COMMITTEE ON OVERSIGHT AND REFORM

SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

INTERVIEW OF: ANNE SCHUCHAT

Friday, October 1, 2021

The Interview Commenced at 9:00 a.m.

Appearances.

For the SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS:

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

For the U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES:

KEVIN BARSTOW, Senior Counsel

JENNIFER SCHMALZ

JoANN MARTINEZ

LESLIE ZELENKO

ERIC WORTMAN, CDC

Exhibits

Exhibits

Exhibits

Exhibits

Exhibits

Exhibits

P R O C E E D I N G S

[Majority Counsel]. Let's go on the record.

Good morning. Today is Friday, October 1st, 2021 at 9:00 a.m. This is a transcribed interview of Dr. Anne Schuchat conducted by the House Select Subcommittee on the Coronavirus Crisis. This interview was requested by Chairman James Clyburn as part of the committee's oversight of the coronavirus crisis.

I would like to ask the witness to state her full name and spell her last name for the record.

The Witness. Good morning. My name is Dr. Anne Schuchat, A-N-N-E, S-C-H-U-C-H-A-T.

[Majority Counsel]. Thank you, Dr. Schuchat. My name is [Redacted], Majority counsel for the Select Subcommittee, and I want to thank you for coming in today for this interview. We recognize that you are here voluntarily and we appreciate that.

Under the committee's rules, you are allowed to have an attorney present to advise you during this interview. Do you have an attorney representing you in a personal capacity today?

I'm not sure. Can you hear me?

[Transmission interference.]

The Witness. We lost you for a little bit. I don't know if everybody lost it or just us.

[Majority Counsel]. Can everyone hear? I want to confirm that the court reporter can hear.

The Court Reporter. Yes, I can. Thank you.

[Majority Counsel]. Okay. Good. So, Dr. Schuchat, my question was do you have an attorney representing you in a personal capacity today?

The Witness. No, I do not have a personal attorney representing me in a personal capacity today.

[Majority Counsel]. Is agency counsel accompanying you today and, if so, can they identify themselves for the record?

The Witness. Yes.

Mr. Barstow. Kevin Barstow.

[Majority Counsel]. At this time, I would like to ask the additional staff who are present to identify themselves for the record. If there are additional individuals from the Department or from CDC, please identify yourselves now.

Ms. Martinez. Good morning. My name is JoAnn Martinez. I'm the deputy assistant secretary for legislation and oversight at HHS.

Ms. Schmalz. And this is Jenn Schmalz, legislative analyst at HHS.

Ms. Zelenko. Leslie Zelenko. I'm senior adviser with the assistant secretary for legislation at HHS. And

my colleague will switch out. I'm taking notes for HHS today, so my colleague Kelsey will join probably midway through the interview.

[Majority Counsel]. And just for purposes of our record, what's counsel's last name?

Ms. Zelenko. Her last name is Mellette M-E-L-L-E-T-T-E.

[Majority Counsel]. Anyone else with the HHS or CDC?

Mr. Wortman. Hi, this is Eric Wortman, CDC, Washington.

[Majority Counsel]. All right. Let's turn to Majority counsel.

[Majority Counsel]. [Redacted] for the Majority.

[Majority Counsel]. [Redacted], Majority counsel.

[Majority Counsel]. [Redacted], Majority counsel.

[Majority Counsel]. Minority counsel.

[Minority Counsel]. [Redacted].

{Minority Counsel]. This is [Redacted] with the Minority.

[Majority Counsel]. Thank you.

BY [MAJORITY COUNSEL].

Q So before we begin the questions, I would like to go through a standard set of ground rules for this interview.

First of all, the scope of this transcribed interview has previously been agreed to by the Majority staff and HHS staff. The scope of the interview is the federal government's response to the coronavirus pandemic from December 1st, 2019 to January 20, 2021, as well as a review conducted of certain CDC guidance documents in 2021.

So next I would like to talk about the structure. The way this interview will proceed is as follows: The Majority and Minority staff will alternate asking questions, approximately one hour per side per round, until each side is finished with their questioning.

The Majority staff will begin and proceed for an hour, then the Minority staff will have their hour, and we will alternate back and forth like that until both sides have no more questions.

We've also agreed that if we're in the middle of a line of questions, we may end a few minutes early or go a few minutes past the hour to wrap up a particular topic in the interest of efficiency. And in this interview, while one member of the staff might lead the questioning, additional staff will ask questions from time to time.

Additionally, there is a court reporter taking down everything I say and everything you say to make a written record of the interview. In order for the record to be

clear, I ask that you please wait until I finish each question before you begin your answer, and I will also try to wait until you finish your response before asking you the next question.

And I just want to note that the court reporter can't record nonverbal answers, such as shaking your head, nodding, so it's important to answer each question with an audible verbal answer.

Do you understand?

A Yes, I do.

Q We also want you to answer our questions in the most complete and most truthful manner possible. So we are going to take our time, and if you have any questions or don't understand any of the questions, please let us know and we'll be happy to clarify or rephrase.

Do you understand?

A Yes, I understand.

Q If I ask you about conversations or events in the past and you are unable to recall the exact words and details, you should testify to the substance of those conversations or events to the best of your recollection. If you recall only a part of the conversation or event, you should give us your best recollection of those events or parts of conversations that you do recall.

Do you understand?

A Yes, I understand.

Q If you need to take a break at any time, please let us know and we are happy to accommodate. Ordinarily, we will try to take about a five-minute break at the end of each hour of questioning, we'll also take a longer lunch break midway through the day. But if you need a break in between, just let us know. I'd just ask that to the extent there is a pending question, that you complete your answer before we take that break.

Do you understand?

A Yes, I understand.

Q Although you are here voluntarily and we are not swearing you in under oath, you are required by law to answer questions from Congress truthfully. This law applies to questions posed by congressional staff in an interview.

Do you understand?

A Yes, I understand.

Q If at any time you knowingly make false statements, you could be subject to criminal prosecution.

Do you understand?

A Yes, I understand.

Q Is there any reason why you would be unable to provide truthful answers in today's interview?

A Not to my knowledge.

Q Finally, I would like to talk about privilege. The Select Subcommittee follows the rules of the Committee on Oversight and Reform. Please note that if you wish to assert a privilege over any statements today, that assertion must comply with the rules of the Committee on Oversight. Committee Rule 16(c)(1) states: "For the chair to consider assertions of privilege over testimony or statements, witnesses or entities must clearly state the specific privilege being asserted and the reason for the assertion on or before the scheduled date of testimony or appearance."

Do you understand?

A Yes, I understand.

Q Do you have any questions before we begin?

A No, I don't have any questions.

{Minority Counsel]. [Redacted], this is [Redacted]. I know you didn't ask if I have any questions. I just wanted to interject real quickly and say that we were not told until this morning that Dr. Schuchat's agency guidance review would be included in the scope of today's interview.

Our discussions with your staff, with HHS, always centered around the December 2019 to January 2021 timeframe. So we want to put on the record that we were

not informed until about 47 minutes ago that that would be a part of today's interview.

That's all. Kicking it back over to you.

[Majority Counsel]. Your position is noted.

BY [MAJORITY COUNSEL].

Q So let's start with some background questions. I know, again, that today is your last day at CDC after, is it, 33 years?

A Yes, I've been with CDC for 33 years.

Q Congratulations. So I know you've held many roles. In the interest of time today, I'm not going to talk through all of those roles, but I do want to talk a little bit about your last or second to last role as principal deputy director.

How long did you hold that role?

A I began as principal deputy director in September 2015, and that has been my position of record since then. I had two stints as acting CDC director during that period, but that's since September 2015.

Q As principal deputy director, did you report to the director?

A Yes, that's correct. I reported to the director during that period.

Q And did you report to anyone else?

A No. My supervisor was the director of the

agency.

Q And understanding that it may have changed at times, an approximate answer is fine. How many people reported to you directly when you were principal deputy director?

A It changed several times with the organizational changes. As of now, the associate director for policy and strategy reported to me, the director of NIOSH reported to me, and the chief medical officer reported to me. But prior to that period, I had direct reports that included deputy directors of the agency.

Q Roughly, what were your general responsibilities as principal deputy director?

A My general responsibilities as principal deputy director were the science and program leadership for the agency. But I would like to clarify that during an emergency response, the organizational hierarchy changes. And during an emergency response where we have activated our emergency operations center, we have an incident management structure and the incident manager reports directly to the CDC director. And I would not be in that chain unless I was the incident manager.

Q Understood. And I want to talk about that structure in a little bit more detail in a few minutes.

But first, just in general, in the nonemergency context, when you were principal deputy director, how often did you communicate with personnel outside of the agency? And let's start with the Department of Health and Human Services.

A Probably weekly on programmatic and scientific matters rather generally with the career staff. And I'm not sure in the question if you're differentiating the department from other agencies within the department?

Q My question wasn't specific on that. So why don't you tell me how that would differ.

A Depending on which topic I was focused on, because my portfolio would shift depending on the issues, I might frequently be in contact with scientific or programmatic staff at NIH or at FDA, for instance. With the department, there would be often contact with the assistant secretary for health, but infrequent contact with political appointees other than those I mentioned.

Q How about personnel in the White House. Was that a regular part of your -- did you communicate with the White House personnel regularly in that role?

A In previous emergency responses, there was a unit in the National Security Council's staff that I had frequent contact with. With emerging infections, I was

frequently in contact with individuals, or around influenza, both seasonal and pandemic or avian. So it was usually on scientific or situational issues.

Q How about the Office of Management and Budget. Did you interact with them often?

A I did not. You know, they visited, you know, twice a year for program updates and interacted with them, but I wasn't a day-to-day type of contact with the Office of Management and Budget. That was really handled by our chief of staff.

Q So how did this change then during the response to the coronavirus pandemic?

A Could you clarify what you want me to say?

Q So stepping back, let's talk about the incident response structure.

A Okay.

Q When was that set up for COVID-19?

A Early in January we established a center-led incident management structure. The National Center for Immunization and Respiratory Diseases convened individuals from multiple centers, and then on, I believe, January 20th or 21st, we formally activated the agency-wide emergency operation center for an agency-wide response and appointed an incident manager who then began reporting directly to the CDC director.

So I think there was a holiday that weekend, so it was either that Monday or Tuesday that the official standup began. In 2020, sorry, January 20th, probably, 2020.

Q Understood. Is that structure, generally speaking, still in place as far as you know or has it changed since then?

A The incident management structure continues to be in place. We adjusted over the course of an epidemic as priorities shift or as staffing needs demand. So there have been several transitions in that, but we still continue to have an incident management structure for this terrible pandemic.

Q Understood. At the time that that structure was established in that time in January 21st or 22nd, I believe you said, 2020, what was your role?

A I was not within the incident management structure. I was a senior leader who provided intermittent advice to the incident manager or to other task forces based on my technical expertise. So I was not in the hierarchy for the incident management structure in January.

Q Who was at the top of that at the time?

A The first incident manager was Dr. Daniel Jernigan.

Q At some point, did you take on an official role in that hierarchy?

A Yes. In late March, Dr. Jernigan traveled to Washington, DC to be our lead on the National Response Coordination Center where CDC, HHS, and FEMA were coordinating an all-of-government response, and I became the incident manager for the response on his departure.

Q You said late March. Do you have an approximate date?

A Yes. March 20th, 2020.

Q How long did you stay in that position?

A I finished April 30th, 2020, and Dr. Jay Butler assumed the role of incident manager that day. We may have overlapped for a couple days before that, but May 1st I was finished.

Q Since May 1st of 2020, have you had any official role in the -- and I'm sorry, I might not be using the correct name for the response team. How do you refer to it?

A You could call it the IMS.

Q Okay. Since May 1, 2020, have you had any official role within the IMS?

A I have not been located within the organizational structure in the IMS since May 1st of 2020.

Q Have you had an unofficial role since then?

A I have provided regular strategic advice to the incident manager of the response since around July or August 2020, with some breaks in that. But my main focus has been the rest of the agency as the IMS was focused on the response.

Q Could you tell me a little bit more about what regular advice -- were these informal conversations? Were there meetings? How did that play out?

A I do not remember exactly when it began, but I, for much of that period, held -- at least for much of the last year, I believe -- held weekly calls with the incident manager checking in on -- you know, offering my assistance if he had questions, which were generally about scientific issues and what to be worried about and so forth. So I was a sounding board outside of the hierarchy, but I was not directing.

Q Okay. And similarly, now looking backwards to the period before you became the incident manager on March 20th, 2020, how did you interact with IMS during that period of time?

A I attended some meetings and provided backup for key leaders. There were a few weekends where I covered for the incident manager and served as the acting incident manager or served as the acting task force lead

when a key individual needed to be on leave for personal reasons.

So I was not in every meeting or in the -- but there were a small number of individuals at the senior executive level or distinguished consultant level who could be alter egos for the incident manager or sometimes for Dr. Redfield during that early period.

Q Is it fair to say that you had more frequent contact with those who were officially consulting IMS during that earlier period than after?

A Yes, that would be correct. That my engagement in the response from January through May 1st of 2020 was more frequent and regular than after May 1st of 2020, you know, with a couple exceptions.

I should mention, though, that the scientific output of the response, which -- much of which would be released through our morbidity and mortality weekly reports; the review of that scientific content, I'm one of the key senior leaders who reviewed the proofs right before publication. So I was involved in that kind of science chain, but not in a policy or decisionmaking chain.

Q Understood. We'll come back later to some of those things as review and approval, but for now I ask you to take a step far back to late December, early January 2020, and talk a little bit about the basic

picture when everything started.

As you might understand, the purpose of our inquiry, all of our inquiries, is to help inform Congress about how it can help improve present responses and future responses. That's our ultimate goal. So I have a number of questions about what I would like to go through about decisions that were made, things that happened during that early period, and to the extent that you are an expert on them, looking back from where we are now.

But my first question is, simply, when did you become aware that there was a respiratory illness that appeared to be spreading in Wuhan, China?

A On December 31st, 2019, I read the Lister report in SOMED, which had a brief mention of a small number of cases of severe pneumonia in individuals in Wuhan, China. On reading that, I sent an email to a number of staff who scientifically or organizationally might have known more about this situation and asked, you know, did they know anything and could they let me know. So that was my first awareness.

Q Did anyone know anything?

A Yes, I believe a few hours later I got a response that I think instead of -- I forget if it was five or seven, whatever the early number of cases was -- a handful of cases, I think they were aware of

something like 27 cases and that there was more than was in the report; and, you know, that they were also probing their colleagues and contacts and our CDC staff in country to see what else we could find out.

Q Do you know how they were aware of this?

A Through calls or emails. I don't know if they called their colleagues or emailed, but the CDC has, I think, a 40-year history of collaboration and scientific work in China, and many of us worked on the SARS response in China, a number of our staff worked on avian influenza in China, and there were conversations with our staff in China and probably with some of the counterparts.

But I just got the report of, you know, we've got a couple dozen cases we're aware of and we're looking into it in more detail.

Q After you collected that information, did you take any action or take any further steps?

A Could you clarify if you mean me or you mean the CDC?

Q Well, I'm interested in understanding both. I understand that the CDC has taken many steps since then. You said that you had asked your colleagues if they had any awareness and some of them had. Does anyone direct any next steps after that point?

A Yes. In the early part of January, the National Center for Immunization and Respiratory Diseases began a more structured way of coordinating and compiling situational awareness from the different parts of the agency that would be involved -- you know, our travel health group, our laboratory group, our epidemiology group -- because they established daily check-ins and briefings upwards. And then eventually a written situational report that I think was shared upwards so that we would know what was going on. And then soon thereafter, you know, we had formed a more formal agency-wide incident management response. But they had gathered and prioritized.

Then I believe January 7th or 8th, they issued what we call a HAN, H-A-N, Health Advisory Network alert, which went out to clinicians around the country to say there's unusual pneumonia in China. Please think about this, ask people about travel histories, quite similar to what we did in SARS in 2003, or what we would do with Ebola, for instance. So get the word out that we don't know much, but keep an eye out and remember to report in to your health departments.

So they began, the early steps would be heightened awareness among clinicians and public health so that consistent information could be developed. And then of

course soon thereafter our laboratory scientists began working on a diagnostic test once the Chinese had posted the sequence of the virus. I think they posted that on January 10th, and the team began working on developing an assay.

Q I understand. And I do have some questions about that. But just to step back, is it fair to describe the first steps -- in this type of situation where you just have a potential risk, is your first priority risk assessment, or are there multiple priorities at the same time? I'm just trying to get a sense of this from your point of view at that time.

A Yes. Information is typically fuzzy in the first days of something like this, and it's hard to know whether a cluster is going to turn into something very important or is just, you know, another cluster.

It's important to say that the January time period is often the peak of other respiratory and viral illness, and so a handful of adults getting hospitalized with pneumonia is not that unusual on its own. But -- so differentiating signal and noise is the first focus. The issue of risk assessment includes understanding transmissibility and severity.

And then, of course, if there is a pathogen identified, which happened by January 10th, there are

many steps that can help with that risk assessment. So looking into, you know, animal studies, looking into assessed virulence in other models, looking at comparison with prior coronaviruses, because we certainly have the common cold and then we've also got SARS and MERS, which were the earlier coronaviruses which caused severe disease.

So those first days are really gathering data to clarify the signal to noise, setting up systems to be able to learn more, convening with colleagues around the world because exportation to other -- China or to countries was a signature event that happens pretty soon. And then, you know, garnering a travel detection system so that if we did have importations, we'd be able to -- try to be able to recognize them. And that was all happening in the first couple weeks of January.

Q You mentioned coordinating with international partners. At what point was there intergovernmental coordination in this incident? At what point did you start communicating with other governmental agencies about it?

A Within the U.S. you mean?

Q Within the U.S.

A Okay. Yes, I believe that was very prompt. You know, I know that Dr. Redfield was briefing up to the

department. Some of our intelligence gathering would involve our colleagues at NIH who also have collaborations in China or DoD.

So I can't speak specifically about who was talking to whom. I can say that I'm part of a -- I sit on the World Health Organization's infectious hazards strategic technical advisory group, which involves individuals from about a dozen countries. And we were having calls as part of our routine, we were talking about Ebola in DRC, and we began talking about what people knew about what was going on with this virus as well around that time in January.

Q Did you make Dr. Redfield aware of what you had found out, or did he already know?

A The initial information was shared with him as soon as we got the additional cases. And he very promptly contacted his counterparts in China, I believe, on January 3rd.

Q I thought you had mentioned -- and please let me know if I'm missing -- but he was the one who was primarily contacting other governmental agencies in the U.S.; is that correct?

A Let me clarify.

Q Yes.

A Dr. Redfield would have been likely, I

believe, the individual making the Secretary or the chief of staff for the Secretary aware. Our CDC scientists were talking to their counterparts at scientific and technical agencies in government. And a key scientist in NIH is also part of the WHO committee that I'm on.

So in those early days, there was quite a bit of offering support to China and trying to get a team to be able to travel to the site and learn more. That was another part of the early steps.

Q You referenced some past incidents, SARS, Ebola. How unusual is it to see a cluster like this, reporting on a cluster like this in some other country and have it turn out to be nothing?

A Very frequent. But the issue with some of the very bad things we've had have emerged from clusters like this. So we take it very seriously.

A report of something that the Chinese believe to be new that was causing severe pneumonia, I think our initial thought was it sounds a lot like SARS. Is this SARS again? Because the animal reservoir is likely in southern -- you know, still around?

But the virologists who have been testing did not detect with the assets they had the SARS coronavirus, number one. So we take this kind of event very seriously, but you can imagine in the middle of influenza

season so-called clusters wouldn't be unusual.

But there was something unusual in that it got reported into SOMED. So we took it pretty seriously.

Q At what point did you determine or at least start to consider that there was a real risk in this situation?

A You know, I think by mid-January, when there was exportation to -- I think Thailand might have been the first country where exportation occurred. We then on a Friday, I think, dispatched about a hundred CDC staff to five different airports to begin enhancing the screening of travelers.

So we were worried from the beginning of the report, but it could easily have fizzled out. And we were -- once confirmed exportation and I think together with the sequence being posted and showing it was a coronavirus, it wasn't just a normal respiratory virus we had seen, but it was a novel one, that the weeks of January had increasing concern, and daily meetings and frequent -- you know, all day long, you know, an increasing number of people spending all of their time on it.

Q Is this before the IMS was formally sort of organized?

A Yes. It would have been -- that weekend when

we dispatched folks to the airports, what we planned through the agency-wide emergency operation center, then we had clearly exceeded what a center-led response could manage and needed a greater surge. So at that point we formalized the agency-wide structure and brought in additional key staff to engage.

Q What level of staff did you bring in?

A Well, for instance, the incident manager was the division director for influenza in his regular job, and a number of others from the influenza division or from migration and quarantine, other groups that had expertise in the nature of this epidemic, you know, we were going to need epidemiologists and laboratory staff and travel health people and clinicians and communicators. And so our formal incident management structure allowed for us to surge in each of those areas as well as us.

Q Were you coordinating with other government -- federal government agencies at this point? I understand you would have coordinated with Customs and Border Protection about the airport screening. But in terms of determining the need for a global response, how were you coordinating?

A I don't recall exactly when the daily calls convened by the Department of HHS Office of the Secretary

began, but there were situational calls daily that involved the program expertise.

And as you mentioned, the travel area, there were a lot of intergovernmental policy meetings and situational meetings with Homeland Security and Department of Transportation and the Department of State and HHS and CDC, including with the National Security Council where there were some organizational changes during that January-February period. But there was very frequent contact with them. So I believe -- but exactly when in January, I can't say.

Q So focusing on the airport screening, I understand it started -- at least it was announced on January 17, 2020. My understanding is that CDC decided to screen travelers who had been in Wuhan during the past few weeks coming into three or four major airports. Do you know how those locations were selected?

A The selection of airports was based on information about traveler frequency. And the number of airports changed over time. You know, it went up, it went down, it got broader. And then there was the ban on arrivals that weren't citizens or long-term permanent residents.

This was in conjunction with the idea of funneling passengers to selected airports so that we, in a small

number, could have this ability into people returning from -- I can't remember if it was initially just Wuhan. I thought it was Hubei Province because there were cases in the entire province.

Q I see. So was there a concern about travelers who had been in Hubei Province coming in through other ports of entry?

A This was one of many decisions that related to resources versus efficiency. And so the majority could be reached with certain places, but the idea of funneling the passengers meant that you interrupt their -- you change their routes so that you catch all. But there would still be some gaps, because people traveling through some other intermediary place might be missed in the visibility of whether that person had originated in the province of concern.

Q Okay. So the decision to focus, tell me if this is a fair statement, was based on simply the fact that there weren't enough resources to deploy to other airports that people could have been coming in through?

A Let me clarify. I don't recall exactly, but I believe the general idea was that travelers that were planning to go to Minnesota or Denver instead would have to go through one of the few airports where we had staff and where the Customs and Border Protection was surging

their staff.

So that the intent was if you knew the itinerary originated in Hubei Province, and then later China, these individuals would be routed to first screening at those airports before they went on to their final destinations.

That said, that's based on the travel itinerary that the airlines know about, not somebody who's driven to another country and comes in from someplace else.

Q That was going to be my next question. Whose responsibility, meaning which government agency is responsible for determining that, how to collect the travel history and what screening was required?

A I think that, to the best of my knowledge, the Department of Transportation and the Department of Homeland Security and the Department of State all have interest in this. There's a difference between those who needed visas to come in, those who were not permanent residents, long-term permanent residents or dependents.

So I probably shouldn't say exactly which of those got the final say, but they're all part of these discussions with FAA and CDC and DHS and CBP and State because they're all part of these daily conferring on the funneling and so forth. This isn't my area of expertise. I had to be engaged sometimes, but I was not doing the daily planning around this area.

Q Who at CDC was doing the daily planning around this area?

A This is part of our division of global migration and quarantine scope of work, and that division director is Dr. Martin Cetron. This work is the kind of thing that we did during SARS in 2003, and that was surged in the Ebola response in 2014 to 2016.

Q I understand that you authored an MMWR that assessed the early response. I think the period -- the scope of this surfaced a little later. But I'm just wondering if, sort of realizing what happened afterwards, you think that the steps that were taken to conduct airport screening on or around January 17th was sufficient at the time, or whether in retrospect more should have been done to capture possible infected people coming into the United States?

A Looking at things retrospectively is quite different than decisionmaking at the time. I think it's important to say that in 2003, when the SARS epidemic hit China and then several other countries, numerous countries in the world shut down travel and trade. And the analysis of the policy and global health implications of that prompted an update to the international health regulations so that there was a greater focus on transparency in reporting and on proportionate impact.

Because there was a $40 or $50 billion impact of that travel or trade shutdown for what turned out to be an epidemic of about 8,000 cases and perhaps 800 unfortunate deaths. But it wasn't the pandemic that people feared it might be.

So there is often a big balance between the level of concern that prompts decisions. A number of countries were very aggressive in not allowing travelers from anywhere or not allowing travelers from Asia into their arena after the exportation to Thailand.

So the question about should more have been done on January 17th, I think that whether this could have been contained completely is a good question.

Q Well, I understand that travel restrictions, which might be different from screening practices or travel advisories which was controversial, within the public health community even as to their efficacy.

Do you have a perspective on them, on restrictions, and has it changed since January 2020?

A I think a key concept for this virus, which could happen again, is that this virus can spread when an individual hasn't symptoms. So absent a laboratory test and screening every single person, the feasibility of which in the United States is a question, the ability to detect people who might be spreading this virus through

any kind of surge at an airport is difficult.

I do think that Taiwan and Singapore and Hong Kong, who had such terrible experiences with SARS 1, you know, were really aggressive at the borders and quarantined arrivals for an extended period and then were testing everybody at the airport. That type of intervention was limited to importation to those countries. The ability for us to do that in retrospect or prospectively would be a question.

And a thing to say for the record is that, for restrictions which I guess is the question, the U.S. can't restrict residents, long-term permanent residents or citizens, anyway, from coming in. So we needed to be able to let them, but then we would need to be able to manage their mobility.

So I would say my thoughts continue to develop on this area and I haven't fully processed. I think the key for the future is that we really need to enhance, modernize, and integrate a travel and quarantine system for the U.S. But what we had at the time the epidemic began and what we still have right now is not adequate for the threat and the catastrophic impact of the threats. There's a lot more we could do that needs both resources, policy, and strategy to achieve, but I think that's a key priority for the nation.

Q Thank you for that. So going back to January, on January 21st, we do know that the first U.S. case from international travel had been confirmed; the second was announced on January 24th. How did this confirmation change the response, if at all?

A The CDC deployed teams to the locations of the two cases and initiated an extensive investigation of both their clinical situation and then the extent of spread they may have initiated. So there were numerous contacts both of the individuals and in the healthcare environment who were evaluated to see whether the virus importation was leading to secondary spread. We were trying to learn as much as we could from these individuals as well as from reports in other countries, other reported cases.

So I would say the temperature raised, because obviously importation that we had feared and expected had happened. But the initial reports of those two cases were misleading, I think, in terms of no secondary spread except for two household members, where if you were going to have spread, that's where you would have it.

The individuals also provided an opportunity to try to learn how long people shed virus to figure out what was the infectious period, and that would have implications for how long people would need to be

isolated if they were detected with the virus. So it launched a much enhanced investigation, because rather than getting into China to investigate their cases, we had a couple of cases of confirmed importation here and we also had clinical specimens then that could be used in validating the assays that were being sent.

Q So who was responsible for monitoring those cases during the testing that you described?

A When CDC deploys to a state or county, we are working under the jurisdiction of the locale. So the Washington State Health Department would have been the lead, and based on their invitation, we had a team in place.

I believe the second case was in Chicago, and whether it was the Illinois State or the Chicago or Cook County Health Department, they would have been lead with our technical team working in concert with them.

Q You've used the term "misleading." You said that the cases identified, and I didn't capture the exact words, were the fact that the cases were misleading, I think. What did you mean by that?

A We had a -- perhaps some could say we got reassuring information, because those two individuals did not spread to healthcare contacts, they didn't spread to friends and family; you know, the hundreds of contacts

that were assessed did not appear to get the virus. But in retrospect, we know there was already other viral circulation within the United States and in Washington State in particular.

Q I think I understand.

A We basically tested -- I didn't mean to interrupt. But what I say by misleading, what I really meant was that we did an intensive contact investigation which did not find contact other than two spouses, I believe, who got the virus.

So the idea that this was a virus that was highly transmissible, which we know now, we missed in that first batch of contact investigations, or we had people who were not very infectious at the time that we identified them. So we didn't miss it because we looked for it, but they may not have been the typical individual with the virus.

Q You continued to announce individual cases throughout February and, I believe on February 26th, announced the first instance of possible community spread, I think, in reference to Washington State? Looking back now, do you believe that community spread was occurring before February 26, 2020?

A Yes.

Q So I think you were already describing this,

but for the record, as to what could have been done, if anything, to detect community spread sooner?

A The rest of testing of individuals with respiratory symptoms, and possibly in some way individuals without respiratory symptoms, might have identified additional cases. Were that to occur, we would have needed a very-large scale commercial availability of clinical testing.

In South Korea, which had a very negative experience with the Middle East Respiratory Syndrome, their government leadership incentivized industry development and scaleup of rapid tests or of testing that would rapidly become available, so that PCR testing of almost anybody, large numbers of people, could be done.

