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Salad Bar Salmonella Report

On September 17, 1984, the Wasco-Sherman Public Health Department in Oregon reported cases of gastroenteritis. The increase in cases could be traced back to two restaurants. The symptoms of the infected individuals consist of fever, chills, nausea, vomiting, pain, and bloody stool. Thus, the increase in infections was attributed to Salmonella poisoning. The outbreak was presumed to be linked to the salad bar. As a result, the restaurants restricted access to the salad bars in Dalles, Oregon.

Due to the scale of the outbreak, the local health department contacted the CDC via phone. The EIS officers of the CDC identified the following salad bar items that had been contaminated: macaroni, potato, four-bean or pea salad, and blue cheese dressing. The cases consisted of a total of 751 individuals infected with Salmonella and 45 were hospitalized. This is in direct comparison with the 3-year period prior to the outbreak where a total of 8 cases were confirmed.

Environmental contamination studies concluded that there were no water line breaks, no shared food distributors, and an unhygienic food practice at various restaurants. Thus, the epidemic concluded in mid-October of 1984. One year after the outbreak, a police investigation and the FBI identified that cult members in the neighboring areas of Oregon commercially obtained lab cultures in the cult's headquarters and contaminated the salad bars at restaurants in the area to defile local election proceedings. Thus, in 1986, the defendants were found guilty and sentenced to 4.5 years for conspiring to tamper with consumer products by food poisoning.

If this outbreak occurred today, the local health department in Oregon would have had a more efficient way to contact the CDC and notify the organization of a potential outbreak. Thus, the CDC would have had been more efficient when controlling and mitigating the outbreak and when identifying its source. If this case occurred today, there would be more effective security measures, such as cameras, put in place to monitor the food stations.

Consequently, as this contamination was caused intentionally, the case would have been managed differently according to terrorism protocol. As a result, the police department/FBI would have been notified earlier upon discovering the outbreak. The case can be labelled as a public health disaster due to ineffective handling of food safety within a restaurant setting. The coordination between law enforcement and public health departments should have begun at the onset of the outbreak when the CDC was contacted. I would make sure that the necessary facilities be contacted once an infection was linked to the restaurant, and proper health security measures be taken to ensure the restaurant has proper food hygiene protocol. These measures would have prevented the onset of an outbreak.

References

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