COMMITTEE ON OVERSIGHT AND REFORM

SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

INTERVIEW OF: HENRY WALKE, M.D.

Friday, February 18, 2022

The Interview Commenced at 8:58 a.m.

Appearances.

For the DEMOCRATIC STAFF:

[Redacted]

[Redacted]

[Redacted]

For the REPUBLICAN STAFF (MINORITY):

[Redacted]

[Redacted]

[Redacted]

[Redacted]

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

KEVIN BARSTOW, Senior Counsel

JoANN MARTINEZ, HHS

ERIC WORTMAN, CDC

Exhibits

Exhibits

Exhibits

P R O C E E D I N G S

[Majority Counsel]. Dr. Walke, we're going to have one more colleague who is going to join a little bit later, but we can certainly get started now.

The Witness. Sounds good. Can you hear me okay?

[Majority Counsel]. Good morning, Dr. Walke. I want to make sure you can hear me as well. My name is [Redacted].

The Witness. Yes, I can hear you.

[Majority Counsel]. As [Redacted] said, we are ready to go on the record. Is that right, [Redacted]?

[Majority Counsel]. We are.

[Majority Counsel]. Good morning, Dr. Walke. This is a transcribed interview of you, Henry Walke, 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 federal government's response to the coronavirus pandemic.

I would like to ask the witness to state his full name, and spell his last name for the record, please?

The Witness. Yes, my name is Henry Thomas

Walke, Jr. And my last name is spelled W-A-L-K-E.

[Majority Counsel]. Thank you.

Dr. Walke, as I mentioned briefly off the record, my name is [Redacted]. And I am Majority counsel with the Select Subcommittee. I want to thank you for coming in today for this interview. We recognize that you are here voluntarily, and we really 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 with you today?

The Witness. I do not.

[Majority Counsel]. Is there an attorney present representing the agency?

Mr. Barstow. Yes.

[Majority Counsel]. Would counsel please identify themselves for the record?

Mr. Barstow. Kevin Barstow, senior counsel at HHS.

[Majority Counsel]. And for the record, can the additional staff in the room please introduce themselves for the record as well? Why don't we start with the Majority?

[Redacted], I didn't hear you. Others may

have.

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

[Majority Counsel]. Thank you. And Minority?

[Minority Counsel]. [Redacted] for the Minority.

[Minority Counsel]. [Redacted] for the Minority. And [Redacted] is here as well.

[Majority Counsel]. Is there anyone else who is on, who has not announced their appearance?

Mr. Wortman. Eric Wortman, CDC, Washington.

[Majority Counsel]. Thank you.

Before we begin, I would like to go over the ground rules for this interview. As previously agreed to by Majority staff and HHS staff, the scope of this interview is the federal government's response to the coronavirus pandemic from December 1, 2019 through January 20, 2021.

The way that this interview will proceed is as follows. The Majority and Minority staff will alternate asking you questions, one hour per side per round, until each side is finished with their questioning.

The Majority staff will begin, and proceed for an hour. And the Minority staff will then have an

hour to ask questions. We will alternate back and forth in this manner until both sides have no more questions.

We have agreed that if we are in the middle of a line of questioning, we may end a few minutes before or go a few minutes past an hour, just to wrap up a particular topic.

In this interview, while one member of the staff may lead the questioning, additional staff may ask questions from time to time. As you likely see, there is a court reporter taking down everything I say, and everything you say to make a written record of the interview.

For the record to be clear, please wait until I finish each question before you begin your answer. And I will, in turn, wait until you finish your response before asking you the next question. The court reporter can't record nonverbal answers, such as shaking your head, so it's important that you answer each question with an audible verbal answer. Do you understand that?

The Witness. I do, yes.

[Majority Counsel]. We want you to answer our questions in the most complete and truthful manner possible, so we are going to take our time. If you

have any questions or do not understand any of the questions, please let us know. We will be happy to clarify or rephrase our questions. Do you understand that?

The Witness. I do.

[Majority Counsel]. If I ask you about conversations or events in the past, and you are unable to recall the exact words or 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 a conversation or event, you should give us your best recollection of those events or parts of conversations that you do recall. Do you understand that?

The Witness. I do.

[Majority Counsel]. If you need to take a break at any point, please let us know. We are more than happy to accommodate you. So you know, ordinarily we take a five-minute break at the end of each hour of questioning, but if you need a break before that, again, please just let us know. We would ask, though, that to the extent there is a pending question, that you finish answering the question before we take the break. Do you understand

that?

The Witness. I do. Thank you.

[Majority Counsel]. Although you are here voluntarily and we will not swear you in, you are required by law to answer questions from Congress truthfully. That also applies to questions posed by congressional staff in an interview. Do you understand that?

The Witness. I do.

[Majority Counsel]. If at any time you knowingly make false statements, you could be subject to criminal prosecution. Do you understand that?

The Witness. Yes.

[Majority Counsel]. Is there any reason that you are aware of that you are unable to provide truthful answers in today's interview?

The Witness. No.

[Majority Counsel]. 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 statement today that assertion must comply with the rules of the Committee on Oversight and Reform.

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 that?

The Witness. I do.

[Majority Counsel]. Before we begin, do you have any questions?

The Witness. No.

[Majority Counsel]. Great. Okay.

EXAMINATION BY COUNSEL FOR THE COMMITTEE

BY [MAJORITY COUNSEL].

Q Let me please start out by asking you to provide a brief summary of your educational background.

A Yes. I have a medical degree. I have a master's in public health, and an undergraduate degree in -- bachelor of arts, an undergraduate degree.

Q Thank you. I understand that you currently work for the Centers for Disease Control and Prevention. How long have you worked at CDC?

A Since July of 2001.

Q Can you please briefly walk us through your career path at CDC?

A Yes. I was hired in the middle of July

in 2001. And for almost the next four years, I worked in the country of Jordan, supervising, running a field epidemiology program that trained public health staff, Jordanian public health staff in the methods of epidemiology.

In 2004, I returned to CDC Atlanta, and then ran the headquarters program for that same field epidemiology program until 2011, at which time I took a job -- and that was within the Center for Global Health.

In 2011, I took a job with the National Center for Emerging Infectious Diseases, NCEZID, Emerging Zoonotic Infectious Diseases, as a branch chief in Bacterial Special Pathogens. And then worked in that position until 2019.

The -- January of 2019, I became the division director in the Division of Preparedness and Emerging Infections, and was the division director that -- the division director. I was in the Center for Emerging Zoonotic Infectious Diseases throughout 2019.

Currently, in November of 2021, I became the director of the Center for Preparedness and Response at CDC, and currently in that role.

Q And was there any position between the division director of Preparedness and Emerging

Infections and your current role?

A Well, I officially was in the Division of Preparedness and Emerging Infections until my current role. I certainly was the incident manager for over a year, over the COVID response, during that period of time, as well as the incident manager for the Ebola DRC response from July of 2019 until early January of 2020.

Q So in the period when you were incident manager in connection with the coronavirus response, were you also in your position as director of the Division of Preparedness and Emerging Infections?

A Yes, that is correct.

Q Thank you. Generally speaking, what were your responsibilities in the role of director of the Division of Preparedness and Emerging Infections before the coronavirus pandemic?

A That division is responsible for staffing an emergency operations center during a response, as well as preparing for any biological terrorism event or emerging infectious disease in the country.

So that division has a laboratory response network as part of the branch. So that's preparedness on the laboratory side, to be able to

detect any biological agent that's a threat.

Also had a branch that was engaged in response and operations management, in connecting with the interagency related to a threat, as well as had another branch that -- called the ELC Group that -- epidemiology and laboratory capacity cooperative agreement that put out a lot of money to the states to help the states build up capacity for laboratory -- - on the laboratory side, and their epidemiology workforce. So that was the general mission of the division.

Q Did your responsibilities in that role change over the course of the pandemic?

A Right. Not really. You know, I was only really there for six months, from the beginning of January of 2019 until July of 2019. And then I rolled on to the DRC Ebola response for six months. And then took a month off in January.

And then rolled back on the coronavirus response and the COVID response in February of 2020. So, yeah, I managed the staff and vacation times, signed off on various things, but a lot of the staff actually in that division were in the responses.

Q In that position or role of being director of the Division of Preparedness and Emerging

Infections, who did you report to?

A I reported -- my direct supervisor was Rima Khabbaz, who was the center director of the National Center for Emerging and Zoonotic Infectious Diseases.

Q Understood. And who were the types of folks who reported to you? I imagine there were many.

A Yeah, I had four branches, so the branch chiefs reported to me, policy person, communication person. So seven to probably eight or nine people.

Q And in that position, did you regularly interact with anyone outside of the agency?

A Yes. In that position, certainly we were funding partners, to work on infectious disease preparedness, including APHL, the American Public Health Association on the laboratory side; CSTE, an association for epidemiologists; IDSA, the Infectious Diseases -- infectious doctors association.

So in those partners, yes. And then certainly a lot of interactions with ASPR within HHS.

Q So I believe you said it was in July that you took on the role of incident manager, right?

A The DRC -- the Ebola response, that's correct, of 2019. So just trying to -- which

incident manager? I was incident manager --

Q Understood. In July 2020, the role in connection with the coronavirus pandemic.

A That's right. That's right. So I was the incident manager July 1 of 2020.

Q And just so I don't conflate the titles again, what is the accurate way to distinguish those? In July 2020, the title was incident manager of?

A Of the coronavirus -- the COVID-19 response.

Q Okay, great. Thank you. So generally, what were your responsibilities as incident manager of the coronavirus response?

A The incident manager directly reports to the agency director, at that time Dr. Redfield. The incident manager pretty much is a manager of the whole response, and so sets out the priorities of the response, manages the day-to-day operations of the response, manages the budget, and is basically the -- is in the driver's seat, in terms of this large CDC response and management operations, and review of scientific materials.

And also an important part is the interaction with the interagency, representing the CDC response on interagency discussions related to SARS-CoV-2.

Q That's really helpful, and a lot of information there that generally I'm interested in. You mentioned that you reported to the director, and that was Dr. Redfield. How often were you interacting with him in that role?

A Daily. He would call me, I would call him. We had scheduled meetings once a day. Probably two or three times a day, we would talk, yeah.

Q And it's my understanding that there was a broader or larger incident management structure; is that right?

A Yeah, that's right. So I was the IM. And underneath me were deputy incident managers. There was a principal deputy incident manager, and then several -- and it's evolved over time -- several deputy incident managers. And below them, there were task forces and task force leads.

So there were anywhere from seven to nine task forces that were focused on particular aspects of the response, including worker safety or hospital infections, or community mitigation issues. So the response was large, almost 2,000 people.

Q Wow. I'm sure a difficult question to answer, but is there a way to give a sense of sort of the day-to-day work of the incident management team

or the incident management structure?

A Right. So, you know, we have -- we put together these priorities for the week, priorities for the month, priorities for the next 90 days. And so we have overarching goals, in terms of this week, we're going to push out and try to finish up guidance X and/or we've got these three publications that are coming out.

There's also a potential -- you know, the director's going to be going out in front of media, so we have a plan for the week. And then sort of an overall strategy for several weeks.

And the day-to-day was really a lot of meetings with either the director, discussing particular topics of the day, any concerns, what was happening with the pandemic. And then a series of meetings with the various task force leads, the deputy incident managers.

We had scientific sessions two or three times a week to try to dig in to some of the issues that -- foreign issues, technical issues related to the response. And then had standing meetings really with the interagency, with ASPR or NIH. So a busy, busy time.

Q I can only imagine how busy it must have

been. You touched on the intergovernmental or interagency aspect of the work, which I was curious to ask about. Can you generally talk a little bit more about that interaction? I know you mentioned ASPR and HHS. Was there any other interagency coordination?

A Well, during that time, we had an 8:30 meeting every day. The Secretary's call, HHS Secretary's call. That -- and on that call was the Secretary, the ASH, the Assistant Secretary, Brett Giroir, the Surgeon General, Jerome Adams, Francis Collins, head of NIH, Dr. Redfield, myself, and some of the Secretary's staff. For example, Michael Caputo was on that call sometimes.

And so that call really was more NIH, the Secretary, the ASH, CDC, and of course, FDA was on that call as well, either the agency director or his deputy. So that 8:30 call, we ran through the various issues. Everyone reported out. And that was a daily 8:30 call for 30 minutes. So that was where hot topics were discussed, or follow-up calls were planned, et cetera.

Q Do you recall about when those calls started, in terms of time? What time of year was it, January, February, March, or maybe until July when

you were in that role?

A Yeah, they were already in place when I rolled on in July. So I'm not sure when they started, frankly.

Q Do you recall if they continued throughout the rest of the year?

A They did. We had that call every day when I was incident manager during this time period, yes.

Q Sure. Was there someone who sort of led the call or took the lead every day, or was it more of an ad hoc approach?

A Well, the Secretary -- it was a call for the Secretary. The Secretary was on. You know, we had the Coast Guard at some point became engaged. And I forget the admiral's name, but the Coast Guard was supporting the Secretary in some of the work that was going on. And this admiral in the Coast Guard, whose name I'm embarrassed, I forgot, sort of managed that call. So he would start it off. We had a set people that would go around the room. He would have high-level comments at the top, give the Secretary a moment to say something. And then we would go to each of the agencies and report out.

Q Were there --

A And back and forth, in terms of questions and answers.

Q Sure. Were there, do you recall, agendas for those calls?

A There were agendas. But the agenda really was, you know, Secretary remarks, CDC, NIH, FDA, you know, Surgeon General, the ASH. It was just really -- that was the agenda. That -- it was really, you know, who was going to speak at what time. And we were -- after months of doing this, we all sort of knew who started and who was next, yeah.

Q Sure. Did you do anything to prepare for those calls, or was it more sort of you had your institutional knowledge based on whatever you were working on the previous day, and so you sort of just relied on that?

A Well, you know, what I did at the top of the call was to give sort of the status of the pandemic, which was cases, hospitalizations, anything new that was happening from the epidemiology standpoint.

And then point out if there were any MMWRs that were coming out that day, or that were coming -- that had come out really the day before, and report out on sort of those significant findings.

So my prep was basically my staff put together a one or two-pager that had the highlights of both the pandemic, where the latest increase in cases, or where the latest outbreaks were. And then, you know, a summary of the MMWRs.

And I would read the MMWRs to refresh my memory before I got on that call, because we would get into some technical back and forth about these manuscripts.

Q That's helpful to know. And I definitely want to ask a little bit more about MMWRs in a minute. I guess in terms -- beyond this call that you mentioned, was there any other interagency coordination that was happening on a regular basis while you were incident manager of the coronavirus response?

A Well, I mean, there were a lot of different activities going on. For example, our chief medical officer was engaging with NIH around long COVID. And so that was sort of a working group that was happening in the background.

Obviously, on the vaccine side, the vaccine task force was very engaged with NIH, and BARDA, and Operation Warp Speed, related to vaccine manufacturing and distribution, guidance related to

vaccines.

So I guess within -- there was a lot of -- depending on the topic, our worker safety group was engaged with the Department of Labor, related to guidance that potentially might be coming out. So there were -- depending on the topic, we were trying to coordinate across the interagency and in many ways.

Q Thank you. I know you mentioned that you interacted on a daily basis with the director. I wondered if you had any interactions ever with Dr. Anne Schuchat?

A Yes, absolutely. I had a weekly meeting with Anne, Dr. Schuchat. And then over time, it evolved into twice weekly meetings, or 30 minutes one-on-one, just to talk about any particular issues in the response. I saw her as a mentor and would reach out to her as needed, if there were any particular topics, or she would reach to me and we would talk about some technical, scientific issue or something she had recently read. So we were in contact quite a bit.

Q What about -- and I want to ask about a few others within the agency. What about Kyle McGowan?

A Not as much with Kyle. You know, Kyle was -- I knew Kyle. Kyle -- we would interact a couple times a week, potentially. Kyle was -- when we'd have a conversation with Dr. Redfield about a particular topic, sometimes Kyle would be on the phone. So not as much interaction with Kyle, but I knew him. We talked once or twice a week.

Q And what about Amanda Campbell?

A Amanda, again, not as much. You know, our principal deputy incident manager that was more engaged, because Amanda was part of sort of a clearance in sharing information with HHS, if I remember correctly.

So Amanda was part of the chain that was basically engaging with HHS, and saying -- you know, trying to coordinate, here's what's coming out of CDC, et cetera. So we kept Amanda in the loop, and I talked -- she would call me about, you know, what's coming up tomorrow, what about this topic, when are you releasing this? That sort of thing. But a lot of her engagement was really with my principal deputy incident manager.

Q And apologies if you already mentioned who that was, but could you remind me who that was?

A Yeah, it was Michael Beach.

Q Okay. One other person at the agency that I'm curious whether or how often you interacted with is Nina Witkofsky?

A Yeah. So after Kyle left, Nina came. And I interacted with Nina quite a bit. Again, Michael -- Michael Beach, my principal deputy incident manager, interacted with Nina much more than I did. But Nina, like Kyle, was on the phone with Dr. Redfield frequently, and was following up on issues. I would receive a call from Nina, Dr. Redfield wants to talk about this or -- so we would -- she would get Dr. Redfield and I together or -- so, yeah, I had probably daily or every other day conversations with Nina.

Q So during your role as incident manager for the coronavirus, did you interact ever with anyone at the White House?

A I did. I had -- well, Dr. Birx was the primary person I interacted with. We had a standing meeting at 8:00 on Mondays, I believe, weekly, where Dr. Birx and I would have a conversation and talk about the MMWRs that had come out in the past week. She would give me her thoughts about the pandemic, and where things were going, and where the priorities were.

And she was traveling a lot, you know, around the country, and would hear things I wasn't hearing. So she would share those concerns with me. So I checked in with Dr. Birx once a week. I certainly was on calls with her with Dr. Redfield, you know, probably another once or twice a week as well. So in terms of the White House, it was Dr. Birx.

You know, we got -- in the middle of the summer, there were issues related to testing shortages. And Brad Smith also was working with Dr. Birx at the White House. And so I was engaged with Brad Smith, trying to coordinate state coordination around laboratory reagents and testing. I think Brad and then Dr. Birx, and who else.

You know, those are probably the primary folks. Steve Redd was a CDC employee, but detailed to Dr. Birx's office. So Steve Redd and I would have conversations as well. And then Daniel Gastfriend also was on Dr. Birx's team. And so Daniel Gastfriend and Steve Redd and Chuck. I'm trying to figure out Chuck's last name. I apologize. They were all sort of on Dr. Birx's staff.

And so as things were ramping up, and we were having outbreaks in various states, and we were looking across the country where the hot spots were,

we started doing the hot spot surveillance, to try to figure out in various counties where cases were going up. And then reaching out to counties and states to see if they needed additional assistance, staff on the ground, laboratory reagents, whatever it was.

And so there was a moment during the summer -- no, that was actually during the spring of 2020, where I was having daily engagements with that group, the hot spotting group, trying to figure out how we could better help the states. So that was going on for several months, maybe around the March to May timeline.

Q And so that was before you were in the role of incident manager?

A That's right.

Q And so you did have some focus on the pandemic response in that window?

A Yeah. To be clear, I ended my -- the Ebola response in early January of 2020. I took January off. In February of 2020, I was asked to deploy to Travis Air Force Base to lead the repatriation efforts, from a CDC perspective, at Travis Air Force Base.

I was there a month. And then in March, I came back, took a couple weeks off, and then rolled back

on the response as the lead for a task force that was focused on state, tribal, local, territorial, STLT -- they call it the STLT task force, which is focused on trying to assist states with staffing deployments, outbreak investigations, connecting the states back to the rest of the response. Pretty much one-stop shop for state and local needs.

