

## **E.coli Public Inquiry**

**Chair: Professor Hugh Pennington**

### **NOTE OF EMERGING ISSUES**

#### **Introduction**

1. The first phase of the Inquiry required me to enquire into the circumstances that led to the outbreak of *E.coli* O157 in South Wales in September 2005. That phase is now substantially completed although, as I said at the oral closing submissions hearing on 14 May 2008, the Inquiry is seeking further material relating to the performance and functions of the Meat Hygiene Service. That material has only recently been provided; when it has been considered by the Inquiry Team, however, a short further hearing may be required to deal with it. Subject to that, however, the Inquiry is now in its second phase which requires me to consider the implications for the future and to make recommendations accordingly.
2. The purpose of this Note is to identify the salient issues that have emerged during the course of Phase 1 of the Inquiry and in relation to which I shall consider whether to make recommendations. I emphasise, however, that this Note is not, nor is it intended to be, an indication of what my findings will be on the evidence that has been presented to the Inquiry.
3. The Note serves two purposes. First, it identifies various matters on which I am asking the Core Participants to provide me with comprehensive and up-to-date information about how systems and procedures may have changed since the outbreak. Secondly, however, I also intend to seek the views of others who were not Core Participants but who have expressed an interest in

contributing to the Inquiry's work. Accordingly, this Note is also intended to assist them, and indeed anybody else who feels they have any information relevant to my terms of reference, to focus on topics of particular interest to me in terms of possible recommendations.

## **Inspections**

4. The Inquiry would welcome from Bridgend County Borough Council a full factual description of the current policies, practices and procedures governing the inspection of food business premises such as those that were operated by John Tudor & Son. It would be helpful if this description could specifically highlight significant changes since the outbreak, and indicate when these changes were made.
  
5. The issues of particular interest to the Inquiry in relation to the current systems and practices are as follows:
  - 5.1. What system exists for ensuring that the inspectors are kept up-to-date with all relevant regulations, guidance, codes, best practice etc?
  
  - 5.2. What systems are in place to ensure that inspectors (a) are properly trained, and (b) demonstrate and continue to demonstrate competence?
  
  - 5.3. What system exists within the Public Protection Department for flagging issues of significance or concern about an inspected business?

5.4. What checks are carried out by inspectors before an inspection? In particular, what guidance is given as to the nature of such checks, including in particular how far back in the inspection history they should check prior to making an inspection?

5.5. What guidance and/or direction is now given, and what practices are followed, in deciding whether an inspection should be announced or unannounced?

5.6. What steps or practices are followed to ensure that the Inspector has the best chance of discovering (a) how the business in fact operates in relation to food safety, and what practices are in fact followed by it in that respect, and (b) cases in which records are being falsified? In particular:

5.6.1. What guidance is given about the structure of, and approach to be adopted by inspectors towards, inspections? Is the guidance that is now given sufficiently detailed and clear to provide a practical working guide?

5.6.2. What guidance is given about particular warning signs that might need to be looked out for?

5.6.3. To what extent do inspectors talk, in addition to management, to staff (in particular staff responsible for critical parts of the business's

Hazard Analysis Critical Control Point Plan  
("HACCP"))?

- 5.6.4. More generally, is an audit style approach operated – if so, what does it entail; if not, why not?
- 5.7. What system of oversight and checking of the work of inspectors is in place to ensure that inspectors are correctly, competently and effectively performing their functions? Put another way, how does management ensure that quality and consistency of inspections is being achieved and that key messages and techniques are in the minds of and operated by the inspectors on the ground?
6. In relation to HACCP plans:
  - 6.1. What steps are taken by inspectors to validate a food business operator's HACCP plan – ie to ensure that it is effective as a plan?
  - 6.2. What steps are taken by inspectors to verify the HACCP plan – ie to ensure that it is being properly followed in practice?
  - 6.3. To what extent is the HACCP plan used as the basis or cornerstone of inspections?
  - 6.4. What training is in place to ensure that inspectors properly and clearly understand both HACCP and how effectively to check that

HACCP is being operated properly with a butchers' business such as Tudors?

- 6.5. What guidance is given to inspectors on those issues?
7. The issues in paragraphs 4 to 6 are primarily factual. They relate principally to Bridgend but, given that guidance and direction exists above the local authority level, they also relate to others such as the Food Standards Agency ("FSA"). However, it may be that others have views on how those issues should be approached, on the guidance available, and on any developments relating to it. If so, their views would be welcomed.

