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—Wednesday, 24 June 2020

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WITNESSES

Professor Brett Sutton, Chief Health Officer,

Dr Angie Bone, Deputy Chief Health Officer, and

Mr Greg Stenton, Deputy Secretary, Corporate Services, Department of Health and Human Services.

The CHAIR: I declare open the Standing Committee on Legal and Social Issues public hearing and, as we have done more fulsomely at the beginning, I would certainly like to acknowledge the traditional custodians of the various lands on which we are gathering today and receiving evidence and pay my respects to elders past and present and any who are watching the proceedings today. I would also like to welcome back anyone else who is watching this inquiry via live broadcast.

This afternoon the committee is hearing evidence in relation to the Inquiry into the Closure of I Cook Foods. All evidence taken at this hearing is protected by parliamentary privilege, as provided by our *Constitution Act* but also the standing orders from the Legislative Council, therefore any information that you provide this afternoon will be protected by law. However, any comment repeated outside the hearing may not be protected. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament. As is obvious, all evidence is being recorded. You will receive a transcript in due time—it will probably be in a couple of weeks—and we would love it if you could have a look at that and make sure that we have not made any significant errors. Ultimately these will be available on the committee's website.

So, welcome. I understand you have some prepared statements and some opening remarks, so if you would like to make your opening remarks, then we will open it up to the committee for discussion. Thank you.

Prof. SUTTON: Thank you, Chair and committee members. I would like to thank you for giving me the opportunity to speak today. Before I go on, I would like to acknowledge that the closure of I Cook Foods started with a severe case of listeria infection in an 86-year-old woman that contributed significantly to her death. This inquiry must be extremely difficult for this woman's family, her friends and staff at the retirement village where she had lived, and my thoughts go to all of them. I do also want to acknowledge that 41 people lost their jobs subsequent to the closure of I Cook Foods. Losing one's livelihood is very hard for anyone, but losing a job in those circumstances compounds that further. I do acknowledge the stress and anxiety and hardship that those staff have gone through.

With regard to my role as Chief Health Officer, the *Public Health and Wellbeing Act 2008* requires that I am guided by a number of principles, one of which is the precautionary principle in my role of protecting the health of Victorians and to uphold the primacy of prevention—or, in other words, prevention of harm is better than cure once it has arisen. I acted to prevent the potential widespread transmission of Listeria infection to a vulnerable community of hospital patients, Meals on Wheels recipients and residents in aged-care facilities. If I had not closed at the time I did, there was a significant risk of many vulnerable Victorians contracting listeria. The *Public Health and Wellbeing Act* also states:

> If a public health risk poses a serious threat, lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control the public health risk.

That means sometimes I am legally required to act and respond with imperfect knowledge where we might not have all the facts of a case but the potential for public health risk is nonetheless serious. In this case, with the closure of I Cook Foods, I did have abundant evidence and stood on more than sufficient grounds to act in the way I did. But my point is that sometimes I am legally obliged to act with less than that.

The closure of I Cook Foods centres around the serious health impacts of listeria. Listeriosis, or infection with listeria, is a notifiable disease under the *Public Health and Wellbeing Act*, meaning that laboratories must notify the department on diagnosis so that we can take public health action to prevent spread of infection. It is caused by eating food contaminated with a bacteria known as *Listeria monocytogenes*. Healthy people may develop few or no symptoms, but for some people with chronic illness or immune deficiency, pregnant women and newborn babies and the frail elderly, the infection can be invasive, meaning it invades the blood or brain tissue, requiring hospitalisation, and can result in death in about 30 per cent of cases where it is invasive. Listeria meningoencephalitis, or infection of the lining and the substance of the brain, was a significant factor in the

death of this woman. It is a particularly serious illness in any individual, but for the most vulnerable—those I have listed—it can be fatal. Outbreaks of listeria due to foods are known from foods such as soft cheeses, milk, coleslaw, hot dogs, pâté, rockmelons—that has been reported in Europe, America and Australia. Outbreaks have also been reported in relation to sandwiches supplied to health services in the UK.

So safe food handling and safe storage of food are important for everyone, but especially so for those providing food to vulnerable people. Listeria bacteria, like most bacteria that cause foodborne illness, are readily killed during cooking. However, unlike most other food-contaminating bacteria, listeria can grow in the refrigerator, and that is why Listeria infection is commonly associated with ready-to-eat foods. This is why food preparation, storage and hygiene practices are crucial in preventing Listeria infection.

With regard to the role of the department and council, I would like to outline the respective roles. Local council has several roles in the regulation of food businesses, chief among them being regulator of food businesses under the *Food Act 1984*. As the regulator, councils register and inspect food businesses, review reports by food safety auditors and ensure action is taken to address issues identified in audit. When there is a possible foodborne illness, council environmental health officers, or EHOs, take food and environmental samples, guided by the department, and assess hygiene, cleaning and food safety practices. The department administers the *Food Act 1984*, approves food safety auditors, coordinates recalls of unsafe and unsuitable foods and provides advice to councils. In cases of outbreaks of foodborne illness the department conducts interviews with cases to take a food history to try and identify a common source, advises council on sampling and liaises with the laboratories. It regularly works with manufacturers of all sizes to help them identify the cause of a food safety problem and resolve it. So while there is a clear separation of roles between council and the department in the investigation and control of foodborne illness, the system is designed for close cooperation to identify and remove foodborne hazards that put the community at risk.

Under normal circumstances a closure order under section 19 of the *Food Act* would be issued by council as the regulator. On the evening of 21 February 2019 the Chief Executive Officer of the City of Greater Dandenong, Mr John Bennie, disclosed to me that he and council had a conflict of interest that prevented him from issuing the closure order. But in the interests of protecting vulnerable members of the community I therefore issued the order under the powers of the *Food Act* that have been delegated to me by the Secretary to the Department of Health and Human Services, an action permitted pursuant to section 19(9)(a) of the *Food Act*.

Just in relation to the information that I used in my decision-making to close, then vary and ultimately lift the closure order on I Cook Foods, there was a suite of information provided to me by Department of Health and Human Services and council-authorised officers. In doing so I also want to address frankly a number of falsehoods that have been presented in the media and allegations made by Mr Ian Cook at the hearing of this inquiry on 17 June 2020.

The information can be categorised into four areas: the investigation into the food eaten by the deceased patient, the laboratory evidence of the listeria isolated from food samples from I Cook Foods premises, the condition of the I Cook Foods premises and their food safety processes, and the general vulnerability of the community being served by I Cook Foods. This information was provided to me by several authorised officers over a number of days and in different formats—verbal, oral, emailed—which led me to consider that the food being prepared, sold or otherwise handled at I Cook Foods was unsafe or unsuitable. No one single piece of information was used in isolation to come to that decision. Rather, it was the collective picture of public health risk that I believed I Cook Foods' continuing food production represented.

With regard to the investigation into the food eaten by the deceased, the patient had been an inpatient at Knox Private Hospital since 13 January 2019 and was improving until she suddenly deteriorated 10 days later on 23 January. A blood culture test that day grew listeria. That was reported on 25 January to the department, when we were notified. The patient was too unwell to be interviewed. The department conducted interviews with her next of kin and the treating doctor to obtain the food history for the four weeks prior to listeriosis illness, including information on the patient's food selection whilst in hospital. These interviews revealed that whilst in hospital the patient only consumed food from the hospital, with all food provided by Knox Private Hospital's sole caterer, I Cook Foods. The patient's daughter indicated that her mother was fond of eating the sandwiches provided in hospital. The interview also revealed a range of other foods that her mother was eating prior to her admission to hospital and the locations where her mother shopped.

As a result of the information obtained, the department asked Manningham City 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 possible sources of contamination. Knox City Council undertook a food safety assessment of Knox Private Hospital, and the hospital took environmental swabs from all kitchen sites exposed to I Cook Foods products.

Manningham City Council also took food and environmental samples from Coles, Woolworths, Mirabella Bros and the Aveo Domainé retirement village itself, but no listeria was detected in any of these samples taken by Manningham Council, nor in any of the samples taken by Knox Private Hospital. The City of Greater Dandenong took food and environmental samples from I Cook Foods' premises. On 18 February 2019 food sampling testing indicated positive listeria and *Listeria monocytogenes* in food from I Cook Foods.

Thus I had good information that the patient had consumed food supplied by I Cook Foods during her incubation period—so the period from potential consumption of food until becoming unwell—and that I Cook Foods was the only premises where listeria was detected. You have a summary of all the positive and negative food and environmental samples in your pack.

Secondly, the laboratory evidence of listeria in samples from I Cook Foods: these results arrived in stages, each providing more and more detail to refine the identification of the bacteria detected. So, for listeria, first we understand the species that has grown—*Listeria monocytogenes* is the one associated with human illness—then the molecular serotype, the binary type and the multilocus sequence type or MLST, and finally the whole genome is sequenced. This test is like a DNA fingerprint. This identification is undertaken by Victoria's public health laboratory, the Microbiological Diagnostic Unit of the Doherty Institute.

The full identification of the listeria isolated from the patient's blood was received on 11 February 2019. At the time of issuing the closure order on 21 February, listeria had been detected in seven foods sampled at I Cook Food's premises. Six of these had grown *Listeria monocytogenes*, and four of these had grown a *Listeria monocytogenes* that had the same molecular serotype and the same binary type as that found in the patient. These foods were sliced cucumber, sliced silverside, egg-and-lettuce sandwiches and corned-beef-and-mustard sandwiches. It was later shown that the listeria isolated from these four foods had exactly the same genetic sequence as each other. The report also noted that the genetic sequence of the listeria from these four foods was a very close match to the strain found in the patient, and the investigation to explore the links between the patient and the foods was recommended by the laboratory. It was also later reported that two of the six original samples taken by City of Greater Dandenong at I Cook Foods had grown a *Listeria monocytogenes* with a different molecular serotype and different binary type and multilocus sequence type—that is, different strains.

