T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the Closure of I Cook Foods Pty Limited

Melbourne—Thursday, 2 September 2021

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WITNESSES *(via videoconference)*

Professor Brett Sutton, Chief Health Officer,

Dr Angie Bone, Deputy Chief Health Officer,

Mr Greg Stenton, Deputy Secretary, Corporate Services,

Mr Paul Goldsmith,

Ms Pauline Maloney, and

Ms Sally Atkinson, Department of Health.

The CHAIR: Thank you, everyone, and welcome back. I am very pleased that we are now joined by Professor Brett Sutton; Dr Angie Bone, the Deputy CHO; Mr Greg Stenton, the Deputy Secretary of Corporate Services; Mr Paul Goldsmith; Ms Pauline Maloney; and Ms Sally Atkinson, all from the Department of Health. Thank you again for joining us.

I am Fiona Patten, the Chair of the committee. I am joined by Dr Tien Kieu, the Deputy Chair; Mr Craig Ondarchie; Ms Kaushaliya Vaghela; Mr David Limbrick; Ms Wendy Lovell; Ms Sheena Watt; Ms Georgie Crozier; and Dr Matthew Bach—the people swishing around on my screen.

If I could just also advise that all evidence taken is protected by parliamentary privilege as provided by the *Constitution Act* and further subject to the provisions of the Legislative Council standing orders. Therefore any information that you provide here today is protected by law during this hearing. You are protected against any actions for what you say here, but if you go elsewhere and repeat the same things, those comments may not be protected. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

As you would be aware, all the evidence is being recorded by our Hansard team, and you will be provided with a transcript of today's hearing. I would encourage you to look at it and make sure that we have not misrepresented you or misheard you. Ultimately that will form part of our report and be made public on our website.

I understand there is an opening statement that will be around 10 minutes, and Professor Sutton, if you would like to open.

Prof. SUTTON: Thank you, Chair. And thanks, committee members, for the opportunity to speak. You have heard who I will be joined by, so I will not reintroduce them. I would like to acknowledge Mrs Painter's next of kin and provide my condolences as well.

I understand the purpose of the reopening of this inquiry is to deal with a matter not specifically addressed when the inquiry first sat: namely, the emails from Mr Ray Christy of Knox City Council to the department on 22 February 2019, which suggested that the patient was on a soft diet and the impact this has on testimony previously provided to this inquiry. First I would like to start by saying that, save for one specific matter for correction, which I will address in a moment, I stand by the testimony previously provided to this inquiry. As such I will not readdress the inquiry on the matters subject to that previous testimony and will focus on the additional information related to the Ray Christy emails.

With respect to these emails I would like to address two primary points: firstly, these emails postdate the making of the closure order and were therefore clearly not something that I could have taken into account and obviously did not take into account in the making of the closure order; and secondly, even if these emails had been brought to my attention at the time or shortly thereafter, they would not have changed my decision to issue the closure order.

The first point is a simple one: I issued the closure order on I Cook Foods under the powers of the *Food Act* that had been delegated to me by the secretary to the department on the evening of 21 February 2019. This closure order was served on I Cook Foods at their premises at 4.00 am on 22 February 2019, prior to morning

production commencing at half past 4. Mr Christy's first email to the department, which has recently been brought to my attention, was sent at 10.34 am that same morning. A subsequent email was sent by Mr Christy at 12.41 that day. As such, clearly Mr Christy's emails, even if they had been relevant and provided to me, which I will get to in a second, were not something I could have taken into account at the time of making that decision to issue the closure order. Nor, should I add, do I think it was a critical input that I should have waited for before being in a position to make a decision on the closure order, given all the information provided to me indicating that there was an immediate risk to public health arising from the food produced by I Cook Foods.

Secondly, I wish to address the relevance of the Christy emails and the bearing they would have had if they had come to my attention. I should point out the Christy emails were considered and appropriately addressed by the relevant teams and therefore were never escalated to me. I will allow Dr Bone to address that in a moment.

As I have discussed previously with this inquiry, at the time of making the closure order the following matters were known to me based on oral and written information provided by several authorised officers over a number of days prior to that order. First, after the department was notified of the case of listeriosis confirmed by blood culture, the department conducted interviews with her next of kin, as you have heard, and the treating doctor to obtain the food history for the four weeks prior to the onset of her Listeria infection, including information on the patient's food selection whilst in hospital. This investigation included email advice from the principal infection control consultant at the Knox Private Hospital that the patient was on a full ward diet, food served at the hospital was provided by I Cook Foods and any food items that are recognised as high risk for Listeria were supplied through I Cook. I understand that a copy of this email has been provided to the inquiry.

I would like at this juncture to point out that when I previously addressed the inquiry, I erroneously referred to I Cook being Knox Private Hospital's sole caterer. This is what was initially understood and had been told to me. I have since been informed that subsequent information provided by Mr Christy indicated that this was incorrect, and I do apologise for any confusion caused. Of relevance, items identified in the food history as being consumed by the patient while in hospital were sandwiches, and it was known that I Cook Foods provided the hospital with sandwiches for those on a full ward diet as well as providing a range of other foods. For the purposes of this investigation, nothing turned on whether I Cook Foods was or was not the sole caterer for the hospital.

Second, the department asked Manningham council and the City of Greater Dandenong to take food samples and environmental swabs for testing from multiple sources in order to cast a wide net to try and capture all the potential sources of infection. The results for food and environmental samples from Coles, Woolworths, Mirabella Bros and Aveo Domaine retirement village were all negative for Listeria. However, at the time of issuing the closure order Listeria species had been detected in seven food samples at I Cook Foods premises. Six of these had grown *Listeria monocytogenes*, the organism responsible for invasive listeriosis, and four of these had grown *Listeria monocytogenes* that had the same molecular serotype and the same binary type as that found in the patient. It was later shown that Listeria isolated from these four foods had exactly the same genetic sequence—or fingerprint if you like—as each other and that it was a very close match to the strain found in the patient, providing strong evidence of a link between I Cook Foods and the patient. Indeed this strain of Listeria with this particular genetic sequence has not been matched to any other isolates in Australia before or after this event, so there is really no other reasonable explanation that the source of the patient's infection was anything other than I Cook Foods.

Third, reports from senior environmental health officers at the City of Greater Dandenong stated that I Cook Foods staff, including the food safety supervisors, had little understanding of food safety practices and that the food safety program was inadequate for the scope and scale of production. These deficiencies were subsequently confirmed when the department's authorised officers visited the I Cook premises on the day after the closure order was issued to determine what specific remediations were required before I could lift or revoke that closure order.

Fourth, the City of Greater Dandenong advised the department that I Cook Foods supplied 10 Melbourne hospitals, eight council Meals on Wheels programs and two aged-care facilities. I was informed that I Cook Foods prepared approximately 7000 meals per week. It should be assumed that in all of those particular settings vulnerable patients and residents make up the vast majority if not everyone in those settings. That indicated to me that there was potentially a large number of individuals who could be exposed to Listeria and that this could be a very significant public health risk, because the infection could be invasive, infecting the blood and/or brain

in those most vulnerable, causing serious illness and death. If there was ongoing exposure to contaminated foods and subsequent infections, then further serious illness and/or deaths were a strong possibility. As I have stated previously there was no single piece of information that I used in isolation to come to the decision of the closure. It was on the basis of that collective picture.

