COMMITTEE ON OVERSIGHT AND REFORM

SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

INTERVIEW OF: BRETT GIROIR

TUESDAY, MAY 3, 2022

The Interview Commenced at 9:55 a.m.

APPEARANCES:

FOR THE MAJORITY:

Jennifer Gaspar

Beth Mueller

Nate West

FOR THE MINORITY:

Ashley Callen

Mitch Benzine

Lauren Holmes Phelps

Mark Marin

FOR HHS:

Kevin Barstow

P R O C E E D I N G S

Ms. Gaspar. Good morning. This is a transcribed interview of Brett Giroir conducted by the House Select Subcommittee on the Coronavirus Crisis. This interview was requested by Chairman James Clyburn of the federal government's response to the coronavirus pandemic.

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

The Witness. My name is Brett Paul Giroir. Last name G-i-r-o-i-r.

Ms. Gaspar. Dr. Giroir, my name is Jennifer Gaspar. I'm majority counsel for the Select Subcommittee. I want to thank you for coming in here today for this interview. We recognize that you're here voluntarily, and we sincerely appreciate that.

At this time I'd like to ask the additional staff in the room to state their names for the record.

Mr. Barstow. Kevin Barstow from HHS.

Mr. Marin. Mark Marin with the minority.

Ms. Holmes. Lauren Holmes with the minority.

Mr. Benzine. Mitch Benzine with the minority.

Mr. West. Nate West, majority counsel.

Ms. Mueller. Beth Mueller, majority.

By Ms. Gaspar.

Q Before we begin, I would like to go over some

ground rules for this interview.

So first, under the Committee's rules, you are allowed to have an attorney present to advise you during this interview. Do you have an attorney representing you today?

A No, I do not, but HHS is here representing the HHS interests.

Q Okay. And you're agreeing to participate in this interview voluntarily without an attorney representing you?

A Correct.

Q Okay. So the way this interview will proceed is as follows: The majority and minority staffs will alternate asking you questions. We'll take about one hour per side each round until each side finishes with their questioning. The majority staff will begin. We will proceed for an hour, and then the minority staff will have an hour and so on.

If we're in the middle of a line of questioning, we might go a little bit over or a little under an hour just to wrap up a particular topic. And in this interview, while one member of the staff might lead the questioning, additional staff may ask questions from time to time.

There is a stenographer in the room taking down everything I say and everything you say to make a written record of the interview. For the record to be clear, I'd just ask that you wait until I finish each question before

you begin your answer, and I will also wait until you finish your response before asking the next question.

The stenographer cannot report nonverbal answers like shaking your head or nodding, so it's important that you answer each question with an audible verbal response.

Do you understand?

A I understand.

Q We want you to answer questions in the most complete and truthful manner possible, so we're going to take our time. If you have any questions about what I'm asking or you don't understand the question, please let us know. I'll be happy to try to clarify or rephrase.

Do you understand?

A I understand.

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 do recall.

Do you understand?

A I understand.

Q If you need to take a break at any point, please let us know, and we'd be happy to accommodate you.

Ordinarily we'll take a five-minute break at the end of each hour. If you need a break before that, just ask. And we just ask that if there's a pending question, you answer it before the break.

Do you understand?

A I understand.

Q I just want to address false testimony briefly. Although you are here voluntarily and we're not swearing you in under oath, 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 I understand.

Q So, in other words, if at any time you knowingly make false statements, you could be subject to criminal prosecution.

Do you understand?

A I understand.

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

A No.

Q Finally, I'd like to address privilege. The Select Subcommittee follows the rules of the Committee on Oversight Reform. Please note that if you wish to assert a privilege over any statement today, that assertion must

comply with the rules of the Committee on Oversight.

And Oversight Committee Rule 16(c)(1) states: "For the chair to consider assertion 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 court appearance."

Do you understand?

A I understand.

Q Do you have any other questions before we begin?

A I do not.

Q Okay.

Let's just start by talking a little bit about your background. I don't want to spend too much time on it, but I'm just interested in hearing a little bit about your background before you began as Assistant Secretary for Health.

A Starting when?

Q Well, I understand that you're a medical doctor and were a pediatrician. Is that right?

A So literally my entire background has been focused on immunology and infectious diseases. I graduated magna cum laude from Harvard in biology with a thesis in immune responses. I went to medical school at UT Southwestern, worked in laboratories focused on viral

diseases. Was Alpha Omega Alpha -- that's sort of the Phi Beta Kappa equivalent in medical school.

I did training as a pediatrician at Parkland Memorial Hospital, which is a large public hospital in Dallas and Children's Medical Center. I did three years of pediatrics. I did a year as a chief resident and then specialized in pediatric ICU and trauma care, where I was focused on severe infectious diseases, primarily in children. I remained on the faculty there for 10 years.

I was a tenured professor with two endowed chairs, again focused on infectious diseases. During that time when I was faculty member, I was asked by an agency at the Department of Defense sort of out of the blue, the Defense Advanced Research Projects Agency, or DARPA, because of my infectious disease background and expertise to be on an advisory -- it wasn't an official FACA, but a technical assessment committee for DARPA, which I did for many years.

I left academia in 2004 to become the first physician office director in the history of DARPA. I was a deputy, then the director of the science office. Very broad portfolio, but a lot of it was not only battlefield medicine, but pandemic preparedness and biowarfare defense. That is a short -- a short stint, because by definition you can't be there more than five years. That's DARPA culture.

I came back to Texas A&M as the vice chancellor for a

search for 11 universities, seven agencies. Worked on pandemic preparedness and new models for vaccine manufacturing to establish a national center to scale up vaccines quickly in the event of a pandemic.

