

DNV

# The Role and Responsibilities of the MHS in Animal Disease Outbreaks:

Report for DEFRA and the FSA  
Report No: 22322672

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**The Role and Responsibilities of the MHS in Animal  
Disease Outbreaks**

for

DEFRA and the Food Standards Agency

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## Executive Summary

This document contains a review of the roles and responsibilities of the Meat Hygiene Service (MHS) in Animal Disease outbreaks. The reference case for this study is the Highly Pathogenic Avian Influenza (HPAI) outbreak at Holton, Suffolk in February 2007.

This outbreak was one of the first real tests of the Defra Framework Response Plan for Exotic Animal Diseases with an exotic zoonotic disease. The HPAI outbreak was contained to a single turkey finishing unit. The contingency plan was put into effect immediately and there were no additional outbreaks or human infections. This is a clear demonstration of the success of the contingency planning process.

There were a number of special features about the outbreak that required close co-operation between the various government departments and agencies involved and resulted in a bigger role for the Food Standards Agency (FSA) and MHS than would be normal in animal disease outbreaks.

MHS staff members are clear about their roles and responsibilities. However during the outbreak there was some uncertainty, from 3<sup>rd</sup> parties, about the role of the MHS in two key areas:

- Designation - What the MHS role was is the designation process.
- Enforcement - On what grounds the MHS were able to initiate prosecutions.

Difficulties in establishing early, high level contact between Defra and FSA have coloured the perception of communications throughout the outbreak. However, the MHS were at the ground level of the chain of communications and local contacts and communication between the Local Disease Control Centre, Animal Health and MHS representatives worked smoothly with no reported major problems.

The communication issues raised show that more time should have been invested in building relationships and communication channels at a high level between the different organisations before the outbreak.

A series of specific observations have been made in this report, they can be seen in Section 5.

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## 1. Introduction

An outbreak of highly pathogenic avian influenza was confirmed at a Bernard Matthews turkey farm at Holton in Suffolk in early February 2007. The outbreak was successfully contained to the one site and there were no human infections. However, the outbreak generated significant media interest and had a number of unusual features that required close co-operation between the various government departments and agencies involved.

One special feature of the location was that there were slaughter, processing and cutting plants adjacent to the farm where the outbreak occurred. This led to an enhanced role and engagement for both the Food Standards Agency (FSA) and the Meat Hygiene Service (MHS) in what was essentially an animal disease outbreak. As part of the overall incident review process within both Defra and the FSA it was felt that an independent review of the roles and responsibilities of the MHS, in such incidents, would provide helpful input into the contingency planning process. As a result Det Norske Veritas (DNV) was commissioned to carry out this review.

The terms of reference of the study are to:

- identify the roles and responsibilities of the Meat Hygiene Service (MHS) where the MHS is carrying out activities on behalf of both the FSA and Defra. To explore how these operate both in normal periods and during an animal disease outbreak, with a particular emphasis on mechanisms for reporting and communicating;
- identify how the animal disease enforcement activities of the MHS relate to others' responsibilities (e.g. Health Protection Agency, Animal Health and Local Authorities); and
- make recommendations on improving lines of accountability, communication, and co-ordination when the MHS is delivering animal health requirements, including liaison between FSA and Defra.

The study is intended to be a short, high-level review. It has been based primarily on interviews with the key players in the various organisations involved. It is not intended to be a detailed, evidence based, investigation of the Holton outbreak.

## 2. Overview of MHS Role

The Meat Hygiene Service (MHS) is an Executive Agency of the Food Standards Agency (FSA). The MHS are responsible for the protection of public health and animal welfare in approved meat premises in Great Britain, through proportionate enforcement of legislation.

### 2.1 MHS Day To Day Operations

The work of the MHS at slaughterhouses places them at the point of a transition between animal issues (as live animals arrive for slaughter) and food safety (as meat enters the food supply). Consequently, different work tasks are done on behalf of both FSA and Defra, as well as Local Authorities and some other organisations. This fact that the MHS can have a number of masters can lead to some perceived confusion in roles and responsibilities.

The MHS functions are carried out by the Official Veterinarian (OV) and Meat Hygiene Inspectors (MHIs) at each meat plant.

The main functions carried out by the MHS in meat premises are summarised below, grouped by the agency with prime policy responsibility.

