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Chair

Mr. Larry Miller

Subcommittee on Food Safety of the Standing Committee on Agriculture and Agri-Food

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● (1600)

[*English*]

The Chair (Mr. Larry Miller (Bruce—Grey—Owen Sound, CPC)): I call this meeting to order.

If I could just speak to the media, while we welcome you here, the table is reserved for members and witnesses. Thank you very much.

Welcome here today to our meeting of the subcommittee on the review of food safety, basically brought about by the listeriosis outbreak last summer, as we all know. I hope everyone had a good Easter break. We'll get down to business.

I'd like to welcome our guests here today, Mr. McCain, Mr. McAlpine, and Mr. Huffman from Maple Leaf Foods. This first part of the meeting today will go from 4 till 6, at which point we will break.

We'll keep the presentation to 10 minutes, if we could, Mr. McCain, and then we'll go from there.

Welcome, and thanks for coming.

Mr. Michael H. McCain (President and Chief Executive Officer, Maple Leaf Foods Inc.): Thank you, and good afternoon, Mr. Chairman and members of Parliament. Thank you for the invitation to be here today to discuss food safety.

I know the primary reason you want to talk with me and my colleagues is that Maple Leaf Foods, a Canadian institution of which I am the responsible custodian, failed in our efforts to protect consumers last August and was responsible for the deaths of 21 Canadians, and illness and worry for many more.

This was by far the most awful event in the 100-year history of our company and one of the worst food-borne catastrophes in Canada. I can't properly describe the overwhelming sense of grief and responsibility we all felt and I felt personally. In the shock and grief that occurs when one is responsible for an event like this, a company has only its values to fall back on and to guide it.

Our primary concern was to do everything possible to contain further risk, including providing Canadians with as much information as possible to protect themselves and their families. That is why we immediately took full responsibility to bring clarity to a confusing and scary time for consumers. We went to extraordinary lengths, including television advertising, to inform people directly of what had happened. All major retail customers and food service head offices, distributors, and franchises—more than 15,000 in all—were personally contacted in writing and via phone to notify them of the recalled product and provided with instructions for product removal, a process that began within hours of our notification of CFIA findings.

It is no consolation to you, or certainly to us either, but we believed we had effective food safety programs in place at the time of the outbreak. We had a proprietary "40 Steps to Food Safety" program that set higher operational standards for ourselves covering every step of the supply chain, from the purchase of raw materials through to food processing, packaging, and distribution. In addition to complying with all applicable regulations, including those of CFIA and Health Canada, we invested millions to achieve these higher, self-imposed standards. And we had third-party auditors evaluate our performance annually.

Let me spend just a moment on the testing we were doing at the time, and feel free to come back to this in your questions afterwards if you like. The CFIA has recently implemented a new set of policy regulations—all of us have learned lessons from last August—that are strong upgrades from what was in place previously. Last August there was no requirement that food processors even have an environmental monitoring program in place for listeria control. Nonetheless, Maple Leaf was testing for it extensively across our packaged meat plants. We were conducting 3,000 tests per year at our Bartor Road plant alone. These test results were continuously available to the CFIA, and every time we found a test of listeria anywhere in one of our plants, we cleaned, sanitized, and retested that location. And every time we retested the site, the listeria was gone.

However, what we did not do then, and what we do do now, is apply sophisticated investigative and pattern recognition science to analyze test results to better determine root cause. This might have warned us earlier about the problems of last August.

Maple Leaf's conduct through the recall has been the subject of much commentary. Our own judgment is more self-critical than that. Our established food safety practices, as strong as they were relative to best industry practices and regulatory standards, failed us. As a result, we enhanced every element of our program.

First, we've implemented enhanced sanitization procedures, including disassembly and deep sanitization of all slicing equipment well beyond recommended guidelines.

Number two, we've doubled the amount of testing in our facilities, including more rigorous testing on food contact surfaces, which is the best early warning system we can have.

Number three, we analyze every single positive sample event looking for patterns. We look at the bigger picture every time we get a positive sample, so that we can investigate the root cause of that individual positive sample site. These may be patterns on entire lines or patterns of repeat occurrence, but our technical people study each one.

Number four, our executive staff and our technical and operating people review our food safety test results on a conference call daily. Every positive finding is chased down, with Dr. Huffman and me personally participating in these calls each and every day, with few exceptions.

Number five, we now have product quarantine procedures in place to hold product for additional testing if we have concerns.

● (1605)

Number six, and lastly, we have delivered comprehensive training to our employees across our packaged meat plants on our enhanced food safety protocols and standard operating procedures. Continuous training and awareness-building is critical to the effectiveness of our program.

Let me be very clear here, please. I believe that had we known then what we know now, and had we done then what we do now, we might have saved 21 lives. This tragedy was a defining moment for Maple Leaf Foods and for those of us who work there. We are determined to make a terrible wrong right. That is our obligation to those who died and to their families.

Our intention is to discharge that responsibility in three ways. First is by raising our own standards for food safety to provide consumers with the highest safety assurance possible. We had to improve, and we did immediately, and we will continuously. Second is by advocating and participating in industry-wide initiatives designed to raise the level of food safety practice amongst all companies. We believe strongly that food safety knowledge should not be the source of competitive advantage and must be shared for the benefit of all Canadians. And third is by doing what we can to educate Canadians about food safety risk, about how to assess risk, and how to minimize risk for themselves and their families through proper storage and handling and the preparation of foods.

One of the most important steps we took was to hire the gentleman to my immediate right, Dr. Randall Huffman. Last fall we created the position of chief food safety officer, I believe the first in Canada. Dr. Huffman has the mandate to ensure that Maple Leaf Foods is at the cutting edge of global food safety practices. We are better today than a year ago, but as knowledge and technologies evolve, we will be better again next year and the year after that. This is the process of continuous improvement.

Now, none of this is said proudly. The steps we took to become a food safety leader are our penance for being the company behind the worst food-borne outbreak in Canadian history. Our determination to make something good of this tragedy goes beyond our own practices. We would like to work with this committee, with the appropriate government agencies, and within our own industry to raise the standards for food safety across the board. As an industry, we are only as trusted as our weakest link.

The role of government and the role of industry in food safety are interdependent. A food-safe system cannot exist without both working within their respective jurisdictions towards the same goal: safe food for all Canadians. In fact, a strong, credible regulator administering a science-based policy is critical. If all stakeholders were candid about learning together, we believe what happened last summer was a failure of expectation, not a failure of inspection.

We believe that the role for government would be built around four key principles: one, defining with detail the requirements and expectations of an operator to deliver a strong and effective food safety program; two, building inspection and testing that is adequate to validate and verify the compliance with regulatory expectations, with tough accountability for those who are not meeting those requirements; three, ensuring consistent application and inspection nationally and at our borders; and four, developing policies that encourage responsible and proactive behaviour by operators.

We are certainly not experts in government processes, and making policy is the responsibility of Parliament, but if these responsibilities require more resources for the CFIA, we would certainly support that. When you're assessing the many potential approaches for food safety for Canadians, we would urge you to keep these perspectives in mind: first, you cannot see bacteria, so visual inspection has very limited value. You can only discover it by looking at delayed test results and data over time. Second, these bacteria don't live everywhere. They set up camp in any one of a million potential homes, and the trick is to find where they actually do live, because it's pretty easy, but often misleading, to determine where they don't live.

● (1610)

The revised CFIA policy on listeria that has just been put into place has indeed strengthened the approach to regulatory oversight of the industry's ability to control listeria in certain ready-to-eat foods. It describes a regulatory testing plan that will ensure that the concepts of Health Canada policy on listeria are properly implemented by industry. The Health Canada policy is based on sound scientific principles and is recognized globally as an appropriate approach to listeria control. The CFIA's new testing protocol represents a significant increase in environmental and product testing and will require many Canadian food processors to adapt and improve their approach to listeria control. These are all strong improvements, and we support them.

The key to the success of the policy will be for CFIA to enforce it consistently across the industry and to ensure that the details are properly communicated to inspection staff and the industry itself. Response to positive findings under the new testing regime must be rigorous in every facility. Interpretation of trends and patterns of environmental results over time must be carefully conducted to avoid misinterpretation.

The CFIA must also appropriately ascertain the safety of imported ready-to-eat products by equal enforcement of its revised listeria policy at the border. And we would go further to advocate that this new policy should represent the common standard for all ready-to-eat plants nationally, regardless of whether they are federally or provincially inspected.

Government food safety regulations to us are a floor. We also answer to the Canadian public, who vote with their purchase decisions daily. Our job, as industry, is to produce safe food each and every day, minimizing risk to the lowest practical level possible, and implementing best-practice food safety systems and procedures at or above the minimum requirements specified by government. We are the ones who make the food. Government should set the rules and provide oversight to ensure the rules are being complied with, but ultimately, safe food depends on the food company, and we have a very material obligation to deliver.

The final prong in our approach is consumer education. Most Canadians first heard of listeria from us, despite how common it is. However, as a string of recalls in recent months has indicated, it is hardly unique to Maple Leaf Foods. We have used and will continue to use a variety of methods to educate consumers about listeria, how to assess the risk and how to minimize the risk once the food is in the home. It's a difficult issue for us to be talking about, but we believe talking about food safety is our responsibility.

Mr. Chair, members, we are determined that Maple Leaf Foods be worthy of its great history with Canadians. We look forward to helping you with your efforts to understand both what happened to create the tragedy of last year and what lessons can be learned to improve our food safety system in Canada. To support this, we certainly would like to extend an invitation to you to tour our Bartor Road facility.

With these remarks, Dr. Huffman and I look forward to your questions and to our dialogue.

● (1615)

The Chair: Thanks very much, Mr. McCain.

We'll start our first round of questioning with Mr. Easter, for seven minutes, please.

Hon. Wayne Easter (Malpeque, Lib.): Chair, I have a question on process first. I assume first rounds are seven minutes, and then we're going to five minutes, because we haven't established a process, and there'll be—

The Chair: It was suggested earlier at the main committee that it be the same process, and that was the assumption under which I was running, Mr. Easter.

Hon. Wayne Easter: Okay, and we'll go until we've exhausted questions, I gather.

Mr. McCain, thank you for coming. I might say, in beginning, that I think your performance in this whole exercise, in this crisis, really shows such forthright transparency in terms of your operational concern, if I can say that, and I think honesty certainly goes to your credibility as a person and to your credibility as a company. I want to say that on the record because I'm pretty sure your lawyers were probably advising you otherwise. I think you've done the right thing for Canadians with the direct approach you've taken, and I want to congratulate you on that.

In your remarks today you've certainly accepted a lot of responsibility yourself. I understand that and I congratulate you for it. But there is another player, if I can put it that way, in this crisis, and that is the Government of Canada and the Canadian Food Inspection Agency. I guess one of my concerns is that we need to have the overall authority as the Government of Canada, through whatever agency it may be—it's supposed to be CFIA and Health Canada in this case. We need that overall authority. In your case, in your plant, in your operation, you may have been able to handle this kind of a crisis, but there are a lot of other players out there who might not be able to handle it in the way you have.

I just want to outline that in the beginning. Certainly one of my concerns is that we have to look at the industry as a whole, and not just specifically Maple Leaf.

You can answer me if I'm wrong on this, but I understand the cause of listeriosis, in the end, was in fact a slicer. As I understand it, from talking to people in the food inspection business—and you were following, no doubt, the manufacturer's specifications, and you can answer that as you see fit—at one point in time in our food inspection system, auditors would actually go in and they would go further. CFIA auditors, or whatever they were called prior to CFIA, would actually go in and do an audit, do an analysis, maybe tear the equipment apart, and maybe go above and beyond the manufacturer's specifications. That's the understanding; it's not happening now. Maybe you can inform us as to how that specific machine would have been inspected by the government authority in the past versus how it's done today, and how we propose doing it in the future so that this kind of problem doesn't occur again.

● (1620)

Mr. Michael H. McCain: That's an excellent question, Mr. Easter, and I'll try to resist giving you a technical answer.

The root source of the contamination was deep inside a piece of equipment called a slicer. It's important to understand that the harbourage point inside that piece of equipment is just not accessible on a daily basis. It requires many hours for the maintenance department to disassemble parts that are not prescribed by the manufacturer as being “disassembleable”. Such is the nature of bacteria. As I said in my opening remarks, it's a bacteria; it's a micro-organism that can exist in many millions of places inside a facility, and it resided deep inside this equipment.

To your real question about the role of inspection, you cannot see this in an inspection. There is no inspection where you can visually, with your eyes, see that outcome. The only way you can detect it is by taking a sample, a swab site, at various points in the production process and then analyzing the results of that swab site several days later when they come back from an accredited laboratory. On the epidemiology and the scientific process, I would encourage you to ask Dr. Huffman or any of the other experts why that's so.

I genuinely don't believe this was a failure of inspection per se, where we used to inspect at one level and now we don't inspect at another level. I think the root cause was something very different from that. That's not to say we don't need more resources in the CFIA to do appropriate things; I believe we've been on the record to date saying we do believe we should. But let's not have false expectations about trying to discover bacteria or a pathogen that's not visible to the eye in an assembly or disassembly process that can't be done in any kind of routine manufacturing environment. It requires a set of engineers to disassemble a piece of equipment. That again is the nature of microbiology.

The Chair: Mr. Easter, we'll come back to you.

Mr. Bellavance is next for seven minutes, please.

[*Translation*]

Mr. André Bellavance (Richmond—Arthabaska, BQ): Thank you for your presentation, Mr. McCain.

Are you going to reset the clock, Mr. Chairman?

[*English*]

The Chair: I'm not going to take that time away from you.

[*Translation*]

Mr. André Bellavance: From the beginning of this tragic event, you explained the situation publicly on several occasions. You did not try to hide anything and you accepted your responsibilities. I will not repeat what Mr. Easter just said about how transparent you were.

In the statement you just made, you virtually take full responsibility for what happened. I am uncomfortable with that. I have a hard time believing that Maple Leaf is solely responsible for these deaths. There is joint responsibility. Several incidents that occurred over time lead us to believe that the government also has some responsibility to bear. We cannot say that the government has no say in public health. Inspectors from the Canadian Food Inspection Agency must be in plants, and Health Canada also has responsibilities for food safety.

For some time now, you have been saying that if we had done things differently, 21 people would not have died. You appear to be taking full responsibility. What leads you to say such a thing?

● (1625)

[*English*]

Mr. Michael H. McCain: First of all, we did take responsibility and accountability for this, because it occurred in our plant, on our watch, with Canadian consumers eating our product. We have an obligation to produce a safe product, and it's an obligation we've held very close for over 100 years. We had systems and protocols in place that we felt were best practice, and they failed us. So accountability and responsibility for that series of events does rest very squarely on our shoulders as an organization, and I'm personally accountable for that organization, so that rests very squarely on my shoulders.

But I think there are lessons to be learned from our responsibilities and what we've learned since August that apply to the rest of the industry or the regulator. I think all the stakeholders, from the regulator to other industry participants and Maple Leaf, can learn from this tragedy and improve in the future. Examples of that are reflected in the new listeria policy that is effective April 1. The CFIA and Health Canada have reflected a large portion of the learning from this in the new policy. Going forward, we believe that policy will be a strong underpinning for food safety in this country. Our caution point is that success in that policy will depend on the rigour and consistency of its implementation nationally and at the borders.

So just because we are the company that has accepted accountability and responsibility for this tragedy does not mean others can't learn from it. I think the whole industry and the regulators need to learn from it, and they are getting better right now. The process of continuous improvement is ongoing, so we need to be better again next year than we are today.

[*Translation*]

Mr. André Bellavance: I agree with you that there are some lessons to be learned and that other organizations should do the same. But before the crisis occurred, the agriculture committee had held briefing sessions on the firing of a CFIA employee because he had revealed to his union the government's intention to reduce the agency's operating budget by 5%.

The agency also put in place a plan to allow plants to inspect themselves. We must not simply focus on what happened following the crisis at Maple Leaf and on what unfortunately happened to the victims, we must examine the entire food inspection system. Neither Maple Leaf nor the government is on trial here. A series of chronological events lead us to believe that the responsibility does not lie solely with the company, but also with the agencies and governments that are responsible for public health and safety.

● (1630)

[*English*]

Mr. Michael H. McCain: That is an excellent question.

I agree with you that these lessons learned should span the industry and the government, and we should look at what those lessons were prior to this. Maybe it would be helpful if I described what the protocols were prior to 2008 versus what they are today. That contrast would help illuminate the response to your question.

As I articulated in my opening remarks, prior to 2008 there was no requirement—zero—to have an environmental testing program inside a processing facility for ready-to-eat foods. Now, I respect the fact that it's possible to say, well, that's an element of deregulation. But I don't think that's an accurate or fair characterization, because that regulation never existed. It never existed and was cut; it never existed and was reduced: that regulation to have an environmental monitoring program never existed.

In the face of that, at the Maple Leaf facility we had an environmental monitoring program. We did have one of those. We were testing at the rate of 3,000 samples per year. We had our own "40 Steps to Food Safety" operating plan. We spent over $20 million on capital, including biosecure access, and we had third-party audits—but against the backdrop of no environmental monitoring program in place.

When there's no monitoring requirement—that was the expectation established not by a government but by industry and the government since the beginning of the food processing industry centuries ago, meaning never—then that becomes the foundation of that expectation. No amount of inspection, higher or lower, would have changed that outcome.

I think there are important policy questions here. There are important policy questions around the role of inspection, around the role of regulation, around product testing versus environmental testing. Those are very important questions. But if you want to go to the exact cause of this outbreak, it was not about a lack of inspection. It was not about a lack of product testing or a lack of inspectors. It was about a failure to analyze test data that we weren't even obligated to collect—a failure on our part to analyze that data and look for root cause analysis, to investigate and follow up on individual trends, to look for patterns, so that we could find the bacteria that we couldn't see inside these facilities and end up with a different result. So it was more a failure to analyze those findings for root cause and a failure of those protocols than it was a failure of inspection, per se.

