Appendix 1

Review of Food Withdrawal and Recall Processes

Tracking Live Case Studies

Analytics Unit

Science, Evidence and Research Division

Food Standards Agency

Background

1. The Analytics Unit (part of Science Evidence and Research division in the Food Standards Agency) tracked a small number of food incidents reported to the FSA or FSS as they unfolded, to obtain in-depth information about how the recall process operates in practice. The purpose of this was to identify and understand in more detail the types of issues that may arise as incidents progress. In addition, the study aimed to collect additional information, such as the display of in store notices and related social media comments.

Methodology

2. The Analytics Unit created selection criteria for the types of recall we wanted to review. The incidents team informed us of any cases meeting the criteria where a decision had been made for product to be recalled, or where it looked like it would become a recall. The criteria aimed to cover at least:

    a. Two Allergy, two Microbiological and two Physical Contamination recalls

    b. Two Large businesses, two small businesses, a franchise and a branded manufacturer (as the recall owners)

    c. Geographic spread, including recalls affecting each of the four nations, and with nationwide reach

    d. Cases where there was, and where there was not, a Primary Authority arrangement

    e. Covering both working hours and out of hours cases

3. In all we looked at 10 cases. Except for a franchise we covered all these areas, including at least one of each of: a recall that affected Scotland only, one where the product was manufactured in Wales, one manufactured in Northern Ireland and one manufactured in England. At least one had nationwide and international distribution. The recalls studied were:

    - A national retailer for an allergy alert
    - A national retailer for a microbiological issue with an imported product
    - A national manufacturer and retailer for a physical contamination issue
    - A national retailer for a physical contamination issue
    - A large manufacturer for a microbiological issue
    - A large manufacturer for a physical contamination issue
    - An allergy alert for a branded product sold nationwide in multiple retailers
    - A small business for a microbiological issue
    - Two separate small businesses for allergy alerts

4. In each case we spoke to the FSA or FSS incident handler. We spoke to the Local Authority in all cases except two, and spoke to the relevant business in five of the cases. Due to the sensitivities relating to three cases, we were advised by the FSA/FSS incident handler not to speak to the businesses involved, and did not speak to the businesses in two other cases where we were mainly interested in how store notices were displayed.

5. The purpose of the case studies was to highlight key themes and issues that can arise through investigating the following areas, either during or shortly after a recall:

    a. How consumers are informed

    b. Proportion of customers reached

    c. How much product is returned

    d. Detail on risk assessment

    e. The decision making process

    f. How prepared was the FBO in advance

    g. Role of the Local Authority

    h. Time lags

    i. Volume and type of discussion on twitter or other social media

6. The purpose of the case studies was not to review the performance of any specific recall. Information gathered during the case studies was not used for the handling of the case, nor was it deliberately passed back to the FSA/FSS case handler for that particular incident.

7. The case studies tried to cover a wide variety of situations, but they did not attempt to be representative. Therefore, findings here cannot be assumed to apply generally.

8. Some of the other research for this project has been divided into four key areas of interest: (1) issue **identification**; (2) withdrawal/recall **notification**; (3) product **removal**/disposal; and (4) **review**/learn. The headings in the Full Results section have been subtitled with these four areas, though it should be noted that the issues do not necessarily fall neatly under just one area.

Summary of Results

9. There were several main themes that came out of the work:

    - The large businesses had generally decided a recall was necessary before contacting FSA/FSS. There was sometimes a lengthy process leading to the recall for small manufacturers.

    - Product recall notices were not always prominently displayed, and were more difficult to find in larger stores. In small stores there was often less space to put notices, so they tended to be put close to the tills. In contrast, in larger stores the notices tended to be displayed in the customer

services area, and would not necessarily be seen by customers that were not visiting that section.

- In all cases studied, we were not aware of any attempt to actively contact specific consumers regarding the recall, such as by email, where their details and purchase history might have been available to the business.

- Several triggers within a business were mentioned or observed that contributed to a food recall being necessary. These included change of ownership, change of key personnel such as technical manager, or introduction of new product lines.

Full Results

10. Results have been grouped by theme under the headings below. These are set out in the rough order of how an incident unfolds, with other issues covered at the end.

How the incident occurred (IDENTIFICATION)

11. There was huge variety in how the cases unfolded. However:

- In each of our case studies focussing on recalls related to allergenic ingredients, allergy alerts from large businesses all occurred where two products had been mixed up, for example the product was put in the wrong packaging or the wrong label was fixed on. For the cases we looked at (plus at least three other recent allergy alerts), the products had the correct ingredients but they had been given the label for the wrong product. The wording on the label was correct for the product it was intended for, but not the one it was fixed to.

- For small businesses, the allergy alerts were due to incorrect labelling: one not understanding the requirements for how to label allergies, and one having changed their ingredients but not having updated their labelling.

