PREVENTING AND RESPONDING TO FOOD INCIDENTS

June 2006

FOOD INCIDENTS TASK FORCE
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>3</td>
</tr>
<tr>
<td>Aim and Scope</td>
<td>3</td>
</tr>
<tr>
<td>General Responsibilities of Key Stakeholders</td>
<td>4-6</td>
</tr>
<tr>
<td><strong>Chapter 1 Incident Prevention</strong></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>7</td>
</tr>
<tr>
<td>Why incident prevention is important</td>
<td>8</td>
</tr>
<tr>
<td>Basic Principles</td>
<td>9</td>
</tr>
<tr>
<td>Principles 1-7</td>
<td>9-16</td>
</tr>
<tr>
<td>Possible Control Measures</td>
<td>16-17</td>
</tr>
<tr>
<td>Traceability</td>
<td>18-19</td>
</tr>
<tr>
<td>Where to Get Further Information</td>
<td>20</td>
</tr>
<tr>
<td><strong>Chapter 2 Incident Response</strong></td>
<td></td>
</tr>
<tr>
<td>Responding to Incidents – Process and Rationale</td>
<td>21-23</td>
</tr>
<tr>
<td>Incident Notification</td>
<td>23-24</td>
</tr>
<tr>
<td>Information Gathering for Risk Assessment</td>
<td>24-25</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>25</td>
</tr>
<tr>
<td>Risk Management</td>
<td>25-28</td>
</tr>
<tr>
<td>Risk Communication</td>
<td>28</td>
</tr>
<tr>
<td>Follow up, Review and Lessons Learned</td>
<td>28-29</td>
</tr>
<tr>
<td>Post Incident Actions</td>
<td>29</td>
</tr>
<tr>
<td><strong>Annex A Chemical Hazards</strong></td>
<td>30-33</td>
</tr>
<tr>
<td><strong>Annex B Radiological Hazards</strong></td>
<td>34-37</td>
</tr>
<tr>
<td><strong>Annex C Microbiological Hazards</strong></td>
<td>38-40</td>
</tr>
<tr>
<td><strong>Annex D Physical Hazards</strong></td>
<td>41-42</td>
</tr>
<tr>
<td><strong>Annex E Guidelines for Risk Communication</strong></td>
<td>43</td>
</tr>
<tr>
<td><strong>Annex F Guidance on storage, recycling or disposal</strong></td>
<td>44-45</td>
</tr>
<tr>
<td><strong>Glossary</strong></td>
<td>76</td>
</tr>
</tbody>
</table>
PREFACE

WHY IS THIS DOCUMENT IMPORTANT?

1. This document is intended, to support the prevention of and response to, food and feed incidents in the UK. The contents are voluntary in nature and do not replace legal obligations set out in EC General Food Law Regulation 178/2002 but aim to summarise current best practice in incident management. They draw on lessons learned by all key stakeholders in the prevention and management of food incidents and updates will be added as approaches are refined and improved. Lessons learned include the output of an Incidents Task Force convened in 2005. The Task Force which consisted of senior representatives from the food industry, enforcement authorities and consumer organisations, as well as two independent members was chaired by the Agency’s then Chief Executive, Dr Jon Bell.

An incident is any event where, based on the information available, there are concerns about actual or suspected threats to the safety or quality of food that could require intervention to protect consumers’ interests.

AIM AND SCOPE

2. The aim of the document is to outline the roles and responsibilities of all key players in preventing and responding to food and feed incidents. It outlines the main elements of incident prevention and also a coherent process of incident response from notification, through risk assessment, risk communication and risk management, to post-incident actions. The document provides guidance for those who have a role in incident prevention or response in the food industry, enforcement community or competent authority (Food Standards Agency).

3. The main part of the text is generic in its scope, highlighting actions that apply equally to every type of incident, whatever the nature of the hazard. A number of annexes then cover specific issues related to a particular class of hazard.
GENERAL RESPONSIBILITIES OF KEY STAKEHOLDERS

The Food Standards Agency
http://www.food.gov.uk
4. The Agency exercises its powers to ensure that the interests of consumers are adequately protected in respect of any event that may threaten the safety of food available in the UK and that proportionate, timely and effective action is taken by the food industry to address the problem. The Agency carries out risk assessments and gives advice and information to consumers. It also seeks advice from, and provides information to, bodies such as EFSA and is the UK point of contact with the European Commission Rapid Alert System for Food and Feed (RASFF).

5. The main objectives of the other principal stakeholders are as follows:

British Hospitality Association (BHA)
http://www.bha-online.org.uk/aboutus.asp
6. The British Hospitality Association represents all sections of the hotel, restaurant and catering industry - not just the large organisations but also thousands of individually owned hotels. The membership also includes restaurateurs, contract caterers, clubs, transport caterers, theatres, attraction, outside caterers, universities, suppliers to the industry and many others.

7. The Association exists to ensure that the views of the British hospitality industry are represented in a forceful, coherent and co-ordinated way to government and policy makers in the UK and internationally.

British Retail Consortium (BRC)
http://www.brc.org.uk/mission04.asp
8. The British Retail Consortium is the lead trade association representing the whole range of retailers, from the large multiples and department stores through to independents, selling a wide selection of products through centre of town, out of town, rural and virtual stores.

9. The BRC exists to campaign to promote and protect retailers’ interests; advise retailers on threats to and opportunities for their businesses; offer a range of competitive, professional services; and improve the general perception of the retail industry in the UK.

Food and Drink Federation (FDF)
http://www.fdf.org.uk/about_fdf.aspx
10. The Food and Drink Federation represents the UK food and drink manufacturing industry, the largest manufacturing sector in the UK. Membership includes food and drink manufacturing companies, large and small, and Trade Associations dealing with specific food and drink sectors.
11. The FDF help manufacturers operate in an appropriately regulated marketplace and communicate the food and drink manufacturing industry's values and concerns to a range of audiences in the UK and abroad, including Government, regulators, consumers and the media. The FDF also work in partnership with other main players in the food chain to help ensure that members food is safe and that consumers can have confidence in it.

**Local Authorities Co-ordinators of Regulatory Services (LACORS)**

http://www.lacors.gov.uk/pages/trade/whatislacors

12. LACORS provides advice and guidance to help support local authority regulatory and related services. It was set up in 1978 to co-ordinate the enforcement activities of trading standards. Since 1991, LACORS has also worked on food safety and is currently responsible for a range of other regulatory and related services.

13. Central to LACORS' work is the promotion of quality regulation, development of policy and dissemination of comprehensive advice, guidance and good practice, which is principally aimed at local authorities.

**Agricultural Industries Confederation**

http://www.agindustries.org.uk/content.template/30/30/Home/Home/Home.mspx

14. The AIC has over 300 members in the agri-supply trade (chiefly merchants and compounders), representing 90% of the businesses active in this sector.

**Grain and Feed Trade Association**

http://www.gafta.com/

15. GAFTA comprises international grain and feed traders and currently has members in over 80 countries, dealing in grain, animal feed, pulses and rice.

**National Farmers Union (NFU)**

http://www.nfuonline.com/x203.xml

14. The National Farmers' Union represents the farmers and growers of England and Wales. Its central objective is to promote successful and socially responsible agriculture and horticulture, while ensuring the long-term viability of rural communities.

**Chartered Institute of Environmental Health (CIEH)**

http://www.cieh.org/about/

15. Founded in 1883, the Chartered Institute of Environmental Health is a professional and educational body, dedicated to the promotion of environmental health and to encouraging the highest possible standards in the training and the work of environmental health professionals.
16. The CIEH has approximately 9,800 members worldwide, the majority being located in England, Wales and Northern Ireland. As well as providing services and information to its members, the CIEH also advises government departments on environmental health and is consulted by them on proposed legislation relevant to the work of environmental health professionals.

Trading Standards Institute (TSI)
http://www.tsi.org.uk/institute/

17. The Trading Standards Institute is a professional association which represents Trading Standards professionals in the UK and overseas - in local authorities, the business and consumer sectors and in central government.

18. The TSI exists to promote and protect the success of a modern vibrant economy, and to safeguard the health, safety and wellbeing of citizens by enhancing the professionalism of members in support of empowering consumers, encouraging honest business and targeting rogue traders.

Scottish Consumer Council (SCC)
http://www.scotconsumer.org.uk/about/index.htm

19. The SCC is an independent policy organisation with a solid foundation in consumer research. Its purpose is to make all consumers matter with a special focus on the needs of disadvantaged consumers.

Small Business Council (SBC)
http://www.smallbusinesscouncil.org/

20. The SBC was set up in May 2000 as an advisory Non-Departmental Public Body that:
- Reports to the Secretary of State for Trade and Industry on the needs of existing and potential small businesses in order to increase their opportunities for success and growth.
- Advises the Chief Executive of the Small Business Service (SBS).
- Advises and reports on the effects on small businesses of the activities and potential activities of Government, including the Small Business Service itself.

21. The approach of the Council is to work within Whitehall seeking to influence and educate Ministers and senior policy makers about the concerns of small business. This involves commenting on new proposals as well as current Government actions. The Council also works to establish procedures that will ensure policy makers always consult small businesses when proposing a change that will affect businesses.
CHAPTER 1 INCIDENT PREVENTION

INTRODUCTION

1. European General Food Law Regulation 178/02 places a number of legal obligations on food and feed businesses. Readers are referred to both the legislation and Guidance on it for further information (see page 20). The key obligations on food and feed business operators, summarised in general terms by the European Commission\(^1\) are:

<table>
<thead>
<tr>
<th>Safety</th>
<th>Operators shall not place on the market unsafe food or feed</th>
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</thead>
<tbody>
<tr>
<td>Responsibility</td>
<td>Operators are responsible for the safety of the food and feed which they produce, transport, store or sell</td>
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<tr>
<td>Traceability</td>
<td>Operators shall be able to provide information about the food they buy and sell</td>
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<td>Transparency</td>
<td>Operators shall immediately inform the competent authorities if they have a reason to believe that their food or feed is not safe</td>
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<tr>
<td>Emergency</td>
<td>Operators shall immediately initiate procedures to withdraw food or feed from the market if they have a reason to believe that it is not safe</td>
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<td>Prevention</td>
<td>Operators shall identify and regularly review the critical points in their processes and ensure that controls are applied at these points</td>
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<tr>
<td>Co-operation</td>
<td>Operators shall co-operate with the competent authorities in actions taken to reduce risks</td>
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</tbody>
</table>

\(^1\) [http://europa.eu.int/comm/food/food/foodlaw/responsibilities/obligations_en.pdf](http://europa.eu.int/comm/food/food/foodlaw/responsibilities/obligations_en.pdf)
WHY INCIDENT PREVENTION IS IMPORTANT

2. Incident prevention is paramount to the protection of consumer interests. Food and feed businesses are legally responsible for ensuring that the food they produce and sell is safe in all Member States. Companies incur substantial costs when faced with a food incident, for example, the Sudan I incident involving a batch of Worcestershire sauce reportedly cost the food industry £150m in 2005. It is in the interest of food businesses to minimise the number of food incidents to lessen the economic loss arising from lost sales while shelves remain empty until replacement products become available and from a potential loss of public confidence. Frequent food incidents also erode consumer confidence in both the food industry and in Government. This is why the Food Standards Agency has set a challenging target to reduce the number of high and medium risk incidents by 25% by 2010. Achieving this target, which is fully supported by the food industry, requires the Agency and the industry to strengthen the current system of checks and safeguards throughout the food supply chain.

3. Food or feed business, whether they are a producer or a retailer, need to ask themselves at all times, how can I be sure that the products I am buying or selling are safe?