#### *Functions carried out on behalf of the FSA:*

<i>Post Mortem Meat inspection</i>	Every carcass is inspected to ensure fitness for human consumption.
<i>Hygiene at Slaughter and Cutting</i>	The MHS team is responsible for ensuring that the slaughter and dressing process is conducted by the Food Business Operator (FBO) in accordance with the legislative requirements. This includes attention to temperature controls, working practices, and the general upkeep (cleaning and maintenance) of the premises.
<i>Health Marking</i>	The OV is responsible for the application of the Health Mark. This stamp is applied to carcasses produced in approved premises in accordance with the regulations, under veterinary supervision. It is an internationally-recognised symbol indicating that the meat has been inspected and passed as fit for sale for human consumption.
<i>Enforcement of food hygiene regulations</i>	If meat is not produced in accordance with the relevant regulations, MHS staff takes proportionate enforcement action, which may include informal action, serving notices, making recommendations for prosecution or suspension / revocation of approval. When carrying out any enforcement activity the MHS acts in accordance with the MHS Enforcement Policy and the Government's Enforcement Concordat.
<i>Auditing</i>	In a slaughterhouse, an OV is present on an on-going basis to carry out inspections and other duties. In other meat plants, such as cutting plants or wild game plants, the OV is only required to audit on an occasional basis. The frequency and duration of audits are determined by the type of plant and a formal risk assessment process that is set out in the Manual of Official Controls (MOC). The minimum audit frequency can range from 2 to 12 months.

*Functions carried out on behalf of Defra:*

*Ante-mortem inspection*

A key role of the OV is the ante-mortem inspection of all animals presented for slaughter. This puts the OV in a unique position for disease surveillance, and an important aspect of the ante-mortem inspection is the identification of any zoonotic or notifiable diseases.

MHS staff members have a duty to report any suspect case of a notifiable disease to Animal Health (AH). The OV must then follow the instructions given by AH.

*Animal Health and Welfare in Approved Meat Premises*

The monitoring of the actual slaughter process itself enables the MHS team to ensure that welfare at slaughter is maintained to the highest standards. Checks are made on the positioning of stunning equipment, the effectiveness of the stun, and the efficiency of bleeding, so that the risk of any animal suffering during the process is minimised. The MHS licences slaughterers and enforces legislation relating to animal welfare at slaughter on behalf of the Defra and the devolved administrations in Wales and Scotland.

*Animal By-Products and Controls for Specified Risk Material*

MHS staff check on the appropriate disposal by the FBO of animal by-products, to ensure that they are stained, stored, and despatched according to the relevant legislation. Animal by-products include parts of the carcass that are not intended for human consumption (such as skin or feathers) or have been rejected as unfit by the MHS team. By-products are categorised broadly according to the degree of risk they could present to human and animal health, and are used or disposed of accordingly.

Particular attention is paid to the removal, staining and disposal of Specified Risk Material (SRM) - those parts of cattle and sheep that are most likely to contain Transmissible Spongiform Encephalopathy (TSE) infectivity. The policy responsibility for SRM controls is split between FSA (public health) and Defra (animal health).

*Sampling (e.g. Supervision of TSE testing)*

The MHS is well placed to facilitate testing and surveillance on behalf of other Government departments and agencies. It conducts this work under formal Service Level Agreements. Work currently being undertaken includes collection of samples for statutory veterinary medicines residue testing, on behalf of the Veterinary Medicines Directorate (VMD), and the collection of samples for TSE testing, on behalf of Defra.

*Animal Identification*

MHS staff in red meat abattoirs check cattle passports and ear tags to ensure that animals presented for slaughter for human consumption have been correctly identified. Pre-slaughter checks are the responsibility of the FBO. Cattle passports are stamped by MHS staff and sent to the British Cattle Movement Service (BCMS), where details of the animal are entered onto the Cattle Tracing System (CTS).

## 2.2 MHS Role in Outbreaks

In case of an outbreak, such as an AI incident, the role of the MHS is enlarged and fits in with national contingency planning. The aspects to this are discussed below and are outlined in more detail in the Manual for Official Control (MOC).

### *Slaughterhouse Designation*

In the event of an outbreak of HPAI, slaughterhouses need to be designated by the Divisional Veterinary Manager (DVM), the local veterinary lead for Animal Health, before they can receive or process poultry originating from premises within a Protection Zone (PZ), Surveillance Zone (SZ) or Restriction Zone (RZ). This also applies to a slaughterhouse located within a PZ. The application for designation is made by the FBO but the MHS OV must carry out an inspection and complete part of the form.

