# EXECUTIVE SUMMARY

This Executive Summary comprises a selection of only some of the points discussed in Sections I and II of the Inquiry's report (and the Appendices). As explained in Section I, the Inquiry considered a wide range of sometimes complex matters; and any summary involves simplifications – this Executive Summary being no exception.

Further, as explained in the Preface, any major inquiry will tend to accentuate a few negative considerations. This tendency requires a balancing reminder about the many positive considerations – here including the impressive quality of Fonterra's people and plants, and its pre-existing commitments to food safety and quality and continuous improvement across the organisation.

## The WPC80 precautionary recall

X1. Very early on Saturday, 3 August 2013, Fonterra issued media statements headed "Fonterra advises of quality issue". These stated that Fonterra had advised eight of its wholesale customers of potential contamination in its manufacturing of a relatively small quantity of whey protein concentrate (*WPC80*), an ingredient used in various food products, including some designed for babies and infants. This advice related to the potential existence in the affected WPC80, and downstream food products, of a micro-organism, *Clostridium botulinum* (*C. botulinum*), associated with the toxic but rare condition known as botulism.

X2. The potential connection of *C. botulinum* toxins with the WPC80 and downstream products, especially infant formula, caused immediate grave concerns for consumers, Fonterra's ingredient customers and health safety agencies in New Zealand and overseas. Several countries imposed more or less focussed product bans on imports and sales, and precautionary recalls were undertaken by manufacturers.

X3. These concerns and consequences were relayed and compounded by intense coverage, in New Zealand and globally, in the traditional news media and in social media. This media coverage remained intense throughout much of August. However, it tapered off markedly following advice on 28 August 2013 by the New Zealand Government that further commissioned testing of the suspect Clostridium samples had established that they were not *C. botulinum* and they were not toxigenic. In other words, the earlier testing (pre-August, which had led to the precautionary advice by Fonterra and New Zealand Government) had involved "false positives". With hindsight, the consumers of products containing the relevant batches of WPC80 were never in fact in danger from *C.botulinum*.

## The Inquiry

X4. The Fonterra board promptly established an independent inquiry (*Inquiry*) into the WPC80 events. The Inquiry's terms of reference included verification of the relevant sequence of events (*narrative*) and identification of the stages within that narrative where choices were made within Fonterra which contributed to the occurrence and scale of the events and the effectiveness of the responses (*decision points*). More importantly, the Inquiry was required to report on lessons to be drawn from the narrative and decision points, including in respect of governance, management, culture, accountabilities, procedures and training, and from a range of perspectives (e.g. food quality and safety, crisis management, communications and government relations).

X5. To ensure its independence, the Inquiry was given its own mandate to review the entire narrative of the WPC80 events and responses, including the acts or omissions of the Board, management and of other Fonterra personnel. The personnel involved in the Inquiry team, and a majority of the oversight Committee are neither employees nor elected

directors of Fonterra. And the Inquiry proceeded without direction, monitoring or constraint by Fonterra's senior management.

## Inquiry focus on organisation, not individuals

X6. As with most critical incidents, neither a single event, nor the actions of a single person can be held entirely responsible for the WPC80 precautionary recall. Crises are usually the product of a chain of actions, decisions and coincidences, whose compounding effect triggers a significant threat to safety or security. Consistently with the preceding discussion, the Inquiry has made a conscious decision *not* to name individuals in this report. The Inquiry has necessarily focussed on issues broader than the performance of particular individuals. Individuals within Fonterra operated in the context of the organisation's contemporary processes and guidelines – or lack of such. Further, naming individuals who may have made errors of judgement could only (and gratuitously) create other difficulties for those who have already faced considerable stress in the context of the WPC80 narrative.

X7. The Inquiry has not recommended that "heads should roll" at Fonterra over the WPC80 events and responses for several reasons. *First*, "heads should roll" is essentially a colloquial reference to termination of employment, and employment law issues are properly a management responsibility and involve questions of confidence, privacy and fair procedures beyond the scope of this Inquiry. (As it happens, the Inquiry has not identified any action where the relevant Fonterra personnel were not seeking to act in what they assumed were Fonterra's best interests.) *Second*, the Inquiry has seen no basis to suggest to the Board any review of the employment of the Chief Executive. *Third*, because the errors of judgement which might be attributed to individual employees are essentially the result of gaps in Fonterra's procedures and training. *Fourth*, because the most valuable and long term consequence of errors of judgement by employees is to be able to identify and fix gaps in Fonterra's procedures, training, structures and incentives.

## Primary findings: "things that went wrong"

X8. While bearing in mind the reminders above about simplification of complexity, and Fonterra's qualities and achievements, the Inquiry has necessarily addressed two central questions, most simply stated as:

- What went wrong (the contamination concern events, and Fonterra's responses)?
- What needs to be done to avoid a repetition?

X9. This report addresses those questions in some detail by reference to the "narrative" of events and the "decision points" (i.e. where choices were made within Fonterra which contributed to the occurrence and scale of the events, and the effectiveness of the responses).