We believe the CFIA should have, as they're now implementing, the new listeria policy as part of a new mandate. Now, that's not to say that there aren't very important issues in there for this committee to investigate for food safety, as Mr. Easter says, for the benefit of all Canadians and the whole industry. There are important questions in there, moving forward. But if you want to get down to the root cause, to what caused this, we don't believe that was one of them.

The Chair: Your time has expired, Mr. Bellavance.

Mr. Allen, seven minutes, please.

● (1635)

Mr. Malcolm Allen (Welland, NDP): Thank you, Mr. Chair.

And thank you, Mr. McCain, for joining us today and for your opening remarks. Let me perhaps go back to the comment you just finished with and bring it into another context. It's on page 5 of your report, in the first paragraph. It says “you cannot 'see' bacteria so visual inspection has limited value.” I would take it, because you're an extremely articulate man, that you paid close attention to the words. I think we all agree we can't see bacteria. You can't get those glasses that you used to be able to buy in the back of the comic that told you you could see everything. So we're not able to do that. We all accept that.

What you do talk about is how visual inspection has limited value. I would ask you to comment on the issue of having very experienced and qualified inspectors on site who work for third-party agencies like CFIA, who understand the processes of your particular industry, because that's what they do and that's what they learn. These aren't folks who don't have biochemists in the industry and don't have bioscience degrees. These are very educated people who understand how these sorts of pathogens can actually take hold in the particular factory they're working in, because really they're working in a factory; they're not working on a farm. This is a food that's produced in a very large facility. With the type of experience these inspectors have—albeit they can't see bacteria—is it not plausible that indeed with their experience they could see circumstances that might lead to the bacteria actually starting to colonize and indeed be a problem for your production systems and be able to help your folks interpret that so that we're looking and testing in an appropriate way? As you said in the page before, you took 3,000 tests that the CFIA had access to, but in the report it doesn't say whether your folks actually said to them, by the way, we found listeria and we eradicated it by sanitizing. It doesn't actually tell us.

So there are two questions here. It doesn't really tell us. Did you inform that inspector who was responsible for your plant that they'd actually seen listeria at that point in time, during that period of testing, because that's a different timeframe?

Mr. Michael H. McCain: That's an excellent question. The role of an experienced and seasoned, educated inspector is indeed critical. I'm going to turn it over to Dr. Huffman to talk about the role of an inspector and what they can see visually versus what they can't and how that can be relied on. I think relying on just the visual can be dangerous, if not misleading, but it can be instructive, and he'll get into that. But I would ask him to also talk about what we were informed of versus what we weren't, because it is the law, sir, that we make all of our data available to the CFIA, and we have always made our data available to the CFIA. That has always been the case and presumably always will be.

Randy, maybe you could address that.

Mr. Randall Huffman (Chief Food Safety Officer, Maple Leaf Foods Inc.): Mr. Allen, you raise a good point. Visual inspection certainly plays a role in producing safe food, and having a trained, knowledgeable, and experienced inspection force is a critical factor in food safety. There's no debate regarding this. We would all agree.

Over the past 10 or 15 years, the food industry has begun to understand what it takes to control listeria within a refrigerated food processing environment. We've learned that visual inspection is not enough. You must have an aggressive environmental testing program that provides data on which you can make informed decisions. An experienced and competent inspection staff would also play a role in evaluating these data. As part of the new CFIA policy that went into place on April 1, this will certainly be happening in all of our facilities going forward. In fact, it's probably happening today. We expect this to enhance the safety of the products that we and our peers in the industry produce.

Just to reiterate, I agree that visual inspection plays a role in safety. But with respect to this food safety hazard, listeria monocytogenes in ready-to-eat foods, it's even more important to have data. You need data generated through an aggressive environmental testing program that provides you with a view of what's actually happening in the process.

With respect to the second question regarding data sharing, the information was in the past generated before August. The information related to the listeria testing program that Mr. McCain refers to was available for review in a binder in the office. As Mr. McCain says, we are obligated to share this information upon request. It certainly was available for inspection.

● (1640)

Mr. Malcolm Allen: Let me be clear. I wasn't suggesting that it wasn't being made available. But you have to take into account that the CFIA inspector you had at that time had six other plants besides your own. Knowing the frequency of the CFIA inspectors' visits, was someone notifying the inspectors of possible detections, as opposed to simply showing them where you kept the binder? When you have seven plants, you have limited time to look at the data. That's not necessarily Maple Leaf's problem, but perhaps highlighting those events would make the inspection process more effective. It wasn't about somebody trying to obfuscate information; it was more about clarity.

Mr. Michael H. McCain: The question of who has the obligation to point out particular test results is certainly an issue, but the test data were made available. We cannot comment on the allocation of an individual inspector's time and their additional responsibilities, but we can comment on the fact that they have an obligation and were at our facility each and every day. How long during the day they were there is another matter. But they were present in our facility each and every day, by law, when we were producing. There is a presence there daily regardless of how they allocate their resources.

I think the most important question in enhancing food safety has to do with how you interpret the data. Going back to first principles, we were collecting these data without being under any obligation to do so. There's no regulation requiring us to collect the data in the first instance—there never has been in the history of food processing. When you're not required to collect something, it tends to colour your sensitivity to interpreting it.

Finally, given the mandate that we believe is appropriate for the CFIA, for the government and regulator going forward, we would share your view that more resources are required, not less. But that is not for us to decide.

The Chair: Thank you, Mr. McCain.

Mr. Anderson, seven minutes.

Mr. David Anderson (Cypress Hills—Grasslands, CPC): Thank you, Mr. Chair.

Thank you, Mr. McCain, for being here today.

I would like to acknowledge your willingness to take responsibility for the products that were produced in your plant, which resulted in the deaths of 21 people. I'm glad to hear you say again today that you stand by those statements and take full responsibility for the role that Maple Leaf played in that.

I want to talk to you a little bit about the environmental testing here. I guess I need a little bit of clarification. You said there is no environmental monitoring policy in place, or there wasn't last summer. There was a policy in place up until 2005. Can you tell me how that impacted on testing in the plant? I understand it was changed. It's mentioned in our “Lessons Learned” document here. I'm just wondering if you can tell me what was happening prior to 2005, and what changed at that point? Would that have affected the discovery of listeria?

● (1645)

Mr. Michael H. McCain: To my knowledge, and I will confess that I am not a regulatory expert, there has always been a policy from Health Canada that reflects an environmental monitoring program as being best practice, but it was never transitioned into a regulation that required the implementation of that policy. So to the best of my knowledge, and I certainly stand to be corrected, I don't know of there ever being a regulatory requirement for a listeria monitoring program in place inside the food facility, unless I'm misinformed on that.

Mr. David Anderson: Was it in place? Were companies using it at the time? I don't have time to go over the section in “Lessons Learned” here, but it seems to me that samples were required to be taken. I'm wondering, were the plants doing that, or did they choose not to? The requirements did change in 2005, and I think it was because the American government first changed their sampling procedure and then we changed ours.

Mr. Michael H. McCain: Are you referring, sir, to the M205 sampling plan?

Mr. David Anderson: Yes.

Mr. Michael H. McCain: Just to be clear, the M205 sampling plan, if I recall, required 10 samples twice per year—10 samples twice per year.

Mr. David Anderson: What did you have to do with those samples?

Mr. Michael H. McCain: For technical clarity, I don't think any scientist would say 10 samples twice per year would constitute an environmental monitoring program. So where that statistically falls out, you'd better talk to Dr. Huffman, but I just don't think that would be viewed by the industry as an environmental monitoring program.

Again, these aren't reflective of any particular period in history or time or regulation or deregulation. These are practices that have never been in existence, that we're aware of, over time.

Is there anything you'd add to that?

Mr. Randall Huffman: I'd just like to add that I'm not certain of the reference you have for 2005 and the changes that were made then. I'm not aware of any environmental testing that was required by CFIA prior to this most recent policy. However, there was a requirement to take product samples to be tested for listeria monocytogenes as part of export requirements, as part of the FSIS USDA government regulations. So there were product samples required for facilities that would be exporting to the U.S.

Just to be clear, testing of product for LM is quite different from testing the environment for the organism.

Mr. David Anderson: This was end sample product testing or sampling, right? What you're saying is there was no environmental monitoring, but there was in fact a sampling plan in place that did sample product. The end sampling plan, I understand from M200, was specifically for end product sampling; M205 had to do with sampling product as well. You're saying there's no environmental monitoring or sampling, but there was in fact an end product sampling plan in place that was removed in 2005?

Mr. Michael H. McCain: Are you referring, sir, to the M200 and M205 sampling plans that existed several years ago that required 10 samples twice per year? Is that the one you're referring to?

Mr. David Anderson: Yes.

Mr. Michael H. McCain: The M205 raises a very good point. The M205 sampling plan was a CFIA sampling protocol and not a requirement of the operator to have a sampling protocol, which is a very important point of distinction. The new regulation requires both an operator program and a CFIA validation/verification program, which we think reflects global best practice.

On the CFIA policy, going back to the very old CFIA standard that existed for many years, and I can't say with clarity just exactly how many, but on the M205 sampling plan that required a CFIA sample of 10 samples per year, when you're talking to the scientists over the course of the next several weeks and months, I would ask you to talk to them about the efficacy of that.

Mr. David Anderson: That was the one in place and it was removed. Any efficacy it did have would then not exist. You're saying that was taken out and your voluntary program was put in. Obviously that did not work all that well because you had positive samples through last summer, but then you apparently either did not have to report them or did not report them until we had an issue.

● (1650)

Mr. Michael H. McCain: That observation would be directionally accurate in the sense that we had a voluntary program for reasons that I think we've articulated. Any aggressive—and I emphasize this—environmental monitoring program in a food plant, if it's designed properly, I hope will detect positive findings for listeria, because it's ubiquitous. The learning from that experience was how we respond to those positives and how an operator and therefore the regulator responds to the positives that you determine by design, I hope.

Mr. David Anderson: What was the response through the summer prior to people beginning to get sick from it? You had numerous positive samples. What was the response?

Mr. Michael H. McCain: Our protocol at the time, I emphasize again, was a protocol we had confidence in because we felt it represented best practice at that time. Our program and protocol was that when we determined a positive listeria finding in the environment, we remediated or cleaned up the site where the data indicated we had a positive and then retested it in successive periods. When we got negative findings in successive periods we then assumed that positive finding was remediated and we closed the case.

Mr. David Anderson: The positive finding was not remediated then.

Mr. Michael H. McCain: No. As I say, an environmental program is a control indicator for your facility. That's what we did then. What we didn't do then is we did not look at those positives in the context of a pattern. So what's the pattern of positive findings either on a line, in a product group, or repeat positives? What we didn't do was scientifically investigate the root cause of each one of those positives, because a positive event is only an indicator. We didn't do those things, and I'll say again that it's important that we recognize we're doing that today. It is built into the program today and it is built into the new listeria management policy that was implemented on April 1. Had we been doing that then, we believe there would have been a very different outcome.

The Chair: Your time has expired, Mr. Anderson.

Ms. Duncan for five minutes, please.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Mr. Chair.

Thank you, Mr. McCain and your colleagues, for coming. We appreciate your openness and your accountability. This must be very difficult. And we appreciate your concern for the families who are affected.

What I'm struggling with is the lack of coordination regarding the investigation. We should have been in a much better position to deal with the outbreak, as Canada had already been through SARS, and PHAC and public health units and other departmental agencies have spent the last several years planning for pandemic flu—a different disease, but still planning. And the basics of any plan are the same: who takes the lead, what is the reporting structure, and what is the cycle of communication with the media and the public?

The point is, lessons were learned from SARS and lessons have been learned throughout pandemic tabletop drills, and yet we see the same mistakes occurring in the investigation of the outbreak. It would seem as if our country is less prepared for an epidemic than in the past.

I'm wondering if you could comment on that.

● (1655)

Mr. Michael H. McCain: Dr. Duncan, I can only say that we would welcome anything that would shorten the timeline in these types of investigations. Nobody wins by extending these timelines beyond what science will allow.

We would ask that we keep the process science-based—that's very important—but we would welcome any action by industry or government that would reduce the timeline and enhance the process of identification of a food-borne illness outbreak and a reaction to that.

Dr. Huffman has extensive experience around these things. As you know, he was a leader in this area, working in the United States. He's a world leader in food safety and has experience in many similar situations. Maybe he would comment on that.

Mr. Randall Huffman: Thanks, Michael.

You raise an excellent point, Dr. Duncan. The science of food-borne illness investigations and epidemiology into food-borne illness outbreaks is a very difficult one. It's one that our scientific community, our government communities, and the industry are getting much better at, but there is still plenty of room for improvement. We need to come up with better and more innovative ways of assigning cause and identifying the food that may be associated with a given cluster of illnesses. Molecular techniques and DNA fingerprinting techniques have greatly enhanced our ability to track food-borne illnesses and to identify their causes, but we've got a lot to learn. We still need to enhance and improve our ability to do that and reduce the timelines.

As a participant in the food industry that has a vested interest in selling safe food, certainly we would welcome any ideas and any additional resources that could improve that.

Ms. Kirsty Duncan: Thank you.

To pick up on the questions regarding data, you mentioned that you were collecting data, that the data was made available, and yet only 10 samples were required, I think twice a year.

Could you tell us how quickly listeria grows, and how often it would need to be monitored?

Mr. Randall Huffman: You've asked two questions. I'll answer the second first, if you don't mind: how often does a food processing plant need to be monitored for listeria to assess control?

That's actually the subject of a two- or three-day workshop to really get at the answer to that question. But to try to simplify it as much as I can for this purpose, it requires a tremendous amount of data and data analysis and sophisticated pattern recognition and understanding of the unique processing environment in which you're assessing.

One thing we've learned in the industry is that one size doesn't fit all with listeria control. So for one facility we may need *x* number of samples on a daily basis, yet in another facility it may be significantly more than that.

The plan that was laid out in the new policy that went into effect April 1 represents a level and frequency of sampling that is very appropriate as a starting point for a food manufacturer to feel confident about whether or not that process is under control. At the end of the day, what you're really trying to assess, as a manufacturer, is whether or not that particular line is operating under control. So we use statistical process control techniques, SPC, commonly used in the food industry. We use techniques like that, and other analytical tools, to assess whether or not the process is under control. The only way to do that, as we talked about in the earlier questions, is to have a reliable set of data, and assessing the amount of data that's needed in any one case really requires a look at the historical sampling of that particular line within that particular facility.

● (1700)

The Chair: Thank you, Mr. Huffman.

Your time has expired, Ms. Duncan.

Mr. Lemieux, you have five minutes.

Mr. Pierre Lemieux (Glengarry—Prescott—Russell, CPC): Thank you very much, Chair.

Thank you once again, Mr. McCain, for being here.

As you know, there are four separate reports that have been released in this last week with lessons learned—three by federal government agencies and of course one by the Ontario health department—and they all have their recommendations. I'm sure you're up to speed on the recommendations that have come out in each of them.

One of the criticisms that has come out in the media is that Maple Leaf did the recall and CFIA did not step in and do it for you. I would like to examine this a little bit further.

My understanding is that the minister, or CFIA, has the ability to order a mandatory recall. However, if it's not necessary, if a recall is already happening, then that's good. If they're able to work in a constructive way with a company, then in fact that is good. It shows teamwork and it shows corporate responsibility, as we've seen particularly on behalf of Maple Leaf.

I know you sent a letter out to committee members a couple of weeks ago, and it had your own statements and your timelines in there. One of the things that seemed to stand out for me, in reviewing that report, was that you were working cooperatively with CFIA, and that oftentimes CFIA would provide you with information or suggest something to Maple Leaf and Maple Leaf would be right onto it.

To give a couple of examples, I notice, for example, on August 16, Maple Leaf initiated a recall, but it was after CFIA provided confirmation that there was listeria present. On August 19, as well, Maple Leaf took further action, but once CFIA had informed you of more positive test results.

Certainly, I've been impressed with your corporate responsibility and with your personal responsibility regarding the listeriosis crisis, but I think what I'd like to get your viewpoint on is whether you agree that you and Maple Leaf followed the recall process, your own recall processes, to the best of your abilities.

Mr. Michael H. McCain: That's an excellent question and certainly something that's topical in both Canada and the United States, and that is the role of the voluntary recall.

It's important to recognize that what is referred to as a “voluntary recall” by a regulator and an operator is so in name only. The reality is that if what's required under the form of a voluntary recall is not completed expeditiously, the voluntary recall will become a mandatory recall in extraordinarily short order. And everybody in the industry knows that's the case. Whereas the word “voluntary” is used ubiquitously in the United States and in Canada, the reality is there are mandatory undertones and requirements that everybody knows exist.

That being said, what Maple Leaf did last year went well above and beyond what would have been a voluntary or mandatory requirement. Industry is required to recall product that is proven to be contaminated. That's what is required of any industry anywhere in the world—recalling the product that you know to be contaminated. We voluntarily went above and beyond that. That's not to say that the mandatory recall wouldn't have been sufficient. It may or may not have been. But we chose, for reasons that were important to us and our public trust, to recall all 198 products from that facility, even though only a very small handful were proven to be contaminated. It was that extra precaution that no government, that we're aware of, or regulatory framework would have absolutely required.

I'm not sure if that distinction is helpful.

● (1705)

Mr. Pierre Lemieux: It's very helpful, in fact. You're sort of underscoring where I was coming from. I understand your comment that if a company doesn't undertake a voluntary recall, it quickly can turn into a mandatory recall. But in enunciating that, you pointed out that a mandatory recall was not required in this circumstance because not only did you and Maple Leaf Foods respond quickly and adequately, you went above and beyond what would have been required in a mandatory recall.

I'm just responding to things I've read in the media that said that CFIA should have used that heavy stick. All I'm trying to bring to light for the committee and for those who are in attendance is that because of the close working relationship you had with CFIA, because of your corporate responsibility, you acted more quickly than a mandatory recall might have produced results, and secondly, you went beyond the call of duty probably because of your corporate responsibility and the harmonious relationship you had.

Mr. Michael H. McCain: I think that is accurate. I can understand why people would sometimes become concerned about the term "voluntary requirement" when mandatory requirements are certainly implied. I reiterate that nobody is under any misconception that if it is not voluntary, very shortly it will be mandatory. But in our case, we did take the steps, as you articulated.

