
REPORT TO:	ETWALL JMC	AGENDA ITEM:	7
DATE OF MEETING:	15 TH APRIL 2002	CATEGORY:	DELEGATED
REPORT FROM:	DEPUTY CHIEF EXECUTIVE		OPEN
MEMBERS' CONTACT POINT:	CHRIS MASON 5794	DOC:	
SUBJECT:	SHOWER HOT WATER SYSTEM	REF:	e:\leisure\committee reports\etwalllegionella_.doc
WARD(S) AFFECTED:	ETWALL, HILTON, WILLINGTON, NORTH WEST	TERMS OF REFERENCE:	

1.0 Recommendations

1.1 That the report and the actions taken be noted.

2.0 Purpose of Report

2.1 To advise members of a recent incident of high Legionella organisms located in a recent routine test at the Centre and the precautions taken to reduce the likelihood of this re-occurring.

3.0 Executive Summary

3.1 As part of routine monitoring of hot water systems, a sample taken on Thursday 7th February 2002 proved positive for Legionella. The system was immediately shut down and sterilised and the problem was resolved with minimum disruption. The report outlines the possible reasons for this positive test and lists actions taken to reduce the likelihood of positive tests re-occurring.

4.0 Detail

4.1 Hot water systems are tested and water storage tanks and hot and cold water systems disinfected by specialist contractors on 4 occasions per year. In this particular instance, the system was tested and sterilised as normal on 1st February 2002. On 7th February 2002 information came through that the sample was positive and, on the advice of the specialist contractor, the system immediately shutdown.

4.2 The specialist contractor was brought back on site that afternoon. The system was disinfected again and checked for any irregularities such as temperatures and pump failure. Nothing untoward was found at this stage.

4.3 Further investigation identified that the centre had been closed for 17/18 days over the Christmas period, which meant that water was left standing in the system. Also, water temperature log books identified that there had been abnormally low readings at certain times during the weeks before testing. The problem was traced to the

school boilers, which supply primary heat to the Centre's hot water systems.

- 4.4 The protracted closure and the boiler failures were identified as possible contributory factors to the positive result.
- 4.5 On 9th February 2002, the contractor returned to site and cleaned out the cold water storage tank on the roof of one of the school buildings and disinfected the system again. The showers were then put back into public use. Further samples were taken on 19th February 2002. These were within prescribed limits.
- 4.6 The contractor made the following recommendations to minimise the likelihood of this problem arising again:

The water storage tank on the School roof is too large for the demands of the Centre and a 24 hour turnover of water in the tank can not be achieved. The tank should be replaced with a smaller tank. **Cost £1980**

A thermometer should be fitted on the hot water return pipe adjacent to the calorifier and readings recorded at frequent intervals. **Minimal Cost**

Log-books should be provided to record all work carried out on the systems and kept on site. **Minimal Cost**

5.0 Financial Implications

- 5.1 Main cost is the replacement of the water tank. This has been met from the 2002/2003 allocation for Building Improvements.

6.0 Corporate Implications

- 6.1 None

7.0 Community Implications

- 7.1 No additional implications

8.0 Conclusions

- 8.1 On a positive note, while problems have been identified, the incident has shown the benefits and effectiveness of the routine inspection regime.

9.0 Background Papers

- 9.1 Letters from Sterilizing Services dated 14th February 2002 and 26th February 2002