

# **Food Safety Short Stories**

## ***87 Real-Life Cases***

By  
**Peter Overbosch, Yasmine Motarjemi**  
**and Huub Lelieveld**

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**Lelieveld**

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# CONTENTS

<b>Preface</b>	<b>vii</b>
<b>About the Authors</b>	<b>ix</b>
<b>1 Food Safety Management and Whistle Blowing</b>	<b>1</b>
1.1 Letter to the CEO	
1.2 Employee negligence or management failure?	
1.3 A question of professionalism, integrity and courage	
1.4 Leadership responsibility of food safety managers	
1.5 QAFS and senior management - Good intentions may go wrong	
1.6 What lessons from the Great Wall of China?	
1.7 Get your HACCP certificate, hurry, hurry!	
1.8 Food Safety: A corporate social responsibility	
1.9 The hermit and whistle blower	
1.10 Can food safety be translated into financial value?	
1.11 Off with their heads!	
<b>2 Communication, education and (mis)information</b>	<b>34</b>
2.1 Moving a mountain- changing perceptions on childhood diarrhoea	
2.2 The risks of risk communication in food safety	
2.3 Bread in times of pandemic – the fabrication of disinformation	
2.4 Risk perception and food safety priorities	
2.5 The rise of food safety- the long walk	
2.6 Lessons from a Food Hygiene Training	
2.7 Misinterpretation of foodborne disease surveillance systems	
2.8 Human factor in food safety	

<b>3</b>	<b>Incident investigations and management</b>	<b>65</b>
3.1	Ice cream - contaminated product destruction	
3.2	Syringe in ice cream	
3.3	What if your customer becomes a threat?	
3.4	P. roqueforti in cans	
3.5	Allergen ignorance	
3.6	Baby food and failure in the sterilization process	
3.7	A botulism outbreak at Christmas	
3.8	Fruit juice spoilage	
3.9	Managing the safety of cheese made with raw milk	
3.10	A process override	
3.11	Powdered raw material	
3.12	Suspicious meatballs?	
3.13	The role of laboratory surveillance in the detection of outbreaks	
3.14	One way trip – pathogen environmental monitoring program	
3.15	Fish soup intoxication: where is the investigation?	
<b>4</b>	<b>Hazard and risk assessment</b>	<b>116</b>
4.1	Process sampling lessons learned	
4.2	Binomial coffee milk cups	
4.3	May contain peanut	
4.4	Why is the food not warm enough?	
4.5	Meat with or without salmonella	
4.6	It never rains in Southern California	
4.7	Risk assessment of the vegetable oils and fats supply chain	
4.8	Variation process understanding and profitability	

<b>5</b>	<b>Hygienic design and cleaning</b>	<b>140</b>
5.1	Managing Listeria, don't forget the human touch	
5.2	Plate heat-exchanger as thermal insulator	
5.3	Aseptic flowmeter in a dairy cream line	
5.4	Lessons learned from a contamination investigation	
5.5	Superhygienic very expensive membrane valve	
5.6	Feeling the heat with E.coli	
5.7	Listeria in grated cheese	
5.8	Microbiological problems with a meat processing line	
5.9	Spoilage of UHT milk	
5.10	Mold problems	
<b>6</b>	<b>Auditing</b>	<b>173</b>
6.1	Audit tales	
6.2	Wing nuts and a blowtorch	
6.3	Poisonous patisserie (or why management attitude determines safe food)	
6.4	What to do when factories do not meet food safety standards?	
<b>7</b>	<b>Hygiene, pests and contamination</b>	<b>188</b>
7.1	Insects in pasta	
7.2	A foreign object is found in harvested product	
7.3	Glass in confectionery	
7.4	Rodent droppings on fish	
7.5	Ahmad's favourite laksa stall	
7.6	Recycling a mold problem	
7.7	Hygiene issues in the food chain	
7.8	A dangerous past	
7.9	Foreign material prevention gone wrong	
7.10	Failures in incident investigation and root cause analysis	