The second part of your question is on collaboration. It's imperative that we have a working relationship with the CFIA every day. Our plant staff and our technical staff each and every day have to work collaboratively with a regulator. That's an important consideration to an effective food safety system.

That doesn't mean that people don't understand their job. The job of the regulator is to set the rules. The job of the regulator is to make sure the rules are being adhered to in the strictest way and to enforce them when they're not. The role of the operator is to produce safe food.

We do have that type of a collaborative relationship. And that's a very constructive thing for the industry—any industry—to be able to achieve: safer food for Canadians.

Mr. Pierre Lemieux: Right. Very good.

Thank you, Mr. Chair.

The Chair: Your time has expired, Mr. Lemieux.

Before we move on to the next round, Mr. McCain, I was wondering what direction CFIA has given your company on changes to record-keeping and what changes or recommendations you have made to assist CFIA in regard to future recalls. Did you touch on that at all?

Mr. Michael H. McCain: I'm not sure I understand. Are you asking about changes to their record-keeping requirements of us?

The Chair: Yes. What direction, if any, has CFIA given you on changes to record-keeping and what have you, and what changes have you made to assist CFIA with future recalls? Have you come up with anything on that?

Mr. Michael H. McCain: Is it with respect to environmental monitoring programs, or with respect to recalls themselves?

The Chair: Well, I think to recalls. Obviously, you've had to go through this; you did this voluntarily. I'm just inquisitive, wondering if you've come up with any recommendations that you've suggested, whether you're suggesting them here or have already suggested them to CFIA.

Mr. Michael H. McCain: On the recall record-keeping that we've had, although we're not perfect, we don't think we're a significant contributor to the timelines here, maybe down to the sake of a few hours. I think our data collection on recall actually performed reasonably well. I don't think that's been the top priority for the CFIA in addressing it. I think most of their focus has been on improving the record-keeping and reporting and analysis and the rigour I referred to earlier around the food safety systems themselves, and the processes inside the facility. What we describe as an environmental monitoring program I think they would describe as their new listeria management policy. Unless I'm misinterpreting the question....

Is there anything you would add to that?

● (1710)

Mr. Randall Huffman: I would only add, Mr. Miller, that we just received the "Lessons Learned" report, as I assume you did as well, over the weekend. As our food safety team reads through and analyzes the lessons learned from CFIA and the other agencies, we'll look for the take-away lessons from that and assess what we can do better as a company and as an industry.

I think traceability was one issue that was raised. Certainly we support enhanced abilities to trace our products. We think we're reasonably good right now, but we know there's room for improvement. Our food safety team is assessing how we can become even better at tracing our products throughout the system.

We'll take the "Lessons Learned" report and look for opportunities for us to enhance our ability on that.

The Chair: Thank you very much.

Mr. Easter, for five minutes.

Hon. Wayne Easter: Thank you, Mr. Chair.

You can answer this in the course of your answers, whoever may be able to. It's more a point of clarification. You kind of left the impression that there were no environmental regulations in place up until a short while ago, and I would like you to clarify what was there as compared to the new overall environment protocols that are in place now.

The more I listen to you, in fact, the more I'm concerned about government agencies not doing their jobs. There's no question industry has a responsibility, but government ministers and agencies have the overall authority and responsibility for public health in this country. So let's not lose sight of that fact. We were in a time-set—and Mr. McCain, you were part of this time-set as well—that there's a view from the government side to deregulate, and the industry side wanted to reduce costs, so if deregulation was part of that, then that was great. That's kind of changed in the very recent past.

I'll come back to my earlier question on the slicer. A witness who will be coming before the committee was an auditor of the auditors of CFIA. He will be before this committee. He maintains that if CFIA was doing its job, they would not be looking just at the manufacturer's specifications on the slicer; they would have detected that potential problem before it occurred, if CFIA had been on the job doing the proper audits in a preventive sense that they ought to have been doing.

Do you believe that to be a way we ought to be going? Is there a way of better prevention here, by better foresight, by CFIA as an overall authority doing its due diligence to protect the Canadian public, but also to protect you in industry from running into the kinds of consequences that you faced as a result of the listeriosis outbreak?

I know you're accepting responsibility, but I think a higher authority has a responsibility here, and that maybe this could have been prevented if CFIA had been on their job.

Mr. Michael H. McCain: There is a higher authority in food safety, and that rests with a regulatory agency. I don't believe that means they are the primary responsible party here. I think we've accepted that because this occurred in our facility and on our watch.

I've articulated what we believe the role of government and the regulator should be going forward, and I'll reiterate that. First is to define the expectations of an operator in tremendous specificity and detail, as reflected in a food safety protocol. Second is to have the resources and processes in place to validate and verify that those regulations are being complied with. Third is to ensure the consistency of implementation across the country. Fourth is to encourage responsible behaviour by the operators. We believe that mandate will require more resources by the regulator, not less.

A great deal of this has been reflected in what we're doing today that we weren't doing before and in the new listeria policy in place today that wasn't there before. Now it's down to the quality of the implementation across the country to make sure it gets implemented well.

But your question is really about whether or not there was an obligation, and if somebody had been doing something different previously, whether it would have been detected. At the end of the day, with something as scientifically difficult as this, I don't know if anybody could go back and say what looks obvious today. Things of this nature, in retrospect, look incredibly obvious to us and to anybody else who might examine that data and say, “If I'd known that at the time I would have been able to do something.”

Goodness knows we were collecting a mountain of data at that time. We think the operative regulatory question is that no data was required to be collected at all, not how that data was being interpreted at the time. But could somebody go in after the fact and say they could have analyzed the data if they had the time, the resources, the skills, the training, and come to a conclusion? Maybe they could have; maybe they couldn't. I know it's voluminous, very scientific, and highly interpretative data. You have to spend the time and energy to examine it all, and in retrospect we've said we should have known that. We should have had the systems in place to see that. Others could have come to the same conclusion.

● (1715)

Hon. Wayne Easter: My point being—

The Chair: Sorry, Mr. Easter, your time has expired. You're well over it.

Mr. Bellavance is next for five minutes, please.

[*Translation*]

Mr. André Bellavance: Thank you, Mr. Chairman.

For a few moments, I would like everyone to put themselves in the shoes of consumers, which is not difficult, as we are all consumers. We eat your products and those of your competitors. We eat products that come from Quebec, Canada, and other countries. So we have reason to be concerned when events like the one last August and others occur. Listeria is one strain of bacteria, but there is also E. coli. There is no doubt that several products were inspected, but some of them made it through the inspections and controls and ended up on store shelves, causing diseases and, unfortunately, death. I am not just talking about your products. There was the case of spinach from the United States as well as carrot and pear juice. At one point, a host of products were contaminated in one way or another and made people sick and some cases, caused death, unfortunately.

Consumers who follow the work of this committee or who read the papers are entitled to question the number of inspections and inspectors. Unfortunately, we will never be able to prevent such unfortunate events from occurring and certain products from being missed. People tell themselves that they pay taxes to the government so that the government will protect them. But sometimes there is no such protection.

When people read in the papers that some inspectors whose work involves protecting them spend the bulk of their time in an office with paperwork instead of inspecting food, they are entitled to question whether their safety is in jeopardy. When people read that an employee at the Canadian Food Inspection Agency claims the government wants companies to regulate themselves by doing their own inspections, they are entitled to wonder whether they are adequately protected.

You say you are accepting responsibility because these events occurred under your watch. I want to correct you, Mr. McCain: they also occurred under the government's watch. Employees and inspectors from the Canadian Food Inspection Agency must be involved. They must work in conjunction with the industry in order to prevent these kinds of problems.

Here's another aspect that raises questions in people's minds. Up until April 2008, federally accredited meat facilities were required to undergo a full verification. Monitoring in that area has been relaxed. At the Maple Leaf plant where the listeriosis contamination broke out last summer, there had not been a complete verification of the systems for at least a year prior to the Listeria outbreak.

I will repeat that responsibility must be shared. I would like you to put yourselves in the shoes of the people who see these events and who will be better informed following the meetings of this committee. They will know a lot more following the investigation demanded by the government and conducted by Ms. Weatherill, which was done without our knowing exactly what happened. If you put yourself in the place of consumers, you will understand that they are entitled to ask questions about public health, their health and the health of their families.

● (1720)

[*English*]

Mr. Michael H. McCain: That is an area and a topic that is most important to us. We are a consumer-facing organization. We have built our trust with consumers over a hundred years of history, and as you well know, trust built over a hundred years of history can be broken in minutes.

We know that Canadian consumers have the concerns you describe. We feel those concerns very deeply. Certainly out of respect for and recognition of those concerns, we took the actions we did in this very tragic situation, putting the interests of consumers first.

We recognize that trust will take time to rebuild. Their trust in the whole food safety system in Canada has been impaired, and we feel very sorry for that. We certainly played the dominant role in that impairment, and we feel very sorry for that outcome.

Of course, everybody has a role to play in capturing the lessons learned. We've tried to be clear on what we believe those lessons are for the regulator. We've tried to articulate what we feel is an appropriate regulatory framework going forward, and we've been very clear that we regret the fact that...had we known then what we know now, we might have saved 21 lives. Under the circumstances, I think we are responding to consumers by putting their interests first and taking the steps to improve going forward, as I think the regulators are as well.

Just to complete my answer, on your question specifically around the inspection that was dropped, I believe—if I'm not mistaken, and I hope I've understood your question appropriately—you are referring to the annual inspection that used to be engaged by the CFIA. A best practice in quality assurance and food safety is globally recognized as what's described by hazard analysis and critical control points, or HACCP, programs. HACCP programs replace annual one-time inspections with inspections that are implemented each and every day.

Dr. Huffman can respond more articulately than I as to why that's so, but I believe the regulatory approach was replacing annual one-time inspections with the implementation of what is recognized as global best practice, effectively, in the form of daily and weekly HACCP programs, that for all intents and purposes replace annual one-time audits with daily and weekly audits and inspections.

● (1725)

The Chair: Thank you very much.

You have five minutes, Mr. Allen.

Mr. Malcolm Allen: Thank you, Mr. Chair.

Let me just quote back to you what the Auditor General said in 2000, Mr. McCain, about CFIA, in particular, and about HACCP, since you've just raised it. This is the CFIA they're talking about: "... the Agency did not maintain sufficient dialogue with stakeholders, particularly Parliament and the public", including on the implementation of the hazard analysis critical control points, or HACCP, food safety systems. And there has always been considerable debate about the role being left to the private sector, in particular with respect to implementation of HACCP systems.

So as you talked about the HACCP system, the part of that that I think the public has some concerns about—and they may or may not be entirely justified, depending on where the situation and the plant is and who the operator is—is that the third-party inspector, CFIA, reduces its actual inspection role and allows, as you call them, the global best practices under HACCP to be done by the operators themselves. Sometimes there can be a disconnect between the public's faith in the operators, justified or not—and I'm saying this in a broad-based food process across North America, not at Maple Leaf in particular. So that becomes one of the points of contention, I think, around the HACCP issue: it's not so much that HACCP may indeed be more testing, because you can say, "Well, we only had one audit before, we may have multiple testing now during the year", but it's who is actually doing the testing, who verifies it, who audits, and who does all those subsequent steps in the process. That's part of the question.

But let me go back to some of the things that I see in your opening remarks and the paper you put together. It talks about advocating, and I assume you mean by Maple Leaf, and I appreciate the leadership role that you're taking around this: "advocating and participating in industry-wide initiatives designed to *raise*"—and I emphasize the word "raise"—"the level of food safety practice among all companies", and the leadership role you want to play in that. That's to be commended, and I think all of us want to see that happen right across all the food industries that provide us with food and manufacture it. But you go on to say that you're "not experts in government processes, and making policy is the responsibility of Parliament, but if these responsibilities"—one of which I just mentioned, and you have some others there as well—"require more resources for the CFIA, we would certainly support that", which brings me to the nub, if you will, of the whole situation.

You talk about third-party inspection and audits that help your company. I'm not so sure if you meant CFIA, around a third party. You mentioned that someone does a third-party audit for you. I didn't know if that was in addition to CFIA, an outside party as well. But it seems to me that one of the things in all of this that we could get to, which actually takes some ownership away from the corporation, in the sense of inspection duty, and gives confidence back to the public, is this whole sense of third-party audit.

Now it may be unfair for the public to sometimes think that companies don't necessarily do it the way they're supposed to. There is a certain element of faith in a third-party audit, which says we don't have any distinct gain to be made by saying whatever about an inspection, whereas a company obviously has, around certain issues it produces. Whether that be in the auto sector or in the food sector, it doesn't really matter the sector, a company has an intrinsic value in saying, "We're the best at whatever", whereas when we're inspecting something as delicate as food—and I use the word "delicate" in the sense of a car won't poison you, necessarily, but food can—we engage in a process....

I think what you're saying to us here, and I may be mistaken, when you talk about companies coming together to share their knowledge and to truly get global best practices—and I hope this country can be a leader in this, to be truthful—is that the only way you get trust back with the public is really through third-party verification at the beginning and at the end of that process, not somewhere in between, sort of taking snapshot samples here or there as the process goes by.

But I'm not so sure, even with your leadership, Mr. McCain, that your competitors may necessarily all come to this table of food safety and want to share all their best practices. Policy, through government, can indeed make them do that, whereas you don't have the ability, sir. And I know you probably wish you could, but you don't actually have that authority, as you mentioned earlier, but we do.

I know that's sort of a wide-ranging topic. If you could make some comments, I'd appreciate it.

● (1730)

The Chair: You used the whole five minutes.

If you could comment as briefly as possible, I'd appreciate it.

Mr. Michael H. McCain: I think on the debate about the relative role and resources in a world-class, global, best practice, food safety outcome as to who has the greater responsibility for food safety, government or industry, the evidence is not either/or, it's not one or the other. In fact, I think if the policies of the government or industry go down the path of either/or, then the Canadian consumer will lose. The appropriate best answer is "both".

Mr. Allen, I have been living in a food manufacturing environment for my 30 years in this business. We have an ambition to produce great-quality product. I have a manufacturing group and I have a quality assurance group. Any time I've tried to make that responsibility for producing safe food or high-quality food as one or the other, it's never had a satisfactory outcome. The right answer is "both", in our view, and there's a role for each. I think finding the right balance and the integrity of the role for each, for both the regulator and the operator, is critically important for this committee and for the regulator and policy-making going forward.

The Chair: Thank you very much.

Mr. Tweed, five minutes.

Mr. Merv Tweed (Brandon—Souris, CPC): Thank you, Mr. Chairman.

Thank you for being here today.

Like the others, I would like to say it, too, but I think I'll say it on behalf of the people of Brandon, which hosts one of the largest Maple Leaf hog processing plants, I suspect, in North America. I pass on the message, Mr. McCain, that the community of Brandon is very proud of you for your acceptance of the responsibility and for your company's acceptance of the responsibility. I think in today's economic crisis we see executives running away from problems. I think in this case we've seen the chairman step up and try to resolve them.

I have four questions, and I'll just maybe read them off and let you answer. I know we have limited time.

It's been suggested by some that maybe more inspectors is the answer. My first question would be, do you believe that more inspection of your specific incident would have found the root cause on that particular day? You mentioned that you think resources for the inspection should be more available. Would processing companies such as yours be willing to partner in that cost?

You mentioned guidelines in your presentation, about these guidelines being applied provincially as well as federally to all ready-to-eat plants. There are two points. I'm wondering how many that would impact. Do you see that eventually being spread into the complete slaughterhouse industry?

The last question I have is this. You did mention, and it was mentioned in the "Lessons Learned" report, that there was some difficulty transferring the information from your corporation to CFIA and it created a delay. I guess more than anything I'm hoping...and I'll ask you to tell us that those things have been corrected and obviously the record-keeping is compatible now. I'll ask you if they are and if you've done that.

● (1735)

Mr. Michael H. McCain: I'll try to answer your questions as succinctly as possible.

We think one of the more difficult things to conclude here is that there was no one single cause. We believe it was a failure of the total food safety system inside our plant, as I referred to earlier. So on one hand, I can easily say that additional inspectors would not necessarily have contributed to a solution, but on the other hand, I can say that to fulfill the mandate going forward, I believe the CFIA needs more resources. I'm not sure if I'm adequately explaining that point of difference because I do believe those are very compatible observations.

On the second question, with respect to partnering the cost, frankly, we've not even considered that. We've looked at doing the right thing and we've just not paid attention to the cost. I don't think that should be anybody's interest in the short term. How we divide up the pie going forward is something that should be a future consideration. Our primary concern has been public health and improving the food safety systems in Canada.

Your third question was as it relates to provincial versus federal. We recognize that will be a very contentious issue. We do believe that bacteria does not know borders, and consumers in Canada do not fully recognize the different standards between provincial inspection and federal inspection. They deserve to know, and we think the time has come to put an end to that.

On your last question, with respect to the transfer of information and did it case any delays, I'm not sure I understood the question.

Do you know the answer to that one?

Mr. Randall Huffman: As I responded to Mr. Miller earlier, our team has assessed the "Lessons Learned" document. There is one reference to the transfer of information in PDF format versus an Excel spreadsheet that would be more readable during a crisis situation, and certainly we can put in systems to address that need. As I said earlier, we're taking a look at all the documents that were provided over the weekend, and we'll learn from those as well and implement everything we can.

The Chair: Ms. Duncan, five minutes.

Ms. Kirsty Duncan: Thank you, Mr. Chair.

Mr. McCain, you've talked about the importance of a role for both the company and the authority, and I think that's really important.

When we look back at SARS, we had shared understanding, shared responsibility, and shared lessons learned, so one of my greatest concerns is in looking at the chronology of events and seeing the repeated delay between the time information was gathered and the time it was shared. I'll provide some examples.

There was an increase in listeriosis cases in June and July; the first notification among partners was July 29. There were delays in sending samples. Toronto Public Health sent 11 samples on July 21, Ontario received them on July 22, that lab sent them on July 23, and they were received at the reference laboratory on July 24. The public health division detected an increase in reported cases of listeriosis on July 25. They requested additional data on July 28.