### *Verification*

The MHS must be present at all times when slaughtering in a designated slaughterhouse. The OV must verify with AH that the slaughterhouse is designated before releasing birds for slaughter and verify that the FBO is complying with all the conditions of the designation.

The OV or MHI must inspect the Movement Licence of all birds arriving at the slaughterhouse to ensure that everything is in order and any special conditions are met. The Local Authority is the enforcing authority for movement controls and any non compliance must be reported to the Trading Standards Department.

### *Cleaning and Disinfection (C&D)*

Additional MHS checks are required to verify compliance with the C&D conditions attached to the Licences. 100% checks are required of the C&D of crates, modules and vehicles used to transport birds from a PZ. Where C&D is not satisfactory, the MHS must serve a notice on the person in charge of the vehicle and report the incident to the Local Authority.

### *Bio Security*

MHS maintain on the ground oversight of bio security arrangements for the slaughter and cutting facilities for both public health and animal welfare reasons.

Further production process plant (cooking) falls under the jurisdiction of local trading standards officials.

### *Information Requests*

In an outbreak MHS will assist in dealing with requests for information.

The MHS will also supply information to assist investigations.

### 3. The Holton Outbreak

An outbreak of avian influenza (AI) was suspected and reported on the Bernard Matthews turkey finishing farm at Holton in north Suffolk on the 1<sup>st</sup> February 2007, following a high mortality rate in one of 24 sheds (2 were not stocked).

On Friday 2<sup>nd</sup> February, initial results of laboratory tests indicated the presence of the Influenza A virus, and on the following day, Saturday 3<sup>rd</sup> February, the presence of highly pathogenic (HP) H5N1 AI virus was confirmed. The statutorily required Protection Zone (PZ), Surveillance Zone (SZ) and Restriction Zone (RZ) were put in place immediately and the National Disease Control Centre (NDCC) and Local Disease Control Centre (LDCC) were established.

In the UK farms and processing facilities are generally located at physically separated sites. An unusual aspect of the outbreak site was that there was a turkey slaughter plant, cutting plant and processing facility immediately adjacent to the turkey finishing unit. The whole site is owned by Bernard Matthews and based on a large disused airfield. The processing facilities can be seen in the aerial photograph below. Although under the same ownership, the turkey finishing unit and processing facilities are two separate sites, employ different staff, are managed separately and have separate entrances. It is thought that there are only one or two comparable sites in the UK.



**Figure 1: Aerial Photograph of Processing Facilities and Poultry Sheds at the Holton Site**

The proximity of the slaughter plant gave the option of using this facility to cull the non-clinically affected birds and so significantly reduce the time required to complete the cull. This decision was taken on Saturday 3<sup>rd</sup> February and the cull started that day and was completed on the evening of 5<sup>th</sup> February. It should be noted that the affected birds had already been culled by Bernard Matthews.

On the 8<sup>th</sup> February, further results of laboratory tests on the virus indicated that the AI virus found in Suffolk may be identical to the virus in recent outbreaks in Hungary. It was subsequently confirmed that the strain of the virus in Suffolk is a 99.96% match to one found in Hungary. Immediately following this finding an investigation, led by the FSA, was set up to check the source of turkey meat imported by Bernard Matthews from Hungary for processing at the Holton plant, and especially whether any had originated from the restricted zone in Hungary. This report was published on the 15<sup>th</sup> February and found no evidence that product received at the Holton premises during the risk period had originated from farms within the Hungarian restricted areas.

The Surveillance and Restricted Zones were lifted by Defra on the 12<sup>th</sup> March and specific disease control measures were removed.

#### 4. Critical Events of Holton AI Outbreak

This section contains an outline of critical events which occurred during the Holton outbreak. This is not intended as an exact timeline, events and themes have been grouped in order to facilitate the discussion of findings.

*[n] The top section of the page contains observations.*



The bottom section of the page contains a concise description of the event and the significant aspects in play at that time.

The synopsis of these critical events has been developed based on a series of 18 interviews with representatives from Defra, FSA, MHS and Animal Health who have had involvement in the Holton outbreak. Interviews were a mixture of face-to-face meetings and telephone conference calls. Without exception interviewees gave full and constructive comments.