In light of this, the emails from Knox City Council suggesting that the patient was on a soft diet for one or more days, and we have heard which admission it appears to apply to, would not have in and of itself impacted my decision on the closure order. The information supplied by Mr Christy that the patient was on a soft diet contradicted the advice obtained by the department directly from a member of the infection control team at Knox Private Hospital with respect to that first admission after conferring with the ward's menu monitor, who confirmed the patient was on a full ward diet for the period 13 January to 23 January 2019. That is just prior to her being diagnosed with listeriosis. Even if the patient may have been on a soft diet for one or more days in that time, the overwhelming evidence of the presence of Listeria in I Cook Foods samples being so closely related to that from the patient would suggest that she had come into contact with food originating from I Cook Foods regardless of other potential diets during her days in hospital. In any case by the evening of 21 February, when I issued the closure order, it was clear that investigations of I Cook Foods had identified the presence of *Listeria monocytogenes* at their premises and inadequacies in their food safety practices and their food program.

That was the information available to me for my judgement, and given these concerns, regardless of the potential days of soft diet and other suppliers, I would have considered it appropriate to issue the closure order to ensure that these matters were addressed before I Cook could resume producing food for vulnerable people in the community. I will allow Dr Bone to continue. Thank you.

The CHAIR: Dr Bone, I am just very conscious of time. You have got about 4 minutes. I do not know if you and Mr Stenton want to divide that. Mr Stenton might like to answer the questions fully and give his statements later in the day. Dr Bone.

Dr BONE: Thank you. So yes, thank you, everybody. I will go as quickly as I possibly can, but I think I have some key information that is important for you to hear. Really I am going to address the inquiry on the investigations undertaken to determine the source of Listeria infection in the patient, particularly in light of those emails from Mr Christy on 22 February. I will not reiterate how important *Listeria monocytogenes* is for public health or how some of those investigations can be quite challenging, but I do want to emphasise that our main aim is to prevent or limit any ongoing risk to public health, and that is achieved by acting in a timely manner to identify risk and then try and remove it.

From the department's perspective the process undertaken to investigate the source of Listeria infection in this patient was conducted in the usual manner and followed usual processes following notification of a listeriosis case. I understand Mr Christy spoke to the inquiry about the specific procedure followed for a single case of gastroenteritis. I should pause here to make it clear to the inquiry that this was a case of listeriosis and not a single gastroenteritis case and also be clear that the two situations are managed very differently. Gastroenteritis refers to inflammation of the lining of the stomach or intestines and can be caused by things like salmonella or campylobacter. Whilst we know that *Listeria monocytogenes* occasionally causes diarrhoea, that is not the main symptom and it is not often observed; it is usually a septicaemia.

Gastroenteritis cases are about 100 times more common—probably more—than listeriosis, and the investigation of a single gastroenteritis case is usually much more straightforward. There is a shorter incubation period for pathogens, and it is much easier to get a food history in that situation. As such, single cases of gastroenteritis are usually referred by the department to council to interview the patient in question and follow up any risk factors. In order to do that councils are provided with the case's personal details. However, in cases of listeriosis, such as this one, the patient and their next of kin are interviewed by the department, and it would not be usual for us to pass details on to the council.

Victoria's guidelines for the investigation of gastroenteritis are available on our website, and they set out the various actions expected of councils. They clearly state that listeriosis cases are not referred to local government but investigated by department officers, who may request assistance from local government for specific tasks.

The CHAIR: I am sorry to cut you off, Dr Bone, it is just that we do have a short period of time. No doubt we will explore more of the information that you have to provide, and Mr Stenton no doubt will do that. If I could start. Given the numbers that you spoke about, Professor Sutton, of the variety of locations, the possible 7000 meals that were coming out of I Cook Food, is it surprising that there only appears to have been one case of listeriosis and there were no other recorded cases at Knox Private Hospital as well?

Prof. SUTTON: Thank you, Chair. I do recall addressing this in the original inquiry. There are a number of steps that you need to go through in order to have a confirmed case of listeriosis, invasive diarrhoeal listeriosis. There will be a number of people who consume potentially contaminated food or indeed contaminated food who do not become unwell. There are a proportion who may have a milder illness, and a diarrhoea illness is another potential consequence. If they provide a faecal specimen to their GP or to an emergency department and there is a specific request for Listeria to be looked for, then a diagnosis might come from that gastrointestinal illness. Invasive Listeria is either an infection of the bloodstream or infection of the lining and substance of the brain. Clearly that is a much more serious illness. There would be tests done for those individuals. But you need a blood culture in order to identify it in someone who has got a fever, and you would need a lumbar puncture or some other diagnosis—based on a CAT scan or MRI scan, for example—that would support meningitis.

The reality is not everyone is vulnerable to invasive listeriosis. There may well have been a number of people who were exposed to contaminated food who had a milder illness, who never got diagnosed, and there may well have been a number of people who would have become unwell and had serious illness if that closure order had not occurred.

Mr ONDARCHIE: You do not know that. You do not know that, though.

The CHAIR: Excuse me. Mr Ondarchie, please. Thank you, Professor Sutton. Yes, I appreciate that. Just turning to Mr Christy's emails, which really were part of the reason we reopened this inquiry, and personally I was quite surprised reading from Mr Christy's emails that the patient had been on a soft diet the whole time and therefore could not have consumed sandwiches provided by I Cook Foods. Were you or Mr Goldsmith—Mr Goldsmith, I believe these emails were addressed to you—surprised by his findings? Was this something that caused you to go back and review what information you had?

Prof. SUTTON: For myself, Chair, I have only become aware of these emails very recently, so they were not provided to me at or around the time of the closure order, so I will allow Angie or Paul to speak to how they considered that information.

Dr BONE: Yes. I am happy to answer that question. We discussed the Christy emails at our incident management team on 22 February, so the day after the very early morning when the closure order was issued. We considered them, but we also compared them with the other information that we had. We saw that he had said that it was more than likely first of all and then it was confirmed, but his information was not specific to the time period and did not say who had given him that information, and we had this whole host of other evidence from our discussions with the infection control nurse and from the discharge summary, all of which stated that the lady was on a full ward diet. And of course we had the information from the City of Greater Dandenong about concerns about food safety programs and practices, and we had the strongest evidence, which was the typing link and the genetic link between the Listeria in the case and the foods at I Cook Foods. So in the end we just decided that the information was not as credible as the other information that we had.

The CHAIR: Thank you, Dr Bone. Thank you, Professor Sutton. Dr Kieu.

Dr KIEU: Thank you, Chair. Thank you, all from the department, for appearing today and also for providing us with the chain of emails about the food diet. I may have a question for Professor Sutton. First of all, thank you very much for appearing. I know that you are very busy with the situation at hand in Victoria and in Australia. I will just go back to what you said at the previous hearing, quote:

> No one single piece of information was used in isolation to come to that decision—

namely, the closure of I Cook foods.

> Rather, it was the collective picture of public health risk that I believed I Cook Foods' continuing food production represented.

Just now in your opening statement you presented several pieces of evidence leading to your decision and also the issuing under the delegated power under the *Food Act*. Was there any single evidence that most strongly influenced you in coming to that decision?

