Ep. 33. Maple Leaf Foods: Food Safety After Tragedy

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Introduction

Stacy: Hello everyone and welcome to Food Safety Matters, the podcast for food safety professionals. I'm Stacy Atchison, publisher *Food Safety Magazine*, and I'm very pleased to bring you an episode that, frankly, we only dreamed of being able to present to you. It's important. It's engaging. It's inspiring. And, sets a bit of a challenge to the food industry.

Recently, we were quite honored to receive a call from Randy Huffman, Chief Food Safety and Sustainability Officer at Maple Leaf Foods. We've known and worked with Randy for many, many years. He reached out to say that as Maple Leaf Foods approached the 10-year commemoration of the *Listeria* tragedy that killed 23 people in 2008, that he and Maple Leaf's CEO, Michael McCain, would like to come on the podcast and share with the industry the story of the outbreak and the effects that it's had on Maple Leaf foods.

Listeners to the podcast and food safety professionals throughout the world know how important it is to have a food safety culture that starts at the very top and works through every aspect of a company. Still, it remains relatively rare to have a CEO who would take the step to sit down for this type of discussion. So, we want to thank you, Michael, for your willingness to share your story and your powerful example of what food safety leadership looks like in practice. Not just during a crisis, but every day.

Before we hear the interview, I'd like to give you a little background on the company and the event that has forever changed it.

Maple Leaf Foods is a leading consumer protein company, making high quality, innovative products under national brands including Maple Leaf, Maple Leaf Prime, Maple Leaf Natural Selections, Schneider's, Schneider's Country Naturals, Mino Light Life, and Field Roast Grain Meat Company. Maple Leaf is one of Canada's flagship food companies, with sales of $3.3 billion. It employs approximately 11,500 people. And it does business in Canada, the U.S., and Asia. Maple Leaf is headquartered in Mississauga, Ontario.

In August of 2008, Maple Leaf foods initiated the largest recall in the company's history. Three SKUs of deli products manufactured at Maple Leaf Food's Barter Road facility in Toronto, Ontario, were found contaminated with *Listeria monocytogenes* and linked to illness and death.

Products were distributed to food service customers including groups to have a high risk for contracting listeriosis. To contain risk, a decision was made to close the plant and recall all products back to January of 2008. This involved a massive recall of 191 products. In total, 23 people died, and thousands became ill as a result of this food safety crisis. One of the largest and most serious in Canadian history.

As we mentioned, Michael McCain is President and Chief Executive Officer at Maple Leaf Foods. Michael has devoted his career to the food industry. Starting at McCain foods in the late '70s, where he held a variety of roles, including President and Chief Executive Officer of McCain Foods USA. He joined Maple Leaf Foods in 1995. Since then, he's been instrumental in establishing Maple Leaf as a strong and sustainable, values-based company with leading brands and a bold vision for the future.

Dr. Randy Huffman joined Maple Leaf in 2009 and is currently Chief Food Safety and Sustainability Officer at the company. This role encompasses food safety and quality, occupational health, safety and security, environmental sustainability and compliance, animal care, and corporate engineering. Randy also leads the company's Food Safety Advisory Council, a team of external experts with the mandate to increase Maple Leaf's access to global knowledge and expertise in food safety,

including best practices, regulatory compliance, microbiology, and fostering a food safety culture.

Prior to joining Maple Leaf Foods, Randy served as President of the American Meat Institute Foundation, as well as Senior Vice President, Scientific Affairs for 9 years at AMI.

So now, without any further ado, here's the interview.

Barbara Van Renterghem, editorial director, *Food Safety Magazine*: I'd like to welcome both of you to Food Safety Matters and thank you for your desire to share your experiences about this tragic event with the food industry and our listeners today. I don't believe that it's an exaggeration to state that lives will certainly be saved from others learning about your story and taking your lessons and applying it to their own situations.

I'd like to begin with you, Michael, to set the stage for our listeners about this recall. I know that as the CEO of this company, you had put everything in place at Maple Leaf. You were going above and beyond what the current regulations required. Can you describe for our listeners what types of programs you had in place and why this outbreak really came as such a surprise to your company?

Michael: Thank you, Barbara. And first, let me begin by thanking you for having Randy and I in this discussion today. I do think that continuing to focus on both the events that transpired and the learnings that resulted from that will enhance the entire industry. So, let me take you back to those events.

