

Codex-Standard on (micro)-biological Crisis and Outbreak Management

A "need to have" guidance

CCFH49 17-11-16 Zanne Dittlau

Food borne outbreaks – a matter that's concerns all of us

An estimated 600 million – almost 1 in 10 people in the world – fall ill after eating contaminated food and 420 000 die every year.

Foodborne diseases impede socioeconomic development by straining health care systems, and harming national economies, tourism and trade

Food supply chains now cross multiple national borders. Good collaboration between governments, producers and consumers helps ensure food safety

A cross-country and cross institutional network of efficient global preparedness against food borne diseases with standardized methods and standardized interpretation and exchange of results is essential.

A common Codex guideline is an essential step in the right direction



Ingrediens in a successful investigation and case handling

Denmark has a comprehensive system in place and the system is based on a large and necessary governmental cooperation as well as a good knowledge of and cooperation with companies and industries both nationally and internationally.

Competent health and food authorities handling:

- Human surveillance / analyses data
- Food/veterinary surveillance / analyses data
- Laboratory capacity and methodology
- Epidemiological methods and means of data collection/ evaluation
- Knowledge on food technology and consumption patterns
- Food control systems and traceability (national and international)
- International trade and communication

However there is always room for improvement



28/4-2014

A sample of lamb meat roll sausage was taken in line with normal official control. The sample was found positive for Listeria monocytogenes.

6/5-2014

The batch of lamb meat roll sausage was withdrawn from the marked. The product had "only" been sold to catering, institutions and to one establishment for further processing / slicing.

10/7-2014

State Serum Institute reports an outbreak of listeriosis with distinct type ST224. At the time of the outbreak SSI had 4 cases dating back to 2013 and 13 cases from May to July 2014.

10 of the cases were fatal

Interviews were ongoing at the time. And new cases were expected.



SSI (human) and DTU (food) compared listeria isolates by WGS. Initial comparison showed no match between food isolates and human isolates however one food isolate seemed to be closer related than others.

16/7-2014

New analyses were started on this isolate towards the human isolates performed at the same equipment at SSI.

18/7-2014

Suspicion was raised by SSI that some of the cases had acquired the infection from food served at institutions to where they were admitted (hospital and/or nursing home). Information on the locations were forwarded to DVFA for further tracing in the period between 18/7 and 25/7-2014. At this time the outbreak counted 29 cases and was growing



28/7-2014 to 7/8-2014

Interviews revealed that "suspicious" food items was served at 4 institutions where the patients had been hospitalized and that they related to FBO "X" and "Y" directly og indirectly. Evidence was found that products from two establishments could be the source of contamination: Products from FBO "X" and products from FBO "Y". "Y" received products from "X" for further slicing besides their own production.

7/8-2014

Result of the new analyses on isolates was ready – A match between the lambs meat roll sausage and cases was found and reported by SSI.

8/8-2014

Inspection with sampling of products and environment was performed at FBO "X". Until that date only on sample had shown Listeria monocytogenes in the period from 2012 to 7/8 2014.



11/8-2014

Results of samples were received: 1 environment sample was positive and samples from 9 products showed presence of Listeria monocytogenes.

11/8-2014

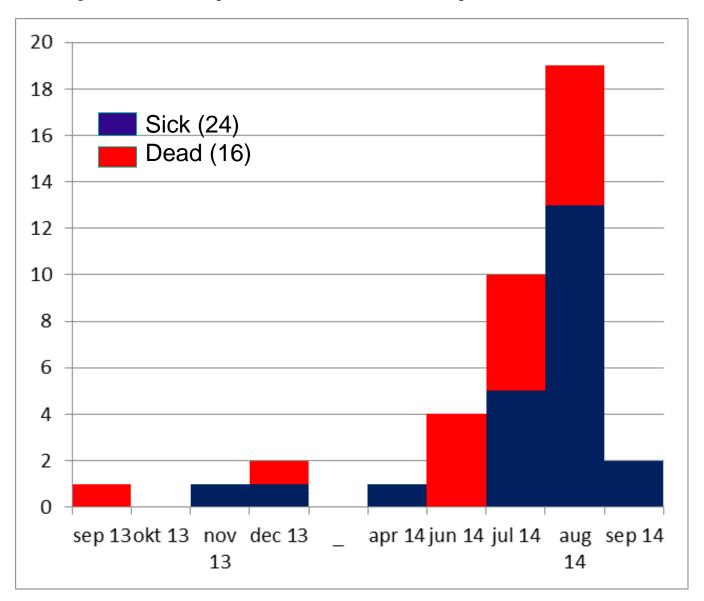
Sampling was performed at FBO "Y" and two establishments more which initially had received products from FBO "X" for further packing or processing.