Furthermore, a separate sample taken on 22 February by Whitehorse City Council of an I Cook Foods meal was later found to contain yet another molecular serotype, binary type and MLST of *Listeria monocytogenes*—another different strain. The fact that there were four separate foods with exactly matching listeria indicates cross-contamination, and the fact that this is a close match to that identified in the deceased patient provides strong evidence of a link between I Cook Foods and the patient. This was further reinforced by the knowledge that the patient had eaten food at Knox Private Hospital and that I Cook Foods was the sole food supplier. Noting that this strain of listeria with this particular genetic sequence has not been matched to any other isolates in Australia before or after this event, there is really no other plausible explanation than that the source of the patient's infection was I Cook Foods.

I have heard it suggested that the listeria was introduced by a supplier, as I Cook Foods had detected listeria in an unopened package of ham. This listeria was a different molecular serotype to that identified in the patient and so could not have been the source of her infection. But it does demonstrate that listeria can be brought into a food premises and the importance of any food premises having a plan to manage listeria, particularly one providing food to vulnerable people. I Cook Foods did not have a listeria management plan. The fact that there were three different types of *Listeria monocytogenes* identified from I Cook Foods strongly indicates that I Cook Foods was not in control of its environment with regard to listeria. There was a soup of listeria strains.

Lastly, I want to address the claim made by I Cook Foods that the listeria detected in their foods was within safe levels. The samples taken as part of this investigation were taken to determine whether listeria was present in the foods sampled and whether the listeria matched that found in the patient. So the quantity in the foods sampled does not imply that that same quantity was consumed by the patient. We were looking backwards

from a patient who had already developed invasive listeriosis, and so we were looking to see whether there was a listeria identified at any site that could match the listeria in that patient. The witness statement available in your pack from Mr Deon Mahoney, a food safety expert, provides more information on this. The samples that were taken provided results that were within a standard set in the *Australia New Zealand Food Standards Code*, or the code, for compliance purposes, but that does not necessarily imply they are safe, and the standard does not use this language. Furthermore, a business supplying food to vulnerable consumers would be expected to achieve the highest standards possible.

On the third matter, the condition of the I Cook premises and their food safety processes, there were two major cleans of I Cook Foods undertaken on the 20th and again on 21 February. Both cleans were deemed unsatisfactory by a senior manager, an environmental health officer at City of Greater Dandenong, who contacted the department's food safety team to advise of her concerns that I Cook Foods staff did not seem to understand clean-down procedures or the risks of cross-contamination.

As an illustration of the risks of food contamination that were raised, the officer reported the presence of biofilm—that is like a slime that is contaminated with bacteria, that holds bacteria of various types—on a chopping blade, which prevented cleaning chemicals from adequately reaching all surfaces, indicating that the slicing unit had not been dismantled and cleaned properly, raising the question as to whether in normal operations the blade was cleaned between foods as it should be to prevent cross-contamination from one food to the next—sliced ham and sliced lettuce or sliced cheese, for example. Ovens were situated in an external side entrance in a shared space that was also a delivery entrance, a cleaning chemical and equipment store and a waste marshalling area. There was ponding of water on the floor and broken flooring—a concern because this creates an ideal place for listeria to harbour and grow. Sandwich crates used to transport food were being washed on the bin room floor, and there was ready-to-eat food being prepared at a point where many staff passed through.

Furthermore, the City of Greater Dandenong senior environmental health officer 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. Food safety programs support the safe production of food at commercial premises, including how food is prepared, stored and transported, to minimise food contamination. Food safety supervisors, who are employed by businesses and hold a statutory role under the *Food Act*, should have the ability and authority to supervise other people handling food at or from the premises and to do so safely. Environmental swabs after these cleans were negative, which I believe may be the basis of claims by I Cook Foods in the media that the business had been cleared of listeria. However, these one-off samples should not be so surprising to be negative on their own. They do not provide assurance that a premises is safe to operate.

Given these concerns that the fundamentals of food safety were not in place, I could not be satisfied that the risk would not arise again without significant intervention. These deficiencies were subsequently confirmed when my department authorised officers visited I Cook premises on the day after the closure order was issued to determine what specific remediations would be required before I could lift the closure order. Their observations included (a) the cross-contamination risk posed by the ponding of water and damaged flooring in several places through the premises; (b) that the kitchen sink appeared to have multiple uses, including the cleaning of equipment parts and the washing of some ingredients, such as lettuce, and that it was located near equipment used to chop and slice foods, representing an additional potential cross-contamination point for bacteria; and (c) workflow processes where raw ingredients, food in preparation and cooked food crossed each other, again posing cross-contamination risks. Photographs and explanations of some of these issues are in your packs.

The visit on 22 February led to the issue of the varied order on 23 February intended to enable I Cook Foods to restart lower risk lines: the extended-shelf-life pasteurised foods; texture-modified, pasteurised formed foods; and modified atmospheric packaging foods. The order included a number of conditions that needed to be met by I Cook Foods, including a gap audit to assist in identifying the number and range of issues with process flows and the physical fabric of the premises, a full food safety program audit, confirmation that management and staff understood revised procedures and, lastly, a test and hold program—a standard industry process where food is not released to market until the results of food samples are known and acceptable.

Both the gap audit and the food safety program audit, undertaken by independent auditors, revealed several deficiencies that required rectification before the order could be lifted. We have provided you with copies of

these audits so that you can see for yourselves their findings. This rectification unfortunately took much longer than would have been expected, as I Cook Foods management repeatedly questioned many of the food safety issues raised and the remediation that was advised. I would also note that in my experience this is not a usual response from food manufacturers where the possibility of a link with serious incidents of foodborne illness has been raised. In my experience manufacturers are more commonly very concerned to discover that they may have inadvertently caused illness, usually cease production voluntarily and are keen to work with us constructively to resolve the problem and restart production as quickly as possible.

This leads me to the last area of information that I considered in my decision-making: the particular vulnerability of I Cook Foods customers. 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, so it should be assumed that in all of those settings vulnerable patients, vulnerable residents, make up the vast majority, if not everyone, in those settings. This indicated to me that there was a large potential exposure to any listeria hazards associated with I Cook Foods, because in those most vulnerable the infection can be invasive, causing serious illness and death. If there were subsequent infections, further deaths were a strong possibility.

In closing, I would like to underline that I took the action that I did with the sole purpose of protecting vulnerable Victorians from the potential risk of listeria infection associated with I Cook Foods, as is my statutory duty. In coming to my decisions I had a range of evidence from authorised officers, including the food history of the patient, laboratory results indicating a link between the premises and the patient, reports that raised significant concerns about the safety of I Cook Food's premises and practices and the knowledge that the food provided from this business was going to people with a high risk of potentially fatal consequences of listeria infection. Taken together, this information left me in no doubt that production had to be stopped whilst further investigation was undertaken. As the delegate of the secretary for the purposes of section 19 it was my job to consider all these relevant factors and make a decision as to the appropriate action to be taken in this case. Recognising the impact of a closure order on a business, my team spent many weeks working with I Cook Foods to try and get them back up and running as quickly as possible. It is very unfortunate that I Cook Foods had such difficulty in understanding and achieving the standards that were acceptable to protect the health of the vulnerable people they served so that reopening could occur. In my view the time taken to resume full operations was really due to the lack of sufficient compliance and responsiveness of I Cook Foods.

Mr STENTON: Over to me.

The CHAIR: Over to you.

Mr STENTON: Apologies, Chair, I did not bring copies of my opening remarks, but I am happy to leave these for copying and we can provide copies.

The CHAIR: That is fine, Mr Stenton.

Mr STENTON: My name is Greg Stenton. I am the Deputy Secretary of Corporate Services at the Department of Health and Human Services and have been in this role since January 2019. Prior to this I was the chief finance officer with the Department of Health and Human Services and its predecessor, the Department of Health, from December 2012 to December 2018.

Relevant to the deliberations of this committee, I have previously held positions of manager, financial operations, and director, planning and resources, in the rural health and aged-care division from October 2004 to December 2009. This was the period in which consideration was taken by government to support the establishment of Community Chef through payment of a capital grant in 2008. Now, the underlying policy objective of this decision at the time was to ensure the continuity of food provision to vulnerable people under the home and community care and disability programs, primarily through the Meals on Wheels program. The grant supported purchase of equipment to enable the aggregation of a number of smaller local government food services to a larger, more contemporary shared service.

I have been asked to appear before this committee to give evidence regarding the department's financial relationship with Community Chef, including any plans to acquire shares in Community Chef. Before I commence I would like to take the opportunity to say that the public expectations of honesty and integrity for public officials are rightfully higher than those expected of most citizens. The senior leadership of the

department takes these responsibilities extremely seriously and has structures and processes in place to ensure ongoing compliance with the Victorian public service code of conduct. The department maintains high standards of integrity and behaviours, which are a credit to the professionalism and hard work of our staff. The Chief Health Officer's decision to close I Cook is not related in any way to a financial interest between the department and Community Chef. The department's organisation and governance structures are specifically designed to avoid potential conflict between the Chief Health Officer's regulatory roles on public health matters and the department's financial and funding decisions on policy matters.

I will talk a little bit about the department's governance. The Department of Health and Human Services is a large and complex department which administers policy development, funding, regulation and advice across a range of ministerial portfolios, including public health, health service delivery, disability, aged care, housing, children and family services, and family violence. The department's organisation structure separates briefing and advisory functions between policy divisions to support individual portfolio ministers as well as to separate regulatory activities and corporate-enabling functions from policy and service delivery functions. The separation is partly for administrative efficiency but mainly to separate the tensions between the multiple functions of the department as system manager, policy adviser, funder, performance manager and regulator. Each division is led by a deputy secretary accountable to the secretary for the functions within the division. Deputy secretaries are delegated to brief ministers independently on operational matters and via the secretary on policy matters.

The Chief Health Officer function is administered through the regulation, health protection and emergency management division, which is responsible for advancing public health through identification of risk and the use of social regulation to influence behaviours. Notification processes for infectious conditions, including decisions and advice from the Chief Health Officer, are managed by this division. The health and wellbeing division leads policy, strategy, workforce funding and performance of Victorian hospitals and healthcare system, amongst other policy and funding functions for prevention and population health and mental health and aged care.

This division, in conjunction with Corporate Services, has been responsible for providing policy advice on financial support for service continuity for vulnerable people and, more recently, potential acquisition of Community Chef to support business continuity and capacity in public hospitals. Based upon my experience in the department, I do not consider there are any circumstances where the advice to close I Cook for breaches of public health would have intersected with any decisions relating to financial support for Community Chef. As mentioned, the financial relationship between the department and Community Chef dates back to 2008, to the inception of the shared service through the payment of an establishment grant. The grant was conditional upon as repayable by Community Chef on the occurrence of any default event. The commonwealth government also provided establishment funding at the time, as part of shared responsibilities under the home and community care agreement.