## Contents

7.11	And it burns, burns, burns	
7.12	Foodborne intoxication caused by eating street food	
7.13	Pesticide poisoning in agriculture	
7.14	A better mousetrap	
7.15	“Mankoushe” gluten exposure	
7.16	Travel-related foodborne illness: salad versus chicken	
<b>8</b>	<b>Food fraud and counterfeiting</b>	<b>236</b>
8.1	Food fraud and counterfeiting	
8.2	Economic adulteration of ingredients with unapproved food colourants	
8.3	Horse Gate – The European meat adulteration scandal	
8.4	Counterfeit mayonnaise	
<b>9</b>	<b>Dangerous products (or are they?)</b>	<b>254</b>
9.1	The memory of a mushroom poisoning	
9.2	Say no to puffer fish	
9.3	Oil safety story in Taiwan	
9.4	Bufotoxin poisoning caused by eating toad meat	
9.5	Goat liver with “Arak” a controversial myth	
9.6	Risk with glass jars	
9.7	Salmonellosis outbreak during a religious feast	
9.8	Warm chicken	
9.9	A mysterious outbreak of “sleeping sickness” in Angola	
9.10	Dilemma of cheese in a sack	
9.11	Safe first food	
	<b>Epilogue</b>	<b>289</b>
	<b>Acknowledgements</b>	<b>291</b>
	<b>Index</b>	<b>295</b>

## Preface

### **The story behind the book: Food Safety Stories**

It is well known that conversations in informal gatherings such as coffee breaks stimulate creativity and productivity. It was during such a meeting that we came up with the idea for this book.

It was November 2020. We were sitting at the airport in Amsterdam discussing a project on ethical practice and whistleblowing. In the course of the discussion, we recalled memories of our professional experiences. Some were foolish, others extraordinary. Each illustrated a point or gave a lesson. In this context, we thought it might be useful to collect these stories and share them in the form of a book for the younger generations or as a learning tool with trainers. Some of the stories raise also issues worth consideration for policy makers and legislators.

The idea of this book was born: a book that would capture the field experience of practitioners in their respective field, with the objective to serve as an education and training tool and that would make the training of professionals more effective. In the process, other experts joined us and generously contributed to the book with their experiences and stories.

Presented in the form of short stories, the book is a collection of unusual events or real-life situations experienced or witnessed by professionals in the food sector, with a focus on food safety, as well as related areas such as quality and legal/regulatory compliance.

The stories convey a lesson of good or bad practices in a scientific, technical, operational or management setting, or provide a lesson in ethics. They would also illustrate the kind of mishap that can happen in real life.

The objective of the stories is to provide present or future food professionals with the benefit of the work experience of other professionals. The stories also serve the lecturers/trainers in their teaching to illustrate a point and bring a lecture to life. They could also be used in classrooms for group discussions. For instance, trainers could present a story and invite participants to discuss the story and the lessons learned.

As such, the book is a complement to other existing books (e.g., Food Safety Management - a practical guide to the food industry (first edition 2014 and second edition 2022) or the Handbook of Hygiene Control in the Food Industry (2016). It is aimed at food professionals from all sectors: students, scientists, managers, trainers, professionals from the food industry or food control agencies, policy makers, certification bodies, and possibly all professionals working in the areas of risk management, public health or other sectors.

Each contribution has been anonymized to the extent possible and needed, as the objective is to support learning and focus readers' attention on the message and the points that the story would like to raise.

**Yasmine Motarjemi, Peter Overbosch and Huub Lelieveld**



## About the authors

The idea for this book originated from discussions between three Global Harmonization Initiative members (GHI, <https://www.globalharmonization.net>), in the context of the GHI Working Group for Ethics in Food Safety (<https://www.globalharmonization.net/wg-ethics>).