On July 21, the public health division asked the listeria reference laboratory to prioritize food samples submitted a week earlier. On the 24th.... As a result of the additional information entered by public health units retrospectively, public health identified 16 cases of listeriosis in the month of July.

Was there a delay in entering data? Was there not enough data entered? What is a reasonable time in which to enter data when the delay of a day can make a tremendous difference during an outbreak?

I'll give you a few more. On August 11, Ontario's central public health reported two open packages of meat cold cuts had tested positive for listeria. The Halton regional health department issued an advisory to local homes about a possible link. There was no other warning. CFIA informed the public health division and PHAC on August 13 that Maple Leaf was the manufacturer. Why was it two days later?

I could go on and on. Why didn't CFIA post a warning to its website until August 17, five days later? What other methods did it take to inform the public?

I have many other examples. I won't continue with them. I want to bring it back to you. You said there should be shared responsibility. You've talked about your responsibility. I'm wondering if you can comment on the delays that seemed to happen in many areas.

● (1740)

Mr. Michael H. McCain: I wish I could comment, Dr. Duncan, but I am not privy to those processes or dialogues or to the outcomes of them. Those types of exchanges and processes occur without our engagement.

Most of your examples were in July. The first notification we had was on August 8. On August 8 we were only asked if we could trace certain products, and that was the only thing we were asked: whether or not we had the ability to trace certain items. We obviously took steps to respond to that question.

The only thing we're able to respond to is factual information from the CFIA, which notified us on August 16 of a positive finding in product. We were notified, I believe, somewhere around 9 or 10 in the evening of August 16. I know I was personally notified about an hour later, and we began our recall procedures within minutes of being notified.

I would reiterate, though, that anything that could be done to shorten those timelines, which are very challenging, would be welcome.

Randy, maybe you'd comment on timelines.

Randy has had extensive experience on timelines in the United States in other circumstances.

Mr. Randall Huffman: Very briefly, I'll reiterate what I said earlier, which is that food-borne illness epidemiology is a challenging subject, and getting to root cause and collecting these types of data takes time. Certainly it might be instructive for this committee to contrast the timelines of this event to those in other recent large food-borne illness outbreaks. We would probably find examples of timelines that were actually much longer; there may also be instances of shorter timelines. Hopefully, we can learn from this.

The Chair: Your time has expired, but thank you.

Mr. Anderson, five minutes.

Mr. David Anderson: Mr. McCain, I'd like to go back to your statement to go over a couple of things.

On page 4—and you said this a couple of times—you note what happened last summer "was a failure of expectations not a failure of inspection." And then you wrote:

> We believe that the role for government should be built around four key principles:
>
> 1) Defining with detail, the requirements and expectations of an operator to deliver a strong and effective food safety program.

I'd like your opinion on whether the changes on April 1 have done that. The CFIA have made a number of changes there. We had a convoluted discussion about M200 and M205 earlier, but I understand that what was in the M205 sampling program is back in there, six times a year, and that's going to be part of that.

Your second statement is:

> 2) Building inspection and testing adequate to validate and verify compliance with the regulatory expectations, with tough accountability....

I would like to focus on that and ask you for your suggestions on how we can ensure corporate cooperation in the light, first of all, of our wish to ensure that a number of small operators continue to survive. That may not be your focus, but I think it should be part of the focus, especially of those of us who come from rural areas. I wonder how we can set a system in place that can deal with operations like yours, but with those that are much smaller as well.

Secondly, how do we do this? How do we build this inspection and testing structure, when you say that the failure really was not inspection? It sounds like there was enough inspection. Is it the analysis of the data? Is that what we need? Do we need more data? Do we need to analyze it differently? And if that's the case, what suggestions do you have for the CFIA in order to do that?

● (1745)

Mr. Michael H. McCain: With respect to your first question, the new listeria policy, we believe, is a very significant material step forward in capturing the learning from last year and does represent a global best practice requirement of the operators to implement a best practice environmental monitoring program.

Certainly, the M205 sampling protocol is built in there. But I think if you asked the scientific community, it is other features of that policy that will truly enhance food safety in the system, things like the requirement for operators to have sampling in the range of 10 food contact surfaces on a weekly basis.

I reiterate, the role of inspection is very important. We do believe that to implement this policy it will require the CFIA to probably include more resources. I think what's critical is that they focus those resources on the things that will actually enhance food safety, which, as Dr. Huffman referred to earlier, is making sure they analyze data, looking for patterns, looking for root cause analysis and so forth, as opposed to visual inspection in the plants, which can be misleading.

Is there anything you would add to that, Randy?

Mr. Randall Huffman: To your second question regarding support for smaller companies and smaller plants, certainly, that is a concern. One of the objectives we'll have as part of our leadership role in this area of food safety is to encourage and work with our peers in the industry to develop and share best practices. In fact, that is going on now through an industry working group that is developing a best practice document that provides guidance to not only companies of Maple Leaf size, but also to medium and small-sized operators. We think what's good for them will also be good for us and the industry at large, so we'll work cooperatively to get those messages out and assist where we can.

I've spent the last nine years doing just that at the American Meat Institute in Washington, working to share best practices across the industry, and there are some success stories we can build upon through that activity.

The Chair: As a follow-up, could you tell us the type and number of product and environment samples taken by your company and CFIA inspectors during an average day of inspection?

Mr. Randall Huffman: Is this what is required from April 1 going forward, as part of the new listeria policy?

The Chair: Yes, I guess so. I was curious about what it was like beforehand. And I was wondering what a normal inspection day would be under today's guidelines.

● (1750)

Mr. Randall Huffman: Prior to the recall in August, Maple Leaf had what would be considered a relatively aggressive sampling program for listeria in the environment. This includes two areas within the environment: the food contact surface; and the rest of the plant environment, which could take in the sides of equipment, the floors, the drains, the walls, the walkways, and so forth. So there are two separate sets of data collection. This information was being collected prior to the recall. In 2008, about 3,000 samples were collected before August.

In addition to that, there was some routine product testing at the request of customers and as part of our U.S. export requirements. But a minimal amount of product testing was taking place at that time. The expectation from CFIA at that time was also minimal. In fact, before August, there was, to our knowledge, no specific requirement to have an environmental program for food contact surfaces or for the general plant environment.

As part of the new policy that went into place April 1, these components are captured within the CFIA requirement. We view the recommendations as being quite appropriate. Maple Leaf has a program that includes daily testing of every one of our processing lines within our 24 ready-to-eat plants, together with weekly sampling. We take enough samples on the food contact surface to meet the new regulatory requirements. In addition, we test the environment, the non-food contact surfaces, as suggested in the CFIA policy. There is also a requirement to test product about six times per year, depending on the size of the facility and the risk level assigned to that product. These tests are taking place as we speak.

The Chair: Thank you. I now have a better understanding of that.

What would be the difference between what you would have done before and what you would do now in the event of a positive sample being found?

Mr. Randall Huffman: Before August, the process, as recommended in global best practice, was to respond to each product-positive sample by remediating the site. This means aggressive sanitation, cleaning, and monitoring of the site. Our internal policy was to get three consecutive negatives after a positive on a food contact surface. So before August, this was what the Maple Leaf company did in that facility.

Today, however, we take a much more holistic approach to every positive finding. We dig deeper, and we're more rigorous in our evaluation of that root cause. We look for patterns in the data. We ask whether that particular site on that particular line has been positive in the past, and if so, we look for a linkage. What can we learn from the historical data? These are the types of things that are different today than they were then. We maintain the concept of following every positive site with consecutive negatives until we're certain that the product passing across that line is safe.

The Chair: Thank you very much. We've had two full rounds.

Hon. Wayne Easter: It's not six o'clock yet, Larry.

The Chair: It's not, Wayne, but if I start a round...we have four or five minutes left.

Hon. Wayne Easter: I don't think it matters. We have witnesses here for two hours, Larry. We need to get in all the questions.

The Chair: In order to be fair, we'll go around the room, and if you have a brief question, you can ask that specifically. I'm going to keep it to two minutes or less.

● (1755)

Hon. Wayne Easter: On April 1, going forward, there was a new protocol established in the plants. We've been led to believe that when CFIA went in to do that new protocol, Maple Leaf informed the higher reaches of CFIA that these people doing the swabbing in the new line of testing were not consistent in their testing.

The reality is that CFIA is supposed to be monitoring the operators of the plant and not the other way around. As a result, those inspectors, or those people doing the work for CFIA, had to be recalled and retrained. What happened there?

The Chair: Mr. McCain.

Mr. Michael H. McCain: I think it's a very complex scientific policy that requires training and commitment to be implemented by both the industry and the CFIA. It's very fair and reasonable to expect that it's going to take a bit of time to implement across the country, but I think everybody is committed to accomplishing that.

There are other things, Mr. Chair, that we are doing in addition to what Randy talked about earlier regarding product quarantining, which we didn't do before, and executive oversight on each individual positive sample. Those other things are equally important to the success of our new program and illustrate that it's about the rigour as much as it is about the other attributes. That training and that commitment, Mr. Easter, I think are there for both the CFIA and the industry to implement.

The Chair: Thank you.

I'll give the government side one question.

Make it very brief, Mr. Storseth, please.

Mr. Brian Storseth (Westlock—St. Paul, CPC): Thank you very much, Mr. Chair.

I can fit in a couple of questions in a shorter time than Mr. Easter fits in one.

Mr. McCain, I want to thank you for coming and being so abrupt, open, and honest with us. I'm sure you're aware of the independent investigator who has been appointed by the government, Ms. Sheila Weatherill, former president and CEO of the Capital Health Region. In 2003 she was named one of Canada's most influential women by *Maclean's Magazine*. As well, in 2003 the Edmonton Capital Health Region was named number one in all of the 57 health regions in Canada.

I'll ask all of my questions at once. Have you had an opportunity to meet with Ms. Weatherill yet? Has Maple Leaf turned over all the records and documents that she has requested? In your opinion, is Ms. Weatherill doing a good job? Do you agree that the Prime Minister's appointment of Ms. Weatherill is a positive development in getting to the bottom of this?

Mr. Michael H. McCain: We made a commitment to collaborate and cooperate with all investigations or any process that will enhance food safety in this country. Indeed, we have, at her request and ours, met with her and her staff on several occasions. We have turned over all the information that she's requested. We believe that as much as this process is a valued process, that one is as well. I recognize her credentials and respect them immensely. I have every confidence that she will fulfill her mandate.

The Chair: Thank you very much, gentlemen, for being here today. I think a lot of questions were answered. We certainly appreciate you taking the time out.

We do have another hearing. For the members of the committee, with your indulgence, CFIA could be ready to go by 6:15.

I understand there's going to be lunch or dinner served. If you could grab that, then we'll get going.

The meeting is suspended.

● _____ (Pause) _____ ●

● (1810)

The Chair: We'll reconvene the meeting. As discussed earlier, we're going to get started with this portion of the meeting 15 minutes earlier, and therefore we'll be finishing at 8:15 p.m.

I'd like to very much thank all of our witnesses from the CFIA for coming here today. It's a very important study.

I'll turn it over, first of all, I understand, to Ms. Swan, for 10 minutes.

● (1815)

Hon. Wayne Easter: I have a point of clarification before we start, Mr. Chair. We have the CFIA before us now. We're going to hear from a lot of witnesses over the course of the next several meetings. We do reserve the right to recall the CFIA before us again if necessary, based on information from other witnesses. Is that correct?

The Chair: I think anybody has that option, Mr. Easter.

Go ahead, Ms. Swan.

Ms. Carole Swan (President, Canadian Food Inspection Agency): Thank you.

Mr. Chairman, ladies and gentlemen, I appreciate the opportunity to appear before this committee. My name is Carole Swan and I'm the president of the Canadian Food Inspection Agency. We look forward to assisting the committee with its important work.

Let me start by saying how saddened and disheartened all of us at the CFIA are by the food-related illnesses experienced last year. We want to express our sincere sorrow to those families who lost loved ones or were otherwise affected.

Secondly, I want to state that our agency staff, be they inspectors, lab technicians, recall investigators, scientists or any other classification, are highly skilled and committed professionals dedicated to the protection of Canadians. This is an organization that cares about food safety.

Third, we're not perfect. The “Lessons Learned” documents that we released on Friday were direct and honest. We did not use that process to point fingers at others. We are focused on improvement.

In my remarks today I'd like to cover three areas: first, what the agency does; second, the challenges regulators face in a global food market; and third, what we are doing to continuously improve food safety. I will then ask Dr. Brian Evans to outline what the CFIA has done specifically in relation to the listeriosis outbreak.

[*Translation*]

The CFIA is a science-based regulator with a mandate to safeguard food, animal health, and plant protection. Our plant and animal mandates also relate to food safety, as foods are derived from these resources.

In support of this mandate, the CFIA works to identify and prevent risks to our food safety, whether the foods come from Canada or abroad; to identify and control animal diseases that pose a risk to human health such as BSE, or mad cow disease as it is commonly referred to, and avian influenza; and to protect the country's animal and plant resources, both in the field and in the forest, from devastating foreign pests and diseases that could negatively affect the food supply.

The CFIA has inspectors, veterinarians, scientists and other specialists in nearly 500 locations across Canada. It operates at border crossings, processing plants, slaughterhouses and in labs and research facilities throughout the country.

[*English*]

The CFIA is part of a national network responsible for food safety, which includes Health Canada, the Public Health Agency of Canada, provincial and territorial departments of health, and the public health units found in local municipalities.

Health Canada sets food safety policy and standards. The CFIA puts these policy and standards into effect through regulation, inspection, and enforcement. The Public Health Agency of Canada focuses on disease detection, reporting, and prevention. It is the primary federal contact with provincial public health authorities. Our work intersects with the Public Health Agency of Canada if there is an illness caused by food-borne diseases, as the Public Health Agency of Canada monitors and reports on such illnesses.

In terms of the CFIA's role in food safety, we inspect, test, audit, and review food production to verify that industry lives up to its legal requirement to produce safe food. When it doesn't, we take enforcement action to bring it into compliance. We conduct investigations when we think food safety has been compromised or when we are alerted to a problem, and we issue food recalls where necessary.

All partners in food safety have a responsibility to be constructive in their efforts to improve the protection of human health using science, international best practices, and new techniques. We look forward to hearing from other witnesses as well as to this committee's report and that of the independent investigator.

Like food regulators around the world, the CFIA is facing new challenges. The trading and processing of food has become more complex than ever due to globalization and the sourcing from all over the world of food ingredients that go into processed finished food products. This economic trend is also spurred by changing demographics and consumer preferences for fresh, convenient, exotic, and imported foods.

Since the agency was established in 1997, the nature of the challenges we face has evolved, as has the frequency of events having significant health or food safety implications. For example, in the past two years we have dealt with several significant challenges, including melamine contamination in Chinese dairy products, E. coli in Canadian and American beef, salmonella in U.S. peppers, and, currently, salmonella in U.S. peanuts and pistachios. I cite these to illustrate that the CFIA, like food inspection agencies around the world, is facing increasing pressures and challenges.

The listeriosis outbreak from contaminated Maple Leaf food product last year was the largest food recall in Canada. The events of last summer exposed vulnerabilities in collective surveillance and in the national protective network. In the agency's “Lessons Learned” review, our goal was to provide an assessment that was comprehensive, honest, and sincere. We do recognize that our work to improve is never done, that continuous improvement is key to food safety. Through the review process we determined where immediate improvements could be made and we made them. There is more to be done, and we welcome the guidance of this committee and of the independent investigator to advance this effort yet further.

Given the increased complexity of challenges in food safety, a number of steps have been taken to make improvements. Let me provide some examples. In December 2007 the government announced the food and consumer safety action plan to strengthen Canada's food and product safety system. Over the past year the agency has hired additional inspectors to provide front-line protection against food safety risks. Last year we established an academic advisory panel of independent experts to review food safety and public health protection. We have established an external audit committee to provide oversight to the operations of the agency, and for listeria control we put in place strong additional requirements for industry that will give us a better early warning system. We've stepped up our own verification testing to monitor industry compliance with those requirements. Dr. Evans will provide detail on this.

Let me conclude these brief remarks by assuring you that the CFIA is committed to food safety. Food safety is our number one priority. As an institution and as individuals, we are committed to doing the best job we can.

● (1820)

Following the events of last summer, we took a hard look at ourselves and immediately began to make changes. We did not wait to act. The events of last summer continue to guide our efforts to provide strengthened protection and detection. While it is important to understand the past, the job is left undone if we don't translate that understanding into action.

We appreciate the committee's guidance, as well as that of Sheila Weatherill, the independent investigator, in considering further improvements for all the partners in food safety.

Thank you. I will turn it over to Dr. Evans.

The Chair: Thank you.

Go ahead, Dr. Evans.

Dr. Brian Evans (Executive Vice-President, Canadian Food Inspection Agency): Thank you, Carole.

Thank you, Mr. Chair.

In full respect of the committee and their desire to question, I'll be as brief as possible.

Mr. Chairman, ladies and gentlemen, I appreciate the opportunity to appear before this committee, and I welcome your contributions to our sincere efforts to achieve the highest possible standards of health protection for Canadians.

As indicated, my name is Dr. Brian Evans. I am the executive vice-president of the Canadian Food Inspection Agency, and I serve as the Chief Veterinary Officer for Canada.

I'd also like to start by extending our profound sympathy to the families affected. It is clear that, collectively, we did not meet the expectations of Canadians.

I'll begin by giving you a brief timeline of the events of last summer related to the recall. I'll then talk a little bit about our meat inspection framework. Finally, I'd like to share with you what the CFIA and its government partners have done to strengthen our food safety system with regard to both the prevention and response to listeria to contribute to higher levels of protection.

With respect to the outbreak timeline....

● (1825)

[*Translation*]

The listeriosis outbreak began in early June and was detected by public health officials in Ontario over the ensuing seven weeks. Detailed investigative work at municipal and provincial levels led to their advising the CFIA on August 6, 2008, that a possible food link was suspected. As there has been some confusion around it, let me underline that date. It was on August 6 that the CFIA was first informed of a public health investigation into two listeriosis cases in a nursing home. Samples taken 16 days previously from meat used to make sandwiches in early July at the facility had tested positive.