So I led that task force from mid-March until the end of June, until I rolled on as the incident manager in July 2020.

Q That's really helpful context. Thank you. And I do want to ask you a few questions about those experiences. Just really quickly wanted to finish up a couple questions that you made me think of, based on some of the answers you gave on the incident management structure, if possible. The first of which is, was there any work product that the incident manager structure or team was putting out on a regular basis, whether public or internal guidance, or agency-wide updates, anything like that?

A Well, we had -- within the response, we had these priorities of the week that were -- we had the task forces, you know, put forward their priorities. And then we -- I reviewed those. And we disseminated those within the -- across the response.

We had an incident action plan, an IAP that at a high level, laid out the requirements for notifying the director of critical information requirements and goals and objectives of the response.

And so that incident action plan was updated monthly. And so that was something we disseminated to the whole response. We also had a sitrep at a high level that was disseminated weekly, in terms of where the -- what was happening within the response. There were those type of documents.

And then daily, we had an incident management, IM, meeting, where the task forces on a rotating basis would report out to the much larger CDC community about what was happening in the response. So we had these incident manager meetings, IM meetings that happened daily for about an hour, which was basically a series of PowerPoint slides that went through the highlights of progress on the various task forces.

So, yeah, so there was a number of documents that were shared to sort of make sure everyone was aware in a big response like that, what other parts of the response were doing.

Q That's helpful. Thank you. The daily incident manager meetings that you referenced, I'm

assuming that you sort of led those. Is that accurate?

A I did. I did. So we had them at 10:00 or 10:30. We changed the time. Yeah, so that was a time where -- and again, we were remote most of that time, so I would sit in the emergency operations center, myself, and my principal deputy. And then people would go through the slides remotely on Zoom. And then I would ask questions back and forth, clarify issues. Yeah, it was -- yeah, so that was a daily meeting.

Q And was there any type of agenda that was prepared for those meetings?

A Well, we had a rotation of who was going to report out, you know, Monday, Wednesday, Friday, the epi team would report out. On Tuesday, Thursday, the lab team. So we had that type of agenda. And these products were cleared. It was a pretty big audience on the line. Sometimes between 500 to 100 to 1,000 people. They were listening in.

And so we tried to keep that presentation very tight, very scientific, very technical. And it was a sharing of information. So in that way, I mean, there wasn't a, quote, agenda. The expectation was that people would report out on developing events,

you know, the most recent research, the most recent developments, or guidance or manuscripts that had recently been published. And kind of take the audience through that. So more information sharing.

I mean, we had that IM meeting that was huge, very big. And then we also had, as I think through it, a regular smaller meeting, we call it the 5:30 meeting, where we would pull together the task force leads and the deputy incident managers, and update -- you know, we would run through the highlights -- more operational technical meeting, and again updates.

So that was a 30-minute meeting -- 30, 40-minute meeting on task -- any issues, sharing across the task force leads. So that was another way of sharing. So multiple ways to sort of make sure everybody was on the same page.

Q I'm appreciating your point about the number of meetings as you're walking through them. With regard to the daily incident manager meetings that happened in the morning, not the 5:30 one, you noted that people often gave presentations. Were those usually oral, or was there any type of written or PowerPoint component to those?

A There were PowerPoint slides that were presented.

Q And as you were describing the various distribution, you mentioned that there was one that was weekly. And I apologize, I missed who that went to, or what exactly that distribution was.

A It was an incident action plan that I was discussing. And that was internal to CDC. So it was disseminated across the response. We would also -- I would share the incident action plan, high level goals, mission, you know, what -- so that was also shared with the SOC, the HHS SOC.

There was a weekly -- and it may be the one you're talking about -- weekly priorities document that was also prepared. And again, that was internal to the response. And so the task forces would discuss -- would put on paper what their weekly priorities were. And then we would -- that also gave me visibility on some of the actions that were happening across the response. I would review those priorities. And then we would share those across the response.

Q That's helpful. Thank you. And I know you've mentioned priorities quite a bit. I'm curious, when you started as incident manager, what were your immediate priorities, or what was the focus of your work?

A There's a couple things here. One is, you know, July, when I started, one of the roles of the incident manager is to maintain the resiliency and the health of the responders. So that's the primary role, especially -- we had been at it for maybe six months at that point, almost six months. And so that was one of my objectives, to make sure of the health and resiliency of the CDC staff.

It's a big response, you know, over 2,000 people, a lot of things happening. So making sure that we weren't duplicative, that people who were coming into the response had actual -- a lot of management issues -- actually had roles and responsibilities. A lot of recruitment as well, making sure we had good leadership in the response to lead the task forces. So a lot of the IM role is management of leaders, recruitment, resiliency.

From the technical side, we were -- had come through -- we were still engaged in a lot of the work that was -- hot spots around the country, trying to think through what our next guidance might be, preparing for -- when I came on in July, school opening in the fall was coming. So certainly school guidance was top of mind.

Our testing guidance was an area that we were

particularly interested in. So, yeah, I mean, and it's a pretty dynamic situation. So, you know, day-to-day, I think, priorities or week-to-week priorities would change. But we put out a lot of guidance. So my role as the IM was really to manage the big response, to make sure I was hearing from Dr. Redfield what his priorities were on a daily basis, hearing from the response what their priorities were, what they were hearing from partners, and from the task forces.

And then trying to pull that together, and drive the response forward in the most efficient manner as possible. So the IM role is really a lot of great, incredible, technically, scientific astute people. And the response is to try to keep the train rolling, and making sure that I'm hearing priorities from our director, and hearing issues around -- throughout the response.

Q That makes total sense. I want to come back to the sort of early days of the pandemic that you referenced before. And specifically, I wanted to confirm that what you said is that in January of 2020, you were effectively not working on the coronavirus pandemic response for various reasons, including that you were -- I think you said on

vacation; is that right?

A Yeah, that's right. I wasn't -- I think I rolled off of DRC January 4th or 5th. And then didn't come back on to the COVID response until February 1st.

Q And when you came back on February 1st, you mentioned that you were doing repatriation efforts. Was that -- did you say at Travis Air Force Base?

A Travis Air Force Base in California, yes.

Q In California. Okay, thank you. Can you tell us a little bit about what those efforts entailed?

A Right. So it was a large effort. I was leading multiple bases that were engaged. We were repatriating citizens -- residents of the U.S. back from China, from Wuhan, into the U.S. And there was certainly concern around transmission and protecting -- making sure those citizens and residents were safe, and were safely repatriated to the U.S., while at the same time a desire to -- because there were so many unknowns, to put them in quarantine for a period of time, to ensure that there was no transmission to the surrounding community in

the U.S.

And so multiple planes came in from Wuhan, four or five of them landed at Travis Air Force Base. And we basically -- CDC staff was there, which I led, along with the U.S. Marshals Service, and ASPR representatives. And the other HHS entities were on the ground, basically receiving these travelers as they came off the plane. Running them through screening in a large warehouse. And then transferring them to a hotel, where they were monitored for 21 days for signs and symptoms of infection.

So my role really was to provide that public health input, the expertise to the rest of the HHS staff, and manage that repatriation event. So we received passengers from Wuhan. And then around the middle of the month in February, we also received passengers from the Diamond Princess. That was the cruise ship that was parked off of Japan, I believe. There was a repatriation of passengers from the Diamond Princess that also came in to Travis.

Q That's interesting. Thank you. How did you come to work on those efforts?

A I am known to be -- run to the fire. I was a CDC leader. February 1st, I got a call from

the response saying that there's a plan in place to repatriate citizens and residents from Wuhan. We're calling senior leaders to lead these teams in multiple airports. There's one in Texas, Nebraska, Southern California, and Travis. And they asked me to deploy. So that's how I came to be at Travis.

Q Thank you. It may not apply directly to you, but in terms of others who were working on the ground, was there any training that was provided or given, in terms of infection prevention or control or emergency response, or anything like that?

A Yeah, we had our infection --

Q We might have lost you for a minute there. At least it's frozen for me.

[Transmission interference.]

(Recess.)

[Majority Counsel]. We can go back on the record.

BY [MAJORITY COUNSEL].

Q And I think to just pick up where we left off, you were telling us about the training that was provided to those who were working on the repatriation efforts at Travis Air Force Base.

A Yeah, that's right. So our infection prevention experts, we had a couple of them on the

CDC team. We all deployed together. And then the staff that was going to interact with the passengers, starting from the time they landed on the tarmac and the door opened, and everything from when they were received and greeted coming down the stairs, through going through a whole screening process within the hangar, and over to the hotel.

We had our staff provided PPE, as well as training to all the staff members, went through their roles and responsibilities as they escorted the passengers off the plane and through our screening process. So we provided PPE and we provided training.

Q And when you talk about PPE that was provided, you mean to the staff or to the citizens being repatriated?

A The citizens who were repatriated had a mask on. They had a surgical mask on when we received them. So this was to the staff. The staff, the CDC staff, the ASPR staff, HHS staff that were there to basically assist the passengers.

Q To your knowledge, was there any delay in providing that training to the folks who were on the ground at Travis Air Force Base? I guess what I'm asking is, was that training given to them on day

1, or was it later in the tenure of their role there?

A We gave training -- we did -- I don't remember what day it was, but the passengers -- airplanes started arriving early in the morning. We did a walkthrough and training the day before. Got all the staff that were going to participate, and there were over a hundred of them doing various roles. Divided up the roles, and then gave people training, depending on what their roles were.

And so, yeah, that training in the hangar was given the day before everyone arrived, as I remember. And then we actually had infection prevention experts, our two experts roaming around the hangar every time we did this, every time planes would land, to make sure that our infection control practices were being followed.

So there was this initial training. And then there was supervision of the various roles during the time. And then as new people would come in and out from that team, the CDC team, or the HHS team, or the Federal Marshals, or whoever, we had training sessions throughout the whole month that I was there.

Q So I think you said earlier, and please correct me if I'm wrong, that you worked on those efforts for a couple weeks into February, or even

maybe into late February; is that right?

A Yeah, it was a month. It was probably towards the end of February. I was there at least three, three-and-a-half weeks.

Q By late February, what was your assessment of the risk posed by the virus to the United States?

A I mean, we were concerned. And I was really focused on doing this one thing, which is helping these passengers come in, get through the quarantine processes, and then get them on a bus to go home. And so there was a lot happening in the bigger sphere.

So the real concern was around transmission, incubation period, was it days, 14 days, 21 days? And then, obviously, we didn't know a lot about asymptomatic transmission. And so at the time, we thought that the role of asymptomatic transmission was minimal, or there wasn't a lot of asymptomatic transmission.

People without symptoms could transmit SARS-CoV-2 to someone else. So we were learning. And studies were going on, and we were learning from China and other places. So certainly we didn't know what we didn't know, but we were -- there was still a

time. That's why we did the whole thing. There was still this idea that maybe potentially, we could contain the spread of SARS-CoV-2 in the U.S. by these repatriation and quarantine efforts.

Q I appreciate your point that we didn't know what we didn't know. But with what we do know now about the virus, do you think more could have been done at that time to prepare the public for what was coming?

A Well, of course. I mean, if we knew that asymptomatic spread was a significant part of transmission, that people were -- two days before were able to transmit. But, you know, we just -- it's hard to say. It's really hard to look back, and we were operating on the best evidence that we had at that time. So I wouldn't want to speculate too much there.

Q Considering what we know now, were there things CDC could have handled differently at that time?

A It was a lot of unknowns, a lot of anxiety around this new emerging virus. And we were trying to -- I mean, communication is the key here, telling the public what we know, and what we don't know. So you can always communicate more.

And so I think that's always, in every event, you look back and think, well, how could we have done this better? So -- but again, I think we were -- it was fast-moving, a lot of unknowns. And I hate to critique too much, looking two years -- it's really been two years since that time. We've learned a lot.

Q So I think that brings us to about March 2020, if I'm not mistaken. And you mentioned that you were working on a state and local, tribal task force, if I have that correct.

A Yes.

Q I wonder if you could tell us a little bit more about what those efforts entailed.

A We had a -- first of all, we were deploying a lot of CDC staff out to the states. They were asking for technical assistance, for more epidemiologists, more data analysts to help them with analyzing their data, as well as staff, boots on the ground, to help with investigations in a lot of different settings, mostly congregate settings.

We had, as you remember, a lot of outbreaks in nursing homes, a lot of deaths in nursing homes. And we were intensely interested in not only helping the states, but also trying to learn about transmission in these various settings.

So the task force that I led, one of the things they did was to coordinate with the states. We had these state liaisons who would work with the states, try to understand what their challenges were, what their needs were, and if they needed staff on the ground, or they were having trouble with shortages of laboratory supplies, or issues related to understanding our guidance or clarification.

So we had these state liaisons who pretty much was an one-stop shop for any state concerns. And so we connected them to the rest of the response. So if there were questions around our infection control guidance, we would reach across that task force, and set up a call.

If there was a concern around how to operationalize our guidance, whether it's in the worker safety, or whether it's in a school setting, we would set up a call and bring those SMEs on. A big thing we did was coordinating deployments. We sent CDC staff to long-term care facilities, to correctional facilities, to homeless shelters, trying to help the states, but at the same time, also try to learn about transmission in these various settings.

We sent a lot of staff to meat and poultry processing facilities, because they had a lot of

outbreaks in those settings. And -- yeah, so we internally recruited teams of people, CDC staff, organized them, made sure they had the right balance of SMEs, listen to the states, and organize these deployments for weeks at a time. And then set up calls with the field teams with our subject matter experts, to try to -- with the states, to try to coordinate, provide technical assistance, et cetera.

So very busy around the congregate settings, deployments, listening to the states. We also were -- as I said, a lot of hot spots, a lot of different counties and jurisdictions were having increasing cases. And we were constantly reaching out to those counties and states to see if they needed any additional assistance.

So we also did a lot of tribal work. There were outbreaks in tribes. We had a tribal unit section, Navajo, big outbreaks in tribal lands. So we were supporting them, those outbreaks, with staff and technical assistance. So that was kind of big picture, what the job was. And mostly managing, coordinating, listening to the states, making sure they were connected to the right subject matter experts.

Q That's really helpful. Thank you. Were

you ever -- I guess, were you doing anything with the information that you were collecting from the states, or was it more -- the flow was the other way, you sending support and information to the states?

A Yeah, I mean, we -- yeah, it was more us providing support to the states. Listening to the states, trying to understand what their needs were, and -- yeah, it was us trying to provide service. And then trying to understand where their gaps were.

Certainly if we had a number of different states with outbreaks in nursing homes, or schools, or whatever it was, we then would take that information and try -- if we get three different jurisdictions asking about how do we complement -- or what do we do in schools, or what do we do in meat packing facilities, then we try to look at our guidance, and say, okay, we need to update the guidance. There's a lot of demand out there for understanding, you know, how to be safe in these various settings.

And so we would both provide that assistance to states, but also try to -- at a higher level, try to understand in multiple jurisdictions what their technical -- their guidance needs were. And then we would try to put out new guidance.

Q Thank you. I want to discuss some CDC guidance documents in more detail, but before we do that, I would like to understand a little bit about how CDC develops its public-facing guidance. Could you briefly summarize the process for developing public health guidelines or guidance documents at CDC?

A Usually the initiation of a guidance would start within a task force, within subject matter experts, whether that was infection control, the correctional facilities group, or the school group. In the beginning, we knew that people would need guidance in health care facilities. A lot of people were sick, and a lot of health care professionals wanted to know. This is an obvious issue that we needed to put out quick guidance around protecting health care professionals.

So there's some obvious things that were worked on in the very beginning right away. But guidance normally starts within a task force. And the initiation of that guidance can come -- as I've said, they're hearing a lot of input from the states, a lot of concerns from the states around, we need guidance in this particular area. That subject -- that group of subject matter experts would draft guidance. That

guidance would clear the task force, would be debated, discussed within the task force, would be cleared by the task force lead.

And then we have an extensive clearance process, where the document would go through CDC clearance from the task force to the deputy incident managers, and across multiple task forces.

So school guidance, for example, would need to be cleared not only by the school group, but also by the epidemiology group. And touched on by the laboratory. So cross-cleared across multiple task forces. Then it would go to the deputy incident manager for clearance. And then it would go to the IM or the principal deputy incident manager for clearance. And then, ultimately, would land on Dr. Redfield's desk. And Dr. Redfield would review, give any -- highlight any concerns, or would clear it. And then we would post.

[Majority Counsel]. And I just want to note, I think we're at about our hour. I just have a couple last questions on this guidance point. So if possible, I'll just finish those up briefly, and then we can take a break and switch sides, if that works for everyone.

BY [MAJORITY COUNSEL].

Q So did that process that you just described change at all over the course of the pandemic?

A That was the -- that was, and is the process still. The clearance process at CDC up through the director, as I said, remains the same.

Q You mentioned that the director reviewed, as part of the clearance process. Does HHS review guidance as part of the clearance process?

A Usually HHS is given a heads up that we're working on guidance. And our guidance, especially if we're going to release new guidance, you know, that may be controversial or the public has a lot of interest in, you know, CDC -- HHS would have a heads up that this guidance was coming. And for communication purposes, sometimes that guidance -- that final draft was shared with HHS.

Q And when you said heads up, if it wasn't a draft that was shared, was it just like a summary or something else?

A A summary. We put out a lot of guidance. And you know -- and so usually it was a running list of, here's what's coming out this week, here's -- so to let -- to make sure HHS was aware of that, and there were no surprises, that we were

working on this guidance, or we were anticipating that this guidance would be released on X date. So there was a running list that was shared between HHS and CDC.

Q And who at HHS would CDC communicate that guidance was forthcoming or share the draft with?

A Well, this was really a chief of staff issue. So Kyle, Nina, Amanda, the folks we talked about before would be interacting with HHS on these issues. I don't know everyone that they talked to, or who they worked with, but certainly ASPA was part of that, because it was on the comms side to make sure that they were aware that this was coming out.

Q Did HHS ever provide comments or edits to that guidance that CDC was planning to put out?

A Yes, there were times when guidance was reviewed and suggestions were made on -- mostly, it was on the comms side, trying to better understand our guidance. And there's a lot of this, here's how I read this. Is this what you meant to say? That sort of thing.

The majority of our guidance, you know, was just sharing information. There was a guidance that HHS was particularly interested in, testing guidance

being one of those, and certainly the school guidance.

[Majority Counsel]. We can go off the record here.

(Recess.)

[Majority Counsel]. I want to note that this is [Redacted] joining for the Majority.

BY [MINORITY COUNSEL].

Q Dr. Walke, my name is [Redacted], I'm on the Minority staff of the Committee on Oversight and Reform. Thank you for being here, and I have a few questions for you.

In the last hour, you said, we don't know what we don't know, which [Redacted] so rightly pointed out is so true in this situation. In your experience during this pandemic, was the Chinese government cooperative and forthcoming in information sharing?

A Yeah, I don't really have any insight there. I know Dr. Redfield -- my knowledge is that Dr. Redfield reached out to the Chinese government and the health authorities multiple times to try to get -- to provide CDC assistance, and to try to get information. And we were not able to put CDC staff on the ground. That's really my knowledge.

Q So China denied your offer to help?

A We offered, and they did not accept. That's right.

Q Okay. What about the WHO? Were they forthcoming with information, to your knowledge?

A To my knowledge, they were forthcoming. Again, that was early on, early days in the response. And so I -- and my general knowledge is, I thought they were, but I don't know any details, especially early on.

