COMMITTEE ON OVERSIGHT AND REFORM

SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

INTERVIEW OF: JAY C. BUTLER, M.D.

Tuesday, November 30, 2021

The Interview Commenced at 9:02 a.m.

Appearances:

For the DEMOCRATIC STAFF (MAJORITY):

[Redacted]

For the REPUBLICAN STAFF (MINORITY):

[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 (CONT'D)

P R O C E E D I N G S

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

BY [MAJORITY COUNSEL].

Q Good morning, Dr. Butler. This is a transcribed interview of Dr. Jay Butler 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'd like to ask the witness to state his full name and spell his last name for the record.

A My name is Jay Butler. Last name B-U-T-L-E-R.

Q And Dr. Butler, my name is [Redacted]. I'm Majority counsel for the select subcommittee. I want to thank you for coming -- well, appearing virtually for this interview today. We recognize that you're here voluntarily and we appreciate you taking time away from your duties at the CDC.

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

A I do not have a personal attorney present. I do have an attorney from the department, Mr. Kevin Barstow.

Q You anticipated my next question.

[Majority Counsel]. So Agency counsel, would you please identify yourself for the record.

Mr. Barstow. Kevin Barstow, senior counsel --

[Majority Counsel]. Kevin, we're having trouble hearing you.

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

[Majority Counsel]. And would any additional Agency staff here introduce themselves for the record.

Mr. Wortman. Eric Wortman, CDC.

Ms. Martinez. Good morning. JoAnn Martinez, HHS.

[Majority Counsel]. And I'd ask my colleagues on the Majority staff to identify themselves for the record.

[Minority Counsel]. Good morning, Dr. Butler. [Redacted] with the Republican staff.

The Witness. Good morning.

[Minority Counsel]. Hi, Dr. Butler. This is [Redacted] with the Republican staff. Thank you for joining us today.

[Majority Counsel]. This is [Redacted] with the Majority staff.

[Majority Counsel]. Hi, [Redacted] with the Majority staff.

BY [MAJORITY COUNSEL].

Q Dr. Butler, I'd like to go over the ground rules before we start. As previously agreed by the

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 this interview will proceed is as follows. The Majority and Minority staffs will alternate asking you questions. We'll have one hour side 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 have an hour after that to ask their questions. We'll alternate back and forth in this manner until both sides have no more questions.

We have agreed that if in the middle of a line of questioning -- well, if we are in the middle of a line of questioning, we may end a few minutes before or go a few minutes past the hour just to wrap up a particular topic. In this interview, while one member of staff may lead the questioning, additional staff may ask questions from time to time.

There is a court reporter on the line who is going to take down everything I say and everything that 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 wait until you finish your response before asking the next question. The court reporter cannot record nonverbal answers such as shaking

your head, so it is important that you answer each question with an audible verbal answer.

Do you understand all of that?

A Understood.

Q We want to ask our questions in the most complete and truthful manner possible, so we're going to take our time. If you have any questions or do not understand any of the questions, please let us know. We'll be happy to clarify or rephrase.

Do you understand that?

A Yes.

Q 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 recall.

Do you understand?

A Understood.

Q If you need to take a break, please let us know. We're happy to accommodate you. Ordinarily, we take five-minute breaks at the end of each hour of questioning, but if you need a break before that, you can just let us know. To the extent that there is a pending question, we

just ask that you finish answering the question before we take a break.

Do you understand that?

A Yes.

Q Although you're here voluntarily and we will not swear you in, you are required by law to answer questions from Congress truthfully. This also applies to questions posed by congressional staff in an interview.

Do you understand?

A Yes.

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

Do you understand?

A I do.

Q Is there any reason that you are unable to provide truthful answers in today's interview?

A Not that I'm aware of.

Q Okay. So the select subcommittee follows the rules of the Committee on Oversight and Reform; and please note 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?

A I believe that I do.

Q Okay. Do you have any questions before we begin?

A I do not.

Q So on behalf of my colleagues, I want to thank you again for participating today. We appreciate how difficult and stressful the last year-and-a-half have been for you and everyone at CDC. We appreciate your hard work and admire your dedication to the country. And I think we realize that this is probably one of the last things you want to be doing right now, so we are very grateful for your time.

I think that a good place for us to start is to ask a few questions about you. I know that you've had a long career at CDC and in public health in Alaska. So I'd like to ask you first about your current position. So you are still serving as deputy director of infectious diseases; is that correct?

A Yes.

Q And how many years in total have you been with the CDC?

A During this time and in this role it has been almost three years now. I started as the deputy director for infectious diseases at CDC in April of 2019. So the majority of my time at CDC has been focused on during the COVID pandemic.

Prior to 2019, I had been with the CDC initially in Atlanta during the 1990s for seven years. I was director of the CDC's Arctic Investigations Program in Alaska. As a federal employee, I was a detailee to the state for about four years. And then 2009, I deployed back to Atlanta from my home in Alaska to be director of the H1N1 vaccine program as part of the pandemic response in 2009. So I returned to CDC in 2019 after being away from CDC for about ten years.

Q And can you walk us through some of your duties and responsibilities as deputy director for infectious diseases sort of at a high level?

A Yeah. So at the highest level, it involves oversight of the three infectious disease centers, the National Center for Immunization and Respiratory Diseases, the National Center for Emerging and Zoonotic Infectious Diseases, and the National Center for HIV, Hepatitis, Sexually Transmitted Diseases and TB Prevention.

Q And who do you report to in the chain of command?

A I report to the director of the CDC.

Q And let's start with January 2020, sort of our relevant time period. At that time, who are you regularly interacting with in CDC's leadership?

A At that time, January of 2020, it was mostly -- other than my direct reports -- you mean upward in the command chain, the CDC director at that time was Dr. Bob Redfield, and then also the principal deputy director who did a lot of the day-to-day supervision, Dr. Anne Schuchat.

Q Were you working directly with the CDC's chief of staff, Kyle McGowan, around that time?

A Increasingly, as we got into the pandemic response, yes.

Q Okay.

A And I had been working with Kyle also in the HIV epidemic initiative.

Q And we understand that the National Center for Immunization and Respiratory Diseases had a meeting in January to activate the emergency operation center and to respond to the pandemic; is that right? This was around January 20th?

A The initial activation of the center's response occurred either December 31st or January 1st. I think the first situation report that I had received from

Dr. Nancy Messonnier, who was director of NCIRD at that time, was on January 1st.

So there were multiple meetings every day, so I'm not sure which particular meeting you may be calling out. As we get into the time around January 20th, I remember it was Martin Luther King holiday is when Dr. Messonnier had contacted me to inform me that we had a case that had been diagnosed in Washington state in a recent traveler from China, and we agreed at that time that there really needed to be an agency activation. So that if -- I'm not sure if that's what you're referring to, but that's when we activated agency-wide using the emergency operation center at CDC.

Q Can you walk us through what that activation entailed?

A Well, it involves establishing a leader for the response, someone who is going to manage the response, and that was Dr. Dan Jernigan, and then organizing the way the different teams would be able to orchestrate the response and, most importantly, support our state tribal, local and territorial partners who are on the frontline of any national response.

I tend to think of the Emergency Operations Center and the activation as a communications tool. It's a way to basically break down the traditional bureaucratic

communication lines to be able to establish an emergency setup to be able to streamline communications between different parts of the agency, both from a support standpoint, but also to be able to have subject matter experts gathered together to be able to work in concert.

Q Sort of prior to that activation, what was the structure of the folks who were working full time on coronavirus?

A So prior to that activation, for the first almost three weeks of the response, it was out of the office of the director of the National Center for Immunization and Respiratory Diseases and really focused on the subject matter experts that were within that center. Although, of course, agency leadership was following closely and getting daily updates. At that time, the response was led by Dr. Messonnier.

Q Okay. And once the incident manager -- the incident response structure was set up, can you just walk us through the succession of incident managers --

A Sure.

Q -- starting with the initial and then moving on?

A Dr. Jernigan stepped into that role and organized the initial response and was in that role until mid-March of 2020, when he came up to Washington to support

the response that was -- the whole of government response that was being led out of the FEMA headquarters at the -- I actually have their name band here, the NRCC, the National Response Coordination Center.

And then Dr. Anne Schuchat was the incident manager for the next six weeks until May 1st of 2020. I was incident manager then from May 1st through the end of June, about eight weeks all together, passed the torch over to Dr. Henry Walke, who ran the marathon and was incident manager until, I believe, September of this year. So about 14 months all together.

Q Can you talk to us, I guess, in broad strokes about that role and what are some of the primary responsibilities of the incident manager?

A Yes. So again, using that analogy of the Emergency Operations Center and the activation as a communications tool, the incident manager functions as a hub channelling information up and coordinating activities below as well as trying to get information down to the front lines as well.

So some of that is tasking, some of it is helping to take some of the information that's developed by the subject matter experts as we developed guidelines and to be able to get them out to policymakers, to the public, to partners at the various levels of public health across the

country.

There's also a prominent role in communications particularly with those partners, as well as there were not infrequent calls with congressional staff as well. So a really broad audience.

And I should stress that the incident manager is not a sole hub of information. It's a very big job. So that at various times through the response, there's been a variable number of principal deputy incident managers. And each incident manager has their own strengths, and so the role of the principal deputies shifts with the incident manager as well to be able to provide the best support to be able to have as efficient of a response as possible.

Q I think it would be helpful for us to focus on this very early period in terms of the first report coming out of China. So when did you first become aware that there was this respiratory illness spreading in Wuhan?

A As I recall, it was December 31st of 2019 in the form of an email from Dr. Messonnier that was sent to myself and also to Dr. Redfield and maybe a few others as well, probably Kyle McGowan and Sherri Berger as well, and Anne Schuchat of course.

Q Were reports like this unusual in terms of unknown respiratory illnesses circulating?

A I wouldn't say it was unusual. This one was a

bit concerning given the link to the market. There were things that certainly maybe less at an intellectual level, but more at a gut level, I think, impacted several of us and made us concerned. So it's always hard to know how an initial report like this may pan out.

And at that time, of course, we had no laboratory results yet. We did have reports of a number of negative tests for things like influenza. So there was certainly concern about what it could be.

And at that point in time, we couldn't even say for certain that it was an infectious disease. So the concern of the cluster was there and certainly our minds were open and wondering what it could possibly be.

Q Speaking for yourself, what sort of gut concerns did you recognize from this report?

A Yeah. It's been almost two years now, so it's a little hard to say exactly. But it was certainly concerning. And my approach has oftentimes been that of a physician, as when you're evaluating a patient who is sick without a diagnosis, what's the differential? What are the possibilities here, and how to pursue each of those possibilities.

That was the work that Dr. Messonnier was already undertaking. So those first few days was waiting primarily to see what some of the results of those tests would be and

also were there more cases being identified.

Also, was there more epidemiological data to suggest that this was a point source from the market itself, or was there evidence of spread outside of the market.

Q What steps did you take in those early days?

A In the early days, it was mainly staying informed by Dr. Messonnier of what was happening in China and getting more information. Primarily, I was on the receiving end of the information at that point, and asking people if there's anything that I can do to help support them to do their job.

Q When in those early days or weeks did other agencies get involved?

A Tell me more about what you mean by other agencies.

Q In terms of communications to the White House or other agencies in HHS. How does that work? After you receive a report like this, you do your preliminary research at CDC. When does this get escalated outside of CDC?

A Okay. Thanks. Yeah. You know, I was not involved in the initial communications within the White House or the HHS. The CDC director was more involved in that. Having been a former state health official, though, I had reached out to colleagues, particularly the

Association of State and Territorial Health Officials, just asking what questions the state health officials might have.

As I recall, during that first week, this really wasn't much on the radar of state health officials.

Q Okay. When did you, if you did, become involved with communications or collaborations outside of CDC in that timeframe?

A It's hard to say because there's not like a sudden switch that's thrown and we start communicating outside of the agency. So I'm not sure I can -- sometime in January is as exact as I can be.

Q Okay. And in terms of what you recall, what did that look like working in terms of collaborating, communicating outside of CDC?

A I don't recall anything remarkable. CDC does not operate in a vacuum, it's part of HHS, and so there's communication between agencies that occurs all the time.

Q Were there daily group calls or was it -- how did the communication take place in broad terms?

A Yeah. During January, there may have been calls that I was not involved in. By late January, there were more calls with HHS, including the secretary of HHS and also the assistant secretary for preparedness and response.

Q Okay. So you became involved in those calls sometime in late January?

A Yes.

Q And what about calls with the White House?

A That might have been more into February. There were calls with the National Security Council that occurred. I don't remember a specific first one, if that's what you're asking. But by the first couple weeks of February, these types of calls were occurring as well.

Q And in broad strokes, now we're talking mid-January to February, what were the priorities for you and for those working under you?

A By that time, we had the evidence that this was a newly emerged coronavirus, a novel coronavirus, one that had not been recognized before, one that had not been known to infect human beings. So we knew by that time we were dealing with something that appeared to be brand new.

The focus at that point became how do we limit spread. And to answer that question we had to understand the epidemiology of the disease; answering questions such as, is there asymptomatic infection? Over what period is somebody infectious? Are they only infectious when they're symptomatic with the disease that came to be known as COVID-19, or does transmission occur from people who have no symptoms at all or have not yet developed symptoms?

The other aspect that was occurring at that time was how do we slow spread as we continue to learn more about this particular virus. You probably remember the term "flattening the curve" became a household phrase at that time. And that's a term we've used in pandemic planning for a long time, to try and spread out the number of cases over as long a period as possible so that the healthcare infrastructure doesn't get overwhelmed, and also to be able to buy as much time as possible until new preventive measures such as vaccines are developed to be able to eventually protect people from infection.

Q I want to ask you about a few of the early steps that were taken. So on January 17th, CDC and U.S. Customs and Border Protection announced that they would begin screening travelers who had traveled to Wuhan in the prior two weeks at three major airports.

Did you play a role in this decision to start these airport screenings?

A Not directly, no.

Q Were you part of the discussion indirectly?

A I was involved in some of the briefings, yes. The quarantine station system and the responsibilities related to control of infectious diseases being introduced from outside of the United States, also our division of global migration, which is in the National Center of

Emerging and Zoonotic Infectious Diseases. So that is under my purview.

Q Okay. And that's led by Dr. Cetron, right?

A That's correct.

Q Maybe on a high level, can you talk about the rationale behind this step that was taken on January 17th?

A Yeah. I think the rationale is that we want to use the -- strike the balance between what's reasonable to be able to limit spread of the infection based on what we know and what could potentially be overkill.

Excuse me. The alarm is ringing here. One moment, please.

[Majority Counsel]. No problem.

The Witness. So the focus was on people that we felt like would be at highest risk of transmitting infection, that is, people who are actually symptomatic.

It gets back to the comments I was making earlier of one of the big unknowns at that time was, was there potential for spread from people who had no symptoms at all. This virus appeared to be fairly closely related genetically to the coronavirus that caused the SARS outbreak in 2003.

In the case of SARS, the peak of infectivity is at the time of peak symptomatology; in other words, the people who are sickest are the ones who are shedding the most

virus. And there was very little evidence in the case of SARS that people without symptoms or prior to onset of illness were highly infectious.

This was an unknown for us at that time with regards to the behavior of SARS-CoV-2. So we focused on what we thought would be the least restrictive means, but also be able to screen out people that would be at highest risk of transmitting into communities in the United States.

Q And I guess that was identified as people who had been to Wuhan recently initially?

A That is correct.

Q Were there discussions about travelers coming from other places? I think that same day CDC released an alert about infections in Japan and Thailand. Obviously the virus had been moving. Can you talk to us about the decision just to focus on travelers who had been to Wuhan recently.

A The focus on Wuhan was really driven by the fact that that was the epicenter. And that was the place where there was clearly widespread transmission in the community; whereas in these other areas, the cases were generally in people who had recently been in Wuhan. So although cases were being identified in other parts of the world, the majority had some tie back to Wuhan.

Q Was there any discussion in CDC about wider

screenings?

A I'm sure there was.

Q Okay.

A I mean, that's part of how we go through the intellectual process, is to look at the whole breadth of options to be able to control a pandemic. I mean, if there had been an order for everybody in the world to stay home at that time, I don't think -- we would have been laughed off. It wouldn't have been reasonable. We didn't have evidence that that was needed.

But you make the best decisions you can as timely as possible based on the data that are available, and continue to strive to get better data to make better decisions.

Q I think a lot of commentators have the benefit of hindsight, and some viewed airport screenings as a missed opportunity to prevent transmission in the U.S. one thing I saw that was interesting on March 4th you spoke at Emory and you talked about these screenings, and you said up to that point, there had been 50,000 of them done and only one had detected an infection.

So I'm wondering what your assessment of this as a tool was in this early period.

A It did not appear to be very efficient as a way to identify cases of infection. It did not really support that there was going to be a lot of asymptomatic

transmission, although the testing data at that time was still fairly limited.

Q If this wasn't effective, what could have been effective looking back?

A Well, I'm not sure that we can say that it wasn't effective at all. I mean, one out of 50,000 is a lot of work to identify one individual. But one individual has the potential of infecting a number of other individuals who then have the potential of infecting yet another group of individuals and spreading out.

So I think it's hard to say what might have been a better approach. I'm sure there's lots of commentators with time to reflect with hindsight being 20/20, but I'm not sure at this point in time I am fully convinced what is the one thing that would have been a better approach based on the information we knew at that time.

Q And what about any -- we've seen this work in other contexts. But in this early period, was there any discussion within CDC about restricting the mobility of travelers after they entered the U.S.?

A Yes. So what you're talking about is the concept of quarantine, giving people the opportunity to be able to separate themselves from other potential exposures in the community until enough time has passed to be assured that they weren't bringing infection into the country.

So one of the key questions in our minds at that time is, well, what is the incubation period for this? In other words, what is the time period between exposure to the very latest time of onset of symptoms or the period of infectivity? And based on the data at that time, it appeared to be mostly in the range of about two to 14 days.

So as we talked about, particularly people coming out of Wuhan where there might be the most intensive exposure, we were really focused on how we might be able to achieve quarantine in a way that would be as safe as possible, but also as least restrictive as possible.

Q Okay. It was around this time that, again, as you said, that the first case in the United States was detected in Washington state on January 21st.

How did that change? Now that that first case had happened, you'd mentioned sort of the formal structure had been stood up as a response. Tell us a little bit about the change in resources after this event, the case being detected here, at CDC in terms of people working full time on coronavirus?

A Yeah. So when you say resources, it sounds like you're saying specifically staffing.

Q Yes.

A This involved pulling more people into the response and also getting a -- working with our colleagues

at the local health department as well as the state of Washington to offer support on the ground. And we did have a team go out to Washington state to help with the evaluation of this individual and help make -- hence, be able to make sure that isolation was as good as possible. Isolation being the instrument for people who are known to be infected to prevent further transmission, and that happened fairly quickly.

I know even at that time there was concern about resources at the state and local level to be able to do the investigation, so our team was able to provide that support.

Q And I'm wondering if you could just tell us specifically, what do you mean by that? Is it people on the ground treating, contact tracing, that came from CDC in terms of the support that you provided the state public health?

A Yeah. So a lot of it was finding out who might have been exposed to this individual and have contact tracing that you're describing. And also, consultation to the hospital where he had been admitted regarding the best way to make sure that isolation was set up in a way that was safe, particularly for the healthcare workers, but also for other patients. And there was also the aspect of clinical management, what was the best way to be able to

treat this individual.

Q Okay. I guess, broadly, what were the important things that CDC learned from these early cases?

A So in the early cases, the numbers were relatively small. There was evidence of transmission within households but not in communities. And so that early evidence suggests that while it was an infectious agent that spread person to person fairly easily, the highest risk individuals were those contacts within the home.

