Report of the Sudan I Review Panel

July 2007

Food Standards Agency

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Sudan I Review Panel

JULY 2007

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Chairman's Foreword

The Sudan I contamination incident in 2005 was a major and costly event for the food industry. It related to the adulteration of chilli powder - an important and popular flavour ingredient. At the same time the incident posed a massive challenge for the Food Standards Agency and local enforcement authorities.

It is appropriate, therefore, that the Board of the Agency has initiated an independent review of how the incident was handled and what lessons were learnt.

The panel was impressed by the fact that all the participants we interviewed generally agreed that firm action by the Agency was necessary. There were, however, some strong observations about failures in communication and media handling, and on relationships and coordination between the Agency, industry and the local enforcement authorities. Our views on these matters are dealt with in the report that follows.

We questioned all parties about what has been learnt in relation to prevention of similar incidents. Industry representatives told us of improvements that had been made in the supply chain for ingredients such as chilli. We believe more can still be done in terms of early warning of problems or hazards originating in distant source countries.

I would like to record that the various stakeholders and the Agency officials who attended our sessions were open and forthright in their contributions. As a result, we believe that, despite the short time allocated for the review we have been able to identify some key areas which need attention for the future.

I should also thank the members of the panel, who were diligent in preparing for the interview sessions and then active in the discussions which followed, thus enabling a report to be prepared in a very short time. The Secretary of the panel needs special thanks, for recording detailed and complex discussions and then distilling these into a clear report and list of recommendations.

Professor Douglas Georgala

Executive summary

1. Following the major food incident in 2005, in which the largest ever recall of food products in the United Kingdom (UK) was undertaken because they were contaminated with the illegal dye, Sudan I, the Food Standards Agency (FSA) Board decided in January 2007 to appoint an independent panel to review what lessons have been learnt following the incident, what changes have been introduced as a result and how well different parts of the food chain are able to identify emerging issues and prevent them developing into food incidents in future. We undertook the review in an open and transparent way by inviting written submissions from interested parties and holding two public meetings at which we discussed their views and experiences with invited organisations.

2. We make recommendations to the FSA, to the food industry and to local authority enforcement bodies. These are grouped as they relate to incident prevention, incident handling, communications and relationships. The main recommendations are given below, whilst others are included in our full report.

Incident prevention

3. We argue that a vital tool in preventing future incidents is adequate horizon scanning and early warning activities involving all stakeholders. We recommend that these activities should be more intensive and far reaching and that the FSA should take a central role in ensuring more co-ordinated attention to intelligence gathering and horizon scanning and implementing early warning systems as well as proactively sharing this information with the food industry. The food industry should seek ways to share information based on its ingredient sourcing practices and experience of hazards. We are aware of the lessons learnt by the industry in relation to colours in spices and are impressed with the practical steps they have taken. However, we are not convinced that this has been carried across to a wider range of potential contaminants or to other ingredients and recommend that contamination of minor ingredients of distant origin should be clearly identified as potential hazards in the industry's Hazard Analysis and Critical Control Point (HACCP) plans.

Incident handling

4. We considered where responsibility for undertaking a risk assessment lies in an incident such as this and how it should be communicated. We concluded that the FSA must have primary responsibility. Use of risk assessments undertaken by the European Food Safety Authority (EFSA) could lead to more consistency of risk management actions across Europe but we are uncertain as to the practicalities of this, especially in respect of speed of action. We recommend that, if and when it is practicable, risk assessment should be based on EFSA output.

5. FSA stakeholders deal with a number of Government agencies and departments about other risk assessment/risk management issues. We recommend that the FSA should keep this in mind in reaching and communicating its own risk assessments and emergency procedures in order to provide operational consistency as far as possible.

6. As in the Sudan I incident, laboratory capacity and methodologies are likely to be a key factor in any future major food incident. We recommend that the FSA should ascertain the UK laboratory capacity available for such work and pursue the matter within Government if it is deemed to be insufficient. We also recommend that the FSA should develop an understanding or protocol with key laboratories for agreeing rapidly on a method of analysis and sampling priorities for any new contamination incidents.

7. Following the 2005 incident, the FSA established a Taskforce on Incidents, which produced guidance on the prevention and responding to food incidents. This included the use of a Scoping Group at the start of major and complex incidents. Having heard in our meetings of some confusion over when and how such a group would be convened, we recommend that the onus should normally be on the FSA to do this in all but the most minor incidents. We also recommend that the FSA organises regular practice exercises with industry and enforcement bodies to ensure maximum readiness to deal with any future, major incidents.

Communications

8. We see major difficulties in communication between the FSA and the majority of the 600,000 food businesses in the UK, which do not belong to any trade association. These are currently reached via local enforcement authorities and via the media. We recommend that the FSA and local enforcement authorities continue to develop channels of

communication with such businesses and that food business registration is fully enforced and the relevant databases used to enable information distribution.

9. Dissemination of information to local authorities and, through them, to food businesses proved to be particularly complex in the Sudan I incident. It was an incident that involved both Trading Standards Officers (TSOs) and Environmental Health Officers (EHOs). It raises questions of which of these should take the lead; whether the FSA communicates direct to businesses or through local authorities; the roles of Local Authorities Coordinators of Regulatory Services (LACORS), the Chartered Institute of Environmental Health (CIEH) and the Trading Standards Institute (TSI) in disseminating information to local authorities; and whether the same procedures would be followed to respond to incidents in the four countries of the UK. On all of these questions we detected a lack of consensus on the proper procedures and we recommend that the FSA and local authority representatives get together urgently to agree transparent, uncomplicated but effective procedures for handling these issues in a future incident.

10. All FSA stakeholders recognise that communication by the FSA to the public and small food businesses via the media during a major food incident is a vital activity. We understand the difficulties of explaining the nature of risk and proportionality to the general public and have come to the view that the FSA should aim to explain food risks in simple language which can be understood relative to other risks in everyday life. We recommend that the FSA should consider the potential for devising a range of simple messages to the public, giving in non-scientific language different examples of risk relating to everyday life and we note the report of the Better Regulation Commission on this issue.

Relationships

11. One of the issues that struck us most during this review was the lack of real partnership between the FSA and the local enforcement authorities. Despite all the existing framework agreements, protocols and codes of practice, the relationship appears not to work in practice. In addition to the procedural issues we recommend that there should be a re-evaluation of the relationships between the FSA, local enforcement authorities and their representative bodies. We expect this to begin from the tops of the respective organisations in order to ensure an effective partnership in dealing with future food incidents.

Report of the Sudan I Review Panel

Introduction

1. The presence of Sudan I (an illegal dye) in food was first identified within the European Union (EU), in May 2003, by the French authorities, who informed the European Commission that they had found Sudan I in a product containing hot chilli. Between May 2003 and February 2005 nearly 300 products were recalled in the UK. In February 2005, following the discovery that an adulterated batch of chilli powder had been supplied to a manufacturer of Worcester sauce in 2002, the UK's largest ever recall of food products was undertaken. These events showed how a contaminated minor ingredient (chilli powder) with a long supply chain had been used in different products, many of which had a long shelf life. Some of these contaminated products were themselves later used as ingredients in other products, some also with a long shelf life. This incident had a major impact on the food manufacturing, distribution, retailing and catering industries, local authority enforcement bodies and the Food Standards Agency (FSA).

2. After the incident occurred, the FSA undertook an internal review of the lessons learnt from Sudan I. It also set up a Task Force on Incidents, which prepared a guidance document, *Principles for preventing and responding to food incidents*, published in March 2007. In January 2007 the FSA Board decided that an independent panel should be established to review what lessons have been learnt following the incident, what changes have been introduced as a result and how well different parts of the food chain, including manufacturers, retailers, enforcement authorities and the FSA, are able to identify emerging issues and prevent them developing into food incidents in future. The Terms of Reference for this review are set out at Appendix 1 and details of the membership of the independent panel are at Appendix 2.

3. At the start of our work (mid April) the FSA, on behalf of the Panel, issued to interested parties a letter (copy at Appendix 3) inviting written comments to inform the review. We particularly asked for comments addressing the following questions:

- What was your impression of the 2005 incident? How did you feel at the time, what went well, what could have been done better?

- What would you do differently if faced with another large scale incident tomorrow and what could others do differently in future?
- In the light of all this, what are the lessons that can help all those involved with food incidents in the future?
- What challenges does sourcing of ingredients/products from around the world present and how can the safety of UK consumers best be protected as a result?

A list of those who responded is at Appendix 4.

4. We held two full day meetings at the FSA headquarters in London in May at which we discussed their views and experiences with invited organisations in the presence of public observers. A list of the organisations which participated in these public sessions is at Appendix 5. We made clear that the review was not just about another possible contaminated spice incident but about dealing with any possible contaminant that might appear in minor ingredients in the food chain in future. It was not a judicial inquiry, we were not taking evidence for legal purposes and not allocating blame. The review was intended to be forward looking, rather than raking over past details, and we wanted to hear how things stand at present and what still needs to be done to improve things for the future. Our emphasis was on lessons learnt. We did not examine in detail and do not report on the events leading up to the 2005 incident, which have already been reported on by officials and discussed by the Board.

5. The timetable for the review, which was laid down by the FSA, gave us and other participants only a very short time in which to marshal all the necessary information (both written and oral) and this has dictated the nature of our report. We do, though, have important messages to convey to all concerned.

Discussion

6. The issues we considered during the review come under the following main headings:

- incident prevention;
- incident handling;
- communications; and
- relationships.

We therefore show below under these headings what we learned during the review and give recommendations where appropriate.

Incident prevention

7. All those we spoke to stressed that they had learnt a great deal from the Sudan I incident and some went so far as to call it a "wake-up call". Good traceability systems are clearly an important aspect of ensuring sufficient knowledge of the supply chain to prevent an incident. Although these systems were generally thought to have operated well during the incident, several bodies told us they had made improvements to their systems since then. The legal requirement is for traceability to work on a 'one up, one down' basis. However, both the Seasoning and Spice Association (SSA) and Premier Foods (part of the Food and Drink Federation delegation) told us they were now insisting on traceability for spices to be taken back as far as the grinding stage as contamination or adulteration of the product is much easier after grinding. The SSA now advises its members not to buy pre-ground material.

8. Industry representatives told us that more scientific work was now being done to test for various potential hazards, to develop methodologies and screening devices and improve limits of detection. They stressed the need for EU wide analytical methods.

9. The issue of horizon scanning (a system of early warning) formed a major part of our discussions. Could the hazard from Sudan I have been identified earlier? We had drawn to our attention, in a written submission, a paper published in 1995 in the Indian Journal of Food Science and Technology describing the adulteration of spices in India (including by Sudan I), which could have been picked up by the industry, yet no-one seemed to consider the hazard until the French discovery in 2003. All the industry bodies we spoke to claimed that, within their membership, horizon scanning was undertaken as part of their business but it seemed to us to be rather limited. For instance, more illegal dyes in spices have been identified by SSA members through random testing but there did not appear to be any push by them to test for new contaminants other than dyes. Some in the industry monitor information emerging from the European Food Safety Authority (EFSA) and the European Commission's Rapid Alert System for Food and Feed (RASFF) and surveillance information is shared within trade associations. However, there is insufficient co-ordination of horizon scanning across the industry as a whole and a real problem with sharing potentially commercially confidential information.

10. It is important that the industry should include issues like this in its HACCP plans and use and share the information gleaned from them. We therefore recommend that contamination of minor

ingredients of distant origin should be clearly identified as potential hazards in the industry's HACCP plans. We further recommend that the industry should seek ways to share information based on its sourcing practices and HACCP work.

11. The FSA accepted that it would have a role in facilitating horizon scanning and also pointed to the EFSA group on emerging risks and the World Health Organisation (WHO) Infosan network, which should assist in this area. We recommend that the FSA takes a central role with stakeholders in ensuring more co-ordinated attention to intelligence gathering and horizon scanning and implementing early warning systems as well as in proactively sharing this information with the food industry. The FSA should invite and collect information from all sources (including an analysis of RASFF data and local authority monitoring and laboratory sampling data and industry sourcing practices) and issue regular reports. The FSA Board should keep oversight of this.

Incident handling

12. We had drawn to our attention several issues around risk assessment and risk management procedures. All agreed that it was for the FSA to undertake a risk assessment following notification of an incident. However, in the case of Sudan I, stakeholders felt that the FSA's risk assessment lacked transparency and was badly communicated. A number of the submissions stated that Sudan I was handled differently in different EU member states. This was said to have caused particular problems for companies which operate across Europe. In the time available we were unable to assess whether the problem was on the same scale in these countries. Most of those who participated in our meetings were of the view that, ideally, EFSA should undertake the risk assessment in the hope that that would lead to common risk management actions across the EU. There was, though, concern that EFSA could not produce a risk assessment quickly enough for industry and national authorities to take speedy action. The FSA stressed that it was not important who did the risk assessment (eg EFSA, WHO or UK committee) as long as the body was independent and expert. We recommend that, if and when it is practicable, risk assessment should be based on EFSA output. We were pleased to hear that things have moved on in the EU since the Sudan I incident and welcome the publication by the EU Commission in 2006 of a 'Modus Operandi for the management of new food safety incidents with a potential for extension involving a chemical substance'. This should help enable consistent actions to be taken across the EU in the case of future incidents.

13. FSA stakeholders deal with a number of Government agencies and departments about other risk assessment/risk management issues. We recommend that the FSA should keep this in mind when reaching and communicating its own risk assessments and emergency procedures in order to provide operational consistency as far as possible.

14. A major, complex food incident requires co-ordinated and prompt action by many different sectors across the food chain. The Sudan I incident showed that, although much effort and co-operation was provided by all relevant parties, there was sometimes confusion about who had responsibility for certain actions and why certain decisions were taken (or not taken). Since then, much work has been done, particularly by the Taskforce on Incidents (mentioned in paragraph 2 above) to iron out problems for the future. Despite this, we found that there was still some confusion about certain aspects of the guidance produced by the Taskforce and we are concerned about the apparent lack of ownership by local authorities of the guidance. We recommend that the guidance should be revisited and distilled into a simple, up-to-date protocol for action.

15. One of the important steps included in the Taskforce guidance is the convening very early in a major incident of a Scoping Group. The Scoping Group will comprise FSA officials, representatives from industry, enforcement authorities and consumer organisations. It will establish the nature and scale of the issue, collect information to inform risk assessment and risk management decisions, agree an action plan and identify roles and responsibilities and agree a co-ordinated communication plan. All the organisations which participated in our meetings supported the idea of such a group but several expressed concern about when and by whom the Scoping Group would be called to consider an incident. The Taskforce guidance states (at section 2.2.5): "When a food incident is deemed … to be large and complex … the Agency *will* [our italics here and below] convene a Scoping Group. … The Scoping Group can be convened at the suggestion of any stakeholder." However, at section 3.1 of the guidance is stated: "In the case of large and complex incidents it *may* also be appropriate to convene a Scoping Group … ." and at 3.2.1 "…For severe/complex incidents convene Scoping Group, *if required*." Further, the FSA's own internal Incident Response Protocol states (at section 4.8): "*Some* complex incidents *may* also benefit from a Scoping Meeting … .". The FSA referred to the incident Response Protocol in their written submission as a key plank in their response to future incidents. This was clearer on procedures but appeared to be an almost entirely inward looking FSA protocol. We struggled to see how

these FSA procedures linked to the stakeholder interfaces identified in the Taskforce document.

16. Several industry and enforcement representatives thought the Scoping Group should be called by the FSA and were surprised this had not happened in subsequent incidents, such as those involving melamine in feed and GM rice. The FSA, though, deemed those incidents as not requiring a Scoping Group as they were not sufficiently complex. We recommend that the onus should normally be on the FSA to convene the Scoping Group, whilst any stakeholder could still suggest that the group be convened. It would be quite easy, as soon as it became clear to the FSA that an incident was any more than a very minor one, for a Scoping Group to be convened very quickly (as a teleconference if necessary) to assess the likely scale of the incident. Sometimes the incident may turn out to be only minor after all, in which case there will not have been much waste of resources. (In any event Scoping Group activities would help to maintain good working relationships between stakeholders.) In other cases, though, the early convening of the group could pre-empt the development of a major incident. We recommend that the Scoping Group should always be convened at the start of any but the most minor incidents. We further recommend that the references in the documents quoted in paragraph 15 above should be amended to be made more consistent and to take account of the recommendations in this paragraph.

17. We became aware during our meetings that during the Sudan I incident there were major concerns about the availability and capacity of analytical laboratories to undertake the necessary testing of samples. In the short time available to us we were unable to pursue as far as we would like the underlying causes of this and the extent to which it hampered the handling of the incident. We recommend that the FSA should ascertain the UK laboratory capacity available to assist in major incidents of this nature, including Public Analysts, and pursue the matter within Government if it is deemed to be insufficient. We also heard that there was confusion about the methodology to be used. This is reinforced by the written submission we received from the Government Chemist. It is clearly very important that, in such a hectic situation as a major food incident, everyone involved should be able to work to clear and consistent instructions. We recommend that the FSA should develop an understanding or protocol with key laboratories as to a) the process for agreeing rapidly on a method of analysis for any new contamination incidents and b) a process for the prioritising of samples for analysis in the early stages of an incident.

18. Traceability has a major part to play in the handling of an incident as well as in incident prevention. We commend the broad improvements in traceability systems mentioned in paragraph 7 above and urge the industry to continue with this work. For food manufacturers and major retailers and some caterers it is relatively easy to keep track of ingredients and products right through to the final sales outlet. Food products sold through supply/distribution operations, such as smaller 'Cash and Carry' outlets, to so-called 'micro-businesses' (retail or catering) are likely to be much more difficult to trace. We recommend that the industry undertakes work to see how this loophole can be closed.

19. We are aware that the FSA has participated in some practice exercises with other Government departments relating to contamination of the food supply. We recommend that the FSA organises regular practice exercises with all sectors of the food industry, enforcement bodies and other key stakeholders so as to ensure maximum readiness to deal with any future, major incidents.

Communications

20. During our meetings it became clear that problems with communications were a key issue during the Sudan I incident. We will consider these in the following groups: communications between the FSA, enforcement and industry bodies; communications between the FSA or local authorities and food businesses not in trade association membership; and communication with the public via the media.

FSA, enforcement and industry bodies

21. Both the industry and enforcement bodies raised with us the problems they had in obtaining from the FSA accurate information on products affected by the incident before the FSA briefed the media. They also complained about the inaccuracy of the product lists on the FSA website. We have some sympathy with the FSA on this matter. They judged it better to publish quickly possibly inaccurate information rather than delay publication by double checking. We recommend that the Scoping Group should consider this point at an early stage in an incident.

22. There appears to be a particular problem in communication between the FSA and Local Authorities. We were told that the FSA did not seem to understand who in the authorities should deal with the Sudan I incident and often contacted environmental health departments when they should have been in touch with trading standards departments. This, we were told, hampered speedy

enforcement action. We consider this further at paragraph 30 below. In addition, although the CIEH, the TSI and LACORS were members of the FSA's Taskforce on Incidents, some individual local authorities do not seem to be aware of the Taskforce's guidance document. We recommend that LACORS and the FSA work together, where necessary with the help of the CIEH and TSI, to ensure that all individual authorities are aware of the guidance and any future amendments. We were told that LACORS is an agreed conduit for communication with different enforcement authorities and, if this is so, we recommend that LACORS regularly reviews its procedures in this respect to keep them up to date. We further recommend that the FSA and local authority representatives get together urgently to agree transparent, uncomplicated but effective procedures for handling all these issues in a future incident.

23. As mentioned at paragraph 9 above, we have some concerns about the lack of information sharing within the industry. We recognise that this situation might now be improving but we recommend that those involved should intensify the preparation of procedures for sharing of sensitive information in contamination incidents with other businesses, through trade associations and, where appropriate, with the FSA in order to help prevent other major incidents.

Food businesses not in trade association membership

24. In discussing and working on food incidents and other matters with the food industry, the FSA communicates mainly with a limited range of trade associations. This, though, leaves a huge number of food businesses across the manufacturing, distribution, supply, retailing and catering sectors out of the loop. We were told that a minority of food related businesses are in trade association membership. As far as we can tell, the only way for the FSA to get information to such businesses (most of which are small or medium-sized enterprises or micro-businesses) is through the trade press and specialist trade media, through local authorities or via the generalist media. Recently, the FSA has been able to use its newly established staff in the Government Regional Offices to raise general awareness of incidence response procedures and it has instigated a free text message alert system. Major wholesalers can also be a useful additional conduit for information, particularly in the food service sector.

25. However, the main burden of contacting the majority of food businesses rests with the enforcement authorities. All food businesses are required by law to register with their local authority. Thus, those authorities should have complete lists of food businesses

operating in their area. It is understandably difficult for them to keep these lists up to date, especially when businesses move or cease trading. At times (such as during a major food incident) when urgent contact is needed, local authorities therefore often need to visit businesses in person, which clearly has major resource and timing implications. We were told, for instance, of a small retailer who claimed to be unaware of the Sudan I issue and was selling goods subject to the recall. At the same time he was selling newspapers with headlines referring to Sudan I. This is a very difficult problem to solve but is of major importance. We therefore recommend that food business registration is fully enforced and the databases used as a resource to enable information distribution. We further recommend that the FSA and local authorities continue to develop these channels of communication.

Communication via the media

26. Communication to the public and small food businesses via the media during a major food incident is recognised by all FSA stakeholders as a vital activity. However, the media are not a public information service. In the case of food 'scare' stories, emotive language is often used and the risks to the public are sometimes exaggerated. The industry and enforcement bodies with which we discussed this thought that, in the Sudan I incident, the FSA either used emotive language in briefing the media or gave a scientific briefing which the media translated into emotive language so as to make it more understandable to the general public.

27. We have sympathy with the FSA, which underlined the difficulties of explaining the nature of risk and proportionality to the general public, especially when the risk is not fully characterised or is chronic rather than acute. We had an interesting session with a journalist from the Observer newspaper, who confirmed that, whatever the nature of a factual briefing on a food incident, headline writers would always use emotive language to get the message across. The general view of those with whom we discussed this issue was that the FSA should aim to explain food risks in simple language that the general public can understand relative to other risks in everyday life. We recommend that the FSA should consider the potential for devising (in advance of possible future food incidents) a range of simple messages to the public, giving in non-scientific language different examples of risk relating to everyday life, which could be used in the briefing of the media. We note the report of the Better Regulation Commission[1], which was submitted to us, on this issue.

[1] Risk, Responsibility and Regulation – Whose risk is it anyway?
Better Regulation Commission, October 2006

Relationships

28. In discussion with the Local Authority enforcement organisations, it became clear that, during the Sudan I incident, there had been a lack of clarity about whether local authorities were to take formal (ie with a view to prosecution) or informal (advisory) action to ensure speedy action during a recall. The organisations claimed that the FSA had changed its view (and wanted formal action) part way through the incident, by which time the collection of evidence had been dealt with informally and hence would not support a prosecution. Some authorities had also felt under undue pressure from the FSA to prosecute. We are informed that whether formal action should be taken is a local authority decision informed by guidance from the Ministry of Justice on the basis of public interest. We recommend that the FSA and enforcement bodies discuss and resolve these issues very soon so as to avoid similar problems in any future incidents.

29. The strong impression we have from our discussions with the various parties is that there are generally good relationships between the food industry and the FSA and between the industry and enforcement authorities. We also heard that the 'home authority' principle had worked well in this incident.

30. We were told by the enforcement bodies that they had had problems working with the FSA during the Sudan I incident. They perceived a lack of understanding by the FSA of the role of local authorities (including the respective roles of environmental health officers and trading standards officers) and felt they were under pressure to prosecute companies when this was not necessarily appropriate. They stressed that they needed to be treated as equal partners with the FSA and thought a culture change was needed at the FSA. They did, though, think that the FSA's new staff in the Government Regional Offices was a help in improving this situation. When we put this to the FSA they were unaware of these views and undertook to find out how to do better. We noted that, despite all the existing framework agreements, protocols and codes of practice, the relationship appears not to work in practice. We were unable to speak to the FSA Director of Enforcement in advance of drafting our report to establish how he views this very important relationship. Nevertheless, we recommend that, in addition to the procedural issues, there should be a review of the relationships between the FSA, local enforcement authorities and their representative bodies. We expect this to begin from the tops of the respective organisations in order to ensure an effective partnership in dealing with future food incidents.

31. We asked the various industry bodies whether they thought it would be beneficial for members of FSA staff to be seconded for a period to companies in their sector so as to gain some expertise in that area which would then enable them, on return to the FSA, to advise other FSA staff dealing with incidents and other work affecting that sector. We know that this was suggested at a workshop in the run up to the FSA's establishment in 2000 but are unaware of the FSA taking it forward. The industry bodies all saw the suggestion as very useful and would be pleased to co-operate with the FSA in taking it forward. This was particularly true of the British Hospitality Association, which expressed the view that the FSA has insufficient understanding of how the food service industry operates and often brings it in to important discussions only belatedly. We recommend that the FSA takes forward with all interested parts of the food industry the possibility of seconding staff in this way but without compromising its independence in any way.