Q Okay. Thank you. So you said for January, you were on vacation. And then the 1st of February, you were deployed to California?

A That's correct.

Q When did you return from California?

A I want to say February 24th, or sort of in that timeframe. Sort of the end of February.

Q Was that the time that you took on the incident manager role?

A No, I became the incident manager on July 1 of 2020.

Q Okay. Thank you. So the Majority staff asked you about the guidance preparation process. When you explained the official process, you had mentioned sending it to outside groups. Is it common for CDC to work with outside groups on their

guidance?

A It's common to have -- to try to get input from our stakeholders around what their concerns are. So, you know, whether it's the worker safety, or occupational health, or hospital infections. So it's common to reach out to our partners in these particular areas, and try to understand what their concerns are.

So, yes, there is this back and forth between the partners that -- in the same way we do with the state and locals. We try to get all sides, as we develop guidance, and try to understand what the ramification of CDC guidance would be, and how it would affect these various partners. And we do our best to try to reach out to partners, state and locals, to understand what their concerns are.

Q For the record, can you further define partners? You mean groups unaffiliated with the federal government?

A Yeah, that's right. So, for example, the American Association of Public Health Labs is one of our partners. The Council for State and Territorial Epidemiologists is one of our partners. A group that represents counties in the U.S., NACCHO, is one of our partners. So, yeah, absolutely. IDSA,

the Infectious Disease Society of America is one of our partners.

So we would reach out to their various partners, already had standing meetings with them, because it's important to have that feedback, and would talk about -- try to listen to them about what their concerns were. And at the same time, have a discussion around potential upcoming guidance, and how it would affect them.

Q Is there a list online of the partners that you normally consult with?

A I don't think there's one list. It certainly depends on the subject matter. If it's hospital infections, then there's one group. If it's schools, it would be another group. So worker safety, another group. So -- yeah, so the big partners.

And I rely on the task force leads to understand that those subject matter experts within those groups would pull together -- the policy groups would pull together those partners, and have listening sessions or try to -- yes, I don't think there's a definitive listing where --

Q Are the partners consulted with on specific guidance acknowledged after the guidance

drafting process for the public?

A No, not usually. Not that I can think of. I mean, the idea is that this is CDC guidance. And we are reaching out to a broad swath of various groups to try to understand everyone's challenges, and putting out our guidance. And in our guidance itself, we don't document that we talk to XYZ partner.

Q I want to get back to the process of working with the outside partners. When you consult with them, is it -- I assume it's prior to publication of the guidance?

A Yeah, that's right. I mean, a lot of these folks, we were having standing meetings with. Sort of the CSTE, APHL, NACCHO. We meet on a regular schedule to kind of hear from these large partners, representing state and locals around some of what their needs are. So, yeah, before -- as we're formulating documents, we're listening to the partners' input, yes.

Q Okay. Are there types of guidances, either for sensitivity or any other reason that you wouldn't want to coordinate with outside partners?

A Our stance is to try to coordinate as much as possible, and to be as forward-leaning and

sharing as we can. Or at least hearing input from people.

Of course, in a fast-moving pandemic, we're not able to incorporate or hear from everyone, but I think we do our best to listen. We try to hear from the -- whatever the topic is, from those partners, the major partners in those areas, yes.

Q So you mentioned schools, so I imagine it would be teachers that you would usually coordinate with. Would you also coordinate with parent groups?

A Yeah, it would be parent groups, school administrators, teachers. We would try to hear from, obviously, the Department of Education, and try to understand what they felt their substantial partners were in that space, and provide a forum where we could hear from those various groups, yes.

Q Are drafts of the guidances sent to the interagency process, so Department of Education, would you send a draft to get comment on?

A We have shared language or excerpts from -- to get feedback on particular parts of guidance to see -- because sometimes where we're trying to coordinate closely, for example, with the Department of Education, we want to make sure that

we're synced up in our language.

So, yeah, we absolutely would share portions or particular parts of our guidance internal to the federal government, to make sure that as we roll out that school guidance, for example, CDC and Department of Education are aligned.

Q Does that include OMB and the White House?

A You know, there's a process of where OMB -- where there's clearance in the interagency. And that's always a bit murky for me, in terms of -- and so the chief of staff took care of those sort of clearance processes with OMB.

You know, for the White House, in general, you know, we didn't share our guidance with the White House during the -- but there were certainly instances where the White House was keenly interested.

Q Would you share it with the task force, when the task force was a thing?

A Well, I wouldn't share it. You're talking about the COVID -- White House COVID Task Force?

Q Yes.

A Yeah, so Dr. Redfield, in his role,

would get feedback from members of the White House related to guidance. So in that manner, yes, there was sharing of early -- of drafts of guidance -- guidance documents.

Q Thank you. So this has all been inside the government. And it sounds like it's pretty limited sending even excerpts of drafts inside the government, let alone a whole draft. Is it common to send draft deliberative or predecisional guidances outside of the government to those partners?

A We may send summaries, like, the day before we're going to release something, or the day of, to give our partners -- to give people a heads up that this is coming, so they can help with their communication, get their talking points, so there's no surprises.

We don't want to drop our guidance, and then on a particular day, and everyone's scrambling. So we would either give high-level summaries or draft -- mostly high level summaries around what was happening. And if we released our whole guidance, it would be sort of in an embargo state, meaning several hours before, we would share with our partners, this is coming out, and here's some talking points around -- for our guidance.

Q Okay.

(Minority Exhibit A was identified for the record.)

BY [MINORITY COUNSEL].

Q I would like to insert for the record, the Minority Exhibit A, which I sent around during our break. Let me know when you have it in front of you. Is it in front of you?

A It's not. I'm sorry.

Q Okay.

A I'm having some real difficulty right now bringing it up. Hold on.

Q While you work on it, I can describe it to you. It's an email chain regarding school reopening guidance. And on the last page of the chain is an email from Kelly Trautner, who works for the American Federation of Teachers. And it's to -- sort of people at the White House, CDC, and then some other union employees.

And the last paragraph begins with, "Finally, we were able to review a copy of the draft guidance document over the weekend, and were able to provide some initial feedback to several staff this morning about possible ways to strengthen the document."

So you just testified that it is uncommon to

send a draft document outside of the government. This was sent February 1st, 2021. The guidance was published February 12, 2021. You also testified that if you did, it would be within a day or two. That's ten days. Why was this guidance sent outside the government?

Mr. Barstow. [Redacted], I'm going to have to instruct Dr. Walke not to answer that question. That's outside the scope of the interview.

[Minority Counsel]. Okay. I will keep going.

BY [MINORITY COUNSEL].

Q So knowing that it's uncommon to send draft guidances outside the government, is it common for outside groups to send draft language to you, being the CDC?

A It's uncommon. You know, certainly, we receive incoming from all sorts of partners, usually in discussions. And they would give suggestions to say that it would be helpful for their constituents, for their groups if CDC could comment on X, or if CDC could address this particular challenge. Our constituents or our partners are having difficulties with this particular topic. It would be helpful for CDC to address this topic. That's the normal type of input we get from our partners.

Q But uncommon for, like, line-by-line edits or additions?

A That's correct.

Q And in your employment with CDC since 2001, have you ever personally incorporated edits or additions that came from an outside group?

Mr. Barstow. [Redacted], that's outside the scope of the interview.

[Minority Counsel]. No, it's not. We've asked for context questions throughout the scope of -- throughout the course of these 15 interviews. I'm asking about, in his career, has he ever done this. Not about a specific instance.

Mr. Barstow. If he wants to answer from the time period December 1, 2019 through January 20, 2021, he is allowed to do so.

The Witness. Would this be outside the federal government?

BY [MINORITY COUNSEL].

Q Yes, any edits that came from outside the federal government.

A I don't remember any instance in my career.

Q So to be clear, you're saying you don't remember any instance in your career, or any instance

between December 2019 to January 20th, 2021?

A So thank you for clarifying. Again, understanding that I do not remember any instance between -- within the scope of this interview, of an outside partner -- a partner outside the federal government or the White House providing line-by-line edits.

Q Were you able to get the exhibit up, or should I keep describing it?

A I apologize. I can't seem to get it up.

Q Okay. I'll do my best to describe it in as much detail as possible.

A I could pull it up on my phone, I guess, if you want to hold on. I'll reboot at our next break. If you continue to describe, I'll pull it up.

Q Okay. So in that same email chain -- actually, the same email from Kelly Trautner representing the American Federation of Teachers, she suggested a line-by-line edit to the draft guidance that was sent.

The edit said, "Employers should provide reassignment, remote work, or other options for staff who have documented high-risk conditions, or who are at increased risk for severe illness from COVID-19 to limit the risk of workplace exposure. Options for

reassignment include telework, virtual teaching opportunities, modified job responsibilities, environmental modifications, scheduling flexibility, or temporary reassignment to different job responsibilities.

"These options should likewise be extended to staff who have a household member with documentation of a high-risk condition or who are at increased risk for severe illness from COVID-19. Policies and procedures addressing issues related to teachers and other staff at higher risk of serious illness should be made in consultation with occupational medicine and human resource professionals, keeping in mind Equal Employment Opportunity concerns."

Director Walensky responded to the union and said this language would be added. Specifically, she responded, "Regrets for my delay in reply, but I wanted to be certain you knew it is being worked into (with just a few small tweaks) the school reopening guidance?"

Do you recall adding that language to the school reopening guidance?

Mr. Barstow. Once again, I'm going to instruct Dr. Walke not to answer the question. It's outside the scope of the interview.

BY [MINORITY COUNSEL].

Q Do you recall if the final guidance issued February 12, 2021 included this change?

Mr. Barstow. Again, I will instruct Dr. Walke not to answer that question. It's outside the scope of the interview.

BY [MINORITY COUNSEL].

Q Going further up the email chain, Ms. Trautner responds again, this time on February 11th, 2021, at 11:25 a.m., so less than 24 hours before the guidance is released.

And she recommends another change. And it says, "In the event high-community transmission results from a new variant of SARS-CoV-2, a new update of these guidelines may be necessary."

She explained this change was important because the American Federation of Teachers was concerned the absence of a closure threshold might put safety of adults and kids in school settings in jeopardy. And they urged the inclusion of clear closure triggers in the imminent guidance.

Was this change incorporated into the guidance?

Mr. Barstow. Once again, that question is outside the scope of the interview, so I'll instruct Dr. Walke not to answer that question.

BY [MINORITY COUNSEL].

Q So after that email, Dr. Walensky sent that change to you. It is redacted. You responded, "Yes, will work with the team," and the next day responded with the edit in the guidance.

Did you edit that guidance to include the American Federation of Teachers' language?

Mr. Barstow. Once again, that question is outside the scope of the interview.

BY [MINORITY COUNSEL].

Q Do you recall what the final guidance on February 12 stated?

Mr. Barstow. That is also outside the scope of the interview.

BY [MINORITY COUNSEL].

Q The final guidance said, "In the event of increased levels of community transmission resulting from a new variant of SARS-CoV-2, updates to these guidelines may be necessary."

That's a word for word, line-by-line addition from an outside group, based on a draft guidance that went outside of CDC. You said that all of that situation is incredibly uncommon, and could not remember a time during the scope of this interview that it happened before. It would appear that the

CDC tried to appease the teachers' unions. And in fact, wrote guidance that they knew would include a closure threshold for schools.

Dr. Walke, do you think it is appropriate to take line-by-line edits from an outside group and incorporate them into a CDC document?

A In general or -- I'm now confused, in terms of the scope. So are we talking about during this period of time, or are we talking about in general?

Q A context question. In general, if an outside group sent you a line-by-line edit, do you think it's appropriate to accept it without any additions, without any CDC guidance?

A As I said before, it's -- we don't -- it would be uncommon for us to incorporate line-by-line edits into our guidance. We certainly are trying to receive input from all types of different partners.

Q So if it's so uncommon, why did it happen with the American Federation of Teachers?

Mr. Barstow. I'm going to instruct Dr. Walke not to answer that question.

[Minority Counsel]. Thank you, Kevin. That's all I have. [Redacted] is going to ask a few.

BY [MINORITY COUNSEL].

Q My name is [Redacted]. I'm with the Republican staff. I just have a few quick questions. You mentioned early on in your conversation with my colleague, the Center for Preparedness. Can you just describe what that looks like a little bit?

A Yeah, the Center for Preparedness and Response, which I currently lead as of November of 2021 --

Q Is it a physical space?

A Well --

Q Is it an actual center, or is it just a "center"?

A I'm not sure what the quotations mean, but it's a center within CDC. CDC has multiple centers that -- where they pull together basically various activities. The Center for Preparedness and Response is focused on trying to provide technical assistance to state and locals related to preparedness for emerging threats, biological incidents, biological threats.

Q So what does the center look like? Is there a physical space that you can describe for me?

A I'm having a little trouble with the question. But the center is made up of almost 700 people, three divisions. And we work in -- we work

remotely by telework now, but if we weren't in this particular -- if we weren't in a pandemic, we would -- the majority of the staff are located in Atlanta, within the Roybal Campus at CDC.

Q Okay. And is this the 2,000 people that were responding to the pandemic that you've been referring to throughout the interview?

A The CDC response is made up -- the agency response is made up of staff from multiple different organizations across CDC, which would include the Center for Preparedness and Response. So the 2,000 people, some of those people were from the CPR, the Center for Preparedness and Response, some of them were from other centers, the National Center for Respiratory Diseases, the National Center for Emerging and Zoonotic Infectious Diseases, the National Center for Environmental Health.

So that 2,000 strong response was made up of CDC employees from across multiple different organizations.

Q Thank you. How many employees comprise the Center for Preparedness?

A Around 700, I believe. Around.

Q And when did the folks -- that approximately 700 start working remotely? Was it

around March 12, 2020, or before?

A You know, in the spring of 2020, we certainly -- within CDC, there was instructions to allow people to work remotely. So in the spring. I'm not sure of the date.

Q And those 700, approximately, are still working remotely today?

A The majority of them are still working remotely, are teleworking, we would say. Yes, working remotely. There are staff who are in the response who are in the office or in the emergency operations center, but we have been able to pivot from person -- we have been able to pivot from the in-person staffing of the emergency operations center to this remote Zoom Teams environment that we're in now.

Q Okay. What does the emergency operations center look like? Can you describe that?

A [Redacted]. It's made up of multiple -- a big open space with a lot of computer monitors. And people can sit side by side normally, outside of a pandemic, like this and interact. There's a sort of 50 people, 75 people can sit on the main floor. There's offices around the floor. And there's a large number of television monitors that have

various -- that are monitoring the epidemic.

Q Are these people considered, that sit here, frontline responders or no?

A We, CDC, would consider them frontline responders, yes.

Q In the spring of 2020, were they working remotely?

A A number of them were working remotely, and either working remotely or working -- or in the field, deployed to various states and local jurisdictions, depending on the outbreaks.

Q How many -- approximately how many deployed in the spring of 2020 to the field?

A We've had -- I don't know, during the spring. We had -- there's publications on this. We've had hundreds, literally hundreds of deployments early on during the spring. Each of those deployments had anywhere from five to ten CDC staff. So a lot of people were deployed.

Q All at once -- let's say -- okay. What do you consider the height of the pandemic, Dr. Walke?

A Well, during the scope in which we are talking about, you know, the fall and winter of --

Q 2020?

A 2020, yeah, was the height.
Q So how many -- approximately how many CDC employees were deployed during that time period?
A Over a hundred, probably over 200. So I don't know exactly.
Q Okay. If there's a report that you can get to Kevin and provide us, that would be helpful.
A Sure.
Q And you were deployed, right, to Travis. Would that be considered a deployment?
A That's right, yes.
Q Okay. So in the summer of 2020, can you tell us what you were doing in the summer of 2020 or the spring of 2020 -- spring of 2020 into the summer of 2020?
A Spring of 2020, I was leading a task force, the state, territorial, local, tribal, STLT, task force from -- go ahead.
Q I think you talked about that with my colleague. What did a day in your life look like during that time period?
A A series of meetings within the task force to, again, prioritize the work of the day. The IM meetings. As a member of the task force, meeting with the IM to talk about what we were doing.

And then a series of conversations, usually with the states, to try to address -- to help them with the deployment, if they needed -- a lot of internal management issues, administrative issues, trying to make sure we were recruiting for the staff -- CDC staff onto our task force, and making sure we were sending CDC staff out to the field.

And then talking with our partners, like CSTE or APHL, talking with the interagency, HHS, around laboratory reagents and laboratory shortages in states, trying to coordinate state needs with the resources for laboratory, you know, from HHS.

Q Okay. Where were you physically, at that point, located?

A I was actually on the Roybal Campus. At that time, we had -- we were trying to limit the number of people within the emergency operations center. There were people in the emergency operations center, but I was located, along with some other leadership, within that task force, within [Redacted] in my regular office. So I ran the task force out of the CDC campus.

Q Do you have any idea -- this is more of a question. But those deployments in the spring of 2020, were there any lives lost at CDC, do you know?

A I don't remember any deaths from CDC staff during that period of time.

Q You've mentioned the interagency a few times, and in conversations with my colleague. Can you just tell us exactly who you consider the interagency?

A That's a good question. I think that HHS, so NIH, BARDA, FDA, ASPR, those were the main -- when I think about the interagency, I think about those groups. Certainly we were coordinating with FEMA as well, which is outside of HHS.

Q So it's actually intra-agency, because a lot of those entities that you mentioned are under the umbrella of HHS, except for FEMA.

A Yeah, the Department of Education. So that's a broad term that would incorporate both within HHS and outside of HHS, the way I think about it. But you're correct, if it was only HHS, it would be intra.

Q Okay. Who was the point person on dealing with states and localities in the spring -- in the 2020 timeframe, which is the scope for today? Were you the point person, or was there somebody even more hands-on with states and localities?

A I was the task force lead. And within

that task force, which was fairly large, up to 300 people or so, you know, we had individual points of contact for each state.

So those individuals, the health department liaisons, we called them, would have more intimate day-to-day conversations with state and locals. But ultimately, that would filter up to me or my deputy. And then we would -- we would assist states.

So we would normally jump on a call if needed. If the state epidemiologist, the state health officer or the governor's staff from a particular state was going to be on a call, we would try to -- as leadership, would be on those calls.

Q Who is your deputy? Who was your deputy then?

A The deputy was Peggy Honein.

Q So during the relevant timeframe, who would you say you talked to most outside of CDC?

A During the spring of 2020?

Q Or all of 2020.

A My deputy, which was Peggy Honein, from pretty much March until June of 2020. And then from July to January of 2021, I think -- 2020, I'm sorry. The dates -- it's like two years ago, if you will give me a little bit of a break. But during the

timeframe, it was Peggy Honein was my deputy for the STLT. And then Michael Beach, who was my principal deputy.

Q Okay. Did you -- and then you talked to the interagency, of course. Did you ever talk to the media?

A Well, I was asked to speak to reporters or the media. And Dr. Redfield and I, and other CDC staff, held telebriefings, where reporters would ask CDC questions around a particular guidance that we were releasing. So, yes, in that way, I both did interviews with reporters, as well as the telebriefings with a group of reporters on particular topics, yes.

Q Who asked you to do these?

A The request would come from our OADC, the Office For Assistant Director of Communication. So normally, that request for an interview would come to the CDC communications staff. And then they would reach out to me and say, Henry, are you available? We think it's a good idea. Are you available to talk to X reporter on this particular topic? So that's the usual way that I was engaged.

Q So these requests would be in your emails somewhere, probably?

A Potentially. I mean, there's a lot of -- I would get a call, Henry, we would like you to talk with X on this particular topic. But I'm sure there is, in my email, a record of being asked, I would assume.