X10. The Inquiry found that the primary "things that went wrong" were as follows:

(1) Fonterra did not include any SRC tests in relation to any of its production of WPC, notwithstanding its acceptance of SRC tests under at least one contract with a major customer to manufacture products utilising WPC80.

(2) Some errors of judgement were made in preparation for the reworking process applied to the relevant WPC80 batches at Hautapu.

(3) The standard pre-start up automatic cleaning regimes used by Fonterra plants required improvement.

(4) There was insufficient senior oversight of the crucial decision to engage AgResearch to test for *C. botulinum*.

(5) The commissioning, design and limits of the *C. botulinum* testing were inadequate.

(6) Fonterra was unable to promptly and definitively track the destinations of the affected WPC80 batches.

(7) There was only belated recognition (and delayed escalation to senior management and

the Board) of the explosive reputational risk involved – a failure to "join the dots" between (a) *C.botulinum*, (b) infant food products, (c) consumer sensitivities, and (d) Fonterra's global reputation.

(8) Fonterra's crisis management planning, including the external communications aspects, was inadequate for an event of this kind and scale.

(9) Fonterra management of these events in the critical early period, including the external communications aspects, was not well executed.

(10) There was some lack of alignment and confidence between Fonterra and the New Zealand Government in the critical fortnight after the contamination concerns were advised to the Government and made public.

## Operational recommendations

X11. Inevitably, a list of things to be done to avoid events and responses of a comparable nature will track those matters identified as having "gone wrong" in the context of the WPC80 events and responses. These can be considered at both a practical level and a governance/culture level. Again, the risk of oversimplification should be kept in mind, as should the acknowledgements and reminders mentioned earlier.

X12. The principal operational recommendations by the Inquiry include:

*First*, that Fonterra's food quality and safety specifications and testing be reviewed to ensure that they are of "best in class" standard: consistent with the most rigorous requirements of customers, and with international best practice.

*Second*, that risk management and crisis management processes be strengthened, including by establishment of a specially trained and multi-disciplinary (but not full-time) Incident Management Team and regular relevant training, global best practice product tracing systems, and a new Risk Committee of the Board.

*Third*, that reputational risk assessment form part of the criteria for escalation and assessment of non-standard external scientific tests.

*Fourth*, that plant cleaning programmes be amended.

*Fifth*, that there be continued building of a directly-employed strong, specialist and experienced communications team, including in key global markets, supplemented with contracted high calibre local expertise where appropriate.

*Sixth*, that there be enhanced and sustained efforts to address a "Fortress Fonterra" perception held by a material proportion of key stakeholders, by Fonterra redefining the style and substance of its engagement with them.

*Seventh*, that the Inquiry be reconvened after nine months and again after 18 months to review Fonterra's progress on those recommendations.

(A list of all Inquiry recommendations is set out in the separate "Recommendations" section, and – with context – in Section I of the report. A number of these operational recommendations relate to work already in progress within Fonterra, including as a result of its August 2013 Operational Review: see Appendix J.)

## Recommendations relating to the Board

X13. The principal Inquiry recommendations relating to the Fonterra Board include:

*First*, the Board should endorse explicitly as a core principle that Fonterra, as "one company", always strives to perform at the best practice level for leading global food product organisations.

*Second*, the Board should similarly explicitly endorse the paramount importance of food quality and safety to Fonterra's global and local reputation.

*Third*, the "risk" component of the Board's Audit, Finance and Risk Committee should be transferred to, and developed by, a separate Risk Committee.

*Fourth*, the Board should accept greater responsibility for developing and maintaining relationships at the most senior levels of Fonterra's external stakeholders, including in government and media within and outside New Zealand.

*Fifth*, the Board should actively review ongoing progress towards shedding the adverse "Fortress Fonterra" perception held by a material proportion of external stakeholders.

## Specific matters

### *- Fonterra's plant operating standards*

X14. Insofar as the WPC80 events commenced with contamination during processing at one of Fonterra's operating plants, it is appropriate to record the relevant conclusion of the Inquiry team's international dairy industry expert. After his inspection of eight Fonterra operating plants, in the North and South Islands and in Victoria, he concluded that Fonterra is operating in a way expected of a good producer of nutritional products. That is a very high standard, even if there is always some room for further improvement.

### *- Absence of "routine" tests for C.botulinum?*

X15. There is no available "routine" test to identify *C. botulinum* in dairy processing. There can be (and is already) expanded routine testing for SRC levels, but identifying *C. botulinum* is very difficult – the most definitive tests still involve injection of test mice for mouse bioassays. An August 2013 report by the International Union of Microbiological Societies (*IUMS*) explains that detection of *C. botulinum* is difficult, partly because of the numerous different strains which require multiple different methods to detect. Furthermore, confirmation of toxin production requires mouse bioassays which not only raise ethical issues, but also are not suited to routine food microbiology laboratories as special security and biosecurity precautions are required. There are only a limited number of specialised laboratories in the world that are able to do this work. And even then, mouse bioassays have drawbacks, including mice deaths related to causes other than *C. botulinum.*

### *- Failure to escalate*

X16. The Inquiry received substantial comments about organisational culture and escalation, in the context of decision-making. In particular, those comments reflected the well justified frustration that knowledge of the WPC80 issues arrived far too late at senior management and board levels. Insofar as the cultural objective here is the asking of pertinent questions about food safety or non-standard testing issues, including asking more senior personnel, the Inquiry agrees that this is essential, and that all Fonterra personnel should be encouraged (from induction) to consider their work in its wider context – to be able to "join the dots".