Immediately before I was -- came here -- or came there to HHS, I was not at Texas A&M. I was adjunct professor at Baylor College of Medicine for pediatrics, tropical medicine, and policy and medical ethics. I was on the advisory boards -- scientific advisory boards of MD Anderson Cancer Center in Texas, University of Michigan, Talmud Medical Research Institute, and was doing consulting as well in the area of healthcare delivery and health policy.

There are a lot of other things, but that's kind of -- you know, sort of my brief, brief resume before I came to HHS.

Q And I understand that you came to HHS as the Assistant Secretary for Health on February 15, 2018. Does that sound right?

A That's correct. I was confirmed on February 7, and I was sworn in on February 15 at HHS, and, as you know, I had a second position through the State Department that was later.

Q So focusing on before the coronavirus pandemic began, what were your primary responsibilities or rather areas of focus?

A So the Assistant Secretary for Health, as you probably know, could have a wide spectrum of interests depending on the administration and the secretary. I was the principal public health policy person within the department.

So the typical roles of the Assistant Secretary -- the ASH, if I could use that term, ASH -- would be to construct -- to receive input to develop through a scientific process, to receive input on, and then to publish major policy recommendations; for example, the national vaccine plan, the physical fitness guidelines for America, the nutrition guidelines for America, the plans to end HIV, the hepatitis plan, similar issues like that.

I had some specific interests that were important for me. Very early I was named the senior advisor for opioid policy, which sort of started a sequence of roles that I had that would help integrate major across-agency efforts. As you remember, and still dramatically awful today, opioids and methamphetamine deaths were increasing. This was not -- there were lots of points of light, but there was not an integrated strategy.

So my role for the secretary was to integrate the entire department strategy, act across the department to set metrics of where we wanted to be and to achieve them.

And in general, as an overriding theme, we were not

trying to make bad people good; we were trying to make sick people well. This is a public health emergency, and we treated it as such.

I also had other roles for initiatives; for example, ending HIV in America. I certainly treated HIV very early on in my career. All my patients died. All my patients with hemophilia, with renal disease, all the children, because we had nothing.

But I had not been in the field, but during my long preparation time between nomination and confirmation, it seemed unacceptable to me that we had 40,000 new cases of HIV in the country every year despite the fact that we had medications that could treat and eliminate transmission. So on day one I said we can decrease HIV by 50 percent within five years. This is not a big issue.

So I led -- got Tony Fauci and Bob Redfield, worked with the president, and then he announced that in the February state of the union address.

I was also very involved in sickle cell disease from my background as a pediatrician, but also in mentoring roles. So that was a major effort.

I had occasional other duties as assigned, including being the acting FDA commissioner at the end of February 2019.

So we did the major health policies that were

traditional within the role, and those took a huge amount of effort, as you know -- the national vaccine plan, et cetera. But we also had very special public health initiatives.

And the final thing, I was an admiral in the commission corps. The Public Health Service needed a substantial transformation. It also needed enhanced training, funding, budgets, et cetera, which we really worked on intensely from day one.

And, of course, I deployed as a physician to many emergency areas, including the border four times when we were having issues with measles, influenza, and even meningococcemia among the migrants who were in CBP.

Probably too much of an answer, but that's sort of the things -- that was the general -- you know, before the pandemic, those were my responsibilities. And obviously you can go into any of those that you would want.

Q That's really helpful. I'm not going to focus on any of those particular initiatives, but I'm just curious about getting an understanding as to who you worked with most closely. Maybe we can just talk through different areas.

Did you have a core team that reported to you throughout that time?

A Are you talking about before the pandemic?

Q I am.

A So I was a direct report to Secretary Azar, so I worked with Secretary Azar very closely.

I worked with the typical assistant secretary offices, also minority health, women's health. We combined HIV and the vaccine office because they were doing almost the same work, and we needed those synergies.

On the large initiatives, I worked with all the operational division heads directly, so the head of the CDC, FDA -- you know, Francis Collins or Larry Tabak or occasionally some of the center directors.

So really on the cross-agency initiatives like HIV, on opioids, it was really the principals there, and often they had a senior scientific person who was sort of their operations officer to make that happen. But it was really direct with them and very frequently.

Q And how much contact did you have with the White House before the pandemic?

A The White House -- like in general, the big White House? Or do you want anyone in specific?

OMB was through all the budgetary times. That was very specific. On -- you know, for opioids, again, if you ask -- I'm just -- if you ask more specifically. For example, Kellyann Conway had an opioids, quote, cabinet meeting every week where the leads from all the departments would meet in the Eisenhower building. I guess that's a

contact with the White House.

With the vice president, maybe once, and with the president, a few times, rarely. On the HIV initiative, obviously, several times on opioids. Because of substance use issues within his family, he was very personally interested, I think, in those issues. So he had interest in that.

I did some travels with the First Lady primarily on neonatal opioid withdrawal syndrome. That was one of her causes, and we went to several children's hospitals and worked to understand that.

E-cigarettes with the president particularly. But they were relatively, you know, small in number and focused on those big initiatives.

Q Okay. Thank you.

I want to switch gears and just talk a little bit about when you first became aware that a respiratory illness was spreading in China. I think the first public reports were the last couple of days of December 2019, January 2020.

Do you remember when you first heard about that?

A I don't remember when I first heard about it. I know it was in December where there were, you know, discussions. I really don't remember, you know, exactly, but there were discussions with the secretary and Dr. Redfield and several of the principals about sort of

trying to understand what was going on. And Dr. Redfield, as the CDC director, was sort of the point of information.

My first, you know, focused memory was January 2 when I got called because it was clear that we were going to be -- and I'm not using this as a legal term -- repatriating. I don't know if that's appropriate.

But we were bringing all the Americans back from Wuhan, and it was clear that my officers in the Public Health Service would be doing a lot of the operational deployments for that, and I envisioned a lot more in the future.

So that was my first sort of direct "my hat is in the ring" with a particular responsibility to ready the officers for what was going to be -- we didn't understand it then, but a very long mission set. But clearly there was going to be a mission set involved with repatriation.