In 2011–12 and 2012–13 the department provided funding to Community Chef to support service continuity of food provision to vulnerable people through the home and community care and disability programs. The business model for Community Chef as a shared service provider was evolving during this period, and they were experiencing higher than expected start-up costs and lower than projected revenues. Initially payments were made as a cash grant, with further payments made as recallable grants. As part of the grant agreement the department commenced a process to monitor financial performance on a monthly basis. Similarly, in 2014–15 Community Chef again approached the department seeking financial support to ensure service continuity for the provision of meals for vulnerable people in the community. An additional recallable grant facility was put in place, with payments made in 2014–15 and 2015–16.

It is worth noting that the arrangement to support the operations of Community Chef, who were delivering approximately 12 800 meals to vulnerable people, was considered in the context of the home and community care program transferring back to the commonwealth, to the administered home support program with the commonwealth, which commenced on 1 July through to 30 June 2018. Similarly, the transition of vulnerable clients to the disability insurance scheme began in 2015 in Victoria and is due for completion in June 2020. Both these events impact significantly on the food provision landscape in these sectors.

Current policy for provision of food for health services is administered by Health Purchasing Victoria and requires health services to obtain food services from central production kitchens owned and operated within

three health services, unless specifically exempted. Exemptions from this policy can be made. However, any exemption requires health services to tender for services in an open market.

In February 2018, as part of an internal review of the metropolitan Melbourne food services strategy, the department identified a significant business continuity and infrastructure risk with a small number of our central production kitchens. In considering options for mitigating this risk, the department has explored the option of leveraging the capacity of Community Chef facilities, specifically for the provision of food services to metropolitan hospitals. Given the level of funds provided to Community Chef in the form of recallable grants, independent advice was sought, which recommended that DHHS seek to acquire 100 per cent of Community Chef's shares from existing council shareholders to mitigate continuity risk at Western Health and improve service capacity across metropolitan health services. In-principle agreement was reached with councils, and contract details for the transfer of ownership to Western Health are currently being finalised. Western Health are a separate financial entity within the department's portfolio, with an independent board and independent governance arrangements.

At no time during the advice and decision-making of provision of financial support to Community Chef was there any consideration of I Cook as an entity. The advice and decisions were purely based on the need to maintain service continuity to vulnerable people in our community during a significant period of change and more recently changes in funding arrangements. Similarly, more recent decisions to seek to acquire Community Chef for the provision of health services food were taken in the context of business continuity risk and the system capacity at western central production kitchen and in consideration of recallable grants previously paid to Community Chef and, again, did not consider I Cook as an entity. Thank you.

The CHAIR: Thank you both, Mr Stenton and Professor Sutton. We will now move to discussion and questions from the committee. I have been given a note that we have about 7 minutes each on average, but given that Ms Maxwell is not here, I will try and work out a way to divide that 7 minutes amongst the remaining nine of us.

Dr KIEU: Thank you for appearing here today, given your very busy schedule. We very much appreciate your appearance, Professor Sutton. My apologies for being late; there was something urgent. But I got your opening remarks, so that is good. There are many questions that I am sure our members will be asking. Given the time, I only want to home in on a few things. First, the whole thing was triggered by the death of a lady who was 86 years old. Has it been confirmed or established that the death was caused by listeria? Secondly, from your opening statement, on the department's dealings with I Cook—there has been some delay due to, according to the statement, the response or collaboration or lack thereof from I Cook. Could you elaborate on that a little bit further? And thirdly, we have heard many different and also contradictory remarks and submissions, so one of the things I would like to find out and understand more is that according to I Cook's representation last week, the contamination sources were actually from the smallgoods. Has it been confirmed if it is or if it is not? Is there an investigation going on at the moment into that source, according to the submission by I Cook? I will stop there, and then if we have time, I will come back.

Prof. SUTTON: No problem. Regarding the cause of death, the death certificate listed pulmonary oedema, so fluid on the lungs, as the immediate cause of death; and ischaemic heart disease, or narrowing of the arteries around the heart, as a contributing factor. It was obviously recorded 'listeria meningoencephalitis', so infection of the lining of the brain and the substance of the brain as an additional diagnosis. As I say, up to one in three people with that serious an illness will die from invasive listeria infection. The relative contribution of it, I cannot say, but I know that it is a very significant invasive illness. I also know that the woman in question, as a patient, was comatose and was having seizures, and seizures are well known to cause a pulmonary oedema called neurogenic pulmonary oedema. So the fluid on her lungs may well have been a consequence of her meningoencephalitis from listeria.

On the issue of the smallgoods, it was a different genetic fingerprint, so it was a different type. It was investigated by PrimeSafe, as the regulator of that supplier, so it was not the cause of this woman's illness. But it was an indication that any food premises might receive contaminated goods, any primary producer might have listeria contaminate that primary production site. PrimeSafe, as I understand, looked at it, understood that this particular primary production facility had a listeria management plan, did subsequent sampling that they were satisfied with and were overall satisfied with the way that they were managing the risk of listeria. We were not involved in decisions for its ongoing operation or otherwise.

And the—

Dr BONE: Delayed response.

Prof. SUTTON: delayed response—can you address that?

Dr BONE: Yes. Hello, committee, Madam Chair.

Prof. SUTTON: Dr Bone is Deputy Chief Health Officer on the environment side, overseeing a number of teams, including the food safety unit.

Dr BONE: So my team worked very closely with I Cook Foods from before the closure order and then going forward. The sorts of things that I was hearing from them about challenges in I Cook understanding what needed to be done surrounded particularly the training, the changes to the food safety program, their understanding of what was required in the varied order. So first of all, a gap audit was required, which was to identify gaps, and the intention of the full food safety program audit afterwards was to show that those gaps had been resolved. But unfortunately I Cook Foods treated these rather as a sort of tick box—'I have a list of things I have to get through'—so that the second audit was done before the gaps had been resolved, which also delayed things. I also remember being told that they had done some patching to the floor but they had not understood that the entire floor needed to be redone because of all of the risks related to the ponding of the water. That is what I remember being one of the major issues.

The last issue I would say is that there was a lack of understanding that the varied order was only intended to allow them to reopen the lower risk lines, but they had not understood that from the order and from all of the conversations we had had with them. So I believe there was a meeting where it became clear to them that they were not able to restart the production of sandwiches on the basis of completing the things needed in the varied order.

The CHAIR: Thank you, and thank you for the presentations. That was very thorough. I am just looking at the time line of the series of events. Certainly we were informed by Dandenong council that they attended on 1 February to take some samples that later were found to contain the listeria. Then it was not until, it would appear, 18 February that any concerns over the production processes, over the equipment or anything were found. Given that we had a death on 4 February, can you explain why there was such a lag in the time line?

Dr BONE: Would you like me to take that?

Prof. SUTTON: Sure; I can add to it.

Dr BONE: Yes, certainly. So we were notified on 25 January of the case of listeria, and then that prompted an investigation. So 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, that we understood they had eaten, and their suppliers. So the swabs were taken on 1 February. We did not get those positive results back until 18 February. So I think from listening to the statements from MDU earlier on, I think they gave an explanation of the process that the laboratories have to go through. Because at that time we did not know that the lady had died and we did not know that there were particular issues at I Cook Foods the samples were just put through routinely.

The CHAIR: We understand that the woman died on 4 February but your office was not informed of that.

Prof. SUTTON: There is a statutory obligation to notify notifiable diseases, including listeria, so that will come from either the laboratory or the medical practitioner. There is no obligation to notify of a death, even if it is suspected to be of an infectious disease, only of the disease itself.

The CHAIR: According to our time line and certainly looking at the facts, the dates, on the MDU reports, they were finalised on 11 February, sent to your department on the 12th or sent to Dandenong on the 12th. Then it seems a week later, on 18 February, there was another visit. Then we found the significant problems. It seems surprising that none of this was picked up either in the two and a half weeks from 1 February or in the years leading up to this. I am wondering how this was not picked up, because it was so significant that it forced the closure of a large corporation.

Prof. SUTTON: I guess the notification and the detection of those samples in foods was the prompt to investigate the setting where those positive samples were identified. With respect to all the months or years prior, it is really for the City of Greater Dandenong council to speak to what they looked into, what they identified over that period of time.

The CHAIR: I have got a couple more questions, but I will let Ms Crozier.

Ms CROZIER: Yes, thank you very much. Thank you all very much. I know that you are terribly busy, so we do appreciate your time. Dr Bone, can I just get some clarity—you said your team worked with I Cook before closure, was that right?

Dr BONE: That was misspoken, actually. They did not work with them before closure; they worked with the City of Greater Dandenong. It was only after the closure that they had that, so thank you for clarifying.

Ms CROZIER: Did you get reports from the city of Dandenong on a regular basis?

Dr BONE: From the 18th, when we had the positive samples from I Cook Foods, I did not get them directly but my team did, and they were coming to me with the information during that week as they were discovering more and more information.

Ms CROZIER: What sort of information was that? The sample testing and various bits of evidence?

Dr BONE: Yes, so the results of all of the sample testing that we were getting back plus all of the reports that we were getting from the City of Greater Dandenong about their concerns about the condition of the premises and also the food safety processes and training of the food safety supervisors.

Ms CROZIER: Thank you, I am just whizzing through because of time. Just in relation to the sample testing from Box Hill, from reports I recall it was taken from a dumpster. There were different bits of food in a dumpster that was taken as sample, and that was a part of the evidence or part of the sampling process. Can you comment on that?

Dr BONE: It is not my understanding that any of the samples came out of a dumpster. I know that was in the media, but that is not what I have been informed about. What I was told was that the positive sample came from an I Cook Foods order that had been delivered as part of Meals on Wheels—delivered on 21 February and sampled on 22 February and found to be positive with a different type of listeria on 4 March. That is particularly concerning because that was a food that had already been cooked and therefore should have no listeria in it.

Ms CROZIER: Who told you?

Dr BONE: Who told me? Whitehorse City Council told us through my food safety team.