Upon notification, a similar level of investigation was immediately undertaken to confirm the source of the contamination through multiple lines of inquiry. We needed to provide Canadians with credible information upon which to base their actions and decisions.

[*English*]

The investigation entailed determining the source of the meat products through purchasing and supply records, identification of the specific product, and the relevant lot and production codes that were used in the making of sandwiches from which the test samples had been taken. Once determined, a further search was undertaken, in cooperation with public health partners, based on distribution records to other locations in order to find an unopened package of the same type and code. This is critical in such investigations to ascertain whether the contamination of the product occurred during handling and preparation at the nursing home or whether the product had been contaminated at production.

A sample was located on August 12 and submitted to the CFIA food laboratory in Scarborough. Also on August 12, the CFIA was advised by another district health unit of two additional listeriosis illnesses in a hospital in Halton region and of positive test results on two samples of meat served at the hospital. However, the patients did not have a history of having consumed the product.

Based on these new developments, the CFIA office of food safety recall initiated a teleconference on August 13 to bring all the jurisdictions—municipal, provincial, and federal—together to review all the laboratory and epidemiological information. A detailed sampling plan to cover all products produced on the same production lines was shared with all the parties to assist in locating and collecting samples over the next two days for testing at the CFIA Scarborough laboratory. These calls continued for the next two days to facilitate information sharing and analysis, and to collectively determine if the evidence supported the conducting of an advisory or recall.

On the evening of Saturday, August 16, the CFIA laboratory confirmed that the sample collected on August 12 was positive for listeria monocytogenes. Although the molecular typing would not be available for another seven days to confirm that the isolate from the meat product matched those of the illnesses, a public health advisory was issued in the early morning hours of August 17.

I'd like to take a moment to talk about one area of our inspection activities that was frequently cited as germane to the listeria issues of last summer.

One of the techniques that governments around the world have adopted for effectively identifying and preventing food safety risks is called hazard analysis critical control points, or HACCP.

● (1830)

[*Translation*]

Its use has been mandatory in federally regulated food establishments in Canada since 2005. It is a standardized, internationally recognized system used by most of the developed world. An emphasis on prevention is absolutely critical in limiting the potential contamination of meat products with pathogens such as Listeria, given their presence in the environment. Traditional physical inspection approaches are not effective, as their presence cannot be detected by sensory means such as seeing, tasting, touching and smelling.

HACCP identifies the various stages in food production where food safety hazards are known to occur. A food safety check is inserted at these stages to detect and prevent problems early on. If a problem is found, corrective measures are immediately taken. This process puts the focus on the prevention of food safety risks rather than "after-the-fact" detection on end products.

[*English*]

This is not privatization. It serves to increase industry's accountability and efforts for the safety of the foods they produce. There has not, is not, and will not be any diminished role for investment by the government through the mandatory use of HACCP. The setting of standards, the verification of compliance, and the application of enforcement actions by government remain unchanged.

At the CFIA we use an inspection framework and tool set called the compliance verification system, or CVS. Essentially a detailed checklist that guides inspectors, it assures consistency and uniformity in our inspection activities and prescribes inspection frequencies. Again, the CVS does not change the government's role in establishing food safety standards, in verifying compliance with food safety requirements, or in our enforcement activities.

I would now like to provide some detail on what the CFIA has done in the aftermath of the events of last summer to strengthen food safety in the context of listeria as part of our ongoing commitment to continuous improvement. Our reviews of the events of last summer pointed to the need to enhance protocols and activities to strengthen protection against this potentially lethal pathogen. In parallel, we need to continue the same important work against other microbial threats to the food supply. This should not be a one-horse trick.

Specifically, we identified a previously unknown risk for the harbouring of organic material deep within slicers, in spite of their routine cleaning and sanitizing. We now direct industry to clean slicing equipment more thoroughly and aggressively. We have enhanced CFIA direct oversight and verification of equipment sanitation and equipment maintenance. Environmental testing for listeria in ready-to-eat meat establishments is now a mandatory component of an approved HACCP plan. Results of all environmental tests, as was previously prescribed for end product tests, are reviewed daily. We conduct trend analysis of positive test results for listeria in the plant environment. This is important, because looking at aggregate environmental tests over a period of time will provide us with early warning of potential problems so that corrective actions can be taken before a positive test is found in food. Environmental testing as part of the CFIA inspection tasks has been reintroduced, and along with government end product testing, this is occurring at a higher level of frequency. Investments have also been made at the laboratory with ongoing validation of new test methods and increased capacity to conduct genetic fingerprinting of isolates.

[*Translation*]

The CFIA worked with Health Canada to update directives regarding the control of Listeria in federally registered ready-to-eat meat processing plants. The improved directives focus on early detection and control of Listeria in the environment, to prevent the transfer of bacteria to contact surfaces and food. The CFIA proposed, discussed and challenged the revised directives and implementation strategies with food safety scientists, industry experts, inspection staff and relevant unions.

Full implementation of the new government product and environmental testing programs was completed on April 1, 2009. Furthermore, the CFIA will promote equivalency in these measures from our trading partners, with additional verifications of products imported into Canada.

● (1835)

[*English*]

Taken together, these actions will help reduce the chances of a similar outbreak occurring and will allow us to do a better job in the future of monitoring the shifts and trends in microbial pathogen presence in the operating environment of federal meat processing establishments.

In conclusion, listeria, as with other bacteria, is commonly present in food production environments. It can and must be controlled, but it cannot be entirely eliminated. The effort to control listeria is ongoing and requires a collective commitment. We welcome the work of this committee and its contribution to guiding additional investments to protecting Canadians.

Thank you for your time. We'd be pleased to respond.

The Chair: Thanks very much, Mr. Evans and Ms. Swan.

We'll move on to seven-minute rounds.

Ms. Duncan.

Ms. Kirsty Duncan: Thank you, Mr. Chair. Thank you to all of you for coming. We appreciate your comments.

I'm struggling with the lack of coordination regarding the investigation. CFIA, Health Canada, and the Public Health Agency have all been involved in pandemic planning, for example. The basics are the same: Who takes the lead? What is the reporting structure? What is the cycle of communication? I feel we've made the same mistakes regarding listeriosis as some that were made regarding SARS.

We've just had Maple Leaf here, and they discussed shared responsibility from both the company and the government authority. When we talked about SARS, it was shared understanding, shared responsibility, and shared lessons learned. I appreciate you've been very detailed in how you will go forward. You mentioned you took a hard look at yourselves and you took immediate action. I don't hear the word “responsibility”.

My question is going to be around who was to take leadership. Where was government oversight for this? I'll give some examples. You will have to bear with us because the dates are different in different reports.

CFIA informed the public health division and PHAC on August 13 that Maple Leaf was the manufacturer. Why was it two days later when the Halton Region Health Department issued an advisory to local homes about a possible link? Why didn't CFIA post a warning on its website? On the 13th, why was there no discussion among partners or communication to the public? Why didn't CFIA post a warning on its website until four days later, on the 17th? What other methods did it take to inform the public? Why did CFIA wait until the 19th to issue a health hazard alert, advising the public not to eat 23 ready-to-eat deli meats packaged at Maple Leaf?

I know this is not CFIA, but it's again government oversight. Why did the Chief Medical Officer of Health wait until the 20th to issue a public news release? Why did the Chief Medical Officer of Health wait until the 21st to notify the LHINs to ensure products on the CFIA list were thrown out? The Chief Medical Officer of Health ordered the preparation of clinical practice guidelines for front-line physicians at a still later date. These are real concerns. This is government oversight.

I'm going to add one more to that. This is a comment in the Ontario report. Because the local and provincial public health units were not directly involved in inspecting the plant, it was difficult for them to obtain information about its production processes and the extent to which contaminated products had been distributed across the province. Why was it difficult? Who made it difficult? How could these challenges have been circumvented?

My questions are really around government oversight.

● (1840)

Ms. Carole Swan: Thank you. Let me start, and I will ask Ryan to provide some additional detail.

You are quite right, food safety is an important, shared responsibility among a number of federal partners, provincial partners, municipal partners, and industry, as we've heard as well. The challenge is to make sure that people pursue their responsibilities and carry out their tasks with as much coordination as possible. I think we have learned a number of lessons from this particular experience, many of which we're putting in place now in terms of different protocols and different relationships.

I would point out that the CFIA focuses on the food part of this. This is not surprising.

You have raised a number of questions that I think the Public Health Agency of Canada will be able to address when they appear before this committee, related to the whole epidemiological work that was going on.

Ms. Kirsty Duncan: It's still government oversight.

Ms. Carole Swan: It is government oversight, absolutely. One of the things we found during this particular outbreak was that it was important for CFIA to bring people together. We did, in fact, starting on August 13, as I think you will have seen in our chronology, bring together all the partners to make sure there was a common base of understanding and that the facts were shared appropriately among all partners in the food safety chain.

I'm going to ask Brian to touch upon the timeline a little bit because I think it's important to understand that this is a complex timeline with a number of people becoming involved at different points in time.

Ms. Kirsty Duncan: Thank you. I appreciate that.

Before you go to Brian, does CFIA accept shared responsibility? As you point out, your interest is the food part.

Ms. Carole Swan: I think all partners in food safety would accept responsibility: the CFIA, other federal agencies, provincial ministries of health, and industry, as we've heard today. We all have a role to play in making sure food is safe for Canadians.

Ms. Kirsty Duncan: Thank you.

Dr. Brian Evans: Thank you for the question, honourable member.

Again, I take your points as very valid. I think if you look across the lessons learned, the issue of coordination, early engagement, and information sharing is a common theme that's been picked up by all jurisdictions. We're all passionate about getting it right. We're all passionate about bringing the best expertise we collectively have to a common purpose.

We do have protocols in place. We have a food-borne illness outbreak response protocol called the FIORP, which guides the activities of the federal government and the provincial government in the early stages of the epidemiological investigation and then transfers the lead from the province to the national lead on the epidemiological side when the outbreak extends beyond provincial borders.

At CFIA three years ago, we entered into a memorandum of understanding with the Ontario Ministry of Health and Long-Term Care to help guide these types of activities. It is fair to state that while we have the documents in place, they were not operationalized to the level that would have made them as effective as they could have been—and that is a work that needs to be further extended. It's one thing to have protocols in place, but if everybody doesn't act in accordance with them, or they're not aware of their roles, they are not effective protocols.

Ms. Kirsty Duncan: These are different illnesses.

The Chair: I'm sorry, Ms. Duncan, your time is up, if you're going to interject.

I'll let you finish, Mr. Evans, what you were talking about.

Dr. Brian Evans: I apologize to the member. We'll hopefully reconnect on another round.

Again, as Carole has indicated, what is really important about this is to put in true context for everybody not just the roles that people were playing but the information we were dealing with individually and collectively. The death of 22 individuals and the illnesses of some 57 individuals, as we've all identified, are not acceptable. It's tragic. Any preventable death is unacceptable, and our policy in CFIA is that any food-borne illness is not acceptable, even though that's probably a standard that nobody could ever meet.

At the time this was unfolding, it was unfolding in real time, as has been indicated by Dr. Williams in his message on Friday. It takes time for people to consume a product, to develop clinical illness, to take the decision to seek medical attention, and then, on the part of the medical community, if they receive patients, will they pursue symptomatic treatment or will they test? If they opt to test, it takes time for those results to come back and for them to be analyzed and collated. It is a time process.

What we were aware of, as CFIA, is this. On August 6 we were approached by one public health unit to advise us of two patients ill in one facility. That was the basis on which multiple lines of investigation started. As most food safety experts would say, the largest percentage of food-borne illness occurs in preparation and handling, not normally at production. So the early assessment of that circumstance, again, even with a common food source, would say not all members in the nursing home who had consumed food of the same type were ill. So again, there was no immediate predisposition to suggest that this was something much bigger that would lead to the end result, as Public Health hopefully will share.

The first confirmed death associated with this outbreak, in fact, was confirmed on August 23, a full week after the recall had been initiated. What triggered activities in bringing the jurisdictions together, as we've indicated, was that on August 12 a second public health unit contacted CFIA from a different region to indicate they had a hospital circumstance with two patients who were also ill. Again, this did not represent, in a traditional sense, a massive outbreak across the entire population nor even within those institutions. What was critical in coming to the determination on the advisory and alerting the public was being able to give credible information to the public that allowed them to take decisions to protect themselves and their families, either through their behaviours and/or their purchasing circumstances.

To that extent, from our perspective, the decision to issue an advisory.... All jurisdictions involved had the authority at the point that they felt that trigger had been met. That was part of the day-by-day discussions, and there was not agreement around the table that we had reached this point, primarily because, in truth, that threshold also takes into account very recent experiences that we've all gone through. There was reference earlier to the salmonella Saintpaul outbreak in the United States last year, which extended for some seven months on the basis that it was a tomato-based circumstance. It ultimately turned out not to be tomatoes but peppers.

We're also informed by the circumstance several years ago when there was an epidemiological determination that strawberries from California were in fact infected with cyclospora. That changed—on the advisory—the purchasing behaviour of people. They chose to buy other products. At the end of the day, one of the products they were buying was raspberries. It was determined that the true source of the outbreak was raspberries from Guatemala.

So we do recognize the importance and the primacy of sharing information with the public at the point that we can give them information that we feel will protect their interests and allow them to take an appropriate decision, but to give them information that we can't validate and perhaps put them at greater risk or cause them to change their behaviours.... Again, this was not a decision taken in isolation but one that involved the best experts for multiple jurisdictions to reach that level of conclusion.

● (1845)

The Chair: Thank you.

Before we go to Mr. Bellavance, as you will probably have noticed in the first two hours tonight, and in this one here, since this is a very important issue that we are studying, I'm being much more lenient with the time, and that's with everybody. I'm not going to accept any questions from any member after the seven or five minutes. I know some of it is very complicated testimony, but I must ask that we keep the answers as brief as possible. I'm going to be lenient, as I said, as I see fit, and you'll have to bear with me on that.

Mr. Bellavance, seven minutes, please.

[*Translation*]

Mr. André Bellavance: Thank you, Mr. Chairman.

I would like to thank our witnesses for their testimony.

I would like to clarify the issue of shared responsibility with you, Ms. Swan. In answering a question asked by Ms. Duncan, you said that the agency accepted that it had a role to play as regards food safety and public health. However, we are specifically interested in the events that occurred last year at the Maple Leaf plant in Toronto and that are the reason for this meeting of the subcommittee today. The fact is that Listeria was discovered in foods that were sold, and as a result, 21 people died. On this specific point, does the agency accept at least a share of the responsibility?

Mr. McCain told us earlier that he accepted full responsibility for what happened. That may be entirely to his credit, but the general public and we, their representatives, will think that the agency and other agencies and the government also have a responsibility regarding what happened. Does the agency accept some of this responsibility?

● (1850)

[*English*]

Ms. Carole Swan: Let me say that responsibility is shared across a number of fronts. It is government's basic responsibility to set standards for safe food, to hold industry accountable, to monitor, and to consequence industry when it fails to produce safe food. It is quite clearly industry's fundamental responsibility to produce safe food.

In terms of the recall, as I've mentioned, the ability to identify food-borne illness, the ability to warn the public, and the ability to make connections with a food substance are shared across a number of players federally, provincially, and municipally. I think it is fair to say that everyone involved in that continuum has a role to play.

[*Translation*]

Mr. André Bellavance: You do not accept a direct share of the responsibility for what happened last August at the Maple Leaf plant. In 1999 or 2000, the Auditor General stated in a report that one of the agency's problems was that it had a great deal of difficulty accepting its responsibility, at least publicly, because it was afraid of lawsuits. Is that what is preventing you from admitting today that you too have some responsibility for what happened?

[*English*]

Ms. Carole Swan: I have said, Mr. Bellavance, that there is a great deal of shared responsibility. CFIA is one player in a continuum of players who are responsible for making sure the food Canadians eat is safe. I can direct you to our "Lessons Learned" documents, which we worked at long and hard to make sure we could identify in the agency what had happened and what we could have done better. I find them to be quite stark documents. If you've read them, you'll know they're not public relations pieces. They are quite detailed, technical attempts to understand what happened, what didn't happen, and what we could do better.

[*Translation*]

Mr. André Bellavance: Perhaps you will not be able to answer my question immediately, but I would ask you to forward this information to us, where appropriate.

How many CFIA inspectors were at the Maple Leaf plant when this situation occurred? Let us take the months of July and August, for example. What exactly was their job there? Were these people working on the floor, inspecting the food? Were these inspectors there throughout all the operations? I think it is important to know these things. From the information we have obtained, the inspector at the contaminated Maple Leaf plant in Toronto was responsible for seven plants at the time of the listeriosis outbreak.

We are entitled to ask the following question: did the inspectors have enough time to ensure the plants for which they were responsible met the food safety requirements? Various pieces of information have been gleaned here and there since these events occurred. You can help us get some very specific answers. Is it true that this inspector was responsible for seven plants? Do you think that is appropriate? Is this how things should be, or do you think there is room for improvement?

Our objective is to ensure that tragedies of this type are as infrequent as possible. I know you cannot prevent everything. Mr. Evans said that, and we also realize that Listeria cannot be eradicated. It would be nice if we could, but that is not possible. Listeria is always present.

This subcommittee can definitely try to find some improvements. Would one improvement not be to ensure, first of all, that there are enough inspectors, and second, that they do not have more bureaucratic duties than actual work on the floor?

● (1855)

[*English*]

Ms. Carole Swan: Thank you, Monsieur Bellavance.

I'm going to ask vice-president of operations, Cam Prince, who has a direct relationship with our inspection workforce, to answer your question specifically about the inspectors in the plant and the work they did.

Mr. Cameron Prince (Vice-President, Operations, Canadian Food Inspection Agency): Thank you for the question.

At the Maple Leaf Bartor Road plant, we had at that time, the time you specified, two inspectors. There were two shifts. Each inspector would have been present on the day shift or on the night shift. And it is true, as you indicated, Monsieur Bellavance, that the one inspector on the day shift had seven facilities that he was looking after. His primary facility was the Maple Leaf Bartor Road plant. He had his office there. He operated from that plant. He spent most of his time at that plant.