The regulatory environment in January and February in the U.S. had a number of barriers to commercial entities or even academic laboratories enhancing their testing because of the requirements for lab-developed tests to go through emergency use authorization. This is a big investment of a lab, whether it's a clinical, academic, or commercial lab. And to get large numbers of tests out there for something that we believed in retrospect was relatively rare would have required a pretty huge scaleup.

The retrospective studies suggested a pretty low

percentage of people with respiratory symptoms, even in the affected areas, had the virus. In Washington State, they looked at the flu surveillance that they were doing in specimens that had been saved, and there was very little evidence of the virus before the reported case in Santa Clara County, which also had one of those first community spreads. I forget if it was the first or the second. They did a flu surveillance testing of specimens. And influenza was a lot more common than this, but it could be detected the same way that the first clinical case was.

So because the clinical symptoms looked just like other respiratory viruses that are common, and because I think you would have really needed large-scale testing that was bigger than what CDC could have done and would have needed a regulatory environment that incentivized that and perhaps government policy that made that surge more possible. And that is one of the things I believe that's being looked at now for better preparedness for the future.

Q You had earlier -- when we were talking about travel, I think you said that it wouldn't be feasible to test every American. I don't know if you -- I think you maybe meant every American coming into the country?

A Yeah. The laboratory -- we've learned that

SARS-CoV-2 is most infectious; the people who are infected with it are most infectious right at the beginning of their symptoms or in the one to three days before they developed symptoms, and people who never develop symptoms can spread the virus. So those tools that some countries try with temperature screening or symptom screening will not detect in people who could be spreading.

So what some countries did was just required everybody who came in to be quarantined, you know, to stay, to be in a government hotel or in an airport location before they were allowed to circulate with anyone else or let the individuals come in from certain destinations.

So what I meant about the Americans was the volume of U.S. citizen travel typically exceeds the volume of travel from others. So that was certainly the case with the European outbreaks. There were a huge number of travelers arriving from Italy and from other parts of Europe when the outbreaks were occurring there and many of them were Americans.

So our management of that, we weren't prepared for large-scale quarantine of travelers. And I guess at the policy level, there wasn't a decision to shut everything down that we could until later in March than I think many

of us would have liked.

Q You just said that there wasn't a decision to shut everything down in the way that many of us would have liked. When you say "many of us," who are you referring to?

A I think that there's a balance between the public health and economic impacts of restricting travel. And doing it voluntarily versus doing it by policy or Executive Order is a big decision. And so I think that as the severity of outbreaks in Italy, in Iran, and then the UK, you know, the European spread, was of great concern to CDC staff and our travel health team.

You know, we had met the criteria for raising the alarm, whether it was restricting or just warning people about going or telling people no nonessential travel or nobody who's elderly or all the different things we could have done.

I would say that the swiftness of taking action was not -- was, in retrospect, making the travel alerts broad and prompt could have prevented some of the importation. We do believe that the viral strains or clones or variants from Europe were the ones that exceeded much of the country more than the original importations from China.

And so taking swifter action to reduce the risk of

importations from Europe either through travel regulations, warnings, or how we handled individuals who came back in terms of their restricted motion, might have delayed some of the spread that really took off in late February and March.

Q Were you, you meaning CDC, pushing for further travel advisory warnings, restrictions that were not implemented at the time that you wanted them to be implemented or were recommending that they should have been implemented?

A Yes.

Q Which ones?

A I believe, or to the best of my recollection, we had proposed additional advisories related to arrivals from Europe versus the group called the Schengen countries because of the open borders in Europe, as well as the cruise ships, the people traveling on cruise ships. Those were the categories in general that were raising concerns that we wanted to get ahead of, so -- in terms of the timing.

Q Were you proposing CDC advisories or State Department restrictions? What specifically was being proposed with -- let's start with the Schengen countries?

A I don't recall all the specifics. CDC works closely with the State Department in our travel alerts

and advisories. We usually draft or contribute to the public health aspect in the State Department to the security and other issues. And so my recollection is that we were focused on the aspects that CDC had -- you know, they usually would be proposing rather than the Executive Orders. But I don't have all those details, so I should only speak to the travel health advisories which we are responsible for drafting.

Q Who at CDC would have most knowledge of that?

A Again, this is a division of global migration.

Q So the head of that division?

A Yes.

Q Do you recall in the instance, if there was an advisory, approximately how long it was delayed?

A I don't recall exactly.

Q But there were advisories that were delayed?

A What I would say is, to the best of my recollection, there were a number of factors being considered. For instance, are there individual travel recommendations or is there a global travel recommendation? And it's clear that this is not just going to be one country after another every day; that we should do a global one.

So whether it's a delay or a preference for one over

the other from the initial concern to the date when the heightened advisory went up was longer than I think our staff were hoping for.

[Majority Counsel]. Dr. Schuchat, you said you didn't recall exactly how long it was delayed. What about approximately? Was it a day? Days? Weeks? Months?

The Witness. I think it would be more in the category of a week than a day, but this was just a period of acceleration where increasing -- we still had frequent travel from Europe whereas the travel from China had really dropped off.

So with the volume of travel and the type of travel, you know, for conferences and so forth, we know in retrospect that one individual from Europe traveled to Boston and 175 or so people at a conference became ill. And I think tens of thousands of cases in the U.S. are genetically traced back to that variant.

So, you know, days matter in that period. And the ceding of many, many parts of the country was a challenge at that point. So, you know, days would matter, but this wasn't months of delays. This was probably more like a week or so.

BY [MAJORITY COUNSEL].

Q Do you know who was turning down CDC's

recommendations?

A I don't know. No, I don't.

Q Who would have been handling the intergovernmental communications on that?

A To the best of my knowledge, on the national -- the White House NSC group had been convening, but there was an organizational change during this time period from one directorate to another directorate of how the travel work was happening.

The travel entities that we talked about earlier, State and Homeland Security and Department of Transportation, FAA, which I guess is part of that, and CDC and HHS have a regular group that convenes around travel. But the convening, I believe, changed from either one individual to another, but I think it was one group to another. And that, I wouldn't have all the awareness of how that decision was made. I think there were a number of factors being weighed.

Q Understood. We are just about our hour, but I'm going to just wrap up with a few more questions on this topic and then we can take our five-minute break.

So was there someone from CDC who was in the room in that group and, if so, who?

A The division director that I mentioned, Dr. Cetron.

Q Do you think that implementing travel restrictions or warnings earlier could have reduced the early impacts of the coronavirus in the United States?

A In retrospect, it appears that we could have delayed some of the spread, yes.

[Majority Counsel]. Let's go off the record.

(Recess.)

{Minority Counsel]. Hi, Dr. Schuchat. My name is [Redacted], I work for the Republicans on the committee. Thank you for joining us, especially on your last day at CDC. You've obviously had a wonderful career.

I am not going to take up too much of your time. I thought the hour you had with [Redacted] was easily the most informative hour we have had in all of these interviews to date, so thank you for that very informative back and forth.

I just have one question for you before I kick it over to my colleague. It's sort of an out-of-the-box question. I'm not sure if you'll know the answer, but let me read you the quote and see if you can identify for me who said this quote.

The quote is: "The world is small, the problems are big, but there are solutions everywhere. Make your life be about solutions."

Do you know who said that?

The Witness. Yeah, that's a way that I often end talks with students.

{Minority Counsel]. So you said that when you received your honorary degree from Swarthmore in 2005. I was there, I graduated the year before, and I had a hard time letting go. So I went back the following year to see many of my friends graduate. I did not graduate summa cum laude. We had three in our entire class who did, two from the English department, and I think the outside examiners probably had a different idea of what highest honors was to the political science department. But you're one of the many reasons that I could say I'm proud to have gone to Swarthmore. People like you rise to the top of their field. I obviously took a path much traveled and went into Republican politics. But I just want to say thank you for a wonderful career, and good luck on your retirement.

And, with that, I'm going to kick it over to my colleague [Redacted].

BY [MINORITY COUNSEL].

Q Hi, Dr. Schuchat. My name is [Redacted]. I'm on the Republican staff for the Oversight Committee. I just have a few questions, and they're a bit varied in topic, so I'll try to preface each one with "we're going in a change of direction" before I ask you so I don't

catch you off guard.

So early on in your role, you said from January to March 2020, you were kind of tangentially involved in the response, but no official role; is that correct?

A Let me clarify. I was not within the incident management organizational structure as a principal deputy director and senior leader and a former director of our immunization and respiratory disease center. My counsel was sought frequently, and I substituted for leaders at selected events.

Q Okay. But you weren't in the response structure, per se?

A Right. I wasn't in a box in the structure.

Q Okay.

A I was outside of the boxes of the structure.

Q Okay. And then you were incident manager from March, I forgot the exact date, but to May 1st-ish, correct?

A Well, as I mentioned earlier, I was a substitute for the acting incident manager a couple different weekends or three-day periods in the February-March timeline. And then on March 20th to May 1st, I was the incident manager in Atlanta.

Q And then you kind of went back to your outside-the-box, maybe less used, but still

outside-the-box role after May 1st?

A After May 1st, I was less involved than I had been prior to being incident manager in March. So in terms of the activity from May, at least May to the summer, I probably was placed separate from the response. I was out for a couple weeks or a period in May. My mother passed away, and so I was very disconnected from the response. And then when I came back, I was really on other duties of the agency to a great extent.

Q What were the other duties?

A A meeting with each of the center directors about their issues and their progress, meeting with staff, trying to help -- I was very involved with, you know, employees' morale, I guess, during all hands with some of the centers that were not heavily involved with the response and, you know, doing introductory talks for the new disease detectives, that type of thing. I was having quite a few meetings and engagements, but on non-COVID kinds of issues.

And then, as I mentioned, I continued to clear the scientific level aspects of the morbidity and mortality weekly reports, whether on COVID or others things.

Q Would those duties that you just described be more of the kind of regular day-to-day, nonemergent role for you?

A That's right.

Q Okay.

A They would be the nonemergent. And it was important, because the response was taking the majority of -- it was the highest priority by far. It was important to connect with other leaders, and part of that would have been encouraging them to approve their staff participating in the response and some of that sort of organizational effectiveness work, helping them get their staff focused, dealing with all the teleworking that we were doing.

So there would be a lot of organizational stuff that was unique to the period. People were having all-hands, trying to stay connected through Zoom.

But, yes, it would be the nonurgent aspects of what the agency was working on in general.

Q Thank you. I want to talk about the travel restrictions and various things around that.

Is airport screening and travel restrictions more important in a human-to-human communicable disease than a non-human-to-human disease?

A Well, airport screening is a broad area. So one of the CDC's -- CDC has the quarantine and authority for -- implements or executes the quarantine authority for the federal government. And part of that is cargo,

the animal cargo. You may recall, in 2003, the monkey pox and the exotic animals being imported.

So I wouldn't say it's just human-to-human that we worry about. But in terms of assessing travelers, the person-to-person transmission by whatever means, the people are important in that route.

Q Yeah.

A But as I mentioned earlier, more complex with an asymptomatic, an infection that spreads from people with no symptoms, the type of assessment or evaluation that travelers would need differs.

Q So for COVID, which has proven to be a very effective human-to-human transmitter, knowing that information would have been crucial in making travel restriction or quarantine decisions?

A Knowing which information?

Q The possibility of human-to-human spread and asymptomatic human-to-human spread.

A Well, I would say that the assumption from the original reports was that this was spreading from one person to another person. That was the operating assumption even from the first report, but the efficiency of that spread was the big question. You know, is it very transmissible and is it very severe? Those are always our first questions with respiratory infections.

Q When was that first report that you made the assumption that the assumption was based off of?

A I think December 31st. That report raised the specter of the first SARS outbreak. So the question -- which we believe was animal-to-human and then a mutation made it much more easily spread human-to-human, whereas MERS we think was camel-to-humans and less efficiently spread human-to-human, primarily enhanced in the hospital environment.

Q So we were operating under the assumption of human-to-human spread December 31st. When did the first airport screening begin, and when did kind of like upgraded airport screening begin, if there was a delineation?

A Well, as I mentioned, I think January 6th or 7th or maybe 8th, we did the HAN to alert people about this, and to say when you see a person with respiratory symptoms, ask them about travel history.

So that level, that's usually the more efficient way to detect things because, as was the case, most of the people we think who brought the virus into the country were probably asymptomatic at the time. So there's little you can do at the airport environment.

But the more intensive deploy to the airport was January 17th. And I should clarify that it wasn't

just -- what was ramped up then wasn't just looking for, evaluating people who had symptoms, but it was also focused on enhancing gathering contact information. So, you know, how to contact an individual who is arriving so that there could be additional follow-up from the state and local health departments.

So during -- and I don't remember if that was January 17th or that was later, but that was a perpetual challenge in this response as it was really back to 2003. That if there's a subset of people coming from certain countries compared to other nations' approach to travel, we have had great difficulty getting the electronic contact follow-up data about people so that we'd be able to monitor, are you feeling sick? To do the sort of automated things that technology allows us to do, we haven't had that information and needed to get people to airports at different times to manually get this information from people because of some policy counts.

So that was part of it. It wasn't just, are we looking for clinical illness, but actually trying to improve the ability for contact information about -- not their contacts, but how to contact them, could be gathered.

Q So just a quick to clarify for the record. We were operating under the assumption of human-to-human

spread post-December 31st.

A There's a difference between occasional person-to person or human-to-human spread that doesn't go anywhere in what we call sustained human transmission. And that was actually the big question in January. We think people are getting this from other people as opposed -- probably, based on the histories and so forth, as opposed to everybody eating a certain food or having contact with a certain animal.

But we were all looking for does it spread beyond one person? That's the typical thing with influenza pandemics or a typical avian flu, is this a one-off that it goes from one person to another, but it doesn't really go -- the virus hasn't evolved or mutated in order to have efficient human-to-human spread, where we talk about sustained transmission that you could have many people in the chain, and we weren't seeing that yet.

You know, that's where I said earlier about the reassuring data, that we looked at all these contacts and it only went to the staff, it didn't go beyond the staff. It didn't go to second-level contact, it didn't spread in the hospitals. With some viruses we see this explosive -- they're very easily spread, you know.

So when you say were we operating under the assumption of human-to-human, yes, as the primary

hypothesis. But the question was, is it adapted to be easily sustained, you know, continue to spread on? That's one of the triggers for increasing concern.

Q Yeah.

A It's associated with severe disease, because there lots of viruses that spread easily person to person to person to person, but don't cause much of any clinically relevant illness.

Q So in official communications, when making that distinction between it jumps from human to human, but maybe not human to human to human to human, and sustained with, how would you make that distinction? Would sustained or another word be in those official communications?

A We typically refer to that as sustained human-to-human transmission. That kind of gets to that R-naught that you all have been hearing about, you know, how many people does one person infect? Are there multiple generations of spread? Or is it just it gets into the family and then it's over? So those are the kinds of things that epidemiologists look at early on in a new syndrome.

Q So on January 14, 2020, the WHO tweeted, "Preliminary investigations conducted by the Chinese authorities have found no clear evidence of

human-to-human transmission of the novel coronavirus identified in Wuhan, China."

That seems to be not what we were seeing, not how we were operating. Why would the WHO make that statement?

A Based on the information that China was reporting, the individuals who they reported to have this syndrome and confirmed with this virus all had -- what they told us, anyway, as I recall, was that they had exposure to a common location where they -- you know, if it was multiple people and a family member, the family was all in that food market. So the kids were sleeping there. You know, there was -- so that ability to say, oh, wait, no it's spreading in households, or no, it's not, it's outside workers at that site, what we were told initially was that that was what was going on, that it wasn't sustained spread between people.

And while we were asking about healthcare workers, which was sort of the signature issue in SARS 2003 or in MERS, you know, spread in the hospital or healthcare environment, we were told there isn't -- the initial reports were no, no, these cases were limited to this other kind of exposure.

So that was what the early reports -- I guess by January 14th, that was what the WHO knew or believed they knew.

Q Or what they were being told?

A Right.

Q Have you read the recent U.S. intelligence report that President Biden commissioned on the origins of the coronavirus?

A No, I haven't.

Q Have you read the unclassified summary?

A No, I haven't. I've been retired and enjoying my summer.

Q Trying not to read intelligence reports.

It said the intelligence community determined that China hindered global investigations, resisted sharing information, and blamed other countries instead of themselves.

From how you just characterized what we were being told versus what might have actually been happening, do you agree with that assessment?

A I think, in retrospect, that assessment sounds right.

Q Dr. Fauci said in an interview this past spring that China's delay in that transparency had a direct impact on the U.S. response. Would you agree?

A Yes, I believe that's likely true.

Q Thank you. Back to kind of these travel restrictions, travel guidelines. When you spoke earlier,

you talked about shutting everything down was slower than you wanted, the CDC scientists wanted it to be. Were you referring to travel or the economy generally?

A In the earlier questioning, I was referring to the travel situation. I was not referring to closing businesses and so forth. I was referring to reducing the travel from affected areas and reducing the circulation of individuals who had been in those areas to try to reduce their spread, help them know to take precautions and to be staying home when they arrived.

Q You talked about it a little bit, but can you go back over the process of the CDC releasing a travel advisory, what agencies were involved, and who has the final go/no go?

A Let me qualify my answer by saying that I may not have this exactly right in that the protocols were pretty clear, but others work on them and this wasn't my main focus.

But CDC runs the travel health unit and we post advisories. Let's say there's an outbreak here, take precautions, don't travel; or people with certain conditions shouldn't travel, or be aware of this and tell your doctor.

So we have a whole set of things we post travel notices about. We have a system of escalating the level

of the notice based on the information we have about what's going on, the quality of that information, and the consequences of travel. We base those decisions on the condition, the data, and the public health implications as well as the healthcare system in the location. You know, if you're going to such and such place, all bets are off on whether you'll be able to get your dysentery treatment.

The State Department also has travel notifications and advisories, and those typically are informed by their information on the stability, the security, the threats that aren't to health, beyond health. But the CDC and Department of State work very closely to coordinate, and their numbers look a little bit different than ours, but the information that each has is shared. And this is done for measles outbreaks and meningitis outbreaks and, you know, you name it.

In the kinds of discussions we were talking about earlier where questions about what we call funneling passengers, rerouting people from what the tickets they booked was to another itinerary, the Department of Transportation and FAA are involved. And then when you're talking about citizenship or not, and the long-term permanent residents or dependents excluded versus others, Department of Homeland Security and the

Customs and Border Patrol have a big role.

So all those entities would be part of the deliberations, depending what was being discussed, whether it was just upgrading what CDC has posted on our website from a 1 to a 2, or a 2 to a 3, or do not travel or you're not allowed in, you know, more of those entities would be involved.

FAA would be talking to the airlines, or Department of Transportation likely, I believe, talking to the airlines, Homeland Security talking to the airports and the Customs Border Patrol individuals or TSA and CDC and State, figuring out what the consumer or the traveling member of the public need to know. And Department of State probably talking to other governments to coordinate the timing and the issue of diplomacy.

They do this a lot for minor things. And so, of course, it was many levels up for this particular pandemic.

Q So that sounds like the more people that are -- as often is -- the more people that are involved, the longer that process might take?

A Well, I actually think that the career staff that do this kind of have it down, but that the policy level of this particular issue was very complex. And this wasn't just scientifically what do we know, but

there were going to be policy options to be weighed. So timing.

You know, I think things can move very quickly, but the coordination and the familiarity of the individuals involved can help these things move more quickly.

Q So it can be more complicated the more factors are associated. So if it's just a public health issue, that can go a little bit faster. But if we're talking about public health, plus diplomacy, plus changing airline tickets, plus canceling flights, it can gain in complexity?

A That's right.

Q Last year, Dr. Fauci was in front of our committee and testified that early travel restrictions from China, Europe, and the UK saved lives. Would you agree with his assessment?

A Yes.

Q Have travel restrictions and quarantine been used in previous communicable disease outbreaks?

A Yes.

Q Are they usually helpful in at least curtailing early spread?

A I would not be able to give you a usual. I think that one of the challenges of this, the policy decisions for this response were timing and duration. So

sometimes it took longer than perhaps was optimal to institute, and sometimes it was very, very difficult to stop; so that some of the policies that were important at a certain stage might not have been beneficial at later stages and some of the policy decisions -- I'll just stop there.

Q But it's fair to say for the coronavirus pandemic, limiting at least early travel probably limited early spread?

A I would differentiate kind of from Europe, because one of the things we saw with China, they did a very aggressive exit block. So they put a wall around Hubei Province and didn't let people travel outside, and so travel from China to the U.S. dropped substantially before our policy was implemented.

Europeans didn't stop traveling to the U.S. or Americans didn't stop traveling back from Europe when the outbreaks were occurring. In fact, there was a lot of travel back from Europe when the outbreaks were occurring because of course people wanted to get out of there. So I wouldn't call those as early, because I think we probably had quite a bit of transmission here by the time those warnings or restrictions went into place.

Q Okay. Some people -- so you've said they worked; in this case they saved lives, they've been used

before. Some people have characterized public health-based travel restrictions as xenophobic.

Would you agree?

A Is the question would I agree that people have characterized that, or do I think --

Q Do you think travel restrictions are xenophobic for public health reasons?

A I don't generalize in that way. I think it's important to understand what is going into a policy. And there were some decisions that didn't perhaps weigh the evidence in an epidemiologic way in terms of timing and nature. So I would just say I don't like to see broad generalizations like that.

Q Okay. So what are current travel restrictions on American citizens boarding planes from, say, South American countries?

A Let me qualify by saying, for the past many weeks, I've been on leave and so it could have changed.

Q Let me --

A As I understand it, everybody, citizen or non-citizen, coming from another country to the United States has to have either a negative laboratory test confirming within the past, I think it's three days, or proof that they had received -- had had the infection within a certain period of time, meaning that they've

recovered from the infection, but they didn't have to have a test.

I believe that is what the requirement is for citizens to travel, to arrive internationally here. And that's something other countries had put in place before we did, but we put that in place last January, I believe.

Q I think it's only by -- I just looked. It's only by air travel -- is that your understanding?

A The Executive Order I'm talking about was air travel.

Q Okay. Do you think that same kind of restriction for nonessential travel is important for people coming to America by foot or car?

Mr. Barstow. I think we're starting to get outside of the scope of the interview. If you want to ask about the time period in question, I think that's fair. I think decisions or actions that have taken place after the time period are outside the scope.

[Minority Counsel]. Well, this is still travel restrictions during the time period. They haven't changed.

Mr. Barstow. Okay. That's fair enough.

BY [MINORITY COUNSEL].

Q So I'll reask the same question.

Do you think the same kind of restrictions are

important for individuals coming into America, U.S. citizens or not, if they're coming in by foot or car for nonessential travel?

A I think that's a very complex question in terms of how you define nonessential travel, the volume of back and forth along our land borders where people live in one place and work in another, and the feasibility, I guess.

So laboratory tests, of course. With the airline travel, generally the reason for the negative test is that there's a time where you're going to be on that airplane, you're going to be in an exposed space with other people. We don't want anybody getting on that airplane who might infect somebody else.

And then we recommend people get retested after they get here, you know, and that they restrict their motion once they're here until another test has been done. So that the controlled nature of international airline travel in that gap between departure and arrival is quite different than crossing a border for a few minutes every day.

So I would say I don't have a strong opinion about how that ought to be handled, but it's a pretty different story.

Q If it were to occur in five foot, for

example, or if it were to occur in kind of mass numbers and mass quantities in close quarters, would that change your assessment?

A What's the question? I'm sorry, I've lost the thread.

Q Yes. So I'm understanding air travel is more confined than foot or car. But, hypothetically, if that foot travel was in the thousands and coming from, like you said, countries that have poor medical conditions, poor healthcare conditions, poor vaccination rates, would that change the need for them to be tested prior to entry?

Mr. Barstow. [Redacted], I think we're getting outside the scope. If you want to talk about actions that took place during the timeframe in question, you can do that. Other than that, I'm going to instruct Dr. Schuchat not to answer that question.

[Minority Counsel]. I don't think anything I said was outside the scope. It was a public health hypothetical question on how she would react. It was not talking about anything specific.

The Witness. Let me give you a way that epidemiologists often think about this.

Once there is widespread community transmission in the United States, the incremental value of what you were

describing, you know, testing at a land border would be in question. And at the time that decisions were made about restrictions on individuals crossing land border, you know, from Mexico and Canada, the U.S. had much, much higher transmission than the other countries did.

So the issue of trying to put a lot of resources into preventing entry versus putting resources into controlling the transmission in the U.S., you know, the relative value of those interventions looked quite different versus an Australia that didn't have much going on in Australia.

So our situation was the U.S. had widespread community transmission, including on the land border with Mexico when there was quite limited evidence initially of a big problem there. However, the congregate settings that occur when people are housed together are always a consideration.

And one of the areas that we focused on in terms of recommendations for screening for those settings so that there wouldn't be transmission in a congregate setting, whether it's a correctional facility or a long-term care facility or some of the refugee settings and so forth.

So the transmission is different when people are going to be put in joint housing than when -- you're basically protecting that joint housing environment. So

I would just say -- I'm an epidemiologist and we provide qualifications on things, just to clarify the reason I'm giving you all these details.

BY [MINORITY COUNSEL].

Q Would that incremental benefit apply today? Would there be -- so you said kind of once it's here, it's here. Like adding more -- if our community spread is -- if the positivity rate of cases is 8 percent, adding more positive cases into that is not going to change the 8 percent?

A May I just say that today is apples and oranges to a year-and-a-half ago, and we are so fortunate to have vaccines now. And the tools that we have are quite different and, of course, the country is very different; where, you know, many parts of the country are doing pretty well in terms of vaccination and the hospitalizations and deaths, and some parts of the country are not doing very well in terms of vaccination as well as the disease burden on healthcare sectors.

So it's actually always been the case that we have had a heterogeneous pandemic here in the U.S. But I just think talking about interventions today versus a year-and-a-half ago is just really different because of the vaccines that we can protect ourselves with and the potential availability of testing, very frequent testing

here, that we can do for individuals.

Q Okay. I just have one more question. Do you think Title 42 authority is important?

A Could you be more specific?

Q Do you think Title 42 authority used at ports of entry is important?

A Appropriate use of quarantine authority is an important asset for public health when used judiciously and for public health purposes. So I think that, as with almost every authority, understanding the purpose and the use cases and the rationale is critical. So I think, in general, that's a qualified yes, basically.

Q Okay. Thank you.

[Minority Counsel]. That's all I have for now.

[Majority Counsel]. Dr. Schuchat, would you like another break, or should we continue with the Majority's hour?

The Witness. Could we take a brief break, if that's okay?

[Majority Counsel]. Let's come back in five minutes then.

(Recess.)

BY [MAJORITY COUNSEL].

Q Dr. Schuchat, I want to stay on some of the topics that we were talking about during the previous

hour.

We had been discussing travel restrictions, and you, I think, had mentioned cruise ships. So first, before we talk about restrictions on cruise ships, I want to briefly touch on some of the CDC's repatriation efforts in February and, I think, March 2020.

Were you involved in that at all?

A Some of that occurred while I was incident manager or covering as incident manager. And certainly when we sent folks out to the repatriate station sites, I was involved.

Q Did those efforts mainly involve cruise ships that had been involved in any Americans coming from China and other locations?

A Yeah. The initial repatriation was for the -- you know, primarily diplomatic committee or ex-pat community in Hubei Province. And CDC sent staff -- CDC works with ASPER and ACF, ACF and State, and then eventually DoD, because the individuals were located at DoD sites to facilitate the repatriation.

We were not in the lead, but we had staff in the sites and were part of the team that went. Later, the evacuation on the Diamond Princess and then other cruise ships we were involved, again, because of our quarantine authority that were executed for those returnees.

Q There has been some public reporting, I think that it may be surrounding the Diamond Princess and other cruise ships, that there was a disagreement between CDC and State Department and possibly others about the manner in which Americans were being transported from.

Are you familiar with what I'm talking about?

A Yes, I am.

Q Can you tell me what happened there?

A Sure. Once it was clear that there was ongoing spread of the virus among individuals who were being quarantined in place on the Diamond Princess, while those who were ill were being evacuated for care in Japan, and the Japanese were doing a great job of supporting the individuals who became ill, and then the elderly individuals, to protect them.

Once the decision was made to try to bring or offer repatriation to individuals who were quarantined on the cruise ship, there was -- you know, I was involved as acting incident manager during a weekend period, a three-day weekend, I think it was.

And the issue in place was that the members -- individual passengers on the cruise ship had been staying in their staterooms and doing everything they were told to do in order to not get the virus or spread the virus, and thought, you know, maybe I should

finish out my quarantine period here in Japan; or I really want to get home and be with family, and if I get sick, I would rather be home.

There was information that CDC drafted -- that I believe the State Department probably distributed because they had the authority in Japan -- to passengers about flights that, you know, tomorrow or two days from now there will be a flight. You will have the availability to evacuate to the United States. You will have to begin your quarantine again when you get to the U.S. If you don't do this, you will have to essentially complete a full quarantine period off the ship in Japan and be on a do-not-board thing until you come home.

So basically people were told, you can come back or you can stay in country, but you may be infectious and you can't circulate yet. And part of that information included, we will be testing people and we will not let people who are positive on the plane.

So there was a dispute, difference of opinion. At the time of the evacuation there were people on buses coming from the ships to the airport, and everybody was getting tested before they would depart, but there were a lot of people and the testing was coming back in batches. So between the time of getting on the bus and the time that they got to the ship, I believe 14 people in

different buses were identified as having been positive from tests collected the day before, I think, or sometimes before they were getting on the bus.