Again, I use that word. I'm not trying to -- I know there's discussion around that, but bringing them back from the hot zones.

Q I think that's the term that I've seen. I've seen it used in that context.

So other than repatriation efforts, did your office have a role in the response or even just assessing the threat in that, focusing on that pretty early period of January 2020?

A Yes. And it's hard to remember the specifics. My primary -- I was not primarily involved in the response, but I was a member, you know, in the operations of the response. Aside from -- and I don't want to underestimate this -- getting the officers ready and trained in an unknown virus with unknown transmission, sending them out. And eventually the rescue of people in the hospitals, you know, provision of emergency care, eventually with the cruise ships.

But I was not sort of involved in the operations of that. However, I was a member of the disaster leadership group called the DLG. That is something that existed long before COVID, primarily for pandemic planning, but also other issues that was led by the ASPR, who was Dr. Kadlec.

So I was a member of that and participated, you know, pretty -- pretty intensely not only because of my position, just -- but because I had been involved in pandemic, you know, planning responses, you know, really for 20 years.

So I was a member of that, provided input to that, but was not sort of in the operational chain early on. And we're speaking the January-February time frame.

Q Yes. And I want to distinguish that time frame to when you later joined the White House task force, and we will definitely talk about that.

So the disaster leadership group led by Dr. Kadlec,

how often was that group meeting at the time?

A To the best of my recollection, it was a weekly meeting, but there were also, from very early on in February, five or six task forces that I was not directly a member of because they were sort of staff-level task forces on things like PPE, hospital utilization, repatriation.

I don't remember all the task forces, but there was several that were ongoing during that time that met during the weeks in between our weekly sort of, you know -- principals are at different levels.

I'm talking about at the assistant secretary and the interagency would be with at that level would be about a weekly meeting.

Q Who else participated or who else was a member of the DLG, to the best of your recollection?

A I don't really remember specifically. There were representatives from the interagency -- from the interagency within HHS, but there were also -- FEMA was part of it. DOD was part of it. I don't remember. I'm sure those records are available.

It was a very read -- OSHA was available, for example. I remember that because talking about masking and orders for masks very early on. OSHA was involved for those kind of issues.

So it was really across the departments that -- and,

again, this was Dr. Kadlec as the ASPR function in that role.

Q Do you remember -- you said that there were five to six staff-led task forces. I understood you to mean within HHS. Is that correct?

A Within the DLG.

Q Within the DLG. I see.

A So the DLG sort of had -- I don't want to say -- it's sort of a leadership steering committee, DLG, but there were working groups that were working -- well, we met once a week and maybe had some calls, and Bob Kadlec's office was right down the hall from me. You know, the staff level, this is what they were doing. This is their job, you know, sort of 24/7 working on those.

And I don't remember. I remember there were five or six of them, and they were sort of allocated in the -- you know, hospital resources, PPE, repatriation. There were a few others.

Also, my officers were manning the SOC, the Secretaries Operation Center, which was led by ASPR. But, again, a lot of what you see went on either used my officers who were permanently or -- not permanently, but assigned to CDC or ASPR or we deployed them specifically from other areas to staff those roles.

Q So apart from those groups, did your office and

the repatriation efforts by the Public Health Service core, did your office have other involvement in the January or February time frame?

A Not really. I was -- I can't say always, but when the secretary had meetings with Dr. Kadlec and Dr. Redfield and sometimes the NIH, I was generally at those meetings. Secretary had sort of frequent sort of update meetings on that.

I was technically the only public health person in the office of the secretary aside from the ASPR, but I was a policy person. So I was at those meetings, but I was not -- I did not have a specifically assigned role aside from, you know, gaining understanding and contributing where I could.

Q On January 29, 2020, the president announced the formation of a coronavirus task force. At that point it was chaired by Secretary Azar. I don't believe you were a formal member of that task force; is that right?

A I was neither a formal nor an informal member. I was not involved with the task force.

Q I see. So when you're talking about the meetings that Secretary Azar was convening, these were other informal --

A These were HHS meetings with the operational. We call them divisions, OpDivs and StaffDivs -- with the relevant OpDivs and StaffDivs heads. I was part of that. I

was not part of the White House nor the task force, nor involved at any level at that time at that level.

Q What was your -- what was your sense of the threat to the United States at that point in time?

A At what?

Q Well, I'm assuming it changed during the course of January and February 2020. Could you just walk us through that, how you first assessed it, when you became aware of the reports of the respiratory disease and how that changed.

A So I think everyone shared concern, because it was unknown. We didn't have information on patterns of transmission. The Chinese were not forthcoming particularly early on and did not let the CDC in. That was a big concern.

You know, I'm an intensivist, a pediatric ICU doctor, so I always plan for the worst, because you plan for the worst so if it happens you're prepared for it. So sort of like the military, God forbid, plans for nuclear war and hope it never happens, but you have to plan for it.

So in mid-February with the Public Health Service, we started planning for, you know, sort of the worst case scenarios. It didn't -- didn't mean that we thought it was going to be that way, but we were just preparing because, as is typical if things would have gone badly, the Public

Health Service would have been called to carry the brunt of that load.

So, you know -- so we were concerned about it. We were, you know, as always, concerned about it. But it was more we have to do scenario planning. Not knowing what it was going to do, we planned for, you know, all the scenarios within my realm of influence, which was primarily, again, preparing for deployment.

And, for example, we saw that there were alternate care sites in China in mid-February. If those were going to happen here -- we had no idea if they were or not -- I knew my officers would primarily be called upon at short notice, so we were making those kinds of preparations.

Q Did anything specifically trigger your sense that there was a need to start planning for the worst-case scenarios?

