# **Lessons Learned Foot and Mouth Inquiry, 2002**

Submission by Helen O'Hare, veterinary surgeon. 8 March 2002.

I worked as a temporary veterinary inspector (TVI) for MAFF/DEFRA at Kenton Bar, Newcastle Disease Emergency Control Centre (DECC) from early April to the end of November 2001. I worked both in the field on surveillance work, licensing, blood sampling and restocking and in the office in the licensing dept. During this time I also worked at the Intervention Board based at Newcastle, on the Livestock Welfare Disposal Scheme (LWDS)\*.

Some comments apply nationwide; some are specific to the northeast.

This was not the biggest outbreak of FMD- but due to government policy resulted in the greatest number of animals being killed and often under unacceptable circumstances. It was a holocaust and was driven by economics.

Farmers did not receive compensation - rather their animals were compulsorily purchased.

# Organisation and control of the epidemic by MAFF/DEFRA

Massive inability to cope due to:

- 1) Running down of the state veterinary service over the years resulting in inadequate staffing levels and staff very capable of managing paper but not instant decision-making. The Newcastle animal health office (AHO) was a sub office of Carlisle with only 3 full time veterinary officers (VO) at the time of the outbreak and no direct telephone line. (Calls were taken via Carlisle).
- 2) Inefficient recruitment of staff

Recruitment of vets:

- Veterinary recruitment was via personnel at Page Street, London who did not seem to have a clue as to the urgency of the situation. This resulted in huge delays from the outset. I visited my local AHO at Reigate and told Page Street the following day I was willing to travel anywhere and was told I would be based at Newcastle. I waited 3 weeks despite numerous phone calls to both Carlisle Newcastle and Page Street to be then told no vets were required. The army (whose phone no I had acquired from a south African locum vet in small animal practice) had told me to go to Newcastle immediately. Other vet colleagues found themselves in similar positions. Many UK vets registered as being available but were then not contacted.
- b. Failure to agree on adequate conditions of employment initially
- c. No quality control

There was no interview procedure and no monitoring of performance. Thus, there was ample opportunity for misdiagnosis of disease with the clinical signs of common diseases such as Foot rot and Orf being confused with foot and mouth disease (FMD). There was no obligation to call for second opinions and decisions from a distance i.e. Page Street allowed further confusion.

The language barrier was often a problem as was the unfamiliarity with UK diseases

Foreign vets were often unfamiliar with U.K welfare codes.

Also, there was no middle management of vets.

- 3) A hierarchy where no one makes immediate decisions or wants to take responsibility
- 4) Decision making centrally in London-most decision making was based at Page Street, especially on report cases, by people in offices often with no local or farming knowledge.

This was inadequate to cope with local situations. Farming in the northwest area is much different to that in the northeast. The decision makers initially often had never seen FMD. However it did ensure control of figures and the possibility of zero cases by election date.

5) The disease control strategy was inadequate

Initially there was failure to detect the disease promptly:

- Perhaps due to welfare visit strategy initially: Welfare visits involved notifying the farmer of a visit, often days in advance, and continuing to do so and thereby allowing bad practice to continue. There is also a lack of routine visits.
- The inability to cope with the situation due to inadequate staffing levels.
- Failure to stop animal movements immediately.
- Strategy based on little science and inadequate models which used little
  real data. There was also little science applied to following the course of
  the disease, and incorrect entry of data allowing misinterpretation of actual
  figures.

The output from any model is only as good as the input.

- 6) An out of date computer system with most farm information based on the last census of 10 years ago, despite annual farmer input of data to MAFF.
  - Missing or ineffective computer information recording and flow
- 7) Bio security
  - Poor training and education of staff, farmers and the public
  - Poor enforcement by MAFF when dealing with breaches among MAFF personnel, especially slaughter teams. It has been suggested that FMD was brought to the Berwick area via a slaughter team member.

- Inappropriate staff employed to deal with bio security measures
- The video eventually produced was not very educational. Was there any consultation with field vets/ farmers as to its value?
- 8) Jobs were allocated daily by non-AHO administration staff who often had no knowledge of what the job entailed. This, together with lack of computer data organisation and flow, led to massive inefficiency in the system and the waste of veterinary time.
- 9) Masses of paperwork. This included emergency instructions that were often difficult or impossible to understand, or open to many interpretations.

## Welfare

(Human welfare has been covered by others but words can never describe the misery and lasting effects of this epidemic. For example, the eight year old child whose farm was culled because she had been visiting the pony on the neighbouring farm.)

Breaking of the welfare codes without justification which included:

- 1) Transport to burial sites of
  - live animals in late pregnancy
  - animals giving birth
  - animals having recently given birth, mainly sheep
  - lame animals unfit to travel
- 2) Herding of newly born animals and their dams, and very lame animals
- 3) Restrictions allowing conditions to develop which would normally result in prosecutions. For example
  - starving animals unable to move across the road to available food
  - animals born and drowning in mud.
- 4) Lack of a system to deal with welfare cases

The LWDS was totally inadequate and disastrous for many reasons but especially because it could take four weeks to process a case (see later).

