

# 6

## Examples of Success and Failure During Outbreaks of Food-Borne Illness



Outbreaks of food-borne illness, caused by eating food presumed to be safe, produce one of the most common forms of organizational crises. If you have never been affected by a food-borne illness, consider yourself fortunate. Anyone who has ever suffered from some form of food poisoning is well aware of the physical discomfort that comes with it. The Centers for Disease Control and Prevention (CDC) estimate that 76 million food-borne illness cases occur annually in the United States alone. Of the 76 million, approximately 325,000 cases are so severe that the victims must be hospitalized; worse yet, 5,000 people die due to food-borne illnesses every year (CDC, n.d.). The volume of sickness tracked by the CDC clearly establishes the significance of food-borne illness to studies in organizational crisis communication.

In this chapter, we offer three examples of food-borne illness outbreaks that were dangerous or deadly to consumers and potentially devastating to the organizations responsible. First, we apply the lessons for managing uncertainty to an *E. coli* 0157: H7 outbreak in Jack in the Box restaurants. Second, we apply the communication effectiveness

## 84 APPLYING THE LESSONS

lessons to an outbreak of Hepatitis A in a Chi-Chi's restaurant. Last, we apply the lessons of crisis leadership to a Salmonella outbreak caused by Schwan's ice cream.

❖ LESSONS ON UNCERTAINTY:  
JACK IN THE BOX'S *E. COLI* 0157: H7 CRISIS

In May 1992, a seemingly routine letter from the Washington State Department of Health arrived at Jack in the Box restaurants' corporate headquarters. The letter informed the fast-food chain that the minimum grill temperature for frying hamburgers had been raised to 155 degrees Celsius, a temperature even higher than the federal standard. The higher temperature was required to enhance consumer safety. For reasons that may never be known, the letter was not discussed or acted upon by the company's leaders. Instead, the letter was placed in a file where it remained until a comprehensive investigation was conducted 7 months later.

**Photo 6.1** One of the many Jack in the Box restaurants located in the Pacific Northwest



Source: Photo courtesy of Sarah Quesenberry.

### **Crisis Planning and Preparation**

The Washington State Department of Health demanded the higher cooking temperatures to avoid outbreaks of food-borne illnesses such as those caused by the *E. coli* O157: H7 bacteria. For most people, an *E. coli* O157: H7 infection results in the same symptoms as a severe case of the stomach flu. For the very old and the very young, however, *E. coli* O157: H7 is potentially deadly, and it poses the greatest danger in ground hamburger.

Jack in the Box received the first clue that its restaurants were responsible for a serious outbreak of *E. coli* O157:H7 in January 1993. Seattle Children's Hospital notified the Washington State Department of Health that an unusual number of children were suffering illness caused by *E. coli* O157:H7. Two days later, on January 13, Jack in the Box was notified of a possible connection between its restaurants and the outbreak. By January 18, the evidence pointing toward Jack in the Box was convincing. As the following press release issued by Jack in the Box indicates, the company addressed the crisis but remained ambiguous regarding responsibility for the outbreak:

Although it is unclear as to the source of an illness linked to undercooked beef, JACK IN THE BOX announced today that it has taken measures to ensure all menu items are prepared in accordance with an advisory issued yesterday by the Washington State Department of Health. (Foodmaker, January 18, 1993, p. 1)

Jack in the Box argued further that "some but not all of the persons being treated for the illness had eaten at area JACK IN THE BOX restaurants, as well as other restaurants several days before developing symptoms" (Foodmaker, January 18, 1993, p. 1). At this stage in the crisis, Jack in the Box remained defensive and limited its response to routine safety procedures. No clear ongoing crisis management plan was evident. Instead, Jack in the Box took a wait-and-see approach: waiting to see what the Washington State Department of Health found in its investigation and planning to determine its response after more evidence was available.