A Not -- I don't think it was anything specific. You know, you just have to take in sort of all sources intelligence and, you know, when you see -- when you see -- and I'm not sure exactly the time period. I know by the end of February we were fully set for deployment teams should they -- should they needed to go. So we were planning a couple weeks before that.

But when you see reports even in the New York Times about major convention centers being converted into

alternate care sites in China -- again, I had a lot of different duties as the ASH, but in that moment, you know, we were the deployable healthcare force that was arguably understaffed and undertrained historically.

And, you know, my main objective during the early time was preparing my officers for whatever mission and to the degree that we could, you know, keeping them safe. And of course we were deploying to the repatriation sites at the Air Force bases and bringing people over. So all that was an ongoing deployment operation. So that's where I was really focused.

I can't say it was a single thing. It was just -- it was just the overall -- my responsibility was to plan for all scenarios within the realm I was given at the time. And my primary responsibility at that time was really the uniform Public Health Service and getting them ready, keeping them safe. My first obligation is to keep all my officers safe and to be ready for whatever mission we were sent to do.

Q And did this all happen as a result of your assessment that it was necessary, or was it a directive that, you know, was given for the secretary or whoever that it's time to start ramping up preparedness?

A No. It was primarily discussions between myself and Rear Admiral Orsega, who I had appointed as the

director. She's a two-star admiral, rear admiral upper half, nurse practitioner, veteran of deployments to Africa for Ebola in 2014-2015.

It was really discussions between her and myself, because she was responsible for all the preparations for deployment, et cetera. She was the headquarters chief and myself. There was no directive. You know, this was something within my realm of responsibility and needed to do it.

Q Okay. So then apart from the areas that we've discussed, did you have any other involvement in the response or preparedness for a potential response in January or February 2020?

A You know, there may have been some, but really I was -- those were my major -- those were my -- those were my major areas. And, again, participating in the intraagency meetings with the secretary and the principals, you know, and the secretaries. I was not involved at the White House level at all in January and February.

Q Well, let's move forward to when you did become involved at the White House level.

So you were -- on February 12, I believe, you were asked -- I'm sorry. March 12, 2020, I believe you were asked and March 13, 2020, announced as taking over responsibility for --

A Let me back up just a second.

Q Yes.

A So I really got involved on March 3.

Q Okay.

A So it might have been March 4, but March 3 or March 4. The secretary officially -- you know, there was an incident commander at CDC. ASPR legislatively is in charge of the response. So on March 3 or 4 -- it was right around that -- the secretary officially had Dr. Kadlec named as the incident commander, so running the response for HHS. And then I was named as his deputy incident commander. So that was the first time I truly had an operational responsibility working, you know, at that level.

So, again, I didn't mean to interrupt you, but I just want to say there was an intermediate step before that.

Q That's helpful. Thank you for clarifying.

Do you know what prompted the secretary or Dr. Kadlec to ask you to do that on March 3 or 4?

A I don't know. You could read between the lines. But between February and March, as the calculation of the threat occurred, the secretary asked me to do it, but, of course, Dr. Kadlec and I were very good colleagues, and I thought that was -- I thought that was the right position.

He was legislatively and also by training the best person to run the response. I had significant knowledge and

could work to complement him. So I thought that was a really good scenario, and I was happy to do that.

Although I was, quote, his deputy, my primary responsibilities was working with the CDC, and thus I think on March 3 I went to the CDC for two or three days and did so the following week as well.

Q And what exactly were you doing there? What was your -- what were you trying to effectuate with them?

A Its coordination. The CDC is a thousand or 800 miles away. It's a very large organization. And it's really coordination and gaining understanding at a very granular level what they're thinking about.

And because of my technical background, I worked not only with the leadership, but also met with a lot of the, you know, staff-level technical experts to understand because, you know, there can be -- not saying there was, but there can be a lot lost in translation as it moves up the ranks and gets to the office.

So it was really to help coordinate, which is very important to coordinate between the ASPR, CDC, and the other organizations. And CDC had a very active operation with maybe 400 people in their incident command center at the time.

So that's what I was primarily working on to make sure that there was, you know, seamless integration,

understanding, and, you know, sort of synergy in the response.

Q So, in other words, you weren't focused on any one sort of subject area?

A No. I was a deputy incident commander. This is very defined in the federal emergency response, you know, plan, what the incident commander should be, what the deputy incident commander. So we generally try to follow that framework, whether it's a hurricane or whatever it is. Part of that is it's a very scalable kind of systems that everybody understands the roles.

So no, I was not topically focused. I was the deputy incident commander, but I had a clear focus. You know, ASPR needed to be here in the SOC. Dr. Redfield, because he was on the task force, was often in the White House. So I had a clear focus on working with the CDC.

And, you know, that was natural for me. I had worked with the CDC a lot as the ASH. I was on the budget committee. I was the only public health person on the secretary's budget committee. I had occasionally been, quote, the senior advisor for CDC, you know, with sort of some of the structures meaning that I was sort of their primary contact. Even though not a line authority, I really worked with them on everything and budget.

So I had a great relationship with the CDC, so it was

a natural thing. It wasn't like I was thrown over the transom and showed up. I knew everybody, they knew me, and we had a great working relationship.

Some of the people either were in the core or they had previously been in the core. So it was very natural.

Q Who were you primarily working with at the CDC?

A So obviously I worked with Dr. Redfield a lot. Anne Schuchat -- I think she was still in uniform at the time or she might have just been out of uniform. Dan Jernigan was the incident manager, I think, at that time. I worked with Nancy Messonnier quite a bit at that time.

And there's a lot of people who came in and out of the CDC. And then I worked with people in the modeling group. I don't remember specific names, but certainly the incident -- you know, the incident commanders down there. But also I did work with -- when I say "work with," I listened to and got briefed by several of the working level groups, including the modeling groups.

Q And how long did you end up staying down there or working with them?

