Review of Food Standards Agency response to the incident of contamination of beef products with horse and pork meat and DNA

An Independent Report

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Forward

In mid-April I was invited by the Chairman and Chief Executive to carry out a short focused review of the response of the FSA to the horse meat contamination incident. Whilst there were many positive aspects to their response, they wished to learn the lessons that it showed and ensure that these were incorporated into any future response. I was advised that I would have access to all papers and all staff would be available for interview. I also contacted a range of external organisations and individuals, and without exception they agreed to talk to me. I am grateful to all for their openness and frankness in those discussions. I found much that was good, but inevitably in any review the emphasis is on what could be better, but this should not detract from the hard work and commitment clearly demonstrated in this incident.

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1 Introduction

On 15 January 2013, the Food Safety Authority of Ireland published the results of a targeted authenticity survey of beef burgers and other products which were tested for the presence of horse and pig DNA. Of the 27 beef burger products analysed by FSAI, ten products tested positive for horse DNA. In all but one of the positive beef burger samples, horse DNA was found at very low levels. These burgers had been produced by three companies one of which was located in the UK. In one sample, the level of horse DNA indicated that horse meat was present and accounted for approximately 29% of the total meat content of the burger. This product line was sold at a major retailer in the UK. The FSAI had alerted the UK Food Standards Agency to its findings on 14 January.

In the UK, the FSA took a lead in the response to this incident, working in partnership with many organisations. Extensive testing programmes were undertaken by the FSA, local authorities and industry, as well as complex investigations in different parts of the UK. As the incident developed, sampling and investigations by authorities across Europe identified multiple instances of the adulteration of comminuted beef products. Although investigations continue in relation to implicated products and premises in the UK, the initial response phase of this incident is completed. More details of the incident will be available in a report to be published by the FSA.

At its meeting on 17 April the Food Standards Agency Board agreed to commission an independent review of the FSA's response to the incident. This was to be a short focused review of the FSA's organisational response, making recommendations to the FSA on actions to maintain or develop the FSA's capability and capacity. The outcomes of this review will also inform a wider review into 'The integrity and assurance of food supply networks', announced by Government on 4 June.

Professor Pat Troop was appointed as the independent reviewer on 17 April 2013. The initial findings of the review were presented to the FSA Board on 4 June. This report presents the final outcome of the review and makes recommendations for the Food Standards Agency to consider.

2 Terms of Reference

The review has the following terms of reference:

'To review the response by the Food Standards Agency to incidents of the adulteration of comminuted beef products with horse and pig meat and DNA , and to make recommendations to the FSA Board on the relevant capacity and capabilities of the FSA and any actions that should be taken to maintain or build them.

This includes:

- the response of the FSA to any recent prior intelligence on the threat of substitution of horsemeat for beef in comminuted beef products available in the UK;
- the FSA strategic, tactical and operational response to the FSAI announcement on 15 January 2013 and subsequent developments, including: key roles and responsibilities assigned to FSA staff engaged in the response; the operation of the incident response protocol; resourcing the incident response; information flows within the FSA, including to the FSA Board;
- communication from the FSA to the public, parliament, and other stakeholders, including but not limited to the FSA website, media and social media engagement, and the FSA Helpline;
- the response of the FSA, in terms of its engagement with the food industry and collaboration with other regulatory agencies in the UK and overseas, including other arms of UK and devolved governments;
- the enforcement response of the FSA, in terms of the powers available and arrangements for conducting investigations into potential breaches of food law or other law, including liaison and collaboration with other law enforcement agencies;
- other factors which emerge in the course of the review which offer the opportunity for lessons to be learned that could improve the ability of the FSA to respond to incidents of food authenticity or food safety in future.'

3 Methodology

The evidence gathering for the review took place over a six week period from 17 April to 31 May and included the review of documentation and interviews with a wide range of individuals and organisations involved in the response to the incident. Full details are given in Annex A.

Review of documentation

The FSA provided copies of all documentation that was requested. This included:

- Key procedural documents such as the FSA's Incident Response Protocol;
- FSA internal documents including minutes of all key meetings, Incident Situation Reports, briefing documents, correspondence between key individuals and internal review documents.
- Media analysis including press releases, cuttings, social media analysis and websites.