### **Jack in the Box's Response To an Uncertain Crisis**

Nearly a week after the Washington State Department of Health alerted Jack in the Box of a possible connection to the *E. coli* O157:H7 outbreak, Jack in the Box took significant action. On the brink of a

public announcement by the Washington State Department of Health implicating Jack in Box, the company issued the following press release:

Up to this point we have been reluctant to say that the source of the problem was contaminated meat, simply because we did not want to speculate until test results were in. We have been told that the State will be issuing a press release later today with specific results. However, we believe, based on information from the State, that the problem is in fact due to contaminated hamburger. (Foodmaker, January 21, 1993, p. 2)

Having admitted to at least serving contaminated meat, Jack in the Box responded by recalling and destroying 28,000 pounds of hamburger from a shipment determined to be infected. The company emphasized that not all hamburgers sold by Jack in the Box in January were infected. The company also called its decision to seize and destroy so many products an "extraordinary step." Jack in the Box was extremely critical of its meat supplier, Von's. Jack in the Box argued that the blame for the outbreak should be shifted away from its restaurants to Von's and the government agencies that are charged with inspecting meat before it is sold to stores and restaurants. Sadly, the day after Jack in the Box's announcement, the first child died of complications resulting from eating a Jack in the Box hamburger. Two more children died later.

Destroying contaminated meat means little when *E. coli* O157:H7 is involved. Even contaminated meat is safe if cooked properly. Destroying one lot of beef, then, cannot ensure safety. Another lot of contaminated meat is likely to follow at some point. Only appropriate cooking procedures can protect the public from this kind of infection. Knowing this, it is not surprising to learn that an investigation of Jack in the Box's grills during the crisis indicated that they were operating well below the minimum standard established by the Washington State Department of Health. When the State's findings were shared with Jack in the Box, the company made two unfortunate claims. First, it stated that it had never been notified of the need for higher grill temperatures. Second, it added ambiguity to the situation by insisting that its grills were operating at a temperature that met a lower national standard. Neither argument proved helpful in its crisis communication. The company had indeed been informed of the higher temperature requirement. Moreover, the temperature of the grills was indefensible, since more than 400 people had already fallen ill after eating at the restaurants. Distinguishing between state and government standards

for grill temperatures did little to address the concerns of parents nationwide who feared for the safety of their children.

On February 12, the regrettable denials regarding grill temperature were addressed by Jack in the Box's CEO, Robert Nugent: "A search of our files revealed that in May, 1992, a bulletin from the Bremerton-Kitsap County Health Department was received in our corporate headquarters. That bulletin contained information about the new state standard" (Foodmaker, February 12, 1993). In essence, Jack in the Box's failure to raise its grill temperatures was the source of the crisis. The cause of this failure can be linked to a communication breakdown. The content of the letter from the Washington Department of Health was never shared with the organization's leadership. In response to this communication failure, Nugent announced the following five changes in Jack in the Box's organizational communication procedures:

1. We have established a new communication system between corporate headquarters and every county and local health department in areas we have restaurants.
2. All written regulations are on file and being made known to appropriate field operatives.
3. We have created a computer database with key regulatory information pertinent to our operations.
4. Responsibility has been assigned to a corporate Technical Services Manager to document all regulatory changes that affect Jack in the Box Operations.
5. We are requiring follow-up documentation to verify that preparation procedures impacted by any new regulations are correctly modified. (p. 2)

In short, the *E. coli* O157:H7 crisis motivated Jack in the Box to almost totally reinvent its internal communication procedures.

In the end, the crisis was financially distressing for Jack in the Box. The company finished fiscal year 1993 with a loss of \$44.1 million. Yet the company survived by making strategic changes. Jack in the Box instituted rigorous safety standards in all of its restaurants following the crisis. The company now closely scrutinizes all the beef it purchases and maintains grill temperatures in excess of the highest standards. Jack in Box also improved its communication procedures both inside and outside the company. In addition to the five internal communication changes listed, Jack in the Box completely redesigned its public relations and crisis planning procedures.