- One microbiological case occurred due to unhygienic conditions. When the Local Authority (LA) Environmental Health Officer (EHO) spotted this, some product was tested and found to be contaminated. Products were also being given longer shelf life dates than was supported by the shelf life testing / documentation. The other microbiological case was due to potentially unhygienic conditions, lack of documentation and lack of shelf life testing all leading to potential risks, rather than due to a laboratory-confirmed contamination. At the time of the case study, the cause of the microbiological contamination for the imported product was unclear, and the product had not been put back on sale more than a month later.

- The physical contamination cases were generally due to machinery breaking during the production process.

12. One EHO talked of several triggers that can cause a business to slip and end in a recall. These included change of ownership, change of key personnel such as technical manager, or introduction of new product lines.

Issue identification (IDENTIFICATION)

13. The method of identification varied by issue:

- Many of the issues were originally identified by consumers: particularly physical contamination and allergy issues. If customers found foreign objects in a product they might contact the business. One business said that if they have one complaint about physical contamination they don't take action, but once they have had two reports of the same issue in the same product they immediately set up a crisis management team.

- The allergy issues were generally detected by customers noticing something wrong with the product, such as taste where two products have been swapped. One was also noticed by a competitor: they had mislabelled their own similar product, and noted that their competitor didn't have the correct wording and reported it.

- The two domestic microbiological contamination issues were discovered by an EHO having concerns on a visit to the plant and carrying out further investigations. The imported microbiological issue was detected by the retailer carrying out random sampling on products they received.

Time to recall or notify FSA/FSS (IDENTIFICATION)

14. There were differences in the time taken to recall a product, but there were some common themes:

- The large businesses had generally decided a recall was necessary before contacting FSA/FSS. They had already investigated the issue, had usually set up a crisis or incident team, worked out what the issue was, what batches or products were affected and what action needed to be taken. Only then did they contact FSA/FSS and their Local Authority.

- Some of the small manufacturers had a lengthy process leading to the recall. In the allergy alert case, there was a week and a half between first discovering the issue and issuing a recall. This was due to several factors: slow responses from the business owner particularly while he was away for a few days, very limited stock affected and sold locally only, unclear how many products or lines actually affected, and unclear whether they were still on sale. The Local Authority initially weren't sure of the business's capability to effectively identify customers, contact them and recall back any product.

- Microbiological cases also tended to take longer to be notified. This is in part due to the need for investigation and product testing, and the decision being based on a change in risk associated with the product. Allergy and physical contamination issues in our studies were more clear cut: an issue was identified (incorrect label or metal pieces in the product), so a recall was automatically carried out. This could be slower where the business needs to wait for a consumer to return a product for examination, to help identify the cause. This could be to identify what item the product was contaminated with, or for one allergy recall where products had been switched, to identify why consumers were complaining about the taste and determine that there were allergy labelling concerns due to the switch.

- One small manufacturer was quicker: they were contacted by a customer, who advised them to seek advice from an Allergy organisation, which they did. That organisation advised what they needed to do, including informing their Local Authority and FSA/FSS. The business made contact but, due to bank holidays and internal IT system failure, there was a delay of several days and FSA/FSS first found out about it as a subscriber to alerts from the allergy organisation. However, the business had acted promptly, and had initiated the recall before the FSA alert was issued.

15. For one large business allergy alert, the FSA/FSS recall notice was issued less than two and a half hours after FSA/FSS had been made aware for the first time via the business submitting an incident notification form. However, in most cases it was longer, often at least overnight.

Time until products removed from shelves (REMOVAL)

16. Only one business referred to any targets or standards for withdrawal times. That retailer said they had clear emergency recall process in place, and claimed that the product would definitely have been removed from shelves in all of its stores within two hours of central office issuing the alert. It takes a little time to get the notice out to all stores, but then store managers are required to confirm within one hour of receiving the alert that they have carried out the necessary action.

Contacting customers (NOTIFICATION)

17. During the case studies, we visited several stores of different retailers to see how in-store notices were displayed. A colleague not affected by allergies also purchased a product that was being recalled for allergy reasons shortly after the recall using a loyalty card to see if they would be actively contacted. In addition, two colleagues happened to purchase one affected product as part of their regular shopping – one online and another in store.

18. Overall, the process to inform customers was not totally effective. Not all store notices were prominently displayed, particularly in larger stores, and no active contact was made with purchasers in cases where information would have been available to the retailer to allow this.

<u>In store notices</u>

19. In-store notices were not always prominently displayed. The annexes give examples of how some notices were displayed.

20. In smaller stores, due to lack of space, the notice was often displayed around the till area, and that was usually fairly visible. However for large stores (even of the same retailer), the notice often was put in a customer service area, which customers would not necessarily walk past or visit when entering or exiting the store.