It's important to emphasize, too, that as new variants emerged as time went on, the behavior of the virus can shift as well. So at that time we were dealing with really the original virus out of Wuhan. So looking back at that time may be a little different than what we saw just a few months later with some of the other mutations that occurred in the virus.

Q And looking at some of the other announcements out of CDC around this time, so CDC reported the first instance of person-to-person spread on January 30th and then the first instance of possible community spread on February 26th. I think it's been established by CDC that community spread was happening before February 26, 2020; is that right?

A That's correct. There's evidence that silent

transmission was occurring at a low level on the West Coast, that this was primarily the strain that had come out of Wuhan. And then by late February, early March, we were seeing multiple strains on the East Coast -- again, this was recognized in retrospect -- that was likely multiple introductions from Europe.

The clinical surveillance, based on emergency department data, was not showing major increases in respiratory infections. So it was a small number of cases that were being identified retrospectively. And there was data from, for instance, some of the influenza surveillances that suggested that until we get up into February, as I recall, there was really very little evidence of spread.

There were about 11,000 respiratory specimens that had been collected as part of routine influenza surveillance, and the first positive from those specimens was not identified until February -- was collected on February 20th.

Again, these were tested in retrospect.

Q It seems like an interesting -- I think your discussion goes to this. But this gap between detecting the first case and then detecting community spread, I guess, was January 21st to February 26th.

Looking back, and I understand this is one of these

hindsight questions, what could have been done to detect community spread sooner?

A That's a really good question. It gets back to what I was saying earlier about the unknowns, particularly whether or not people without symptoms could transmit the virus. Because that would change how we move from a response of containment to one of more community mitigation.

And the whole spectrum of the interventions, the goal is to delay the spread for as long as possible and to -- when there is spread in the United States, to be able to stretch that out over as long a period as possible. Again, so that the healthcare system is not overwhelmed and so that we have more time to be able to have better prevention tools for people who are not yet infected.

I think the thing that was most challenging was how this virus behaved differently than the SARS coronavirus even though genetically it was a close cousin. It's like maybe all of us have kinfolk that behave very differently than we might, and that was the case with these coronaviruses as well.

The SARS-CoV-2 clearly can be transmitted from people who never developed symptoms, and the peak of infectivity appears to be at about the time of symptom onset and can begin as long as a couple days before symptom onset. It's

a much more -- therefore a much more challenging infection to be able to contain and to limit spread without more Draconian measures to mitigate in the community.

Q What would be needed the next time a novel virus is detected? What would be needed to detect community spread early on?

A I think --

Q Resources specifically.

A Yeah. Better surveillance would definitely be helpful. I mean, we have systems that are set up to detect certain respiratory viruses where they're very -- it's patchwork, though. There's no national surveillance of etiology of respiratory illness that is really without some degree of gaps.

And in the case of an emerging infectious disease, to be able to have specimens that are banked away, such as the 11,000 that I mentioned from the influenza surveillance, is really a gold mine; yet there were many, many, many more phases of respiratory illness during January and February of 2020 than 11,000.

So I think more complete and comprehensive surveillance would go a long way. Data systems are a part of that as well to be able to understand when a new pathogen is identified or there's an outbreak of known pathogen, what are the possible sources? What are the

opportunities for intervention to prevent further spread?

And then supporting the laboratory capacity, particularly at the state and local level as well as at CDC, to be able to apply new diagnostic technologies as quickly as possible. I'm sure there's more, but off the top of my head those are the three areas that come to mind.

Q Moving forward through the early timeline. On January 29th, the President announced the formation of the coronavirus task force and it was originally chaired by Secretary Azar. At this period, did you have any role advising the White House task force?

A Not that I recall. There were a lot of phone calls and meetings, but I never was a briefer at the White House task force that I recall.

Q Okay. At this time, or at any time?

A Well, there was a lot of evolution in the whole of government response that occurred over the time, so I'm not sure quite how to answer that question.

Q I'm just asking --

A To my knowledge, there was no one group that sort of was the center of everything. So, I guess I'm not sure I really understand the question.

Q Yeah. Let me rephrase, because I think I was just responding to the last thing you said about you weren't a briefer of the task force. Did you brief them at

any point during the pandemic?

A I don't recall --

Q That particular group out of the White House.

A I don't recall briefing the entire group. Certainly I was involved in some calls with Secretary Azar, later on calls with Dr. Fauci. And at that time, Dr. Birx was not yet at the White House, but also with Dr. Birx.

Q Around this same time, January 28th, the CDC advised travelers to avoid all nonessential travel to China. Were you involved in that decision?

A Tell me more what you mean, involved in the decision.

Q Yeah. Were you involved in discussions that led to that announcement on January 28th?

A As I recall, there were discussions around that. It's not a small decision to make.

Q Okay.

A Again, you know, the decisions about limiting travel are really going to be -- are going to come forward from at that point our global migration task force within the response, which was staffed primarily by individuals from the Division of Global Migration and Quarantine.

Q But they ultimately report up to you in the structure?

A No, they would report to the incident manager.

Q Oh, by this time --

A Getting back to incident management and the Emergency Operations Center, the traditional structures kind of become irrelevant in response to the pandemic to be able to assure that there's efficient communication.

Q And let's move to sort of the February timeframe. And I realize these things blend together, so it's hard to recall specifics and you've done a tremendous amount.

So with the benefit of hindsight, a number of commentators have said that critical time was lost in February, and that, in particular, those working on the response spent a lot of time and resources on repatriation involving cruise ships.

I'm wondering if you could tell us broadly about the time and resources spent on that particular issue with the Americans on cruise ships.

A Yeah. There was more than just cruise ships, because we also had people who were being moved out of -- Americans that were in Wuhan, there were several thousand, and giving them the opportunity to return to the homeland, but in a way that was as safe as possible involving quarantine and making decisions about where they would best be quarantined.

Which actually, I guess, highlights an additional

answer to your earlier question; we need better plans of how to be able to provide quarantine -- safe and comfortable quarantine conditions for people who require it such as during repatriation. There's no big facility for several thousand people to be able to be housed when they require a 14-day quarantine on return to the U.S.

So that was a very heavy lift, finding where people could be safely quarantined, and that was a challenge. But ultimately there was housing identified on some military bases that were utilized for that purpose.

Q And my question in terms of the focus in February, I wonder, what's your assessment of that, that too many people and too many resources were focused on the issue of repatriation at the expense of focusing on community spread?

A Well, I think what are the options that are on the table? That we leave Americans in China? Is that what's being suggested? That we just let people come in and return to the community regardless of whether they're symptomatic or not?

So I guess I need a little more guidance of specifically which commentator you're referring to because we get it from all sides.

Q Sure. I think, we have spoken to a number of people at CDC, and I think one point was made and a high

level leader at CDC said that a number of resources -- that you couldn't really overestimate the number of resources that were focused on this repatriation issue and, in that person's words, we were focusing on this smaller issue while the tsunami of community spread was coming.

Looking back, do you agree with that assessment? What do you think could have been done to focus on the larger issue of community spread in February?

A Yeah. Okay, that's very helpful. Yes, I do think that's a fair statement.

And the issue of housing people who are under a quarantine order is not a traditional part of what CDC has done. So I guess, looking back, I'm not sure quite how that fell to CDC, but it did, probably because the quarantine order authority lies with CDC. Although CDC is not a regulatory agency, that is one of the legal authorities that we have.

I think some of the opportunity lost includes being able to prepare the public for what might be coming. I think Dr. Messonnier was doing an incredible job doing that during the telebriefings. And of course, on February 25th, she was very explicit in that and it captured a lot of attention.

Q We'll talk about that telebriefing in some detail later. I want to ask you about other steps -- and I

thought it was interesting, going back to your presentation at Emory on March 4th. You mentioned the shortage of N95 masks in the strategic national stockpile.

Do you have a view on what should have been done in terms of getting those supplies around that time, I guess leading up to your comments in March?

A Right. Well, the strategic national stockpile, by CDC at that time and had not been, as I recall, for about a year-and-a-half. So the question of what might have been done to have a better supply of N95, I think, is quite a valid one.

It also, I think, highlights one of the challenges of the pandemic response at a much broader level is, you know, for a quarter of a century now, increasingly there's been a movement towards just-in-time inventory. And anything that perturbs that flow of resources and supplies in a just-in-time environment creates a vulnerability.

In this case, the increased global demand for personal protective equipment, including N95s, really overstrained the system entirely. And at least in terms of the strategic national stockpile, we weren't ready to respond to that increased demand.

Q Do you have a view of whether the handoff of management from CDC to ASPR in 2018 affected the preparedness of the strategic national stockpile?

A I do not. I'm sure there are many who do.

Q Okay. So moving from February to early March, CDC was obviously monitoring the outbreaks in Europe, and Italy in particular.

Again, at that event at Emory, you said the most concerning hotspot for us right now is going on in Europe, well over a thousand cases in northern Italy and a significant number of cases in Germany, France, and Spain. And of course there's lots of travel to the East Coast -- really to the United States -- well, and all over the United States from Europe.

So tell us about sort of monitoring these things in Europe and what the CDC was doing for the United States for similar outbreaks here.

A So the concern at that time, which is maybe more of my personal view than necessarily things that we were highlighting at our internal meetings, was that -- looking particularly at the situation in Italy, it seemed to be more challenging than what we had heard from Wuhan in January, that the transmission rates seemed higher, the impact of the virus particularly on older persons was really pretty profound, which led to a lot of questions. And at the time, commentators were debating back and forth, had the virus changed? Is it the older population structure of Italy that's driving that? I mean,

these were all possibilities that were on the table.

And as you've already mentioned, the number of travelers between North America and Europe is much greater than the number between China and the United States. So this really opened up a lot more in terms of questions about how could we best limit spread from other parts of the world, and how do we transition from the containment approach to one that's more focused on mitigation based on the assumption that it's -- as Dr. Messonnier said on the February 25th telebriefing -- it's not a matter of if, it's a matter of when.

Q In our discussions with others at CDC, we've learned that there was an internal discussion of broader travel advisories and restrictions and it may have been delayed for some time. Were you aware of that delay, and were you part of those discussions?

A Yeah, the discussion at the time was focused on, as I mentioned earlier, the challenge of transmission occurring in Europe, much larger number of travelers and a larger number of ports of entry from Europe. And, you know, would this make a difference or not? Would it slow introduction of the virus?

So the discussions that I was involved in focused primarily on consistency of application of the policy that was being utilized for containment from China as well as

whether or not the science was indicating that that would be effective at this point in the pandemic.

Regarding the specific timing of the interventions on limiting travel to and from Europe, that I was less involved in the actual timing of the decision. But in retrospect, as we look at the genetic lineages of the virus, it appears that on the East Coast there had been multiple introductions from Europe that had occurred before the travel advisories and the travel ban was implemented.

Q In retrospect, should there have been broader restrictions for European countries earlier on?

A It's hard to say based on the data we had at the time. As we've already discussed, it was debated back and forth.

Q Okay.

[Majority Counsel]. I think I have a couple of minutes left, but rather than opening up a new topic, I will turn it to my colleagues in the Minority.

[Minority Counsel]. We'll take the five minutes.

[Majority Counsel]. So let's take a five-minute break and we'll start at 10:10.

(Recess.)

[Minority Counsel]. Dr. Butler, thank you so much for being here. We have no questions at this time. We'll let you get back to it.

BY [MAJORITY COUNSEL].

Q Dr. Butler, I'd like to take this next hour to talk about public health guidance. I think it would be helpful for us, and I guess we can start -- we can focus in the context of the pandemic response. But if you can walk us through the process for developing public health guidance and public-facing documents that the CDC posted on its website.

A Sure. So the events that lead to specific guidance sort of comes from two levels. One is the messaging that we want to get out to our partners and to the public, and the other is what we hear from our partners specifically requesting from the CDC.

So, for example, as we get into March and early April, we were hearing of outbreaks that were occurring in shelters for people experiencing homelessness. So developing specific guidelines for organizations that provide services to people experiencing homelessness was just one of many aspects of the response.

And also, being able to provide these guidelines to the state and local public health agencies and the tribal agencies that oftentimes have to actually do the boots on the ground public health practice of applying these guidelines.

That interaction between CDC and the local level is

really crucial to try to make the guidelines as practical as possible. There's lots of ivory tower guidelines that could be generated, but it's important to have that communication with the people who are actually on the front lines of the pandemic response to be able to revise those as needed.

The process generally starts with the subject matter experts. And in the incident management team, there was, for instance, the community intervention and at-risk populations task force that focused on specific areas of opportunities to prevent spread. And subject matter experts would often draft these. They would go through a review process within the response and eventually would, particularly at that time, be posted to the CDC website.

The other aspect of that is when the telebriefings were occurring once or twice weekly, to be able to provide updates to the media of what the new guidelines were, what was the scientific rationale, and to be able to make people aware of that information being available.

Q Let's talk about this, to hear a little bit more about the mechanics of this. Let's stick with the context of the incident response and the team working on public-facing guidance related to the coronavirus.

Who would actually do the drafting?

A The drafting would be done by the subject

matter experts on the team.

Q And how would the determination that a particular guidance was needed come about?

A It would be, as I was saying earlier, through a couple of mechanisms. One would be internally as we learned more about the virus. As we saw opportunities to get information out, we would want to take advantage of that.

An example would be as more evidence was accumulating of spread from people without symptoms, the guidelines on masking when in public as a part of the overall community mitigation would be an example of that. We also would get requests from our state, tribal, local partners as well as the territories, do we have any guidelines on specific situations? And so some of the guidelines were developed in response for that.

Q Okay. What about within government? Were there requests from agencies outside of CDC to develop guidance?

A I suppose there were, and I'm thinking of examples. And you raise a good point in terms of one of the partners that I really didn't mention is other federal agencies.

So an example that comes to mind would be the Department of Homeland Security with questions about

protection of their individuals working, for instance, at TSA or at Customs and Border Protection. So that would be an example of a request coming from within the federal government for guidelines. And that continues to a large extent really throughout the response and even today.

Q And what is the approval process within CDC?

A Well, within CDC, it generally is a development of guidelines as part of the response. It goes up ultimately up through the IM or through the principal deputy incident managers and then to the office of the director.

And it depends on what the guidelines are. If it's a matter of a minor change or a clarification, that's very different than a major change. Again, I'll use the example of specifically recommending mask wearing by the public in community settings.

Q And what about input from other agencies. When does that happen?

A Well, it evolved throughout the response. As the response grew from -- response led primarily by the CDC to a whole of government response, there were more players involved in the review process.

Q And before the pandemic, did the White House specifically review CDC's guidance that was posted on its website?

A Not that I'm aware of. But, again, I've only been in this role at CDC since 2019, less than three years. I'm not sure I could say definitively a firm answer to that question.

Q Okay. From our conversation with other folks at CDC, we've learned that Director Redfield while serving on the White House task force was asked to develop guidance for a number of different settings, and CDC went to work developing that. I guess we're talking now in the April timeframe.

Does that sound right?

A That sounds right. But it's important to remember that the White House was also talking with some of the state partners, oftentimes at different levels. They were more often communicating directly with the governors, whereas we might be more likely to be communicating with their state health officials. And, in general, they were the same requests. So there weren't a lot of shocks in terms of what we were being asked to develop.

Q Okay. And can you talk about this process in terms of developing guidance for a number of different settings for the public?

A Yes. So there would be a triage process of the request generally done by the incident manager and/or the deputy incident manager working with task force leads

to identify the right subject matter expert to initially put in the paper and start developing the draft of the guidelines.

And of course that would be done in consultation with other subject matter experts to have the input of what do we know from our own investigations, what do we know from what's being published currently or what's available online.

Q Were there any guidance documents that were not drafted by CDC?

A Tell me more. What do you mean?

Q That were drafted by other agencies and posted by CDC or primarily drafted by other agencies and reviewed by CDC. I'm talking about guidance documents that, in terms of putting pen to paper, it wasn't your folks at CDC doing it.

A Yeah, I was told that happened. I'm not aware of that happening during my time as incident manager. And, again, there were actually a couple of thousand guidelines by the midsummer of 2020. It was fairly extensive. So I can't say definitively that that didn't happen, but I'm not aware of a specific incident that occurred during my time as incident manager.

Q You said you were told that happened. Who told you that happened?

A That probably was from other individuals at CDC. I don't recall specifically a phone call or anything like that.

Q Do you recall which guidance?

A I think there were some guidances related to school reopenings. But, again, I'm sort of stretching my memory on this one.

Q Okay. Let's talk specifically about some guidance documents. And the example you mentioned was the recommendation regarding face coverings. So that's Exhibit 6.

A Okay.

Q Let's just pull that up.

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

BY [MAJORITY COUNSEL].

Q So this would have been released, I guess, prior to when you were incident manager.

A I'm looking for a date. It looks like April 3rd, I believe. Early April.

Q Yes. In terms of when this went up, it looks like April 3rd. Were you involved at all in preparing or releasing this guidance?

A I was involved in some of the internal discussions about this fairly big change in direction. The

accumulating evidence of transmission from people who had not yet developed symptoms was of great concern. As I was mentioning earlier, this was one of the big questions that we were asking as early as January; and, unfortunately, the answer to the question was not the one that we were hoping we would get. So this was a next step to be able to prevent spread in the community setting.

In many ways, in my mind it was an expansion of what we had been saying from early on in terms of using face coverings as a source control method, that is, how to prevent spread of respiratory droplets and small particles from individuals who were infected.

In the very earliest times built on some of the pre-pandemic planning, our recommendation was for people who were symptomatic and needed to go into a healthcare environment to have a mask on, such as a surgical mask, to prevent the likelihood of spread of droplets.

Now that we knew that spread could occur from people who were asymptomatic, it seemed quite rational then to expand that to people without symptoms, because at that time in particular we really didn't know who in the community might be infected and who didn't, and we were at a time when we were seeing a dramatic increase in the number of cases, it made sense to make very broad recommendations for use of masks when in a community

setting, particularly indoors.

Q Can you talk about, when CDC releases a recommendation like this, the importance of public buy-in and getting sort of widespread acceptance of a mitigation measure like that.

A Yeah. It gets back to some of our earlier conversations about doing the least restrictive means and making recommendations based on the best available science and at the right time. We could have recommended school closings and business closings and all kinds of things back in January, but no one would have paid any attention to us at that time.

By the time we get into March, it's recognized that this is a pandemic, many more people recognized the reality of transmission in the United States. One of the challenges though, of course, is that the spread in the United States was not -- was somewhat regional. That first wave in March and April particularly impacted the northeastern United States. There were many parts of the country where people had moved to multiple levels of community mitigation, including business closures, stay-at-home orders, things like that.

And that may have actually contributed to limiting spread in those areas. But as time passed, I think many people became skeptical that they didn't really need to do

that, that this was overblown. We didn't hear that kind of comment from the northeast, which had been really heavily impacted during that first wave of the infections.

So I think, maybe getting back to your question, it's critically important to have buy-in. And part of that involves the timing of being able to point to evidence that it's needed, that it's going to make a difference and provide protection.

Q And when CDC rolled this out, all those things were true, it was needed, the science said it would provide protection, so this was based on sort of that rationale?

A Yeah. The only thing that we didn't emphasize as much, and more data became available, was the actual protection for the wearer of the mask as well. That even though, say the filtration value of my little mask here may not be as great as an N95 respirator, there still is some protection for the wearer as well. And those data accumulated fairly quickly over the next couple of months, and really we were able to use those to strengthen the case for mask wearing.

Q So I think it's safe to say that the large portion of the public first learned about this guidance from an announcement made by the President at a White House press briefing. And he said that he would not -- it was a voluntary thing, he would not be wearing a mask, but others

could if they wanted to.