So we had a conversation within HHS with ASPR, Dr. Fauci and myself and I think a couple others from ASPR besides the ASPR about what to do. Should those people be allowed on the plane? Should they be required to go back to do a quarantine in Japan?

CDC's position, including my own opinion, was that being put on an airplane for a dozen or so hours with other people was -- that we couldn't ensure infection control on the airplane, and that we had told travelers that we're not going to let anybody we know is positive on that plane. And many travelers had made -- we knew from social media, people were, like, I don't know if I should go or I shouldn't go. People were making decisions about risk.

So we had differences of opinion, and we couldn't get the State Department lead in country on the phone with us during that conversation before the group. I contacted them after the group call where I said I think we should not let them on the flight. And if we let them on the flight, we need to tell the passengers before they get on the flight they're going to be traveling with some people who are infected.

Anyway, when I spoke to the State Department lead in country, he felt that he had been briefed already by the State Department medical lead in country and thought, well, the guy told me we could guarantee infection control. I said, not really, not with a plastic sheet. Plus, if you put them on there, please tell them in advance that you're doing this, because some of them may change their mind about their decisions or will lose the trust that we were trying to have.

So he wanted to get them -- it was a messy operation. People were -- it was hard on all the travelers. We all felt for that.

So basically they did put people on the flight. They didn't tell them about it in advance. To my knowledge, people found out about it when they're seeing all these people being moved around on the flight, and I think some were on social media where it became clear.

So I think what was touchy -- and this is probably pre-deliberative, but it was in the media so I can tell you. There was a draft press release that was being put together to let people know what had happened, that yes, they are being evacuated and so and so. And there was a line about after consultation with CDC and NIH, or something like that, after consultation with ASPR, CDC, NIH, the decision was made to blah, blah, blah, to put

them on a flight.

And I asked if CDC could be taken out of that, because I felt that the implication was CDC was telling them to do this whereas we really weren't. So I didn't think -- I thought, let's be silent, let's not say that CDC objected. Let's just take ourselves out of a press release since this wasn't our public health recommendation.

But somehow -- anyway, you know, people could have differences of opinion about the evacuation, but I do feel strongly that the transparency was an important issue for the passengers involved. And, of course, that was -- well, that's more than you wanted to know about that incident, but that is all I remember.

Q And so you on behalf of CDC had made your objections clear, it sounds like?

A Yes.

Q Who made the ultimate decision not to tell the passengers?

A I don't know if there was a decision not to tell them versus an active effort to tell them. But in terms of protocol, overseas the chief of mission, which is the State Department, has authority for, like, a go/no-go. Everybody else is in the consultative mode, but I think it was the consul general or the deputy. You

know, it wasn't the ambassador, it was somebody else at a high level who was saying put them on the flight. Whether he said don't tell them, I have no idea. That would be speculation versus my "please tell them."

I have no -- I think that -- personal views in a very intense conversation was he had a lot of pressure on him; the last thing he wanted was one more thing he had to do. So, you know, something that was quite important to me in terms of the -- transparency and honesty is really important in responding to an emerging infection and being a united government.

I'm fine about we're all in this together and let's go with the decision that's been made. I think the way decisions are communicated is very important, and that was one where I felt that -- you know, I felt they should have let people know. And many of them would not have changed their mind, but they would have felt that they were being treated more open.

Q And was the decision not to tell them coming from the same place as the decision not to just actually separate them and put the infected passengers on a separate flight or quarantine them somehow or whatnot?

A I can't say exactly how things worked overseas. But the official authority is the State Department, so they had the final say.

Q Just one more question on repatriation very broadly speaking. Well, what's your assessment of the extent to which the repatriation effort impacted spread in the U.S. during this early period?

A I don't think I can convey how much technical, policy, and human resources were focused on repatriation in February. As you can imagine, every location, cruise ship, had a jurisdictional issue with multiple departments and state as well as federal level authorities, and a good number of ASPR, CDC, and the leadership, HHS or other departments, were focused on repatriation at a time when the virus was spreading, and the issue of initiating mitigation and other measures in affected communities in the U.S. I believe was a higher priority.

So I think that while bringing Americans home is an important mission and doing it safely and carefully is important, my personal view is that there were key areas, like scaling up PPE and getting our arms around the supply chain and protecting the healthcare system and so forth, it didn't get sufficient attention because of the leadership and policy time that was going into the repatriation mission.

If you think about what's the ASPR role in an emergency response like this, I'm not sure that many of

the key duties were being tended to because of the focus on repatriation. And it's just another sign of how under-prepared we were, you know, frontline public health organizations and on certainly the policy level.

Q You mentioned ASPR, which I believe was Dr. Kadlec at that time in that role. Were there other authorities whose attention you believe should have been focused on those bigger picture items that you were talking about?

A I would say the whole of government needed to be focused. And certainly this has been, and continues to be, such a difficult pandemic with so much loss of life and so much disruption. And the first few months were important. Obviously, many, many things were not preventable, but a smoother, more effective leadership and policy environment would have been helpful, I think.

Q Let's actually talk a little bit about some of the structures that were set up for more of a whole government perspective around that time.

I understand that on January 29th, 2020, the President announced the formation of a coronavirus task force, which was at the time to be chaired by then-Secretary of Health and Human Services Alex Azar.

Did you have any role in advising the task force at that point in time before that element was established?

A You know, as I recall, there were a series of daily meetings, some to prepare the director to participate in the task force meetings. So exactly which were the task force meetings, I'm having trouble remembering right now. So I was aware and involved, but not an official member of the task force. I think our director was the member. And HHS was convening usually based on the Office of the Secretary staff doing the convening.

Q I think there were about 12 or so members at that planning, including Dr. Redfield. And so just to clarify, would you sometimes attend their actual meetings as a nonmember, or were you primarily advising Director Redfield about his participation?

A I don't recall specifically. What I do remember is that a few key people would have daily calls with him so that he would know the situational information. And then whether I sometimes attended those or other meetings, it's kind of -- I just don't actually recall.

It seemed like there were meetings all day, and which were the task force versus which were with the NSC group and which were with the chief of staff, I'm not really sure. But I know that we pretty much daily, multiple times a day, but definitely daily, had a call

with Dr. Redfield who was essentially in Washington the whole time. Here's the overnight information, here's the things we're worried about. We need to queue up mitigation, we need to get this on the agenda.

So I was probably at some of them, but I don't really recall what was an actual task force meeting versus a prep meeting for those. And I'm not sure how much they had the task force meetings versus the staff level meetings.

Q Is the chief of staff that you referenced, is that CDC's Kyle McGowan or is that HHS's chief of staff?

A HHS chief of staff would convene the different folks. Our chief of staff was, of course, in the briefings for Dr. Redfield, but he wasn't convening the other agencies or the other departments.

Q Were you getting feedback from Dr. Redfield about what the task force was doing in terms of that sort of big picture planning that you were talking about, you know, focus on the situation versus acquiring supplies and things like that?

A Yes. Yes.

Q And so you just gave us a little bit of your perspective on the focus on repatriation during that time. Was that something that was becoming apparent at the time as sort of lack of maybe forward separation, or

is that something that you've assessed more in hindsight?

A I missed a little bit of that. A lack of preparation or -- could you say that again?

Q Yeah. So what I'm trying to say is that you had just given us an assessment that there was sort of a -- I don't want to put words in your mouth, but I'm trying to recapture what you said.

A lot of resources focused on repatriation, and perhaps some of those resources could have been focused on more forward-looking planning efforts at that moment of time. Is that fair to say?

A I would say that's fair. And at the time we had, you know, an intimate management structure with lots of task forces, and they were thinking forward in terms of scaling up surveillance and developing lab tests and reaching out to counterparts and getting the clinical world prepared.

But I think for the policy decisions of should people coming back from Hubei Province need to be quarantined at the frontal airport, or could they travel to home and then stay at home? What are we going to tell schools, universities, and businesses? And all these issues having reached this next trigger, we were trying to queue up the planning for community mitigation for -- you know, in our efforts to delay the spread, we

were trying to queue up the healthcare preparedness in terms of PPE and reusables, and what was the strategy to get enough where we knew we didn't have enough supply.

That couldn't get onto the agenda because most of the conversations were, how are we going to deal with this batch of cruise ship people. Or are we really going to be able to stop people from getting -- you know, there were many, like, can we get a cruise ship advisory out before the day that -- you know, once a week all those cruise ships board. Every week there was another one of these cruise ships boarding with a huge follow-up as the cases emerged on that cruise ship, and individuals and groups had to be evacuated or quarantined.

So I think there was a lot of forward-planning work and workers with the health departments and so forth. But at that HHS or White House policy level, we had a real focus on the repatriation challenges and the cruise ship issues. You know, every member of Congress had people, had constituents who were on the cruise ships. So it was top of mind because it was where cases were occurring, but we knew there were cases likely occurring or about to occur in many other places.

So it was -- I believe that we didn't have the right policy governance to get the key issues escalated and decisions made.

And then, of course, we also didn't have -- we were not ready for a very large-scale quarantine effort either at the federal level or at the state level. We didn't have the systems, we didn't have the people, we didn't have the technology or the agreement on the technology to do that in a swift and efficient way.

Q What would have been the right governance? Is that the kind of things on the agenda? Why couldn't you get the items on the agenda, in other words?

A I think during this relatively chaotic period there wasn't strategic level governance. And I do think that there had been a lot of planning and practicing and preparation. But NSC had convened in prior administrations around pandemic planning, and of course we exercised that with the Ebola response that helped get critical issues surfaced and closed out with the right people making that happen.

I think this was -- whether the ASPR should be in charge or the NSC should be in charge, people can look at that and study it, but I don't think we had a strategic convening happening that allowed the highest priority issues to get settled. I think there was pretty much -- that that was a problem, not just in those first couple months, but probably in the first -- maybe the first year.

Q And we'll talk more about what happened over the course of the year. But in those first months -- in that first month of that task force that -- the White House task force, then chaired by Secretary Azar, was not providing that proceeding convening?

A It might have been convening, but it was much more tactical, at least what I saw. I mean, I wasn't in every room. And I believe Dr. Redfield would have a better sense of what the task force was focused on than I would. But certainly the meetings I was in were tactical about the small issues rather than the big -- you know, the tsunami that was coming.

Q Do you know if anyone in that room, Dr. Redfield or otherwise, was saying, hey, we should be focusing on these other issues as opposed to what we are focusing on?

A Well, the meetings that I was in, we were saying that. I don't know about the other ones. I think that -- you know, I can't say.

Q You were saying that?

A Mm-hmm. Yes. Yes.

Q Meaning you personally, not Dr. Redfield?

A Yes, I was, and others at CDC were also.

Q Okay. So did you remain involved in that task force in any capacity after Vice President Pence

took over from Secretary Azar on or around February 26, 2020?

A Again, when the vice president began convening the task force, there were times where I participated in calls, you know, in addition to Dr. Redfield. Or I know I -- the vice president, his first call with all the governors I was asked to be on that, you know, for CDC. I think Dr. Redfield had something else going on. So I was involved early on maybe in a delegated way, you know, providing the situational information or occasionally being a senior voice from the CDC perspective.

Q Did the vice president's takeover of that task force change your role in any way?

A The vice president -- I think I was at the first call that he convened. So when he took over -- what was the question?

Q Did part of that change the task force from your perspective, or did it?

A Well, initially I think that -- yes, it did change things. And I think initially he tried to make it more strategic. You know, I can say on that call that I was on with the governors, he said, you know, we're starting this. This is the most important thing everybody's doing. You all need to -- he's been a

governor, so he said, you all need to review your authorities and understand what you can and can't do, because that's going to be important in terms of the months ahead.

So I do think the initial meeting I thought he sounded more strategic, but I wasn't in on many subsequent task force meetings.

Q I just want to go back briefly to one topic that we've touched on, which was the CDC's efforts to develop testing. I don't want to go into detail about the lab issue, but I do have a few questions that relate to it.

So it has been publicly reported that before, for various reasons, tests that were developed in CDC's lab, which I understand was under the direction of Dr. Stephen Lindstrom, had become -- or resulting in faulty tests, and that tests that were sent up to labs had been determined to fail 33 percent of the time.

Does that sound correct to you?

A The test kits that were sent out, state health departments' labs were asked to do essentially a trial run or sufficiency testing. The test design had three components and so the 33 percent meant that one of the three results was problematic. So what percent of the time the different health departments were having

problems isn't exactly the 33 percent. It's more that that third -- I forget which of the three components it was -- was not giving reliable results.

The protocol was that if you tried this out with the positive and negative controls, and if you have problems, let us know. And very quickly states were reporting in, hey, we can't get this. This third one isn't reacting right.

So that, I believe, is where 33 percent came from.

Q Understood. It's been reported that CDC, at least the staff working in that lab, were aware of that problem before the tests were sent out.

Do you know if that's true?

A That, again, may be an oversimplification. What the issue was, to my knowledge, based on the evaluation that both outside and inside folks have done, is that there were multiple labs helping with this test kit, both the development, but also the preparation of kits to ship out before a contract lab got set up to do the production, and that at least one of the labs it was doing all this testing of the quality control found the same problem that the states found.

So in that sense, you know, they were running the tests and they were like, okay, yes, yes, yes. No, that should be a no. But one of the findings of our

investigation of the quality control issues was there hadn't been a pre-set, you know, how much error is okay, and what do we do when that happens? And that's one of the corrective actions that's been taken. You know, you have tests developed and evaluated outside, and then when you have a protocol that is clear on whether the criteria for release.

But they did have a check in the system for when it arrived at the state that the state wasn't going to use it for a clinical decision or, you know, for a public health decision until they were sure they were getting the expected results and running it in their hands.

So that, on the one hand, that's the test of the problem; on the other hand, the nation wanted a whole lot more testing before testing became available, and that was part of the problem, a small part, because the bigger part was the commercialization scaleup, but a very critical part at a time when the disease was spreading.

Q That brings me to the next area, which is at that time that CDC developed tests was the only tests available in the country; is that right?

A Yes, to my knowledge, that was the only tests that could be used because it had an emergency use authorization. I do believe that a number of universities and others had developed their own PCR tests

and were using them, but they had these restrictions on what they could do with the results.

They weren't allowed to use them outside of research or they weren't allowed to tell anyone. They basically were playing around with the results, but they didn't have authorization for the use of the tests. And under the FDA regulatory rules at the time, they were not offering them up to the hospitals or using them in a practical means until the end of February when the FDA announced they were not going to exercise -- or they were going to exercise enforcement discretion, which is some way of saying, look, we're not going to stop you from using these. It's okay. Please go ahead.

And then also, the companies -- you know, it's a big lift for a company to get an emergency use authorization for a test. So I'm not sure how many companies had committed to that regulatory pathway at the time that the CDC test was being offered to the states. Some of them were probably working on it, but they hadn't gotten it through the system.

Q Right.

A I'm sorry for the long answer. There's a lot of baggage there.

Q No, it's very helpful.

So I think the timelines that was going on there is

there had been -- the first case had been identified on January 20th; CDC had developed its test; FDA authorized that test on February 4th. CDC announced it would begin shipping 200-plus test kits to labs around the country on February 5th, and each of those kits could test 700 or 800 specimens.

Does that sound about right?

A Yes, that sounds about right.

Q So according to my math, the 200 kits would be capable of conducting up to 160,000 tests. Was there anyone at CDC at that time when they were being shipped out thinking we should have been thinking about the need to scale up beyond the 160,000, beyond what CDC's lab was fit for?

A Yes. I think that traditionally the CDC lab test development has been to facilitate public health testing, which is always a very small percentage of what the clinical or commercial or even academic-hospital kind of testing involves. And it's usually for surveillance kinds of purposes, you know, first arrival of a certain thing in an area, but the individual testing would be carried out by commercial labs or clinical labs.

So we had individuals that I understood were talking both to the APAHL, American Public Association of Public Health Laboratories, and there's a commercial lab sort of

equivalent kind of group that were doing outreach to try to discuss this. And I don't have details about this, but this is a clear lesson learned that there needs to be a more consistent approach.

I can tell you that I was getting calls from person A or person B about, we think we have a new something or other. And I was referring people to BARDA because traditionally -- you know, a lot of individuals were playing around and traditionally, BARDA has that advanced development, you know, we can give you some money to help commercialize that or help get it to the next level.

So I was sending people there rather than to our folks who were kind of focusing on the public health stakeholder group, the public health labs stakeholders group.

Q The World Health Organization had already developed a test by that time; is that right?

A Yes, I think it was in the -- January 20th or 24th, sometime in the third or fourth week of January maybe. I don't know what the date was. But essentially after the Chinese posted the sequence, many individuals started to work on test development.

And the German company that developed the test offered it up to WHO, and that is typically done to help with facilitating distribution of lab tests to lower

income countries who may not have the capacity to test, or the cost or the quality and so forth would be difficult. You know, China was doing a ton of different tests. Lots of countries were working on this.

But the tests from WHO -- you know, essentially when CDC developed our tests, we posted the protocol before we got the EUA. I think we posted, like, here's what we're trying to do by working on an EUA, I believe. I'm not positive about the sequence there. But the German company was also doing something at the same time, but with a much larger scaleup approach and with an audience, besides their commercial use in Germany, an audience of the lower-income countries that the WHO usually helps out.

Q Was it -- was anyone talking about using that test in the U.S. and do you know why the decision was made not to?

A I don't know if there was active consideration. But one thing to say was that the German company would have needed to apply for an emergency use authorization just as any other company in the U.S. would need to in order to make available tests. And I don't know what their capacity was.

My sense was they were producing them, but that the idea was to get some kits in every country that needed

them in terms of the lower-income countries rather than at scale for clinical use.

So, short answer, the focus was let's get -- this is not so complicated to make a test. Let's figure it out. We thought that the test that CDC was developing was on track to be useful, as it eventually was, in that the bigger issue was getting the commercial scaleup for broader use.

Q I see where you reference a dozen areas of lessons learned in terms of the strategic thinking on commercial scaleup. When should that have happened, and who would have been able to pull the trigger on that in a coordinated fashion?

A Yeah. Well, I like to contrast this with the South Korean example, because they made a decision. And I don't know whether it was -- you know, what level of government or which department did, but they made a decision that they reached to industry and said, make us tests, we'll buy them. Here's the policy we need. If you get a product, you're going to have a market for it because we want to be able to test a lot of people quickly.

And with the science being what it is right now, it wasn't so hard to get a test developed. The performance criteria did turn out to be a tricky issue. As FDA has

reported, they gave preliminary okay for people to use a lot of tests, but when they got the performance data, the tests had to be polled. So some of the tests were better than others.

And then there's also questions about what kind of performance you want. Do you want to have a test that's really good at recognizing a high-level virus in a person? Because we want to get those people out of circulation, you know, stop them from spreading. Or do you want a test that can find everybody with just a little bit of viral nucleic acid? And those different -- the different sensitivity and specificity use cases mattered.

So when I say what we need in the future, it involves a policy decision and an economic decision and a sophisticated supply chain visibility. Because you can have one perfect test that you can scale and then not have the swabs you need. So then the laboratories that you want to run that test don't have the right equipment for it, or the information that you get the data from aren't all connected.

So I think that the recommendations moving forward need sort of that holistic, comprehensive government-industry collaboration in the setting of an emergency to get what the country needs rapidly, with

quality, but where the industry really is ready to do some things at risk because they're going to get a return on their investment of time.

Q So I just want to make sure I understand. Do you have a perspective on why that didn't happen?

A I would say there are probably several factors. I'm not sure any entity squarely views it as their job. I think BARDA, to some extent, was trying to do this, reaching out to industry and trying to get some things going, but I don't know that -- I would have to speculate whether there was -- and whether it was an omission, an oversight, or it was a we don't really want that to happen. I don't know, so I couldn't speculate about that.

But I do think that going forward, we need that capacity and it's got to be, you know, one day's trigger ready, both funding, policy, governance, all in place.

Q So I understand that CDC labs didn't have the capacity. But could it have been CDC's job, or could it have been CDC's job if that was somehow directed?

A That's a much bigger job than CDC authorities and -- you know, I think -- just think through how medical testing is done in the United States. CMS reimburses for some of it, private insurance reimburses for others. Companies don't make tests that are for rare

conditions because, you know, who cares about Ebola or something?

Usually the public health system is involved for relatively rare issues that are not going to have a commercial use case. And that decision of is it going to go -- will I be able to sustain my investment, is based on forecasting about what that threat's going to do.

I think some analysts would say that we didn't get commercial tests for Ebola because it wasn't -- even when we were worried about it in terms of importation, it wasn't going to be a sustained market here. And that really slowed down the availability of accurate testing for those outbreaks and travel and so forth.

So I don't think it's an FDA thing or a CMS thing. I think it's a higher level policy decision about how to ensure that we have that capacity. And it could be part of the ASPR/BARDA realm, but, again, I don't think ASPR was thinking about like lab testing. I think they were thinking about repatriation.

Q Okay.

A Now, that's just to my knowledge. I didn't mean to interrupt. But as far as I know, the extent to which beyond BARDA there was attention on this, I can't say.

Q Understood. Thank you.

I'm going to switch topics. I think we have about 16 minutes left or so in this hour. So I want to spend some time talking about public communications, the federal roles in public communications and public health emergency, and also some specifics to them.

So to start out, I would be interested in your perspective on the role of public communication, public briefing in a public health emergency.

A Thank you. My personal view is that the most important intervention in a public health emergency is effective communication, in that communication provides the tools for those people in leadership, technical staff at any level, to provide public stakeholders/partners with what they need when they need it in a way that they can absorb it. And that you can have an effective operation and fail if you don't communicate effectively.

And if you don't have an effective operation, you know, you're going to fail, but doing communication well can mitigate some of that. So strong execution with poor communication is almost as bad as no execution, because your execution will not be effective without strong communication. It couldn't be a higher priority, as far as I'm concerned, in all of the responses that I've been part of.

Q How does CDC determine when information

should be shared with the public?

A One of the features of risk communication is transparency. The principles are being open, honest, empathetic, telling people what you know, telling them what you don't know, what you're doing about it. And so our sort of mantra is we want to be first, but we want to be right and we want to be credible. And when you're first, you may not have all the facts, it may be hard to be right, but you can retain your credibility by being open about what you don't know.

So that first HAN that was issued, we don't know very much, but here's what we know and here's what we think the clinicians should do. The many briefings that were done in January, that CDC did in January, were like textbook risk communication: We found out this other information, here's what we think it means, here's what it means to you, here's what you can do to protect yourself.

So I think that we generally -- I would say when we think we know something we want to tell people, because getting out there quickly can help frame the narrative in a way where you build trust rather than have suspicion. So the transparency is very closely linked to credibility.

Q And then from more of an administrative

perspective, how is public communications handled, who sort of drives the decisionmaking, and what offices coordinate in that?

A Well, it would depend, of course, on the nature of the information and then the impact and how extensive is the need to know. Is this a very obscure scientific result, or is this something of interest to the general public or just to healthcare professionals?

But for our communication products or certainly our media engagement, the CDC's office of communication works with the HHS Assistant Secretary for Public Affairs, or ASPA unit in proposing and getting approval for our media communications. There's lots of little things that might not need that, but media briefings would certainly go up through ASPA.

Q What was your role -- and let's focus on starting in the January 2020 time period. What was your role in determining when and whether CDC would give media briefings or press conferences, public briefings about the coronavirus?

A I wasn't directing that, but I was aware and happy with the frequent briefings that were occurring. In some other responses I've said, hey, you guys, you're so focused inward, you've got to do a HAN or you have to do an MMWR. Can we just do a telebriefing? We need to

make sure other people know what you all know.

But there was very regular media briefings, sometimes with very little new information, to just help people see we're still on it, we're looking at it, or something else happened that we need to frame for you.

So I wasn't in the decisionmaking authority there, I was aware in that January timeline, January-February timeline, pretty much.

Q Did you become part of the decisionmaking authority when you took over as incident manager?

A Yes. Well, yes in the sense of recommending. I would say perhaps more than media briefings, I was trying to -- I would learn about something and say this is really important. We need people to get this out. Can you put it together for an MMWR that can lead to the media explanation of what's going on?

But by the time I was incident manager, the White House task force had been reconfigured and they were really leading the media engagement. By March 20th, we were not doing the briefings anymore at that point.

Q So in that early period, when you were not approving -- or, sorry, you were not driving the briefings, who was actually determining what should become public briefing or press conference?

A Well, in the incident management structure,

the incident manager's essentially leading the entire response. And we have a Joint Information Center that has all the communication stuff in it that reports in to the incident manager, and that reports to Dr. Redfield who reports up to the department.

Dr. Messonnier was designated initially as the lead spokesperson for the response. I had done the same thing in 2009, when I had the same position that she had at that time as Director, National Center, for Immunization and Respiratory Diseases and a subject matter expert. In 2009, I did a lot of the briefings when the director didn't, and Dr. Messonnier did them relatively consistently for CDC during that January period.

So I think that while the communication staff would be sort of helping to shape what went in, she was delivering and enabled, of course, with her expertise to answer a lot of the questions that would arise.

Q At that time, what was the approval process to having the briefing? And I don't know if there should be a distinction about the facts of the briefing and the content that was being given at the briefing, but if there is, please feel free to interject.

A Yeah. I think that while the incident management structure is in place, a media briefing goes from the response, from the IMS to our office of

communication, as I understand it, to ASPA for decisionmaking. The office of communication could clarify, does it ever go just directly from IMS to ASPA without the office of communication engagement can get a little blurry, because a lot of people from the office of communication were part of the response.

But my sense is that we have sort of a protocol of, you know, we'd like to do one tomorrow. Here's the time we'd like to do it. Here's a general update. Or we've gotten new information about airplanes, and the spokesperson would be so and so, and this is the general nature. But I don't believe -- I don't personally know whether any kind of text has to go up.

When I was doing these briefings on H1N1, it was realtime. I was in the response and knew what was going on as the chief health officer, and so it was, like, we're doing it tomorrow what we significantly know now, here's the first situation, and then answer any questions people have.

So I'm not sure there's like a script that goes up. But certainly the date and time partly because you don't really want NIH and CDC both having a press conference at the same time. That could be awkward. Or there's sometimes often in H1N1 where there was a decision, why don't we do an HHS one? And Dr. Fauci and Dr. Goodman,

who was the FDA counterpart, and I would do them together as a joint.

So a long answer to say we've always for media briefings submitted the proposals to HHS. And usually the spokesperson is sort of, you know, almost preapproved because they've been doing that. They're listed, but it's like, yeah, this one will be the one who's usually on that list of spokespeople you're familiar with.

Q And ASPA is the one that's always giving the approval to move forward with the briefings?

A We would receive the approval. I mean, I would be speculating because I'm not in this chain. But my sense, I know from my time as incident manager, are we going to do a briefing? We're waiting to see if ASPA approved it.

I don't know who with ASPA or what they do, whether they have to get approval from elsewhere, but they would be the ones reporting back to us, yeah, it's okay, but could you do it at 3:00 instead of 2:00? Could you do it at 11:00 instead of 12:00, or something.

Q So you never heard either in January, February 2020 or prior, of the White House or others outside of ASPA approving or denying CDC requests for briefing?

A I think if they did, we would have known,

because the message would be delivered by ASPA to us. I mean, we wouldn't be seeing who or what office. You know, the chain of communication goes through HHS if others need to tell us.

[Majority Counsel]. We are just one or two minutes before our hour, so this is probably a good place to take a break.

And I propose, if the Minority questions -- if they have any questions, we take a longer lunch break, but we can see how much time. You mentioned, [Redacted], I don't know how many questions you'll have, so depending on that, we can discuss after?

{Minority Counsel]. [Redacted], Dr. Schuchat, I'm sorry, our next round of questioning will probably be under 10 minutes, in that type of range. So we could take a break now if Dr. Schuchat wants, or we can just go for 10 minutes if she wants, if that's okay with you, [Redacted], and then maybe break for longer. I just want to throw that out there, whatever you guys decide.

Mr. Barstow. Let us talk for a couple minutes and we'll be back on.

The Witness. For less than 10 minutes we'll talk and then tell you.

[Majority Counsel]. Okay.

(Recess.)

BY [MINORITY COUNSEL].

Q So, Dr. Schuchat, you were just talking about the importance of telebriefings particularly when information changes. I think you said that they are an important aspect of risk communications during public health emergencies. Is that a fair characterization?

A Yes.

Q Are we still in a public health emergency?

A Yes.

Q So it would be important to have telebriefings on subjects like the delta variant?

Mr. Barstow. It's outside the scope of the investigation.

[Minority Counsel]. Are you directing her not to answer that question?

Mr. Barstow. Yes.

BY [MINORITY COUNSEL].

Q Would it be important to have telebriefings about access to booster shots?

The Witness. Can I clarify something?

Mr. Barstow. Sure.

The Witness. Just to clarify that frequent communication with the media in a way that allows for substantive questions to be answered by appropriately informed scientific, technical people is important,

whether they are group telebriefings or frequent media access.

I can say that in 2009, at the beginning of the H1N1 pandemic, we did many regular telebriefings, but we were -- we were instructed, don't turn anybody down. You need a pool of people who can answer. There's going to be a thirst for information, and the more we are sharing the better. And so many venues, telebriefings with a pool of reporters asking a ton of questions, plus the media availability and other things.