Ms CROZIER: If I can move to Mr Stenton, please. In relation to the financial position of Community Chef, you talked about an independent report. Was that the Pitcher Partners audit that was undertaken in 2017 or 2018?

Mr STENTON: There were a series of reports that we had commissioned. Those specifically around the acquisition, you mean?

Ms CROZIER: Yes, and the financial position of Community Chef. I am very keen to understand because all papers show that they were in financial difficulty, and we know that various grants were given by state, federal and local government. I want to understand the full amount of money that has been provided to Community Chef. We could not get that through the evidence this afternoon, and I am wondering if the department could provide that. Additionally, in terms of that financial situation that they were in, were they sustainable? Could they be sustainable without ongoing financial assistance from the government?

Mr STENTON: Yes, so it was part of my opening remarks: we were providing funding to support the delivery of meals, so they came to the department with cash flow issues and some financial sustainability concerns.

Ms CROZIER: They had gone to the banks too, hadn't they?

Mr STENTON: They had taken a loan from a bank.

Ms CROZIER: How much was that?

Mr STENTON: I do not recall.

Ms CROZIER: Could you find out? Could you provide that? Take it on notice?

Mr STENTON: That would be part of their financial statements. What I was going to say is their financial position was signed off annually by the Auditor-General as being a going concern, so we had no other assessment of that. The reason we started looking at doing financial monitoring is that, from a food provision point of view, we did not want them to get into a position where they could not trade, because we had a whole group of vulnerable people who needed those services.

Ms CROZIER: How much did the department pay, or how much was Community Chef paid? How much were they bought for by the government last week in terms of the negotiation from Western Health? How much did Western Health pay, or the government pay, for Community Chef, is what I am trying to say.

Mr STENTON: Again, I think I said in my remarks, the final details of the contract arrangements are being worked through as we speak.

Ms CROZIER: When will they be known? When will they be finalised?

Mr STENTON: Like all negotiations and contract arrangements, when they are finalised.

Ms CROZIER: So the reports of being paid for a dollar per council or a peppercorn amount?

Mr STENTON: A peppercorn amount is probably the right expression for the share transfer. Obviously there are the financial position of Community Chef and the existing contract, so they are the things that need to be—

Ms CROZIER: The reason I am asking that is obviously a major competitor has gone out of business—been closed down—and that this organisation has been continually propped up by government over a very long period of time. If you are monitoring them, as you said in your statement, on a monthly basis, it indicates that their financial sustainability was questionable.

Mr STENTON: Yes. Our monitoring was more to ensure that they were doing all they could to keep their costs in train because we were providing them with financial support, which was secured by funding agreements.

Just on a couple of points you have made—a competitor organisation—in our consideration for acquiring Community Chef for hospital provision, there is no competitor issue there. Hospitals are required to procure their food from a central production kitchen. As I said, we have got some continuity risk in some of those kitchens; they are getting old and a bit tired. We had already put some funding support into Community Chef, and the advice back from consultants was, 'You've got some interest here. You could use that facility for this purpose'.

Ms CROZIER: Thank you. My time has run out, but one last question: could you provide the Pitcher Partners report that was given to the department?

Mr STENTON: I will take that on advice.

Ms CROZIER: We would very much appreciate it.

Ms VAGHELA: My question is to Professor Sutton. How often do your department make the decision to give a closure order?

Prof. SUTTON: It is really quite unusual. Normally a closure of a food premises would come from the CEO of council. That would be a normal practice. If the food premises is within the council responsibility, then the

CEO is empowered under the *Food Act 1984* to be able to make that closure. This was an unusual circumstance when the CEO stated his inability or conflict of interest in being able to do so. I am empowered under the *Food Act* to do it, but it is an exceptionally unusual circumstance to be found in.

Ms VAGHELA: You said that it is a requirement for wherever the listeria is found to report to your department. Do you hear of those reportings? How common is it to hear of listeria reportings?

Dr BONE: Because that was a conversation this morning, I have looked that up especially. We have between eight and 35 human cases of listeria per year. We started a surveillance program for listeria in food in 2016 where we take under section 32 of the *Food Act* about 10 000 food samples a year. Over those four years we have had 175 notifications of listeria in food.

Ms VAGHELA: In this instance in the submission it says that I Cook Foods did not have a listeria management plan. Is it unusual for businesses not to have a listeria management plan?

Dr BONE: Yes. I would say certainly a business supplying food to vulnerable people absolutely must have a listeria management plan

Ms VAGHELA: So where have things gone wrong? Is it from the I Cook business side or an authority like Dandenong council who is overseeing whether the food safety programs are being done properly by the businesses? Why do you think this has happened? Why did they not have a listeria management plan?

Prof. SUTTON: I would say it is a collective responsibility. Clearly the business needs to have a listeria management plan when it is providing, especially at scale, food to vulnerable Victorians. But council does have a responsibility in oversighting and in the audit processes it should bear that in mind in terms of the complexity of the operation, the scale of the operation and again the vulnerability of the people that it is serving.

Ms VAGHELA: Also in the submission it says the personnel at I Cook Foods did not have proper understanding of food safety. Does that surprise you?

Prof. SUTTON: Look, I think we come across it in food businesses not infrequently. A lot of the time there is rectification through training and on-the-spot education and awareness raising, but there seem to be more substantive issues of failure to understand with respect to listeria especially. Again with a large at-scale operation there are some complexities with management of listeria that is different to other organisms, so it does require a higher bar to understand, but it is an absolutely necessary one in those circumstances.

Ms VAGHELA: So the other question is following on from what Ms Patten said. In one of the reports, once the officer visited the site they found quite a few non-conformances or issues which were non-compliant. What I am trying to understand is: was this an ongoing issue or was it that all of a sudden these problems started? If there were ongoing issues, if there was history—whether there were two, three, four, five years—why were they not captured? Is it because the business did not understand what the food safety processes were—whether there was lack of training—or has the council failed to do their job in terms of overseeing if they have gone in the past? This time the death of this woman has triggered this and someone has gone and done the check. But how do we know that, with the findings which have come out now, if those checks were done, would they have come up three years ago or two years ago? So that is what I am trying to understand.

Prof. SUTTON: We have not been involved as a department in the previous inspections that have been done by council. But I would say that some of the findings that were apparent when we were part of the investigation following this event would have been deficiencies that had been longstanding. Some of them were structural, many of them were process and some of them related to training and understanding. There can be ebbs and flows in some of those aspects, but a number of them seem to be deep-seated issues. I think, in some respects, council needs to take responsibility for having failed to identify how substantive those issues were and to have rectified them up to this point in time.

The issue with listeria is that if it is not introduced into your food premises for a number of years, or if it is introduced at very low levels and by good fortune or chance does not become embedded and established within the environment of the kitchen or a food premises, then you will not see it manifest. But looking at what has happened here, it was clear that listeria could be sustained in that environment, and the issue of cross-contamination is either one of a failure to work through the appropriate flows—where there is separation of raw

and cooked food, where there is dirty and clean equipment—and the way that things are washed and the way the things move around through that setting. It may well be that you can dodge a bullet for a number of months because listeria has not been introduced at a level that allows it to become established. But these critical events obviously put the microscope on these settings, and they can be found wanting, obviously, once it is clear that the circumstances allow it to become established.

Ms VAGHELA: So you have emphasised a lot in terms of public health issues. It just makes me wonder how many businesses are out there probably not having proper understanding of food safety protocols, and maybe the councils are not following up the role that they have to play. I wonder how many businesses are out there where it is still happening, and we do not know.

Prof. SUTTON: Look, I guess it is an ongoing challenge. There are literally millions of retail food meals produced and delivered every day. It is not enough to be 99.9 per cent safe, you have to be 99.999 per cent safe at least, because you will have cases of food poisoning or foodborne outbreaks unless you have really rigorous oversight from a regulatory and compliance point of view. Angie, you might want to say—

Dr BONE: Yes, if I may add just one or two sentences to that. I think those are valid concerns, and it is something that we are very aware of. Our role in the department is really to try to ensure consistent administration of the Act, and we are trying very hard to get consistency and to raise the level of knowledge and understanding and ability of council environmental health officers. So we have recently had some money from Treasury, which is a sort of regulatory reform program that is partly to support small businesses but it is also to ensure that councils have as consistent and as high-quality compliance and enforcement and regulation as possible around food premises.

Ms LOVELL: Professor Sutton, your media conference, I am told, on the day of 22 February was at about 2.30 pm in the afternoon. At what time during the day did you actually make the I Cook name public? Was it made public at that event, or did you name it earlier in other media?

Prof. SUTTON: No, by me it was made at that time for the first time.

Ms LOVELL: Was that the first time it would have been released by the department?

Prof. SUTTON: As a media statement, I think it was—

Dr BONE: Yes, as a media statement, I can answer that. But it was a condition of the order that the order had to be displayed when it was put on the door.

Ms LOVELL: Where would that be displayed?

Prof. SUTTON: On the premises.

Dr BONE: On the premises, yes, at 4.00 am.

Ms LOVELL: On the premises? So someone had to actually go to I Cook to look at that to know that it was them.

Dr BONE: Yes.

Prof. SUTTON: Yes, but we had also written to all of the vulnerable clients in order to inform them that they needed not to eat the food that had been delivered and to dispose of it.

Ms LOVELL: So what time would that have been done?

Prof. SUTTON: That would have been done on the day of the closure. I think it was.

Dr BONE: So it was the evening of the 21st when all of the decisions were being made. There were some letters that were sent out to all of the Meals on Wheels and the private hospitals and the councils—

Ms LOVELL: To the customers of—

Dr BONE: Yes, exactly—to warn them what to do.

Ms LOVELL: Thank you very much. Given council's really specific role in the enforcement and inspection of food safety, do you think it was responsible for the CEO to actually take on a position on a board of a food company that put him in this position that he could not make that order, which is one of his substantive roles?

Prof. SUTTON: Look, I think it became problematic in terms of the closure on that night. It led to delays in that coming into effect, and it took some efforts for my department to contact him, my team to contact council, and to make him available to even have the conversation. So I think it was problematic in that regard.

On the issue of the conflict within council, having a part share and also being potentially responsible for a closure, I guess that is a question for the department at large and the minister as to whether the *Food Act* needs amendment.

