Dr Angie Bone

Thank you Brett. Thank you Chair and committee members.

I now wish to address the Inquiry on the investigations undertaken by the Department to determine the source of the listeria infection in the patient, particularly in light of the emails received from Mr Christy on 22 February 2019.

For context, I should reiterate that *Listeria monocytogenes* poses a serious risk to public health particularly for those most vulnerable. As such, the aim of any investigation is to prevent or limit any on-going risk to public health and that is achieved by acting in a timely manner to identify and contain the source of the infection. Trying to find the source of a *Listeria monocytogenes* infection can be difficult because there is a long list of foods that are a risk for listeria, the disease has a long incubation period so it can be difficult for people to recall what they have eaten, and if people are very unwell we have to rely on others for that food history. It is also difficult to sample everything that a person might have eaten, although we do try to follow up every possible source until we find the most likely cause.

From the Department's perspective, the process undertaken to investigate the source of the listeria infection in this patient was conducted in the usual manner and followed usual processes following notification of a listeriosis case.

I understand that Mr Christy spoke to the Inquiry about the specific procedure followed for a single-case of gastroenteritis. I should pause here and make clear to the Inquiry that this was a case of listeriosis and not a gastroenteritis case, and also be clear that the two situations are managed very differently.

- Gastroenteritis refers to inflammation of the lining of the stomach and intestines caused by enteric pathogens like Salmonella or Campylobacter. Whilst *Listeria monocytogenes* can cause diarrhoea, this is a rarely observed symptom, and septicaemia (blood poisoning) is the more usual presentation.
- Gastroenteritis cases are over 100 times more common and outcomes are usually much less severe.
- The investigation of a single gastroenteritis case is usually more straightforward, for instance the incubation period for pathogens that cause gastroenteritis is very much shorter than that for listeriosis and therefore a food history much easier to establish.
- As such, single cases of gastroenteritis are usually referred by the Department to the Council to interview the patient in question and follow up any risk factors. In order to do that councils are provided the

case's personal details. In cases of listeriosis, the patient (or their next of kin) are interviewed by the Department and it would not be usual for their details to be passed on to the council.

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

Listeriosis is an 'urgent' notifiable condition under the *Public Health and Wellbeing Act 2008*. As such, the pathology lab is required to notify the Department immediately by telephone upon initial diagnosis and must follow up in writing within 5 days.

The initial notification to the Department of a positive listeria case occurred on Friday, 25 January 2019 by Dorevitch Pathology. Following this notification, the following steps were taken:

1. In accordance with the routine practice of pathology laboratories in Victoria when they detect *Listeria monocytogenes* in human samples, Dorevitch sent the isolate to Microbiological Diagnostic Unit Public Health Laboratory for further typing and genomic sequencing.

2. The following work day, being Tuesday, 29 January 2019 due to the public holiday, the Department spoke to the treating doctor to get a background history of the patient. The doctor informed the Department that the patient had entered hospital for abdominal symptoms – pain and diarrhoea – on 13 January 2019. Investigations revealed gastritis, colitis and ulcers. Gastroenteritis from a foodborne source was excluded through stool culture. Reviewing all the medical information we have, there is no suggestion that she was suffering from listeriosis on admission on 13 January.

3. By 23 January, the patient was discharged to a rehabilitation hospital, but her condition deteriorated quickly and she had developed a fever, confusion and difficulty swallowing. She was readmitted to Knox private hospital later that day at which time they took more tests and identified a listeria infection from a blood culture.

4. Given that it was not possible to interview the patient as she was quite unwell at the time, the Department also obtained details of the patient's daughter, being her next of kin, and interviewed her also on 29 January 2019. The patient's daughter explained the sort of food that her mother would regularly eat, including ham and salad

sandwiches, and provided the Department with a list of shops and cafes she normally went to. The department followed the usual protocol of trying to obtain a four week food history, although it is recognised that a two week incubation period is more usual for this type of clinical presentation of listeriosis – the longer incubation periods referred to by Ms Rogerson refer to pregnancy related listeriosis.

5. The Department also made contact by telephone with the Infection Control Nurse at Knox Private Hospital as is its usual practice. The Infection Control Nurse of a hospital is responsible, among other things, for making internal enquiries with the hospital staff and to review the medical records held by the hospital prior to providing advice to the Department in relation to the food consumed by the patient – medical records would not be accessed by a catering department. The Infection Control Nurse at Knox Private Hospital informed the Department that
    a. The patient was on a full ward diet from 13 January to 23 January 2019.
    b. The hospital did not keep records of what patients order from the menus but that the Menu Monitor was familiar with the patient's ordering preferences, because the Menu Monitor regularly helped the patient order her food so she could therefore recall what the patient ordered. The Menu Monitor stated that the patient's ordering preferences were mainly cooked meals or ham and cheese sandwiches or assorted sandwiches which can include chicken, ham, turkey roll or silverside.
    c. The sandwiches were prepared and provided by I Cook Foods.
    d. The hospital kitchen did not do anything with the food from I Cook Foods other than serve it (or in some cases, re-heat and serve).

Further to these investigations, 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 infection. These sources included the patient's usual residence, the Aveo Domainé retirement village, and the Coles, Woolworths and Mirabella Bros grocer that she was known to visit.

Of all of the samples taken by the respective local councils at each of these sites, no listeria was detected in any of the samples taken - except for the food sampling which indicated *Listeria monocytogenes* in food from I Cook Foods. There had been suggestions that I Cook was unfairly targeted in the Department's investigation and this is plainly untrue. Several potential

sources of listeria were identified from both during and prior to the hospitalisation of the patient. We follow the evidence and each of these sources were investigated. It was only once I Cook returned positive results for listeria that the focus turned to I Cook.