4. This chapter is intended to help food and feed businesses to do this and to set out the role of the Food Standards Agency in ensuring that consumer interest is, and remains, fully protected.
**BASIC PRINCIPLES**

5. The basic steps that all businesses should follow to prevent food incidents are based on the seven Codex Alimentarius HACCP principles. HACCP is a tool to assess hazards and establish control systems that focus on prevention rather than relying mainly on end-product testing. HACCP is science based and systematic, identifies specific hazards and measures for their control to ensure the safety of food.

The HACCP system consists of the following seven principles:

<table>
<thead>
<tr>
<th>PRINCIPLE 1</th>
<th>Conduct a hazard analysis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRINCIPLE 2</td>
<td>Determine the Critical Control Points (CCPs).</td>
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<td>PRINCIPLE 3</td>
<td>Establish critical limit(s).</td>
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<td>PRINCIPLE 4</td>
<td>Establish a system to monitor control of the CCPs.</td>
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<td>PRINCIPLE 5</td>
<td>Establish the corrective action to be taken when monitoring indicates that a particular CCP is not under control.</td>
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<td>PRINCIPLE 6</td>
<td>Establish procedures for verification to confirm that the HACCP system is working effectively.</td>
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<td>PRINCIPLE 7</td>
<td>Establish documentation concerning all procedures and records appropriate to these principles and their application.</td>
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</tbody>
</table>

**UNDERSTANDING THE THREATS**

Actions to be taken include:-

1. **CONDUCT A HAZARD ANALYSIS** Identifying all potential hazards, that must be prevented, eliminated or reduced to acceptable levels, associated with each step in the production process. Conducting a hazard analysis, and

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consider any measures to control identified hazards. Listing all potential hazards associated with each step.

6. Food businesses should examine food production, processing and preparation operations with a view to identifying hazards and assessing the associated risks. This should lead to a determination of critical control points and the establishment of a system to monitor production at these points. It is important that care is exercised throughout the whole production-processing and distribution chain, to identify and correct any problems at the earliest opportunity before they pass further up the supply chain rather then rely on end product testing.

7. The process of conducting a hazard analysis will benefit from mechanisms to gather intelligence on potential hazards or problem areas. There are a number of useful sources of information about potential problem areas. Some of these are available to and can be utilised by food industry, such as:

- chemical usage patterns
- changing industrial and agricultural practices
- developments in food production practices
- scientific literature, conferences, and expert fora
- feedback from Local Food Authority enforcement activities

and others may be more easily accessible to Government, for example:

- notification via EU RASFF system
- EU Framework research
- contacts with EFSA, European food authorities and equivalent bodies outside Europe, WHO/FAO
- expert advisory committees and working parties
- stakeholder consultations
- contacts with other Departments/Agencies in the UK and overseas

8. The FSA will disseminate any useful information of this sort that it receives or discovers.

9. In addition to their own horizon scanning mechanisms, food and feed business operators should also ensure that-

- they are kept updated about concerns regarding similar products produced elsewhere, using information from within their own company, Trade Associations, trading partners
- they are aware of the Agency’s Mobile/PDA/E-mail update facility which provides the latest food alert details. Information on this is available from the Agency’s web site.
10. Questions that food businesses may wish to ask themselves as part of the hazard identification phase:

- What are the main threats?
- Have there been any previous food safety issues associated with this product?
- Are there any signs or rumours of unacceptable practices?
- If someone else was aware of such practices that might affect your products would you want to know about it?
- If you belong to Trade Association do they have a mechanism for disseminating this information to their members and the Food Standards Agency?

11. In conducting the hazard analysis, wherever possible the following should be included:

- the likely occurrence of hazards and severity of their adverse health effects;
- the qualitative and/or quantitative evaluation of the presence of hazards;
- survival or multiplication of micro-organisms of concern;
- undeclared presence of allergenic ingredients or misleading allergen information;
- production or persistence in foods of toxins, chemicals or physical agents; and,
- conditions leading to the above.

2. **DETERMINE THE CRITICAL CONTROL POINTS** Identifying the Critical Control Points (CCPs) at the step or steps at which control is essential to prevent or eliminate a hazard or to reduce it to acceptable levels.

12. There may be more than one CCP at which control is applied to address the same hazard. The first CCP should be the arrival of ingredients or supplies from outside the company to check that they meet established specifications. The determination of a CCP in the HACCP system can be facilitated by the application of a decision tree (e.g., Diagram 1), which indicates a logic reasoning approach. Application of a decision tree should be flexible, given whether the operation is for production, slaughter, processing, storage, distribution or other. It should be used for guidance when determining CCPs. This example of a decision tree may not be applicable to all situations. Other approaches may be used. Training in the application of the decision tree is recommended.

13. If a hazard has been identified at a step where control is necessary for safety, and no control measure exists at that step, or any
other, then the product or process should be modified at that step, or at any earlier or later stage, to include a control measure.
Diagram 1
Example of decision tree to identify CCP’s
(answer questions in sequence)

Do control preventative measure(s) exist?

Yes

No

Modify step, process or product

Is control at this step necessary for safety?

Yes

No

Not a CCP

Stop (*)

Is the step specifically designed to eliminate or reduce the likely occurrence of a hazard to an acceptable level? (**)

Yes

No

Could contamination with identified hazard(s) occur in excess of acceptable level(s) or could these increase to an unacceptable level? (**)

Yes

No

Not a CCP

Stop (*)

Will a subsequent step, prior to consuming the food, eliminate the identified hazard(s) or reduce the likely occurrence to an acceptable level? (**)

Yes

No

Critical Control Point

Not a CCP

Stop (*)

(*) Proceed to the next identified hazard in the described process
(**) Acceptable and unacceptable levels need to be defined within the overall objectives in identifying the CCP’s of HACCP plan.
3. **ESTABLISH CRITICAL LIMITS** Establishing critical limits at critical control points.

14. Critical limits should be specified and validated for each Critical Control Point. In some cases more than one critical limit will need to be elaborated at a particular step. These critical limits should separate acceptability from unacceptability for the prevention, elimination or reduction of identified hazards.

15. An issue food businesses need to take into account is whether the product complies with current legislation (both national and European). The Agency’s Food Law Guide provides information on food legislation and is available from the Agency’s web site ([http://www.food.gov.uk/foodindustry/regulation/foodlawguidebranch](http://www.food.gov.uk/foodindustry/regulation/foodlawguidebranch)). Copies of the relevant European Community legislation are available via the European Commission web site ([http://europa.eu.int/comm/food/food/index_en.htm](http://europa.eu.int/comm/food/food/index_en.htm)).

**APPLYING CONTROLS**

4. **ESTABLISH A SYSTEM TO MONITOR CONTROL OF THE CCP** Establishing and implementing effective monitoring at critical control points.

16. Monitoring is about measuring and observing the CCP in relation to its defined limits. The monitoring procedures must be able to detect loss of control at the CCP. Further, monitoring should ideally provide this information in time to make adjustments to ensure control of the process to prevent violating the critical limits. Where possible, process adjustments should be made when monitoring results indicate a trend towards loss of control at a CCP. The adjustments should be taken before a deviation occurs. Data derived from monitoring must be evaluated by a designated person with knowledge and authority to carry out corrective actions when indicated. If monitoring is not continuous, then the amount or frequency of monitoring must be sufficient to guarantee the CCP is in control. Most monitoring procedures for CCPs will need to be done rapidly because they relate to online processes and there will not be time for lengthy analytical testing. Physical and chemical measurements are often preferred to microbiological testing because they may be done rapidly and can often indicate the microbiological control of the product.

17. All records and documents associated with monitoring CCPs must be signed by the person(s) doing the monitoring and by a responsible reviewing official(s) of the company.
5. **ESTABLISHING CORRECTIVE ACTIONS WHEN MONITORING INDICATES THAT A CRITICAL CONTROL POINT IS NOT UNDER CONTROL.**

18. Specific corrective actions must be developed for each CCP in the HACCP system in order to deal with deviations when they occur.

19. The actions must ensure that the CCP has been brought under control. Actions taken must also include proper disposition of the affected product. Deviation and product disposition procedures must be documented in the HACCP record keeping.

6. **ESTABLISHING PROCEDURES, WHICH SHALL BE CARRIED OUT REGULARLY, TO VERIFY THAT CONTROL MEASURES ARE WORKING EFFECTIVELY.**

20. Verification and auditing methods, procedures and tests, including random sampling and analysis, can be used to determine if the HACCP system is working correctly. The frequency of verification should be sufficient to confirm that the HACCP system is working effectively.

21. Examples of verification activities include:
   - Review of the HACCP system and plan and its records;
   - Review of deviations and product dispositions;
   - Confirmation that CCPs are kept under control.

22. Where possible, validation activities should include actions to confirm the efficacy of all elements of the HACCP system.

7. **ESTABLISHING DOCUMENTS AND RECORDS COMMENSURATE WITH THE NATURE AND SIZE OF THE FOOD BUSINESS TO DEMONSTRATE THE EFFECTIVE APPLICATION OF THE CONTROL MEASURES.**

23. Efficient and accurate record keeping is essential to the application of a HACCP system. HACCP procedures should be documented. Documentation and record keeping should be appropriate to the nature and size of the operation and sufficient to assist the business to verify that the HACCP controls are in place and being maintained. Expertly developed HACCP guidance materials (e.g. sector-specific HACCP guides) may be utilised as part of the documentation, provided that those materials reflect the specific food operations of the business.

24. Documentation examples include:
   - Hazard analysis;
• CCP determination;
• Critical limit determination.

25. Record examples include:
• CCP monitoring activities;
• Deviations and associated corrective actions;
• Verification procedures performed;
• Modifications to the HACCP plan;

POSSIBLE CONTROL MEASURES

26. There are a number of critical control points in the food and feed supply chains. As with ‘threats’ many of the controls are applicable, with varying degrees of sophistication and formalisation, to virtually all stages of the food and feed chains. These can take the form of pre-planned actions or reactive procedures and will include measures such as-

Quality Assurance/Quality Control

27. Questions food and feed businesses should ask themselves include:
• Do your suppliers carry out Risk Assessments?
• Do your suppliers carry out Risk analysis?
• Are you and the businesses that you deal with approved or registered establishments?

28. Laboratories used for defence and enforcement purposes must use methods that are fit for purpose and sensitive enough both to demonstrate compliance with any limit and/or to perform a suitable risk assessment.

Third party specifications, and compliance checking

29. These include-
• Codex Standards
• Trade Association Standards
• Retailer’s Standards
• Small Business Standards

Trusted sources

30. Operators should:

• use companies and/or suppliers who have recognised accreditation and proven good practice monitoring; and
• ensure compliance of products with purchase/supply specifications is audited.

31. Questions food businesses should ask themselves include:
  • How can they demonstrate that their products do not present an unacceptable risk to consumers?
  • Do they routinely check that their raw materials comply with the specifications of the relevant legislation?

Assurance Schemes

32. Questions food and feed businesses should ask themselves include:
  • Which assurance schemes are available for their raw material or final products?
  • Are they members of such a scheme?
  • What aspects of the scheme assure the safety/composition of products?
  • Are suppliers members of any Industry Standards and/or Assurance Schemes and is their compliance 3rd party audited?

Codes of Practice

33. Questions food and feed businesses should ask themselves include:
  • are there Codes of Practice covering particular industry sectors and are these followed?
  • are the Codes of Practice relevant to food safety? and
  • what evidence is available that Codes of Practice have been followed?
34. New, legal traceability requirements for all EU food and feed businesses took effect on 1 January 2005.