Recommendations

32. Although most of the recommendations we make above are directed at the FSA, we are keen to ensure that all the other parties involved in dealing with food incidents also continue to make improvements in their procedures. It is, after all, in everybody's interest that as much as possible is done to ensure that, if at all possible, further major incidents are prevented and, if any are not, that they are handled with the maximum efficiency and minimum risk and disruption to the public and all others concerned. We set out below our recommendations according to their 'owners'. The layout of the recommendations does not reflect importance ranking of any specific recommendation but simply follows the order in which the recommendations arose in the foregoing text.

33. **For the Food Standards Agency**

1. The FSA should take a central role with stakeholders in ensuring more co-ordinated attention to intelligence gathering and horizon scanning and implementing early warning systems as well as proactively sharing this information with the food industry. It should invite and collect information from all sources (including an analysis of RASFF and local authority sampling data) and issue regular reports. The FSA Board should keep oversight of this (paragraph 11);

2. If and when it is practicable, risk assessment should be based on EFSA output (paragraph 12). The FSA should keep in mind its stakeholders' dealings with other Government departments when reaching and communicating its own risk assessments and emergency procedures in order to provide operational consistency as far as possible (paragraph 13);
3. The Taskforce on Incidents guidance should be revisited and distilled into a simple, up-to-date protocol for action, which should include a communications strategy (paragraph 14);
4. The onus should normally be on the FSA to convene the Scoping Group, whilst any stakeholder could still suggest that the group be convened. The Scoping Group should always be convened at the start of any but the most minor incidents. The references in the Guidance Document of the Taskforce on Incidents and in the FSA's Incident Response Protocol to the use of the Scoping Group should be amended to be made more consistent and to take account of these recommendations (paragraph 16);
5. The FSA should ascertain the UK laboratory capacity available to assist in major incidents, including Public Analysts, and pursue the matter within Government if it is deemed to be insufficient. The FSA should develop an understanding or protocol with key laboratories as to a) the process for agreeing rapidly on a method of analysis for any new contamination incidents and b) a process for the prioritising of samples for analysis in the early stages of an incident (paragraph 17);
6. The FSA should organise regular practice exercises with all sectors of the food industry, enforcement bodies and other key stakeholders so as to ensure maximum readiness to deal with any future, major incidents (paragraph 19);
7. The Scoping Group should consider at an early stage in an incident the issue of whether to give priority to speed or to accuracy when information on affected products is published (paragraph 21);
8. LACORS and the FSA should work together, where necessary with the help of the CIEH and TSI to ensure that all individual authorities are aware of the guidance document produced by the FSA's Taskforce on Incidents and any future amendments. The FSA and local authority representatives should get together urgently to agree transparent, uncomplicated but effective procedures for handling issues of responsibility for

dissemination of information in a future incident (paragraph 22) (see also recommendation 35.2 below);

9. The FSA and local authorities should continue to develop channels of communication with food businesses which do not belong to the major trade associations (paragraph 25) (see also recommendation 35.4 below);

10. The FSA should consider the potential for devising (in advance of possible future food incidents) a range of simple messages to the public, giving in non-scientific language different examples of risk relating to everyday life, which could be used in briefing the media (paragraph 27);

11. The FSA and enforcement bodies should discuss and resolve very soon their apparent differences of opinion and approach to prosecutions so as to avoid problems in any future incidents (paragraph 28) (see also recommendation 35.5 below);

12. There should be a review of the relationships between the FSA, local enforcement authorities and their representative bodies. We expect this to begin from the tops of the respective organisations in order to ensure an effective partnership in dealing with future food incidents (paragraph 30) (see also recommendation 35.6 below);

13. The FSA should take forward with all interested parts of the food industry the possibility of seconding staff to companies in the industry to gain expertise in relevant sectors but without compromising its independence in any way (paragraph 31).

34. **For the food industry**

1. Contamination of minor ingredients of distant origin should be clearly identified as potential hazards in the industry's HACCP plans and the industry should seek ways to share information based on its sourcing practices and HACCP work (paragraph 10). The industry should intensify the preparation of procedures for sharing sensitive information in contamination incidents with other businesses, through trade associations and, where appropriate, with the FSA in order to help prevent other major incidents (paragraph 23);

2. The industry should undertake work to see how the loophole in traceability between smaller supply/distribution operations, such as 'Cash and Carry' outlets, and so-called 'micro-businesses' can be closed (paragraph 18).

35. **For local authority enforcement bodies**

1. LACORS and the FSA should work together, where necessary with the help of the CIEH and TSI to ensure that all individual authorities are aware of the guidance document produced by the FSA's Taskforce on Incidents and any future amendments. LACORS should regularly review and update its procedures for acting as a conduit for policy and other communications between FSA and individual local enforcement authorities. The FSA and local authority representatives should get together urgently to agree transparent, uncomplicated but effective procedures for handling issues of responsibility for dissemination of information in a future incident (paragraph 22) (see also recommendation 33.8 above);
2. Food business registration should be fully enforced and the databases used as a resource to enable information distribution (paragraph 25).
3. Local authorities and the FSA should continue to develop channels of communication with food businesses which do not belong to the major trade associations (paragraph 25) (see also recommendation 33.9 above);
4. Enforcement bodies and the FSA should discuss and resolve very soon their apparent differences of opinion and approach to prosecutions so as to avoid problems in any future incidents (paragraph 28) (see also recommendation 33.11 above);
5. There should be a review of the relationships between the FSA, local enforcement authorities and their representative bodies. We expect this to begin from the tops of the respective organisations in order to ensure an effective partnership in dealing with future food incidents (paragraph 30) (see also recommendation 33.12 above).

APPENDIX 1

Terms of Reference

- To identify lessons learnt by different sectors of the food chain, including manufacturers, retailers, enforcement authorities and the Food Standards Agency, from the Sudan I issue (2003-2005) and what actions have been put in place as a result
- To advise whether there are any deficiencies in current procedures and, if so, to make recommendations

The panel may wish to explore how the food chain can best be protected given the underlying causes of the Sudan I incident. How the supply chain deals with intelligence, particularly when it relates to on-going incidents over a long period of time.

Working methodology

The Panel will receive evidence over a two day period from senior representatives of the food industry (manufacturers, retailers, caterers, small businesses), enforcement authorities, the Food Incidents Task Force and the Food Standards Agency.

Deliverables

The Panel will deliver its report to the Board of the FSA by Autumn 2007, or earlier.

Membership

It is proposed that the panel should consist of 5-6 people to include those with a background in the food industry and consumer organisations.

APPENDIX 2

Members of the Sudan I Review Panel

Chairman

Professor Douglas Georgala CBE – Formerly Head of Unilever's Colworth House Laboratory; subsequently Director of the BBSRC Institute of Food Research, and also past Chairman of the Advisory Committee on the Microbiological Safety of Food.

Members

David Clarke – Trained as a microbiologist before joining the UK's largest food service organisation where he worked for more than 20 years mostly in supply chain management. During that time he was a member of a number of expert advisory committees. He now manages UK industry farm assurance initiatives.

Sue Davies MBE – Chief Policy Adviser at Which?, working on a range of food issues from a consumer perspective, a member of the Advisory Committee on the Microbiological Safety of Food and Food Incidents Task Force and chair of the European Food Safety Authority's Stakeholder Consultative Platform.

Noel Hunter OBE – Currently Chair of the Trading Standards Institute Executive Board. Formerly a Director of Warwickshire County Council with responsibilities including the enforcement of trading standards legislation including food safety. Former Director of the National Consumer Council.

Tom Miller OBE – A retired food regulatory affairs consultant, his career in the hospitality industry, of some 35 years, spanned roles in product development, supply chain management and engagement with trade, regulatory and consumer interest bodies. He is a past Vice President of the National Consumer Federation.

Geoff Spriegel – Works as a consultant to the Food Industry on all aspects of food technical management. He has 37 years experience having worked at a senior level for a variety of major food and drink manufacturers and retailers prior to setting up his own consultancy 4 years ago.

Secretary

Barbara Richards – Took early retirement from the Senior Civil Service in early 2006. During her career she worked at the Ministry of Agriculture, Fisheries and Food and the Food Standards Agency.

REGISTER OF INTERESTS

	Prof Douglas Georgala	David Clarke	Sue Davies	Noel Hunter	Tom Miller	Geoff Spriegel	Barbara Richards
Consultancies and/or direct employment	None	Chief Executive, Assured Food Standards	Salary from Which?	None	None	Arla Foods 2005 – present. British Standards Inst 2004-2006. Global Food Safety Initiative 2005-2007. British Retail Consortium – to begin June 2007	None
Fee-paid work	None	Tottel Publishing	None	None	None	None	None
Shareholdings; Personal or close family member	**Personal:** Unilever plc	None	**Personal:** none **Close family:** My father has some Marks and Spencer shares	None 150 shares	**Personal:** Fewer than plc in Whitbread plc	**Personal:** J Sainsbury	None
Clubs and other organisations	None	None	None	None	Member of the National Consumer Federation. Ordinary Member Which?	None	None
Other personal interests	None	None	None	None	None	None	None
Fellowships	None	None	None	Chair, Board Executive of Trading Standards Institute	None	None	None
Indirect support	None	None	None	I receive small amounts of sponsorship from a variety of business sources, normally for the support of specific events in which I have no pecuniary interest	None	None	None

REGISTER OF INTERESTS (Continued)

	Prof Douglas Georgala	David Clarke	Sue Davies	Noel Hunter	Tom Miller	Geoff Spriegel	Barbara Richards
Trusteeships	None	None	None	None	None	None	None
Land and property	None	None	None	None	None	None	None
Other public appointments	None	None	None	Chair of Steering Board of National Weights & Measures Laboratory	None	None	None
Other non-personal interests	None	None	None	None	None	None	None

APPENDIX 3

Call for Written Comments

To: Interested parties

19th April 2007 Reference: CMA 03/366

Dear Sir or Madam,

Sudan I Review Panel – Call for written comments

You are invited to submit written comments to inform the review of the Sudan I incident by 10th May 2007.

In March 2005 the Food Standards Agency announced its intention to review the Sudan I incident upon completion of any legal action.

The incident involving Sudan I was an example of a situation where an ingredient with a long supply chain was used in many products. Some of these products had a very long shelf life. Some of the products which included the contaminated ingredient were themselves used, sometimes much later, as ingredients in other foods. The incident involved both large and small food businesses. These factors make such incidents difficult for those involved to deal with.

The Agency has agreed that an independent panel should take the review forward. The review will:

- identify lessons learnt by different sectors of the food chain, including manufacturers, retailers (including catering), enforcement authorities and the Food Standards Agency, from the Sudan I issue (2003-2005) and what actions have been put in place as a result; and
- advise whether there are any deficiencies in current procedures and, if so, make recommendations.

The review panel may also explore how the food chain can best be protected given the underlying causes of the Sudan I incident and how the supply chain deals with intelligence, particularly when it relates to on-going incidents over a long period of time.

The Panel is inviting interested parties to submit written comments for their consideration. They will also be discussing experiences and lessons learned from the incident with invited parties in person. These discussions will be held in public at the Agency's Head Office in London on the 24th and 30th May. Annex A to this letter provides important background information to this review that you should read before submitting your comments.

Written comments should be made available to the Panel before it begins its hearings on 24th May. They should therefore be sent to Richard Sinclair at the Food Standards Agency by Thursday 10th May at the latest. Comments may be sent by normal mail or as an attachment to an e-mail to the contact addresses at the foot of this letter. Please ensure that electronic attachments are in MS Word format or Rich Text Format.

Your comments should begin by clearly saying who you are and which, if any, organisation or group you represent along with any particular expertise or qualifications you have. Your comments should be factual and any recommendations that you wish the Review Panel to consider should be clearly identified. If your comments are longer than can be contained on one page, please number your paragraphs and, if you need to continue over many pages, please also provide a one-page summary of your comments.

Publication of personal data and confidentiality of responses

This independent Review Panel is acting within the normal rules of business that apply to all Government organisations including the Food Standards Agency. As the publication of responses may include personal data, such as your full name and contact address details, please advise us of any objections to this by fully completing and returning the Publication of Personal Data Form Annex B together with your response to the consultation. Return of this form does not mean that we will treat your response to the consultation as confidential.

In accordance with the provisions of freedom of information legislation, all information contained in your response may be subject to publication or disclosure. If you consider that some of the information provided in your response should not be disclosed, you should indicate the information concerned, request that it is not disclosed and explain what harm you consider would result from disclosure.

Any automatic confidentiality disclaimer generated by your IT system will not be considered as such a request unless you specifically include a request, with an explanation, in the main text of your response.

Yours sincerely,

Richard Sinclair

Annex A

Important background information that should be read before submitting comments to the independent Sudan I Review Panel.

The Review

This was an incident that involved what was effectively a minor ingredient to products over an extended supply chain. It involved products with a long shelf life and it involved large and small businesses. Some of the products which included the contaminated ingredient were themselves used, sometimes much later, as ingredients in other foods. It is important that we identify the lessons that come from this particular incident based on the experience of those involved. The Review Panel will not be able to talk to everybody that was affected by the incident but it is keen to hear from as many as possible among those it cannot talk to directly.

Your comments are invited on your experience of the incident involving the contamination of chilli powder with Sudan I. The Review Panel is particularly interested in receiving comments in the following key areas from those affected by the incident:

- What was your impression of the 2005 incident?
  How did you feel at the time, what went well, what could have been done better?
- What would you do differently if faced with another large scale incident tomorrow and what could others do differently in future?
- In the light of all this what are the lessons that can help all those involved with food incidents in the future?
- What challenges does sourcing of ingredients/products from around the world present and how can the safety of UK consumers best be protected as a result?

Submissions must address these questions and should be as brief as possible, and certainly no more than 3,000 words. Paragraphs should be numbered for ease of reference, and the document must include a brief executive summary.

APPENDIX 4

List of Written Submissions

Better Regulation Commission

British Hospitality Association

British Retail Consortium

Chartered Institute of Environmental Health

G Costa & Co Ltd

Derbyshire County Council

Food Additives and Ingredients Association

Food and Drink Federation

Food Standards Agency

Government Chemist

Mr Malcolm Kane

Lincolnshire County Council

Local Authorities Coordinators of Regulatory Services

Rochdale Metropolitan Borough Council

Seasoning and Spice Association

Unbar Rothon Ltd

APPENDIX 5

List of those who Participated in Public Sessions

British Hospitality Association

British Retail Consortium

Chartered Institute of Environmental Health

Essex County Council

Food and Drink Federation

Food Standards Agency

Local Authorities Coordinators of Regulatory Services

Lincolnshire County Council

Rochdale Metropolitan Borough Council

Seasoning and Spice Association

The Observer newspaper

Trading Standards Institute

APPENDIX 6

List of Acronyms

CIEH	Chartered Institute of Environmental Health
EFSA	European Food Safety Authority
EU	European Union
FSA	Food Standards Agency
GM	Genetically modified
HACCP	Hazard Analysis and Critical Control Point
LACORS	Local Authorities Coordinators of Regulatory Services
RASFF	European Commission's Rapid Alert System for Food and Feed
SSA	Seasoning and Spice Association
TSI	Trading Standards Institute
UK	United Kingdom
WHO	World Health Organisation

APPENDIX 7

Copies of Written Submissions to the Panel

This annex contains all the written comments that were submitted to the Sudan I Review Panel prior to its discussions with selected organisations. They provided the basis for the discussions that the Panel held in public on 24 and 30 May 2007.

Only one document has not been published here, following a request from the organisation that submitted it to treat it in confidence. The Panel has agreed to that request which was made on the basis that it could be prejudicial to another party.

The submissions are provided in this annex according to sector and then alphabetically.

Annex A

Written comments from the business sector

(i) The British Hospitality Association
(ii) The British Retail Consortium
(iii) The Food and Drink Federation
(iv) The Food Additives and Ingredients Association
(v) G Costa Limited
(vi) Marti and Malcolm C K Kane
(vii) The Seasoning and Spice Association
(viii) Unbar Rothon Limited

Annex B

Written comments from the enforcement sector

(i) The Chartered Institute of Environmental Health
(ii) Derbyshire County Council
(iii) LACORS
(iv) Laboratory of the Government Chemist
(v) Lincolnshire County Council
(vi) Rochdale Metropolitan Borough Council

Annex C

Written comments from Government bodies

(i) The Better Regulation Commission
(ii) The Food Standards Agency

Annex A

Written comments from the business sector

Annex A (i):

The British Hospitality Association

Evidence for Sudan I Review Panel

Introduction

The British Hospitality Association (BHA) is the National Trade Association for the Hotel and catering Industry. Its membership includes every publicly listed Hotel Group, all of the major contract food and service management companies, Motorway Service Areas, Chain Restaurants and Clubs. In addition two major wholesale food suppliers and two major retailers are in membership. The Restaurant Association which is part of the British Hospitality Association includes many small to medium enterprises in this sector.

Executive Summary

This document is intended to provide the perspective of the BHA and 3663 (one of the major food distributors to the catering industry) with respect to the Sudan 1 incident. Both organisations will give evidence to the Review Panel.

Many of the issues raised have subsequently been addressed as a result of the work of the Incident Taskforce set up by the Food Standards Agency upon which the BHA is represented.

The main issues covered by the document are:

1. How risk assessment and risk communication undertaken at the time of the incident which created difficulties for the Hospitality Industry and its Supply Chain.
2. The impact of the incident on the supply chain and how this was dealt with by the industry.
3. The need for greater understanding by the Food Standards Agency of how the supply chain operates in Food Service.

The Sudan I incident from the Industry perspective:-

The Incident

From the commencement of the incident the Food Standards Agency concentrated its efforts on the Retail Sector and it was over a week before there was significant communication with the British Hospitality Association. This situation meant that discussion on how the incident could be most effectively be handled was late from the Hospitality Industry point of view and the resulting subsequent media reaction more negative than might have been.

From a Suppliers perspective:-

3663 contacted in excess of 5,000 customers over 32 product recalls in February 2005 and a further 1,000 customers in July 2005 over 2 further specific product recalls. Difficulties were created by the following:-

a) the grey area into which Sudan I fell because many suppliers did not know whether a full product recall was needed because of very low theoretical levels of Sudan I (below the level of detection). Guidance was slow and when issued didn't answer questions which required answering.

b) The list from the FSA was useful back-up but not as a point of reference. Often three days would elapse between 3663 being informed and an affected product appearing on the list.

How did you feel at the time, what went well and what could have been done better.

From the Industry's perspective

The majority of small catering businesses depend upon the Local Authority Environmental Health Officers for information on product recalls. This process worked well when it got underway but it took some time to commence.

"Risk communication" of the incident itself tended to emphasis the "cancer causing" nature of Sudan I and its illegality rather than quantifying the nature of the risk is understandable terms. Saying that the risk is extremely "small" does not provide businesses, the Media, and consumers with an accurate appraisal of the risk from a relative point of view.

The involvement of the European Food Safety Agency (EFSA) to give clarity to the scientific appraisal and testing methods needed to be more clearly explained to stakeholders and during the incident there needed to be a more rapid response from EFSA with a cohesive and co-ordinated approach across EU. We recognise the difficulties created by the separation of Risk Assessment i.e. EFSA and Risk Management. The experience of businesses including Hotel Groups who trade in different countries in Europe showed a completely approach depending upon which country you are trading in.

From a Supplier's perspective

In general communications from suppliers were received in a timely manner. 3663 were informed of all specific product and range recalls before the public could be aware and therefore recalls could be completed before calls could be received into the 3663 Advice Centre. Some suppliers/importers were offering lists as and when they identified supply links to relevant producers others were holding back until all affected products were identified. No one really knew what they 'should' be doing as no clear advice was offered early enough in the proceedings.

- Update lists from the FSA were difficult to match to 3663's range data. A supplier product code/barcode/GTIN being added to the FSA list would aid this lookup in the majority of cases;
- Product information on the update lists was too vague, thereby compounding the issues of matching products from 3663's range file;
- Unreliable updates from the FSA. At the outset of the issue, the FSA stated there would be one update a day. In some cases two updates were given a day and in others, no update was issued for several days; and
- The information from the FSA was vague with regards to the different sectors of the food industry. I.e. no advice was given as to whether wholesalers had to go to customer level - this was clarified by the EHO after a period of time.

What would you do differently if faced with another large scale incident tomorrow and what could others do differently in future?

From the Industry's perspective

Actions taken in the face of another large scale incident will by and large depend upon the nature of the incident.

As a Trade Association, communication with members is now largely electronic and therefore we are in agreed position to rapidly communicate information to the membership and receive responses which can be fed back.

There is however a large number of food businesses who are not in membership of Trade Associations and they will have to rely on the Press, Local Authorities, Supply Chain and the FSA website.

Clearly, early communication by the FSA with all parts of the Industry will assist.

Involvement by the Industry in the Risk Assessment and Risk Communications proves will greatly improve the confidence of the Industry in the management of the incident.

In the light of all this what are the lessons that can help all those involved with Foods Incidents in the future

From the Industry's perspective

The guidance produced by the Incident Task Force will assist businesses within the Food Industry in the management and prevention of Food Incidents.

The Food Standards Agency has taken steps to improve its communication with all of the Food Industry and other stakeholders by agreeing to the formation of an "incident scoping group" in the early stages of an incident.

The four major Trade Associations have created a Safe and Local Supplier Assessment Scheme (SALSA) which will not only assist small suppliers access major food service and retail businesses but also improve standards in small suppliers which should assist in the prevention of incidents.

We have already stated that communication with small catering businesses depends largely upon Local Authorities. In our opinion the Supply Chain i.e. wholesalers and food service distributors could be a good avenue for communication of information with respect to products involved in food incidents.

From a Supplier's perspective

A possible improvement could be Food Manufacturers/Wholesalers Registering for a password to a secure section of the FSA website or to a more restricted mailing list, in order that advanced/more up to date warning of affected products can be given. With a large number of Own Brand products 3663 were checking 700+ specifications for supplier information each time a new link was identified, therefore although a direct link wasn't evident a timelier update on the situation would reduce the feeling of dependency on a large and complicated supply chain.

The only way the food industry gets to hear about the products affected is through a public domain web site; thus 3663 don't have any time to act on the information before the public/media get to see the affected products. The above suggestion would aid more timely and coordinated provision of correct risk information to the public.

Improved ownership of the issue with swift guidance/advice where applicable is required from the FSA. Absolute unambiguous information must be issued swiftly to cover all aspects of the crisis and as much as possible remove the possibility of different areas of the industry taking different stances.

What challenges does sourcing of ingredients/products from around the world present and how can safety of UK consumers best be protected as a result?

Companies buying from outside of the EU must better understand their suppliers and the differences in legislation/perception/behaviour between supplying and receiving countries. Greater guidance is required as to the implication on the change in status of additives/processing aids and to (likely) current usage. This is still the case today.

Conclusion

Although we have made comments about the lessons to be learned from the Sudan I incident, it is true to say that the Food Incident Task Force which was formed by the Food Standards Agency has been able to address many of the the issues and we welcome the recent publication of the guidance to business in responding to and incident prevention. We also believe that the formation of the "scoping group" at an early stage in an incident will be critical in ensuring that the incidents are handled more successfully.

Annex A (ii):

The British Retail Consortium

14 May 2007

Sudan I Review - BRC written submission

THE BRITISH RETAIL CONSORTIUM

The British Retail Consortium (BRC) is the lead trade association representing a 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. Our members account for approximately 75% of all groceries sold in the UK, a market where food and drink sales are worth over £82bn pa.

The BRC and its members have taken every step, throughout the Sudan I incident, to act responsibly and swiftly to minimise any health risk to the consumer. We now welcome the opportunity to provide written comments to the independent panel in charge of the review, in the same way as we took a very active role in the Food Incident Task Force, which was set up in May 2005 to discuss the role and responsibility of different stakeholders in the risk management of food contamination incidents.

RETAILERS' RESPONSIBILITIES AND BRC GLOBAL STANDARD FOR FOOD

Food Safety is of paramount importance to BRC Members. Retailers, like all sectors involved with the supply of food, recognise their responsibility towards their customers under Regulation (EC) 178/2002 to take all reasonable precautions and exercise all due diligence in the avoidance of failure, whether in the development, manufacture, distribution, advertising or sale of food products to the consumer. In 1998 the British Retail Consortium (BRC) developed and introduced the BRC Technical Standard and Protocol for Companies Supplying Retailer Branded Food Products (the BRC Food Technical Standard). Although originally developed primarily for the supply of retailer branded products, the BRC Food Technical Standard has been widely used across a number of other sectors of the food industry such as food service and ingredients manufacture.

The Standard was developed to assist retailers in their fulfilment of legal obligations and protection of the consumer, by providing a common basis for the audit of companies supplying retailer branded food products. The Standard requires:

- the adoption and implementation of Hazard Analysis and Critical Control Point (HACCP);
- a documented and effective quality management system; and
- the control of factory environment standards, products, processes and personnel.

