ENVIRONMENTAL CRIME AND JUSTICE

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E. coli O157 infections in humans are commoner in the UK than in any other European country, and they are a lot commoner in Scotland than in England: we have the highest incidence of infections in the world. The only good news is their relative rarity: Scotland recorded 234 in 2012 but 6333 Campylobacter cases. Norovirus is even commoner, by orders of magnitude. It is the common cold of the bowels. However, excepting civil actions by passengers who contract norovirus gastroenteritis on cruise liners and in hotels, neither of these common pathogens involves lawyers, except as victims. This is not true for E. coli O157. Its life changing effects and lethality explain why.

In evolutionary terms it is brand new. It appeared suddenly in the early 1980s. In the US it was called the “burger bug”, because of its association with the consumption of fast food chain beef burgers. Not so here. We prefer our burgers well cooked.

The natural home for E. coli O157 is the intestines of cattle and sheep. It is very well established in Scottish herds and flocks. It causes no illness in them, only in a person who inadvertently consumes bacteria from their faeces.

The biggest UK outbreak ever, occurred in central Scotland in November and December 1996. Contaminated meats sold by the Wishaw butcher John Barr infected 503, and killed 17 elderly people. The outbreak came to light on 22 November and the local Outbreak Control Team met on the evening. On 28 November the outbreak was still in progress, with 5 deaths, and the Secretary of State for Scotland established an expert group, chaired by the author, ‘to examine the circumstances which led to the outbreak … and to advise on the implications for food safety and the lessons to be learned’. We met in private at St Andrew’s House, Edinburgh (without lawyers) and delivered our interim report on Hogmanay. Our final report was presented to the House of Commons in April 1997. It recommended the legislative acceleration of the implementation of full HACCP principles by food businesses. HACCP (Hazard Analysis and Critical Control Point System) is a structured approach to identifying the potential hazards in an operation, dealing with them, and documenting what has been done. To fast-track this for butchers we recommended a licensing scheme, the award of a license being dependent on implementing HACCP or an equivalent prescriptive scheme. It started in England and Scotland in 2000, in Wales and Northern Ireland in 2001, and remained in force until 2006.

A police investigation lasted from 29 November until 7 February 1997, and on 10 January 1997 John Barr was charged with culpable and reckless conduct arising from the supply of cooked meats. At trial in January 1998, he pleaded guilty. His firm was fined £750 for breaches of hygiene under the Food Safety Act and £1500 for selling meat contaminated with E. coli O157. His business closed. At the time of the outbreak it was successful and expanding, employing 40, and he was ‘Scottish butcher of the year’ by customer vote.


He said ‘I have no doubt Mr John Barr liked a clean shop and maintained a clean shop. What he failed to do was maintain a
safe shop and the main ingredients of his failure was ignorance of the requirements which would produce that result.' He listed the hazards – the lack of provision of separate knives, work tables, scales and vacuum packers for raw and cooked meats, the cleaning of work surfaces with a detergent that had no bactericidal effect, and the lack of a clear management structure to enforce food safety measures - and criticised the environmental health officers who had inspected the premises for failing to identify them.

Outbreaks of infectious intestinal disease associated with butchers fell, from five in 2000, three in 2001, one in 2004, to none in 2002 and 2003. But in autumn 2005 the second biggest UK outbreak (157 cases) occurred in South Wales. Most were in schoolchildren at 36 primary and eight secondary schools. Eight developed severe complications and on 4 October, Mason Jones, age five, died. Contaminated cooked meats supplied to the schools by a butcher's business run by William Tudor caused the outbreak. A committee of the Welsh Assembly proposed in November that I should chair a Public Inquiry under the 2005 Inquiries Act. The Inquiry formally started on 13 March 2006. An Inquiry team and office were established and background work began.

The prevention of E.coli O157 infections is paramount. Once established, very severe and possibly lethal complications cannot be prevented by any medical measures. It can have tragic consequences. I was instructed as an expert witness in the case of four-year old Tom Dowling. On June 30 1997 he visited an open farm near London, where he stroked animals and clambered on fences. He became infected with E.coli O157, developed severe neurological complications with epilepsy and quadriplegia, and was left unable to speak or eat. Legal proceedings started in January 2001, and a settlement of £2.6 million was agreed. He died in 2006.

The prevention of E.coli O157 infections is paramount. Once established, very severe and possibly lethal complications cannot be prevented by any medical measures. Carriage of the organisms cannot be controlled or routinely identified in farm animals; a few excrete very large numbers, many none, almost certainly explaining why butchers like John Barr and William Tudor operated unsafely for years and why open farms can become complacent. The E.coli O157 challenge for them is very infrequent.

HACCP works. Ideally a food business prepares its own plan, but SMEs will probably buy one. Their understanding of hazards is sometimes poor. And there is dishonesty; William Tudor lied to environmental health officers, and John Barr was economical with the truth. Such behaviour poses a big challenge for regulators. While it is a step too far to continually invoke Paxman's principle ('Why is this person lying to me?'), box ticking will not do; personal experience and even intuition is very important in detecting the ill-intentioned but well-informed operator.

In my experience Inquiries have been good at identifying lessons but less effective at ensuring that they are learned. It is paradoxical that once a costly Public Inquiry report is delivered, the Inquiry's standing stops forthwith. Debates about how best to investigate a catastrophe continue. Parliamentary Committees usually divide along party lines. Public Inquiries need lawyers so are expensive (my team prided itself on limiting expenditure to £2.4m) and take years. Expert Groups report quickly and are inexpensive (mine cost £45,000). But the Scottish Government has a particular faith in judge-led processes under the 2005 Inquiries Act. Making Lord Hardie's Edinburgh Tram Inquiry statutory is intended to force recalcitrant witnesses to cooperate. One hopes he has better luck than Lord MacLean had in his Vale of Leven Inquiry with NHS Greater Glasgow and Clyde and some key witnesses. Like my South Wales report his findings make sorry reading, particularly his conclusion after comparing reports of Clostridium difficile outbreaks in England with what happened later at the Vale of Leven Hospital. The similarity was striking: ‘Lessons had not been learned’, he wrote.

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