35. All food and feed businesses within the EU are required to:-

- identify the name and address of suppliers of; food, feed, food-producing animals and ingredients to their business;
- identify the businesses to which products have been supplied;
- identify the nature of the products, the date of transaction, and the volume or quantity; and
- maintain appropriate records and ensure that such information is made available to competent authorities on demand.

36. These legal requirements do not require internal traceability, that is, a system which would allow linkages to be made between the sale of finished products and the source of materials used to produce them. Nevertheless, there are benefits to be gained from such systems, specifically:

- improved consumer protection through better targeted, and more rapid recalls and/or withdrawals;
- greater efficiency within businesses, with more information to assist in process control and management;
- provision of reliable information to consumers to support authenticity claims about products;
- deterrence of fraud; and
- increased consumer confidence.

37. It is for businesses to decide whether to adopt internal traceability on the basis of costs and benefits.

38. In addition to meeting regulatory demands, traceability systems:

- provide information within food and feed businesses to assist in process control and management e.g. stock control, efficiency of material usage and quality control; and
- assist businesses when problems arise supporting effective withdrawal or recall of products and allowing detection of the cause of a problem so that targeted action can be taken to prevent recurrence.

39. The provision of accurate and timely information and continued confidence in the information provided can be brought about by improved traceability records and regular testing of the robustness of their traceability and recall procedures.
40. Some questions food and feed businesses should ask themselves include:

- how reliable are your traceability records?
- have you tested the robustness of your traceability and recall procedures? and
- are they subject to regular review?
- how far can you be sure that traceability extends?
- what steps have you taken to verify the reliability of the traceability systems of your suppliers?
- in the event of an incident, would you be able to narrow down the problem to the affected batch or batches?
Where to get further information

EU legislation


HACCP

42. Further details of the implementation of procedures based on HACCP can be found in guidance published by the European Commission at http://europa.eu.int/comm/food/food/biosafety/hygienelegislation/guidance_doc_hacc p_en.pdf

43. Small catering businesses are encouraged to read the safer food better business pack produced by the Food Standards Agency. This can be found at http://www.food.gov.uk/multimedia/pdfs/sfbbfullpack.pdf
A guide to using the pack can be found at http://www.food.gov.uk/multimedia/pdfs/sfbhowto.pdf
CHAPTER 2 INCIDENT RESPONSE

RESPONDING TO INCIDENTS – THE PROCESS & RATIONALE

INTRODUCTION

1. A range of bodies, including food and feed businesses, is responsible for notifying the FSA, as the competent authority, about potential or actual incidents. In responding to this information, the FSA deals with a broad range of hazards, classed as chemical (C), radiological (R), microbiological (MB) and physical (P) contaminants. Within the Agency, the principles adopted and the process used to respond are exactly the same for each class of hazard, thus providing coherence and consistency of response. For each class however there may be differences of detail arising from the particular nature of the hazard e.g. the nature of the further information that should be sought to underpin a risk assessment. These are reflected in Annexes A-D which provide stand-alone guides.

CORE PROCESS

2. The overall objective is for the food and feed industries, FSA, enforcement authorities and other stakeholders, to ensure that chemical, radiological, microbiological and physical hazards do not pose an unacceptable risk to public health through the consumption of food. An incident is any event where, based on the information available, there are concerns about actual or suspected threats to the safety or quality of food that could require intervention to protect consumers’ interests. In all cases the key steps are the same:

- Incident Notification
- Information Gathering for Risk Assessment
- Risk Assessment
- Risk Management Options & Decision Making
- Risk Communications (aligned from the outset)
- Follow Up, Review and Lessons Learned
- Post Incident Actions (if required)

3. Within FSA, consistency, including an audit trail for decision-making, is achieved by managing all incidents according to an agreed Incident Protocol (Annex G), which is distributed throughout the Agency and is complementary to this document. The Protocol is risk-
based and can be tailored to the size and complexity of the incident. At the core of the Agency’s response is an **Incident Team** (based in Emergency Planning, Radiation & Incidents Division, EPRID) who manage the backbone of incident response and management – log all notifications, ensure Protocol is followed, organise and support appropriate meetings, maintain the audit trail, help gather information from stakeholders.

4. In accordance with the Incident Protocol, a core principle is to convene an **ad hoc incident group**, chaired by the Head of Division in the relevant policy area (e.g. Chemical Safety Division, Microbiological Safety Division), which manages the process from risk assessment to outcome. It is important to note, that from the outset, membership of the ad hoc team must include representatives from the Incident Team, Lead Policy Division, Legal Division, Communications Division, and other relevant policy areas such as Local Authority Enforcement Division, as required. The Group will meet daily, if required, in the early days of an incident. The Chair of the ad hoc group is accountable to Directors for the outcome of the incident.

5. It is important to stress that **the communication of risks** and advice to consumers and other stakeholders is not simply an activity to be added to the end of the incident management process. A communications strategy must be discussed in the ad hoc group from the beginning of the process and throughout the consideration of risk management options. Wider communication with stakeholders, including trade associations, consumer groups, enforcement community, Other Government Departments and Ministers, about the progress of an incident must also be carried out, as early as possible, and particularly for large and complex incidents. The European Commission will also need to be alerted at an early stage as possible, where products are likely to have been distributed to other EC Member States, even if insufficient data are available to issue an immediate alert through the EU Rapid Alert System.

6. Some distinction is made in the Protocol between routine incidents and severe and/or complex incidents. The latter may require a strategic level **Gold Command** to be assembled, with membership akin to the ad hoc group, supported by an operational level Silver team. This chapter draws attention to dealing with large and complex incidents in particular.

7. In the case of **large and complex incidents** it may also be appropriate to convene a **Scoping Group**, whose objectives are:

- To help establish the nature and scale of the issue and to map out the part of the supply chain involved.
- Trade Association representatives to facilitate collection of information from their membership and/or sector and pass to FSA.
• This information will be used to inform the FSA risk assessment and risk management decisions.

• To agree an action plan and identify the roles and responsibilities of each stakeholder; this will be reviewed and revised as necessary.

• To agree a co-ordinated communication plan for stakeholders; this will be reviewed and revised as necessary.

• All outputs from meeting(s) of the Group will be recorded by the FSA and circulated within an agreed timescale.

• Life of the Group will be decided on a case by case basis

8. The need for the Group and the frequency of its meetings will be determined by the Agency according to the potential size and complexity of the incident and will comprise Agency officials and representatives from industry, the enforcement authorities and consumer organisations. It is likely to meet either before or just after the ad hoc group, depending on how events unfold. In addition, wherever possible, the harmonisation of a large incident with EC Member States, should be considered. Gold Command must include this consideration on its standing agenda. Further information at http://www.europa.eu.int/comm/food/committees/regulatory/scfcah/toxic/summary19_en.pdf and http://www.food.gov.uk/multimedia/pdfs/itf0528.pdf

INCIDENT NOTIFICATION

9. Best practice indicates that stakeholders should alert FSA immediately of a potential problem using the definition of an incident at paragraph 2 above, and that all relevant information be shared by those notifying in an open and timely manner. Food and feed business operators at all stages of production, processing and distribution of food and feed must comply with the requirements of EC General Food Law Regulation 178/2002. In particular, brand owners must initiate procedures to withdraw/recall food in question and notify the competent authorities (in the UK, the relevant Local Food Authority and the Agency). FSA will provide an online incident report form for incident notification. Operators must also notify their Local Food Authority.

EXAMPLES OF SOURCES & TYPES OF INFORMATION NOTIFIED

• Notifications under EC General Food Law Regulation 178/2002 by the food industry
• Surveys (conducted by the Agency/others)
• Uncontrolled/accidental release to the environment, reported by e.g. Environment Agency
• On farm incidents
• Reports from Local Food Authority enforcement officers
• Reports from ports of entry
• Significant cases/outbreaks of food poisoning/suspected food poisoning from public health bodies
• Pesticides Safety Directorate, Veterinary Medicines Directorate reports
• Information from other EU Member States via the RASFF system (Rapid Alert System for Food & Feed)
• Food or feed that contains a substance at a concentration above the legal limit, or one prohibited in food and feed.
• Food with incorrect allergy labelling.

INITIAL ACTIONS POST-NOTIFICATION TO FSA

• FSA Incident Team logs report on Incident Database
• Move swiftly to determine additional information required, via ad hoc group
• In the case of significant outbreaks FSA makes early contact with the Outbreak Control Team.
• Assess likely severity and complexity of the emerging issue.
• For severe/complex incidents FSA must provide early warning to key stakeholders both internally and externally, explaining that updates will follow as information becomes available.
• For severe/complex incidents convene Scoping Group, if required.

INFORMATION GATHERING FOR RISK ASSESSMENT

10. The extent of the initial information available will vary from one incident to another. In addition, the key questions may vary according to the class of hazard and the cause of the incident. Detailed lists are provided at Annexes A-D to act as a guide.

• Broadly, the aim is to establish the detailed nature of the hazard, where and when the incident occurred, who is likely to be affected, size and complexity (UK, overseas), potential for wider implications (e.g. other parts of the food industry) and if food products are affected, their quantities, distribution and availability to consumers.

3 Severity will be based on public health risk (low for many, high for few, impact on special groups). Complexity will be based on size and scale (local/national/international, numbers of reports received, number of products affected, number of organisations likely to be involved e.g. manufacturers, retailers, Government bodies, other Agencies).
• In FSA, the incident ad hoc group will review the information gathered and use it to underpin a risk assessment.

• In large food incidents there may be many hundreds of products affected. This will require coordinated action through the **Scoping Group**.

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**RISK ASSESSMENT**

11. Following notification, in FSA, the ad hoc incident group will undertake a risk assessment. In some instances, assessment of the issue may be relatively straightforward and consist of comparison of information received with pre-existing limits, guidelines or standards.

12. In most cases, however, assessment of the issue will require informed scientific judgement to assess from the information received, the potential consumer exposure to any hazard and the size and acceptability of any resultant risk. In many situations, FSA will seek expert advice on risk assessment from its standing scientific advisory committees, or, where necessary, from other independent experts.

- A preliminary risk assessment will be undertaken rapidly and recorded by the ad hoc group with the relevant policy Division in the lead.
- This preliminary assessment will help identify whether further, independent expert advice is required e.g. from the Committee on Toxicity (COT). This is likely to be the case when there are uncertainties or if for example, a Tolerable Daily Intake or Acceptable Daily Intake does not exist. The FSA assessment should always be confirmed with the relevant committee chairman. If EFSA has published a risk assessment, then this should be used.
- The broad aim is as outlined in paragraph 9 with the output being an interim or full risk assessment to inform risk management options.
- Details of the process for each class of hazard may vary, including the context for assessing exposure, and these are provided in Annexes A-D.
- Ongoing discussion of a communications strategy must occur during this phase.

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**RISK MANAGEMENT**

13. In managing the implications of incidents, the primary objective of FSA is to protect consumers. In most cases, this means protecting consumers against public health risks that, on the basis of a risk assessment, we judge to be unacceptable. In carrying out its functions
the Agency also has a statutory duty in protecting other interests of consumers and we may therefore also take action where – as a result of work on food authenticity or labelling – we believe there is the potential for consumers to be misled. It also aims to protect consumers against activities which are illegal.

14. When FSA selects a risk management option it has a statutory duty to be proportionate, taking into account not only the nature and magnitude of the risks that have been assessed but also the likely costs and benefits of any action. In reaching a decision the Agency takes into account factors such as any uncertainties in the information, size and complexity of the response required, considerations of illegality and any actions already taken. Consumer expectations may also be an important factor. The process is summarised below:

- The interim or full risk assessment will be used by the ad hoc group to develop risk management option(s) and a communications strategy. Consultation with the relevant expert committee will have take place.