The UK is one of the very few countries which has a statutory 'due diligence' defence requirement within its legislative framework. This effectively means that a retailer cannot accept and rely on a 'warranty' defence, if legal proceedings were presented. The due diligence defence is a general defence of 'all reasonable precautions and all due diligence' against principal offences in the relevant UK statutes and can be defined as 'it shall … be a defence for the person charged to prove that he took all reasonable precautions and exercised all due diligence to avoid the commission of the offence by himself or by a person under his control'.

The relationship that existed between a Standard user and their suppliers was recognised by those involved with the development of guidance for the provision of a due diligence defence, and the considerable influence of the retailer over product formulation/design, and standards existing within the production environment and control systems were reflected by the content of guidance. The responsibility for the safety and legality of product is shared between the supplier and the retailer, with emphasis for the retailer being placed on five main areas of control, namely:

1) To ensure the presence of a detailed specification which is not unlawful or inconsistent with any compositional/safety standards or good manufacturing practice;
2) To ensure they satisfy themselves that a supplier is competent to produce the specified product, complies with legal requirements and operates appropriate systems of production control;
3) From time to time make visits, where practical, to verify the competence of the supplier or receive the result of any other audit of the supplier's system for that purpose;
4) To establish and maintain a risk-assessed programme for product examination, testing or analysis; and
5) To monitor and act upon customer complaints.

The BRC Technical Standards have been developed to ensure that these requirements are met and monitored. Supplier evaluation against these Standards forms an integral part of a retailer's and Standard user's legal conformance systems and it is therefore essential that suppliers, certification bodies and accreditation bodies are fully aware of their responsibilities and their critical role within this legal framework.

SUDAN 1 CONTAMINATION - SPECIFIC ACTIONS BY RETAILERS

2003

Retailers took action in July 2003 when tests by the French food authority discovered that a variety of minor brands producing ambient sauces contained contaminated chilli powder. Retailers instructed all suppliers to only use chilli

powders as an ingredient if verified by analysis as being free from Sudan I. End product analysis was undertaken on high risk lines (i.e. products containing a high level of chilli powder). No positives were found. In February 2004 this instruction to supplier was extended to cover other Sudan dyes in line with the EU commission decisions.

One of the failings of this approach was that subsequently it was discovered that the levels present in many of the products may not have been detectable by analytical methods due to the dilution effect. As a consequence positives may not have been found even if products contained affected raw materials.

2005

Immediate steps were taken by BRC and its members when the incident regarding the contamination of Worcester sauce with Sudan I was made known to them by their suppliers on 14 February 2005. Significant resource was put into place to identify possible products affected and their withdrawal instigated.

By the afternoon of 17 February, the traceability systems employed by BRC members were able to identify over 250 affected products and confirmation of the total withdrawn product was supplied to the FSA in a spreadsheet format and to customers through notices placed in store and on the web. By 24 February the vast majority of affected products had been removed from sale and consumers informed through notices in store as well as through the FSA website.

After the incident, BRC members undertook a review of their due diligence procedures in relation to the Sudan I incident through considerable dialogue with suppliers, as the control point rests within the suppliers systems. Further to this review, one of the additional controls put in place was an externally managed traceability/audit system for those spices identified as being high risk ingredients because of the possible addition of illegal colorants.

The programme is designed as a risk reduction tool and covers the validation of controlled spice status through the examination of objective evidence (e.g. systems, procedures and records). A web-based database lists suppliers and materials that have successfully completed the programme and have been recognised by participant retailers. At present the following powdered spice ingredients are included: capsicums (paprika, chilli, cayenne pepper), turmeric and compound ingredients which include these spices such as blends, flavourings, sauces etc.

LESSONS LEARNT

We believe that the initial coordination of the incident could have been handled better by the FSA as the magnitude of the incident was poorly understood, appropriate sectors were not initially well represented and little consideration was given to industry concerns regarding the proportionality between the risk presented by Sudan

I (at the levels believed to be present) and the enormous public concern that would likely occur given the approach suggested (and subsequently taken) by the FSA.

Retailers' traceability systems are very advanced, as seen in our ability during the Sudan I issue to rapidly identify and withdraw affected products, much faster than other sectors. This could have been assisted by having received information from the FSA earlier. In addition, some confusion was created regarding affected products as duplicate information was publicised by the FSA who, in some instances, received data about the same products both from manufacturers, through local authorities, and retailers as brand owners. Finally, we also had some concerns about the apparent difference in response to this issue across European member states as it is believed that some countries took very strict action whilst others seemed to take little action.

All of these points have subsequently been considered and discussed as part of the FSA Food Incidents Task Force established following the Sudan I issue and we believe much progress has been made in both industry and FSA ability to coordinate and manage this type of issue.

Annex A (iii) (a):

THE FOOD AND DRINK FEDERATION

SUDAN I REVIEW

Written submission on the lessons learned from the Sudan I incident in February 2005

1. FDF welcomes the concept of urgently convening a Scoping Group, comprising key stakeholders including consumer organisations, to establish the nature and scale of (potentially) large and complex incidents, but we have yet to see this put into practice;
2. It is important that a proportionate, risk-based response is agreed at EU level, including standardised analytical methodology and levels of detection. The approach taken in the UK has generally been more prescriptive than in other Member States - particularly in requiring the recall of all potentially affected products based on traceability when the contamination is at such low levels that it cannot be detected analytically;
3. It is important that a risk assessment is undertaken by EFSA, as soon as an emerging risk has been identified, to determine if there are any public health implications;
4. Effective communication with companies not in trade association membership needs to be addressed. We understand that currently FSA can only communicate with these companies by providing information publicly on its website;
5. Communication with the media needs to be addressed to avoid the gross exaggeration of potential risks as seen during the Sudan I incident;
6. The EU Rapid Alert System for Food and Feed needs to be improved to provide a more effective tool for communicating key information across Member States; and
7. FSA's on-line incident report form, which is currently being revised, should address the problem of product information being mis-reported on FSA's website.

The UK Food and Drink Manufacturing Industry

The Food and Drink Federation (FDF) represents the food and drink manufacturing industry, the largest manufacturing sector in the UK, employing over 500,000 people. The industry has an annual turnover of £70bn accounting for 15% of the total manufacturing sector. Exports amount to almost £10bn of which 64% goes to EU members. The Industry buys two-thirds of all UK's agricultural produce.

The following Associations are members of the Food and Drink Federation:

ABIM	Association of Bakery Ingredient Manufacturers
ACFM	Association of Cereal Food Manufacturers
BCA	British Coffee Association
BCCCA	Biscuit, Cake, Chocolate and Confectionery Association
BOBMA	British Oats and Barley Millers Association
BSIA	British Starch Industry Association
CIMA	Cereal Ingredient Manufacturers' Association
EMMA	European Malt Product Manufacturers' Association
FA	Food Association
FOB	Federation of Bakers
FPA	Food Processors' Association
GPA	General Products Association
IDFA	Infant and Dietetic Foods Association
MSA	Margarine and Spreads Association
NACM	National Association of Cider Makers
SB	Sugar Bureau
SIBA	Society of Independent Brewers
SMA	Salt Manufacturers' Association
SNACMA	Snack, Nut and Crisp Manufacturers' Association
SPA	Soya Protein Association
SSA	Seasoning and Spice Association
UKAMBY	UK Association of Manufacturers of Bakers' Yeast
UKTC	UK Tea Council

Within FDF there are the following sectoral organisations:

FF	Frozen Food Group
MG	Meat Group
ORG	Organic Food and Drink Manufacturers' Group
SG	Seafood Group
VEG	Vegetarian and Meat Free Industry Group
YOG	Yoghurt and Chilled Dessert Group

Annex A (iii) (b):

Food and Drink Federation

Sent by email 31 May 2007

Professor Douglas Georgala,
Chairman Sudan I Review Panel,
Food Standards Agency
Aviation House
125 Kingsway
London WC2B 6NH

Dear Professor Georgala

SUDAN 1 REVIEW

At last week's discussion with the review panel, I agreed to provide you with further details of the survey undertaken by our European Association, CIAA, of the advice received by national federations from their national authorities. This survey showed that no specific action was being taken to withdraw products apart from in Ireland and Spain.

I have also taken the opportunity to include further information on the recently-launched Safe and Local Supplier Approval (SALSA) Scheme which we were jointly involved in developing with BRC, BHA and NFU. This scheme provides a common, low cost, approval process for small suppliers, particularly those for whom the BRC Global Standard is inappropriately complex and costly for the size of their business. It is a scheme designed to help small suppliers improve their food safety performance, including appropriate awareness of the quality of their incoming raw materials. The SALSA website will hold a list of certified suppliers of both ingredients and finished products, the former being of particular interest of our members. This new venture is an example of sharing good practice beyond the confines of trade association membership.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

Helen McDermott Corporate Policy Manager

Enc.

Food and Drink Federation ■ 6 Catherine Street ■ London WC2B 5JJ ■ Tel: +44 (0)20 7836 2460 ■ Fax: +44 (0)20 7836 0580 ■ Web: www.fdf.org.uk

Sudan 1: Contact with National Federations (21 February 2005)

Austria: FIAA	The national authorities had informed interested parties. FIAA received a list of products affected. This list had been passed onto industry and a meeting convened. Confident that none of these products had been shipped to Austria.
Belgium: FEVIA	No advice received from the national authorities. Members were aware of issue but FEVIA was not aware of any specific actions being taken them apart from one company which was undertaking traceability checks. Some limited coverage in the press but not perceived to be a problem.
Czech Republic: PKCR	No specific advice received from the national authorities. Reported in the press but limited coverage. PKCR had informed its members and put information on its website.
Denmark: FI	FI received a press release from the national authorities and was waiting to receive notification of products to recall. Members had been notified directly by FI and the issue had also been covered in the press. Retailers had taken action to remove Worcester sauce from the shelves.
Finland: ETL	No advice received from the national authorities. Some coverage in the press but not seen as an issue.
Germany: BLL/BVE	No specific advice received from the national authorities. Not seen as an issue. Strict controls in place relating to Sudan I. Worcester Sauce had not been imported.
Greece: SEVT	SEVT were informed of the issue via the press – they were not contacted by the national authorities. They had not issued any statements to their members or to the public. They had held informal discussions with several members who were involved and there had been a limited number of products withdrawn. They had not been contacted by any the general public over the issue.

Ireland: FDII	FDII in close contact with FSA Ireland. Identified members with affected products – 4 manufacturing companies and a few caterers. Conference call with FSA Ireland and companies over the past couple of days. Industry notice in 3 major national newspapers: companies not named specifically. Freephone industry funded careline set up - received a lot of calls – public very concerned. The phone line would remain in operation for a week or more.
Italy: Federalimentaire	No advice received from the national authorities. Not aware of issue.
Latvia: LPFI	Information was received from the national authorities. LPFI informed its members. No press coverage. No products affected in Latvia.
Netherlands: FNLI	No advice received from the national authorities. Not aware of issue.
Norway: NBL	The national authorities had contacted NBL and the 4 major supermarket chains in relation to import and own label products. A formal press release had been issued. The press release was covered by the press but the topic was seen as a minor issue. No problems or enquires were received by NBL from the general public. Two products were identified as potentially contaminated products. Both were named in the press and were withdrawn from sale. NBL circulated a combination of national authority and FSA information to its members.
Poland: PFPZ	First knowledge of the issue came from the DG SANCO site and internet news groups. The national authorities followed up on this approximately ten days later. No formal information from the national authorities and nothing formally issued to members. Very limited press coverage. No products recalled.

Romania: ROMALIMENTA	ROMALIMENTA was unaware of the Sudan I issue and no information was received from the national authorities. No members appeared to be affected and no interest had been shown in the issue. The press had picked up on the story and there was a high level of coverage. No information had been issued by ROMLIMENTA to its members or to the general public. It was felt that little was known about Sudan I as an issue in Romania and that there was no analytical capacity for determining the presence of Sudan I in food.
Slovakia: PKS	PKS were not informed by the national authorities and did not send anything specific out to their members. There was some limited press coverage. Products on the market in Slovakia were not affected.
Slovenia: GZS	GZS were informed of the issue via international food news sites. The national authorities contacted GZS ten days later. The national authorities issued a statement and this was used as the basis for a release to GZS members with advice on checking suppliers. No products had been withdrawn. There was radio coverage.
Spain: FIAB	FIAB were informed via RASFF. No additional information was circulated by the national authorities. The issue was reported in the press with some strong coverage. Some products were withdrawn from sale but consumer response was limited. FIAB did contact its members with basic information on the issue.
Sweden: LI	LI were informed of the incident via RASFF notifications and a notice on the Swedish Food Administration's website. This listed the affected products known to be in the Swedish market and it affected only two producers. There had been a low level of press interest. None of LI's members were affected and no additional advice has been issued.

Annex A (iii) (c):

The Safe and Local Supplier Approval – SALSA – Scheme

What is SALSA?

SALSA is a supplier approval scheme with a strong local emphasis. It is not only an auditable standard but a scheme, based upon a standard, which can offer help to small companies in improving their food safety performance and attaining to the required criteria. Its administration centres on its website http://www.salsafood.co.uk/ which is a developing source of supportive information.

SALSA is a non-profit making joint venture between the four main trade associations that represent the UK food chain:

The National Farmers Union (NFU)
Representing farmers and farm diversification.

The Food and Drink Federation (FDF)
Representing food and ingredient manufacturing.

The British Hospitality Association (BHA)
Representing foodservice and catering.

The British Retail Consortium (BRC)
Representing retail.

The Institute of Food Science and Technology (IFST) will administer and operate the SALSA scheme and maintain this website on behalf of the joint venture. Scottish Food Quality Certification (SFQC) is providing auditing and co-ordinating mentoring resources in Scotland.

The scheme will be self financing and has received set up funding from DEFRA and support from the Food Standards Agency in England and from Highland and Islands Enterprise and Scottish Enterprise in Scotland.

A Governance Council, made up of independent parties with mutual interests in local sourcing, has also been formed which includes, in addition to the four main partners, Food from Britain, DEFRA and the FSA.

Why is SALSA needed?

The demand for locally or regionally sourced food and drink is gaining momentum. The local sourcing challenge has now been taken up by many of the UK's major buyers including supermarkets, foodservice companies and other national or institutional buyers. This growth in local sourcing initiatives has reinforced the need for a common, low cost, supplier approval process for smaller food (and food ingredient) producers and processors, particularly for those for whom the BRC Global Standard is inappropriately complex and costly for the size of their business.

Many buyers have already initiated their own local or regional supplier approval programmes and believe that SALSA will be able to support or augment their own local sourcing initiatives.

National buyers, traditionally geared up to source food and drink in quantities suitable for national distribution, require an assurance that the locally sourced food which they are buying meets fundamental legal, food safety and due diligence requirements.

SALSA has been developed to meet these needs.

Some of the benefits of SALSA

Enquirers to the SALSA website can register to gain access to SALSA documents, including the Standard. Suppliers can, therefore, see what is required and self-assess at the outset to determine whether they might be ready for a SALSA audit or would benefit first from the help of a mentor to develop their procedures. SALSA will put a company in contact with an approved, local mentor on request.

The cost of a SALSA audit (currently £450 for a half-day audit plus reporting and certification) is kept down partly because it focuses on core requirements and partly by using an approved team of locally-based auditors, thus avoiding the overheads of travel and accommodation often associated with audits.

By being entered onto the list of SALSA certificated suppliers on the website, a company can be made more visible and gain access to larger markets in its local area. Joining the scheme and gaining approval also gives a supplier access to valuable resources to help meet and retain the SALSA standard.

SALSA provides local or regional buyers with an up to date fully searchable directory of SALSA registered and approved suppliers which have practically demonstrated to the best qualified auditors in the locality that they are capable of meeting the standards that are appropriate to their operation.

SALSA provides local work for independent food professionals, as auditors and/or mentors. (One person would not fulfill both roles for the same company.) To qualify to represent SALSA, an auditor or mentor must be able to demonstrate their competence against defined qualification, experience and training criteria within a controlled and managed framework.

The SALSA standard

The SALSA scheme is based upon the supplier's self-assessment against the SALSA Standard followed by a formal audit by a professional SALSA approved local auditor.

Approval will only be granted to suppliers that demonstrate they are able to produce safe food and are committed to continually meeting the requirements of the Standard.

Annex A (iv):

-44 1E22 ,,62119 PHONE NO. : +44 1622 682119 14 MAY. 2007 10:03AM P1

FOOD ADDITIVES AND
INGREDIENTS ASSOCIATION

11 **May** 2007

Richard Sinclair **Esq**
Food Standards Agency Room 515c,
Aviation House
125 Kingsway
LONDON
WC2B 6NH

Dear Mr Sinclair

Sudan 1 Review Panel - Call for written comments

I refer to your letter of 19 April on the above subject.

This Association has no specific comments to submit with regard to the incident itself and it could possibly be regarded as inappropriate for us to comment in any detail as Unbar Rothon, the company most involved with the incident is a member of this organisation

We should, however, make the point that we are surprised that the FSA has seen fit to initiate *the Panel Review at this time*. *The second* paragraph *of your* letter *of* 19th April implies that legal action has been completed. Whilst that may be the case in terms of action by food law enforcement bodies litigation is still outstanding where Unbar Rothon is concerned and it would be unfortunate if the outcomes of the Panel Review were in **any way** prejudicial to the resolution of that litigation

I might add that I have seen a copy of Mr Rothon's submission to the Panel and, in a **personal capacity** as a professional graduate food technologist I believe he has set out the facts in a fair and reasonable way.

I should **be pleased** if this letter is made available to the Panel.

Yours sincerely

Richard Ratcliffe BSc CSci Hon
FIFST FIFST MCQI Executive
Secretary

10 Whrtehurvn Close Madstone Kent ME16 8UR 01622 682119 infoefaia.ar9.uk

Annex A (v):

E-mail Comments received from Paula Davidson – G Costa & Co Limited

"Paula Davidson" pdavidson@gcosta.co.uk 01/05/2007 12:17

To: Rusty.Odihiri@foodstandards.gsi.gov.uk

Subject: RE: Sudan 1 Review

Dear Rusty,

G.Costa is an importer and distributor of foods from all over the world including a large percentage from Asia. We also have two manufacturing sites in the UK.

When the Sudan Red issue hit us I had to initiate a programme of analysis for a large number of our imported products for each consignment. I also had all products, potentially affected, already in our warehouse analysed.

The difficulties we faced initially included:

1 Finding a laboratory that could carry out the analysis (for our Asian suppliers no laboratory was set up for this) and provide results in an acceptable time period
2. The huge costs involved for each analysis and overall when 75 products per consignment needed to be covered

I would be very interested to learn:

1. Why the FSA made the decisions that it did and initiated the biggest ever recall in UK history
2. Why a detailed risk assessment approach was not advocated
3. Why no thought was given to how the legislation was to be effective when laboratories were just not set up for the Volume of work they were faced with & actually the analysis was not available in other countries
4. The sensitivity of the analysis differed from lab to lab with variations on the method

I could go on...

Please let me know what dates are available.

Many thanks and regards,

Paula

Paula Davidson, Technical Manager G.Costa & Company Ltd,
Unit 6 Mills Road, Aylesford, Kent. ME20 7NA

Tel: 0044 1622-713320 Fax: 0044 1622-713321

Annex A (vi) (a)

Marti & Malcolm C K Kane JP, BSc.
The Copse, 30 Brewery Road, Pampisford, Cambridge, CB22 3EN
Tel ; 01223 833708 Fax ; 01223 830918 Mob ; 07887 850884
e-mail; martikane@camdance.co.uk ; malcolmkane@foodcontrol.co.uk

08 May 2007

Tom Miller
7 **Tring Road**
Edelsborough
Bedfordshire
LU6 2EQ

Dear Tom,

I note with interest that you are appointed on the FSA Sudan 1 Review Panel. I have communicated with the FSA throughout this incident and have prepared a summary of my communications for consideration in the Review, which I'd like you to submit for me.

The documents I have attached are;

Item 1 The 23 May 2003 RAS report containing the first Sudan 1 entry.
I have tracked all these RAS reports regularly. They are a record of the international Sudan 1 exposure which is still happening.

Item 2 My 29 November 2004 email to the FSA submitting 3 questions for the FSA Board Meeting of 9th December 2004. In the event I was unable to attend this meeting in person.

Item 3 Andrew Wadge's reply of 15 December2004 confirming that my questions were raised at the meeting. No comments to my questions were given. The letter does repeat the Agency's position on Sudan 1 at that time.

Item 4 My 'thank you' reply to Andrew of 02 Jan 2005 addressing the points made in his letter, where I specifically list the points I take issue with and argue that the Agency's whole recall strategy was inadequate.

Item 5 My e-mail of 19 February 2005 after the second massive tranche of Sudan 1 product recalls emanating from the 'Premier Foods' problem.

Item 6 A copy of the anonymous minutes of a meeting on 30 March 2005 held between two representatives of the FSA and ten representatives of the FDF, where the Sudan 1 crisis was discussed. This minute was obtained with great difficulty by a Times journalist using the FoI Act.
You will note these minutes refer to a similar meeting between the FSA and the BRC, but which have successfully been kept confidential. I raise two points;

1 How can the FSA possibly claim to be open and transparent with the public while such clandestine meetings are even considered?

2 Are there any members of your Review Panel who may have a conflict of interest, having attended either of these meetings?

Item 7 My notes rebutting various FDF comments recorded in these minutes. Frankly the only valid reason for keeping these minutes confidential and anonymous is the embarrassment of their content.

Throughout the Sudan 1 incident, the Agency commendably published updated lists of recalled products;

02 Oct 03	28 Brands	94 products
19 Feb 04	40 Brands	170 products
22 April 04	55 Brands	194 products
09 Aug 04	78 Brands	225 products
14 Sept 04	80 Brands	230 products

The rapid increase of identified adulterated products through 2004 reflected the pace of analysis being undertaken. Combined with the similar pattern in the RAS reports during 2003 and 2004, and by careful estimation of the manufacturing dates from the recorded BB dates, it is an inescapable conclusion that the Sudan 1 adulteration problem started well before 2003; probably even before 2000. This implies a very long exposure period for the consuming public, particularly those ethnic minorities more likely to consume chilli flavoured foods, (who were never targeted for recall).

This was why I argued repeatedly that the Agency's position statement (item 3) regarding the Sudan dye as posing 'no immediate risk to health' because of its presence at low levels was an inadequate position; and more than a little complacent.

Post the second 'Premier Foods' phase of the recall saga in February 2005, the Agency published further lists of 'new' adulterated products. Analysis of their BB dates, particularly of long shelf life canned foods reveals that product was being manufactured with adulterated ingredients throughout 2003 and 2004.

The lessons to be learned are well documented in my attached correspondence, which only represents a summary of my total communications through this period.

The Agency was complacent; equivocated on the toxicological evidence for expediency; created the conditions for a false lack of urgency within the food industry and as a result received no real support from industry for the recall. The second 'Premier' phase of the recall was inevitable, predictable (indeed predicted!) and a direct result of the management failure of the 2003/4 recall.

I hope you find the attached interesting and informative for your important role. Please contact me if I can be of any further assistance or explanation.

Regards,

Annex A (vi) (b)

THE RAPID ALERT SYSTEM FOR FOOD AND FEED
WEEKLY OVERVIEW OF NOTIFICATIONS TRANSMITTED.