In addition the review considered additional material provided by interviewees to support and amplify points raised in interviews.

Interviews

Central to this review was gathering evidence through interviews with those most closely involved in the response. These were conducted under 'Chatham House' rules to encourage open, honest and frank discussions, with a commitment given that comments would not be attributed to individuals. 35 interviews were conducted with around 50 individuals, including a wide range of FSA officials, officials in other Government Departments and Bodies, Ministers, the Food Safety Authority of Ireland, industry representatives, Local Authority bodies and consumer representatives.

4 Findings

4.1 Introduction

Through the evidence gathering phase it was possible to gain a broad perspective of views about the response and the wider implications. Although individuals had their own perspectives, there were clear themes that emerged. This section examines these themes in more detail.

One consistent view that came out was the dedication and hard work of the staff. This was the largest incident managed by the FSA. Around a hundred staff were involved demonstrating a high level of commitment, working long hours, sometimes in new roles.

4.2 Prior Intelligence

Respondents inside and outside the Agency were asked if they had considered adulteration with horsemeat as a possibility – did they 'spot it coming? could it have been foreseen?'

Looking back over previous months, it was generally recognised that meat is a high value product, which can be open to adulteration. Species substitution was known about and action had been taken, but this focussed on for example cases of pork or chicken in beef or lamb substituted by beef. The desire of companies to source cheap meat was recognised but thinking was around expected meat such as chicken or pork, or cheaper sources of beef.

In the UK, the presence of unlabelled equine meat had historically been investigated and detected in a very small number of cases. In some circles there was some knowledge of an excess of horses going to slaughter and it was reported that, worldwide, prices for horse meat had dropped. Nevertheless, equine meat is not routinely used in the UK and the possibility of this adulteration had not been considered, not just by the FSA.

In November 2012, the FSAI had made the FSA aware of their method development work, and the FSA had suggested some joint work if they were validated. In January 2013, the FSAI informed the FSA of their validated results, which triggered the response in the UK.

Many industries and the FSA itself do have systems to identify emerging issues. For example the FSA has in place an 'Emerging Risks Programme' and a Food Fraud team, who use intelligence to inform targeted enforcement action. This incident has demonstrated the need to strengthen this horizon scanning and intelligence analysis, but it is not possible to say that this adulteration would have been detected even with a more substantial programme.

All respondents agreed on the need to develop and improve intelligence gathering and analysis and wider horizon scanning capabilities. There is much to be learnt from others in this field. Emerging Health Risks programmes are well established (for example run by the World Health Organisation and the US Centre for Disease Control and Prevention) and the police have an established national intelligence management system. Electronic systems including open information systems and web crawlers can also provide valuable information.

An intelligence management system should be developed which includes horizon scanning, intelligence gathering and analytical capability, that is, the right people to ask the right questions. The FSA should take the lead in building capability, but a collaborative approach will be essential. This process should be further backed up by targeted sampling programmes, delivered by not just the FSA and local authorities, but also by industry.

4.3 FSA Response

Early response

The FSA was advised by the FSAI on 14 January of the outcome of their investigation. The FSAI advised that they had informed the affected companies on 14 January and would be meeting with them on 15 January. The FSAI then made a public announcement late in the afternoon of the 15th in which they announced the detailed results of their survey, and gave information on producers and affected retailers. Based on the intelligence the FSA activated its incident response in accordance with its Incident Response Protocol, and established a Strategic Incident Management Team (SIMT) which met in the afternoon of the 15 January.

At that meeting, this team decided that the FSA should lead the UK response to the incident, recognising that although this was an authenticity issue, the FSA were best placed to respond. They also discussed the potential that there were two different issues, contamination and adulteration. They set out a strategic aim for their response, 'to identify and control the supply of affected products'.

On 16 January, there was a Scoping Group meeting held by the FSA with industry representatives, as defined in the Incident Response Protocol. The FSA published a Four Point plan for its investigation, which it stated would be implemented in conjunction with other Government departments, local authorities and the food industry. The plan was:

1. To continue the urgent review of the traceability of the food products identified in FSAI's survey. The retailers and the UK processor named in the survey have been asked to provide comprehensive information on the findings by the end of Friday 18 January.