Do you think that public statement as this was rolled out undermined the CDC's recommendation?

A It's hard to answer that question completely objectively. I mean, I'm not aware of a good control comparison country where the leader wore a mask consistently and firmly endorsed the wearing of masks to be able to compare the differences of impact on community and individual behavior. Of course, Americans behave a little differently than citizens of many other countries, so I'm not sure that would be a valid study anyway.

Personally, I was disappointed to hear the President say that, though.

Q It seems that you by July were publicly -- I mean, in your public statements as the manager, you always mentioned that you were wearing a mask and that masks be part of your personality. And in July, you wrote jointly with Director Redfield about the broad adoption of cloth face coverings as a civic duty and a small sacrifice on a highly effective low-tech solution that can help turn the tide favorably in national and global efforts against COVID-19.

That's well-put. Do you think framing this as a civic duty early on would have made a difference from political leaders?

A It's really hard to say. I mean, it gets at one of the challenges in public health. When you're successful, people assume you're not needed, because it's always hard to document what you have prevented from happening. Also, we tend to love technology. So something as simple as a mask you put on your face is not quite as sexy as the latest monoclonal antibody cocktail or some high-tech solution that makes the problem go away.

But this is true really across public health. When we look at why do we live twice as long today as we did at the beginning of the 20th century, it's not because we have ventilators and left ventricular assist devices. It's because of things like window screens, municipal water systems, vaccines, which really are technology, but they're an old technology now. These are the reasons we live longer.

But people don't want to have national window screen day because we prevented mosquito-borne diseases and control of vector sources. They really want to talk about the high-tech, cutting-edge biotechnology solutions.

Q Okay. And just the timing of this, your public endorsement with Director Redfield of masks in July of 2020, why was that done then?

A I think it was really a consistent reiteration of a message that we had been speaking for a couple of

months, really, since early April.

Maybe to add a little more, public communication doesn't just involve saying it once and walking away. This is sort of my personal learning over the years is I may get tired of saying it, it may become boring to me, but there's always someone for whom it's a new message. And so you want to be consistent, you want to be clear, and if need be, you want to use every opportunity to deliver that message again and again and again to anyone.

I mean, as a state public health official, I once traveled to speak to an audience of two. And I didn't -- would love to have spoke to more people, but having had that opportunity to speak to two people, well, that was two people that heard a message that I'd probably delivered several dozen times, but those two people had never heard it before.

Q And I want to move on to another document and it's marked as Exhibit 7. It's a set of slides that are titled Opening Up America Again.

(Exhibit No. 7 was identified for the record.)

BY [MAJORITY COUNSEL].

Q This set of guidelines aimed towards the states was a joint effort between the White House and CDC. Were you involved directly in working on these?

A No, I was not involved directly. I remember when they came out, though, yes.

Q Okay. Who at CDC was working on these particular guidelines?

A I'm trying to remember the exact date that these came out. Do you have that available?

Q Yes, these were posted on the CDC's website on April 15th.

A Right. So I suspect that was the incident management, the teams that were working during March and particularly during April.

Q Okay.

A That was at the time when we were beginning to see the downward trend from the first wave of the pandemic.

Q And in that context, these guidelines lay out a three-tiered system of reopening and they have steps at every tier. Broadly, were these guidelines based on the best available science related to controlling the spread while reopening?

A I believe that they were. I remember reviewing this when it first came out. I was in more of an advisory role in the response at that particular time; this was just before I came on as the incident manager. And they seemed rational, they seemed well-communicated in that they were relatively simple, and they seemed well-grounded

to me at the time.

Q And --

A Let me say a little more what I mean by well-grounded at the time. Based on what we knew about COVID-19 and the behavior of SARS-CoV-2 in April of 2020.

Q Several states, notably Georgia, immediately reopened after this guidance was released. Was this advisable under what you and CDC knew about the virus at that time?

A I think many of us were using the analogy of a light switch at that time and saying that it's really a rheostat, not a switch. We need to basically back off on mitigation measures and watch what happens, that there's not a drum roll and a symbol crash and, hey, it's all over. Let's go back to 2019.

That is what some leaders wanted to do, however, which I think is somewhat understandable in terms of the impact of community mitigation on local as well as the national economies. But whether or not it was the best public health practice or not, I think, is debatable.

Q Who are those leaders who wanted to just flip the off switch at that time?

A Well, I think you used an example just now. I haven't done a review survey of what different states did, so I can't really give a good answer to that question, but

I think you may know the answers better than I do at the moment.

Q Okay. Did reopenings in those places by those leaders like the governor of Georgia undermine mitigation efforts?

A Tell me more what you mean by undermine mitigation.

Q Did they contribute to the recurrence of the virus? Did they undermine mitigation efforts in other parts of the country?

A Yeah. So maybe the second part is harder to answer. I know it probably created political pressure to basically throw the switch off. In terms of did it support ongoing transmission of the virus, eventually it probably did.

I think, getting back to a comment you made earlier about the acceptability of guidelines and preparing the public for them, the messaging around rolling back mitigation rather than just saying it's over and stopping everything and we're going back and partying like it's 2019 were two different routes that could have been taken. And I think a more gradual rollback of mitigation might have been a better response.

Q And who was advocating the first route that you talked about, the sort of quick return back to normal

life rather than a gradual step-by-step process?

A I suppose it depends which cable news network you're listening to. But most of them had lots of talking heads with a variety of opinions on this.

Q Within government -- you were serving in an advisory role. Who within government was advocating that sort of a quick return to normal?

A Good question. There certainly were people in the federal government advocating for that. Again, it gets back to that issue that we've touched on all morning of the right balance of least restrictive means and the greatest gain for protecting individuals as well as communities.

The impact of mitigation on the economy certainly hurt people as well in terms of being able to have an income, to be able to house and feed a family. If people are losing their jobs, that was a public health downside of mitigation. So it's really a process of balancing the risks and benefits. And the equation that various people use for that calculation sometimes is weighted differently depending on your perspective.

Q And back to the question. I understand the context of balancing, but CDC had its position. Who in government had the counter-position at that time?

A I'm not sure I can really answer that question that there was one -- only one person in government that

had an opposing point of view or wanted a quicker reopening. I'm sure there were multiple.

Q Agencies that you were talking to, maybe not specific people, but entities?

A Yeah. I'm not -- again, I wasn't directly involved in the response in April, so I'm not sure that I can really answer that question.

Q Okay. So this document was released on April 16th. And I guess after you became incident manager, there was a set of guidance documents, a lengthier set, released by the press that was created by CDC, and that is Exhibit 8.

(Exhibit No. 8 was identified for the record.)

The Witness. Yes.

BY [MAJORITY COUNSEL].

Q Okay. Can you tell us a little bit about what this document is and how it came to be created?

A Yes. So for the record, this document looks like probably about 40 pages. So it's not insignificant.

Q Yeah. It's actually 68 pages.

A Okay. But who's counting.

Q And I think it covers seven different settings and has seven pages of decision trees to go along with it.

A Yes.

Q So clearly a lot of work went into this. Tell us a little bit about how this was created and who was working on it.

A Yes. So this was something that was finalized during my time as incident manager, and sometimes used the analogy of a Christmas tree where you wanted to have a theme, you wanted to have a trunk that supported it all, but you had ornaments on the tree.

And so the trunk is the scientific rationale of how we control spread of COVID-19. The individual ornaments are the specific guidance documents. And these are some of the venues that we were hearing the greatest interest from our partners. So schools and universities was one looking forward to the fall, summer camps looking forward to a shorter timeframe for what kids would be doing during summer; childcare facilities, which we knew would be an important part of people being able to return to work; mass transit, again, part of returning to work.

Recommendations for restaurants and bars, that being an important driver of the economy. But also, particularly bars being an area where we had evidence of significant community transmission. Work sites very broadly and, of course, some specific work sites as well, but being able to make recommendations so that people could, if needed, return to onsite work if necessary or be able to provide

the best protection for people who had been in face-to-face encounters such as at the grocery store, really, throughout the pandemic. And, finally, recommendations for houses of worship and communities of faith.

Q So you said you oversaw this document as it was finalized as incident manager. Who created this?

A Each part of it came out of various subject matter experts and teams. As I recall, most all of these came out of the task force focused on community interventions and at-risk populations.

Q And who specifically at CDC led that task force?

A Wow, that's straining my memory. I remember a number of individuals involved, but I don't know that there was -- I mean, there were probably co-leads as well. So there's no one person that comes to mind.

Q Who are the multiple people that come to mind?

A So Dr. Grant Baldwin was one that I worked with particularly on some of the items and documents. Dr. Erin Sauber-Schatz was very involved with some of the community prevention efforts as well at the leadership level.

Q Okay. The public did not see this document, right, in this form, and a number of stories were written about that. Why don't you tell us why the public didn't

see this document in this form.

A I can't answer that question. I don't know. I'm not sure I was aware that -- I mean, aren't these materials that were posted to the CDC website? Certainly some of these pages look like printouts from the public-facing website.

Q They were eventually. But initially these were -- this particular document in this form was released by the Associated Press on May 13th.

So in terms of public reporting, there were stories that reported that officials in the Trump White House had told CDC that this guidance would quote "never see the light of day." Other quotes from Trump officials were that these were documents which were “too prescriptive.”

So obviously, this was finalized under your watch, maybe released under your watch. What was the White House's position on this particular set of documents in this form?

A So some of this as you were saying was draft, so still in development. I mean, when we develop documents, it's not magic. We don't just point a pen at a paper and the final draft pops out of the end of the pen and then it goes right up on the internet. It's a fairly long and drawn-out iterative process, although the pressure is to get it up and out as quickly as possible.

I don't know that I understand all of the pushback that occurred or can say how long that delay might have been. The longest delay would have been with the recommendations for communities of faith. I believe that that draft actually had been sent up the chain sometime in late April and it wasn't finally posted until May 22nd.

Q Yeah. And we'll discuss that in some detail. But the pushback, let's understand that a little bit more. You're sitting on the top of this structure, the people below you are creating these documents working really hard to get these things right and they're being pushed back by other people.

Tell us what you were hearing from your people at this time.

A And keep in mind that the structure as you've described it is not entirely accurate, that this was, by this time, a whole of government response. I think I had already mentioned that Dr. Jernigan was representing CDC at the National Response Coordination Center. So to say that sitting on top of the entire response, I think, underestimates the whole of government response that was occurring at that time and required multi-agency coordination.

Q I'm sorry. Just to be clear, I meant you're sitting on top of the CDC response, and the people who are

working on these documents are in CDC working hard to create these detailed guidance documents and there's pushback from the White House.

So my question is, what were you hearing from your people, the people reporting up to you, about that pushback?

A Well, I think we continued to work on the documents. I mean, it's not uncommon that there's -- a lot of deliberation occurs in any document or guideline that's put out. Let me use a different example, such as immunization recommendations. It's not that every member of the advisory committee on immunization practices walks into the room totally cold, is presented with data, and within five minutes has a recommendation. There's an iterative process and oftentimes there's pre-meetings that occur before the meeting that ultimately leads to publication of a guideline.

So I think for people developing the guidelines, it's not unexpected that questions would be raised.

I'll use another example. The MMWR goes through processes within programs when they're drafted, they go to the MMWR editors for review and decisions about whether or not to publish. Then there's a process where a board of reviewers that serve the function of scientific peer review occurs prior to final publication.

So I don't think everyone was necessarily feeling like this was terribly outside of the ordinary, although I will say it did seem like there were a lot more people providing input than normal because, again, it was a whole of government response, not just a CDC response by this time.

Q So who was involved in providing input?

A I don't --

Q Outside of CDC, which agencies?

A I can't answer that question. It's generally funneled back down to us through the CDC chief of staff, but I don't have visibility on who all outside of the agency was reviewing guidelines.

Q Why wouldn't you? So your subject matter experts are preparing these documents, they're not being released, there are comments from others in government, these documents are the work product of people reporting to you. I'm just wondering why you wouldn't have visibility into what was going on with those documents.

A Yeah. There was a lot going on at that time, but that really is the role of the chief of staff and the director of the CDC.

Q Okay. So you're saying those discussions were happening -- on particular documents happening above you, and you were just receiving them through other people? Is

that what you're saying?

A Well, there's no -- there was no one process that I think could apply to every guideline. So, I mean, it's not as simple as I think you're presenting it.

Q Okay. I think maybe looking at some of the discussions around the faith guidance might be helpful, and I'm going to show you what's been marked as Exhibit 11.

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

BY [MAJORITY COUNSEL].

Q This is a document that's going to be new to you because it's an email that you're not on, but I think it's helpful for this discussion. I'll give you a chance to view it.

A Okay.

Q So this is an email sent on April 26th from Paul Ray, who's an official in the Office of Management and Budget. And he writes, "I'm attaching for your review" -- to several people, including Dr. Birx and Marc Short in the Vice President's office, along with other folks at the Office of Management and Budget and the White House.

"I'm attaching here for your review edits of the current drafts of the reopening guidance and decision trees. These drafts are the product of an agency

resolution processes held over the weekend (with the exception of the faith-based guidance; I am circulating the EOP-preferred version of that guidance, which the CDC has maintained disagreement)."

I want to focus on that last line about the disagreement. At this point, what was the disagreement on the faith-based guidance?

A I don't know. I was not yet back into the response. I noticed that the agency resolution process is lower case, so I want to be clear that that was probably a single call and it was not uncommon to have calls with multiple agencies on, but it wasn't necessarily a set process. So I can't address what those differences were in late April.

Q Okay. But you came on board May 1st, the following week, and the folks underneath you were working on this; and I think they had maintained disagreements about that faith-based guidance through that time, through the time that you were incident manager?

A The disagreements were highlighted most sharply once the guideline was posted.

Q Okay.

A Multiple drafts were moving around, so it's hard to say what points of disagreement were being discussed at that time.

Q Okay. Let's sort of move forward to closer to when it was released. So on May 22nd, I guess Friday, during Memorial Day, the CDC released its faith-based guidance earlier in that afternoon. The President announced the release of this guidance in a task force press briefing.

I think it's worth just briefly going over what the President said. He said, "At my direction, the Centers for Disease Control and Prevention is issuing guidance for communities of faith. I want to thank Director Redfield and the CDC for their work on this matter and all other work they've been doing over the past, which was a long time. I call upon governors to allow churches and places of worship to open right now. If there's any question, they will have to call me, but they are not going to be successful in that call."

So at the point of that announcement, were you aware that the President was going to be making this statement?

A No.

Q Was there any consultation between the White House and CDC about the release of the guidance on this day?

A Yes. So maybe to clarify your question, if you're asking was I presented with a text of what the President was going to say on the afternoon of May 22nd?

No. We were asked to finalize the draft and have it ready to post on the 22nd, and were informed that the President would be making an announcement about that.

So we got the go-ahead to finalize the draft, have it ready for posting probably at least a day before the actual announcement by the President. It didn't necessarily have a long lead time of awareness that the President was going to be announcing that, or that that would create a -- part of the -- say the tick tock for when we needed to get it up on the internet.

Q Okay. His statement that he called upon governors to allow churches and places of worship to open right now, is that something that was outlined in the guidance?

A The guidance doesn't address that, no.

Q Is that something you would have recommended, that all houses of worship open right then?

A I wouldn't have, no.

Q Why?

A Because I think at that point in time we were still -- again, it's the question of is it a light switch or a rheostat? Do we begin a process of reopening or do we say we're going to live like it's 2019? It sounded like just saying we're all going to go back to doing what we did in 2019, which is part of what created 2020. So that gives

me a great deal of pause.

Q Would -- and I think the guidance goes into this. Would opening up houses of worship in places where there was community spread pose a public health risk?

A I think any gathering could potentially do that. The virus is not a virus of faith. It doesn't decide it's going to go to bars rather than churches. It's transmitted person to person. So wherever people gather, there's an opportunity for spread to occur without certain steps being taken to reduce the risk of that spread.

Much of what we knew at that time was based on some of the outbreaks and clusters of cases that we had seen. There was a cluster of cases that occurred at the choir practice in Washington state. There was also a fairly high attack rate that occurred at a church in Arkansas. Both of these outbreaks were reported in the MMWR. So those are some of the experiences that I take very seriously and which went into the drafting of the guideline.

Q Those outbreaks in the MMWRs are – I am sure you are very familiar with them -- but they are included as Exhibits 9 and 10.

(Exhibit Nos. 9 and 10 were identified for the record.)

BY [MAJORITY COUNSEL].

Q I'm wondering specifically about this setting,

and what were the risks related to the coronavirus that became clear from those studies?

A So the risks are like any other venue, where you have people gathering, particularly in close contact with -- in close proximity to one another increases the chances of transmission. That can be mitigated somewhat by mask wearing, by hand hygiene, ideally by some degree of social distancing also, and limiting the number of shared objects.

That is a change from how many churches operate as well as synagogues and perhaps even mosques. Focusing on Protestant worship services, it's not uncommon that there's a period of greeting, people will shake hands or even hug. So it's practices like that that would give me more pause than say people just gathering together to pray or to hear a sermon.

Based on the experiences at the choir practice and also what we know about droplet and airborne-spread diseases, the more forceful the exhalation of breath such as what might occur during singing or shouting is concerning as well, particularly without a mask. So the way that people might worship through song might need modification during the time of the pandemic as well.

Q How --

A Just as people are working remotely, many,

many houses of worship provided online remote worship services as well.

Q Yeah. It's interesting that both titles highlight the attack rate. How did that compare to other settings in terms of the transmission? I guess in the Washington state study, there were 61 people who attended the choir practice, 53 cases, 33 confirmed, 20 probable, three hospitalized, two died. And then in Arkansas, 35 cases among 92 people.

Can you talk a little bit about that attack rate relative to others in other settings?

A I don't think it would be valid to do that. They focused primarily on differences between SARS and COVID. But here's one of the similarities, is that certain instances that are still fairly ill-defined are what we call super spreading events, where one person for reasons that are still, I think, more theoretical than really understood, is successful in infecting a large number of other persons.

These two outbreak reports show that it could occur at a choir practice, it could occur at a church. But there were many other outbreaks as well that were occurring in other venues with relatively high attack rates. I think part of what helped with gathering data from these two instances is they were fairly discrete exposures, whereas

assessing what might occur, say, at a restaurant or bar where people come from all over the community into that one place and then go out again and being able to track all of those people down and come up with an accurate attack rate is somewhat challenging.

So the bottom line is, first of all, the attack rate in a specific venue is not a constant because it's a super spreading event. And methodologically, it would be very difficult to have valid data to be able to compare, say, a church service to a bar to a school to a congressional hearing.

Q Okay. But the study did find, as you said, the act of singing might have contributed to the transmission here, at least in the Washington state example.

A Yeah. Actually what I said was that we know from other respiratory pathogens that a forced exhalation is going to generate more droplets or, in the case of an airborne disease, more respirable particles. That's true with tuberculosis, for example.

When we talk about forced exhalation, it's more than just singing. That would include shouting. It would include breathing heavy such as during aerobic exercise, particularly in an indoor environment. We haven't mentioned gymnasiums, but we also were investigating

outbreaks that occurred in exercise classes at the same time.

So the common denominator there appears to be the forcefulness of the exhalation. So when we look at the continuum of risk, quiet is better than loud. I try to tell my kids that.

Q Yeah, I know. I was going to say that's generally a good philosophy.

[Majority Counsel]. I have another document to show you, but I think my hour is up, so I will flip it to my colleagues on the Minority before showing you the next exhibit.

[Minority Counsel]. We'll do another five-minute break.

(Recess.)

BY [MINORITY COUNSEL].

Q My name is [Redacted]. I work for the Republicans on the committee. I just have a couple questions for you.