A I think I went there for two or three days, and then I came back the next week for two or three days. And that's sort of when the next transition, you know, happened.

Q And so we'll go back to the next transition in a moment.

But did you remain in that role after the -- as deputy incident commander? Did you leave that position when you joined the White House task force?

A So there was -- so there was the March 12-13 when Secretary Azar had me lead testing for HHS. And I was still, you know, deputy incident commander, but there was a transition within the next four or five days to go to FEMA. So the entire structure changed then.

And when that structure changed, it was when it was the national disaster declaration, and the primary agency got moved to FEMA. Then I was on the UCG, the unified coordinating group, which was the decision-making leadership at FEMA. It was not -- the structure of that kind of changed, so that was Pete Gaynor, who was the FEMA director, ASPR, Bob Kadlec, the CDC incident manager, who was Dan Jernigan at the time, and myself.

So we were the UCG that really was the policy and decision-making group for the response, and we were all sort of equal in that role.

And it moved into a FEMA structure where the incident commander was the director of the NRCC, the National Response Coordinating Center, who is Josh Dozier. So there was a couple iteration of the leadership during that time.

So, yes, I was deputy incident commander, but we were already migrating sort of toward a FEMA structure, and when

the president pushed that button, that's when the UCG got established.

I'm happy to talk about what we did. And the task forces all got organized under, you know, the FEMA structure to the UCG.

Does that -- is that sort of clear?

Q Yes. I do want to break it down a little bit more, but let's pause before we do that and just -- since I think that that transition to FEMA, that happened after -- the FEMA structure began after you joined the White House task force; is that right?

A Correct. In joining the White House task force, when I started participating in the meetings, yes, right. So the March -- I think I was named by the HHS on the 12th, and I think the 13th was the major Rose Garden press conference with the CEOs.

And that weekend of work, and then the Sunday -- the Sunday press conference with the president and the vice president in the press room. And then I started being invited to all the task force meetings. You know, I never got a letter saying "you're on the task force," but I was at every meeting and on most agendas, you know, from then.

So that happened like on the 15th or 16th, but I think it was like March 19th or 20th when FEMA changed, so it was a very short period of time.

These are all, you know, obviously objective things. I'm just trying to remember three years ago. But there was only a four- or five-day split between when I started being invited to the task force meetings and when the FEMA button got pushed.

Q I understand. That's helpful. And we're not trying to test your memory on exact dates or anything like that here.

A That's good, because it was a long time ago.

Q It's helpful --

A In a year with very little sleep.

Q I can imagine.

How did the possibility of you becoming responsible for testing arise, or how was it presented to you in the first instance?

A So I think -- you know, I'm just going to speculate just a little bit, because you really have to talk to the secretary. But clearly testing was a multiagency problem and a multidimensional problem. There was clearly a regulatory dimension with the FDA. There was clearly a public health dimension with the CDC. There was a technical dimension, you know, what lab test and how -- you know, how to make them, et cetera.

And the reason why I went into my background a little bit with the secretary, it was very common for him to have

me sort of lead, which is -- could be the role of the ASH, but also just because of my background. So it was not uncommon when there was a multiagency, multidimensional problem that he would ask me -- like opioids, for example -- to kind of be the lead for that.

So this was clearly a multidimensional, multiagency problem that needed coordination and integration, and he needed somebody to be responsible and to be accountable. The secretary was all -- always empowering, but you were accountable. And I was fine with that. So he wanted me to do that.

I think you know the memo for the purposes of testing and diagnostics. I was legally in charge of CDC and FDA, which gave me the authority, but I also had all the accountability for achieving the objectives of the secretary and, you know, the nation.

Q And did you say that the secretary approached you?

A Yes.

Q Okay.

And he told you that you would be in charge, including of CDC and FDA?

A Well, he asked me if I'd be willing, but I'm always going to say "yes, sir" if I could be that way. And we had a very good relationship at that time. So he

requested that I do that. I, of course, said yes and it kind of went from zero to a thousand miles per hour very quickly over the next 24 hours.

Q So that happened very shortly before it became publicly announced?

A Like one day, yes.

Q And when he approached you, how did he describe the need, you know, the status of the issue at that point?

A I don't remember, but I sort of knew it, because I was, you know, involved and I was, I would say, for a couple weeks before that really trying to help him technically understand what the status was. And a lot of that was with my liaison with CDC. Right. Understand what the status of testing, what the numbers meant.

So I was -- he didn't have to explain to me. I was -- you know, sort of had been helping him to understand a little bit more what things -- what things meant and where they were.

Q What specifically were you helping him to understand about these things?

A Numbers, you know. How many tests there are, what's the status of them. What's in a test, what does that mean. You know, those kinds of things that, you know, took a little while, actually, for me to even understand.

But, you know, at a secretary level, he really needed

somebody who could be strategic and understand, but also technical. I mean, I ran a research lab for 10 years. You know, it was a little out of date, but a lot of the tests that were now fielded were things that we had invested in at DARPA, like the CEPHIA team expert, and that's all right out of the DOD.

So I had been involved in developing those, so even though I wasn't a laboratician, I trained in molecular biology. I knew all these things that I ran in my lab every day. So it was natural for me to help with that.

So it was really just gaining a better understanding of what the numbers and trajectory, you know, meant. So I never thought I would sort of be in charge of it, but, you know, I often functioned as sort of -- I'm not going to say a filter, but the secretary trusted me on levels of science and medicine, and I was in his office. And as I said, you know, the name assistant secretary means something. I'm there to assist the secretary.

So I tried to help always put -- he was very bright technically and scientifically, but he was trained as a lawyer, and he always sought the medical scientific perspective, which I tried to help him, you know, gain the full knowledge of.

I mean, sort of like what is PCR; right? I mean, what does that mean, how is it involved, what does it do. He

really wanted to understand that at a level enough that he could be, you know -- because it was important enough that he needed to gain some technical information about that.

