KEY POINTS AND COMMENTS ON THE PENNINGTON REPORT

E. COLI O157 OUTBREAK IN SOUTH WALES
By Dr Verner Wheelock

In September 2005, there was an outbreak of food poisoning caused by E. Coli O157.

A total of 157 cases were identified. 31 people were admitted to hospital and tragically one boy, aged 5, died.

Professor Hugh Pennington, who conducted the Inquiry on the outbreak of E. Coli in Central Scotland, was asked to conduct the Inquiry. The terms of reference were:

“Inquire into the circumstances that led to the Outbreak of E. Coli O157 infection in South Wales in September 2005 and into the handling of the Outbreak; and to consider the implications for the future and make recommendations accordingly.”

The Inquiry considered a substantial volume of written and oral evidence. All relevant evidence and transcripts of proceedings, including the Inquiry report, can be accessed at www.ecoliinquirywales.org

This document provides a summary of the key points in the report, plus some comments.

The outbreak was caused by cooked meats which had been contaminated by E. Coli O157. This was due to hygiene failures at the premises of John Tudor and Son. The responsibility for it falls fairly and squarely on the shoulders of the proprietor. There were serious, and repeated, breaches of Food Safety Regulations.

The proprietor failed to ensure that critical procedures, such as cleaning and the separation of raw and cooked meats, were carried out effectively. He also falsified certain records that were an important part of food safety practice.

The business’s Hazard Analysis Critical Control Point (HACCP) plan was not valid. In some respects it was positively inaccurate and misleading.

William Tudor, the proprietor, misled, and lied to, Environmental Health Officers on some issues, such as the use of the vac packing machine and a machine being away for repair.
Bridgend County Borough Council was responsible for the inspection of John Tudor & Son.

The inspections undertaken by Environmental Health Officers were made less effective by William Tudor’s dishonesty. Even so, the inspections did not assess or monitor the business’s management of food safety as well as they could, or should, have done.

Clues were missed. Those that were spotted were lost in the system because there was no way of alerting other Environmental Health Officers to issues or concerns for subsequent inspections.

The effectiveness of the inspections conducted by EHOs of Bridgend County Borough Council with respect to HACCP were considered in detail by one of the expert witnesses, Brian Curtis.

His principal conclusions in the light of all the evidence, and leaving aside the vac packer issues, which are dealt with separately below, were as follows:

- The inspections undertaken failed to identify the deficiencies and weaknesses in the HACCP plans because the validation exercise was not undertaken effectively.

- The inspections failed systematically to assess the accuracy and effectiveness of the underlying HACCP documentation. For example, the cleaning schedules were not very helpful, the temperature records and the chilling records had deficiencies and threw up the issues dealt with above.

- There was insufficient focus on identifying and assessing the working practices and procedures that were in fact being implemented for the purpose of ensuring that the HACCP plan was applied in practice. There was particular concern about the balance between announced and unannounced inspections; and about a failure to talk to employees to establish what really went on.

- There was inadequate reaction by inspectors when they did come across breaches of the HACCP plan: for example, when the records indicated that the cooling temperatures identified in the plan as critical limits were being regularly breached.

- There was real concern as to whether the true importance of HACCP to ensuring food safety was in the minds of inspectors; and, following on from that, whether the inspections were in fact structured and approached effectively to test the HACCP plan and its implementation. That in turn raised concerns about the adequacy of the procedures and the internal guidance given to EHOs about these issues.
There was no system within Bridgend for red flagging issues of particular concern identified on previous inspections, such as the suspicions about the falsity of the documentation maintained by William Tudor noted by an EHO at an earlier inspection.

The result of these matters was a failure in the series of inspections to identify and deal with the poor hygiene and unsafe working practices in Tudors.

These conclusions were endorsed by Professor Pennington.

He went onto say that none of the inspectors considered HACCP in a sufficiently rigorous or systematic way. Furthermore, the practices of the inspectors varied. It was clear that the HACCP plan was not valid and that the fundamental flaws could, and should, have been picked up during the inspection.

