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Bartor Road Sliced Meats Recall - Background

Maple Leaf Foods Inc. is a leading food processing company, headquartered in Toronto, Canada. The Company employs approximately 24,000 people at its operations across Canada and in the United States, the United Kingdom and Asia. The Company had sales of \$5.2 billion in 2008. Maple Leaf is comprised of three operating groups: Meat Products, Bakery Products and Agribusiness. Maple Leaf Consumer Foods (MLCF) is part of the Meat Products Group, and is made up of two leading national brands, *Maple Leaf* and *Schneiders* in addition to *Prime Naturally* and a variety of regional brands including *Shopsy's*, *Mitchells Gourmet Foods*, *Larsen's*, *Parma* and *Hygrade*. Product lines include packaged meats, ready-to-cook and ready-to-serve meal products and value-added fresh pork, poultry and turkey. MLCF operates 24 processed meats facilities. Michael McCain is the President and CEO, Maple Leaf Foods, and Rick Young is the President, Maple Leaf Consumer Foods.

Bartor Road is one of MLCF's processed meats facilities and it is located in north-west Toronto. It is a federally registered plant and approved for export to the U.S. The plant produces sliced meats, bologna, and deli meats for national distribution to retail and food service operations. Bartor Road employs approximately 300 people, including 10 food safety and quality assurance staff.

Listeria is a bacterium and can be found in soil, water and foods. There are six species of *Listeria*, but *Listeria monocytogenes* is the only one that causes human illness. Approximately 1-10% of all ready to eat foods contain *Listeria monocytogenes*. Given that *Listeria* is everywhere, elimination is not possible and therefore risk mitigation needs to be achieved through surveillance and sanitation programs. In the food industry, best practice is monitoring *Listeria* using regular swabbing and sampling within the plant environment. Listeriosis is the serious infection caused by eating food contaminated by *Listeria monocytogenes*. It is very rare, affecting 1-5 people out of 1,000,000 people per year and can result in death. Listeriosis can cause high fever, severe headache, neck stiffness and nausea. Pregnant women, the elderly and people with weakened immune systems are particularly at risk. Infected pregnant women may experience only a mild, flu-like illness, however, infections during pregnancy can lead to premature delivery, infection of the newborn, or even stillbirth.

Chronology of Events

The events leading up to the *Listeria* tragedy started on August 7th, 2008, when Maple Leaf Foods was made aware through one of their distributors, that a local public health authority in Ontario had launched an investigation into a sliced meat product. Maple Leaf was not contacted by the local health authority, but proactively contacted them to offer any assistance. The local public health authority thanked Maple Leaf for its contact, but advised that no assistance was needed.

On August 8th, the Canadian Food Inspection Agency (CFIA) asked Maple Leaf if three products could be traced, and to investigate if they were still in inventory. On August 11th, the CFIA conducted a trace, and on August 12th, they informed Maple Leaf that an investigation had been launched. On August 13th, Maple Leaf notified customers in writing of the need to place three products "on hold" and not to ship or sell. Those were:

- Sure Slice Roast Beef, best before date July 28th and August 9th
- Sure Slice Corned Beef, best before date August 16th and August 23rd
- Sure Slice Black Forest Ham, best before date August 9th and August 21

The letter to customers said, "we are recommending that any remaining inventory of the products listed above be placed on hold as a precautionary step." This hold order was not a regulatory requirement, but a Maple Leaf best practice and the first step in protecting consumers. The CFIA food safety specialist (Toronto region) visited Est. 97B as part of her investigation. All samples taken and tested to that date, had been either open packages or packages with no identifiable code dates, making it more difficult to determine whether announcing a recall was the appropriate action to take.

On August 14th and 15th, Maple Leaf worked internally to prepare and plan for the possibility of a recall. While no information had been received regarding the outcome of the product testing, Maple Leaf nonetheless set in motion a protocol for recall. The goal of this work was to ensure the fastest possible response in the event of positive test results for *Listeria*.

On August 16th at 10:00 p.m., the CFIA notified Maple Leaf that tests for *Listeria* on one of the three products above had returned positive. Maple Leaf immediately set its recall protocol in motion. Since the products in question were sold to the food service industry, Maple Leaf targeted its efforts on contacting the distribution chain. Maple Leaf then confirmed that all affected product had been produced at the Bartor Rd. plant on lines 8 and 9. All products that had been manufactured on those lines, and that was still within the facility was held, and subsequently destroyed.

On August 17th at 3:30 a.m., Maple Leaf issued a news release to all media in Canada with notice of the recall and product information. During the next two days, Maple Leaf worked diligently to contact 100% of food service customers.

On August 19th, Maple Leaf was made aware by the CFIA that two more tests on products produced at a different time on the same lines had come back positive. Maple Leaf voluntarily expanded the scope of the recall to include all products manufactured on lines 8 and 9 from June 2nd (the earliest affected production date). These products were predominantly food service products, but also included some retail products under the Burns and Schneider's brands.