Q You were often referred to as "the testing czar." Is that a term you used yourself or is that just how the media described your role?

A Literally before it was going to be announced I was in control of testing, Politico put out an article that I was the new testing czar, and nobody ever gave me a crown. I never had a national title. I was technically the coordinator for testing within HHS, but that sort of got translated to the next -- to the next level. And that was Politico.

Q How did you refer to your role internally or how were you referred to among the task force?

I just want to make sure I use the right term in questions going forward.

A I don't know if I was ever referred to as anything. I mean, I was always the person who was developing, implementing, leading the testing initiatives. I reported on testing. We started new initiatives.

Obviously, you know, we had a diagnostics task force. We had a community-based testing task force. We set all those up and I worked with them, clearly, but obviously particularly I worked -- you know, I worked very closely

with a lot of people. With Dr. Birx for sure. You know, Brad Smith, obviously operationally. I won't get into that.

But I don't think I was referred to anything, but clearly that -- you know, we all had domains and that was my primary domain, and I was clearly the person responsible -- you know, primarily responsible. But, you know, all the docs worked together on a lot of the issues.

And certainly we had a lot of input from, you know, the docs on the task force and the docs on the White House task force and also -- you know, each of those task forces probably had 50 to 70 members that were integrated from CDC and FDA and some DOD. So they were all integrated in those multi -- multidisciplinary task forces that were organized under the FEMA UCG; right?

So there was a lot of inter action across the board, but I don't think I ever had a title.

That's just reminding me that I'm supposed to be at the Subcommittee hearing today.

Q Well, I want to, you know, focus on actually the issues that you were taking on.

So when you stepped into that role, whatever we'll call it -- and I might refer to it as "the testing czar," but maybe we'll try to say "coordinator."

A Sure.

Q What was your view on what was causing the

shortages that you inherited? And I don't think it's -- it's pretty widely understood that there were considerable shortages of coronavirus tests by early March. Would you agree?

A I don't like the word "shortages," because there were shortages of testing in the middle of 2021. You would have liked to have a billion tests a month, and you can't do that. There were no tests in the stockpile. There was no plan from any administration.

So we needed to ramp up testing. But "shortages" sort of implies something that I don't think characterizes it very well.

My first job -- it was actually assigned to me on that first day before the Rose Garden -- was to get a system of national, quote, drive-through testing sites and do it as quickly as possible.

So the first task, which really involved 48 hours of continuous work that Brad Smith and I led, was to -- along with Public Health Service officers, was between that Friday in the Rose Garden and the Sunday in the press room to develop and have an implementation plan for the first federally supported drive-through sites and everything that went into that, which was quite -- which was not -- which was not easy, actually.

Q I can't imagine it was.

Who gave you that directive?

A Dr. Birx and Jared Kushner.

Q I definitely want to talk more about how you effectuated that and the many tasks you took on afterwards.

But just going back to that characterization and regardless of how you frame it -- and I think I understand what you meant -- you know, I think on March 6, for example, the vice president said we don't have enough tests today to meet what we anticipate the demand will be going forward. So I think there was an acknowledgment that there was a need for more tests.

A 100 percent agree with that.

Q Okay. So --

A In my entire time as the testing coordinator was to get as many tests as possible as quickly as possible with the diversity of tests that were needed to fill out the ecosystem. And that was a very important role, not just PCR tests, but to develop the point of care tests, molecular, and the point of care antigen tests, because it's -- the numbers are important, but the ecosystem of how it fit together was also critically important.

Q Absolutely. But I want to get an understanding of your sense of the situation you were taking on.

So there were a number of things that people pointed to around that time as contributing to the need for more

tests. There had been failure at CDC's lab. I'm sure you're familiar with that. It was either a contamination or a flawed test developed.

There had been -- FDA was proposing EUA requirements. Some people said they should have waived them sooner. They eventually did, I think, on February 29. I think there were media supply shortages. There were a number of things going on.

And I just want to get your assessment of prior to you taking on that role, are there things that you think should have happened differently, whether intentional, whether accidental, you know, policy-wise, whatnot, that could have led to a better situation in March 2020?

A So I'm happy to comment on my assessment at the time I took over. I didn't have a full, you know, assessment then.

You were correct that the CDC did a spectacular job of developing a test, but the contaminated test really meant that there were several weeks that that test could not be -- or the tests that were distributed to the public health laboratories could not be utilized.

And, obviously, those -- you know, that's a fact. I mean, that is a fact.

It is also a fact that the FDA decided -- and I would say FDA career individuals decided -- to impose premarket

review on laboratory-developed tests on LDTs, which also delayed major academic centers from implementing tests without fulfilling the FDA requirements to those times.

These are -- these are facts, and you stated them to me and I'm stating them back to you, and you can draw whatever dots there were there.

When I took over -- you know, again, I think what you pointed out are the interagency interactions that needed to be worked on and prioritized as well as the entire scope of the supply chains that were involved in the testing milieu. The CD -- so, period.

Q So since -- I imagine you've developed considerable expertise on this since that time. Do you have a view -- you know, our primary goal in this entire exercise is to develop lessons learned to, you know, prevent or do better if this situation ever arises again.

What could have been done differently that would have led to you taking on a better situation in March 2020?

A So the major problem is that there had been no administration -- and I at least go back four administrations -- that thought testing was important. And that's the underlying issue.

The -- and I'm not blaming, but the Obama playbook mentions testing once with regard to humans. It was not in a stockpile. There was no understanding of the supply

chains. And, again, I'm just speaking broadly and I'm not blaming our administration, the Obama administration, the Bush administrations. It just wasn't.

And the reason why, I believe -- I don't know, but the reason why was that we planned for pandemic influenza, and testing just wasn't that important for flu. Everybody's symptomatic. There were flu tests already on the market. In 2008-2009 pandemic, you know, sort of the flu diagnostics worked. We didn't need to care, often, if you didn't get diagnosed, because you did a clinical diagnosis.