There were also repeated failures to verify the HACCP plans to ensure that they were being followed in practice. If an inspection had HACCP at its heart, and had adopted the approach of selecting particular important aspects of the plan and then thoroughly testing how they were being implemented, the failures at Tudors would have been identified.

In particular:

- None of the inspectors talked to employees (other than Mr Celyn Williams in William Tudor's absence) to ascertain if Critical Control Points and monitoring procedures were being dealt with effectively.

- None adopted with any degree of rigour or thoroughness the sort of audit-style approach that should have been followed.

- The Hazard Analysis and the Butchers’ Licensing Assessment Forms indicate that the checking of the underlying HACCP records was far from satisfactory, with examples of records not being checked, and other examples of relevant details e.g. in relation to training, not even being filled in as the form dictated.

- Even when there was some indication that the underlying records were checked obvious inconsistencies and problems were not picked up. For example, the temperature and chilling records which were examined by one of the inspectors indicated clear departures from the HACCP plan itself; and that was not picked up. To the extent that it was picked up, the reaction to clear breaches of the plan was insufficient.

Professor Pennington concluded that the monitoring of the quality and effectiveness of inspections by EHOs appears to have been inadequate. There does not appear to have been a plan implemented to ensure that inspections were being carried out in a thorough manner.
It is very unfortunate in this respect that the only section in Bridgend’s Procedures document that was aimed at monitoring quality of inspections was the victim of the decision, made on resource grounds, not to implement it.

Special attention was directed at the role of the vac packer. EHOs were told that one machine was being used for both raw and cooked products temporarily, because the second one was being repaired. This was not true, and in reality there had always been just one machine. According to Brian Curtis:

- The use of a single vac packer to pack both raw and cooked meats carried with it a serious risk of cross-contamination.

- A judgement needed to be made at the first inspection in January 2005, in the light of the explanation given about the other vac packer being away for repair. The judgement was whether the use of the single vac packer presented an imminent risk to public health.

- However, the EHO would have approached the matter by first asking what the HACCP plan provided for in such a situation; and then by discussing its use in detail with William Tudor. Given the seriousness of the risks involved, the EHO would have discussed it with others back at the office who had experience of Tudors.

- At the January 2005 inspection, there was no HACCP plan available. However, by the February 2005 revisit, it would have been clear that the use of a single vac packer for raw and cooked meat was in clear breach of the HACCP plan. It had already been established that some staff had not been trained in food hygiene and that elements of routine cleaning had not been carried out. Those matters would have heightened the concerns surrounding cleaning the machine as an acceptable alternative.

- In order for the vac packer to continue to be used, the EHO said he would have needed to be satisfied that an effective cleaning process could be devised; and then to be satisfied that that process was clearly set out by way of amendments to the HACCP plan and written procedures. He considered that it would have been extremely difficult for him to be satisfied about “effective cleaning” as an alternative given the nature of the equipment and the difficulty of ensuring that the cleaning left the vac packer in a microbiologically safe condition on each occasion, and also given that, given its low dose infectivity, *E.coli* O157 risks needed to be met by ensuring that all the bacteria were eradicated.

- Brian Curtis was reluctant to state that it would never be possible to achieve safety by cleaning a single vac packer. However, it was also evident that his view was that, for a machine of this complexity and in the light of the *E.coli* O157 risks, it would not be practically possible to ensure such safety. That view was reinforced by the features of Tudors, such as its relatively small size as a business, the lack of training and the history of concerns over food hygiene issues.
The additional element in the analysis was described as “a bit like playing Russian roulette”. The cleaning, with all its difficulties and risks, needed to be completely effective each time it was done. Prolonged use increased the chances of that not occurring.

The EHO would have been concerned the explanation being given, namely repair, did not then lead to a swift conclusion.