We were notified on the night of August the 23rd in 2008 that two of our products made at our Barter Road plant had been linked via DNA testing to what was described, at the time, as a national outbreak of listeriosis. We were notified that three people had died, and it was expected, based on the illness that were present, that that death toll would rise. Obviously, that was alarming in an extreme and visceral way.

On the 24th of August, we made the decision to recall just over 190 of our products. And because the root cause and the status of other products coming out of that facility was opaque to us at the time, we made the decision to close the Barter Road facilities so that we could both protect the interests of consumers and complete our investigations to determine root cause as best we possibly could.

Your question about what that reflects is very important, because we did feel, at the time, we had a bit of false confidence that our programs were secure and effective. Largely because we benchmarked those programs against what we understood to be best practice in the Canadian industry, but what we didn't realize is that the regulatory framework in Canada was less than adequate. We were living in a world of the complacency of best practice against a Canadian industry that was not world's best practice, and that created risk. The complacency for us is that our consumers, they trusted us. They didn't trust any excuses that we could generate or fingers that they could point. They just trusted us. And so, we had to honor that trust, or respect that trust, and take accountability for our outcomes.

And as we dug into it, it became crystal clear that the complacency of the Canadian industry was unsatisfactory to us, and every other participant that was a stakeholder. So, the first order of business was dealing with the crisis at hand. We contacted more than 4,000 stores, retail stores, to explain our situation and address the recall. The foodservice channels are much more difficult to access. We made over 8,000 calls to foodservice and users through an external call center to advise them and work with them on executing recall as fast as we could through distant foodservice channels.

Product was recalled, disposed of. We worked with the CFIA [Canadian Food Inspection Agency] to determine root cause in the Barter Road facility. And at the same time, begin the process of remediation with all of our stakeholders across the organization and working with the CFIA to completely rebuild the regulatory framework that existed for all the industry in Canada.

We came to the conclusion, at the time, that the only way we could honor the death of 23 people on our watch, which is, as I said, an incredibly and deeply tragic and emotional experience, given the passion that we have for the products and the role that we play in the food system. The only way we could bring meaning to that was to make the long-term commitment that we would become world leaders in food safety. And I think we've made the significant material progress along that continuum over the last 10 years.

Barbara: You know, it's a little mind boggling to think of the resources that you had to mobilize to respond so quickly in this situation. Randy, what did the company have in place to facilitate this response, and what did you need to assemble to start your investigation as to the source?

Randy: Well, thanks for that, Barbara. In fact, I'll just start by echoing Michael's comments that we appreciate the opportunity to share our story both with you and the industry, your readers and listeners. Because I do think our story can play some small role in helping others improve their performance and potentially avoid a situation such that we experienced 10 years ago.

To answer your question, as Michael said, we had a very robust food safety and quality program in place, and a very good process for evaluating *Listeria*, environmental findings within the Barter Road facility. And in fact, across the Maple Leaf network, at the time. But what we found is, clearly, that wasn't good enough, as a result of the outcome, which was a tragic outbreak and recall.

And so, what we did immediately, and I joined as an advisor just the day after the recall, [was to work] with Michael and the team on the ground to put in a process for truly getting at the root cause and trying to understand what happened. And for, I'm sure many of your listeners would know, that getting at true root causes is not always easy. And certainly, in this case, it became even more challenging because we were doing the investigation in the context of the plant being shut down, which was the right decision, but conducting an investigation in a plant that's not operating can be very challenging because many of the factors that could cause problems are actually not occurring when you're not operating.

But with that challenge in front of us, we did bring in an external panel and put together a very good group of people with many diverse experiences that were able to work with the team on the ground at Barter Road. And I'll just take this moment to say that starting with Michael, who gave us all the resources we needed, and certainly the motivation to find the problem, we were able to generate a list of very likely causes. And I'll say, while we'll never know with absolutely certainty, we have a pretty good belief that the root cause was a harborage point within the slicer in the facility. The slicers, two lines were affected. Deep within the scaling mechanism on those slicers, that were simply not being fully disassembled during normal routine sanitation every night, and not being disassembled to the level of disassembly required to eliminate the harborage. And we believe that was likely the source. And the root cause would be inadequate disassembly of that equipment. There were some other findings throughout that investigation, but we believe that was the most likely source. And we worked closely with CFIA in developing that finding.