Q And so you only spoke to reporters in sort of official fashion, where the requests came from the communications -- what was the acronym you used, OADC?

A OADC. So reporters would reach out to me, either through email or would even text me, and say, Henry, are you available to talk about X? And I would always refer them back to our communication people, and say this request came in.

So I always tried to keep CDC -- we have a clearance process for talking to the media. I would refer all those queries over to our comms staff. Some reporter even left a note in my mailbox one day. That was in 2020.

Q They're persistent.

A So I immediately called our staff members, and said, you know, this person, this reporter asked me to talk to them off -- you know, talk to them. All of these, in my mind, should be cleared through our communications staff.

Q So as far as your recollection goes, you always cleared things with the communications staff?

A That's correct.

Q Okay. Have you ever spoken to a reporter named Dan Diamond that you recall?

A I may have. That name is certainly familiar. But again, whether being asked a question on a telebrief or -- so the name is familiar, yes. So I don't remember an actual conversation. I want to be clear about that, but the name is familiar.

Q Okay. Would you be willing to search your email for this relevant time period for any emails you may have exchanged with Dan Diamond? Is that something you would be willing to do? Maybe Kevin could assist.

Mr. Barstow. If there is a Committee request for a document, we'll be happy to take a look at it.

[Minority Counsel]. So you're requesting we put that in writing?

Mr. Barstow. As always.

[Minority Counsel]. All right.

BY [MINORITY COUNSEL].

Q There was a lot of guidance coming out in the spring of 2020 that affected children, school guidance, summer camp guidance. Who was the point

person, the key drafter, who you would say was really in charge of those guidances?

A We had a community mitigation task force. And within that task force, there was a school unit. And so Greta Massetti and Erin Sauber-Schatz led the task force intermittently through that period of time. And so those two were engaged.

But within that large community mitigation task force, there was a school unit, with a number of different people on it. But the task force lead for community mitigation was primarily responsible for clearing -- making sure that initial draft was written. Then clearing it from the task force before it went into the larger CDC clearance chain.

Q Okay. And that would cover summer camps, too?

A That group would cover summer camps as well, in that task force, community mitigation. So they had a school unit, and they had another group that was also working on camp guidance. So it was in that same task force.

Q Okay. When -- in your mind, when did we have firm scientific data evidence, whatever you want to call it, on outdoor transmission being extremely

low? Like, when did you know, if I'm outdoors, I'm pretty safe?

A Yeah.

Q Or do you acknowledge that today, I guess I should ask.

A I'm trying to think about when we knew what. We always thought, it's a respiratory virus, so even in the early days of Wuhan and the repatriation work we were doing in February, we were doing a lot of those meetings outside, because we knew with outside, it was safer dispersion of any respiratory droplets. So I think we were always emphasizing outside ventilation.

Q So around February 2020, you think? Is that fair to say?

A Well, ask me the question again, because we're talking about not a black and white. We knew that -- you know, for a respiratory virus, that transmission was safer -- it's safer to be outside than indoors, especially better for ventilation versus no ventilation. A general principle with the transmission of a respiratory virus, which was known before SARS-Co-V-2.

Now, there were certainly studies being done looking at indoor transmission versus outdoor

transmission, to show with this particular virus, that outdoor transmission was a much lower risk. But honestly, I don't remember the date.

Q So if that's the case, do you have an explanation for why the CDC recommended that children at summer camps should mask outdoors?

A Well, I think we were still learning about transmission and infectiousness of this particular virus. So we knew that outdoor was safer, but we were still learning about the viral dynamics. And so especially with kids, even if outside, it can be a crowded -- kids can group together, especially in play or in physical activity. And so I think we were still learning about the virus, and also concerned around clusters, groups of kids clustered tightly together, even outdoors, about transmission. So that was our concern.

Q It's also hot outdoors. Actually, the guidance I'm referring to is 2021. So it would seem by then that we knew a little more. And so maybe the recommendation should have been children shouldn't cluster outdoors, instead of children should mask outdoors all the time, which was what it was.

But that's outside of the scope, so I won't actually pose that question to you. But if you have

any information or thoughts on that --

A On our 2021 guidance?

Q Yes, to mask outdoors, children at summer camps.

Mr. Barstow. Outside the scope.

[Minority Counsel]. As I noted.

BY [MINORITY COUNSEL].

Q I want to switch topics really quickly, and talk about partners again. You talked to my colleague, [Redacted], a lot about partners. Are industry considered partners, stakeholders, whatever language you want to use, you can choose? Are industry?

A Industry would be a group of -- usually we would try to work with an association that's representing a particular type of industry. But, yes, we would hear from industry and any of their concerns.

Q Is the American Academy of Pediatrics considered a partner stakeholder?

A Yes.

Q So if there were a list, they would be on the list?

A That's right, yes.

Q Did you work with the AAP on school

guidance, do you recall?

A I don't recall. It certainly would be reasonable for the task force that was working on school guidance to elicit input from the Academy of Pediatrics, yes.

Q And who would have been the point person that would have dealt with the American Academy of Pediatrics, do you know?

A Again, it would be the task force lead within that. If we're talking about school guidance, it would be the task force lead for the community mitigation task force, or that school unit within the community mitigation task force.

Q Who was the lead of the school unit again?

A I don't recall during the spring of 2020.

Q Who is it now?

A I don't know who the head of the school unit is now. And again, I would just suggest that there are over 2,000 people in the CDC response at any one time.

Q Okay.

[Minority Counsel]. I think that's all the questions. We can go off the record.

[Majority Counsel]. Dr. Walke, we're happy to continue or take a break for a few minutes, based on your preference.

The Witness. We can continue.

BY [MAJORITY COUNSEL].

Q Dr. Walke, during the last round of questioning, you were asked hypothetical questions about whether line-by-line edits to CDC guidance provided by outside groups are appropriate. Does the appropriateness of any such edits depend on the content of those edits?

A We really want to provide the best guidance possible. And so it is uncommon to have line-by-line edits. That said, we would look at any reasonable suggestions, and try to understand, would that provide clarity or -- in our guidance. That's what we're looking for, to meet the mark, to be helpful to the American public, and also to provide as much clarity as possible.

Q I guess, in other words, if the edits are or were something that CDC would have otherwise implemented on its own, might it then be appropriate to implement those edits, for example?

A That's correct.

Q Since we are talking about guidance, I

would like to discuss some of the specific guidance developed during the coronavirus pandemic. I know when you were talking about the STLT task force, you mentioned meat packing as one of the industries that you worked with at the state level.

And I wanted to ask you a question about some guidance that was issued in April. And at this point, it might be helpful to look at the documents that we sent over that I hope you have. And specifically to look at the document that was marked as Exhibit 1. Do you have those?

A Hold one second. Maybe I should have taken a minute to reboot my computer. Let me see. Can I ask your patience in going off the record to allow me to reboot the computer? That would be helpful, I think, in going forward.

[Majority Counsel]. Not a problem at all. Let's go off the record, and we can take a few minutes. And we'll be here when you have rebooted.

The Witness. Thank you.

(Recess.)

(Majority Exhibit No. 1 was identified for the record.)

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

record. I just want to note, I see JoAnn Martinez on as well from HHS. I could be mistaken, but I think that's a new addition, so I just wanted to note that for the record.

BY [MAJORITY COUNSEL].

Q Dr. Walke, I think you said you have Exhibit 1 up, which is great. Is that right?

A That's correct. I have it in front of me.

Q Thank you. So this is interim guidance for meat and poultry processing workers and employers from both the CDC and OSHA, issued on April 26, 2020. Are you familiar with that guidance?

A Yes, I am.

Q Did you have any involvement in formulating that guidance?

A Yes, I reviewed the guidance and was aware of the guidance, yes.

Q In terms of reviewing it, does that mean you reviewed it before it became final?

A I did review it before it became final.

Q But you didn't necessarily have a role in drafting the guidance?

A No, our worker safety occupational health group drafted the guidance.

Q Understood, thank you.

(Majority Exhibit No. 2 was identified for the record.)

BY [MAJORITY COUNSEL].

Q If we could look next -- this one has been marked Exhibit 2, for the record. This is Bates stamped HSSCV-Smith-00000877. Dr. Walke, that just refers to the little number down in the right-hand corner for sort of our internal recordkeeping.

A Sure.

Q This is an email dated April 27, 2020 that Dr. Redfield sent to Ken Sullivan, the then CEO of Smithfield Foods in Sioux Falls, South Dakota. And I note that you are CC'd on this email. Are you familiar with Smithfield Foods?

A I am.

Q How or in what capacity are you familiar with Smithfield?

A Well, I recognize the company. And I was -- I recognize the company, and I was on a call with Dr. Redfield with Smithfield.

Q Is the call that you were on with Dr. Redfield, the call that he seems to reference here in this email?

A That's correct.
Q Do you recall what took place on that call?
A This is about our concern from Smithfield around our guidance, and hearing from Smithfield about some of their concerns. They wanted to make sure -- or to tell us that they were trying to keep their plants open. And had a discussion with Dr. Redfield around the risk balance of trying to keep the plants open, and at the same time provide safety to the workers. That's what I remember about that call.
Q Other than you and Dr. Redfield, did anyone else participate in the call from CDC?
A I can't remember, to be honest. I can't remember.
Q Do you recall generally who else was on the call? Presumably Mr. Sullivan was on?
A That's right. Mr. Sullivan was on, Dr. Redfield, and myself. I'm not sure of anyone else.
Q Following the call, do you recall what happened?
A We talked to a lot of people. And you know, I was on many calls with Dr. Redfield. So

relating to this particular call, you know, we -- I don't remember exactly. To me, this is a call of many calls. We were hearing from various groups around concerns around our guidance.

[Majority Counsel]. I want to, if we can, take a look at the document that's marked as Exhibit 3.

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

BY [MAJORITY COUNSEL].

Q This is an April 22nd, 2020 site visit memorandum and recommendation from CDC to Smithfield titled "Strategies to reduce COVID-19 transmission at the Smithfield Foods Sioux Falls Pork Plant." Are you familiar with this memorandum?

A I am.

Q Did you have any role in that site visit?

A I didn't. I knew about the site visit. I knew that -- because we were deploying -- we were part of the team that was helping NIOSH deploy to South Dakota. And at a high level, I was -- I remember the memo, looking at it now. And this was one of the issues we were -- one of the congregate settings that we were concerned about. So at a high

level, I remember the deployment. I remember this memo.

Q But you weren't part of the team that deployed to the site; is that right?

A That's correct.

Q Did you have any role in drafting this actual memo?

A I did not.

Q Did you review or approve the memo?

A I remember reviewing the memo. You know, it was cleared through our NIOSH group. And they really have the deep expertise in this space, so I remember reviewing the memo and -- yeah, that's what I remember.

Q Sure. On August 26th, 2020, CDC's National Institute -- NIOSH, National Institute for Occupational Safety and Health told the House Committee on Education and Labor that a prior version of this memo had been cleared internally by two task forces within CDC. The prior version was dated a day before, April 21st. That was a day before this final memo was subsequently issued. Are you familiar with that April 21st version of the memorandum?

A I am not intimately familiar with it, no. It's hard for me to remember the document before

this document, if you hadn't put it in front of me.

Q That's a good point. Let's look at it. It's been marked as Exhibit 4 in your bundle of materials.

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

BY [MAJORITY COUNSEL].

Q So looking at this document, generally, you're aware that there was a draft that had been internally approved, prior to the final version issued on April 22nd?

A Yes. But, you know, we have a lot of documents, a lot of drafts.

Q Yes.

A So, yes.

Q The April 22nd, 2020 version of the memo contains changes to the guidance from -- as compared to the April 21st version of the memo. And I want to just point out one or two of those to you. For example, the April 22nd version contains certain qualifiers. So, for instance, the first bullet on the top of page 8 of that memo -- again, this is Exhibit 3.

A Yeah.

Q -- says, "If feasible, all employees should wear the face covering being used by the company to cover their nose and mouth in all areas of the plants."

And in the original draft from April 21st, which, again, is Exhibit 4, on page 7, the second bullet under "source, control, and hygiene" lists the exact same sentence, but does not contain that "if feasible" language. Are you aware of why changes like that were made to the April 22nd memo?

A Some of this, as I remember, was based on concerns from USDA and industry around if they were going to be able -- if industry was going to be able to implement our recommendations. And I remember a conversation with Dr. Redfield internally around trying to acknowledge that these recommendations were recommendations, and trying to give some leeway in our recommendations.

Q So you mentioned that there was concerns from both USDA and industry. How were those concerns communicated to you?

A I was on calls with USDA during this period of time with Dr. Redfield and Sonny Perdue, with USDA at that time, and his staff, where this topic was discussed. So that's what I remember, that

-- this concern of the feasibility or the ability of industry to implement our recommendations, knowing that a number of these facilities were older, and had narrow hallways, for example. And trying to strike the right balance between what was possible and our guidance. And I think that's what I remember.

Q Were the concerns that USDA and industry communicated separate concerns, meaning that they each had their own set of concerns, or was the USDA translating industry concerns to you?

A The way I remember this conversation, the general conversation was USDA talking about industry concerns. So that's really sort of the extent of my memory, that there was this general concern that our guidance would incorporate, or at least acknowledge that there were some actual physical barriers or challenges in implementing guidance in these settings.

And so I remember a discussion around -- particularly around the narrow hallways that sticks out in my mind for some reason. And then having a discussion with Dr. Redfield around trying to provide some flexibility.

Q And what was your reaction to hearing those concerns from USDA and industry?

A My personal reaction, you know, I saw their point. I -- I think we're always trying to -- we were interested in making sure there wasn't transmission within the facilities. And from a public health standpoint wanted to stop transmission, and -- but I understood their perspective, that you want to keep the plant running. You want to keep people employed. I wanted to see how we could find a way to both keep the plant running and at the same time keep workers safe.

So I think that's what these conversations were about, trying to receive input, trying to understand what were some of the challenges. But our -- my particular interest was in trying to keep workers safe.

Q And did the changes that ultimately made it into the April 22nd memo do that? Did they keep workers safe, and did they align with the best science at the time?

A We don't like to put these types of waffle words into our guidance, if feasible, for example. I think it undermines the clarity of the guidance itself. These are the recommendations. And so I was resistant to try to incorporate this type of language into our guidance, because it really muddies

the guidance, when we start putting these waffle words into it. So I felt that was watering down our guidance.

Q You mentioned that you don't like including those types of words in guidance, generally. Why don't you or CDC like to do that?

A Well, I think it -- you know, we try to be as clear and direct as possible with our recommendations. And I think that if we include phrases like that, if feasible, then it dilutes our recommendations.

And so I think we try to -- when we put out guidance, to have a more firm recommendation, do this, not that. We recommend X. And so the qualifiers really, I think, dilute our message. So in the editing and clearance process, we try to either strike that kind of language or think, well, do we even need to -- this recommendation is going to be so watered down, should we include it or not. So that's an internal debate that we have. And we try to be as direct and clear as possible.

Q You mentioned the possible harm from diluting or watering down guidance. What is that harm, or how would it manifest?

A Well, I mean, it could manifest by

undermining the whole recommendation. So basically, people could opt out of our guidance, because it wasn't feasible. So I think that's the harm, that we provide such a -- it's so wishy-washy that -- is it guidance at some point? And is it a CDC recommendation or not? So we try not to put out this type of guidance, or these types of qualifiers.

Q You mentioned that you were resistant to incorporate that type of qualifying language. In what ways were you resistant? Did you voice that to someone?

A Dr. Redfield and I had many conversations around these -- very frank, open conversations. And in the end, he's the director, and he wanted to include this language. And so that's what we did. But we would have open discussion. I would -- we would bring in -- he would listen to a group of us. We would go back and forth around what we felt was the right way forward, and he had the ultimate decision.

Q Do you know more specifically why Dr. Redfield wanted to include that language? I know we mentioned some concerns from USDA and industry. But more specifically, how this language made it into the memo?

A I don't. I couldn't speculate, really. I remember Dr. Redfield wanting this language, if feasible, in the memo. And having the discussion around this, and thinking that, okay, but this is diluting the message. You know, I told you we had concerns around the conversation with USDA and industry, but that's really all I remember.

Q Sure. Do you know if the request came from industry?

A What I remember, and I want to be careful, because what I remember is the conversation around trying to make sure our guidance was as flexible as possible, or was flexible for these older facilities. And so that's what I remember in the discussions.

Q And in any of your discussions with Dr. Redfield, did you explicitly raise your concerns with that language?

A I did. But, you know, this is one of many conversations Dr. Redfield and I had during this period of time. But, yes, I remember expressing my concern about diluting the message.

Q And what was his response to that?

A I don't remember exactly. I mean, he heard me. Very polite man. We had open discourse.

I remember him being firm about wanting that language in there. That's all I remember.

Q Do you know if there was a feeling of pressure from any outside group or organization to adopt the changes?

A I don't remember. Again, what I remember is the conversations I talked about before.

Q Thank you. That's helpful to understand that. Do you know, did Smithfield have any access to the draft of the guidance from April 21st before the April 22nd version was released?

A I don't have any knowledge. No, I don't. To my knowledge, I don't believe they had a draft, no.

Q Do you know if they had expressed any dissatisfaction with any prior drafts before the April 22nd version was released?

A Of the guidance or the memo?

Q Of the memo, I'm sorry.

A I don't know. I don't know.

Q Did you discuss any of the concerns or the fact that you were resistant to incorporating the qualifying language that we discussed? Did you discuss that with anyone, other than Dr. Redfield, of course?

A I'm sure that I discussed it with my deputy, Peggy, Peggy Honein, at the time. And I probably discussed it with the NIOSH staff who were drafting the guidance, yeah. So we were -- that's -- I'm sure I discussed with Peggy, and I'm also sure that whoever was on for NIOSH at that time, maybe it was Doug Troutman here, what we discussed. But again, this was -- but that was the decision to put that in, and that's what we did.

Q Sure. Are you aware whether NIOSH shared those concerns?

A I don't remember specific conversations, honestly. I remember that this was the decision, and that's what we executed on. I don't think -- well, I don't want to speculate. I don't remember a specific conversation.

Q I want to ask you another question or two about the email that we looked at briefly, which is Exhibit 2. That was from Dr. Redfield to the then CEO of Smithfield. In his email, Dr. Redfield connected Mr. Sullivan with you and Douglas Trout, and I wanted to clarify, who is Douglas Trout?

A So Doug Trout works with NIOSH, a CDC employee. And, you know, he was involved in a number of -- he might have been the chief medical officer.

Anyway, he was a leader in NIOSH and -- yeah, that's what I -- yeah, so Doug worked for NIOSH, and was a leader in that group.

Q Were you ever able to -- or did you ever connect with Mr. Sullivan?

A You know, I tried to. I don't remember any connection with Mr. Sullivan outside of that phone call. But I -- yeah, I don't remember. Again, I was on a number of phone calls with Dr. Redfield, so I don't remember a conversation with Mr. Sullivan outside of this phone call.

Q And I'm sorry if you mentioned this in your previous answer, I might have missed it. Did you say Doug Trout was assigned to the Sioux Falls field team on this?

A He was certainly at headquarters for NIOSH, and engaging with the Sioux Falls field team, but I don't remember if he was on the ground or not.

Q Exhibit 3, the April 22nd Smithfield memo, the final version.

A Yeah.

Q Was Mr. Trout working on the Sioux Falls review when this memo was released, do you know?

A I don't know.

Q The first author listed on the memo is

Michael Grant. Could you tell us who that is, Michael Grant?