*[i] Emergency contact information for all key contacts should be reviewed on a routine basis and a robust system is needed to ensure that communication process works properly in future.*

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## 1. Incident Reported

On Wednesday 31<sup>st</sup> January, the high number of bird deaths in Shed 10 is acted upon by the company vet and reported to the local Animal Health office on Thursday 1<sup>st</sup> February.

In Defra the details on the ND1 reporting form indicated the potential for an AI outbreak and a warning was issued on Thursday 1<sup>st</sup> February.

Restrictions were put in place on the farm, laboratory tests initiated and the diseased animals were culled in situ. The cull of the diseased animals was initiated and carried out under the control of Bernard Matthews staff.

## 2. Disease Confirmed

On Friday 2<sup>nd</sup> February lab tests confirmed Avian Influenza and the response plan was set in motion.

The Amber alert teleconference was called at 21:00 in the evening of Friday 2<sup>nd</sup> February. The FSA would not normally have been a party to this call, but Defra had wanted to include them on this occasion.

Defra and the FSA did not communicate effectively at this time and these difficulties in establishing early, high level contact have coloured the perception of communications throughout the outbreak.

The following day, Saturday 3<sup>rd</sup>, the presence of highly pathogenic (HP) Avian Influenza virus subtype H5N1 of the Asian type was confirmed.

This subtype can cause illness and death in humans and, is identified as a possible human pandemic disease if the virus were to mutate and be transmissible between humans.

*[ii]. Key features of the site and environs should be established and communicated by Animal Health at an early stage in the response process.*

*[iii] Explicitly considering the roles of other organisations in potential scenarios would improve contingency planning and aid preparedness for future events.*

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### 3. Initial Response (NDCC/LDCC)

Following the planned contingency response the National and Local Disease Control Centres (NDCC/LDCC) were set up.

The statutorily required area restrictions were established:

- Protection Zone (PZ), 3 km around site
- Surveillance Zone (SZ) 10km around site
- Restricted Zone (RZ) E Suffolk & SE Norfolk

At this early stage there appears to have been some lack of clarity as to the full nature of the Holton site, and some officials and Ministers did not appreciate the scale of the Bernard Matthews operation and that the adjacent industrial unit was in fact a slaughter plant. This set the tone for many of the subsequent communications difficulties.

Within the Defra contingency plan there are few references to the Food Standards Agency and none to the Meat Hygiene Service. Thus the MHS may not have been involved or informed of all issues.

*[iv] Significant deviations from the planned procedure (an improvised action) should be subject to a risk assessment. This should have two key considerations. Firstly the contingencies that are needed to be in place if the improvised action fails, and secondly how the transition from the end of the improvised action to the established procedure is controlled.*

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## 4. Use of the Slaughterhouse for Culling

Animal health has a well established and flexible approach for controlling AI outbreaks. In this case the expected method was to cull the birds on site using containerised gassing units. In the event these were geared up but never used, as it was decided that it would be quicker to use the slaughterhouse facilities adjacent to the farm.

The decision to use the slaughterhouse for the cull was taken at the NDCC, with subsequent approval by the FSA. Under the new Hygiene Regulations it is no longer necessary to suspend the plant approval but the competent authority can impose conditions to be met prior to re-starting production. The Veterinary Directors of the FSA and MHS conferred to verify that they had the necessary powers, to consider public health implications and what would need to be done to restart the plant for food production. Agreement on the use of the slaughterhouse happened rapidly on the morning of Saturday 3<sup>rd</sup> February and the cull commenced later the same day. 159 thousand birds are culled over two days with the cull being completed on Monday 5<sup>th</sup> February.

This eventuality had not been pre-planned, although the scenario of using slaughterhouses for disease control was not un-imaginable. Indeed there was some experience of using slaughterhouses for welfare culling (rather than disease control purposes) during the 2001 FMD outbreak.

The decision to use the slaughterhouse had some important implications:

- The boundary fence was taken down to give direct access to the slaughterhouse from the farm. So, whilst a 'clean path' was established, the physical separation of the sites was removed giving the potential to add to the confusion concerning the physical nature of the site.
- The decision process may be commended for speed but it would seem that there was no formal consideration given to the subsequent operational consequences, risks and actions that would need to follow from this decision.
- The section of the slaughterhouse used for the cull became subject of a restriction notice.

