The Public Inquiry into the September 2005 Outbreak of *E.coli* O157 in South Wales

Press Statement by Professor Hugh Pennington

Good morning.

Today, I publish my report of the Public Inquiry into the major outbreak of *E.coli* O157 in South Wales in September 2005.

The Outbreak is the largest outbreak of its type in Wales and the second largest in the UK.

One hundred and fifty-seven cases were identified of which one hundred and eighteen were confirmed microbiologically. One hundred and nine were of a strain of *E.coli* O157 that was unique to the Outbreak.

Most of the cases were children in schools in four local authority areas in the South Wales valleys. The infection resulted in very serious illness for some people and, very sadly, the death of young Mason Jones.

I was asked to examine the circumstances behind the Outbreak and the way it was handled. I was also asked to

make any recommendations I consider necessary to help prevent such an outbreak from happening again.

My report sets out in detail my findings and recommendations. Copies of the report and a summary document, and copies of what I am about to say, will be available at the end of my statement. All three are in the process of being published on the Inquiry's web site as I speak.

I will not be taking questions after my statement. Immediately afterwards, I will meet briefly with the families who were affected by the Outbreak after which I will be available for press and media interviews.

The Inquiry has lasted much longer than I anticipated. There were two principal reasons for this: the need for the Inquiry to avoid risking prejudice to the criminal investigation and subsequent proceedings, and the breadth and depth of the investigations I considered necessary for a thorough Inquiry.

I know a thorough Inquiry was important to the families. I thank them for their patience. I also commend those of them who gave evidence not only for their willingness to appear in public but for the quiet dignity with which they relived harrowing and tragic events.

I must also say that while the criminal investigation did affect the Inquiry's progress, the evidence it generated was very helpful. And on that note, I thank all who gave evidence during the course of the Inquiry. I considered a substantial volume of written and oral evidence.

E.coli O157 is a particularly nasty organism but it can be prevented from causing infection in people. It has not gone away. It remains a potential threat to people's health. There are no specific treatments yet available to prevent the onset of complications - which are often severe and sometimes fatal. Prevention is paramount.

Steps must be taken at points throughout the food chain to prevent contamination and cross-contamination, particularly in abattoirs and in butcher's premises that handle raw and cooked meats.

The food safety requirements that were in place at the time of the Outbreak had been reformed in the years before it. They were relatively modern. One of the measures, Butchers' Licensing, had even been introduced as a result of the 1996 outbreak of *E.coli* O157 in Scotland. This makes the fact that the Outbreak occurred particularly shocking.

The extensive microbiological testing and typing that was done during the outbreak and the additional testing and typing I commissioned during the Inquiry shows that the strains of *E.coli* O157 in people who were infected were indistinguishable from those found on cooked meats recovered from schools, in a sample of raw meat recovered from John Tudor & Son, a catering butcher's business based in Bridgend, and in samples of cattle faeces from a farm.

Cattle from the farm were slaughtered at the abattoir of J.E. Tudor & Sons Ltd which, until the beginning of 2006, operated in Treorchy in the Rhondda valley. The abattoir was one of John Tudor & Son's suppliers.

The Outbreak occurred because of food hygiene failures at the premises of John Tudor and Son. The proprietor, William Tudor, 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. On some issues, he misled and lied to Environmental Health Officers.

The business's Hazard Analysis Critical Control Point plan, or "HACCP plan " as it is more commonly known, was an essential component of the Butchers Licensing Scheme that applied to William Tudor's business at the time of the Outbreak. It should have ensured that food produced from the premises was safe. But the plan was not valid. In some respects it was positively inaccurate and misleading.

Businesses are responsible for producing safe food. The responsibility for the Outbreak therefore falls squarely on the shoulders of William Tudor. Despite being well-qualified in food hygiene, he had a significant disregard for food safety.

Food safety measures are underpinned by legislation and enforced by inspectorates. I considered three separate regulatory regimes.

I examined the records of Bridgend County Borough Council, which was responsible for the inspection of the John Tudor & Son butcher's business.

I examined an audit of Bridgend's Food Law Enforcement Service that was undertaken by the Food Standards Agency.

I also wanted to check if there was anything further down the food chain that was could have contributed to the circumstances behind the Outbreak. What I found led to the inspections of the abattoir by the Meat Hygiene Service, part of the Food Standards Agency, becoming a significant and, if I may say unanticipated, strand of the Inquiry's work.

I will take each of these in turn.

The inspections undertaken by Environmental Health Officers from Bridgend 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. Failures around the HACCP plan were the most important. The fundamental flaws in John Tudor & Son's plan could, and should, have been picked up.

There was insufficient focus on identifying and assessing working practices and procedures to ensure that the plan was being applied in practice.

The audit of Bridgend's Food Law Enforcement Service was undertaken in February 2004, some eighteen months before the Outbreak. The Food Standards Agency found little systematically wrong with Bridgend's team and method of working. However, the audit was systems-based. It focussed on the processes in place around inspections rather than on the merits of individual decisions made during inspections or the techniques of an effective inspection.

