13. What went right and what went wrong?

1140 In previous chapters we have described the BSE story. Here we review certain aspects of the story, discussing what went right, what went wrong, and why. We begin with the practice which ensured that BSE spread so widely – the use of meat and bone meal (MBM) in cattle feed. Then we look at the identification of BSE, and the major policy decisions, before considering what may have been the major causes of shortcomings. We conclude with general comments on the criticisms of individuals found elsewhere in our Report. An Inquiry inevitably focuses on shortcomings, and these comments are designed to redress the balance.

A recipe for disaster

1141 There is a body of opinion that believes that farmers had only themselves to blame for the epidemic of BSE. Cows are ruminants. They do not naturally eat animal protein. They were fed animal protein in order to boost their milk yield or fatten them up. Some say that it offended against nature to feed animal protein to ruminants. Some say that it was doubly offensive to turn grass-eaters into cannibals. Some say that it was not surprising that a plague was visited upon those that tampered with nature in this way.

1142 Objection can be taken to many intensive farming practices on ethical or aesthetic grounds. We have resisted the considerable temptation to enter into this debate, which would take us well beyond our Terms of Reference. Of relevance to our Inquiry is the narrower question of why those responsible for the practice of using MBM in cattle feed did not foresee that this might be a recipe for disaster?

1143 The MBM used in cattle feed was produced by rendering. This involved pooling and then processing material from hundreds, perhaps thousands, of animal carcasses at a time. As with other processes where ingredients are pooled, there is a risk of contaminating the pool if any single source is infective. It is thus of crucial importance to make sure that the rendering process will destroy any potentially harmful organisms or other agents in animal carcasses. This is particularly important if animal protein is being recycled within the same species, so that there is no species barrier to infection.

1144 The suggestion has been made to us that the 1979 Royal Commission on Environmental Pollution warned against the risk of recycling animal waste. The risk to which the Commission drew attention was that of recycling poultry litter by including it as a protein supplement in ruminant feed. But the Committee went on to encourage this practice as an environmentally sound re-use of materials ‘given that care is taken to avoid health hazards’. An Agricultural Research Council report on ‘The Nutrient Requirements of Ruminant Livestock’ in 1980 drew attention to the value of undigested protein, of which MBM is a prime example, in ruminant rations to promote milk and flesh production. This authoritative report by leading
animal nutritionists, including the Agricultural Development and Advisory Service (ADAS), gave a boost to the use of MBM by feed manufacturers.

1145 The practice in the UK of recycling animal protein as an ingredient of animal feed dates back to at least 1926. In the 1970s attention was directed within MAFF to the danger that this practice would result in the spread of infectious diseases. The diseases considered were those caused by conventional viral and bacterial organisms. No consideration appears to have been given to the risk that scrapie might be recycled in sheep, or even transmitted to other farm animals. This may seem surprising. The answer probably lies in the fact that half a century had elapsed without any indication that animal feed containing ovine protein was infecting sheep or any other animal.

1146 The measure that MAFF introduced to address the risk of the spread of infectious diseases as a consequence of incorporating MBM in feed was the Diseases of Animals (Protein Processing) Order 1981. This laid down a mandatory sampling regime designed to ensure that the rendering process inactivated all conventional viral and bacterial pathogens. The measure was not designed to ensure that the rendering process would inactivate Transmissible Spongiform Encephalopathies (TSEs). No rendering process has yet been devised that will guarantee to inactivate BSE.

1147 What went wrong was that no one foresaw the possibility of the entry into the animal feed cycle of a lethal agent far more virulent than the conventional viral and bacterial pathogens, and one which would be capable of infecting cattle despite passing through the rendering process. When regard is had to the experience of what, by 1981, was over 50 years of recycling of animal protein, we can understand why the risk of a disease such as BSE was one which was not anticipated or addressed by farmers, renderers, feed compounders, animal nutritionists or government.

The identification of the disease and its cause

1148 Identification of the emergence of BSE was always going to pose a challenge:

- It had a long incubation period.
- It tended to strike down a single animal in a herd.
- It produced clinical signs which resembled those of other conditions.
- It could only be identified as a TSE by histopathology.

1149 It is to the credit of the system of passive veterinary surveillance and the skill of the Central Veterinary Laboratory (CVL) pathologists that the disease was identified at a relatively early stage of the epidemic.

1150 Great credit is due to Mr Wilesmith for his rapid identification of MBM in feed as the immediate source of infection. His individual contribution to the response to the challenge of BSE was of the highest value. His deduction as to the
probable reasons why MBM was infectious was reasonable, but wrong. It was 
unfortunate that his explanation – the scrapie theory – was one that provided 
unwarranted reassurance that BSE was likely to behave like scrapie and would thus 
not be transmissible to humans.

1151 It was also unfortunate that, although problems with Mr Wilesmith’s theories 
became increasingly apparent to the scientists as more was learned about BSE, no 
reappraisal ever received publicity. When our Inquiry began, most members of the 
public remained under the impression that BSE was scrapie in cattle and that the 
reason why cattle feed had become infectious was that renderers had altered their 
methods of production to the detriment of safety standards.

The Government’s response

1152 In earlier chapters we have seen how the emergence of BSE confronted 
government with three challenges:

- how to eradicate BSE in cattle;
- how to address the possibility that BSE might be transmissible through 
animal feed or otherwise to other animals; and
- how to address the possibility that BSE might be transmissible through 
human food or otherwise to humans.

1153 Those chapters summarise our discussion in Volumes 3 to 9 and 11 of the 
adequacy of the response to those challenges, having regard to the state of 
knowledge at the time. In the remainder of this chapter we draw attention to the 
major policy decisions in relation to these matters, which we have concluded were 
appropriate. We have shown that shortcomings attended the introduction, 
implementation, enforcement and monitoring of the measures pursuant to these 
decisions, and we identify some underlying features which led to shortcomings.

Eradication of BSE

1154 Banning the incorporation of ruminant protein in ruminant feed was the 
correct policy to adopt in order to eradicate BSE. Had it been fully implemented it 
would probably, by today, have achieved its object. As it is, it brought about a 
massive reduction in the number of new cases of infection so that, by 1996, it was 
apparent that the epidemic had been brought under control.