- The chair of the ad hoc group will seek endorsement and/or a decision from FSA Directors. For serious and/or complex incidents, Gold Commander will seek endorsement from the Chief Executive or Deputy in his absence. The Chief Executive will keep the Agency Chair and Deputy Chair informed and may seek a debate or challenge for the proposed course of action.

- **Communications** are critical at this stage, especially for serious and/or complex incidents and they would follow on from the early warning provided at the outset. Effective two-way channels of communication will be established with contacts in other Government Departments and major stakeholders including Trade Associations, Consumer Groups, LACORS, CIEH, TSI and Local Food Authorities. The FSA Board and Ministers will be informed of the risk management and communications strategy, including Ministers in the devolved administrations where affected food producers are available in Scotland, Wales or Northern Ireland.

- Other EU Member States will be alerted through the RASFF system (by the Incidents Branch) where affected products have been distributed outside the UK.

- In the case of severe/complex incidents, Gold Command will establish a dedicated **Information Cell**, with the sole purpose of providing timely, regular and accurate updates to key stakeholders and establishing effective two way communications. This cell will be led by an Agency Head of

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4 Section 23, Food Standards Act, 1999
Division, appointed by Director of Food Safety Policy. The Incident Team will ensure that details of stakeholder points of contact are kept up to date to underpin this approach.

- Members of the incident Scoping Group will assist with routes of communication through the affected part of the supply chain, to help prevent duplication and confusion. The Group will also consider how best to reach small businesses and those companies not represented by a Trade Association.

15. Food and feed business operators are required to take action in certain circumstances as set out in Articles 19 and 20 of EC Regulation 178/2002. The management options include withdrawal of product from within the food business' direct control and/or from the supply chain or to recall product that has reached consumers. The operator must also inform consumers of the action taken and inform the competent authorities (Local Food Authority, FSA). Guidance is available in “Product Recall Guidelines, A Good Practice Guide for Product Recall, BRC 2003”. Risk management options and the associated communication routes may vary with the nature of the incident. Some specific considerations for risk management specific to each class of hazard are provided at Annexes A-D.

**Examples of risk management & communication options include**

- Informing stakeholders that no action is required
- Providing information and advice to consumers, perhaps tailored for special groups
- Use of voluntary restrictions
- Withdrawing affected food products or batches
- Recalling affected food products or batches
- Imposition of an emergency control order under the Food Safety Act
- Imposition of a FEPA\(^5\) order

**Food Alerts** Where action has led to withdrawal or recall of product(s), FSA will alert Local Food Authorities. The most appropriate way of communicating with Local Authority officers is through use of a Food Alert, either For Information or For Action. Food Alerts are issued electronically to Local Authorities and have attached any parallel FSA press release, which may be used as the basis for a local press release in accordance with the Code of Practice. The Incident Team will always endeavour to issue Food Alerts in a timely fashion, consistent with progress on the incident as a whole.

\(^5\) A Food and Environment Protection Act Order
• **Food Alerts** are also e-mailed or faxed to other key stakeholders for the incident. The Food Alert is also published on the FSA website.

• It is the Agency’s usual practice to publish details of those products affected by an incident and the options for doing so will be discussed as early as possible in the incident handling timetable. Besides the use of the FSA website, these also include Trade Association websites and/or notifications in the press by the companies concerned and/or trade associations where consumers need to take action themselves. Under 178/2002, if the product(s) may have reached consumers, food business operators are legally obliged to inform consumers of the action they have taken and this will include point of sale notices.

• **Quality Assurance and Testing** It may be appropriate, depending on the nature of the contaminant, for the Agency and industry stakeholders to agree as early as possible which testing methodologies are considered to be reliable and what limits of detection should be applied.

RISK COMMUNICATION

16. The communication of risks and advice to consumers and with other stakeholders is not simply an activity to be added to the end of the process once risk management decisions have been taken. Food business operators have a legal obligation to inform consumers of the action they have taken, if the product(s) may have reached consumers, including, for example, point of sale notices. In FSA, a communications strategy must be discussed within the incident ad hoc group from the outset. Communications should also form part of any ongoing discussion of risk management options.

17. FSA presumes in favour of publishing all relevant information from incidents, and advising consumers and other stakeholders on the implications for them and any actions they should take. The tools used will vary depending on circumstances and audiences.

18. FSA guidelines on risk communication are provided at Annex E.

FOLLOW UP, REVIEW & LESSONS LEARNED

19. All incidents are subject to review by the FSA Incident Team once complete. The Incidents and Emergencies Committee (IEC) will select a subset, maximum of six per annum, for a wider, formal review. The selection of incidents for this higher level review will be based on a number of criteria including unresolved issues or questions, cross-
cutting issues (especially those affecting stakeholders) and clear successes or failures of process.

20. The review of incidents for submission to the IEC will be undertaken by the Head of EPRI Division (Chair), using an agreed format (outlined in the Incident Protocol). A meeting will be organised by the Incident Team, which will be attended by all key internal stakeholders for the incident. A questionnaire will be distributed prior to the review meeting so that appropriate feedback can be considered. An action plan, focusing on successes and lessons learned, will be prepared, based on the outcome of the review meeting, for submission to the IEC, which will then audit implementation. One key outcome of lessons learned is likely to be an update of this document and additions to the Incident Protocol.

21. For each major and/or complex incident, a review may also take place with all key players, including external stakeholders. Lessons from such reviews are also likely to be reflected in an update of this document.

**POST INCIDENT ACTIONS**

22. The follow up to any incident should include elicitation of feedback from brand owners, Local Food Authorities and other stakeholders as appropriate to ensure that actions (such as withdrawal of foods from the market) have been completed effectively. Communication with consumers and other stakeholders should be reviewed if the situation changes. A number of specific post incident actions may also be required either by FSA or by stakeholders. These will depend on the nature of the incident.

23. For example, **disposal of affected products** may be required. Detailed guidance endorsed by the Trading Standards Institute is provided on disposal at Annex F. Advice should be provided by manufacturers/retailers to consumers on how affected products should be collected and/or disposed of. A secure area should be provided for the storage of affected products until they can be disposed of properly.

24. Formal enforcement action may also be required.
ANNEX A  Chemical Hazards

1. The pathway from primary production to the consumer may often be complex with many routes by which various potentially toxic chemicals may enter food;

   • Raw materials may contain unacceptable levels of natural toxins produced by food crops (such as lectins in red kidney beans) or by moulds or other pests growing on them (such as mycotoxins). They may also contain excessive levels of chemicals derived from the environment in which they were produced (such as dioxins or heavy metals).

   • Food processing may induce chemical changes in the food (such as the formation of ethyl carbamate or chloropropanols).

   • Storage and distribution may lead to chemical deterioration or to the migration of chemicals through or from food packaging materials into food.

Collecting information for risk assessment

2. The information initially available to inform a risk assessment of chemical hazards will vary from one survey or incident to another. For surveys conducted by the Food Standards Agency, there will be direct access to information on the nature and identity of the foods that are contaminated, on the levels of contaminant found and associated measurement uncertainty and, in most cases, on the likely extent of any problem. Past experience shows that information is likely to be more limited for many environmental and on-farm incidents, particularly when these are first notified. In such cases, further information should be sought to inform the risk assessment. This should include as much of the following as possible:

   • What is the nature of the hazard, and is it clear which chemical(s) are involved?

   • What is the amount or concentration of the chemical(s), or other indication of the size of the incident?

   • What is the duration of the incident so far, and is it likely to continue?

   • At what stage has any fault occurred or is likely to have occurred – on-farm, in processing, or downstream - and how has it led to the reported problem?
What is the location of the incident and the nature of the production or processing environment that is or may be affected (e.g. farm-land, types of crops, watercourses, food ingredients or products implicated)?

Are there other affected or potentially affected products or commodities produced or stored on the same premises or within the affected area?

Are there wider implications for others in the same industry or for premises using similar processes in other food industries?

What are the possible points of entry into the food and feed chains for the contaminant and food products or commodities that may be affected?

What are the likely quantities and distribution of the particular food in the food chain up to the point of consumption, including any supply outside the UK?

Can the affected and/or implicated batch(es) be accurately identified and traced?

Are downstream processes, such as cooking, likely to affect the risk?

If identifiable food product(s) are affected, are they still within their recommended shelf life and likely to be available either at the retail level or after frozen or other storage by the consumer?

What group of the population is likely to be affected and to what extent if this product is consumed; are they particularly vulnerable?

Is any action being taken by other organisations?

What uncertainties exist in any of the above information and what are the implications of this uncertainty?

**The risk assessment process**

3. The Chemical Safety Division (CSD) of FSA should be consulted for toxicological advice on chemical issues. Experts within CSD will conduct a preliminary risk assessment consisting of hazard identification, hazard characterisation, exposure assessment and risk characterisation.

- **Hazard identification and characterisation** involve identification of the nature of the toxic effects associated with a substance,
information on the dose response, and consideration of whether any established safety guideline values are applicable.

- Exposure assessment typically consists of an estimation of dietary exposure – by the general population and any relevant affected subgroups - from any specific foods implicated by the survey or incident, together with an assessment of the contribution from the rest of the diet to total dietary exposure. It may also be necessary to consider the importance of dietary exposure in the context of other sources of exposure.

- Risk characterisation involves comparison of the exposure assessment with the relevant safety guideline values, or with the dose response information if no relevant guideline values are available.

- If the preliminary risk assessment indicates that exposure is at or above the safety guideline and the uncertainty associated with the estimate is likely to be significant, there is a need to try to refine the exposure assessment as quickly as possible. Wherever feasible, the uncertainty in the exposure assessment should be expressed as a lower bound to upper bound range.

4. The preliminary CSD risk assessment will help identify whether independent expert advice is required, taking into account as appropriate factors such as:

- The nature of the chemical toxicant.
- The likely variation in concentrations of the toxicant in the matrix in which it has been detected.
- The possible exposure of members of the public.
- The nature of the health effects of concern.
- The likelihood of there being immediate or long-term effects on health.
- The existence of sub-groups of the population with particular sensitivity to the material/toxicant (e.g. allergy). and
- The distribution of the product, ie potential size of exposed population.
- Potential exceedance of a statutory limit, taking into account any uncertainties associated with the analytical methodology, whether the sample containing the non-compliant level was representative of the relevant production run, batch, lot or
container, whether the incident of non-compliance is indicative of a wider problem.

5. If no Tolerable Daily Intake or Acceptable Daily Intake is available or it is likely to be exceeded, independent expert advice is likely to be required. This should be sought from the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT). The COT Secretariat is responsible for communications with the COT chairman or members, and will be able to advise on whether and how to consult the committee.

6. For incidents, or other cases, such as surveillance results, where the preliminary risk assessment indicates a potential for immediate and serious risk to consumer health, urgent advice may be requested from an ad hoc group of the COT or from the COT Chairman. The advice of the COT is published with relevant supporting papers on the COT website. Any urgent advice received from the COT is the subject of an information paper presented to the full Committee at its subsequent meeting and is then published.

**Risk management options**

**Public health considerations**

7. Where levels of a chemical contaminant in a food have the potential to cause serious adverse health effects or immediate harm, the affected batch(es) of product should be withdrawn from sale immediately and recalled from consumers' homes as quickly as possible. Consumers and other stakeholders must be informed about the situation and what it means for them.

8. Where levels of a chemical contaminant in a food have the potential to cause harm following repeated or chronic exposure, the affected batch(es) of product should be withdrawn from sale. Consumers and other stakeholders must also be provided with appropriate advice about products that they have already bought or consumed.