Prof. SUTTON: The really key ones are the epidemiological link through the food history that I Cook Foods supplied Knox hospital and that the patient ate foods in Knox hospital that were described as the normal ward diet, which I Cook supplied foods for. That was one key piece. Of equal and maybe even greater importance was that genetic fingerprint or the genetic typing of the *Listeria monocytogenes* which, as I say, was identical across food types within the I Cook Foods kitchen and very, very closely related to the sample from the patient—and that was closer than any other food or environmental sample taken from across Australia for some years prior to that time and for years subsequent. So those two pieces of information in particular really linked the plausible exposure to contaminated food and showed that genetic link that we do in the same way for COVID diagnosis to understand where it has come from but also understand, for example, whether someone has been exposed to that infectious agent.

Dr KIEU: Yes. Also I note that, apart from the City of Greater Dandenong and the department, you have also sought assistance from other councils like Whitehorse, Knox and Manningham. What did you find there?

Prof. SUTTON: There were a number of deficiencies that were identified in terms of food safety understanding and food safety practices by the department's environmental health officers but also through the third-party auditor. Angie may have more of the specific details; I think she was going to go to them in her presentation. But there were a number of deficiencies that, again, between environmental health officers from the City of Greater Dandenong council, the department and independent auditors, were found.

Dr KIEU: Okay. So I just want to close this session, my part, with the remark that Mr Cook, in appearing last week, said something about the department or some other people using science to bamboozle the committee, which I myself, a scientist, could not understand. That is all. Thank you.

The CHAIR: Thank you. Ms Crozier.

Ms CROZIER: Thank you very much, Chair. And thank you all for being with us this afternoon. Dr Sutton, I just want to go straight to the death certificate of Mrs Painter. She died of acute pulmonary oedema, ischaemic heart disease and Listeria meningoencephalitis, but an autopsy was not undertaken. So, based on that, there is no way to determine cause of death, is there?

Prof. SUTTON: Cause of death is not only confirmed through autopsy. The great majority of people who die have a diagnosis for cause of death on the basis of their clinical presentation, pathology samples that are taken, imaging samples that are taken. So I do not agree with that. The pre-existing condition of ischaemic heart disease would have made her more vulnerable to pulmonary oedema. Equally, having invasive Listeria in the bloodstream, so a septicaemia, is known to cause pulmonary oedema, especially for people who have got pre-existing heart disease, and indeed inflammation of the lining of the brain and the substance of the brain is one of the most serious illnesses that you can get. It is meningoencephalitis with bacteria, that has a one in four mortality rate for those individuals who have that infection.

Ms CROZIER: If I can just go into this, you have just given us a whole heap of documents, just a few minutes before we came into this hearing. In that there is some pathology, and it states that on admission to hospital Mrs Painter had four days of feeling unwell, blood tests were taken, faecal cultures, and it showed that she had a history of gastroenteritis. It was subsequently found that she had colitis and gastric ulcers. Now, Listeria can cause gastroenteritis, can it not?

Prof. SUTTON: Yes, it can.

Ms CROZIER: And in some of these blood tests—I think Dr Bone was referring to salmonella, but it was not detected in the faecal sample that was taken when Mrs Painter was admitted, and there are other notes in these admission notes that talk about her being unwell for quite some days before she was admitted to hospital on 13 January. So is it entirely possible that there could have been an underlying case of Listeria that had caused her gastroenteritis for admission?

Prof. SUTTON: I do not believe so. She obviously had a history of colitis. The—

Ms CROZIER: But how do you say that when no specific tests were done at that time of admission to rule it out?

Prof. SUTTON: Well, just to answer, she presented with colitis and she had investigations of gastroscopy and colonoscopy that confirmed that. You can have both infectious and, not uncommonly, non-infectious causes of colitis, and with a recurrent illness it is more likely to be non-infectious. The—

Ms CROZIER: But her neutrophils were raised and there was—you know, as time went on she got sicker.

Prof. SUTTON: Indeed, and that can be caused by any other infectious or non-infectious cause of colitis. She did not have a diagnosis of Listeria at that time, and she developed fever and had blood cultures taken several days later. You would not have an invasive Listeria infection and not become critically unwell with septicaemia for several days after your admission.

Ms CROZIER: But Listeria symptoms can appear anywhere between three and 70 days post-exposure and can include symptoms such as what Mrs Painter experienced; is that correct?

Prof. SUTTON: Yes and no. The incubation period for illness is often described as between three and 70 days. In fact it is between three and 67 days in the literature. Up to 67 days is exclusively for pregnant women. For other invasive listeriosis cases it is essentially up to 14 days only. So for septicaemia and meningoencephalitis it does not have an incubation period up to 67 days; it is really only up to 14 days. She spent 10 of those 14 days in hospital prior to developing her illness, so the great majority of the likely incubation period where she might have been exposed to Listeria was during her Knox Private Hospital admission.

Ms CROZIER: There is no definitive here, is there, Dr Sutton? Because of her medical certificate, the death certificate, you cannot exclusively say that she died of listeriosis based on that death certificate—that is correct, isn't it?

Prof. SUTTON: Yes. You cannot say on any one single piece of information that it is absolutely definitive. What I am saying is that if you have invasive listeriosis you have got a one in four chance of dying. Whether or not it was the sole cause of her death or the most significant contributor to her death, she got invasive Listeria disease from eating contaminated food that was linked to the I Cook kitchen both epidemiologically and genomically.

Ms CROZIER: But you have already admitted in this hearing that you got it wrong in the evidence that you provided to the committee last year. You said—

The CHAIR: Ms Crozier, you have run out of time.

Ms CROZIER: What a shame.

The CHAIR: Yes. Thank you. Mr Limbrick.

Mr LIMBRICK: Thank you, Chair. Thank you all for appearing today. Professor Sutton, you mentioned something at the start of today about how you were not aware of the multiple suppliers that were going to the hospital. And in the very short time I have had to look at these email trails, they seem to definitively say that I Cook Foods are the only supplier to the hospital. Does this sort of indicate that at the time the department was not aware that there were other food suppliers, that they were acting as if I Cook Foods was the only supplier? Because these emails do not seem to indicate any sort of awareness that I can see that there were other suppliers, and therefore they would not have been investigated if they were not aware of them.

Prof. SUTTON: I will pass to Angie, because she was involved in the incident management team on the following day that had that additional information from Mr Christy, if I may.

Dr BONE: Yes, certainly. Happy to answer that. I think it is important to know that we only investigate suppliers of high-risk foods for Listeria, just to try and focus our investigations. So the information that we were being provided by Knox Private Hospital through their infection control team, which is our normal procedure, was that any high-risk foods for Listeria were provided by I Cook, so that is why our attention went to I Cook. It does not mean that that was our exclusive focus. As you have heard, we were investigating other

areas. But we followed the evidence, and eventually the focus became clearer and clearer that I Cook had to be the focus of our investigation because of everything that we were finding. I hope that answers your question.

Mr LIMBRICK: Thank you. But we also heard evidence that there were some other high-risk foods—like apparently some of the soft sandwiches—that were being produced that were not from I Cook Foods; they were produced within the hospital itself. So were those sources investigated as well?

Dr BONE: Yes, it is correct that there were some other high-risk suppliers, but we only heard about those on 22 February after the closure order, and by then we had such a clear focus on concerns about an ongoing risk to public health that we focused on that as opposed to looking at those other suppliers. I think it is worth also noting that there were no further cases of Listeria after that point and there have been no further cases ever since with that particular genetic type. I think our focus was in the right place in I Cook.