So I think it's -- I wouldn't want to say it's just one tool, but availability is important. And in the beginning, it is the most important period because of that framing and that trust building.

BY [MINORITY COUNSEL].

Q So telebriefings are more like a tool in the toolkit than the end all be all?

A Yes. For the transcriber, I was nodding my head yes.

Q So daily briefings from the White House briefing room would be a good alternative?

A I would say that is only if the briefings are viewed as informative and not politically driven. So in some responses the risk communicators, their little books and everything say it can be important to have -- it may

depend who's the right spokesperson, but that the messenger is important.

And that it's totally fine to have this briefing kind of thing be from the White House or from someplace else, but that it is viewed as neutral and not a political spin, you know, in terms of the trust and the skepticism that is natural.

So you could see in a number of countries how this was handled differently, whether it was the health ministry in other countries or it was the chancellor or somebody. But I think the issue is what is being shared and who is answering the question.

Q Does that trust and skepticism you referenced swing both ways? I imagine, at least in the partisan framework that you mentioned, some Democrats might be skeptical of information coming from Republicans and the other way around, some Republicans might be skeptical of information coming from Democrats?

A We think it's really -- I think, in general, trusted messengers are critical and those are at every level. So in a complex emergency where state, local situations are very different, hearing from people close to you in terms of your situation can be very helpful. And the national level of briefings may be more on that high-level, generally this is what's going on, your

health officer is going to know what's the circumstance in your state.

But there's been a number of issues in some of the emergencies, this one or the H1N1, where there were national level issues going on, you know. So that's just to say that you don't generally want -- you know, you want your spokespeople to be viewed as nonpartisan, credible, empathetic, trained, good communicators.

Q Do you think Dr. Fauci falls into that category?

A He has been a go-to during this response and many prior. And -- yes.

Q Do you think Dr. Birx falls into that category?

A I probably don't have a simple answer to that.

Q Okay. Do you think --

A Maybe I could just say that Dr. Fauci has been a public spokesperson during numerous national infectious disease emergencies, and Dr. Birx was new to that role. As an HIV specialist and global health specialist, she hadn't covered the early days of a domestic focused respiratory infectious disease outbreak, and Dr. Fauci had, as had some of the other people who, you know -- so that was my qualification there on

Dr. Birx.

Q So do you think generally having political-led briefings is problematic?

A Well, I think the content and the way the information is delivered is the most important. And -- you know.

Q Sorry to cut you off. You said that these briefings should be nonpartisan. Do you think having partisan people provide COVID-19 information can be seen as problematic?

A Let me just give an example.

I think having situational updates where the President is part of the briefing could be problematic, and whereas having a task force do a briefing that is not viewed as -- it could be helpful. But it's hard to generalize about -- you know, this has been a response that involved multiple sectors, so it isn't just health of course, with travel and trade and business and so forth. But I think that what you really want to do is build trust and be supporting a view of openness, honesty, transparency to build credibility.

So there are probably politicians that can do that and there's politicians that don't do it as well. So I'm again trying to be specific and just not really focus on -- you know, this is an all-of-government response,

and so the political level is important. But I think that you want the public to believe that what they're hearing is going on is not being shared through a spin, but rather in an honest way. There are probably lots of ways to achieve that.

Q So would you say, hypothetically, a political person announcing a medical countermeasure prior to that countermeasure being approved would be problematic? I can be more specific.

Announcing the use of a vaccine for an age group prior to that vaccine being approved for that age group would be problematic?

A What I would like to share is that announcing hydroxychloroquine as a --

Q That's not what I asked.

A -- by a political spokesperson is very problematic. So that would be my answer to your question.

I think that one thing to say about vaccines that's quite complex for both administrations is that -- and it's important for Congress and the public to understand. There are a number of levels of decisionmaking with vaccines that the government's been doing since March of 2020 in terms of decisions about development, decisions about investment, decisions about manufacturing of scale,

decisions about production, procurement. So there are a number of things that are aspirational, and then there's some that are operational.

So there are different ways to communicate the different -- you know, that you would have to plan and then you have a process to carry out the plan, and sometimes the nuances are lost in the translation and sometimes they are obscured in the translation.

So I think you want -- it's fine from my view for politicians to be announcing, we want to be able to achieve X by Y, but I think the public needs to be able to trust in the systems that will get you there.

Q Okay. In your 30 years at CDC, how many times has the CDC director overridden a recommendation from ACIP?

A So let me just say that ACIP is a deliberative group, and the structure is that they openly, publicly deliver and review data in order to have that considered. They have something called an evidence recommendation framework, which is transparent, about where there is data and where there isn't, and what the competing values are, you know, if they see risk, benefit, et cetera.

So unanimous decisions or unanimous views or recommendations from ACIP are not usually tinkered with.

Issues where there's a lot of differences of opinion and it comes down to values, I'm aware of that happening before.

Q How many times, directly overridden?

A What I would say is the concept of overridden doesn't really apply when there's a -- I think the way that ACIP members deliberate, they deliberate, stakeholders deliberate, the public gets their voice, and then each of them makes their decision.

So I would say nine people saying one thing and six people saying another thing for different reasons is not something that is really overridden versus taken in consideration for a final decision by the director. And that's why you want a strong scientist, clinician, parent kind of person, not necessarily having to have all of those things, but you want someone who is able to handle complex information and gaps in information and make the best recommendation.

I think this is different than a body where the CDC director doesn't have a role, but I don't -- anyway, that's maybe more than you wanted, but I have seen ACIP have trouble making the decision. Sometimes they don't even want to make a decision or a recommendation, and so there's opportunities for the director to suggest and consider. And so I don't think -- you know, that's

probably what I would say.

Q Okay. The vote you just mentioned was the booster shot vote for 18 to 64, 18 to 64-year-olds that work in places that have occupational hazards, but they themselves have no underlying medical conditions. ACIP voted 9-6 to recommend them not need boosters, and they said their recommendation was based off a lack of evidence.

Overnight, the CDC director, Director Walensky, pretty much eliminated that recommendation and instead, contrary to the evidence and contrary to ACIP, recommended boosters for that group of people.

How many times does that happen?

Mr. Barstow. I think Dr. Schuchat can clarify one thing you just said, [Redacted], but we are now over the scope of the interview. So I will allow her to clarify one point you just made, but not to further engage in any discussion about routine actions.

[Minority Counsel]. Kevin, for clarity, she opened the scope.

Mr. Barstow. No, no, no. You opened the scope, but --

[Minority Counsel]. She mentioned the exact vote of what I hadn't asked about yet.

Mr. Barstow. [Redacted], everyone knows what you're

getting at. You're the one who opened the scope. She can clarify something you said. After that, I'm instructing her not to further answer any questions about this matter.

[Minority Counsel]. Okay.

The Witness. Her decision was what we call a permissive recommendation. You had said she recommended that group be vaccinated. Her recommendation was that they may be vaccinated, which is equivalent to saying they can make a decision based on their discussion with their doctor or their personal concerns or whatever, as opposed to they should not have access.

So it was different than the recommendation for those over 65, which was they should. So it was a may, not a should, you know, a direct recommendation versus a permissive.

And related to permissive recommendations, ACIP over the years has had a lot of trouble with coming to agreement on how to handle that. So it is not at all unusual that there are different views on what is a permission consideration. Those are usually where -- whether there's evidence gaps or whether there's different ways to value the evidence of benefit and risk, those are the hardest ones because it's not clear cut, slam dunk, or absolutely don't. There are reasons that

many may not want to have them.

So that's just what I want to clarify.

Q I appreciate the clarification. You don't need to answer this, but ACIP didn't have an issue in this case. It wasn't 50/50. It wasn't we can't make a decision. It was 9 to 6. I understand it was a close vote, but it was still a vote.

So I'm going to ask you the question, in your 30 years prior to this year, how many times had a CDC director altered, overridden, changed, otherwise modified an ACIP recommendation on a vaccine?

A I don't remember in my 33 areas at the CDC, including 10 as the National Center for Immunization and Respiratory Diseases director, any vote that was in that range of 9 to 6.

Q That's not what I asked. It's a simple --

A There's 15 to zero, 14 to 1, 13 to 2. I don't recall any that were that way that passed, actually, in the sense that it's really unusual for there to be that much division in an ACIP vote. That, you could look through. They're all on the web how these things go. But basically they're usually -- they usually are quite close to unanimity. So this would be -- this was a very unusual set of deliberations, I would say.

Q So how many times has an ACIP recommendation

been altered, modified, overridden by a CDC director prior to January 20, 2021?

A I don't actually know. I think I answered you in my last response, but I don't think I know based on my saying it was extremely unusual for there to be nine people and six people.

Q Okay. Thank you.

[Minority Counsel]. I think that's all I have for this round. Thank you.

[Majority Counsel]. How much time would you all like for a break?

The Witness. I think a half an hour.

[Majority Counsel]. One o'clock sounds great. We will see you then. Thank you.

(Lunch recess.)

BY [MAJORITY COUNSEL].

Q On February 26th, 2020, Dr. Nancy Messonnier gave a telebriefing update on COVID-19. During this briefing, she warned about the risk of community spread saying, "We will see community spread in this country. It's not so much a question of if it will happen anymore, but rather more a question of exactly when."

Are you familiar with this particular briefing?

A I think it was the February 25th, but, yes, I'm familiar with that briefing when she spoke and used

those words, yes.

Q Okay.

A We can all double-check on that. I think it was the 25th.

Q I think you might be right. I think the transcript was the next day.

A Yes.

Q 26th on the transcript.

Do you believe that Dr. Messonnier's remarks were accurate at the time based on the best known information?

A Yes, I do.

Q It's been recorded that the President was angered by Dr. Messonnier's remarks at the briefing, I think it has been widely reported publicly. I'm wondering if at that time you were aware of any feedback CDC received from HHS or the White House?

A What I can say is that on February 25th, I was in Washington, DC doing some briefings and so forth. And I was not following what CDC had done a briefing on, but I was asked to adjust my schedule so that I could join the Secretary in a media briefing that afternoon on COVID.

So my familiarity was there had been a briefing in the morning and then there was another briefing that afternoon that I was asked to be part of. And I didn't

know why, I was just asked to attend.

Q Did you later find out that there were other reasons for the later briefing?

A The impression that I was given was that the reaction to the morning briefing was quite volatile, and having another briefing -- you know, later I think I got the impression that having another briefing might get -- you know, there was nothing new to report, but get additional voices out there talking about that situation.

But my remarks were quite similar to what Dr. Messonnier said in the morning based on the situation at the time.

Q How did you develop the impression that the afternoon briefing was meant as a response or reaction to follow the morning briefing? What did you get that impression from?

A I don't remember exactly. It may have been from our chief of staff, Mr. McGowan, that I got that impression. But I don't remember exactly. So that's just a vague sense of how I may have gotten it from the discussion.

Q Was all the information assigned shared at the afternoon briefing complete and accurate?

A Yeah. I mean, everything I said was based on the situation as we knew it. And I had gotten some

material from briefings, so I would know what the situation numbers and so forth were.

Q Apart from what you may have heard from Mr. McGowan or perhaps in conversations with him or others, did you ever hear about any reaction or blow-back from the morning February 25th briefing?

A I mean, it was widely covered in the media, so it's hard for me to remember what was reading about later versus aware at the time.

Q Well, I guess specifically, I think there have been some reports about the President or others wanting to take employment action against Dr. Messonnier. Did you hear any internal conversations about that possibility around that time?

A I did not directly hear conversations about that.

Q So I think following that particular briefing, CDC conducted, I think, four more public briefings in the next few weeks. I'm going to assume they actually happened the day before they are listed here, so February 27th, March 1st, March 2nd, and then March 9th. I think that my understanding is that on March 9th, Dr. Messonnier also took over the briefing and gave similar warnings.

After that point, CDC stopped providing public

briefings until about June 11th or 12th, 2020; is that correct?

A That sounds right.

Q Do you know why CDC stopped providing public briefings during that period?

A I think there were two factors. One was a request. We would submit a request to the others to do a briefing and it was declined, and then -- or we didn't get approval to be able to do one. And then at some point during that period the White House task force began doing briefings that were not really -- I would say they didn't get carried out exactly the way we would have done them in terms of the content or Q&A or availability. But as a whole of government response, the communication center moved to the task force.

Q You mentioned having requests denied. Who communicated that denial to you?

A In general -- let me speak generally.

When the media would request for me to speak, you know, in a one-on-one or some sort of -- you know, if there was an ask for me personally, I had the CDC media contact a public affairs support person who would submit a request through our office of communication to HHS for the ASPA to let us know.

And so my contact -- there were several requests for

me personally, and basically she said we didn't get approval or we haven't heard back or it's too late. They either said no or they didn't say anything.

For telebriefings, it would be a different story that our office of communication would be directly communicating with ASPA. And I wouldn't have seen the back and forth on that. So I'm only familiar with when somebody asked for me, and it got to the point where I was surprised when there was approval. I was, like, are you sure? Did they really say I could do that interview? Let's make sure before I do it.

So there were not too many interviews after the February time period.

Q So just to make sure I understand, in the sense a media outlet, say, requested you for an interview, that request process would run its way up through ASPA. And before this time period, were those requests generally approved and then after they started being denied?

A That's right.

Q And were you ever given any explanation of the reasons for the denials?

A Only one time where I pushed and said, you know, do we know why not? You know, I got the email trail on that one, and it was from the White House

communications had said, no, we won't have time to prep her. We've made lots of announcements this week and we can't get her ready by the morning show.

So that was the reason that that one was not approved.

Q Do you remember what the subject matter of that briefing was going to be and why you wanted to push so much for it?

A It was a morning show asking for a COVID update. So it wasn't a particular topic. But, you know, as the prior responses, I did a lot of general updates of the respiratory infectious disease expert and emergency response person, helped frame what we think is going on. Not policy updates, but just situational. So anyway, that was what we got back.

Q Do you recall any specific telebriefing requests being denied?

A I do recall the agency asking to do briefings, but I don't recall when and which ones. I know there was a point where they stopped asking because they kept saying no. So I knew where there were some we asked -- you know, there was enough going on or we had important content coming out.

The typical rhythm was if we had a lot of new science coming out, we wanted to push it rather than just

respond or not respond at all and let others be trying to interpret it. And in that March-April period, there was a lot of -- in the U.S. in terms of the field investigations we were doing and the emerging understanding of the situation both here and around the world.

And so rather than -- you know, if we had two or three MMWRs coming out, the ability to explain them as a narrow focus rather than as a policy kind of thing could have helped disseminate that fast-moving case of understanding that was going on.

So, basically, we didn't get approval for most of those, so far as I know.

Q Do you have any sense of how many requests were denied?

A No. That -- I wouldn't be in the right chain to give you that sense. But I do think that, after many denials, it was like they're not going to submit those, so let's find other ways to -- you know, we did lots of what I call webinars or we have something called a COCO call, which is a clinician outreach communication activity where we reach tens of thousands of clinicians with, here's what that study found, or pulling together this expert from this hospital in this state and this other researcher to make available information. But

rather than using the media to get to the public, we did a lot of partner outreach and lots of reports that would get information out for others to digest and disseminate.

So we had to go through third parties pretty much as opposed to most of the responses in the past.

Q So is it fair to say that you shifted your strategy in order to reach the public during that period of time?

A Yes.

Q I think you had mentioned something earlier during the Minority's questions about regular communication being particularly critical during early part of emergencies. Why is it so important to have more communication earlier in the emergency rather than later when perhaps the emergency is ongoing, but the situation is more stable?

A The first period or the first few days, sometimes hours of an emergency, information is usually sparse and the situation is quite dynamic. And to establish and sustain credibility, it's important to foreshadow that what we're seeing now is based on what we know now, and that could change.

So, you know, right now we're not aware of widespread transition in the U.S., but that could change. Right now we think masks need to be given to healthcare

workers, but that could change. Right now we think masks protect you from spreading to other people, but we don't know if they protect you for yourself. So our message is, wear them in order to protect you spreading to other people. Hey, we've got some studies, now we know, it actually protects you also. That's why we're updating the mask information. Or, hey, the virus has changed. Now we know it's spreading in a more efficient way. It's important even for vaccinated people to wear masks.

So the first few days you're setting the stage for a dynamic learning experience and you're keeping the public with you. And so if you're not doing that or you're doing it in a way that is very overconfident, you lose your credibility as more information emerges.

We learned actually after the anthrax response in 2001 that when CDC puts out guidance in an emergency response, we have to call it interim, because it's always interim. Because things can change, we can learn more, some things work even better than we thought or not work at all. And we need to condition clinicians, the public, you know, the public health for that very fast-moving period.

And I'm really passionate about the topic, so I'd go on at length. But that's why it could be so important in an emergency response to be helping frame -- I don't

think it's the same as - the same, I think it's interpreted based on what we know, but we have these gaps.

So that's why in past emergencies CDC did these very long briefings so the media could get it, they could ask their questions, they could get the scientists answering to the best of our knowledge and then move on.

Q You mentioned one of the reasons that you were given or that you understood for the CDC not doing the briefings during this period is that the White House task force had taken over that role.

In your opinion, were the White House task force briefings that occurred an adequate substitute for the CDC briefings or other information that CDC would have disseminated through the media?

A I should qualify this by saying after a certain point, I didn't watch them anymore. But my sense of the ones that I saw were that they were not, in general, an adequate way to -- you know, there were parts of them that were probably fine, but that the -- you know, the intrusion of conflicting points of view from the speakers were -- you know, I used the example of the briefing where the policies to recommend masks for the general public, which I think was a critical, essential tool in our toolkit early on in this accelerating

epidemic, were at the very same briefing where the scientists were describing these new policies, a politician said that he was not going to use that.

That, to me, was a poor way to announce the new policy that had been reviewed and bought into and agreed upon. So I think the idea of conflicting messaging, even in the same press briefing, let alone insufficient time for media to really ask their questions.

Q I think you might be referring to the President's comment on April 3rd, he said, "The mask is going to be really a voluntary thing. If you do it, you don't have to do it. I'm choosing not to do it, but some people may want to do it, and that's okay."

Is that what you're referring to generally?

A Yes.

Q I believe -- and we will talk about this a little bit more -- I believe the CDC had put out guidance on face coverings that same day.

A That's right. And the way that guidance was announced was in that press conference, because we didn't do a press briefing ourselves. It was through the task force essentially.

Q So is it your opinion that comments like that at those briefings undermine the government's response to the pandemic?

A I think that that was potentially confusing to the public and may have reduced use of a preventable tool that we had before we had vaccines or many other means to reduce spread. And particularly at a time where a number of -- where a lot of thought was going into how some settings could reopen or could partially open, the masks were a key tool in that toolbox. And so that mixed messaging or contradiction of the message was unfortunate.

Q I don't want to belabor this at all, but I will just read you one other quote. You had mentioned hydroxychloroquine before. On March 19th at a White House briefing, the President said that he described it as very encouraging. He said, "I think it could be a game changer."

Was that true at the time, in your opinion?

A No, it was not.

Q So, again, is it your perspective that that kind of information being put out in that type of press briefing could have been harmful to the response?

A I agree with that.

Q I'm guessing your colleague has spoken to the media often, not by name, but there are some quotes that they have made about CDC's authority to communicate to the public during this period of time.

I think one quote reported in CNN in May 2020 said that CDC officials say they've been, "muzzled and that their agency's efforts to mount a coordinated response to the COVID-19 pandemic were hamstrung by a White House whose decisions are driven by politics rather than science."

Do you agree with that assessment?

A That is the feeling that we had, many of us had.

Q Do you think that allowing CDC to speak publicly -- or perhaps a better way to say it is, is having clear, consistent, and accurate messaging, regardless of the speaker, particularly in that early stage of the pandemic, could or would have resulted in fewer infections and deaths in the U.S.?

A Yes, I do. And I think that we can look around the world or even to local health departments where there was a consistent, coordinated messaging helped to build trust and cooperation. You know, this is a difficult pandemic and it's lasting a very long time, and everyone's tired and people have lost loved ones and, you know, it's been incredibly difficult. But the divisiveness early on, I think, was a major challenge. And so, you know, I do share the sentiment of this.

Q And just to put a point on it, the issue is

really not numbers of CDC briefings and whether there's telebriefings versus other forms of communication, but really the substance of clear, consistent, complete, and accurate information. Is that something you generally agree with?

A Yes. And I think we also recommend empathetic delivery. So I think with the mask issue, where I think it's a very important tool, you know, and it has been for most of the response, the idea that we recommend it for this reason and that reason, and then we learn more and have additional reasons, but that we don't make fun of people who are wearing masks for their protection.

So, anyhow, I do think that it doesn't have to be CDC. It can be others doing communication. It's how, what, when, and the trust that they have and the way that they deliver what I hope is accurate information.

Q Is there anything else you think we should know about public communications from CDC or about the pandemic response in general?

A That over-communicating is better than under-communicating and that using lots of channels, because different people are trusted and that the situation is different in different local areas. So that having the strongest frontline public health system that

is skilled at both understanding the data that they're getting and communicating that back to their public in many channels, you know, the infrastructure of public health as well as pulling politics out of it as much as you can is really important for the nation's protection and our security.

Q Thank you for that.

I want to turn to a new topic. First talk about some of the public health orders, Title 42 orders that were entered during the pandemic, and then turn to some of the public policy guidance. And in almost all these cases, we have pre-marked exhibits with copies of these guidance documents; however, in the interest of recognizing the short amount of time and the amount that we would like to cover today, I'm going to try to avoid marking every one or introducing every exhibit. And to the extent you're familiar with it, we won't really parse through the language, but I just want you to know that they are there and if you need to refresh your recollection, they can be marked.

So the first public health order I want to talk about pertains to cruise ships. But just before we go into what happened with regards to the no-sail order in March 2020, what was your role? And I understand that this is before you were back full-time for that period on

the incident -- as the incident manager of that.

What was your role in terms of recommending, adjusting CDC's public health orders or approving?

A I wasn't involved in drafting recommending, revising the public health orders around transportation.

Q So did you have any involvement in the March 14th no-sail order?

A I don't recall involvement. That doesn't mean I wasn't at a meeting where it was being discussed, but I don't recall specifics about that.

What I do recall was the epidemiology we were seeing of numerous outbreaks on cruise ships and the idea that it wasn't possible to make it safe for individuals, crew, travelers to be on a cruise ship during this phase of transmission of the virus.

Hence, whether -- like I don't remember like no-sail order versus global advisory against cruise ships. I don't recall the policies deliberation, but I do recall many briefings. Daily we were getting updates about other outbreaks on cruise ships and the number of ships out there that had active outbreaks and the challenges which devolved to public health, state or local or sometimes federal, to get people off of those ships and into safe handling.

So I recall the issue being quite active, but I

don't recall the decisionmaking tree to get to a no-sail order. And, again, I wasn't the incident manager on March 14th when that decision was made.

Q There have been some reporting that -- or our understanding is that CDC had wanted to institute the no-sail order earlier than March 14th probably for the reasons that you're suggesting, the pattern of outbreaks on cruises and high risks posed by the close quarters on those ships.

Do you have any knowledge of any discussions regarding whether or when a no-sail order should be implemented?

A What I can say is that the transmission on cruise ships had spawned an entire task force. And we had a -- within our enormous emergency operations center and so forth, there was a whole war room really just tracking cruise ships and how to support the issues that were emerging on these individual ships.

And the idea of stopping the new cases was quite -- you know, both for the health and safety of the travelers and crew and for the communities they would return to, that it was a major concern. And whether it was voluntary or through an order that -- stopping initiation of cruises was a strong recommendation from the agency, insofar as even after the order went out.

I don't have the details, but I believe it was quite a long period where the crew were still on the ships with outbreaks that were being managed. And so it wasn't like you had a no-sail and suddenly everything was fine. It was a very long tail for the mitigation of those individuals that were at risk and a way to safely get the ships back to port.

And then it was a big issue for the ports they were getting back into. So I think the earlier we could have reduced the new infections, the better.

Q There's similarly been reporting that in September, when the original March 14th order had been extended several times, but it was set to expire on October 31, 2020, and the reporting said that Dr. Redfield had intended to extend it through February 2021, and that the White House overruled that decision.

Do you have any familiarity with that outside of public reporting?

A Yes, in the general sense that our team was trying to make it -- it was inconceivable that everything was going to be fine, and that the volume of work involved with a monthly review versus the time that -- that same team was going to be thinking through how can they help the industry figure out how to make this longer term.

But with the surge that began in the fall, the idea of just going to October 31st seemed like it was going to be extremely, like, improbable that you wouldn't want to extend it. And yet every review is labor intensive and the efforts could be better used by extending it longer, through that winter period and through -- as we've seen, it was longer than February that there were challenges with transmission.

Q Do you know what that team was told in terms of why the order couldn't be extended?

A No, I don't. I don't have direct knowledge of that.

Q Who would have the most direct knowledge, apart from Director Redfield himself?

A Probably our chief of staff Kyle McGowan. He was sometimes in the negotiations about policy on behalf of the agency, the political conversations that were going on. Dr. Redfield was very involved in this, and so he was probably aware of why his request wasn't given. But if he doesn't know or you're not talking to him, I would say Mr. McGowan would probably know.

Q I think that this particular reporting -- and I don't know when the decision was made internally, but my understanding is that Mr. McGowan left in August 2020?

A This was September. Okay, sorry.

Q So --

A But it still may be, though, that the negotiation was happening before he left because they knew it was going to be expiring. When was it -- it was going to expire September 30th. Anyway, I think he would be aware of the conversations, but if not him, I would say Dr. Redfield, possibly even Dr. Cetron who I mentioned earlier. But he may not have been told the reason it wasn't, and Dr. Redfield would have been told or our next acting chief of staff might have been told, Ms. Witkofsky. She picked up the portfolio.

Q So moving on to another public health order.

On March 20th, 2020, there was an order under Title 42 suspending the introduction of certain persons from countries where a communicable disease exists. In other words, there was an order to close borders and to support unaccompanied children in asylum.

There's been public reporting about the way in which this order was instituted. Do you have any knowledge about how it came to be instituted at this time?

A I don't have knowledge about the final decision. I'm familiar with the CDC's presentation of data about the relative risks of disease in different sides of the border. And at that time, there was a lot more disease in the U.S. than south of the border. But

the decisionmaking process that led to that I wasn't familiar with, but that case wasn't based on a public health assessment at the time.

Q Do you believe that that order was necessary to prevent the spread of coronavirus in the U.S. at that time, at this specific time, March 20, 2020?

A No.

Q Why not?

A The focus on reducing spread on our side of the border was critically needed. And, again, the -- that's what I would say.

Q It's been reported that Mr. Cetron refused to sign it. Did you ever discuss that with him?

A Can you hold on a second?

I apologize for that.

I did have some discussions with Dr. Cetron about the issue, yes. Is that the question?

Q That was actually the question. I'm just wondering if he told you the reasons why he wouldn't sign it.

A Dr. Cetron takes the regulatory authority for quarantine very seriously and weighs -- you know, the typical issue is, the least restrictive means possible to protect public health is when you exert a quarantine order versus other measures.

And the bulk of the evidence at that time did not support this policy proposal; that there was focus on trying to improve the conditions in the facility during -- where individuals were housed to reduce the risk. There were CDC recommendations to ICE and to ACF and everything about how to make the transit of individuals less problematic.

But his view was that the facts on the ground didn't call for this from a public health reason, and that the decision wasn't being made based on criteria for quarantine. It may have been initiated for other purposes. So I don't think he was comfortable using his authority to do that because it didn't meet his careful review of what the criteria are.

Q Did you have a view on what those other purposes were?

A I would just be speculating.

Q Do you have any information on, if this order wasn't based on a public health assessment, what it was based on?

A You know, that would just require me to speculate. I think, obviously, this area of policy is quite -- there are strong opinions about border policies that are not related to public health, and the authorities that CDC has are only for public health

purposes.

So I do believe that, for Dr. Cetron, it was really important that we preserve the authorities we have and use them appropriately so that we don't lose those for when we really need them.

Q Do you know why Dr. Redfield made the decision he decided not to render his opinion?

A No. I imagine that Dr. Redfield was put in many impossible situations over the course of his position.

Q By impossible situations, you mean the pressure from a political perspective?

A I would agree with that.

Q Do you know whose job it is?

A I don't. There's a whole legal set of folks in different departments that help with that to make sure they are done the right way, but I imagine it was a number of people. Or usually those kinds of things CDC fills in parts, but the full content of the team is multi-agency even if it's CDC ordered.

Q Do you know if it was adopted within CDC?

A No, I don't have direct information.

Q Okay. I want to talk about another situation. This was in October 2020. And you don't actually have a copy of this proposed order, but there's

been reporting in The New York Times, an article about it that was marked as Exhibit 3 if you want to take a look it.

(Exhibit No. 3 was identified for the record.)

BY [MAJORITY COUNSEL].

Q The reporting says that the White House blocked an order adopted by CDC in September 2020 requiring all passengers and employees to wear masks on all forms of public and commercial transportation, including airplanes, trains, busses, and subways as well as in transit hubs.

Are you familiar with CDC's plans to institute that order at this time?

A I have some familiarity from after the fact in the sense that the science and public health understanding of what masks could offer in that period where the disease was spreading widely across the country was, you know, masks seemed to offer benefit.

The federal government has limited authorities for mandates of masks, but the federal property and federal corridor would be under the federal government's jurisdiction. And the role that translocations of the virus had from one jurisdiction to another was such an important factor in ceding of the nation or resurgence of

the virus.