Professor Sutton has already spoken to the fact that six of these samples from I Cook had a positive result for *Listeria monocytogenes* and the factors that contributed to his decision to issue the closure order on 21 February 2019, so I do not propose to address that matter further.

Rather, I will skip to 22 February 2019, the day after the closure order was signed by Professor Sutton, when at 10.32am the Department received an email from Raymond Christy of Knox City Council advising of findings of food safety assessment of Knox Private Hospital. In this email, Mr Christy reported that the patient was “more than likely” on a soft food diet. It was not specified in the email who provided advice that the patient was “more than likely" on a soft diet. Further, the email advised that patients on a soft food diet are provided with modified main course items and soups provided by I Cook, soft diet sandwiches prepared by the hospital kitchen using ingredients from other suppliers, and desserts provided by other suppliers.

I have been informed that there was no communication received from Mr Christy about his findings prior to his email at 10:32am that morning. I believe this is consistent with Mr Christy's recollection as he attested to last week.

At 12:41pm on 22 February 2019, Mr Christy sent a further email to the Department in which he stated that the hospital was unable to provide a full food history for the patient but had confirmed that the patient was on a soft diet. Mr Christy's email did not disclose who at the hospital had "confirmed" that the patient was on a soft diet or what time period was being referred to. On that point I note that Mr Christy referred in his testimony to obtaining a four-day food history (not a four week food history as would be appropriate for a listeriosis investigation) and it is possible that the soft diet was prescribed during her readmission on 23 January, when a soft diet would be consistent with her reported difficulties swallowing and her deteriorating consciousness. I believe this to be consistent with the testimony that has just been provided by her daughters.

The suggestion that the patient was on a soft diet was contrary to earlier advice from the Infection Control Nurse at Knox Private Hospital that the patient was on a full ward diet, obtained further to consultation by the Menu monitor who was familiar with the patient’s ordering preferences. It was reported that the Menu monitor provided information that the patient ordered sandwiches from the full ward menu, which were reported to be produced by I Cook. It also contradicted information on the written

discharge summary covering the period 13 to 23 January which indicated the patient would have received a full ward diet during her admission from 13-23 January.

Later that same day, the Department held an Incident Management meeting in relation to the I Cook Foods closure order. Among other things, the Food Safety team raised the Christy emails and it was decided that this did not impact the closure order given the contrary information from the Hospital that the patient was on a full ward diet, and the multiple concerns about I Cooks operations and the risks they posed. The information directly from Knox Private Hospital was considered more credible in light of the fact that:

(a) the hospital had spoken to the Menu monitor familiar with the patient's ordering preferences and this information was obtained during the patients admission - not three weeks later when Mr Christy enquired from what we had understood to be the hospital catering department;
(b) even if the patient had been on a soft diet, she may have consumed soups or texture modified main course items produced by I Cook;
(c) even if the patient was supposed to be on soft diet, this may not always be implemented in practice;
(d) testing had been completed of I Cook Foods and Knox Private Hospital which showed genomic links between the listeria monocytogenes found in I Cook food and the listeria monocytogenes found in the patient
(e) the Department had been made aware of concerns with the food safety practices and food safety program at I Cook Foods by environmental health officers from Dandenong City Council, but no reports of significant concerns about Knox hospital operations were being made.

However, in view of the Christy emails, on 22 February 2019, the Department again contacted the Infection Control Nurse in relation to whether the patient was on a soft or full ward diet while at Knox Private Hospital. During that telephone conversation the Infection Control Nurse confirmed again that the patient was on a full ward diet.

At the time, the Department had also been in communication with the Infection Control Nurse to understand the distribution of I Cook sandwiches to other areas of the hospital to determine the possibility of other cases. At no point during these telephone calls or emails did the Infection Control Nurse amend her previous advice that the patient had been on a full ward diet.

On this basis, the Department considered the question of what type of diet the patient had been on had been definitively investigated and considered.

As such, it was clear to the Department that the Hospital's position was that the patient was on a full ward diet and had eaten food produced by I Cook Foods during her admission from 13 to 23 January. In addition, by this stage the initial results of all of the testing the Department had requested – of I Cook Foods and the potential sources from prior to the patient's hospitalisation – had returned and identified that *Listeria monocytogenes* was only present at I Cook Foods and that four samples had the same molecular serotype and the same binary type as that found in the patient. Given this, the evidence of a link between the listeria and I Cook was substantial and there was no reason for the Department to test the ingredients or other foods on the soft diet menu.

Lastly, I note that Mr Cook made reference to a recent example of a listeriosis notification leading to an investigation into the source of that infection. I can confirm that the Department did recently investigate a company producing meals on wheels meals and some samples linked to this business were positive for *Listeria monocytogenes*. However, unlike the I Cook Foods situation,

- the genomic sequencing demonstrated that these Listeria isolates were NOT related to the human case in this situation - indicating an alternative source of infection that we continue to pursue.
- furthermore, whilst some shortcomings were noted in business's practices these were not to the scale of the risks that were reported, and the Department observed, at I Cook Foods, and it was considered that these could be addressed while the business continued to operate.
- Lastly, the business in this case has been wholly cooperative, taking on board all the recommendations for improvement and increasing the safety of the community they serve.

The intention of the Closure Order of I Cook Foods was to enable I Cook Foods to rectify the issues identified so that they could be quickly back up and running and supply safe food to their vulnerable consumers. I understand that they were provided the opportunity to close voluntarily to allow time to resolve the problems, but the I Cook Foods rejected this. Unfortunately, our best efforts to work with I Cook Foods to help them to do this were not accepted, and it took far longer than should have been necessary to resolve the issues with their food safety processes and systems.

I will now pass to Mr Stenton.