Mr LIMBRICK: But those samples from the other suppliers, like meat products, for example—were they not tested?

Dr BONE: They are tested routinely under the regulatory regime that is managed by PrimeSafe, but not specifically for this particular investigation.

Mr LIMBRICK: Okay. I understand. Thank you.

Prof. SUTTON: And just to add, Mr Limbrick, I think Dr Bone is saying: if there were an unmitigated ongoing source of contaminated food that had not been identified—because if it had been through routine testing or through other illness it would have been known to us—and if that had continued without being mitigated, we would have seen ongoing cases in the community for another source that was never identified.

Mr LIMBRICK: But didn't you just say earlier that there were thousands of these meals sent out from I Cook Foods that we did not see any results from, that were not identified; we only saw one that was identified. Surely that could have been the case from another supplier, couldn't it?

Prof. SUTTON: Listeria, as you have heard previously through the inquiry finds an environmental niche and then continues to cross-contaminate or contaminate food in those premises unless it is identified and addressed. So if there were another supplier, whether primary production or a kitchen, that was never addressed, then the likelihood of there being no further illness with it not being addressed is quite small.

Mr ONDARCHIE: But you did not check.

Prof. SUTTON: We have had no subsequent identification of genetically related *Listeria monocytogenes* anywhere in Australia with this genetic fingerprint.

The CHAIR: Thank you. Ms Vaghela.

Ms VAGHELA: Thanks, Chair. And thanks to the team for appearing today in front of the committee for this hearing. My question is for Dr Bone. The committee heard in the inquiry last year that the department first became involved in investigations on 25 January after being notified by Knox Private Hospital that the patient's blood culture test had grown Listeria. How did your team determine the source of the patient's listeriosis? You touched base on this one, but I would like to hear a little bit more about this.

Dr BONE: Yes. So we have a very clear listeriosis protocol. One of the first things we do is try to speak to the patient to find out what their food history is. If we cannot find out that food history directly from the patient, then we go to other sources. Particularly if a case is related to a hospital, we are speaking to the infection control team because they are the people who are responsible for infection control in the hospital but also have access to the medical records, unlike, say a catering team who would not have access. Then we obtain a four-week food history because of this longer incubation period. I noticed that Mr Christy was referring to a four-day food history, and that is really not correct for a listeriosis case. So we look at all possible sources. We cast the net as wide as we possibly can, and then we will approach council to go and take samples and just check the food safety processes of the various suppliers, and that is what we did in this case. I hope that answers your question.

Ms VAGHELA: Yes. So then what evidence made you decide that there was a need to ask the City of Greater Dandenong to further investigate I Cook Foods as the potential source of contamination?

Dr BONE: As you will see from the emails that we were getting from the infection control nurse, we were being clearly told that the supplier of any high-risk foods for Listeria was I Cook Foods, so that is why we went straight to I Cook Foods, and the City of Greater Dandenong is the regulating authority for I Cook Foods, so it was appropriate for them to go and do the sampling.

Ms VAGHELA: And this question either you can answer or Professor Sutton can answer: why are food premises like I Cook Foods required to have a food safety plan that outlines how they control and manage food safety hazards, including Listeria?

Dr BONE: Shall I take that, Brett?

Prof. SUTTON: Yes.

Dr BONE: That is absolutely part of the food standards code and all of the *Food Act* legislation. It is really very important, particularly when you are handling food for high-risk, vulnerable consumers, that you identify all hazards and you put in all critical controls that you need to mitigate that hazard. This was one of our contentions—that I Cook Foods had not done an adequate assessment of the hazards but also had not put in adequate controls to ensure that the food they were supplying was safe and suitable, as required by the *Food Act*.

Ms VAGHELA: So the department had concerns about the food safety program in place at I Cook Foods.

Dr BONE: Yes, that and many other aspects of their operations.

Ms VAGHELA: Going back again to the patient, given the patient had been in hospital for over a week, how do you determine that the woman was not ill from food she ate before she was admitted to hospital? Because we are hearing this conflicting information, so how did you determine that?

Dr BONE: Well, we got information from the treating doctor and we had access to the discharge summary notes, which provide a lot of information about the tests and the condition that the lady was suffering from, and there was no suggestion of listeriosis on admission at all. I note that she did have a slightly raised white blood cell count, which you would see in an infection, but more often you just see that in the kind of inflammation that gastritis and colitis have. If she had had invasive listeriosis on admission, she would have been much, much more unwell and there would have been many more signs, and I think that the doctors and the nurses at Knox hospital would have been able to make that diagnosis. So as far as I am concerned there was no suggestion of listeriosis, and as Brett has said, given the incubation period—

Ms CROZIER: That is pure speculation, Dr Bone.

The CHAIR: Ms Crozier.

Dr BONE: Yes, if I could finish. The incubation period fits, and also if you look at the death certificate, the onset is suggested to be around 21 January as well, two weeks before her death. So it all just ties up. We can never be absolutely definitive in this situation, but we do not have to be absolutely definitive in order to take action to protect public health, and I think that is also an important point. We have heard about this idea that it needs to be beyond reasonable doubt or we need to be 100 per cent certain, and that is not the requirement. And if it was, we would have many more public health challenges than we do already.

Ms VAGHELA: And would Professor Sutton like to add anything to the answer that Dr Bone has given?

The CHAIR: In 30 seconds.

Prof. SUTTON: Yes, only that the food history obviously included the foods that she might normally have eaten at home, and the sampling at Coles and Woolworths reflected that—so some of the high-risk foods that she might have purchased from those establishments as well.

The CHAIR: Thank you. Ms Crozier.

Ms CROZIER: Thank you. If I can just go back to Dr Sutton, if I may. Dr Sutton, you spoke about the authority that you had under the various Acts. Have you got a signed instrument of delegation?

Prof. SUTTON: Yes, I do.

Ms CROZIER: Okay. Could you provide that to the committee for us?

Prof. SUTTON: Of course.

Ms CROZIER: Thank you. In relation to that sandwich I want to just go back to this issue about the other six suppliers. Bidfood, who is a supplier to Knox, actually has meat and other products that could be contaminated with Listeria, and the department never went there to investigate those six suppliers. Isn't that negligent? In this very serious issue, you have gone out there and you have shut a business. And Dr Sutton, you said you did not get any emails. Well, on the very day that you issued the closure order Dr Bone said to you in an email:

> No records of what food is eaten by patients—choose from a wide menu.

Now, there are a whole lot of conflicting issues going on here, and this is what this committee is trying to establish, because only just a few weeks ago a man died. A company was investigated by the department. It was not shut down. You did not go out and make a public statement about the dangers of that company and the listeriosis that caused that man's death. Why is there such a difference here? I think this is what the public want to understand, and this is why we are having this. So I think there are a lot of issues here, and your evidence of last year does not stack up with what we heard from Mr Christy last week and the emails that were provided to the department. So can you explain why those six companies, those other providers to Knox, were not investigated?