1155 Precautionary measures could have been taken to address the possibility that 
BSE would prove to be maternally transmissible. Maternal transmission, of itself, 
might prolong but could not perpetuate the disease. It was reasonable to refrain from 
culling the offspring of BSE dams unless and until it was shown that maternal 
transmission was taking place on a scale that justified this. There was room for 
argument as to whether or not breeding from the offspring of BSE dams should be 
discouraged or forbidden, but this was not a major policy issue.
The possibility that BSE might be horizontally transmissible was addressed by:

- guidance to farmers on preventing other cattle from coming into contact with the placenta of a calving dam; and
- a ban on the use of protein derived from Specified Bovine Offal (SBO) as fertiliser.

**Possible transmissibility to other animals**

Although the primary motivation for the compulsory slaughter and destruction of cattle showing signs of BSE was the protection of human health, it had the added benefit that the carcasses of these animals could not be rendered for animal feed. Thus this measure was in part a response to the possibility that BSE would transmit to other animals.

The measure specifically adopted to address this possibility was the animal SBO ban. The object of the ban was to prevent the inclusion in animal feed of protein derived from SBO. The leading pet food companies and the bulk of the animal feed industry had previously adopted this ban on a voluntary basis. MAFF made it compulsory after experimental transmission to a pig by inoculation had been achieved. This ban affected predominantly the content of pig and poultry feed. Although no express application of the ALARP principle was involved in this decision, we consider that, if effective, it would have reduced the risk of transmission of BSE to other animals through feed as low as was reasonably practicable, having regard to:

1. the reasonable belief that BSE was unlikely to be zoonotic;
2. the fact that there was no history of transmission of TSEs to, or experience of TSEs in, either pigs or poultry; and
3. the economics and waste disposal consequences of going further and imposing a total ban on including any animal protein in animal feed.

Measures were also taken to reduce the risk of transmission of BSE to other animals through veterinary medicines. Guidelines were issued to manufacturers of both human (see below) and veterinary medicines, which advised that certain bovine products should not be used in the manufacture of certain medicines, suggested that action should be taken to reduce contamination in the collection and production processes, and advised on sterilisation or discarding of the equipment used.

**Possible transmissibility to humans**

The principal policy decisions which addressed the possibility of transmission of BSE to humans through food were those to introduce:

1. compulsory slaughter and destruction of cattle with symptoms of BSE; and
ii. the human SBO ban.

1161 These were two vital measures for the protection of human health. Each was introduced at a time when the possibility that BSE might be transmissible to humans in food was considered remote. On that basis we consider that they constituted a proportionate response that satisfied the ALARP principle, albeit that the policy decisions did not result from the application of that principle. It is necessary, however, to go on to consider the decisions about which tissues should be proscribed as SBO.

1162 For the reasons that we have set out earlier, we consider that the decisions about what should and what should not constitute SBO were reasonable, having regard to what was known at the time. It should be recognised that in drawing the line so as to exclude the abomasum, from which tripe and rennet were derived, and offal from calves aged less than 6 months, commercial considerations are likely to have weighed in the balance.

1163 The possibility that BSE might be transmissible to humans through non-food products was addressed by issuing guidance to a number of relevant industries about the potential risk, including occupational risk, from the use of bovine products. Perhaps the most important was that issued to manufacturers of medical products, which, as we have noted, applied equally to medicines for human use and veterinary medicines.

1164 The potential risk from occupational contact with bovine materials was also addressed by advice and guidance to many of those whose jobs brought them into contact with such materials. This advice was developed and issued over a period of time.

1165 The final policy decisions with which we are concerned were those reached on 20 March 1996:

i. a requirement that carcasses from cattle aged over 30 months be deboned in licensed plants supervised by the Meat Hygiene Service (MHS) and the trimmings classified as SBO; and

ii. a prohibition on the use of mammalian MBM in feed for all farm animals.

1166 If there had been no need to consider practicality or public perception, a case could have been made for saying that the deboning scheme satisfied the ALARP principle. In the event it was not viable. On this occasion the wrong policy option was selected.

1167 The prohibition on the use of mammalian MBM in feed for all farm animals was we consider an appropriate response under the ALARP principle to the change in knowledge of the risk posed by BSE to humans, consequent upon the conclusion of the Spongiform Encephalopathy Advisory Commitee (SEAC) that the cases of vCJD were probably linked to exposure to BSE.
Shortcomings and possible reasons for them

Putting hindsight aside, we have no doubt that the policy decisions that there should be a ruminant feed ban, that clinically affected cattle should be destroyed and that SBO should be kept out of human food and animal feed, were right. Because the right policy decisions were taken, BSE is today within reach of eradication and millions have received a high degree of protection from the risk of ingestion of potentially infective products or by-products of the cow. This reflects credit on our system of government and, in particular, on the State Veterinary Service (SVS), which bore the brunt of the demands made on this country by BSE.

Plaudits must, however, be muted. Not all went well. All too often the correct policy decision was marred by:

- the time that had been taken to reach it;
- lack of rigour in considering how to give effect to it;
- lack of rigour in implementing, enforcing and monitoring the Regulations introduced to give effect to it.

In order to see what lessons can be learned from the BSE story it is necessary first to consider what may have been the major causes of the shortcomings that we have identified.

Was there a conflict of interest in MAFF?

We begin with a criticism that has been widely made of MAFF’s position in relation to BSE. This starts with the complaint that MAFF had a conflict of interest between the aim, on the one hand, of supporting producers of agricultural produce (as ‘sponsor department’ for the industry) and, on the other, of protecting consumers of agricultural produce. The criticism continues that in resolving that conflict MAFF was more concerned to protect the interests of the producers.

We discussed the question of conflict of interest with a number of witnesses, including Sir Michael Franklin, who served as Permanent Secretary at MAFF up to the end of September 1987. He accepted the potential for conflict of interest, but commented:

... you have to ask yourself whether it makes sense, and this is a great philosophical discussion on the machinery of Government, whether it is better to have these potentially conflicting interests in a separate department so that the tension is between the two departments, or whether it is better to have a single department with a single minister who can resolve those tensions within his own command. I have said earlier why I think, in terms of the food chain going from the farmer to the food industry and through to the rest of the food chain, there is in fact a positive advantage in having it all under one minister, and where tensions arise resolve them within the department.