### You Make the Call

After examining this case, it is time to determine whether Jack in the Box dealt effectively with the type of uncertainty we described in Chapter 2. First, take a moment to refresh in your mind the lessons established on managing uncertainty. These lessons should help you to identify the strengths and weaknesses of Jack in the Box's crisis response. As you check the boxes to the questions that follow, consider whether Jack in the Box was effective or ineffective in addressing the crisis from beginning to end. We have rephrased the lessons into subsequent questions so that you are better able to address the key issues in the case.

#### **Managing Uncertainty in Food-Borne Illness Outbreaks: Lessons on Uncertainty and Crisis Communication**

*Lesson 1:* Organization members must accept that a crisis can start quickly and unexpectedly.

In what ways did Jack in the Box's crisis start quickly and with uncertainty?

*Lesson 2:* Organizations should not respond to crises with routine solutions.

Did Jack in the Box respond to the crisis in a routine manner? Was their response effective?

*Lesson 3:* Threat is perceptual.

In what ways was the threat associated with this crisis perceptual? How did perceptions differ among stakeholders?

*Lesson 4:* Crisis communicators must communicate early and often following a crisis regardless of whether or not they have critical information about the crisis.

Did Jack in the Box communicate early and often following the crisis? Were they effective or ineffective?

*Lesson 5:* Organizations should not purposely heighten the ambiguity of a crisis to deceive or distract the public's attention.

Were there issues that were uncertain or ambiguous for stakeholders following the crisis? Did Jack in the Box heighten the ambiguity surrounding the crisis to deceive or distract the public?

*Lesson 6:* Be prepared to defend your interpretation of the evidence surrounding a crisis.

Did Jack in the Box defend its interpretation of evidence surrounding the crisis? Was Jack in the Box effective or ineffective?

*Lesson 7:* Without good intentions prior to a crisis, recovery is difficult or impossible.

Did Jack in the Box develop good intentions with stakeholders prior to the crisis?

*Lesson 8:* If you believe you are not responsible for a crisis, you need to build a case for who is responsible and why.

Did Jack in the Box build a case for why it was not responsible for the crisis? Was Jack in the Box effective or ineffective?

*Lesson 9:* Organizations need to prepare for uncertainty through simulations and training.

Did Jack in the Box plan adequately for the crisis?

*Lesson 10:* Crises challenge the way organizations think about their business.

In what ways did Jack in the Box change the way it conducts its business following the crisis?

## Summary

The Jack in the Box crisis is a classic case of how threat, surprise, short response time, and uncertainty can impact decision making and communication following a crisis. Under the stress and uncertainty of the crisis, Jack in the Box made a critical mistake by shifting blame for the crisis outside the organization when the company had not checked to make sure that it was not responsible. Jack in the Box capitalized on the uncertainty of the situation in the short term, but when an internal investigation revealed that the company's headquarters had received

the new state standard, the company quickly moved to accepting responsibility and learning from the crisis.

❖ LESSONS ON EFFECTIVE CRISIS  
COMMUNICATION: A DEADLY HEPATITIS  
A OUTBREAK AT A CHI-CHI'S RESTAURANT

On a hot day in September 2003, farm laborers worked in the Mexican sun to pull green onions. The onions were rinsed, placed in 8.5-pound boxes, packed with ice, and shipped to the United States. Unbeknownst to the Mexico farm's management, its workers, and the Chi-Chi's restaurant that would buy the scallions, the ice wedged into the boxes was made from water that was infected with the Hepatitis A virus. As the boxes made their way over the border and to a Chi-Chi's restaurant at the Beaver Valley Mall in Monaca, Pennsylvania, the ice melted. Water from the ice soaked the green onions, permeating the product with the virus. At Chi-Chi's, the green onions were washed—an action that had no affect on the contamination—chopped, and served in Chi-Chi's salsa. The result was a full-blown food contamination crisis.