Again the conclusions of Brian Curtis were endorsed by Professor Pennington. In his view there was plainly an imminent risk to health in the use of the single vac packer to pack raw and cooked meats.
THE ROLE OF THE FOOD STANDARDS AGENCY

The Enforcement Division of FSA Wales has the responsibility for monitoring and overseeing the food law enforcement activities of all Welsh local authorities. It also provides training, advice and support to enforcement officers in the authorities. An important part of this function is the formal auditing of enforcement activities. Each audit is led by Environmental Health and Food Standards Officers with lead auditor qualifications.

Bridgend County Borough Council’s Public Protection Department was audited by the FSA in 2004, some 18 months prior to the Outbreak.

The FSA contacted Bridgend County Borough Council during the summer of 2003 to inform them that they were to be audited. The Council requested that the audit be delayed as it was experiencing ongoing staffing problems within the Department. That request was agreed and the planned audit timeframe was deferred by a few months.

Another letter was sent to Bridgend’s Chief Executive on 22 October 2003 informing him of the FSA’s intention to undertake an audit.

The audit team was led by Mrs Davies and included four of her colleagues. Three of the five members of the team were qualified Environmental Health Officers and members of the Chartered Institute of Environmental Health; one held a Certificate of Competence in Food and Agricultural Standards and the other an Advanced Certificate in Food Safety. All had undertaken and completed a training course on the assessment of quality systems.

At the outset of the audit, Mrs Davies described the main components of this exercise as follows:

- The auditor would take a file and would then analyse its contents against a series of published checklists and protocols.
- The auditor would tend to look at the three most recent inspections, but would go back further into the file if necessary.
- In looking at the files, the object of the exercise was to consider whether it indicated that the correct processes had been followed and that consideration had been given to the appropriate legislation.
The process would also include an assessment of whether:

(a) The relevant documentation relating to an inspection was present.
(b) The relevant matters had been considered.
(c) The appropriate boxes had been ticked.
(d) The appropriate options been circled.

Correspondence generated by and relating to the inspection would also be viewed as important in assessing whether or not the action taken by the inspector was in fact the correct action and consistent with the corresponding inspection report.

In summary therefore, the audit was “systems” based. It focussed on whether processes were in place rather than on the merits of individual decisions and on individual decision making techniques. The audit process was principally directed at ensuring that on the face of it, the documents had been filled in correctly i.e. that the right boxes had been ticked.

So, for example:

- In relation to staff training certificates at a premises such as John Tudor & Son, the audit would only assess whether the EHO had asked the question on staff qualifications. It would not go behind the detail written on the form to identify how EHOs had satisfied themselves that the information given by the food business operator was in fact correct.

- Similarly, the processes were not designed to test how EHOs went about checking the effectiveness of the HACCP procedures in respect of an individual premises, either from a validation point of view, obtaining evidence that the elements of the HACCP plan are effective, or a verification point of view; that is, ways of determining compliance with the plan.

Mrs Davies acknowledged in her oral evidence that the FSA audit system that operated prior to the Outbreak was not set up to identify the sorts of problems identified.

The audit system did not allow for access to the underlying HACCP documentation or its review, and auditors did not accompany EHOs on inspections.

Counsel for the Inquiry asked a number of questions about the interviews. Some of the answers were a cause of concern to Professor Pennington.
For example:

One of the questions was on the topic of “Knowledge of inspection procedure”. How would you undertake an inspection?” The records show that there was a blank space and Mrs Davies accepted that she had not asked the question of the EHO and could not say why that was the case.

It was also evident that although structured forms had been developed by the audit team, only two of the five interviews that took place at Bridgend were conducted by reference to those forms. It was unclear what, if any, structure was followed in the other three interviews or by reference to what criteria or objectives these had been conducted. For example, whilst the pro forma had room to make notes on the topic of inspections, one auditor who had not followed the pro forma had simply written the word “inspections” and placed a tick after it – providing no information on what, if anything beyond the fact of inspections having taken place, had been discussed with the EHO.