Michael mentioned the fact that the real tragedy of this event would be to not learn from it and be better. And one of the most important learnings out of this, for us, was this notion of finding the problem through our routine *Listeria* surveillance within the facilities, and then implementing effective corrective actions and preventative actions that fix the problem. So, I like to use the mantra, "Find it, and then fix it." And I think looking back, we actually had data from the facility dating back several years of *Listeria* findings. But they weren't properly actioned. They weren't actioned to the level of rigor necessary to fix the problem.

And if you want to break it down in real simple terms, looking backwards, we did find the problem many times through our routine sampling plans in the prior year, and that was recorded in the records, but we didn't do enough to fix the problem, to put in corrective actions and to truly get to root cause. And if there's one thing that your listeners take away from our experience, it's to make sure that you get that lesson, that every time you find an issue, whether it's a *Listeria* problem or any other food safety challenge, the surveillance of your systems, tells you when you have a problem, it's just as important to put in effective corrective actions to prevent it from happening again.

Barbara: When I've talked to folks about *Listeria* and environmental monitoring, a couple things are always brought to light. One is, *Listeria* is so ubiquitous in plant environments that when incidental positives come up, sometimes people are a little blasé about, "Well, it's there." Or, if it's popping up in different places and they're not seeing a trend in a particular location, folks might get a little maybe lackadaisical about really investigating where it's coming from. So, do you treat every positive that you see as something that you need to find the source? Has that changed in your facility in response to this?

Randy: Well absolutely, Barbara. And actually, Michael, you may want to comment on this as well. But we actually respond to every positive result in a very aggressive way. Our operational teams form a, what we call a seek and destroy team. It's a very standardized team that has cross-functional representation. And that seek and destroy team responds to every positive environmental *Listeria* that we get, whether it's on a food contact surface or a nonfood contact surface. And we attempt to get to the root cause of every one of those findings. We actually instituted, with Michael's leadership, a daily call that we still have today, 10 years later, that addressed the outcomes of each of those findings. Michael, maybe you want to comment on those early days and how we executed that 8:30 call.

Michael: Yeah, it was pretty intense, and I think that is a central point to the discipline of the processes that were put into place, is this idea of not allowing that, the ubiquitous nature of *Listeria* to become a source of complacency.
We had to follow this in a very disciplined way, the seek and destroy process that looks to find root cause and resolution and mitigation for every single finding. So, we did put this [seek and control process] into place: Once the resources were applied in the surveillance system around the environmental monitoring program, the standards against that could be

measured, as well as what mitigation would be standard practice in the event of a positive. Then we overlaid that with, as Randy said, this idea that food safety and our safety promise is something that has to be executed every day. Every single day. Every minute of every day. And it was going to bubble up to the very top echelon of the business.

Everybody in the network, operations, executive, and the food safety team participated in this daily 8:30 call, that, for at least, I think, Randy, 2 or 3 years, was chaired by me, I think. Was it not? For a couple, 3 years.

Randy: Yeah, I think it was, for sure.

Michael: We basically reviewed every finding every day from the prior day. Every swab, every positive result was reviewed every day in terms of the seek and destroy, the root cause hypothesis, and what the mitigation was. And that kind of rigor and discipline exists still to this day. The participation is a little different today because the frequency then was very high. The frequency today is almost nonexistent. But having said that, I still get a report everyday about yesterday's findings on anywhere from L1s all the way to L4s and take every one of them—even though they're few and far between today, but they still exist—we take every one of them seriously. And there's a root cause analysis, and the resources are applied to them.

We use the phrase here, it's like brushing your teeth, you gotta do it every day for hygiene. And we are very focused on those disciplines and they have a dramatic impact on the outcomes.

Randy: Yeah. Barbara, I'd just add that some of those early calls with Michael and the senior management team were quite animated, and they really drove discipline and rigor in our processes. And a few plant managers and FSQA [Food Safety Quality Assurance] managers learned very quickly that explaining the root cause through just saying, "we need to retrain employees," that did not fly. And Michael didn't let that explanation ever survive. We challenged our teams to dig deep, to truly find what the root cause of the issues were. And I think that has made us a better company in many ways. Not just with *Listeria* control, but it's led to rigor and discipline in many areas.

Barbara: I would think that for employees who had gone through that, you wouldn't need to convince them that all of these steps were important, that they would understand what the impact on the business would be. Randy, you've talked about completely disassembling the slicers daily. And you and Michael have talked about addressing all of the positives that come in and doing a root cause analysis. What other improvements can you say were taken as a result of the investigation and what you were able to find?