Ms LOVELL: But that is a separate thing to safety and—

Prof. SUTTON: Yes, that is right.

Ms LOVELL: And perhaps it is something to be considered that those who are involved in that inspection and enforcement should not be involved in also the administration of a food company.

Prof. SUTTON: I think that is a fair point, yes.

Ms LOVELL: Okay. Did you check any of the reports that were supplied to you by the City of Greater Dandenong?

Prof. SUTTON: Reports in what regard?

Ms LOVELL: So reports that were prepared by Leanne Johnson and Elizabeth Garlick that led to the decision to make the closure—were they checked in any way before the decisions were made or were they just taken at face value?

Prof. SUTTON: Well, they were certainly taken as reports to the department and in a number of conversations with those environmental health officers. There was a day of the closure when DHHS authorised officers from the food safety unit also went out. If they had found those reports to be manifestly wrong or inadequate, then I would have lifted the closure order then and there. So there was an immediate, if you like, checking of the claims or the statements that EHOs from council had made.

Ms LOVELL: Thank you very much. Also, I asked this question this morning of the City of Greater Dandenong. Obviously there were several ingredients that were found to have listeria on them, and there is no way of really knowing whether that was a cross-contamination within the packaging of the sandwich et cetera. I asked them did they actually make any inquiries of the suppliers of I Cook Foods to see if that listeria had been imported on, say, the deli meat or something like that. They said that was not their role, that their only role was to investigate into I Cook and that they supplied the names of the suppliers to the department and that it would be the department's role to see if the primary source came from somewhere else. Was that checked? For instance, deli meats are made by several different companies and it could be quite problematic to the state if it was one of the major suppliers that is in every deli in Coles et cetera. So was that further checked, where the primary source of it might have been?

Prof. SUTTON: Yes, I think I addressed that with Dr Kieu in relation to PrimeSafe having regulatory oversight. So when the specific contaminated ham was identified there was a primary producer, and it is PrimeSafe's regulatory role to look into that. I think they were able to identify that it was a specific primary producer who supplied that rather than it being a more widespread issue because it was identifiable as coming from there.

Ms LOVELL: But was that primary producer investigated to see if there was any listeria in their factory—

Prof. SUTTON: Yes.

Ms LOVELL: and was there any found in any of those suppliers?

Prof. SUTTON: I do not believe so. We are not PrimeSafe, obviously, but I do not believe that they identified, in subsequent sampling at that site, listeria. But I would take it, again, on face value that it would have been there in some form in some sample at some time.

Dr BONE: May I add something as well? Just to say: as part of this surveillance that I was talking about both of food and human samples, because of this situation we were scanning very carefully all of the information that was coming in to see if there were any other cases that could be linked that perhaps would suggest that it was the supplier, as you were saying, supplying someone like Coles, in which case it would be much more widespread, and there was not any.

Ms LOVELL: Yes—it would be a problem if it was there for everyone's Christmas ham.

Dr BONE: You've got it.

Ms LOVELL: Absolutely. The other thing I was just interested to know is: is it common for slugs to be found in summer?

Prof. SUTTON: I have no idea.

Ms LOVELL: No-one has been able to tell us that one.

Prof. SUTTON: I should add that I did not know about any slug at the time that I made the decision for closure, and it obviously formed no part of my determinations around I Cook.

Dr BONE: We only heard about the slug from the media reports.

Ms SHING: I hope that everyone can hear me. Thank you for your evidence. I would like to, Professor Sutton, put something to you in relation to the biofilm issue and the question of deep cleans. We heard evidence from Mr Cook last week that a deep clean was undertaken every day at I Cook Foods, and we have heard evidence around biofilm on a knife blade surface and chopping board. Would a deep clean, to the extent that I understand it to be, rather than a forensic clean, have removed any biofilm, had it been undertaken on a daily basis?

Prof. SUTTON: I guess 'deep clean' is a bit of a lay term.

Ms SHING: This is one of the things I am grappling with.

Prof. SUTTON: For the purposes of making food production safe, equipment needs a clean that would remove a biofilm, so by definition an adequate clean needs to remove that biofilm. So by definition, finding it means that there was not a sufficiently adequate clean that would reduce the risk of cross-contamination from listeria or indeed other bacteria like salmonella.

Ms SHING: So you would refute the evidence given by Mr Cook that a deep clean, to the extent that it would remove that risk, had taken place before the presence of biofilm was discovered?

Prof. SUTTON: Correct.

Ms SHING: You have also referred to a soup of listeria strains, and we have heard evidence around the ponding or pooling of water, the co-location of food preparation in entrance and exit areas through which staff passed on a regular basis, and the personnel door which was used frequently to move inside and outside the premises. How do we work with an environment where people are responsible for preparing food for vulnerable cohorts on the one hand whilst dealing with static food preparation areas which have been in place for a number of years? We have heard evidence in relation to the council and the work that it did to undertake an understanding of the risks that were present in that workplace, the issues of pooling and the issues of moisture and droplets potentially moving from the dishwasher area and sinks through to the food preparation area. How is this able to be improved in a continuous improvement setting if a building is set up in a way where those areas and workstations are proximate? Can that risk be managed in an acceptable way?

Prof. SUTTON: Sometimes not, if there are intrinsic structural issues that make it impossible to have the appropriate linear flow from lower risk to higher risk areas through a food production premises. But sometimes

yes; sometimes it needs a thorough review of the food safety program and a listeria management program that defines exactly the entrances and exits, the location of all of the processes within that premises in order to manage that risk of cross-contamination and the introduction of dirty-into-clean areas or the introduction of lower-risk-into-higher-risk areas of contamination. But Dr Bone might have something more as well.

Dr BONE: No, I thought that was quite a good explanation. I would say you can never totally reduce the risk to zero but there is a lot that you can do to reduce that risk, and that is why eventually Brett was able to lift the order, because you felt satisfied that enough had been done to reduce the risk significantly.

Ms SHING: I would like to also touch on a history of complaints which had existed in relation to I Cook Foods—not according to the evidence given by Mr Cook last week but in relation to evidence from Ms Johnson at the council of the City of Greater Dandenong—and the issues around ongoing requests for them to change their practices and to change what they did. When should it be, in your opinion, time for a council to escalate a series of significant concerns to the department where, but for happenstance, there may well be an outbreak of listeria or you may well creep above that magic 100 cfu number which is set out in the guidelines, the standards or the regulations? How should that be managed in a process? Because you have talked, particularly Professor Sutton, about the potential issue in a conflict of interest and how councils should manage that in response to a question from Ms Lovell. We have 17 councils though who are shareholders so, you know, what should be done in your collective view to make sure that risk can be managed, that practices can be improved in a continuous fashion and compliance encouraged and enforced wherever necessary but that you have got appropriate mechanisms between councils and governments in that situation where a conflict might arise?

Prof. SUTTON: Yes, I guess Dr Bone has addressed the specific role of the department in terms of getting consistency of application of the *Food Act* across councils and ensuring that expert guidance is provided for their regulatory function, but it is ultimately council's regulatory role to manage that. I think they have powers that are very substantial in terms of things that are not addressed, so if it gets above a threshold that makes them not satisfied that a premises can continue to operate, then they can close that premises or they can provide improvement orders or whatever requirements they feel are needed in order to mitigate that risk sufficiently that a premises can continue to operate. But I think the point about when we hear about it is an important one. It is a bit unclear to me exactly how it can be managed if a council is not taking appropriate action if we do not have line of sight of that council's response to issues that it identifies.

Dr BONE: May I add something?

Ms SHING: Yes, absolutely.

Dr BONE: So everybody has a critical role in this—the manufacturer, the council, the auditor, the department—and I think one thing we have not mentioned is the role of the auditor. So in a class 1 and many class 2 premises an independent audit is needed, and the department authorises those auditors. So the auditor is also an absolutely crucial part of identifying problems and then rectifying them. Council should review each audit report, and we have now put in a process called 'audit the auditor' that has been in place for the last two years to make sure that we are also looking at examining every audit that is done in a period of time by all of our auditors so that we can identify problems, and then we have a sort of performance management escalation of where we are seeing problems now because we understand how critical that role is.

Ms SHING: Thank you very much.

Dr BACH: Thank you all for being here. Obviously we are taking this inquiry really seriously and I know you are too, notwithstanding the fact that you have other very important work to be doing right now. Can I go, Dr Bone, to the issue of exactly what information you were provided by Dandenong council. I am looking at page 9 of the document that you, Professor Sutton, very kindly gave us at the start of your evidence today, and you refer to the fact—at the top of page 9—that after major cleans of I Cook premises on the 20th and 21st, then staff at Dandenong council started to engage with you to inform you about what they had found. So I take it that the senior environmental health officer at the City of Greater Dandenong is Ms Garlick, isn't it?

Dr BONE: That is actually Ms Johnson.

Dr BACH: That is Ms Johnson?

Dr BONE: Yes, Leanne Johnson.

Dr BACH: Okay, thank you so much. So in particular it was Ms Johnson liaising with members of your team?

Dr BONE: Exactly.

Dr BACH: That is great. So would you mind just talking us through in particular the format that that information came in? I am sorry to sound like a pedant, but I tried to get this information out of the council earlier today and did not get very far.

Dr BONE: Of course, yes. It was a series of telephone calls and emails between various authorised officers in the department and Ms Johnson.

Dr BACH: Okay. Thank you very much. And then I might ask you this question, Professor Sutton, perhaps. You noted that obviously you had the information from the City of Greater Dandenong and that played a significant part in ultimately the decision that was made, and then subsequent to that, very soon after that decision was made, staff from the Department of Health and Human Services also went out to I Cook Foods—and here I am looking at page 10; you have given us a bit of a precis, if you like, of exactly what they found. But it is interesting to me that, if I am reading this correctly, only one of the substantive issues that the council raised with your team, Dr Bone, was then raised again in the Department of Health and Human Services report. I may be wrong, but the only substantive issue that I can find that is common across all your reports is the issue of the ponding of water. Am I getting that right, and did it strike you or members of your team as at all odd that there was such a discrepancy between the two reports?