Hepatitis A is a potentially deadly virus that attacks the liver. The virus is typically avoided through good personal hygiene and proper sanitation. Hepatitis A can, however, spread through contaminated food. Fiore (2004) explained that food contamination can occur from sources such as an infected worker or water source. Fiore contends that Hepatitis A outbreaks from a food source are extremely difficult to track and identify. Some of the reasons cited for this difficulty are relevant to the Chi-Chi's case:

**Photo 6.2** A vivid headline announcing the Chi-Chi's restaurants crisis



**Three Dead, Nearly 500 Sickened In  
Nation's Largest Hepatitis A Outbreak**

Source: Used with permission of The Associated Press Copyright © 2003. All rights reserved.



Infected patients may have difficulty identifying where they have eaten during the 2-6 weeks before becoming ill.

Cases may accrue gradually or be unreported.

Some exposed persons have unrecognized infections.

Some exposed persons have preexisting immunity to the virus.

Cases are geographically scattered. (p. 6)

Unfortunately, the difficulty in identifying a food-related case of Hepatitis *A* means that many people can be sick or dying before the source is known.

The long incubation period and the general difficulty in tracing the cause of the outbreak led to the expansive impact of the Chi-Chi's crisis. In the end, 10,000 people were screened for Hepatitis *A* in the Beaver County area, and 9,100 were inoculated in hopes of preventing the spread of the virus. Of the 10,000 who were screened, 660 were positively identified as having been infected, and 130 people were hospitalized.

### **A Complicating Factor for Chi-Chi's**

Prior to any sign of the Hepatitis *A* crisis, Chi-Chi's was in the midst of an unrelated crisis. In October 2003, 1 month after Chi-Chi's received the shipment of infected green onions, its parent company, Prandium, filed Chapter 11 bankruptcy. Prandium's bankruptcy filing was due to serious cash flow problems. When the Hepatitis *A* crisis hit, Prandium was already deep in debt.

The Prandium bankruptcy posed a complicating factor for Chi-Chi's as it attempted to respond quickly to the Hepatitis *A* crisis. Because of it, Chi-Chi's lost much of its financial flexibility. Chi-Chi's could not offer financial compensation to the victims in Beaver County without the consent of the creditors to whom Prandium owed large sums of money. Thus, Chi-Chi's faced a tension among stakeholders that most crisis victims do not confront. The company could not respond to its primary stakeholders, Chi-Chi's customers, without seeking permission from external stakeholders whose only interests were based on Prandium's ability to pay its debts.

### **Chi-Chi's Crisis Response**

Cases of Hepatitis *A* were mounting in Beaver County at the start of November 2003. By November 3, the outbreak was confirmed, and

the Pennsylvania Department of Health announced the threat, informing residents of treatment and prevention options. Chi-Chi's had a good idea they were the source of the outbreak when six of its employees were identified positively for Hepatitis A. On November 7, Chi-Chi's made the following public statement:

We sincerely apologize to all of our loyal customers and want to inform the community that Chi-Chi's will do everything within our power to make sure that our patrons continue to enjoy a healthful and rewarding dining experience and that our employees have a safe and sanitized working atmosphere. (WPXI, 2003)

Chi-Chi's wasted no time in admitting at least a share of the responsibility for the crisis. The company pledged diligence in identifying the cause of the problem and in recovering from the crisis. The restaurant remained closed until the source of the infection was determined and removed.

Chi-Chi's response was further complicated by the fact that the source of the infection came from another external stakeholder, the Mexico farm. A week after Chi-Chi's publicly accepted that its restaurant was responsible for the outbreak, the company stopped serving green onions. By November 21, health officials definitively identified green onions as the source of the outbreak. On November 22, the United States government halted imports of green onions (Sjoberg, 2005). Clearly, Chi-Chi's was, to some extent, a victim in the Hepatitis A crisis. The source of the outbreak was a product that was infected before it ever reached Chi-Chi's kitchen. Although this fact may have been useful in litigation, it lacked appeal in the court of public opinion. Chi-Chi's and all restaurants are aware of the potential for Hepatitis A and other food-borne illnesses to contaminate their products. Consumers expect restaurants to take precautions to avoid such infections. Chi-Chi's wisely did not base its crisis response on a strategy of blaming the supplier.