5) Staffing

VOs from other areas of the country were placed in positions of authority. They most commonly had no experience of working at a DECC and often could not make a decision at a DECC. They would stay for 2 to 3 weeks and then leave, to be replaced by another inexperienced person. This was especially noticeable in licensing and sometimes welfare animal movements, and appeals would not move for the time that certain individuals were in charge.

TVIs were not allowed to make many decisions although many had various skills and experience. They could however, decide single-handedly that a farm

had foot and mouth, and be responsible for all that that entailed. In normal times it is the ministry vet who confirms foot and mouth.

The management of the disease, which went from delays of days before sending vets to inspect report cases, to concentrating on an unscientific contiguous cull policy rather than dealing with new cases. This allowed the disease to spread. It is interesting that many of the contiguous premises 'missed' are still disease free - many appeal cases also remain disease free. Welfare was a low priority.

## At slaughter

- Emergency instructions allowing one vet to supervise up to 10 slaughter sites this is not possible and is most likely unethical. A minimum of one vet per case is required plus at least one veterinary support staff and also support for the farmer. No matter how good the slaughter team, payment per head obviously leads to cutting corners, health and safety risks and, more important, poor welfare.
- Inadequate training of personal involved
- Inadequate placing of personnel. For example, placing a non-English speaking and inexperienced vet in charge.
- Poor planning especially in the case of beef cattle
- Inadequate review of situation
- No policy on correct/adequate procedures; no input from organisations such as the humane slaughter association
- Payments: the per-head (i.e. per animal) payment was completely inappropriate.
- Slaughter team
  - Many unlicensed and incompetent slaughter men were employed, and the screening and monitoring of performance was poor or non existent.
- Contracts were very badly drawn up resulting in difficulties terminating contracts and excessive payments, especially for waiting time.
- Killing methods
- Sedation prior to killing is often required in wild animals, for example limousin beef crosses, to enable a humane kill to be carried out. It initially was not considered necessary and finally, during the Allendale outbreak Arthur Griffiths, DistrictVeterinaryManager at Kenton bar, Newcastle, banned its use as it was too expensive. The cost of the commonly used sedative is approx £5/animal which is negligible when the animal may be valued at £900 and when the total cost of the kill is considered.
- Killing by shooting fails to kill unborn animals immediately. Injecting was said to be too time consuming-this is debateable.

- Newborn animals: The recommended method of killing newborn and young animals was by lethal injection. This was not always done. There were also cases of inappropriate methods of injecting with regard to the site and method e.g. injecting into the chest, not changing the needle each time, using dosing guns.
- Adult animals: The main method of killing adult animals was by captive bolt pistol applied to the head. This renders the animal unconscious when used correctly and can kill. In the slaughterhouse death is ensured by exsanguination when the blood vessels are cut immediately post stunning i.e. while the animal is still unconscious. During this epidemic death was ensured by Pithing and not exsanquination. Pithing involves pushing a thin, usually metal, rod through the bullet hole in the head and down into the spinal cord thereby 'scrambling' the brain.
- This was NOT always done in cattle and often seldom done in sheep.
- Pithing was not always done immediately post stunning especially where animals were shot in groups in make-shift pens. Therefore in such cases pithing was performed possibly as the animals were regaining consciousness. This is not acceptable and is illegal for good reason.
- The pithing rods used were plastic disposable rods which were not as efficient as metal ones. They were only left in place in the heads of cattle (but not always) and never in sheep. Thus it was not always immediately obvious that the animal had in fact been pithed.
- There was only one vet with pig slaughter expertise at Kenton bar. There was no slaughter training in the field for vets, even when overstaffed.
- TVIs were informed that they were there only for FMD duty and many welfare problems were ignored. Welfare problems that were reported were not recorded on computer. This made it difficult at a later stage for others to decide on the severity, follow up, etc.
- All of the above contributed to the unacceptable occurrences on some farms such as
  - Chaos and stress during the gathering, penning, and slaughter of animals
  - More than one shot being used to kill
    - In one case, 300 housed bull beef each received a minimum of three shots to the head. One animal got off the wagon after being loaded. The slaughter team comprised three gamekeepers using inadequate firearms and bullets, and the slaughter took 2 days to complete.
  - Over crowding of animals in pens during shooting so that some animals were buried alive

- Animals missed during the initial kill e.g. a distressed newborn calf reported in a field by neighbours 4 days later.
- Loading bodies too early before ensuring they were dead and not just unconscious
- Untrained and incompetent marksmen often called in too early or because animals had escaped due to poor planning
- There were no vets with experience of using dart guns for sedation

## Disease control

The disease can cause abortion, death in young and old animals and drop in milk yield. Cattle are the most severely affected whilst the disease can be insignificant in sheep. Most animals survive and get over it within a few days. The manifestation of disease such as blisters could be treated with available medication. Exposed animals are then immune for a period.