Professor Pennington concluded that the limitations of the FSA’s systems-based approach are evident from the notes of interviews with EHOs. Specifically, there was no focus on the approaches that officers took when reviewing HACCP and the effectiveness of HACCP in the butchers’ premises that the officer was examining. Nor do those notes indicate any real “drilling down” into what the EHO was, in fact, doing in order to generate not merely an answer, but the right answer, placed on the inspection form.

At the closing meeting, Mrs Davies made it clear that no major concerns had surfaced during the audit. She said there was general satisfaction with Bridgend’s food hygiene performance and the Department was particularly strong in formal food hygiene enforcement. The audit findings were summarised and key areas for improvement set out. The representatives of the authority acknowledged the weaknesses and issues that had been identified during the audit and said that these would be addressed.

The Inquiry report made it clear that the FSA’s audit of Bridgend’s Food Safety Team in February 2004 found little systematically wrong within the team and its method of working.

Professor Pennington was especially concerned because of the inability of the audit scheme to evaluate the thoroughness of inspections, especially in relation to the assessment of HACCP in food businesses as a core component of food hygiene and food safety.
THE ROLE OF THE MEAT HYGIENE SERVICE

Conditions in the abattoir of J.E. Tudor and Sons which supplied the meat to John Tudor and Son were far from satisfactory.

The Inquiry examined in some detail the role of the Meat Hygiene Service which is an executive Agency of the Food Standards Agency.

Abattoirs are required to comply with The Fresh Meat (Hygiene and Inspections) Regulations 1995 which came into force on the 1st April 1995.

For a business such as the Abattoir in question, three requirements needed to be met:

(i) The construction, layout and equipment used at the premises had to meet the detailed requirements set out in the Regulations.

(ii) The method of operation had to meet specified requirements.

(iii) The meat processed had to be inspected post-mortem, and if rejected, should not be used.

The Regulations also lay down the responsibilities of the Official Veterinary Surgeon (OVS) as follows:

- The ante-mortem health inspection of animals in accordance with Schedule 8 of the Regulations.
- The post-mortem health inspection of slaughtered animals in accordance with Schedule 10.
- The Health Marking of fresh meat.
- Securing the observance of the requirements relating to the premises and the practices as set out in the Schedules, including Schedules 5 and 7.

Regulation 20 was specifically entitled “Duties of the occupier”. It set out a variety of precise and express duties, including duties on the occupier/operator to:

- Keep an adequate record of the number of animals received into the premises, and the amounts of fresh meat despatched from the premises during each week.
- Take all practicable steps to secure compliance by any person employed by him or by any person invited onto the premises with the provisions of the Regulations.
• Ensure that an OVS, Inspector or Veterinary Officer is provided with adequate facilities so as to enable him to carry out his duties under the Regulations and that he is given such reasonable assistance and access to records as he may from time to time require for that purpose.

• Take all necessary measures to ensure that, at all stages of production, the requirements of the Regulations are complied with and carry out checks (including any microbiological checks the Minister may require) on the general hygiene of conditions of production in his establishment to ensure that equipment and, if necessary, fresh meat, comply with the requirements of the Regulations.

Mr Peter Hewson, Acting Veterinary Director of the FSA, suggested in his statement to the Inquiry that the 1995 Regulations were less than satisfactory. The implication appeared to be that this made the task of the MHS more difficult. The particular issue he identified was what he characterised as a blurring of the lines of responsibility for the production of safe food as between the operator and the OVS.

Professor Pennington did not consider that to be an accurate or relevant characterisation of the 1995 Regulations or their effect. It is not accurate because the duties and functions on those involved are clearly and expressly set out in the 1995 Regulations. As appears from the terms of the 1995 Regulations, the operator has to comply with the requirements in relation to the premises and the practices operated at the slaughterhouse. It is the OVS’s job to take whatever steps are appropriate and necessary to ensure that the operator does so. Professor Pennington saw no evidence to suggest that there was any real confusion in the case of the Abattoir.