### **Use of equipment**

8. There is an issue of obvious importance in relation to the use of vac-packers to pack both raw and cooked meats. In relation to this issue, the following principal issues have emerged. Views on them (in addition to any submissions already directed to that issue) would be welcomed:
- 8.1. Is it appropriate ever to use a single machine to pack both raw and cooked meats in view of the obvious risks of cross-contamination?
- 8.2. If it is or may be appropriate to do so, (a) in what circumstances, (b) what sort of safeguards would need to be in place to ensure microbiological cleanliness and to avoid the risk of cross-contamination, and (c) how could such safeguards be effectively checked during the course of an inspection?

- 8.3. Is the current guidance on the use of vac-packers in a butchers' business (a) acceptable, and (b) sufficiently clear?

### **Other issues relating to inspection**

9. The Inquiry is interested more generally in views on whether, and if so in what ways, the current Codes of Practice applicable to inspections and regulation of premises such as John Tudor & Son are being, or could be, improved or clarified. The Inquiry is interested in current or planned developments relevant to the enforcement of food safety/food hygiene standards and significant initiatives that have been shown to improve food hygiene practice.

### **FSA audits**

10. The role of the FSA in auditing the inspection function has been examined in the context of its inspection of Bridgend in 2004. As to that area, the Inquiry would welcome from the FSA information about the following:
- 10.1. What is the current approach to the structure and performance of such audits?
- 10.2. To what extent have there been significant changes in either structure or performance since 2005?
- 10.3. Are there currently funding issues potentially affecting the effectiveness of FSA's auditing function?

11. Again, views would be welcomed in relation to the broader issues as to how most effectively such audits could be carried out, any changes that have already been made, and any planned changes.

## **Procurement**

12. The Inquiry would welcome a full factual description, if possible agreed between the four Core Participant local authorities in the Inquiry, of the current systems and practices in place concerning the procurement of meat.
13. The issues of particular interest to the Inquiry in relation to the current systems and practices are as follows:
  - 13.1. What is the current national guidance in relation to due diligence in relation to potential suppliers and monitoring of contracted suppliers of meat? What is the status of any such guidance?
  - 13.2. What are the current arrangements for joint working between the local authorities concerned? In particular, are the roles and responsibilities of each clearly defined and understood?
  - 13.3. What systems are in place for sharing information about food safety issues relating to suppliers between the authorities concerned or those authorities and other authorities with responsibilities relating to food safety?

- 13.4. How is food safety and food quality of meat provided by suppliers ensured? In particular:
  - 13.4.1 What steps are taken to assess these issues as part of decision making about potential suppliers;
  - 13.4.2. What steps are taken to monitor and resolve those issues during a contract?
  - 13.4.3. To what extent are third parties and experts involved in those processes; and should there be greater involvement of experts?
14. What is the system for recording and escalating complaints relating to a supplier? Does that system now involve a requirement to record all complaints? How are complaints fed into the processes of (a) monitoring the contract, and (b) making decisions about extension or renewal of contracts?
15. The Inquiry would welcome any comment by the authorities concerned or anyone else as to desirable elements in any system of collaborative procurement of safe food.

### **The Meat Hygiene Service**

16. As noted in my introductory comments, the issues relating to the Meat Hygiene Service ("MHS") will be subject to review once the Inquiry Team has considered the further information recently provided.

17. In what ways are the MHS's current systems, practices and procedures governing inspections, monitoring and enforcement of slaughterhouses such as J E Tudor & Sons Limited materially different from those in place in September 2005? The Inquiry is also interested in receiving information on changes and developments that are presently being planned or under consideration.
18. Is the Hygiene Assessment System ("HAS") an effective way in principle of monitoring performance? To what extent is the operation of that system in such slaughterhouses now different?
19. In relation to enforcement and, specifically, the escalation of enforcement action:
  - 19.1. What level of tolerance or leeway is currently shown to operators?
  - 19.2. To what extent is formal action currently taken and escalated?
  - 19.3. To what extent is more senior management involved in making decisions about operators who appear to have consistent compliance problems?
  - 19.4. What are the practical difficulties or problems that are encountered in relation to enforcement as a means of ensuring compliance with the current legislative regime ?

20. What are the current mechanisms in place for senior management to ensure that those responsible for day to day monitoring are acting effectively and (particularly in circumstances in which there are different personnel involved on the ground) consistently?
21. What is the current system for auditing the MHS's performance - whether internal or external; and is that system working effectively as a trigger for change?

### **Outbreak control**

22. Has the Welsh Assembly Government approved the draft *Model Plan for the Management of Communicable Disease Outbreaks in Wales*?
23. Dr Lowe informed the Inquiry that she had been appointed as Chair of the Welsh Generic Communicable Disease Outbreak Plan Task and Finish Group, with a mandate to work towards the combination of existing outbreak plans? What stage has the Group reached? The Inquiry would welcome further information from the National Public Health Service ("NPHS") and/or the Welsh Assembly Government regarding the current position of any combined Plan that now applies in Wales, its status, any developments and improvements that have been made since the outbreak, and the anticipated benefits of those.
24. What, if any, improvements could be made to the composition or structure of the Outbreak Control Team, or its workings, particularly in relation to outbreaks that cover more than one area?