21. In one larger store, the recall notice board was on a wall in the customer services area that would not be easily seen or likely to be noticed by customers entering the store, and would not be passed by customers leaving the store directly from the checkouts. The board also contained at least 15 A4 black and white notices, some of which overlapped. Most were product recalls (both food and non-food), but there were also other notices. They were behind

the customer service desk and would be very difficult to read from any point where a customer would stand, even those using customer services. The store did have a big notice board behind checkouts that many customers would walk past as they exit the store, but this was only displaying community project information rather than recall notices.

22. One large retailer was visited around a week after a recall. There was a recall notice board set back at the customer service desk. It was on the route customers would walk down to exit the store, and it was on a sloping wall so angled slightly towards customers, though it was set back some way. The recall notice for the case study in question was not there, however there were eight other recalls: three non-food products, plus five food recalls: one that had been issued late on the evening before the visit, one issued three weeks earlier, one three months earlier, one five months earlier and one as far back as a year and a quarter earlier for a product that had a long shelf life. It was not apparent that there was any consistency over which notices were displayed or how long they were displayed for.

23. While the point of sale notices were generally more visible in smaller stores, that does not mean they were always visible. In one store that had four manned till points and three self-service tills, there were no recall notices near any of the self-service tills. Three of the manned tills had a different recall notice attached to it, so customers would not be likely to see all the recall notices that were displayed on one visit.

Online communication

24. Website recall notices are not obvious: customers are unlikely to read them without actively looking for them. At the time of looking, on one large retailer website, there were three rows of menu and search options at the top, eleven further larger sections with photos, then ‘about retailer’ at the bottom, where the product recall option was. Another retailer website labels it ‘Product Notices’ rather than product recalls. Two other large retailers did not have a link to product recalls on their homepage (while they might not have had a live recall at the time of viewing there was no obvious place where a link would be put if there was a recall).

25. Several of the notices displayed on one product recall webpage were out of date: there were 14 recall notices displayed, of which 9 were for food products. Four of these had passed their best before date, sometimes by up to four months. While some products might have been frozen by customers at home, at least one was a product that was not suitable for home freezing. For both in-store and online notices there was no clarity on how long notices should be displayed for. One business spoken to said they would leave the in-store notice displayed until there had not been any returns for two weeks, but this was not a universal standard.

Active communication

26. We purchased some of a product recalled due to allergies shortly after the recall was issued using a store loyalty card, to see whether any customer message was sent out. It was a different batch to that recalled, but that would presumably not be known from the barcode. However, no contact was received by the loyalty cardholder. In addition, one of the retailers spoken to

said they did not think this happened (we spoke to a technical manager, who did not know for sure).

27. A member of FSA staff also happened to purchase one of the recalled products as part of their regular online shop. It was a product where only part of a batch was contaminated (see Miscellaneous Errors below), and the supplied product had the batch codes and best before date of the recalled product, though it was delivered a few days after the affected period. This customer did not receive any alert to check or return their product.

28. One business used their social media accounts to alert customers to their recall, in addition to point of sale notices and a notice going on their website. This is in contrast to at least one national retailer, whose policy is not to publish recall notices on their social media channels, which are reserved for marketing purposes rather than for providing other information, which should go on their website or as in-store notices.

29. One business that published the recall on their Facebook page did question whether social media covered the correct audience.

Other communication

30. All recall alert notices are put on the FSA website. Our web analytics showed that during a period covering the display of 97 notices (not necessarily those that were part of our case studies), the most frequently visited had 95,000 unique views (0.2% of the UK adult population). The least viewed had 109 unique views.

31. Allergy recalls only affect a certain portion of the UK population. Many allergy sufferers sign up to allergy organisation email alerts. Several of the allergy alerts in these case studies were publicised through these organisations. This is a good way to reach a targeted audience, though it cannot be assumed that all allergy sufferers would be reached this way, particularly the elderly.