We knew by then from the genomic work about variants spreading across the country, and of course we had documented the implications. And so the idea that this was one zone that federal government could institute some stronger recommendations in led the quarantine team to develop a draft federal mask recommendation. If we were using the full strength of government to protect the nation, this was a reasonable move. So that's why the draft.

(Exhibit No. 4 was identified for the record.)

BY [MAJORITY COUNSEL].

Q There was on October 19th -- and this was -- we marked this as Exhibit 4 -- guidance. So it was policy on wearing face masks on public transportation and transportation hubs, but we understand since the original order that CDC sought to implement, at that time, was blocked.

Do you have any knowledge about the reason why it was released in the form of guidance as opposed to an order at that time?

A The only thing I could say beyond what I already said was, to the best of my recollection, the transit industry was really interested in there being

strong guidance; that, as you may recall, lots of venues, private-sector venues were trying to require masks, you know, on the airlines and so forth, but the federal government being more clear or strong about this might have -- they thought it was an unusual, perhaps, circumstance where government regulation was really desired on the part of industry.

But I don't know why the recommendation wasn't followed, if it was a philosophical view about regulation or the industries that were calling for it weren't on the favored list. I really don't know. Or perhaps the constituencies that didn't want to wear masks might have objected. I really don't know whether there were philosophical, political, or technical reasons. But later it was made and the Executive Order was passed in the administration.

Q Do you know who made those decisions to institute that as guidance rather than an order?

A No, I don't.

Q Apart from these instances, are you familiar with any trends in 2020 where CDC either sought to institute public health orders that were rejected or were forced to enter orders that were not so contrary to the judgment of CDC scientists that occurred at the time?

A The travel and masking are the main areas

that I recall. There may have been others, but I'm not remembering them right now.

Q Okay. I want to focus here --

A Sorry. May be the time of day. If I missing something big, I apologize.

Q I'm just wondering if there's something we don't know about. That's all.

[Majority Counsel]. [Redacted], just one question.

It's been publicly reported that CDC sought to take other steps to update guidance, perhaps calling them updates instead of issuing new guidance as a way to get around White House approval or HHS approval.

Is that accurate?

[Majority Counsel]. We're about to start on guidance. That was specific to orders, sorry.

[Majority Counsel]. Got it.

[Majority Counsel]. You're welcome to answer that question then.

The Witness. I can wait for the full suite of questions, if that's okay with you.

[Majority Counsel]. Thank you.

BY [MAJORITY COUNSEL].

Q So I want to step back and talk about the process for developing public health guidance at CDC during an emergency and -- including drafting for

approval. If you could just talk us through that.

A Yeah. Maybe I could talk about the usual approach and then maybe what was different in some cases of this past year-and-a-half.

As new information emerges or as concerns arise, we, CDC, the IMS may develop priorities for developing guidance. Sometimes those come from the director, sometimes they come from partners who say we really need help with how we should be doing contact tracing, or we need to understand what's the best approach to infection control.

So one of these issues being identified based on new knowledge or new demands will lead a technical team that might involve multiple parts of the response, sometimes with partner organizations, health organizations, for instance, to pull together the best evidence and try to put together something that's evidence-based, clear and actionable, and also that can be implemented. So there's always a compromise between the perfect and the feasible.

That draft that's developed would be iterative as more information came to light, and it would involve a clearance within the IMS of the relevant task forces so you don't have two task forces doing the same thing. You would have visibility across. And depending on the nature of the topic, it might need to go outside the

agency for review if it involved another sector, perhaps FDA or perhaps education or somebody else would be helping with the content to make sure it was appropriate for the topic.

During this response, the kinds of things that needed to have the view of outside the agency at HHS or the White House or OMB, the list expanded to things that might have been viewed as, well, this is just a technical update. There was a lot of reluctance for almost anything to leave the agency. And so that was challenging because the field really needed clarity, and we weren't able to get things out as quickly or sometimes at all.

So sometimes things that were really important right now might be ready a month from now when it was usually after the fact of that phase and sometimes never came out.

Q Do you remember any specific guidance documents that never came out?

A Well, I have to say these exhibits were a little confusing. I just looked at them fast. But I know that we were initially asked by the White House to develop guidance for a number of settings. Dr. Redfield was at a meeting, came out of the task force with, okay, here's, I don't know, six, eight -- I don't know how many

settings they want. Parks and recreation, schools, businesses, mass gatherings, faith-based settings.

So we were specifically asked to draft something for that setting. And, of course, at the time we had a bad outbreak in a church in Arkansas where the pastors themselves sort of closed down the in-person services after this large outbreak occurred and they had a big outbreak associated with choir practice. It was huge. Given -- you know, really emphasizing that asymptomatic individuals could spread this and they could spread it into normal settings.

So we were asked to develop the faith-based guidance, and not able to release it based on concerns from those, OMB, OIRA, intergovernmental reviews.

So I don't know who didn't want it, but that was one which I don't believe we put it out, or if we put it out, it wasn't the way that it was initially drafted. I'm not positive if it ever came out.

Q When did OMB and OIRA start becoming involved in reviewing and approving CDC guidance?

A Separate from pandemics and epidemics, they are involved in high-consequence, multisector issues, you know, new policy that is going to have an economic impact. That's the kind of thing that they do reviews and then not able to release. But what I would say in

this response was -- there was kind of this vicious cycle that the White House task force would ask for something, we would draft it. OMB would say, why are you doing this? Then we would go back to the White House task force and then they would come back to us.

Things were just spinning around in that world in a way that, you know -- and then there was a point where we were not really asked to develop guidance; we were asked to review guidance somebody else might have written and make sure this is okay. Sometimes our comments were taken and sometimes they weren't.

Q Okay. It is helpful to know about the general involvement. In general, can you just talk a little more specifically about how the approval process worked for CDC guidance? Or is it so different in the context of a public health emergency that a regular process is not really relevant?

A Yeah. I mean, an emergency would involve a different hierarchy than the usual. We have scientific communication and policy teams in the response, and a clearance of a strictly scientific product would just go through the scientific forum. Something that has policy implications would have others who needed to take a look.

So the policy stuff would typically need more review because of its impact, and there are sometimes things

that are kind of on the border. You can imagine, nursing home guidance. Is it really technical or are we going to say everybody needs to get tested every week? There's a lot of economic implications, so CMS would be part of those types of documents as we had joint interests in long-term care facility settings.

So I think the principal thing that was different this time was the -- I'm not sure how good the communication and coordination was between the White House task force and the OMB/OIRA group, and the federal -- well, I guess it was the FRCC and then the JCC, which was the FEMA, HHS, CDC group of responders, really.

There were perhaps multiple governance processes that weren't linked up effectively. So, you know, there were things where Dr. Birx would draft something and send it around and then receive comments within a couple hours. And then the question of either those or whatever was a little unclear.

So after a certain point, CDC wasn't fully -- wasn't close enough to the driver's seat, I would say. Dr. Redfield may have been, but the full task forces were not necessarily close enough to the initiation of some of the guidance. We were more being tasked, and then not exactly sure why things weren't moved forward.

Q I see. And was there ever a clear cadence, here are the approvers; once these three people signed off, it can be published? Or how did that work?

A Well, Mr. McGowan pretty much negotiated this. After the White House task force got stood up and got a little more staffing, we didn't have our scientists trying to negotiate the changes. Our chief, Mr. McGowan, was trying to help keep things moving and negotiate, can you live with this? Is this wrong? You know, is enough of what you all think is necessary included? So he was the go-between facilitating the process coming to conclusion.

And so whether -- is it ready for posting or is it not? He might have been delivering that message. I don't think he was deciding, but he was communicating what had been decided on -- either through the White House task force or that OMB processed.

(Exhibit No. 5 was identified for the record.)

BY [MAJORITY COUNSEL].

Q Exhibit 5 is a document titled "Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission." This guidance was published on April 3rd, 2020. It was guidance that was

being introduced at that briefing we spoke about; is that right?

A Yes, that's right. I'm looking at it, yes.

(Exhibit No. 6 was identified for the record.)

BY [MAJORITY COUNSEL].

Q The next exhibit is an email chain that has a summary of the guidance. It has the guidance itself or a draft of it, rather, on the second page. The document is Bates stamped SSCC-9218, an email dated April 3rd 2020.

So on this chain, Kyle McGowan received a copy on the lower part of the chain, you're copied, and he says, "Dr. Schuchat has reviewed and weighed in."

The next part of the chain seems to show Mr. McGowan sending it to Dr. Redfield, and then at the very top of the chain we see Dr. Redfield forwarding it to OMB director Joseph Grogan, Deborah Birx, and Marc Short; is that correct?

A Yes.

Q So my question is simply whether these three individuals were regular participants or necessary participants even in the approval of CDC guidance at this point in time?

A It's hard for me to know, because Dr. Redfield was in the room, so he was discussing -- we

had material, he would take it in; he would be asked to clarify, correct, and we'd get the reference for this. So he was communicating back to us, they need more information.

And I don't know whether it was just Mr. Grogan and Dr. Birx and Mr. Short who were in that chain, or if that was on behalf of the task force and the domestic policy council, which is, I guess, where Mr. Grogan was. I don't know. But this was coming out of that White House task force would be when, yes, you know, put it up or it's not ready.

So this particular one, as you may recall, we had increasing evidence about the masks and were drafting not just what we wanted to say, but making it accessible, which is why the Surgeon General's video was a nice complement to it, to show people when we didn't yet have a supply chain how to make it accessible to everybody. Because it's bad to make a recommendation that you don't know how to follow through. So I don't know whether there were others.

Q Was there anyone in particular who seemed to be driving or asking for guidance, or did it just vary depending on the guidance?

A I don't really know. Dr. Redfield would communicate back to us.

Q You described a process that involved a lot of negotiation and back and forth. Is that typical for CDC to draft guidance, or is this unusual?

A This was a very unusual process. It's clear this was a very extraordinary pandemic, but the approach of who was influencing the direction was, I would say, highly unusual.

Q I think we're just about at our hour, but I'm going to ask the question that I think my colleague was trying to ask you before.

We've seen some reporting suggesting that because of the back and forth required or the multiple participants and sort of difficulty of getting new guidance drafted, CDC sometimes made recommendations in the forms of updates or things like that that could work around the approval process.

Does that sound accurate to you, or do you know what that might have been referring to?

A I don't know exactly what that's referring to, but I would say that there had been some looseness in calling something a guidance. And I think at a certain point in the response, there was an attempt to have a better discipline. That's not a guidance, that's a tool that is based on other guidance that is just putting into words that this industry will understand. Or partners

who said, we love your business guidance. Can you make guidance for our business sector?

So it wasn't new guidance, it was adapted, more customized implementation. So I don't know that there was workaround so much as more discipline, and this is an actual guidance policy. But there was, I think -- perhaps at a certain point there was fear of surprising. They didn't want to have something go up that was going to surprise authorities in Washington because they viewed it as a substantive release versus a paralyzed agency that couldn't meet the needs of the public health community.

So there's probably -- I'm not aware of workarounds. I think there was a let's focus on the work that needs to be done. It's not in that policy sphere which we're not leading.

Q Did most of the guidance that was published during this period actually -- could it have reached an idea or a perception of a need for it to originate within CDC, or was it mostly coming from the top down?

A I can't say most. There were events that naturally led to a need for more -- you know, for us to figure out, what next? If you're saying let's take a pause or let's have people stay at home for a certain time. It was sort of natural to say, well, how do we

turn that off? What's that going to look like? What is the criteria or triggers, or what's the best way for that to happen?

So we may have begun initiating on the technical side of a likely needed set of guidances, while people in Washington were figuring out we're going to need these three things to get queued up.

And, again, this was a period where the situation every day was changing. The world knowledge was expanding, and the tools that we had, whether they were testing or treatment or learning about risks or highly effective subpopulations where lots of new issues were being identified, which individuals were more likely to have severe disease, who were more likely to get disease, what were the ways that could be mitigated.

So I think probably both groups were initiating, trying to have good visibility and not doing the same thing, but being efficient working together.

[Majority Counsel]. Let's go off the record since we are at a little bit past the hour.

(Recess.)

BY [MINORITY COUNSEL].

Q We spent some time talking about Title 42 expulsion authority. Was Title 42 expulsion authority or some resemblance of it still in effect when you left?

A I'm not sure. I mean, look, today's my official last day, so I'm not sure about the timing. I honestly have really been off this summer, so I don't know where we are with some of these rules.

Q Okay. Just for your awareness, the Biden Administration won a court case to keep it in place yesterday.

We were talking about the February 25th CDC briefing that Dr. Messonnier gave and the President and the White House's reaction to it.

Were you with the President on February 25th?

A No, I wasn't on the 25th. No.

Q The 26th?

A Yes, I was.

Q Okay. Did you have any firsthand knowledge of his reaction to everything?

A Hold on one moment.

There was a general conversation I was present for, but that's about as much as I can say.

Q Okay. Thank you. My colleague quoted unnamed CDC sources from what I think is a CNN article that said the CDC feels they've been muzzled. And you responded, and I believe you characterized it as "we have."

Were you the source of that quote?

A No, I was not.

Q Have you ever --

A May I just maybe short-circuit all your questions that my only interactions with media during the course of this response has been with approval of the authorities, which was HHS, ASPA saying that I could speak to them. So I have not spoken off the record or on the record anonymously with any sources of media.

And I would like to say on the record that some of the media reports that seem to have firsthand knowledge about me -- for instance, my reason for retiring and so forth -- were completely inaccurate. So I just want to get that on the record.

Q Okay. What was your reason for retiring, then, since the media reports are inaccurate?

A I have been looking forward to retirement for several years. But faced with the worst pandemic in a century, it wasn't the right time for me to do so during 2020, but had planned that if a new director was identified, that I would want to have time to help orient them and get them set to go, and that there would be plenty of others to facilitate leadership across the agency.

So I couldn't have had a more amazing 33-year public health career than I had, and the timing of my retirement

was essentially long planned. And then once Dr. Walensky arrived and was such a quick study and a joy to work with, I felt really confident that the agency was in great hands. Not that I was holding the agency up, but just that the future was strong. And at the time that I planned to retire, to step down, things were going in a good direction so that it was a good -- my last official day on site was the 30th of June, practically the low point of cases all year. Sadly, the delta variant hasn't made the trend easy.

But, anyway, essentially I had no fights with her or wasn't upset about any kind of guidance that had come out. I think she's a fantastic leader and is doing a great job.

Q Well, thank you for your decades of service.

Do you have any inside knowledge as to why Dr. Messonnier left the agency?

A I don't.

Q Okay. Since January 1st, 2020, have you testified before a federal grand jury about COVID?

A Not a federal grand jury. I've only testified for Congress.

Q Okay. Have you been served with a subpoena to testify before a federal grand jury?

A No, no, not to my knowledge. If something

got lost, I haven't gotten it.

Q Thank you. We were talking about the guidance approval process before. When official guidance is drafted, is it common to reach out to stakeholders during the approval process, both government or nongovernment?

A For many kinds of guidance, it is very common, yes. It's a principle that you want to understand the constituency and have the constituency understand what the recommendation is. And Dr. Friedan actually had a line. He'd been a city health commissioner. When he joined the agency, he got a line for the staff: He didn't want us issuing guidance that prompted eye-rolling, meaning if they don't understand our world, then how the heck are we going to implement this?

So it would be typical for us to confer with individuals and sometimes organizations as we're learning about the issue and the best way to go.

Q Does that include both other government agencies and nongovernment organizations -- nonfederal government organizations?

A It would depend on the particulars, because obviously some things have -- what's the word -- there may be proprietary implications or there may be

commercial implications, and there's probably some guidance that can inform some individuals and not others.

So I would say that the nature of the kind of guidance CDC issues in general would be -- when it's not regulatory -- would be the type, whether it be informal and formal ways to gather constituents in listening sessions, town halls, such as that.

Q What are some of the topics of guidances that would involve nongovernmental outreach?

A Well, I spoke earlier about the transit sector and masks, you know, that we were hearing from the airlines. Many of the private companies had issued requirements for airlines and were coming up with lots of -- you know, the Flight Attendants Association and so forth were getting beat up.

So that's the kind of thing where those constituents' views, traveling public, flight attendants, airline executives, all of them had views on the recommendations before there was an order. So I would say that would be an example.

Q Would schools be an example? Would you reach out to local state boards of education, the Department of Education, teachers?

A Yes.

Q What does that usually involve? You said

town halls, listening sessions. Are there other ways that you do that reach-out?

A Sometimes we have liaisons. In 2009 H1N1, we had a CDC public health person at the Department of Education and vice versa to sort of know your world. And so that would be a way to familiarize intergovernmental awareness.

So we did a lot of joint -- during that response and both years of this response, lots of partner calls where we would talk about, you know, here's what's going on. What are the issues that you're concerned with here? And whether they were pushing for gleaning information about what's important to your constituency in terms of the situation.

And often we would hear then about things we hadn't heard about and things we hadn't recognized, you know, whether it's -- I don't know, you know, issues that were front and center for that industry that weren't as obvious to the public health world, some of which the public health world really didn't have anything to do with and some of which it was helpful to us to have awareness.

Q You mentioned that was intergovernmental. Does that apply to nongovernmental as well? Mostly phone calls?

A Well, just for the example, because you're asking usual. You know, with something like a hurricane, we pretty much have -- the American Red Cross will be in on emergency operations center as a box, helping us understand what the volunteer world is hearing and needing and how can we be coordinated.

So we did tabletops for flu planning where we had industry, Disney was here, some of the big companies were here to figure out what they need for their workforce or their customers. This is the family of issues that they're going to be trying to manage for their continuity of operations or their worker protections. So I would say there was a variety of response.

Really, the more open one can be, the better informed guidance can be. On the other hand, there's -- I would just say leave it at that.

Q Okay. Do these events, either in person or phone calls, ever involve the CDC director directly communicating with the stakeholders?

A Sure. In all administrations that I've been part of, yeah.

Q And earlier you said that there was a reluctance for draft guidances to leave the agency. You mentioned going to OMB, OIRA, various other places. Is that a fair characterization of what you said?

A Not really.

Q Okay.

A I'm trying to think what did I say. I might have misheard what you just said, but it didn't seem like I said that. So, no, that doesn't sound like a summary. Maybe you could rephrase it.

Q I'll ask it then.

Is there a reluctance for draft agency guidance to leave CDC?

A When CDC is drafting guidance, CDC wants the guidance to see daylight. So if it's the type of guidance that needs OMB review, we certainly do want it to go to OMB. So I don't think there's a reluctance.

Q Okay.

A I may have misspoken or perhaps you misheard what I said, or I mis-communicated. Similar things, it wasn't just OMB.

Q Within the reach-out process, I understand drafts go to OMB, OIRA, HHS, or other organizations. Would drafts be sent outside of government?

A I think it would depend on what. For instance, we're working on some infection control guidance or laboratory guidance. Can we have a user take a look at it and see?

The way that we actually do this in response is with

the public health organizations. They will have committees that facilitate prompt review. The Council of State and Territorial Epidemiologists, the Infectious Disease Society of America, the Association of Practitioners of Infection Control, they're developing something. They can help us. They can inform on a technical side the way forward.

You know, we may have -- particularly the public health providers in a usual response, we would want their input. Rather than like a million of their inputs individually, they will usually designate that committee of five people on behalf of the Council of State and Territorial Epidemiologists or the Infectious Disease Society of America will liaise with the CDC and give feedback.

Q You said users. Does that include like who the guidance will actually be affecting beyond the technical side? Like if you're issuing guidance for how office workers should behave during the coronavirus pandemic, do you send it to large office corporations to look at?

A What I would say is for the less technical issues, our practice would be a verbal communication. You know, we might set up a call with that stakeholder group. There was a business roundtable and so forth that

would set up industry-wide calls and a subject matter expert or a deputy manager or something would give a quick snapshot of the issues that we're wrestling with and solicit feedback rather than lording of actual guidance. But I think it may depend on the topic and, you know, the familiarity of that world.

I think in the transit, transportation, travel world there's a group, I forget what they call them, but the interagency, interdepartmental travel and transit people, they are just really used to convening and they have a way that they -- I think FAA organizes all the airline guides. Here's what everybody's thinking about. What do you all think about it? You know, pull it all together with all of their constituencies. And that's not just for this response, that's in general.

So I would say that, regardless of administration, there's kind of a way that that type of thing would have been navigated to efficiently get feedback or to give need-to-know awareness. For instance, if there's going to be funneling, there's a lot of entities that need to know about in a way that doesn't compromise Wall Street decisions. So in a trusted way.

Q Would you characterize sending predecisional order deliberative documents to a nongovernmental group as uncommon?

A Not really.

Q Okay.

A Yeah, that's where it just would depend on the sector. And whether it's whole documents or parts of documents, I don't think it's uncommon. And, of course, so -- I wouldn't say it's uncommon in terms of the responses I've been part of, which are a lot.

Q When you send those out, do you get comments back or changes?

A There would always be comments. The issue was everything is food for thought. And if it's a CDC document, the agency is making the decisions. If it's a government one, there would be a plan. But we get all kinds of conflicting comments from people about the bigger things that we're doing, because obviously the bigger they are, the more complex and perhaps multiple pieces on them.

Q So an outside group wouldn't normally suggest draft language?

A No, we get draft language. You should see my emails. Well, you probably have seen my emails. We get comments from individuals, which I think it's actually good that people care and want to express their views. But I don't think it would be surprising for us to get draft language just as you guys get draft language also.

The question is what's done with it.

Q So, what's done with it?

A It will depend on the topic and the evidence and the state of things. You know, as I said before, in this pandemic, you know, something going on in March of year one might be quite different in October of year two or something.

So the knowledge, interventions, we really don't have vaccines, we really don't have large-scale labs testing. Things keep changing, and we've learned that this is important, or we've actually learned there's this other stuff that could be important.

So forget about the beginning, but -- you know, in the best world, and especially with technology now there's an easier way to gather input, to evaluate it and to formalize recommendations. I would say that some of our kind of peacetime processes have more time to have an orderly comment period and review and assessment of each comment. And then the response time is really critical. So how do you rapidly gather insights and continue to try to protect the nation?

Q How are the draft comments you receive vetted?

A Well, within the incident -- if this is some sort of guidance that the incident management structure

is drafting, there's a whole clearance process as I mentioned. You know, does that contradict the evidence? Does that conflict with some other recommendations? In which case, which one has to get fixed up?

And in that case, that would go up from the incident manager to the director and for her or him to -- you know, as I said, before chiefs of staff would be figuring out the OMB order/White House task force world to understand who else has assets.

So depending if it's a scientific guidance or a policy type guidance, it may be adjudicated within the response or it may be adjudicated higher up.

Q That's the same with nongovernmental comments? They would send an email back to you with hey, we want to change this for that. You would send it to technical experts to make sure that's okay, and then send it to other stakeholders to make sure that's okay?

A It's hard to generalize there in terms of -- I would say individual comments like you're describing, it would be more typical that that would be helpful input for us to understand. Okay. The implications of that, whatever the comment is, are going to be important in the rollout of this guidance. Or we're going to need to get support because this isn't something that they can just do.

You can imagine recommending home quarantine, that there are enormous numbers of social service supports that would be needed around telling individuals you need to stay home for seven days or ten days or 14 days. And so at that local health department level, they need to be prepared for that: Can this person really do that, protect their families and themselves and their workplace? How are we going to facilitate that?

So that comment might be like, whoa, yeah, we'd better think about that if we're putting this out. And that can spawn a whole other chain of activity from other sectors as well. Okay. The community organizations are going to get together and help the health department. Or there may be economic relief that will help those who can't stay at home.

So, really, every response is different and the nature of input -- I just can't tell. But I would say nongovernmental partners are really important in an all of a society pandemic like this, because that's where the rubber’s hitting the road.

Q Did the CDC accept verbatim changes to the school reopening guidance from the American Federation for Teachers?

A I don't believe that's within the timeline that we're talking about.

Mr. Barstow. And that's outside the scope of the interview today.

[Minority Counsel]. Are you going to instruct her to not answer?

Mr. Barstow. I am.

[Minority Counsel]. Okay. That's all the questions I have. Thank you.

[Majority Counsel]. So it's been about 20, 25 minutes. Do you want another break before we get started, or do you want to keep going?

The Witness. I think this time I can handle it knowing that we're probably talking about an hour.

[Majority Counsel]. One of my colleagues is going to forward a few more exhibits that we didn’t include in the prior packet, so we'll wait until after the next break to actually talk about them so people have time to print them out. But I just wanted to get warnings out so nobody is surprised when they get that email.

BY [MAJORITY COUNSEL].

Q For now, I would like to keep talking about the guidance -- some of the coronavirus guidance documents that were published last year. We'll just put a selection of them and try to move as quickly as we can.

So turning to what has been premarked as Exhibit 7.

(Exhibit No. 7 was identified for

the record.)

BY [MAJORITY COUNSEL].

Q This is a draft, as I understand it, of a document that was never published. It was obtained by the Associated Press. And the reporting surrounding it suggests that it was part of CDC's planned reopening guidance to be published on or around May 1, 2020.

Have you seen this before?

A Yes, I have.

Q So you were serving as the incident manager around the time that this was drafted; is that right?

A Yes, that's correct.

Q So why was this study published?

A At the time in mid-March when the White House task force or federal government announced the 15-day pause, Dr. Redfield let us know that we should begin working right away on how do we unpause. And of course the pause is extended, but we got basically ordered or directed the very sensible idea that if we have a fairly -- if people are staying at home, what are the criteria for people to circulate?

So I think that we were asked to develop particular guidance for reopening in that context of that very early spring stay-at-home guidance that had come out. So that was the initiation.

During this period when I was incident manager, as I mentioned, the federal response coordination cell had stood up in Washington with FEMA, HHS, and CDC, and there was a community intervention task force or pillar within the FRCC that CDC co-led. And I forget who was in the department, but I'm blanking on which departments they co-led it with.

In any case, they were essentially the lead for this suite of materials working in that joint command center in Washington. But we reached back to Atlanta to the technical expertise we had in some of these areas.

And then the issue of, well, could we not just have long-word documents, but could we have the visuals that would make it really easy for the different sectors to follow the pathways? So it was based on that request from, I believe, the White House communicated through Dr. Redfield to both our agency and then to the FRCC community intervention task force to put something together for consideration.

Q And is it correct that it was never published?

A I thought parts of it were, but not all of it. So there was a total evidence -- there was a backup document, Appendix F, I think, that had more than the flow charts. But I honestly -- as I mentioned, towards

the end of April, this was a big focus, and then in May we got the response and my mother passed away. So exactly which things got out versus not, I do believe the faith-based part of this didn't get okayed for release, and I don't know how much the rest of it mirrors what was released. Sorry, I just don't know.

Q There's been reporting that the White House found this guidance, "overly prescriptive." And I don't know if that's referring to this particular part of the documents or other parts that were not published, but I'm just wondering if you received that feedback about this or anything associated with it?

A I was at one meeting where this guidance as well as our surveillance plans were discussed, and this guidance was discussed at length. Why are we telling people? You know, there was a bit of -- I feel like I already told you this this morning, but there was a why are you doing this?

And I said, you asked us to do this. That's why we drafted this.

But I at that meeting heard that this might not be -- be careful what you ask for. If you ask us to develop guidance, we're going to; and if you don't like what it says, that's -- sorry.

Q I'm sorry, did anyone say they didn't like

what was said?

A I don't think that they -- I think the issue -- at that meeting, that was the issue of OIRA wasn't comfortable with the faith-based piece and others were asking, well, why did you draft something?

And I said, well, you asked us to draft something for that sector and so that's why we did it. And I don't know where in OIRA or exactly what the concerns were, but that seemed to generate concern. And perhaps, as I mentioned earlier, we had by this point -- in such a frequent practice for the American public to gather in person in a congregation of one sort or another, we had documented spread from pretty limited singing, talking kind of environment. So we did think it was important for us to put out some advice for that time.

(Exhibit No. 8 was identified for the record.)

BY [MAJORITY COUNSEL].

Q There's another document that we've marked as Exhibit 8 that was posted on CDC's website called Guidelines Opening Up America Again.

Have you seen this?

A Yes.

Q I understand this could be one of three documents that you identified during a review you

conducted this year as being posted on CDC's website, despite having to be sent to be finalized outside of the agency; is that right?

A Yes. This was one of the three that I found in my review.

The principal concern about this one was that it was drafted and was directed at the context of, I believe April 2020, and by the time of my review in January/February 2021, the context of the U.S. epidemic was very, very different. So I don't think there was much traffic to this document because it was an early one. But it was a little bit like a forensic, oh, wow, is that still up here? We should probably -- it might lead to confusion. So we took it down at that point rather than -- because it was not primarily drafted by us.

Q What was the concern about it not being primarily drafted by CDC as opposed to just no longer being relevant generally?

A In general, it's absolutely fine for different institutions or organizations to draft guidance. I think the issue of CDC posting something without it being clear the author and whose document this is can be confusing for the public.

So there were times where our communication,

digital, web operation was the most capable across HHS and then actually at times across federal governments. So we were sort of the location for things to be posted. But something that was another agency's document probably needed to be on their site, not ours.

So but this one, that wasn't the issue of taking it down. It was we were at this other point. And this was -- as you can see, it's cobranded White House/CDC, but it maybe perhaps should be the White House that was posting it. And I believe at the time the White House didn't yet have a site to post it at. So that may be to the story on that one.