2. To explore further, in conjunction with the Food Safety Authority of Ireland, the methodology used for the survey to understand more clearly the factors that may have led to the low level cases of cross-contamination.

3. To consider, with relevant local authorities and the Food Safety Authority of Ireland, whether any legal action is appropriate following the investigation.

4. To work with the Department for Environment, Food and Rural Affairs (Defra), the devolved rural affairs departments and local authorities on a UK-wide study of food authenticity in processed meat products.

Whilst there was early action from the FSA, there was also some hesitancy. This arose firstly as this was not a food safety incident with major health implications, and for some staff this resulted in a lack of appreciation of the potential impact of the incident. A number of people also reported that they had limited experience of such a major incident.

There was also a 'wait and see how this develops' view from a number of people. The reasoning appeared to be that there was only one company with a product with significant contamination, so it may be a 'one-off'. The alternative approach might have been 'there is one major well known company involved. This is likely to cause a big reaction and if they are affected, so might others be' i.e. the precautionary principle. In general, it has been shown that it is wiser to work to the latter and scale up accordingly, otherwise an organisation can find itself running to catch up. It is much easier to scale up then scale down.

In any incident the early response may be critical. There may be limited information, so the incident plan should be able to be put into practice and the organisation quickly scaled up to take action. This activation phase should be addressed by the FSA in the revision of the Major Incident Plan.

<u>The role of the FSA</u>

Throughout the review, comments were made about the role of the FSA in food authenticity. Within the FSA senior team and Government Departments it was understood that the FSA was in the lead for this incident. This was reinforced by the Prime Minister's statement of 16 January, in which he asked the FSA to urgently investigate, and the publication of the FSA's Four Point plan. However not all staff were clear why the FSA was in the lead, particularly in the early stages, suggesting that the reasons for this could have been better communicated within the organisation.

Outside Government there was further confusion. In 2010, under Machinery of Government changes, responsibility for food labelling and food composition policy, where not related to food safety, was transferred from FSA to Defra in England. This

included food authenticity policy. Policy for nutrition, including nutritional labelling, was transferred to the Department of Health. In the devolved administrations, the FSA retained these responsibilities (other than in Wales where nutrition policy transferred to the Welsh Government).

These changes contributed to the confusion outside Government, which was compounded by joint meetings where attendees were not clear whether FSA or Defra were in the lead. Some commented that they had found it easier when all of authenticity was under one organisation, whereas others said that clarity was needed as to who did what.

The Cabinet Office briefing, produced to explain Machinery of Government changes in 2010, stated:

> 'The FSA also handles food related incidents'.

At this time both the FSA and Defra described FSA's role as including:

> 'food safety incidents, including misleading labelling and food fraud with possible food safety implications.'

There is some ambiguity between these two statements which could give rise to two potential models for response. Although the Cabinet Office guidance states the FSA handles 'food incidents', the FSA and Defra guidance is more specific that the FSA handles incidents when there is a 'food safety' aspect. In a scenario such as horse meat, with an early statement from the FSAI that there was no risk to public health, either department could have taken a lead, although the FSA would have a key role to play regardless. In such situations the critical action is to agree at the very outset between all parties which model is being followed, and to communicate this to all involved.

That said, within the FSA, because the SIMT took the early decision to lead this did not materially affect the response**.**

The arrangements for authenticity and in particular the management of incidents need to be clarified and placed on the FSA website.

Although most of the comments were about incident management, it was also noted by some that since the 2010 changes, the 'consumer' aspects of authenticity had been reduced.

As one of the major effects of this incident was on consumer confidence, the arrangements for authenticity should be revisited to ensure that the 'consumer oriented' programme is given sufficient priority.