Turning to the abattoir, on the balance of probability, the *E.coli* O157 that caused the Outbreak entered the premises of John Tudor & Son on meat from the J.E. Tudor and Sons Ltd abattoir.

The likelihood of meat becoming contaminated with *E.coli* O157 at the Abattoir would have been significantly reduced if the Meat Hygiene Regulations that were in force in 2005 had been followed and enforced. There were big shortcomings in relation to both.

Over a prolonged period, the Meat Hygiene Service failed to perform effectively its overall enforcement function in relation to the Abattoir. Despite knowledge of longstanding, repetitive, failures, the Abattoir was allowed to continue functioning in breach of legislative requirements. The limited enforcement

action taken was demonstrably ineffective to achieve compliance with legislative requirements.

For J.E. Tudor & Sons Ltd, the "light touch" enforcement approach was wrong. Hygiene problems at the Abattoir had not been missed. The signals that the premises and its practices were unsafe were strong. They passed up lines of management in the Meat Hygiene Service.

The abattoir was allowed to continue in business without significant improvement. 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.

As I said earlier, most cases of infection were children in schools across four local authority areas. I therefore examined another step in the food chain; that is, the supply of meat for school meals.

The path to infection for the majority of cases in the Outbreak was contaminated cold cooked meat that had been supplied for school meals.

Schools were supplied with meats by John Tudor & Son under a contract with the Rhondda Cynon Taf, Bridgend, Caerphilly and Merthyr Tydfil County Borough Councils.

The process by which the contracts were awarded in 1998 and 2002 was seriously flawed in relation to food safety.

The arrangements for the joint contract were inadequate, with a particular lack of clear and agreed roles and responsibilities between the organisations and key individuals.

In addition, the system for contract monitoring was not operated properly and the system for recording complaints was seriously flawed.

In the unfortunate event that an outbreak of *E.coli* O157, or indeed any form of food poisoning, does occur, the critical issue then becomes the action taken to control it. I examined what was done to control the Outbreak and how quickly.

An Outbreak Control Team led by the National Public Health Service for Wales was formed as soon as the possibility of an outbreak was identified.

The Outbreak Control Team identified a common link between cases at a very early stage. They reacted quickly, which led to the early removal of cooked meats from the food chain. It also resulted in some cooked meats infected with *E.coli* O157 being recovered from schools before they could be consumed.

The Outbreak Control Team involved staff from the National Public Health Service for Wales, from different departments in local authorities, from Local Health Boards and health services, and the Foods Standards Agency. They put in considerable time and effort to tackle the Outbreak, including extra hours and out-of-hours working.

Environmental Health Officers in particular did a huge amount of work in tracking down, interviewing and advising people caught up in the Outbreak while many other local authority personnel, including schools, cleaning and catering staff, were also involved in action to control it.

Some difficulties were experienced in communications and with the availability of hand washing facilities in some schools. Fortunately, these do not appear to have had any adverse effects on the control of the outbreak .

In-patient hospital care was as effective as it could be in the face of an infection that produces severe complications.

My overall conclusion is that Outbreak control was done well. I am in no doubt that, but for the quality of the analysis and the control measures taken, the Outbreak would have been considerably more severe and prolonged.

Having said that, the aim must be to prevent an outbreak of *E.coli* O157 from happening in the first place.

And with that in mind, I now turn now to my what I believe needs to be done to help prevent such an outbreak from happening again.

E.coli O157 is not going to go away. There is no room for complacency. Outbreaks due to food sources, fortunately much smaller ones, have occurred elsewhere in the UK since the Outbreak here in South Wales. But the target must be zero outbreaks from food.

I had hoped that the lessons from the shocking events in Scotland in 1996 would stay in people's minds but some ten years after leading a review into that outbreak, I have found myself looking at issues that are, disappointingly, all too familiar.

A comparison of the failures that led to this Outbreak in South Wales with those in the outbreak in Scotland shows that some lessons have either not been learned or perhaps been learned and forgotten over time.

In looking to the future, the first point I will make is a broad one but it is particularly important as it sets the context for my recommendations. The food safety regulations that were in force at the time of the Outbreak, particularly the application of the HACCP approach, were relatively modern. In my opinion, if implemented correctly, they were sufficient to prevent an Outbreak.

My recommendations therefore reflect what I believe needs to be improved, tightened up or reinforced.

I have made twenty four recommendations. I am not going to run through them one by one but will highlight the key ones. All recommendations are listed in the summary document. My full report also provides a commentary on each.

I'll start with businesses because that is where the prime responsibility for safe food lies.

All food businesses must ensure that their systems and procedures are capable of preventing contamination or cross-contamination with *E.coli* O157. The outbreak should be a lesson for all. *E.coli* O157 is a real threat. There is no room for complacency. It will exploit weaknesses and failures in hygiene practices be they down to a lack of knowledge, to sloppiness, or even downright indifference to the risk.