**Peter Overbosch** worked until 2014 as Vice President of Corporate Quality Assurance, Metro Cash & Carry (based in Düsseldorf, Germany) and before that as Senior Director Quality Kraft Foods Europe, Middle East & Africa (Munich, Germany), Senior Director Quality Kraft Foods Latin America (East Hanover, NJ, USA), VP of Quality at Nabisco Inc (East Hanover, NJ, USA) and Head of Quality for Unilever Foods worldwide (Rotterdam, Netherlands). Peter is a member of the Global Harmonization Initiative (GHI), where he heads up the working group on “Ethics in Food Safety Practices”, with a personal focus on establishing Food Safety Professionals as a regulated profession. Peter is a citizen of the Netherlands and holds a PhD in Chemistry from the University of Amsterdam.

**Yasmine Motarjemi** holds a MSc degree in Food Science and Technology from the University of Languedoc, Montpellier, France (1978) and a Doctoral degree in Food Engineering from the University of Lund, Sweden (1988). After her academic career, in 1990 she joined the World Health Organization (WHO) in Geneva as senior scientist. From 2000 to 2011, she held the position of Assistant Vice President in Nestlé and worked as the Corporate Food Safety Manager. In April 2019 she received the GUE/NGL award for Journalists, Whistleblowers and Defenders of the Right to Information, in Honour of Daphne Caruana Galizia <https://www.w-t-w.org/en/award-for-journalistswhistleblowers-and-defenders->

of-the-right-to-information/ Yasmine is a member of the Global Harmonization Initiative (GHI), and participates in the working group on “Ethics in Food Safety Practices, leading an initiative on legislation and practices regarding Whistle-Blowing.

Prof. dr. h.c. **Huub Lelieveld** is President of the Global Harmonization Initiative (GHI), Founder and Past-President of the European Hygienic Engineering and Design Group (EHEDG). He is also a Fellow of the International Academy of Food Science and Technology (IAFoST). Formerly, at Unilever, he was responsible for hygienic processing and plant design and novel processing technologies.

## Chapter One

# Food safety management and whistleblowing

## 1.1 Letter to the CEO

It was in the days before globally recognized Food Safety (FS) certifications had become the norm in the food industry and before Hazard Analysis Critical Control Points (HACCP) was a leading FS principle in the legislation of many countries around the world. A consumer wrote to the Chief Executive Officer (CEO) of a European company operating around the world, along the following lines:

I love this particular product of your company. Now, I am about to travel to a south-eastern Asian country for a vacation. Your product is on the market there too, I know, produced locally. As the product is potentially vulnerable to microbial contamination, I am asking you whether it is as safe there as it is here in your (and my) country?

The Public Relations (PR) department suggested that the only possible answer was a simple “yes,” but the CEO felt there was more to it and gave the letter to his senior technical manager responsible for common systems within the company, with the following questions: (i) how exactly should we answer this letter? (ii) if our answer is “yes” (it is as safe there as it is here), how can we be so sure? and (iii) if our answer really is “no” or “don’t know” (never mind what we actually answer to the consumer), what do we need to get to “yes.”

The technical manager made inquiries in the Asian country mentioned and decided that - on an ad hoc basis - the letter could indeed be answered “yes,” but he also realized that this might not necessarily be true for all the company’s products in all the countries they operated in, if only because there was no way for him to be sure. Things needed to get organized,

not on a market-by-market and factory-by-factory basis, with company experts assisting faraway factories as needed and on-demand, but on a much more systematic basis.

Local operating units typically jealously guarded their independence from the company's international head office and argued that de facto standards were simply different in different parts of the world and that they knew the accepted and appropriate conditions for their markets better than head office ever would. Not all things should be measured by European standards, they felt, and nobody should be under the illusion that they could get to a state of "zero risk," not even in Europe, but certainly not everywhere in the world.

While there seemed to be an element of realism there, it would also mean that the consumer's letter could never be answered with a simple "yes." It could only be a "that depends." This was felt to be unacceptable and while the "zero risk" point was well taken, the central senior technical manager told the operating units bluntly: "in this company, we will not have differential kill rates around the world" (the PR department made sure the message was not to be repeated in this form).

That started the corporate Quality Assurance/Food Safety (QA/FS) initiative, with global technical and systems standards being issued, training and audits organized, central incident management being involved whenever things went off the rails, and regular reporting to senior leadership. By the time HACCP was introduced into legislation around the world and companies needed to be certified in accordance with globally recognized standards, they were ready. All because a consumer wrote a letter (and management was smart enough to think through the implications and organize follow-up).