Randy: It's a great question. And the list would be long and probably I wouldn't be able to highlight all of the various things, both small and large, that we've done to try to improve our overall performance with respect to *Listeria* control. But I will highlight a few things. And this is not news to many people that would be listening, but in the ready-to-eat, the high-risk ready-to-eat environment, obviously segregation is key. And having segregation between raw and ready-to-eat is a basic tenant, but it needs to be honored. And in some of our older facilities, we didn't have physical separation in every instance. And so, wherever there was a chance for employee crossover or lack of segregation, whether it be materials or people, we had to put in very effective management processes to prevent risk. So, segregation would be a big topic. And building engineering segregation, physical segregation into your ready-to-eat facilities is critically important. If you don't have that now, you need it. And that's one thing we've worked to do through the investments that we've made in our infrastructure.

Secondly, keeping the environment dry is critically important. Having a wet environment in a ready-to-eat, high-risk area is a very challenging situation. And sometimes, it's unavoidable for certain types of products. But I would challenge anyone to work really hard with their engineering teams to put in adequate air handling systems and other procedures that eliminate water on the floors and water in the processes, because that dramatically improves your ability to control *Listeria* and keep it away from food contact surfaces.

Those are two. Segregation and dry environments are two very important concepts, and we've tried to implement those wherever we can. Of course, good employee practices and hygiene and wearing proper PPE [personal protective equipment], those are important factors as well. And then the last thing I would say, it's all about the people. And instilling in all the management teams as well as all the employees on the floor the importance of following the protocols and understanding 'the why' we ask them to follow certain protocols. Getting the culture within a facility to a point where they really understand the basics of food safety practices and really embracing that and understanding why it's so important. I'd highlight that, as well.

Michael: The only thing I might add, Randy, to your thoughts is the very significant focus that we've placed on this very important point of cultural shift across the organization. Because all of the systems and processes in the world are not going to mitigate a culture that's not aligned to this goal. We started that ... everybody understood the need. That was clear. I was able to communicate this collaboratively with all of the leadership team to the entire organization as the essence of why we existed,

to provide safe food, great tasting food, in a safe work environment. We packaged it up as our safety promise. So that was a great call to action across the organization.

But our model of cultural shift, which starts with defining our expectations, followed by teaching the hell out of those expectations so everybody's given the tools and the understanding and the capabilities to be able to meet the needs of those expectations and then finally acting in a way that's consistent with that target outcome was, I think, as fundamental as all of the core systems and process and follow-ups. In fact, I think those systems and processes and daily actions were part of that cultural shift continuum. Again, everything from our food safety foundation program, which all employees of all disciplines have to go through, to how we report on food safety at the plant level, all the way up to the executive level today, I think underpins that cultural shift.

Barbara: All right, this is a good time to give a shout out to you, Randy, for being involved in our food safety culture e-Book that Lone Jespersen organized for us. And your contribution to that was very much appreciated.

Michael, what have you learned with regard to key leader competencies that should be used in crisis management that you would advise? Advice you would maybe give to a CEO of another food company who thinks that they've already done what they need to do, and they've got everything all together?

Michael: I would say that advice in this context is very situational, I think we have to put that into context, of every circumstance is a bit different, every culture's a bit different, every company, if, God forbid, they face a crisis, is probably unique. I would say that the biggest enemy of a positive outcome in food safety is complacency. So, a leader that feels, "I have this covered. We are good. We don't have risks. Our systems are secure," likely is concluding that complacency is starting to have some effect on their business, and they might wake up to a surprise someday.

So, avoiding that complacency, recognizing that a dose of paranoia is probably your best friend is very healthy, coming into these circumstances and leading in a world of food safety.

Feeling that your next crisis is just around the corner is likely a very constructive attitude at the executive level. In terms of the crisis ... if there is the tragic outcome that we experienced, our response to that, I think was defining for us. It was a reflection of the leadership culture that existed at Maple Leaf. It was characterized by three attributes that I think, again, are defining of our organizational culture, the leadership culture at Maple Leaf.

Number one, it was very action-oriented, and we accepted the need to create an action plan that was both visible and immediate with a sense of urgency throughout the organization.