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## 5. Investigations Initiated

As part of the National Emergency Epidemiology Group (NEEG) investigation a team of Ornithologists visited the area for an investigatory visit on the 3<sup>rd</sup> February and then the site together with a field epidemiologist on Tuesday 6<sup>th</sup> February. The findings from these visits included:

1. The discovery of a wrapper indicating that meat products have been brought to the processing plant from Hungary, the source of a recent AI outbreak.
2. Pictures of waste bins that are accessible to gulls.
3. The time period of the outbreak did not coincide with a period of significant wild bird migration.

These three indicators pointed to an infection pathway from Hungary.

Suddenly this was no longer purely an animal health related outbreak, but had potential implications for the human food chain.

This development put the FSA in the spotlight to give appropriate advice about the food safety dimension to the event.

## 6. Birdtable

The use of the 'Birdtable' in the response to the outbreak worked well. This was the first occasion that people had phoned into birdtables so coverage was geographically diverse.

Ministers sat in on some NDCC Birdtable sessions, as they are explicitly entitled to do.

Attendance at Birdtable sessions exposes participants to speculation and unverified evidence. It is possible that through this forum Ministers and Defra officials picked up a partial picture of MHS responsibilities which contributed to misunderstanding of roles in the subsequent events.

*[v] All parties (Defra, FSA, MHS and the FBO) would have been better informed if official documentation was issued containing guidance of what would happen after the slaughterhouse had been used for culling.*

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## 7. Slaughterhouse Disinfection

Following the cull, cleaning and disinfection of the slaughterhouse was done by the FBO under supervision from AH. On the ground this happened relatively smoothly but took longer than expected. Following the standard procedure, MHS activities commenced after the cleaning and disinfection had been completed. The MHS conducted a pre-slaughter audit following a request in writing from FSA and as agreed when the decision to use the slaughterhouse was made. The cleaning and disinfection was then approved by both MHS and AH. Technically this means that, given a supply of birds, the slaughterhouse was ready to be operational again.

There was some pressure to get the slaughterhouse operational again. To minimise economic impact Defra guidelines allow for the resumption of operations as soon as appropriate C&D activity is complete. Understandably, at this point the FBO was keen to resume operations.

The FBO approached the MHS to discuss the restarting of operations; the disinfection was complete, a licence was in place and in the absence of any other official documentation there appeared to be little argument to prevent this happening. In fact, there was a restriction notice on the slaughterhouse based on it being a 'dangerous contact' premises rather than an infected site.

It seems that there was some confusion about process and terminology with discussions about re-licensing and designation. The licence was never altered, and designation is a different matter which is dealt with in the next section.

*[vi] Given that the designation process was in flux, time and effort could have been saved by maintaining the established procedure rather than attempting to change the process during an outbreak.*

*[vii] The MHS and Animal Health need to work together to build greater awareness of roles and to develop trust and confidence.*

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## 8. Designation

In the event of an outbreak of HPAI slaughterhouses need to be designated by the DVM before they can receive or process poultry originating from within a PZ, SZ or RZ. This also applies to slaughterhouses located within a zone subject to movement restrictions and wishing to receive poultry from an area free from disease control. In order to be designated, the slaughterhouse must meet a number of additional requirements over and above normal operating requirements, such as enhanced segregation and capacity for separation of birds in the lairage, during slaughter and chiller capacity for storage.

Before a slaughterhouse can receive birds from controlled zones, the designation must be activated by the OV confirming to the DVM that the slaughterhouse can comply with the conditions of the designation. For example, the FBO will need to have stocks of packaging bearing the special mark required for any poultry originating in a PZ.

The application for designation is completed by the FBO, but the OV is required to undertake an inspection and sign Part 4 of the Application for Designation form and attach the completed Inspection Report form.

It is possible to apply for designation before any outbreak occurs, but this had not been done by Bernard Matthews.

The designation process was under review by Animal Health and Defra at the time of the Holton outbreak. There was an agreed process in place which was understood by the MHS, but the pending process changes (to remove the OV from the process and simplify arrangements for FBOs) complicated matters. There was a lack of clear direction from Defra on what was wanted from the changed process.

The FBO made the application for designation when the cull had been completed, but this could not be approved by AH until the cleaning and disinfection had been completed and signed off by both AH and the MHS.

*[viii] Representatives from the different organisations should establish and test ways of working as a matter of routine. This will ensure that when an outbreak occurs the channels of communication are open and requests for information can be co-ordinated as far as possible.*

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## 9. Slaughterhouse Restarts

Once C&D had been completed AH approved designation and the slaughterhouse restarted on the 12<sup>th</sup> February.