Four of the seven facilities, in fact, were not really plants as we think of them. They were cold storages. Those cold storages are registered with the federal government, and the work at those cold storages is for export certification and the inspection of imports. It's important work. It's not as time-consuming as in-plant inspections.

As far as the workload and what they were doing in the plant, these inspectors were operating under the system Dr. Evans mentioned—the compliance verification system—which very clearly sets out tasks for each inspector and targets risk areas. It sort of rotates between certain parts of the plant and certain functions, such as sanitation, employee hygiene, and construction—all these types of things. In that plant, those tasks were completed, as prescribed by the program, by those two inspectors. They had to have been busy, I'm sure, but they did meet all those tasks, and we have that documented.

As far as time spent on the plant floor, this is something that's been talked about quite a bit since last summer. The allegation seems to be that inspectors don't have an opportunity to walk around the plant, look at the construction, talk to employees, and look at the equipment. In fact, that's an integral part of what an inspector does.

I had the opportunity last fall to go across the country and meet with more than 100 inspectors to discuss this and other really important issues and how they felt about this. The consensus was that the compliance verification system is a good system. It had some growing pains, but they were able to spend an adequate amount of time on the plant floor. Our records indicate that about 50% of their time is spent on the plant floor. They're looking at the whole system. They're looking at the plant records and making sure that they're all appropriate, and then they're going out onto the plant floor and verifying that those things are done correctly.

The Chair: Thank you, Mr. Prince.

Mr. Allen, seven minutes.

Mr. Malcolm Allen: Thank you, Mr. Chair.

Thank you all for coming.

Let me just read a line from what we heard earlier: "Most Canadians first heard of *Listeria* from us, despite how common it is." Those are the words of Michael McCain earlier this evening. It begs the question, at least for me, on behalf of Canadians.... Mr. McCain, by all means, as the spokesperson and CEO of Maple Leaf, has a responsibility, and may indeed want to speak about his responsibility, and he did do that. But where were we, as government agencies, whether that be Public Health, if you believe that's appropriate, the Minister of Agriculture, who is responsible for CFIA, or the Minister of Health, who is responsible for the health of the country? Where were they in all of this process?

I think if you went out this door and walked down Wellington Street and asked ten Canadians, who do you think speaks about listeriosis, they would say Maple Leaf or Michael McCain. I think that's an indictment of us, as a government, and it's an indictment of the systems we've put in place to protect Canadians that the CEO of the affected company is seen as the true spokesperson. As well intentioned as he was, as forthright as he was, and as honest as he was, that's not his responsibility. His responsibility is to speak for Maple Leaf, and he's done that. Our responsibility is to Canadians, and it seems to me we fell down on that one. I'd like a response on that.

I'll go to Mr. Prince because I see he is the operations manager. I have a couple of things. I don't know if you can answer them at the moment or not, but you can get back to us, as Mr. Bellavance has said. The information we received in the House from the minister was that 200 new inspectors were hired. Could you break that down for me as to who actually works in meat inspection and who works on the plant floor?

We also heard there is going to be an additional 58 inspectors hired. Have they been hired, and if so, are they doing meat inspection or are they doing other things? As you articulated through your opening statements, you do many other things besides simply meat inspection, which is highly important. You look at imports, you look at foreign plant material, and you look at foreign species of insects, which can have devastating effects across this country. So there are other things you do. You also have specialists who work in labs and all those sorts of different places. When folks think of CFIA, they sometimes think everybody is inspecting meat or food substances, and that's not necessarily the case.

Could I get comments on those two specifics?

● (1900)

Dr. Brian Evans: Thank you, honourable member.

Very briefly, on the issue of what I believe Mr. Michael McCain was alluding to, the issue of consumer awareness or consumer education is a very significant element of a robust food safety system. We certainly do have an obligation to inform Canadians of risk and how those risks are being mitigated on their behalf.

With respect to listeriosis, and listeria itself, in fact there has been advice to the public, and issues on listeria have been posted on the Health Canada website for a long period of time. The issue is, are we keeping it current and are we keeping it in front of Canadians so that it resonates with them? I think that's a very honest question that we have to collectively look at. But there certainly has been information available to Canadians on the website and through the "Healthy Canadians" website that speaks to the risks associated with listeria, and the risks particularly for vulnerable populations, those who are immuno-compromised, those who are aged, women who are pregnant, and young children.

So that information is out there, but we need to keep it out there and visible at all times for people to really understand what risks do exist and what they can also be doing in terms of proper food handling to deal not just with listeria, but I would say equally with E. coli, with salmonella, and with campylobacter. As people have pointed out, these are risks that you can't see, you can't smell, you can't taste, and you can't touch. So you need to know that it's there and you need to be taking precautions at all points across that.

Again, we fully accept this obligation to educate, to inform, and to keep ourselves aware.

Mr. Cameron Prince: I probably won't be able to answer all of your detailed questions on numbers, but certainly I can give you some initial responses, and we'd be very happy to provide additional information later on.

Since the agency was created, the number of front-line inspectors has steadily gone up, and we currently have 3,228 front-line inspectors. Of those, 1,467 are in the meat program. We did hire the additional 200; you would like more information on that, I understand, and certainly we can provide that to you in writing as soon as possible.

Mr. Malcolm Allen: Thank you for that.

I understand what you're saying about the education component, and that's admirable, but let's not be mistaken that somehow everyone is hooked into the Internet. A great many Canadians across this land don't have access. In fact, this summer I gave up using mine. When you're still hooked into dial-up, you don't do it anymore. And I'm pretty savvy; I know how to use it. I have the equipment. I don't have to go to my public library like a lot of folks do.

So that becomes an issue unto itself, but clearly when we were looking at a situation where Maple Leaf foods, and Michael McCain as the CEO, thought he needed to do something in a public manner that we didn't do, he communicated openly through every means he had available to him—through an Internet website, through the press, through press conferencing—making sure he became the public face of listeriosis. He's a private person and a private operator of a company that was affected by that.

Where was our public face across this country that asked what we needed to disseminate information? I've said it to Mr. McCain, and I'll say it here again: I believe Mr. McCain did everything humanly possible and was as open and honest as he humanly could be, but it was his plant that the contaminated food came from. How do you restore trust and confidence in the public if it's not our face out there saying here's how you have faith and trust in the process, when someone from private industry who is affected by it is saying...? We could have supplemented...in fact, we should be leading. He would have been the supplement to us as that voice, so we could have been saying what you needed to do, what was happening, the recall was happening, what you do next in the process, and absolutely could have helped Mr. McCain and Maple Leaf by being the validator of all these correct things. I didn't see that, and Canadians who talked to me in my riding are saying they didn't see it either. I'm wondering why we didn't.

● (1905)

Dr. Brian Evans: I think we all, as CFIA and Canadians, recognize the outstanding work that Mr. McCain did in terms of bringing issues forward to Canadians in a very responsible, timely, transparent way. He's to be commended for that. We encourage all industry leaders, and government leaders, to follow that model.

I can honestly indicate to the committee that efforts were made to inform the public beyond the use of the Internet, for sure. In our food recall unit, during that period of time, there were—I believe the figure is over 400—media calls that were responded to in the agency by food safety specialists to try to get information into print media. Over and above that, subsequent to the initial release, when we went to the expanded recall on August 23, I think, as the other honourable member has pointed out, from that point forward, initially technical briefings were held by Dr. David Butler-Jones, the Chief Public Health Officer, to share information about listeria and the events that were unfolding.

There was a briefing as well involving Minister Ritz and some of our technical staff, and daily technical briefings were provided for over a 14-day period from the latter part of August through until early September. So on a daily basis, officials were made available, press were notified, and we made people available to share information about how the recall itself was progressing, the steps that were being taken, the identification of the products, to help Canadians, to remind Canadians...again, at that time of year, if you've been at the cottage and somehow you've not been aware, these are the things you need to be looking for. You should be looking at your freezer at home, and on the long weekend you should be looking in the refrigerator at the cottage as well.

So while I can appreciate the views that perhaps the messages weren't picked up, certainly there was a concerted effort and a considerable investment made by a number of people both to respond to media and to be out there trying to get the information out to Canadians. Lesson learned: we obviously didn't hit the mark; we need to review why that was.

The Chair: Your time has expired, Mr. Allen.

Mr. Anderson, for seven minutes.

Mr. David Anderson: Thank you, Mr. Chair.

I want to talk a little bit about some of the specifics of the environmental testing and then missed opportunities. I've taken a quick look at the "Lessons Learned" reports, and I just want to talk a little bit about those. It appears to me CFIA did its job according to the protocols and the information it had at the time.

Mr. Evans, last summer you said, "Now, in hindsight, we do recognize that environmental testing is a critical component of food safety." I want to ask either you or Ms. Swan this. In 2005, under the previous government, mandatory environmental testing was removed. Is that correct?

Dr. Brian Evans: At no time were there mandatory requirements for industry to do environmental testing.

Up until 2005, as the government, we were conducting environmental testing on a twice-per-year basis. With the introduction of mandatory HACCP in 2005, the greater percentage of the industry undertook to do environmental sampling. Even prior to 2005, some level of the industry was doing environmental sampling at a level of intensity much greater than that of the government.

● (1910)

Mr. David Anderson: Did they have a responsibility then to report back to you? It's out of your "Lessons Learned" report, in section 4.2, and I'll quote:

> Subsequent to the outbreak, Est 97B

—which is the Maple Leaf plant—

> staff provided the CFIA with documentation that the environmental sampling program for Est. 97B had identified positive results for Listeria spp. on a number of occasions between May - August.

They were not required then to report to you?

Dr. Brian Evans: It's been a regulatory requirement for a number of years that should they detect...on end product testing there is a legal obligation for them to report. But there was no legal obligation for them to report to us immediately on an environmental sample that was positive. They did have obligations, themselves, to conduct sanitation and to retest. Based on the Health Canada policy at the time, a retest that was negative following sanitation was deemed to have addressed the insult.

Mr. David Anderson: Did those changes in 2005 affect the end product sampling at all?

Dr. Brian Evans: No. The end product testing has persisted on the part of both the federal government and the industry, and in fact it has also been ramped up in response to the circumstance as well.

Mr. David Anderson: If those changes hadn't been made in 2005, then is it possible that the problem could have been caught sooner than it was? Could a recall have taken place earlier? What's your opinion on that? Or could it have been prevented entirely?

Dr. Brian Evans: I can give you my considered scientific opinion; I can't speculate as to whether it would guarantee that we would have found the circumstance.

Again, I think the difficult reality of the consequences that occurred last summer was that there were unknowns about this issue of the ability for slicers and equipment.... The issue of what happened last summer was multi-factoral. There were a number of contributing factors. I think Mr. McCain and others, and even our own assessment beyond the investigation done by Maple Leaf, indicated that there were a number of factors in the plant in terms of product movement, people movement, situation of elevators, positive pressure movements, and other things that were detected in terms of equipment.

Having said that, what was critical to this whole event was this determination at the end of the day that in spite of cleaning and disinfection and breaking down of equipment according to manufacturers' specifications, beyond the cutting and contact surfaces, a new threat, a new issue, was identified in this particular circumstance, which we had no knowledge about, that could colonize deep into the equipment and well away from the normal operating events. That, in combination with the fact that a product that in true terms is recognized to have higher health consequences to vulnerable populations....

One of the parts of the tragedy of this is that the vast majority of people who died and who had illness last year were a vulnerable population. The fact that these products were being served in institutions without cooking, and other factors, is another critical element to this.

So to say that doing environmental testing twice a year would have found this I suspect would not have stopped it at the level of the plant.

Mr. David Anderson: The changes that were made April 1, 2009, by our government have instituted mandatory testing. Are these going to deal with that in an adequate way, then?

Dr. Brian Evans: Having identified this previously unknown risk, we believe we have—and this is important to the memory of those... and to those families who have lost loved ones—prevented, to a large extent, this type of scenario from unfolding again in the future.

The measures that have been introduced from April 1 include mandatory environmental testing within the HACCP plans conducted by industry. There is mandatory reporting of those results, on a daily basis, or on review by our staff. When those samples are submitted to a private accredited lab, a positive sample is also directly notified to CFIA by the accredited lab. There is the reintroduction of environmental testing by CFIA at a greater frequency than we had been doing previously. Over and above that, there is the continuation, at a greater frequency, of end product testing both by government and by industry.

Mr. David Anderson: I want to talk a bit about the timeframe that Ms. Duncan was talking about earlier. It seems your report says it took a number of valuable days to trace where the meat came from, that there wasn't enough information with the original sampling, and that perhaps some of the sampling procedures were not performed properly. I want your opinion on that.

The Ontario report said the original samples collected July 21 were routine samples. Was there enough information with those original samples to do an effective recall? You talked a bit about this before, but what would you have needed at that point to do a recall?

Dr. Brian Evans: Again, a number of the reports, ours and Ontario's, recognized the need for ensuring that when samples are taken in these types of circumstances, they're identified as high priority for testing on the basis that we are actually dealing with investigating food-borne illness, in this particular case, as opposed to randomly testing in the environment. The second component of that reality, again, is that when the samples were taken, these were samples that were what are called retention samples. The hospital retains the elements of the foods that are served to the patients for a period of time, should the circumstance warrant.

These were samples for meat. There were retention samples, so meat was placed into a retention box with cheese, with lettuce, with other elements of the sandwich, and held at the location. Part of the challenge was, while it was identified as meat, there was no way to verify that the cross-contamination couldn't come from one of the other elements and how it was maintained at the nursing home.

Beyond that, even identifying it as meat, there were no identifiers at that time as to the production, in terms of whether there was an establishment number, a production date, a lot code, anything that would have given us earlier information to help narrow it down, based on the supply records of those supplying the nursing home, so that we could fix it on a date. Nor was there any information available from the nursing home that linked the actual production dates, per se, with what was put into the sandwiches. So, again, this was part of that information verification activity that we were confronted with on August 6, and we worked closely, then, with Toronto Public Health to gather that information.

● (1915)

Mr. David Anderson: So you have the capacity—

The Chair: Sorry, your time has expired, Mr. Anderson.

Mr. Easter, five minutes.

Hon. Wayne Easter: Thank you, Mr. Chair.

Thank you, folks, for coming.

Ms. Swan, you are the president of the Canadian Food Inspection Agency. I'm correct, right?

Ms. Carole Swan: Yes, you are correct.

Hon. Wayne Easter: Well, let's try this question one more time. Who is ultimately responsible for food safety in this country?

Ms. Carole Swan: Government is responsible for setting strong standards, monitoring industry, and holding them to account. Industry is responsible for producing safe food in this country.

Hon. Wayne Easter: Ms. Swan, I respectfully disagree, and I disagree strenuously.

You answered a question earlier—and I think it was to Mr. Bellavance—and you said it was quite clearly industry's responsibility for the safety of food. Ultimately, I believe it to be the Government of Canada and the Canadian Food Inspection Agency. I submit, Ms. Swan, it is your responsibility, as president, to oversee food safety in this country.

Ms. Swan, I don't pull any punches. Based on your response to that question, I really have to question whether or not you, as president, are up to the task of being in charge of the food safety system of this country. I'll just lay it right out on the table right now, because I am shocked by that answer. I am shocked that the president of the Canadian Food Inspection Agency would sit here and transfer blame to industry. I'm shocked.

Now, what happened in the listeriosis crisis...and Mr. McCain accepted full responsibility at the time. He did here today. What would have happened if it had been ABC Meat Packing Company with 40 employees? Would that individual have had the resources or been capable of going out there to be the face for food safety in the public arena?

You and the minister were both missing in action last year. The Canadian public wanted some transparency and honesty from the government and they never got it. And I submit here today, I'm questioning whether we're getting it from you.

I'm shocked by that answer. Would you reconsider?

Ms. Carole Swan: Mr. Easter, responsibility for food safety does not reside in one person or one institution. There is a network of people and organizations responsible. Government has an important responsibility. We are responsible for setting strong standards and holding industry to account. But ultimately industry has responsibilities as well. They have responsibilities for producing safe food.

Hon. Wayne Easter: I believe the buck stops here someplace, Ms. Swan, and I believe it stops at your desk. I'm shocked, but anyway, we'll set that aside for the moment.

In terms of the chronology of events, when asked a question in the House today, the Ontario Chief Medical Officer of Health confirmed that CFIA was involved in a conference call on July 30 concerning the listeriosis outbreak, yet documents released on Friday by the CFIA—and you said it here again, Mr. Evans—indicated it first became aware of the crisis on August 6.

Why the discrepancy in terms of the dates? We have the Williams report. The date is in there. Why that discrepancy?

● (1920)

Dr. Brian Evans: Honourable member, if I could say, I spoke with Dr. David Williams earlier today, and one of the areas I identified with Dr. Williams was the fact that we did not have an alignment in our understanding. We've gone to great lengths to try to determine who from CFIA might have been involved in any call that occurred on July 30. We have the point of contact established—the recall coordinators in Ontario. They are the primary point of contact for district health units and the Ontario Ministry of Health and Long-term Care and the Office of the Chief Medical Officer of Health. There was no verification from their level that they participated in such a call.

The Public Health Agency of Canada, which has indicated that they in fact coordinated that call on behalf of the Ontario Ministry of Health and Long-term Care to assess and get a better understanding of the small spike in listeriosis cases they had seen and to work with them to provide a common investigative protocol, has clearly indicated to us that their records show they did not invite CFIA to the call, and they have no record of CFIA participating in the call.

When I spoke with Dr. David Williams this afternoon about this particular issue, and others—because it is an important issue of fact—he commented that there were multiple calls taking place with multiple people on the line, and that it's very difficult to know who was there. They legitimately thought it was a federal call, which would have incorporated that family, but he has no definitive evidence to suggest that we were in fact on that call.

So between verifying with the organizers of the call and the roll call and verifying with our contacts both in the Office of Food Safety and Recall here in Ottawa and our people on the ground in Ontario, we have tried desperately to get to the bottom of that circumstance. At this point, all the evidence we've been able to come up with points to the fact that we were not on the call on July 30.

The Chair: Your time has expired, Mr. Easter.

Mr. Bezan, for five minutes.