## **1.2 Employee negligence or management failure?**

In 2002, as part of an internal audit, I visited an infant formula factory together with one of my colleagues. He was the lead auditor and an expert in good manufacturing practice. He was particularly skilled at identifying production problems that can pose a risk to food safety.

We entered a hall where the product was mixed in a large container, with the help of a shaft. The axle was leaning on the boarder of the vessel and scratching the bowl as it turned. During the process, due to friction, metal dust was spilling into the product. Very quickly, my colleague saw the problem and raised the issue with the factory quality manager who was following us. He replied: “Yes, you are right, during your last visit, 4 years ago, you noted the same issue!”

My colleague met with the plant manager and he immediately fired the quality manager.

### **Discussion and key learnings**

This story raises many questions. First, we cannot only rely on audits or inspections to ensure food safety. Audits or inspections, carried out periodically, are the only measures “to verify” if preventive measures are observed, in this case, hygienic engineering and maintenance.

The only guarantee of food safety is to ensure that staff is well informed and trained, committed to product safety, and have the time and resources to do their job. If this is not the case, they should be allowed to speak up without fear of reprisals. The accountability of each level of management needs to be clarified and specified in their job descriptions.

Additionally, when there is an audit, the identified gaps, and the required corrective actions, as well as the time frame for these to be carried out, need to be documented in a report. Sometimes, as in this case, the problem may be so critical that the operation needs to be stopped and the problem corrected immediately. The plant manager should ensure with the quality manager that follow-up measures have been taken. Future audits should also verify that past identified gaps have been addressed adequately.

Also, when such events occur, before dismissing the person in charge, it is important to investigate why such a problem had lasted for several years (root cause analysis). How is it that the plant manager did not supervise and ensure that corrective measures were taken? The cause of noncompliances, be it complacencies or resource problems, needs to be reported to the top management.

Finally, inquiries should be made if the problem could occur elsewhere in the company. Were there other vessels with the same technical problem? Were equipment suppliers aware of the problem? The story does not tell, but it is advised not to fire staff before the root causes of issues are known, and accountabilities are determined.

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### **1.3 A question of professionalism, integrity, and courage**

In the company that I worked it was taboo to say that resources and/or expertise was lacking. Anyone who would dare to say so would fall in disgrace. However, being the corporate food safety manager, I had to raise it, when necessary. Perhaps unsurprisingly, this was not well received and I suffered the consequences.

It is reported that one day, in another country, the King, escorted by his generals, visited a military hospital where my father worked. He was a surgeon colonel and the director of the hospital. The King asked my father what he needed for the hospital. He answered: "We need more qualified nurses." The King ordered the generals to follow up on this request. After the King left, the generals jumped on my father and reprimanded him for raising this issue.

Reportedly, my father replied: "If you wish, you can demote me and take away my military status; but I remain, first and foremost, a physician, and that you cannot take away from me!"

In my own situation, after multiple attempts to raise awareness about the issues surrounding food safety management in my company, I lost my job. I remembered the words of my father. I said to myself, "They took my job away from me, but they can't take away my profession and the fact that I am still a food safety and public health professional." It was then that I decided to blow the whistle on the abuses in food safety management, for the sake of public health.

### **Discussion and key learnings**

This story is not about the King but about my father, who had the courage to speak the truth, to stand up to bullying, and to



put public health above his career. It is also about the heritage that we leave to our children, that is the model that we show to future generations. It is about resilience and standing for our principles, professionalism, and dignity.

## 1.4 Leadership responsibility of food safety managers

I was working as the corporate food safety manager in a multinational company. One day, a new Director of Quality was appointed as my boss. His focus was on the business, even at the expense of consumers' health and safety. For instance, he was not paying attention to consumer complaints about potentially dangerous products, and he was unwilling to have raw materials monitored for possible contamination. Not only he was giving wrong advice, he was also preventing me from doing my job. Professional frustration on my side had been building up for some time, when one day, when I couldn't stand this situation any longer and I found myself at a crossroad in my life.