Remarks:

Carnica Batalle S.A. NORFRISA 2003.121: , 2003.013; 2003.038;

MANUFACTURER/PRODUCER_____ This week's notifications_____ Previous notifications

New Information Notifications:

DATE:	**NOTIFIED** BY:	REF.:	**PRODUCT:**	**REASON FOR** NOTIFYING:	**COUNTRY** OF ORIGIN:	**MANUFACTURER/ IMPORTER/ DISPATCHER/RETAILER:**
12/05/2003	ITALY	2003.AZT	Frozen swordfish (Xiphias gladius)	Cadmium	SINGAPORE	Manufacturer: Far Ocean Sea Products (PTE) Ltd - AP-N°: VPH- FE-009 (Singapore)
12/05/2003	ITALY	2003.AZU	i Dried oregano	Moulds (Aspergillus gnus)	CHILE	Marzfacturer: Agro Prodex International S.A. (Chile)
12/05/2003	ITALY	2003.AZV	Mushrooms in brine	Clostridium sulphite reducer	CHINA	Manufacturer: (Pleurotus ostreatus) Hebei China Resources I/E Co. Ltd (China)
12/05/2003	NETHERLANDS	2003.AZW	Maca (crushed root of the Lepidium peruvianum (chacon) spp)	Non authorised Novel food	PERU	Manufacturer: MG Investments S.R.L. (Peru)
12/05/2003	NETHERLANDS	2003.AZX	Maca (crushed root of the Lepidium peruvianum (chacon) spp)	Non authorised Novel food	PERU	Manufacturer: Calex S.A. (Peru)

Annex A (vi) (b) (Continued)

MANUFACTURER/PRODUCER_____ This week's notifications_____ Previous notifications _____

New Information Notifications:

DATE:	**NOTIFIED** BY:	REF.:	**PRODUCT:**	**REASON FOR** NOTIFYING:	**COUNTRY** OF ORIGIN**:**	**MANUFACTURER/ IMPORTER/ DISPATCHER/RETAILER:**
12/05/2003	GREECE	2003.AZY	Peanuts without shell	Aflatoxins	BRAZIL	Manufacturer: Yoki Alimentos, S.A. (Brazil)
12/05/2003	GREECE	2003.AZZ	Pistachios in shell	Aflatoxins	IRAN	Manufacturer: Amin Padidar Co. (Iran)
12/05/2003	GREECE	2003.BAA	Pistachios in shell	Aflatoxins	IRAN	Manufacturer: Amin Padidar Co. (Iran)
12/05/2003	GREECE	2003.BAB	Pistachios in shell	Aflatoxins	IRAN	Manufacturer: Amin Padidar Co. (Iran)
12/05/2003	GREECE	2003.BAC	lementary feed for	it constituents (fish bones)		Manufacturer: Mako Ltd (Serbia)
12/05/2003	FRANCE	2003.BAD	Hot chilli powder	Colour Sudan 1	INDIA	Manufacture fiutam Export Corporation (India)

AP-N°: Approval Number

A May, 2003

Annex A (vi) (c)

Malcolm Kane

From: Malcolm Kane [malcolmkane@foodcontrol.co.uk]

Sent: 29 November 2004 10:49

To: 'boardquestions@foodstandards.gsi.gov.uk'

Subject: Food Adulteration with Sudan Dyes....3 questions

Dear Sirs,

Why has the largest national food product recall in the history of the UK food industry (for arguably the Sudan recall can be so described) been conducted with such a low profile over the last 18 months, that many food industry managers and smaller retailers are unaware of the problem, let alone the wider consumer base, or specific `at risk' consumers, such as ethnic minorities?

The FSA's comment on the recent BBC Newsnight programme (in which I participated), indicated that the Agency's response would have been different (presumably more robust and effective) if there had been a 'more serious risk to public health' (or words closely to that effect).

This apparent and ill-judged complacency probably referred to the low level of contamination and/or the safety assessment of the Sudan dyes involved.

This is a very unsatisfactory answer which fails to properly demonstrate due concern for the consumer's safety, let alone their perception of food safety, and also fails to demonstrate a consistent implementation policy regarding the safety assessment of food additives; dealing with these two points in turn.

Following the original notification of the problem by the French authorities in May 1963, given the pattern of disclosure of 'positive' samples, the number of Company Brand Names and the number of individual product lines involved, it is clear that this adulteration incident by a known carcinogen must have predated the discovery date (in France, not the UK) by several months and that therefore the UK consumer's exposure period must exceed 2 years if not longer.

The original food adulteration pattern, focusing upon chilli-based foods, highlighted an obvious 'at risk' consumer group, predominantly, but not exclusively UK ethnic minorities, where their frequency of exposure, coupled with their prolonged period of exposure must more than offset any 'low level' of contamination.

t The toxicity of all food additives are safety assessed by an established procedure, involving significant error margins, and which, rightly, the Agency endorses as a matter of policy where anecdotal consumer evidence is raised about particular approved food additives. This explains why tartrazine, for example, remains an approved food dye despite anecdotal consumer concerns about it causing hyperactivity in children. If the Agency expects the wider consumer base to accept and trust such policy positions regarding approved food dyes that have, by definition, 'passed' the additive safety assessment tests, then it behoves the Agency to be seen to act robustly where an adulterant is found that is known to have 'failed' these safety assessment tests (in this case by being shown to be carcinogenic).

To appear to equivocate on 'relative safety' during a food adulteration crisis is academic sophistry that I risks undermining consumer perceptions of the safety assessment processes for all food additives and of wider trust in the Agency itself. The Agency must earn the consumer's trust through policy consistency.

Why was the nature of the national public recall not radically re-assessed after 3 4.6 months, when the pattern of focused food adulteration on chilli-based foods, the complexity of the international food ingredient trading network, and the extent of clearly inadequate traceability systems, was clear?

Compared to most food product recalls, which are completed in 2-7.6 weeks (a timescale that may or may not be regarded as satisfactory, but is at least a yardstick), the Sudan recall clearly indicated a criminal adulteration problem of deep penetration of chilli-based foodstuffs production and of such a widespread nature that exposed the food chain's system of traceability had completely failed. (The term 'food chain' fails to describe the food supply network that exists).

Surely an appropriate action, by at least the 6 month stage, would have been to recall all chilli-based foods from the market (these are hardly 'bread and butter' products) *unless and until all manufacturers and retailers of such foods could provide local health authorities with proof of safety compliance*.

In other words changing the `burden of proof' from `innocent till found guilty' to the more robust `guilty till found innocent', on the precautionary principle.

The recent extension of the problem into Palm Oil (where the African and Caribbean ethnic people are 'at risk') and even more recently into Paprika powder (Germany) and Turmeric (Spain) is demonstrating that criminal adulteration of foodstuffs with Sudan dyes is still active and spreading, as well as the need for the enforcement process being able to change the burden of proof in such adulteration incidents. This type of criminal incident will occur again.

Is the Sudan adulteration incident being used as a model for predicting and identifying vulnerabilities in the food chain `network' to bioterrorism and other criminal malicious product adulteration, as well as for strengthening the UK system of enforcement of all recalls?

The absence of effective traceability systems in the food chain network has been clearly exposed, which will not surprise many specialists who work in this field. While proper focus and emphasis on improving traceability systems is clearly to be supported, specialist workers in this field will advise that realistic timescales of 10 20 years should be considered as a certainty before we can have full confidence there will be an effective world-wide, industry-wide system of traceability in place.

Equal, if not greater current effort should be made to simplify the food supply chain. The complexity of ingredient sourcing and partly-processed food commodity sourcing is a relatively recent development arising from complex structural changes that have evolved in food production and processing, commoditisation of significantly greater numbers and types of partially processed foodstuffs and more aggressive marketing of `new, regional and fusion foods'. Chilli peppers need not be imported into the UK as they are quite capable of being grown in the UK and Europe, yet these structural changes in the food chain network do not `drive' such simplification changes to domestic (and intrinsically safer) sources.

> The fact that BBC Newsnight was so easily able to demonstrate several recalled foods (of some time lapse since recall date) were currently on sale and that shopkeepers were clearly claiming complete ignorance of the Sudan recall demonstrates a fundamental weakness in the enforcement procedures in the UK, particularly with regard to the intermediate food distribution (wholesale) outlets, which has been known to many in the UK food distribution industry for many years.

I have applied for registration to attend the next Board meeting in London and I will look forward to your response to my questions.

Sincerely,

Malcolm Kane
The Copse
30 Brewery Road
Pampisford Cambridge CB2 4EN

tel; 01223 833708
fax; 01223 830918
e-mail; malcolmkane@foodcontrol.co.uk

Annex A (vi) (d)

FOOD
STANDARDS
AGENCY

Mr Malcolm Kane
The Copse
30 Brewery Road
Pampisford
Cambridge CB2 4EN

15 December 2004 Reference:

Dear Mr Kane

Thank you for your e-mail to the Board Secretariat and I am sorry that you were not able to attend the Open meeting in person. You will wish to be aware that your questions were raised during the Question and Answer session at the meeting.

The Agency has adopted a risk-based approach when dealing with food contamination incidents. An initial independent assessment of the risk posed by the Sudan dyes concluded that, although they are carcinogenic in laboratory animals, there was no immediate risk to health given the very low levels present. However the dyes should not be present in food at any level and our policy in relation to Sudan dyes has been consistent and robust throughout in that when products contaminated with Sudan dyes, at whatever level, are traced, action has been taken to withdraw any such products from the market and alert the public. The Agency has acted promptly to publicise the contaminated products on our website and via other initiatives such as press releases so that the information reaches as wide an audience as possible, as quickly as possible.

We consider that the action we have taken is proportionate to the risk posed by the Sudan dyes. Only a small proportion (below 3%) of over 1600 chilli-based products tested by Local Authorities in the UK between August 2003 and July 2004 tested positive for Sudan dyes. A total recall of all such products would therefore have been disproportionate. In addition, the policy adopted by the EU Member States to require all hot chilli products imported into the EU to be accompanied by a certificate showing they are free of Sudan dyes places the burden of proof of safety firmly on the importer.

You will also be aware that from 1 January 2005 Regulation (EC) 178/2002 will strengthen controls on traceability, recalls and withdrawals on all food and feed businesses across the European Union. Food and feed businesses will be required to retain information about suppliers and those to whom their finished products are supplied. This information must be available to the competent authorities on demand. The requirement is intended to improve food safety by ensuring food products can be readily traced and withdrawn from sale or recalled from consumers as necessary.

Finally, I can assure you that information from our investigations of incidents, including those on Sudan dyes, forms an integral part of the Agency's contingency planning activities for cases of deliberate contamination and these feed directly into ongoing central government work in this area.

Yours sincerely

Dr Andrew Wadge

Room 604, Aviation House, 125 Kingsway, London WC2B 6NH
Tel: 020 7276 8511 Fax: 020 7276 8404
E-mail: andrew.wadge@foodstandards.gsi.gov.uk

Annex A (vi) (e)

02 January 2005

The Copse
30 Brewery Road
Pampisford
Cambridge
CB2 4EN

Dr Andrew Wadge
Food Standards Agency Room 604
Aviation House
125 Kingsway
London WC2B 6NH

Dear Andrew,

Thank you very much for your letter of 15 December 2004 in response to my questions submitted to the Board meeting.

It was unfortunate that at short notice I had to miss the meeting but I would be interested to see a transcript of the answers, if that is available.

My main objectives and concerns in addressing this issue with you are;

- To assure you of my intentions to be fully constructive in my contributions, accepting that the Agency did not 'cause' the Sudan 1 problem, but have had the thankless task of solving it thrust upon them.
- The maintenance of public confidence in the additive safety approval system.
- The security issues exposed by the incident relating to the bioterrorism and other criminal threats.

Let me firstly assure you that I am quite prepared to accept your assurances relating to these issues that;

- You believe there was no immediate risk to health given the very low levels present (of Sudan dyes).
- The Agency acted promptly to publicise the adulterated (this is criminal adulteration, not contamination) products on your website.
- (such issues) form an integral part of the Agency's contingency planning activities for cases of deliberate (adulteration).

Without repeating my e-mail of 29 November (of which I am sure you will have a copy) with my original questions and notes for the Board meeting, I would highlight the following points which I believe your assurances do not fully address;

- The scope of the Sudan dye adulteration makes it the biggest single criminal food product adulteration ever experienced in the UK.
- The full extent of international food product adulteration by product type and geography, beyond the UK experience, is as yet unknown.
- The original adulteration must have occurred over two years ago, judging by the pattern of 'detection and exposure', a period of exposure that must mitigate against considerations of 'low levels' of dye being present (all dyes are invariably present at low levels).

- The focus of the adulteration has disproportionately exposed 'at risk minority groups' of the population, which has not been highlighted or specifically addressed in the Agency's recall notices. Ethnic food retailers have been particularly ill-served.
- The Sudan dye range failed the standard food additive safety approval system, which is a 'GO : NO-GO' approval system.
- For the sake of consistency, the Agency should be seen to support the standard additive safety approval system, without any overt reference to the `extent' of the failure involved. There are no provisions for `shades of grey' in the system and this is not good PR. If the Agency is seen to play down an incident on these grounds, it will have little argument to counter future claims by activist groups when they claim a particular adulterant/contaminant is unsafe, because it is only `just' within the safety limits.
- While the Agency very commendably did act promptly in publicising the adulterated products on the web, such action has failed to successfully alert the UK public to the issue, because new adulteration continues and recalled product is evidently still on sale.
- It is still the case that people generally and food industry management in particular, are largely unaware of the Sudan issue.
- In my experience food industry management will not take such issues seriously unless there is clear, authoritative enforcement.
- The Agency's use of the web for this recall mimics the Supermarkets' use of `local recalls' in place of `National recalls' to minimise their adverse publicity and establish a pre-emptive, nominal, `Due Diligence' defence position (whether co-incidentally or otherwise). I have specific knowledge of this tactic, which can be properly justified in some circumstances, but also has been abused.
- Most of all, the whole incident demonstrates the inadequacy of current food product recall enforcement procedures.
- The inadequacy of the `food chain' concept, and associated traceability, recall and enforcement procedures, is demonstrated by the pattern of adulterated products being exported and re-exported, such that the description `food chain network' is more applicable.
- The problem continues to expand in scope with adulterations of palm oils, curry pastes and other spice mixes, still focused upon ethnic minority 'at risk' community groups within our society.

My proposed concept of a `food chain network' with its analogy to the movement of data across the web, is important new thinking.

If a traceability/recall procedure is implemented today along an identified `food chain', adulterated products find alternative routes through the `food chain network' that actually exists. This is why I have suggested that different product recall strategies now need to be developed.

I also suggest a concerted effort to ensure that geographically extended ingredient sourcing should be highlighted within HACCP as a CCP.

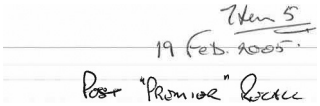
I remain concerned about the vulnerability of the UK food supply to the threat of criminal adulteration (I draw little practical distinction between criminal adulteration and so-called bioterrorism) through the route of minor ingredients such as herbs, spices, colours and flavours, which receive minimal screening, coupled with the relatively recent development of a complex supply chain network for prepared foods.

The supply and logistical trends in the food industry are leading to greater such complexity, particularly for short shelf life foods.

I have some experience in managing food safety incidents and recalls, as you may be aware, and seriously welcome every opportunity to add to this debate. Will you be representing the Agency at the forthcoming CBRN conference on 18 January by any chance? If so then perhaps we may get an opportunity to discuss these matter.

Sincerely, and wishing you the compliments of the Season

Annex A (vi) (f)



Andrew,

My purpose here is not to say 'I told you so' because the Sudan recall situation now needs recovery solutions.

You have all my comments and correspondence dating back to my questions tabled at last year's Agency Board meeting, so I will not recap anything.

I will simply focus on expanding my earlier suggestion that a different product recall strategy needs to be developed for this new type of recall situation.

I believe I have as much practical management experience of handling product recalls as anyone and very much more than most.

Current recall procedures are developed on the concept of the 'food chain', which conditions our thinking and understanding of the structure of the food supply routes.

In fact, we don't have a 'food chain' as such. The scale and complexity of geographic ingredient sourcing; complexed with increased pre-processing of intermediate ingredient products at the raw material source and other downstream sources; complexed with developments of outsourcing, co-packing and commoditization of a whole range of foods and intermediate ingredient products; all duplicated again and again at an international as well as intranational level, actually describes a complex web, or network of food supply routes.

That is why I refer to the 'food chain network'. This is not mere semantics, as it changes our perception of the recall challenge now faced.

Current recall procedures are based on the 'standard of proof' when sampling products, of 'innocent until proven guilty'. You keep on sampling 'candidate' products and cutting off their supply chain. One by one, you hope this will cumulatively solve the problem. What has happened with the Sudan recall is that contaminated ingredients in a wide range of part-processed status have multiplied through a network of multiple entry routes. The statistical non-significance of sampling numbers that you are capable of analysing only adds to your difficulty. You have a 'needle-in-a-haystack' problem and always will have. One Agency will never have enough resources to carry out statistically significant sampling regimes for the whole food market. In my experience in the food industry, there are very few statistically significant sampling schemes employed, save for in-line automatic measurements such as checkweighing. Certainly individual product compositional analysis sampling is not statistically significant.

With Sudan 1 type recall challenges, we now need to think laterally and reverse the 'standard of proof to one of 'guilty until proven innocent'.

What should have happened at about the six-month stage into this recall, when it was clear there was a widespread contamination of hundreds of chillie-based products; and what should most certainly be implemented now, is the following;

All food producers and retailers of products containing red chillies as an ingredient should be immediately advised to either;

a) Withdraw and recall every such product, of all date codes, from the market, commencing no later than five working days from notification

OR b) Provide their local Home Authority Environmental Health Department with positive proof, by way of analytical evidence of the 'free-from' status of all their products, with respect to Sudan dye contamination, which will be accepted as the only basis for non-implementation of a recall.

I appreciate this may seem drastic, but drastic action is needed to restore consumer confidence in the food supply (five days could be slightly negotiable).

If food businesses have an effective traceability system in place and if they have adequately secured the bona fides of their supply sources and revised their HACCP plans, they should have no difficulty in complying with (b) above.

Equally, if technical managers have been paying attention to the Sudan episode as it has developed in their industry over the last 22 months they should be in a position to provide analytical evidence without difficulty. Copies of all FSA Sudan recall reports and all European RAS reports have been available since the start of this problem; active managers in the food industry should be well prepared for this.

The truth of course is that this action will expose a large degree of deficiency in the food industry with respect to the above. They will simply have to go through the pain barrier. Considerable good will come out of the Sudan incident if this proposal is adopted, as the insurance market will ensure that food businesses in future will invest a more realistic level of management attention and priority to HACCP and food sourcing controls. There will be a spin-off benefit for bioterrorism threat management.

Longer term, there must be a more robust approach to enforcement proceedings with food businesses that have inadequate traceability and HACCP plans.

The new sentencing guidelines for Courts now provide for four levels of seriousness with respect to management and corporate culpability;

Culpable Intent

Culpable Recklessness

Culpable Knowledge

Culpable Negligence

There is ample scope now to progress corporate negligence and corporate knowledge proceedings through the Courts. With the most serious contraventions there will be scope to consider proceeding at the corporate recklessness level.

I am more than willing to assist further in any way.

Sincerely,

Malcolm Kane
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Annex A (vi) (g)

Note provided by FDF of meeting on `Lessons to be learned from the Sudan I incident' held in FDF offices on 30 March 2005

Present

[FDF Representative] [FDF Representative] [FDF Representative] [FDF Representative] [FDF Representative] [FDF Representative] [FDF Representative] [FDF Representative] [FDF Representative] [FDF Representative]

[FDF Secretariat] [FDF Secretariat] [FDF Secretariat] [FDF Secretariat]

[FSA] [FSA]

1. Discussion with FSA

NOTED that this was an opportunity to discuss the recent Sudan I incident, informally and frankly. There would be further opportunities to review this incident, including as part of FSA's independent review.

1.1 Review of the lessons learnt from the Sudan I incident

The Chairman stressed that food safety and instilling public confidence in the food chain were the overriding objectives of the industry. Industry had followed all the controls, including obtaining certificates of analysis and undertaking additional testing, both at port of entry and at various stages in the supply chain. Sudan I had, however, still managed to enter the food chain as in the more recent incident: Loyd Grossman Curry Sauce. In industry's view, the most likely reason appeared to be cross-contamination with adulterated chilli powder intended for the domestic Indian market.

In the light of recent experience, industry was considering what (if any) additional actions could be taken to eliminate (or reduce) the risk of Sudan I entering the food chain. This could include increased testing at UK level and improved supply chain relationships (vendor assurance).

The Chairman explained that industry had a number of concerns about FSA's handling of the Worcester sauce incident, including its decision to undertake a public recall and the misreporting of information on its website. Industry was also concerned by the press coverage of the incident which, through headlines, such as `Killer Worcester Sauce', had fuelled consumer concerns.

Key points arising from the discussion:

1. [FSA Official] commented that the chilli powder implicated in the Worcester sauce incident had entered the UK prior to the July 2003 controls. There was evidence that adulteration by Indian suppliers was more common before this date, but testing at port of entry over the last two years had identified only one positive batch (and some mislabelling). This suggested that controls had been put in place in India to prevent these illegal practices.
2. [FSA Official] commented that industry needed to have a better understanding of practices in the food chain, particularly at the raw material level, to ensure that controls and checks were in place. Industry also needed to use its knowledge and intelligence of practices within the food chain to identify potential for adulteration.
3. [FSA Official] commented that, even if chilli powder had not been deliberately adulterated with Sudan I, it was still unacceptable that contaminated powder had entered the food chain. He particularly stressed the complexity of the UK supply chain and that some food companies used brokers to supply raw materials. Members commented that this was not common practice and reputable companies only sourced from a dedicated list of trusted suppliers.
4. [FSA Official] commented that, in the two most recent incidents (Asda Moroccan Chicken Pizza Flatbread and Loyd Grossman Curry Sauce), Sudan I had been detected at very low levels. Public Analyst laboratories were able to detect Sudan I at the level of 1 ppm, but research laboratories were able detect it at much lower levels. The meeting agreed that guidance on methods of sampling and analysis would be useful. FSA was currently investigating the feasibility of setting a reporting level for Sudan I. FDF fully supported this approach and suggested that it be broadened to the EU.
5. [FSA Official] explained that FSA's approach to genotoxic carcinogens in food was based on advice from the UK Committee on Toxicity that there was 'no safe level of exposure' and thus levels should be kept 'as low as reasonably practical'. This meant that contaminants such as Sudan I, which were deliberately and illegally added to foods, were avoidable risks and that measures should therefore be taken to ensure that products containing them were removed from the market. On the other hand, contaminants such as acrylamide, which were formed during the food production process, were unavoidable risks. Measures should be taken to minimise levels in food, but products did not need to be removed from the market. Threshold (action levels) had been set for contaminants such as aflatoxins below which no action is required.
6. FDF commented that the publicity surrounding a recall was a key concern and suggested that FSA needed to take a proportionate approach and secure removal of products from the food chain without the type of media headlines seen during the Worcester sauce incident.
7. [FSA Official] reported that the Irish, Swedish and Spanish authorities had taken the same action as the UK. FSA would be discussing this further with its counterparts in other Member States to seek to harmonise the approach taken across the EU.
8. Establishing a robust and reliable mechanism for companies to provide information had been identified by FSA as a key lesson to be learnt, noting that it would have preferred to have been supplied with a definitive list from FDF for food manufacturers and from BRC for retailers. Members commented that they had been particularly concerned that

the mechanism for providing information to FSA was not secure. Information had been accepted from retailers on branded products and there appeared to be no measures in place to prevent malicious reporting by, for example, disgruntled employees. FDF **AGREED** to take this forward with BRC, including the development of a Standard Template. The possibility of an automated reply to emails to acknowledge receipt of information should also be explored. FSA **AGREED** to take this forward.

9. Both [FSA Official] and [FSA Official] acknowledged the importance of communication between FSA and industry during these incidents and accepted that some improvements were needed. FDF suggested FSA providing regular updates to a nominated FDF contact during a crisis.

10. In terms of dealing with media interest in a public recall, [FSA Official] commented that it was difficult to predict how the media would react to any particular incident. In this incident, FSA felt that the involvement of the media had been necessary given that so many affected products had been sold through small retail/catering outlets and consumers would have had products stored at home. This was also important in terms of FSA's openness and transparency for FSA. Public trust would be lost if FSA was not seen to be communicating openly with consumers.

11. It was **AGREED** that [FSA Official] would have a meeting with SSA members to gain a better understanding of the spice supply chain. **Action: SSA**

In summary, the Chairman concluded that:

- the industry would increase testing to seek to eliminate (or reduce) Sudan I from the food chain;
- FSA would consider the feasibility of providing guidance on a standardised method of sampling and analysis coupled with a reporting level;
- further intelligence was needed on practices within the food chain to identify potential for adulteration. This included FSA making information available on rogue suppliers.

  a proportionate approach was needed by FSA in determining the most appropriate course of action in a particular incident: trade withdrawal or public recall;
- FDF would provide a recommendation (with BRC) for a secure mechanism for reporting production information to FSA.

[FSA Official] stated that overall the recall had been handled within a timely and efficient manner.

The Chairman expressed the Group's appreciation to [FSA Official] and [FSA Official] for agreeing to an early meeting and willingness to participate in a frank and constructive dialogue.

1.2 Independent Review

[FSA Official] advised that the FSA Board would shortly be discussing proposals for an independent review of the Worcester sauce incident. An independent chairman would be appointed and all stakeholders would have the opportunity to contribute to the review.

In response to a question, he added that the Government review, called for by the EFRA Select Committee, would be separate from the FSA review and was unlikely to be taken forward until after the general election. [Now appears unlikely]

Annex A (vi) (h)

Comments on the note provided by the FSA of a 'frank and informal' meeting between the FDF and the FSA, at which all attendees remain anonymous, on 'Lessons to be learned from the Sudan 1 incident' held in FDF offices on 30 March 2005.

1.1 Review of the lessons learned from the Sudan 1 incident.

It appears that the FDF has learned pitifully few lessons from the Sudan 1 incident. In the very first paragraph of the minutes of their meeting with the FSA they make five worryingly complacent statements in private, on behalf of the whole food industry;

- 'Industry had followed all the controls'
- 'including obtaining certificates of analysis'
- 'undertaking additional testing'
- 'Sudan 1 had however still managed to enter the food chain'
- 'In industry's view the most likely reason appeared to be cross-contamination with adulterated chilli powder intended for the domestic Indian market.'

Let us analyse each of these statements in turn;

- Controls?