A Michael Grant, as stated here, is also -- works for NIOSH within CDC, in the worker safety group. So I believe he was the team lead on the ground for the field team.

Q Let's open briefly Exhibit 5, if we can.

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

BY [MAJORITY COUNSEL].

Q This is a document marked HSSCV-Smith 00000898, and it's a May 5, 2020 memo from CDC to USDA, recommending that the Sioux Falls plant be reopened. And it doesn't list Grant as one of the authors. Do you know, was Michael Grant removed from the Sioux Falls review at some point?

A I don't remember. I don't remember him being removed. I remember Erin Kennedy, who is on this Exhibit 5, being deployed in Sioux Falls. So I'm not sure what happened with Michael Grant. Is it Michael? Grant, yeah.

Q Got it. Thank you. We were talking a bit briefly earlier about the toned down or qualifying language that was added to the Smithfield

memo. I wondered if you're aware of whether language like that was added to any other guidance for other industries?

A Not to my knowledge, that comes to mind. Not for other industries. There was language or testing guidance that was added around "do not necessarily need to." That was -- that sticks out in my mind as sort of waffling, which that was added. But other than that, nothing else. I can't remember anything else.

Q I do want to ask about that. But, first, I just want to stick with this meat packing guidance. Let's look back at Exhibit 1, if we can, which is the actual guidance itself.

A Okay.

Q And this guidance also contained qualifiers like "if possible" and "if feasible," similar to what appeared in the April 22 Smithfield memo. If it's helpful, one example is on page 3, in the first paragraph, which says, "Add additional clock in/out stations, if possible, that are spaced apart, to reduce crowding in these areas."

Do you know if you or any of your colleagues consulted the April 22nd Smithfield memo during the process of formulating this guidance?

A This is more of the same, isn't it? So when was the release of this one?

Q This was April 26th, 2020.

A And the memo was Exhibit 3, you said?

Q Yes. And that was April 22nd, for reference.

A Right. So I mean, it is a similar conversation around -- almost the same conversation about utilizing this type of, "if feasible," "if possible" language in our guidance. So it's not something that we want to do, but -- and as I said before, it gives more flexibility, and it gives a lot of flexibility, I think, in the recommendation. So it's something we try to stay away from.

Q Do you recall having any discussions with Dr. Redfield on including language like that in this guidance, separate from the discussions you had in connection with the April 22nd memo?

A To me, it's sort of the continuation of the same conversation, which is to give this kind of flexibility in our guidance. So Dr. Redfield really wanted this type of language in the guidance, and so that's what we did.

Q Did you play any other role in connection with any meat packing plant closures or

coronavirus outbreaks at meat packing plants or guidance related to meat packing?

A Other than deploying a lot of CDC staff to many poultry and meat packing facilities, no. You know, all of these meetings sort of run together, in that we deployed a lot of staff. There were a lot of outbreaks. We were doing a lot of studies, trying to look at transmission in these various settings. And then would update our guidance intermittently to try to update the science, and update our recommendations based on what we learned. So that's what I remember from this time period.

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

BY [MAJORITY COUNSEL].

Q Sure. I want to ask you next about guidance for communities of faith. On May 22nd, 2020, CDC released guidance for faith communities that included recommendations that religious communities, "Consider suspending or at least decreasing use of a choir/musical ensembles and congregant singing, chanting, or reciting during services or other programming, if appropriate within the faith tradition." And that, "The act of singing

may contribute to transmission of COVID-19, possibly through emission of aerosols." Do you recall that?

A I recall the -- yes, I recall that.

Q Did you have any role in developing those guidelines?

A I did not.

Q The guidance on the CDC website changed over the course of that weekend. Are you familiar with that?

A Retrospectively? I mean, now I am. At the time, I wasn't aware of what was going on.

Q I know you said retrospectively. Do you recall about when you became familiar? Was it very recently, or just soon after the event actually happened?

A When I was IM, you know, in July, you know, holding conversations, that sort of thing, I became aware of it. At the time, I was not aware of what was happening.

Q How did you become aware, then?

A I believe Dr. Butler told me about it, Jay Butler. And potentially another leader in the response. But that's all I know.

Q Do you recall the context in which it came up, the conversation with Dr. Butler?

A I don't. Jay and I talked about a lot of things. I took over the IM from him in July, and I remember it coming up in that context. But not with any -- a lot of detail.

Q Moving on to some other guidance. Were you involved -- I think you mentioned earlier that you might have been involved in efforts to draft guidance related to schools, including reopening schools during the pandemic?

A That's right. I mean, I didn't draft the guidance, but I did review the guidance and did work with the subject matter experts to discuss, and then discuss with Dr. Redfield, and the guidance -- and had the school experts on. So, yeah, I was part of those discussions, yes.

Q And I think you mentioned that you would review guidance that would come from the subject matter experts on the task force or the committee within the task force --

A That's right.

Q -- who would do the initial drafting, and you would review?

A That's correct.

Q Okay. Great. On July 8, 2020, President Trump tweeted that he disagreed with the

CDC's then current guidelines for safely reopening schools, which encouraged hygiene, the use of cloth face coverings, modified seating layouts to allow social distancing, and closing of communal spaces. I think you've told us that you were incident manager as of July 1st, so I wondered, did you have any involvement in drafting the guidelines that President Trump tweeted about on July 8th?

A You know, yeah, that was -- a lot of that work had already been started by the time I took over as incident manager. But, sure, I was -- whenever it was released, I was -- I had reviewed it and had conversations with Dr. Redfield about it. But the initial drafting of that guidance, you know, was ongoing as I took over.

Q When you were in your role before incident manager on the state, and local, and tribal task force, you weren't involved in drafting or reviewing guidance related to schools; is that right?

A That's correct.

Q President Trump tweeted his disagreement with the guidelines, saying that they were, quote, very tough, and quote, expensive. During a press briefing a few hours later, Vice President Pence said that the CDC would issue new guidance on reopening

schools the following week. Do you recall that?

A I do.

Q Did you have any reaction to President Trump's tweet?

A Well, I mean, it's not helpful. The President -- we release guidance, and the President, in a tweet or otherwise, undermines the guidance we just released. So it's not a -- it's not speaking with one voice, really, from the federal government. So -- yeah, that was my thought.

Q In what way did you feel that it undermined CDC's guidance?

A Well, I mean, we were putting out guidance, based on our expertise within CDC, consultation with multiple partners. We thought, at the moment, we would keep schools safe. So -- and so by the President undermining that message, these are recommendations to school districts, to jurisdictions, states, locals, to implement, you know, within their school districts.

By undermining the message, that dilutes our recommendation. And then eventually, you know, people wouldn't adhere to our recommendations or people wouldn't utilize our recommendations if we're not speaking with one voice. And so I think it

diminishes the impact, really, of our guidance.

Q Did you have any reaction to Vice President Pence's press conference, during which he said that CDC would issue new guidance?

A Well, that was the -- yeah, I mean, I was surprised that the Vice President said that. I guess my initial reaction was, what is that going to look like, when he says, we will revise?

Q On July 23rd, 2020, CDC did post on its website revised guidance, a page titled "The importance of reopening America's schools this fall." Are you familiar with that?

A I am.

Q Were you involved in efforts to draft that guidance?

A No, I was not.

Q What about in reviewing or approving it?

A This was a document that was -- had been -- I believe had been drafted by SAMHSA that had been discussed with our school group at CDC. We were not involved -- I was not involved. And my understanding is that our school CDC staff were not involved in drafting that document.

Q Just to clarify, SAMHSA is the Substance Abuse and Mental Health Services Administration; is

that right?

A That the correct.

Q Do you know how they came to be involved with drafting that guidance?

A I don't know how they came to be involved. Obviously, in their name, they're concerned about mental health issues. And I remember the leader of SAMHSA was very vocal about getting kids back to school.

Q Was the SAMHSA guidance that was ultimately posted on the CDC's website based on the best available science at the time?

A We thought our guidance -- the CDC guidance was based on the best available science. The document that was posted on our website was not a CDC document. And we had issues with the document. Our school team had issues with the document.

Q Did anyone voice any of those concerns with the document to anyone?

A Our school team informed me about the document, and voiced their concerns to me about the document. And in our conversations -- I don't remember. I know that we had, I believe, our school team. And I talked to Dr. Redfield about our concerns with the SAMHSA document, but I don't

remember the specifics.

Q Do you remember what Dr. Redfield's reaction was to that conversation?

A I don't.

Q Do you know who ultimately determined that the guidance would be released and posted on CDC's website?

A That's the director's decision. So ultimately, Dr. Redfield decided to post it on our website.

Q Do you know if anyone else at CDC, other than the school team, or you, as you've mentioned, expressed concerns about the SAMHSA document?

A I don't remember. I don't know.

Q Do you know if anyone at the White House insisted on specific language to be included in the guidance that CDC disagreed with?

A There certainly were conversations between the White House and Dr. Redfield on this topic, and -- but I don't really remember the specifics of it, to be honest.

Q In September 2020, the New York Times reported that Dr. Birx wrote to Dr. Redfield to ask him to incorporate the SAMHSA document into the school reopening guidance. Are you familiar with

that email?

A I think it's one of your exhibits, I believe. I was not familiar with the email before, no.

Q We have the New York Times article which has a snippet of the email.

A Okay.

Q But not the email itself. And so I was wondering if you, yourself, received the email or not. But I think you just said you did not.

A I did not.

Q Based on your experience, is it typical for White House advisers to request that this type of language be included in CDC guidance?

A No, it's not typical.

Q Is it something is that had happened at any other time before?

A For a whole document like this to be posted on our website as a preamble to our CDC guidance, no, that had never happened before, to my knowledge.

Q To your knowledge, did the White House direct changes to any other school guidance that you're aware of?

A Not to my knowledge.

Q To your knowledge, did the White House ever direct that CDC not release any guidance related to school reopening?

A Not to my knowledge, no.

[Majority Counsel]. I think we are a bit shy of the hour, but I think this is a good place to take a break, so we can go off the record.

(Whereupon, at 12:27 p.m., the testimony in the above-entitled matter was recessed, to reconvene at 1:00 p.m., this same day.)

AFTERNOON SESSION

(1:00 p.m.)

EXAMINATION BY COUNSEL FOR THE COMMITTEE (RESUMED)

BY [MINORITY COUNSEL].

Q Dr. Walke, I want to read you a few statements, and you just give me a yes or no on if they are accurate. Children appear to be at lower risk for contracting COVID-19 compared to adults. Is that accurate or not accurate?

A Is this based on what we know now?

Q Is that an accurate or inaccurate statement?

A Okay. Just -- fine. Can you start again? I apologize.

Q Children appear to be at lower risk for contracting COVID-19 compared to adults?

A I can't say. I think that they are -- it depends on how you -- yeah, early on, we thought they were at lower risk. We have more data that looks like it is equivalent risk. So I would say that it's not a yes/no. It's a -- I think they're at equivalent risk of contracting SARS-CoV-2.

Q Is the R-naught for pediatric cases lower than adult cases?

A Whether or not they can transmit to others. I can't say that it's lower, no. I think that, yeah, I mean, children have milder, more asymptomatic infections. But in terms of transmission early on, again, we were studying -- I think it's -- it's enough transmission to be concerned about. That's what I think we would say.

Q I'll put a date on that statement, if that changes your assessment. By September 30th of 2020, was that statement accurate?

A I believe at that time, and this is my recollection, that the data was showing that kids were less likely to transmit. In your case, the R-naught was lower. But again, at a level that we were still concerned about.

Q Okay. By September 30th, 2020, was this statement accurate or not accurate, scientific studies suggest that COVID-19 transmission among children in schools may be low?

A May be low. Yes, that's accurate.

Q Okay. By September 30th, 2020, was this statement accurate or not accurate? The best available evidence from countries that have opened schools indicates that COVID-19 poses low risks to school-aged children, at least in areas with low

community transmission, and suggests that children are unlikely to be major drivers of the spread of the virus."

A I think that has to be in context, because there's different layers of mitigation, which would include ventilation, masking. So we were -- so with appropriate mitigation levels and with those layers of the mitigation, ventilation, masking, distancing, the thought was that, yes, when community transmission is low, schools are reflecting the transmission rates in the communities, so transmission in schools would also be lower.

Q So that statement by September 30th, 2020 would be accurate?

A That's correct.

Q One more. September 30th, 2020, is this statement accurate or inaccurate? Early reports suggest children are less likely to get COVID-19 than adults?

A You know, it's all in the -- epidemiology is not a yes/no field of science. So, yeah, I believe, yes, what you said is accurate, less likely to be infected. But, again, at a level that we -- and without those layers of mitigation, a level that we would be concerned about. So it's not a --

there's a lot more to that statement than a yes/no. But, yes, it's accurate.

Q Are there fewer pediatric cases of COVID-19 today than there are adult, in total?

A That's right, yes, there are.

Q Okay.

A Yes. But of course, that's a rate issue, isn't it? It's a denominator issue as well. So there's the numerator, there's more adults than there are kids. But even looking at the rates, there are fewer cases in the pediatric population.

Q Okay. Thank you. We were talking a little bit about the guidance as it relates to meat packing plants. And you said the last hour that qualifiers in these guidances are frowned upon, because it waters down the guidance, and people may not follow it. Is that a fair characterization?

A Yes.

Q Is the CDC a law-making agency?

A There are parts of the CDC that have a regulatory function. So in that scenario, yes.

Q Is your meat packing guidance equivalent to law?

A No, these are recommendations.

Q Director Walensky, recently, it was

reported, said, "I will say that guidance is just guidance. And all of these decisions, we continue to say, have to be made at the local level." Do you agree with that statement?

A We take the local -- yes. Yes.

Q Okay.

A CDC makes recommendations. States and locals have the authority.

Q So CDC cannot make law. Guidance is just recommendations. Is it fair to, then, demonize people that may alter your recommendations to what's practical in their communities?

A The key here is demonize. That seems like a strong term.

Q Is it fair to say that a governor is actively killing their population because they're not following CDC guidance?

A No, I don't think that's fair to say.

Q All right. Thank you. Are you currently the director of the Division of Preparedness and Emerging Infections in the National Center for Emerging and Zoonotic Infectious Diseases?

A I am not.

Q When did you stop having that role?

A In November of 2021, I left that role

and became the director of the Center for Preparedness and Response.

Q Okay. Would you consider yourself an expert in zoonotic diseases?

A You know, in the general -- in the general term, I have expertise, yes.

Q Okay. Do you know Ralph Baric?

A Ralph who?

Q Dr. Ralph Baric. He's at the University of North Carolina?

A I do not know him, no.

Q Okay. Have you worked on -- I assume, as being the director of the Emerging Zoonotic and Infectious Diseases Center, have you worked on responses to zoonotic diseases prior to COVID-19, MERS, or SARS-1?

A I did not work on SARS-1 or MERS. I did work on Ebola some, both in 2014 and recently in the DRC outbreak.

Q Okay. Have you been able to see the sequence of SARS-CoV-2?

A It's published, yes.

Q And you're aware of it, and have seen it?

A I'm aware of it, yes. I haven't gone

through all the genetic code, but I know it's published and easily found.

Q Okay. Have there -- understanding that you haven't gone through all the genetic code, is there anything in the sequencing that would strike you as unusual?

A That's not my role or expertise, so I really can't comment.

Q Okay. As the director of zoonotic diseases, it's not your expertise to look at zoonotic sequences?

A We have very -- the genetic epidemiology or sequencing interpretation of sequencing, and mutation rates is a very narrowly defined field. So, yes, there are people within the CDC who are experts in this area, but my training is in epidemiology, and not in molecular laboratory methods.

Q Okay. Do you know what a furin cleavage site is?

A I'm aware of what furin cleavage site is, as far as CoV-2, yes.

Q In your work in zoonotic diseases, particularly in Ebola, and just as the director of the center, have you seen any coronaviruses before with a furin cleavage site?

A I'm not aware of -- and again, this is not really my expertise. So we can continue here, but if you get deep into genetic code and 3D dimensional makeup as far as CoV-2, I'm not going to be able to say much. But, no, I wasn't aware of a furin cleavage site before this response.

Q Okay. Do you know Dr. Bob Garry at Tulane?

A I do not.

Q Okay.

[Minority Counsel]. Unless any of my colleagues have any questions, I'm done. We're good for this hour. Thank you, Dr. Walke.

[Majority Counsel]. We can take a break or just keep going, based on your preference.

The Witness. Let's keep going.

(Majority Exhibit No. 11 was identified for the record.)

BY [MAJORITY COUNSEL].

Q I want to show you a document that we've marked as Exhibit 11 in the materials that we sent you.

A Okay.

Q I think this will look familiar to you. You've alluded to it during our conversation already

today. And this is the CDC testing guidance from July 2020.

A Right.

Q Did you say you're still pulling it up or you have it?

A I have it.

Q Great. So to confirm, do you recognize this document?

A I do.

Q Do you know who drafted this guidance?

A This guidance comes from our laboratory task force within the CDC response. So they took the lead on this overview of testing document.

Q And then did you review it, like you've told us you've done with other --

A I did.

Q You did. Did anyone review it after you?

A After it was published or before it was published? I just want to clarify.

Q Prior to it being published.

A Usually the -- after the incident manager review, it goes to our Office of Science, and then it goes to the CDC director. So that's who would review it after me.

Q So this guidance appears to be the guidance that was available on CDC's website prior to August 24, 2020. And it reads, in part -- this is at the very top of page 3 of 4. "Testing is recommended for all close contacts of persons with SARS-CoV-2 infection. Because of the potential for asymptomatic and pre-symptomatic transmission, it is important that contacts with individuals with SARS-CoV-2 infection be quickly identified and tested."

Do you see that?

A I do.

Q Did you think that the guidance was consistent with the best available science at that time?

A Yes.

Q And how did others react at the CDC to this guidance? Did they agree with it?

A Yes.

Q The guidance was updated in August 2020, and we can look at that. It's Exhibit 12.

(Majority Exhibit No. 12 was identified for the record.)

The Witness. Yes.

BY [MAJORITY COUNSEL].

Q The August 24th version changed the

earlier guidance to say, "You do not necessarily need a test unless you are a vulnerable individual, or your health care provider or state or local public health officials recommend you take one." And I should have told you before I was reading that, but that's in the middle of page 2. But you may be familiar with it anyway.

A I'm very familiar with it, yes.

Q Do you know why the guidance was changed?

A There were multiple drafts of this guidance between -- over a period of several weeks. There was concern that there was a testing shortage, and that we wanted to prioritize tests for those individuals at the greatest risk.

So over -- and this was a conversation that was going on within the response, and with HHS. And it landed here. You do not necessarily need a test because the thought was, if you didn't have symptoms and you weren't vulnerable, then you would be a lower priority for testing. And therefore, those individuals who were vulnerable, who were symptomatic, could be prioritized for testing. So that's really how we ended up here.

Q So you mentioned that there was concern

about a testing shortage, which is what played into this change. Who was expressing that concern?

A This really came from Admiral Giroir, the Assistant Secretary for Health. But also in conversations with the White House, with Dr. Birx. And a subtext of this as well was that people were -- Dr. Atlas also had come into the White House. And there was another conversation around the need for testing at all, or the need, honestly, for quarantining at all among those who were close contacts.

So there was a lot of discussion around our testing guidance during the period of time, conversation related to prioritizing those who really needed testing, because the wait times, the turnaround times for testing were extensive in some cases, to make sure those who really needed testing could be prioritized for testing, as well as the bigger conversation of do people -- asymptomatic, well appearing people need to be tested at all. And do they even need to quarantine at all. So that's what I mean.