Number two is, it was rooted in accountability and accepting accountability. It's an abject lesson in the difference between responsibility and accountability. Often times we're accountable things that we're not fully responsible for, but our consumers trust us, and there was breach in that trust. We failed them. Our accountability for that, regardless of the ability to point fingers or not identify direct links to responsibility, we were clearly 100% accountable for that outcome, and accepting that accountability defines the response.

And finally, our culture is rooted in a level of transparency that is shocking to some, very gratifying and comforting for us. But that transparency has to be reflected in how these things are managed. And we've tried to make that very real in how we went through that crisis, to be completely transparent, to be ... the good, the bad, and the ugly. And we took that through to the end. So, in advance of any tragedy of this nature, I would urge any executive to not allow complacency inside their organization to have any oxygen. And in the event of a crisis, those core values that are part of our DNA of an action orientation of transparency, and ownership and accountability, is, I think, central to finding your way through a very difficult path like this. But also recognizing that accountability and action orientation and transparency doesn't age well. So, you've got to exhibit those things in a real hurry. Because a week later, they may be stale dated.

Randy: Yeah, I'd add to that, I think Michael has really answered that question very well. And it's very, very good advice for other leaders in the food industry. And that last point about timeliness is so important. Barbara, we actually have received calls from other companies, CEOs from other companies, during a crisis and asking for advice. And unfortunately, and I can point to a couple of examples where the calls came about two or three weeks after the crisis occurred. And frankly, the advice Michael just laid out about being action-oriented, being accountable and owning it, and then being transparent, none of those really work three weeks later.

During the crisis, you have to be front and center right away. In a very timely way, you've got to understand the problem quickly and own it and react accordingly. And I think, and if I can say so, this is what I feel Michael and his leadership team did so well in the light of a very difficult, very difficult situation back in 2008.

Barbara: You know, given the call centers that were set up and how many phone calls you folks had to make to spread the word that these products needed to be pulled, it is kind of mind boggling how much had to be put in place almost immediately. But looking back, so 10 years ago, as fabulous as your response was to those first calls and what you had to do, is there anything that, if the same thing happened today, which of course it won't, because you guys have all the proper programs in place, but God forbid should something like this happen again for you today, is there anything that you would do differently?

Michael: First of all, under the column of complacency, I would never buy into the statement, "Of course it won't." We live in a paranoid world of "it could be just around the corner and we're going to manage appropriately". So, we genuinely believe in that principal of complacency is our enemy.

If I looked back and say what would we do differently, I think there are some things in our messaging and our communication that we probably could've done a little bit differently. I think there was an initial desire to move on from the subject. And it took us a few months of reflection to recognize that actually, we're never entitled to forget. This is not something you can ever move on from. The initial feedback from many in the organization is, "Oh, Michael can't we move on now?" And the realization comes to roost that actually, we can never forget, the victims are entitled to move on, and they're entitled to forget in their own way, but we're never entitled to forget. And that's showed up in a few areas. I think our systems and approaches to the management of *Listeria* are always under continuous improvement, so we could always look back and say, "Yeah, I wish we'd known in 2008 what we know today." There's always elements of system and technical improvement that I think we could add to it.

I wish we'd have engaged stakeholders, maybe the broader stakeholders more effectively. Because in an industry like ours, you're only as good as your weakest link. I think we could've done a better job, maybe, of engaging all of our other industry competitors and stakeholders, because it affected them, as well. Negatively, and for a period of time. Nobody wins in these types of crises, and we've subsequently made food safety a noncompetitive factor in our business in every way possible. We probably could've done a better job of that.

And finally, our attention is ... I think we have moved into simply world-class status. Not perfection. We don't, or certainly don't expect ever to achieve perfection, but I think we are in a world-leading position around *Listeria* management today. But there are other pathogens out there, that the bar keeps rising, and we need to continue to be focused on some of these other pathogens in the same way that the bar was raised for us in listeria. Then certainly the top of mind would be in *Salmonella*, and how we build a multi-year strategy to become world leaders in *Salmonella* management across our portfolio and the Canadian industry is very top of mind for us in the spirit of continuous improvement. I would probably point to all of those things, Barbara. Randy, you might have some things to add to the list?

Randy: I'd just add ... I think you said it really well, Michael, but with respect to other pathogens, I'd just add to that other processes as well that we operate over 20 manufacturing sites and multiple farm locations, both in pork and poultry. And more recently, our company's now into alternative plant-based proteins, which carry their own unique pathogen risks and hazards. And so, for our business, it's a constant challenge to keep up with what the key hazards are and how to best manage those hazards.

