

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	CORONER I am Michelle Brown, Area Coroner, for the coroner area of Essex
2.	DATE OF REPORT 31st July 2026
3.	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.	THIS REPORT IS BEING SENT TO 1. Wensley House Care Home 2. AquaCert 3. Swiftclean You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th September 2026 date. I, the coroner, may extend the period if an appropriate application is made.
4.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages <u>Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary</u> .
5.	SUMMARY OF CORONER'S CONCERN Mrs Freedman, arrived at Wensley House Care Home in April 2023, and she occupied Room 44 which was a top floor large room and had it own wet room. The room had been unoccupied since 2019. Rhoda was 91 years of age, profoundly death and preferred her own company and never left her room at any time during her stay there. Her family would visit often and communicated with her by iPad and a whiteboard was in her room for staff to respond to her needs. She disliked having showers preferring a strip wash at her sink, whilst she had underlying co morbidities these were not causing her obvious active problems in the lead up to her death. She became unwell with a fever, and string smelling urine and was admitted to Princess Alexander Hospital in Harlow, where she died 5 days later on the 18 th May 2024. On

admission to hospital, a urinary antigen test was carried out confirming the diagnosis of Legionnaires disease, the hospital gave a Cause of Death, but a Post Mortem was undertaken and her cause of death was 1a. Bronchopneumonia, 1b. Legionnaires. Following UKHSA there was a positive test of Legionnaires found from the shower and the sink in Mrs Freedman's room 44

The concerns are that Wensley House sought to rely on the sample methods by AquaCert and guidance around writing of Legionnaires risk assessment from Swiftclean the latter following her death.

The Water treatment expert who gave a full and detailed report, and gave live evidence at the Inquest, and had sight of responses by AquaCert at the inquest around some of the issues raised, (this sharing of the expert report for the inquest purposes only) and the responses by this company AquaCert were only known to the coroner in the middle the coroner made a ruling that these answers in response to his report finds from AquaCert could be put before the jury and he could address these in evidence The Water Treatment expert gave evidence on his report and also addressed the responses made by AquaCert his evidence was that the testing of the samples in bulk i.e. 4 different samples of water in one bottle is not compliant with British Standards BS7592:2022, and other testing and transportation of such samples was also not compliant as set out as AquaCert instructions on their bottles and website. Therefore, based on this the coroner has concerns that if these continue there is a risk of future deaths, not just within Wensley House but other Care Homes that AquaCert supply them to.

In relation to Swiftclean, who the court were told provided the risk assessments, the expert stated that these as provided to the Care Home after Rhoda died were none compliant, they should be living documents, and contain far more detail, and address each individual risk and when identified what action was taken as a result, the work undertaken to show what had been done and when. Therefore, the coroner has concerns around this company and their methods of assessment of risk, how it is written and how lacking these are to be compliant, the coroner has concerns that these will give rise to risks of Legionnaires disease not being recorded correctly, or that all risks are not detailed in their documents, therefore the risk of lack of information may result in someone else dying in the future.

The coroner also has concerns with Wensley House, that they should not have delegated their responsibility to these companies, they are the owners of the Care Home, or employees of such and therefore they should be fully aware of the legal requirements of the testing of the systems, the writing of reports and risk assessments for their Care Home.

The Care Home risk assessments were based on historic writing by a person unknown at a point in time unknown, before Mrs Freedman died and due to staff and management within the care home having inadequate training and no specialist lead person responsible for water testing and completion of risk assessments around Legionnaires disease itself and the risks of Legionnaires disease for elderly and vulnerable residents these risks were not addressed, and the admitted they were unaware of the risks and therefore as a direct result more than minimally caused the death of Mrs. Freedman.

The coroner is concerned that the position remains the same some two years after Mrs Freedman died.

A further concern by the coroner is that the Water Systems and pipework and boilers within Wensley House are not maintained to a sufficient standard, to prevent further Legionella infections, these include but not exclusive to, dead legs and cut and capped pipes and the service or maintenance or otherwise of their boiler and water systems.

One such cut pipe coming from the toilet of the office into Room 44 where Mrs Freedman contracted Legionnaires disease. The coroner is concerned that these Water Systems and Pipe Work remain the same now as they did when Mrs Freedman died in 2024 and therefore continues to be a current and real risk to vulnerable residents within the Care Home and to staff working there. .

6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths, and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 23rd May 2026, an investigation was commenced into the death of Rhoda Lilian Freedman AGE 91. The investigation concluded at the end of the inquest on 27th July 2026. The conclusion of the inquest by a Jury was- The death of Mrs Freedman was a consequence of numerous missed opportunities, giving rise to the presence of Legionella Bacteria in the water system at Wensley House, and that this led to Mrs Freedman developing Bronchopneumonia.
8.	CIRCUMSTANCES OF DEATH Mrs. Rhoda Lilian Freedman was a 91-year-old lady who died on the 18th May 2024 at Princess Alexander Hospital, Harlow, Essex due to Bronchopneumonia, from Legionnaires Disease, contracted from the Care Home room 44 of Wensley House, Bell Common, Epping, Essex.
9.	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: <u>Wensley House</u> 1. The Water Systems and pipework within Wensley House are not maintained to a sufficient standard, to prevent further Legionella infections. 2. There is inadequate training within Wensley House Care Home Staff and Management, around the risks of Legionnaires disease 3. There is no lead person with specialist and recognized formal training on all aspects of Legionnaires disease and Risk Assessments at Wensley House. 4. The Water Testing is not compliant with British standards BS7592:2022 5. Risk Assessments are not robust or compliant <u>AquaCert</u> 6. The Water Testing is not compliant with British standards BS7592:2022 <u>Swiftclean</u> 7. Risk Assessments are not robust or compliant

10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Family of Mrs Rhoda Freedman 2. Princess Alexander Hospital 3. Care Quality Commission 4. UKHSA I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's <u>PFD Publication Policy (2026)</u>. Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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