Mr. James Bezan (Selkirk—Interlake, CPC): Thank you, Mr. Chair.

I also want to thank our witnesses for showing up.

I have to take exception to Mr. Easter's comments. He wants to lay all of the blame on the federal minister and the federal departments, and he's essentially saying that people are missing in action. Well, the Minister of Agriculture was holding press conferences every day from August 24 to September 5 to relate to the public exactly what was happening.

So if Mr. Easter wants to sit around and start pointing fingers, maybe he needs to look in the mirror. When he was parliamentary secretary to the Minister of Agriculture back in 2005, they were the ones who cut the funding for mandatory testing of listeriosis through an environmental test. So if he really wants to start thinking about the big picture here, he also needs to put himself in the group of suspects so that we can actually get down to the basis of this.

I want to go back to the comments Dr. Evans was making. I think it's important that you made the comment about HACCP. I know that through this process last summer there were a lot of stories in the media and a lot of issues that were coming up from the opposition about HACCP being an example of privatization. I'm glad you said that it does not actually involve privatization. This approach has been going on for 15 to 20 years, when the HACCP protocol was first developed and brought into the meat processing industry and the food processing industry. We were even talking about it at the farm gate, of doing these things as well as farm HACCP, noting that it essentially increased accountability and provided a paper trail.

So if HACCP weren't in place, would listeriosis and this situation have been caught sooner, or would there have been someone else looking at this? Would this just have fallen through the cracks and actually made your job more difficult?

Dr. Brian Evans: Thank you for the question.

Again, it is well known to the members of this committee and others that the HACCP application to food safety was actually developed several decades ago in the United States by the Pillsbury Company, when they were contracted by NASA to develop food safety programs for astronauts, because obviously it would be catastrophic if an astronaut developed a food-borne illness in space in the absence of medical attention. The development of that programming, as was indicated, has been adapted. It is the gold standard, as referenced by the United Nations groups on food safety, Codex Alimentarius, and the World Health Organization. It is advocated globally as the best standard or the best way, because it allows you to map known risks, to map and document, as you've indicated, how you will manage that risk, and then to document—through verification—that you did what you said you would do. When things don't work out properly, it then provides the framework to go back and verify properly where the breakdown was. It's real-time analysis and a real-time response. It doesn't wait for someone to find the problem later on.

I'm a firm believer that in the absence of HACCP this issue would not have been identified. I suspect that some of the very important work done by Maple Leaf Foods in their internal assessment was to relook at their HACCP plan, to look at the unidentified risk and try to come to a.... It was actually the HACCP that said to them that if they were getting positives in the environment and then getting negatives after sanitation, but it kept persisting, there was then something in their HACCP plan saying there was something about the location they needed to rethink.

So I think HACCP helped them arrive at a conclusion much earlier than would otherwise have been the case.

● (1925)

Mr. James Bezan: So you hear the stories in the media and people talking about how we need to have an army of white-coat inspectors right through every food processing facility, but that would not have made one iota of difference probably, because we already had the HACCP in place; we had the certified compliance verification system in place. There's already been a lot done that helped us get to the results in a timely manner.

Dr. Brian Evans: Again, this is not me speaking as a member of the Food Inspection Agency, but certainly in our discussions with our academic panel, certainly in our discussions with experts outside of Canada, there is this recognition collectively across the board that you cannot inspect, you cannot test your way to food safety. Food safety is a culture. Food safety, as you've indicated, starts at the farm. It starts with input. It starts with everybody along the chain having that opportunity to identify risk, whether it's E. coli or something else, and to mitigate it to the best extent possible. It's not about risk transfer, it's not about consequence transfer; it's about managing it at the earliest opportunity that you can identify it and having effective mitigation.

The presence of a massive inspection regime, in and of itself.... Again, on the basis of what we learned out of this, there was a previously unknown risk factor that would not have changed, I believe, the timeliness of the discovery. This was a concerted team effort across a number of jurisdictions to get to the bottom of the circumstance, for sure. As we said, traditional inspection, organoleptic inspection, which was largely physical presence—looking, tasting, testing, and poking—is not effective in dealing with these types of risks as they continue to evolve within the food system, and it does take our continuous efforts to improve inspection technologies to figure out how we find them as quickly as possible and how we respond to them as quickly as possible.

Mr. James Bezan: Now, I agree with you that—

The Chair: Your time is up, Mr. Bezan. You're well over. I have to treat everybody the same.

Before we move on to our second round—and I meant to read this at the start—Mr. Allen, you had a motion that was presented before the committee just before the break in regard to some documents from the minister's office. I understand those documents were delivered to the clerk's office earlier today, and I understand they'll be sent for translation and will be ready, hopefully, for our meeting on Wednesday.

Mr. Malcolm Allen: Thank you, Mr. Chair.

The Chair: Okay, we're on to our next round.

Ms. Duncan, again, for seven minutes.

An hon. member: [*Inaudible—editor*]

The Chair: No, we finished our first round, everybody, so we're going to start our second round—our first full round, I'll put it that way.

Ms. Duncan, seven minutes—no, five minutes, sorry.

Ms. Kirsty Duncan: Thank you, Mr. Chair.

I'm going to present a number of questions. The first will focus on laboratory testing.

Is there any way for the federal government to streamline the steps involved in testing for listeriosis from hospital and private labs to, for example, the Ontario public health laboratory and the National Microbiology Laboratory in Winnipeg for fingerprinting? What backup systems exist if one or more labs are unavailable? What action might the federal government take to increase greater regional laboratory capacity?

I now have some specific questions. Why was there a delay—August 13—in requesting unopened samples of food from Maple Leaf when the first food results were available on August 6?

Why didn't the CFIA or, better yet, the Chief Medical Officer of Health order a recall of packaged meat products? Why was it left to the corporation to do, and why was it voluntary?

I'm wondering if there is a minimum standard, i.e. number of cases, contaminated food samples, deaths, higher-than-average number of cases, that would have triggered concern regarding listeriosis and then triggered subsequent health advisories to the public.

If I may add one last question, I think we all appreciate very much how Maple Leaf responded. There's one inconsistency. Maple Leaf undertook a voluntary recall, temporarily shut down the plant, and made a public apology when government failed to do so. Why did Maple Leaf not go public on August 13 when it notified selected customers asking them not to use products with the same product codes as the Toronto sample? What did “selected customers” mean? Did it include all customers? If not, who were left out? What systems were in place to identify the number of locations and establishments that received product during the outbreak?

Thank you.

● (1930)

The Vice-Chair (Hon. Wayne Easter): Ms. Swan or Mr. Evans.

Dr. Brian Evans: I'd like to address the first issue, on lab capacity, and then I would ask Paul Mayers if he could respond to the subsequent questions posed by the member.

With respect to lab capacity, streamlining tests, etc., this comes back largely to part of your coordination opportunity question. As we've said, we've tried to be very frank in our report, because the circumstance warrants us being very frank, in light of what happened.

We have lab capacity regionally. We have a food lab in Scarborough since the events in this particular circumstance, and it was critical to some of the food sampling once CFIA was actively engaged, as of the 6th, because it has the capacity to do culture for listeria. In fact, it was the sample submitted to them on the 12th, which was returned to us on the 16th, four days later, that triggered our advisory and the voluntary recall.

On the issue of backup systems, since that time not only have we expanded our lab capacity, but the lab has always been available to operate on a 24/7 basis, and it does operate on a 24/7 basis when we're involved in active investigation mode. Over and above that, we've also expanded it to the extent of getting it certified to do the PFGE or the fingerprint testing again so it can be done in one site, as opposed to multiple sites. So we believe we do provide federal regional support in the area if the provincial jurisdiction chooses to pursue that.

Again, we will continue at CFIA to work in parallel with Health Canada, because part of this also says that we need to continue to invest in test methods development. We need to get the tests that can be used either in food products or on contact surfaces that give us earlier results than the current gold standard of a culture test.

Ms. Kirsty Duncan: So this is a real change since the outbreak?

Dr. Brian Evans: That's correct.

If you're okay with that, I would ask Paul if he could respond to your other points.

Mr. Paul Mayers (Associate Vice-President, Programs, Canadian Food Inspection Agency): Thank you very much.

Let me start with the issue of a minimum standard to trigger concern, because it is an extremely important consideration.

My colleague earlier noted that what we seek to do is to be in a position to provide information to Canadians that allows them to take action in their own interest. In order to do that, there is a certain minimum amount of information that we need. We need to be able to point them to a food that we have a reasonable certainty is associated, so that we don't modify behaviour in a way that might have negative consequences for the public. That becomes very important, and frankly characterizes our minimum standard.

What that means is, once informed on the 6th, we launched multiple lines of inquiry in order to reach that point, that minimum standard, that would allow us to communicate that to Canadians. Unfortunately, the information we received on the 6th didn't specifically identify the products associated with the sample, as you heard Brian explain. That was the focus, in fact, of our investigative activities, to get to a point where we could rule out contamination in the preparation facility and identify, if indeed a particular plant was involved, what particular products, so that Canadians could be informed. That is the minimum standard.

● (1935)

The Chair: Thank you very much, Mr. Mayers.

Mr. Bellavance, five minutes.

[*Translation*]

Mr. André Bellavance: Thank you very much.

Despite what the government claims, when we talk about the investigation headed by Ms. Weatherhill, we are not questioning her competency, but rather the lack of transparency regarding the inquiry implemented by the government. This individual, who will conduct her investigation in private, is accountable only to the Minister of Agriculture and Agri-Food), or the Prime Minister's Office. That is who she will submit her report to in July, apparently. However, neither the public nor parliamentarians will really know what is happening. I want to clarify this because transparency is the reason for this subcommittee.

With regard to the files that have been established since the beginning of the listeriosis crisis, questions, grey zones persist with regard to the role of the agency and the meetings that it held and information that is still unknown. You are here, Mr. Evans, and that is a good thing because you have been at the centre of a controversy in this regard. In fact, a meeting with Maple Leaf took place on July 24, 2008. This controversy might not have gotten bigger if you and Maple Leaf had admitted that listeriosis was discussed during that meeting. This meeting took place two weeks before we learned about this pathogen discovered at the Maple Leaf plant in Toronto.

Based on the articles I have here, two parties, meaning the agency and the company, denied from the start that Listeria and bacteria in general had been discussed during that meeting. First, I wonder why you denied this only to later admit that it had been discussed, but that the discussion did not focus fully on that issue. The public still believes however that you denied that this discussion had taken place.

Furthermore, information was made public following media request under the Access to Information Act, but the Canadian Food Inspection Agency had hidden some information. I would like to know whether you are prepared today to ensure transparency by telling us what that information was and why it was hidden. Someone in the agency made some comments, but then refused to say any more. Minister Ritz's office refused to make the slightest comment. We are talking about transparency. We are talking about an event that caused the death of 21 individuals and eroded public confidence in our food safety system, which has been undermined as a result of what has happened.

The subcommittee is trying to determine what happened, but we are also trying to ensure that insofar as possible, this never happens again. We want everyone to be able to admit their mistakes and their responsibilities. That is why I'm asking you today whether you can tell us what was discussed at the July 24 meeting and, if information is still hidden, then why so. I want to know if you are able to divulge that information. I am telling you that if we obtain a satisfactory answer, we will move on.

[*English*]

Dr. Brian Evans: Thank you, Monsieur Bellavance. It's a very important question.

I've appeared before committee on multiple occasions. My commitment to public service and my commitment to Canadians is not in doubt, I hope, with this committee.

I would point out very clearly that, yes, there was a meeting on July 24 with one of the representatives from Maple Leaf Foods. In the disclosure it was indicated very clearly that this meeting had been originally scheduled for February, earlier in the year, but because of other commitments it had had to be postponed and cancelled because I was not available. This was also part of the ATIP release. In fact, this was a deferred meeting. I was contacted by Maple Leaf officials about a week before July 24. They indicated they were coming into town for other meetings and asked if we could re-engage on those issues that we hadn't been able to talk about in February.

In the Access to Information Act and the Privacy Act there are provisions that indicate issues that might relate to corporate interests and issues that might relate to.... In effect, we talked about seven different topics, and it was clearly indicated in the meeting notes that we talked about seven different topics. Some of those topics dealt with internal Maple Leaf restructuring, which was deemed by those people responsible for ATIP to be information private to the company, and at CFIA we did not have the option to disclose that.

The Access to Information Act also looks at issues as they relate to other departments. In our discussions with Maple Leaf we also talked about some of the technical negotiations that we, as Canada, were involved with on food safety at the global level. We and Maple Leaf have been very clear about this. Because the discussion made specific reference to engagement with other countries, it was deemed by Foreign Affairs and by other officials to be confidential government-to-government information.

There was never a denial that we talked about microbial issues. The inference in the press was that we talked about listeria and the Canadian circumstance with listeria. We were very clear, when pressed on that issue, that listeria specifically was not mentioned. What we did talk about—and I think Mr. McCain raised it here as well—was that it's very important for Canada to ensure that whatever standards apply to domestic industry in this country also apply to imports.

Members of this committee will recall that at that particular time we had gone through a circumstance with one of our trading partners in which it had increased border testing, or import testing, of Canadian products, and the nature of that discussion was to outline to them some of the activities we were undertaking to ensure reciprocity in microbial testing. It covered listeria, E. coli, campylobacter, and salmonella. That was the only context in which listeria was mentioned.

I personally apologize to this committee, I personally apologize to Canadians, and I personally apologize to any media if there's any inference from what we discussed that there was any information provided to us at that time by Maple Leaf that gave us any early indication of a problem in the plant. As we've indicated, we did not become aware of an issue of listeria operating in Canada that could have a food source until August 6.

● (1940)

The Chair: Thank you.

Your time has expired.

Go ahead, Mr. Allen, for five minutes.

Mr. Malcolm Allen: Thank you, Mr. Chair.

I'll make more of a statement, on the first piece, as we talk about this issue—and I spoke to it earlier—on who the public face is. Since you've put together a large document on lessons learned, perhaps one of the lessons should be looking at the late Dr. Sheela Basrur in Toronto in relation to SARS. She really was the public face, a public figure about a very public epidemic. That's what I was trying to allude to in the questions when I talked earlier to you about the sense of who the public face is, and I think she becomes.... In her memory, at least, perhaps we ought to look at that situation to see if we can learn a lesson.

Let me talk a little more about this idea of compliance verification systems. I think that might probably go to Mr. Prince again, but anyone is free to take it up.

My understanding is that there is such a system within CFIA and that your inspectors do that sort of thing, but one of the things I've been made aware of—and hopefully you can verify it for me—is that although you normally do pre-operational compliance verifications during the summer period when producers are down or not working, last summer there was actually a cancellation of overtime, and inspections for compliance verifications didn't go into facilities that were down. This has been my understanding. Perhaps you could comment on that. I don't know if Mr. Prince is going to take that on, but if you could comment on it, I'd appreciate it.

Mr. Cameron Prince: Yes, certainly; I welcome the question.

Last summer there was really no change in terms of cancellation of overtime. In fact, we've always approved essential overtime.

I want to come back to the point about inspection of equipment and inspection of sanitation procedures. Going back to my earlier comments, we had two inspectors in the plant. At the night shift, there was an opportunity for that second inspector to have a look at the company employees actually cleaning equipment. He got to see, just immediately after the shift, the pre-operational cleanup and so on. So there was plenty of opportunity through the course of that working day of two shifts for our inspectors to do pre-operational inspections.

I'll just leave it at that. If you have any further questions, I can answer them for you.

● (1945)

Mr. Malcolm Allen: I guess that begs two questions in response.

One, is that normally how we do compliance verification—in between shifts? It sounds more to the effect of what's called a preventive maintenance program, which I'm quite familiar with. It's called PPM work. Industries do that in a global structure. That isn't quite the same, it seems to me, as compliance verification, which is a more stringent piece that you want to be doing. It isn't between shifts or in between lots of things that are done.

The other part is that this was more of a general question, Mr. Prince. It wasn't specific to just Maple Leaf. Yet I think that's what you were referencing when you talked about two inspectors. This question was more general. It may well be there too, but really what I'm asking is whether compliance verifications were being done by CFIA inspectors at all locations, right across this country, when they should have been. Were some missed because of an overtime policy that perhaps was getting in the way of allowing that to happen?

Mr. Cameron Prince: The overtime policy did not get in the way of completion of the compliance verification tasks. In fact, there was no limitation or cancellation of overtime.

The compliance verification tasks require various elements, including pre-operational and post-operational inspections. That's part of the overall approach. Those things are covered off in the course of a month or a year as we rotate through the various elements of the plan.

Mr. Malcolm Allen: I think I have some time left, Mr. Chair?

The Chair: You have a minute.

Mr. Malcolm Allen: Thank you. You can see my questions are short, Mr. Chair.

I guess the question I'm really asking—maybe you can't answer it for me right this very minute, but maybe you can provide the information—is this: was all of the compliance verification testing done that should have been done last year all across this country? If it was done, and you can provide the documentation to show it, I would appreciate it. If it wasn't done, can you identify the plants where it wasn't done?

Mr. Cameron Prince: I can't answer your question right now. I can't sit here and say that every single compliance verification task in every meat plant across Canada last year was done. That would be impossible for me to say. But we certainly can provide you with some data in that regard fairly quickly as to what was done in each of the plants.

Mr. Malcolm Allen: I appreciate that. Thank you.

The Chair: Mr. Anderson, five minutes.

Mr. David Anderson: Thank you, Mr. Chair.

I'd actually like to go to the discussion about some of the other participants in this whole scenario. The Ontario public health officer on Friday, in their lessons learned report, basically said that they think the level of evidence is too high, that you wouldn't.... I guess you were accused of not letting them into the plants and sharing information adequately.

I think the timeline shows that you were talking to Ontario officials, so I want to ask you some specific questions about that. Was the CFIA engaged with Ontario officials from August 7 onward?

Dr. Brian Evans: We actually have the individual here from the Office of Food Safety and Recall who was the lead contact point on this. If you would like to speak to him directly, Mr. Anderson, he could walk you through it.

Alternatively, I can say unequivocally that in fact we had good working relations. Again, bear in mind that what we were engaged with, or informed about on August 6 by Toronto Public Health, was a single location with two illnesses. That relationship worked extremely well over the course of the summer, we believe, although there's always room for improvement.