And so that's really what drives a lot of our focus and activity today. We do feel our *Listeria* control programs are, I'll say stable, I think is the right choice of words. Never satisfied, but stable. But we've got challenges in other parts of our business. We produce fresh poultry in a large way in the Canadian market. And there's challenges in fresh, raw products. Raw agricultural products that don't receive a kill step, a heat treatment step. And we've had to manage the food safety challenges with those.

I'll just continue that briefly, Barbara, and just talk about one way that we try to stay abreast of, as a company, is we established a Food Safety Advisory Council back in 2009 with some world-renounced experts advising us and challenging us. And they come in several times a year and work with our team and critique our programs and provide challenge to how we're going about managing our food safety programs and processes. And that's proved very helpful over the years. Several of our Council members have been either on your Advisory Board, or have been guests on this podcast. So, they prove very useful to us on a regular basis.

Barbara: It sounds like these are all terrific ways that you're combating complacency, as you mentioned, Michael, one of your major challenges, by bringing in fresh eyes to look at the systems that you've put in place. And I know Randy, that you and I have talked separately about new programs that you're putting in place at Maple Leaf that we hope to have an article for our readers sometime next year.

As we wrap up today, I wanted to ask you about the commemoration of this event that is happening this year. And particularly to ask you, Randy, about the symposium that you folks are developing.

Randy: Sure. I'll take both of those. Michael, please comment as well. But as part of Michael's point earlier about we can never forget, as a company, about this event. We use this moment in the annual calendar, actually specifically August 23rd, to commemorate what happened at our Barter Road facility 10 years ago. And this year, actually, a couple of weeks ago, we held that commemoration event where all employees were invited to a hosted webcast with Michael and myself. We hold a moment of silence where the lights were turned down in our facilities and we spent a moment of silence to think about what happened for those victims and the families that were affected by that outbreak. And we use that as a way to remind our team members of how important our jobs are in producing safe food. And it's a nice moment in the calendar for us to do that every August. And this year was particularly meaningful, and one of the reasons we wanted to join this podcast to share our story at the 10-year anniversary mark of this event. We think it's a milestone for us, and that we appreciate the opportunity to share the story. And our employees are quite motivated by the message and reinvigorated once a year to the importance of what we do, to produce safe food.

Secondly, the other part of your question is just about our food safety symposia. We're actually hosting our tenth annual event. It's a 1-day session that we host every year in October. It's actually October 2nd. We'd welcome anyone who's interested to attend. We'll provide to you a link to the registration page and the show notes, Barbara, so maybe you can place that there. But this year, we're focusing on this notion of culture and trust, the importance of trust in building effective food safety programs. And we've got an excellent lineup of speakers. I can list a few names. Mike Taylor, former head of FDA and now working with the STOP organization. Mike will join us as a keynote along with two victims who will tell their story of how they were personally impacted by foodborne illness, and, create that significant point about why it's so important we do our jobs well.

And then we've got a whole series of speakers afterwards that will talk about how they bring culture and the notion of trust and building relationships within their own food processing operations. We're welcoming anyone and everyone to join our day on October 2nd, and I'd extend that invite to anyone. So thank you. Michael, anything to add to our commemoration?

Michael: Just how important it is to us–important and how deeply emotional it is for us to commit every year to never forgetting. It's a very meaningful part of our annual calendar. And finally, to highlight the reflection on this annual Maple Leaf Food Safety Symposium, as a reflection of the fact that our industry is united in this effort, in that we have to approach food safety excellence collaboratively, because we're only as good as the weakest link. And that's, I think, been an important dimension of the annual symposium. I think government, academia, industry, and our customer base have all been highly vested in that, the journey together and the symposium is a great event. So, I'd hope, as much of the audience of this podcast can sign up and attend both in the past and in the future.

Barbara: I want to thank you both again for being with us on the podcast. And given the really important lessons that you've learned, I would encourage food company leadership to contact you in a preventive way, rather than when they're in the middle of trying to deal with a crisis. Because as you said, Randy, it's nice to get that information sooner rather than later, because the communication and the actionability of the response needs to happen right from the very beginning. Again, thanks to both of you.

Michael: Thank you.

Randy: Thank you, Barbara.

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