Q You're incident manager at the time. There was an initiative called 15 Days to Slow the Spread, which I think later became 30 Days to Slow the Spread; is that right?

A The 15 days, I think, started before me, but when it was extended, I was there. So I think the 15 days might have been the 15th or 16th of March, and I came in on the 20th. So that announcement was the White House.

Q Were you involved in discussions about the messaging surrounding either of those initiatives?

A No, that messaging was really led out of the White House task force. So there were times where the

first time I would see a document was after the press conference from the White House task force.

Q This document Opening Up America Again was posted on CDC's website on April 16, 2020, and as I recall, the coroner's case numbers were still increasing at that time. Did you think that it was appropriate at that moment to be messaging guidelines on Opening Up America Again in this manner?

A There are a few parts to your question.

I would say that in April of 2020, there were very heterogeneous circumstances across the country. Some places had large outbreaks. Some places didn't really know what was going on. Some places probably didn't have much virus yet. So having a roadmap of what are the factors that are going to go into the commercial sector or the educational sector, that could be appropriate even if we're seeing increases in the Northeast and not yet in the Midwest or South.

But I don't think it's inappropriate to be looking that way forward, and it may help places plan, because certainly part of that -- you know, places without a whole lot of disease where there's adequate spacing and so forth can probably open up before other places. These are the factors to consider.

So that side of the timing is sort of okay. The

issue is how is it communicated? And I would say that in April -- April 16, 2020, our national picture and what we had learned from Europe or Asia, it was not the time to tell the country great news. We can go back to how things were in January, because we were clearly seeing the virus alive in a lot of places.

And I don't think a guidepost of what you should be looking for is inappropriate. So just that expectation that it's over, that's not appropriate.

Q Understood.

(Exhibit Nos. 9 and 10 were identified for the record.)

BY [MAJORITY COUNSEL].

Q I'm going to move ahead to two documents that were published in May -- on May 22nd and 23rd, 2020. These are guidelines for communities of faith and we talked a little bit about this subject matter. And I understand that this coincides with the period of time when you were no longer the incident manager and you may have actually been on leave.

Did you have any personal knowledge of the drafting or approval of these documents, Exhibits 9 and 10?

A No, I didn't have personal knowledge of this one.

Q In that case, we'll move on.

(Exhibit No. 11 was identified for the record.)

BY [MAJORITY COUNSEL].

Q There was a document published on March 9, 2020 called Recommendations for Election Polling Locations.

A Mm-hmm. Exhibit 11?

Q Yes.

A Mm-hmm.

Q Were you involved in drafting or approval of this document?

A I was not involved in drafting or approval, but was involved with prioritizing the urgency of getting something out. This was one of those instances where, as the disease was accelerating around the country and the response was busy with that, we got questions from the public and I believe poll workers about are you going to give us guidance on how we should operate? Because, of course, the primary season was fast and furious then. And we were very appreciative of that notice, and our infection control venue team rapidly developed information.

So that was like a stat request kind of thing, like the public jurisdictions all around the country are about to deal with this. What ought they do? You know,

touchscreen, lines, spacing, what's the advice based on what you know right now?

So, yeah, I was involved with the concept, but not the physical specific reviews and everything. And we got amazing positive feedback after it came out from those people who were having to oversee the polls. Oh, good. Now we can buy, we can prepare, we can staff, and we could be as orderly as possible.

Q One of the items says, "Encourage mail-in methods of voting if allowed in the jurisdictions."

Do you agree that that recommendation made sense at the time?

A Yes. This would be very analogous to our workplace business guidance about telework when possible. If needed to be in person, you know, social distancing. So this would be accomplishing tasks in a safer way to not have people congregating, in March, when we had exponential growth in transmission.

So, yeah, I absolutely agree that a mail-in approach would be safer for the public and the workers at the polls.

(Exhibit No. 12 was identified for the record.)

BY [MAJORITY COUNSEL].

Q In June, an update to this guidance was

published and that is marked as Exhibit 12.

Do you see that?

A Yes.

Q This version removes the discussion of mail-in voting as a safer alternative and in fact highlights its risks.

Were you aware of that change being made at the time?

A No. This is something that I only became aware of recently. So this was a period where I wasn't involved in the response, and I find it surprising that that was taken out.

Q Why is it surprising?

A Because crowds, indoor in particular, are potentially places where amplification can occur. And this was a period where we were really trying to slow the spread and to take advantage of some of the progress that was being made in some of the jurisdictions.

So the idea that what was essentially crowd control, by reducing the need for as many people to be in person in a short period of time by early voting and mail-in voting and so forth was counter to common sense at that point.

Q So you don't have any knowledge of how that change came about?

A No, I was outside the response and don't have knowledge directly on that.

Q Apart from those directives, do you know who at the agency would have knowledge of how this change came about?

A Dr. Redfield or Mr. McGowan might know. Whether there were considerations, I'm not privy to.

Q Okay. Thank you. I'll next refer you to Exhibit 13.

(Exhibit No. 13 was identified for the record.)

BY [MAJORITY COUNSEL].

Q This is a document that was published titled The Importance of Reopening America's Fall. It was posted on July 23rd, 2020 and then removed from CDC's website on October 29th, 2020.

I understand that this was one of the documents identified in the review as having been developed or finalized outside of the agency?

A That's right.

Q What did you learn about this document and how it came to be posted on the CDC website?

A Let me state that I was not part of the response directly at this time; that my direct knowledge is limited.

My recollections about this might be affected by what I read in the media, and I can't differentiate that from the agency's inside information. But I do recall that this was viewed as -- that the team was handed this essentially to post and had not drafted it. And on the part of staff, some of whom were quite expert in education and school health issues, I think concern that this be read as more of a thought piece rather than a mutual status document.

So there was some concern that it was being put out as a CDC piece. Whether it's appropriate to be put out, certainly lots of people would want this to be put out, but whether it should be put out with a CDC orient rather than whoever had initiated this or whatever institution had drafted it.

So I think that in terms of the agency's credibility and control, this may have been kind of a low point for some of the response staff that was working hard to get documents out, and then a document they weren't aware of was put out as a release from the agency. So that's -- those comments are influenced probably by, you know, retrospect and media articles. But I do know that -- so that's all I should say.

In my review, this had already been taken down. So -- by the time that I did my review.

Q Your assessment that this was a low point, was that your view at the time it was published, or is that a conclusion you came to after dealing with staff in the course of your review?

A I wouldn't say this document was the low point. But I think the summer of 2020 was a very challenging period for the agency, because at this point we knew a lot more than we knew in the winter. And while some things were moving full force, there was a lot of concern about resurgence of the disease in the fall and our ability to protect healthcare, to protect people, to mitigate disease, clearly trying to prepare for vaccination if or when that became possible.

But the idea that -- I think it was a low point in the summer that there was a feeling like there was a bit of a denial going on about how much of a risk the country was under versus how to balance the economic, the mental health, social, and health needs of our communities. So I think this was a period where, perhaps for many staff, the feeling that CDC was able to protect our science brand became, you know, more at risk.

Q When you conducted your review, did you obtain any information about how this document came to be posted on the CDC's website?

A No. I didn't have the direct information

about that even during the review, just that it was already taken down. That document that didn't come from us was no longer there. So -- but the time and date and so forth is what I got.

Q One of the statements in this document includes, "There were very few reports of children being the primary source of COVID-19 transmission among family members."

And then there's also a statement that children who are asymptomatic, "are unlikely to spread the virus."

Were those conclusions clear at the time?

A No, not to my knowledge. CDC initiated a series of household studies early in the pandemic to try to understand when there was a case confirmed, were others also infected? Who was symptomatic first, you know, how did things move?

We supported several state and local health departments with investigations of outbreaks. A childcare one, I believe, in Utah. You know, just a family of investigations to help us understand.

You know, the information from populations of course was that children were underrepresented in hospitalizations. Of course, factors for chronic disease and age might have -- the elderly have their own risks, but it was a critical factor to understand the dynamics

in children, their actual risk of both COVID. And what we learned was the multisymptom inflammatory complex.

So it was a big priority to learn about what we could about children. We did several MMWRs on the data for hospitalizations. Who are these kids? Are they ones with known risk factors or are they ones with known chronic conditions? What about the MSI-C condition? What's that about? And who's likely to get it? And what are the consequences?

So I don't think we were yet at that stage ready to say, hey, no problem. But we all knew it was important to understand when children congregate, what happens. As in the summer camp outbreaks or evaluations tested.

(Exhibit No. 14 was identified for the record.)

BY [MAJORITY COUNSEL].

Q You mentioned something about -- some reporting about this. I have Exhibit 14 here, a New York Times article. This article actually includes segments and they are blown up within the document on pages 2 and 6. There's an email sent by Dr. Birx to Dr. Redfield, and the reporting indicates that she attached a guidance document that had been drafted by SAMHSA, the Substance Abuse and Mental Health Services Administration, which is also attached to this document at the end.

Did you receive that email at the time or are you otherwise familiar with it also from this article?

A I do not recall seeing this email. And it's helpful for me to see it, because I know some people talked about that SAMHSA document, but I didn't have direct knowledge who had drafted. So I guess I didn't read this article or go to the link about this article. So I am seeing this for the first time, and I don't believe I was copied on this email.

Q And you may have said this. You haven't seen this SAMHSA document that's attached?

A No, I don't recall it. Sorry.

Q There was other guidance related to school reopenings published around this time. Were you involved in or otherwise aware of any of that when it was published?

A No, I wasn't involved. I was either -- that summer -- by this point in the year, I was essentially clearing MMWRs, but not engaged in the response or the guidance development and review.

Q So a guidance or response wouldn't have passed through your desk, in other words?

A I'm sorry, could you repeat that?

Q So guidance that was drafted, you said, the coronavirus response around this time wouldn't have

passed by you necessarily?

A Yes. For July, August, no, it wouldn't have. I might have learned about it after it was posted and wanted to understand, but I wasn't part of that chain that was providing input or insight. There were others within the formal response doing that.

(Exhibit Nos. 15, 16 and 17 were identified for the record.)

BY [MAJORITY COUNSEL].

Q So the next three exhibits, in that case, might be documents that you have less familiarity with, but I still want to make sure because they were widely reported.

It is Exhibits 15, 16, and 17, and they are each titled Overview of Testing for SARS-CoV-2, COVID-19. Exhibit 15 is dated July 17, 2020, Exhibit 16 is dated August 24, 2020, and then Exhibit 17 is dated October -- hold on, I'm sorry -- September 18th, 2020.

The version that was updated on August 24th changed a statement in earlier guidance which recommended such change for close contact of persons with concerned coronavirus infections. It says, "You do not necessarily need a test unless you are a vulnerable individual or your healthcare provider or local health officials recommend you take one."

First of all, I just talked a lot, but are you familiar with these changes that took place at the time?

A When the August 24th document was posted and released, I was contacted by a partner, an expert who was concerned about the guidance and wondered, what was the rationale? What were we thinking? And I wasn't familiar with this before it came out, and so I looked into it and spoke with the leadership of the response to understand what happened? That doesn't seem to follow.

There were two things. One was, if there's an asymptomatic contact, it's okay, they didn't necessarily need to be tested. But also, the issue of we had in the earlier draft apparently had a line about -- the draft under development had a line about maybe they should stay home during that period until they were out of the incubation period or have an appropriate negative result showing that they're not still incubating. And both of those things were taken out, you know, the don't bother testing necessarily, but also don't restrict our motion, movement. And that was very counter to the idea in August 2020 of trying to reduce the risk of spread and reintroduction or escalation in different environments.

So when that came out and the colleague contacted me, I said, I don't really know what the rationale was. Let me see if I can learn more.

I did actually get the documents, which I don't know if they were shared -- I don't know if these were part of the record for you all, but I did get the extensive history of this document under review. And there were, I think, 22 or something, there were many versions of this draft, and the CDC experts were pretty concerned about this August 24th version. So somebody did a careful comparison of documents to see, well, what's in it, what isn't in it, and what were our technical concerns.

So you could sort of see how this thing evolved, because there was frequent comments in earlier drafts as it was moving towards completion. And then I guess from the second-to-last to the last version, that change about the asymptomatic contact was introduced.

And all that to say that this was another low point in confusion for our partners about why the change was being made. It didn't make sense to most of the public health community. And was CDC -- people really did look to us for advice. And if this is what you're advising and you can't even explain why you were advising it, it's because we weren't really advising it.

So I didn't have a role in developing, drafting, reviewing. But after it came out, I looked into it because of that, due to concern on the part of the practitioners of why wouldn't we want the asymptomatic

contacts to stay home during that period and get tested to be able to understand whether their contacts also needed to be quarantined or -- you know, self-quarantined or isolated.

So it seemed to go against the idea of trying to slow spread and contain ongoing infection from spreading further.

So a lot there, but I didn't know if part of the documents you all had gotten was with that paper trail of how this all got developed.

[Majority Counsel]. I'm not sure if we have that, but I do want to let agency counsel know that if it hasn't been produced, it's pretty clearly responsive and we'll follow up on that.

BY [MAJORITY COUNSEL].

Q I have a number of questions about everything you just said, just to start.

Who was the person that called you originally? Was it somebody outside of CDC?

A Can you just hold on one second?

Q Yes.

A I'm just double-checking.

Dr. Mike Osterholm contacted me, a noted public health expert who was often speaking publicly. And he was like, okay, if this has been the guidance, what the

heck are you guys thinking?

And that was where I didn't have an answer and needed to go look into it. But I believe others were contacted by other partner groups. I think there were official protests about this and so forth from some of the professional groups.

Q Who did you then go to obtain the information about what had happened?

A I went to our incident manager.

Q Who?

A So Dr. Henry Walke was the incident manager for the longest period. Really I think from July 1st until this past week.

So I went to him to say, do you have a sense of what happened here? And he shared with me kind of this point-by-point review of the evolution.

You know, this was an important work. Admiral Brett Giroir, who was the testing czar, was convening the big picture of testing, because so much had been learned, so many tools were available. There was a need for a big picture, everything you need to know about testing in one place.

So this document was developed over several weeks at least with several of the HHS entities contributing, reviewing, and revising. And then this last version that

went out, I don't think either -- in media reports, Admiral Giroir distanced himself from the final piece.

Dr. Fauci, he commented on the earlier draft. He was having surgery when the thing was finalized, and, of course, it was updated later without that change.

So this wasn't -- sorry, I don't even remember the question.

Q No, I think the question was who you went to find out --

A Yeah. I went to Dr. Giroir to ask his brief summary, and he shared with me a written one.

Q At the time, he was familiar with the advice having been changed to advice about testing asymptomatic close contact?

A He was familiar with what had happened and shared the version evolution with me. So he was aware, and also he knew that this was the final that had gone out and that that was how -- and our team just tried to document what are the inaccuracies so that if we did get a chance to update it, we could fix those.

Q Did he tell you who had instituted these changes that were inaccurate?

A I believe it was just the White House. I don't know who.

Q Did he mention -- he didn't mention any

names, possibly Scott Atlas?

A I don't recall. I know that's been what the media has said. In some of the notes I got from him, it looked like there were -- in a much earlier draft there was some feedback from --

Mr. Barstow. Stop.

The Witness. Stop? Okay. I don't know. I don't know.

[Majority Counsel]. Kevin, you're on mute.

Mr. Barstow. I think we're happy to follow up on this one, but I don't think we should get into potential institutional interests regarding the clearance process today since Dr. Schuchat is here voluntarily, and I don't think we're prepared for that today. But I'll be happy to continue that conversation on this topic.

[Majority Counsel]. Okay. Let's have a continuing conversation about it, because I do think we want to know what happened that led to this change.

But, Dr. Schuchat, we wouldn't want you to testify beyond your personal knowledge. So happy to move on from here.

BY [MAJORITY COUNSEL].

Q Do you know what happened that led to the revised version then being posted on -- was it September 18th, I believe?

A What I am aware of is there was substantial public health and clinical confusion. There was an attempt to clarify with some verbal -- I can't remember if it was a hearing or an interview that Dr. Redfield tried to explain the rationale. I think he tried to walk back from you shouldn't get tested necessarily, you didn't necessarily need to be tested, and with some language about if you're going to get tested, it should be an actionable result in the sense that you should do something different if there was a result.

I don't believe that issue of staying home, not circulating was -- that he clarified that part. But I think that the partner groups and those who were implementing the contact tracing had so many questions that it was pretty evident that an update was needed.

So whether there was negotiation in order to update it or -- I don't have the specifics about that, but I know that update followed as quickly as possible, which was September 18th.

Q Did that guidance on September 18th correct the inaccuracies in the earlier guidance?

A That's my understanding, is that the point there was to have the information be more -- whether you want to say to make it clear or to change what was written in our August 24th, I think the September 18th

guidance was at that point, based on the tests available at that point and the availability of the different types was something that more of the experts were able to stand behind.

Q Do you know why it took almost a month, maybe three weeks, August 24th to September 18th, to make those corrections?

A No, I didn't. I don't have any knowledge of that.

Q Okay. Moving on to a different subject of guidance. The next three documents are all versions of Considerations for Restaurants and Bars. So these are marked as Exhibits 18, 19, and 20. Eighteen is dated May 27, 2020, Exhibit 19 is dated September 6, 2020, and Exhibit 20 is dated November 18th, 2020.

(Exhibit Nos. 18, 19 and 20 were identified for the record.)

BY [MAJORITY COUNSEL].

Q The Wall Street Journal reported that the OMB director and other OMB officials had been urging Dr. Redfield to make changes to the May 27th guidance that recommended social distancing for bars and restaurants. I believe that the September 5th version was edited to contain general recommendations in favor of social distancing that were guiding people to stay six

feet away from each other.

Do you know what happened that led to this change?

A No, I don't have direct information about this, sorry.

Q Did anyone ever relate concerns about the same to you?

A I don't recall. Yeah, I don't recall this being among the things people brought to my attention.

Q Moving on to Exhibit 21.

(Exhibit Nos. 21, 22 and 23 were identified for the record.)

BY [MAJORITY COUNSEL].

Q This is a document that is entitled, "How COVID-19 Spreads." Actually, this is another series and I think we may have mixed up the order here, but all three documents, Exhibits 21, 22, 23, are titled "How COVID-19 Spreads." There is a version dated September 18, a version dated an update on September 21st, and then an October 5th update.

Do you have all three of those in front of you?

A Yes, I do. I have them all, yes.

Q Are you familiar with all three versions of this document?

A I'm not familiar with the specific contents. I have a general recollection of the sequence of events

of frequent updates of the same sort of document. I have a general recollection of what was happening.

Q Okay. Well, tell me what you recall happening at the time.

A You know, I think this is my recollection without having been involved in any of the versions. But what I believe I heard at the time was that one part of the response was drafting something without awareness that there was another group working on it, and there was a miscommunication with our Joint Information Center when the one group, when that task force was done, I think the Joint Information Center posted it thinking that it was all the way through. And then -- it was recommended, wait a minute, that's just the early stage because it's not been cross-walked.

So this may have been a -- and there's a lot of nuances in how language is used and what the implications are. So I think this was one of those times where there was some internal disorganization rather than any kind of interference or pressure to change wording.

So that was my understanding of this one, but that is without having read all three versions to know what changed. Just that there was -- it wasn't ready for prime time, but it accidentally got posted, let's get it ready. And I don't know why there were two more

versions. I don't know what happened that they couldn't get it figured out in one. But, again, people were working 24/7 to the best of their abilities and things happen.

Q There's language in here about airborne transmissions. Separate from the incident that led to the change in this document, did you ever hear concerns or data about referring to the coronavirus as an airborne disease?

A Yes, I think that the public health and clinical community has had some challenges with terminology. For some, airborne diseases are typically spread at great distance from one person to another, you know, as the norm. For others, it's just a shorthand for aerosol, that there are times where the particles can float and go further with travel spread, and that everybody doesn't mean the same thing when they use that term.

So I know that the phrase "airborne transmission" seemed interpreted differently by different folks with one that made the response by WHO and a lot of groups trying to say, well, can we actually get underneath the wording and say what we're really talking about? Because people are talking past each other with some of the terms.

(Exhibit Nos. 37, 38 and 39 were identified for the record.)

BY [MAJORITY COUNSEL].

Q I want to go back in time. But before we do that, do you now have the documents that we've circulated at the beginning of this hour that are labeled Exhibits 37 through 39?

A I don't.

Q Okay.

A Yes.

Q This goes back to April 2020, when I understand you were the incident manager. So I understand there were several outbreaks early on at meat packing facilities around the country.

A That's right.

Q Were you involved in the response or investigation of those outbreaks?

A These were being done when I was incident manager, and we prioritized getting teams in place with the right type of expertise to support appropriate investigation in conjunction with the state or local authorities.

This involved both our industrial hygiene worker safety individuals from our National Institute for Occupational Safety and Health or our worker -- worker

safety task force, I believe, it was called at the time, as well as individuals from our refugee health program who are used to populations in lots of different situations. So we had a -- an epidemiologist and others.

So we had multidisciplinary teams deployed, first to one of the facilities and then to several, and then did other consultations long distance.

But it became a very intense focus while I was incident manager. And my main role was calling our director of the National Institute for Occupational Safety and Health, saying this is important. We need experts on the ground and telling the response, you know, we need to disseminate this as quickly as possible. Please prepare an MMWR, which they did.

I wasn't involved in the guidance that they developed. I would say, although I guess this is a trip report -- is that what this is? This is a trip report. Usually our team on the ground will assess things and write a quick trip report and then follow up later with more detail. So I didn't review this trip report, I guess, that is Exhibit 37.

I don't recall reviewing this. But the role that I described was how, yes, this was a big focus. Were these different reports or is it the same report, different versions? Yeah, I wasn't working on any of this. I was

more like a traffic cop than on clearance on this investigation.

Q So there have been reportings that there was -- well, there are changes that I think are visible if you read the two versions of the report.

For example, the April 22nd version has qualifiers such as if feasible, with that being the qualifier, "All employees should wear the face covering being used by the company to cover their nose and mouth in all areas of the plant." This is on page 7 of the Exhibit 38.

On the same page, the third bullet says that, "Employees should wear the supplied facial covering to cover their nose and mouth, if possible."

Exhibit 38 has the same language, but without the it's feasible, it's possible.

There are also recommendations in Exhibit 37 that weren't included in Exhibit 38.

So you weren't familiar with these tables before?

A Not before they came out. Again, this was an incident where later I became aware through -- I don't remember if it was media or FOIAs, about the issues and the same questions. I believe this was Dr. Redfield leading the decisionmaking on this work. My role, as I said, was let's get the right people on the ground, multiple places, urgent, and let's get what we find out

quickly so that we share what we know because this may affect other sectors, and these are really complex work environments that need to be protected.

Q There has been a claim that Dr. Redfield had a phone call with the Agriculture Secretary on April 22nd 2020, which is the same day that the memo was revised. Do you have any awareness of that call or what came out of it?

A No, I don't. I just have the media type of information that you just shared. I did not speak with Dr. Redfield about that or have any direct awareness of what happened if he had that call.

Q It's also been reported that the vice president's chief of staff, Marc Short, instructed, directed Dr. Redfield to soften the recommendations at the industry's request.

Did you hear about that directly from anyone at CDC?

A No, I didn't hear about that directly from anyone at CDC or from others outside of CDC.

Q Generally, how involved was Marc Short in this CDC aspect of the coronavirus response? How often did you -- was he visible to you as incident manager or otherwise?

A You know, as incident manager, you know, I was going through Dr. Redfield. There were -- you know,

I had a lot of contacts with Admiral Giroir. I think with Mr. Short, I wouldn't have had contact with him. I don't recall ever being directly contacted by him or being on some emails with him. So I think he would have been directly dealing with Dr. Redfield, I believe.

Q Other than Admiral Giroir, who else at HHS or in the White House task force did you have the most contact with throughout the response?

A The Commissioned Corps offices, the Commissioned Corps headquarters, there were a lot of staffing needs. So Admiral Susan Orsega was in frequent contact as we were trying to figure out getting more correction officers deployed, or how are offices being -- which mission might they be part of.

The Surgeon General at times -- I think Surgeon General Adams contacted me about, how would you explain this or some questions about do you all have more information about this topic or that? Because he was doing quite a bit of media.

You know, early on with the ASPR, Dr. Kadlec. But once things shifted to that NRCC, the teams in place in Washington were dealing more directly with ASPR. I wasn't dealing with them, except with a few exceptions around the Diamond Princess situation.

So with the White House, we were pretty much going

through Dr. Redfield or Mr. McGowan in general, or I was delegating to others for, you know, they need that version of the document. I wasn't directly doing negotiations at all.

We were trying to respect the NRCC as what we were feeding into and -- as well of course for their director and his information needs.

[Majority Counsel]. I think we are almost at our hour, so we can go ahead and go off the record and take a five-minute break.

(Recess.)

BY [MINORITY COUNSEL].

Q Dr. Schuchat, are you aware of March 13, 2020 CMS and CDC guidance regarding nursing homes?

A Yeah, in general. I guess I'd need to see just to -- yes. In general, we were issuing guidance together with CMS around that time.

Q I'll read a little bit from it.

So it says it was entitled Guidance for Infection Control and Prevention of Coronavirus Disease 2019 in Nursing Homes.

It says, "Nursing homes should admit any individual that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present only if the nursing home can

follow Centers for Disease Control quarantine and guidance."

What would have been your quarantine guidance on March 13th?

A I don't have the specifics in front of me. What I can say is that the evidence-based underpinning quarantine recommendations evolved as we learned more about the duration of infectiousness.

So initially I believe we were recommending 14 days after the onset of symptoms. And then eventually more information was gathered about, if a negative test was available by day seven, perhaps that could be shortened to ten days. But it was different with -- across people who could have longer durations. So exactly what our recommendations were on March 13th, I don't recall.

But I would just state that the issue of one infectious person, whether it's a staff or a patient entering a long-term care facility, on March 13th we were aware that this was extremely dangerous in terms of the vulnerability of the population. And that was really what was behind that multiple -- the challenging outbreaks in Seattle counties and some of the early outbreaks in New York state.

Q So as you just said, it would have been dangerous for a nursing home -- for an infected person to

enter a nursing home, staff, patient, anything?

A If you knew they were infectious, yeah.

Q So a few states issued some guidance around March 13th. I'll read from New York's in particular.

The title of the guidance was called Hospital Discharges and Admissions to Nursing Homes, issued on March 25, 2020. And it said, "No resident shall be denied readmission or admission to the NH solely based on a confirmed or suspected diagnosis of COVID-19."

Would it have been CDC or CMS guidance to allow confirmed or suspected diagnosis of COVID-19 into a nursing home?

A I'm not looking at the two documents, I guess, to comment, so I would not want to speculate about the differences you point out.

Q Okay.

A I can imagine, for instance, that there were some nursing homes that were setting up isolation wards, they were cohorting people, they were setting up quarantine areas. We call that in some jurisdictions the balance between having beds in the hospital for acutely ill people and having isolation quarantine set up elsewhere was an ongoing challenge.

So I don't have the specifics of what New York state was doing and whether it was or was not in conflict with

the CMS guidance at the time, I'm sorry.

Q Well, I'll ask. New York's guidance went on and said, "Nursing homes are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission."

Do you think, prior to readmission to a nursing home, a patient should have a negative COVID test?

A On March -- again, the issue of testing is one that has evolved over the year-and-a-half, so testing availability, accuracy of testing, turnaround time of testing. And I think throughout, especially the first six months, there was this ongoing challenge to balance the healthcare capacity, the patients that were particularly vulnerable, the infection control context in wherever they were going, and the availability of information about them, as well the issue of stigma and denying patient rights.

So I guess I would say I just don't have the specifics about what New York was doing and why and whether it was appropriate, and wouldn't want to comment based on that extracted sentence. I'm sorry.

Q Generally, then, is it common medical practice to prohibit a negative test -- prohibit testing an individual prior to going into anywhere? I mean, if -- I'll do a hypothetical.

If a state were to issue guidance right now prohibiting a negative test as requirement to go into a concert, would you have a problem with that?

A Well, I'm sorry, prohibiting?

Q So if for me to go to a concert in Virginia the concert venue says you need to show us a negative COVID test, and the state passes a law and says, I'm going to prohibit that concert venue from doing that, would that be problematic?

A You know, I have to say this experience has taught me a lot about authorities and the law that I do not know. So that sounds like it's unwise, and I would need to understand better why that would happen.

I do think that the long-term care facility context has been extremely challenging as an essentially limiting resource in a community that's intersecting with the acute care system and our need to surge both of those and our need not to cherry-pick patients and discriminate against one or another.

So I imagine what you're describing is something that the lawyers could be better able to delegate than I can as a public health person. You know, it's really hard to just take a line out of context. But I know that we had a healthcare systems team working closely with CMS and providing a lot of technical support to states. So I

just can't comment on the specifics there.

Q Okay. Shifting gears a little bit. In the letter that the Majority sent to HHS requesting your interview today, it says they are trying to gather information on the government's response to COVID-19, including what went wrong, what needs to do better, and future corrective steps.

While they were asking you about various guidance, you mentioned talking to Dr. Fauci a few times. Obviously, as the head of NIAD, he has a very wide breadth of infectious disease expertise. Do you think he would be an important person for this community to talk to to cover those three things that the Majority would like to investigate?

A He is extremely knowledgeable. I think one thing that differs between Dr. Fauci and myself is that he has been facing to the public and the Hill almost daily for a year-and-a-half, and, you know, I hadn't -- you all hadn't heard very much from me. So whether he has more to say than what you've already heard, I know people have heard a lot from him already. That's all I can say. He's very knowledgeable, obviously.