  Exactly what controls had the food companies involved followed? Had they checked the bona fides of the sources of their ingredients? Obviously not. Had they conducted a sound risk analysis of sources of chilli products from India? Obviously not.

  Criminal adulteration of food ingredients is as old as history. From adulteration of Roman wine with herbs and spices, to the adulteration of Austrian wine with antifreeze, or from the adulteration of poultry with pork protein slurry, to the adulteration of beef with kangaroo meat, etc, the food industry has been aware that every sector has its particular 'wrinkles' where criminal adulteration is a known risk.

  Anyone in the red chilli pepper business knows that the value of chilli peppers declines in proportion to their loss of natural red colour. Chilli peppers have long been vulnerable to colour adulteration and every trader in the chilli business will know this.

  Whether the adulterant is a relatively benign substance Such as tomato powder (with its notoriously robust colour stability) or any one of a number of illegal synthetic red dyes, the chilli business will have long been aware of such risks; The chilli business is, frankly no different in this respect to the banana business or the, cured sausage business or any other food industry sector.

Each will have its 'wrinkles' known to the inside traders and it is up to importing businesses to do their homework whenever they are auditing a new ingredient source. So exactly what 'controls' have the UK food companies involved followed in respect of illegal red dyes in chillies? The only and obvious conclusion is that this responsibility has been neglected.

These companies have knowingly imported food ingredients containing chilli powder, knowingly accepted inadequate ingredient verification systems and knowingly turned the 'Nelsonian eye' to the 'traceability' controls they are legally constrained to follow.

The result is that chilli products adulterated with Sudan 1, 2, 3, 4, Para Red, and goodness knows how many other illegal dyes of known toxic profiles have been imported into the UK for probably the last five years at least.

These companies are in no position to effectively challenge this, or demonstrate due diligence in this whole issue.

- Certificates of analysis?

  When did simple certificates of analysis ever become worth more than the paper they were written upon? Such certificates do have a legitimate position in food sourcing, but it is essential, understood and accepted by all professionals 'in the industry that such certificates must be supported by evidence of the bona fides of the laboratories issuing the certificates. There are abundant laboratory certification systems in existence to plug this credibility gap. A 'second opinion' is an essential due diligence precaution.

  The main commercial value of certificates of analysis is to retrospectively demonstrate culpability (in Court if necessary) for compensation when evidence of adulteration or contamination is found during post-receipt monitoring.

  So where is the FDF's evidence of such verified certification systems being employed and (therefore) being corrupted by falsely endorsing imports of chilli products for the last five years? And where is the evidence that the food companies involved have detected adulteration in certificated imports (prior to the FSA recall) and having implemented legal action for compensation?

- Additional testing?

  Additional to what? Clearly not additional to accredited certificates of analysis. Have the companies involved presented any evidence of appropriate additional testing that demonstrates relevance to the Sudan 1 adulteration issue at a sampling rate of sufficient statistical significance, related to a prior risk assessment? The food industry has a vested interest in protecting itself from the business risk of purchasing adulterated and contaminated food ingredients. Food business operators who fail to recognise this responsibility do not deserve to be in the food business.

The fact remains that whatever additional UK testing may or may not have been done actually failed to detect the problem. The problem was originally identified in France in March/April 2003. Only then did the UK seriously address 'additional testing', whereupon the full scale of the scandalous adulteration problem was exposed. Informed analysis of the pattern of exposure of adulterated foods concludes that the problem had been in existence for several years before the 2003 discovery.

The ease with which such widespread adulteration was subsequently identified *proves* the absence of any significant level of UK testing prior to; the French alert. There was so much adulterated food subsequently found on sale in the UK that even a minimal level of earlier testing would most certainly have exposed it much earlier.

- Sudan 1 'still managed to enter the food chain'?

  Are these FDF representatives seriously asking us to accept that Sudan 1 ...a simple chemical... has a mind of its own and 'managed' to enter the food chain by some kind of chemical migration? Are they deliberately minimising systems, management and criminal elements involved in this matter? Are they claiming that criminal adulteration is none of their business or their responsibility to proactively predict and prevent? If they are not prepared to accept this responsibility for UK imported foods and ingredients then exactly who do they propose is responsible?

- The domestic Indian market...?

  Are Indians not equally as important as anyone else in deserving protection against criminal food adulterators? If they were so aware of the, lax standards' of the Indian market (the Indian authorities may wish to comment upon this) why were they importing chilli products from India? And if they were not aware of these subsequently claimed lax standards of the Indian market...why not? Or if this remark is intended to imply that only subsequently to the FSA recall?

  Clearly the food industry's risk assessments of the Indian market were lamentably lax; as lax in fact as their now claimed standards in the Indian domestic market.

In the second paragraph, the FDF effectively confirms the above in their comments that 'in the light of recent experience' they should 'increase UK testing' and improve 'supply chain relationships'. 'Supply chain relationships' means supply chain risk assessment, auditing and spot checking...which the minutes refer to correctly as 'vendor assurance'.

This does raise the single most important issue of all to be learned from the Sudan I incident. The UK food industry relies heavily upon the; BRC Certification system for vendor assurance of imported food and ingredient sources for establishing their food safety bona fides. While initially designed for foods produced for UK supermarkets, the use of BRC certification has spread much wider. It is now used

internationally and increasingly for branded manufactured foods also. To this extent it is an established and successful management system, deserving of credit.

BRC Certification of supplier's product and quality systems is effectively a third party audit conducted by businesses accredited through UKAS or its equivalent.

So important is food safety and compliance with quality management systems, that this third party BRC audit is now equally as important to food businesses as their longer established 'external' audit of their company accounts. Numerous financial problems and professional accountancy reviews have resulted in very necessary improvements in the standards of financial auditing and in particular the establishment of best practice guidelines for the use of external (i.e. third party) financial auditors.

Two important improvements in financial auditing have been;

1 the recommendation that companies should change their external financial auditors frequently; every third or fifth year has been proposed for example.

2 the recommendation that audit companies should not provide separate consultancy services for their audit clients.

The time has now come for food safety third party BRC auditing to be supported by the equivalent improvements in best practice in the food industry.

Food manufacturing companies should be required to change their BRC auditors every third year. Obviously this proposed frequency will be debated, but the principle should be established and accepted quickly by the FDF for phased implementation.

There should also be a clear ruling that accredited third Party BRC auditors should not provide consultancy or other services for their audit clients.

The UKAS accreditation does provide for this to some extent, but the blunt fact that should now be aired and admitted is that this is not rigidly enforced. Some of the biggest providers of third party audit services are also the biggest providers of consultancy and other services.

A related problem that needs addressing is the policing of the standards of auditing. It is anecdotally well known within the food industry that certain third party auditors will be more 'helpful' than others with obtaining BRC certification. Clearly this is not the kind of issue that will be openly reported, but it now needs airing.

There is a need for a separate monitoring of professional standards of BRC auditing and this should be a role that the IFST should consider adopting. A standards committee should be set up in co-operation with UKAS and should establish a system for comparative checking of the audit standards of accredited certification companies. There are sufficient IFST members of high professional standing and with appropriate experience to both serve on this committee and conduct the comparative checks.

Any future incident like Sudan 1 that also causes attributable consumer harm will seriously challenge the whole validity of the BRC Certification system for the whole UK food industry know that its weaknesses have been exposed by are Sudan I incident. The urgent need for such reforms is therefore demonstrated by the Sudan I incident.

All the more so by the fact that the very concept and language of a 'supply chain' is now exposed to be seriously wrong. If the Sudan I incident demonstrates anything, it demonstrates conclusively that there is no such thing as a 'supply chain'. What we now have to deal with is a 'supply network', which bears more comparison to the World Wide Web. If a server goes down, e-mail does not stop, it simply re-routes through another server. When a source of Sudan 1 adulterated food was cut, it simply was re-routed through another source, often another Country and more often, several Countries.

The Sudan 1 incident has been a saga of abject failure by the food industry companies involved. Failure to conduct appropriate risk assessments. Failure to establish effective supplier assurance systems. Failure to provide statistically relevant raw material testing schemes. Failure to implement an effective Product recall (now three years and still going?). Failure to be properly focused on consumer safety. Failure to understand and predict consumer perceptions. Failure to identify at risk' consumer groups for priority product recall attention...i.e. UK ethnic minorities who are disproportionately greater purchasers of chilli based products.

No separate recall was ever targeted at the UK's ethnic minority population.

I would have been more impressed with this 'frank and informal' meeting between these FDF representatives and the FSA if in the first place these failures had been tabled as the basis for frank discussion and forward planning.

And all the participants should have had the courage and professionalism to be publicly named. It should not have required a Sunday Times Newspaper request through the Freedom of Information Act for these minutes to be disclosed. The UK food industry and the FDF will never earn a 'good press' until it learns to be more transparent.

Finally, item 6 of the 'key points' raised during this meeting records the anonymous FDF request for a 'proportionate approach' to recall procedures as the publicity surrounding a recall was a key concern.

This apparently relates to both a complaint about the publicity surrounding the FSA recall and also a suggestion that 'recalls' and 'trade withdrawals' should be distinct and that there should be some discretionary agreement between industry and the FSA on an 'incident by incident' basis as to which is which.

The latter is a deeply disturbing suggestion that should be 'strangled at birth'.

Traditionally, recalls (or Public Recalls as they were always known) have been very distinct from Trade Withdrawals. Public Recalls always related to incidents involving

food safety and the Sudan 1 incident would always have been a Public Recall issue because of its illegal status and genotoxic reports. Trade withdrawals were only ever related to issues of product quality, minor labelling errors etc.

A survey of the FSA website reveals a total confusion wild ambiguity of these terms in use. The traditional interpretations should be re-established with immediate effect and both the FSA and industry should be careful to maintain the understood distinction. Any suggestion that the FDF should be allowed a position of equivocation around the decision to have a Public Recall should be immediately quashed. Nothing would serve to undermine public confidence in the safety of the food supply than if such a suggestion were to be accepted. On the contrary, the FSA should be responsible for checking all Trade Withdrawals to establish whether they are appropriate or should be a Public Recall, by reference to clear, established and published criteria.

As to the FDF complaint about (excess) publicity surrounding the FSA recall, the truth is that the most appropriate complaint should be at the low-key ineffectiveness of the FSA recall. This biggest recall in UK history was in fact marketed as a series of separate recalls, all deeply buried on an inaccessible website. It was not until 2004 and the Newsnight article that the wider public became aware of the Sudan issue at all.

It is understood that some in the FDF have argued that Sudan 1 did not justify a full Public Recall because of the toxicological evidence. If they were also to argue they can drive safely at 40 MPH in a built-up area, they will still deserve to be prosecuted, however convincing their evidence about the speed of their reactions or superiority of their car's brakes. The law is the law and must be enforced. If anyone disagrees with a particular law they should lobby their MP to get the law changed.

The role of the FSA here is as a law enforcement agency and there should be no scope for equivocation, so the same logic holds for food safety issues. The proper position for the FDF, if they want to argue the safety of Sudan 1, or any other illegal adulterant is to fund the research necessary to properly present their case to the appropriate food additives and contaminants committee to have the status changed to a permitted additive. The system is there and it works and there is no need to change it.

Annex A (vii) (a)

Representing

the Seasoning

and Spice Industry

Richard Sinclair BY EMAIL

FSA 8 May 2007

Sudan 1 Review Panel – response to call for written comments.

Dear Richard,

I am writing on behalf of the Seasoning and Spice Association (SSA) to submit written comments in advance of the Sudan 1 Review to be held on 24 and 30 May:

SSA Comments:

1. SSA has kept members informed of developments regarding contamination of spices with Sudan I and other dyes from the very start of the crisis in 2003. In September, October and November 2003, SSA issued position statements and advice documents, alerting members to the need for testing. When the second crisis broke in 2005, SSA officers contacted members by phone and confirmed that members were indeed carrying out the necessary testing.
2. SSA worked with members of the FDF Residues and Contaminants Committee to develop further guidance for members on controlling non-permitted colours in food. Draft guidance was issued to members on 6th June 2005.
3. The SSA guidance was adopted largely unchanged by the European Spice Association (ESA) and was issued to all ESA members in July 2005. This ESA guidance was formally adopted by SSA and re-issued to SSA members on 19th July 2005.
4. The ESA guidance was reviewed and re-issued in slightly amended form in September 2005. The September 2005 version of this document is appended below for information.
5. SSA believes that it acted responsibly in developing and issuing guidance to its members in the UK. This guidance was quickly made available to spice companies across Europe via ESA.

Yours sincerely

John Lepley
Executive Secretary
Seasoning & Spice Association

Appendix: ESA Non Permitted Colours in Spices – Rev. 1 September 2005

esa
european
spice
association

September 2005

Rev. 1 *

ESA Advice to Members
Non-Permitted Colours in Spices

INTRODUCTION

Since July 2003 there have been a number of EU alerts in respect of non-permitted colours in spices. It is understood that these illegal colours have typically been added at the grinding or crushing stage of the process. This document is therefore designed to provide guidance for the spice industry to minimise the risk of contaminated spices entering the food supply chain.

1. TERMS AND DEFINITIONS

1.1 Non-Permitted Colours

Non-permitted Colours are those that are not listed in the Colours in Food Directive 94/36/EEC of 30 June 1994. These colours may not be present at any level in foodstuffs.

Following Annex II of Directive 94/36/EEC of 30 June 1994 it is illegal for any type of colour to be added to an individual spice or mixture of spices intended for sale as such. However a seasoning may contain permitted colours.

1.2 Supplier Batch

A quantity of product identified by the supplier as having been produced under the same manufacturing conditions during a defined period of time.

1.3 Positive Release

A system under which batches of materials/products are quarantined from use and only explicitly released for use by an authorised person once all defined criteria are satisfied.

* This rev.1 version replaces the first version dated July 2005

1.4 Retained Sample

A sample which is representative of the batch, normally consisting of at least 100ml or 100g, which is retained securely as a reference sample for analysis if there are any future issues with the batch.

1.5 Approved Supplier

A supplier that has clearly demonstrated an ability to meet all the relevant criteria of the risk assessment.

1.6. Traceability

All batches of materials must be traceable back through the supply chain to the country of origin and the supplier.

Definitions of spices and seasonings can be found in the glossary of terms section in the ESA advice to members document, which is reproduced as Annex 1 of this document.

2. RISK ASSESSMENT

Where materials are imported directly from the point of origin, the importer should undertake an appropriate risk assessment and ensure that all relevant systematic controls are in place to prevent adulterated materials entering the food chain. Risk assessments and controls should be based upon known and foreseeable food safety issues and the possible use of non permitted colours. Materials should only be released under a positive release system.

The following elements should be considered as part of any risk assessment*:

- Country of origin of the product
- Nature of the material (e.g. whole, ground or crushed)
- Type of spice
- Supplier selection and approval:
    - — Raw material control
    - — History of supply
    - — Capability of meeting EU legislative requirements
    - — Adherence to Good Manufacturing Practice (GMP)
    - — Adherence to HACCP principles
    - — Traceability
    - — Third party certification
    - — Testing capabilities and accreditation to ISO17025

* Members should be aware that colours illegal for spices can be found in the environment, e.g. in lubricants for the equipment, packaging materials, stitching of bags, printing inks.

2.1 Sampling

If, following the risk assessment, testing is deemed to be necessary the following sampling plan should be used:

1. For each supplier batch received, the square root of the number of packing units (e.g. box or bag) delivered should be randomly sampled, up to a maximum of 10 sub-samples. If the delivery is of less than 5 packaging units, all of them should be sampled. Each sample should consist of a minimum of 100ml or 100g. The samples should be combined and well mixed to produce a composite sample for analysis and be regarded as representative of the supplier batch from which they came.
2. A retained sample should be kept for the shelf life of the product. This sample must be representative of the whole batch, must be adequately labelled to identify the batch from which it was drawn, and stored in such a manner as to protect its integrity.
3. If materials are accepted from approved suppliers under a certificate of analysis, it is recommended for due diligence purposes that a level of surveillance testing commensurate with the outcome of the risk assessment and available historical data be undertaken. This need not follow the above sampling plan.

2.2 Analysis

As agreed at the 10 May EC Standing Committee meeting, a network among some Member States, coordinated by UK, is on going to develop and validate analytical methodology within one month. This method will probably be an HPLC method. ESA expects Member States to apply this method for official control.

EFSA are also carrying out a review of toxicological data available on Para Red and other similar dyes on a tentative time scale of 2 months.

Changes to analytical methods and limits of determination should be made in accordance with the advice given by the Standing Committee on the EFSA web site (http://www.efsa.eu.int/).

Analysis should be carried out by an ISO 17025 accredited laboratory where possible. Testing laboratories should have adequate quality control procedures in place, e.g. as described in ISO 17025.

The list of colours in Annex 2 of this document should be covered by such analysis.

ESA will review its position in light of further developments or advice from the EU Commission.

2.3 Non-Conforming Materials

1. Any non-conforming materials must be clearly labelled, segregated and accounted for.
2. The supplier should be informed.
3. The relevant regulatory authorities must be notified.

4. The affected materials should be disposed of appropriately, taking into account any potential insurance requirements.
5. The local authority can provide advice and instruction on method of disposal.
6. A certificate of disposal issued by a licensed waste disposal operator should be retained.

2.4 Actions to be taken

Stocks must be checked for all dyes mentioned in annex 2 of the ESA document. Products to be tested are paprika, chilli, turmeric, curry, crushed or ground.

Tests shall be conducted by ISO 17025 accredited laboratories where possible.

All incoming material should be checked for the same annex 2 colours. This may be reviewed when a reliable supply chain has been clearly demonstrated.

Annex 1. Extract from SSA's Advice to Members Glossary of Terms

Seasoning	A blend of permitted food ingredients containing one or more whole or ground spices/herbs and/or other flavour-enhancing or flavour-imparting ingredients. They often contain added functional ingredients in order to achieve the technological purpose for which the seasoning in question is designed	**SSA Definition**
Spices	Edible parts of plants, including but not restricted to the roots, rhizomes, bark, flowers, buds, fruits, seeds, that are commonly added to foodstuffs for their natural flavouring, aromatic and/or visual properties.	**SSA/ESA Definition**

SSA = Seasoning and Spice Association
ESA = European Spice Association

Annex 2. List of non-permitted colours found in spices since 2003

Butter Yellow	[CAS 60-11-7]
Orange II	[CAS 633-96-5]
Para Red	[CAS 6410-10-2]
Rhodamine B	[CAS 81-88-9]
Sudan I	[CAS 842-07-9]
Sudan II	[CAS 3118-97-6]
Sudan III	[CAS 85-86-9]
Sudan IV	[CAS 85-83-6]
Sudan Orange G	[CAS 2051-85-6]
Sudan Red B	[CAS 3176-79-2]

ESA thanks its member SSA for the permission to use the SSA documents.

Annex A (vii) (b)

Representing

the Seasoning

and Spice Industry

To: Professor Douglas Georgala
By e-mail
c/o Richard Sinclair, FSA
31 May 2007

Dear Professor Georgala,

I am writing on behalf of the Seasoning and Spice Association (SSA) to thank you for allowing us the opportunity to give evidence at the Sudan 1 Review on 24th May.

We have prepared a supplementary submission, including structured answers to the sample questions which were not included in our original written submission.

This supplementary submission is intended to clarify and augment the verbal answers we provided on the day.

The submission includes further detail and additional information on certain questions, for example on the challenges of sourcing ingredients around the world.

We hope that you will find this information helpful and that you will be able to take this supplementary submission into account when developing your final report.

Yours sincerely,

John Lepley

SSA Executive Secretary

Annex A (vii) (c)

SEASONING AND SPICE ASSOCIATION

SSA Sudan Review Supplementary Submission:

1.0 Introductory Statement:

John Lepley	SSA Executive Secretary (from Jan 2007) (Previously worked for a seasoning manufacturer)
Linda Stokes	SSA Technical Chairman (from April 2007)
Simon Cripps	SSA Executive Chairman

The Seasoning and Spice Association (SSA) represents both herb and spice processors and seasoning manufacturers in the UK. SSA is a member of FDF and is also an active member of the European Spice Association (ESA).

SSA currently has 22 member companies, which range from SMEs to large multinational companies. At the time of the 2005 Sudan incident, SSA had 19 member companies.

SSA members operate in both the industrial and retail herb, spice and seasoning markets.

SSA does not require its members to submit data on the value and volume of herbs and spices that they process annually. It is therefore difficult for us to accurately calculate the share of the UK market represented by SSA members.

We have however estimated that SSA represents under 50% of the total UK herbs and spices market. A range of brokers, traders and independent companies supplies the rest of the market.

Our share of the market of herbs and spices supplied directly and indirectly to the major supermarket chains is however much higher. We have estimated this to be at least 90%.

The SSA Executive Committee consists of managing directors and senior managers from our member companies and meets at least twice annually. In addition the SSA has an active Technical Committee which meets at least four times a year to discuss technical and regulatory matters. Additional ad hoc meetings are convened as required to allow members to co operate together to manage specific issues as they arise.

The SSA Technical Committee issues guidance and advice to members on technical and regulatory matters. The Sudan (and Para Red) contamination incidents were no exception and the development, issue and updating of our guidance on non permitted colours has been covered in detail in our written submission.

It is important to note that SSA is only able to issue this advice within its membership and cannot directly influence the rest of the UK herb and spice industry.

2.0 What was your impression of the 2005 incident?

- Our overall impression was that some things worked well whilst others caused additional workload and confusion without additional benefit;
- The SSA's primary concern was for public health and the need to protect and reassure the consumer as quickly as possible;
- In this situation, the key requirement was for a clear risk based assessment, including identification of the origin of the contamination, so that we in turn could undertake a thorough traceability exercise and thereby prevent any contaminated product getting onto the market;
- SSA members have good traceability in their supply and manufacturing systems and given correct information as to source, would have been able to identify all contaminated products rapidly; and
- Our other lasting impression was of a food industry 'under siege'. We believe that neither the measures taken nor the media response was proportionate to the risk. This may have been caused by the "sensitivity" of the food authorities, the media and the food industry to the previous 2003 scares involving Sudan dyes.

3.0 How did you feel at the time, what went well, what could have been done better?

The following went well:

- Liaison between seasoning manufacturers, spice suppliers and their spice supply chains;
- The testing laboratories (e.g. Campden, Leatherhead, CSL etc.) did well in responding rapidly to the increased need and increased complexity of testing, providing workable turnaround times whilst developing improved screening tests;
- SSA Members traceabilty systems were tested to the extreme and proved to be very effective given the widespread nature of the contamination. Once the detailed information became known, at risk products and customers were swiftly identified by SSA members, and where appropriate, SSA members controlled products in line with FSA requirements; and
- SSA guidelines for members were drawn up and provided to members and ESA.

The following elements hampered our ability to react quickly and professionally:

- Lack of agreed test methodology and limits of determination;
- The number of false positive test results because methodology was still under development;
- Withdrawal based on traceability rather than test results;

- Absence of a single contact point within the FSA;
- Absence of detail data collection at FSA which often meant repeating the same information several times over;
- Inability to contact FSA outside office hours;
- Incorrect details recorded on the FSA web site and not corrected in a timely manner. (Provision of information to the FSA from retailer, manufacturer and ingredient supplier led to confusion and over-reporting of affected products.);
- Information was accepted by the FSA for the web site from persons other than the 'brand holders';
- The lack of co-ordination, co-operation and uniform approach between the various EU member states caused major problems for the industry, particularly those who supply products across Europe or who operate in several Member States; and
- For example risk assessments carried out by some Member States were not taken into consideration by other Member States, leading to confusion within industry. So in some Member States product recalls were required whereas in other Member States this was not the case.

4.0 What would you do differently if faced with another large scale incident tomorrow and what could others do differently in future?

As a Trade Association:

- As a trade association within FDF, SSA would link into the FDF incident management team (which was formalised following the Sudan crisis); and
- We would work harder to seek to establish a common pool of 'confirmed' information for the members.

Requirement from the Authorities:

- **See below**

5.0 In the light of all this what are the lessons that can help all those involved with food incidents in the future?

- There is a need for information from all National Authorities to be clear, concise and consistent;
- EU approved test methods are essential;
- Unless there is an immediate, serious, acute food safety risk, consultation should take place between Member States and trade and retail bodies to develop a consolidated, co-ordinated and proportionate risk assessed position;
- This should be agreed and binding across EU Member States;

- Known risks should be identified to industry together with associated proportionate recommendations for action;
- The media should be involved once a proportionate response has been developed, so that they are in a position to present to the consumer an accurate and balanced report of the incident and provide fast dissemination of vital information to the consumer;
- EU Rapid alerts (RASFF) system must be allowed to identify the source of the reported incident to relevant stakeholders to ensure the fastest possible response to minimise consumer risk. In any major incident it is essential that supply lines can be verified as free from contamination as soon as possible;
- Information flows need to be managed to ensure systems do not become overwhelmed. For example, it may be useful to have dedicated personnel and telephone contact numbers for those companies 'involved' in a recall and a separate number for 'general enquiries';
- It goes without saying that traceability systems need to be very robust, both internally and externally. SSA members already had very effective systems; however the incident reinforced the need for this information across the wider industry;
- Whilst we can disseminate information to our members, industry led communication with businesses which are not members of the trade association is not possible. Information and advice can only be communicated to local businesses through Local Enforcement Authorities via the FSA; and
- SSA members have always shared market intelligence and are now moving towards a "horizon scanning" approach - in line with other organisations.