We do not propose to be diverted at this point into a great philosophical discussion. At the general level, it should be recorded that Mr Gummer initiated
measures which addressed this conflict by creating a separate Food Safety Directorate within MAFF and a Consumer Panel to advise the Ministry. We are concerned, though, to deal with the criticism that in the course of the BSE story MAFF leaned in favour of the agricultural producer to the detriment of the consumer. So far as the policy decisions are concerned we are satisfied that this criticism is without foundation. The ALARP principle does not aim to achieve zero risk. It involves an exercise in proportionality. For the reasons given earlier, we are satisfied that the consideration given to the details of the human SBO ban was a fair application of that principle. Once SEAC had been set up, MAFF’s approach was always to consult it on whether the risk BSE posed to humans called for further precautionary measures. Whether that was the best way to use SEAC, we shall discuss in due course. The fact is that MAFF never did less, and on occasion did more, than SEAC recommended. MAFF officials and Ministers were, in our judgement, as concerned as anyone else that if there was a possible risk to human health, appropriate measures should be taken in response to it. Concern for the industry meant, however, that officials and Ministers were particularly concerned about how the public would perceive the risk from BSE.

Other conflicts of interest

1174 Many Departments have potential conflicts of interest between responsibility for regulating an industry and being custodians of its interests within general government business. Examples in the BSE story included the dual role of the Department of Trade and Industry (DTI) on cosmetics and toiletries, and the multiple role of DH in fostering the pharmaceutical industry, looking after the interests of the NHS as a large-scale purchaser, and licensing individual products to safeguard consumers. Commonly, Departments seek to operate internal arrangements that keep the different roles separate. In the case of medicines, the ring-fencing arrangements, as we have seen, included heavy reliance on advice from statutory advisory committees of outside experts. This itself can create problems because many such experts may have their own financial links with companies for whom they are carrying out research or acting as advisers. There has been increasing emphasis on the need for all such interests to be declared when relevant to particular items under discussion.

1175 We have seen no indication that vested interests were allowed to influence the approach to safety in these areas.

Perception of risk

1176 We have identified three types of challenge posed by BSE: the need to eradicate the disease, the potential threat to other animals and the potential threat to humans. The rigour with which each of these challenges was addressed was bound to be affected by the subjective belief of those involved as to whether BSE was, in fact, a potential threat to human life. We have formed the view that the vast majority of those who were involved in this country’s response to BSE believed, subjectively, that it was not a threat to human health. In their heart of hearts they felt that it would never happen – BSE was not, potentially, a matter of life and death for humans – and this belief was shared by many who could see, objectively, that the potential risk was there.
This view is based largely on impression as a consequence of having heard oral evidence from those who were principally concerned. It is also supported by a small statistical survey that we carried out. We asked more than 270 witnesses, including those who were involved in the response to BSE either as Ministers, officials or scientists advising government whether they had changed their diet as a result of learning about BSE. All but a handful said BSE had had no relevant effect on their diet.

Although most of those concerned with handling BSE believed that BSE posed no risk to humans and understood the available science as indicating that the likelihood that BSE posed a risk was remote, they did not trust the public to adopt as sanguine an attitude. Ministers, officials and scientific advisory committees alike were all apprehensive that the public would react irrationally to BSE. As each additional piece of data about the disease became available, the fear was that it would cause disproportionate alarm, would be seized on by the media and by dissident scientists as demonstrating that BSE was a danger to humans, and would lead to a food scare or, even more serious, a vaccine scare.

From the moment in December 1986 when Mr Bradley classified his first minute about BSE as ‘Confidential’, to the Chief Medical Officer’s (CMO’s) reassuring recorded message of 20 March 1996, ending with the statement ‘I myself will continue to eat beef as part of a varied and balanced diet’, officials and Ministers followed an approach whose object was sedation. In the first half of 1987 there were restraints on the release of information about BSE. After this there was no attempt to conceal facts from the public. The approach did not set out to deceive. It set out simply to redress the balance that it was feared would otherwise remain tilted as a consequence of alarmist media cover. One witness described it nicely as ‘leaning into the wind’.

Examples of this approach are legion. Here is a selection:

- The repeated statements that ‘there is no evidence that BSE is transmissible to humans’, which did not explain that such evidence would take many years to emerge.
- The repeated invocation of the assessment in the Southwood Report that ‘the risk to humans is remote’, which continued long after the assumptions made by the Southwood Working Party had been shown not to be valid.
- The agreed presentation of the human SBO ban as being a convenient means of giving effect to the baby food recommendation.
- Presentation of oral transmission of BSE to mice and transmission to a marmoset as demonstrating that BSE behaved like scrapie.
- Statements that the cat did not increase the likelihood of BSE transmission to humans.
- Dr Metters’s statement that: ‘Every effort has thus far been made to underline the Government’s position, based on advice from the Southwood and Tyrrell Committees, that the disease is not a risk to humans.’
- The attempt to get SEAC to produce publicity soundbites.
The publicity documents submitted by MAFF officials to their Ministers on the very day in March when the balloon went up.

The public presentation of the medicines guidelines as if they had secured the situation without indicating that products were not required to be withdrawn.

1181 The campaign of reassurance focused particularly on the safety of beef. Successive DH CMOs, and a CMO for Scotland, made unqualified statements that it was safe to eat beef. They did so, not on the basis that they were satisfied that BSE was not transmissible in food, but on the basis that they were satisfied that the portions of the cow which might infect were not permitted to enter the food chain. This was not made clear to the public, who equated statements that it was safe to eat beef with statements that BSE posed no risk to humans.

1182 The official line that the risk of transmissibility was remote and that beef was safe did not recognise the possible validity of any other view. Dissident scientists tended to be treated with derision, and driven into the arms of the media and to exaggerated statements of risk. Thus views expressed on risk became polarised. Dispute displaced debate.

1183 The need to provide a reassuring message also featured strongly in the presentation of measures to ensure the safety of medicines. Concerns that the public might boycott vaccines if their safety was called into question were considered paramount.

1184 The anxiety of Ministers and officials not to provoke alarm was shared by the scientific advisory committees. The Southwood Working Party told us that they did not wish to raise needless alarm in those who might have been infected with BSE before any precautionary measures were taken. They accommodated the concern of those responsible for advising on the safety of medicines that their Report should not suggest that vaccines posed any risk. Their Report gave the impression that in all circumstances the risk of transmission of BSE appeared remote. It had the caveats that they had had little evidence to go on and that, if their assessment were proved wrong, the implications would be extremely serious. These caveats were, however, quickly lost sight of. So that, for instance, the Committee on Safety of Medicines (CSM) in a position statement said: ‘The CSM agrees with the Southwood Working Party that the risk to man of infection via medicinal products is remote. As a precautionary measure, and for the sole aim of seeking to guard against what is no more than a theoretical risk to man, the CSM and the Veterinary Products Committee (VPC) have agreed joint guidelines on good manufacturing practice for the manufacturers of human and veterinary medicines who use bovine, or other animal materials either as an ingredient or in the production process.’