Dr BONE: I think it is worth bearing in mind that these are just summaries of the reports, so they are not complete reports at all. So this was my summary of the information, and what I was trying to demonstrate here was the breadth of issues rather than any consistency between the two of them, but the ponding of water was such a critical thing that I felt it was important to emphasise that.

Prof. SUTTON: And there were a number of common elements that were found by both council environmental health officers and departmental authorised officers in their full estimations.

Dr BACH: Thank you for that clarification from you both. I wonder, is it possible to get the full copy of the departmental report?

Prof. SUTTON: I will take it on advisement.

Dr BONE: We can certainly provide you with a copy of the visit that the department officers made on 22 February. There is a report there.

Dr BACH: But this information here on page 10, that is a precis—a summary—of a report.

Prof. SUTTON: Multiple reports back from various visits from various officers.

Dr BACH: So there is not a report.

Dr BONE: No, there is no one report, and I think that is something that people keep looking for and asking for: 'Is there one standalone bound report?'. The reality is in something that is very, very fast moving, as this was, and urgent, it is a number of different reports that are taken collectively, and the *Food Act* does not specify how that report needs to be given. Bearing in mind it was 1984, it probably would not have mentioned email, for example, so that is the summary answer.

Dr BACH: Again thank you for clarifying that, but again I would note that, as you said, Professor Sutton, you would take it on advisement as to whether or not you can provide those reports, but if we could have those reports, that would be very useful for us as a committee.

Professor Sutton can I take you to the day, then, that you made this decision. You noted before that you and your team had made some effort to get in touch with the CEO of Dandenong council. Would you mind talking me through exactly how that happened? I am concerned that, as you say, there was your team seeking to get in

touch with senior officials at the City of Greater Dandenong, and obviously the health risks that we are talking about here are very, very serious indeed. My understanding from your testimony thus far, Professor Sutton, is that there was a delay that was, well, far less than ideal, to put it mildly.

Prof. SUTTON: It did take some hours. They were not my personal efforts in picking up the phone, but there were a number of senior medical folk who were trying to contact council. They got some messages through. They got messages back that council were in a meeting and would not come out or could not come out and would be available at a certain point in the evening. It was, I think, approximately 9.30 pm from home when I managed to speak to John, but it took some time. I think we were only reassured by the fact that we knew that I Cook had ceased production for the day and would not recommence until approximately 4.00 am the following day. So we really had overnight, if you like, to ensure that our closure order was completed and able to be served. It was close to midnight, I think, when it was walked out and provided to the factory.

Dr BACH: That is fine. Thank you. I appreciate that, that is right, you have teams working for you, so it would not necessarily be you personally, Professor Sutton, picking up the phone, but nonetheless it was made very plain to the City of Greater Dandenong that this was a very serious priority, and yet you were told, well, you know, there was a meeting.

Prof. SUTTON: Yes.

Dr BACH: All right. Fine. Thank you. Dr Bone, I was just going to come back to you on the matter of exactly when the department was informed of the death of this poor lady. I only sort of half understood what you and Professor Sutton were saying earlier about the fact that, given the circumstances surrounding her death, it was not necessarily an imperative—or a statutory imperative, let us say—for the department to be notified. Would you mind talking to us a little bit more about that? Still, wouldn't it have been optimal, wouldn't it have been better, for you to have been notified far earlier of her death?

Dr BONE: The actual fact of her death actually was no part in the decision-making around the closure and the investigation here. It was very unfortunate, but if she had got listeria and survived, it would not have made any difference to our investigation. So I think that is the first thing to say on the outcome of that. I was informed of her death on the 18th, because I was told about the case in the morning and I asked specifically, 'Can you find out how the lady is?'. Because that was the first time I had heard. I do not know if our communicable disease colleagues on the other side of our business may have been told of her death earlier and it had not come through to me, but that was when I first heard.

Mr ERDOGAN: Thank you, everyone, for coming today. Professor Sutton, last week Mr Cook told us at the hearing and claimed that you did not have authority to issue the closure order and in fact issued the order under the wrong section of the Act. What is your response to that?

Prof. SUTTON: With regard to authority? I was—

Mr ERDOGAN: Did you have authority?

Prof. SUTTON: I did. I was delegated as Acting Chief Health Officer at that time. I am now obviously the substantive position holder. But I need to be a medical practitioner and I need to have the delegated authority by the Secretary of the Department of Health and Human Services, and I did have that some months prior to this event.

Mr ERDOGAN: Did you issue the order under the right section of the Act?

Prof. SUTTON: Yes.

Mr ERDOGAN: What came out from last—

Prof. SUTTON: The section of the Act is a routine section used for the closure of premises, usually by CEOs of council, that relates to a specific premises within council. There are other sections where emergency powers can be used, but they relate more to food recalls statewide or multijurisdictional issues of food contamination.

Mr ERDOGAN: I did notice with the initial order—and this is probably something that Dr Angie Bone could answer—is that there was an initial order made and then it was varied. What was I Cook required to do to have the order varied?

Dr BONE: So the idea behind varying the order came about following the visit of the authorised officers in my team on 22 February, which was the Friday, and that is because they visited the premises and they understood that not only the ready-to-eat food but also some lower-risk production lines were in process. And so it was an attempt to try to get I Cook Foods up and running sooner—to vary the order so that they had some specific things they could do to get the lower-risk lines running.

Mr ERDOGAN: Broadly speaking, were the requirements under the initial order quite onerous for I Cook to comply with?

Dr BONE: They should not have been. They are fairly standard, all of those things. But it did seem that I Cook found it difficult to comply with them. But there was nothing unusual, and most of those things should have been in place anyway.

Prof. SUTTON: I would add, though, that listeria presents specific problems for food premises. If there is a salmonella contamination of food, it has sometimes been introduced. You need to throw away food that is not going to go through a subsequent kill step. You need to make sure that processes are all rectified, and you need to go through a thorough clean of a premises. But listeria—and I think Deon Mahoney's report might allude to this—can establish itself within the environment of a food premises. Some of you might recall the Jindi Cheese listeria outbreak. They had to go through a process of weeks of rectification, and again it was the kind of engineering and structural and flow changes to ensure that listeria that establishes itself in the environment does not reintroduce itself at any point subsequently into a food production line.

Mr ERDOGAN: So would you say that the set-up at I Cook was a hazard?

Prof. SUTTON: Yes. I think with respect to listeria especially, there are some requirements for a smooth and level floor and the ability to move food through a production line that minimises to the fullest extent possible the risk of cross-contamination.

Mr LIMBRICK: Thank you for your evidence today, everyone. Professor Sutton, one thing that does not make sense to me is that I Cook Foods—it seems that you are quite certain that they were the source of this listeria infection with the unfortunate lady who contracted listeriosis. They distribute thousands and thousands of meals to the most vulnerable members of the community. One thing that I do not understand is: why did only one person get sick?

Prof. SUTTON: I would say the first reason is because we closed I Cook. I think there was a significant risk of subsequent illness and potential deaths. But obviously at some point in the contamination of a food premises listeria will get to a point where it is at a level that causes invasive disease in someone who eats it. Every single individual will have their specific vulnerabilities and some people will be highly vulnerable, others less so. It is clear that age on its own is a risk, but people who have no other chronic illnesses and who are over 70, 75 years of age might get a gastro illness. We would never be notified about that. They might have no illness whatsoever. But there are others who might develop an illness but not be diagnosed because they do not get a blood sample. It is really only through invasive illness that the notifications come to us.

Listeria is not grown from cases of gastroenteritis, so we are not going to see the gastro that might occur with listeria infections. We are only going to see it where it causes septicaemia or bacteraemia and meningitis or encephalitis, so those really significant invasive illnesses. I think this woman might have been the first. It may well have been that there were other individuals who did not get a blood sample, who did not get a spinal cord sample and who might have died and remained uninvestigated who might also have died of listeria. But my suspicion is she was the first case of invasive listeriosis from this premises.

Mr LIMBRICK: But if she was diagnosed, on the timeline I have, on 23 January, and the business was shut down almost a month later, that must mean there was a month where thousands and thousands of meals were going out and no-one else got sick.

Prof. SUTTON: As I say, there may well have been dozens of people who got sick but with milder illness and non-invasive illness. At a certain threshold invasive illness becomes more likely, and for certain very vulnerable individuals—and I think she was one of them—the risk of invasive illness becomes much greater. I do not expect that in any contaminated food premises that all meals will be contaminated or that all meals will have a level of contamination that is likely to cause illness. But obviously within that food premises there will be some foods that are produced that are contaminated to an extent that they are much more likely to cause invasive disease.

Mr LIMBRICK: Thank you. One other thing, from a public health point of view, does it concern you that we have an ownership structure here with Community Chef where one of the shareholders, the City of Greater Dandenong council, regulates a competitor and then we have the Hobsons Bay City Council regulating itself? Do you see that as a risk from a public health point of view?

Prof. SUTTON: Look, I am not a regulatory expert, but I see it being potentially problematic in as much as I would want a fair and fearless investigation into any premises if there is a potential public health risk to the community at large.

Mr STENTON: As a conflict of interest, I think I have gone to lengths to the decision-making about Community Chef and the department—nothing to do with I Cook. I think the issue here—and I am not going to talk about the city of Dandenong's structures—is as a board member of Community Chef, whoever they are, they haves board obligations under ASIC rules and they operate under ASIC rules, so that is the first sort of obligation of an individual. As the CEO of Dandenong, he has a regulatory obligation for that LGA for compliance with the food services act.

Your point about Hobsons Bay, similar issue. Different roles for different purposes within our own department we would expect. If Community Chef were competing in a market with I Cook, then there is a real conflict of interest and people should recuse themselves. We would expect people in our own department to recuse themselves if they were on a board and there are dealings with that board, regulatory or otherwise. So I think being clear what the various roles of an individual are—

And, as I say, on one level we would expect all of our staff to do exactly what occurred, which is to recuse yourself from the decision because you have a perceived conflict of interest.

Mr LIMBRICK: Even ignoring the issue about Mr Bennie being on the board, if we ignore that for a moment and just consider the councils as a whole, as an entity—so Dandenong and Hobsons Bay councils—those councils, there are significant financial and other problems if Community Chef fails, right? So doesn't that set up some sort of problem with incentives if they are regulating themselves effectively?