Prior to August 19th, Maple Leaf had not been notified that there were concerns about illness or loss of life. This information was the catalyst for the company's next sequence of actions. Even though CFIA indicated that they had not confirmed the linkage to the Maple Leaf products by DNA pattern testing; the company proceeded with the voluntary recall.

A media release was issued on August 20th to all Canadian media notifying them of the expanded voluntary recall and that the plant was being closed for a comprehensive sanitization. The Maple Leaf website was updated with brand and best before date identifiers.

On August 22nd, the CFIA and Royal Touch Foods warned the public not to serve or consume the Shopsy's deli-fresh Classic Reuben sandwich, best before dates August 22nd and August 24th because the product might be contaminated with *Listeria monocytogenes*. This recall was initiated because the product contains sliced corned beef, one of the ready to eat deli meat products recalled by Maple Leaf Consumer Foods. There had been no reported illnesses associated with the consumption of these sandwiches.

On the evening of August 23rd, the CFIA and Public Health Agency of Canada concluded that the strain of *Listeria* bacteria which was linked to the illness and death of several consumers matched the *Listeria* strain identified in some Maple Leaf products. Although there was no evidence of *Listeria* contamination in product beyond the production lines originally under investigation, as a further precautionary measure, Maple Leaf made the announcement at 9:00 p.m., that the product recall was expanding to include all production from Bartor Rd. dating back to January 2008. Michael McCain reported, "Tragically, our products have been linked to illness and loss of life. To those people who are ill, and to the families who have lost loved ones, I offer my deepest and sincerest sympathies. Words cannot begin to express our sadness for their pain."

On August 24th at 4:30 p.m., the CFIA and Maple Leaf simultaneously posted the recalled list of products and codes on both websites. Originally 220 products were posted and over the next week, the product list was revised down to 191 products as duplicates were removed.

Upon announcing the expanded recall, the immediate focus became working with customers to remove all recalled products from store shelves. The following activities were executed:

- Customer Direct Head Office: Between the evening of August 23rd and the end of the day August 25th, 90 Maple Leaf employees (Executives, Quality Assurance, and Account Managers) called approximately 400 direct head office customer contacts (Executives, Quality Assurance, Merchandise Buyers) at all major retail and foodservice customers across Canada to inform them of the expanded recall. A follow up customer letter was emailed to all of these same customer contacts providing them with specific details on products and stores affected.
- Customer Retail Stores: On August 24th and 25th, Maple Leaf's national retail field sales force of approximately 155 sales people made telephone calls and in-person visits to each of the stores in their territories, covering 4,228 stores.
- Indirect Customers: For those customers who buy through small distributors and cash and carry outlets (rather than directly from Maple Leaf), on August 23rd and August 24th, Maple Leaf sales representatives contacted the head offices of these customers and worked with them to support their recall efforts. For example, Costco contacted their entire business and individual membership base that had purchased any affected products.
- Foodservice: Most foodservice distributors did not have the manpower to contact their extensive customer base quickly totaling approximately 9,400 "end users". As a result, on August 24th, Maple Leaf engaged a third party call centre to contact these "end users". During that week, Maple Leaf was successful in making direct contact with 8,000 end users, and they made three attempts using voicemail to make contact with the remaining 1,400. It is believed this supplemental support is unique in the history of food recalls in Canada.

By end of day on August 25th, the vast majority of the recalled products were off the shelves at major retail grocery stores. Products in customer warehouses for retail and foodservice were held for pickup by Maple Leaf. Over the next several days, sales conducted in-person audits of retail stores and foodservice outlets across Canada to ensure that the products were off the shelves.

On August 25th, a Technical Panel was established to conduct a comprehensive investigation of food safety at Bartor Rd. The panel was comprised of Maple Leaf employees with technical expertise in Food Safety, Manufacturing, Regulatory, Food Science, Six Sigma methodology and three external technical experts in *Listeria* control and prevention. The mandate for the panel was to identify the root cause and likely source of the *Listeria* contamination and to ensure that Bartor Rd. was ready and fit to be re-opened.

On September 5th, Maple Leaf announced that both the CFIA and the Technical Panel concluded that the most likely source of *Listeria* contamination was deep inside the slicing machines on lines 8 and 9. Although rigorous sanitization of this equipment had been completed on a daily basis in accordance with or exceeding the equipment manufacturer's recommendations, upon full disassembly, areas were found where bacteria may have accumulated deep inside the mechanical operations and avoided the sanitization process. There were also other environmental factors relating to the age and location of the building, such as condensation, air flow and drain back ups; that do not directly affect product contact surfaces, but that may have contributed to the contamination. The management of

those issues, combined with inconsistent compliance to GMPs (Good Manufacturing Practices) within the plant contributed to the overall risk.

The Technical Panel also recommended initiatives to improve the physical and operational systems and processes that contribute to food safety, as well as enhanced food safety protocols for Bartor Rd. and all ready to eat plants. These recommendations included improved sanitation practices, equipment upgrades, facility improvements, extensive and rigorous environmental swabbing, enhanced finished product testing, development of detailed standard operating procedures, and improved data analysis, measurement and reporting.