Prof. SUTTON: Firstly, I did not have that information at the time of the closure order, so there was no possibility for me to consider that with respect to the closure, but I made the closure anyway on the basis of all that information that I have provided. With respect to the other suppliers, as Dr Bone has had, many of them provide very low risk foods—tea, coffee and the like—some of which is not so-called ready-to-eat food. It goes through a cook-kill process, which would remove the risk of Listeria if done properly. And the foods that were noted in the food history were examined both in the case's normal purchasing as well as at I Cook Foods, and when we had definitive, really, genomically linked evidence of—

Ms CROZIER: But you did not. You said 'close to genetically'. It was not definitive. I am sorry to cut across you, but that is the point here. Close is not good enough. This business was shut down. Businesses were lost. And no other patient got sick.

Prof. SUTTON: It is expected that there would be minor genetic differences in the evolution of bacteria as they move from foods to patients or from foods sampled at one point in time to a later point in time. As I have said, there have been no other foods, environmental swabs, food samples or patient samples at any other point before or after across the—

Ms CROZIER: But you did not investigate them. Did you investigate other patients?

Prof. SUTTON: All invasive Listeria cases are notified in every jurisdiction in Australia. Every—

Ms CROZIER: We were told last week—I am sorry again; just time is of the essence—that those sandwiches came in a big tray. If they were contaminated, you would think that there would be multiple sandwiches contaminated and multiple people getting sick, would you not?

Prof. SUTTON: There may well have been multiple sandwiches contaminated. Not everyone becomes sick when they ingest contaminated food. Some of them will have mild illness and never seek medical care. Some will seek medical care and never have a specimen taken—

Ms CROZIER: But they were in a hospital. They were not outside.

Prof. SUTTON: Indeed. The point remains: not everyone becomes unwell if they consume contaminated food.

Ms CROZIER: But the meat came from Bidfood. I mean, that was linked in other states, was it not? That meat came from other states, which you did not look into properly.

Prof. SUTTON: Angie, do you want to address that?

Dr BONE: Certainly. All I would say is that we follow the evidence and we focus our investigations on where that strongest evidence is, and I can only reiterate the evidence that we had that revealed that there were severe problems and an ongoing public health risk that meant that we needed to act there, and we have had no further cases.

Ms CROZIER: Well, why didn't you shut the last company down and go out there and publicly name them?

Dr BONE: Yes, I think that is a very good point. As I say, we follow the evidence and we take a risk-based, proportionate approach. So the other company that was involved in the listeriosis case—you are quite right, there has been a case and we did investigate them. Firstly, the case had a very different Listeria genetic sequence to the isolates that were found in this company. But secondly—

Ms Crozier interjected.

Dr BONE: Shall I finish?

Ms CROZIER: Yes, but I am—

The CHAIR: Ms Crozier, let her answer the question.

Dr BONE: Thank you. Secondly, whilst there were some minor shortcomings in their processes it was nothing to the scale of the failures—

Ms CROZIER: A man died.

Dr BONE: I would still like to finish responding if I may. Yes, a man died, but as I say, if you just let me finish I can explain to you what the issue is. There was a different genetic sequence of the Listeria in the case to those isolates from the company, so that means that there was another source. The second thing is that whilst there were some minor shortcomings in this company, just like there always are, they were nothing to the scale of the shortcomings from I Cook Foods. And thirdly—

Ms CROZIER: But the genome—

The CHAIR: Ms Crozier, you are out of time.

Ms CROZIER: The genomes were found in WA and Queensland—

The CHAIR: Ms Crozier, you are out of time. Thank you. Ms Watt.

Ms WATT: Thank you, Chair, and thank you to our witnesses for appearing before us today. I just have a question about outside suppliers to I Cook Foods. How did you determine that the Listeria was not due to contaminated items from outside suppliers, such as ham and cheese brought in to make the sandwiches?

Dr BONE: Yes, thank you. Shall I take that?

Ms Watt interjected.

Dr BONE: No, that is fine. So we did follow back through the suppliers particularly of the meat, the smallgoods—so the ham and the silverside. The regulator for those businesses is PrimeSafe, so we referred it to them to follow up. They looked through the records that they had in the previous sampling and were not able to find any records of Listeria detections that were relevant to the investigation, and for one of the suppliers they were actually able to do a sample of the exact batch. So that is the main explanation. The other thing I would

just say is that we had evidence of cross contamination between foods in I Cook Foods because four foods had exactly the same genetic sequence, which suggests that it perhaps was brought in by one supplier. But then I Cook Foods, because of their poor handling, spread that Listeria strain from one food to another to another to another, so that we had four all with the same Listeria sequence.

Ms WATT: So cross contamination clearly was a very big issue. Now you spoke just in the last answer about the scale of difference. Can you talk to me about the scale of the problem that was there at I Cook Foods that led to cross contamination and other issues?

Dr BONE: Yes. So from what I was informed by the team who visited, from the information that we had from the City of Greater Dandenong, there were real issues with the way the processes were set up, so the workflow processes—the way raw foods and cooked foods and ready-to-eat foods were kind of crossing each other, the way people were crossing each other in the business—meant that it was very easy for cross contamination. There were also issues, as we know, around the floor. And wherever it is damp, this is where Listeria can grow and get worse, and we also have evidence that the food safety program just was not adequate for the scale and the scope of the business that I Cook was undertaking. And lastly, there were issues to do with the training of supervisors, which meant, again, that we could not be sure that I Cook operations were providing safe and suitable food as required by the *Food Act*.

Ms WATT: Thank you, Dr Bone. According to the *Public Health and Wellbeing Act* if the public health risk poses a serious threat, a lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control a public health risk. Can you talk to us a little bit more in detail about what that means for you in your role as the deputy chief officer or indeed the chief officer—whoever is most appropriate to answer that question?

Dr BONE: Yes, I can start, and I am sure Brett can add further.

Ms WATT: Yes, indeed.

Dr BONE: Yes, absolutely. The standard of beyond reasonable doubt and being 100 per cent certain applies to things like when you would do a prosecution. When your focus is on protecting public health we always have to act with the best information that we possibly have, and we are balancing the information that is coming in with the risk that is being posed—and eventually we get to a point where we feel that we have sufficient evidence, which means that it is appropriate to act in order to protect public health. And I honestly think in this situation that if we had not acted, there may well have been further cases, and if we had not acted we would be before a committee explaining why we had not acted given all of the evidence that we had. But I will hand over to Brett; he may wish to add further.

Prof. SUTTON: Thanks, Angie. Obviously the lack of scientific certainty is one of those considerations against the potential severity of the public health risk. That includes the potential number of people who might be affected and indeed their risk of developing serious illness. And so those two factors were both at play here. There were 7000 meals produced and, as I said earlier, the overwhelming majority of those populations—patients in hospital, Meals on Wheels recipients and those in aged care settings—are particularly vulnerable to severe illness and a higher risk of dying, a higher risk of invasive listeriosis. And so it is the combination of those things that means that you should take action, because if you wait, for example, for a cluster of cases, then there might be several thousand individuals who have already been exposed to Listeria and their incubation period is yet to play out, and you cannot intervene to, for example, prevent them from becoming unwell if they have already consumed that food and if the incubation period is already playing through.

Ms WATT: Thank you. No further questions, Chair.

The CHAIR: Thank you. Mr Ondarchie.