9. Where levels of a chemical contaminant in a food have the potential to cause harm only if consumed by a particularly affected population, advice must be issued to that population and the need for further action considered on a case-by-case basis.
The source of radioactivity in food

1. Naturally occurring radioactivity is found in most foods and accounts for the majority of the dose received from this source by most consumers. Man-made radionuclides can enter the environment, and hence food, in a number of ways. The most likely route is by authorised discharges from licensed nuclear sites. These discharges can be made to the atmosphere or to water and the Food Standards Agency, the Scottish Environment Protection Agency in Scotland and the Environment and Heritage Service of the Department of The Environment in Northern Ireland undertake routine monitoring around UK sites to check that authorised discharges do not give rise to unacceptable levels in foods.

2. Radionuclides can also be found in foods as a result of past weapons testing, accidents at nuclear sites (such as the Chernobyl disaster of 1986), transport incidents, satellite re-entry or accidents involving radioactive sources.

The basis for risk assessment

3. Acceptable levels for radioactivity in food may be expressed either in terms of the annual dose a person receives from all sources of radioactivity, including the contribution from food, measured in millisieverts (mSv), or the amount of a particular radionuclide in a particular foodstuff, measured in Becquerels per kilogram of food (Bq/kg).

4. For all practices that add to the background radiation exposure of the public, the International Commission on Radiological Protection (ICRP) recommends a system of radiological protection based on justification, optimisation and limitation. For a member of the public the annual statutory dose limit is 1 mSv from all sources excluding medical and natural radiation. This compares with the overall dose received by a member of the public from such background radiation of about 2.6 mSv.

5. Specific EU legislation sets limits for radioactivity in foodstuffs in certain situations:

- Council Regulation (Euratom) No 3954/87 lays down the maximum permitted levels of radioactive contamination of food and of animal feed following a nuclear accident or any other radiological emergency.

- Council Regulation (EEC) No 737/90 on the conditions governing imports of agricultural products originating in third countries following the accident at the Chernobyl nuclear power
station sets limits for certain foodstuffs.

6. In the UK, restrictions on the movement and slaughter of sheep grazing in certain areas were made under the provisions of the Food and Environment Protection Act 1985 (FEPA) after the accident at the Chernobyl power station in 1986. These Orders have since been amended by partial revocations to reduce the area covered. Farmers may be granted a consent to move sheep out of the restricted area if the sheep are monitored and the level of caesium-137 in the meat is below the UK limit of 1000Bq/kg.

Collecting information for risk assessment

7. Where food is found to contain, or suspected of containing, elevated levels of radioactivity, an immediate risk assessment must be conducted. This will be led by experts in Emergency Planning, Radiation and Incidents Division (EPRID) in FSA. Information on the type, level, and source of contamination must be ascertained.

8. For problems highlighted by surveys carried out by the Agency there will be direct access to much of the information required. For other incidents there will be a need to gather much of the information needed to inform the risk assessment. This should include as much of the following as possible:

- What is the nature of the hazard, and is it clear which radionuclide(s) are involved and what form they are in?

- What is the amount or concentration of the radionuclide(s), or other indication of the size of the incident?

- What is the nature of the incident, and what pathways are affected?

- What is the duration of the incident so far, and is it likely to continue?

- What is the location of the incident and the nature of the production or processing environment that is or may be affected (e.g. farm-land, types of crops, watercourses, food ingredients or products implicated)?

- Are there other affected or potentially affected products or commodities produced or stored on the same premises or within the affected area?

- Are there wider implications for others in the same industry?

- What is the duration of the incident so far, and is it likely to continue?
• Is any action being taken by other organisations?

• What uncertainties exist in any of the above information and what are the implications of this uncertainty?

**The risk assessment process**

**Statutory limits**

9. If the contamination is the result of a nuclear emergency such as an accident at a nuclear reactor, the level of the radioactivity in the food should be compared with the levels specified in Regulation No 3954/87. In the initial stages, if samples are not readily available, the levels of radioactivity should be calculated using computer models available to EPRID. The main model used is R91STAR, which can estimate ground level air concentration or deposition values from an atmospheric dispersion model and thereby inform risk management and communication. Samples shall be collected as soon as possible from the area that may be contaminated, and sent to an accredited laboratory for determination of the actual levels of radionuclides present in exposed foodstuffs.10. For food imported from outside the EU, the country of origin and the level of radioactivity should be compared with the specifications in EU Regulation No 737/90. If the level is above these limits, Port Health Authorities/local authorities have powers under the Imported Food Regulations 1997 to issue a notice requiring the removal of the consignment from EU territory.

**Exposure assessment**

11. For elevated results when the situation is not classified an emergency, technical experts in EPRID should estimate the dose that consumers would receive from the food at typical and high levels of consumption. To calculate the dose, the level of the radioactivity from the particular radionuclide in a foodstuff is multiplied by the dose per unit intake factor for that radionuclide, carried out in accordance with ICRP-60 methodology. The consumption rates of the foodstuff from habit surveys or the Total Diet Study are then taken into account to calculate the total effective dose of radiation caused by the radionuclide over a set timescale. This dose is compared both with the dose limit and also the natural background dose that consumers would receive. The levels of contamination should also be compared with World Health Organisation guidelines where appropriate, such as levels of radioactivity in drinking water, as well as to those given in Regulation 3954/87.

12. If the radiological contamination results from a terrorist attack, the levels in Regulation 3954/87 are the most appropriate for comparison.
Risk management options

13. If either the level of contamination or the annual dose received were considered to be unacceptable immediate measures must be taken to restrict the access of consumers to affected food. Consumers and other stakeholders must be informed about the situation and any action they should take.

14. If elevated levels are found but the dose limit is unlikely to be breached, the need for precautionary public advice to protect affected groups such as infants consuming milk should be considered on a case-by-case basis.

15. A rolling monitoring strategy should be developed for foods produced within or in areas adjoining the affected area designated in any FEPA Order, or of foods containing ingredients which showed elevated levels. Such monitoring would help confirm the extent of any contamination and allow evaluation of the risk over time. Again, consumers and other stakeholders should be informed of the action taken by the Food Standards Agency, the reason for this action, and any action that they themselves should undertake.
ANNEX C Microbiological Hazards

The nature of microbiological hazards

1. There is a diverse range of potential microbiological hazards which may include:

   - Reported cases or outbreaks of food poisoning or of suspected or alleged food poisoning.
   - Food incidents associated with clinical illness or potential illness, including:
     - microbial contamination;
     - bacterial toxins;
     - marine algal toxins;
     - processing or packaging defects (e.g. undercooking, defective seals in canning);
     - incorrect instructions (e.g. risk of undercooking; unsafe recipes);
   - Microbiological hazards reported through the RASFF system.
   - Adverse results from the marine algal toxin monitoring programme.
   - On farm incidents with implications for the food chain, such as outbreaks of botulism in cattle, untreated sewage contamination of agricultural land.

Collecting information for risk assessment

2. Gathering of detailed information for a risk assessment must include as much of the following as possible:

   - What is the nature of the hazard and are pathogens involved?
   - What group of the population is likely to be affected and to what extent if this product is consumed; are they particularly vulnerable?
   - What are the likely quantities and distribution of the particular food in the food chain up to the point of consumption, including any supply outside the UK?
   - If identifiable food product(s) are affected, are they still within their recommended shelf life and likely to be available either at the retail level or after frozen or other storage by the consumer?
At what stage has the fault occurred or is likely to have occurred - processing, packaging, distribution, storage, handling - and what is its likely relevance to the problem?

Are there other affected or potentially affected products produced on the same premises?

Can the affected and/or implicated batch(es) be accurately identified and traced?

Are there wider implications for others in the same industry or for premises using similar processes in other food industries?

What uncertainties exist in any of the above information and what are the implications of this uncertainty?

3. This information can be obtained from the notifying local authority. Other Local Authorities, such as the home and/or originating authorities for the implicated manufacturer/retailer/supplier/importer, should also be contacted to gather additional information.

4. When an outbreak has occurred, information on the epidemiological and microbiological investigation will generally be obtained from Divisions of the HPA in England, the National Public Health Service (NPHS) in Wales and the equivalent bodies in Scotland and Northern Ireland. The lead in outbreak investigation and control rests with the local public health officials who form the Outbreak Control Team (OCT). The lead in investigation of national outbreaks in England rests with the HPA, in Wales with the NPHS and in Northern Ireland with CDSC(NI). The National Health Service Board and Local Authorities share the responsibility for the control of communicable disease in Scotland. In Northern Ireland, communicable disease control is the responsibility of the area Health and Social Services Boards which are supported in this function by the Environmental Health Service. If the investigation suggests an association with a nationally or regionally distributed food, the Food Standards Agency is responsible for advising Local Authorities and food companies on the action that should be taken. In this type of incident, it is important that roles and responsibilities of the OCT and FSA are clearly established.

The risk assessment process

5. An assessment of the risk will be carried out by experts in the Microbiological Safety Division of the FSA.

Risk management options

Public health considerations

6. Risk management and communication options will vary depending on the nature of the hazard. These could include:
• No further action.
• Further testing to be carried out.
• Product withdrawal by food business operators from warehouses, the distribution chain, retailers, caterers and/or
• Product recall by food business operators

7. Where a microbiological hazard has the potential to cause serious adverse health effects or immediate harm, the affected batch(es) of product should be withdrawn from sale immediately and where necessary recalled from consumers' homes as quickly as possible. Consumers and other stakeholders must be informed about the situation and what it means for them.

8. Where a microbiological contamination of food has the potential to cause harm only if consumed by a particular population, advice must be issued to that section of the population.

**Microbiological standards and guidelines**

9. In the case of microbiological contamination, statutory limits, if they apply, generally do so at the point of production, rather than at the point of sale. In general, products containing micro-organisms in excess of statutory limits should be withdrawn from sale, irrespective of any risk to health. The decision will take into account:

• Whether the sample(s) was representative of the relevant production run, batch, lot or container;

• Whether there is potential for multiplication of the microorganism(s) within the shelf-life of the product;

• Whether there are any steps that will reduce or remove the microorganism(s) of concern;

• Whether the incident of non-compliance is indicative of a wider problem.
ANNEX D Physical Hazards

The nature of physical hazards

1. In any food production process there is the potential for physical contaminants to be introduced into food. The risk of such contamination occurring can be minimised by the use of adequate and appropriate controls. Examples of physical contaminants and how they may be introduced into food include:

   - Raw materials may contain foreign bodies such as insects that have been living on food crops, or remnants of packaging materials.
   - During food processing or preparation potential physical contaminants can enter food (such as plastic, glass, wood or metal) due to poor maintenance of equipment.
   - Poor design or maintenance of food premises may lead to physical contaminants entering the food (such as flying insects through unscreened vents).
   - Poor storage and handling may lead to physical contamination.
   - Miscellaneous cases of malicious contamination of foods.

Collecting information for risk assessment

2. The information initially available to inform a risk assessment of any physical hazard will vary from one incident to another.

3. In some instances initial information may be limited. In such cases, further information should be sought and include a summary of the following as possible:

   - What is the nature of the hazard?
   - At what stage of food production or processing has any fault occurred or is likely to have occurred – and how has it led to the reported problem?
   - What is the location of the incident and the nature of the production or processing environment that is or may be affected?
   - Are there other affected or potentially affected products or commodities produced or stored on the same premises?
   - Are there wider implications for others in the same industry or for premises using similar products or processes in other food industries?
• What are the likely quantities and distribution of the particular food in the food chain up to the point of consumption, including any supply outside the UK?

• Can the affected and/or implicated batch(es) be accurately identified and traced?

• If identifiable food product(s) are affected, are they still within their recommended shelf life and likely to be available either at the retail level or after frozen or other storage by the consumer?

• What group of the population is likely to be affected and to what extent if this product is consumed; are they particularly vulnerable?