1185 SEAC’s 1994 ‘Summary of Present Knowledge and Research’ on TSEs could have been the occasion for a public reassessment of the risk of transmissibility of BSE to humans in the light of all that had been learned since Southwood. It should have replaced the Southwood Report as the document to which anyone seeking an up-to-date and authoritative assessment of risk referred. But the message that it gave as to the reassessment of risk was muted and, so far as the public were concerned, it seems to have vanished without trace.
What was the effect of the campaign of reassurance? The precautionary measures that the Government introduced against the possibility that BSE might be transmissible to humans called for care and diligence in their implementation and enforcement. This was to be expected from those involved only if they were persuaded that such a possibility was a real one and that the precautionary measures were therefore important safeguards of human health. We have noted evidence from those responsible for enforcing the SBO Regulations in slaughterhouses that BSE was not regarded as a risk to human health. Local authorities told of the confusion among their staff about the line to take. We have also identified areas where the bureaucratic process ground on very slowly in responding to BSE – the preparation of guidance on operational risks and dissecting bovine eyeballs are examples. In the case of medicines and cosmetics, a relaxed attitude was taken to using up stocks. We believe that lack of diligence in implementing Regulations and lack of urgency in other areas of response to BSE were attributable, in part, to the success of continuous efforts to make sure that news about BSE did not give rise to public concern.

We do not suggest that all were sedated by the official presentation of risk. Some were sceptical and the media were not slow to point out that, while MAFF persisted in maintaining that the risk to humans was remote, this message was accompanied by a series of measures aimed at reducing risk still further.

Whether they were sedated or sceptical, the reaction of many members of the public to the announcement on 20 March 1996 was the same. They felt that the Government had not been telling the truth about the risk to humans from BSE; the public had been deceived.

It is in the context of communication of risk that we feel that there is more force in the argument that it was unsatisfactory for a single Department to be concerned with protecting both consumers and producers. MAFF’s dual role meant that their officials and Ministers were particularly apprehensive about the possibility of alarmist consumer reactions causing harm to the producers. We note, however, that DH officials who were not confronted with this potential clash of interests with regard to food, showed themselves as eager as MAFF to present information in a manner calculated to cause the least alarm.

To an extent the Government’s response to BSE was driven not by its own, and its advisers’, assessment of risk, but by the public’s perception of risk. The introduction of the human SBO ban is the most notable example. At times media response to BSE was exaggerated, but often media critique was pertinent and well informed. The media played a valuable role in reflecting, and stimulating, public concerns which proved well-founded and which had a beneficial influence on government policy.

Ignorance and failures of communication

Some of the responses to BSE were inadequate because those responsible for them were not party to aspects of the state of knowledge at the time which should have informed their decisions.
The earliest example of this was the delay in discovering the extent to which cattle were succumbing to BSE consequent upon restraints imposed at the CVL on dissemination of information about the disease in the first half of 1987.

Another example was the delay in deciding to introduce a slaughter and compensation policy, which resulted from the failure of MAFF officials to inform DH of the disease and to get its input into the consideration of BSE’s implications for human health.

A third example was the delay in addressing the risk from bovine products in human medicines, which resulted from that same lack of communication between MAFF and DH.

**Ignorance of views as to the minimum infective dose for cattle**

A further example is provided by the consequences of the failure to focus on the question of the minimum infective dose. At the end of 1990 interim results of the Neuropathogenis Unit (NPU) experiment to transmit BSE to sheep and goats had indicated that eating infective material weighing only ½ gram had sufficed to infect a sheep. Had scientists at the NPU, or Dr Kimberlin, or Mr Wilesmith been asked in 1988, they would have advised that it was at least possible that the minimum amount of material that would suffice for oral transmission to a calf would be very small. Yet the result of the CVL attack rate experiment, which showed, at the end of 1994, that a single gram had transmitted BSE orally to a calf, caused widespread surprise and concern.

When the ruminant feed ban was introduced, some officials within MAFF were under the impression that a cow would have to eat a substantial quantity of infective material to contract BSE. This impression was shared by the UK Agricultural Supply Trade Association (UKASTA). It believed that the quantity of pig and poultry feed that might get into ruminant feed as a result of cross-contamination in feedmills was not a matter for concern. Mr Meldrum made the same assumption. The need to address the problem of cross-contamination of ruminant feed was not appreciated or tackled until 1994.

When the animal SBO ban was introduced in 1990, none of those involved appreciated the extent to which contamination of MBM with SBO in rendering plants would give rise to infectivity in that MBM, let alone that this would be enough to pose a threat to cattle as a result of a second round of cross-contamination in the feedmills. Steps were taken to agree a rendering code to reduce contamination, but not with any urgency, and two years elapsed from the introduction of the ban before the code was in place. Even this was insufficient to prevent significant contamination. Only after the result of the attack rate experiment became known in 1994 was the decision taken that renderers would have to process SBO in separate facilities.
Ignorance of views as to the minimum infective dose for humans

1198 The question of the minimum amount that was capable of infecting was equally of importance in the context of the safety of human food. It was a vital element in any evaluation of the potential risk of contamination of human food by slaughterhouse practices, such as brain removal, and the production of mechanically recovered meat (MRM).

1199 In 1989, when the SBO Regulations were being prepared, the safety of MRM received consideration, which we have concluded was inadequate. Scientists were not asked for their views of the minimum amount which might infect. An assumption was made that any contamination of MRM with spinal cord was unlikely to be sufficient to be significant. In the following year MAFF officials adopted a similar approach to the question of contamination as a result of head-splitting and brain removal.

1200 SEAC’s robust advice, that removing the brain before the head meat was not acceptable, gave some indication that the Committee considered that a small quantity of contaminant was cause for concern. SEAC never so stated expressly, and its paper on the safety of beef was capable of conveying the false impression that only a substantial quantity of infective material would pose a risk of transmission by the oral route.

Ignorance of pathways of infection

1201 One of the questions asked by Sir Richard Southwood before the first meeting of his Working Party was:

What are the routes to man of parts/products of cattle, especially dairy cattle, before and after slaughter?