The recall was initiated on the 11/8 including all FBO's which had received products from FBO "X" and all products produced at FBO "X" from the 28th of April to the 11th of August 2014 (everything on the market, stored and frozen). Inspection at all recipients was performed (> 6000 establishments)

The recall was proved effective - the outbreak stopped.

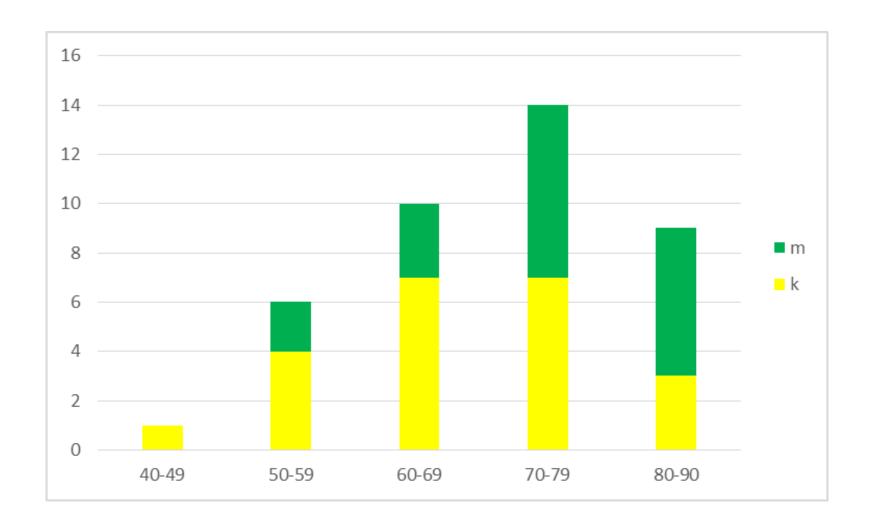


Epicurve september 2013 – september 2014



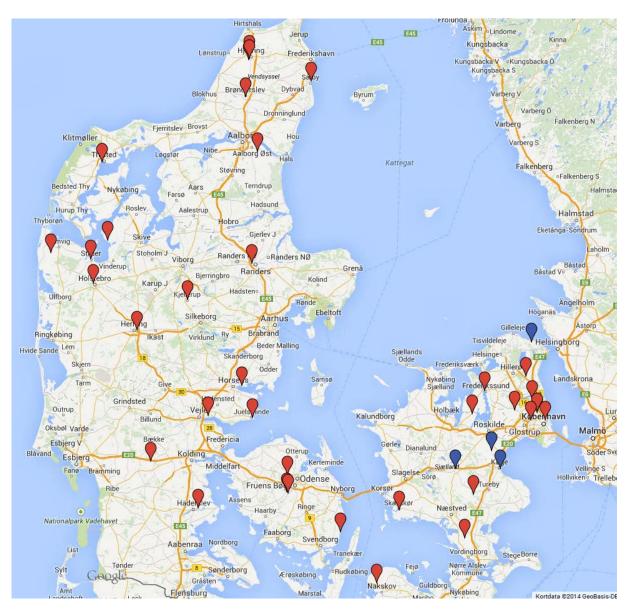


Gender and age N=40





Geografi september 2013 - september 2014 N=40





2013: 4



Consequences of the listeriosis outbreak

Press and political level

During the process the political level was informed multiple times including at the 8/8-2014.

The Ministry and Minister of Agriculture at the time were not satisfied with the work performed by the DVFA at the beginning of the outbreak investigation.

Especially the media interest in the outbreak put pressure on the ministry to solve the case.

By the 15/8-2014 this resulted in the removal of the responsible head of section in the DVFA.

This was actually put forward to the media by the Minister himself.

A largescale investigation and redrafting of the Listeria control system was performed. Better options for control and better tools were created and are still being developed.



Consequences of the listeriosis outbreak

What happened to the establishments involved?