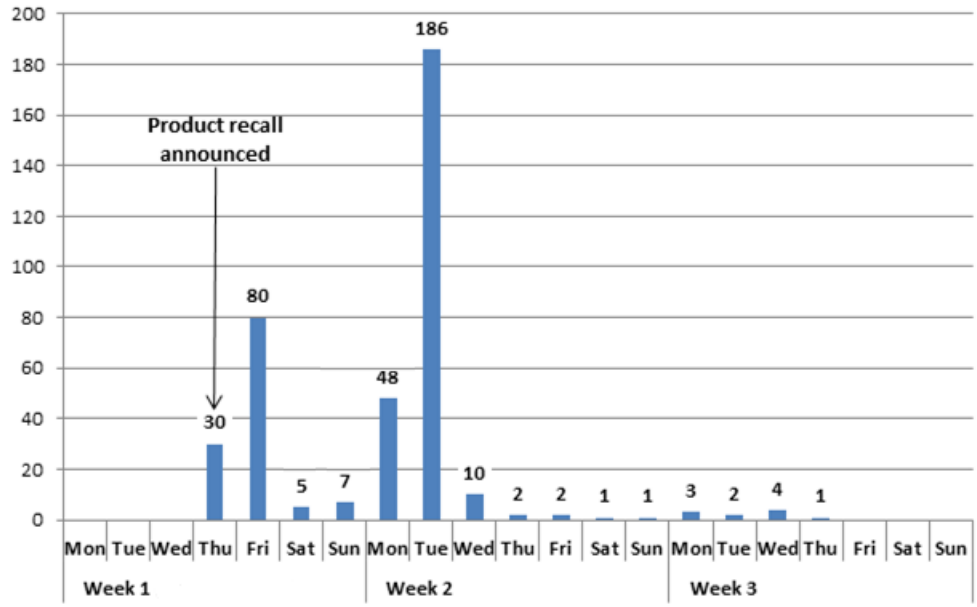
32. Many of the recalls also generated media interest in a variety of different media outlets. For example, in one case several journalists contacted one FSA/FSS incident handler asking about size of distribution, including from the BBC and a newspaper. A few local news sites or papers reported recall alerts, particularly where there had been a few announced around the same time.

Twitter response to recalls (NOTIFICATION)

33. We reviewed social media responses to two recalls.

- For a large retailer allergy alert, there were 125 online mentions we could track related to the recall, all within a week of the incident: 62 news articles, 61 Twitter messages and 2 blogs. (This excludes Facebook, due to privacy restrictions).

- For the branded product allergy alert, the chart below shows the pattern of Twitter messages over time:



Contact from customers (NOTIFICATION)

34. Some manufacturers encourage customers to contact them directly rather than through the retailer, as that is the best way to monitor the scale of any issue or to identify any issues people are complaining about. They said retailers don't always pass customer complaints or product returns back to manufacturers.

Volumes returned and customers reached (REMOVAL)

35. For one business, there was an issue that later investigation suggested involved one day's production only (11,000 items). However, a recall was issued for all batches of the affected product – totalling 600,000 units. Due to the nature of the product, the shelf life and the timescales, most product was likely to have already been consumed by the time of the recall, but the business confirmed return numbers of:

    - 17,923 units withdrawn
    - 4,448 units returned to stores
    - 43 units posted to head office

    This equates to a total of 22,414 units; double the number that came from the affected batch – though returned items would have been spread across many batches.

36. There was other evidence of more than 100% of affected stock returned. Some retailers do not spend the time sorting batch codes, so if a manufacturer recalls a product, the retailer might send all current stock back to the manufacturer, which can add up to more than the total affected units.

37. However, most businesses said it was very difficult to work out how many customers had been reached, or how much product was returned. In the majority of cases we could not get this information.

38. The retailer for the imported product said that, from their perspective, they should have recalled all batches of the product at once rather than specific ones. This recall notice was initially issued for one batch, but this was subsequently extended to a second (therefore covering all stock currently on sale).

Disposal (REMOVAL)

39. Unsold products subject to an allergy alert could be relabelled and resold if they were within shelf life and had been stored correctly in the interim. However, this did not happen in any of our cases. One small manufacturer of a product with a four-week shelf life decided to dispose of all product, rather than re-label, saying they would not have confidence reselling that stock.

40. One retailer volunteered information on its disposal process, confirming that they would charge the manufacturer for disposal if the manufacturer did not collect the recalled and withdrawn product. They also said that in many cases the manufacturer would want to collect product, either to test it to understand the problem, or because it might be required for insurance claim loss adjudicators.

41. The manager in that retailer had previously worked in a manufacturer, where there was previously concern about recalled products not being disposed of appropriately, and re-entering the market, for example through car boot sales.

Post incident review or action (REVIEW)

42. Several of the businesses described follow up action they planned to take, which included carrying out post-incident reviews, changing authority required for lane re-allocation in production lines in a factory, additional training for staff, checking parts of machines liable to break after each batch, or for retailers seeking assurances from the manufacturer.

43. In several of the cases involving small businesses, the Local Authority said they would work with the business going forward to improve their understanding of labelling requirements or improve the safety of manufacturing processes. For larger businesses, the Local Authority talked of checking resolution of the issue at the next regular inspection.

Liaison with the Local Authority (IDENTIFICATION)

44. Local Authorities generally had more contact with smaller businesses than large ones. For one allergy case, the product was a new launch, and the LA had been advising the business on what they needed to do to launch a new product in advance, including labelling, but still the label was not right, so the product needed recalling. The LA also had to work hard to obtain traceability information from the business, and advised on appropriate action to recover stock.

