PRESS RELEASE

Laval, 1st February 2018

Health-related accident in Craon
Causes of contamination and perspectives for Dryer number 1

The Lactalis Group has been committed to determining the origin of the contamination of the infant milks and nutritional products manufactured in Dryer number 1 in Craon. We now have the elements enabling us to understand the origin and the causes that led to the health-related accident. We are also in a position to learn from them in order to envisage perspectives for the future.

Preamble, as a reminder

The Craon site comprises two very distinct installations, Tower number 1 and Tower number 2. All our investigations have led us to confirm the presence of Salmonella confined to Tower number 1.

Since the alarm was raised by the authorities at 7:30 pm on 1st December, the Group's Industrial and Quality teams, at the Group level, in the Craon site and in the division have consistently conducted investigations to identify and understand the origin and the cause of the Salmonella Agona contamination of products manufactured in Craon. The work has been conducted in collaboration with the Authorities, assisted by external experts. We outline the conclusions of the work below.

The source of the contamination was identified at the base of Dryer number 1, before spreading in a dispersed manner to the entire dryer. The contamination was sporadic but lasted for several months, and sufficiently to present a risk at several places in this tower.

The accident can be explained by successive periods of works starting at the beginning of 2017, to take down partitioning walls and perform floor repairs in the building.
Our investigations lead us to conclude that the Salmonella Agona was 'freed' during these works and developed in several areas of Dryer 1 despite plans for monitoring and containment of the areas undergoing work.

Dryer number 1 is used for manufacturing small volumes for specific nutritional products. This activity involves the use of specific equipment depending on the products manufactured. Yet

these removable tools cannot be cleaned using the usual automated technologies and must be maintained separately. It is during cleaning operations for these circuits, following the works, and through contact with equipment infected with the bacteria, that the contamination occurred.

Today, we are also able to confirm that the strain of Salmonella Agona at the origin of the 2017 contamination is the same as that of the 2005 contamination. Indeed, the results of our investigations today converge and indicate the presence of the bacteria in the facilities of Dryer number 1, in a confined manner, with no development due to the sanitary barriers and the procedures that are put in place.

As a reminder, all analyses of finished products are systematic and accepted: they concern each of the batches before distribution and are performed entirely by an independent external laboratory.

Before the alarm was raised on 1st December, we were not aware of the contamination of some of the products manufactured in Craon. Our reinforced inspections since this date, and our investigations to understand the causes indicates that our inspection plan must be improved. In accordance with our commitments, an action plan will be presented to the authorities.

Questioning the effectiveness of our inspections is necessary as is the question of the sensitivity of the analyses entrusted to an external laboratory.

Indeed, to this date, having performed close to 16,000 analyses on our finished products in 2017, all of which were compliant, we cannot explain that infants were contaminated by our products and that we were informed of it by the Health Authorities.

Today, we are striving to understand why thousands of systematic analyses, covering all batches, failed to identify the presence and the progression of the Salmonella Agona.

If the analyses on finished products had revealed the presence of Salmonella Agona, it is certain that we would not have distributed the products and would have avoided the crisis.

Dryer number 1 activity halted in order to start activity again in a safe and secure manner.
Consequently, we have decided to shut down Dryer number 1. The decision is difficult, and we are aware of the social impact.
We have made this decision with the commitment that the employees concerned may benefit from in-house mobility in one of the Group's seven industrial or logistics sites located within a radius of 50 km.

The closure of Tower number 1 in no way means that the Group is withdrawing from the infant milk market. Over the coming weeks, we will be sharing a relaunch plan for Tower 2 and the packaging lines. Meanwhile, we are already working on a construction project for a new facility.

A commitment to maintain jobs within the Group

Since the beginning of the crisis, we have done all we can with our social partners to safeguard our employees. We commend their responsibility, commitment and support along with the Nutrition team, while they are affected by the crisis and the media attention that it has attracted. We will pursue this work with our social partners.

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