Mr ONDARCHIE: Professor Sutton, 7000 preprepared meals a week by I Cook Foods and no other cases of Listeria, other than, according to you, that there may or may not have been a number of other suppliers to Knox hospital—Bidfood, S.A.J., Redi Milk, Juice & Co, GWF Tip Top, Mr Donut, and of course I Cook Foods—and only I Cook Foods were checked out. When Dr Bone says there were severe problems, there was ongoing risk to public health, are you satisfied that when you signed that order—albeit you said you did not have all the information in this hearing—are you satisfied that you got all the things you needed to sign that off,

despite the fact none of these other people had been checked out and there were 7000 preprepared meals a week and no other cases of Listeria, other than your speculation?

Prof. SUTTON: Yes, I am.

Mr ONDARCHIE: That might come back at you. The CEO of the City of Greater Dandenong yesterday in his evidence said that the advice to close I Cook Foods bore no relation to what was happening at Knox hospital. He said that in evidence yesterday. Yet you went out in your statement and absolutely tied the two together, including the evidence that you have given today. So was the CEO of the City of Greater Dandenong wrong, was he?

Prof. SUTTON: I have not heard his testimony, but as I have stated here today and previously, the food supplied to Knox hospital, in particular the high-risk foods and the foods identified by food history, including next of kin, including information provided by food monitors at Knox Private Hospital, indicated that the case consumed those foods and that those foods were sandwiches and that those sandwiches were supplied by I Cook Foods.

Mr ONDARCHIE: Is it usual practice that patients source food from other sources?

Prof. SUTTON: I do not know what you mean by that, sorry, Mr Ondarchie.

Mr ONDARCHIE: Well, when I have visited loved ones in hospital I see patients in the hospital consuming food that is other than that from the hospital.

Prof. SUTTON: Oh, indeed. That can happen for some individuals, no question.

Mr ONDARCHIE: Would that form part of your investigation, to check that that was the only source?

Prof. SUTTON: Yes. In taking a food history you would try and determine all potential sources of food in that four-week period, absolutely.

Mr ONDARCHIE: So if that was the case, why weren't the other suppliers, as I have mentioned today, given what Dr Bone said about the challenge of ongoing risk to public health, about being sure that this was the case at I Cook Foods, investigated as a thorough part of this process?

Prof. SUTTON: I think we have spoken to that. At the time that we investigated, the highest risk foods were from I Cook Foods' kitchen. We then subsequently identified contamination of their foods across a number of foods that indicated the potential for cross contamination and *Listeria monocytogenes* establishing a niche in that kitchen and the genetic fingerprint, which would indicate that any other source was vanishingly unlikely.

Mr ONDARCHIE: I think—and I think I speak on behalf of myself and my constituents—they are looking for some certainty from you in terms of what actually happened as opposed to what did not happen. They look for that every day through your press conferences. I am not sure that we have had some certainty from you that the process was completely thorough.

Prof. SUTTON: Is there a question there?

Mr ONDARCHIE: Do you agree or disagree?

Prof. SUTTON: I disagree.

Mr ONDARCHIE: So having not investigated those other companies and not checked out where other food sources came from—7000 preprepared meals a week out of I Cook Foods and no other cases of Listeria, from your speculation—you are convinced that you got it right on this occasion?

Prof. SUTTON: I am. I accept that there is no single piece of evidence that is definitive. On the body of multiple issues of evidence with regard to the food safety program, the food safety supervisor's knowledge, the sampling that was done that identified a unique genetic fingerprint across foods that was highly related to that of the case, the case eating foods that were epidemiologically linked to I Cook Foods—these are things that satisfy me that the closure order, despite having really awful and significant consequences for the business and

all of the individuals that it employed, was the right thing to do to protect potentially thousands upon thousands of people from being exposed to a deadly illness.

Mr ONDARCHIE: I do not think the job was done thoroughly. No further questions.

The CHAIR: Thank you. Ms Vaghela.

Ms VAGHELA: Thanks, Chair. Professor Sutton, can you please explain why a varied order was issued to I Cook Foods on 23 February, two days after the initial closure order was signed?

Prof. SUTTON: Essentially it was because we had the information about what the deficiencies were with respect to the food safety program and the structural issues at play that would contribute to the risk of Listeria being maintained in that environment, and it was to allow the lower risk foods to continue production on the basis that those issues were addressed, so as to give I Cook Foods a pathway to reopening, to producing foods again in a way that could be done safely and to keep the business operating.

Ms VAGHELA: So how did the management at I Cook Foods respond to this varied order? Surely they would have been pleased that they would be able to restart production of some food items and minimise the impact of the closure on their business?

Prof. SUTTON: I am not entirely sure; you would have to go to them directly. But it was intended as a pathway for them to produce food safely again, and clearly there were some costs involved, as there always have been when we have shut factories with Listeria contamination in the past. Jindi Cheese is an example. It was an extremely expensive process for them to bring the structural issues up to a standard to make sure that that risk was addressed in full. So there would have been costs involved, but we were working to ensure that they understood the standards that needed to be met and the specific remediations that needed to take place in terms of the food safety program, the cleaning and the remediation structurally.

Ms VAGHELA: So did you observe any remedial actions taken by I Cook Foods to follow the advice provided about what they needed to do before the closure order could be lifted?

Prof. SUTTON: Yes, there were some. Mr Goldsmith might have more details, but there were some actions taken, no question, in terms of work being done on the floor. The cleaning was done, and there was work on protocols and flows. For whatever reason, that process stalled and the conditions for reopening really informed by the independent audit were not met, so reopening did not occur.

Ms VAGHELA: Is that the usual response from food manufacturers when they are told that there is a potential link between their food product and serious incidents of foodborne illness?

Prof. SUTTON: No, it is not. I do accept that again the impost for getting all of the issues right for Listeria contamination are really substantial. For campylobacter or salmonella it is less often a structural issue of a kitchen and more the introduction of bacteria and food processes and food safety standards, and those can be addressed somewhat more readily than those really substantial engineering changes that are often required for Listeria contamination. But most businesses would say, 'What do I need to do? How can I do it most quickly?', and seek the guidance and cooperation of the department to make that happen.

Ms VAGHELA: So what support did your team give to I Cook Foods to help them resolve the issues and restart production as soon as possible?

Prof. SUTTON: Paul or Angie—I know they worked with them every single day and there were tensions around some of the things that we understood to be required, but I know that they made themselves available and provided guidance on a daily basis.

Dr BONE: Yes, I just confirm that. We had two members of staff who were visiting the premises to try to assess what the problems were and then provide advice, and we also had multiple telephone calls over the weeks that it finally took to try to get I Cook up and running again. And that was always our intention—to be as positive and as supportive and to get them to the standard that they needed to be at to be able to provide safe and suitable food to vulnerable people.

Ms VAGHELA: Professor Sutton, there is some confusion. We heard before that the closure order was done incorrectly, under the wrong Act. Can you please shed some light on that about what Act it should have been, or was it done under the correct Act?

Prof. SUTTON: Yes, it was done under the correct Act. I guess the unconventional element was that it was under Chief Health Officer powers in the *Food Act* rather than CEO of Greater Dandenong council. I approached the CEO of City of Greater Dandenong council to put into effect that closure himself. He spoke of his conflict of interest, and therefore it was my powers under the *Food Act* that needed to be exercised in order for that recommendation to be put into effect.

The CHAIR: Thank you, Ms Vaghela.

Ms VAGHELA: Thanks, Chair.

The CHAIR: As I mentioned previously, it was Mr Christy's emails that instigated the reopening of this inquiry. I am interested to hear what triggered the request to Mr Christy to undertake further investigation at the hospital.