6.0 What challenges does sourcing of ingredients/products from around the world present and how can the safety of UK consumers best be protected as a result?

- The possibility of fraudulent activities will always be present. This risk not only relates to products from developing countries but also occurs inside the EU;
- Whilst from the UK perspective, the standards applied to food products imported from around the world must be the same as those for foods originating in Europe, it must be understood that local standards and legislation may be different. This is not only the case in instances of trade with developing countries, but is also an issue with developed countries outside Europe e.g. USA;
- Many spices are produced by small-scale farmers / growers and it can be difficult to reach and communicate with these individuals due to distances, language barriers and literacy issues;

- SSA therefore believes that it is essential that importers fully understand their supply chains. This includes knowing precise details about the product they are purchasing, the supplier of that product and the limitations of both;
- SSA recommends that following a risk assessment appropriate controls should then be established, for example:
  - robust intake testing and
  - supplier audit visits where appropriate
- SSA recommends that long term trading relationships should be built with suppliers to develop and maintain confidence;
- SSA also recommends that supply chains should be as short as possible;
- There is also a need to engage at Governmental level with producing countries as effective control on exports by the relevant authorities at source is required. This may require assistance from EU authorities; and
- SSA members already encourage overseas suppliers to develop effective traceability systems and to adopt HACCP principles and formally accredited quality systems.

Annex A (viii):

UNBAR ROTHON LTD

Submission to the Sudan 1 Review Panel

1. My name is William Rothon and I am the Chairman and Managing Director of Unbar Rothon Ltd. These comments are mine and represent the position as seen by my company. The company sells seasonings, herbs, spices and other food ingredients to the food manufacturing industry. I have worked in the company since 1969 having gained a degree in Food Technology. I am also a Director of World of Spice Ltd., a wholly owned subsidiary of Unbar Rothon Ltd. I am a Fellow and an Honorary Fellow of the Institute of Food Science and Technology, a Member of the Royal Society of Chemistry and a Chartered Scientist.

2. The supply chain in the Sudan 1 incident was from East Anglian Food Ingredients Ltd to World of Spice Ltd to Unbar Rothon Ltd to Premier Foods.

3. Annex A of the FSA letter of 19th April inviting comment asks that various questions be addressed. As you can appreciate, I have been, and still am, closely involved in all that occurred. I have devoted most of my time since February 2005 into researching all aspects of the incident as well as being closely involved in the resulting litigation. I will not dwell on the effect that this has had on me and on my company beyond stating that it has already fundamentally changed my life and the prosperity of my company.

4. Because litigation is still outstanding, my comments have been checked and amended, as necessary, by my legal advisors, If you require additional information it might not be available for a public hearing at this time. My comments are arranged in chronological order.

5. In 1995, a paper was published in the Indian Journal of Food Science and Technology describing the adulteration of spices in India (J. Food Sci. Technol., 1995, Vol.32, No.5, 373-376). The article describes the examination of spices for sale in rural areas of India and includes positive findings of several dyes in various spices, including Sudan 1 in chilli power and Metanil Yellow in turmeric. One of the problems when dealing with adulterants is knowing what to look for. This is an example of valuable information that was not used to alert or further check the extent of the problem. If it was restricted to the rural spice supply at that time it would have been an early warning to stamp the practise out. It is possible that Sudan 1 contamination had been common practise for home and export trade for many years. The paper should at least have come to the attention of the Indian Authorities and of the Indian Spice Board. Perhaps the French discovery of contamination in May 2003 was a result of this paper I have been unable to find out why the French test was carried out. We now have information transfer through the European Rapid Alert System. Should attempts be made to extend this exchange of information outside Europe? Such a scheme could certainly warn the Authorities of an emerging adulterant problem. (The Indian paper was brought to my attention after February 2005)

6. In June 2003, the potential contamination of chilli powder was first brought to my attention. In conversations with Premier Foods and with Campden and Chorleywood Food Research Association (CCFRA) it was established that CCFRA had been instructed to use the (then) official method of analysis for colours by the FSA. This meant that the natural pigments would be detected at the same time as, and inseparable from, oil soluble contaminants, guaranteeing a positive result

that indicated possible contamination. We had no knowledge of the levels that might occur and we only had a 5 gram retained counter-sample of the chilli powder that was subsequently found to be contaminated. We developed an in-house test but, because of the small amount of sample, our sensitivity was only 200 ppm of Sudan 1. The basis for the test was approved by the client because at that level there would be well below 1 ppm in the final Worcester Sauce — an insignificant amount below the level of detection. At that time CCFRA could have detected the contamination in the chilli powder if they had not been tied to the official method. Why did the FSA insist on the use of an official method knowing that it did not work? At that time the contaminated chilli powder was pickling in barrels at a factory in the Manchester area and could have been destroyed at a thousandth of the subsequent cost and before any of it had reached the public.

7. It is questionable why it took so long to approve and publicise an analytical method A temporary screening test for any azo dye contamination would have been better than the lack of timely guidance that resulted. I believe that the first guidance was in February 2004, 8 months after the EU legislation on the control of contaminated chilli came into force (Official Journal of the EU L154/1 14 — 115 published 21.06.2003). CCFRA could have detected Sudan I as early as July 2003 and Eurofins were analysing it commercially in August 2003.

8. The decision to initiate a recall was contentious at the time and I query how it was reached in light of the risk assessments that were available and the reaction of other European Member States. I am not a toxicologist but there were a number of experts in the field who thought that the recall was unnecessary. My concern is that the FSA did not carry out a balanced safety risk assessment. I have been told by my legal advisors that the FSA has no duty of care to the food industry. Additionally the FSA states "the risk of loss of consumer confidence in the regulatory system" as being a key principle in deciding whether to intervene. Taking these two statements together I do not believe that (in circumstances of doubt) the FSA is capable of carrying out an unbiased safety risk assessment and that its use of Food Safety legislation to enforce action in such circumstances could therefore be regarded as an abuse of its powers.

9. I am concerned that the FSA should consider it appropriate to carry out the review at a time when there is still outstanding litigation. The statement in the FSA letter of 19th April announced its "intention to review the Sudan 1 incident upon completion of any legal action". I wish that that statement was true! I am expecting litigation to continue for at least 12 months if not longer.

10. Although incident handling can be described in relation to a list of potential principle activities, in order to learn fully from the Sudan 1 incident it would seem obvious to me that the key parties involved should be drawn into the discussion. Otherwise the findings are likely to be flawed. I can state that at no time since February 2003 has the FSA made a direct approach to me or any member of my company in order to obtain information. Discussions with Essex Trading Standards, which might have been at the instruction of the FSA, were confined to traceability and ensuring that all of the contaminated material had been accounted for. I am therefore greatly concerned that even at this late stage there has been no direct attempt by the FSA to find out if we can contribute useful information. I believe that the FSA needs to address its attitude towards those parties that are directly affected by its decisions. As stated the FSA owes me no duty of care but that should not be translated into a communication vacuum.

WL Rothon

4th May 2007

Annex B

Written comments from the enforcement sector

Annex B (i) (a)

Our ref GMJ/JM/6235

11 May 2007

Professor Douglas L Georgala
Chairman, Sudan 1 Review Panel
Food Standards Agency
Aviation House
125 Kingsway
London WC2B 6NH

Chartered Institute of Environmental Health

Dear Professor Georgala,

Sudan 1 Review Panel

The Chartered Institute of Environmental Health (CIEH) welcomes the opportunity to discuss with the Panel its direct experience and that of its members of the Sudan 1 incident. The CIEH will be represented at the meeting on 24th May 2007 by Mrs Jenny Morris, the Food Policy lead.

In order to assist the Panel in determining areas for discussion at that meeting , brief written comments accompany this letter.

Yours sincerely

Graham Jukes
Chief Executive

Direct line 020 7827 5836
Direct fax 020 7827 5831
Email g.jukes@cieh.org

Annex B (i) (b)

Sudan 1 - Review Panel

Written comments from the Chartered Institute of Environmental Health

Executive Summary

The Chartered Institute of Environmental Health was involved in the Sudan 1 incident both directly through its Policy team and also through the work of its members enforcing food control in local authorities.

Whilst acknowledging that the incident was on a much greater scale than previously experienced, it exposed certain flaws in the effectiveness of the response mechanisms. In regard to the Food Standards Agency these were particularly around effective communication and co-ordination, especially in relation to certain parts of the local authority community.

For the future, contingency plans agreed with key stakeholders, identifying roles and responsibilities might ensure more effective action and reduce the likelihood of varying interpretation of expectations.

Effective and timely traceability of foodstuffs will always be a key component of any withdrawal or recall process. The appropriateness of current arrangements might merit further investigation.

Sudan 1 - Review Panel

Written comments from the Chartered Institute of Environmental Health

1. Founded in 1883, the Chartered Institute of Environmental Health (CIEH) is a registered charity, dedicated to the promotion of environmental and public health and to encouraging the highest possible standards in the training and the work of environmental health professionals. Its mission is to *"Maintain, enhance and promote improvements in public and environmental health"*. CIEH has over 10,000 members in England, Wales and Northern Ireland, working in central and local government, the health services, non-governmental organisations, private sector companies and the armed forces. The majority work in the public sector and many will be involved in food control enforcement.

2. The Chartered Institute of Environmental Health welcomes the opportunity to contribute to the Sudan1 Review panel's considerations. The experience of the incident will be addressed below, both from the involvement of CIEH staff and from the perspective of members generally involved in actions arising from the contamination.

Question 1 (a): What was your impression of the 2005 incident?

3. Answer: The lead CIEH food policy advisor, along with a LACORS advisor, was called to the Food Standards Agency shortly before the initial "Sudan 1 Contamination of Worcester Sauce Information letter" was issued to local authorities. The stated intention was to discuss likely problems for local authorities, arising from the potential need to assist in a large scale withdrawal and recall of contaminated food products i.e. as a result of any subsequent Food Alert. At that meeting it was proposed that any action to assist in the removal of products from the market should be undertaken by both Trading Standards officers and Environmental Health officers, in light of the scale of the incident. CIEH and LACORS both supported this proposal and suggested that the need for a joint approach should be explicitly identified in the initial Food Alert. This recommendation was made in light of the fact that protocols set out in the Food Safety Act Code of Practice indicate that where issues involve chemical contamination, in two tier authorities, the matter should be investigated and enforced by County Council Food Authorities. The Code further states that in situations where there is a clearly defined health risk, responsibilities for action will be defined in the Food Alert, which supports the abovementioned recommendation.

4. It was accepted that, at the time of the meeting, the extent of the contamination had not been fully determined but it was strongly recommended that in light of the emerging scale of the incident, all local authorities (Las) should be provided with timely information to address enquiries and concerns that were likely to arise, from both the public and the media. (It is noted that the FSA were at this stage in contact with local authorities thought to have received affected Worcester sauce) Unfortunately neither of these suggestions appeared to have been fully implemented. The consequences of this were that, in the first matter, different approaches to investigation and enforcement were taken in different areas. Some involved both Trading Standards (TS) and Environmental Health (EH) staff, others only TS staff and consequently capacity for action and the burden on the authorities was inconsistent. CIEH members working in local authorities have commented about a general lack of clarity in the Food alerts issued, the intention of the Agency regarding officer involvement being a case in point.

5. Alongside this the lack of timely warning to Las, sufficiently in advance of the press release providing details of the contamination, resulted in some only becoming aware of the incident when they were contacted by media over the weekend. This did not promote media or public confidence in the authorities' ability to "protect public health", nor improve partnership relationships between the Las and the FSA.

6. The CIEH food lead was requested to participate in a range of media interviews on the subject of the removal of product from sale, which questioned the ability of enforcement officers to provide the appropriate level of public protection. Whilst the incident was always likely to garner media interest the fact that local

authorities were not fully prepared for the scale of the issue had the opportunity to dent public confidence in their ability to act effectively. This to some extent was exacerbated by the initial approach of an information letter, on a Friday afternoon. A Food Alert for Action was issued on the following Monday but the better approach might have been to issue an Alert at the outset, thus advising Las about the action they should take to assist in a swift and effective removal of product from the market.

Question 1 (b): What went well?

7. Answer: From the CIEH perspective the opportunity to engage in discussions with the FSA as the incident unfolded should have been beneficial in avoiding certain pitfalls.

8. From members' perspectives the incident provided a robust challenge test to their incident response mechanisms. In general these were seen to be effective across and between Las, with specific comments from members in single tier authorities about the effectiveness of partnership working between environmental health and trading standards professionals.

Question 1 (c): What could have been done better?

9. Answer: The opportunities offered by engaging with CIEH and LACORS at an early stage were not exploited i.e. practical suggestions for improving the process did not appear to be taken up.

10. A key issue raised by local authority members was the general lack of clarity across the event. This applied to expectations around involvement i.e. TS/EH or both and to the rapidly changing lists of contaminated products. In relation to the latter, comments were made that regular updating of businesses about the product list was difficult and costly, raising queries about proportionality of action and thus resulting in differing levels of activity. Whilst there are likely to be difficulties in establishing affected products in a contamination of this scale, better identification mechanisms would assist the process.

Question 2: What would you do differently if faced with another large scale incident tomorrow and what could others do differently in the future?

11. Answer: CIEH and its members will seek to assist in incident control. CIEH is developing contingency planning materials for its own operations and is assisting members in understanding good practice through sharing information. A "formal contingency plan" for large incidents, set up between the FSA and local authorities and other key stakeholders might assist in delivering effective and timely responses.

Question 3: In light of all this what are the lessons that can help all those involved with food incidents in the future?

12. Answer: Past incidents offer the opportunity for learning and as a consequence findings should be fully shared. It is hoped that the FSA will share information previously gathered from local authorities on action taken in respect of the Sudan 1 incident, as well as any learning to be gained from other large scale incidents.

13. Outside this the following comments are made in relation to future approaches. Partnership action should be adopted wherever possible. For local authorities early warning, albeit with areas of confidentiality clearly identified, should be the norm in large scale incidents. In such circumstances local authorities will be subject to considerable pressure from local communities and the media and opportunities for early activation of contingency plans will assist in effectively ensuring necessary actions can be carried out.

14. Developing effective partnerships with business, to facilitate the sharing of information and intelligence might also assist in prevention of incidents. The FSA action in setting up a multiple stakeholder Food Incidents Task force is commended for adopting the partnership approach, together with ongoing initiatives such as the recent international workshop on food incidents and the establishment of this panel. It is hoped that all the outcomes from these initiatives will be fully shared and widely promoted, without this good practice and learning opportunities may be lost.

15. One specific issue emerging from the Sudan 1 incident and further identified at the international workshop was the key importance of effective traceability. The appropriateness of current guidance and/or legislation might merit review to ensure that measures are appropriate to ensure effective and timely identification of contaminated products in all circumstances, particularly for cases such as the Sudan 1 incident involving a wide product range with extensive distribution.

16. A key consideration in any incident must always be good, concise communication of appropriate information to relevant stakeholders. For local authorities this should involve clear information on the risks posed and the appropriate risk management strategy for action at the earliest possible stage.

Question 4: What challenges does sourcing of ingredients/products from around the world present and how can the safety of UK consumers be best protected as a result?

17. Answer: There are potential conflicts arising from the wish to encourage developing nations to trade on the global market and balancing this with the need for proportionate public protection. Food safety controls are likely to be more difficult in large agrarian economies where producers are very small and independent with fragmented overarching food safety co-ordination. Effective implementation of

HACCP based systems would appear to offer the best approach but the need for testing to validate systems should be consistently re-iterated to manufacturers and to importers into the European Union (EU). Ensuring that sufficient risk based sampling can be carried out by enforcement officers at points of entry will be a key tool in validating the control systems of producers. Funding mechanisms to support this will need to be ensured as well as a sufficiency of suitably equipped and appropriately staffed laboratories to undertake the relevant testing. Currently concerns are being expressed by Public Analysts about the sustainability of their services and the reconfiguration of the Health Protection Agency Food, Water and Environment laboratories may also bring additional challenges. These issues should be addressed/ kept under regular review.

18. Given that entry into the EU can happen at many points partnership working with other Member States across the EU should be a key goal to ensure consistency in the application of common standards.

Annex B (ii)

Robert Taylour
Head of Trading Standards
Derbyshire County Council
Trading Standards Division
Chatsworth Hall
Chesterfield Road Matlock
DE4 3FW

Personal Detail

1. I am Head of the Trading Standards Service in Derbyshire and have overall responsibility for the enforcement of Food Standards legislation by authorized officers of this Division.

Background

2. As background this service was contacted by Colin Houston, the then Deputy Head of Enforcement Division of the Agency, in writing on 19 December 2005. The purpose of this correspondence was to detail the circumstances surrounding the manufacture and supply of Branston Spicy Pickle, allegedly contaminated with Sudan 1, in Derbyshire in 2003.

3. Information had been obtained by other local authorities, in particular Rochdale MBC, as well as by the Agency directly from Premier Foods, which showed that Premier Foods had ownership of a factory at Hadfield in the north of Derbyshire for approximately a year up until late 2003, and had used contaminated Chilli Powder, linked to other batches of contaminated product subject to the investigation, in August 2003.

4. A meeting was subsequently held with David Walker, working on behalf of the Agency, to discuss the various options available to both parties, and to Lincolnshire Trading Standards, who had become involved in the enquiry. As a result it was determined that Derbyshire Trading Standards would conduct their own enquiries into the circumstances of production at Hadfield, in conjunction with Lincolnshire, who were considering various statements made by the company (from their effective Head Office) relating to the Pickle manufactured at Hadfield.

5. Lengthy enquiries were carried by an officer of this Division, analyzing information passed on from other authorities, and also acquired under powers by this Division.

6. The Agency were made aware of the outcome of the enquiries which concluded that we were not able to establish beyond reasonable doubt that the directing mind of the company knowingly sold or supplied contaminated product.

Comments

7. It remains unfortunate that a period of 10 months elapsed between Premier Foods contacting the Incidents branch, during February 2005, and notifying them of the additional product used at the Hadfield factory to the letter to Derbyshire Trading

Standards. It is clear that information was available to the Agency at that point which would lead them to contact this Department, but regrettably it was December 2005 until we were alerted to possible offences in Derbyshire. This 'delay' was noted, and commented on, by Premier Foods in correspondence between the authority and the company. In the view of this authority it became a major mitigating factor against proceeding further. Contact was made with this Department at a time when the initial investigation and findings of Rochdale MBC were becoming clear (where a decision was made not to proceed).

8. Whilst we would acknowledge it is the case that a balance must be retained between protecting rights of any potential defendant and the need to protect the public we have concerns regarding the route by which some information was passed to this authority from the Agency. It could be considered that the volunteering of information to the Agency by Premier, or any other company, which subsequently becomes subject to legal scrutiny within a formal investigation by a food authority, may raise issues regarding that organisation's legal rights.

9. The role of David Walker, working on behalf of the Agency at the time of notification to this Department, became unclear following our initial contact and meetings. Mr. Walker had obviously put extensive efforts into the broader investigation, and was extremely keen to encourage both Lincolnshire and Derbyshire to carry the investigation forward. However little, if any, subsequent contact was received after the initial liaison period. Whilst the Department values the fact that the Agency was content to let investigations progress without any direct intervention, this lack of contact from Mr. Walker, or the Agency in general, throughout our investigation raised concerns as to the perceived status of our enquiries.

10. The provision of a European-wide opinion, regarding 'permitted' levels of Sudan 1 in foods (0.5mg/kg) before a withdrawal should occur (reference ENF/E/06/046) during our investigation raised issues, and comment from Premier, given the levels found in the company's own tests. Whilst the opinion suggested that it related to raw material levels of Sudan 1, rather than finished products, this was not particularly clear in the document. There were also concerns that the initial toxicological opinions regarding consumption of the affected foods and associated low risk levels were not helpful

when trying to establish offences for unsafe/unfit food, or food not of the quality demanded. Greater clarity and/or guidance on the maximum permitted levels of the contaminant in the finished product and the associated risk would have been helpful.

11. The investigation into the actions of Premier Foods and potential offences in a number of authority areas did raise issues of how best to investigate problems of this nature. There was a potential conflict between ensuring that the rules of evidence were followed whilst at the same time minimizing the burden on the company to respond to three separate investigations. Whilst I appreciate that the FSA attempted to broker a joint investigation and the sharing of evidence, this did not seem to happen for whatever reason.

12. Whilst I accept that it was entirely appropriate for Derbyshire Trading Standards Service to conduct a criminal investigation into alleged offences in Derbyshire, there was a perception that the Agency felt that a prosecution should be initiated. This perception was reinforced by negative comments expressed by the Agency of local authorities that were made public. This was regrettable and also seemed at odds with the government's stated desire to reduce burdens on business and to find alternative remedies to that of initiating legal proceedings. The decision as to whether or not to prosecute is, of course, for the local authority to decide upon and I am grateful that the FSA supported the decision that Derbyshire Trading Standards Service came to.

Recommendations

13. That relevant information, made available to the Agency, should be discussed with the originating authority for any connected offences as soon as possible. Any delay in this process can be regarded adversely by interested parties, particularly potential defendants.

14. That some thought is given to evidential considerations where documents and information are provided to the Agency. Difficulties could arise where a business volunteers information which could become evidence in a case against them. In the same light industry needs to recognize that legislation, in particular the General Food Regulations 2004, require certain actions in the event of breaches of the food safety requirement. The information that a business may be required to provide by law, must be provided to 'competent authorities' – this includes both the Agency and local authorities.

Robert Taylour

10th May 2007

Annex B (iii) (a)

Our Ref : LJB/LJB/Q18.1/170507SINC

Mr R Sinclair
Food Standards Agency
Room 515c
Aviation House
125 Kingsway
London WC2B 6NH

17 May 2007

Sudan 1 Review Panel : Call for Written Comments

I refer to your letter dated 19 April 2007 (Your ref : CMA 03/366) inviting written comments to inform the review of the Sudan 1 incident.

LACORS comments, which also reflect those of the individual local authorities closely associated with this incident are set out in the attached paper structured and formatted as requested.

If you have any queries or require clarification of any point please do not hesitate to contact me.

Yours sincerely

Les Bailey

Policy Officer – Food
e-mail : les.bailey@lacors.gov.uk
Direct Dial : 020 7665 3862

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Annex B (iii)(b)

SUDAN 1 REVIEW PANEL: LACORS COMMENTS: 17 MAY 2007

Executive Summary

1. LACORS view is that the liaison between the FSA and the Home Authorities and Originating Authorities did not work well which created problems and additional and avoidable resource burdens for those authorities.

2. LACORS was not able to contribute to and therefore had a poor understanding of the risk assessment carried out by the FSA. It is also therefore difficult to fully understand how this assessment influenced the subsequent risk management of the incident by the Agency.

3. The media facing view of the FSA that prosecutions and wholesale withdrawal should be the prime focus of enforcement authorities hindered a more constructive approach in partnership with industry interests.

4. LACORS would welcome more transparency in relation to the FSA risk assessment and risk management procedures and early involvement in the scoping and required action in relation to future incidents.

5. Consideration should be given to the development of a formal contingency plan to provide clear guidance on standard communication procedures between the FSA, LACORS and local authorities. This is particularly relevant if there were to be a large scale food incident.

General Comments

6. LACORS is the central local government body established by the local authority Associations to coordinate the regulatory activities of UK local authorities which includes food law enforcement. LACORS is represented on the FSA Food Incident Task Force and the Local Authority Stakeholder Group on Food Incidents.

7. The work of LACORS is underpinned by the LACORS Home Authority Principle which seeks to encourage close liaison and co-operation between individual local authorities (Home Authorities) and businesses located within their area and between individual local authorities identifying problems with food originating from outside their areas (Originating Authorities). The value of this coordinating mechanism has been acknowledged and is being developed by the Cabinet Office and LBRO.

8. The importance of the role played by Public Analysts in food incidents should be carefully considered. Liaison with Public Analysts during a food incident is as important as liaison with enforcement authorities. Public Analysts both analyse and report on food samples and provide wider scientific support which are a vital part of any food incident.

Q1. What was your impression of the 2005 incident?

9. LACORS view is that the protection of public health is of paramount importance and that careful consideration of the risk to public health should be given to ensure that the most appropriate action is taken. The FSA's approach in this case and the role expected of enforcement authorities was not entirely proportionate.

10. Enforcement authorities and LACORS did not have a clear understanding of the risk assessment applied by the FSA and how this then translated into the action required by enforcement authorities particularly with regard to the wide scale product withdrawals.

11. The boundary between risk assessment and risk management was not clear and nay possible enforcement actions were complicated by FSA media briefing implying that prosecutions would be taken against the principal food businesses involved. This briefing failed to take into account local authority concerns legal and evidential constraints including " due diligence defences ".