X17. On the other hand, a simple emphasis on escalation may be a recipe for the avoidance of decisions and

the responsibility of managers to make decisions. It is not practicable to be prescriptive about any particular balance between these factors, and others (including efficiencies). The objective will always be considered and intelligent decision-making, and discussion (including escalation) where there is doubt.

### *- Attention to stakeholders, relationships*

X18. The sheer size of Fonterra's economic footprint is enough to attract exceptional scrutiny. But this is compounded by its statutory foundations (the 2001 merger which created Fonterra required enabling legislation), and its being so large in the New Zealand economic context that it has come to be perceived as the national economic flag bearer. Those factors attract heightened political and news media scrutiny, and a sense of the public as a stakeholder, not applicable to other private New Zealand businesses.

X19. A perception of Fonterra that was conveyed to the Inquiry, mostly by those outside the organisation, was of self-centredness – that Fonterra is focussed on its own immediate interests and insufficiently concerned with the interests of, or relationships with, others. For any business, a perceived neglect of some stakeholders is problematic. For Fonterra, with its involuntary "national champion" status, such perceived neglect requires serious remedial attention.

X20. The larger the organisation, the harder it needs to work to ensure its stakeholder relationships are trusting and sustained, that it acts with transparency and credibility and it does not suffer from lack of responsiveness and accusations of being a "fortress". Based on the views put to the Inquiry by a large number of different stakeholders, Fonterra is not immune from this imperative. (See Appendix I.)

X21. These views evidently persist in some areas notwithstanding Fonterra's serious efforts to build up the relationships with its stakeholders. Thus, for example, Fonterra's recent and current roll-out of the "Milk in Schools" programme is (at some NZ$20m per year) the largest community and social responsibility (*CSR*) programme in New Zealand's history. Nevertheless, the Inquiry considers that one of the most important steps Fonterra should now take is to use this opportunity to review and enhance both the substance and the style of its engagement with the people, organisations and communities that are important to it, to re-establish trust (where necessary) and to ensure lasting, mutually-beneficial relationships.

### *- Crisis management planning, performance*

X22. The need for preparations for crises, including credible and relatively frequent simulations, is well understood in international business. Close to home, Air New Zealand was cited to the Inquiry on several occasions as exemplary in this regard. And it is an important aspect of a food products business. As noted earlier, while the WPC80 events were complicated because the immediately affected product was an ingredient, and the Inquiry has all the benefits of hindsight, the Inquiry is satisfied that better crisis management processes and planning within Fonterra, including rehearsals and a designated crisis (or incident) management team, would have made a substantial difference.

X23. In the first few days after the WPC80 issue became public, Fonterra did not seem to make it clear the recall was precautionary, it did not say sorry, and it was inconsistent in its tone – sometimes quite alarming, at other times seeking to minimise. The persistent adjustments to the estimates of affected product were corrosive of Fonterra's credibility with Ministers and officials. There is a significant body of research and "best practice" knowledge on how to promote strong relationships and communicate during usual times, and in times of risk and crisis, so as to maximise trust and credibility. Fonterra's communications style and substance did not consistently demonstrate the characteristics of that knowledge.

### *- Regulatory framework*

X24. The nature of the regulatory framework is a matter for the New Zealand Government. As this Inquiry could not require information and attendance by government agencies, that topic is appropriately considered in detail by the current Ministerial Inquiry (which has relevant statutory powers). However, on its analysis, and its comparison with overseas regime, this Inquiry considers the New Zealand regulatory architecture to be sound. Further, this Inquiry did not see the various cumulative factors contributing to the WPC80 narrative as having been compounded by any deficiencies in the regulatory framework. The Inquiry did see scope for significant and sustained investment in deepening relationships and confidence between Fonterra and both regulatory organisations and the New Zealand Government generally.

### *- No assessment of government agencies*

X25. The Inquiry has not assessed the performance of various government agencies and personnel during the WPC80 events for several reasons: *First*, basic principles of natural justice count against any assessment where the party to be assessed cannot engage fully with the assessors. That is the position with government agencies and personnel who generally have no direct obligations to Fonterra, but do have their own accountability and obligations under statute, or to Ministers. *Second*, there is a need for both Fonterra and government agencies to invest more (and more consistently) in improved relationships. This objective could only be damaged by this Inquiry seeking to judge those government agencies on incomplete information, and then reporting such judgements to the Board and more widely. *Third*, this is a topic eminently suitable for the Ministerial Inquiry.

## Will anything really change?

X26. Yes. The Inquiry is confident that both the Board and the senior management of Fonterra have a strong and genuine belief that Fonterra must change (by making major operational improvements and re-evaluating its stakeholder relationships) in the light of lessons from the WPC80 narrative.