

Transport and Environment Committee

10.00 am, Tuesday, 27 August 2013

Interim Report on the South West Edinburgh Legionnaires Disease Outbreak June 2012

Item number	7.14
Report number	
Wards	City Wide

Links

Coalition pledges	Not applicable
Council outcomes	Not applicable
Single Outcome Agreement	SO2

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Executive summary

Interim Report on the South West Edinburgh Legionnaires Disease Outbreak June 2012

Summary

The purpose of this report is to present for information the Interim Report on the Legionnaires Disease Outbreak in June 2012 which has been produced by NHS Lothian Incident Management Team (IMT). This report was considered by the Board of NHS Lothian on 24 July 2013 following which the Board agreed to accept all the recommendations and to commend all those involved in dealing with the consequences of the outbreak.

On 3 June 2012, NHS Lothian identified an outbreak of Legionnaires Disease. The outbreak was declared over on 17 July 2012. During the intervening 45 days there were 56 confirmed, 10 probable and 26 possible cases (Total 92) identified and treated by NHS Lothian. Tragically, four confirmed cases died as a consequence of the disease.

Epidemiological evidence through mapping of cases, analysis of travel diaries and of wind speed and direction suggested that a common outdoor airborne exposure occurred over South-West Edinburgh, near to or in the EH11 2 postcode sector, which is in the Gorgie area, with an end date of around the 30 May 2012.

An Incident Management Team led by NHS Lothian was established on 3 June, in accordance with Guidance on the Management of Public Health Incidents, published by the Scottish Government, and The Management of Legionella Incidents, published by the Health Protection Network. The Council's Environmental Health and Scientific Services are members of the IMT, as are the Health and Safety Executive. To date the IMT has met a total of 18 times.

Health and Safety enforcing authorities are investigating the circumstances of the deaths under the direction of the Crown Office and Procurator Fiscal Service Health and Safety Division.'

The conclusion to the executive summary of the Interim IMT Report is that "a coordinated response and prompt action by Public Health, Primary Care, Acute Services, Environmental Health, and Lothian Unscheduled Care Services (LUCS) resulted in less morbidity and fewer deaths than in previous outbreaks of similar size".

Council officers continue to work closely with partner agencies taking forward the recommendations listed in the interim report.

It is proposed that a further detailed report on the lessons learned and measures to be taken to minimise the risk of a future outbreak of the disease will be made to the Transport and Infrastructure Committee following publication of the full IMT report on the incident. Publication of the full report has had to be delayed due to the ongoing investigations by the Police and the Health and Safety Executive.

Recommendations

It is recommended that Committee;

- a) note the recommendations for action contained within the Interim Report to NHS Lothian's Board;
- b) instruct the Director of Services for Communities to provide such support and assistance as is necessary, to assist Lothian Health to take forward the actions and activities identified in the report as a result of the Incident Management Team's review of experience gained in investigating and controlling the outbreak.

Measures of success

An assessment of the effectiveness of the Incident Management Team and supporting personnel across all stakeholders in dealing with this outbreak will be included in the final report of the IMT.

Financial impact

There are no cost implications directly arising from this report.

Equalities impact

This report proposes no change to current policies and procedures and as such a full impact assessment is not required. The contents have no relevance to the public sector Equality Duty of the Equality Act 2010.

Sustainability impact

This report has no relevance to the Council's legal duty under the Climate Change (Scotland) Act 2009.

Consultation and engagement

This interim report has been produced following detailed discussions with all members of the Lothian Health led Incident Management Team.

Background reading / external references

1. Management of Public Health Incidents Guidance on the Roles and Responsibilities of NHS Lothian Incident Management Teams Scottish Government Act 2011.
2. Guidance on Management of Legionnaires Incidents, Outbreaks and Clusters in the Community Health Protection Network 2009.

3. Initial report on the Legionnaires Disease Outbreak NHS Lothian 21 June 2012.
4. [Update on Legionnaires Incident in South West Edinburgh - Policy and Strategy Committee 12 June 2012](#)
5. [Report on South West Edinburgh Legionnaires Disease Outbreak June to July 2012 -TIE Committee 11 October 2012.](#)

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Director of Services for Communities

Links

Coalition pledges	Not applicable
Council outcomes	Not applicable
Single Outcome Agreement	SO2 Edinburgh's citizens experience improved health and wellbeing with reduced inequalities in health.
Appendices	<p>Appendix 1a - Board Paper</p> <p>Appendix 1b - Report to NHS Lothian Board, dated 24 July 2013, Title: Edinburgh Legionnaires' Outbreak June 2012 and the associated appendix, 2013 Interim Report to NHS Lothian Board, Legionnaires' Disease Outbreak June 2012 Summary of Results of Epidemiological and Microbiological Investigation.</p>