12. There was a lack of a clear indication of a uniform action level, although the figure of 0.5mg/kg later emerged as an EC recommendation. It is not clear if the initial FSA risk assessment was reviewed as the incident developed in the light of this and other developments. The practical difficulty of detecting Sudan 1 at such low levels also caused problems. The information from the EC also meant that the unfit for human consumption arguments may not be sustainable.

Q2. How do you feel at the time, what went well, what could have been done better?

13. The legislative controls in relation to traceability designed to assist in relation to food incidents and recalls worked well even with the large number of products and diverse distribution chains concerned. See comments under Q3, Q4 and Q5 for views on what could have been done better.

Q3. What would you do differently if faced with another large scale incident tomorrow and what could others do differently in future?

14. At an early stage in the incident LACORS would press the FSA to convene a scoping group consisting of all directly involved stakeholders, including all relevant local authorities, but especially Home Authorities and LACORS, to identify risks and agree appropriate action and liaison/information exchange arrangements.

Q4. In the light of all this what are the lessons that can help all those involved with food incidents in the future?

15. Following the experiences of local authorities during the BSE and FMD animal health incidents the lead Central Government Agency, DEFRA, has now developed in conjunction with all stakeholders, a framework contingency plan to deal with future incidents. There is merit in the FSA adopting the same approach with regard to food incidents though understandably this need not be complex. Clear planning of communication structures prevents the need for this to be done when trying to react to a serious threat to food safety.

16. The wording of food alerts/hazard warnings should be made much clearer particularly with regard to Article 14 of the EC General Food Law Regulation in terms of "unfitness" criteria. There should be better synergy between FSA Food Alerts and associated FSA Press Releases to prevent mixed messages.

Q5. What challenges does sourcing of ingredients/products from around the world present and how can the safety of UK consumers best be protected as a result?

17. The tremendous variety and volume of ingredients and products imported into the UK does present enforcement authorities with potential significant problems in ensuring that UK consumers are protected.

The main problem is in establishing what incidents may occur in relation to contaminants etc and the foods or ingredients and exporting countries which may be involved. Whilst useful intelligence is provided by the RASFF system and the developing UK Food Surveillance System further improvement in this area would be of assistance. Initial work carried out by the Association of Public Analysts in risk based food sampling is also worth further development and refinement.

18. The systems put in place by industry in terms of contractual conditions, third party accreditation and testing and certification also provide enforcement authorities with useful information.

19. Public Analysts were asked whether they could assist with the recent incident involving melamine in rice protein and wheat gluten. The outline methods provide are relatively straight forward and within the capabilities of most Public Analysts. However, there is no mechanism for funding the development and validation of these methods by Public Analysts. Recovering costs by means of fees charged to local authorities will seriously inhibit or even prevent the submission of samples for such checks. Some form of central funding may be required to remedy this situation which is likely to occur with future incidents.

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Annex B (iv)

LABORATORY OF THE GOVERNMENT CHEMIST

Government Chemist Response to Food Standards Agency Review of Sudan I Incident

The terms of reference for the panel are:

1. To identify lessons learnt by different sectors of the food chain, including manufacturers, retailers, enforcement authorities and the Food Standards Agency, from the Sudan I issue (2003-2005) and what actions have been put in place as a result

2. To advise whether there are any deficiencies in current procedures and, if so, to make recommendations

The panel may also explore how the food chain can best be protected given the underlying causes of the Sudan I incident and how the supply chain deals with intelligence, particularly when it relates to ongoing incidents over a long period of time.

The Government Chemist Response

Detection Limits and Method Validation

When the French food control authorities first detected Sudan I in chilli powder in 2003, it was a relatively new development and analytical methods had not been developed to the meet the criteria normally applied for food control purposes across the EU.

Sudan I is not permitted at any level in food. It is, therefore, a banned substance. Laboratory techniques used for control of banned substances must be fit for the purpose. It is impossible to show by analysis that an analyte is absent from a sample. There is always a minimum amount of substance that must be present before the method can actually detect it (the detection limit) and this varies from method to method and laboratory to laboratory. The method applied can show that the analyte is undetectable and is, therefore, present in an amount less than the detection limit. For a banned substance that may present a danger to consumers it can be argued that in accordance with the precautionary principle of EU food Law (Regulation (EC) 178/2002) (16), the detection limit for a method of analysis used to detect that substance should be as low as reasonably practical, taking into account the risk associated with it presence, in accordance with that regulation.

It is important to note that analytical method development and validation is a complex and expensive process. International standard protocols, and in some areas, legislative requirements exist for method validation that are designed to ensure that their operating characteristics are objectively assessed in relation to the purpose for which they are intended. Food control laboratories do not carry out such

work *a priori*, therefore, unless they have reason to consider that such methods are required and that the costs of development and validation can be recovered through the offering of services to the industry or the control authorities. It is, unfortunately, often the case that analytical methods suddenly become required urgently yet they take a considerable time to develop to the extent that they are unequivocally fit for the purpose of food control.

In the case of an emerging analytical issue, where a method needs to be made quickly available single laboratory validation is more appropriate since it can be achieved with a much shorter lead-time compared to a method validated by collaborative trial.

Zero tolerance is unavoidably related to the limit of detection for the substance in question, which can vary considerably with the method of analysis used. Thus, for banned substances the detection limit of a method is crucial. In view of this, it would have been helpful if analytical methods and their capabilities had been quickly established in the face of such an international incident. This information could have been used to set a more realistic decision limit than using the 'zero tolerance' approach, which was adopted by the UK from, 2003 – 2005. The European Commission Standing Committee on the Food Chain and Animal Health set a limit of detection (LOD) of 0.5 – 1 mg/kg for most illegal dyes similar to Sudan I in spices using HPLC on 10 May 2005. They stated that any food or food ingredients found to contain the dyes by this method should be withdrawn from sale.

Food Standards Agency Advice on Methods of analysis for Illegal Dyes

The advice from the FSA on methods of analysis in May 2005 has been, at best, confusing and, at times, contradictory. In February of 2004, the Agency made reference in a guidance note, to two HPLC methods, which were said to be known to work for Sudan I and II, together with a reminder that analysts were required by Regulation (EC) 178/2002 to use validated methods. Neither of the two HPLC methods had been validated, but had been offered for collaborative trial in September 2003. In the meantime, in the absence of validated methods and to improve detection limits, stakeholders were developing methods based on HPLC-MS. Over three years later, no report on the collaborative trial has ever been published.

On 3 May 2005 Dr Clair Baynton of the UK Food Standards Agency (FSA) requested a product recall of food found by HPLC-MS to contain Para Red at 200 or so parts per billion, considerably below the detection limit for Sudan dyes using HPLC with UV detection. She then issued a letter to "Interested Parties" on 19 May 2005, in which she provided an up-date about recent developments concerning analytical methodologies for industrial dyes in spices and other foods, particularly the recent findings for Para Red. In the letter Dr Baynton expressed the opinion that the HPLC method had become the standard method for detecting Sudan I and related dyes. She commented on the fact that LC-MS methods had been used more recently to provide results for Sudan I and Para Red and went on to report that, according to the

initial work of the "Working Group" (European Network - the Illegal Dyes Analytical Network (IDAN)):

- LC-MS methods were not available in many laboratories;
- LC-MS methods showed considerable variability between laboratories analysing the same samples; and
- LC-MS methods could produce false positive results at low levels.

Dr Baynton then went on to advise that, in the light of these developments, the recommended method for the detection of Sudan I and Para Red should be the HPLC method.

We have not been able to find any published preliminary results from the IDAN Working Group that supported the second point. If, as she suggested, the method was not available in many laboratories it is difficult to understand how meaningful data could have been obtained. In fact, the most recent report from the IDAN (December 2006) came to the opposite conclusion from that expressed by the FSA i.e. LC-MS was found to be superior to HPLC methods on the basis of the evaluation so far, especially at lower levels and when standard additions are used.

We were unable to find any published reference at the time of the FSA letter to evidence that LC-MS, as applied to the detection and quantification of illegal dyes in chilli, was subject to false positives. Again, the IDAN report concluded that it is relatively rare to get false positives. We were not aware of any issue with false positives in relation to method development that was being carried out at this time by LGC. However, in Appendix 2 of the Dec 2006 report from the IDAN there is a comment about the LC-MS method from one laboratory of the eight that used this technique that "at these levels of detection [about 10 μg/kg], the possibility of false positive results remains an important issue, so additional clean-up steps have been introduced, based upon solvent partition and solid phase extraction (SPE) to remove isobaric interferences". Without any detail it is not possible to evaluate the basis of this opinion.

Any analytical method for trace contaminants has the potential to report false positives and this risk is assessed and managed by analysts in the development and validation process. The only work published at the time of the incident using LC-MS of which we are aware (a method published by Calbiani et al, 2004) makes no reference to problems with false positives. In the absence of any documented evidence to the contrary we can only assume that the statement about false positives in the letter was anecdotal or based on the unpublished comments.

The comment from Dr Baynton that the LC-MS method could be subject to false positives was not supported by reference to a publication in a peer-reviewed scientific journal. This comment on methods has certainly been shown, with the benefit of hindsight from the work of the IDAN, to have been questionable.

This advice from the FSA was based on analytical findings, apparently without full knowledge of the issues related to the analytical methods in use by industry and enforcement stakeholders. The result has been costly disputes between suppliers and manufacturers which have focused clearly on the confused advice given by the FSA on the methods used to detect and quantify illegal dyes in foods.

Recommendation

The Food Standards Agency should foster a market place for a rapid response from laboratories in such circumstances so that decisions taken can be best informed by good analytical science. The FSA could have a pre-agreed specification for this, based on the international harmonised protocol that exists for single laboratory validation, to which laboratories could respond.

21 May 2007

Annex B (v)

Trading Standards Service
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For the attention of Richard Sinclair
Food Standards Agency
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125 Kingsway
LONDON
WC2B 6NH

Our ref: pjh/pja

Your ref: CMA 03/366

10 May 2007

Dear Sirs

Lincolnshire County Council

Written Evidence to the Sudan 1 Review Panel

1. As background to the evidence which Lincolnshire County Council's Trading Standards Service wishes to submit regarding the above matter, this authority first became involved in this problem in February 2005. At that time it was informed by Premier Ambient Foods (UK) Ltd, for which it is Home Authority, that a laboratory in Italy had detected Sudan 1 dye in Worcester sauce manufactured by the company in the UK. In response to this information this Service's Home Authority Liaison Officer advised them to report the matter to the Food Standards Agency. This resulted in the recall of a large number of products during the first half of 2005.

2. This authority's initial investigation into the matter at that time concluded that there was no basis for Lincolnshire County Council to take action against the businesses involved because the products concerned had not been manufactured or supplied within Lincolnshire. There were, therefore, no offences within Lincolnshire County Council's jurisdiction that could be investigated or prosecuted. Lincolnshire's Trading Standards Service did, however, participate extensively in the overall investigation of this issue and the subsequent recall of products.

3. At that time Lincolnshire's Trading Standards Service was made aware that other local authorities, including Rochdale Metropolitan Borough Council and Essex County Council, were also investigating the matter with regard to possible offences under the

Food Safety Act 1990. Those authorities, during the course of their investigations, obtained information and documents which, after being viewed by a representative of the FSA, were thought by that representative to disclose possible offences under Section 1(1)(a) of the Trade Descriptions Act 1968. The FSA then brought this information to the attention of this authority and Lincolnshire County Council conducted an extensive and thorough investigation of those alleged offences.

4. The conclusion of that investigation was that, for a variety of reasons, a prosecution for any of the alleged offences would be unlikely to succeed. In its considered opinion, and on the advice of Counsel, there were both legal and evidential difficulties which would need to be overcome for a prosecution to succeed. Even if sufficient evidence of offences under the Trade Descriptions Act 1968 had been found, and it had not, Lincolnshire County Council considered that it would not have been in the public interest to prosecute. It did not, therefore, take any formal action.

5. This authority strongly believes that important lessons need to be learned by all involved. Although this incident created a public scare relating to the safety of hundreds of food products it was, in fact, an excellent example of regulation and traceability working well. However, the opportunity to show regulators and responsible businesses working together to protect the public, even when there is little or no evidence of risk to the individual consumer, was lost.

6. In the eighteen months prior to the major recall in 2005 which is the subject of this review, numerous withdrawals of products contaminated with Sudan 1 had been instigated by the FSA. These related to spices directly contaminated by Sudan 1 and recalls were conducted at a low level, without unnecessary concern for public safety. They were undertaken without extensive media involvement or pursuing a policy of formal action against suppliers. Most of the local authority alerts on these incidents issued by the FSA were “For action as deemed necessary” and some were “For information only”. Suggested actions included removing products from shelves, using powers if necessary. When the businesses involved had not notified their customers of the problem, local authorities were asked to consider doing some local publicity to alert consumers who may already have purchased the product. The main difference with this new event was its scale in terms of the number of products affected, albeit at very much lower levels of contamination than many of those which were the subject of earlier alerts. However, the considerable number of products involved attracted media interest and the FSA’s position on pursuing formal action seemed to change.

7. All local enforcement authorities have published enforcement policies, devised in accordance with the Enforcement Concordat, and with which they must abide when taking prosecutions. Prosecution is only one of the tools available to local authorities in order to protect their communities and it needs to be used with care and always as a means of serving the public interest.

8. All the above factors needed to be considered before any indications were given regarding the actions which local enforcement authorities would take. Despite this, the wording of information on the FSA website implied that local authorities were investigating with a view to prosecution. As a result, Lincolnshire received, and continued to receive until recently, media enquiries about which company it is going to prosecute and when.

9. In addition to the implied prosecution of the producers of the contaminated food, the FSA, during the recall period, announced a "policy" of prosecuting retailers who failed to take affected products off their shelves by a certain hour. This was announced at the very time when this authority was writing to retailers advising them of products affected and asking them to contact it for advice if they were in any doubt. The retailers were "victims" of this issue and their help and co-operation was needed. In reality, there was never any possibility of a retailer being prosecuted because of both evidential and policy issues. Therefore, while the announcement of a deadline by the FSA may have had the intent of helping enforcement authorities deal speedily with the matter, it was, in fact, empty as a threat, counterproductive as a means of recall and placed enforcement authorities in a very bad light with local, small businesses. Discussion and negotiation with the local authority enforcement representatives could have avoided that situation while, in partnership with the FSA, they could have continued to pursue an effective and speedy recall.

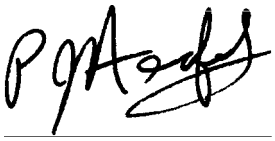
10. This authority recognises and fully understands that dealing effectively and responsibly with an issue related to the safety of food, affecting so many products, has been extremely difficult. The duty of all authorities and agencies to protect the public is, of course, paramount. While everyone accepts that action in these cases needs to be proportionate, the perspective of various interested groups as to what is "proportionate" will vary.

11. It is also accepted that effectively communicating issues of extremely low level risk to the public via the news media is an almost impossible task. In these circumstances the FSA and local authorities are faced with the need to strike the right balance between being seen to act while not creating unnecessary concern. Once the media is involved, achieving that balance becomes even more difficult and detailed control is not possible. This is all the more reason why close liaison and discussion between all enforcement agencies should take place at the earliest possible stage when dealing with such issues.

12. The problems caused by the Sudan 1 contamination of spices is now, hopefully, at an end. However, similar issues continue to arise and indications are that not all the lessons regarding the importance of close partnership working and early consultation between our respective organisations have been learned. Lincolnshire has recently been involved in a meeting with LACORS and the FSA to discuss local authorities' continuing concerns about food incident handling which included an example from

Lincolnshire. Originating, home and investigating authorities should be involved in planning the response to an incident after the scientific risk assessment has been carried out. It is important that the FSA and local authorities agree strategies and take joint decisions on actions needed at an early stage. Only when the correct mechanisms to achieve this are fully in place, are understood and followed by all, will we ensure that the public are adequately protected in a proportionate manner.

Yours faithfully



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Annex B (vi) (a)

ROCHDALE METROPOLITAN BOROUGH COUNCIL

Roger Ellis
Chief Executive

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Your Ref:
Our Ref: CE/2550/CMT
Enquiries to: Roger Ellis
Telephone: 01706 925401
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Date: 10th May 2007

Dear Mr Sinclair

CALL FOR WRITTEN COMMENTS – SUDAN 1 REVIEW PANEL

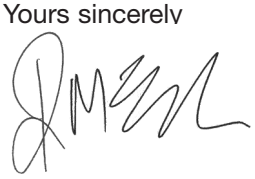
I refer to your letter dated 19th April 2007.

As you will be aware, this Authority was involved in a twelve month investigation into possible offences by the manufacturer of the Worcester Sauce, one of the products which was at the centre of the incident being examined by the review panel. We would like to put on record our concern that we have not been given the opportunity to discuss our involvement with the panel, particularly given the depth of this investigation and our extensive contact with the Agency.

As requested, please find attached this Authority's comments in relation to the incident and in particular our views on the points set out in the Annex attached to your letter.

If you have any queries or require clarification of any of the issues raised, please contact either Allan Watson, Food Safety Manager or Michaela Monk, Principal Trading Standards Officer, telephone 01706 924147 or 01706 924256.

Yours sincerelv



Roger Ellis Chief Executive

Annex B (vi) (a)

SUDAN 1 REVIEW PANEL

COMMENTS OF ROCHDALE METROPOLITAN BOROUGH COUNCIL

Executive Summary:

Rochdale Metropolitan Borough Council was involved in the incident as the food authority responsible for enforcement of legislation in relation to the production and placing of the market of the Worcester Sauce contaminated with Sudan 1. This product led to the issuing of a Food Alert and the withdrawal from sale of substantial quantities of food during February and March 2005

Our overall impression of the Agency's handling of the incident was that it lacked leadership, was uncoordinated and took place without adequate communication with the relevant parties from the outset. It would appear that the product withdrawal took place without an adequate risk assessment having been carried out and without reference to the approach being taken in other member states.

This Authority believes that it came under undue pressure from senior officials in the Agency to commence legal proceedings against the manufacturer of the Worcester sauce, despite this not having been shown to be justified either evidentially or scientifically.

We believe that revised procedures should be put in place by the Agency for the handling of future incidents and that these should include adequate risk assessments and coordinated arrangements for liaising with food authorities and other parties.

Detailed Comments

Q1: What was your impression of the 2005 incident?

How did you feel at the time, what went well, what could have been done better?

1.1 Our overall impression of the Agency's handling of the incident was that from the outset it was uncoordinated and took place without adequate communication with the relevant parties.

1.2 As the local authority in whose area the contaminated Worcester Sauce which lead to the withdrawal of large quantities of food was manufactured, we were not adequately involved in discussions prior to the initial announcement to local authorities on 18 February 2005 or the subsequent issue of the Food Alert (Ref: 09/2005). In addition, permission was given by the Agency for the manufacturers Premier Foods to recommence production of the product without any consultation with ourselves.

1.3 From the information provided by the Agency, it would appear that the product withdrawal took place without an adequate risk assessment having been carried out. During 2005 we requested this information on numerous occasions, but it was never provided. Had it been available, this information would have played a fundamental role in the investigation carried out by this authority.

1.4 On 21 February 2005 we were asked by the Agency to ensure that an effective withdrawal of the affected products had been carried out. We were advised by the Agency on several occasions that this was to be done on an informal basis and that there was no need for the authority to carry out a formal investigation. However, on 6 April 2005 the Agency requested that the Authority carry out a detailed investigation with a view to a "potential prosecution" of the product manufacturer. This raised a number of concerns which were discussed in detail with the Agency during a meeting at these offices on 21 April 2005 and which are set out in Appendix 1 of our letter dated 3 May 2005 (copy attached).

1.5 The implications of the investigation for this authority were enormous. It required the involvement of a Senior Trading Standards Officer and an Environmental Health Officer on a full-time basis for a period of ten months, as well as requiring a significant input from their managers, the Chief Environmental Health and Licensing Officer, the Chief Trading Standards Officer and the Council's legal advisors. There were also considerable "knock-on" effects for the rest of the Planning and Regulation Service as a result of the time that they were unable to dedicate to their normal duties.

1.6 Throughout the investigation the authority came under undue pressure from the Agency to commence legal proceedings against Premier Foods, despite the fact that this had not been proved to be justified evidentially or scientifically. In particular we refer to the enclosed letter from Adrian Watson and Andy Glover to Dr Jon Bell dated 10 February 2006 and the attached explanation of the reasons why legal proceedings were not appropriate.

1.7 The approach taken by the Agency and the pressure applied for us to launch a prosecution, placed significant and unnecessary stress on the investigating officers. In addition, following completion of our investigation, the Agency sought to criticise the decision of the delegated officers via a press release. Both of these issues are dealt with in the letter from Roger Ellis, our Chief Executive to Dr Bell dated 3 March 2006

What went well?

1.8 The level of support and cooperation provided by the other local authorities involved in the investigation was excellent. Communication between these authorities was also good.

1.9 Funding for our part of the investigation was provided from the Agency's "Fighting Fund". However, the basis of this support appeared to change late in the investigation. Whilst we were initially informed that the Agency would cover the cost of all work involved in the investigation, when we came to submit a claim for these expenses, we were advised that payment could only be made for costs for which invoices could be

provided. We would suggest that the terms of any support and arrangements for recovery of costs should be set out more clearly at the start of any future investigations.

What could have been done better?

1.10 There was a serious lack of leadership within the Agency in relation to the handling of the incident. Concerns regarding a lack of coordination were expressed by several local authorities and our demands ultimately led to meetings taking place at Aviation House. Whilst we fully appreciate that the legal responsibility for enforcement of the legislation lies with the food authorities, the Agency should from the outset have taken the lead role in coordinating the different investigations and ensuring adequate communication between the various parties.

1.11 There was an inadequate response to our repeated requests for scientific evidence, including the risk assessments on which this and previous product withdrawals involving products contaminated with Sudan 1.

1.12 Our other concerns are set out in Paragraphs 1.1 – 1.5 above.

Q2: What would you do differently if faced with another large scale incident tomorrow and what could others do differently in future?

2.1 The Authority is satisfied that it carried out all of it's legal responsibilities and the various actions requested by the Agency to a high standard.

2.2 We believe that the incident should have been dealt with in a much more coordinated manner and by adopting a scientific risk based approach. Many of the concerns set out in our letter dated 3 May 2005 could have been avoided, if the Agency had set out it's requirement for a formal investigation at an earlier stage, rather than leading food authorities to believe that their role was to ensure an effective product withdrawal.

Q3: In the light of this what are the lessons that can help all those involved with food incidents in the future?

3.1 The Agency should establish clear procedures for dealing with such incidents, including adequate risk assessments and coordinated arrangements for liaising with food authorities and other agencies. It should also adopt an effective leadership role coordinating the activities of all involved where appropriate.

3.2 Subsequent experience with a separate incident involved communications with several different individuals within the Incident Branch over a period of time. This led to confusion and requests for information to be repeated. This suggested that coordination of information within the Branch could be improved. A single point of contact for each incident would be helpful.

3.3 We welcome the subsequent publication of the guidance for small businesses contained in the document "Principles for preventing and responding to food incidents".

Q4: What challenges does sourcing of ingredients/products from around the world present and how can the safety of Uk consumers be best protected as a result?

4.1 Following completion of this review, the Agency should provide clear guidance to food authorities on the action it expects them to take in relation to these foods. This should include a more extensive and better coordinated risk based sampling programme.

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Annex B (vi) (b)

PLANNING AND REGULATION SERVICES

Ken Smith Dip.TP, MRTPI
Head of Planning and Regulation Services

ENVIRONMENTAL HEALTH SERVICE

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Colin Houston,
Deputy Head of
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Your ref: Colin Houston
Our Ref: Premier/2005
Enquiries: Allan Watson/Richard Green
Date: 3 May 2005

Dear Colin,

RE: INVESTIGATION: PRESENCE OF SUDAN I IN FOOD

PREMIER AMBIENT FOODS (UK) LTD., MILLS HILL ROAD, MIDDLETON M24 2ED

Thank you for your letter dated 25 April 2005 the contents of which have been noted and to which we would respond as follows:

We feel that we must express our concern regarding the heading of the letter and it's contents which relate to a "potential prosecution" by this authority. Our understanding of the meeting with yourselves on 21 April 2005 was that we had agreed to carry out an appropriate investigation to gather evidence as far as available, which would be considered to determine what further action is appropriate in line with our Enforcement Policies and normal procedures.

You are aware of our concerns regarding the information gathered to date particularly it's admissibility and possible effect on information gathered in the future. These were discussed with you during the meeting and are set out in Appendix 1. It was evident that many of these concerns were shared by your own legal advisor. In addition, you are also aware of our view that many of the parties you identify as part of the investigation may be unwilling to provide information or witness statements.

Also attached is a copy of our minutes of the meeting on 21 April 2005 (Appendix 2). Would you please confirm whether you are happy that they constitute an accurate record of our discussions.