Professor Pennington rejected this opinion. He said that one of Mr Hewson's principal concerns about the regime was that the Tribunal to which revocations of licences could be appealed by an operator was readily satisfied once the operator had rectified specific identified problems. At paragraph 9 of his statement Mr Hewson stated that the Tribunal tended to favour the operator, where it was shown that the specific problems identified at the refusal visit had been addressed. Mr Hewson further stated in oral evidence that the plants would change their company name, re-apply for a licence, and on the day of re-applying, do just enough to comply.

Professor Pennington was unconvinced by Mr Hewson's argument. It is clear that the second of the legislative grounds for revocation would have enabled those considering it to rely on persistent, similar breaches on compliance. The solution to whatever perceived difficulties there might have been with the Tribunal’s decisions was to operate an effective enforcement policy. If that had been done in a way that moved from initial light-touch enforcement to increasingly serious measures, an operator would either have dealt with the source of the repeated non-compliance, or a clear picture would have emerged of a refusal or failure to take the necessary steps. That picture could then have been used as the foundation for an application for revocation that could properly have been defended before a Tribunal.
It should have been possible to ensure that devices, such as changes of name, were not used abusively to circumvent the system.

The Meat (Hazard Analysis and Critical Control Point) (Wales) Regulations 2002 required the implementation of HACCP in slaughterhouses as an additional means of minimising the risks of unsafe food being produced by slaughterhouses.

The HACCP Regulations came into force for “small meat establishments” such as the Abattoir on 7 June 2003. They required operators to apply the HACCP principles set out in Regulation 3(7). Thus, from that date in June 2003, Parliament had decided that operators needed to comply with the HACCP Regulations. This process was not introduced overnight. There had been substantial warning that the HACCP Regulations would be introduced as a legislative requirement in relation to small slaughterhouses such as the Abattoir, given that the Commission Decision was dated 8 June 2001, and larger establishments had been subject to the Regulations since June 2002.

Mr Hewson again suggested in his statement and in his oral evidence that the HACCP Regulations were not easy to implement or enforce.

According to the Inquiry report, the first point was that a difficulty arose because the HACCP Regulations were being introduced in a legislative environment where operators did not have, what he described as “full and unambiguous responsibility for the production of safe food”. Professor Pennington did not consider that this is any more accurate or relevant than his suggestion that the perceived blurring of roles hampered effective implementation of the legislation. The principles set out in the HACCP Regulations were well-established HACCP principles. There should have been no insurmountable difficulty in taking all necessary steps to enable the industry, with such assistance as was necessary from, for example, the MHS/FSA, to comply with them in an effective manner and on time.

Mr Hewson’s second suggestion, made in oral evidence, was that, to have enforced the law as enacted by Parliament would have had the effect of shutting down the meat processing industry. As he put it in answer to questions, “it depends whether you want an industry or not. We could have just implemented it to the letter of the law, as you suggest, and import our meat”. Professor Pennington did not support that expression. He did not accept that this would have been the position and it is of concern that that should have been the position of someone as senior as Mr Hewson. Mr Hewson himself has explained that the answer was given in the heat of the moment and that it was ill-judged and inappropriate.

Professor Pennington concluded that it was for the FSA, as the policy makers, and the MHS as its enforcement arm, to take whatever steps were necessary to educate and train, and then enforce the requirements that Parliament had decided should be in place. That could, and should, have occurred in advance of the date on which the requirement came into force to a level that operators were in a position to comply with the legislation either on, or shortly after, the date set by Parliament.
Mr Hewson stated that there was a deliberate FSA policy to allow operators longer than the legislation allowed on its June 2002/2003 dates to comply with the legislative requirements. He confirmed that in practice, some operators were allowed until 2006 when the 2006 EU Regulations came into force to apply HACCP properly. The other MHS witnesses also referred to a policy of “light” or non-enforcement of the HACCP Regulations.