Some disease control options were

- 1) Do nothing and let the disease run its course and tourism to continue.
- 2) Vaccinate. Everybody was kept in dark with regard to this option in particular. However
  - Farmers already vaccinate for other diseases
  - The consumer already buys vaccinate meat
  - There were enough vaccines available in the country
  - Foreign markets had already been severely affected by BSE and live transport of sheep around Europe needs investigation. The government could have discussed options with regard to vaccinated animals with the EU.
  - There are antibody positive animals present in the country as a result of the disease but all of those below a certain level are not being killed
- 3) Kill
- affected animals only
- affected farms only
- contiguous farm cull-based on what science????

and if everything is dead there is nothing left to catch the disease.

It is an economic disease and not one which causes much distress to MOST animals. In this case the spread was too great to control effectively by culling, as all animal moves had not been banned immediately.

The use of homeopathy was suggested at the Northumberland enquiry. It was claimed that milk yield in cattle returned to normal within a few days.

## Questions

What percentage of infected farms actually had the disease.

What percentage of slaughter on suspicion farms had the disease? - most samples were negative.

What percentage of contiguous and dangerous contact farms had the disease? - most were NOT sampled.

How many farms that were 'missed' during culls are still disease free?

How many appeal cases were infected?

What was the cost of the cull policy and what would alternatives have cost?

Why were less than 10% of the TVIs based at Newcastle DECC UK graduates? Many UK vets left their details with Page street but were never contacted.

# Diagnosis of Disease

- It is not scientific to base diagnosis of disease on clinical signs only, when alternative diagnoses were possible and where the clinical signs of FMD had not been seen before
- Report cases a vet sent to investigate was not allowed to take samples to aid decision-making
- There was often failure to consider differential diagnoses
- There was failure to use rapid result tests
- Samples were not taken in many slaughter cases and ,of those that were, most came back negative
- The final decision was made by Page Street but should have had a second local opinion, preferably from an experienced person
- There was pressure applied by Page Street to reach an instant decision and NOT to re-inspect 12 to 24 hours later in uncertain cases. For instance, this led to one farm being culled following the application of lime by the farmer to his fields. FMD sample results came back negative. Approximately 4,000 animals were killed on this farm and a further 10,000 plus animals on contiguous premises. The appeal case neighbour is still disease free. The neighbour to the neighbour, with a few pet sheep were spared initially and blood tested negative. However it appears neighbour pressure resulted in these animals being taken also.
- Foreign vets especially could misdiagnose Orf and Foot rot as FMD.
- There was sometimes a language barrier

- There was little study and information gathering
- The lessons from 1968 appeared to be ignored

## **Detection and reporting of FMD**

- Too few vets initially
- Most cases were reported by farmers
- Nonsense that six daily veterinary visits are required as quoted in one report
- Difficult to detect in sheep
- There were too few experts although there were plenty selfappointed ones

#### **Questions**

How is the disease transmitted?

What was the basis of the decision to cull all sheep and leave cattle on particular farms?

### Restrictions

• They often lacked common sense

For example, adjacent open weave wire fenced strips of moorland containing sheep owned and managed by the same person. The sheep from both strips were not allowed to be dipped in one of the strips of land unless proof of mixing such as broken fences could be supplied. This can be or can lead to a welfare problem.

The farmers however were more concerned about grouse shooting, people and dogs moving through fields, stressing the sheep, leaving gates open and failing to abide by biosecurity regulations.

e.g. the distance for a move was based on the distance from the farmhouse and not from the field containing the stock to be moved. This also lead to incorrect animals/farms being culled and missing others (who all survived?).

Animals are not inanimate objects unlike paper that can wait while decisions are made!

 The staff were often ignorant of their subject and thus of the situation. Many farmers had no income and no feed but were expected to manage - how? The intervention board was NOT a solution being too slow four weeks not uncommon

# The Intervention Board and the Livestock Welfare Disposal Scheme

Intervention board-LWDS scheme was set up to deal with welfare cases due to FMD restrictions such as running out of food, unable to move to available food etc. This scheme caused more welfare problems than it solved. This was due to:

- Site: The Intervention Board is part based at Newcastle, part based at Reading with historical rivalry and conflict between the two sites. Cases were first dealt with at Newcastle and, if approved, slaughter would be arranged at Reading-on farm or abattoir. There was no full computer link between the two sites leading to further delays.
- Staff ignorant of their subject. Often too few staff or inadequately placed leading to delays in the overly long paper trail. Failure by admin staff to recognise the urgency of these cases.
- Too little veterinary input. Vets only made decisions on Farms which were under restrictions i.e. Form D and only after they were first processed by ADAS.
- Decisions were taken by ADAS who were often very unsympathetic and not often knowledgeable of animal health (veterinary) issues. They made the final decision where the farm was not under any restrictions so that there was no veterinary input into these cases.
- The farmer's own vet was required to support the case. The decision makers then considered this report biased. This could easily have been rectified by having an independent veterinary report.
- The application Form was in 2 parts. One sent in by the farmer, the other by his/her own vet possibly leading to bias and time delays.
- Inability of MAFF/DEFRA to check on cases due to staff shortages (Welfare visits). It was fortunate that the RSPCA were available to help although they had severe reservations about the scheme and withdrew their support at one stage.
- Decisions taken by Page St animal Welfare Team sometimes showed complete ignorance of the subject and its problems. For example sending newborn piglets to abattoir, transport of pigs in hot weather.
- Poor use of abattoir slots and delays in issuing licences to move to abattoir. This resulted in missed slots and was mainly due to animal health offices closing over the weekends or finishing early during the week. In the middle of a crisis!

- Once a case was approved further welfare problems could ensue especially due to failure to pay up if the local vet used some initiative and slaughtered some animals on farm. Examples include killing a first time calver and her newborn calf on farm rather than killing the newborn on farm (as too young to travel) and then sending the heifer off alone. This is very stressful for the heifer but was the IB method.
- Incompetent staff at ground level especially the MLC who tried, and sometimes succeeded, in overruling veterinary decisions e.g. forcing the farmer to transport animals unfit to travel. This is illegal.
- Because these animals were not going to abattoir for meat, the condition they arrived in was irrelevant at abattoir and during transport. The animal welfare team at Page St have yet to issue figures for mortality rates during transport.
- The complete waste of the meat produced from LWDS abattoirs was incomprehensible.
- There was failure to check animals at abattoir for pregnancy. Thus farmers claiming for the cow in calf rate could do so illegally. This led to a large waste of taxpayers money.
- There was at least one case where money was paid out because of 'contacts in high places' rather than the case being eligible.

## **Commendations**

- Divisional Veterinary Manager during most of the outbreak was very approachable and willing to discuss things. He worked long hours and coped well under severe conditions. His successor was a very poor replacement
  - Executive Officer in licensing, extremely capable and should be promoted.
  - VO from Beverly, Temp DVM Licensing at Newcastle-a very hard working and modest man who always tried to do his best for all concerned.
  - VO Newcastle, left to deal with all the cock-ups with little support. He was extremely hard working, capable of making decisions, extremely helpful and always smiling.
- Trading standards at Morpeth and Durham especially
  Bottlenecks occurred in the DEFRA section and not in trading
  standards who, with less staff, were working very efficiently and

- effectively with regard to autumn movements. They were also more than helpful during my time at the DECC.
- The vicar in Allendale, Judith Hanson, who offered so much support to that community.
- All those drafted in from other departments who did their best to help in an unfamiliar situation.
- And especially the farmers whose hospitality was unfailing and who
  managed to survive these dreadful times in such a commendable
  manner.

# Suggestions

- Research is essential into the disease diagnosis, transmission, control and vaccination
- Planning for future outbreaks with decision making by informed experienced individuals and not based on politics, in consultation with all affected and interested parties and based on lessons learnt from previous outbreaks. An adequately staffed and funded state veterinary service
- Routine/Welfare visits
- Welfare legislation update
- General legislation update, not least to deal with those responsible for wiping out huge areas, such as Baldersdale, due to their inability to look after their stock and abide by basic biosecurity measures. The same farmer received vast compensation. Some of this payment was for stock that was certainly overvalued as most of the animals were severely neglected and in poor condition. Carcasses were to be found either lying about on the land or half buried under the muck within the sheds. This farmer has now been allowed to restock.

**BUT this does NOT suggest passing the ANIMAL HEALTH BILL**. It is clear from MAFF/DEFRA's performance during this epidemic that they must not be allowed any additional power. MAFF/DEFRA has

Misled the public, and

attempted to bring the veterinary profession into disrepute by lowering our professional standards.

They have blatantly abused their position and broken the law without justification. There is also the environmental impact of burial/burn sites and the pollution not least of all the tyres burnt at these sites and on farms during the cleanup post FMD. They would seem to consider themselves above the law- a very worrying situation.

- Education of
  - Farmers

- o Vets
- o Support staff and organisations
- Accountability
- Changes to farming practice

Subsidies based on a per head basis are completely inappropriate leading to over stocking and poor animal welfare.

Perhaps a licence to farm should be mandatory.

- Adequate legislation and enforcement facilities to deal with bad practice
- Slaughter teams/marksmen training and licensing

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