Prof. SUTTON: Angie?

Dr BONE: Yes, I can take that. As I was saying, listeriosis investigations are led by the department. We were focusing down on I Cook Foods because we were following the evidence, but we wanted to contact Knox city hospital to just also understand how they were handling I Cook Foods once it had arrived, because we wanted to ensure that they were not mishandling, for example, the food once it had arrived and we wanted to understand more about which patients received what foods. So that was really why we made contact with Knox City Council. We wanted to look at the food safety program and food safety audit as well for completeness there. That was the reason. But it was not something that we needed to do right at the very beginning. I know there was talk about this delay, and I think that was because there was confusion about whether this was a single case of gastroenteritis procedure or a listeriosis procedure.

The CHAIR: Yes. Look, it is probably my ignorance on this, but why weren't swabs and that type of investigation—swabs—taken of the Knox hospital kitchen at the time? I would have thought that would have been the first place to go.

Dr BONE: Really, because of the information, again, that we were getting from the infection control nurse that all of the high-risk food was coming from I Cook Foods, that was the first place that we looked. We did eventually get some swabs from Knox city hospital, but that was, I think, around 26 February. I do not know, Sally—I know that you were very involved in those decisions—at the moment, whether you wanted to add anything to that.

Ms ATKINSON: Just that we had been indicated that the foods that were brought in from I Cook came in sealed, and so the risk of contamination at Knox Private was pretty minimal because they already came in presealed and ready to serve—things like that. So in a normal investigation where food is already sealed and just served straight to the patient, in this instance we then go straight to the manufacturer of the food because there has been no ability to cross contaminate or anything with that food at that time.

The CHAIR: Can I just seek some clarification on that. I think we had heard that the sandwiches came on big trays, but I know certainly that the patient's family said that she had a packaged sandwich. So is that how they arrived, as a single-serve packaged food?

Ms ATKINSON: That is what I understood them to come in as, yes, which is why I went directly to—

When I spoke to the infection control nurse—that is the sort of information we get right at the beginning—it was indicated in the email on 29 January that things came in ready to go from I Cook, and the information I had was that they came in as a single-serve, sealed, ready to go.

The CHAIR: Thank you. Ms Watt.

Ms WATT: Thank you, Chair. I might be a little different and have a question for Mr Stenton that goes to Community Chef in particular. You have told the committee that the Department of Health's organisation and

governance structures are specifically designed such that we avoid—you avoid, sorry—potential conflicts between the Chief Health Officer and his regulatory roles on public health matters and the department's financial and funding decision roles. Given the separation of these roles that has been the subject of recent scrutiny, particularly by some witnesses, can you please provide details of how indeed they are kept separate there at the Department of Health?

Mr STENTON: Thank you, Ms Watt. First, as in the evidence I gave in the last inquiry: the organisation's structure itself separates the regulatory functions of the department and the management of those from policy and funding decisions, so we have different divisions. There is a public health division which holds the regulatory functions. Policy decisions, particularly those around funding for Community Chef at the time, were in a separate division—an aged care branch in a separate division. The decision-making of those divisions in a policy sense, if we were taking a decision to provide funding to Community Chef or to acquire Community Chef, that would flow up through the management line to secretary or minister.

The regulatory functions—as Brett has outlined, there are specific statutory powers that the Chief Health Officer has, and I will not purport to know them as well as Brett, but they are statutory in nature and authorise Brett to take certain decisions and/or advise ministers and secretaries of risk-mitigation strategies, and they flow directly from the public health division.

So the two conversations never meet in terms of decision-making. They are separate and kept separate for that very reason—that the department is a funder of many services, some of which have regulatory intersections with public health.

Ms WATT: So further to that, what involvement does, then, the office of the Chief Health Officer have in the relationship with Community Chef?

Mr STENTON: None, other than in the same way that Community Chef as a commercial provider would be subject to food regulation rules and in the same way that I Cook have inspections from local government and where there is an issue such as this one would be subject to Chief Health Officer directions. Community Chef would be the same. As previously advised to the committee, the relationship between Community Chef and the department was around food security and food continuity for home and community care and disability. When I last appeared at the committee, we were in the process of finalising acquisition of Community Chef for food continuity at Western Health. That acquisition has now been finalised, but that was a policy relationship on food for vulnerable people in the community, and subsequently, again as previously advised, we had provided recallable grants. We had some food and kitchen continuity issues at Western Health. We looked at various options for that, and they were policy decisions. No conversation—at no point was I Cook ever considered as part of that, and it was not discussed, mainly because the people making those decisions would have been completely unaware of the I Cook issue as a public health issue. So that transaction has now been finalised.

By way of comparison, I know from a public interest point of view that transaction involved us forgiving those recallable grants and funding Western Health to pay out the liabilities of Community Chef in the order of about $7 million. To build or replace the kitchen facility that we required at Western Health was in the order of $25 million to $30 million, so from a community value-for-money proposition it was the right policy decision and, as I say, had no consideration whatsoever of anything happening at I Cook.

Ms WATT: So the Chief Health Officer and the office of the Chief Health Officer were never consulted regarding the purchase decision for Community Chef?

Mr STENTON: None whatsoever.

Ms WATT: Okay, I am happy to leave it at that. If there is anything else—

The CHAIR: Thank you, Ms Watt. Dr Bach.

Dr BACH: Thank you, Chair. Dr Bone, why didn't you correct Dr Sutton when he was misleading this inquiry and this committee on 24 June last year?

Dr BONE: Regarding the sole caterer, I believe you are referring to.

Dr BACH: Yes.

Dr BONE: Yes, that is because I had also understood at that point that I Cook was the sole caterer, so—

Dr BACH: But that is not true. You said, Dr Bone, to this committee just earlier in this particular hearing that on 22 February you met with your team to discuss the email from Mr Christy that Dr Sutton himself said was the reason, when he ultimately—apparently very late in the day—became aware of it, for his change of heart. So you did know, Dr Bone.

Dr BONE: If you would let me finish, I can explain to you what happened.

Dr BACH: Please.

Dr BONE: Thank you. So it was raised, as I say, at this meeting at the IMT on 22 February. What was raised was that there was a possibility that the patient was on a soft diet and that some of the components of the soft—

Dr BACH: It was confirmed. There was not a possibility—

The CHAIR: Dr Bach, please let her answer the question.

Dr BACH: But the language in the report was that it was confirmed. Dr Sutton also verballed Mr Christy earlier on in his testimony. He said it was 'suggested' she was on a soft diet. The language of the official report that you received and you discussed on 22 February 2019 was that it was 'confirmed'. So please do not misrepresent the evidence that you are referring to.

Dr BONE: Again, if I could finish, then you would understand what I am trying to say to you. It was raised at the IMT, but I did not receive an email that said it was confirmed. That was sent to the staff, not me. I did not see that email. What was raised at the incident management team was that there was a suggestion. The incident management team was at 1.00 pm. The confirmatory email arrived at 12.41 pm. I am not even sure it had been read at that point, but regardless, what was raised was that there was a suggestion of a soft diet and that some of the soft diet items were made in the hospital. When we followed that up we were told again that it was a full diet, and I had understood from the team—and that may be my misunderstanding—that it had also been discounted, that not only was she not on a soft diet but that the food was not supplied by the hospital. So when we came to prepare statements last time, my own understanding had been that it had been concluded that they were the sole caterer. So when all of these emails were raised, having gone through back through all of the records and my own notes, I was reminded of this situation, and that is all that that situation was. It was no deliberate attempt to mislead. It was a misunderstanding. And as Brett has said, and as I would have said if I had been able to continue my statement, that component of the information did not mean that any of the decisions hinged on that particular component of the information. I hope that is clear for you.