• Is any action being taken by other organisations?

• What uncertainties exist in any of the above information and what are the implications of this uncertainty?

The risk assessment process

4. Advice on the potential public health risks associated with foreign bodies in food should be sought from Emergency Planning Radiation and Incidents Division within the Food Standards Agency, which might in turn seek advice from external experts.

Risk management options

5. Where a physical contaminant in a food has the potential to cause serious adverse health effects or immediate harm, the affected batch(es) of product must be withdrawn from sale immediately and steps taken to recall them from consumers’ homes as quickly as possible. Consumers and other stakeholders must be informed about the situation and what it means for them.
ANNEX E Guidelines for risk communication

Principles

1. The Food Standards Agency’s approach to communicating about incidents is underpinned by its commitment to consumers’ interests, protecting public health and an open approach to publishing work it commissions.

2. There is a general presumption in favour of publishing all relevant information from incidents, and advising consumers on the implications for them and of any action they should take.

Practicalities

3. The communication of risks and advice to consumers and other stakeholders is an integral part of the process of risk analysis. A communications strategy must be discussed between Communications Division and interested Food Standards Agency policy Divisions at an early stage of the process. Communications issues should form part of any ongoing discussion of risk management and communication options.

4. The communications tools used by the Agency will vary dependent on circumstances and audiences, but may include media relations, website material, face-to-face briefings and in special circumstances leaflets and other material. The specific approach and methods, particularly where there is a food safety risk, will be determined by the risk assessment and the Agency will adopt the most appropriate communications methods to reach those identified to be most at risk. The nature and scale of the risk, who it will affect, the type and distribution of any particular products etc enable the Agency to identify audiences and appropriate communication tools and messages.

5. Communication will involve wide-ranging stakeholder engagement. Press releases will be issued, incorporating consumer advice; guidance will be issued simultaneously with the publication of any Food Alerts. The specific communications approaches will be determined by the nature of the incident and who is most affected by it. The media will be regularly used, as will further information on the website. Where particularly communities are affected by a food safety risk, the Food Standards Agency will undertake face-to-face briefings and produce other publicity, including materials in relevant languages.
ANNEX F Guidance on storage of goods during testing and 
recycling or disposal of rejected material.

Storage.

1. Food should be stored in such a way as to keep the food from
deterioration yet not in a way that might inhibit future analysis. For
example perishable food and frozen foods should be kept frozen and
other items e.g. ambient shelf stable, canned and dried samples at
temperatures not exceeding 40°C. For legal continuity purposes the
food should be kept in a secure place, sealed to ensure the integrity of
the food and clearly identified. Food must be kept in suitable
containers which prevents, leakage or spills, deterioration of the food
and contamination to and by other foods

Recycling or disposal of rejected matter

2. Third portions of food samples or other food stored can be
disposed of in the following ways
   a. Recycled as animal feed or as biofuel
   b. Disposal into landfill
   c. Incinerated, rendered, composted or disposed of by other
      approved methods specified in the regulations

Recycling

3. Only food which is not from an animal origin and that is within it
minimum durability date and has been stored in accordance with its
storage instructions should be recycled as animal feed. Oil can still go
to landfill however the recommended route for disposal is to bio-diesel
production or for burning as fuel. Store used cooking oil in covered
leak-proof containers and check that your collector transports it
separately from other waste.

Landfill

4. All other food, which is not of animal origin, should be disposed
into landfill. Each container must be labelled ‘Not for Human
Consumption’.

Incineration, rendered, composted or disposed of by other
approved methods specified in the regulations

5. Any ‘foods of animal origin’ or ‘former foodstuffs of animal origin’
are disposed of by methods that don’t lead to contamination of other
foods or to water supplies (including those provided for livestock). In
simple terms this means that disposal of such foods to landfill is no
longer an option. The food must be incinerated, rendered, composted
or disposed of by other approved methods specified in the regulations.
‘Former foodstuffs of animal origin’ includes cooked meat and fish,
salami, pate, ready meals, pies, pasties, smoked salmon, sushi, cooked prawns.
Food Standards Agency
Incident Response Protocol
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No(s.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>- 3</td>
</tr>
<tr>
<td>Definition of an incident</td>
<td>1.0 4</td>
</tr>
<tr>
<td>Classification of incidents</td>
<td>2.0 4</td>
</tr>
<tr>
<td>Notification</td>
<td>3.0 4-5</td>
</tr>
<tr>
<td>Roles &amp; Responsibilities</td>
<td>4.0 6-13</td>
</tr>
<tr>
<td>- Incidents Team Leader</td>
<td>4.1 7</td>
</tr>
<tr>
<td>- Incident Manager</td>
<td>4.2 7</td>
</tr>
<tr>
<td>- Incidents Branch</td>
<td>4.3 8</td>
</tr>
<tr>
<td>- Lead Division</td>
<td>4.4 9</td>
</tr>
<tr>
<td>- Ad-hoc Incident Group</td>
<td>4.5 9</td>
</tr>
<tr>
<td>- Ad-hoc Group Meetings</td>
<td>4.6 10</td>
</tr>
<tr>
<td>- Out-of-hours</td>
<td>4.7 10</td>
</tr>
<tr>
<td>- Escalation of Incident</td>
<td>4.8 10-11</td>
</tr>
<tr>
<td>- Information Management</td>
<td>4.9 12</td>
</tr>
<tr>
<td>- Agency in a Supporting Role</td>
<td>4.10 12</td>
</tr>
<tr>
<td>Records</td>
<td>5.0 13</td>
</tr>
<tr>
<td>Updates</td>
<td>6.0 13</td>
</tr>
<tr>
<td>Disputes</td>
<td>7.0 13-14</td>
</tr>
<tr>
<td>Closure</td>
<td>8.0 14</td>
</tr>
<tr>
<td>Routine Reviews</td>
<td>9.0 14</td>
</tr>
<tr>
<td>Formal Reviews</td>
<td>10.0 14-15</td>
</tr>
<tr>
<td>Quarterly Review</td>
<td>10.1 15</td>
</tr>
<tr>
<td>Incidents and Emergencies Committee (IEC)</td>
<td>10.2 15</td>
</tr>
<tr>
<td>Records</td>
<td>10.3 15-16</td>
</tr>
</tbody>
</table>

## Appendices

- Appendix 1 – Process Map & Checklist | - 17 |
- Appendix 2 – Incident Classification System and Triggers | - 18-19 |
- Appendix 3 – Members of the Incidents Branch | - 20 |
- Appendix 4 – Definition of an Emergency | - 21 |
- Appendix 5 – External Meetings | - 22 |
- (Strategic Co-ordination Centre) |
- Appendix 6 – Internal (Gold, Silver & Bronze Meetings) | - 23-24 |
- Appendix 7 – Incidents Involving Devolved Administrations | - 25 |
- Appendix 8 – Incident Management & Communications | - 26 |
- Flow Diagram |
- Appendix 10 – Outline Agenda for Incident Review Meeting | - 28 |
- Appendix 11 – Incident Manager Checklist | - 29 - 30 |
Foreword

Investigating incidents to ensure that food safety is protected and food standards are maintained has, and will continue to be, a key part of the Food Standards Agency’s work. Since the Agency was set up in April 2000, it has investigated approximately 3600 incidents and acted to prevent them threatening food safety.

The Incident Response Protocol has been created to provide Agency staff involved with incidents with a user-friendly guide to the procedures that should be followed. The protocol includes details of notification procedures, roles and responsibilities during incidents and arrangements regarding closure and review. It is vital that all Agency staff involved in incident work have a clear understanding of their respective roles and responsibilities during an incident, and how they fit into the overall process. Familiarisation with the protocol will provide staff with this expertise.

Incidents are at the heart of the Agency’s new Strategic Plan for 2005-2010. Two of the incident related targets are to work with the food industry and local authorities to achieve more comprehensive reporting of incidents, and establish an agreed system for classifying their severity by the end of 2005. With this last target in mind, the protocol includes draft definitions for ‘Low’, ‘Medium’ and ‘High’ incidents. These definitions will be finalised in due course, following consultation with key stakeholders.

The Agency has additional incident-related targets under the new Strategic Plan to establish a baseline measure for incidents by 2006 and work with industry to reduce by 25% the number of ‘High’ and ‘Medium’ cases by 2010. By following the protocol, and alerting the Incidents Branch to all incidents notified to the Agency, all staff can play their part in ensuring that a representative baseline measure is established.

Andrew Wadge
Director of Food Safety Policy

March 2006
INCIDENT RESPONSE PROTOCOL

1.0 DEFINITION OF AN INCIDENT

An incident is any event where, based on the information available, there are concerns about actual or suspected threats to the safety or quality of food that could require intervention to protect consumers' interests.

2.0 CLASSIFICATION OF INCIDENTS

Incidents in future will be classified as either ‘High’, ‘Medium’ or ‘Low’. Draft definitions for each classification are included in Appendix 2. To determine which incidents are ‘Low’, ‘Medium’ or ‘High’, a classification matrix is being developed in-house.

3.0 NOTIFICATION

Any part of the Food Standards Agency HQ may receive an incident report. Any officer receiving information meeting the criteria listed in Section 1.0 must pass the information immediately to the Incidents Branch (IB) in Emergency Planning, Radiation and Incidents Division. If in any doubt please consult the Incidents Branch. Out of hours reports are received via the Defra Duty Room and handled by the FSA On-Call Officer.

The Agency also receives incident reports via the European Commission’s Rapid Alert System for Food and Feed (RASFF Alerts). The Incidents Branch shall be notified, without delay, of any RASFF Alert with implications for the UK. The Incidents Branch shall log all incidents on the Agency’s Incidents Database.

The Incident Response Protocol should be activated as soon as the Agency is notified of any incident by whatever means. The protocol will also apply to emergency situations. An emergency is defined in Appendix 4.
This protocol has been developed for FSA HQ use and reflects its systems. See Appendix 7 for information on incidents involving the Devolved Administrations.
4.0 ROLES & RESPONSIBILITIES
The following section summarises key roles and responsibilities for Agency staff during incidents.

The majority of incidents that the Agency deals with are either classified as ‘Low’ or ‘Medium’. The following paragraphs outline roles and responsibilities during these particular incidents. During ‘High’ incidents, where senior management may need be more actively involved in the process, different roles and responsibilities apply. Arrangements for ‘High’ incidents are covered within the ‘Escalation of Incident’ and ‘Information Management’ sub-sections (pages 10-12 refer).

A diagram showing the incident management process for both ‘Low’ to ‘Medium’ incidents and ‘High’ incidents is included below.

![Diagram of incident management process](image-url)
4.1 INCIDENTS TEAM LEADER
The Incidents Team Leader, who is the Head of the Incidents Branch, is responsible for the overall process management of an incident investigation, ensuring that all relevant stakeholders are consulted and that work streams are delivered within the agreed time-scales.

The Incidents Team Leader is responsible for identifying a Head of Division to act as Incident Manager for each incident and to ensure that Directors and other interested parties receive timely briefing on the progress of incident investigations. The Incidents Team Leader shall seek the views of Directors in the event that a Head of Division cannot be identified for the role of Incident Manager.

Each Incident Team Leader must identify a deputy with the authority and responsibility to take decisions in the Incident Team Leader’s absence. The role of the Incidents Team Leader is summarised in the process map in Appendix 1.