Early February

There was significant activity in early February. On 4 February the FSA had met with retailers and suppliers to agree publication of results of routine industry testing, and also announced that meat detained in a cold store had been found to contain up to 80% horsemeat. On 6 February the FSA published its protocol for the UK wide survey of food authenticity undertaken by Local Authorities. However, whilst the Agency had been taking action since they had been informed on January 14, it was the finding by a major company of another product containing high levels of horsemeat on February 7 that further escalated the incident and the response. On this date FSA announced that it was requiring widescale industry testing, and this was confirmed at a meeting with industry on 9 February.

The response was now becoming much more complex with many strands of work running in parallel. In addition to both the Local Authority and industry testing programmes, an audit of meat premises was underway and there were investigations and enforcement action in progress. The FSA was working with faith groups who were concerned about the contamination of beef by pork, and as the incident progressed, the European engagement and requirements were gaining momentum. There was a sustained high level of media interest and demand for information, all of which required significant on-going briefing.

As a result it was recognised that the FSA's Incident Response Protocol was not sufficient for a response of this scale. The FSA put new stronger arrangements in place. Internally senior staff were given responsibilities to lead each aspect of the response. Daily Stocktake meetings were established involving senior FSA staff together with Defra and Cabinet Office officials. These were complemented by daily 'birdtable' meetings with stakeholders, which are short and focused, to provide regular updates. The FSA refreshed its Incident Situation Report to a more comprehensive and outward facing document which became the key briefing document internally and for other Government Departments and the Briefing Cell was expanded to meet the needs of government, stakeholders and the media.

There was some initial internal concern and confusion amongst FSA staff, with some reporting that the normal protocol could have been enhanced to meet the need of this incident. There was also insufficient communication internally about the changes. It is always difficult to change course during an incident, but a review of the FSA Incident Response Protocol shows that whilst it may be adequate for a routine food incident plan, it is not a major incident plan.

The enhanced arrangements worked well, with the incident then being effectively managed, and should form the basis of a revised Major Incident Plan. **This should include the following elements:**

- **Strategic Director**
- **Operational Director**

- **Command and control structures**
- **Infrastructure arrangements – Operations Room; information management systems; standard operating procedures**
- **Communications team**

The FSA will need to develop and increase its resilience. In this incident at the top level staff were rotated, however at many other levels this did not happen and many staff were in danger of suffering 'burn-out'. A strong cadre of staff will need to be trained for different roles. The Major Incident Plan should be developed with partners, and supported by a robust programme of testing and practice.

4.4 Investigations of premises

The FSA's investigation of premises became widespread and complex, with enquiries taking place at a number of premises. An experienced senior manager was put in overall charge with a senior recently retired police officer drafted in to provide additional investigative support and expertise. Multiple locations were involved nationwide, requiring liaison with a large number of Local Authorities, and, as investigations progressed, links were established with five police forces. These investigations built into a national picture, and FSA was able to work with the City of London Police who took a national co-ordination role, establishing a Gold Group across forces.

The collaborative working was essential, but in some cases these relationships were stronger than in others. The need to establish and maintain a wide range of partners can be time consuming with potential delays in the investigations. The incident also highlighted some limitations in the FSA's powers, for example around powers of entry, which leaves vulnerabilities where delays can result in loss of evidence.

The diverse nature of these investigations raised issues of capacity for the FSA, and the need for more senior staff trained as Senior Investigation Officers and more people with an understanding of the powers and requirements when carrying out enforcement action.

The overall management of a complex investigation also requires a set up rather like the overall Incident Plan, with strategic and operational management, an operations centre and intelligence management.

4.5 Communications

Central to any incident response is the issue of communications and this incident was no different. The review has examined the different elements of this

- External, primarily media, website and social media
- Internal
- External with stakeholders (covered under section 4.6)

External

This was a huge media story, featuring extensively on TV, radio and in print media over an extended period of time. The FSA used multiple routes to update the media, including releasing information on its website, fielding spokespersons for numerous interviews and making use of social media to support the usual communication team activities. The majority of respondents during the review were positive about how the FSA managed the media, although there were a small number of more negative comments, highlighting concerns over use of language, for example the need for plain English and the early certainty with which it was reported that there were no food safety concerns. This latter comment came primarily from professionals and highlighted the need for early engagement with other bodies and explanation of the risk assessment. FSA press teams in each of the four countries led media engagement in their areas, which enabled them to put messages into the local context. This was well received, but this devolved approach requires strong coordination to ensure consistency of the core information.