Should I report my boss's dysfunctional behaviour and the dire situation of the department to senior management, or keep quiet and put up with what was going on? Accepting the status quo involved the risk of a serious incident endangering the health of consumers or the reputation of the company. On the other hand, knowing the culture of the company, I knew that calling out my boss could get me dismissed.

It was a difficult decision to make, but a memory of an encounter that I had with some of our product development managers, whom I had instructed about safety aspects in product design, helped me decide.

One day, one of our operating companies reached out to my department for approval of a new product they had developed. It was an ice cream, where the wooden stick had been replaced by a glass stick, with a liquid solution that changed color. It was supposed to be attractive to children. Of course, immediately we vetoed the product. After a while the operating company

came back with the same idea but had replaced the glass stick with a plastic one. After verification, we discovered the solution contained a carcinogenic substance and, on the package, a strong warning was given to consumers. Naturally, again, we strongly objected and the project was abandoned.

A few months later, I was giving a course on food safety to project managers in the ice cream business. I advocated for food safety and advised them that during product development they had to take into account all potential food safety issues and design out any potential risks. As an example of bad practice, I referred to the idea of replacing the normal wooden stick with glass and confronted them: "How could you think of producing such an ice cream? Had you lost your mind?" Then, one of the participants raised his hand. He said that this product had been designed in his market and that many opposed its production, but that they had been fired. Later, I learned that he himself was ostracized for opposing the design of the product. I replied: "Whatever happens to you, you must never accept products that you know are dangerous to consumers."

So, when I had to decide what to do, I remembered this event and realized that the problem was a pervasive "business over safety" culture. It was not just me having my own frustrations. Now could I, the person responsible for food safety, stay in my position and maintain credibility without openly opposing and reporting such situations? So, I made my report and suffered the consequences I feared. Nevertheless, to this day, I do not regret my decision.

## **Discussion and key learnings**

Being in charge of food safety in a company, small or large, you will be confronted with situations that require you to

stand your ground, in some cases against formidable internal opposition. If food safety is not a real core value within the company culture at such moments, your credibility, your authority, and indeed your continued employment may be at stake. Blowing the whistle at such moments may be unavoidable from a perspective of personal responsibility and integrity, but it may also have very negative personal consequences.

Because the importance of food safety and the critical role of food safety managers in a potentially very challenging environment is increasingly recognized, the regulatory framework around the protection of whistleblowers is slowly changing, and more and more countries are legislating for their protection.

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## **1.5 QA/FS and senior management; good intentions may go wrong**

In my working life, I have had the privilege of working with a number of very experienced senior managers in large food companies. Most of them, typically coming from financial or marketing backgrounds, were supportive of QA/FS programs but not familiar with what we were actually doing. They also felt that food safety should not be used as a competitive advantage “we are not going to tell the general public that our product is safer than our competitor’s, even when that might be true” and that the focus of the company should be on those activities that drive the business. Asked why quality and safety had not been mentioned at all in a long-term visionary plan for our company, one CEO told me that “quality is a given” and he did not seem to appreciate my question as to who had given it to him.

Another CEO in another company informed me that he wanted “no more public recalls,” after we indeed had a few of them in the recent past. My answer that we were working on it and that I was confident that over time we would significantly reduce the risk if we continued to implement our programs was not well received. “You did not understand me,” he said, “I want no more public recalls.” With the help of some other senior managers, he was brought to see reason and afterward continued to be supportive of our efforts. One of his lieutenants later told me that he had explained QA to his boss “it’s like an insurance policy,” he said, “QA doesn’t drive the business, but we need to spend the money, to keep safe.” I did tell him that we are the exact opposite; insurance allows you to continue doing what you are doing, but it will pay out when things go wrong. QA tells you that you must change your ways, and we don’t pay out when things go wrong after all.