I think it has been pointed out that in fact we did engage with Toronto Public Health. We did not preclude their entry into the plant. We have no authority to stop them from going into the plant. Under Ontario provincial law, they have very strong authorities. They have the right to go into the plant under their own authorities without being escorted or admitted by CFIA.

Mr. David Anderson: Did they participate in that, or did they choose not to?

Dr. Brian Evans: As part of the early process, we had earnest discussions with them about the merits of doing an occupational health and safety assessment in the plant, in the context that potentially, once listeria was identified as a factor in the plant, that would have impacts on employees of the plant itself. Alternatively, could there have been an employee in the plant who was already infected that was a contributing factor? In fact, they did itemize what it was they would like to do as part of the audit team, and they were part of the audit team that went into the plant during the shutdown period to determine root cause analysis of what had happened in the plant. I think it has also been well articulated that in fact we did receive a letter of appreciation from Toronto Public Health for our cooperation, for our information sharing, that helped them be as effective as they thought they could be.

● (1950)

Mr. David Anderson: So you feel that you provided them with all the relevant information you could and the records that they needed when you were working with them, from your perspective.

Dr. Brian Evans: We recognize, and I'm sure others would recognize it as well, that information exchange in these circumstances is extremely critical. We worked very hard to provide the information in a timely manner that people were looking for. Part of that was making sure the information we had was relevant to what was happening, that it was in a format we could all collectively use, and that the analysis indicated it would take us to where we needed to go.

Part of what we need to revisit, I think, as we fine-tune the existing arrangements with all the jurisdictions, is that we have a clear understanding of how information is exchanged, what the time standards are to do that, and what the processes are to make it happen as quickly as possible.

Again coming back to my discussions with Dr. Williams this afternoon, this is one of the areas about which we wanted to assure him, that if he had a specific information need that he felt was outstanding, if they could identify it to us we would ensure they had it before the close of this week. He is reviewing with his staff whether there are any outstanding information requests that they feel would be relevant to the ongoing improvement of activities.

Mr. David Anderson: Because Maple Leaf was cooperating and it was deemed that a mandatory recall wasn't necessary, would things have gone more quickly if there had been a mandatory recall? Or does this fit into that experience you're talking about where you need to determine that there's an issue before you can move?

Dr. Brian Evans: No. Unfortunately, I think people are misconstruing "mandatory recall". While it is true that under the CFIA Act, section 19, the minister has the authority to require a recall, by obligation, by law, this power is normally executed where a company is either not in a position—they've gone bankrupt—or they've refused to cooperate.

In fact, by all standards, a voluntary recall is much more effective than a mandatory recall, because you not only have your own staff—in our case working with public health units—to go out and verify effectiveness checks and trace through the distribution chain. Normally in a voluntary recall, the company itself contributes by making their salespersons, their distributors, also available to carry out those functions. In fact, voluntary recalls actually unfold in much faster time with a much higher level of achievement than a mandatory recall, where you're working with a supplier who is not being cooperative.

Mr. David Anderson: You may not know this, but I'm wondering, had this been a provincial plant, would it have been possible to enforce a mandatory recall, or would that have typically been done through a voluntary recall as well?

Dr. Brian Evans: I would certainly like to confirm this officially with all the provinces and territories. I know that Quebec has mandatory recall policy in this area in provincial jurisdiction. I would like to verify with all other jurisdictions before I would answer that definitively.

As I said, I know that Ontario officials have extraordinary powers under the Health Information Protection Act, as do the district health units, which in many cases exceed our authorities. I can't say definitively what the trigger in Ontario would be, or the definition of mandatory recall, but we'd be pleased to get that for you.

The Chair: Your time has expired, Mr. Anderson.

Five minutes, Mr. Easter.

Hon. Wayne Easter: Thank you, Mr. Chair.

With respect to the Maple Leaf plant itself, at the time of this incident, was there a pilot program under way with respect to inspection activity, in other words, taking the approach of more of an oversight role and actually direct inspections?

Dr. Brian Evans: There were no pilot inspection activities under way at the time of the circumstance, honourable member. The compliance verification program, in fact, was piloted in 123 different ready-to-eat meat establishments as part of the validation process. That had taken place over the previous two years, including Maple Leaf. Maple Leaf was part of the pilots over the previous two-year period. So as of April 1, when it was made mandatory across the system, there was in fact no inspection regime change in Maple Leaf. They had already been operating under that system for an extended period of time.

Hon. Wayne Easter: Just to make sure I have this correct, you're saying the project was piloted, and then the inspection system changed to what was trialled as a pilot. Is that correct?

● (1955)

Dr. Brian Evans: Yes. As I say, the pilots were validated, and over the previous two years their effectiveness was confirmed. Maple Leaf was part of that system, along with 123 other plants. When that was then extended to other plants, it had already been tested and verified in other locations, so on April 1, there was no change whatsoever to what was going on in Maple Leaf when it was instituted nationally across other jurisdictions.

Hon. Wayne Easter: Thank you.

Earlier, when Maple Leaf was before us as a witness, we were talking about the slicer in question. I have talked to—and he, in fact, will be a witness before the committee—one of the previous employees of CFIA, who was an auditor of the auditors. It was his view that if CFIA had been doing things properly, manufacturers' specifications wouldn't have been followed; that unit would have been looked at more closely by CFIA auditors themselves, and maybe—not necessarily, but maybe—the problem would have been found, in a preventive sense.

What are your thoughts on that? Has there been a weakening of the audit system over the years? And that doesn't have to be recently; it could be five, six, or ten years ago.

Dr. Brian Evans: My response to that, honourable member, is at two levels.

In previous discussions I've had with Dr. Randy Huffman, who I believe was accompanying Mr. Michael McCain earlier today, and drawing on his broad experience again...these—for lack of a better term—slicers, because that's how they're referred to, are monstrous machines. These are computerized. These things are bigger than my car. To insinuate that we, at CFIA, would have the ability or engineering skills to dismantle or go further than the manufacturer's ability.... First and foremost, I don't think most companies would let us do that, because they might not get them back together again by the time we were done with them. These machines require a strong degree of sophistication in order to be disassembled to the point where you would find something that was contributing to this circumstance.

With respect to the audit, I can honestly say that there was a time, going back to 1999, when in fact we did annual verification audits that were quite extensive. What we determined from that, of course, was that in 1999 we would be better off to do audits quarterly than annually, because, again, doing so would give us a much more intense look, on a more frequent basis, than we would have if we waited for a year for these things to happen.

So, in fact, there was an adjustment in 1999 to go from an annual audit to quarterly FSEP and verification audits, to increase that frequency, and to find things in a faster way. So that program, in effect, ran up until the start of this year, with the quarterly audits being undertaken. And then through the piloting of CVS, the major components of that audit system were then incorporated into daily, weekly, and monthly activities through the CVS program.

To infer that in fact we, at CFIA, were somehow dismantling slicers on our own in past years I don't think is accurate, sir.

Hon. Wayne Easter: That's not what I'm saying, but I do know that in the drug manufacturing area equipment is dismantled.

Dr. Brian Evans: Yes.

The Chair: Your time has expired.

Mr. Bezan, you have five minutes.

Mr. James Bezan: Thank you, Mr. Chair.

I just want to go back to this whole issue of shared responsibility. You look at the production side, and we were talking before about having the farmer involved, having the food processor, and in the food processing area you have multiple levels of people involved in that, and you often have other companies. Especially as you move up the processing chain, there are more places where you source the product to bring it into processing. After that, you have distribution; you have food retailers, you have the food service industry, and then, ultimately, it gets to the consumers, who also have some responsibility for how they keep it at home.

And then you look at the shared responsibility from the regulatory standpoint. You have CFIA; you have the Canadian Public Health Agency; you have provincial organizations, as well as municipal ones. You were already talking about how the Toronto health board was involved in this as well. You have so many people at play here that the question really becomes, who's in charge? Who's the lead agency? And even if CFIA is the lead, are you independent or are you still dependent upon your processes, in collaboration with all these other agencies?

Dr. Evans or Ms. Swan, would you like to answer?

● (2000)

Ms. Carole Swan: Thank you.

Let me start by talking about the independence of CFIA, because it's something we really haven't discussed with this committee today in terms of the food recall.

We have an Office of Food Safety and Recall that is in charge of doing our food safety recall when we have a suspicion that a food is the reason for a food-borne illness. That office operates independently. They have protocols that require them to take action as soon as they suspect something. They have sampling plans, go out to industry, and make sure that as quickly as possible, when we are involved in a food safety investigation, the CFIA is on the case.

We talked earlier about standards, and standards for recall. When there is a food safety recall we try to make sure information goes to consumers that allows them to take some kind of reasonable action. We heard from colleagues that in the past there have been occasions when misinformation has gone out. There was the example of the possibility of infection of strawberries. Consumers were alerted early, although no specific product at that point had been identified as a source of the food-borne illness. There was a change in behaviour from strawberries to raspberries, and it turned out at the end of the day that raspberries were the culprit. So we take our responsibility very seriously.

There is an issue on which we look forward to receiving guidance from this committee. At what point is it appropriate, reasonable, and in the best interests of the consumer—which is our angle on this—to make sure there is notification and that information that is actionable is given out? As the food safety regulator, the CFIA has done that when we can identify a food and say to the consumer, "This is contaminated." However, we think we can have a good dialogue about the point at which we should enter into that kind of discussion with the consumer, and we look forward to the advice of the committee.

Mr. James Bezan: So right now you have established protocols with provinces like Ontario to respond to food-borne illnesses. In the situation of the Maple Leaf listeriosis contamination, could the Ontario public health agency have issued their own food recall, as long as it involved the CFIA food safety and recall office?

Ms. Carole Swan: There are many players who could have issued information. "Recall" implies that you know what specific food you're recalling, and you're able to tell consumers, "It is this product with this best-before date." But there are many other opportunities for issuing information advisories to consumers.

Mr. James Bezan: So who would have been the lead on issuing those advisories? Could the Ontario Chief Medical Officer of Health have provided those advisories, done all the press conferences, and been the lead spokesperson on such an outbreak?

Dr. Brian Evans: Certainly the authorities do exist and have been exercised in the past. Recently, most people would recognize what occurred in North Bay at one of the restaurant chains. It was local, but was subsequently found to be in other parts of Ontario. Ontario was the lead face in managing that because it remained constrained to Ontario at that time.

As indicated here, advisories to the public are an important tool, and we all recognize that. It is extremely important to establish what that threshold is.

In this circumstance, through daily calls that took place from August 13 to 15, we aspired to have that dialogue between public health units, Ontario Public Health, PHAC, Health Canada, and ourselves. That was an important element of the discussions each and every day, so no decisions were being taken in isolation. But on the basis of those calls we all agreed we needed to go further so we could provide a level of information that would allow the consumers to take an appropriate defence posture.

The Chair: Your time has expired, Mr. Bezan.

Mr. Easter.

Hon. Wayne Easter: When you came in with your new protocols on listeriosis, one of your expert advisers, Rick Holley, was quoted in an article on CanWest news services on the new testing rules on ready-to-eat meats. He said this:

> From a regulatory perspective, yes, I think that it serves as a clear indication to industry that government is serious about this.

But he believes, and states in the article:

> In a large operation, such as we see in companies the size of Maple Leaf, they would be well advised to increase food-contact surface sampling frequencies beyond the description and the scaffold that has been given by this document.

He was talking about your announced plan. Maple Leaf clearly indicated to us earlier that for a considerable time they have tended to go beyond established rules or practices.

What are your thoughts on that statement, Brian?

● (2005)

Dr. Brian Evans: I have tremendous respect for Dr. Holley, his colleagues at the University of Manitoba, and the good work they do in food safety. Dr. Holley raises a valid point—one size does not fit all. What we've attempted to do, with the introduction of mandatory testing under HACCP, is to establish a baseline with which the company assessments and our more frequent assessments can be related. What we're keen to do in this process, now that we have that established and we know there's a consistent way of looking at this, is to take it to the next level. This will mean looking at the individual risk profiles of plants—volume, type of product, destination of marketing, use of food processing aids that inhibit microbial growth, adoption of sodium diacetate. I think there was some media coverage recently about an operation in Ontario that has introduced a new packaging technology in which there's high pressure applied to the packaging following the cook stage and the filling of the packaging. This technology will also reduce or inhibit the growth of listeria.

Having that baseline—and I think this is fully in line with what Dr. Holley is saying—we can adjust it over time to incorporate best practices. If we find a problem, either through our testing or through the trends analysis in the company testing, we have the authority to ratchet that up immediately and go further. So it doesn't mean that it's static at any time, and I think this is in keeping with where Dr. Holley is going. You can't be dependent on environmental testing alone. There are other things you have to be able to do. But with respect to environmental testing, it's important that we have a threshold, and that we have the capacity to go further. This will include environmental testing in other areas and it will be based on compliance, performance, and consideration of other factors in the plant, such as new technologies, that would reduce the level of regulatory intervention but still achieve the food safety outcome.

Hon. Wayne Easter: I think it's accurate to say one size doesn't fit all. With regard to David's earlier question on some of the smaller plants across the country, if we impose the same rules on all the plants based on size, then we could jeopardize the economic livelihood of some smaller plants across the country.

The bottom line has to be food safety, no question about it. But one size doesn't fit all. There are different criteria that may meet the same objective, depending on the size of a plant and the products that the operation handles.

Dr. Brian Evans: I concur, and I hope my comments reflected your summation. Food safety comes first. But in any good inspection system, in any good regulatory system, if new information comes forward, based on the level of monitoring we're doing, and it doesn't appear that other factors in the plant are adequately controlling, there are other authorities that we can exercise. We can stop production. We can suspend the licence. We can do any number of things. At the same time, we can also look at other ways of helping to get them back into compliance. Ultimately, food safety does come first and we have to exercise our authority in the public interest, while recognizing that other dynamics come into play.

The Chair: Mr. Anderson.

Mr. David Anderson: I want to affirm what Mr. Easter said. I think it's important for this committee—particularly for those of us who have an agricultural background—that a baseline be set that protects people without being unrealistic for smaller operators. Earlier tonight, Mr. McCain was suggesting that one size would fit all. I agree with you that this is not the case. So we look for some wisdom from you in that area.

I want to talk a bit about your lessons learned and then I will ask a few questions. Some of these you may have partly answered before. In your report, you stated that you should have activated the National Emergency Operations Centre. You also have CFIA's Office of Food Safety and Recall. Can you tell me about those two parts of your operation? How do they work together, or how should they have worked together in this situation?

● (2010)

Dr. Brian Evans: Thank you for the question.

I think people need to understand what the lessons learned really were intended to achieve. As President Swan has indicated, in effect we have this Office of Food Safety and Recall. It operates 24 hours a day, seven days a week, 365 days a year. It doesn't stop. It works full time all the time. Therefore, it is in itself an operational centre that is equipped to handle most emergencies as they occur.

Once we were into the circumstances in the week of August 14 and the information was starting to build that it was beyond one or two facilities and one or two people...the reality was that we had discussions with the Public Health Agency, who were activating their emergency centre, because on August 14 it was recognized that in fact there were illnesses outside of Ontario. This had moved from a provincial focus to a national focus. So we embedded ourselves in their operation centre. We had people deployed to be with them full time to make sure we were coordinated, sharing information, understanding what the needs were that we could supply directly to them.

What we realized in hindsight by doing this is that it's still the right thing to do, and we would do it again, but by not activating our own emergency operations centre, what we lost was an internal capacity to track the information, to document the information in real time. Again, it had no impact whatsoever in terms of speeding up recall. It had no impact whatsoever in speeding up the investigation. But when we went back to do the lessons learned, we had to go to multiple places to get the consolidated history. If we had operated a national emergency centre...you operate then with what's called the "war diary", so it's minute by minute, who spoke to who, what was said, and if there was a decision taken, what information did you know at that time on which to base the decision.

In hindsight, that type of compilation, which is very important in terms of when you do go back and do lessons learned...we had to rebuild that to some extent, so that's what that issue gets at. Even though we were embedded with PHAC and operating very closely within their operation centre, the fact that we didn't have our own internal single point of information gathering meant that when we went back to do the review, we had to pull that all back together again.

Mr. David Anderson: I'm going to cut you off there.

Dr. Brian Evans: I'm done.

Mr. David Anderson: I appreciate that answer.

Secondly, you've taken some steps to try to prevent a similar outbreak in the future. How do our new listeria prevention mechanisms stack up to other countries? Are they as good? Do they compare well with other countries?

Then I have one other question, because we're going to run out of time. Have you cooperated with the independent investigator, and do you believe from what you've seen of her work that she's doing a thorough examination?

Dr. Brian Evans: For respect of brevity, honourable member, I'll ask Paul to answer the first question and perhaps the president to answer the second.

Mr. Paul Mayers: Thank you very much.

Our controls would be characterized as being consistent with or exceeding the controls in any of the developed countries that have similar food safety systems. The combination of environmental testing and end product testing conducted by the industry, complemented and overseen by the verification testing that the Government of Canada does through the Canadian Food Inspection Agency, provides a set of controls that now in some cases exceed the requirements elsewhere.

Did I miss a part of the question?

Dr. Brian Evans: No, you did very well on the question. I just wanted to clarify again, because it did come up in a previous question from the other side here, that having made those adjustments in our system, it's now incumbent on us in our import verification activities—and I think this comes back to a point that Mr. McCain has made publicly many times—to make sure that we're not allowing product into the country that isn't meeting our standard in terms of what our domestic production standards are.

That was the only point of clarification.

Ms. Carole Swan: On the last part of your question, the CFIA is committed to complete cooperation with the independent investigator.

Mr. David Anderson: Does she seem to be doing a thorough job?

Ms. Carole Swan: She's been meeting with a number of CFIA officials, and we've been providing a large amount of information to her.

The Chair: Thank you very much. Your time has expired.

As it is now 8:15 p.m., I'd like to thank all of you for coming in today. There was some pretty intense questioning, I think, and I appreciate your time here.

We'll now adjourn until 4 p.m. on Wednesday.

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