The FSA made good use of social media, monitoring the prevalence of horsemeat related tweets and engaging where appropriate, and the Communications Team clearly understand the importance of this both as a vehicle to reach certain sectors, including young people, but also to check reception and understanding of its key messages. Social media provides a fast way to pick up the mood and engage with the public and journalists, and FSA did this well. There is a need for a wider understanding in the FSA of the importance of social media to ensure the Communications Team is given the right support for this.

More formally FSA also commissioned an independent survey to check the public's understanding and reaction to the horsemeat incident, providing the FSA with valuable feedback on these points. The survey also checked where the public were obtaining information, their understanding of messages and their trust in the FSA.

During the review press cuttings were analysed. Although the FSA was reported in these, it was generally a short reference, and so FSA's main media presence was via television and radio. The survey had identified that these were the main sources of information for the majority of the public so FSA were reaching their target audiences. The FSA used its website as the main method by which it released information to the public and media and was updating this regularly. There was a comment that it was difficult to locate key information on the website, and so other external websites, in particular the BBC, were used instead. However, the FSA website was more factual in its content.

The survey, social media and press cuttings showed that the message about food safety was well picked up, but the message about the difference between trace contamination and more significant adulteration was not.

External communication is now across many platforms and this was well recognised by the Communications Team. With such unprecedented media interest this placed intense pressure on the FSA teams and a number of correspondents raised issues of the capacity to manage all aspects of communications.

As part of its Major Incident Plan, the FSA should consider ways to strengthen its capacity for communication, including examining opportunities to draw on colleagues from partners.

Internal communications

Internal communications need to be aimed at both those who are directly involved and those who are not. This latter group are often forgotten, and as they often have to take on extra work and cover other people to maintain the work of the organisation, giving them an understanding of the situation is helpful. In the early stages there was insufficient internal communication for both groups leading to some misunderstandings, but the FSA did recognise this and introduced changes which had positive outcomes.

From the 15 February the FSA developed a comprehensive Incident Situation Report which was used as a key document for internal use and for other government departments, and which replaced the earlier internal document. This was initially updated on a daily basis with frequency decreasing over time. This was an excellent briefing document that was well received across Government.

4.6 Stakeholder engagement

Throughout its response the FSA worked across Government, with enforcement authorities, other organisations and industry.

Across Government the FSA worked with a number of Government departments and there was close co-operation with Defra in particular. There were occasionally tensions over such matters as agreeing press notices, as the FSA is used to working independently, but generally speaking, this joint working went well. Defra and the Cabinet Office attended Stocktake meetings and received the Incident Situation Report. The FSA worked in partnership with DH and the Chief Medical Officer to agree positions and to provide regular updates. There was good joint working between FSA and Defra on European issues. Devolved Administrations reported working better with local FSA officials.

Local Authorities provided an integral part of the response and overall relationships worked well, with the majority of LAs taking a proactive response. However, it must be recognised that there are differences in priorities and resources between LAs which may influence their ability to respond. The FSA has a number of arrangements for working with Local Authorities, and whilst these are fairly comprehensive, they now relate more to food safety than authenticity. This was also

a national incident, and **there should be a review to ensure that the FSA role in a range of incidents is still sufficient, especially for a national incident.**

The review considered the views of other agencies and professional bodies. These bodies, Trading Standards Institute, Chartered Institute of Environmental Health and Public Health England, suggested that they could have offered support to the FSA, for example disseminating guidance, information and advice to their members, and that this potential support was not capitalised on. These organisations were also approached by the media and could only provide general comments, rather than reinforce and further disseminate FSA messages. In future it would be helpful to bring these bodies in at an early stage.

There was more mixed feedback from industry representatives. All appreciated and accepted the enforcement role of the FSA and recognised the need for action to restore consumer confidence. There was broad support for the testing programme and particularly the early decision to use a threshold of 1% was appreciated and supported. However there were concerns expressed about the laboratory capacity for sampling and analysis and industry representatives felt these concerns were not listened to. Presentation of results and the tight timescales also caused some difficulties and tensions. Some joint FSA/Defra meetings were felt to be confrontational, which industry noted felt at odds with previous engagement with the FSA. However, the bird table meetings were found to be a useful format and although there were concerns, most industry responders thought that in the main the FSA's response was reasonable.