Q And those conversations that you mentioned with those folks at the White House, were you part of those conversations?

A I was not part of the White House conversations. These were discussions with Dr. Redfield and Dr. Giroir at the time.

Q The discussions between Dr. Redfield and Admiral Giroir, or Dr. Giroir, when did those begin, do you know?

A In July, late July, Admiral Giroir was asking a lot of questions around our testing guidance. He was the testing czar, very interested in our testing guidance, and wanted to better understand how we were prioritizing those who needed testing.

Q What, if anything, else was he asking, in terms of questions on your testing guidance?

A It was -- he was particularly interested in the prioritization in whether -- who was -- who needed to be tested. And was -- we drafted several drafts. Admiral Giroir, at one point, took a -- draft 5 or 6, and basically drafted new guidance. And sent it back to us in a very different -- not a CDC style. Very simple, more consumer language guidance that laid out priorities for testing. And was having conversations with the COVID task force, with Dr. Birx and Dr. Atlas, Dr. Fauci, and Dr. Redfield around a way forward, in terms of what

made sense for testing guidance.

Q So these drafts that Admiral Giroir sent over, what happened with them or what became of them?

A We continued to -- part of those drafts introduced the phrasing, you don't necessarily need a test. So that's when some of the waffling had started to be introduced. So there was multiple iterations over time, documents that were being passed back and forth. And we, in the end, ended up with this document, the document that was published on August 24th.

Q What was CDC's reaction to receiving the language from Admiral Giroir?

A Well, at first, it was very unusual to have the Assistant Secretary for Health actually take over the task of drafting CDC guidance. So that was unusual.

And we did not like the qualifiers, "do not necessarily need," because we -- again, as we talked about before, it introduces a lot of waffling into our guidance, so it's not very clear.

And a number of us felt that close contacts do need to be tested. And what is not here is the issue of quarantining. Because we moved from testing close contacts, and quarantining those for 14 days, to some

intermediate drafts, which were basically, you don't necessarily need a test, but quarantine for 14 days.

So this particular guidance, which says you don't necessarily need a test, and doesn't reference quarantining. So we had a lot of concerns around this guidance.

Q Did you express any of those concerns to anyone?

A I did. The laboratory task force, the principal deputy Incident Manager Michael Beach at the time. I had many discussions around this guidance. And I had many discussions with Dr. Redfield around this guidance.

Q What resulted from those conversations, where you expressed your concerns?

A Dr. Redfield took our concerns, took them back to the COVID -- the White House COVID Task Force, and we had more iterations of our guidance. So, you know, it is a product -- it was a product, at the end, that was not something that we felt comfortable with.

Q Did you feel that the concerns that Dr. Redfield expressed to the White House Coronavirus Task Force were heard and addressed?

A My -- if I remember, in my discussions

with Dr. Redfield, he was also frustrated that he wasn't able to move forward on these issues. So we discussed his frustration in not being able to make any headway, in terms of CDC's position.

Q You noted that it was very unusual for someone in Admiral Giroir's position to sort of take the pen on guidance. Why do you say that?

A It's usually CDC staff writes CDC guidance, not the Associate Secretary for Health -- or the Assistant Secretary for Health. So that was very unusual.

Q And when you say that Dr. Redfield felt like he couldn't act, what was stopping him? He was the director of CDC at the time.

A Yeah, I can't speak for Dr. Redfield. I can only speak to what -- you know, our conversation. So I don't know why. I don't know.

Q Did you ever discuss with Dr. Redfield why he felt like he couldn't act?

A Dr. Redfield expressed his frustration to me, but I did not go into my director's reasons for what he did or didn't do. I didn't feel like that was my place.

Q I think you mentioned another person at the White House who was in discussions with CDC about

the testing guidance in August was Dr. Birx. Can you tell us a little more about the interactions she had with CDC on the testing guidance?

A What I remember from this is that Admiral Giroir was in the lead. He was circulating documents, and I was on emails with Dr. Birx and Admiral Giroir that -- you know, where she made comments and edits to various drafts. So that's what I remember.

Q I know you mentioned as well Dr. Atlas. And I would like to ask you a couple questions about him. How often did you interact with Dr. Atlas?

A I never interacted with Dr. Atlas. I don't -- maybe I was on the phone at one point, but I never had a direct interaction with Dr. Atlas. Never had a conversation with him.

Q Do you know the views that Dr. Atlas held regarding measures to limit the spread of the virus?

A My understanding was that Dr. Atlas did not -- wanted to pull back on some of the mitigation measures, and that was widely reported in the news. That was my understanding. He wanted to pull back on some of the mitigation measures, pull back on the testing, and masks, for example. So that was my

understanding.

Q What did you think of his views?

A They were contrary to what our current -- to our CDC guidance at the time. And so I felt they -- his views were undercutting our -- CDC's recommendations. And I thought it was -- I thought it was risky to pull back mitigation while we were still learning about transmission of the virus, and was against current recommendations.

Q Is it fair to say that he advocated for a herd immunity via infection?

A Yeah, I don't want to put words in Dr. Atlas's mouth. I didn't hear him say that. That certainly was the -- that's what it appeared, that by reducing mitigation -- mitigation measures, then more people would end up becoming infected, which was the theory for the herd immunity. The more people got infected, the more would be protected. And then we'll more quickly reduce transmission levels in the U.S.

Q Did you ever discuss Dr. Atlas's views with anyone?

A The issue occurred immediately. We discussed within the task force, sort of general discussion around, was that a viable -- did that make

sense or not. And I think that the general consensus at CDC was that the number of hospitalizations and deaths to achieve herd immunity would be unacceptable to pull back all mitigation.

And then not even knowing what actually herd immunity is in a changing virus like this. So the consensus opinion at CDC was -- and this was reflected in our guidance -- was that we needed these mitigation measures in place, certainly until transmission levels were lower, or we had more effective countermeasures, like a vaccine and/or therapies.

Q So regarding the August testing guidance, are you aware -- and apologies if you already said this, and I missed it. But are you aware of whether or to what degree the other doctors on the White House Coronavirus Task Force provided input on the guidance?

A I saw drafts with Dr. Birx's comments, Dr. Fauci's comments, and you know, obviously, Dr. Giroir's comments. So that's what I'm aware of.

Q Is it a fair assessment to say that the August testing guidance didn't go through CDC's normal review process that you've described for us?

A That's fair to say, yes.

Q Did anyone within CDC reach out to you to express concern or confusion about the guidelines after they were posted?

A There were a number of people in CDC who were unhappy about these guidelines, and wanted to express their concerns to me. I tried to have an open door, an open window. So there was a lot of concern about the guidance. And also concern of -- about our partners, with whom we had a very close relationship with, and their reaction to this guidance.

Q Who were those people that came to you to discuss their concerns, and what concerns did they express?

A I don't remember specific names, but I remember conversations with the task force lead, epi laboratory -- the epi task force and the laboratory task force, in particular, were concerned.

And of course, within the STLT task force, there's a group there responsible for contact tracing, and they were upset. So it was a general concern around the response, because one of the reasons to test close contacts was to see if they were positive, and potentially infectious, at high risk of becoming a case.

So we wanted to remove them from the population, test them to see if they had other contacts that we needed to put in quarantine. But also to test them, and then break the chain of transmission. So we were -- there was a lot of dissatisfaction with the guidance.

Q Did you ever speak with Dr. Schuchat about the August guidelines, if you recall?

A As I said, we had weekly meetings. I'm sure I did. I don't remember the conversation. There was also a moment where she pulled away a bit from any response, and I wasn't talking to her as frequently. I don't remember any conversations with Dr. Schuchat about this particular guidance.

Q You mentioned -- sorry.

A I was just going to say, I'm sure I talked to her about it. I just don't remember the conversation.

Q Understood. You mentioned that the guidance led to confusion with CDC's partners. Can you tell us a little more about what you meant by that?

A Well, I think they disagreed, CSTE, Council of State and Territorial Epidemiologists felt like contacts should be tested and quarantined. And

APHL as well, and American Public Health Association, the laboratories. So there was general disagreement. There was a lot of -- it wasn't even polite. A lot of pushback on CDC for the release of this guidance.

Q What form did that pushback take?

A Calls, emails. We had conversations. We had regularly scheduled meetings with the core group, CSTE, APHL, NACCHO, and ASPA, and Association For State Health Officers. So within those weekly meetings, large groups, smaller groups, there was even a core group of epidemiologists from CSTE, from the states, all expressed their concern around the guidance. And not only to me, but also Dr. Redfield as well, him directly.

Q And beyond causing confusion with CDC's partners, did the changed guidance lead to public confusion?

A I believe so. You know, it complicated the whole thing about contacts, and contact tracing and six feet. So these are -- it's hard to get all that into a simple message, so people can understand.

So when we flip in our guidance, and change our guidance, we have to be able to be direct and clear, and explain why -- why we made a change. And so when we say, "do not necessarily need a test," it really

makes it confusing, that kind of language.

(Majority Exhibit No. 13 was identified for the record.)

BY [MAJORITY COUNSEL].

Q Let's look at the guidance that was ultimately revised and issued on September 18th, which is Exhibit 13.

A Okay.

Q And that guidance revised the August 24th guidance, and said that if you have been in close contact with someone with COVID-19, "You need a test." And that's on page 2 of 4.

Who was involved in the decision to revise the August guidance?

A So we're on Exhibit 13?

Q Yes, Exhibit 13?

A September 18th, correct?

Q Correct.

A Okay. I was involved, the laboratory task force was involved. We were asked by Dr. Redfield to revise the previous guidance on August 24th, and we took that as an opportunity to update the guidance, and move it back in line with what we felt was more appropriate, which is close contacts needed tests. I think that's pretty direct.

If you've been in close contact, you need a test. And you should self-isolate for 14 days. So we put the test and we put the quarantine back.

Q Got it. I know previously with regard to the August 24th guidance, you felt that Dr. Redfield wasn't able to sort of revise the guidance to include language that he might have liked. Why was he, at this point in time, able to ask you and others at CDC to now revise the guidance?

A There was so much pushback with CDC around the August 24th guidance that I believe he was able to take all of that input from all the various state and locals, and all their various public health partners, and then bring the revision of this guidance back into CDC, and publish it as CDC guidance.

Q Got it. Was Dr. Birx involved at all with the September revised guidance?

A I don't remember her involvement in this. I think what I remember was relief that we are revising this guidance, and we actually can revise it in the way we wanted to. Revise it and then put it out.

Q Who ultimately drafted the revised guidance?

A We sent it back to the laboratory task force, who then revised, and the epi task force cleared as well. So it was their clearance. And then Michael, my deputy, and I cleared -- revised, cleared, and then sent it up to Dr. Redfield.

Q So that September version went through the standard CDC clearance process?

A That's right.

Q A couple questions just with regard back to the August guidance. Was there a concern that as a result of the August guidance, there would be a decrease in testing?

A The concern, as I remember, was twofold. One, that contacts weren't going to be tested. And then -- but also concern of sending the message that testing wasn't important anymore. So it was really close contacts. And then with the more general message of the testing is not as important as it once was.

Q Was there any resistance to releasing the revised September guidance from anyone?

A Not that I remember in my role. We were happy to revise that guidance, and get it out as quickly as possible. So I don't recollect any resistance, at least within CDC with that guidance.

Q What about any resistance from outside CDC?

A I don't remember resistance. Again, we had spent weeks working on this guidance, the August 24th guidance. And then a lot of pushback. And then was given the opportunity to revise that. So I think we revised, and then moved on.

Q So you don't know -- is it correct that you're unaware of anyone from the White House or HHS reaching out to Dr. Redfield about the revised guidance and any resistance to it?

A I'm not aware.

Q Do you believe that this revised September guidance was the better guidance at the time?

A Yes.

Q Why is that?

A Because it reverts back to our previous guidance. It was written in a more -- in our usual CDC tone, removed the modifiers of not necessarily. And I felt was more scientifically correct, in that it was promoting testing of groups like those who are close contacts.

Q And I think you've alluded to this, but why did it take the amount of time that it did to

issue the revised guidance in September?

A Well, we put out the August 24th guidance, and then there was a lot of pushback. I don't remember the timing, other than there was some uncomfortable days with a lot of pushback from various groups around our guidance. And then we needed the green light to change. So I don't remember why there was the time period.

Q Okay. Let's move on. In October 2020, the New York Times reported that the White House had blocked an order drafted by CDC in September requiring all passengers and employees to wear masks on all forms of public and commercial transportation, including airplanes and trains and buses and subways and transit hubs like airports. Do you recall that?

A Well, I recall the -- yes, the article that you mentioned.

Q Do you recall the order that CDC had drafted?

A I do remember the order. Things related to public transportation, conveyances, masking on conveyances, a lot of that work was really done between the head of our Division of Global Migration, Marty Cetron. Marty was super-engaged with Dr. Redfield, HHS, Department of Transportation, on

these issues.

And so that was really -- and there were a lot of conversations between Marty and Dr. Redfield and HHS. And in response, Marty was the expert, and a very complicated regulatory space. I was happy for Marty to take that piece, and then I was running the rest of the response.

Q So just to confirm, do you have any knowledge why that order didn't move forward?

A I do not.

Q On October 19, 2020, the CDC published guidance that recommended, but did not require the use of masks on public transit. Are you familiar with that guidance?

A I am not familiar.

Q That --

A I knew about the guidance, but I don't know anything more than that.

Q And again, that might have been something like you just mentioned that Marty Cetron worked on?

A That's right.

Q Director Redfield, Dr. Redfield, publicly called for universal adoption of masks in July. He wrote that, "At this critical juncture,

when COVID-19 is resurging, broad adoption of cloth face coverings is a civic duty, a small sacrifice reliant on a highly effective low tech solution that can help turn the tide favorably in national and global efforts against COVID-19."

Do you agree with that?

A I do.

Q Did you have any role in Dr. Redfield's decision to publicly endorse universal masking in July 2020?

A I did not. I saw the work was being discussed, so I rolled on as incident manager. I don't recall exactly who made that statement, but we were -- when I rolled on as incident manager, we were moving in that direction already.

Q In May 2020, CDC released guidance for bars and restaurants, and subsequently released revisions to that guidance in September, and then again in November. Are you familiar with that?

A I'm familiar with the guidance and -- not necessarily May. I was a bit more involved in September, meaning I remember the guidance and reviewed it.

Q The Wall Street Journal reports in October of 2020 that Office of Management and Budget,

or OMB, Director Russell Vought and other OMB officials had urged Dr. Redfield to remove or change social distancing guidance to bars and restaurants.

The final version retained a recommendation to social distance, but removed more specific language advising people to stay six feet apart, if possible. Are you familiar with that change?

A I vaguely remember this, yes. And -- yes. I don't have detailed knowledge of it, but I do remember it.

Q Do you recall who directed the removal of the social distancing specifics?

A I don't recall.

Q And do you recall how it was communicated to you?

A I don't. I really don't. Michael, my principal deputy, Michael Beach, clearing a lot of documents, was organizing a lot of the guidance pieces. So, if anything, Michael told me about it.

Q Do you recall what your reaction was to that suggestion?

A You know, it doesn't make a lot of sense, you know, indoor space, crowded indoor space. So that's my reaction, that it doesn't seem to make sense. But in -- and this is all dependent upon

community transmission. A lot of these -- a lot of their guidance, we're more flexible when there's low community transmission. But when there's high community transmission, we're much more conservative.

Q Do you recall if anyone at CDC expressed concern or an objection to any of those changes?

A I don't.

Q In a December 16, 2020 New York Times article, Kyle McGowan said that he and Dr. Redfield negotiated with OMB Director Vought over social distancing guidelines for restaurants, as Mr. Vought argued that specific spacing recommendations would be too onerous for businesses to enforce. Mr. McGowan is quoted in the article saying, "It is not the CDC's role to determine the economic viability of a guidance document."

Do you agree with Mr. McGowan's statement about the CDC's role?

A Yes, I do.

(Majority Exhibit No. 15 was identified for the record.)

BY [MAJORITY COUNSEL].

Q I want to show you a document that has been marked Exhibit 15. For the record, this is Bates stamped SSCC-0034459-34462. And while you're

pulling that up, this is a September 8th, 2020 email thread regarding testing strategy considerations for K-12 schools that include you and various other CDC employees.

In the first email in time, which is on the page that's ending 61, Erin Sauber-Schatz -- I'm probably saying her name wrong, but I know you mentioned her previously. She shares a copy of interim considerations for K-12 school administrations for COVID-19 testing, at 11:41 a.m. And that's just up a couple pages, on the page ending 59. You replied, asking for the latest version, and saying, "Have to do another summary of what we are thinking to HHS. Will not share doc."

Do you see that?

A I do.

Q Is that one of those summaries that you mentioned at the outset of our conversation today?

A Yeah, that's right.

Q And could you remind us about how frequently you provided these summaries to HHS?

A We had a weekly meeting with HHS around our upcoming guidance. So at least weekly, we were in touch with HHS about upcoming guidance.

Q Do you recall who requested the

summary -- first, in this specific sense, with regard to this email?

A I really don't. I got requests all the time, frankly. You see us going back and forth, here's the latest, you know, current version. Okay. We were -- I don't know who I was sharing with.

Q Do you recall if you provided the summary?

A I'm sure I did. I mean, this was -- it looks like to me, an ask for me to provide the summary. So this was part of my job, to see where we are with -- this is really around testing. I'm not sure. I'm sure I did share it, but I'm not sure who I was sharing with.

Q Do you recall what the result of sharing your summary was? For instance, did HHS provide any feedback on the guidance?

A I'm sorry, I don't remember.

Q Do you recall what you meant when you said, "will not share doc"?

A I think we're trying to, as much as we could, to not share our whole guidance documents until -- as I said before, we were trying to share summaries of what we were doing, or excerpts or -- dealing with a particular test in question.

This looks like it was related to testing in K-12. And whoever was asking had a particular comment, we were trying to share, but not give our whole document out to outside of CDC. So that was just part of general practice, to try to hold our documents within CDC, our draft documents within CDC until we were ready to publish. And documents change all the way up until the final day.

Q Why did you want to share only summaries, and not entire documents outside of CDC?

A Well, first of all, we were trying to maintain a buffer between CDC guidance versus having people from outside of CDC have too much input in our guidance. We were trying to maintain that independence that we felt we needed.

And, frankly, the other piece is that we were having documents leaked left and right. And so we were also trying to not have, you know -- on whatever the front of whatever paper, our draft guidance, because then -- which happened quite frequently, that we would have a document leaked. This is what CDC is going to say. And then actually, it was just a draft, and we were still in internal discussion. So we didn't want our guidance prematurely leaked, and we also wanted to maintain an independent buffer.

Q Later in the email chain, you wrote to Dr. Redfield saying, "You ok with me sharing this? I can clean up the comments." What did that mean?

A Probably asking Dr. Redfield -- and again, I don't remember this particular document. But I want to make sure that he is okay with sharing information outside of CDC. So I think that, again, I wanted to make sure that before I share things, particularly something related to K-12 schools, which is a hot topic, that the director is aware that I'm sharing.

Q Do you recall his response, by any chance?

A No, I don't. Usually in these cases, he would be okay, as long as, in my judgment, if I thought it was okay. But there's a pro forma of making sure that he's aware, and does he have any concerns.

Q Do you recall if CDC ended up releasing that K-12 strategy or guidance?

A I'm sure we did. I'm not sure when, but I'm sure we released it.

Q But you don't recall if it contained any changes suggested by HHS?

A No, I don't recall.