The Manufacturing, Engineering, Food Safety and Quality Assurance teams immediately began work on the physical and procedural improvements recommended by the Technical Panel. Many of these improvements have been implemented across the ready to eat network.

Over the following 90 days, significant improvements were undertaken at the Bartor Rd. facility. In excess of \$4.5 Million was spent on improvements to refrigeration, air-flow and humidity control, plant premises, slicing and packaging equipment, sanitation equipment; and segregation and in-plant traffic flow in order to prevent cross contamination.

Bartor Rd. re-opened and resumed production on September 17th working closely with the CFIA in a highly controlled, phased approach under rigorous start-up requirements. The intent was to start-up cautiously, as several aspects of the plant infrastructure had changed, such as exhaustive environmental and finished product testing, new operating procedures, extensive sanitization, and rigorous customer requirements. In addition, given the unprecedented level of disassembly of equipment, there were many mechanical and electrical start-up issues. During these first few weeks, product was not shipped – it was held in inventory until there was an accumulation of sufficient volume, and to be confident that the plant could continue to produce at a pace to meet customer expectations.

On October 8th, Maple Leaf announced that consistent with an environmental monitoring program involving rigorous and intensive sampling, there were a small number of positive test results for *Listeria* in the Bartor Rd. facility. This was a normal and expected outcome at a rate of positive findings below industry norms and not indicative of a problem as portrayed by the news media. No products had been distributed and therefore, there was no risk to the public. Specifically, since the plant re-opened on September 17th, 841 environmental samples had been taken with one positive test result for *Listeria*. In addition, over 5000 finished product tests had been completed, with only four positive findings for *Listeria monocytogenes*. These four positive findings were in two products produced on line 7, and not related to the prior incident. As a result, Maple Leaf and the CFIA announced they were withholding distribution of any products from Bartor Rd., pending validation of the findings and remediation through sanitization. "We are being ultra cautious in this facility", said Michael McCain, "more cautious than any other plant in North America." Significant time was spent with the media and customers, educating them (using *Listeria* experts) on the ubiquitous nature of *Listeria*, and explaining that a solid *Listeria* management program will encourage finding *Listeria* through environmental testing as it is a normal and routine finding. given its ubiquitous nature, if you test for it you will find it.

That is the point of environmental testing, to find it, eliminate it and prevent it from entering into the food.

While the finding of positive results is a routine occurrence under a robust environmental sampling strategy; the Bartor Rd. management team worked diligently with the CFIA to examine the root cause of the positive results and to continue to implement improvements in the plant.

On October 17th, the CFIA notified Maple Leaf that they were approving the release of product that had been produced since plant start-up, except for product produced on line 7 (where the recent positive results had occurred). Line 7 would require special considerations for eventual start –up, and the remaining lines would continue to start-up under the previously agreed to gradual approach combined with rigorous testing.

On October 21st, Maple Leaf started to ship product from Bartor Road to customers (with the exception of line 7 production).

On October 22nd, the organization attention began to focus on the plan to recover volume and market share to pre-recall levels and to restore the Maple Leaf brand and corporate reputation. By the end of 2008, Bartor Rd. was operating at 80% of pre-recall volumes, with a plan to achieve 100% by the end of January 2009.

On November 5th, Michael McCain announced that effective January 5th, 2009, Dr. Randall Huffman would assume the position of Chief Food Safety Officer for Maple Leaf Foods. Randy is currently President of the research arm of the American Meat Institute, where he led the Food Safety Initiative, and funded over 60 food safety projects. Randy holds a Ph.D. and M.S. degree in Meat and Animal Science.

On December 17th, disposal of 100% of the recalled product was complete. 1.3 million kg's (or 84 truckloads) of product was land filled, under the supervision of the CFIA and Ministry of Environment.

On December 18th, another chapter of the tragedy was concluded – the class action lawsuits were settled for up to \$27 million, subject to court approvals. Michael McCain reported: "Our goal throughout this legal process has been to negotiate a fair and early settlement so that we can obtain court approvals and promptly compensate families who were affected." The cost of the identified and future potential claims (e.g., arising from a pregnancy) is covered by liability insurance.

Conclusion

Since the recall, the changes made at Maple Leaf have been far reaching. In addition to the significant level of change at the Bartor Rd plant, the organization has enhanced its testing protocols, and has created a company-wide, robust environmental monitoring program (EMP) to serve as an early warning system, with daily senior executive oversight. We have undertaken thousands of hours of employee training to reinforce a strong culture of food safety throughout the organization and invested in infrastructure and new technology. An extensive review of all manufacturing facilities has been undertaken to help plan for future infrastructure investments.

Food safety challenges, key learnings and best practices are being shared between departments and facilities. A senior corporate level role (Chief Food Safety Officer) has been created to lead the company in food safety. A dedicated team has been created within the Six Sigma group to address ongoing continuous improvements relating to food safety; and to further entrench a culture dedicated to ongoing food safety improvement. These initiatives will all help Maple Leaf regain its reputation as a leader in food safety practices in Canada.