The final step for restart was for AH to approve the movement of birds to the plant. The communications issues around the decision were not well planned and thought through. Senior management in the FSA and Defra ministers had reservations about this.

Questions from the press about the restart of the slaughterhouse put pressure on Ministers. There was confusion in Defra about whether FSA or AH had responsibility for the decision.

There was no scientific reason to enforce the shutdown of the cutting and processing plant and these restarted on Tuesday 6<sup>th</sup> February. However, this looked like a strange decision from the press point of view with potential contamination of the food chain running as a major issue.

## 10. Any Answers?

The Holton outbreak provoked a large amount of media interest. The media was waiting for the first 'killer flu' outbreak in UK and this combined with the high profile brand name of Bernard Matthews put considerable pressure on questions and their timely response.

With increased press scrutiny the pressure for answers highlighted the cracks in internal communications.

Communication channels between Defra and FSA became strained at times. FSA were acting as an information channel between the MHS and Defra.

Defra were attempting to co-ordinate many requests for information and were having difficulties getting timely information. Co-ordinating the requests for information was more difficult than it should have been due to the lack of established ways of working. Daily communications teleconferences were established towards the end of the outbreak and worked well.

On the ground, the MHS worked hard under pressure to provide information to Defra, the FSA and Number 10. Some issues were raised about the co-ordination of requests for information and time pressure on responses, but the demands of an outbreak scenario inevitably give rise to these pressures.

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## 11. FSA Hungarian Trade Investigation

Laboratory tests confirmed that the virus was a 99.96% match to the strain found in Hungary. The need for an investigation into this link resulted in a more prominent role for the FSA.

The examination of records revealed that turkey products had been transported to the processing plant only from non-restricted regions of Hungary.

Imports of some meat products were held voluntarily by Bernard Matthews in cold storage at the request of the FSA. On the 14<sup>th</sup> February, in advance of the publication of the report, the FSA informed Bernard Matthews that there was sufficient information to conclude that the consignment did not contain any meat originating from the restricted zone in Hungary, and that the meat could be released in to the food chain.

*[ix] In situations where enforcement responsibilities may be shared, legislative requirements and legal roles should be clarified and communicated at the start of investigations.*

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## 12. FSA By-Product Control Investigation

The ornithologist's report and the Hungarian connection led to the hypothesis that a failure in by-product control contributed to the spread of disease. Consequently, there was considerable pressure from Defra to the FSA and MHS to clarify what powers to prosecute existed and if they would be used.

The investigation report looked into possible offences under the Animal By-products Regulations 2005 and the Food Hygiene Regulations 2006.

The MHS view was that there was no evidence for a breach in animal by-product controls in the slaughterhouse, cutting plant or processing plant. The photographic evidence from the ornithologists showed an abnormal situation during the outbreak when normal waste handling facilities were not available and which was not representative of normal operations. There was no hard evidence that the by-product controls had not been effective in the previous weeks when the virus might have been imported.

Investigation revealed some minor breaches of by-product controls in the past, but these had been addressed with verbal warnings from the OV and the FBO had responded appropriately. So under the terms of the hierarchy of enforcement there would be no basis for prosecution. FSA directors requested a legal investigation to verify that the MHS decision not to prosecute was correct, which concluded that there was no realistic prospect of conviction.

Whilst there was no evidence of an offence under the Animal By-product regulations (Defra's legislation) there were some failures under aspects covered by the Hygiene Regulations (FSA regulations). Due to this, the report was referred to Counsel for an opinion.

The report and opinion were discussed fully with the Defra legal department. In line with Defra legal policy the investigation report was circulated to a limited number of named individuals but the Counsel opinion was not circulated.

*[x] There should be mechanisms to review cases where prosecution was explored but not pursued.*

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## 13. Feedback from Incident Investigations

For enforcement activities carried out by the MHS under the Defra SLA (for cases involving animal welfare or animal by-products control) any failures are investigated by the MHS and then referred to the FSA when appropriate.

An FSA Investigation Officer (IO) is appointed if there may be a basis for a prosecution. Defra prosecutors usually only receive IO reports on the small percentage of cases that need to go forward. Due to the high profile of the Holton case the report was sent to Defra even though the FSA had decided not to prosecute.

There are times when there are policy implications in cases which do not go forward to prosecution. As these cases are often in restricted documents there is the possibility that these are not picked up in a systematic way.