As requested, our intended course of action is as follows:

1. We will carry out a thorough review of the information obtained to date, along with an assessment of the concerns discussed with yourselves during the meeting on 21 April 2005 and work with our legal advisors to prepare an initial brief for consideration by counsel. This will include a request for advice on the admissibility of information gathered to date and guidance on any impact this may have on evidence gathered subsequently.

2. Following advice from counsel, we will develop detailed proposals for the investigation and meet with your investigator to agree how they are able to assist. This will take into consideration the guidance contained in your letter in relation to the investigation of potential offences.

3. We will keep the progress of the investigation under constant review in conjunction with our legal advisors where necessary, to determine what further action is appropriate.

4. The investigation will relate only to possible offences committed within this Borough. From the information available to date, this is likely to involve only one product, Worcestershire Sauce and its ingredients.

We are aware of your view that this matter should be pursued as soon as possible and have allocated an Environmental Health Officer and a Trading Standards Officer to work on the investigation, full time with effect from 9 May 2005.

In relation to your offer of assistance in the form of resources we would respond as follows:

1. We would be pleased to use the services of your investigator and will contact him as set out in (2) above.

2. We would be grateful if you could provide additional information on the Trading Standards Officer you refer to, their specific experience and how they may be able to assist us in this investigation.

3. In relation to your offer of assistance from your Legal Services and an appropriate Barrister, following consultation with our own legal advisors, we are of the view that for logistical reasons we would prefer to use the services of counsel located in Manchester. We have a Barrister in mind who we have used previously and who has experience of similar work. If council identifies any additional data which he requires and which is within the purview of FSA officers, then we will be in contact with you on those points.

4. We will submit a detailed application to your fighting fund as suggested within the next 10 working days. This will set out an initial estimate of our costs in relation to, the use of our officers, along with management support for the investigation and replacement staff to cover their normal workloads, the cost of any sampling and analysis and any other expenses arising from the investigation.

During our meeting on 21 April 2005, we discussed the related investigations which we understand are being carried out by authorities in other parts of the country. Would you please confirm how you intend to co-ordinate the individual investigations, share appropriate information and avoid unnecessary duplication so that we can ensure that our resources are used as effectively as possible.

In relation to the assistance to be provided in the form of scientific advice, we assume that the information attached to the email is complete, as we have not to date received the hard copies as promised. We note that none of the information includes a source or references. We would be grateful if you could provide this information and any other relevant material by return as this is required for consideration by counsel and we would not wish to delay progress unnecessarily.

We trust that the above is acceptable to you and look forward to receiving the information requested at your earliest convenience.

Yours sincerely

Richard Green (Principal Trading Standards Officer)
on behalf of Allan Watson, Food Safety Manager

APPENDIX 1:

Rochdale MBC concerns in relation to information gathered to date for Worcester sauce produced by Premier Foods

1. Although Rochdale MBC (RMBC) were aware of a problem on 09th February 2005, advice was given from the Foods Standards Agency (FSA) of no need to take action. FSA involved with Premier on recall without any reference to Rochdale MBC and we understand that Premier recommenced production of Worcester sauce without any discussion with RMBC.

2. The letter issued by the FSA on 18th February 2005 to Local Authorities says 'Local Authorities for the effected companies have been contacted to assist with effective withdrawal and gather information on distribution'.

   FSA did not ask us to do this until 21st February 2005.

3. On 23rd February 2005 RMBC requested a written protocol from Colin Houston, FSA. It was agreed for Colin to email this to RMBC. To date this has not been received.

   Throughout dealings with Premier Foods we were under the impression we were to assist in the product recall. Also we were lead to believe that the presence of Sudan 1 in the finished product had occurred unwittingly and that Premier had acted on supplier assurance.

4. On 25th February 2005 Colin Houston provided limited information to RMBC on a whistle blower at the Middleton factory and said that he would subsequently supply additional details. To date this information has not been received.

5. On 2nd March 2005 FSA solicitor advised at the meeting at Aviation House that at this point there is no need to caution as we are still gathering information.

   Information gathered to date would be likely to be inadmissible in court.

   Note - It was reported verbally at the meeting between RMBC staff and FSA representatives on 22nd April that prior to every meeting between RMBC staff and staff at Premier Foods, our officers were asked the purpose of the visit. They were told, on the instructions of the FSA, that it was an information gathering exercise.

6. The interview of Sarah Archibald on 10th March 2005 by an officer at Wigan BC took place without detailed consultations with RMBC. The information gathered by Wigan BC deals principally with Branston Pickle and we are unaware of the extent to which Sarah Archibald is able to supply details about Worcester sauce.

7. On 06th April 2005 Colin Houston asked RMBC to lead the investigation with full support available, including a barrister. The proposed use of a barrister pre-supposes that there would be a prosecution. Any investigation which might result in matters being considered for legal proceedings would of course have to be in accordance with our enforcement policies and subject to the approval of the delegated officer which is the CEHO and Licensing Officer.

8. On 15th April 2005 RMBC were asked to authorise an FSA investigator in relation to the proposed interview of Michael Robertson. If this relates to offences which may have been committed in our Borough, we would have thought that our own officers should have been involved in this interview. If the purpose of the interview relates to products handled outside RMBC area, our view is that it should be conducted in conjunction with the relevant Local Authority and that the FSA investigator should be authorised by them.

   Note - It was reported verbally at the meeting on 21st April that it was felt that the company should be interviewed prior to any contact with Michael Robertson

9. We understand that other Local Authorities are under the impression that RMBC are to lead a national prosecution. This has not been agreed by ourselves.

10. Actual evidence of possession for sale or actual sale of Worcester sauce is minimal. This relates to the Italian sample (details of analysis arrangements are unknown) or/and a single sample of Worcester sauce taken from a batch which had been quarantined, whether either of these results could be used as evidence is questionable.

11. Lab results were provided by the FSA for samples taken in October 2003 by Premier Foods, and the sample found to contain Sudan 1 was an ingredient rather than a finished product. The lab result does not give an interpretation on the meaning of the result and secondly the result would require significant interpretation to determine the likely level of Sudan 1 in the finished Worcester sauce and whether this would pose any risk to health at that level.

The levels of Sudan 1 present in Worcester sauce and subsequently in foods for which this is used as an ingredient are so low that it is highly debatable as to whether this would render the food so contaminated as to be unreasonable to be consumed in that state, or for offences after 01st January 2005 re: article 14 ‘Food shall not be placed on the market if it is unsafe’. The opinion of the committee on toxicity is that it is prudent to assume that Sudan 1 is a genotoxic carcinogen. Dietary exposure should therefore be as low as reasonably practicable.

This must be a fundamental consideration when determining any prosecution would have a realistic prospect of success.

12. Although the Colours in Foods Regulations 1995 may offer a better prospect of conviction than offences under the Food Safety Act, the maximum fine of £5000 is minimal in relation to the cost already incurred by the company. In addition the complexity and potential costs of any prosecution are such that it may not be in the public interest.

N.B. The above information has been updated to reflect the discussions during the meeting on 21 April 2005

Annex B (vi) (c)

ROCHDALE
METROPOLITAN BOROUGH
COUNCIL

PLANNING AND
REGULATION SERVICES

Ken Smith Dip.TP, MRTPI
Head of Planning and Regulation Services

ENVIRONMENTAL HEALTH AND LICENSING SERVICE

Adrian Watson BSc (Hons), DMS, MCIEH
Chief Environmental Health and
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Dr Jon Bell
Chief Executive
Food Standards Agency
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Enquiries: Adrian Watson
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Andy Glover Tel (01706) 864105

Date: 10th February 2006

Dear Dr Bell,

ROCHDALE METROPOLITAN BOROUGH COUNCIL INVESTIGATION OF PREMIER AMBIENT FOODS (UK) LTD, MILLS HILL ROAD, MIDDLETON.

ALLEGED CONTAMINATION OF WORCESTER SAUCE WITH SUDAN 1

We are writing to let you know about the decisions which we have arrived at in considering our officers' reports following their investigations about Worcester Sauce manufactured in this Borough.

We have made our decisions under our delegated powers, having taken into account legal advice from counsel instructed by Rochdale and by the FSA. We have also had the benefit of the exchange of views at the meetings between officers of Rochdale and the FSA on 21 December 2005 and 24 January 2006 at which we were present. As you are aware, comments had also been sent to us by Premier's solicitors on their client company's behalf.

Our decision is that there should not be a prosecution on this occasion. With regard to possible offences under the former Section 8 of the Food Safety Act 1990 and Regulation 4

of the General Food Regulations 2004 we were not satisfied that the evidential sufficiency test was satisfied. For completeness, we nevertheless went on to address the public interest test.

On Section 14 of the Food Safety Act 1990, we were satisfied about the evidential sufficiency test but did not consider that the public interest was met.

We enclose a detailed explanation of our reasoning for your records.

Premier's solicitors are being informed of our decision at the same time that this message is e-mailed to you. You will also receive a hard copy of this letter.

Premier's solicitors have asked that the Council does not make a public pronouncement about our decision until Premier have had an opportunity to notify board members and to make requisite notifications to financial markets. Those solicitors have been informed of the fact that you are being notified of our decision in your statutory monitoring role and that likewise you have duties to notify government ministers and departments.

Premier's solicitors have been informed that the Council does not propose to initiate a public pronouncement of our decision, but would have to respond to media enquiries. We therefore ask the FSA (as we have asked Premier) to respect each other's positions and not to make any public comment on our decision before **10.00 a.m. on Wednesday 15 February 2006**.

From the detailed paperwork which we have had to study, we are aware of the assistance provided to our officers by officials of the FSA and wish to record our thanks for those endeavours.

Yours sincerely

Adrian Watson
Chief Environmental Health
Manager and Licensing Officer

Andy Glover
Consumer Protection and Registration

Annex B (vi) (d)

ROCHDALE METROPOLITAN BOROUGH COUNCIL
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Chief Executive
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Your Ref:
Our Ref: CE/2399/CMT
Enquiries to: Roger Ellis
Telephone: 01706 865401
e-Mail: roger.ellis@rochdale.gov.uk
Date: 3rd March 2006

Dear Dr Bell

ROCHDALE METROPOLITAN BOROUGH COUNCIL

INVESTIGATION OF PREMIER AMBIENT PRODUCTS (UK) LTD, MILLS HILL ROAD, MIDDLETON

I write further to your recent letter dated 21st February 2006 expressing your disappointment at this authority's decision not to proceed with a prosecution in relation to the above investigation, and the subsequent developments in relation to the Agency's proposed press release linking the investigation with a recent prosecution taken by Essex County Council.

On the former issue, I can understand your disappointment, particularly given the Agency's apparent agenda throughout this investigation to seek for Premier to be prosecuted for this incident seemingly regardless of the procedures and protocols that this and other authorities (and the Agency for that matter) should follow in this type of case. I myself am disappointed in both your synopsis of events and particularly the actions and approach of your senior officials during this investigation.

In line with its duty as a public prosecutor, this authority has, to my mind, at all times adopted an open mind to all possible outcomes and followed the correct procedures to reach its decision. I am not sure that the same can be said for the Agency. At no time has any recognition of the real issues involved in this matter been acknowledged by the Agency. These issues include the need to follow appropriate guidance, to justify the appearance of and prove any offence in a Court of law with an appropriate penalty likely to result.

Even in your most recent letter you make suggestions that this authority could have made a prosecution more likely by mentioning the additional questions provided by Robin Spencer, QC in his advice of 11th January 2006 (i.e. when the investigation had already been completed). As far as I am aware these were either of questionable relevance to the offences allegedly committed within Rochdale MBC or of persons who had already indicated they would not provide statements or had no memory of events so long ago.

With respect to your mention of Section 5.7 of the Code for Crown Prosecutors, again you seem to have "cherry-picked" the part that supports your views and omitted to mention the rest of

the Section. I agree that it says where the evidential test is met, often the "prosecution will usually take place". However, you fail to mention that it continues "unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour..". This is of paramount importance to this case. The very detailed decision by Adrian Watson and Andy Glover, and the means of its making, provided to you on the 10th February, covers this more than adequately, and yet again you make no mention of it in your letter.

The Code for Crown Prosecutors Section 2.2 states "Crown Prosecutors must be fair, independent and objective.....They must not be affected by improper or undue pressure from any source".

Section 2.3 continues " It is the duty of all Crown Prosecutors to make sure the right person is prosecuted for the right offence. In doing so, Crown Prosecutors must always act in the interests of justice and not solely for the purpose of obtaining a conviction"

I am satisfied that this authority has met this standard. Whilst this authority welcomes any assistance, your officials have seemed to put unreasonable pressure on my officers with only one outcome sought. Your Director of Enforcement, together with his deputy and legal advisors, insisted on making two personal visits to Rochdale, one "uninvited" at around the time of the conclusion of the investigation. I understand that only information in support of a prosecution was provided prior to and during these visits. Any "cautionary" views or comments made by my officers and our Barrister, Martin Carter, that might have run counter to that end were, I am told, dismissed out of hand by your officials .

I would now like to move onto the draft FSA press release of 23rd February, of which we were notified some 40 minutes before proposed release. Despite this authority acceding to the agency's request to give adequate time for internal dissemination, the reciprocal consideration did not apply.

In addition the proposal to link the decision made by this authority, and the company involved to a totally unrelated prosecution by another authority, without their permission, was wholly inappropriate. I am only relieved that common sense eventually prevailed, albeit in response to representations from Essex County Council and Premier's legal advisers, this authority not having time to do so, and the release was not made in that format. I would ask for confirmation from you that this was the "public statement" referred to in your letter of 21st February, and this issue has now passed.

The fact that this was even proposed raises some serious questions about the conduct of the Agency. This is something that this authority intends to take up with other authorities involved in similar investigations with a view to involving LACORS and other representative bodies as appropriate.

I look forward to hearing any comments you may have on the above.

Yours sincerely

Roger Ellis Chief Executive

Annex C

Written comments from Government bodies

Annex C (i)

Sudan 1 Review Panel

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5th Floor,
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22 Whitehall
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10 May 2007

BETTER REGULATION COMMISSION REPORT – REFERENCE TO SUDAN 1 INCIDENT

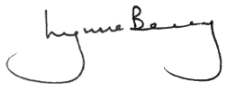
The Better Regulation Commission is an independent body that advises and challenges the Government on its regulatory performance. In light of your review of the Sudan 1 incident, I would like to draw to your attention the "Risk, Responsibility and Regulation – Whose risk is it anyway?" report we published in October 2006, a copy of which is enclosed.

The report explores the way in which risk is managed in the UK and we have used case studies throughout, to illustrate different approaches to risk management and policy-making. We included the Sudan 1 incident (page 6) as it was interesting to compare the different approaches taken in the UK and New Zealand, where the public were given a different message. We also make reference to the Sudan 1 incident on page 17 of our report, where we state that the public would not have been so alarmed about the risks associated with the Sudan 1 food dye had they been aware of the quantities of products containing the dye they would have to consume to put themselves at risk.

Our report calls for a better dialogue around risk, and we believe that some sort of reference point should have been used to put the scale of this particular risk into context. During our research we came across a quote from Gerry Potter of De Montfort University, who noted that you would need to eat 100 000 Pot Noodles per day for a year before you would significantly increase your risk of cancer. The public finds such statements much easier to understand, as opposed to being told there is a "small" risk.

The report makes several recommendations to the Government, which we believe would improve the way in which risk is managed in the UK. The Government has accepted the majority of these recommendations, and we shall be assessing its progress with implementing them later this year.

I hope our thoughts on the Sudan 1 incident are of interest to your review. The Better Regulation Commission is happy to provide further information if required.



Lynne Berry
Chair of Risk Sub-Group - Better Regulation Commission

Annex C (ii)

www.food.gov.uk

SUDAN I REVIEW PANEL – FSA COMMENTS IN WRITING TO THE PANEL

The Panel is asked to note that an annex is provided to these comments. It answers a question the Panel asked in relation to the background paper provided to the Panel for its inaugural meeting. The annex does not relate to the more general points discussed in this submission.

Sudan I Review Panel – FSA written responses to the Panel

Q1 What was your impression of the incident? How did you feel at the time, what went well, what could have been done better?

The incident was a very fast moving and rapidly escalating scenario that presented a great management challenge. The lack of a clear definition of roles and responsibilities at the outset led to a pressurised and intense work environment.

The investigation process involved the co-ordination and collation of information on a very complex supply chain from a large number of stakeholders. The validation of the information was very labour intensive but essential as the data were incorporated into a list of affected products, published on the Agency's website. The list eventually comprised some 600 entries.

The validation of the data was complicated as, in some cases, the same information was provided by a variety of sources, for example "own brand" products where data were supplied by both the retailer and the original manufacturer. The validation needed to be to completed within a truncated timescale in order to meet the demands from the media, stakeholders and the public for regularly updated information. The Agency's website had 100 million hits over a 10 day period and over 1000 emails/ letters that required a response.

Areas of the investigation that went well included good cross-Agency working. At one stage the investigation involved 5 Divisions with 60 Agency staff fully engaged for a period of 3 weeks. The co-operation of food business operators and local authorities with the Agency's Incidents team also assisted investigations.

Actions that could have helped to improve the management of the incident include better clarification of roles and responsibilities at the outset, the preparation of a comprehensive strategic picture, full separation of the information management function and operational role and prompt notification by and engagement of key stakeholders.

The Agency held an internal review of the incident in April 2005. This led to 50 lessons being identified that needed to be addressed in order to improve the management of large scale incidents in the future. The areas of major concern included;

- **The need to scope an incident at an early stage.**

  This is now achieved by using a classification matrix that categorises

  Incidents into high, medium or low categories based on a combination of the incidents' Severity and Complexity. These are defined within the Incident Response Protocol together with "Triggers" for action.

  The incidents' classification system is an internal management tool allowing the management structures and potential resource implications to be identified at an early stage allowing earlier engagement with stakeholders.

- **The need to define roles and responsibilities at the outset of the incident.**

  These are now clearly defined in the Incident Management Processes section of the revised Incident Response Protocol.

  In addition, the Food Incidents Task Force developed guidance on Preventing and Responding to Incidents, published in March 2007. This outlines respective roles and responsibilities and outlines the Agency's actions during an incident investigation. It also introduces the concept of a "scoping group" comprising Agency officials and key stakeholders, formed at the start of a major incident to agree roles responsibilities and sets of actions to resolve the issue.

  Since the Sudan I incident EC Regulation (EC 178/2002) has been fully implemented. The Regulations specify that the responsibility for removing from the market food that does not meet food safety requirements lies directly with the Food Business Operator (FBO). The FBO and is now legally required to withdraw or recall such food **and** accurately notify the consumer and the Competent Authorities of the reasons for the withdrawal.

- **The need for improved information management and communications capabilities.**

  There is now a dedicated cross-Agency incidents database which greatly improves the recording and collation of all information relating to an incident. The database provides an enhanced communications capability as it allows those Agency staff involved in an incident investigation to access information quickly and simultaneously.

  The system provides an audit trail and the updated incident log provides the basis for preparation of timelines and other forms of briefing. The system can also hold images, spreadsheets and scanned documents which can also be accessed. In conjunction with the Food Incidents Task Force the Agency has also developed an enhanced on-line reporting system for Industry. The form allows the uploading of all relevant information, supplied in an electronic format, directly into the database following its validation by the Agency. This will lead to more effective data handling – a major challenge presented by the Sudan I incident.

In addition the Protocol describes the formation of dedicated investigative and information management "cells" to better manage information flow. This combined a defined managements structure comprising "Gold", "Silver" and "Bronze" levels ensures that the strategic and operational aspects of the investigation are managed appropriately.

- **The need to address the resourcing of major incidents**

  The Agency now has a cadre of over 40 appropriately trained Incident Reserves who can be deployed to assist with all aspects of a large scale incident, augmenting the dedicated incidents team.

- **The need to ensure appropriate facilities to accommodate a large investigation team over an extended period.**

  The Agency assessed the IT and accommodation needs to co-locate a team to manage the investigation of a major incident. From the experience of Sudan I the likely number of staff required to provide the investigative and support functions numbered about 30 per shift.

  The Emergency Response Operation Suite project (EROS) was initiated.

  There is now the capability, within Aviation House to co-locate an investigation team and provide the necessary IT, Telecoms and administrative support. This capability will also been replicated at the Food Standards Agency offices in Cardiff, to ensure business continuity in the event of a disruptive challenge that rendered Aviation House inaccessible.

Q2 What would you do differently if faced with another large scale incident tomorrow and what could others do differently in the future?

The internal review led to the revision of the Incident Response Protocol providing a more robust system that addressed the areas of concern raised. This protocol provides the procedures required to manage a major incident. The document is kept under regular 6-monthly review and takes account of the lessons learned from the ongoing programme of incident reviews. All Agency staff involved in the investigation of incidents have now received a copy of and been trained in the use of the Protocol. A programme of update training sessions ensures that staff are kept up to date.

In addition, all staff involved in incident investigation have been trained in the use of the incidents database.

Q3 In light of all this what are the lessons that can help all those involved with food incidents in the future?

Following the Incident Response Protocol is the key to effectively managing a major incident, as the document now incorporates all the lessons learnt from the Sudan I incident and provides clear guidance for all those involved in an investigation.

The Food Incidents Task Force document also provides clear guidance to stakeholders on their roles and responsibilities and outlines what they may expect from the Agency.

Overall, the major lessons are early and continuing dialogue with key stakeholders. The Agency is committed to such dialogue and holds regular meetings with key stakeholders. Another example of such engagement was the international workshop held on 5/6 March this year that began to develop a strategy for the Agency and the food industry working in partnership to prevent food incidents. Initiatives such as these help build mutual understanding of how each party will react when dealing with food incidents.

Q4 What challenges does sourcing of ingredients/products from around the world present and how can the safety of UK consumers best be protected as a result?

- To protect consumers, EU food law requires that all food imports must meet food safety and food standards requirements at least equivalent to those for UK produced food, and imposes conditions and controls on the import of food. These measures distinguish between two broad categories of food: products of animal origin (such as meat, fishery and milk products), and other food products which would include spices.
- In general the potential risks to the consumer from food coming from countries outside the EU are not significantly different from those associated with UK products. Nevertheless, the vulnerability of supply chains increases as they become more extended, covering greater distances and more steps.
- A challenge is to ensure that the large volumes of imported food meet the necessary EU food safety and food standards requirements without imposing a regime that would disrupt importation. To meet this, food safety checks need to be carried out in a manner that is proportionate to the risks involved.
- Previous incidents such as the presence of non-permitted veterinary medicine residues, in imported products, and the Sudan I incident have highlighted the need for improved intelligence of local agronomic and food production practices in third countries and how this can impact on the safety of food imported from such countries.
- UK firms need to be aware of areas of the world that consistently have trouble meeting UK/EC food standards, so that they can put in place their own checks or make sure that control measures at source are adequate. Companies also need to establish that when switching to new sources of ingredients their suppliers are adopting the same levels of quality assurance as previous suppliers.

- Some of this information may come from the RASFF[1] notification system, but it would also be helpful if there could be better exchange of information between companies and the Agency so that emerging food safety issues are identified and addressed at the earliest opportunity.
- Horizon scanning and information sharing methods being developed in the EU and internationally may help but are at an early stage of development. At the recent FSA/EFSA international workshop on incident prevention and horizon scanning, it was claimed that much testing and surveillance effort is duplicated across the food industry which could be avoided if more information was shared, thereby increasing money available for other areas of food safety.
- The Agency is continuing to take forward measures to improve the co-ordination and delivery of local authority enforcement of imported food controls. This work began following a 2002 Government review on the organisation of controls on imported food. Measures taken include a national training programme for local authorities on imported food controls; Agency grants to local authorities for increased sampling and surveillance work on imported food[2]; imported food forming part of the Agency's auditing of local and port health authorities; a dedicated contact point being set up in the Agency to provide advice to enforcement officers on imported food; and an IT database system (GRAIL) that provides easily searchable advice on import legislation to enforcement bodies.

[1] The Commission's Rapid Alert Food and Feed System (RASFF) provides for intelligence sharing between Member States about rejected food products and assists targeting of checks.

[2] In 2006 grants totalled £900,000.

Annex.

This annex deals with a question raised by the Panel that concerned UK follow-up to the initiative taken by the EC Standing Committee to agree a standard for EU enforcement.

At the meeting of the EC Standing Committee on 23 June 2006 the UK proposed that if contamination of spices and other food ingredients with illegal dyes is discovered below the level of 0.5ppm member states should not take action to remove products from the market. This action limit would apply irrespective of whether HPLC or LC-MS/MS analytical methods had been used. Member states agreed with this action limit. This position cannot be adopted in to EU law as action limits can only be established for products of animal origin. Member states are required to provide quarterly returns to the European Commission of monitoring which is carried out for the presence of illegal dyes in spices and other food ingredients. The EC RASFF system is used to convey information to member states where contaminated ingredients have been identified through testing, providing information on product distribution in the EC.

Further copies of this publication can be downloaded from: www.food.gov.uk

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