25. What are the current procedures for disseminating information in the first phases of a suspected or declared outbreak? In particular, are there sufficiently effective and robust systems in place for ensuring that the necessary information reaches those who need to have it – or could the current system be improved? What has been learnt as a result of the 2005 outbreak in South Wales in terms of the approach to disseminating information and providing advice to: (i) the public generally; (ii) people who are infected or who are suspected of being infected; (iii) parents or carers if appropriate; and (iv) organisations who may be involved, including schools. How has the experience informed and/or changed plans and protocols for controlling outbreaks?
26. What contact information is held by the NPHS in respect of Local Health Boards (“LHB”) in the event of an outbreak that occurs out-of-hours? Does the NPHS hold contact details for personnel in all LHBs or is a rota system still in operation with a single LHB contact point?
27. The Inquiry would welcome a factual description, if possible agreed between the five Core Participant LHBs in the Inquiry, of (a) the current systems and procedures in place to ensure that LHBs can be readily contacted in the event of an outbreak, and (b) the current status of their ‘on-call’ system.
28. The Inquiry would also welcome information from the participating LHBs regarding their current role in disseminating information in the event of an outbreak, and in particular: (i) the systems and procedures currently in place for disseminating information; (ii) the role, if any, that the Business Services Centre has in disseminating information; (iii) the use of ‘safe haven’ facsimile messages and/or emails to communicate urgently with

General Practitioners, and (iv) the means of ensuring that information is imparted effectively to others 'on the ground' who need to receive it.

29. In evidence, Dr Lowe referred to a Public Health Alert system operated by the Welsh Assembly Government, to which the NPHS had no access. Is this still the case?
30. Dr Lowe also stated in her evidence that a system operable 24 hours a day 7 days a week, allowing information to be sent to those who would need to know in the event of an outbreak, would be helpful, as would a means of checking that recipients had received the information. She indicated that the Welsh Assembly Government's E.coli Specialist Task and Finish Steering Group were investigating the feasibility of such a system. The Inquiry would welcome further information from the NPHS and/or the Assembly Government about the work of the Group and as to when such a system (if any) might be operational.
31. The NPHS recommended that the Welsh Assembly Government re-establish the Communicable Disease Control Committee. The Inquiry would welcome further information from the NPHS and/or the Assembly Government regarding the current status of that recommendation.
32. In relation to the three hospitals and two out-of-hours service-providers involved with the patient cases selected by the Inquiry for individual consideration, the Inquiry would welcome information about the current policies, practices and procedures that are in place for disseminating information about public health incidents (such as the *E.coli* outbreak) to staff who are dealing with patients. In each case the information provided

should also indicate whether - and, if so, in what way - the approach taken by those bodies has altered since 2005.

33. To the extent not already specifically covered by the above, the Inquiry would also welcome information from the NPHS, the LHBs and the health service providers who were involved with the 2005 outbreak and the Welsh Assembly Government about the policies, practices and procedures that are currently in place for disseminating information about public health incidents to staff dealing with patients in primary care units, hospitals and via out-of-hours services. In each case the information provided should also indicate whether - and, if so, in what way - the approach taken by those bodies has altered since the outbreak.

#### **Chief Medical Officer's Review**

34. The Inquiry would welcome from the Welsh Assembly Government full and up-to-date information about the action that has been taken to implement each of the recommendations made in the Chief Medical Officer's Review and what has been achieved as a result. The information should include any evaluation that has been undertaken, is being undertaken, or is planned.

#### **Schools**

35. The Inquiry would welcome information from the four participating local authorities about the current practices and procedures in place to ensure that toilets in schools are as hygienic as possible; and that the best hygienic practices are observed.

36. The local authority witnesses referred in their evidence to a rolling programme of refurbishments within school premises, more particularly school toilets. The Inquiry would like an update as to the progress that has been made with the refurbishment programme and how it is intended to continue with it in future.
37. Are there any schools in Bridgend, Caerphilly, Merthyr Tydfil or RCT that still do not have the benefit of hot running water in pupils' toilets. If there are, why is that? When is it expected that the situation will be rectified?
38. Audits of the toilet facilities were carried out in many schools following the outbreak. Do such audits continue to take place and, if so, at what intervals are they undertaken? How, if at all, do they feed in to the local authorities' policy relating to improving and maintaining the standards of school toilets?
39. Is comprehensive training and guidance given to caretaking and/or cleaning staff at all schools within the areas affected by the outbreak or only those who contract with the authorities' contractors?

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