You spent a lot of time during the last hour talking about Exhibit 8 on the Guidance for Implementing the Opening Up America Again framework. [Redacted] had mentioned how there were rumors that one official said these documents should never see the light of day.

Do you remember that exchange with him?

A I was not in the room when that was stated.
Q I'm sorry, do you remember the exchange that the other counsel just mentioned half an hour ago?
A Oh, yes. Yes.
Q But you have no firsthand knowledge of anybody saying that, correct?
A No.
Q Now, when these documents ultimately made it out into the press, were you the incident manager at that time?
A Which specific document are we talking about? Exhibit 18 is Overview of Testing for SARS-CoV-2.
Q I'm sorry, Exhibit 8. Eight.
A Oh, okay.
Q I'm sorry.
A Okay. Oh, yeah. We're back to the 60-some page exhibit.
Q Yeah, the 68-page beast. Exhibit 68 will be its subtitle.
A Okay.
Q Were you incident manager at CDC when these documents made it out into the press?
A Yes.
Q Were you aware, prior to public reporting, that the press had obtained these documents?

A No.

Q Are you aware of anybody in CDC who shared these documents with the press?

A No.

Q Were you pleased in your role as incident manager that these documents had made it to the press?

A Well, my concern at this point in time, they were still in draft. As I said earlier, there's a process of finalizing guidelines; and so that is always disturbing if something comes out that really may not be entirely correct, has not gone through the full scientific review, that's one concern.

The other is because implementation of the guidelines oftentimes involves our state, tribal, local, territorial partners, our preference is to be able to give these individuals a heads-up. The last thing that we want to have happen is a governor at a press conference being asked about a new CDC guideline, the governor turns to their state health official standing at their right hand, and the state health official shrugs they don't know what the question is about. So that's something we really try to avoid.

And also, those partners provide really critical feedback to us as well. So when something in draft form is published by the media, the first thing I try to do is see

if there's anything that we think is technically incorrect that we need to intervene and provide correction on.

Q Did you have any discussion with the media after these had been published in the draft form in the day or two after?

A I did not. Not that I recall.

Q Do you know if any media members had tried to contact you?

A I am sure they did, but I don't recall any conversations with media.

Q Would you ever talk to media members who tried to contact you regarding CDC responsibilities without getting proper approval to do so?

A In general, I try to avoid it. Sometimes -- particularly at that time, I answered the phone when it rang even if it didn't show a caller ID number or a name that I recognized. But sometimes there'd be a reporter on the other end.

Q And what would happen if there was a reporter on the other end? Would you normally speak with that reporter?

A I generally tried to defer them to the Joint Information Center as part of the IM response.

Q Are there reporters that you have relationships with either through your time at CDC or

through your time working as CMO in Alaska?

A Yes. You do talk to some of the same people again and again. In fact, speaking of Alaska, I had a radio show in Alaska on the Alaska public media network. So, you know, I even have Facebook friends that I suppose you would say are reporters because I worked with them particularly in the public radio circuit.

Q So in regards to Exhibit 8, when these documents were published by the media, did you do any type of internal investigation or oversee or authorize any type of internal investigation to find out how they were shared with media?

A I did not. Now, whether or not there was other investigation that occurred, I think that would be a question for others at CDC.

Q What's the universe of people that had access to this document prior to its distribution by the media? Are we talking five? Fifteen? Thirty?

A You know, I really don't know because there's different components of it that were developed by different subject matter experts. In terms of the entire package, I don't know the whole direction list that it might -- who might have had this in their hands.

Q But you had access to it prior to its distribution to the media?

A I believe I did, yes.
Q Do you know who Dan Diamond is?
A He is a reporter. I don't recall offhand who he's with.
Q Have you ever spoke with Dan Diamond?
A Certainly during media briefings.
Q Speaking of media briefings, in your role as incident manager, did you conduct any CDC teleconference briefings?
A I did. I can think of at least three. One that occurred specific to the release of an MMWR in late May.
Q Okay.
A One that was a general telebriefing in early to mid-June. And then one more that occurred later in June. There may have been --
Q So three telebriefings that you can recall during your time as incident manager?
A Yes, that's correct.
Q And just to close the loop here, the documents we've talked about in Exhibit 8, you don't know how the press obtained them and you said you had nothing to do with the press obtaining them; is that correct?
A No, I would not want to have a draft released. I would want to make sure that it's technically correct.

[Minority Counsel]. Thank you very much.

BY [MINORITY COUNSEL].

Q Dr. Butler, I just have one question. So you said Exhibit 8 was a draft. Would deliberative drafts -- what's the scope of people that would see a draft like this? Is it just within CDC? Is it CDC/HHS? How many people would be involved with it at the stage that it was released?

A That's a very good question. I would like to know the answer to that, myself, now that you've piqued my curiosity again. This was about a year-and-a-half ago.

Q Yeah, I understand.

A It hasn't been top of mind, but I certainly was wondering how this had been released.

Q In kind of normal course of business, I don't know how close this is to a finished copy, but when would a draft guidance of this caliber or importance be shared outside of CDC?

A I don't know that there's one answer to that question. It depends on, again, getting back to that question of is it a clarification or is it a completely new direction in our recommendations.

Some of this in many ways is, as I was saying earlier, a Christmas tree that's intended to have a theme and to be technically consistent across the venues. So the

process is going to depend. Somewhat in terms of sharing actual written drafts, more often, there's briefings that occur or consultations that may occur with partners so that we can get feedback to make sure that we're thinking along the lines that are going to be practical in frontline public health practice situations.

I mean, I can make all kinds of guidelines and recommendations, but if they're not useful to the state health officials, the city and county folks, the tribal leaders, it's really irrelevant.

Q You said usually it's a briefing with stakeholders to understand what they need or what they can or can't do.

A I think it's a process more than an event, I would say.

Q Yeah.

A It depends on what it is we're discussing.

Q Would it be common then to share actual drafts with stakeholders for comment, or would it be more of an oral situation?

A It could be either one.

Q Okay.

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

BY [MAJORITY COUNSEL].

Q Dr. Butler, we can take a five-minute break now, but if you're good to go, we can just keep moving along.

A I'm fine to keep plowing on.

Q Okay. I'm going to continue on what we were talking about the faith guidance. And there's three exhibits -- three related exhibits that I think would be helpful for you to have out: Exhibit 12, which is a version of the guidance that was posted on the CDC's website on May 22nd; Exhibit 13, which is a version that was posted the following day on the 23rd; and then 14, which is an email chain between you and it looks like some folks who were working on this guidance.

(Exhibit Nos. 12, 13, and 14 were identified for the record.)

The Witness. I'm just looking to make sure that -- okay.

BY [MAJORITY COUNSEL].

Q Okay.

A I think the way you described them is correct.

Q Okay.

A Which one is the 22nd and which one is the 23rd?

Q So 12 is the 22nd.

A Yes, confirming.

Q And 13 is the 23rd. But before we get to these documents, I think our discussion involving those two MMWRs was informative, and just so we know the timeline, those two were released in May, in mid-May.

Does that sound right?

A I believe so. And I think actually the church outbreak is one of the other exhibits.

Q Oh, yes.

A And looking at it, it was published on May 22nd, which -- so, anyway.

Q And the lessons that CDC learned from that work in Arkansas and Washington, did that inform the guidance that you put out?

A Certainly. Not in isolation, but in the context of everything we were learning about transmission of SARS-CoV-2.

Q And what were some of those lessons from those studies?

A Well, it reinforced the concepts of person-to-person transmission; that it can occur in any venue where you have people gathered in close proximity; that the concepts of forced exhalation leading to potential generation of more infectious particles applied to COVID-19 as it does to a number of other respiratory infections; and that the gathering for either choir practice, whether it's

secular or sacred, or gathering for worship is not -- it's not really different from any other gathering from the perspective of how the virus is going to behave.

Q Looking at Exhibit 14, the email chain, and let's scroll down to the second-to-last page which has, I guess, the first email in this chain, and the subject is Faith-Based Guidance and COVID-19, A History. And that was sent by Jennifer McQuiston on Saturday, May 23rd at 7:50 p.m.

So who is -- I think it's Dr. McQuiston; is that right?

A Yes, Dr. McQuiston.

Q McQuiston. Sorry.

A Yes. She was one of the principal deputy incident managers.

Q Can you give us a little context for this email and why it was sent that Saturday?

A Yeah. So as we were discussing earlier, we got the go-ahead for putting up the faith-based guidelines -- I should call them the community of faith guidelines -- a little earlier in the week. So we were working on finalizing the draft to make sure it was consistent with the modifications that had been made for the guidelines in the other venues. And then we were informed that the President himself would be announcing the

posting of the guidelines, and that created a tight timeline to get it posted.

So we were successful with that on the 22nd. And, to be honest, we moved on to other pressing topics. But late in the day on the 23rd, we were informed that the draft that had been posted was not the one that had gone through the entire clearance process. Which certainly created a lot of concern, especially on my part, knowing that we had really rushed to be able to get this posted -- finalized and posted as quickly as possible, and created some uncertainty in my mind of whether or not the wrong draft had been posted.

Q What was the clearance process for this document?

A The clearance process -- let's start with the clearance process in general of the documents that came out of the response through the incident manager and the principal deputies would go to the office of the director, generally be channeled by staff or the chief of staff himself to the department. From there, where all it went, I don't entirely know, but we would receive comments back. They were generally anonymous, although they would also sometimes have an agency attached to them, such as an OMB comment, use that as an example.

What was different about this one was because of the

time rush, it sounds like there was multiple drafts that were going into the clearance process in different streams simultaneously. So my concern on the evening of the 23rd is that somehow a draft that had incorrect information had inadvertently been posted or had language that might potentially be offensive or something -- something was not right was my concern.

At that time, it wasn't until later in the evening that I had -- I didn't have the luxury of you providing me with Exhibit 12 and Exhibit 13 so that I could do the head-to-head comparison. So we had to gather those, working with Dr. McQuiston, and spent time through the evening cross-checking across the drafts to find out whether or not the draft that had been posted had any egregious errors in it.

And my conclusion of that review, along with Dr. McQuiston's review, was no, it did not. And in fact, the draft that had been provided to us as the cleared document actually softened some of the recommendations in ways that we found concerning.

Q Let me start with, what created the time crunch on this particular document?

A Okay.

Q What was it?

A Oh, I'm sorry. We were not aware that the

President would be announcing that the guidelines had been posted. So it was nice to be able to have one of our guidelines called out from the bully pulpit of the White House, but we did not have a lot of lead on being prepared for them.

Q And going into the background, I think Dr. McQuiston's email here on number 1, it says that, "CDC's original community mitigation guidance was crafted in April 2020, included guidance for churches and faith-based organizations."

So is that a reference back to that 68-pager and that guidance that initially had that included?

A I believe it's more of a reference to what I was calling the Christmas tree --

Q Okay.

A -- package. There's probably better analogies to use, but it is November 30th.

The package of guidelines that all tied together in terms of what were the consistent interventions to reduce transmission and how they would be applied in these seven different settings.

Q Okay. And it seems that in May, so after you came on as incident manager, CDC was instructed to publish that document in pieces with the faith-based guidance stripped out.

Were you aware of that instruction?

A That was my understanding. Again, you know, the reasons for the sequential posting rather than posting all as a package, I had no visibility on that.

Q Where did that instruction come from?

A I don't actually recall, or I may not even know.

Q Okay. It seems like it was spelled out in this email, but redacted in May, blank, either a person or an entity it seems likely, instructed CDC to publish that document in pieces, but you're saying you don't recall who that was.

Then the announcement from the President on May 21st. Was there any coordination about this guidance going out and the President making that statement on May 21st?

A Well, the 22nd was his announcement. And we did learn of it. As I recall, I learned of it that morning. Whether or not there were other people at CDC that were aware that he was going to make that announcement, I can't say.

Q Okay. Here it says, "On May 21st, President Trump announced to the press that we would be publishing faith-based guidance." And then there is details about --

(Transmission interference.)

(Reporter read back.)

[Majority Counsel]. I'll start from "May 21st."

BY [MAJORITY COUNSEL].

Q "On May 21st," it says here, "President Trump announced to the press that we would be publishing faith-based guidance."

And then this email goes into some of the steps they took to -- they used the language that had been stripped out.

My question is, were you aware that that announcement was going to be made to the press on May 21st?

A Yeah, I don't recall any awareness of that. What I recall is the morning of the 22nd being informed that he was going to be announcing the faith-based guidelines. I suppose there might have been two different press events. I think you quoted from one of them on the 22nd earlier regarding the call to governors. And I remember that one as kind of our benchmark for when we needed to get the guideline up as quickly as possible.

In terms of what happened on the 21st, I mean, there were a lot of things happening. There was a lot more going on in the response than just faith-based guidelines. So it's possible that I don't remember it. It's possible that, as we were all doing different parts of the response, that that wasn't seen as critical as some of the other issues that we were briefing out on that evening of the

21st.

Q Okay. If it refreshes your recollection, I think what the reference here to is that on May 21st, President Trump had a press event at a Ford plant and he made a comment to the effect of the CDC is going to be releasing guidance.

A One of the things the incident manager does not do is sit and watch TV. So let me be clear about that. We do have video monitors in the EOC, so certainly glance from time to time. From the 22nd, I remember very specifically seeing the President on one of the screens or probably multiple screens with the tag line regarding the communities of faith guidance.

But there were many things going on in response. So I was certainly not tracking every event the President spoke at. And it doesn't mean that we necessarily would have been briefed out on every one of them, either.

Q Was this a typical process, that the President makes a statement to the press about CDC releasing something and then CDC scrambles to release that thing?

A Well, we were -- you've already asked about -- the draft of the guidelines had been developed several weeks earlier. And so we were hoping to be able to get it out and we were very pleased to hear that we would be able to post it. So the scramble was to make sure that

nothing had changed over a period of a couple weeks that would put it in conflict with the final draft of the other venue guidelines that had been posted as part of the overall Christmas tree of guidelines.

Q Okay. Moving on to the next numbered paragraph here. The email states, "Because this happened so fast, CDC, OGC and internal reviews continued in parallel to that process. We received and incorporated additional revisions that had been requested by CDC, OGC and internal SME and leadership review."

Do you recall who the internal subject matter expert was who reviewed this guidance?

A I don't.

Q And what about the leadership review. Would that have gone up to the chief of staff or the director?

A I don't know if that's in reference to the IM leadership, which would be Dr. McQuiston and myself, or up to the office of the director. I tend to think in terms of the latter. I can't say for sure.

Q Okay. And moving on to the next paragraph, the guidance came back as "cleared" via Kyle McGowan.

What does that mean, cleared? What is that process that involves Mr. McGowan?

A So as I mentioned earlier, that when the guideline was ready to go from our perspective in the

response, it went to the office of the director, but then took it to whatever clearance processes or reviews or just heads-ups that needed to occur outside of the agency.

And oftentimes, that feedback would come back through the office of the chief of staff as well. I shouldn't say as well, but primarily through the office of the chief of staff.

Q Okay. So essentially Mr. McGowan was sort of controlling the traffic on these documents; they would be cleared by him, and then he would go outside CDC?

A He was a huge assist to be able to help us to make sure that we had our I's dotted and our T's crossed.

Q And then the email goes on. "We requested and provided a 'tracked changes' version from the White House so we could add those changes to the master document."

Who were the people at the White House who provided those tracked changes?

A I don't know. As I mentioned earlier, comments that we received back did not have names. Sometimes they might have an agency on them, but they were generally anonymous.

Q Okay. And did these comments have an agency attached to them?

A I don't actually recall on this particular one.

Q Okay.

A And again, we're referencing a description of that cleared document to me. You probably have the information that I have in the form of the email.

Q Right. Well, there were also press accounts of who was involved. So it's been publicly reported that Kellyanne Conway, assistant to President Trump, was a driving force behind these changes and provided line-by-line edits of this guidance. Do you recall her being involved?

A I don't believe everything I read in the press, so I am not going to comment on that.

Q Did you speak with Kellyanne Conway about this particular guidance document?

A No.

Q And according to The Wall Street Journal, Conway, along with White House budget director Russell Vought, and Roger Severino, who was then the head of HHS's office of civil rights, were also involved in line-by-line edits.

Did you speak with Mr. Vought about this document?

A I did not.

Q Did you speak with Mr. Severino?

A No.

Q Did you become aware that Ms. Conway -- not

asking about direct conversations -- but from conversations with others, did you become aware that she was involved in line-by-line edits of this document?

A Only what you've already quoted from the media.

Q And did you become aware of Mr. Vought through other sources, not direct conversations?

A No.

Q And what about Mr. Severino?

A No.

Q And any others from outside of CDC that you spoke to about edits to this particular document?

A Not prior to its posting, no.

Q And what about after its posting? I'll ask you those same questions.

A One moment.

(Pause.)

A Sorry about that. So on the 23rd, on Saturday, I was contacted by the White House and spoke with someone in the Office of the Vice President. I actually don't have any notes from that call and I don't recall with any certainty who that was that I spoke with.

Q But it was someone from the Office of Vice President, you do recall that?

A Yes, that's correct.

Q What did you discuss?

Mr. Barstow. Steve, I'm going to instruct Dr. Butler --

(Inaudible.)

The Witness. Did you hear?

[Majority Counsel]. I did, and I'm going to ask you to state your objection for the record.

The Witness. Why don't I mute and let Mr. Barstow speak.

Mr. Barstow. So that's a conversation the Executive Branch has an interest in protecting, [Redacted].

[Majority Counsel]. To be clear, Kevin, are you asserting Presidential communications privilege or deliberative process privilege or some other privilege?

Mr. Barstow. I'm just saying there is an important confidentiality interest in that conversation.

[Majority Counsel]. Are you instructing Dr. Butler not to answer that question?

Mr. Barstow. Yes, I am.

[Majority Counsel]. But you're not asserting a particular privilege at this time?

Mr. Barstow. It's based on deliberative process, but there's an outstanding interest in protecting conversations within the Executive Branch.

[Majority Counsel]. I think we disagree about the

basis of this assertion at this time, and we're going to ask, I think, some questions to set up the record, but we're going to reserve our right to come back to Dr. Butler once we are able to resolve this.

Mr. Barstow. Happy to work with you on what he is allowed to answer today, if you want to work around that.

[Majority Counsel]. Thank you.

BY [MAJORITY COUNSEL].

Q Dr. Butler, avoiding the content of what was said --

A I'm sorry, [Redacted], I got the audio back with the muting. I couldn't have my sound on while Mr. Barstow was unmuted, so if you could begin again, that would be fabulous. Thank you.

Q Sure. So that evening, a call comes in from someone at the Vice President's office. Who was on that call?

A There was someone from the Office of the Vice President, CDC Director Dr. Redfield, and Kyle McGowan, the chief of staff. If there were others on, they didn't identify themselves.

Q Okay. So the identified participants, just to be clear, were the person who you don't recall from the Vice President's office, Kyle McGowan, the chief of staff, and Director Redfield?

A That is correct.
Q How long was the call?
A To the best of my memory, probably about 15, 20 minutes.
Q Okay. And this call was initiated by that person from the Office of the Vice President?
A I can't say who. I don't know who actually initiated it.
Q Okay. How did you learn of the call and who organized it?
A My phone rang about a minute before I was on the line with all these people.
Q Okay. So there was no email invite, no anything, no other discussion. It was just a --
A No.
Q -- call that came in. Okay.
A And calls come in all the time when you're the incident manager.
Q I can imagine. Was the person from the Office of the Vice President male or female?
A Female.
Q Do you know that person's title?
A I don't.
Q Was it someone you had spoken to before?
A I don't recall.

Q Can you describe -- let me scratch that. This person from the Office of the Vice President was the only person outside of CDC on the call as far as you were aware?