Moving forwards there was broad support from industry about sharing intelligence, although this does raise many complex issues, which will need to be worked through in partnership. For example, if a company carries out testing of products to prevent those reaching consumers, they might be unwilling to share results if they are presented in such a way that they appear to be at fault.

The FSA should review its stakeholder management during an incident. However, such relationships need to be well established before an incident, so the FSA should establish an active programme of stakeholder management, particularly where these became strained during the incident.

4.7 Powers

This was a major national incident, where the FSA were required to work with many organisations, especially all local Authorities for the sampling programmes and investigations, with industry, particularly for sampling and the police for investigation and enforcement. This level of complexity relied on the cooperation of all involved, which was largely forthcoming, but it raised the question of the powers of the FSA to compel organisations to contribute.

There are a number of different approaches which could be followed to address these issues, and rather than 'powers', they should be considered in the context of the FSA being able to discharge its responsibilities in a range of scenarios. A collaborative approach involving all key partners will be required to identify, evaluate and implement the most appropriate measures for each situation. The FSA should take a lead in progressing this work. Potential approaches could include:

Code of conduct

Framework Agreement

Legislation changes

Working with Local Authorities is routine for the FSA, and there are a number of arrangements and a Framework Agreement in place to enable this to happen. However, these are now focused more on Food Safety, and as this was a nationwide incident involving authentication, this needs to be reviewed to ensure that the FSA is able to take a national lead.

With industry, the FSA does have some powers, especially for food safety, but had no powers in this situation to require testing or the reporting of the results. Legislation could be complex and difficult to define for the potential range of incidents, therefore alternative approaches such as a code of conduct should be explored.

The FSA should work with the industry through a range of scenarios to review current powers and where these are not appropriate to explore alternative approaches to ensure consumer protection and confidence.

The investigation of this incident at food premises was complex and relied on co-operation between a number of partner organisations, especially Local Authorities and the police. Although generally forthcoming in this incident, when investigations of this size, scale and complexity are required any lack of co-operation could have had a significant detrimental impact. **Consideration should be given to the option of the FSA, as Central Competent Authority, taking a lead responsibility for investigations where national co-ordination is required, liaising directly with police. This national lead role could include the FSA taking responsibility for any and all prosecutions.**

The incident also demonstrated the limitations in the powers of the FSA, for example in power of entry into food premises, which could lead to loss of evidence if papers are removed elsewhere. **These and other powers should be reviewed to ensure action can be taken in a timely way**.

This incident demonstrated the importance of securing early police engagement where the FSA believe that there is evidence of criminality. With diverse locations and police forces this proved a challenge during this incident with things improving

when one force took a national co-ordination role. **The FSA should explore the options of establishing regular working arrangements with one police force who could take a national lead role in future.**

A further point highlighted in this incident is the complexity of the food supply chain and the role of food brokers within this. **Further consideration is needed in relation to the classification of food business operators.**

5 Recommendations

Introduction

This has been a short focused review of the FSA response to the horsemeat incident, taking evidence on, and evaluating the response to the areas as identified in the Terms of Reference. Throughout the review there has been much evidence of a positive response by a range of organisations and of hard work and commitment by those involved in the response. As with all major incidents there are lessons to be learnt and these can be distilled into four key areas.

1. The need for improved intelligence across the food industry

None of those interviewed 'spotted this coming', and this incident demonstrates that there is a need for a wider programme.

An intelligence management system should be developed which includes horizon scanning, intelligence gathering and analytical capability, that is, the right people to ask the right questions. The FSA should take the lead in building capability, but a collaborative approach will be essential. This process would be further backed up by targeted sampling programmes, delivered by not just the FSA and local authorities, but also by industry.

2. The need for the FSA to strengthen its major incident plan

The FSA does have an incident protocol for food safety incidents, but this needed to be revised and strengthened during the incident. These new arrangements should be built on for future major incidents.