Q Do you think he would have inside knowledge on what went wrong, what needs to be done better, and

corrective steps for the future?

A I think he's been sharing what he thinks. I think he's been sharing that. So whether there's inside knowledge, I couldn't say.

Q Okay. Thank you. That's all I have.

A I mean, you all decide who you want to talk to and what you're trying to do. That's not my job.

Q All right. Thank you.

A But I'm trying to help.

[Majority Counsel]. I just want to put on the record after that question that Dr. Fauci has testified before our subcommittee twice.

(Exhibit No. 25 was identified for the record.)

BY [MAJORITY COUNSEL].

Q So on a slightly different topic from where we were before. Exhibit 25 is a HAN update on Multisystem Inflammatory Syndrome in Children Associated With Coronavirus Disease 2019.

Please take your time and look at it, if it would be helpful. Actually, before we turn to Exhibit 26, which goes along with it, I want to just ask what the general approval process is for this type of alert.

You referenced another one of these documents earlier about the early coronavirus in January. How do

these work?

A What I can tell you is about my visibility. But the specific protocols, you know, that would be appropriate for the ones who did these.

These are drafted technically -- if we're in the EOC IMS framework, it would be reviewed by the response and approved. And then our emergency operation center has this protocol where they then send it to a few key leaders for -- I don't know if it's called flash clearance or what, but you basically have about a half an hour to make comments to say there's something substantive, there's a problem here or not, or are you okay with this.

And then I think from there, I believe these are okayed internally, but I think there's awareness of like we're expecting to issue a HAN, and then I think the communication team may send it up to the ASPA. But since I'm not in those chains, I may not have that correct. But we do these for -- we do this a lot and there are different levels depending on what the issue is.

So I believe that it may be that Dr. Redfield and I get them for affirmative review and later we get them finalized for, if you don't say anything, it's going. But I might have that slightly off. But I usually get two looks at them very close to the time they're

published.

Q Who is the intended audience that you send these documents?

A It will depend, and it's one of the preclassified factors. It might be clinicians, it might be a subset of clinicians. The program knows how to direct these root partners to the clinical pediatricians or emergency rooms or urgent care or poison control centers. So depending on what we're worrying about, they will target the distribution list accordingly.

But these are meant to be pretty rapid, you know, not take a whole long time of references and everything, but just what you need to know right now based on more will be coming. As I said, this was the first thing to push out, dealing with the travel-related concerns in January.

Q Generally speaking, is it fair to say the audience is healthcare providers?

A For this one --

Q Scientists, maybe?

A Yeah. For this kind of one, there's a new syndrome in children, please look for it and report it in. And I think this is about a case definition, right, of this is what we're looking for because it could be a lot of different things. If you're seeing this in your

hospital or specialty practice, let your health department know about it.

(Exhibit No. 26 was identified for the record.)

BY [MAJORITY COUNSEL].

Q The next document, Exhibit 26, is an email chain Bates stamped commencing SSCC-0014393. If you go to the third page of this chain, I think you're copied somewhere on this email after it starts at the bottom of the second page, this review process that you were just describing, because the email says, "Dear CDC/HHS Senior Staff, Attached is HAN 432, a health advisory titled "Multisystem Inflammatory Syndrome in Children Associated with Coronavirus Disease 2019.

"Per protocol, you have 20 minutes to do one of the following," and then there's the approval options.

So I guess that's more or less what you were describing 20 minutes for review.

A I remembered it was 30, but okay. Okay. So, right. So there we get how it works.

Q On the next email above this page, you were copied. Ryan Murphy from HHS sends it to Michael Caputo, who was then the assistant secretary for public affairs, senior advisor Paul Alexander, and copies Bill Hall.

I'm first going to pause here and ask if you knew

Michael Caputo at all before he came to HHS?

A No, I did not know him and I don't believe I've ever met him.

Q Did you have any interaction with him directly while he was at HHS?

A I do not recall any direct one-on-one interaction. It is possible he was on conference calls that I was on with the department or with interagency groups. I always tried to know who was on those calls.

Q Did you know Paul Alexander before he came to HHS?

A No. And I have never met him, to my knowledge.

Q Apart from perhaps conference calls and things like that, do you remember interacting with him at HHS, while he was at HHS?

A You know, I was cc'd on some emails that he sent to our MMWR editor Charlotte Kent, some of those were forwarded to me or I might have been on some of those reply all kind of thing. I'm not recalling any direct interaction with him one on one or where he would send a message to me.

Q So if you look further at the next email chain. Starting on page 1, a May 13th 8:51 p.m. email from Michael Caputo instructs saying, "Hold this,

please." And then there's several emails up the chain with instructions to hold.

And then at the top of this, Paul Alexander appears to give Michael Caputo some feedback about this not actually being related to COVID and suggests some inflammatory syndrome like Kawasaki that has always been around but is not COVID. He is saying, "This is sensationalization and the New York governor seeking to get traction and blame the administration and deflect from the catastrophic policy on nursing homes where many thousands of deaths occurred due to that repatriation policy."

I know you're not copied on this and you've probably never seen it before, but do you remember any efforts -- and I realize this now was May 2020 and you were no longer the incident manager and may have been out at this time. But do you have any awareness of efforts to hold this alert because of its contents?

A Hold on one second.

Okay. I apologize for that, I just wanted to double-check what your question was before I answer your question.

Q Okay. The question was whether you had knowledge of any efforts to delay the publication of the MMWR health alert.

A To the best of my recollection, what I recall wasn't necessarily linked to the health alert, but was that I was contacted by Dr. Giroir about coordinating across the department on the MIS-C work. And so essentially finding out, well, who is our lead and so forth so that he could link them in our group at NIH and potentially others.

So I don't recall whether or not that call was connected -- when it was and whether or not it was connected with holding on. I don't recall that.

Q The third email down here actually says, "Giroir is spending time on this issue and will have an action plan by end of this week or early next week. Let's hold until we have an answer."

Although the publication date suggests that it wasn't actually held, it looks like it was published the next day. But is that what you're referring to, Dr. Giroir's coordination, that discussion of the action plan there?

A Yeah. Yeah. He was going to do a convening and figure out who should be doing what in this space, yes.

Q I thought his role was testing. Do you know why he was handling this particular multisystem inflammatory disease in children? The syndrome in

children?

A Admiral Giroir is a pediatric intensivist. So whether or not this would have been his duties related to testing czar or Assistant Secretary for Health. He has a lot of expertise in the critical illness in children. So it may have been out of his specialty interest. Or I would say that he played a number of coordinating roles for the department that may have fallen through the cracks of the incident -- of the FRCC. Something clinical is usually an NIH/CDC thing or something. But it would probably be, hey, this is my world, you know. And also, just to make sure that all the assets of the department were being brought to this question. I would imagine that was why, whether he was asked to do it or he stepped up and volunteered.

Q Is your memory of his role specific to this plan primer that it continue over the ensuing months?

A In the MIS-C?

Q Exactly.

A I don't know. I know I gave him, you know, you should speak with Jay Butler, who's our incident manager now, who also is a pediatric infectious disease specialist. This is a hot issue of importance to both local public health and clinicians, and convening and so forth is important. And we're all on board, and tell us

what you need from us.

So I don't know if he just convened and then checked out onto other things or if he continued. But this was the era of Dr. Butler, and it might have been when he contacted me about this. I reminded him I was no longer the incident manager, and the following week I left because of my mother, so.

Q It says that the issue of current events with children were particularly sensitive. Is that fair to say? Were politically sensitive.

A Until reading this email, I was not aware that it was. I thought this was -- I honestly -- the email is the first indication I had that this was -- that I remember having that there was concern about us, you know, trying to gather more information about it. I can't say that I was aware of the earlier.

Q Okay. Let's talk about the Morbidity and Mortality Weekly Reports, or MMWRs.

What was your role? You mentioned them before briefly, but what was your role in the review and approval of MMWRs?

A As the principal deputy director, I was a routine recipient of the first proofs and second proofs, which occur after the product has been cleared and accepted for publication and the MMWR editors have copy

edited and so forth. And that continued during response, that review of first and second proofs -- or with the early version I think we only had first proofs.

And that review is for science and programs for quality control and to make sure that we're not issuing policies for the first time in an MMWR rather than going through our guidance process.

During the response, I also coauthored an MMWR that was developed with input from many members of the response, but I was the named author together with the COVID response team specifically.

Q So I think you're referring to the Public Health Response to the Initiation and Spread of Pandemic COVID-19 in the United States, February 24 through April 21, 2020; is that right?

A That's correct.

Q We have that as Exhibit 27 here.

A Correct, right.

(Exhibit No. 27 was identified for. the record.)

BY [MAJORITY COUNSEL].

Q What was the goal of this analysis at the time you drafted it?

A Honestly, we had hoped to get it drafted earlier, but we just were too busy to complete it, but

felt that the circumstances related to accelerated interaction and spread of the virus would be instructive as we tried to understand focus areas for preventing reemergence or resurgence.

So this was both a -- how did importation and expansion, acceleration here in the United States occur? What were the underlying factors that facilitated the rapid spread? And from those circumstances, those settings where spread was so rapid, can we inform local, state, or other nations' efforts to try to prevent resurgences?

So that was the rationale for what's essentially descriptive of sort of the first few weeks -- well, you know, of that period, which I can't remember the date. What was the title of this thing? So from February 24th through -- that doesn't say the title. The title -- okay. So, stop talking.

Q I think the PDF does say the title date. I think the title provides February 24 through April 21st, 2020.

A Okay.

Q So there's been some public reporting that officials in the Trump Administration viewed this MMWR as an attack on them.

First, as a clarifying question, was this article

intended to be political in any way?

A No, it was not intended to be political in any way.

Q Did you have a concern related to -- apart from possibly reading them in the press, what you may have read about them, did anyone relay those concerns to you internally at CDC?

A Concerns about the MMWR?

Q Concerns from political appointees in the Trump Administration about the MMWR.

A Yes, I had direct awareness of concerns after my MMWR.

Q How were you made aware of that?

A To the best of my recollection, our chief of staff, Mr. McGowan, told me about conversations at HHS and at the White House about concerns about the MMWR. He told me that none of the people he heard from had actually read the MMWR, and he believed their concerns were about a media report about the MMWR rather than what was in the MMWR.

So the first way I knew about the concerns was from conversation with Mr. McGowan. And I believe he gave me a heads-up that I was going to be contacted by the White House chief of staff Mr. Meadows about the MMWR.

So that was the other direct way I knew about

concerns about the MMWR from political individuals within the administration.

Q Did he mention, beyond naming Mr. Meadows, who else had expressed concerns?

A You know, the HHS individuals. I got the sense from him in my recollection that it was the secretary's office. I don't know if it was the Secretary or if it was others in the Secretary's office. But my understanding was it was that -- you know, the higher-level political appointees. Of course since that time, I believe this is part of the emails with Mr. Alexander and Mr. Caputo, but I might be confusing that with my later contacts.

Could you hold for just one moment?

Q Yes.

(Brief pause.)

The Witness. Okay. We're back.

BY [MAJORITY COUNSEL].

Q Did you end up hearing from Mr. Meadows?

A Yes.

Q What did he say?

Mr. Barstow. I think that might touch on, as far as our challenges.

[Majority Counsel]. I don't see how that would even come close. Just because he was the guy with the

President doesn't mean that every communication that he had with the Executive Branch touched on confidentiality.

Mr. Barstow. Because as the President, I think it could touch on a very important interest. I think today I'm going to instruct Dr. Schuchat not to answer the question. She had knowledge there was a conversation and had direct discussions about that.

[Majority Counsel]. Okay. This was a discussion about a public document and there's been public reporting about it. And yes, he was the chief of staff, but there are many communications that the chief of staff has particularly with individuals outside of the Executive Branch that don't even come close to touching on Executive Branch confidentiality.

So I'll register our objection to that and we'll consider whether we have to bring Dr. Schuchat back to answer that question.

BY [MAJORITY COUNSEL].

Q So how long was the conversation with Mr. Meadows? How many minutes did it last for?

A I don't recall.

Q Approximately, under an hour, under a half hour, in that range?

A Under an hour.

Q Do you recall what day, approximately how

soon after the MMWR was published, that you received the call?

A It was the weekend after. The MMWR team met on a Friday and it was over that weekend. I don't recall which day.

Q Did you have any concerns about potential retaliation against you or the potential that action would be taken against you after that call -- or after the MMWR was published?

A Let me just say that I was surprised about the apparent reaction to the MMWR. The public health and medical community -- you know, I got a lot of positive feedback from individuals both overseas and in the U.S. about putting the information together in the MMWR for those who read it, and the reactions that were negative tended to be about the media stories rather than the substance of the MMWR.

In terms of my personal concerns about retaliation, I was surprised about the reaction. And my comments to people, as the same as what Mr. McGowan did, was say, you know, please read the MMWR and perhaps that would help with your concerns.

Q How did you feel after the call from Mr. Meadows?

A I was very shaken.

Q Did you get any other reaction to the MMWR expressed to you directly from anyone outside of CDC? And I should say, anyone in the federal government outside of CDC.

A I don't recall other direct communication. You know, I honestly don't recall getting calls or notes from others within the Executive Branch. You know, the collaborators and so forth with states were part of the reporting, so it was more public health colleagues that reached out to thank me for describing the initial stages. And a colleague from Asia said we encouraged his peers in each of the countries to write something like this. So the circumstances would be better now.

So that was the kind of feedback I generally got. So I was surprised about the negative feedback I got from a few parts of government.

Q Had the White House chief of staff ever called you directly to give negative -- to give feedback about an article you published in your 33-year career at CDC?

A This was the first.

Q Did you take any action after the call?

A You know, not that I -- I was offered a response by this point, having things finished up on the Friday. And then two weeks later my mom passed away, so

I don't recall additional steps. I'm sure that I told Mr. McGowan that I had this call, and he was -- but that is all I remember right now about this.

Q Did Mr. Meadows ever call you again about anything?

A No. I had no contact with him after.

Q Had you ever spoken with him before that date?

A I don't recall. You know, I had some interactions in group settings with Mr. Mulvaney. And I don't recall exactly when Mr. Meadows got there, but earlier in the response Mr. Mulvaney was kind of convening the different agencies. But this was the only single encounter with Mr. Meadows.

Q Was any action taken to impact your responsibilities or your employment at CDC afterwards, after the MMWR?

A Not to my knowledge. Not to my direct knowledge.

Q And did you discuss the call with anyone else in government?

A At the time, I don't believe so. I think I was speaking to Mr. McGowan, you know, since he was aware that it was going to happen. But I don't recall talking to others about it. I feel like, just in the preparation

for this, I'm remembering more about it, but it's a little bit -- I don't recall specifically sharing that I had had that call. I may have, but I don't recall.

Q How about Dr. Redfield. Any memory of sharing it with him?

A I don't remember a conversation. Just for the context, Dr. Redfield was in Washington and I was in Atlanta. Dr. Redfield was working literally 24/7 and so Mr. McGowan was often the go-between.

I always felt I had the support of Dr. Redfield. He would publicly and privately be supportive of me, but I don't recall talking to him about this conversation.

Q Let's turn to some other specific MMWRs, ones that you did not draft, but I think were part of the approval team for.

We have one marked here as Exhibit 28.

(Exhibit No. 28 was identified for. the record.)

BY [MAJORITY COUNSEL].

Q This is titled SARS-CoV-2 Transmission and Infection Among Attendees of an Overnight Camp, in June 2020.

Do you remember the circumstances surrounding the publication of this MMWR?

A Yes. Yes.

Q I believe this was published on August 7th. I'm going to attach to Exhibit 29 --

(Exhibit No. 29 was identified for the record.)

BY [MAJORITY COUNSEL].

Q This is an email chain dated -- the date at the top of the chain is July 27, 2020, and at the very end of the chain it includes a summary of this MMWR scheduled for early release.

A Mm-hmm.

Q Your next email in the chain after the summary from Dr. Kent is a long list of items of questions and some feedback from Dr. Alexander about the MMWRs. He explains his reaction asking them both questions. And then he goes on to explain he thought the MMWR contradicted CDC's guidance on schools.

Do you remember seeing this before?

A Yeah. Okay, I do remember Mr. Alexander sending a lot of comments about this and several other MMWRs, yes. Charlotte would share with the senior leaders both in the science chain about when she had questions about how to handle some of the inputs.

Q You referenced that this is something that Dr. Alexander had, I guess, started a practice of doing, you might say -- is that fair to say -- providing

feedback?

A Yes, that's right. He was in the public affairs office, and typically our MMWRs are -- they're scientific products and they don't go through our communication office or ASPA for review or clearance. You know, they are developed, reviewed, and cleared if they're a single agency or with State through our science chain.

So he was not sending comments on the actual MMWRs, he was sending comments on title or brief drafts, you know, summaries of the general content. But I don't think he understood that what he was sending comments on was not in the actual article.

Q Do you remember reviewing his comments when you received them at the time?

A Of these ones or other comments?

Q Generally speaking, when he sent a reply all -- there were a lot of recipients on this email you can see. Did you take a look at his reaction?

A This email, this one, let me just see. It came in at 1:53 a.m. I don't recall looking at that between -- no, I don't recall looking at that one that morning. And it looks like I wasn't in Charlotte's -- I was reviewing -- I think at this point I was probably reviewing the actual MMWR where I had some comments on

it. But I don't recall going through his points on this one.

Charlotte was really good at being polite and careful and politely responding. This one, I don't personally remember intervening or, you know, putting in my two cents. I directly commented to her about the opening paragraph of the MMWR, where I thought it could be clearer.

Q When did ASPA officials become included in the approval chain for MMWR? Not approval, but recipients on the summary, I think is a more accurate way to say it. When did that start?

A Yeah. I imagine our office of communication staff has a precise date, but I believe this was a practice change in the spring of 2020, you know, probably May timeline or so. I don't know whether it was after my MMWR or if it was after Mr. Alexander arrived. But sometime in the spring of 2020, rather than just awareness that this was coming and here's the general picture of what's in the week ahead or in the days ahead with the communication implications, the technical comments started to come down to our office or to our response.

And, again, I would be consulted sometimes by our editor, but I wasn't line editing or drafting MMWRs by

then.

Q So you don't know if they were added as part of a reaction to your MMRW from May 5th?

A It would be speculation for me to say that that would have --

Q So further up on this email chain where you are no longer copied, this is on the first page, Michael Beach says to Charlotte Kent -- and Henry Walke is copied here -- "Folks on the HHS Secretary's call want to see this MMWR - do we normally do this, how do we do this?

Here, they're asking for -- people from the Secretary's office are asking to see the original summary?

A Yeah. My interpretation is they want to see both what we would call the proof and then the full report with its tables and figures. You know, it may not be the absolute final, but it would have not just the abstract or the summary.

Q Ms. Kent responds at 10:05 a.m. "We do not normally share. Done once before after discussion with Dr. Schuchat. Only comfortable if she approves."

First of all, why would Charlotte Kent say that they don't normally share?

A There's a longstanding practice that the MMWRs are scientific products of CDC, and that there's a

firewall between the editorial production and political levels. So a proof might be -- you know, the authors might include FDA or there might be a state health department that would be reviewing the proofs. But the proofs don't usually go outside of the author and the agency, so we wouldn't be sharing the full content outside. And that's longstanding for every administration that I'm aware of. I can't say that's never been breached, but that's the practice that the agency's had.

Q Well -- so it says here that it was only done once before after discussion with Dr. Schuchat.

Do you remember what she is referencing here?

A I don't, actually. And when I saw that, I think it was in the letter, I wasn't able to reach Dr. Kent to confirm. So I had a couple -- I just don't know which one that was. But she would consult with me at times to protect the scientific integrity and understand was this request appropriate or not appropriate. So there probably was one in her tenure as editor. I don't know for prior editors whether that happened or not.

Q Do you remember her reaching out to you to share in this instance?

A I know that I weighed in. When I reviewed

the MMWR, I know that I weighed in on -- even though the sentence in the first paragraph of this one that -- is this the right one? I think this is the MMWR that had a sentence about schools, but the MMWR was about overnight camps.

And I think, in my clearance, was that sentence doesn't belong in the opening. It makes it sound like this is about schools. You know, it's important to talk about camps, it's important to talk about children, but I think my reply to her was let's take that sentence out of the opening. And it may be that that was one of the comments that the ASPA people had as well, but I don't know. I don't remember -- yeah, I don't recall.

I mean, there were several back-and-forths over this summer about these things that were coming back. Usually I would be copied when responses went back up, but polite, respectful. But -- that's not what the data actually show, or thank you for your interest kind of stuff.

But I don't remember whether this draft was shared, you know, just to say that the practice had -- I think the individuals who got the proofs at some point got expanded to include some politicals other than Dr. Redfield, so there might have been sharing that I wasn't part of.

Q I think one of the responses might actually be in the next email, Exhibit 30.

A Okay, great.

(Exhibit No. 30 was identified for the record.)

BY [MAJORITY COUNSEL].

Q If you look at this, on the second page Charlotte Kent writes to you and Dr. Redfield on July 27th at 1:12 p.m. saying, "There is tremendous interest at HHS in this report. Here is the current draft. The report is being finalized before a proof is developed later this evening. It is likely the first sentence will be revised."

And then in the very next email, in the chain -- and you're still copied here -- she says at 1:37, to Kyle McGowan, that he -- you suggested that he handle the request there. So I don't know if you have any memory of that conversation or perhaps that email, but this suggests that that answers the question.

A Okay. Yes. So it sounds like I did talk to Charlotte about this one. And my general view was Dr. Redfield's part of the clearance or awareness of proofs and was a key spokesperson for the administration on CDC results, and so his familiarity was important in that if there was -- you know, to resolve the dynamics

with Mr. Alexander and the ASPA office, either Mr. McGowan or Dr. Redfield would be the people to settle that.

I was not negotiating with ASPA or the departments by this time, and leaving those negotiations on political kinds of grounds to the chief of staff or Dr. Redfield for prioritization of how to handle some of those requests.

Q I want to refer back to your comments a moment ago about why CDC wouldn't normally share these reports. You talked, I think, about the MMWR being scientifically independent. So I just want to ask, when you saw that these political issues with Mr. Caputo, Dr. Alexander in the communications department at HHS were starting to be included in the summaries, did it give you pause or cause you any concerns?

A Yes. Yes, it gave me many concerns.

Q What concerns did it raise?

A It seemed important for us to double our efforts to protect the scientific independence and integrity of the MMWR.

One of the roles that the senior leaders who review it and clearance take is to assure that we're not making new policies, so we really are independent and we need to clear and confer. But on scientific results, there's an

extensive internal review process like a competitive peer-reviewed process on other journals that is meant to assure the scientific integrity and quality of the articles. And it didn't seem appropriate for political appointees in communication to be involved in that effort from any administration.

(Exhibit No. 31 was identified for the record.)

BY [MAJORITY COUNSEL].

Q Turning back to the document, Exhibit 31. If you look at the email chain, this is between you and Dr. Kent. Does this appear to be the feedback that you were referencing a moment ago?

A Yes, that's right. If we're opening -- the paragraph with -- talking about people about schools, that doesn't seem appropriate given that this is not about a school context. And it's very different than -- you know, that sleeping in tents with dozens of people is very different than the kind of contact that people have at school.

Q Now, moving to Exhibit 32.

(Exhibit No. 32 was identified for the record.)

BY [MAJORITY COUNSEL].

Q This is another distribution of the updated

summary on the lower part of the page on July 28th, a couple days later. And then it says, "Amanda called me to say requested delay by Dr. Redfield and HHS. Delay will make for better training."

Do you recall anything about the publication of this MMWR being delayed?

A No, I can't recall anything specific about that.

Q Would you typically have knowledge of the timing of the publication of an MMWR?

A I often knew that the review by the senior leaders or by some of the doctors and scientists had identified some analytic issues, so that we had a snag. And while our communication office might think we think it's scheduled for tomorrow, I'd sometimes say no, no, it's not happening tomorrow. There's a problem and the office has to reanalyze.

So I did sometimes have awareness about changes in the dates based on the scientific production. But I don't believe I knew about the timing of -- I don't recall this timing being something that I was -- you know, it doesn't stand with me today to remember that. So the answer is, no, I don't remember.

(Exhibit No. 33 was identified for the record.)

BY [MAJORITY COUNSEL].

Q The next email chain references MMWR, but in similar circumstances. So we don't have this whole document here, but the summary, this is Exhibit 33, SSCC-Manual-000017, and on the page that's Bates stamped 21, the subject seems to be Preventing and Mitigating SARS-CoV-2 Transmissions - Four Overnight Camps, Maine, June-August 2020.

There's a broad distribution here, which I believe you're included on. Actually, the second on the list. And then the next email up the chain, Dr. Alexander emails Charlotte Kent with additional feedback. Do you see that?

A Yes.

Q I want to actually skip up to the 11:22 p.m., now on August 26. This is on the first page, the second one down. Dr. Kent writes to you and Michael Iademarco saying that she received the communication from Dr. Alexander and she doesn't know how to respond. She's looking for guidance.

Do you remember what you said, if anything?

A Yes, I do remember this well. When I received Charlotte's email, I believe I called Dr. Iademarco or perhaps Dr. Iademarco called me. But we had a conversation; and I recommended that Charlotte not send

this email, that Dr. Iademarco speak with Dr. Redfield and have Dr. Redfield follow up with HHS.

I didn't think it was appropriate for Charlotte to offer this very polite draft response and didn't think we should wordsmith her polite response. I thought this was an inappropriate offer on his part and that we should have Dr. Redfield follow up.

So, to my knowledge, I spoke with Michael. He said, great. He talked to Dr. Redfield, he followed up with me and told me Dr. Redfield will take care of it. And my interpretation of what Michael said back to me was that Dr. Redfield had said ignore this email, we're not doing that, I'll follow up.

Just this is not -- you know, basically my assessment was Dr. Redfield was on the same page as Dr. Iademarco, Michael and I, and that he was going to follow up in terms of calling whoever the right authority was in the department so that this -- he didn't need this direct communication between Mr. Alexander and our scientific editor of the MMWR.

So that's why I didn't call Charlotte. I followed up with Michael, and at that time Charlotte reported to Michael and Michael was in the right chain to have the conversation with Dr. Redfield.

I would say that often, because Dr. Redfield is the

agency director and MMWR is the voice of the agency, Michael would at times -- Dr. Iademarco would at times have conversations about the MMWR practice and policy procedures with Dr. Redfield.

So that's how we left this one.

(Exhibit No. 34 was identified for the record.)

BY [MAJORITY COUNSEL].

Q I want to go back in time a few weeks prior to this point. There's an email chain that is marked Exhibit 34.

On the second page, Dr. Alexander sends an email to Charlotte Kent and Mike Caputo, Ryan Murphy, Nina Witkofsky, and Dr. Redfield. And he addresses the email to Michael Caputo saying, "I am asking that you put an immediate stop on all CDC MMWR reports due to the incompleteness of reporting that is done in a manner to mislead the public." He goes on from there.

Have you seen this before?

A Yes. And your raising this makes me realize I might have misspoken in my last answer and confused which -- I mean, I probably talked to Dr. Iademarco after this one as well as after the other one. And I can't remember which is the one where Dr. Redfield had the ignore it, I'll take care of it. But I think for both of

them -- I might have merged these two because they were -- you know, one was more hostile than the other.

But we did feel for the acting editor to be put in this position -- Dr. Kent had been handling the situation for some time and during her vacation, this was offered. So I can't promise which is the one that I -- I believe I spoke to Dr. Iademarco during both of them. And, again, we thought either Dr. Redfield or sometimes Mr. McGowan should be the person to take the follow-up.

Right. So this is August 8th, if it matters. Since I'm trying to be as accurate as possible, I know -- it's all the same MMWR memo. Correct. Yeah.

Q I think this one is actually referring to --

A Oh, this is the hospitalization. Right. Okay.

Q But --

A Sorry. So the one that I told you I asked -- okay. So let me just let you keep talking.

What's the question?

Q Well, I think if you recall what -- do you recall more than one conversation with either Charlotte Kent or Michael Iademarco about how to handle these requests -- this type of request from Dr. Alexander?

A My general recollection is that during 2020,

I had many direct conversations with Charlotte Kent as she was wrestling with some tricky issues with is this science okay? Should we go ahead? Should we pause in getting it firmer? Is it a priority for publication on scientific grounds?

As the summer progressed, I don't recall specifically which times I talked to Dr. Iademarco, which times I talked to Dr. Kent. But we were all trying -- I think Mr. McGowan, Dr. Iademarco and I were trying to protect Charlotte.

To do the very, very difficult job of being the editor, you can see how many emails she had at like 1:00 in the morning. And honestly, as of now, I think the response has done 345 MMWRs, most of them early releases on very fast production schedules.

So things that were viewed as not needing for her to resolve, we tried to resolve at a higher level. But if there were political conditions, I think Michael would bring them to Dr. Redfield, or we would say let Kyle handle this for all of us. If they were scientific differences of opinion, I think Charlotte often sought me out to weigh in.

As you could see, Michael said, here's what I think, but I think Anne will probably have something else to offer, have another strategy of how she wants it to go

forward.

So it wasn't probably -- there wasn't a single way we addressed these.