A As far as I was aware. Again, I have no idea who else might have been on the line who didn't identify themselves. And again, it was a cold call on a Saturday evening, so I wasn't standing there with a notebook and pencil to write everything down. I had no idea what the subject of the call would be.

Q Who did most of the talking or was it a back and forth?

Mr. Barstow. We're getting pretty close to talking about the substance of the call, so if we can steer clear of those sorts of questions, we appreciate it. We'll instruct Dr. Butler not to answer that question. I think he said who was on the call, how long the call was, and I think that's about the level of detail that we're comfortable with Dr. Butler providing today.

[Majority Counsel]. I would just disagree that discussing who did the speaking in any way reflects on the content of what was said. So I understand the objection, I understand that Dr. Butler is not going to talk about the content, but I'm going to ask him other details that he recalls about this particular call. It in no way implicates any confidential interest saying who was

speaking.

The Witness. And I wasn't timing individual speakers, but certainly all three of the people that were on the line spoke at various points in the conversation.

BY [MAJORITY COUNSEL].

Q Did you speak?

A Yes.

Q How could you characterize the tone of the person from the Office of the Vice President who was speaking?

A I've been advised to not answer that question.

Q Again, and this doesn't reflect on the content. We're not talking about the content of the call. The tone is something that is a detail that in no way implicates any confidentiality interests. So I'd ask Dr. Butler to --

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

[Majority Counsel]. Okay.

BY [MAJORITY COUNSEL].

Q How did you feel after those 15 minutes on this call?

A I think as I mentioned -- hang on. There we go. I'm back.

The record can show that I inadvertently turned off

my camera there.

I think confused would be the best description, and concern. As I mentioned earlier, I was concerned that somehow a draft with some information that might have been either technically inappropriate or offensive to certain faith communities had been posted. And you know, I didn't have the various drafts in front of me at the moment to be able to make that call.

So given the level of concern that I felt, the cleared version was sent by email immediately after the call, and we posted that fairly quickly, although certainly our curiosity was piqued.

So Dr. McQuiston and I spent the evening cross-checking the drafts to see, trying to put together what had happened that led to the level of concern that was expressed.

Q Immediately following the call, you described yourself being concerned. What steps did you take in terms of conversations you had and people you might have communicated with within CDC?

A Well, I had been informed that the version that was posted was not -- had not been fully cleared. So I asked to have a version that was cleared sent to me, and then contacted Dr. McQuiston, talked about the concerns that I had, and that I think you can see in her email that

she also shared.

And we were pondering what had gone up and what was in this cleared version. So we basically started two processes at once. One was to replace the version that was posted with the cleared version, the other was to cross-check the two versions to see what were the differences. And we did that separately, and then compared notes. And I think you'll see further down in Exhibit 14, some of those differences are outlined in her email.

Q And where did that call fit into this timeline here? So I guess it preceded these emails that she was recounting the history here?

A Yes. So the call was some time at or shortly after 6:30 on Saturday evening. The email exchanges went until considerably later in the evening. That's not reflected in Exhibit 14. As did the phone calls.

Q Okay. So phone calls continued with this same person from the Office of the Vice President, or are you talking about phone calls within CDC?

A No, phone calls within CDC.

Q Okay. And looking back at Exhibit 14, at number 6?

A Sorry, my version does not have numbered paragraphs, so I may need a little better reference.

Q Okay.

A The last page here, okay.

Q Yeah, the last page.

A Yeah.

Q So around 6:45 p.m. on the 23rd, that being Saturday, whatever has been redacted there, and "we were told to remove it and put up the approved version." So how did it get from that call from the Office of the Vice President to removing what was on the website and replacing it with the approved version?

A So there were a couple of steps, and I would caution that these times are approximates as reflected by the verbiage that was used. So I had asked to receive a copy of the cleared version. That was sent to me. I don't recall offhand by whom. And then was on the phone with Dr. McQuiston to talk about the two issues that I mentioned earlier. One, replacing what was posted with this cleared version. And second of all, sorting out what had happened. This was fairly unusual. And I knew it was a situation where there was some risk that perhaps we had posted something inappropriate. I wanted to fix that if that was the case.

You mentioned in our earlier conversation about public buy-in, and I was most concerned that perhaps we had inadvertently used some language or said something that would be offensive to some component of the faith

community. So it was important to me to be able to correct that as quickly as possible.

I knew there was a lot of interest in this. I had actually been contacted by more than one pastor during that week, wanting to know when was it going to be safe to have services again, what steps should they take if they were going to do that. So I knew there was a lot of interest in this, and I knew providing the best guidelines would be compromised if we said things inadvertently that offended people of a faith tradition that I'm not necessarily familiar with or a part of.

Q I think it's helpful to understand the terms here. You mentioned a cleared version and Dr. McQuiston said their approved version. What do you mean cleared by whom?

A Cleared and approved, I think, are synonymous terms here. But this was the kind of language we used at CDC as we finalize documents, whether it's for posting on the internet or publishing in the scientific literature, we call it the process of clearance, which basically involves a lot of technical review. And depending on the subject matter, may include some policy review as well.

Q Okay. But in this instance, when you say cleared, and the cleared version, whose clearance are you referring to?

A In this case, it would be clearance above the CDC level.

Q Okay. So by the Office of the Vice President, the White House?

A We're speculating now.

Q No, I mean, we're talking about this particular -- I don't want to speculate. What is she referring to when it says their approved version?

A I'm not sure that I can answer that question with certainty, but as I mentioned earlier, the documents would go through the chief of staff to other agencies and people involved in the whole of government response. So it basically is what comes back to us with a thumb's up, which we interpret as being across the whole of government response.

Q Okay. It seems like on the 22nd -- and I want to take a step back and look at paragraph 3 in this email, that within CDC, in the last sentence here is, the CIAR TF, with PDIM approval, interpreted the "proposed" changes as optional.

Can you tell me what those acronyms are?

A The CIAR TF? I think I found what you're talking about. CIAR TF? That's community intervention at risk populations. I don't know why we don't have a P on there. And then TF is task force. PDIM is the principal

deputy incident manager.

Q And I guess those two leaders within CDC interpreted the proposed changes as optional?

A That's how I interpret the message here, yes.

Q Okay. And then you just moving up to your email at 10:49 p.m., I'll give you a chance to review it, but it's a detailed email comparing the two versions.

A I'm not finding that as part of my Exhibit 14, I'm sorry.

Q Sure. Just scrolling up from where we were.

A Okay, there we go. I was going too far. Okay, yes.

Q So there's an email you sent at 10:49 p.m. that evening.

A Yeah, I got you.

Q So by that time in the timeline, the original version had come down and the other version had replaced it; is that right?

A That's correct.

Q And then just -- I think it would be helpful to walk us through what you did here and what you noted in terms of the differences between the two versions.

A Well, first of all, I was impressed that the differences were very limited in the number. The version that we posted had less references to the First Amendment,

there was a recommendation to support social distancing by avoiding lines or queues such as people were coming forward to participate in the Eucharist, to be able to be able to space people out more than that. That was a difference. The role of face coverings was deemphasized in the White House version.

Q I just want to stop you there. It was more than deemphasized. It was all references, according -- in comparing these two, all reference to face coverage were removed.

A Yeah, there was a pretty big de-emphasis.

Q Okay. You can continue.

A Okay. The role of choir and musical ensembles was an area of concern, that text was basically struck from the White House version. I'm going to call it the White House version, since it was provided to me after that call. The role of frequently touched objects was different as well. We were still encouraging virtual events if it was consistent with the faith tradition. That was, again, deemphasized or absent, if you will.

And the issue of cleaning and recommendations about use of the building for other functions, again, all focused around social distancing and reducing the amount of person to person contact between people was also different.

The -- one thing that really kind of puzzled me is

there was a section acknowledging the importance of spiritual and emotional care that was in the CDC version that was absent in the White House version. The White House version seemed to be more focused solely on the mechanical process of gathering for a service, rather than the purpose of the service.

And maybe some could say that was out of place for CDC, but I think in public health and at CDC, we care for the whole person, as while we're focused on the body and the physical health, the emotional and spiritual well-being is also a part of that physical well-being.

So that was another aspect that kind of surprised me as a difference between the two versions.

Q And what about the references to considering virtual events? I might have missed it, you might have mentioned it, that was absent as well, even consideration of virtual?

A I believe it was absent in my review. I haven't re-reviewed the exhibits here in quite some time, but yes.

Q At the top of this email, you wrote in the second line here, "and I must admit, as someone who has been speaking with churches and pastors on this –"

A Yes.

Q "-- (and someone who goes to church), I am not

sure is -" I think there's a typo there. "I am not sure I see a public health reason to take down and replace."

What did you mean by that?

A Pardon me while I review that myself.

I'm sorry, I'm not finding the text you're referencing.

Q Sure. It's at the bottom of page ending 247.

A Okay. So this is the 10:49 p.m. email?

Q Yes. And the second line in that email.

A Oh, yeah, thank you. I'm sorry, it took me a minute to find this.

Yeah, so my concern was after comparing the two documents, I was scratching my head a bit in terms of whether or not the concerns that I expressed earlier were really valid after I had compared the two. I just went through some of the differences between the two documents. I don't think that anything in the document that was posted on the 22nd was something that would be offensive.

Again, I don't pretend to represent all faith traditions or communities, but I think it was based on good science and good public health practice. It aligned with conversations that I had been having with pastors as something that would be acceptable. And in the following week, we actually had a briefing that was sponsored by HHS with a number of church and denominational leaders, and we

had very open conversations about things like the risks that might be associated with choirs. And no one objected or found that problematic.

So at the end of that evening, I found myself wondering what this was all about. It seemed like the differences were not things that were going to be offensive. And I felt like they really softened the potential for public health impact. You'll see that frustration surface again the next morning in the 7:00-ish a.m. email, thanking the team for their work, but expressing my concern that these guidelines were not optimal from a public health perspective.

And while it's not explicitly stated there, my plan at that point in time was to do just what I did over the next week, is to communicate what the science said in any venue that I could, to as many faith leaders as possible. And I've done that really since. And I have yet to have anybody from any faith community tell me that I have offended them when I've talked about how respiratory particles are generated during speaking, shouting, or singing.

Q And I think the line, I'm not sure I see a public health reason to take down and replace, and yet this was taken down and replaced. After giving it some thought, what was the reason why these things were stripped out of

this guidance?

A I could only speculate, and I don't know.

Q What would you speculate?

A I don't care to speculate on the record.

Q Okay. I think it's worth getting into the Sunday -- what you said on Sunday morning. I don't know you, but from this morning, you seem to be a very thoughtful and measured person, and these are some strong statements at the end of this email. I'll just read back what you wrote at 7:46 a.m. on Sunday, May 24th. "This is not good public health. I am very troubled on this Sunday morning that there will be people who get sick and perhaps die because of what we were forced to do."

What did you mean by, "this is not good public health"?

A Well, as I was saying earlier, the version that went up the evening of the 23rd, I think softened some very important public health recommendations. And really, my purpose in that message was to share some of my personal frustration and disappointment in what had been posted. And also to encourage, to try to encourage the team that I was acknowledging that this was, I think, somewhat demoralizing.

I mentioned during phone calls the evening before, people had really put in overnight work to get this

guideline finalized and up. And to have it -- I think I used the word compromised in the email by the language that was used in the cleared version was really pretty demoralizing.

Q And --

A Also, I really wanted to communicate to the team, they did the right thing. And while I wasn't saying it explicitly, I was doing a lot of soul searching about whether or not I should have agreed to even make the change in the document. Clearly, it was a directive, but that was a real struggle as I felt like what had been done was not good public health practice.

Q A struggle, a moral struggle?

A Sure.

Q And I think you get into that why in the next part of that sentence, where you say that you were ”very troubled on this Sunday morning that there will be people who get sick and perhaps die because of what we were forced to do.” What did you mean by that?

A Well, again, the public health recommendations, I felt like were not as strong as they needed to be, as they were in the original document. You know, again, I am not prone to magical thinking, I don't think the virus is going to behave differently in a gathering for worship than in any other gathering. Maybe a

miracle could occur, but miracles don't happen very often. I think that's why we call things miraculous.

So I think our goal is to use the science, develop guidelines that can protect people to be able to worship in the way that's consistent with their faith and their tradition.

Q And to put it in those terms, is this something that you honestly -- well, strike that.

I take you to be an honest person. Do you stand by that statement that there will be people who get sick and perhaps die because of the watering down of this guidance?

A Well, I certainly stand by that expression of that concern. Am I aware of specific data that I can point to, to say, look what happened? No, I cannot do that. But that concern will haunt me for some time.

Q Rather than to go into another topic, I'm going to allow us to break there and give the minority a chance to ask questions.

[Majority Counsel]. We've been going for nearly an hour and since it's 12:30. I wanted to check, should we take a lunch break or [Redacted], [Redacted], after a five-minute break, do you have any questions? How long do you think you will be?

[Minority Counsel]. I don't think we have any questions right now, but a lunch break would be preferable,

maybe like 1:10.

[Majority Counsel]. Dr. Butler, Kevin, would about 35, 40 minutes work?

Mr. Barstow. We're fast eaters.

[Majority Counsel]. We will come back at 1:10, then, and go from there. Thank you so much.

(Recess.)

[Majority Counsel]. Back on the record.

BY [MAJORITY COUNSEL].

Q Dr. Butler, I want to ask you one last question about Exhibit 14.

A I'm sorry, which exhibit was that?

Q 14. The email, that Sunday morning email you sent.

A Okay.

Q You concluded that email stating, "our team has done the good work, only to have it compromised."

Were there other occasions where the work of your team was compromised?

A Up to that point, no.

Q Going forward?

A In my time as incident manager, I don't recall other times.

Q I want to talk to you about CDC's communications to the public. The role that CDC had

informing the public about the virus and steps to take. And I know that you spoke publicly quite a few times when you were incident manager, and I was hoping that you could tell us in broad strokes what your perspective is on the role of public communications in a public health emergency.

A Sure. The goal of public communications is basically tell people what we know, what we don't know, and what are the steps being taken to fill that void. Then a fourth area is to answer the question, what can I do, each individual in the community.

So that sometimes is tough, particularly early in a pandemic, where we don't have as much information, but that's an important overall piece of the communication plan. And it's an ongoing and iterative process. I think being able to identify who can deliver, be a trusted messenger, is critical as well, recognizing that it's unlikely that we'll identify a single trusted messenger, but there's people who will have credibility in various communities across the country.

Q Why is that issue of credibility particularly important?

A What does it matter what I say if nobody believes anything I say.

Q And I realize this is an imprecise question, but what principles should guide public health

communications during these types of emergencies?

A I think the most important is what I just went through. Maybe the overarching principle is to be forthright and honest, which then ties into the principles I was discussing earlier about talking about what do we know, what do we not know, and what steps are being taken to fill that gap, as well as if we have specific guidelines to tell people what they can do to be able to get that out as quickly as possible.

Q And what about the consistency of the communication, in terms of both message and for lack of a better word, cadence in terms of how many times you speak to the public about it, as an ongoing public health emergency?

A That is a good question. There's a couple of schools of thought. One is particularly if you're addressing the cadence issue, you don't want to keep coming back and having nothing new to say. But on the other hand, having a regular cadence I think is how you establish trust, that people know that with a certain degree of regularity, you'll be a spokesperson who will be heard from and hopefully would be trusted. Whether that's an individual spokesperson or an agency spokesperson, consistency, I think, is an important part of it.

Q In your role as deputy director of infectious

diseases, prior to becoming incident manager, what were your responsibilities in terms of communications?

A It was mostly responding to individual media requests that came either through the office of the assistant deputy for communications in the office of the director, or through the Joint Information Center of the IM response. I don't know that I can describe the full triage process very well.

I have a senior adviser for communications and policy who sometimes received requests as well. Requests would sometimes come in with a name request specifically asking for one of the leaders or subject matter experts to speak, or sometimes it would be more general requests and then a triage decision would be made depending on what the topic was and the audience.

Q Let's talk a little bit about how communications worked within the incident management structure. I think you mentioned that the Joint Information Center, the JIC?

A Yes.

Q Tell us a little bit about the different structures and how it works.

A Well, the JIC is staffed mostly by people with a background in communications and public relations. And just like everything in the incident management structure,

the idea is to break out of the usual bureaucratic silos and to be able to communicate across the whole agency as effectively and efficiently as possible.

And as I also mentioned earlier, requests would come in through various mechanisms, sometimes through the JIC, sometimes to the office of the associate director for communications, the ADC. And sometimes directly either by email or by phone call or voice mail.

Q And understanding that you may not know all of the details, but in broad strokes, what's the process for clearance of public communications coming from CDC?

A I don't know that I have enough familiarity to describe that process. A request comes to me to speak, that's usually not the first question that I ask, because if it's coming to me, the assumption is it's already been approved and cleared.

Q Beyond requests -- reacting to requests from the press, how does CDC determine on its own that information needs to be shared with the public?

A It's an iterative process, and it depends really on what -- if it's something that translates into a difference in either public health practice or in recommendations for personal protection, those are the highest priority messages to get out. The next area is new science that might be the rationale for what's coming or

what may be helping to guide new recommendations.

But as I said earlier, to tell people what you don't know, as well as what you know, and being able to fill that gap as we learn more about COVID-19 and the behavior of SARS-CoV-2 is an overall piece of the overall communications strategy.

Q Sorry, there's a leaf blower outside.

A It always happens.

Q It seems that the incident manager is a spokesperson as well, and when you were incident manager you engaged with the public directly. Can you talk about that role and how that works in terms of when the incident manager is out there speaking to the public?

A Yeah. In some ways, it felt a little less frequent as incident manager, because it's such a busy job running the response. Think back on March and April, it seems like there was more interaction with the media then, but when there was, when I was asked to take that role, I did it.

Q And when you were asked to take that role, who would have to clear whatever engagement that you were doing with the public or press?

A Well, again, the request that would come to me would be through the people involved in the clearance process and the approvals, so I don't have full visibility

on that. If I received an email directly or a request, I generally referred those most often to the OADC, the associate director for communications, sometimes to JIC also.

Q And what about telebriefings? How did those work?

A So telebriefings were more strategic and planned in terms of exactly what the message would be. So there was more planning that say a conversational interview perhaps like what we're having right now, but it was also a period of question and answer that would follow. And so it was -- it was also fairly spontaneous as well. The opening of the telebriefings generally focused on why we were having a telebriefing, what was new to say whether it be a situation update or some new scientific report or guideline.

Q And focusing on telebriefings, I think I want to show you what's been marked as Exhibit 1, which is a printout from the CDC's news room website.

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

BY [MAJORITY COUNSEL].

Q The title is 2020 news releases. And below it, it lists release dates of telebriefing transcripts.

A Okay. It goes through is it January of 2020?

Yes. Oh, wait I'm sorry it's reverse order. December, November, October. Okay. I'm with you, I'm sorry.

Q Okay.

A Please proceed.

Q You know, from what we can see here and there was a steady pace of telebriefings about coronavirus in January and February, looking on that second page, there were nine in January, eight in February, and then only two in March. And then there was a gap between March 10th and June 12th.

A Just for the record, there's -- it's showing one on March 2nd, 3rd, and 10th. Is that what you see also?

Q Yes, it looks like the top of the March 10th title is cut off a little bit.

A Yes. From the same printer, okay.

Q So in line with what you said about the cadence, there was a steady stream of information January, February, and then a few telebriefings in March, and then a drop-off for three months between March and June. Can you tell us, if you know, why there was this change in the pace of telebriefings?