45. For the small business microbiological case, the issue had been building for some months. The recall was triggered by a court injunction brought by the LA EHO against the business for manufacturing processes that could allow microbiological contamination. The LA also carried out laboratory tests. The business had recently changed hands, and there were traceability issues

associated with the new owner not understanding what stock had been produced, and who it had been sold to before he took over.

46. The FSA/FSS incident handler for the branded product case said that a big business would usually have taken actions immediately. However in that case, the business seemed a little unclear on some of the steps. The incident handler had to go back to the business with a number of questions to clarify details (though answers were all provided promptly).

Business helpfulness, knowledge and responsibility (VARIOUS)

47. Many of the businesses wanted to carry out a recall promptly. As noted above, many had decided to recall before contacting FSA/FSS or the Local Authority. Most of these were large businesses, but one small business had also carried out the recall, including issuing Point Of Sale notices, before contacting FSA/FSS. Many businesses wanted to carry out a recall diligently to protect their brand reputation.

48. However, there were a couple of businesses not so keen to carry out a recall. Both were related to microbiological issues, where the decision to recall required a greater level of judgement about the risk posed, rather than being as clear cut as some allergy cases. There was one business that was not particularly accommodating. For example, they did not let the Local Authority EHO enter their premises, so the council had to obtain access permission from a court. The business also wrote to its distributors after the recall implying the recall was not necessary but they were carrying it out to comply with the LA, who had 'condemned tons of perfectly good stock'.

49. One of the small businesses involved in an allergy recall was also not particularly helpful or responsive during the process, potentially due to not knowing what was required. The product listed Whey as an allergen rather than Milk, so technically did not meet labelling requirements, but it is likely that most milk allergy sufferers would know that Whey comes from Milk. It was also a newly launched product on a very small scale, both by volume and geographic distribution. The EHO at the LA wanted to work with the business to establish how many product lines there were, how much of each was produced, how much had been sold to end consumers and whether it could be recovered. After over a week from initial identification, the EHO lost confidence that the issue could be resolved without a full recall being issued.

50. One incident handler said that there were a few businesses (not all necessarily part of this study) that felt that if the FSA/FSS recommended a recall, as long as they carry it out, they as a business had been cleared of any responsibility: they were therefore happy to process the recall quickly but did not see the need to take further action particularly around contacting customers. An EHO in a separate case noted something similar: a small business can rely on the Local Authority to make decisions as then the business could not be held accountable, despite the regulations making it clear that the business is responsible.

Miscellaneous errors (IDENTIFICATION / REMOVAL)

51. For one allergy alert where the label on two products had been accidentally swapped during production, a visit to a store highlighted that the product with the allergy ingredient had been removed, but the product with which that label

had been swapped was still on the shelf. This did not present a safety issue as the remaining product did not contain any additional or allergenic ingredients (even though the label said it did), but the product being sold was not as described on the label.

52. In one instance, the problem was isolated to all production in part of a batch: production had been checked part way through and was known to be compliant up to that point. When the recall notice was published by FSA/FSS it listed the product batch code and best before date as usual, but also that the product was only affected if bought within certain dates. The retailer's notice did not say this, and the product with the same batch code and best before date was still on sale sometime after the recall was issued. While this might have come from the first part of the batch and so been unaffected, it was confusing for customers that the product on the shelf or that they might have purchased should be recalled according to the in-store notice. It could also have led to errors that there was no way to tell from the packaging whether the product should have been recalled or not: it was only by the delivery date to the store/purchase date that it could be identified. When questioned about whether an item delivered in an online shop should be recalled or not, the customer service staff at the store were unsure.

53. One small business produced and distributed Point Of Sale notices as soon as they knew a recall was required. Neither the EHO nor the FSA/FSS incident handler saw the notice before it was circulated. The incident handler said if they had seen it then they would have advised several improvements, such as a clearer heading, including a photo of the product, and including a contact phone number. However, as the business had been proactive, the incident handler decided against recommending updating the notices.

54. The EHO in one case visited a couple of stores to check for Point Of Sale notices, and did not find one in every case. However, the business could provide email confirmation that the store had been sent a notice, and claimed to also have phoned them, so the issue was with the small store not putting up the notice when requested to by the manufacturer.

Other issues (VARIOUS)

55. One issue that a retailer wanted to ask FSA/FSS was whether there could be a way of informing them that they are not involved in a recall. They had heard about a recent recall of an own-brand product, and they asked FSA/FSS who the manufacturer was but were not told for commercial confidentiality reasons. The technical manager was being asked by their managing director whether they were exposed to the issue that had received publicity, and it took some time to confirm that they were not. It is not clear whether a system like this would actually be practical or legally acceptable.

56. One small business tried to fill in the FSA incident report notification on a smart phone, but had security warning messages, so did not complete it. They got their Local Authority to do it for them.