A prosecution in a particular case can have wider benefits, e.g. to publicise the legislation and to demonstrate enforcement action. But it is clear that policy should not drive prosecution.

## 5. Findings

This section contains a summary of the findings and observations. Where a numbered observation is given, the number in brackets (*n*) refers to where this observation has been made against the event line described in Section 4.

### Overall

The HPAI outbreak in Suffolk in February 2007 was contained to a single turkey finishing unit. The contingency plan was put into effect immediately and there were no additional outbreaks or human infections. This must be regarded as the success of the contingency planning process.

There were a number of special features about the outbreak that required close co-operation between the various government departments and agencies involved and resulted in a bigger role for the FSA and MHS than would be normal in animal disease outbreaks.

*[iii] Explicitly considering the roles of other organisations in potential scenarios would improve contingency planning and aid preparedness for future events. (3)*

### MHS roles and responsibilities

MHS staff members are clear about their roles and responsibilities. However in the event of the outbreak some uncertainty, from outside MHS, was described in two key areas:

- Designation - What was the MHS role in the designation process.
- Enforcement - On what grounds were the MHS able to initiate prosecutions.

### MHS Designation Role

*[vi] Given that the designation process was in flux, time and effort could have been saved by maintaining the established procedure rather than attempting to change the process during an outbreak. (8)*

*[vii] The MHS and Animal Health need to work together to build greater awareness of roles and to develop trust and confidence. (8)*

### MHS Enforcement Role

*[ix] In situations where enforcement responsibilities may be shared, legislative requirements and legal roles should be clarified and communicated at the start of investigations. (12)*

*[x] There should be mechanisms to review cases where prosecution was explored but not pursued. (13)*

### Communications

Difficulties in establishing early, high level contact between Defra and FSA have given a somewhat negative perception of communications throughout the outbreak.

However, the MHS were at the ground level of the chain of communications and local contacts and communication between the

LDCC, AH and MHS representatives worked smoothly with no reported major problems. Some issues were raised about the co-ordination of requests for information and time pressure on responses, but the demands of an outbreak scenario inevitably give rise to these pressures.

The communication issues raised show that time had not been invested in building relationships, trust and communication channels at a high level between the different organisations before the outbreak.

Specific observations include:

*[i] Emergency contact information for all key contacts should be reviewed on a routine basis and a robust system is needed to ensure that communication process works properly in future. (2)*

*[ii] Key features of the site and environs should be established and communicated by Animal Health at an early stage in the response process.(3)*

*[viii] Representatives from the different organisations should establish and test ways of working as a matter of routine. This will ensure that when an outbreak occurs the channels of communication are open and requests for information can be co-ordinated as far as possible. (10)*

#### *Controlling Improvised Actions in the Contingency Response*

The use of the Bernard Matthews slaughter plant for the cull greatly speeded up the cull, but was a deviation from the planned response of using containerised gassing units. In such situations there should be an explicit assessment of risks and implications. This may have resulted in better preparation for the communication of the resumption of slaughter operations.

*[iv] Significant deviations from the planned procedure (an improvised action) should be subject to a risk assessment. This should have two key considerations. Firstly the contingencies that are needed to be in place if the improvised action fails, and secondly how the transition from the end of the improvised action to the established procedure is controlled. (4)*

*[v] All parties (Defra, FSA, MHS and the FBO) would have been better informed if official documentation was issued containing guidance of what would happen after the slaughterhouse had been used for culling. (7)*

## 6. Glossary

AH	Animal Health
AI	Avian Influenza
C&D	Cleaning and Disinfection
Defra	Department of the Environment Food and Rural Affairs
DNV	Det Norske Veritas
DVM	Divisional Veterinary Manager (Animal Health)
FBO	Food Business Operator
FMD	Foot and Mouth Disease
FSA	Food Standards Agency
HP	Highly Pathogenic
HPAI	Highly Pathogenic Avian Influenza
LDCC	Local Disease Control Centre
MHS	Meat Hygiene Service
MHI	Meat Hygiene Inspector
MOC	MHS - Manual of Official Controls, Procedures and Legislation
NDCC	National Disease Control Centre
NEEG	National Emergency Epidemiology Group
OV	Official Veterinarian
PZ	Protection Zone
RZ	Restricted Zone
SZ	Surveillance Zone
VO	Veterinary Officer

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