A This list of news releases are only things that were led by the CDC. The whole of government response really escalated during March of 2020 and the various media

briefings that occurred were increasingly done either by the department or the White House during that period. You know, specifically, why was CDC not doing individual telebriefings during that period, I can't say for sure, but this was during the time when the center of gravity for the response was being run out of NRCC under FEMA.

Q We have spoken to some CDC communications folks, and one of the things we've been told is that there was at least one request for a telebriefing that was denied by a communications official in the Office of the Vice President. Did you have any knowledge of that happening, that CDC wanting to do a telebriefing, but being denied by the White House?

A We were always ready to do telebriefings and eager to connect with the public, and particularly with such a long period of apparent silence, that's -- nothing you're saying surprises me. I mean, we would want to be able to participate in the communication process to have our subject matter experts be able to speak. And so I'm not surprised that there was a desire to do that or a specific request. In terms of why a specific request was turned down, I don't have any visibility on why that would have been.

Q Is that something that ever was communicated to you during this period between March and June?

A Not -- well, I don't recall, specifically. Again, those were very busy days.

Q One thing you did bring up earlier was the February 25th telebriefing by Dr. Messonnier?

A Mm-hmm.

Q I think the response to that within government has been reported by the press. Are you familiar with that briefing on February 25th?

A Yes.

Q And tell us about what your role was. Obviously, Dr. Messonnier was reporting to you at that time; is that right?

A That's correct.

Q Did you have any role in preparing that telebriefing?

A I didn't have a role in preparing that particular telebriefing. For a number of the telebriefings, I was in the room with Dr. Messonnier. For that particular one, I was actually in Washington, DC, meeting with state health officials. But I was listening to it from the CDC office in Washington.

Q And do you believe what she said that day was accurate and based on the best known information at the time?

A Absolutely. And not just with the benefit of

hindsight.

Q And obviously, she was -- let me phrase it this way. She warned the American public about community spread that was, in her view, going to happen. Why was that important at that time?

A I think it was a progression of messaging. So that particular telebriefing, I think, was much more explicit than any up to that date. I wonder sometimes how much of it was the message was being delivered, but it wasn't being heard, but she was quite explicit on that day when she talked about, it's not a matter of if, but when.

When she talked about planning at the individual level, talking with your children about planning and preparedness for the pandemic. So I think that brought it home for a lot of people that we're still thinking of the pandemic as something that was happening in Asia and Europe, but might not have been really seriously considering that it would ever reach the United States or it would impact the United States as it has.

Q In your view, was that a message that the American public needed to hear at that moment?

A Yes.

Q Why?

A Because we had seen the continued progression as the virus spread around the world. Viruses don't need

passports. There was no reason to think it wouldn't impact North America as well. Thinking about the SARS outbreak in 2013 -- 2003, we did not see as much of an impact in the United States, but Canada did.

So we know coronaviruses can be spread internationally, and there was just no reason to think that it wouldn't come to the United States eventually. And of course, now there's the evidence that it was being silently transmitted at a low level in the United States even at that time. And it, of course, was actually the very next day that our first case of community acquired COVID-19 was identified in California.

Q It's been reported, and I think you alluded to this a bit, about the reaction to Dr. Messonnier's remarks. President Trump was reportedly angered by it. Dr. Messonnier received a series of calls, one being from Dr. Redfield and another being from Secretary Azar.

So following that briefing, the call from Dr. Redfield, according to Dr. Messonnier came a day or two after that February 25th briefing. In her testimony with us, she told me that she discussed that call with you. She told us that she discussed that call with you, because you were her direct supervisor. What did Dr. Messonnier tell you about that conversation she had with Director Redfield?

A I don't recall specifics of that call, so I'm

not sure I can really address that.

Q Without getting into specifics from that call, what was your sense of the reaction from Dr. Redfield and others about --

A Again, I wasn't on the call to really know how he responded, so I stress that.

Q Also, Dr. Messonnier told us about the call she received from Secretary Azar. She said she recalled being upset following that call with Secretary Azar, and she told us that she discussed that with you. What did she discuss with you?

A And again, I don't recall specific aspects of that particular call. The conversations that I had with Dr. Messonnier were really -- my goal was to affirm that she was doing the right thing, which I still believe to this day. I actually -- not remembering her specific references to those calls that might have occurred, but of course, in much more public venue, she was getting a lot of criticism which was one of the reasons I had called her maybe even before Dr. Redfield or Secretary Azar, because she was getting some heavy criticism in the press.

The stock market took a hit even. It was not news that was well received, but it was important to get the situation described in a way that people would understand. And clearly, the explicitness of the message got people's

attention. But then also led to a lot of controversy about whether or not this was accurate, was fear mongering. She was in a very difficult situation which I fully understand that.

Q That criticism, who within government was leveling that criticism in her direction?

A I don't know who in government might have been, but certainly in the media, you heard a lot of the pundits being critical. That's more what was on my radar screen, which is also challenging as a public health official when you speak what you believe to be the truth, and people say you have ulterior motives, or for whatever reason, you're just trying to gin up fear in the populace.

Q And was it unusual for her to receive a call directly from Secretary Azar?

A I don't know how often our individual center directors receive calls directly from the Secretary of HHS. Certainly we were having a lot more communications with Secretary Azar than would be routine by this point in time, which was really getting well towards the end of the second month of the response.

Q In going back to the Secretary's call, Dr. Messonnier recalled being upset and he obviously reports to you and discussed this with you. Do you remember why she was upset?

A Well, I think the feedback that she got generally, again, not specifically to the call with Secretary Azar, was critical. I don't think that the calls that she received from either Dr. Redfield or Secretary Azar were to affirm the message that she delivered and for which she was getting so much criticism in public venues.

Q I'm sorry, could you repeat? Those calls did not affirm?

A That's correct.

Q So they fell in line with the criticism that --

A That is what I recall of our discussions. Again, I don't recall specific statements that she relayed from either Dr. Redfield or Secretary Azar.

Q Do you recall if they expressed --

Mr. Barstow. I'm going to instruct Dr. Butler not to answer that question. You took part in an interview with Dr. Messonnier. You know, HHS has an interest in protecting that information. I allowed you to ask some questions around that, but I will not allow him to answer any more specifics about those conversations.

BY [MAJORITY COUNSEL].

Q Without getting into the content, following this conversation with Dr. Messonnier, it seems like you took this as an opportunity to encourage her, and that you

mentioned telling her that she did the right thing. Is that something that you said to her?

A I don't know if I used those exact words, but that was certainly my intent.

Q And what did you mean by that in terms of doing the right thing?

A Delivering the message that expressed the concern that we all felt that this was something that would eventually reach the United States. I think as you used the term earlier today, having the public prepared for various messages, being able to begin talking about the transition that occurs from containment to mitigation to be able to slow the introduction of the virus, the latter to achieve the flattening of the curve, so that the number of cases that are occurring at any given time are as low as possible.

So having those discussions, I think, are important. And I think the message that day was part of the evolution of messaging as we came closer to the time that we anticipated we'd begin seeing cases in the United States, particularly given what was going on in Europe and the widespread transmission that was occurring there.

[Majority Counsel]. I just want to jump in briefly to clarify the record. Kevin, a moment ago, you instructed Dr. Butler not to answer. Are you asserting a particular

privilege?

Mr. Barstow. As we stated in Dr. Messonnier's interview, HHS has a confidentiality interest in protecting conversations that she had with both Secretary Azar and Dr. Redfield.

[Majority Counsel]. Just to clarify, there's no privilege being asserted?

Mr. Barstow. I mean, we can quibble over whether it's process, whether it's something else, but the fact is, I'm instructing Dr. Butler not to answer that question based on our interest in protecting those conversations.

The Witness. And I'm just the audio engineer.

[Majority Counsel]. Thank you. Back to you, [Redacted].

BY [MAJORITY COUNSEL].

Q Around this time, were you aware of any discussions involving potential action against Dr. Messonnier?

A I was not involved or aware of any discussions along those lines, no.

Q Around that time and following the briefing, did CDC make any changes to the way it handled public communications as a result of the fallout?

A Well, I'm not sure which fallout you're referring to. And in terms of changes of how we handled

communications, that would be a question that I would really want to defer to the people in charge of communications as that time. Some of whom I think you've already spoken with.

Q Were you aware of any directives from the Office of the Vice President involving communications that might alarm the public?

A I was not.

Q Moving on. I think the March 10th briefing was along the same lines Dr. Messonnier warned that the coronavirus would rapidly spread and gave the public certain steps they could take involving collecting medicine, other supplies and anticipating community transmission. Were you involved at all in that March 10th briefing?

A I don't recall specifics of the planning for the March 10th meeting, but -- or telebriefing. But what you're describing has been part of pre-pandemic planning for at least a decade in terms of what are some of the preplanned messages to help people prepare for the event that they might need to shelter in place whether it's during an infectious disease emergency, a major winter storm, or an earthquake.

So these are not, at least in public health circles, I don't believe these are shocking messages. It may be

surprising to the public, particularly if they have not gone on to a preparedness website, to hear it proactively pushed forward by a high-level official at the CDC like Dr. Messonnier. But there was nothing in that message that I would describe as shocking in terms of this being completely different from anything that had ever been said before.

Q Why would communications like that about -- I guess are well established in pre-pandemic planning, why were they important at that moment in March?

A Because we were continuing to see a progression of spread globally, and we were increasingly concerned that there would be introductions in the United States and we certainly had seen the evidence of community transmission in California there at the very end of February as well.

Q And what are those sorts of steps, be it mentioned in the telebriefing or otherwise, that are sort of common to you, but would have been new for the American public to hear like that?

A There's -- and again, a lot of this is publicly available. The question is whether or not anybody bothers to look at it. But a lot of the pandemic planning process, whether it's from CDC or other federal agencies or from the WHO, talks about the stages of a pandemic,

starting with recognition of a pathogen with pandemic potential spreading to then documentation of sustained person to person transmission, at a time when containment may be possible or maybe not.

But at least containment slows the spread. As we then move into more widespread transmission, the approach would be more one of mitigation, which is where then we begin to talk about things like social distancing, canceling large gatherings, and by the end of March, the addition of masking when in public as well.

Q Can you give us a sense of in terms of communications to the public, the importance of that format, in particular, telebriefings?

A I really can't. I have not conducted focus groups or media assessment of that format, and so I can't.

Q Maybe not an objective measure, but why -- I'll ask a better question. Why does CDC use that format?

A That's a good question. I'm not sure I have a great answer, but it seems to be one that meets the needs of the participants from the media. So it seems much more efficient compared to, say, not having a telebriefing and taking every one-off call from various media outlets that we might get.

Q Is it something that CDC used regularly in

prior emergency responses?

A Yes, I believe that's correct. Certainly as a state health official during various emergencies, I'm thinking particularly of Zika virus or 2014-2015 Ebola outbreak, there were briefings that were provided that I directly listened in to myself to get the information. So it's not an unfamiliar format, and there are varieties of types of telebriefings. Another is the vital signs briefing, which usually accompanies the issuance of an MMWR that we considered to be particularly important.

Q In prior emergency responses, what was the cadence of telebriefings in terms of were they daily, weekly, monthly?

A It's really varied. I don't have a good answer to that. And sometimes they're more ad hoc. I think a regular cadence actually is probably preferable so that people know a little more what to expect.

Q During the time, so this gap between March 10th and June 12th, much of the public got their information about the pandemic from the White House coronavirus task force and briefings that were held and led by the President. Are you familiar with those briefings and the information that was disseminated by the President in this period?

A I'm not sure how you define familiarity.

Again, that was a very busy time, so I was not watching every telebriefing or briefing from the White House. So I guess the best answer to your question in terms of, was I familiar, the answer would be no.

Q And do you agree that sort of in the absence of CDC telebriefings, the White House and those press conferences became the main conduit for information for the public?

A At least in terms of a conduit from the federal government, I would probably agree with that.

Q I just want to briefly go through some things that were said at telebriefings in that period between March and June, and ask you some questions about them.

So on March 15th, 2020, at a White House briefing, President Trump said, this is a very contagious virus, it's incredible, but it's something we have tremendous control over.

Now, at the time, March 15th, did the available information suggest that we had tremendous control over the virus?

A I think it would really depend on what was meant by the term tremendous control, which I don't really understand what that term means.

Q Well, did we know how the virus would act and was it something that was contained?

A Again, whatever we -- whatever was said, we have the hindsight of the learning from the past year-and-a-half. So I'm really not interested in going through an exercise of Monday morning quarterbacking everything that was said from the administration during that time. There's no shortage of talking heads on cable media that have made a living and now written books to do that.

Q I think I'll just ask, this isn't a talking head, this is a President of the United States, the leader of the free world at the White House podium. Do you think the CDC would have made a similar statement that we had tremendous control over the virus at that time?

A I was actually referring to myself. People have made a career of criticizing whoever they want to criticize as a way to get a message out, promote themselves, and publish books, so --

Q And --

A I don't have a book. I'm sorry.

Q I'm self-aware to know that this entire exercise is Monday morning quarterbacking, but I'm hoping that you can answer this question. Would you have made -- would CDC have made that statement on March 15th that we have tremendous control over the virus?

A I certainly wouldn't have been comfortable

making that statement, no.

Q And why not?

A I think there was still much that we were learning about the transmission. At that point, the emerging evidence was suggesting that, through cryptic transmission or transmission from people without symptoms may be occurring. I think at that point in time, it was really too early to confirm that, but I think to -- my concern with that particular phrasing is it sounds like we are still in a phase of containment, rather than preparing the nation for a transition to more of a mitigation stance.

Q During this time, should the public have heard directly from CDC's subject matter experts?

A I mean, that's a matter of opinion.

Q I'm asking your opinion.

A I think the CDC has been credible in the past, and there's certain familiarity and trust with the CDC. So certainly my preference would have been for CDC to be more -- participating more in the communications, but I'm a deputy director at the CDC, so that's probably a somewhat biased answer.

Q Do you think statements from the President added to the public confusion about the virus?

A There's variability in the comments that were made. As I mentioned earlier, as we talk about what

happened in May, we were pleased that the President was calling out the guidelines on communities of faith. On the other hand, as we've already discussed, there were things that I wish had not been said, such as masks would not be something that he would wear.

Q So after that three-month gap, the next telebriefing was on June 12th, 2020. And you spoke along with Director Redfield and a transcript of this telebriefing from the CDC's website has been marked as Exhibit 2.

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

The Witness. I think there was also a media availability in late May, and I think that transcript is among the exhibits also. So probably it's important to note that the list of news releases focuses primarily on the telebriefings with few exceptions, but may not be an exhaustive list. In late May, there was a media availability that I did with Dr. Redfield and Dr. Greg Armstrong on the MMWR, reporting some of the evidence of earlier presence of SARS coronavirus 2 in the United States than had been previously recognized.

BY [MAJORITY COUNSEL].

Q I plan to cover that in some detail when we get to the MMWRs. Let's talk about the June 12th.

A I'm sorry, which exhibit is that?

Q That's Exhibit 2.

A Thank you. We need a master program for the various exhibits here.

Q Okay. So there's a three-month gap in telebriefings, and can you tell us what led to this telebriefing that you were involved in?

A I don't know everything that led up to that. There was a bit of a transition occurring in June away from the NRCC. I know the leadership at FEMA was concerned that the pandemic response was all consuming and we were moving into hurricane and wildfire season.

So there was certainly a lot of interest to have the public health response be led more by the public health agency. So that may have been a contributing factor, but I'm sort of breaking my rules a little bit and speculating a bit on that.

Q When did you first learn about this particular engagement? Is it something you discussed way in advance or is it something --

A I don't -- advance conversations, no.

Q And looking at the transcript as someone who reviewed this transcript and then reviewed the March 12th transcript where Dr. Messonnier spoke, it's different in tone and tenor. June 12th, there's no update on case

counts, there's no new science, it's a much more positive tone. Who chose the topics to be discussed for this particular telebriefing?

A Well, it was, I think, a team effort of the JIC, OADC, and most certainly the Assistant Secretary for public affairs at HHS as well.

To put this into context, in early June, we were at a real nadir in the number of cases. We had come out of the second wave of the pandemic. We were not yet clearly -- or rather, the first wave of the pandemic, I'm sorry.

We were not clearly into that second wave that occurred during the summer of 2020, although certainly I had some concerns that there were increases beginning to occur in some of the southern states that had been spared somewhat from the first wave.

And I think you'll see in the transcript, at least in the question and answer period, I addressed the fact that some community mitigation measures might need to be reinstituted if the number of cases increased again. Getting back to some of those earlier things we were discussing earlier, we're always trying to strike that balance of the least restrictive means to prevent transmission versus what can give us the most gain to prevent people from becoming ill.

By June, it was very clear that the interventions of

the pandemic also had an impact on the economy and in some ways that was disproportionately impacting people at the lower socioeconomic level. So it was not just a question of the maintenance of the economy but also a health equity issue.

Q You mentioned that the Assistant Secretary for public affairs was involved. That's the Assistant Secretary under HHS?

A That would be correct. I don't know exactly what role his office played in the preparation for the telebriefing, though.

Q And that would be Michael Caputo at that time?

A I believe his appointment was April or May of 2020, right.

Q And you said you weren't sure what his role was, but he was involved in, I guess, the preparation for this telebriefing?

A I didn't actually say that he was involved. I don't know what his involvement was.

Q Okay. I mean, but you just mentioned -- I may have misheard that, but you mentioned the ASPA?

A The office.

Q The office?

A Was the ASPA himself directly involved and have conversations with him, no.

Q Did you work with anyone in that office in preparation for the telebriefing?

A Actually, not even in the office. I was working with our people at CDC.

Q Okay. Do you know who chose the topic to be discussed that day?

A I can't -- I don't have recollection of exactly, or maybe even knowledge, of how they were chosen. Again, as incident manager, the days are very full, they're minute to minute. There was no meeting that I was called to and asked what should we talk about in a telebrief. It was more a matter of what was the ongoing dialogue within the response, and where are we at in the response, what are the important messages to get out to the public. And that's really a team approach to developing those messages.

Q Do you know who drafted the talking points for that telebriefing?

A I do not. I can't name a specific person. Again, we have the team and the JIC as well as the OADC.

Q It appears that, at least to observers from the outside, that this telebriefing fell in line with some of the messaging from the Trump administration around that time. A few days later on June 15th, Vice President Pence published an opinion editorial in the Wall Street Journal entitled There Isn't a Coronavirus Second Wave. Did you

agree at the time that there wouldn't be a second wave?

A No, I would not have agreed with that, and your take was different than my take. No one contacted me directly after this telebriefing, but I heard secondhand that the ASPA was very displeased by some of my responses, particularly the reference to possibly needing to reapply layered community mitigation efforts if there was a resurgence of cases. It was very clear to me, and I think to everyone, the pandemic was not over.

Q And you mentioned that it was communicated to you from the ASPA. How was that communicated to you?

A Yeah, and again, that's not what I said. I said I heard it secondhand.

Q Okay.

A No communication to me directly from the ASPA or even from within CDC. So perhaps it was all rumor, but I think I participated in one more telebriefing after that. But after that, I was not really asked back to do telebriefings.

Q What did you hear secondhand?

A That I was not sticking to the talking points, and that I was raising concerns about returning to lockdown, when actually what I talked about was layered community mitigation.

Q Who did you hear that from?

A I don't recall specifically who that was from, but again, the phone rings a lot during that time.

Q Is that something that happened on other occasions, where you would hear secondhand that your message wasn't in line with things that ASPA wanted to communicate?

A That is the main instance that comes to mind. It doesn't mean it didn't happen other times. And, again, I had no direct communications with them, so what reached me and what didn't is not a defined process.

Q What did you take -- what's your reaction to that criticism that you were off topic by discussing those mitigation measures?