Q On March 14, 2020, Director Redfield had issued a no sail order for cruise ships due to the risk of cruise ship travel introducing, transmitting, or spreading COVID-19. The cruise industry voluntarily announced it would suspend sailing on that same day. Did you play any role in issuing that initial no sail order for cruise ships?

A I did not.

Q The order, originally set to last 30 days, was extended three times through October 31, 2020. Did you play any role in any of the extensions of that order?

A I did not. This is really a conversation between Dr. Cetron and Dr. Redfield.

Q Okay. Are there any guidance documents that we haven't discussed that were changed, to your knowledge, at the request of any outside agencies?

A Not to my knowledge.

Q Or any that were changed at the request of the White House?

A Not to my knowledge.

Q I would like to switch gears a little bit, and come back to a topic that you touched on briefly before, the MMWRs, or as I understand the full name to be Morbidity and Mortality Weekly

Reports. As incident manager, did you have any role in the publication of MMWRs?

A I was part of the clearance chain of MMWRs. So those publications would come through Michael and I, my deputy. One of us would review, make comments, edit, send things back. We were part of the clearance chain.

We also were part of the early discussions around trying to push our various task forces into writing up an MMWR, based on that outbreak, or trying to reach out to states that we knew actually had an interest in the investigation, and asking them to write that up, so -- and also trying to, within the MMWR -- we were publishing four or five MMWRs a week, or even more, trying to work with the editors on timing of when MMWRs came out, meaning trying to lump certain common themes together.

If we were releasing school guidance on Thursday, we might try to release MMWRs related to school, if there were any in the hopper, on that same day, to have sort of a school theme on that day. So that's how we were involved in the clearance chain. And also trying to make sure we were synced up with the publication.

Q To be clear, as part of your review

process, you were reviewing full drafts of MMWRs, as opposed to -- we've seen just those short summaries.

A That's right, full drafts.

(Majority Exhibit No. 17 was identified for the record.)

BY [MAJORITY COUNSEL].

Q Let's look at a document that's been marked as Exhibit 17. For the record, this is Bates stamped SSCCManual-000064 to 70. And this is a July 27th, 2020 email chain with Michael Beach, who you've mentioned, Charlotte Kent, and you.

In the first email of this chain, which is on the page -- or starts on the page ending 68, and goes a couple pages, Dr. Kent, on July 26th, shared an early release summary of an MMWR regarding the COVID-19 outbreak at an overnight summer camp in Georgia, with a pretty large distribution group, including you. Do you see that?

A I do.

Q And then on July 27th, this is on the page that ends in 65, Paul Alexander responded at 1:53 a.m. Who is Paul Alexander?

A Paul Alexander, to my knowledge, was a special adviser to the director of ASPA.

Q Do you know his role at the time of this

email?

A I think he was the special adviser role. All I know, he was up at HHS with ASPA. So I learned that he had taken on the special adviser role with several of these emails that he started sending.

Q Prior to this email, had you had any interaction with Dr. Alexander?

A Yeah, I didn't know Dr. Alexander before this series of emails. He commented on a number of different MMWRs. I'm not sure if this is the first one he commented on, but I did not know him before he started commenting on these MMWRs.

Q Do you know for about how long he commented on MMWRs?

A It was several weeks, it felt like, that he was engaged. And Charlotte would send out summaries to a pretty large group of people, including HHS, as we discussed before. Paul Alexander started receiving these summaries, and then, I guess in July, started having these types of responses.

Q And, generally speaking, how were these responses from Dr. Alexander received at CDC?

A I think we were confused -- confused someone from ASPA, you know, reaching down, making

very specific edits or questions, having specific questions around the MMWRs that were coming out, almost disagreeing with some of the findings behind the MMWRs.

And then they would have a political tone, as if we were undermining the President, we were undermining Dr. Redfield, we were doing something -- very accusatory in his tone. So it was initially confusion, and then anger. And then it was -- and then Charlotte was handling this, and we were all trying to figure out what to do here.

Charlotte handled it very well, was very professional in her responses. And tried to understand, was there an issue of clarity, or was there a scientific technical issue here that needs to be addressed. And then would write back a nice, professional response.

So I felt that Charlotte, the editor of the MMWR, did a really nice job. But, you know, a number of these emails were flowing through. And I raised it to Dr. Redfield. And he pretty much said ignore Paul. And, you know -- and we sort of moved on.

Q So by ignoring Paul, or Dr. Alexander, that means essentially don't implement his comments in the MMWRs, don't respond to his emails?

A Well, I was asking Dr. Redfield, who is this person? And should we be -- what is this? Are we really supposed to take this level of input from ASPA? And he said, no, ignore that. So that was the general comment to me.

Charlotte was doing the professional response, which was taking all of the comments from Paul Alexander, and looking to see if there was anything there that made sense that actually would improve the clarity of our message. And then writing a note back.

So I looked at this as just a waste of time, and felt that editorial staff with MMWR were all over it. They could handle this. And so I intermittently would see these emails, and I personally ignored and kept on.

Q And I think we're at our hour, but I just have two or maybe three questions, if that's possible.

So in Dr. Alexander's response that we were just looking at, his response included an eight-point list, enumerating various things he would like to be altered or included in the report. Just to confirm, with regard to this particular example, did you ever discuss that list or those enumerated concerns with

anyone?

A I'm looking at the list now. You know, I discussed this with Charlotte and Michael Beach. And Charlotte discussed with the authors and -- we can do this line-by-line, but I read this, and discussed with Charlotte. And she wrote a response back, talked to the authors, and tried to see if there was anything here that would be useful, or would improve the clarity of the manuscript that was coming out.

Q And then Dr. Kent responded, "We do not normally share. Done once before after discussion with Dr. Schuchat. Only comfortable if she approves." What do you understand Dr. Kent's concern about sharing to mean?

A Sharing the whole draft of the Georgia camp report. Again, we would normally share summaries, high level summaries. So the way I read this, this is about sharing the whole document. And Charlotte is saying, we don't want to do this. Only if Dr. Schuchat would approve.

Q And is part of the reason you don't want to share the whole document is to protect the integrity of the document?

A That's right, to protect the integrity

of the document, or scientific integrity of the publication and MMWR. And to provide a buffer from any political interference in the editorial process.

Q Okay.

[Majority Counsel]. We can go off the record here.

(Recess.)

BY [MINORITY COUNSEL].

Q I just have a few questions. You said Dr. Redfield told you to ignore Dr. Paul Alexander; is that correct?

A That's right.

Q Do you know Dr. Kent well?

A I -- well, professionally, yes.

Q Do you respect her professional opinion?

A I do.

Q In a transcribed interview, which feels like it was two years ago -- it might have been -- with Dr. Kent, she said that Dr. Paul Alexander never influenced or affected the integrity of an MMWR. Do you agree with her assessment?

A I agree.

Q Thank you. You also said -- switching gears a little bit, you said it's not the CDC's job to take economic considerations into account while

drafting your guidance. Is that a fair characterization of your testimony?

A It is.

Q Whose job do you think it is to take those kinds of factors into account?

A I think it's HHS, it's the White House, it's the larger U.S. government.

Q So the White House, reading a CDC guidance, and saying, this might put less food on the table of Americans is an okay thought for them to have?

A Absolutely. The White House can have their -- I mean, they're looking at a bigger problem.

Q Do you think state and local leaders, governors, mayors, county executives can also make those kinds of considerations?

A They can.

Q All right. Thank you. My final question. Are there any metrics currently the CDC is measuring that would result in ending the pandemic or moving it into an endemic phase?

A Vaccination rates.

Q What would that metric be?

A Your specific question was around ending the pandemic?

Q Yeah.

A So I mean, we'll follow multiple metrics to plot the course of a pandemic, including cases, hospitalizations, and deaths. And then for -- on the prevention side, one of our biggest tools really is vaccination. And of course, natural infection is part of that, because there is immune protection after natural infection.

So that moment of crossing a critical threshold for -- that the majority of the people are protected, or won't be able to have ongoing transmission, we thought it was going to be in the 70 percent range. And then we had Delta and then we had Omicron, each one more transmissible than the other. So it really depends on the virus.

And so I can't say an absolute number. The more transmissible the virus is, the higher -- well, you need higher and higher models of protection. On the other course, there's waning protection, both from natural infection and from vaccination. So it's an area of active research.

Q So there isn't a number of cases per week, number of hospitalizations per week, number of deaths per week, or vaccination rate, that is -- we need to hit this in order to move on?

A We evolved a bit, and are still evolving and thinking through what that number would be. If you look on our website right now, we have yellow, orange, red, looking at community transmission rates. And blue would be 10 per 100,000 over seven days, which would be really low transmission.

So we would love to be in that range. And if we put it blue is that we could really roll back a lot of mitigation measures. If you look at the metrics right now, the whole country is still red, and we still have very high levels of transmission.

So this is -- it's an area of active investigation, trying to figure out, well, even though we have a lot of transmission right now, our hospitalizations as well, but hospitalizations are coming down, deaths are coming down. I don't know what the new normal, the endemic metrics will be. I think we're still learning with each new variant.

Q Do you think it will become endemic?

A It's a loaded term, endemic, but meaning that the virus could change. I hope this is our last big wave with Omicron. And I hope that we will not have new variants that will cause a lot of new cases, and we'll have more cases and hospitalizations. But I think we need to go through another season, through

the spring, summer, and fall to see where we are. But we have a lot more immunity than we had two years ago for sure.

Q Has the CDC done a study on natural infection or natural immunity?

A Yeah, we are collecting information on reinfections, and trying to look at -- in our serology studies, looking at where to detect between the actual infection -- so we can look at the prevalence of those who have been naturally infected versus those with vaccinations. So there are ongoing studies to try to better understand that.

Q Are there any -- I don't know if you've seen what they've looked at. Are there any preliminary results, anything suggesting -- because I know -- I think it's on your website, for quarantine and isolation, it's either vaccinated or had a COVID-19 infection within the last 90 days or something. Is there anything supporting that a natural infection is only worth 90 days, or is it more or less? How did you come to that 90-day number?

A Well, through studies that we did, and studies that other people did to look at that. One of the issues is that we know that after natural

infection, you have some protection. The question is, how long does it last, so -- and we are starting to see reinfection rates with the original Wuhan virus. We're starting to see Alpha reinfections start to increase after about 90 days.

So that's why we said the 90 days. Now, we have people who actually are have natural infection. And on top of that, have vaccination as well, and then get another dose, and then get another dose. So the more you're vaccinated, along with natural infection, the more your immune response is protecting you. That whole 90-day thing, I think as well, is something that's evolving. We're still looking at the latest data on that.

Q And then you were talking about, like, the vaccination rate that we wanted to get to early on. And Omicron kind of changed that. Delta kind of changed that. Herd immunity is kind of a dirty word, but I think it's well established in epidemiology that it is real. Getting to herd immunity matters. Do you have any estimate on what herd immunity for this looks like, with both natural infection and vaccinated protection?

A Yeah, I don't have a number. And it's -- we have such a difference in vaccination rates and

natural infection rates across the country. It's not very uniform, a lot of heterogeneity. So, you know, herd immunity, as you're talking about it for the U.S., is that it's complex, because of just the various levels of vaccination coverage and natural infection.

So I think without a new variant, with natural infection or vaccine -- vaccination, you know, it should be -- the more we vaccinate, the closer we're going to -- the more protection you have, and the less likelihood we're going to have another surge. So that's a lot of words for not giving you a number, but I don't think I have a number.

[Minority Counsel]. I appreciate it. Thank you, Dr. Walke. That's all we have.

[Majority Counsel]. Thanks, Dr. Walke. I want to keep asking about some questions about MMWRs, as we were talking about during our last session. If we could look at Exhibit 19.

(Majority Exhibit No. 19 was identified for the record.)

The Witness. Okay.

BY [MAJORITY COUNSEL].

Q This is another version of the email thread that begins with Dr. Kent sending a summary of

the Georgia summer camp MMWR summary on which you're CC'd. In the next email up in the thread, Dr. Kent wrote to Michael Iademarco saying, "Amanda called me to say, requested delay by Dr. Redfield and HHS. Delay will make for better timing."

Were you aware of that request?

A No. I'm trying to figure out how much of a delay it was. You know, we were shifting publication of MMWRs constantly. It would sort of depend on telebriefs, or was the manuscript actually ready to go? Was there a last-minute edit? So it was a fluid -- MMWRs, within the week, they were going to be published. Sometimes it was a bit fluid on when exactly they would come out.

Q Let me ask you this. Do you recall that Dr. Redfield was scheduled to testify before Congress on July 31st, that Friday?

A I don't recall, but --

Q Do you recall whether the delay was related to his testimony?

A I don't recall. I don't recall.

Q Charlotte Kent told us during a transcribed interview that the reason it was delayed was so that it would be released after the hearing. The hearing was in the morning, and the article was

embargoed to be released in the early afternoon. Does that sound familiar to you?

A It doesn't sound surprising to me, so I -- yeah, I don't --

Q But it doesn't sound familiar?

A It doesn't sound familiar.

Q Are you aware of any other MMWRs that were delayed at Dr. Redfield's request?

A No. Again, these were -- we put out a lot of MMWRs during that period of time, so I -- it was a machine that was going on all the time. So I don't remember specific instance that Dr. Redfield delayed an MMWR publication.

Q Are you aware of any instances in which an MMWR was delayed at HHS's request?

A I am not. I'm searching in my memory. I am not.

(Majority Exhibit No. 20 was identified for the record.)

BY [MAJORITY COUNSEL].

Q Let's look at another document, Exhibit 20, SSCCManual-000046 to 50. And this is a July 28, 2020 email chain that at various times includes you and Dr. Kent and Soumya Dunworth, discussing edits to the Georgia summer camp MMWR.

On the page that ends in 47, Dr. Kent emails you saying, "Dr. Redfield requested that the Georgia camp report state that the camp followed 'some' CDC suggestions. The authors think this mischaracterizes what was done. They followed all provisions in the Georgia Executive Order, and all but two of the CDC suggestions. Would you be comfortable with the attached edits, which more carefully characterize what was done?"

Just to clarify, was the change requested by Dr. Redfield at odds with the change Dr. Kent was asking you to approve in her email?

A I'm just looking at the email now.

Q Sure.

A I remember this conversation. So ask me your question again? I apologize.

Q No worries. I was hoping to clarify, because I myself, from reading this, am not entirely clear. Is the change that is purportedly being requested by Dr. Redfield at odds with the change that Dr. Kent was asking you to approve?

A Yeah. So I think Charlotte was trying to find a middle ground here between -- Dr. Redfield's point is that the camp didn't follow all the CDC's guidance, which would include masking,

universal cloth face coverings, and ventilation.

So I think -- and the authors were saying they didn't like the word "some." And so I would have to see the edit. But Charlotte was trying to be very precise in the manuscript. I mean, also it felt like the authors here were being a bit unreasonable, because CDC was suggesting universal face coverage. Dr. Redfield, I think, had a point.

So Charlotte was trying to be as scientific as possible in the edit, to reflect Dr. Redfield's concern, and also the authors'. So I think this was -- Charlotte didn't want to use "some," the authors didn't want to use "some," but she understood Dr. Redfield's point.

Q Do you know why Dr. Redfield wanted that change? Why did he want to use the word "some"?

A Well, I think the Georgia camp was important because there was a lot of transmission in this camp, and there was some mitigation measures that were in place -- that were put in place.

But the question is, could have this been prevented or not if they followed all of our guidance? And there was a lot of transmission in this particular camp. And so it's -- the Georgia camp, many points to the Georgia camp manuscript, one

of them, the transmission between children, as far as CoV-2.

The specific question was the mitigation involved in this instance. And we weren't able to really say that CDC's guidance would have been helpful in preventing this transmission, stopping this outbreak, because there's intermittent use of cloth face coverage. This was available -- because we were trying to figure out, first of all, incredibly important manuscript, because a lot of transmission in the camp setting, kids to kids, okay? So there can be transmission among children or young school-aged children in this setting.

And so can we actually take the results of the Georgia camp and make some inference to schools or not to school settings? So that's what was happening in the background. First of all, great documentation, big outbreak in a camp.

So then the question becomes, why did it happen? And if they had mitigation measures in place, which mitigation worked, which didn't work? And they may have used -- they may have put in all the measures that the State of Georgia said to use, but our current -- our CDC recommendations, we were really interested in, if you utilized all of our

recommendations, including consistent use of face coverings, would transmission -- would that have been prevented or not.

And so I think that was the point here. And pointing out to the readership that, okay, they did follow all of these mitigation measures, but they didn't follow these others.

So it's trying to be precise, so that people, when they read it, another camp could actually read this and say, okay, maybe if we put all these measures in place, we'll prevent transmission.

Q Thank you. That's helpful. And we can set that document aside. I wanted to ask you a couple other questions about Dr. Alexander, who we were speaking about before. Do you know, did he ever attempt to stop publication of any MMWR?

A You know, he was angry, in general, about our MMWRs, at least some of our MMWRs. And so I think, yes, there was a time where he asked to review all MMWRs, or to have more oversight in the publications of MMWRs.

Q How was that effort by Mr. Alexander -- Dr. Alexander communicated to you?

A You know, Charlotte was discussing with Michael. We're a small group. And so I think I

learned about it through Charlotte and Michael. I don't remember exactly.

Q What was your reaction to hearing about Dr. Alexander's attempt to review and/or stop MMWR publication?

A I thought it was ridiculous, and such an overreach. And how dare he. And this would be the end of the MMWR, and all of our scientific integrity if he was allowed to review and edit CDC publications. This was -- this would be a red line, I think, for all of us.

Q And why, in your words, would that be the end of MMWRs?

A Then it's not a scientific journal anymore. It's not an independent -- it has no independence. Then it's totally tied to political whims of whoever is in -- whatever administration is elected at that moment. And science, at least the MMWR, the flagship of our science, publication of our science, we feel very strongly should be independent of that political process.

Q Did you have any discussions about Dr. Alexander's attempt to stop publication of the MMWRs with anyone?

A I think ongoing discussions with Michael

Beach. Michael Beach and I were -- we would see each other every day for over a year-and-a-half. So we knew each other well. We supported each other. So this was -- so this attempt to stop publication of the MMWR, we certainly talked about and rolled our eyes, and thought this is -- this is -- yeah, crazy to do this. And tried to move on to more substantial matters.

Q Did you have any discussions about Dr. Alexander's efforts with Dr. Redfield?

A You know, Dr. Redfield and I, as I said previously, had a discussion about Paul Alexander. I expressed my reservations. He told me to ignore it, and that's what I did. You know, and tried to let Charlotte handle it. And I had plenty to work on.

Q So we talked earlier about your priorities when you first became incident manager in July 2020. I would like to now ask if you could please tell us what your priorities were in the fall of that year, starting perhaps in September 2020.

A September of 2020, I mean, obviously, health was paramount, but I think September of 2020, the school year was back in session. We were monitoring the impact of our mitigation measures, the guidance in schools, the institutions of higher

education back in session. We were monitoring, evaluating the impact of our recommendations for colleges, universities.

I'm trying to think through. We certainly were worried about a fall surge, since the winter surge and people move back indoors, it got colder. And so we were thinking through how to prepare for a potential increase in cases, and what kind of -- what we can do really to help state and locals in preparing a potential kind of surge. So I think we were reviewing most of our guidance at that time in that process. That's what I remember.

Q Sure. What were some of those steps or efforts that you mentioned, in terms of thinking about how to prepare for an upcoming fall or winter surge?