1202 MAFF and DH were unable to provide a detailed reply. He was told that there was a very low probability that spinal cord formed part of meat products, but that quantitative information on the fate of organs and tissues was unavailable. Since 1996 a survey has disclosed that, at the time that the Southwood Working Party were considering their recommendations, substantial quantities of spinal cord were going into human food as an ingredient of MRM. Had the Working Party known this we wonder whether they would have been content that it should be allowed to continue.

1203 The Tyrrell Committee advised, as a top priority item, that there should be a more detailed investigation into the fate of bovine (and ovine) tissues and products that could lead to infection being spread by as yet unrecognised routes. This recommendation was never implemented. Had it been, timely consideration might have been given to closing pathways of potential infection for humans or for animals that, at least initially, were overlooked.

1204 In June 1990 a survey of cutting procedures disclosed that lymph nodes removed in the course of dressing meat were used in meat products for human consumption.
1205 In 1994 members of SEAC were concerned to learn that the residues that settled in the tank bottoms in the course of refining tallow, including tallow derived from SBO, was still being incorporated in cattle feed.

1206 Until 1995 it was not appreciated by MAFF officials that gelatine derived from cattle was entering cattle feed in substantial quantities as an ingredient of recycled waste foods, in breach of the ruminant feed ban.

1207 Uncertainty prevailed throughout the period with which we are concerned as to the use of bovine products in cosmetics.

1208 Consideration was not given to the question of whether drainage waste from slaughterhouses or effluent from renderers of SBO might pose hazards of BSE contamination which called for review of their disposal.

**Failures of communication**

**Between the Southwood Working Party, the Government and the public**

1209 Many who read, or who were informed of the conclusions of, the *Southwood Report* failed to appreciate that:

- When describing the risk posed by BSE to humans as remote, the Working Party intended to indicate that such precautions as were reasonably practical should nonetheless be taken to address the risk.
- The description of the risk from medicinal products and occupational exposure as remote was predicated on the assumption that the responsible authorities had been alerted to the potential risk and were taking appropriate measures to address it.
- The Working Party’s conclusions on risk were based on very limited data and were inferences drawn from knowledge of scrapie and CJD.
- The Working Party contemplated the possibility that their conclusions might be wrong, and that in that event the implications would be extremely serious.

**Between SEAC, the Government and the public**

1210 The breakdown of communication between MAFF officials and SEAC, when the latter considered slaughterhouse practices and MRM, resulted in the impression being given that the members of SEAC were not concerned by the degree of contamination described as ‘inevitable’ in MAFF’s paper on the topic. That was not the position. Some, at least, of the members of SEAC were advising on the premise that there would be total removal of the spinal cord before MRM was extracted. They gave the same advice about MRM on the same basis in June 1995. Not until November 1995 was it brought home to SEAC that spinal cord was not always being cleanly removed, whereupon at last it advised against the practice of extracting MRM from the bovine vertebrae.
We have commented above on the possibility that SEAC’s 1990 paper on the safety of beef contributed to the erroneous belief that a substantial quantity of infective material would have to be eaten in order to transmit BSE.

SEAC’s 1994 paper on TSEs failed to spell out clearly that events since the Southwood Report had adversely altered the assessment of the likelihood that BSE was transmissible to humans, and this message was not conveyed to the general public.

**Lack of rigorous consideration when giving effect to policy**

We have identified three occasions on which a lack of rigour when considering how to implement policy had adverse consequences. The first was at the time of the introduction of the ruminant feed ban. Because of the lengthy incubation period, years would necessarily elapse before any defects in the operation of the ban would become apparent. The technique of building a dam and then looking for leaks would not do. Rigorous consideration should have been given to ensuring that the dam was watertight in the first place. The question of whether cross-contamination in feedmills would be cause for concern should have been addressed. Advice should have been obtained on how much contaminant might suffice to infect. This would have led to UKASTA being advised that cross-contamination had to be prevented and focused attention on the urgency of developing a test that would detect ruminant protein in compound feed.

The second occasion was when the question of the safety of MRM was raised in the course of the consultation exercise for the human SBO ban. The critical issues of the extent of likely contamination of MRM and the minimum amount of material that might infect were not addressed. It was simply assumed that any contamination would be too small to matter. Thus no guidance was given to local authorities or the Veterinary Field Service as to the importance of removal of all spinal cord.

On these first two occasions the lack of rigour resulted in failure on the part of those considering the implementation of policy to obtain the information that was available and was needed in order to reach the correct decision.

The third occasion was the preparation of the Order that was to give effect to the animal SBO ban. The terms of the Order were in a form that was unenforceable. Rigorous consideration would have led to the conclusion that this was not a ban where self-policing could be relied upon and that Regulations should be drawn up which could be enforced.

**The best being the enemy of the good**

The production of written documents by officials and by advisory committees frequently entailed a process of wide consultation and drafting refinement. This was a ‘Rolls-Royce’ system, but one which tended to result in lengthy delays. Consultees would be tempted to suggest drafting improvements, which would then result in a further round of consultation. These were often not changes of sufficient substance to justify the delay that they caused.
One area in which the effects of this were keenly felt was in the preparation of written guidance on precautionary measures and practices. On some occasions it took many months, or even years, after a decision was taken to issue written guidance, for that decision to be implemented. By way of example, it took two-and-a-half years for SEAC’s advice on the dissection of bovine eyeballs to be passed on to schools and up to three years to issue simple occupational warnings and basic advice to some of the high-risk trades.

When drafts were submitted to advisory committees for comment, delays could be particularly protracted. Again, by way simply of example, we can cite the comprehensive advice of the Advisory Committee on Dangerous Pathogens (ACDP) to those handling risk tissues in laboratories, hospitals and mortuaries. A further example is an excellent draft Advisory Note to farmers on the dangers of cross-contamination of cattle feed with pig or poultry feed that was initially drafted in November 1995, was considered and refined by, among others, both SEAC and Mrs Browning, and had not been issued by 20 March 1996. In all of these cases the desire to perfect a document was allowed to outweigh the need for speedy advice. The best became the enemy of the good.

Inappropriate use of advisory committees

Advisory committees have a vital role to play in assisting government to formulate policy. However, if matters are referred to committees which only meet periodically, this can delay the process of taking decisions. We shall give detailed consideration to the lessons to be learned in relation to the use of committees at a later stage. For present purposes we would draw attention to the following principles:

- resort should be had to committees only where their expertise is needed;
- advice sought should be clearly targeted so as to fall within the expertise of the committee;
- advice given should be reviewed to ensure that it appears to be soundly based; and
- advice should be treated as such, and not as being determinative of policy.