Chi-Chi's accepted responsibility for the crisis and vowed to compensate patrons who became ill after eating at the Beaver Valley Mall Restaurant, consistently emphasizing that the well-being of its patrons and employees was paramount. Chi-Chi's creditors initially questioned and delayed the company's attempt to compensate victims. The bankruptcy court eventually allowed payment of claims under \$35,000 to be paid without a time-consuming extension of the verification process. The payment process was expected to consume all, if not more than, the \$51 million liability insurance policy Chi-Chi's had in place before the crisis (Mandak, 2003).

The Beaver Valley Mall Chi-Chi's was able to maintain the loyalty of its clientele. When the restaurant reopened, devoted customers lined up to be served. In the end, however, the restaurant did not survive. Prandium was financially fragile before the Beaver County outbreak, and the costly compensation paid by the restaurant was more than the company could bear. The Beaver Valley Mall Chi-Chi's closed for good shortly after reopening. Prandium never recovered from bankruptcy. In September 2004, Chi-Chi's properties were sold "at an auction of designation rights" to Outback Steakhouse, Incorporated (Lockyer, 2004).

### **You Make the Call**

After examining this case, it is time to determine whether Chi-Chi's communicated effectively with the many stakeholders involved in the crisis. First, take a moment to refresh in your mind the lessons established in Chapter 3 on communicating effectively and ineffectively during crises. These lessons should guide you in evaluating the strengths and weaknesses of Chi-Chi's crisis response. As you contemplate the questions that follow, consider whether Chi-Chi's was effective or ineffective in coping with the added financial constraints it faced during its crisis response.

### **Communicating Effectively and Ineffectively During Food-Borne Illness Outbreaks: Lessons on Communicating Effectively in Crisis Situations**

*Lesson 1:* Determine your goals for crisis communication.

Did Chi Chi's exemplify clear goals in their crisis communication?

*Lesson 2:* Before a crisis, develop true equal partnerships with organizations and groups that are important to the organization.

In what ways did Chi Chi's develop partnerships with stakeholders?

*Lesson 3:* Acknowledge your stakeholders, including the media, as partners when managing the crisis.

How did Chi Chi's acknowledge its stakeholders following the crisis?

*Lesson 4:* Organizations need to develop strong primary and secondary stakeholder relationships.

94 APPLYING THE LESSONS

Is there evidence that Chi Chi's established relationships with its stakeholders?

*Lesson 5:* Effective crisis communication involves listening to your stakeholders.

Is there evidence that Chi Chi's listened to its stakeholders?

*Lesson 6:* Communicate early about the crisis, acknowledge uncertainty, and assure the public that you will maintain contact with them about current and future risk.

In what ways did Chi Chi's maintain contact with the public?

*Lesson 7:* Avoid certain or absolute answers to the public and media until sufficient information is available.

Did Chi Chi's provide certain or absolute answers about the cause of the crisis?

*Lesson 8:* Do not overreassure about the impact the crisis will have on stakeholders.

Did Chi Chi's overreassure about the impact of the crisis?

*Lesson 9:* The public needs useful and practical statements of self-efficacy during a crisis.

In what ways did Chi Chi's provide statements of self-efficacy following the crisis?

*Lesson 10:* Effective crisis communicators acknowledge that positive factors can arise from organizational crises.

Was there evidence that positive factors could arise from this crisis?

### Summary

The Chi Chi's predicament provides an example of the impact that a crisis can have on an organization even if it tries to do the right thing. Chi Chi's was already in bankruptcy when it learned that six of its employees and hundreds of customers were infected with Hepatitis A. Even though the company appropriately accepted responsibility and showed remorse, the crisis was too difficult to overcome. Crises are one of the key contributors to organizational mortality. As a result, organizations should simultaneously plan for and work to prevent crises through risk identification and crisis planning.