Mr STENTON: I am not sure the councils would be in any financial problem because the company was separate from the councils. The board members operate as board members. And again, without going through the structures of the organisation, there are exemptions for councils to compete in the food market, so they do not need to go to competitive tender for food if they get their food from Community Chef. The point Ms Crozier made, the reason that the department provided financial support is nobody—department, council or anyone else—wanted to see a fledgling company that was getting its operating model right cease to trade and then run the risk of those meals not being available to vulnerable people. So the decision-making by the department, and I suspect councils, is we need this thing to keep going until it gets to a maturity so that we do not run that risk.

Mr LIMBRICK: One further question; maybe this is for Dr Bone. On 21 February, on the evening before that, Mr Cook gave evidence that there was a subsequent—I think he referred to it as a forensic clean of the premises. He claimed that someone spoke to Mira from the department and told them that the clean was not good enough. I think it was Ms Johnson who spoke to Mira from the department. But this was before Ms Johnson had actually gone into the premises that day, on the 21st. What is your response to that?

Dr BONE: That is certainly not what I was told, and I cannot verify whether Ms Johnson had been in or out of the premises when the call was made because I was not there. But yes, I certainly was not given that information, and I would be surprised.

Dr KIEU: This question may be for Professor Sutton or maybe Mr Stenton. There is a discovery process going on in the Supreme Court, so what has the department done in providing or supplying the documents so far?

Prof. SUTTON: Probably a senior legal individual?

Dr BONE: I can answer, certainly. I am not from the legal side of the business, but the preliminary discovery process is complete. We have provided the documents that were requested.

Dr KIEU: Thank you. Now coming back to the acquisition of Community Chef by Western Health. From my understanding, class 1, like the one being held by Community Chef, can prepare and serve the food. Class 2, or 2A like I Cook, can only prepare and not serve the food. So from the different classes like that, I Cook would not have been a competitor or a tenderer for the consideration of Western Health or any hospital or any aged-care facility. Is that correct?

Mr STENTON: Again, without knowing the details of the tender requirement but taking your proposition, the tender would specify the type of food—cook-chill, bulk food, for plating et cetera. So the tender specifies what the requirements for the health service are—in the case of Western Health, this was for the Joan Kirner facility, so it was a cook-chill requirement—and then people respond to the tender. Community Chef were successful in that tender. To say it is unrelated is not quite right because our consideration about acquiring was that we had already funded them to maintain service continuity. The tender proved to us that their capacity was something that would help our capacity in health services. That was part of the consideration about whether we proceed down that path. The Western Health tender was the Western Health tender; I do not even know who applied, I have no idea. But under normal tender process we specify, 'This the type of food'. And we do not go to tender for food very often, because, as I say, in hospitals particularly it is all run out of central production kitchens and provided across the metropolitan health system. The capacity at Western was not sufficient, so they went to market.

Dr KIEU: Now, Professor Sutton, some of the test results coming back from MDU found low levels—I think less than 10 units of cfu. But the regulatory requirements state the safe level to be 100. Is that of concern to you given that different people have different reactions to or tolerances of very serious bacteria like listeria? Is it of concern, and is there anything we should do about that or not?

Prof. SUTTON: In my opening statement I made the point that the investigations into listeria at I Cook and all the other potential sources of food for the deceased patient were investigated for the presence of any listeria whatsoever, because we already knew that there was a sufficient level of listeria to cause invasive illness in that patient. So calling them 'safe levels' is not the appropriate characterisation; they were compliant levels in terms of the Food Standards Code. But the fact that listeria was present but at those low levels is not an indication that they could not possibly have been in greater levels in other food or other samples that were not taken to cause illness in that patient or others.

The CHAIR: I have got a few questions, but I just cannot decide which ones to ask at this stage. Given, Dr Bone, the seriousness that you received, were you surprised that all charges were dropped?

Dr BONE: Yes, to be honest, I was surprised that all charges were dropped.

The CHAIR: Did the department consider taking their own action?

Dr BONE: As we were not the direct regulator, my understanding is that we could not take the action ourselves. But we did not know that Dandenong were dropping the charges until after that happened.

The CHAIR: Right, because I think looking at the fact that this company has been operating since 1986 providing food and then in this sort of flurry of action in three days extremely significant problems have been found to the extent that they were asked to destroy hundreds of thousands of dollars worth of food, and from your advice to us, Dr Bone, they were recalcitrant in their actions, which one would have thought when hundreds of thousands of dollars was at risk. But you would attest that under that section of the Act it was important that that food—anything produced before 13 January—be destroyed.

Dr BONE: Yes, because it would be impossible to tell which foods might have listeria in them and it was an urgent situation so that was the most appropriate action. But I do take your point absolutely that it is surprising that the problems have clearly been not just three days worth—it had been a longstanding issue that had not been picked up before we were involved.

Prof. SUTTON: And it was food since and including 13 January, not prior, just for the record.

The CHAIR: Pardon me. Thanks for the correction. Mr Stenton, if there are 15 councils that have an interest—

Mr STENTON: Seventeen, I think.

The CHAIR: Seventeen, in Community Chef, would this mean that none of them could actually issue a closure order, for all of them would have some—

Mr STENTON: If they are on the board. Again, in my commentary before, I was talking about what we would expect. They would have their own conflict of interest rules within local government. As I understand it not all council shareholders are board members. Again, depending on where the LGA was—so again Community Chef operates out in the west somewhere, I think it was Hobsons Bay that people talked about, that would be a conflict problem for them if they do not recognise the difference between their regulatory role as a council and/or they do not have other delegated people within the council to make those decisions.

The CHAIR: But given the circumstances in Dandenong, presumably this would be the case in numerous other councils that were shareholders. It seems there was some board member rotation as well from councils.

Mr STENTON: Again, Ms Patten, if they were in competition, so again the different roles of a board member—a board member has a responsibility to the company that it is a board member of, as a CEO of a council they have obligations under the food services act to apply those regulations.

The CHAIR: So if any food business in their area was found—

Mr STENTON: Was potentially a competitor with Community Chef or anybody else—

The CHAIR: Community Chef.

Mr STENTON: I do not know what other companies or organisations councils are on boards of. Again, it is not for the department to apply our standards of conflict of interest, but normally you would expect a board member to recuse themselves from decisions at board level but also in their day job.

Ms CROZIER: Can I just go back to the questions that Ms Patten and Mr Limbrick have asked to get some clarity around a number of issues? You are saying, I think, as Ms Patten said, in the last three days there was a flurry of activity and there was this mad rush to shut the company down. But the food was safe before the 13th of—you gave a timeframe, but the food was okay up until the 13th and then there was an issue, number 1. Is that correct?

Dr BONE: That was the date that was picked because that was the date of admission of the patient to hospital.

Ms CROZIER: Okay. So can I just ask about the patient in hospital. Professor Sutton mentioned the Jindi cheese issue, so we know that food—cheeses, soft cheeses—have listeria, processed meats have degrees of listeria. So if a sandwich is left out of refrigeration for a period of time, what effect would that have on the listeria present in any of those food elements in a sandwich?

Dr BONE: The important thing to remember is that listeria can grow in a refrigerator as well as—

Ms CROZIER: I realise that.

Dr BONE: It is more to do with the shelf life of the product rather than whether it is refrigerated or not. Products will be refrigerated if you wanted to stop the growth of something like salmonella, so it is probably not pertinent to this particular issue about whether it was left out of a refrigerator from a listeria point of view.

Ms CROZIER: Okay. So in terms of the shelf life, did you speak to Knox Private Hospital in terms of perhaps some handling that they may have done? Was there any issue with the handling there?

Dr BONE: Knox City Council contacted Knox Private Hospital, because that is the way the system works, to assess their food safety program and their practices, and they were satisfied. Knox Private Hospital did a range of environmental swabs and, as I say, they were all negative.

Ms CROZIER: Okay. They were negative?

Dr BONE: Yes.

Ms CROZIER: Can I go back to Mr Stenton in relation to—Community Chef has a number of contracts with health entities, meaning hospitals and health boards—

Mr STENTON: Only one that I am aware of, but I am not privy to all of their contract arrangements.

Ms CROZIER: But they supply to a range of entities?

Mr STENTON: They supply to a range of private sector entities, I understand, in aged care, yes.

Ms CROZIER: Okay. But what they have entered into with those 17 councils are multimillion-dollar contracts, and now with the acquisition through Western Health that is being negotiated, will that become—

Mr STENTON: So, again, I am not aware of what their arrangements are with other companies. The arrangement with councils, again my understanding is the councils formed a joint venture to establish Community Chef as an entity for the purposes of providing meals, which they were obligated to provide under the home and community care program and the disability program. Part of their business objective, if you like, was to try and grow their business, but that was their primary consideration and that is the consideration that the department looked at in providing funding support over that period. So there are contractual arrangements between the council and Community Chef—they still have contracts in place. But payment schedule—and again, this may have changed since last I was close to it—they estimate their volumes and provide, effectively pay for, that in advance. But there is a refund arrangement if they do not meet those volumes.

Ms CROZIER: So once this negotiation process is finalised with Western Health, I presume that the contract, the details of that tender, will be made public?

Mr STENTON: The details of tender—well, the tender request is in the public domain. The details of—

Ms CROZIER: But you said you did not know who else was—

Mr STENTON: No, I do not, because tender arrangements generally are commercial-in-confidence. People put a submission in confidentially and the department has no knowledge of who the tenderers for that tender were. I know Community Chef were, because they were the winning tender, but I do not know anybody else. Normally with tender arrangements we do not as a department or in health services release those details.

Ms CROZIER: It just seems unusual that an organisation that is under severe financial strain and has been since its inception, since 2009, has been awarded this very large multi-million-dollar contract with Western Health, with very little public scrutiny.

Mr STENTON: Again, Ms Crozier, I do not know the value of the contract, so you—

Ms CROZIER: Well, I look forward to the government being transparent about that and hopefully letting the Victorian community understand.

Mr STENTON: I suspect it is volume based, so it is probably variable.

Ms SHING: Firstly, thank you to the public health team. I know that we are dealing with an actual pandemic and you have had to take time away from that actual pandemic to deal with allegations of a conspiracy and Mr Cook's fight for up to $26 million in damages.

