furness outbreak in 2002.

In recent years, there has been an increasing trend in the number of Legionnaires' Disease cases in the UK.

Some of these cases have been linked to poorly managed cooling towers and hot & cold-water systems, which goes to highlight that some dutyholders have failed to learn the lessons of the past.

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Thank You