A very proactive CEO at yet another company announced that he would introduce a gamechanger, a measure that would show everybody the company's commitment to quality and safety and make it count to his staff and their reports. The end-of-year bonuses would be linked to recalls - if one occurred in your area, that would impact negatively on your bonus. The idea was that we would all focus more on good practices and prevention, but that was not exactly what happened.

The Senior Vice President (SVP) of Operations that I worked with at the time informed me that from now there would be no more recalls issued, unless agreed with one of his product-sector VPs. There seemed to be not much point in escalating this discussion at that moment and things seemed to work for a while (obviously we did not have that many recalls), until one day I was informed that we had a serious problem. One of our products contained an allergen, which in that particular batch was not declared on the label. Consumers had complained of relatively serious allergic reactions and some had informed the authorities.

The situation could not be clearer; a product was mislabeled, therefore illegal; there were serious complaints, and the authorities could be on our doorstep at any moment. This was a textbook public recall. Before instructing the country organization to initiate the recall, I dutifully tried to reach the sector VP, but no luck. And so, the recall was initiated, the general public and authorities informed, emergency messages sent to the sector VP and to his boss, the SVP of Operations. He was furious. Asked why his VP was not contactable at the time and what he felt should have been done differently under these circumstances, he eventually calmed down and we were able to refocus his attention to preventive QA/FS measures instead of prevention of recalls per se. The recall-related bonus measure silently disappeared a bit later.

## **Discussion and key learnings**

The relationship between QA/FS managers and top management is not always easy. The people involved typically come from very different backgrounds; QA/FS does not drive business, cannot be used as a marketing tool, and does not speak in financial terms. Still, it is essential that senior management, who typically are from marketing/finance backgrounds, but not well versed in, e.g., microbiology or HACCP, understands enough about QA/FS to make the kind of decisions that only they can. For QA/FS in large companies, it is therefore essential that they have board-level representation, separate from, e.g., operations or marketing, to avoid important potential conflicts of interest being decided, and potentially hidden from view, below board level.

In this story, the recall-bonus link is a clear example of good intentions with unexpected negative consequences, a perverse incentive to try and avoid even clear case recalls. The intention was to focus people's attention on preventive measures, but that was not sufficiently explained, and it came without additional supportive measures (e.g., "we will invest in a company-wide certification effort," or "we will review all our HACCP plans again the coming two years, with the help of external experts").

There have been cases, however, where a link between recalls and bonuses was introduced with no intention at all to emphasize preventive measures, just suppressing the number of recalls. In some cases, that then led to, e.g., a reduction in the programs to monitor contaminants in raw materials.

The conclusion at this point is that linking bonuses to recalls introduces counter-productive incentives into a company's

food safety practices. Managers need to be encouraged to do the right things and only be (financially) sanctioned if they are found to have violated company rules or principles or neglected their duties.



## **1.6 What lessons from the Great Wall of China?**

When I joined the World Health Organization in 1990, one of the first subjects I was asked to work on was health education in food safety. At that time, a lot of work had already been done in the department and several publications on the subject were in preparation.

The central point of these publications was that biological or chemical sciences and technology, i.e., technical data, are not sufficient to manage product safety. Equal attention needs to be paid to human factors, i.e., education and/or training of operators, whether managers, workers, food handlers, or caregivers, and these need to be based on social and anthropological information.

The idea was that in order to convince and motivate operators of any category to follow recommended safety measures or do their work in a flawless manner, it is necessary to understand their perceptions, constraints, living, and working conditions and also ensure that the recommended measures or instructions are feasible and culturally acceptable.

Later, working in food industry, but also studying incidents in other risk sectors such as aviation, I gained first-hand experience and a deeper insight into the importance of the human factor in food safety management. I realized how much compliance of staff depends on company culture, working conditions, attitude and ethics of the employees themselves, and the behavior of managers.

Recently, I read a story in National Geographic that reminded me of this aspect of food safety management and illustrates the importance of human factors in risk management.

For centuries, nomadic herders living in the steppe territories bordering northern China have posed a threat to the Chinese population.