4.2 INCIDENT MANAGER
For each incident a Divisional Head shall be identified as the Incident Manager. The Incident Manager will be accountable to Directors and the Chief Executive for the strategic management of the incident, for decisions taken by the ad hoc Incident Group (See Section 4.5) and for the outcome of the incident investigation. The Incident Manager and the Incidents Team Leader will discuss and agree at the outset - and as frequently as is required during the incident – the key determinants of the incident management process. These include:

- the scope and severity of the event
- the time-scale to resolution
- the availability of resources
- identifying those responsible for delivering work-streams
- identifying those responsible for initiating and maintaining contact with stakeholders.
They may use the checklist at Appendix 1 as an aide-memoire. They shall also agree the resource necessary to manage the process effectively. The Incidents Team Leader will be responsible for the operational management of the process, within those parameters.

The level of direct involvement of the Incident Manager in the operational management process will vary depending on the nature and severity of the incident. Each Incident Manager must identify a deputy with the authority and responsibility to take decisions in the Incident Manager’s absence.

Where appropriate, the Incident Manager shall decide whether to open the FSA HQ Incidents Room and whether any further accommodation or resource issues need to be addressed. A checklist for Incident Managers can be found at Appendix 11.

4.3 INCIDENTS BRANCH
The Incidents Branch shall maintain the official audit trail for the investigation by co-ordinating the logging, collation and distribution of information required during the investigation. Any new relevant information, obtained by any member of the ad-hoc Incident Group, must be alerted to the Incidents Branch without delay. The branch shall also provide such other administrative support to the ad-hoc Incident Group as necessary.

The Incidents Branch will arrange the issue of food alerts to local authorities, other Government departments, trade organisations etc and RASFF notifications to the Commission.

During ‘High’ incidents, the Agency may set up a dedicated information cell to carry out the information management function normally carried out by the Incidents Branch. Further details regarding the Information Cell are contained within sub-section 4.9 (page 12 refers).
4.4 **LEAD DIVISION**
Once an Incident Manager has been identified, their division ‘leads’ the incident. Lead Division responsibilities, consulting with other Divisions as necessary, are listed, as follows:
- carrying out a risk assessment;
- providing food safety advice;
- attendance at ad-hoc meetings and taking forward action points from those meetings as appropriate;
- advising on sampling protocol and appropriate method of analysis;
- producing briefing for TOTO, Ministers etc, as necessary.
- Producing an audit trail documenting the how, what and why of decisions taken throughout the process.

4.5 **AD-HOC INCIDENT GROUP**
The Incidents Team Leader shall work with the Incidents Manager to identify the members of an *ad hoc Incident Group* to progress the incident investigation. The group will consist of representatives from all of the relevant Policy Divisions, COMS, Legal and any other representatives, as appropriate.

The group will take tactical level decisions, discharge actions needed to collect information and formulate proposals for risk management options or strategic decisions for the Incident Manager to endorse. The group should critically review precedents for action or inaction to establish whether they continue to be appropriate. They should also consider the consequences of action or inaction and these deliberations must be recorded as part of the official record. This should be an ongoing part of the incident investigation.

The relevant Head(s) of Division shall ensure that *ad-hoc* Group members from their Division have the authority and resources to propose, accept and discharge actions that fall to their Division. The *ad-hoc* Incident Group shall be maintained for the duration of the incident investigation and shall not be replaced by sub-groups. Any “off-line” discussions must be documented and brought back to the *ad-hoc* Incident Group for further discussion.
The Incidents Team Leader shall ensure that individuals identified to take forward agreed actions deliver within the agreed time-scales. The Incidents Team Leader shall also ensure that, external stakeholders (e.g., OGDs, industry, consumer groups) are notified and fully engaged, as appropriate, with the *ad hoc* Incident Group.

### 4.6 AD-HOC INCIDENT GROUP MEETINGS

For all but the most straightforward of incidents, the Incident Manager shall call a meeting (or series of meetings) of the *ad hoc* Incident Group to discuss resolution of the incident. The Incident Manager shall chair these meetings.

The purpose of the meetings is to:

- **agree** on the main issue(s) of concern in relation to food safety;
- **decide** what action has been or needs to be taken by the Agency and other organisations to deal with the incident; and
- **consider** what precautionary advice, if any, needs to be given to the general public, farmers, etc.

Meetings will aim to achieve collective decisions. A list of potential issues/questions to be considered at *ad-hoc* Incident Group meetings are summarised in the process map and checklist at Appendix 1.

### 4.7 OUT OF HOURS

Where incidents arise out of hours, or circumstances preclude a meeting being set up, the Incident Manager and Incidents Team Leader will agree which core staff need to be consulted, to ensure an initial risk management strategy is implemented. This may involve one-to-one meetings or telephone calls. Contact lists for incidents during office hours and out-of-hours are maintained by the Incidents Branch.

### 4.8 ESCALATION OF INCIDENT

As soon as an incident has been assessed as potentially ‘High’, the FSPG Director should be alerted immediately. To support this process, the Incidents Branch has developed criteria or ‘triggers’ for the escalation of incidents. These ‘triggers’ are detailed in Appendix 2.
Under the protocol all incidents will essentially be treated the same, with the Agency scaling up or down as appropriate. To ensure that during complex, ‘High’ incidents, the management structure is strengthened accordingly, a three-tier command structure, composed of Gold, Silver and Bronze, would be introduced.

The decision to activate the three-tier command structure would be made by the FSPG Director. Further details regarding internal Gold, Silver and Bronze meetings are enclosed in Appendix 6. Some complex incidents may also benefit from a Scoping Meeting with Industry stakeholders to agree roles and responsibilities and information flows.

Where a ‘High’, complex incident is being led by a devolved administration, a senior level point of contact at HQ will need to be established at the outset who will act as a conduit between the devolved administration and HQ, to ensure effective communication.
4.9 INFORMATION MANAGEMENT

During ‘High’, complex investigations, the Agency may set up a HoD led dedicated ‘Information Cell’. An appropriate HoD will be appointed by Director FSPG. This is to ensure that the information management function is fully separated from the management of the operation. The Information Cell would provide the Daily Brief, TOTO, Board and Minister Briefs, Timeline, Q&A briefing etc, keep Agency staff, including those within the devolved administrations, updated on developments and ensure early and regular stakeholder contact.

The Incidents Branch will maintain a checklist of key stakeholders. A diagram illustrating the role of the Information Cell during ‘High’ incidents is attached at Appendix 8.

4.10 AGENCY IN A SUPPORTING ROLE

There are occasions where the Agency will not be ‘leading’ an incident, but will nevertheless have a key supporting role usually to another Government Department, providing food safety and standards advice and ensuring that any remediation action takes account of food safety issues.

Where the severity of the incident has led the Police to set up a Strategic Co-ordinating Centre or Gold Command (see Appendix 5), the Incident Manager shall determine whether the Agency needs to send staff to the Centre, or whether the Agency’s needs can be met by another organisation present at the centre (eg GOR, DEFRA, HPA).

Similarly consideration by the Incident Manager will need to be given to Agency representation at regional Outbreak Control Team (OCT) meetings during a national foodborne illness outbreak. It should be noted that during these type of incidents it will be the OCT rather than the Agency that dictates the pace of the response and it would be up to the Agency to feed in on food safety issues wherever appropriate.
The Incident Manager shall ensure that officers are adequately supported, briefed, and that such deployment takes account of relevant personnel and health and safety criteria.

5.0 RECORDS
All papers relating to an incident shall be held on an official file. The Incidents Branch shall be responsible for maintaining this record. Currently the Incidents Branch is responsible for maintaining and updating the Incidents Database.  

The Incidents Team Leader shall ensure that a summary of the meeting(s) is produced, which will be circulated to all attendees and Directors. Wherever practicable, the Incidents Team Leader will aim to provide the summary within one hour of the meetings. The summary shall identify the Incident Manager, the action points agreed, the individuals tasked with carrying them out and the time-scales for action. The Incidents Branch shall also take contemporaneous notes of the discussions.

A copy of the summary and linked contemporaneous notes shall be appended to the official incident file. These together with any correspondence with TOTO or others regarding the incident will provide a systematic record of decisions and their basis.

The need for further meetings shall be considered as the investigation continues.

6.0 UPDATES
Weekly, the Incidents Branch will provide the Monday Morning Directors’ meeting with a status list of incident investigations. The Incidents Team Leader shall be available to brief Directors on the progress of incidents at their weekly meeting and shall act as the central point of contact for all internal enquiries related to incident responses.

6 This situation is expected to change in future, following the creation of a new Agency-wide Incidents Database, when nominated staff across the Agency will have input rights and joint responsibility to keep the database up-to-date. Versions 1 & 2 of the new database went live in July 2005 and February 2006 respectively. Agency staff involved in incidents are being trained on the database in 2006, prior to receiving input rights.
7.0 DISPUTES
In general, action points will represent an Agency consensus taking into account the views of all relevant internal and external stakeholders. Wherever possible, the Incident Manager shall resolve disputes during ad hoc Incident Group meetings. Where this cannot be achieved the Incident Manager shall discuss the issues with Directors and seek their views.

8.0 CLOSURE
Using the checklist in Appendix 1, the Incidents Team Leader shall agree with the Incident Manager when the Agency has taken all necessary action and an incident investigation can be closed. The justification for closure shall be documented and form part of the official incident file. Directors and other stakeholders shall be informed that the Agency has completed its investigations and given any further information, as necessary.

9.0 ROUTINE REVIEWS
ALL incidents will be formally reviewed within EPRI Division, by the Incident Team Leader. For any given incident, the Incidents Team Leader will have agreed with the Incident Manager, when the Agency has taken all necessary action so that an incident investigation can be closed. Justification for closure will be documented and form part of the official file. Review and evaluation meetings will be held within one month of closure and minuted.

Routine reviews of incidents may generate lessons learned, which will be recorded within EPRI Division and shared with the lead Division for any given incident. Lessons will be recorded on a rolling basis and combined, where appropriate, with lessons learned from exercise programmes.

10.0 FORMAL REVIEWS
The Incidents and Emergencies Committee (IEC) will select a subset of incidents, maximum of six per annum, for a wider, formal review within the Agency. The selection of incidents for this higher level review will be based on a number of criteria including:
- Unresolved issues or questions
- Dissatisfied stakeholders and/or cross-cutting stakeholder issues
- Clear successes or failures of process
- Political or presentational implications

The review of these incidents will be undertaken by the Head of EPRI Division (Chair), using the agreed format (outlined in Appendix 10). The Incidents Team Leader and IB staff will organise and support the meeting, which will be attended by all key internal stakeholders for the incident. A questionnaire will be distributed prior to the review meeting so that appropriate feedback can be considered. If appropriate, a separate meeting of external stakeholders will be organised.

An action plan, focusing on successes and lessons learned, will be prepared, based on the outcome of the review meeting, for submission to the IEC. A cross check will be made to lessons emerging from routine reviews and from emergency exercises.

10.1 QUARTERLY REVIEW

The Incidents Team Leader shall organise and document focussed meetings on a quarterly basis.

These meetings may concentrate on particular incident types eg “On-Farm” incidents. Lead Divisions may also use the meetings to review trends, statistics or procedures. Relevant stakeholders shall be invited.

10.2 INCIDENTS AND EMERGENCIES COMMITTEE

The Agency’s Incidents and Emergencies Committee (IEC) shall have responsibility for selecting the incidents to be formally reviewed (Section 10.0 refers), auditing the outcome of the incident reviews and quarterly reviews and ensuring that lessons learned are applied consistently across the Agency.
10.3 RECORDS

Discussions from all incident review meetings and quarterly meetings shall be minuted and the papers held on file by the Incidents Branch.

The minutes shall be circulated to all present, relevant Divisional Heads and Directors, as appropriate. The lessons identified from the incident reviews shall be translated into action plans by the Incidents Team for future consideration by the IEC.