So testing had not been a major focus of any pandemic plan, and that is the ultimate root.

Operation Warp Speed was extraordinarily successful and it was needed, and it did things that could not have been done if it wasn't there. But it also built on 15 years of vaccine preparation. Okay? If I would have had 15 or 20 years of diagnostics preparation, there probably wouldn't have been a need for a, quote, testing czar, but there wasn't, and so we need to do it in real time.

Q Do you have a view on what kind of difference that investment -- if all of those administrations, if all the people responsible had viewed testing differently, what kind of difference it would have made?

A I struggle with that, because I believe testing is good and testing was -- you know, we tried to improve it

at every level. It would have helped around the margins, but not substantially.

And when I mean help around the margins, you know, as soon as we had them, we did -- we did nursing home testing, for example. So you could -- you couldn't fence in anything, but you could partially protect some of those groups.

But literally -- look what happened with the Delta wave in 2021 or the Omicron variant. We had tests out of the wazoo, but we still had 560,000 deaths during that period of time, higher than in 2020.

So inarguably we had many more tests then, but it didn't prevent that.

I don't want to give the impression that testing is not helpful, because it really is helpful, but particularly with this outbreak, I think you could look at what happened with Omicron or look at what happened that it can be helpful around certain populations.

And clearly, you know, I wish we had a billion tests on day one, but I honestly don't think it would have made a major change in the trajectory of the pandemic, given this virus in this society, you know, at that time.

You know, we focused as much as we could on the high yield, meaning healthcare workers, first responders, protecting the elderly. Right. You'll probably get into

that in July and August, because I thought we could really make a difference in protecting those populations.

But those are kind of things that could really be -- where testing could have made a difference, and in the current world, test to treat is very important.

That was not in our armamentarium, but the ability to focus testing on those who can get Paxlovid or molnupiravir so that you could link that very tightly. These are the kinds of things that testing could really be helpful for aside from just the overall epidemiology.

Q So another factor that I've seen referenced as contributing to the number of tests that existed in early March was the failure of private industry with the major diagnostic labs to get involved before that point. And I know you eventually worked with them quite closely.

A Daily.

Q I believe that.

I imagine that -- well, one factor that I've seen at least pointed out is that they had invested in tests, developing tests for SARS previously and spent quite a lot of money on it, but then it turned out there was no demand, so they lost money because they didn't have the incentive to do that.

Do you have a view on that as the contributing reason?

A I don't have a view on that. I never discussed

that. I never really discussed that. I mean, the major labs -- literally the moment that I sort of got in the role, the Roche test was authorized and then very soon thereafter Thermo Fisher. So Labcorp and Quest were up and running and some of the major labs.

I never asked them if previous policies -- you know, we were in real time just dealing with the present. So I'm sorry. I don't have a view on that.

Q There were also around that time a lot of comparisons being made between the United States and South Korea, South Korea having -- I'm sure you've heard this -- they were often credited with having engaged their private industry and scaled up testing quite quickly.

Do you have a view on that comparison?

A When I took over, South Korea was -- you know, were performing multiple times the tests per day that we were performing in this country. And there were a lot of limitations to their system that didn't translate, but numerically, they were performing more.

They had -- you know, obviously, when we were developing the initial, quote, drive-through sites, I had direct contact with the Koreans, the Korean CDC, the American CDC people who were over in Korea.

It is a fact they were performing more tests than we were numerically on a population that was a fifth of the

U.S. population or a sixth of the U.S. population. That's a fact.

Q And not to totally repeat my earlier question, but do you have a view on what the U.S. could have done to be performing tests more on par to South Korea at that point or whether we should have been?

A Well, I have to go back is that testing was not a consideration in any of the plans. As I understand it -- and I don't have this from a primary source -- Korea got burned during SARS, and they were -- they had the population, so it became part of their national testing -- their national response framework.

And as far as I can tell, you know, it just was not on the response framework of any administration that I've been aware of. I'd been very involved with the Ebola outbreak in Texas. So you have to test, you know, 50 people; right? Influenza, you don't need testing.

It just was not part of any plan here. I don't think there had been in any administration true discussions with the industry about what a public-private partnership would look like.

So I think that's the major issue. It was just not a primary planning issue for -- you know, I'm going to say at least going back, you know, to when I was heavily involved starting at DARPA in 2004, I don't think that was part of

any of the major, you know, planning situations.

Q Okay.

Ms. Gaspar. Let's go off the record.

[Discussion held off the record.]

By Mr. Benzine.

Q We can go back on the record.

Admiral Giroir, I'm Mitch Benzine with the minority staff. I have a few questions for you, but I want to ask you a few questions from the last hour.

When you took over as testing czar, coordinator of testing, were you doing everything in your power to get as much testing as possible?

A Yes, absolutely.

Q What's needed to build or administer an accurate test? Do you need the viral genome, swabs, PPE, various things?

A Yes. So starting with the virus, if you're doing a PCR, preliminary chain reaction, test, you need the sequence, the genetic sequence of the virus around which to build the components of the test, called "primers," that are important to match the virus.

Later on, for antigen tests, you need the actual proteins from the virus in order to make the antibodies for the test. That was much later on.

So those are the components that you need from the virus.

Then you need a number of components in this regard, you know, for an integrated end-to-end solution is what I like to call it. People talk about a test, and I said this at many press conferences: There's one thing to talk about a test, but an end-to-end solution.

A test is generally referred to what's in the laboratory, sort of like a kit that once you get a sample, you put it in and you put it in a machine. But before that, you need, in this case, swabs to collect a sample, and that could have been nasopharyngeal or nasal, depending on the role. Had to be the right kind of swab for the right kind of test and the right kind of person.