These principles were not always followed in the case of the BSE story. For example:

i. In order to resolve the policy issue of whether cattle showing signs of BSE should be permitted to enter the human food chain, the essential question to answer was whether it was possible to be confident that this would involve no risk. There was no need to appoint the Southwood Working Party to resolve that question. MAFF officials had been able to reach a firm, and correct, conclusion on the limited available data that it was not. Had DH officials been involved with MAFF in considering the risk to human health from the outset, we believe that they would have concurred in that conclusion. The decision to refer the question to a Working Party resulted in a delay of over three months.
ii. The conclusions of the Southwood Working Party were not reviewed. Their recommendations were treated not as advice, but as definitive of the precautionary measures which did, and did not, require to be taken. It was left to public reaction, and the assistance of Dr Kimberlin through the good offices of Pedigree Masterfoods, the pet food manufacturer, to lead MAFF Ministers to conclude, over three months later, that an SBO ban should be imposed.

iii. The advice of the Southwood Working Party continued to be quoted as definitive of the precautionary action required by science long after some of the premises upon which the Working Party had advised were demonstrated to be unsound.

iv. SEAC was set up as a standing, part-time, committee to advise MAFF and DH on ‘matters relating to spongiform encephalopathies’. The breadth of these terms of reference was reflected in the wide variety of matters on which SEAC was asked to advise. It immediately became the practice to seek the advice of SEAC on any policy decision that had to be taken in relation to BSE, without identifying those aspects of the question on which SEAC was particularly qualified to advise or targeting the advice sought from it. Furthermore, once SEAC had advised, its recommendations tended to be treated as determinative of the action to be taken.

1222 On two occasions the intervention of SEAC proved positively unhelpful. The first was when slaughterhouse practices including MRM were referred to it. The untargeted request to SEAC to advise ‘whether any action or guidance is necessary in relation to slaughterhouse practices’ led to advice being given on the basis of SEAC’s assessment of the efficacy of those practices. This assessment was unreliable and was one that MAFF officials were very much better placed to perform. The advice was not in clear terms and led MAFF officials wrongly to conclude that members of SEAC were not concerned about inevitable failure to remove all spinal cord before MRM was extracted from the vertebrae.

1223 The second occasion was when SEAC recommended the deboning scheme on 20 March 1996. This was unhelpful because the Government accepted it without time to review it to decide if it was practically and politically viable. In this context we would quote a pertinent observation made by the Agriculture Committee in its 1990 Report:

> Scientists do not automatically command public trust, particularly when they are in disagreement with each other, and when the issues concerned do not lend themselves to simple yes/no answers but involve computations of whether particular risks are acceptable or unacceptable to members of the public. Decision-making is not a purely scientific process.

1224 By the time that the 20 March policy decision came to be made, the reliance by government on SEAC to answer questions of policy had become so well established that officials and Ministers had been waiting to see what SEAC had to say rather than carrying out their own exploration of the policy options by way of contingency planning.

103 The use of SEAC receives detailed consideration in vol. 11: Scientists after Southwood
Administrative structures

Interdepartmental structures

1225 Evaluation of whether, and in what respects, BSE posed a risk to humans was, in theory, primarily the responsibility of DH, but turned largely on questions that fell within veterinary expertise. Evaluation of whether, and in what respects, BSE posed a risk to other animals fell wholly within MAFF’s responsibility and turned, to a large extent, on the same questions of veterinary expertise. Risk management in relation to both types of risk, as far as animals and food products were concerned, fell almost entirely within MAFF’s area of responsibility, while DH took the lead on other areas, in particular human medicines. Occupational risk fell somewhere between these two Departments and the Health and Safety Executive (HSE). We have already observed, however, that it is difficult to draw the line between risk evaluation and risk management. It was important that MAFF and DH worked closely together. In particular, so far as food risks were concerned, DH needed to be satisfied that MAFF was taking appropriate action by way of risk management to ensure that potential food risks were satisfactorily addressed.

1226 So far as medicines were concerned, the licensing divisions of the two Departments were responsible for implementing the same legislation using the same assessment criteria – safety, quality and efficacy. A similar system of statutory advisory committees applied, and the Medicines Commission spanned both human and veterinary medicines, having an overview of the workings of the system as a whole. Moreover, veterinary and human medicines drew on similar raw materials, types of sterilisation and production processes. This called for a coordinated approach between the two.

1227 The need for such cooperation between MAFF and DH must exist in relation to other zoonoses, as well as BSE.

1228 Relations between MAFF and DH with regard to BSE did not fall within the framework of any formal interdepartmental structure for dealing with known zoonoses or potentially zoonotic animal diseases. If there had been satisfactory interdepartmental communication and collaboration on an informal basis, this would not have mattered. As we have pointed out, however, until Sir Donald Acheson was notified about BSE in March 1988, such communication and collaboration were absent. Had there been an effective interdepartmental body concerned with zoonoses and potential zoonoses, the BSE story might have got off to a better start. That does not, of itself, demonstrate the need for such a body – it raises the question of whether a formal structure may not be the best way of ensuring proper interdepartmental collaboration in this field.

1229 Matters were further complicated when other Departments were involved. The response on cosmetics called for effective communication and coordination between MAFF, DH and DTI, the industry’s sponsor Department. Similarly, it was for DES to send out advice on the dissection of bovine eyeballs in schools, drawing on advice from DH, MAFF and the HSE. On waste disposal the Department of the Environment was involved. All this called for clear allocation of lead responsibility and efficient lines of communication between Departments. These were not always evident.
DH role

1230 DH\textsuperscript{104} had the lead in relation to human health surveillance, being the Department to which the CJD Surveillance Unit reported. On most other aspects of BSE, DH maintained a watching brief over MAFF’s actions. As Sir Christopher France\textsuperscript{105} told us, it was for the Chief Medical Officer and the professional staff who reported to him to take the lead on the DH response to BSE. In the early stages of the story Dr Pickles, who had the DH lead, played a notably proactive role in scrutinising and questioning MAFF’s actions. As we discuss in Chapter 6, in the weeks leading up to March 1996 the DH role was passive, with the result that they did not raise with MAFF the need for contingency planning as soon as it became apparent that BSE might prove to be transmissible to humans.