The documents produced by the MHS after the oral hearings confirmed the existence of such a policy. This policy was the FSA’s. It was reflected in instructions to the MHS. In the initial period, the policy was that the MHS were to encourage and advise small establishments on HACCP but not take any formal enforcement action. This period lasted until the end of February 2004. On 27 February 2004, the policy changed. In relation to small establishments, formal enforcement action was to be taken but only in relation to establishments which had made no effort to implement HACCP requirements. For those which were assessed to have made such an effort, encouragement and cajoling should continue with informal enforcement action, verbal or by letter, being the limit of the enforcement action.

Mr Hewson sought vigorously to defend this policy.

His first reason was that the HACCP Regulations did not add much, or were not perceived as adding much to the current legislation. He stated that in regulatory terms, the prescriptive nature of the 1995 Regulations provided for production of meat as safe as possible and, for slaughterhouses, HACCP did not really add a great deal, except to transfer the responsibility for the production of safe meat to the operator away from the OVS. Mr Hewson stated that if the introduction of HACCP was not critical to the industry, then it should be given time to do it properly.

According to Professor Pennington this was a surprising and unfortunate position. It appears to suggest a deliberate choice by the MHS not to press ahead as quickly as possible with measures that Parliament had decided were necessary for the purpose of enhancing the prospects of safe food being produced by slaughterhouses. The necessity of the HACCP Regulations was a matter for Parliament, whose decision should have been respected and implemented, and not for the MHS whose sole function was to organise and put in place an effective enforcement regime. Further, and in any event, Professor Pennington did not agree with the suggestion that the requirements of the HACCP Regulations did not add materially to the existing regime. On the contrary, those Regulations should have been, and were intended by Parliament to be, an important, indeed a central, part of a new enhanced regime.

The main conclusions reached by Professor Pennington are as follows:

- Over a prolonged period, the MHS repeatedly failed to perform effectively its overall enforcement function in relation to the Abattoir. The longstanding, repetitive, failures were made much worse by the fact that there was an abundant knowledge amongst the staff that it was a failing abattoir. Despite this knowledge, the Abattoir was allowed to continue to function in breach of the legislative requirements.
• It is not in dispute that the Abattoir was in serial breach of the legislative requirements. The nature of those breaches remained substantially the same throughout the period. The breaches did not simply relate to peripheral or technical matters. They went to the heart of the ability of the Abattoir to produce safe food; to the structure and its maintenance, to its layout, to the slaughtering and hygiene practices, and from June 2003 to the very existence of an effective and operating HACCP plan.

• The breaches were not the result of some recent downturn. The documentation that exists in relation to the early to mid 1990s indicates that substantially the same problems had existed un-rectified and unaddressed since that time.

• It appears from the contemporaneous documentation that those responsible for enforcement of the legislative requirements were well aware of these serial and persistent breaches. The MHS had designed a series of forms for recording relevant details. Those forms were well-designed and tailored to the legislative requirements.

• They achieved their purpose, focussing the minds of those responsible on whether the Abattoir complied with those requirements. The Hygiene Reports from 2003 onwards provide a clear picture of the true state of the Abattoir and its operations and practices. The monthly HAS reports also indicated a failing slaughterhouse, at least sufficiently to the point where they should have caused those in management who saw them to examine more closely the true extent of non-compliance at the Abattoir.

• The OVSs knew the true position because they completed the relevant forms, including the Hygiene Reports. However, it is also clear that area management became aware of the state of non-compliance at the Abattoir.

• Despite all this, the position did not improve. The same breaches recurred; the same problems remained embedded. The MHS utterly failed to take the necessary, or any effective steps to secure legislative compliance.

• The responsibility for that failure lies in the first instance with the OVSs but equally, however, with area management. Area management could, and should, have realised that, for whatever reason, the enforcement steps being taken by the OVS were not effective to achieve a state of, or even approaching a state of, legislative compliance.