A Well, part of it was -- a lot of it was around testing. We had just gone through a time when testing reagents were in short supply, so we were still working closely with the test and diagnostic working group within HHS, trying to make sure that states had the appropriate reagents and assays in place.

We also -- if I remember, antigen testing, I believe, was starting to -- point of care antigen

testing was becoming available. So we were busy trying to do studies related to point of care testing, trying to understand how we could utilize that antigen testing in a pandemic.

Looking at hospital -- or hospital infection prevention guidance, to updating that. Seeing if there were -- it seems like such a long time ago, to be honest. So you know, I think it was mostly around resources, PPE, testing, looking across our guidances, to make sure that we have those plans in place.

And then the vaccine was coming, so we knew that was maybe available in the winter, early next year. There was a lot of work in preparation for distribution of vaccine during that time as well. So that was a big component of it, trying to think through when vaccines became available, who would actually receive the first doses, how we would roll it out. Operation Warp Speed. And how do we interact with them. So, yeah, that's what I remember from that time.

Q Thank you. That's very informative. How were those priorities that you just listed or named determined? Did you set those priorities as incident manager or some other way?

A I believe there was -- you know, there was -- what's the word -- you know, we had a very -- I, the leadership, had a very dynamic relationship with all the task forces. And we met all the time. So one-on-one at 5:30, so we had a list of priorities.

And so on a regular basis, we were thinking through, okay, what's coming up in the next week, what's coming up in the next couple of months, where are we with our holidays? Last fall break, we had a surge. We were ready for that with our comms. So just a lot happening.

So it was -- I set overall priorities that a lot of those priorities were coming from the task forces, as they were thinking through their own specific subjects about what we need to do in the next few months.

Of course, we were having conversations with Dr. Redfield, and Dr. Redfield was having conversations with HHS and the White House. And I was meeting regularly with Dr. Birx. So a lot of interest in terms of what we should be working on, you know, right now, and what we should be thinking about three months from now.

Q Were those priorities that you discussed

successfully carried out or implemented?

A We surged in the winter of 2020, so we weren't very successful in terms of prevention, interrupting transmission. So, yeah, we put our guidance out, mitigation measures out, made our recommendations. And then the fall and winter surge really overwhelmed us. And then we got back into crisis mode of trying to help state and locals with crisis care in hospitals, yeah.

Q Why do you think there was that lack of success in interrupting transmission in connection with the winter surge?

A Well, I mean, first of all, it was a pandemic, still is. And we didn't have immunity, even natural infection or vaccines, as we talked about before, to blunt transmission. And we had uneven take-up really of our mitigation, our recommendation.

So whether that was masking or distancing or -- we didn't -- very divided, really, as a nation in terms of tackling SARS-CoV-2. So we had community mitigation measures and recommendations, but because there was uneven uptake of those community mitigation measures, I think that certainly contributed. But also, as we just saw with Omicron, it will probably

be the biggest public health event of my career. So it was unprecedented times, but -- yeah.

Q Was there anything that the incident response team more broadly did to prepare for the winter surge that you haven't already discussed?

A We had intermittently talked about and been working on in the response, more the stage prevention, plan, to think through if we were at this level of community transmission, we could do this. If we were at this level, we could do this level. It was sort of a much bigger document that laid out the -- what our thoughts were.

So we've been sort of -- and pieces of that made its way into our school guidance, for example, and other guidance. So we, in the background, had been trying to pull together kind of the bigger playbook on the pandemic response. And it just wasn't time to pull all that together. And we ended up taking some of that thinking and translating it into our ongoing guidance. That's what sort of comes to mind when you say that.

I think we had always wanted to have kind of a sort of back of our heels a bit, reacting. And we were hoping to try to get a more -- kind of a much more comprehensive plan on prevention, reduction of

transmission. And for whatever reason, mostly because we were overrun by the fall and winter surge, we were not able to get ahead of it.

But, anyway, we -- yeah, so it the vaccine piece of this, the planning for distribution, and who received vaccine was a lot of effort there.

Q Were there any mitigation measures or other steps that CDC would have liked to take to prepare for the winter surge, but didn't?

A Yeah, I think that we stumbled a bit in terms of our ability. I mean, it's really the communication part was difficult. Getting everyone to maintain some distance or use masks indoors. I felt that we had a reasonable strategy for transmission, and it was more of execution. That and sort of spotty uptake in our mitigation measures that, I think, was disappointing.

Q So that's interesting. What was the difficulty in terms of communication, that that sort of blunted the transmission that you just referenced?

A Well, we sort of got into this back and forth around, you know, individual rights versus community mitigation. And it -- we really felt that the use of masks, especially in indoor settings among strangers, would reduce transmission and would

protect people.

And it -- we felt like we couldn't -- our communication to the American public to protect yourself, protect each other. It didn't really take in all the areas of the country. And we would have loved to have had more testing available, point of care testing, over-the-counter tests, just more testing available everywhere to watch transmission.

So I think that was an area that I wish we could have done more. And so on the communication side, it really was -- unfortunately, we got into this sort of battle over one of our mitigation interventions, especially masks. And then I think that undermined some of our prevention measures.

Q Can you explain a little more what you mean that you were in a communication battle over masks? What you mean by that, and how that sort of started?

A I mean, I may have mentioned this before. We didn't -- we went out with the mask guidance. There was uneven uptake. We didn't have a lot of political cover from the President embracing masks. So that caused even more division. We weren't unified within the U.S. government on the mitigation measures. So it certainly didn't help.

Q Can you speak more to any barriers that might have existed to communicating mitigation measures to the American public?

A Yeah. We -- during that time, we went from, in previous responses, being -- subject matter experts being more available for the American public, or at least taking questions from the media on a regular basis, to really subject matter experts weren't as prominent. And we didn't have as many telebriefings.

I think that was also a challenge. I think our guidance and the whole pandemic is complex. The mitigation measures can be confusing. The testing part can be. So there's opportunities to explain our guidance in more clear, simple terms, and that's usually best done by the people who drafted the guidance to explain it to the American public.

And so I think that we weren't as -- some of our CDC subject matter experts weren't as -- we didn't have as many telebriefings as we had had in previous outbreaks.

Q Did CDC seek to push more messaging on mitigation, but found that it was prevented from doing so by any external forces?

A We put our guidance out. We talked

about the guidance a lot. I think it really was a -- I can't say there were external forces. I look back on it, and think what could we have done differently to communicate better, to try to -- or done our studies a bit faster, or with regard to sort of -- done this better.

I think we put our guidance out. We continually tried to update our guidance, revise our guidance, make it as simple as possible. It was challenging, a challenging time.

Q CNN reported in May 2020 that "CDC officials said they have been muzzled" and that "their agency's efforts to mount a coordinated response to the Covid-19 pandemic have been hamstrung by a White House, whose decisions are driven by politics rather than science."

Would you agree with that assessment?

A That is a pretty strong statement. I would say that we think -- or I think it would have been -- I wish we would have been allowed, or CDC scientists would have been a bit more visible during that period of time. I do think that we have excellent scientists, great communicators, who could speak to our guidance, and better explain to reporters and the American people what we knew and

what we didn't know.

And then also try to dispel some of the inaccuracies that were -- or try to explain really our recommendations. I do wish that we were able to do that, or we would have been able to do that more.

Q And from your understanding, why weren't CDC scientists able to be more visible at that time?

A Well, you know, the COVID Task Force really took over communication, took the lead, really, on communication around public health and recommendations. So CDC was a player with -- in a larger government structure. And so it wasn't CDC's time for taking questions. It really was the COVID Task Force, and leaders within that task force, so -- and I think there's a place for that, for sure. I just wish we had more opportunity along the way for the actual scientists to be more visible.

Q And on what topics would it have been beneficial for CDC scientists to be more visible?

A You know, everything from the role of asymptomatic transmission, our school guidance, certainly masking guidance, the -- what we were learning around the reason to quarantine, reason to isolate. Trying to explain why we thought people needed to isolate for seven to ten days, 14.

Differences between isolation and quarantine.

Q You mentioned that if those CDC scientists had been more visible, it would have been helpful to dispel certain inaccuracies. What inaccuracies were you talking about, and where were they coming from?

A Well, you know, I think this concept that, you know, no mitigation, just let transmission happen, and we'll all be okay. I think that was a dangerous strategy that would cause more hospitalizations and deaths. And I think it would be useful to have CDC scientists out talking about the reasons why we think that's a bad strategy.

I think that conversations around the use of masks and the risk of masks versus the risk of SARS-CoV-2 infections. Even the conversation about long COVID, and what we knew and didn't know about long COVID, and the potential, even if you had asymptomatic infection, there was still this risk of having long COVID. And we didn't really understand what the long-term impact of that would be. And we weren't talking about it a lot.

And so I would like to have -- been able to have that conversation a bit more, that it's not just because you had a mild infection, you were

asymptomatic, everything's great. Be careful because we actually don't know what that means, in terms of long-term. It even might put you at risk for long COVID or some other longer term medical consequence that we don't know about right now.

So I think the cautious nature -- that caution should have been explained a bit more. I guess that's what I would say.

Q Thank you. While you were incident manager, were any CDC officials prevented from doing media appearances that they would have liked to have performed?

A We were constantly looking for opportunities to put -- to have a telebrief or put CDC scientists out front. So there was a new MMWR coming out, we would propose a new guidance, we would propose a telebrief just to explain it. And so that went up through our comms group, and then up to HHS. A lot of it was denied. So we constantly tried to see if we could be out front a little bit more.

Q And did that come to fruition? Were you able to hold more media appearances?

A It was sort of hot and cold. And it didn't feel like there was a lot of rhyme and reason to it. So we would pitch an idea and get shut down

two or three times. And then, okay, yeah, you can -- okay, let's brief on that.

So we kept constantly trying to -- Michael, in particular, kept constantly trying to pitch new ideas, new guidance, new MMWRs. Let's get out in front of this, let's explain it. So I think that was just part of the response.

Q When you say Michael, is that Michael Beach, your deputy?

A Yeah, Michael Beach.

Q And do you know when he was -- when it was a cold period? You said it was hot and cold. So when there was a cold period and media appearances weren't happening, do you know who was preventing them from happening?

A Michael could talk to Nina, and Nina would run it by HHS. And then we would get the no. So that was usually the way it went. It was really Michael and Nina asked for a conversation.

Q Are you aware of any policy while you were incident manager prohibiting media interviews without HHS clearance?

A Yeah, I didn't -- I don't know of any policy. I think that we were -- when I became incident manager, we were -- there was a procedure in

place, where we would -- there would be a conversation with ASPA. So I don't know what was -- I mean, that policy was already in place.

Q What was that policy?

A Well, the policy, as I understood it, was CDC would pitch -- we would try to run it upstairs over to HHS, and see if they were willing to allow us to have a telebrief, or allow us to have this event. So that was the simple policy.

Q And that was in place, to your knowledge, before you started as incident manager in July?

A That's right.

Q But you don't recall or know when it first became the policy?

A No, because, you know, it was -- yeah, I mean, I came on in July, and a lot had happened by that time.

Q Sure. Do you know who established the policy?

A I don't.

Q Are you aware of any instance in which a CDC official participated in a media interview without getting any type of HHS clearance or approval?

A I am not.

Q Are you aware of any acts of intimidation or threats or bullying of CDC employees by anyone at HHS?

A I mean, Paul Alexander was pretty aggressive there. I'm not aware of -- I mean, people with strong personalities, but I'm not aware of bullying. I remember a lot of spirited conversations.

Q Are you aware, I guess, similarly, of any acts of intimidation or threats or bullying of CDC employees by anyone else outside of CDC or HHS?

A You know, Admiral Giroir -- let me roll back to your previous -- was a strong personality. And he could come across as very aggressive. And so -- and different people, I remember, were offended by his style. Thinking through your question. But I'm not aware of any acts of bullying or intimidation. So I would say no.

Q Is there anything else that you were working on as part of the coronavirus response in the months of September to December of 2020 that took up a significant portion of your time that we haven't already discussed?

A No, I think we've covered it. That's

all I can remember.

Q What records did CDC keep of what the incident response team was working on in the fall and winter of 2020?

A Well, we had the weekly priorities from that period of time. We have all the IM slides. We have the incident action reports, the IAP, action progress reports. So those types of documents that we have to look at as events evolved.

And then, of course, you know, if you want to look at how the pandemic evolved over time, we could just look at our MMWRs, you know, over that whole period of time, to see what kinds of things we were working on.

Q Apart from you and Director Redfield, who else was most involved in the response at that time, again being September to December 2020?

A Well, I mean, within my team, our core group was Michael Beach, Christy, Michael's deputy. And so three of us were the core IM team leadership. And then there was Dr. Redfield and then Nina. And then Marty was engaged in a number of the leadership conveyance -- all the conveyance pieces. So that was a whole other side.

Dr. Schuchat, of course, was engaged. Jay

Butler and his role as deputy director for infectious diseases at CDC remained engaged at a high level. And of course, our -- Sherry Berger. She wasn't chief of staff, but she was basically chief -- related to budget and management of CDC operations. So she was also engaged.

Those were the core folks at CDC. And then for all our work on hospital infections and -- Denise Cardo was engaged there, and was division director on Health Quality Assurance. So leadership at CDC. That's what I remember.

Q Apart from what we've already discussed, are you aware of any other instances of political pressure at CDC, including but not limited to instances of political appointees trying to influence public communications, guidance, documents, MMWRs, and other reports, or any other scientific work at CDC, or instances of retaliation?

A I'm not.

Q Would you agree with me that the fact that political pressure -- agree with me, excuse me, that the fact that political pressure was a problem at CDC last year is not in dispute?

A During this whole period, yes, I would agree with you.

Q What impact do you feel that had on CDC's ability to fulfill its mission during the pandemic?

A Well, you know, it's a distraction for sure. And it's a hard question, because we need political support and leadership to get through the pandemic, and to lead nation through the pandemic.

At the same time, we need the freedom for scientific inquiry, and publication as science evolves, and trying to get that out without political interference. And so I think we need discussion and briefing, communication between our political leadership and scientists of CDC.

Also, put in context what CDC scientists are warning, and at the same time, getting an understanding from politicians how to view what we're saying. So there is that dialogue that really has to happen back and forth. But it's really a -- political -- when political interference gets into our technical guidance, and into our recommendations, I think it, as we talked about, can dilute our recommendations, can undermine our recommendations. It can make our recommendations seem less strong than they are. They asked us about our recommendations, whether they can be believed or not. So it just

makes it less effective at an agency when there's overt interference in writing our guidance.

Q And I just want to correct one thing, and I apologize. In my last question, I think I said, when I was asking whether you agree that there was political pressure at the CDC, I think I said last year. And of course, I meant, as you rightly noted, within the scope being the year of 2020. But you understood that, right?

A Correct.

Q What do you think can be done to restore morale and allow CDC to continue to be the great agency that it has always been?

A It's -- we're still in the middle of the pandemic. It's been tough for everyone, especially for the average American citizen, if there is such a thing. So I think that allowing CDC scientists to speak to the science, allowing them a standard or clearance process to proceed without interference.

Of course, continuing to really promote the importance of public health community mitigation measures, and the prevention side of our response, including vaccination and the use of indoor masking, for example.

So I think it's recognition that there is a

role for public health, community mitigation. Prevention is extremely -- is a way to prevent a number of these hospitalizations and deaths. And holding that up is -- as a priority, versus questioning the role of measures.

So I think we've -- we can't complain too much. This is a hard -- it's extremely hard, very tough response with an evolving virus. And so it's always helpful if we are synchronized across the federal government in how we're presenting our recommendations. As I said before, if we're not in sync, then it does feel like more outside of CDC, because whatever we're putting out potentially is undermined. And then in a very tough pandemic, public health event, we won't get the support and leadership that we need.

Q Along those lines, what steps could be taken to maintain the independence of scientific work or integrity at CDC?

A Well, I thought we had a pretty good process by communicating what was -- I think separating our scientific clearance process from the communications side, so that CDC scientific clearance stays within CDC. And then we communicate and we work with the other agencies to make sure to work on

the communication of our scientific guidance.

So I think we have -- well, we had reasonably strong processes in place that certainly were threatened. But, you know, as I said, I felt scientific integrity remained in place. Certainly there was an attempt to undermine that.

Q Your last answer may have covered this, but are there any policies and procedures that you wish were in place that could have protected CDC from the political pressure in 2020?

A You know, thanks for the question. I can't think of anything, off the top of my head. I mean, I think ensuring the existence of systems that we have is most important.

[Majority Counsel]. I'm just looking at my notes here. [Redacted], subject to anything else that you might have, I think that's it for me. So we can either go off the record, or if you have questions and want to hop in now, do that, based on Dr. Walke, your preference.

[Minority Counsel]. We have no questions.

[Majority Counsel]. I think we can go off the record, then.

[Whereupon, at 3:38 p.m., the taking of the instant interview ceased.]

Errata Sheet for the Transcribed Interview of Henry Walke
dated February 18, 2022

Page 13, 289/290. Suggest for clarity change to "…epidemiology program until 2011 that was within the Center for Global Health"

Page 16, 374/375. IDSA, the Infectious Disease Society of America

Page 19, 452. Replace foreign with thorny

Page 21, 497. Admiral Abel from the US Coast Guard was the Admiral

Page 22, 524. Delete "sort of"

Page 22, 531. Delete "sort of"

Page 25, 591. Delete "that"

Page 25, 592/3. Rephrase for clarity, "Amanda was part of clearance in sharing information…"

Page 27, 652. Chuck's last name is Vitek

Page 27, 653. Insert "all sort of ***people*** on Dr. Birx's staff"

Page 31, 750. 500 to 1000 people

Page 35, 845. Insert "of ***management*** of great, incredible…"

Page 36, 871/872. Clarify "I was a CDC leader at one base among multiple bases that were engaged"

Page 39, 939. "provide" instead of "provided"

Page 42, 1019. For clarity insert "…two days before ***symptoms*** were able to transmit."

Page 44, 1066. Change "was" to "were"

Page 47, 1146. Insert "professionals wanted to know *how to protect themselves."*

Page 58, 1423. Insert "We don't want to ***just*** drop our guidance, …"

Page 98, 2436. Delete "I tried to" I think I meant I was trying to remember.

Page 101, 2488. Change to "as sort of waffling, ***when*** that was added."

Page 119, 2927/28. For clarity, delete "we have very—the genetic epidemiology and sequencing…" replace with "the interpretation of sequencing and mutation rates is a very narrowly defined field"

Page 130, 3213. Delete "the issue occurred immediately." Unclear meaning, next sentence clarifies

Page 134. 3298. Replace “ASPA” with “ASTHO”

Page 136, 3341. Replace “test” with “testing”

Page 136, 3343. Replace “test” with “testing”

Page 169, 4187. Insert “***staff*** health was paramount…”

Page 171, 4227. Change “And then the ***vaccines were*** coming…”

Page 173, 4279. Change to “and we didn’t have ***enough*** immunity. …”

Page 174, 4298. Change to “if we were at this level, we could do this ***intervention***…”

Page 174, 4312/13. Change to “I think we had always wanted to have a plan but we were sort of back on our heels a bit, reacting.”

Page 176, 4342. Clarify, … “we felt like we couldn’t effectively communicate to the American public…”

Page 185, 4584. Clarity group was Michael Beach, Athalia Christie, Michaels’s deputy

Page 186, 4593. Change “Sherry” to “Sherri”

Page 187, 4631. Change from “how to view”… “to how ***they*** view”

Page 189, 4670. Clarity insert “questioning the role of ***prevention*** measures.”

Page 189, 4677. Insert comma between “like” and “more”.

Page 189, 4678. Delete “because”