1231 The other major area in which DH took the lead was in relation to human medicines. Veterinary medicines were to some extent treated as the poor relation of human medicines. MAFF from the beginning of 1989 took its cue from DH on the handling of existing products and stocks in relation to BSE. Within DH, medicines licensing was the province of Medicines Division (MD), which, as one witness put it, ‘consumed its own smoke’. When reviewing products over which any questions arose, MD looked to advice from its ‘section 4 committees’ of eminent outside experts. During the period with which we are concerned there was a significant reorganisation of the arrangements for handling medicines licensing, in order to address structural and management problems identified in a management review. MD was reconfigured into an Executive Agency – the Medicines Control Agency – in 1991, and the Medical Devices Agency followed in 1994. This reorganisation itself led to some upheaval and confusion, which did not facilitate the management of the BSE measures.

1232 It seemed to us that clearer expectations about reporting to top management and to Ministers would have assisted in the handling of BSE and medicines. By way of example, had Ministers been asked explicitly to consider whether existing stocks of vaccines should continue to be used while guaranteed ‘clean’ replacements were procured, we believe they would have taken a keen interest in the follow-up. This in turn might have influenced the subsequent pace of events and perhaps led to the doubtful material being phased out rather more quickly than in fact happened.

Structure within MAFF

1233 During the period with which we are concerned, Mr Gummer sought to separate MAFF’s sponsorship role from its role in protecting the consumer, by creating a new Food Safety Directorate. Within that Directorate there were what on the face of it appeared to be significant structural changes within MAFF whose aim was to improve the way administrators and veterinarians interrelated.\textsuperscript{106} It had originally been suggested that the CVL and the Veterinary Investigation Service (VIS) should merge into a single Executive Agency. The SVS, however, had successfully made its case that it should retain the VIS within its structure. Administrators and veterinarians were, however, merged into the Animal Health and Veterinary Group in 1990, only to be sundered again in 1994. Most witnesses considered that neither change had much effect on how the two worked together in

\textsuperscript{104} See vol. 15, Chapter 4 and Annex 1 for details of the interrelationship of professionals and administrators within DH

\textsuperscript{105} DH Permanent Secretary to February 1992

\textsuperscript{106} See Vol. 15: Government and Public Administration for details of the interrelationship of professionals and administrators within MAFF
practice. On a day-to-day basis the Chief Veterinary Officer had direct access to the
Minister, and would assist him or her with professional advice in relation to policy
decisions. Major issues of policy would be put before Ministers in formal
submissions prepared by administrators with the assistance of professional advice
from the veterinarians. A rather similar approach was followed in preparing papers
for SEAC – the paper on slaughterhouse practices is a good example.

1234 So far as the quality of the advice was concerned, this system worked well.
However, it was, as we have noted, a ‘Rolls-Royce’ system. Drafts were circulated
and recirculated among a large number of officials, who might have input to
contribute. Submissions were refined, polished and supplemented with minutes as
they passed up the administrative hierarchy on their way to the Minister. The
process could take a very long time.

1235 Where urgency was perceived, it was possible to cut through the red tape and
reach a decision fast. This had its own dangers. Mr Gummer’s insistence that the
Government should announce its response to SEAC’s advice on transmission of
BSE to a pig simultaneously with announcing that advice, led to defective
Regulations, prepared ‘in secrecy and haste’ without the normal consultation.
Similar haste for a similar motive led to the announcement of a response which
proved unviable in March 1996.

Chief Medical Officers and Chief Veterinary Officers

1236 The evidence we have heard about the parts played by the CMO and CVO in
the BSE story suggests that consideration should be given to two aspects of their
roles. It is not our function to define their roles in the abstract, as we have noted in
Volume 6 in relation to the CVO.

1237 The first aspect calling for consideration is their ability to give independent
advice to the public. Mr Meldrum, at least, considered that the CVO did not have
the degree of independence afforded to the CMO in stating publicly his opinions.
Indeed, Mr Meldrum has assumed that the CMO was required to advise the public,
independent of government, even though this might cause difficulty for his
Department, or other Departments. We are not aware of any secure basis for saying
that the CMO can do this. This may be contrasted, by way of example, with the
position of the Food Standards Agency, one of the functions of which is to advise
the general public. The Agency also has a power to publish such advice. We think
it desirable that the CMO and CVO should be in the same position.

1238 The second aspect relates to the effect of the relative status of the CVO and
CMO. We note that the CVO is an official of high standing in the international
arena, but we understand from the evidence we have heard that under civil service
conventions the CVO ranks only with the deputy CMO. We feel it is important that
this should pose no impediment to direct liaison between the CVO and CMO.

Central and local government

1239 The greatest impediment to the efficacy of the Government’s response to the
emergence of BSE was the structure laid down by statute for the enforcement of the
Regulations that were designed to keep potentially infective tissues out of both
human food and animal feed. The first and most critical control point was the slaughterhouse. In the slaughterhouse, the critical point for human health was the inspection and health-stamping of meat as fit for human consumption. For animal health, the critical control point was the gut room, where in practice, though not by any requirement of the Regulations, most of the SBO should have been kept segregated from material to be rendered to produce MBM for animal feed, and where, in accordance with the Regulations, the SBO should have been stained black.

1240 The statutory duty of enforcing the human SBO ban, together with many other Regulations relating to standards and practices in slaughterhouses, rested on the District Councils. In order to comply with European requirements, which were widely considered to be unnecessarily burdensome, District Councils had to employ an enforcement hierarchy, with the Official Veterinary Surgeon at the top. Local authorities faced severe budgeting constraints. Slaughterhouse supervision did not assert a strong claim in the competition for their limited funds, and in a climate of deregulation there was no encouragement from central government to accord priority to this issue. Most councils spent no more than was barely essential to cover enforcement duties in slaughterhouses. Some did not spend that much. When the MHS took over enforcement, it found that insufficient resources had been employed by at least some local authorities to ensure that the obligation imposed by the human SBO ban to remove all spinal cord from the carcass was universally enforced. It also found that familiarity with the Regulations, efficiency of line management and diligence on the part of local authorities in enforcing the Regulations were uneven across the country.

1241 Had the importance of the removal of spinal cord been emphasised in guidance to local authorities and to the Veterinary Field Service (VFS), which monitored performance, we believe that standards could have been improved, but only within limits. The limitations on the enforcement capability of local authorities could only have been remedied had they been persuaded to devote more resources to that task. We can see no way in which that goal could have been achieved.