If a business's systems and procedures can prevent *E.coli* O157 from causing infection, then they can be expected to prevent most other forms of food poisoning as well.

Food businesses must get to grip with food safety management based very clearly on HACCP principles ensuring it is a core part of the way they run their business. It isn't rocket science. The current situation, with problems with the take-up and implementation of the HACCP approach, is unacceptable. It is not bureaucracy or red tape but is the basis for producing safe food. I believe that HACCP it is at the heart of effective food safety management. More needs to be done to ensure that food businesses have an effective system.

I am recommending that additional resources be made available to ensure that all food businesses in Wales

understand and use the HACCP approach and have in place an effective food safety management system that is embedded in their working practice. This does not in any way change the responsibility for food safety. Food businesses are responsible for producing safe food.

But the assistance should help to achieve increased compliance with food hygiene requirements and reduce food safety risks to consumers. This is particularly important for smaller businesses and high-risk businesses. It will supplement and reinforce the advice that can be delivered during inspection visits, and will help strengthen the basis for the robust enforcement of food hygiene regulations.

The majority of businesses co-operate fully with inspectors to ensure they comply with requirements. But as we have seen, that is not always the case. My recommendations therefore reflect the need to improve inspection practices.

I have made a number of recommendations relating to the assessment of HACCP plans, including the development of accredited training provision for all those who check HACCP and HACCP-based plans, and for those who oversee the work of staff performing those checks.

My recommendations on unannounced visits and discussion with employees during inspections reflect the need to reinforce the importance of what should be standard practice anyway. But it must happen.

Decisions about confidence in the management of food businesses must be based on evidence, which in turn is generated by discussion with employees, managers and proprietors. Issues and concerns must be logged so that they are not lost when inspections are undertaken by different officers. Such action will help to build an intelligent picture over time of a business's track record on food hygiene practice and compliance. It will provide more evidence and a strong basis for enforcement action to be taken where necessary.

As a general point, regulatory and enforcement bodies should keep the choice of 'light touch' enforcement for individual businesses under constant review. "Light touch" enforcement based purely on the size of a business is wrong.

A "light touch" enforcement regime, which includes advice and education, has its place. But its limitations must be recognised and it should not be allowed simply to roll on

without a suitable point being reached at which formal and robust enforcement action is taken.

Authorities must come down hard on businesses that present serious risks to health and those that persistently fail to comply with food hygiene and food safety requirements.

I have noted that changes that have been made since the Outbreak and as a result of issues that came to light during the Inquiry's oral hearings.

In terms of food procurement practice, the Outbreak is said to have been the most significant driver of change.

The four authorities involved have made substantial changes to their procurement systems and procedures. The changes include provision for the independent audit of businesses supplying high-risk foods. I am aware of several public bodies that already do this through the system developed by the 'Value Wales' initiative, which includes arrangements for sharing information between organisations. However, I am recommending that all businesses contracting with public bodies for the supply of high-risk foods such as raw and cooked meats must be subject to independent food hygiene audits.

In publishing my report today, my task has finished. But I will watch with interest what is done in terms of implementing the recommendations and, most importantly, ensuring that not only are the lessons learned from the Outbreak, but that they are not forgotten. I know that this is of considerable importance to those caught up in the Outbreak.

The recommendations will take time to implement, some longer than others. I am asking the National Assembly for Wales to monitor and report progress on implementation.

Organisations involved in the Inquiry have put in place a range of developments since the Outbreak and during the course of the Inquiry. But *E.coli* O157 has no boundaries and I want to ensure that lessons are learned.

My Inquiry was limited to four local authorities but the issues it has raised are as relevant to the other eighteen authorities in Wales. I am therefore asking all local authorities in Wales to review their policies, procedures and systems against issues raised in my report. The Welsh Assembly Government and the Food Standards Agency, working with the local authorities and other interested parties, should co-ordinate the reviews to ensure a uniform approach and standard of

review. Local authorities should make public the results of the reviews and details of any action that needs to be taken.

Such reviews should consider not only weaknesses and failures identified in my report but also what worked well.

My Inquiry has been limited to Wales but I am well aware of the level of interest from elsewhere in the UK and beyond. Wales' public health system is strong and is a very solid foundation for strengthening the food safety element which, although sometimes taken for granted, is an important part of wider action to protect people's health. It offers an opportunity to make Wales a model for others to follow.

Outbreaks of *E.coli* O157 can be powerful in terms of learning lessons but their rarity and the passage of time reduces this power.

Mindful of the need for further development and to ensure lessons learned are not forgotten, I am recommending that a substantial review of food hygiene enforcement in Wales should take place in approximately five years time.

The review, which should not be a public inquiry, should help to maintain consistently high standards in the delivery of what

are important public services. Most importantly, it will help ensure that the lessons to emerge from the Outbreak are not forgotten.

We owe it to the memory of Mason Jones to learn the lessons from this Outbreak and to remember them.

Ladies and gentlemen, thank you very much.