Dr BACH: Well, let us get to that, then, because time and time again in our hearing on 24 June last year we were told that I Cook Foods was the sole caterer. Professor Sutton said that on multiple occasions, and you were sat next to him, Dr Bone, and he was not contradicted. As a former official in the Department of Human Services, I have got to say that the idea that this critical information was not escalated either to you, Dr Bone, or to Professor Sutton simply does not scan. But nonetheless both of you say that you knew nothing about it.

Can I ask you about the radical shift in what you have presented today regarding the need to investigate other food sources. On multiple occasions today we have heard that there is only a need to investigate high-risk food sources. That has been the language that you have used. That is utterly different from what you told us, Dr Sutton and Dr Bone, last year. I have got the transcript here. Dr Sutton, you told us—this is a direct quote from you, Sir:

> … all the other potential sources of food for the deceased patient were investigated for the presence of any listeria whatsoever …

That is the polar opposite of what you, Dr Bone, and you, Professor Sutton, have told us today—that you would only focus on high-risk foods. Dr Bone, you said the same thing:

> … we were following up a large number of different potential leads—so not only investigating I Cook Foods but also all of the food that the patient had eaten …

What has led to this radical change, utter change, complete change of position from the department? Because I have got to tell you, it is very convenient for you.

Dr BONE: I would disagree that there has been a radical change. I think really what we are trying to do—

Dr BACH: You would.

Dr BONE: It has always been the case that it is high-risk food only, because that is exactly what is in our protocols and that is how these investigations happen across the world—

Dr BACH: It is the opposite of what you said last time.

The CHAIR: Dr Bach, please let the witness respond.

Dr BONE: Yes. The reason that we have emphasised it this year time is because it became clear that perhaps the committee did not understand fully that we focus only on high risk, so that is why we have emphasised it this time—

Dr BACH: Because you told us the opposite.

The CHAIR: Dr Bach!

Dr BACH: Do not blame us.

Members interjecting.

The CHAIR: I am sorry. You are out of time, Dr Bach. Had you actually let the witness answer the question, you may have got your answer, instead of interrupting.

Members interjecting.

The CHAIR: Thank you. Dr Kieu.

Dr KIEU: Thank you. I have a question for Professor Sutton, but before I go there, I just had a quick look at the statement provided by Mr Christy to the police. The exact quote is that it was unlikely that the patient was on anything but a soft diet. So whether that is confirmation or not, because it is not a very definite statement.

Now, let me go back to Professor Sutton. Last year when we had our inquiry the committee concluded that the closure of I Cook Foods enacted by you, then the acting Chief Health Officer:

> … was prepared and served on valid grounds and for a proper purpose.

So in your view what constitutes 'valid grounds' and 'proper purpose', Professor Sutton?

Prof. SUTTON: It is that I make my judgements on the basis of protecting public health and according to the principles indeed of the *Food Act* and similarly of the *Public Health and Wellbeing Act*. They have been raised in part today. They relate to lack of absolute certainty and the precautionary principle but also that of proportionality and making a reasonable and rational decision that is based on evidence. And so those are the elements that came together in that decision-making.

Dr KIEU: The reason I would like confirmation from you is because there are people who offer different views of that conclusion. Now, going to the proper position, as you were acting Chief Health Officer, could you explain to the committee, for our benefit, the differences in the statutory responsibilities between the *Public Health and Wellbeing Act* and the food safety Act in relation to the closure of I Cook Foods.

Prof. SUTTON: In terms of the statutory powers, they can be effected in the same way. The *Food Act* relates to the entire regulatory scheme in relation to food safety and all of the elements of food production and food service. The *Public Health and Wellbeing Act* is broad and covers all of those protections that you want to ensure with respect to all public health threats. They cut across communicable disease, environmental health threats and those in food safety, and they are, as you would be aware with COVID, broad and flexible in terms of being able to be applied to any particular risk. The *Food Act* has other statutory position holders who have powers enabled under that Act, including the authorised officers under that Act and, as I have said, the CEOs of

local council. But the Chief Health Officer is clearly referenced in that Act as well for some of those important actions, such as the closure of a business or, for example, preventing access to a site or gaining evidence from a site.

Dr KIEU: Thank you. And my next question is to Dr Bone. You mentioned earlier that there were some staff from the department who came to the I Cook Foods facility to inspect it after the closure order was served. Before then were there any staff who visited the place in relation to the concerns raised by the city council environmental health officers? Could you verify the situation there?

Dr BONE: Certainly. I understand that the first time that any of our staff visited I Cook Foods was on 22 February, so the information preceding the closure order, about the food safety program, food safety processes et cetera and the conditions of the premises, was coming to us via City of Greater Dandenong environmental health officers.

Dr KIEU: Okay. Those are all the questions I have. Thank you.

The CHAIR: Thank you. Mr Limbrick.

Mr LIMBRICK: Thank you, Chair. Professor Sutton, the decision to close down I Cook Foods and name them publicly in interviews and in the press—what informs that decision on whether to name a company or not? Because one of the concerns that has been raised is that the idea they would be able to reopen after that sort of publicity is nearly impossible. What informs that decision?

Prof. SUTTON: Clearly the naming of a company makes it the object of focus for media and for the general community. We are acutely aware of that. One of the issues that I consider, certainly, is the likelihood that that information will become public and whether we will be seen as trying to hide information that the public is entitled to know and would seek and be entitled to know. We clearly prompted Knox to send that out to all of the recipients of food—for example, the Meals on Wheels recipients—to make sure that they did not consume that food. It would have been immediately understood where that food was coming from and would have been immediately known to media, and so it was for the sake of transparency that that decision was made.

Mr LIMBRICK: But I mean, if we were acting in an abundance of caution, it seems clear from Mr Christy's testimony that for at least part of the patient's stay in hospital she was on a soft food diet and preferred sandwiches and then likely had eaten something that was prepared at the hospital. It seems strange to me still—I still do not really understand why swabs were not taken earlier at the hospital on the sandwiches being prepared at the hospital as well.

Prof. SUTTON: I am not sure what to add beyond what Dr Bone has said in relation to that - and Ms Atkinson. I mean, the abundance of caution is about closing a food premises when there is a significant risk to very large numbers of vulnerable individuals. The soft diet, as you have heard from Mrs Painter's next of kin, related to a subsequent readmission out of rehab, which was after her illness and was likely related to her confusion because of the beginning of her meningoencephalitis and a risk of aspiration should she be on a normal diet.

Mr LIMBRICK: Okay. Yes. Understood. Thank you.

The CHAIR: Thank you. Thank you to all of you for appearing today and for taking the time. It has been very valuable. As I mentioned at the outset, you will receive a transcript of today's hearing. Please do have a look at it. Make sure we have not misheard or misrepresented you in any way. The committee will just take a short break to bring on the next witness. Thank you.

Prof. SUTTON: Thank you, Chair. Thanks, committee.

Witnesses withdrew.