I would like to put to you just a number of concepts that Mr Cook has outlined in public comment, including an article entitled 'Recipe for "justice"', published by the *Dandenong Star Journal*, in which Mr Cook says that the charges and health inspections were:

> … a set-up from day one …

And then another quote:

> There is not a single scientific report to show we were wrong or breaking any laws.
>
> We were destroyed on the alleged basis of a brought-in (smallgoods) product. It would be like closing down Coles for something similar.

And then finally, 'I don't like conspiracy theories, but why else would you do something like that?'.

To go to the detail in Mr Cook's allegations, I would like to explore how this matter from your perspective, Mr Stenton, as well as Professor Sutton and Dr Bone, compares with the steps and processes taken by the department and/or CEOs or the Chief Health Officer at that authority as required to be exercised in other situations that involved a comparable health risk. I note the evidence that there are between eight and 35 cases of listeria identified by the department per annum. What are the processes like here in comparison to other matters which are acted on by the department following notifications of these serious public health breaches?

Prof. SUTTON: Thank you, Ms Shing. To the point of the threshold for action for some closures or voluntary recalls more commonly, we often have much less evidence or less compelling evidence for a closure. You might recall semi-sun-dried tomatoes being recalled across Australia. That was on the basis of epidemiological evidence only. The organism hepatitis A was not identified in any of those foods, but they were still recalled on the basis that, I think, people were 80 times more likely to have consumed that type of food and gotten hepatitis A versus those who did not have hepatitis A. So sometimes it is simply an epidemiological link. There are other circumstances where salmonella, for example, is implicated because we see a spike in a particular species of salmonella. We do not have the DNA fingerprint to make a link between contaminated food. Sometimes it is not found in a particular food or we just have the species of the organism and we do not have that fine detail of MLST, binary type, serotype or the DNA fingerprint. I think it was more compelling in I Cook's circumstances than a lot of others either that have been closed or where, as I said, more commonly, we have gone to a business to say, 'Look, here's the evidence of an outbreak affecting multiple people in Victoria or across Australia. We think your food is implicated. Here's the evidence for it', and they voluntarily close their production and make a voluntary recall.

Ms SHING: So are you satisfied then from a governance and risk management perspective that you have made the right decision given what you have referred to, Professor Sutton, as abundant evidence, and are you satisfied, Dr Bone and indeed Mr Stenton, that the steps taken to understand what the council had done on the one hand and what I Cook had done on the other were satisfactorily explored prior to that decision being made and prior to the order and varied order being issued?

Prof. SUTTON: Certainly for me, yes.

Dr BONE: Yes, and from my—

Ms SHING: Thank you, Dr Bone. Sorry, Mr Stenton, I interrupted you.

Mr STENTON: That is okay, Ms Shing. As I said, the department goes to great lengths to separate the public health regulatory function from all other decision-making—I think that is the first point. To this conspiracy theory, there were I think three separate processes: one process over a period of about six to eight years of providing funding support so that continuity of meal delivery under the Community Chef model was retained; a separate decision related to potentially acquiring Community Chef for the purpose of solving a business risk in the hospital sector, not the community sector; and then, as I said, a completely separate and unknown and unrelated decision, so at no time did anyone involved in the considerations around funding for Community Chef or the acquisition of Community Chef have any knowledge of or involvement in a separate decision by the Chief Health Officer to close.

Ms LOVELL: When I asked my question earlier about the release of the name of I Cook, you—I think it might have been Dr Bone—said the department would have written to all of the customers of I Cook on the evening of Thursday the 21st. In the evidence that was given to us by Leanne Johnson this morning—the

transcript of her evidence—she said that on 22 February 2019 at approximately 4.00 am, 'I served the closure order on I Cook Foods'. Is it normal practice for DHHS to advise the customers of a company of a closure order before the closure order has actually been served on the company?

Prof. SUTTON: Well, I think it was always going to be served; it was only a matter of waiting for the staff to arrive at 4.00 am for their shift for it to come into effect, as it were, but the order had been written and signed hours before then. So the decision was made and was effectively in place; it just had not been notified to staff because there were no staff to contact until they turned up for work unfortunately. And the email, we felt, needed to go out so that no-one was taking a meal from any time in the morning and inadvertently eating potentially contaminated food.

Ms LOVELL: So an email can go to the customers but not to the actual company?

Prof. SUTTON: Well, we could not serve a closure order other than by taking it physically to I Cook premises.

Ms CROZIER: Should it have been a section 44 of the Act—

Prof. SUTTON: No, I do not think so.

Ms CROZIER: if it was such an urgent issue, if you are doing that?

Prof. SUTTON: No, section 44 does not relate to urgency per se. Section 19 relates to a premises that is within the responsibility of a particular council area. So for settings that sit within a council section 19 is the normal and routine section to use under the *Food Act*. As I say, if you are making a statewide or Australia-wide recall, then the emergency section would be more commonly used.

Ms LOVELL: It just seems like there is a breach of natural justice that the customers are told but the company is not closed—

The CHAIR: Before the company.

Ms LOVELL: Yes.

Dr BONE: Perhaps I could also note that Ms Johnson this morning did say that she had been talking to the company about the fact that a closure order was likely.

Ms LOVELL: Was likely?

Dr BONE: Yes.

Ms LOVELL: Likely, not being imposed.

Ms VAGHELA: Ms Shing touched on smallgoods, so I want to continue on from her questioning. Was any investigation undertaken as to whether the source of *Listeria mono* detected at I Cook Foods originated in presupplied meat products?

Prof. SUTTON: As I have said earlier, the particular implicated meat product was of a different binary type, a different MLST, a different DNA fingerprint, so it was not implicated in the human illness that we were investigating.

Ms VAGHELA: Now going back to I Cook, the licence or the permit that I Cook had, it had a class 2 permit. We have spoken today to Community Chef. They have a class 1. Dr Bone, you mentioned that what they do is once the audit gets done they identify what the gaps are, and the manufacturer is supposed to fill those gaps. We spoke to Ms Johnson today as to how this worked. It was explained that in this instance, because I Cook did not have a class 1, the council would just rely on an independent food safety program where the company will get audited—they will get the report. But, carrying on from what Dr Bach was saying, we were not quite sure in terms of the answers that we got, considering that I Cook was providing to a vulnerable cohort, if they did not have a class 1 or if they did have a class 2 certificate. If the council was relying on independent audits being done for the food manufacturers, we could not identify whether historically, for the

past four years, they had done those audits, those gaps were found and whether those findings were remedied or not. All of a sudden then, once this gap is already done, we see 48 charges coming up, but we are still surprised as to why that was not followed. Or was that followed?

Dr BONE: Yes, so perhaps I can clarify the class 1, class 2 issue, first of all. A class 1 premises—this is defined in the *Food Act*, so it is legislated—supplies potentially hazardous food to vulnerable people. It does not mean that it needs to be directly supplied, as was intimated at the hearing on 17 June. It is just that you are supplying food that finally gets to vulnerable people—so that would be hospitals, aged-care facilities or a caterer like I Cook Foods. A class 2 premises is somebody who provides potentially hazardous food to the general population—so that can be a cafe, a restaurant, a bed and breakfast or something like that. A class 1 premises must have an independent audit and must have a council inspection annually. A class 2 premises that has an independent food safety program must have a council assessment, which is essentially an inspection annually, and also a third-party audit. So actually materially it probably did not make very much difference in this case whether it was class 2 or class 1. Councils should have been doing an inspection, and it is their responsibility also to look at the audit report and feel comfortable and confident that the audit report is representing what is actually going on in the premises. Does that help?

Ms VAGHELA: Yes.

Dr BACH: I just have one quick one. Dr Bone, you and I were discussing before the understanding that the department has about what constitutes a report, so that was very useful. And you had said that there was some confusion about what a report would need to be, and you made a comment that I take regarding email. I have got the closure order in front of me that says, up the top, that you, Professor Sutton:

> … am satisfied from the report …

So I dare say that is where the confusion has come from—that the document states that in the singular. And yet I understand where you are coming from; well, your understanding, in this case at least, is that what you had received verbally on the phone and via electronic correspondence could constitute a report. I noted your comments earlier, Professor Sutton, about the fact that sadly this kind of thing has to be done from time to time. Is that the general understanding that the department has about what constitutes a report? Is there any more information you could give us or are there any guidelines regarding what a report constitutes? Because from a layman's perspective it does seem to me to be a relatively informal sort of process through which to ultimately make some very serious decisions, as you have commented upon already.

Dr BONE: Yes, I can understand the confusion. The language in the Act probably is not that helpful to us. But I think the reality of the speed with which decisions need to be made means that the idea that somebody would be sitting down and writing a full report—

Given the range of different bits of information that were coming in, to do a full report would take a week, and we do not have a week in this situation in order to act.

What happens as a standard protocol is essentially we have this thing called an incident management team, which we had on the 21st, where all the different authorised officers bring in all the information to get a complete, collective picture of what is going on. And then that is recorded. That was recorded in an email because that was the quickest way to get the information to all the people who needed to know.

Dr BACH: I understand. So the incident management team sat down with the various different inputs that you had from Dandenong council and put that together in some sort of document in an email.

Dr BONE: Not just Dandenong council. We were taking into account the laboratory evidence, we were also taking into account the food history of the deceased and we were also taking into account the consumers who were vulnerable. So we were looking at it completely, in the broad picture.

Dr BACH: I understand. But again if it is possible to get access to that document that was created from the department, that would be wonderful.

The CHAIR: Thank you all. Just one final question. Would you have done anything differently, with this great benefit of hindsight?

Prof. SUTTON: I do not know what circumstances might have made it different in terms of working constructively with I Cook. I think it is a terrible shame that they have not gotten up and running again and that 41 people lost their jobs, some of whom have no doubt gone on to other work. But I wish we had found a common ground to constructively find a way to get it up and running. That was our motivation, with safety front and centre. Of course it was Ian Cook's motivation to get up and running as soon as possible, and for whatever reason we could not come to that common view about how to make that happen. I think that is a mystery to me, but I think that is something that I wish we could do differently if we had our time again.

The CHAIR: Thank you. On behalf of the committee, thank you for making the time to meet with us today. It has been very useful in our deliberations. As I mentioned, you will receive a copy of the transcript, and ultimately that transcript will be on our website and will form part of the report. I thank you all.

Witnesses withdrew.