57. One LA referred to triggers that can contribute to a business making an error. One example is a change of owner. In one case one of the directors took on ownership and running of the business, but even though they had previously worked in the business they did not understand the production methods used, or the record keeping for traceability. This meant that they could not verify the

manufacturing process for the product, and when it was recalled they could not identify how much had been produced or where it had been sold.

58. There were discrepancies with Point Of Sale notices. Some retailers use the same notice supplied by the manufacturer, while others create their own. Allergy charities that alert members to issues also create their own notice for circulation, so the customer could potentially get four different-looking notices for the same incident: from the manufacturer or brand website, from the retailer, from the FSA and from an allergy charity.

59. One business that used a compound mix as a base ingredient questioned whether they would know about a change of ingredients. Their allergy alert arose because they added ingredients to the mix but only used the details of the mix for the ingredients list. However, they did say that if the mix supplier changed specification there is no process of communicating that. The business had copied details from the mix specifications when they first ordered it, but they did not update it every time they received an order, so if the supplier changed the mix specification they would not update their own labels.

60. There were some reported discrepancies between practices in different countries. Two particular examples included:

    a. For a case in Northern Ireland with very limited distribution but to both sides of the border, the Republic of Ireland authority (FSAI) issued a national recall some days before it was issued in Northern Ireland. FSAI were thought to issue a recall first and find full details afterwards, whereas the FSA in Northern Ireland wanted to understand the full distribution to see if a recall was proportionate first due to the small quantity produced.

    b. It was reported that there were issues with other EU states recalling food that was considered safe to eat. For some microorganisms, such as Listeria, there are two criteria: a lower level “Before the food has left the immediate control of the food business operator, who has produced it”, and a higher acceptable level for “Products placed on the market during their shelf-life”. The Italian authorities in particular had recalled some Scottish export products where the lower limit had been exceeded for products on the market, but not the upper limit.

61. Due to the number of Local Authorities in the country, each one will not necessarily deal with a recall on a regular basis. One business in a small Local Authority felt that the EHO was unfamiliar with the process and overreacted, as he was keen to have taken action, or ‘tick the right boxes’.

62. One recall occurred in a fairly large, well respected manufacturer. The business had recently had a change of key personnel, and there were a large number of issues that ultimately led to a court fine. The business had not informed their EHO of a serious contamination report from their own auditors for more than a month.

Areas not covered elsewhere

63. The areas below were due to be explored as part of this study, but are not specifically mentioned above. In these cases there was generally not anything

specific to cover that was not as would be expected, or it has been covered under other headings.

Risk assessments (REMOVAL)

64. Large companies had generally carried out a risk assessment before contacting FSA/FSS. Risk assessment was less formalised in small businesses. FSA/FSS also carry out internal risk assessments and in doing so involve colleagues from across the agency as appropriate, such as the allergy team or microbiological risk assessment team.

Preparation in advance (IDENTIFICATION)

65. Pre-incident preparation has generally been covered under other headings. Several large businesses talked about having plans in place ready to set up crisis management teams once an incident occurred. One retailer referred to a system for informing all of their stores in the case of a serious incident, with time limits on action being taken in each store to ensure product was removed from sale.

Traceability (IDENTIFICATION)

66. Traceability was mentioned by several businesses, Local Authorities and incident handlers as being very important to a smooth recall (or withdrawal). This was easier in some cases than others: in one instance the product was a new launch on a small scale, and the business owner had driven round several corner shops selling a few samples to those that wanted it. A change of owner in another small business also made traceability particularly difficult, as the shelf life was long and the paper records were not easy to understand.

67. One thing that could potentially reduce the scale of the recall in some instances would be to know which batches had gone to which supplier. This was known in the case of some large branded products, but not in every case.

68. Traceability was also important for risk assessments: if the product had only gone to a single supplier then a nationwide recall might not be necessary. Alternatively, one EHO wanted to take immediate action where traceability showed the product had been supplied to vulnerable groups (schools and hospitals).

Out of hours delays (IDENTIFICATION)

69. As noted under time to recall, there was a delay in one case due to bank holidays and a weekend. However, in most instances, cases happening out of hours did not delay the resolution of the case. In several cases, Local Authorities made inspection visits over the weekend, and businesses worked out of hours to confirm the scale of issues or finalise a recall notice.

Primary Authority (REVIEW)

70. In the cases studied, no particular issues were identified either with having, or with not having, a Primary Authority. One Primary Authority did mention that the factory where the issue occurred was not within their area, though the Authority did not think it was necessary to inspect the business immediately

rather than wait for the next regular inspection, so it is not clear that being in a different part of the country affected the resolution of the issue.

Conclusions

71. There is no ‘typical’ recall.

72. While the recalls studied are not necessarily representative of all recalls, they do provide some insights into the issues faced by different types of business and by their Local Authorities in different types of situation.