Q Apart from sort of the general concerns that you expressed about the fact of efficiency moving, given the general independence of the MMWR, did you have concerns over the course of the summer about the types of requests, perhaps the frequency of requests, that Dr. Alexander was making?

A I would say that I was concerned about our staff on the response, the authors, the clearers, the production team, working so hard to get information that was actionable out as quickly as possible and the distractions were not helpful.

I tend to feel that the leadership of Dr. Kent and others prevented scientific integrity being compromised, but there was this constant pestering, if you will, that was taking up energy. And so it was those kinds of things here our chief of staff was pretty good at pushing back and they were high level. Dr. Redfield, you know, we would try to have him help out, but his office was pretty busy.

So I don't think those -- I found the ones I was copied on, you know, were irritating, but I felt that we succeeded -- you know, particularly Charlotte -- in

protecting the integrity of the reports that we issued to change things because of scientific reasons and not swayed to any kind of pressure.

Q If Dr. Alexander's suggestions had been implemented, do you think that they would have compromised the scientific integrity of the publications?

A Yes. You know, many of them were not accurate. So he was looking at three summaries and making conclusions versus reading the article and seeing that his assumption that this is an oversimplification, that the full article was accurate, fair, evidence-based and descriptive and not jumping to policy implications; that we were not trying to hide nor overly hype information about children. We were trying to be accurate in sharing.

Q Going back to this August 8th email, the one where Dr. Alexander asked Michael Caputo to stop the MMWRs from being published. Do you know if anyone ever suggested that that email should be deleted or told anyone to delete that email?

A I am not familiar with anyone asking to delete an email. My understanding -- and I actually did talk to Dr. Redfield about this after some publications -- was that his intent in his language was to say ignore it, not physically delete it. And my

understanding from follow-up is that the email was actually still in Ms. Kent's records. She just couldn't find it at the time and thought it had been deleted.

So that's my understanding, indirectly, because I didn't look at her emails. But I believe she found it later, I believe, after the transcript came out from that last interview.

But after that came out, I did speak directly with Dr. Redfield and he said, oh, my gosh, of course not. This was -- ignore it. This is ridiculous. We're not going to stop MMWR. You know, he understood the importance. And I know in his hearing he strongly defended the integrity of the MMWR and on his watch he did not want there to be any compromise of that.

[Majority Counsel]. We are at our hour. We can go off the record for a second.

(Discussion held.)

The Witness. We would like to keep going. We welcome the opportunity to do the next set of questions, and whether we need a break after that will depend on biology.

[Majority Counsel]. Sounds good.

BY [MINORITY COUNSEL].

Q Just very briefly. You've known Dr. Kent a long time, correct?

A Not that long. She's been at the agency 20-some years and I've been 30-some, but I really got to know her when she became the editor for the MMWR. I don't believe I really knew her or worked with her before then.

Q Sure. You trust her judgment?

A Absolutely. Very, very serious and thoughtful about conducting her work with good judgment.

Q If she told us that she was absolutely committed to maintaining the scientific integrity of the MMWR, would there be any reason to doubt that whatsoever?

A No.

{Minority Counsel]. Thank you. That's all I have.

[Majority Counsel]. I'm happy to keep going if you're up for it. We can also take a break.

The Witness. Let's try. We can break in the middle if we have to.

[Majority Counsel]. You are absolutely welcome to take a break at any time.

The Witness. Okay.

[Majority Counsel]. So we will continue.

BY [MAJORITY COUNSEL].

Q So the next topic I want to touch on briefly, in July of 2020, there was a change in the way hospitalization data was collected. It had previously

been collected by CDC through NHSM. The change involved it being reported directly to HHS.

How did you become aware of that decision?

A I don't actually remember how. You know, I know that -- I don't exactly remember how I did it.

Q Do you know if you were informed in advance that the change of reporting was going to happen?

A I don't believe I was. If I was, it was probably -- you know, I was not on the response at this point and so I don't -- so I was aware of it, but it might have been after it happened that I became aware of it. I don't recall.

Q So I can tell you Dr. Redfield testified to the select committee on July 31, 2020 that he learned about the decision to HHS after the decision was made.

Is that consistent with your recollection; is that right?

A Yeah, that sounds consistent, that there was a different management structure in place for, again, you know, NRCC to JCC and the data issues, the White House. And there was a lot of -- you know, the data coordination was happening in a different way that Dr. Redfield probably wasn't in the center of.

Q Did you have any concerns at the time about the decision to have data no longer reported to CDC

directly?

A I don't recall. I honestly don't recall the details of this episode. I have read about it in the media and know that it prompted -- that there was a lot of subsequent concerns. But I guess from my perspective, you know, my familiarity was exactly what was being recommended and why, I didn't -- I wasn't in on that.

Q There's been some reporting -- and I don't know if it referred to this or something else -- that you disagreed with Dr. Birx about the way in which hospitalization data was collected. Does that sound right to you or was that inaccurate?

A When I read that report, I believed that was a miscommunication there. I think the issue that I do know I was present in conversations with Dr. Birx about was that CDC had expanded our influenza hospitalization sentinel system that tracked intensive information, like substantial information about people hospitalized with COVID in a different way than the national reporting worked to get additional data elements that were not in that core short amount that was coming in from some of the hospital systems. And I know that there were conversations -- that's how we measure vaccine effectiveness among hospitalizations for flu and was done as one of the systems for COVID.

So I think somebody -- I don't know who said that to the reporters, but if somebody was saying that, they may have been talking about the COVID-NET, not the NHSN, because COVID-NET was tracking hospitalizations. And I think it's a valuable system, and I'm not sure Dr. Birx agreed on that.

But I don't really know what that comment referred to. So the NHSN issue I was distanced from. I certainly know a lot about NHSN over the years because it's been a really important tool in tracking hospitalization-associated infections, resistant microbacterial resistance, but there were some cumbersome issues related to it that were -- because it's a mandatory reporting system, it's shared with CMS, modifications in it need to go through a different kind of OMB PRA process. And, you know, CDC is under both authorities, and HHS didn't really need to do that kind of review for its systems. I don't know whether that could have factored into whoever made the decision to change -- to proceed with which another system might be stood up.

But NHSN has been valuable, but that whole transition, I was uninvolved and didn't have opinions about it, I guess.

Q Okay. Let's move on to Exhibit 35.

(Exhibit No. 35 was identified for the record.)

BY [MAJORITY COUNSEL].

Q This is a July 17, 2020 email from Kate Galatas to you copying Michelle Bonds.

First of all, do you remember this?

A Yes, I do.

Q Do you recall the circumstances of the incident that's described in this email chain?

A Yes, I do.

Q So Ms. Galatas says, "I am sharing this with you, as I have been forced into providing an OADC employee name to Mr. Caputo at his demands (very long email trail below documenting this).

"In an email to Kyle and R3" -- I think that means Dr. Redfield -- "last night, I noted my discomfort with being instructed to take this action."

Then she says she would like to discuss the incident with you.

Do you remember having that conversation with her?

A Yes, I remember the conversation.

Q What do you remember about that conversation?

A Ms. Galatas was very shaken and felt very threatened and uncomfortable with the position that she had been put into. She described never having been

treated like this in however long she's worked for the government or in public service.

And I recall comforting her and supporting her, told her I was very glad that she had been able to speak with Constance, because Constance's professional expertise was the appropriate type to give her guidance in navigating what she had to do versus what she felt uncomfortable about doing and really offered personal support.

That's what I recall.

Q Did you obtain any knowledge about this incident from anyone else other than in this email from Kate Galatas or any conversation with her?

A Kate was the source of me knowing about this. I don't recall speaking to others about it and I don't recall anybody else telling me about it.

You know, I have to say that the emails that she forwarded -- you know, she forwarded the series of emails, and it was -- just talking to me, the tone and the, you know, the apparent harassment.

I would also say that I was not in these direct links with ASPA. And really, it's through Kate sharing with me her discomfort and then subsequently reading media reports that I became more aware of what may have been going on in that office.

So I was in another change, not -- you know, even

when they were talking about me, I didn't know it.

Q Other than incidents that have been reported in the press, are you aware of any incidents -- whether you describe it as harassment or retaliation or otherwise -- by Michael Caputo or others against CDC employees?

A I don't have personal knowledge of others. You know, that doesn't mean it didn't happen, but I don't have personal knowledge.

Q Do you have knowledge from conversations with other CDC employees?

A Of the ASPA interactions?

Q Yes.

A No, I don't. You know, I don't have other information.

Q Okay. So we want to turn to one more document here, Exhibit 36.

(Exhibit No. 36 was identified for the record.)

BY [MAJORITY COUNSEL].

Q The subject of the email is your name. So I think because this has been reported in the press, that you have likely seen this before. So before you pull it out, I want to tell you that I'm not going to ask you about the response and ad hominem attack in this email.

I just want to ask you a little bit about the circumstances surrounding it.

So I'm making the assumption you were already aware of this. When did you become aware of this email?

A My recollection is this part of this email -- the 6:31 p.m. part of this email, the point/counterpoint about my podcast --

Q Yes.

A -- I believe this was covered in the media, you know, The New York Times or Post or Politico, I can't remember who. So many people have covered these things.

The email that had me as the subject line, I hadn't seen that until this morning when I saw your exhibits, so I didn't know I was actually the subject of the email versus whatever I said. But it was only -- you know, I did that podcast, I believe, June 29th, and I wasn't aware that there was a whole critique of it in writing on June 30th until September when it appeared.

Q So at the July 1st 2:41 a.m. portion of this email is -- actually, Dr. Redfield is copied on it -- do you remember ever hearing from him about concerns about the podcast?

A No. No. As I said earlier, Dr. Redfield was never anything but supportive of me personally and professionally, and personally treated me very well with

respect and collegiality.

So Dr. Redfield and Mr. McGowan earlier, I guess, were aware of some things and they didn't -- they kind of sheltered me from this whole turmoil.

Q One of the statements that this was quoted in The New York Times article says that your goal in the White House was to embarrass the President. Is that accurate?

A No, that's not accurate.

Q Was there any political motivation with -- to the White House?

A No.

Q They also mention herd immunity. In fact, Dr. Alexander in this email makes the claim that "Having the virus spread among young and healthy is one of the methods to drive herd community. This was not the intended strategy, but all must be on deck now and it is contributing positively at some level."

Do you agree with that statement?

A No.

Q You did you become aware of efforts -- at any point in time in 2020 -- efforts to implement a so-called herd immunity strategy?

A I wasn't aware that the policy was to let things go; that that was the approach that Stephen was

taking. And early on people wondered maybe that might be okay if you shelter the elderly, but their results were not more broadly viewed as valuable.

So I was never aware that there was a concerted effort to -- you know, I know there was a concerted effort to rapidly develop and deploy vaccines to protect people as a strategy, but I wasn't aware that there was a policy or a plan for herd immunity to be the strategy.

And, of course, by the summer we had a vast minority of people had been infected. There was an enormous population that hadn't yet been affected by July when this was to be discussed. Or even in the most affected areas, the vast majority of people had not been infected.

Q To bring back to the email itself. The New York Times, when they reported on it, said, "After Mr. Caputo forwarded the critique of Dr. Schuchat to Dr. Redfield, CDC officials became concerned when a member of the health department's White House liaison office -- Catherine Granito -- who was also copied on the email -- called the agency to ask questions about Dr. Schuchat's biography."

Did you hear about that?

A Of course, this is the first -- I don't know whether it was in The New York Times or not. But looking at the exhibit, it is the first time that I have seen

Ms. Granito's name in association with Paul Alexander, Michael Caputo emails.

But I guess the week after my podcast I got a cryptic call from Catherine Granito, you know, asking me some questions about how long had I been at the agency and kind of what kind of employee was I. It was, you know, kind of a mystery. And I recall speaking to Mr. McGowan about it afterwards, but didn't really understand who she was or why she was calling me.

So the media reports may have been referring to that call. I don't know if she was calling other people about what type of appointment I had, but -- I mean, she sort of -- it was a very odd conversation.

Q Do you remember getting any other calls from someone from the White House similar to that at any point in time?

A No, I don't recall any others.

Q Can you recall any other actions taken around this time that could have been connected to this email?

A You know, the following week in a fairly routine -- it was a fairly routine request. At the very last minute the morning of an event, Dr. Redfield was pulled away for a White House event and needed a substitute for some brief opening remarks he was going to make for the National Association of City and County

Health Officials, our local health department leads. And our scheduling team asked if I was free at that moment and could do a brief welcome, which was essentially going to be thanks for your hard work. And I was given the remarks that he was going to make.

So I said, yeah, I can spend about a half an hour and do that five-minute whatever. And shortly after that agreement, I was told actually, they don't want you to do it and so they got somebody else to do that.

So whether that was connected with this or whether it was just coincidence that it was the same -- during the week after the podcast, you know, I was not -- I personally connected it in the idea that I'm not allowed to talk to public health now. And that was a personal blow because that's my community and certainly the community together with the healthcare workers and the affected populations that was working so, so hard to get us through this.

So in my mind it's connected. But I don't know if it literally was connected or if there were other reasons that I was not okay to -- I wasn't okay to be the spokesperson for thanking the public health community.

Q Were your roles limited in any other ways after that incident or around this time?

A Well, I turned to -- you know, continued to

focusing on the rest of the agency. So I was not doing public messaging around COVID and if media requests came in, they either were not approved or we didn't hear back. So I don't believe I did media or other speaking until sometime in the fall, when there were one or two academic kinds of venues that I spoke at.

So I would say I pretty explicitly avoided public -- you know, that I was focusing on the non-COVID mission.

Q Any other communications that were restricted for public appearances, briefings, et cetera?

A Not that I recall. I think we -- you know, there were -- I don't recall which requests. You know, it may have been I got requested and I said, why don't you see if someone can address that one.

I don't recall specifically other ones that were definitely declined, but the idea that I couldn't do a welcome and thank you for county health officials was a bad sign.

Q We talked a bit about how McGowan's name has come up a number of times. Was he someone that you worked closely with and trusted as a colleague?

A Yeah. He was new to public health and CDC, but worked very hard to learn our mission and advocate for the agency and be a good broker in the policy

political realm for us. So I think he was quite helpful.

Q Do you know why he and Amanda Campbell left in August of 2020?

A I don't know the details, no.

Q Kyle was replaced by Nina Witkofsky. Did you end up working closely with her?

A No. By this point we physically worked closely in our office of the director's suite, but we -- our interactions were more about her kids at school or bike riding, but not really about the content. She was going elsewhere for the COVID work, and I think she was basically introduced to me as Anne's on the non-COVID side of the house and she was pretty much focused on COVID.

Q What's your impression of Nina Witkofsky's impact on the agency?

A You know, I had little visibility to her day-to-day or her interactions because I wasn't interacting with her professionally. Really, it was more as teammates.

Q So apart from -- well, actually let me go back.

How often did you interact with the Secretary's office of HHS when you were working on the COVID response?

A Daily.

Q Who were your main points of contact?

A I don't actually -- you know, as I mentioned, there was always the need for testing and that was the big area, and he visited a couple times and reviewed our whole fleet of ongoing investigation, research, modeling, and lab activity and so forth.

There was some interaction with the Surgeon General, as I mentioned, some interaction with the ASPR. Who was in the room at that point was very hard to tell because the chief of staff at HHS would convene calls, and it was really to get updates from the different agencies rather than to know who else was in the room with him or who was on the phone with him. So we didn't really know who was there. So I don't know who else at HHS was in there or not.

Q How much interaction did you have with Deborah Birx?

A Not very much. When I was incident manager, she mainly worked talking to Dr. Redfield. There were a couple times where I got a call or I was on an email, like here's what I've written. Can everybody look at this within the next hour? But I think she was viewing Dr. Redfield and Dr. Fauci, Dr. Giroir to some extent, as her go-to people and theoretically we had been accessing

the CDC response to the NRCC where Dan Jernigan was our lead up there.

So I didn't have lots of contact with her even when I was incident manager.

Q Did you have interaction with any other White House officials during that time or otherwise apart from what we've discussed already?

A I think we discussed the contacts that I had, if I recall. I'm not remembering any other large areas.

Q Or OMB, for that matter?

A Yeah. Usually I wasn't directly interacting with OMB. You know, I would say early in February maybe timeline, February, maybe March, there were a couple hearings and Senate or House briefings I did where a lead from OMB was present and we were talking about budget requests and so forth.

There were some, you know, in that early time period where I was still out there, where people were still traveling and I was one of the voices, that OMB would be there describing their portfolio. But in terms of navigating, I wasn't really with OMB.

Q Are you aware of any instances where political appointees attempted to influence CDC work, whether communications, guidance, documents, MMWRs, or otherwise that we haven't covered today or otherwise

haven't publically reported?

A I think the discussions today and your staff summaries and so forth are pretty extensive. I'm not aware -- not remembering other kinds of areas.

Q How about instances of retaliation or the sources of feedback that happened, I guess is the word, after your MMWR or Dr. Messonnier's press conference, anything else like that?

A There may have been others. It would not surprise me if there were others. You know, I think other agencies, as has been reported, felt some of the same kind of pressure that we were feeling. But I don't have personal knowledge of others. I think the -- and I may have, with the feedback I got, may have really focused on where I could have positive influence.

And my focus was on our people, the mission, the country, how could I be useful. And if there were some avenues the agency or I could not navigate, let's -- there's plenty to do here. Let's focus our energy on where we could have the most impact in this multi, very complex response.

Q Stepping back to the big picture, do you think that CDC was hampered in the way it could perform its functions during this first year of the pandemic?

A Yes.

Q Why do you say that?

A I think there was substantial important information we were learning that we weren't able to share in as clear and accessible way as possible. You know, limitations on whether digital or print in an MMWR outreach is different than the ability to explain and bring the field forward.

We had funding constraints at certain times, not of course eventually, but we also -- you know, when I think the states and cities or counties were looking for national leadership in the public health realm and had been familiar with our voice and role, I think there was a big gap that wasn't necessary filled with the way that the Central Command was structured.

You know, that said, this has been an unprecedented pandemic, very complex. And we all have to be humble about it because I can't say that -- you know, there's a lot to learn going forward about how to do things better next time and how to finish the job with the current response.

But I do feel like CDC couldn't use all of its assets and was sort of set up to take the blame on issues. Of course we made some mistakes and there were areas where CDC's absolutely not perfect, but I think there was set up an unhelpful antagonistic role that we

were placed into with other parts of the government that did not help our credibility.

Q What do you mean when you say set up? Set up to take the blame?

A Yeah. I mean, I think that's pretty self-explanatory.

Q What do you think could have been different that would have allowed CDC to fulfill its mission during this pandemic?

A What I would like to say is there is a lot to think through to improve the state of our public health system, state of our data, our workforce, our governance, our roles and responsibilities across the department, across a lot of different -- ESFA and the other emergency functions.

So there's a lot of room for improvement, much of which is occurring now. But I think that I need more time to digest like what's the best way forward. I think it's really important for the nation that we don't want to have this happen again in this way, and I think all of the institutions and leadership can do better in the future.

So I would say I need some time to digest and think through saying that, you know, we have a lot of work to do.

[Majority Counsel]. Let's go off the record.

(Recess.)

BY [MINORITY COUNSEL].

Q Dr. Schuchat, I have a quick kind of CDC governance question for you. Just yes or no, do you think the CDC director should be a political appointee?

A I can see pluses and minuses.

Q If it stays a political appointee, do you think it should be Senate confirmed?

A I don't have an opinion on that.

Q Okay. Have you heard the term "long COVID"?

A Yes.

Q What is it?

A You know, I'm missing a presentation on it today at the infectious disease meeting, but a friend just texted me that it was a great presentation. So I don't know much about the latest thinking. As I said, a couple months of being out of touch makes me out of date.

But there are concerns that some individuals who are infected with the virus have a higher probability of symptoms many months out compared with others who weren't infected. So there appears to be in some subset of people who have an acute infection lingering problems. The pathophysiology and which of those things are related to the virus or the body's reaction to the virus or the

trauma associated with the infection, I think, are all being teased out. But there are some great studies that are being supported to try to get to the bottom of it.

Q It still sounds like there are still a lot of unknowns. Is it possible that there's symptoms related to long COVID that would not have been original COVID-related symptoms?

A That's one of the reasons for the cohort studies, to differentiate which pattern of illness is likely related to the infection. And the studies to date are identifying some facts -- you know, in that group of people who are being followed, some longer term symptoms that can't be explained by other -- you know, that appear significantly linked to having had an infection.

But there's way more to learn than what we know right now, although my colleagues are learning a lot at this meeting that's going on. But it's going to be archived so I can still see it.

Q Unfortunately, you've had to hang out with us all day and not been at what sounds like a very informative conference.

One last quick thing. It's 5:30 on your retirement day and I'm sure you have a party to get to or something. But we've seen a lot of Dr. Alexander's emails today that he sends and looks over email at 3:00 a.m. with lots of

random thoughts on random things, some of which are, I think, best characterized as not particularly nice.

You said Dr. Redfield has always been supportive of you to HHS leadership; I'll assume to the White House, too, if he has been supportive other places. Is that correct?

A What I would like to restate is that in my interactions with Dr. Redfield and in his public statements, he has been very supportive of me. I don't have direct information about what, if any, conversations he had with other entities about me. But, you know, he was always very collegial and supportive and kind. And, you know, he's a very compassionate man and I think that he had respect for me.

So I don't know what he -- what, if anything, he said to others at HHS or the White House, if I even came up.

Q Fair enough. I probably, like yourself, have read more of Dr. Alexander's emails than I would care to for a lifetime. And I'll be blunt, it's 5:30. Did you take Dr. Alexander seriously at all?

A You know, I respected Charlotte Kent's patient and methodical point-by-point responses to the questions and the issues that he raised. I didn't have direct interactions with him and can't -- you know, tried

not to make conclusions based on that.

So that's all I had say. We had a response to deal with, we had a national and global pandemic, and our energies and emotions really needed to be focused on protecting people which -- you know, who were going through a terrible time.

[Minority Counsel]. Okay. Thank you. That's it.

BY [MAJORITY COUNSEL].

Q I just want to ask one more clarifying question about some of what we talked earlier about Charlotte Kent, and the requests, I guess, you could say she was receiving from Dr. Alexander.

I think your testimony was, in summary, and her testimony was as well, was that she feels, and you said that she was able to protect the scientific integrity of CDC's work ultimately; is that right?

A Yes. My understanding is that her -- you know, that she was able to. And I would say that senior leadership did our part to try to help protect that integrity and always improve the quality, we can always improve, but to try to not let our work be compromised. And so the MMWR, we had more control over, I guess, than some of the others.

Q Now, just because you were successful in your efforts doesn't mean that there weren't attempts by

others -- particularly Dr. Alexander, perhaps under the direction of Mr. Caputo -- to compromise the scientific integrity of CDC's work. Those are two -- I just want to clarify that those are two distinctive things, that attempts happened without the work ultimately being compromised; is that fair?

A I would say that's absolutely true, and that it took great effort to protect that integrity. It took active effort on the part of Dr. Kent and others to make sure that the attempts were not successful.

Q Would you agree that, for instance, a career employee working at CDC shouldn't have to be subject to that kind of political pressure?

A Yes.

[Majority Counsel]. No further questions unless the Minority has any further follow-up.

[Minority Counsel]. All good.

[Majority Counsel]. Thank you so much, Dr. Schuchat. I know it's been a really, really long day. We really appreciate it, and I can tell you this has been incredibly helpful to us in our work.

I know as of this morning this was probably not how you wanted to spend your last official day, but from our perspective, we're really glad that you did and we wish you all the best and really thank you for such a

wonderful public service career.

The witness. Thank you all. And I know that you all are not done with this, so good luck.

[Majority Counsel]. I shared this note. We do have one pending question, and Kevin will talk about that.

The witness. Okay. Thank you. Have a great weekend. Enjoy.

(Whereupon, at 5:42 p.m., the taking of the instant interview ceased.)

Corrections to transcript for subcommittee staff interview with Anne Schuchat, Oct 1, 2021

P 24, line 567 Change 'Lister' to 'list serve'

P 24, line 568 Change SOMED to PROMED

P 30, line 727 Change 'assets' to 'assays'

P 30, line 728 delete 'number'. (Phrase refers to SARS Coronavirus 1, or SARS CoV1)

P 31, line 732 Change SOMED to PROMED

P 32, line 770 Change 'us' to 'others'

P 40, line 960 Change 'sent' to 'developed' (as in, "assays that were being developed")

P 41, line 988 Change 'find contact' to 'find infected contacts'

P 41, line 994 Reword. "So we didn't miss it by failing to look for it, because we did look for it, but…"

p 42, line 1027 add 'at the time' after 'was relatively rare'

p 43, line 1037 Clarify: Instead of "they" say "Seattle investigators did…(a flu surveillance testing of specimens…"

p 43, line 1039 Change 'it' to 'SARS CoV2"

p 44, line 1079 and 1074 delete 'that we could'

p 45, line 1101 Change 'exceeded' to 'seeded'

p 48, line 1174 Change 'ceding' to 'seeding'

p 53, line 1293 Change 'during' to 'doing'

p 56, line 1359 Change 'question' to 'first SARS virus'

p 57, line 1397 Change 'counts' to 'concerns'

p 57, line 1408 Change 'in' to 'and'

p 58, line 1424 Change 'to the staff' to 'to one household member' and change second 'staff' to 'household'

p 59, line 1435 Insert 'are' between 'there' and 'lots'

p 74, line 1822 Change ASPER to ASPR

p 76, line 1867 Change 'thing' to 'list

p 85, line 2092 Change 'intimate' to 'incident'

p 85, line 2099 Change 'frontal' to 'funnel'

p 90, line 2226 Change 'sufficiency' to 'proficiency'

p 92, line 2267 Change ‘of the’ to ‘that had a’

p 94, line 2328 Change APAHL to APHL and change what the acronym stands for to Association of Public Health Laboratories (ie, delete’ American Public’)

p 95, line 2330 Insert ‘our staff’ between ‘that’ and ‘were doing outreach’

p 98, line 2407 Change ‘polled’ to ‘pulled’

p 98, line 2411 Change ‘high level virus’ to ‘high levels of virus’ (i.e., a high viral load)

p 100, line 2455 Insert ‘they think’ before ‘you know’

p 107, line 2654 Insert ‘not’ (Ie, we would NOT have known)

p 124, line 3079 Change ‘my contact’ to ‘my internal CDC public affairs support person’

p 127, line 3139 Change ‘case’ to ‘pace’

p 127, line 3149 Change ‘COCO’ to ‘COCA’

p 128, line 3175 Change ‘seeing’ to ‘saying’

p 138, line 3428-9 Insert ‘safer’ between ‘make this’ and ‘longer term’

p 143, line 3550 I don’t think ‘adopted’ is correct. I believe the question was ‘drafted’ (ie, who wrote the order)

p 144, line 3562 I think ‘adopted’ again here should be replaced with ‘drafted’

p 144, line 3576 Insert ‘transit’ before ‘corridor’

p 146, line 3620 Insert ‘next’ before ‘administration’

p 150, line 3711 Change ‘they’ to ‘there was also, separately, a big…’

p 150, line 3715 Change ‘into’ to ‘within’

p 153, line 3796 Change ‘processed’ to ‘process’

p 155, line 3833 Change ‘Groban’ to ‘Grogan’

p 155, line 3837 Change ‘Groban’ to ‘Grogan’

p 155 line 3839 Insert ‘We would hear back’ before ‘yes, you know’

p 155, line 3846 Change ‘it’ to ‘face coverings’

p 158, line 3916 Change ‘effective’ to ‘affected’

p 158, line 3919 Insert ‘impacts’ before ‘could be mitigated’

p 162, line 4019 Change ‘world’ to ‘words’

p 164, line 4083 Change ‘on’ to ‘our’

p 168, line 4158 Change ‘lording’ to ‘wording’

p 168, line 4166 Change ‘guides’ to ‘guys’

p 168, line 4178 Change ‘order’ to ‘or’. [Note: if the questioner said ‘order’ then I misheard them since my answer would have been different about an order]

p 169, line 4196 Change ‘pieces’ to ‘perspectives’

p 171, line 4237 Change ‘order’ to ‘or’

p 174, line 4317 ‘Study practice’ sounds wrong but I can’t figure out what was actually said.

P 186, line 4613 Change ‘mutual’ to ‘neutral’

P 186, line 4617 Change ‘orient’ to ‘origin’

P 189, line 4686 Change MSI-C to MIS-C

P 196, line 4864 Change ‘Giroir’ to ‘Walke’. This seems to be a substantive mistake (whether I misspoke or the recorder mis-typed I don’t know, but the correct answer about whom I went to in order to gather more information was Dr. Walke and the rest of the answer is referring to my communication with Dr W.

P 207, line 5138 Change ‘offices’ to ‘officers’

P 208, line 5160 Change ‘their’ to ‘the’

P 224, line 5556 Change ‘interaction’ to ‘introduction’

P 228, line 5657 Change ‘met’ to ‘went out’

P 252, line 6271 Change ‘intensive’ to ‘extensive’

P 258, line 6429 Change ‘Stephen’ to ‘Sweden’

P 264, line 6557 Admiral Giroir’s name is accidentally omitted. The syntax is off so his name needs to be inserted before the rest of the answer

P 264, line 6579 Change ‘we had been’ to ‘she would have been’

P 265, line 6580 Change ‘to’ to ‘through’

P 265, line 6591 Change ‘OMD’ to ‘OMB’

P 268, line 6668 Change ESFA to ‘ESF-8’