❖ THE LARGEST FOOD-BORNE ILLNESS OUTBREAK  
IN HISTORY: SCHWAN'S SALES ENTERPRISES

In September 1994, a tanker truck owned and operated by Cliff Viessman, Incorporated, returned to the company's Minnesota facility after hauling a load of raw eggs which, unknown to Viessman employees, were infected with salmonella bacteria. The truck was parked and scrubbed internally by high-pressure washers. The washing, however,

**Photo 6.3** In the middle lane, Schwan's trucks on their way to supply frozen food throughout the nation

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Source: Photo courtesy of The Schwan Food Company.

did not completely eliminate the bacteria, and as the contaminated truck sat idle, waiting for its next load, the bacteria multiplied. Unfortunately for Schwan's Sales Enterprises (Schwan's), the contaminated truck's next assignment was to haul ice cream mix to the Schwan's plant in Marshall, Minnesota. The ice cream mix was severely contaminated by the time it was delivered to Schwan's. In turn, the mix contaminated every part of the Schwan's ice cream processing system that it touched.

Egg-associated salmonella infections are a serious health problem. The CDC explains that persons infected with salmonella experience "fever, abdominal cramps, and diarrhea beginning 12 to 72 hours after consuming a contaminated food or beverage" (CDC, n.d.). The illness typically lasts 4 to 7 days. Antibiotic treatment is sometimes prescribed and, in some cases, "the diarrhea can be severe, and the person may be ill enough to require hospitalization" (CDC, n.d.). Like other food-borne illnesses, salmonella bacteria are most dangerous for the very young and the very old. The bacteria can be killed by thoroughly cooking or pasteurizing infected eggs. The eggs in the Viessman truck were raw and unpasteurized.

In 1994, Schwan's was a private company believed to be earning between \$1.2 billion and \$1.5 billion annually. Schwan's products were and still are shipped throughout the United States. As has been the case since the company began in 1952, Schwan's ice cream and other frozen foods are sold door to door by drivers in yellow, refrigerated trucks. Some of Schwan's products are also distributed to grocery stores throughout the country. Schwan's drivers tend to establish friendly relationships with their customers as the drivers deliver products several times per month.

The popularity and broad distribution of Schwan's products meant that, in a short time, a wide network of customers had purchased infected ice cream. The subsequent outbreak was enormous. At least 224,000 people in 35 states became ill, making the Schwan's crisis the largest food-borne illness outbreak in history ("Ice Cream Poisoning," 1996).

### **A Guiding Philosophy**

From Schwan's perspective, the crisis began on October 7, 1994. An epidemiologist from the Minnesota Department of Health contacted Schwan's telling them that there was a "very, very big statistical relationship" between Schwan's ice cream and a widespread salmonella outbreak (Sievers & Yost, 1994, p. 1). Once this information was

received, the company leaders met immediately to discuss their strategy. Schwan's had a crisis management plan in place, but the guiding philosophy for the company came from a statement made by company president, Alfred Schwan. Schwan's manager of public affairs recalled that Schwan asked simply, "If you were a Schwan's customer, what would you expect the company to do?" (D. Jennings, personal communication, January 29, 1996). Jennings went on to say that this statement by Schwan's leader inspired the company to make the "right choices" throughout the crisis.

### Schwan's Crisis Response

Schwan's did not hesitate to respond to the mounting evidence. Even before the final tests were processed, the company publicly announced that it was recalling the suspected ice cream. In the announcement, Schwan said, "The well-being of our customers is our very first priority at Schwan's, which is why we are willingly withdrawing our ice cream products from distribution and cooperating fully with government agencies" (Sievers & Yost, 1994, p. 1). Schwan's crisis response included apologies and refunds delivered by drivers, a consumer hotline, and compensation for medical treatment.

Schwan's had an advantage over most distributors in that the company's drivers had face-to-face contact with customers. Drivers apologized to customers, collected the recalled ice cream, and refunded them for the cost. Because the drivers had delivered the product, they were able to identify and contact a majority of the people who purchased the tainted ice cream. Most food processing companies have no idea, beyond delivery to a grocery store or restaurant, who has purchased their products.