A I think my message was correct, and ultimately, is what helped limit the second wave, that for instance, the states that were more aggressive in encouraging mask use, there was evidence that in areas where that was applied that slowed transmission.

I think the concept of lockdowns was also something that was not necessary, and getting back to what we were saying earlier mitigation efforts are not an all or none phenomenon. At that point, we were still sorting out what were the effective measures, how do we strike that balance of being able to maintain society -- societal function, while still preventing the spread of this novel and highly

infectious disease.

[Majority Counsel]. I think I'm about at time.

[Majority Counsel]. We actually have a few more minutes, and I just have a couple of quick questions if you're ready, [Redacted].

[Majority Counsel]. Sure.

[Majority Counsel]. Thank you.

BY [MAJORITY COUNSEL].

Q Dr. Butler, a couple moments ago, you mentioned that you heard secondhand that the ASPA, who at that time I understand was Michael Caputo, that he was upset, or I'm not sure -- I don't recall the exact language that you used, that you went off the talking points. Is that accurate?

A Again, that's what I had heard secondhand. So, you know, again --

Q Were there particular -- I'm sorry, Dr. Butler.

A I'd just say that what we're talking about is rumors at this point, so I've basically said everything I can say about that topic.

Q Just a couple of quick clarifications. Were there particular talking points that you were asked to use for this telebriefing or to communication to the public?

A Well, the talking points are for reference.

They're not verbatim messages to be read. At least that's my approach. I think to be a credible communicator, you have to be able to put things into your own words as much as possible and agree with the message.

So in terms of preparation for a telebriefing, as I recall, they would occur late morning. Usually that morning, I would get a chance to see the talking points that had been developed. And there was usually an iterative process of whether or not I thought something was technically right, or how I might prefer to say it, to how it was worded in the talking points.

But you know, you don't need a triple board certified physician to just sit there and read talking points that somebody else has written. We didn't have such a person to do that.

Q So was it your understanding that these talking points were coming from the ASPA?

A No, I had -- I did not ask specifically who developed the talking points. The discussions that I had about the content of the talking points were with our people at CDC.

Q Was it your understanding that Mr. Caputo thought you were being too alarming about the state of the pandemic at that time?

A That was how I interpreted the rumors that I

was hearing. But again, we're really moving into speculation.

Q Understood. And I apologize if you answered this. How did you learn of this information secondhand?

A Again, I heard it through somebody had mentioned it to me. I don't recall, specifically.

BY [MAJORITY COUNSEL].

Q One question, and I want to get your response, is that looking at -- comparing this -- the two ends of this, one we heard from Dr. Messonnier in March, we heard the traditional things that you talked about. What was known, what was not known, what people should do. You agree that this telebriefing was different, in that it didn't communicate those sorts of things?

A Well, it was different in terms of where we were at in the pandemic. In late February, we were preparing for the entrance of the virus into North America, and what that might mean. And basically, preparing for the first wave. In June, the first wave was pretty much over. So the questions were, there's very few cases, but we need to continue to have businesses shut. We need to continue to cancel events.

These are reasonable questions. And one that is continuing to be asked today. When is this over? And that's not a question that's easy to answer because,

ultimately, it may never be over. The SARS-CoV-2 has continued to evolve and it's something that we may very well need to learn to live with for years to come, just as we've learned to live with influenza over the century.

[Majority Counsel]. I think we'll turn it over to our colleagues in the minority.

[Majority Counsel]. We can actually take a five-minute break first.

(Recess.)

[Majority Counsel]. Back on the record.

BY [MAJORITY COUNSEL].

Q Quickly, during that June 12th telebriefing, you also announced new guidance involving events and gatherings; is that right? And that's included as Exhibit 3.

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

The Witness. And I have not reviewed that transcript.

BY [MAJORITY COUNSEL].

Q That's okay. And this was during your time as incident response manager. Can you tell us what led to this guidance being released then?

A Again, the context of the pandemic at that time was the end of the first wave. There were parts of

the country that had minimal impact, and so we were trying to strike that correct balance of what were the least restrictive guidelines versus how do we prevent a second wave or if there was going to be a second wave, how would we mitigate the impact.

I think as I said, there was quite a needle to thread of -- because people weren't going to continue to stay at home. Businesses were not going to continue to stay closed when there was a very small number of cases occurring. And how do we have people ready to be able to respond to a second wave should it develop. And also, what do we do to prevent a second wave from occurring.

So it was, overall, that approach to all of the guidelines at that time was what is the appropriate message as well as guidelines to get out. It gets back to the earlier conversation we were having about the differences between late February 2020 and early June 2020 were different points of time in the pandemic.

Q And at that telebriefing, you were asked about political rallies by members of the press because President Trump had planned -- announced plans to have a rally the following week in Tulsa, Oklahoma in an indoor arena that sat 19,000 people. About 6,000 people showed up. What did the science at the time tell you about holding indoor gatherings like that?

A Well, it certainly raises concern and 6,000 people in a 19,000 seat arena, I think the questions then come down, if the event is going to occur, are people going to be masked, are they going to be able to socially distance appropriately. These were very similar discussions that we were having around sporting events and kind of gets back also to our earlier conversation about worship services as well.

Just as I was saying there's nothing magic about a worship service in terms of how the virus will behave. The same is true of a political event or a sporting event, no matter how much you may love your team.

Q So we know a little bit about this event. The Washington Post reported that Trump campaign staff removed stickers instructing attendees to place empty seats between themselves, and that the overwhelming majority of the people in the arena were maskless. Additionally, there were reports that six members of the campaign staff who had traveled to Tulsa tested positive on the day of the event.

You were leading the response at CDC. You just announced guidance for large gatherings. What message did the President send by holding this event and not taking those precautions?

A I'm not sure that -- it sounds like he might not have -- or his team might not have read the guidelines.

Q What would you have advised in terms of precautions for an indoor event like that?

A Follow the guidelines.

Q Do you think that might have undermined the CDC's efforts to follow the guidelines.

A This is pure speculation at this point.

Q I'm not asking for you to speculate. What is the message here?

A You have the President holding an event not following guidelines at the --

Mr. Barstow. This is not a good use of time. If you want to ask him about statements the President made or Presidential events, then ask his opinion on it, but it's not a good use of Dr. Butler's time. If you want to talk about his time as incident manager or his role as deputy director of CDC, that is fine. But this is not -- we're already at the five-hour mark, and I mean, this is just not a good use of his time.

[Majority Counsel]. I'll move on from this topic.

Mr. Barstow. Thank you.

BY [MAJORITY COUNSEL].

Q I want to talk to you now about the MMWRs and specifically as this relates to the media engagement you mentioned in late May. But just for context, can you tell us what your role was in the MMWR process?

A In general?

Q Yeah, in general.

A So I am a part of the review board that looks at the first draft of MMWR reports. If it's an early release, it's usually about 36 hours prior to release. Usually I have anywhere from eight to 12 hours to provide any comments back. Most of those comments are of a technical nature.

In the case of the specific MMWR, I helped with the drafting, so I was part of the work group listed at the end of that MMWR as one of the authors. So being on the review board doesn't prohibit someone from participating as an author, although in the review process, I would recuse myself from the review of any report that I had direct contributions to.

Q And just to be clear, we're talking about Exhibit 25, the MMWR titled evidence of limited early spread of COVID-19 within the United States. Is that right?

A I believe that's correct. Let me sift through to Exhibit 25. Yes.

(Exhibit No. 25 was identified for the record.)

BY [MAJORITY COUNSEL].

Q So you were actually one of the authors of

this MMWR?

A Yes.

Q And just briefly, what were the principal findings of this report?

A Yeah, so the principal findings were that there was evidence of silent transmission occurring by early February of 2020. And that sustained transmission had likely begun at a low level prior to the recognition of those first two non-travel associated U.S. cases that occurred in late February.

Q And can you talk a little bit about the process of editing and release? Because from some of the documents that we'll go over, it seems to be a drawn out process for this particular MMWR.

A Right. And various reports have various timeframes for the interval of review, so it's important to recognize that. And maybe I can provide a little more context for the MMWR process, particularly when we're talking about a report from within CDC. The first group that's involved is the authors. This their home program to review in terms of technical accuracy and consistency.

The next level is the editors at the MMWR, who oftentimes make the decision of a go or no-go. And in the case of COVID, there was actually a process that had been developed for CDC authors to propose what it was they

wanted to report in the MMWR. After the editors give a thumbs up to move forward, a draft is developed and submitted. That doesn't necessarily mean that it is going to be published by the MMWR, but there's a process of review and refinement that then leads to review by the review board, which as I mentioned, I'm a part of.

The other deputy directors are as well, and also officials from the office of science at CDC. And that occurs in the first draft stage for the early releases, generally around 36 hours prior to release. For the weekly reports that come out on Thursday, or really at the end of the week, the opportunity to review those for routine reports is usually provided to us late in the day on Friday. So it's usually work that we do over the weekend.

Q Did that process change during the pandemic?

A The process that changed was who was alerted about what was coming. During my time as incident manager, we did start providing the one paragraph summaries to HHS. I think they were also getting to the White House. Dr. Birx generally had them as well. I don't know the exact mechanism, but as we move through the summer, I think there were also requests to be able to see the full manuscript prior to publication.

Q Do you know what prompted that change?

A I think COVID was clearly a high visibility

issue, and certainly the sharing of the summary paragraphs makes a lot of sense, just in terms of people not being surprised. As I mentioned earlier, we wanted to try avoiding our partners at state level where, say, a governor is asked a question about something from CDC, they turn to their state health official, and there's no knowledge on what CDC has done.

I think, similarly, as we get into the whole of government response, it's reasonable that people know what's coming from CDC before they're being asked about it by either constituents or by the media.

Q I think we can get a sense of this early release process from Exhibit 26. There's an email chain from May 21st, 2020.

A Yes, and that includes the one paragraph summary of that particular report in question.

(Exhibit No. 26 was identified for the record.)

BY [MAJORITY COUNSEL].

Q Okay. And so that was sent by Dr. Kent and then Dr. Birx was included in that distribution list. And she wrote that -- this was scrolling up through the email at 8:19 p.m., she wrote, “critically important. Grateful for the continued important scientific insights. Any chance this could be released before the weekend?”

And you responded here in the middle of page ending 37, "we agree, which is one reason why we were aiming for Tuesday."

And it talks about coverage. Why was this MMWR critically important at that time?

A Yeah, so as I mentioned earlier, some of the foundation principles of communication is telling people what we know, what we don't know, and sharing new information as we learn it. There were two things that struck me as important, though, about this report. One was that there was low-level transmission prior to recognition of these other, these first confirmed cases of community transmission in the United States.

And that also highlighted the role of spread that is subclinical, either between people or from people who do not have severe illness or who may have no symptoms at all.

In terms of the discussions with Dr. Birx, I mean, I think these are fairly routine in terms of talking about the best way to communicate, what's timely. This report does not translate into any major change in practice or policy over the next 72 hours or even longer. So in terms of the question of whether to publish it on a Friday before a three-day weekend or on Tuesday may be one that is better deferred to the communications experts.

But certainly I was in -- our general practice had

been to avoid those publications coming out particularly on a late Friday before a three-day weekend just because there would be more limited coverage. And when we have something to say, we would love for it to be heard.

Q And scrolling up on the email chain, it looks like part of the chain that you're not on, but it's an email between Kyle McGowan and Director Redfield. And it says, brief Jay, key is to ensure careful brief of AMA. What I take to mean Alex M. Azar. Looking at this email, what did this mean? Why was the key briefing the secretary?

A This report also in some ways changes some of the earlier understanding of the entry of the virus into the United States, showing that it was earlier than when it was detected through surveillance for among symptomatic people. So it was important to make the Secretary aware that we were coming out with that report, to have that on his radar. And also it provided the opportunity for a more technical briefing with Drs. Birx and Fauci. I think both of those briefings actually occurred on Sunday the 23rd.

Q So you did end up briefing Secretary Azar and I guess Dr. Fauci later?

A Yeah, I believe that's right. I actually don't have a lot of specific recollection of the briefing of Secretary Azar, whereas the discussion with Dr. Birx and

Dr. Fauci got into more of the technical aspects which are a little more my area of thinking about these things also. You may have noticed May 21st, 22nd, 23rd, that was a very busy three-day weekend.

Q Understood. One of the things that we have learned from our interviews is that there was a negative reaction to an MMWR that Dr. Schuchat authored earlier that month. Was this mention of briefing Secretary Azar related to that?

A Not that I was aware of. No one mentioned to me any negative interpretations of Dr. Schuchat's MMWR.

Q And I want to show you the next exhibit, which is Exhibit 27.

(Exhibit No. 27 was identified for the record.)

BY [MAJORITY COUNSEL].

Q Let's scroll to the bottom of this last page of this document which ends in 553.

A I'm sorry, what was the question?

Q I haven't posed a question. Just making sure that you're there.

A Okay.

Q Okay. So this email sent at 10:46 a.m. from you to Director Redfield says that, “the internal draft currently under review within the agency is attached.”

And, in bold, "not intended for distribution. Per your request, I am forwarding this to you now."

What led up to you sending this email to Director Redfield?

A As I recall, Dr. Redfield asked to see a draft of the report.

Q And did he explain why he wanted to see this particular report at that time?

A No, not that I recall. As I mentioned already, it was, you know -- scientifically, it was very interesting because it told us a fair bit about the behavior of the virus. It also was utilization of some of our surveillance mechanisms, I think particularly the respiratory specimen collection that's part of the influenza surveillance. It was good use of those resources.

But it -- the bottom line is it documented that transmission could occur fairly quietly before it would be recognized through traditional public health surveillance mechanism. And that would, I think, be an important part of what would guide or subsequent guidelines for mitigation and assessment of the level of community transmission.

Q Were you aware of during this editing process, looking back at the first proof, which is at the bottom of -- or the first summary paragraph at the bottom of

Exhibit 26, the title is "Evidence For Early Spread of COVID-19 Within the United States." By the time this MMWR was published, there was a change in title. Are you aware of how that change happened?

A It's not uncommon that changes would occur even in the title. The evidence that we had, for instance, to say as our summary statement there was evidence of early spread of COVID-19 in the United States in January and February, doesn't necessarily reflect very well that we had tested 11,000 respiratory specimens, and did not find any that were positive before a collection date of February 20th.

We have other lines of evidence to suggest that there was some transmission in the United States even before February 20th, but to say limited is a more descriptive term for the data that's actually in the report which is very important because as this conversation reflects people oftentimes hone in on the title without necessarily reading what follows.

Q Do you know who proposed that change in the title?

A I don't recall. It seems like a very reasonable idea. I don't think it was my idea, but I think it's -- it fits with the -- what the data are. And it -- I've just described to you the rationale that I would

have in supporting using the word limiting.

Q Do you know if anyone at HHS had suggested that change in title?

A I don't know.

Q Scrolling up to the -- and I'll give you a chance to review it quickly, but Dr. Redfield forwarded this draft of the MMWR to Mr. Caputo and signaled, "see title change." Are you aware if Mr. Caputo had any role in suggesting a change of title?

A I was not even aware that Mr. Caputo had awareness of the report coming out, so, no.

Q Was this unusual for the -- well, I'll ask it this way. You wrote in bold, not intended for distribution, to the director, and then he sent it to Mr. Caputo. Would Mr. Caputo be included in the early distribution of this full draft of the report typically?

A Dr. Redfield was my boss, not the other way around. So it was a request in fitting with the normal practice of the MMWR draft that they're fairly close hold and his decision of who to share that with was ultimately his decision.

Q In that close hold, would Mr. Caputo be part of the group that would see an early draft?

A Not in my experience, no.

Q Were you aware of that happening?

A As mentioned earlier, no.

Q And stepping up to this email from Paul Alexander, it looks like the draft was then sent to Dr. Alexander.

A Which exhibit are we on now?

Q We're still on 27.

A Okay.

Q Just moving up the chain.

A Okay. Okay.

Q Were you aware that Dr. Alexander had expressed that the title was "inflammatory"?

A That's an interesting term to use, but, no, I was not.

Q Go ahead. Were you going to say something?

A No, go ahead.

Q You were an author of this MMWR. Why might the title be considered "inflammatory" by someone at HHS?

A I have no idea. That's why I was kind of laughing when you read that to me. I think limited is an appropriate edit, and as I was saying earlier, matches what the data indicate.

Q Did data indicate where importations of the virus had come from primarily?

A The molecular biology suggests that there was an introduction of a single lineage into the West Coast

from China, and probably multiple lineages from Europe into the -- most likely, the East Coast.

So when I inhaled a little earlier and you said go ahead, I was a little puzzled by and was thinking about commenting on was Dr. Alexander's conclusion is the key is the transmission started due to the index case or cases from China. I'm not sure I would have interpreted it quite that way. I suppose it depends by what he means by transmission started.

But then in the second paragraph, he says, several importations of SARS-CoV-2 from Europe followed in February and March. And that's an accurate representation. Now, I would agree with that as well. So I'm just -- I'm seeing this for the first time and trying to interpret exactly what might have been -- why this then led to an email exchange.

Q Understood. I want to talk a little bit about the press engagement involving this MMWR. Can you tell us, first, did you stick to that goal that you set out to get it out that Tuesday following Memorial Day?

A It ended up coming out the following Friday. And for the life of me, I'm not sure what the delay was. Again, there was a lot going on at that time such as the recognition of the multi-inflammatory syndrome in children, and establishing surveillance for that. Operation Warp

Speed was on the upward slope and preparing for vaccine distribution.

So there were many things going on at the time, so I didn't delay the publication in any way. But it did ultimately come out, I guess it was on that Friday. I would have to look at the dates in the exhibits, but it was later that week. It did not come out on Tuesday, and I don't recall or even know -- I'm not sure I ever really knew why it didn't come out on Tuesday.

I think I remember having conversations with Charlotte Kent that we had several drafts that we thought were finals. There's -- as I mentioned earlier, there's the review board process and sometimes there's second final drafts depending on how many edits occur. I think this one had maybe three and I jokingly said that that may be some sort of record, but the fact is it's probably not a record. It was one that at a time when we were so busy needed to inject a little levity.

Q I just want to show you Exhibit 28, I think this refers to conversations about the delay.

(Exhibit No. 28 was identified for the record.)

The Witness. Oh, okay. Yeah, and this basically the documents that I was just saying I'm not sure why there was a delay and there was a lot going on at the time, so I

don't recall anything that is not reflected in this email. And looking at the lines from Dr. Iademarco higher up, I'm not sure who he was quoting when he says, "we addressed concerns over the weekend for Friday's publication. Can you double check to make sure there are no other concerns?"

I'm not sure who that question was being posed from, and I don't know how Dr. Redfield responded to me when I asked him about it, which I reflected I would do that in the 12:16 email back to Charlotte and Dr. Iademarco -- I should say Dr. Kent. But we had the briefing within the day or two. I think the report came out on, I want to say around May 26th or so. No, it wasn't the 26th, because this email was on the 27th, but it was sometime that week.

BY [MAJORITY COUNSEL].

Q It was, according to the online publication, Exhibit 25 indicates May 29th.

A Okay. So that would have been Friday of that four days.

Q Do you recall what Dr. Redfield told you when you asked him about the delay?

A I do not.

Q One thing that email from Dr. Iademarco suggested that maybe this should be taken up with Amanda. Is that a reference to Amanda Campbell?

A That is how I would interpret it. Again,

there's no last name used here.

Q What was Amanda Campbell's role in the MMWR review process?

A I don't know that she really had a role in the MMWR review. She was the deputy chief of staff, so it would be more involved in interactions above the CDC agency level.

Q Why would Dr. Iademarco suggest taking this up with her in this instance?

A It was pretty clear from the chain, none of us were sure quite what the delay was.