73. Some of the issues uncovered might be specific to that one situation. However, certain issues could be reviewed, to see whether any issues identified could be improved, or clearer guidance provided. Such areas include:

    a. Point of sale notices – promoting a consistent approach to where such notices should be displayed in stores; length of time they should be displayed for and guidance on where they should best appear online;

    b. Notification – provide clarity on when food businesses should notify the competent authority of an issue where food needs to be recalled;

    c. Provide good practice/recommended timescales for when a product should be removed from sale after a store has been notified that product is being recalled;

    d. Improving the effectiveness of communications with customers about food recalls;

    e. Providing guidance on roles and responsibilities within food recall processes including ownership of recalled food in relation to disposal and reprocessing.

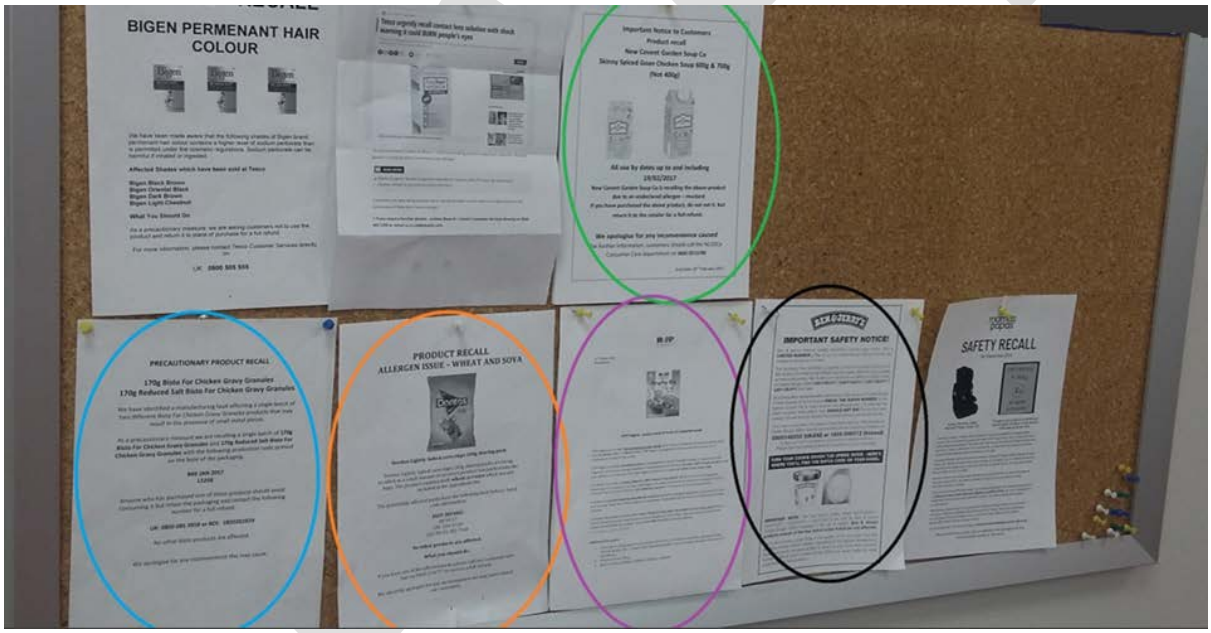
Annex A:

The photo below shows a recall notice in a large retailer, shown in the orange circle. It was printed on A5 paper and was obscured by the clothing. In addition, most customers would not naturally walk past the notice – the exit to the store without visiting the Customer Service desk is to the right of the Jason Bourne stand.

Annex B:

The photo below shows a store for a national manufacturer and retailer. The store was very small (almost the entire width of the store is shown, and the depth of the store can be seen in the mirror). They displayed two point of sale notices (highlighted). This is in contrast to a national retailer that this manufacturer supplies, which is shown in the following two photographs.

The photos below show the notice board in the major retailer visited in regards to the recall of the product in the photo above, around a week after the product had been recalled. The first photo shows the notice board in the red circle. Unlike the store in Annex A, this one is in the passage people walk down to exit the store, and it is on a sloping wall so angled slightly towards customers, though it is set back some way. The second photo shows the notice board more closely: the recall notice for the recall in question is not there, however there are eight other recalls: three non-food products, plus five food recalls: one that had been issued late on the evening before the store visit (green circle), one issued three weeks earlier (orange circle), and three historic recalls for products that were still within their best before date: recalls issued three months earlier (purple circle), five months earlier (black circle) and as far back as a year and a quarter earlier (blue circle).