Schwan's managed the expansive nature of the outbreak by establishing a customer hotline. The company spared no expense with its hotline. Rather than using prerecorded messages, calls were answered in person. Jennings recalled that the hotline received "15,000 [calls] a day at its peak" (D. Jennings, personal communication, November 19, 1996). The hotline gave customers another means of speaking directly with the company to get answers to their questions.

A third strategy in Schwan's crisis response was to compensate customers for any medical expenses they may have incurred due to eating the infected ice cream. The company mailed a letter to customers offering to pay for diagnostic medical exams. The crucial paragraph in the letter read,

If you believe you may have persisting symptoms of salmonella and have eaten any of our ice cream products mentioned, we want to encourage you to see your physician and get the tests necessary to confirm it one way or the other and get the treatment you need. The information on the reverse side of this letter will explain what the symptoms might include and how to go about getting the test. We will pay for the test. (D. Jennings, personal communication, October 14, 1996)

The letter clearly indicated that Schwan's valued the well-being of its customers over all other considerations. The letter, like all of Schwan's correspondence with its customers, emphasized the guiding philosophy established by Alfred Schwan at the onset of the crisis.

### **Learning From the Crisis**

Schwan's immediate and thorough response to the crisis enabled the company to recover quickly without losing its customer base. Schwan's also used the crisis to learn how to make its products safer. In response to the salmonella outbreak, Schwan's made the following changes:

- Schwan's built a new facility allowing the company to repasteurize all products just before final packaging.
- Schwan's contracted to have a dedicated fleet of sealed tanker trucks to transport its products.

Although these changes were costly, Schwan's enacted them voluntarily. These changes established a new standard of safety in the food processing industry.

### **You Make the Call**

After examining this case, it is time to determine whether Alfred Schwan and his company displayed effective leadership in managing the salmonella outbreak. First, take a moment to review the lessons for effective leadership in crisis situations described in Chapter 4. These lessons should guide you in evaluating the strengths and weaknesses of Schwan's crisis response. As you contemplate the questions that follow, consider whether Schwan was effective or ineffective in addressing his customers' needs and concerns.



### **Leadership Successes and Failures in Food-Borne Illness Outbreaks: Lessons on Effective Crisis Leadership**

*Lesson 1:* Effective leadership is critical to overcoming a crisis.

In what ways was Schwan's leadership critical to overcoming the crisis?

*Lesson 2:* Leaders should be visible during a crisis.

In what ways did Schwan's make itself visible following the crisis?

*Lesson 3:* Leaders should work to develop a positive company reputation during normal times to build a reservoir of goodwill.

How did Schwan's develop a strong reputation prior to the crisis?

*Lesson 4:* Leaders should be open and honest following a crisis.

In what ways was Schwan's open and honest following the crisis?

*Lesson 5:* Leaders who manage crises successfully may create opportunities for renewal.

How did Schwan's create opportunities for renewal following the crisis?

*Lesson 6:* Leaders should cooperate with stakeholders during a crisis and should work to build consensus.

Did Schwan's cooperate with stakeholders during and following the crisis?

*Lesson 7:* Poor leadership can make a crisis much worse.

Did Schwan's leadership make the crisis better or worse?

*Lesson 8:* Leaders must adapt their leadership styles and contingencies during crises.

Did Schwan's leadership adapt its leadership style to the nature of the crisis?

*Lesson 9:* A virtuous response to a crisis by the organization's leaders may be the most effective in generating support and renewal.

In what ways was the response by Schwan's virtuous?

*Lesson 10:* Leaders have specific communication obligations for managing and learning from a crisis.

How did Schwan's manage the communication obligations following the crisis? Did learning take place?

### Summary

The Schwan's salmonella crisis is a classic case of effective crisis communication. It is interesting that the company based its response not on a long and detailed crisis plan but on a guiding philosophy. From this philosophy, Schwan's immediately took responsibility for the crisis and worked to repair relationships with its customers. Schwan's received a tremendous amount of support from its customers following the crisis for their response even though many of its consumers became very ill as a result of the salmonella infection. Schwan's had several opportunities to shift the blame outside the organization. However, the company was determined to take care of its customers and move beyond the crisis.

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