A case like this is very costly for an establishment. In this case the FBO "X" did never recover and was closed down.

The premises were sold and a new establishment started production under another name, but existed for less than a ear. It seemed that the very address was connected with the possibility of Listeria contamination.

The second establishment FBO "Y" survived the incident and has later been moved to other premises.

Resources used at the DVFA

2 primary part inspections incl. sampling 22 secondary part inspections incl. sampling in 5 FBO's >6000 inspections in 3-5. part inspections A total of approx. 6100 hours in one week eq. of the entire national official control in 3 days



Conclusions from the 2013-2014 outbreak on Listeria

More focus on early detection and improved preparedness



Sampling at FBO "X" could have been instigated already in the beginning of July 2014 - we might have been able to see the problem already then.



Tracing as a response to the suspicion raised by the SSI on food items served at institutions was not fast enough



The information provided was not sufficient to pinpoint the correct period for tracing. Better reporting schemes needed between authorities.



Corrections to the information already provided by both SSI and establishments took time.



Sampling at FBO "Y" could have been instigated already in the end of July on suspicion raised during the initial tracing information from the items served at institutions.



Better communication and fixed procedures internally in the DVFA and between Authorities



-Coordinated Communication to the media, public, stakeholders, 14 trade partners etc.

Working tools – Handbooks on Outbreaks, recall and withdrawel







Outbreak of Listeria monocytogenes ST8 from cold-smoked salmon in 2017

July 2017

Listeria monocytogenes is detected in one sample of cold smoked salmon taken during a retail sampling project.

Follow up sampling on more lots was performed by the DVFA to assess if this was a single incident or could be a more widespread problem.

23. August 2017

The health authorities (SSI) reports an outbreak of Listeria monocytogenes ST8 with 5 patients Comparison of human and food isolates showed clustering with the listeria strain found in the first food isolate and patient isolates.

30 August 2017

Follow up samples taken at the central storage of the retailer showed 3 positive samples from the same producer.



Outbreak of Listeria monocytogenes ST8 from cold-smoked salmon in 2017

30. August 2017

Recall of all cold smoked and gravad salmon from the producer was performed by the retail chain.

30. August 2017

Results were reported in the European warning systems (RASFF and EWRS/EPIS).

26. October 2017

France responded to these notifications – one patient had been seen in 2016 in France and also a food isolate from September 2017 from the same establishment.

Response from the competent authorities of the producer of the product is still awaited.

The Danish retail chain has temporarily stopped marketing products from this producer. When marketing is resumed the DVFA will consider taking follow up samples to assess if the products are safe.



Why is the new work proposed important?

- No single Codex standard exist covering all aspects of handling a food crisis / food borne outbreak.
- The development world wide in trade and means of communication creates greater demands for rapid and solid information in cases concerning food crises – in order to control the situation and diminish eventual losses (lives and monetary).
- The development in means of analyses and comparative analyses creates greater possibilities for detecting and solving food crises but also puts pressure on the authorities.

What are the ingredients in a successful investigation and case handling – Danish experiences

A network of representatives with "hands on experience" from all competent authorities involved in solving and handling food crises / outbreaks enabling access to:

- Human surveillance / analyses data
- Food/veterinary surveillance / analyses data
- Laboratory capacity and methodology
- Epidemiological methods and means of data collection/ evaluation
- Knowledge on food technology and consumption patterns
- Food control systems and traceability (national and international)
- International trade and communication

The possibility to build up experience and develop effective and coordinated procedures for handling, containing and communicating a food crisis.



How may a successful investigation and case handling be achieved?

Our experience is

- that crises/outbreaks handled in <u>cooperation between</u> <u>relevant authorities</u> in a <u>coordinated way</u> often results in the cases being solved and contained with the lowest costs for all parties.
- that crises are best handled by the responsible authorities within their <u>existing structural framework</u> at the <u>lowest</u> <u>possible level</u>
- that it is essential to <u>know your partners</u> and their capacities before a crisis occur
- that the work must be performed in <u>mutual respect of the responsabilities of each participant/authority</u>



How may a successful investigation and case handling be achieved?

 that <u>communication</u> to the public, stakeholders, establishments, trade partners etc. should be done <u>in a</u> <u>coordinated way</u> and in a timely manner to avoid confusion and obstructions in the trade.

In order to achieve this – we need common guidelines!