BIGEN PERMENANT HAIR COLOUR
PRECAUTIONARY PRODUCT RECALL
PRODUCT RECALL
ALLERGEN ISSUE - WHEAT AND SOYA
IMPORTANT SAFETY NOTICE!
SAFETY RECALL

Annex C:

The photos below show the placement of a point of sale notice from a small branch of a large retailer (details have been blanked out). The left photo shows the product recall information notice, and the right photo shows where in the store it was positioned, circled in orange (the tills are to the left, adjacent to customers paying).

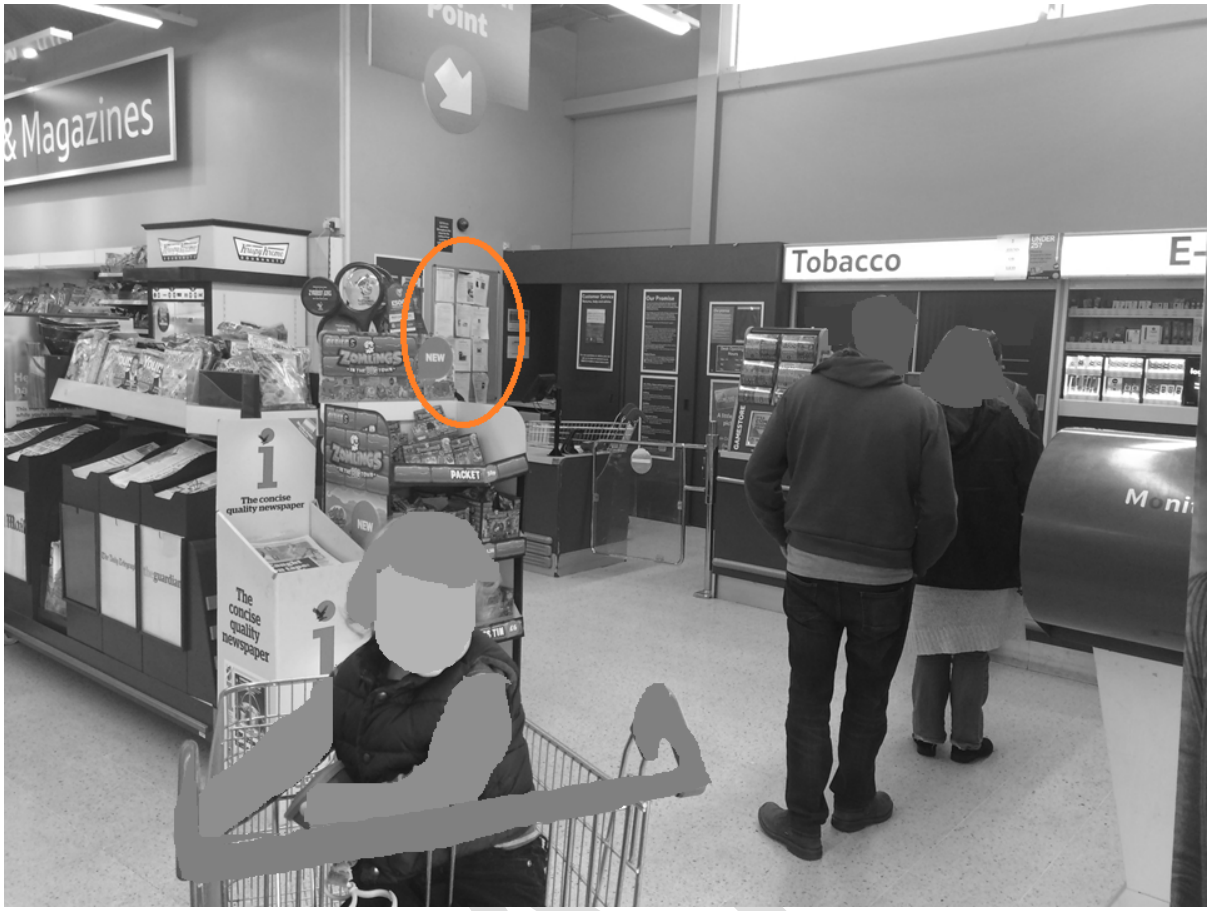
Annex D:

The following example shows the differences in how one Point Of Sale notice was shown in a large store compared with a small store for the same retailer. The first three pictures show the small store: the recall notice is displayed very close to the customer on the tills. However, the third photo shows that each till shows a different notice: depending which till you use is likely to affect which recall you are informed about. In addition, the self-service tills do not have any recall notices displayed on or near them.


Tobacco
Checkout Entrance


Checkout Entrance

The following photos show the large store of the same retailer for the same recall. This shows that the board was tucked away from where any customers would pass by. The board also contained at least 15 A4 black and white notices, some of which overlapped. Most were product recalls (both food and non-food), but there were also other notices. They would be very difficult to read from any point where a customer would stand, even those standing at the customer service desk. The store did have a big notice board behind checkouts that all customers would walk past as they exit the store, but this was only displaying community action projects rather than recall notices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