1242 Turning to the animal SBO ban, the structural problems were that much greater. The County Councils responsible for enforcing that ban had no locus in the slaughterhouse. The District Councils were not in general enthusiastic about doing their job for them. The situation was exacerbated by the fact that the terms of the animal SBO ban imposed no obligations in the slaughterhouse, but we agree with Mr Meldrum and Mrs Attridge that, however well drafted the Regulations, the statutory structure of local authority enforcement would have prevented strict enforcement of the animal SBO ban.

1243 In this situation, monitoring by central government of the performance by local authorities of their enforcement obligations was desirable. MAFF Ministers thought the same, so far as concerned Regulations sponsored by their Department, and required the SVS to perform a monitoring role. The shortcomings in monitoring which we identify in vol. 5: Animal Health, 1989–96 might well have been reduced if that monitoring had had a statutory foundation.
Central government and the Territorial Departments

1244 We have seen that the Territorial Departments were for the most part content to follow the lead of MAFF and DH with regard to BSE. Nonetheless, we have also seen that communication between Whitehall and the Territories was not always satisfactory. DH was not always interested in the views of the Territorial Departments. This was particularly unfortunate with regard to Wales, where the combination of skills and experience in the Welsh Office allowed its professionals and administrators to make some very useful and pertinent comments. It might well have been beneficial had these been taken on board by DH.

Individual criticisms: redressing the balance

1245 It is inevitable that an Inquiry such as ours focuses on what went wrong. The main point of having the Inquiry is to find out what went wrong and to see what lessons can be learned from this. This can be harsh for individuals. Their shortcomings are put under the spotlight. The overall value of the contributions that they have made is lost from view. We do not wish our Report to produce this result. Yet we cannot set out in detail the workload over the years of each of those who has received – at one point or another – a criticism in our Report. We must make some general comments.

1246 The more senior posts in the civil service are seldom sinecures. Ministerial office never is. We have limited our consideration of individual responsibility to those who occupied such positions. The shortcomings that we have criticised have not been the product of indolence; they have for the most part been mistakes made under pressure of work – pressure made the greater by the imposition on already busy lives of the considerable additional burdens of handling BSE.

1247 The day-to-day demands made by BSE on MAFF, and particularly on the State Veterinary Service, were considerable. By way simply of example, in the period with which we are concerned approximately 200,000 suspect cattle had to be inspected, slaughtered and autopsied by histopathology. The carcasses had to be collected and destroyed. Compensation had to be assessed and paid.

1248 Between 1988 and 1995 about 30 Statutory Instruments in Great Britain alone were brought into force making or amending Regulations dealing with BSE. Some of these involved a great deal of work, but more significantly they evidence the ongoing attention being focused on addressing the implications of BSE for both animal and human health during a period when it was considered unlikely that BSE was in fact a threat to humans. Thus the individual criticisms that we have made must be read in the context of participation in a positive response to BSE, which on the one hand brought the animal disease under control, and on the other resulted in the removal from human food and from medicines of a very high proportion of the material that might have had the capacity to infect.

1249 There are aspects of the response to BSE that stemmed from broader government policies, or from particular ways of handling the problem. Again, these may not be matters that give rise to individual criticism, but they may well highlight lessons for the future. For example, we have noted that Ministers often sought
policy advice from SEAC during most of the period. A lesson we have drawn from this is that where the policy decision involves the balancing of considerations which fall outside the expertise of the committee, it will normally not be appropriate to ask the committee to advise which policy option to adopt. It is not our job to examine broad government policies, for example the deregulation initiative. Where relevant, we have examined their implications for the BSE story. For example, our consideration of the impact of the deregulation initiative for slaughterhouses is in Volume 6.

1250 Those who were most active in addressing the challenges of BSE are those who are most likely to have made mistakes. As was observed in the course of the Inquiry, ‘if you do not put a foot forward you do not put a foot wrong’. In this context we think it right to single out for mention Mr Meldrum. Mr Meldrum was Chief Veterinary Officer in Great Britain for almost the whole of the period with which we are concerned. He involved himself personally in almost every aspect of the response to BSE. He placed himself at the front of the firing line so far as risk of criticism is concerned.

1251 Mr Meldrum impressed us as a particularly dedicated and hard-working civil servant. We are aware that many consider that he epitomises an approach on the part of MAFF that placed more weight on the interests of the farmer than on the safety of the consumer. We do not consider such an accusation to be fair.

1252 Mr Meldrum was at all times concerned that the livestock industry should not be damaged by a public reaction to BSE for which there was, in his opinion, no scientific justification. That is not an approach for which Mr Meldrum can be criticised. On the contrary, we consider that it was a proper approach for the Chief Veterinary Officer to adopt.

1253 In the BSE story there were a number of issues on which Mr Meldrum advanced the view that the possibility of risk to humans was too insignificant to warrant precautionary measures:

- Should offal of sheep be removed from human food?
- Should tripe and rennet from the abomasum be included in the SBO ban?
- Should tissues from calves under the age of 6 months be excluded from the SBO ban?
- Was MRM a risk to humans?

1254 We do not doubt that the views which Mr Meldrum advanced reflected his own beliefs.

1255 When Mr Meldrum had concerns about risks to humans, he acted on them. Thus:

- He recommended that there should be no exclusion from the SBO ban of intestines that had been procured to produce sausage skin.
- In 1990 he raised concerns in relation to peripheral nervous tissue going into MRM.
In 1994 he raised the suggestion of banning recovery of MRM from the spinal column.

We are satisfied that where Mr Meldrum perceived the possibility of a significant risk to human health he gave this precedence over consideration of the interests of the livestock industry.

Pressures on busy people go some way to mitigate a number of other criticisms that we have made – for example, the failures to review the Southwood Report, and failures to give rigorous consideration to the form of the animal SBO ban.

We have criticised the restrictions on dissemination of information about BSE in the early stages of the story, which were motivated in part by concern for the export market. We suspect that this may have reflected a culture of secrecy within MAFF, which Mr Gummer sought to end with his policy of openness. If those we have criticised were misguided, they were nonetheless acting in accordance with what they conceived to be the proper performance of their duties.

For all these reasons, while we have identified a number of grounds for individual criticism, we suggest that any who have come to our Report hoping to find villains or scapegoats, should go away disappointed.