Q Okay. On the day this was released, there was a telebriefing that you participated in?

A Yes.

Q And there's an exhibit I want to show you related to that, and I believe that's Exhibit 32.

(Exhibit No. 32 was identified for the record.)

The Witness. 32?

[Majority Counsel]. Yes.

BY [MAJORITY COUNSEL].

Q Were you aware of who drafted the script for that telebriefing with this MMWR?

A No. I usually met with our JIC leads prior to the telebriefings to go over the talking points and the

script, but who all -- who were all the cooks in the kitchen, I don't know.

Q Do you recall having any conversations with Mr. Caputo about the talking points or messaging around this MMWR?

A No, I've never spoken directly with Mr. Caputo ever.

Q And what about Mr. Alexander or Dr. Alexander?

A Again, to my knowledge, I never spoke directly with him.

Q Okay. I want to go to the first page of this exhibit. It's an email from Dr. Alexander. And he writes on May 25th at 6:25, "I think this is on hold, right? The issue I raised is the statement about importation of cases from Europe for it does not read good, and this is in all 3 documents. I highlight them in yellow. So I am asking that this be tweaked."

A As with the grammar in his email.

Q Okay. And then scrolling down through the document, it's faint, but you can see on page ending 255 --

A Okay, I'm with you.

Q -- that what's been highlighted is "followed by multiple introductions from Europe." Again, I think this goes back to some of the things we discussed, but did Dr. Alexander have an issue with this language in the press

materials, from his email? Was that ever expressed to you?

A No, not that I recall.

Q And what's your impression of this process going on here that Dr. Alexander is giving his opinion on some of the scientific work that was being discussed?

A Yeah, I'm not sure exactly what Dr. Alexander's role really was. I mean, we never had a formal introduction of him into the response to know what role he would play. My understanding is he was an adviser to Mr. Caputo. You know, given his credentials, I would certainly be interested in his opinion as a technical expert, but he's not part of the overall MMWR chain.

And as time went on, it seemed to be that he was not really familiar with the MMWR process or purpose, either, so I'm not sure quite where he fit into the overall theme. We got a lot of opinions from a lot of people, so certainly a lot of filtering of what was said.

Q How did that become apparent to you that he wasn't aware of the MMWR process?

A There were emails later that I learned of that -- where he basically wanted the MMWR to stop publication, at least that's how I interpreted it. I should point out that much of this I learned from some of your earlier interviews with individuals as part of the process that I'm now participating in today. So I'm not

providing you any information that you're not already aware of.

Q Do you know if the talking points were changed in response to Dr. Alexander's concerns about cases from Europe?

A I don't know. But I think the message that was delivered was accurate as was the MMWR communication.

Q Were there --

A How relevant his comments were, is the bottom line.

Q In terms of Mr. Caputo, and I guess Mr. Alexander, during your time as incident manager, were you concerned about efforts by them to influence the scientific work of CDC?

A Certainly concerned. Whether or not they really had the authority or power to do that, I think is another issue altogether. I mean, I'm not unaccustomed to many people in many sectors not liking what the data that CDC put out, so you know, if these were a couple more voices in the critics gallery. So if your question was, was I concerned that there was an attempt to alter the scientific content of the MMWR, yes. Do I think they were successful? No.

Q And do you think their efforts, now that they've been publicized, did they have an effect on the

credibility of the agency?

A Good question. I don't know the answer.

Q From your sense, and we've heard from other people about this, that Mr. Caputo specifically threatened CDC employees with employment action. Were you aware of any of those threats directed at people working under you?

A Yes. I did hear of that. And my question is, does he have any authority to do that. He certainly said a lot of things of concern and seemed to be pretty good at putting people on their guard.

Q How so?

A Well, let me use another example. I gave an interview in July of 2020, a time when I was actually on vacation with my hometown newspaper, a reporter that I knew. And I was told that this had been cleared all the way through ASPA. Did the interview. The reporter called me the next day, sounded kind of shaken and said that she had been told by ASPA that they could not run the story, which I don't know how they could actually do that.

But I apologized that it was so difficult to work with the federal government and kind of let it go. I heard from her then the next day that there was then message from ASPA that okayed publication of the story. So I have absolutely -- I think we kind of joked about it was a retraction of the retraction.

But was the kind of thing that just seemed like bizarre behavior, that we would have approval, that someone would reach out directly to a reporter in a way that would make them not run a story and not report that they weren't instructed not to run a story, which to me was the real news. It makes me really wonder how in the world they interacted with individuals that put them on edge like that.

I think as we look at September of 2020 and some of the comments that were made, I'll be honest, one of the first things I did was look out my window at where the driveway was and how -- where a truck bomb would be placed. I somewhat jokingly let security people know that. But, yeah, there was a lot of concern around the CDC, and I think in a lot of quarters about the way that the behavior that we were seeing from the ASPA and from the ASPA's office.

Q That incident in July, that was your hometown newspaper in Alaska. What was the publication?

A The Anchorage Daily News.

Q And did that reporter who you knew, sort of that phone call, did that come directly from Mr. Caputo?

A I don't know. I did not ask.

Q And did the story eventually run?

A It did.

Q After the retraction of the retraction?

A Yes.

Q Okay. Were there other instances like that where calls from ASPA were made directly to people in the press that you were aware of to cancel engagements?

A Not that I recall. That one may stand out more because I was actually, as I said, on vacation that the time. So there's a little more white space in my life to reflect what just happened and realized that was really unusual.

Q What was the subject matter of that piece?

A COVID-19. It was a fairly bland interview.

Q And what were your thoughts if you can recall about it?

A I actually don't remember. I think it was focused primarily on where we were at in the course of the pandemic. It was really not anything very earth-shaking, as I recall.

Q In similar fashion, there have been press reports of people within CDC saying they were muzzled, saying they were victims of intimidation tactics by Mr. Caputo. Is that something that, like you experienced firsthand, is that something that was communicated to you by others as well?

A Well, again, I never had any direct

conversations with Mr. Caputo. Some of the heartburn that I apparently caused him was communicated to me secondhand, so I can't say that I was intimidated in any way by him, but I certainly was concerned about the apparent desire for -- or the suspicion that somehow CDC was politically motivated in what they were saying, which is really reflected in his September 2020 comment.

Q One moment. Apologies. Beyond that time that you heard sort of his displeasure secondhand, were there other instances that you heard about canceling of press engagements, the canceling of interviews by Mr. Caputo and others at ASPA?

A So I probably would not have been party to those conversations, so I -- it's unlikely that I would have heard of the requests before the approval or disapproval in this case had occurred. What was striking to me about the interview with the Anchorage Daily News is that there had been an apparent approval, withdrawal of the approval, and then approval again. That was actually more bizarre to me than not allowing us to speak at all.

Q What impact did this sort of behavior have on the folks working on the response?

A I think, as you mentioned, some people were intimidated, I think some of us were more prone to eye-rolling, it's -- some of the behavior was just

inexplicable. It was a little frustrating, though, because it's a distraction. It slows down the communication. And I think it really draws away from the important public health messages.

I think my biggest concern was that there was intentional discrediting of the agency. So that to me is very concerning, given that CDC is very science based and, in fact, probably you could say to the level of drawing criticism that sometimes we always are saying we need more evidence before making a statement.

So the implication that our messaging was primarily driven by political interests or discrediting the administration, I think, was laughable although concerning given the level of the government that it was coming from.

Q And how did that manifest itself, the intentional discrediting of the CDC?

A I think you've seen some of the media coverage and expressed by CDC employees of being demoralized. Working at CDC has always been something that many people have put a lot of pride in. We do criticize ourselves and joke about our own bureaucracy quite a bit. But people who work there are so very committed to the people of America and really to global health that it's hard to -- when you look at a life that you've committed to particularly with level of talent that we have at CDC, people could certainly

make a much better living in the private sector. But when people have committed to public service, it's really demoralizing to be characterized as a villain in the public health response, or even in the future of our country.

Q Apart from what we've discussed today, are you aware of any other instances or political pressure at the CDC over the course of the last year?

A During 2020, the scope of discussion?

Q During the scope of discussion.

A Another instance that comes to mind is the testing guidelines that were issued, I believe, in August of 2020 that deemphasized the importance of testing people without symptoms. That ultimately led to a discussion I had with Dr. Redfield. I think a number of us were concerned that that was not based upon the evidence that we had on transmission from people without symptoms.

Dr. Redfield's a good scientist and I think asked a very appropriate question about quantitation of the importance of spread from people without symptoms, that certainly we knew it happened, but is there modeling -- basically, he said what proportion is from people who are asymptomatic occurs? And we certainly didn't know at that time.

So I took that as a mandate to work with our modeling team to do an analysis over a broad range of

epidemiological assumptions to be able to come up with a range of what that proportion would be. And ultimately, that actually was published in the literature, but the bottom line was over a broad range of scenario assumptions a half or more of all transmission that is occurring in the community are from people without symptoms. So I think that analysis was really critical to reinforce what we knew about spread from people who had either did not develop symptoms at the time of their infection or had not yet become symptomatic.

Q You're referring, I take it, to the August 24th guidance or change in guidance; is that right?

A That's correct.

Q You weren't incident manager at that time but were you involved in the process that led to that change?

A I was not.

Q Do you know who was?

A I don't know who all was. Again, at this point in time, the White House task force was playing a very active role.

Q And following that conversation you had with Director Redfield, were you involved in changing that guidance on asymptomatic testing?

A I think the change in the guidance occurred concurrently with our analysis. I was focusing on the

scientific exploration of answering the question of the role of transmission from people without symptoms. There were others, including Dr. Redfield who I think were actively involved in changing the guidelines that ultimately led to a revision in September that spoke more affirmatively about the role of testing people without symptoms.

Q During that time, it was reported that you were in communications with public health officials. You wrote, or you signed off on your emails, "keep testing, Jay." Is that true?

A That's true.

Q And was that an effort to encourage people to keep testing asymptomatic patients?

A Yes, it was. Maybe a little less than subtle but it was important.

Q Okay. When did that conversation with Director Redfield happen? So just for the timeline, that guidance went out on August 24th, and was it around that time?

A It was in late August. It was during a scheduled session that deputy directors had with Dr. Redfield. And of course, at that time, almost the main topic we ever discussed was COVID-19. So it was a good opportunity to raise some of the concerns. And it was an

animated, but very, I think, collegial conversation really at the technical level. We did not discuss any aspects of what political pressures might have been behind it, but really focused on was this really an evidence-based recommendation.

And if there was uncertainty of what the evidence was, how could we answer those questions. And I think it's important to put it into context of there was some disagreement. I mean, we finalized the analysis, we began talking about it, because it was important to emphasize the role of spread from people who are asymptomatic, but we also wanted it to be in the peer review process and in the literature. Not just posted to the CDC website.

The first scientific journal we submitted it to didn't even review it. They basically responded there's nothing new here, everybody knows that transmission occurs from people without symptoms. And of course, my first thought was, well, apparently not everybody. But then we submitted it to another journal that published it. And recognized the applicable importance of the findings.

Q From your perspective, was that change on August 24th to the guidance, was that science based or was that not where the science was that the time?

A I don't know. Again, I wasn't involved in development of that change. I did not feel like it aligned

with the science, though, which was the topic of discussion that I had with Dr. Redfield.

Q And why did you feel the need to start signing your emails in that not so subtle way?

A Because I felt that the evidence was strong enough that really needed to emphasize that there is a role of transmission from people without symptoms. There were calls -- literally, my phone was blowing up with people wanting to know why we had made that change. This didn't seem to align with their understanding of the various reports that had come out of CDC. It seemed very inconsistent. So maybe that was a little bit more rebellious than a high ranking federal official should be. I thought it was important to say what I thought was true.

Q Did you also feel that it was inconsistent?

A Inconsistent with the data?

Q Inconsistent with, yeah, the data.

A Yes. Otherwise, I wouldn't have signed my emails that way. The challenge that I was presented with is, I think contextualizing and prioritizing how important this testing of people who don't have symptoms. So that was a scientific challenge that I thought was both intriguing and that we could potentially answer working with our mathematical model. I don't claim to be a modeling expert, but fortunately, I have some that work for

us.

Q I see the time. I have about ten minutes left. So I want to give the minority an opportunity to ask questions at this point.

[Minority Counsel]. Thanks, [Redacted].

BY [MINORITY COUNSEL].

Q Dr. Butler, 15 minutes ago, 10 minutes ago, you were asked, can you think of any other examples of political interference in the last year. And you made a clarifying statement, you mean do you mean 2020 as in the scope of the interview? Do you remember that?

A Yes.

Q Can you think of any political interference in 2021?

A No, but I was just making sure that I was -- we were all oriented to the scope of the discussion.

Q Okay. Thank you.

[Minority Counsel]. That's all I have, [Redacted].

BY [MAJORITY COUNSEL].

Q Okay. I want to ask you about one last episode that was reported in the news media involving you in December of 2020. And it was reported that in the New York Times in December of 2020, Vice President Pence visited CDC with Georgia's Republican Senators who were there running in a runoff and that you raised concerns.

Can you tell us what happened in December involving this visit?

A Yeah, that's a good question. Almost put that one out of my mind, too. So the fact that we were having a visit to CDC during the election season and that it was not a bipartisan event gave me some concern about whether or not it would be a really a political event or would it be a public health event. I think as it played out, those concerns were addressed. I don't know whether the fact that I raised those concerns changed anything, but I did raise those questions.

Q How did you raise them?

A It was in the form of an email. I don't recall exactly to whom, basically raising the question of whether or not -- not so much whether it was a campaign event or would it potentially be construed as a campaign event, if it would be seen as a political stance or CDC being used as a political megaphone. So these were concerns I think, doing all due diligence to keep us on the side of science rather than politics. I have no regrets over raising those questions. I was probably an irritation to some of my superiors, but it was a concern that I had.

Q Who responded to your concerns?

A I don't actually recall. Those are emails that they're not -- are they in any of the exhibits here?

That might actually help.

Q No, they're not. We don't have them, and I'll just -- we can take that up with Kevin. We would like to see them. But it was reported that you received an email from a White House lawyer in the New York Times.

A Okay. Fair enough. And that rings a bell. It's not that I'm a terribly forgetful person, but we live in COVID times, it's kind of like dog years, so we're talking about a decade ago functionally.

Q There was an email from a White House lawyer, and were your concerns addressed?

A I do believe they were, yes. They were acknowledged, at least.

Q Okay. And the visit happened and both of the Republican Senators visited CDC with Vice President Pence?

A To my recollection, yes.

Q Okay. Were you present?

A I was present, yes.

Q Were there any members of the Democratic Party present?

A Not that I recall.

Q Was there anything that concerned you during that event?

A In terms of the actual --

Q In terms of what you actually saw?

A No.

Q Were there other instances that -- where you were similarly concerned that the CDC was being used in this sort of political way?

A Not that I recall at this time.

Q I think you touched on the impact that Mr. Caputo had, and folks at ASPA, but taking a step back, what do you think was the broader impact of the instances of political pressure that was put on the CDC during this period? And I'm referring back to the topics we discussed, the faith guidance and the other things we discussed over the last however many hours?

A It would be really good theme for a book, I have to say. That's a very broad question, and is very, I think, difficult to answer, you know, putting it into a broader context of public health. I mean, prior to the pandemic, certainly there were people that called public health part of the nanny state. Certainly had to deal with that as a state health official whether we were talking about obesity or preparation for a pandemic, somewhat ironically.

And I think some of the rhetoric that was used really discredited hardworking people in public health and discouraged a lot of people who committed their lives to the health of individuals. And we even see that now, in

how health care providers are viewed and treated, which I think is pretty stunning if you think about where we are now in 2021.

We need public health. We need our health care providers. They don't understand why we would say that these are not honorable and noble professions. Unfortunately, much of the rhetoric has vilified the entire health care workforce and particularly for those of us that work in the government side.

Q Another very broad question. What do you think can be done to restore morale and the CDC's standing in American public life?

A That was -- if there were an easy answer to that or an easy solution to that question, we would have already done it. I think much of my focus right now is looking internally, not -- and acknowledging our own shortcomings, being able to address some of the areas where our grade is clearly not an A-plus. Addressing some of the issues surrounding lab quality, data management -- sorry?

Q Sorry, I think we got some -- a hot mic. Can you continue?

A Yes. So addressing some of the data flow issues as well. And I think at the level the agency recognizing that, you know, this is a very large team of people that work together for common goal. We work with

our partners across public health as well as with health care providers, that we should not be in competition.

We should also be better coordinated. I think the data flow issues are a great example of that, and oftentimes resources for data flow in public health have been far too limited. It's pretty stunning to me that in 2020, we still had case reports being faxed from public health agencies. As a provider, everything I did in patient care had transferred to electronic health record a decade ago, nearly a decade ago. Reports from the laboratory were more or less automated and delivered.

We made some progress in public health, but we're nowhere near where we need to be in terms of being able to manage data, surveillance, and be able to do appropriate and timely analyses to be able to get ahead of emerging infectious diseases and ultimately to be able to predict them better than we do currently.

Q Another follow-up question. Are there any specific policies or procedures that you wish were in place that could have protected the CDC's independence over this time period of the pandemic?

A You have a lot of one last questions.

Q That isn't the last one.

A Okay, thanks for that warning. It's hard to say. And I'm sure you're familiar, as am I, in terms of

some of the proposals on how CDC governance might be different than it currently is. Could it be something more akin to the FBI director, for instance? I mean, I think these are questions that are valid to discuss going forward. I don't have a firm opinion and haven't done all the homework to be able to even have a firm opinion at this point in time.

[Majority Counsel]. Okay. That was truly my last question. I wanted to thank you for your time again. I think we've gotten a sense of the incredible amount of work that you and your team at CDC have put into protecting our country. We deeply appreciate your dedication and your service, and we thank you for participating today.

The Witness. You're welcome.

[Majority Counsel]. Before we go off the record, [Redacted], [Redacted], anything further from the minority?

[Minority Counsel]. No, we're good. Dr. Butler, I'll just say thank you again. It's been a long day, and I hope you can drink a beer or something and enjoy the rest of the day.

The Witness. I wish the workday were really over, but it's just going to begin now.

(Whereupon, at 3:40 p.m., the proceedings concluded.)

Errata Sheet for the Transcribed Interview of Jay Butler
dated November 30, 2021

Page	Line	Change
12	265	Insert “if” before “you”
12	276	Insert “End” before “HIV”
13	287	Delete the first “so”
13	304	Insert comma between “state” and “tribal”
13	310	Replace “communication lines” with “siloes”
16	363	Delete “as well”
17	410	“were” should be “whether”
21	485	Replace “aspect that was occurring” to “question we were asking”
21	508	“also” should be “falls to”
22	517	Delete “use the”
26	634	“also getting a” can be deleted
27	638	“hence” should be “infection control recommendations”
27	655	“he” should be “the patient”
31	753	“phases” should be “cases”
35	850	Delete “I think”
37	892	“by” should be “was not at”
43	1050	“that” should be “those requests”
45	1111	“in the paper” should be “pen to paper”
48	1181	“didn't” should be “wasn't”
49	1201	Missing text marked by “--” should be “equal and”
53	1296	Please delete “didn't”
53	1296	“spoke” should be “spoken”
55	1344	“not” should be inserted before “using”
55	1348	“symbol” should be “cymbal”
59	1439	Insert “I” before “sometimes used”
71	1747	“they” should be “I've”
77	1906	“direction list that it might” should be “distribution list that it might go to”
82	2019	“so, anyway” should be “was a busy day”
91	2236	“the Chief of Staff” should be inserted before “took”
99	2437	“concern” should be “concerned”
118	2918	“that” should be “than”
146	3613	“century” should be “centuries”