• In relation to HACCP, the evidence of Mr Hewson and others indicates that a deliberate decision was taken by the FSA not to enforce the legislative requirements. That decision was, and is, unacceptable. The function of the MHS and the FSA was to apply the legislative requirements that Parliament saw fit to impose in order to minimise the risk of unsafe food being produced. It was not for the MHS or the FSA to choose not to enforce that legislation. Moreover, the concerns expressed about the timing of the legislation appear to me to be without real foundation in a case such as this.
In relation to the other failures, the reason consistently advanced by the MHS and OVS witnesses was that they were seeking to work with Jonathan Tudor, they sought deliberately to adopt a co-operative approach to enforcement, and that some warning letters and Improvement Notices were served.

Professor Pennington commented:

As the legislation and the MHS Manual indicates, all the necessary enforcement tools were available, from advice and recommendation to the service of formal notices to suspension of the licence and, ultimately, to revocation of the licence.

The Hygiene Reports clearly indicate that the limited enforcement action that was taken was demonstrably ineffective to achieve compliance with the legislative requirements. Months and then years passed without significant improvement, still less achieving the required compliance.

What was needed, but never put into place, was a rigorous enforcement programme designed to compel compliance, if necessary put in place and overseen by more senior MHS management. If J.E. Tudor & Sons Ltd was unable, or for economic reasons unwilling, to achieve compliance, steps should have been taken, after working up the hierarchy of enforcement in order to demonstrate such inability or unwillingness, to suspend or revoke the licence.

The result of that failure was that an abattoir that should either have become compliant or have been shut down continued to operate whilst failing in serious respects to comply with food safety legislation. By reason of the MHS not effectively controlling compliance with food safety legislation within the Abattoir, there would have been a substantial increase in the risk of *E.coli* O157 on meat coming out of the Abattoir. As a result, the risks of unsafe food being produced and supplied into the food chain were considerably higher than they should have been.
KEY POINTS FROM CONCLUSIONS

The Food Safety Act dates from 1990. The Meat Hygiene Service started work on 1 April 1995. The Food Standards Agency was established in 2000, the year in which Butchers’ Licensing had been introduced as a consequence of the 1996 E.coli O157 outbreak in Scotland. The consensus view in 2005 was that all these changes were leading to improvements in food safety. They had been in place long enough before the Outbreak for them to have bedded down and become effective. So the defences that were in place in 2005 were modern. One of them had even been specifically introduced to prevent E.coli O157 infections. All this makes the failures that led to the Outbreak particularly shocking.

COMMENT

It is clear from various comments made by Professor Pennington that he is frustrated by the fact that there are parallels with what happened in Central Scotland in 1996.

Once again, there has been a failure on the part of EHOs to identify serious weaknesses in food safety management systems. One of the reasons for the establishment of the Food Standards Agency was to ensure that high standards of food safety should be maintained. It is evident that these aspirations have not been fulfilled. The FSA conducted an audit of the Bridgend Food Safety Team and effectively gave it a clean bill of health. Despite the fact that there was a group of 5 FSA staff who spent 4 days in Bridgend, the serious limitations in the inspections procedures were not uncovered. The exercise was described by Professor Pennington as tick-box. In view of this one can quite justifiably ask how of earth the FSA can justify the resources devoted to this type of audit.

The criticism of the FSA/MHS with respect to implementation of the Regulations in slaughterhouses is even more damning. The deliberate policy to have a “light touch”, and the conclusion that the Regulation was difficult to enforce, have been slammed by Professor Pennington. Perhaps it is significant that the strategy of the FSA is currently under review. The conclusions of this Inquiry indicate that the sooner this happens the better. Essentially Professor Pennington has shown that the FSA/MHS is not “fit for purpose”.

One final thought ~ could it be that the regulatory model for ensuring compliance with legislation just does not work? Taking the wider perspective, there are recent failures with respect to the NHS (Stafford Hospital), child protection (e.g. Doncaster) and, of course, banking.

The existence of a regulatory body may reduce the perceived responsibility of those at the sharp end, and probably also diverts attention away from the primary objectives/purpose of those who have to deliver the service to the public.