The FSA should urgently review and revise its Major Incident Plan. This should include the following elements:

- **Strategic Director**
- **Operational Director**
- **Activation procedures**
- **Command and control structures**
- **Infrastructure arrangements – Operations Room; information management systems; standard operating procedures**
- **Communications team**

The plan should address interaction with stakeholders to ensure professional bodies are brought in at an early stage and should be tested and practiced.

The FSA will need to develop and increase its resilience. A strong cadre of staff will need to be trained for different roles, including as Senior Investigating Officers. The

Major Incident Plan should be developed with partners, and supported by a robust programme of testing and practice.

The FSA should examine opportunities to draw on communications colleagues from partners to increase the resilience of this team. There is also a need for a wider understanding in the FSA of the importance of social media to ensure the Communications Team is given the right support with this.

The FSA should review its stakeholder management during an incident. However, such relationships need to be well established before an incident, so the FSA should establish an active programme of stakeholder management, particularly where these became strained during the incident.

3. Improved clarity of the role of Government departments in large, complex incidents

In the early stages of the incident there was confusion both internally and externally about the different roles of Defra and FSA. Whilst this did not materially affect the response, in a different situation where rapid early action was needed, this would be unsatisfactory. There were a number of comments that the authenticity programme had shifted and the 'consumer' aspects received less priority.

The arrangements for authenticity and in particular the management of incidents need to be clarified and publicised.

As one of the major effects of this incident was on consumer confidence, the arrangements for authenticity should be revisited to ensure that the 'consumer oriented' programme is given sufficient priority.

4. Review of the FSA's powers and the use of framework agreements with local authorities and codes of conduct with the food industry.

This was a nationwide and complex organisation which demonstrated the need for the FSA to take national leadership. It also highlighted some gaps in their current powers.

The FSA has a number of arrangements for working with Local Authorities, and whilst these are fairly comprehensive, they now relate more to food safety than authenticity. This was also a national incident.

As well as many local authorities, a number of police forces were involved, and so there were a complex set of relations. Managing all these relationships can be time consuming and lead to delays and potential loss of evidence.

The FSA's powers for investigations should be reviewed to ensure action can be taken in a timely way.

Consideration should be given to the option of the FSA, as Central Competent Authority, taking a lead responsibility for investigations where national co-ordination is required, liaising directly with police. This national lead role could include the FSA taking responsibility for any and all prosecutions.

There should be a review to ensure that the FSA role in relation to Local Authorities for a range of incidents is still sufficient.

The FSA should explore the options of establishing regular working arrangements with one police force who could take a national lead role in future.

With industry, the FSA does have some powers, especially for food safety, but had limited powers in this situation to require testing or the reporting of the results. Legislation could be complex and difficult to define for the potential range of incidents, therefore alternative approaches such as a code of conduct should be explored.

The FSA should work with the industry through a range of scenarios to review current powers and where these are not appropriate to explore alternative approaches to ensure consumer protection and confidence.

A number of commercial organisations were involved in this incident, but not all were classified as food business operators.

Further consideration is needed in relation to the classification of food business operators, and whether any changes to this are required.

Professor Pat Troop CBE FRCP FFPH DSc

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Annex A: Source Information

Documentation

The following documentation was considered as part of the review:

- FSA Incident Response Protocol
- Minutes of all key meetings
- Briefing documents
- Incident Situation Reports
- Incident documentation
- FSA internal reports
- External reports
- Correspondence
- Press releases, cuttings, social media, media analysis and websites.

Interviews

35 interviews were held with around 50 individuals. Individual names are not being released to protect confidentiality. The following organisations and sectors were included in the interviews.

- FSA Officials
- FSA Chair
- Officials in other Government Departments (Defra, Cabinet Office) Ministers (Secretary of State for Environment, Food & Rural Affairs, Scottish Government Cabinet Secretary for Rural Affairs and Environment)
- Chief Medical Officer
- Food Safety Authority of Ireland
- Industry representatives, including trade bodies and retailers.
- Chartered Institute for Environmental Health
- Trading Standards Institute
- Local Government Association
- Public Health England
- Which?