



# Review of FSA Response to Incident of Contamination of Beef Products with horse and pork meat and DNA

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# Introduction

- Terms of Reference
- Method
- Findings
- Recommendations

# 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.

# Terms of Reference

- Response to prior intelligence
- Internal response structures and procedures and their operation.
- Communication
- Engagement with all partners and stakeholders
- Enforcement response and powers
- Other emerging lessons

# Approach

- Review of documentation
  - Minutes of all key meetings
  - Incident Response Protocol
  - Incident documentation and review
  - Reports, internal and external
  - Briefing paper
  - Press releases, cuttings, social media, analysis, websites
  - Correspondence

# Approach

- Interviews (around 35, 50 people)
  - Wide Range FSA staff
  - Government Departments and Ministers
  - Food Safety Authority of Ireland
  - Industry – trade bodies & retailers
  - Local Authority bodies
  - Which?
  - Others

# Findings: Prior Intelligence

## *Did anyone spot this coming?*

- Generally recognised that meat a high value product open to adulteration but within UK equine meat not considered
- FSA has 'emerging risks' process and Fraud Unit
  - ***Need for wider programme, plus horizon scanning***
- Early notification of programme from FSAI, and informed once results validated
  - Led to response from FSA

# Findings: FSA Response

## Early response

- SIMT met on the 15<sup>th</sup>
  - Followed Protocol
  - Agreed FSA would lead
  - Set up scoping meeting
  - Four point plan published on the 16<sup>th</sup>
- But some hesitancy within the Agency
  - Not food safety with major health impact so lack of appreciation of impact
  - Some with limited experience of major incidents
  - Wait and see v precautionary principle
  - Uncertainty of role





# Findings: FSA Response

## Role of FSA

- Govt. departments and SIMT clear FSA in the lead
- Some staff not clear
- Many outside responders confused at first because of 2010 changes, compounded by joint meetings

# Findings: FSA Response

## Role of FSA

Role described in 2010 on FSA website

- “food safety incidents, including misleading labelling and food fraud with possible food safety implications”

Role in Cabinet Office Briefing

- “The FSA also handles food related incidents”

*Potential for 2 Models of response*

***Within the Agency did not make material difference to response, particularly after early stages***

# Findings: FSA Response

- Early February

- 6<sup>th</sup> February Announcement of UK wide sampling with Local Authority
- 7<sup>th</sup> February, announced industry testing
- Situation now more complex and needed increase of tempo
  - Local authority testing
  - Industry Sampling
  - Audit of meat premises
  - Enforcement action
  - Regular briefing needed
  - Media
  - Later added Europe

# Findings: FSA Response

- Protocol not sufficient
- Arrangements for managing incident changed
  - Daily stocktake meetings, senior staff with Defra and Cabinet Office,
  - Daily 'Bird Tables', short round up meetings with stakeholders
  - Incident Situation Reports
  - Briefing Cell
  - Senior people leading each aspect of incident
- Some internal concern about changes, insufficient internal communication

***Nevertheless, these arrangements worked well and incident then effectively managed***

# Findings: FSA Response

- Investigation of premises
  - Became widespread and complex
  - Involved liaison with a number of Local Authorities
  - Links with several police forces
    - Some links worked better than others
    - Highlighted limitations in powers
    - Raised issues of capacity and training

# Findings: FSA Response

- FSA Protocol not sufficient for major incident
- Need to build on new arrangements for Major Incident Plan
  - Strategic Director
  - Operational Director
  - Command and Control
  - Operations room
  - Information management
  - Standing Operating Procedures
  - Communications
  - Increase resilience
- Develop with Partners and Practice

# Findings: Communication

- External
  - Media
  - Social Media
  - Website
- With stakeholders
- Internal

# Findings: Communication

- **Media**

- A few negative comments, such as language used or early apparent 'certainty' on safety
- Majority respondents positive
- Main presence TV and radio
- Good check of reception of key messages through social media and independent survey
- Local staff led media in all 4 countries



# Findings: Communication

- Social media
  - Well understood and used
  - Need understanding of importance across the Agency
- Website
  - Difficult to keep up
  - Some concerns about difficulty finding key findings
- Issues of capacity

# Findings: Communication

- Internal
  - those involved
    - Should be through cascade of briefing
  - those not involved
    - Intranet, briefings
  - Insufficient early on
  - Recognised needed to improve and introduced changes
  - Excellent situation report developed

# Findings: Stakeholder Engagement

- DEFRA, DH, Cabinet Office, other Govt. Departments, Devolved Govts.
- Local Authorities
- Other Agencies, Professional Bodies
- Industry

# Findings: Stakeholder Engagement

- Worked well with DEFRA and other Govt. Departments
  - DEFRA and Cabinet Office attended Stocktake meetings
  - Good joint working in Europe
- Local staff worked well with Devolved Administrations

# Findings: Stakeholder Engagement

- Local Authorities
  - Generally worked well, with most LAs very responsive
  - But raises questions of FSA powers in a national incident
- Other Agencies and Professional Bodies
  - Not involved early on
  - Could have offered support
  - Contacted by media, could have taken some of the pressure

# Findings: Stakeholder Engagement

## Industry

- Confused about lead
- Appreciated enforcement role of FSA and need to restore confidence
- But found joint meetings confrontational
- Understood need for testing, but felt views on this not heard
- Found Bird Tables very helpful
- Appreciated 1% threshold
- Overall thought FSA managed well
- Willing to contribute to intelligence

*Need to consider balance enforcement role and collaboration*

# Powers

ability of the FSA to act

***FSA relied on cooperation to manage the incident***

- **National Incident**

- **Should FSA have overriding agreement to run the incident, rather than relying on many Local Authorities?**

- **Industry**

- **FSA had no powers to require testing or receive information**
- **Should FSA be able to require industry to sample or give information?**
- **In general or only in an incident?**
- **What should be classed as a food business?**

# Powers

ability of the FSA to act

- ***Enforcement***
  - ***Powers need review e.g. powers of entry limited***
  
- ***Potential approaches***
  - ***Code of conduct***
  - ***Framework agreement***
  - ***Changes in legislation***

***Need to be worked through on a collaborative basis***



# Intelligence gathering

- All agree need to improve intelligence and wider scanning
- Learn from others, e.g. Emerging Health Risks programmes, police intelligence management
- Need wide range of inputs of intelligence
- Use of electronic systems e.g. Open Information Systems, Web Crawlers
- Good intelligence management
- Shared analysis and forward thinking
- Backed by sampling

*Should be multiagency and across the sector*

# Key points to consider

- Improved intelligence system across the sector
- Development of Major Incident Plan
  - Infrastructure, training and practice, increased capacity for communication, stakeholder management
- Clarity of respective roles
- Review of 'powers'

*All require collaborative working*