The minutes of IEC meetings shall document the Committee’s discussions. They shall be copied to the EMB Secretariat for consideration by the EMB at its next meeting.
Incident Team Leader will:
- Identify Incident Manager
- Agree handling strategy
- Agree resources
- Identify membership of *ad hoc* incident group
- Circulate papers to all members
- Call a meeting

Consider

### Establishing Roles
- Clarify at first incident meeting roles of all participants, especially if there are multiple demands beyond the incident itself.

### Information Gathering
- Do we have sufficient information?
- Who will gather additional information?
- What is the time scale for this?

### Risk Assessment
- What is the nature of the contaminant? Chemical/ micro/ radiological?
- What/ who is affected?
- What is the estimate of exposure?
- Can risk be quantified?
- What action needs to be taken? Information/ research/ sampling
- Further risk assessment required?

### Risk Management
- What are the options?
- Potential or actual impact on consumers/ industry

### Risk Communication
- Should initial precautionary advice be issued? Within 3 hours of report if possible.
- In what form? Press release/ Food Alerts etc
- If no advice is issued record reason why, specify time scale and revisit as necessary.
APPENDIX 2: INCIDENT CLASSIFICATION SYSTEM & ‘TRIGGERS’

The following are draft definitions covering the classification levels applicable to incidents involving potential implications for food safety and/or standards dealt with by the Food Standards Agency:

Low
Minor incidents, with localised effects and few, if any, food safety implications. Neither the public nor the media would be concerned. Examples of such incidents would be barn fires, vehicles in rivers, minor oil spills. These would be dealt with as routine incidents, at Branch/Divisional level.

Medium
Incidents involving evidence of illness (eg food poisoning), impact on vulnerable groups (babies, pregnant women, or the elderly), breaches of statutory limits eg. mycotoxins. In some cases the public or the media are likely to express some concerns. They could generally be dealt with at Divisional Level, led by an Incident Manger. Drivers to “High” would include scale or increased level of public or media concern.

High
Severe incidents (e.g. potential to cause deaths, serious illness), complex (e.g. a large number of products affected, a high level of resources required to manage), widespread and likely to generate a high level of concern in public and media perception of the issue. These incidents tend to involve more senior managers, normally Directors but also the Chief Executive.

Candidate Triggers
The incidents Branch use criteria for the escalation of incidents (called ‘triggers’) to rapidly identify that an incident has ‘High’ attributes, so that the Agency can plan and resource accordingly. These candidate triggers are as follows:

- Likely severity of public health risk (low for many, high for few, impact on special groups)
- Size and scale of incident (local/national/international; number of companies and products potentially affected; resource required to manage)
- Potential level of media interest
• Public perception of the risk or likely acceptability of the risk
• Precedents in similar cases, earlier risk management decisions
• Novel or unusual aspects

A ‘High’ incident is likely to score highly on two or more of the triggers. It is important to note that whilst these triggers provide an important checklist for aiding decisions, judgement and experience will always be brought to bear on the process.
APPENDIX 4: DEFINITION OF AN EMERGENCY

An event or situation which presents a serious threat to:

- **human welfare.** Events or situations which cause, or may cause loss of human life, human illness or injury, homelessness, destruction of property, disruption of a supply of food, water, energy fuel or another essential commodity, disruption of an electronic or other means of communication, disruption of facilities for transport or disruption of healthcare or other essential services.

- **the environment.** Events or situations which cause, or may cause contamination of land, water or air, flooding or disruption to plant or animal life.

- **political, administrative or economic stability.** Events or situations which cause, or may cause disruption of the activities of banks or other financial institutions.

- **the security of the United Kingdom.** War, armed conflict and terrorism.

(Civil Contingencies Act 2004)
APPENDIX 5: EXTERNAL MEETINGS

STRATEGIC CO-ORDINATION CENTRE (GOLD COMMAND)

For major emergencies an off-site Gold Command will normally be set up, for example at the local Police Headquarters. Here a group of people may form a Strategic Co-ordinating Group led by a senior police officer (Gold Commander, usually an Assistant Chief Constable). The Group will comprise senior officers from the other emergency services and senior managers from local authorities and the other organisations involved in the response. The main tasks of the Group are to:

- set rules for how the overall response should be managed
- make sure that people working at the scene of the emergency have enough equipment and support
- decide when the recovery phase can begin and responsibility be passed to local authorities.
APPENDIX 6: INTERNAL (GOLD, SILVER & BRONZE) MEETINGS

Gold Meetings
A large, complex incident would involve at least three levels of management, led by the FSPG Director (Gold Commander) under a Gold, Silver and Bronze Command Structure. ‘Gold’ in the context of incident related work is defined as a strategic level of management, which establishes a policy and overall management framework within which tactical matters will work.

During ‘High’ level, complex incidents the Gold meetings will essentially be fulfilling the role carried out by the Ad-hoc Incident Group during ‘Low’ and ‘Medium’ incidents. Specifically, Gold will establish strategic objectives and aim to ensure long-term resourcing/expertise. Composition of the Gold Group would equate to that of the Ad-hoc Incident Group but usually would be attended by staff at HoD level.

The Gold commander is responsible for ensuring a full debate at Gold and for recommending a risk management option. The Gold commander must set out a comprehensive strategic picture with consequences and risks recorded; an Action Plan and Communications Plan should be developed allowing Silver to be truly operational.

Part of the process would be to consider whether we follow precedent in all cases. Precedent is a powerful argument in its own right but may need to be balanced against proportionality and practicality (including time and resource investment), and any wider considerations. This might be particularly relevant if the risk was very low. But it is probably impossible to devise general rules – judgement will be key.

Depending on the nature of the incident, the Gold Commander will use their judgement to discuss the developing incident with the Agency’s Chief Executive before a decision is finally made or will discuss the proposed option which Gold has endorsed. The Chief Executive will in turn inform the Chair, Deputy Chair, either seeking to inform them of the developing situation or to seek a debate or challenge for the proposed option. Ministers, Board, EC, EFSA should be informed at this stage.

Version 15: March 2006
The frequency and number of Gold meetings will depend largely on the scale of the incident and the degree of Agency involvement.

**Silver Meetings**
Silver is a tactical level of management providing overall management of the response to an emergency. At Silver meetings, Chaired at HoD level (normally the Incident Manager), representatives will determine priorities in allocating resources, obtain further resources as required and plan and co-ordinate when tasks will be undertaken. Output from Gold meetings would be translated into operational tasks at Silver; and in turn, Silver may refer issues back to Gold for resolution.

**Bronze Meetings**
Bronze covers the operational level of management and reflects the normal day-to-day arrangements to responding to incidents. Bronze meetings would be Chaired at Head of Branch level and attended by front line staff. These meetings would cover specific work-streams (e.g. compiling of a detailed product list). Bronze may also refer issues back to Silver for resolution.
APPENDIX 7: INCIDENTS INVOLVING DEVOLVED ADMINISTRATIONS

1. Wales

The Incident Response Protocol will be used for all Welsh incidents. The Incidents Branch in FSA HQ co-ordinates the investigation of environmental contamination incidents in Wales. Colleagues in FSA Wales carry out the necessary local liaison and ensure implementation of any actions required.

For other types of incident (including outbreaks of foodborne disease and microbiological contamination) within Wales, the Assistant Director (Enforcement), or the Director for Wales (depending on severity and scale of incident) will be the Incident Manager and so chair the Ad-hoc Incident Group or Gold Command.

The Incident Manager will request support from the Incidents Branch and other HQ Divisions, as required.

For incidents centred outside Wales, but requiring action within Wales, FSA Wales will participate in the Ad-hoc Incident Group (or Gold/Silver) meetings and will lead on contacts with local authorities in Wales.

Where an incident, with its origins in Wales, has UK implications, the lead may transfer to HQ following discussions between the two offices.

2. Scotland

FSA Scotland (FSAS) has its own procedures for dealing with incidents. In general, FSA HQ provides technical support to colleagues in FSAS, on request. FSAS retains the lead in such cases. Where an incident, with its origins in Scotland, has UK implications the lead may transfer to HQ following discussions between the two offices. The Incidents Branch will co-ordinate communications between FSAS and FSA HQ and will act as the point of contact for all incident reports.
3. Northern Ireland
   As for Scotland
APPENDIX 8: INCIDENT MANAGEMENT & COMMUNICATIONS FLOW DIAGRAM

Information Management & Communications

Chair/Deputy Chair
  - Chief Exec

D/FSPG Gold Group
  - Early & Regular Stakeholder Contact
    - Daily Brief
    - Board & ToT Briefs
    - Timelines
    - Q&A
    - Intelligence

HOD Silver Group
  - Information Cell, HoD led
    - Inc Br
    - Comms
    - Staff Cascade
    - SWANi Cascade
  - Other peculiar to Incident

HOBs Bronze Groups

HODs

Silver Group

Bronze Groups

Gold Group

HOD

Information Management & Communications

Version 15: March 2006
APPENDIX 9: REVIEW PROCESS FLOW DIAGRAM

Reviews

Incidents & Emergencies Committee

Responsible for auditing the outcome of incident reviews and quarterly reviews and ensuring lessons are learned and applied consistently across the Agency.

Incident Review Team

Convene after closure of incident and involve all internal stakeholders. May meet off site to accommodate external stakeholders.

Overview of incident and action taken

How can the process work better?

Lessons learned

Version 15: March 2006

28
APPENDIX 10: OUTLINE AGENDA FOR INCIDENT REVIEW MEETING

Welcome/Introductions

1. Overview of investigation

2. General impressions: what worked well/did not work well?

3. Roles/responsibilities/leadership

4. Communications/ flow of information

5. Record keeping

6. Procedures and overall management

7. Were the actions taken proportionate?

8. How can we make the process work better?
APPENDIX 11: INCIDENT MANAGER CHECKLIST

CLASSIFICATION/TRIGGERS

Does initial assessment and discussion with the Incident Team Leader suggest that this is a high-risk incident. If YES

- Has Director FSPG been advised?
- Is a GOLD Group required?
- Agree with Director FSPG constitution/membership of GOLD
- Agree membership/constitution of SILVER and BRONZE Groups as necessary
- Alert IB to arrange meetings
- Appoint a deputy, just in case
- Organise mapping of product distribution details, as appropriate

If NO

Is a meeting of the ad hoc incident team necessary? If YES

- Alert IB to arrange meeting
- Appoint a deputy, just in case

PLANNING & RESOURCES

- Are extra resources needed? If so, discuss with IB
- Do you have a strategy for managing the incident? If large and complex, are the outcomes clear?

COMMUNICATIONS

- Has a Communications Strategy been agreed and documented?
- Is a timeline required?
- Is a FAFA/FAFI required?
• Is a RASFF required?

• Is a Press Release/Web story required?

• Do you need to make ‘Early Warning’ phone calls to key stakeholders

BRIEFING

• Consider need to brief:
  - Directors - Trade Associations
  - Board - Consumer Bodies
  - DH Ministers, CMO - LACORS
  - OGDs - CIEH, TSI
  - Europe, UKREP - Helplines
  - Others appropriate to the incident

• Do you need a dedicated person to lead an Information Cell?
  Discuss with D/FSPG

RECORDS

• Do notes of meetings record key decisions and rationale/data to back these up?

• Has risk assessment been documented and kept under review?

• Has the database been kept up-to-date?

• Are decisions proportionate?

INCIDENTS BRANCH

WILL

• Discuss management of incident with you

• Organise meetings

• Circulate data

• Maintain Official record
• Provide link to LAs
• Produce FAFA/FAFI
• Circulate/prepare RASFF notifications

**WILL NOT**

*Ask/answer technical/policy questions*
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<tr>
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<td>British Retail Consortium</td>
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<td>Critical Control Point</td>
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