As a defense strategy, at various times, but especially in the 16th and 17th centuries, during the Ming Dynasty, a wall about 21,000 km long was built. It is known as the “Great Wall of China.” The Chinese rulers were convinced that the wall would protect their people from the aggression of nomads, including the Mongols. However, despite this impressive military construction, the Great Wall did not fully achieve its main purpose.

It is explained that the men who guarded the wall lived in extremely difficult conditions. They lacked food and warm clothing and suffered from hunger, cold, and wind. They were separated from their families for months or even years - a situation that undermined their morale and created mistrust. The guard troops were not dedicated to their task.

There are several accounts of how the guards did not perform their duties or failed to alarm when the Mongols attacked. Some even fled without resistance. Sometimes they had friendly contacts with the enemies or traded with them. Sometimes they even colluded with them.

These conditions meant that, despite the ingenious military structure, nomads could scale the wall with hooks and enter Chinese territory without much defense from the guards.

## **Discussion and key learnings**

Historical events provide valuable life lessons. Great walls and military tactics will all be to no avail without the human factor. The lesson for food safety management is the same:

All the technology and science will not guarantee product safety if the operators are not motivated, do not have a sense of ethics and professionalism, or if they have to work under threat and duress. The recent focus on “food safety culture” seems to formally recognize the towering importance of the human factor in the success of food safety systems. That is great progress, but these lessons really go back to ancient times.

### **Further reading**

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## **1.7 Get your HACCP certificate, hurry, hurry!**

Some years ago, I worked as a quality and HACCP systems auditor. During the audits, I used to observe the reactions of people when asking how they manage the HACCP system. I often found they had interesting views, but most of all they wished the auditor to see as little as possible and to discover as few noncompliances as possible.

In one case, I was auditing a HACCP system at an operating unit of a large food company and I asked the person in charge to present their hazard analysis. It got complicated from the very start, since the site had neither identified and assessed all relevant risks nor their causes or, as a result, defined necessary preventive measures. Furthermore, the HACCP documentation was not systematized and did not provide traceability for certain record sheets and work instructions.

Actual practice was much better, but people responsible for individual processes had difficulty explaining their procedures, since the way they worked was inconsistent with the actual documentation. Still, they tried all sorts of arguments to convince me that their systems and practices were compliant with HACCP principles/systems.

When I reported my findings including inconsistencies with the HACCP system, factory management showed indignation and refused to accept it. They tried to convince me they were in the process of harmonizing HACCP documentation and asked for my understanding. However, my findings stood and as an auditor, I simply had to follow the official standards. This production site failed the audit.

Shortly afterward, the European inspectors also discovered quite a number of inconsistencies. At a follow-up audit later,

I found the situation to be much better and the awareness around HACCP system to be at a much higher level.

### **Discussion and key learnings**

The parent company had marked this production site as a source for export to foreign markets, so they needed to get their certificates ASAP and prepared the necessary HACCP documentation hastily and apparently without any substantial support from the parent company. That is not always the case, many larger food companies issue standard HACCP and general QA system templates for their subsidiaries for them to adapt to local conditions and implement. Not here.

In this case, those responsible for the overall HACCP system and individual processes were aware of the weaknesses in documentation, which was not fully consistent with practice, but they did not want to admit it.

The main issue is that, in general, documentation is often perceived as an administrative paperwork and not as a means of communication among HACCP team members or as a basis for review and reflection. Documentation is also important in case of investigation of an adverse event, or inspection, certification to prove that what is necessary has been carefully considered and implemented. It is also important in case of a change in the process or ingredients and evaluation of possible modifications to be brought.

Additionally:

- Multinational companies that do not provide their operating units with standard HACCP and QA system templates are missing a huge opportunity and opening the door to inconsistent practices.

- Under pressure (to start production for export and get their certificates), people will cut corners and try to defend clearly inconsistent and noncompliant systems to auditors.
- Auditors need to remain calm and focused under pressure. The auditee may not always be happy, but the integrity of the audit and the credibility of a certificate come first. A negative audit or inspection evaluation may in the short term upset but in the long term it may serve the company and protect consumers.
- The importance of documentation needs to be clearly understood (and therefore often better explained) to the management of businesses.