You needed a tube of something called transport media, in general, early on, not for the point of care test, but for the early test, for which you put the swab in. You needed to transport that.

Many of the tests also needed components that were not in the sort of kit. And I'm just going to call those "extraction reagents." In other words, you get this big pile of, you know, nasal mucus with virus particles in there. There's a general group of reagents called extraction reagents that actually extract the virus nuclear material out from this gunk that you send it in before it

can actually go into that.

And there are lots of other components. You know, robotics or high throughput, pipette tips, things that happen in the laboratory. It's a very complex system.

And then, of course, you need the infrastructure to report the tests, which is something that you'd like to do digitally to the Public Health Service, but you got to get the tests back to the people.

So that's just sort of an outline. An end-to-end solution, it's really the idea of the first concept of a test, including who's going to order the test and how you get it done, how is it going to get collected, all the materials for collection, how is it going to get sent, how is it going to get prepared for the test, run the test, and then reporting it out on the back end.

So it's a rather complex, you know, system.

Q So two things were reported: First, that the Chinese government hid the genome of the virus, hid the virus generally and also the genome of the virus for potentially a couple of months.

Would that have delayed the start of testing?

A It would have -- I'm not going to say it would have. It did. It did delay the start of testing and it delayed the development of a vaccine. Because all we needed, really, was the genetic sequence.

Particularly with mRNA technology, once you have genetic sequence, I think the first candidate vaccine was done in 10 days, something really that quick. And for the polymerase chain reaction, the PCR laboratory-based test, all you need is the gene sequence and literally you could develop a test based on that within a few days.

So, you know, every day that that was delayed, delayed testing. It delayed vaccine development. And also -- and this is a little bit more subtle -- but by knowing the gene sequence, you could also make some predictions about the behavior of the virus. So it delayed our understanding of that.

Q So the Chinese government first reported the genomic sequence of the virus January 12, but the Chinese CDC, it was reported, had it by December 27, so a full two weeks prior.

If we had gotten the gene sequence from the Chinese CDC had it, do you think testing apparatus could have been up and running by early January, at least the knowledge of what goes into the test?

A Well, everything gets pushed back by, you know, those two or three weeks. I don't know when they had the sequence. I mean, I know what was reported. I don't have any primary knowledge of when they had the sequence. But literally, they should have had the sequence within a week

of the first -- of the first cases, and that could have been back in October or November.

So I just don't know when that starting point was. But everything moves back literally. That's kind of time zero, and you can count back from that.

So whenever they had it, you know, we needed as much time as possible. It did delay it, certainly.

Q And on May 1, 2020, the Department of Homeland Security issued a report that said the Chinese government not only hid the existence of the virus, but started stockpiling and decreasing exports of PPE. It says they cut the exports of surgical gloves by 48 percent, surgical gowns by 71 percent, surgical masks by 48 percent, ventilators by 45 percent, and cotton swabs by 58 percent.

Would those -- all those things be important in the response to -- the early response to the coronavirus crisis?

A They were all critically important in response, including in testing.

Q Would -- would China intentionally cutting its exports of those to the United States have hampered the testing program?

A I have no primary knowledge of what they cut. You know, that is the report. But the testing program -- the primary reason why we could not have done more testing with our first sites was the fact that there was not enough

PPE. And if they cut that, that directly -- PPE was the limiting factor in our early testing.

Can I explain that?

Q Yes.

A Because early on we had to do a nasopharyngeal swab. That's the one that goes all the way back in the back of your nose, and that had to be done by a healthcare provider. And in between every test, you have to change PPE or else you could infect the next person.

So early on, we could only run our testing sites at a fraction of what they could have been done because of the PPE issue. If we would have had that earlier, we could have ramped up testing much more quickly.

Now, we did a technical -- you know, that's why our number one priority, my number one priority starting that week in March was to get the data to prove that an anterior nares, the tip of the nose swab, was as good or almost as good as a nasopharyngeal swab.

That allowed people to do it by themselves, which means we didn't need that PPE and we could just run people through it as quickly as possible. I think that happened like the first week in April. So that was an all-out technical sprint that we needed the data for that opened up the PPE issue for testing.

Q Thank you.

I want to go -- switch topics a little bit.

I don't know how much you are aware, but this is probably the 15th, 16th, 17th interview in this series of interviews we've done, and the investigatory scope is from December of 2019 to January 20th of 2021, so intentionally leaving out the Biden administration.

In your letter back to Chairman Clyburn, you raised several rhetorical questions, and I want to pose them as actual questions.

You said if America's COVID deaths were due to a failed response under the Trump administration, why may have 560,000 Americans died during the Biden administration, far more than died under President Trump?

How would you answer that question?

A Well, it's a continuing source of frustration to me, because the implications are -- and you hear this all the time -- it was all politicized and we didn't follow the science and that's why so many people died.

You know, not only can I refute those insinuations, but if that were true, why when the Trump administration transitioned the most robust testing infrastructure in the world, 900 million vaccine doses, 70,000 vaccine sites, imminently antiviral drugs, if it was all because the Trump administration was politicizing and we didn't follow the science, why has the Biden administration buried more people

than the Trump administration?

And I'm just trying to make the point that trying to blame politics or those kinds of things is the worst thing we can possibly do, because it makes Americans believe there are simple solutions to this. Just change the president or follow the science and we're not going to have a problem in the future. And that's not true.

So I was not trying to make, you know, negative comments particularly about the Biden administration, although I do later on because I have issues, but I was trying to make the point that the problems are real.

This is not due to President Trump or politics or a lack of science, that we followed the science. We worked as hard as everybody has ever worked on any problem in a collaborative fashion to do what we could in the midst of an unprecedented pandemic.

Q We're going to talk a lot about testing today. In your letter -- and I think Dr. Birx confirmed this in her interview too -- reported that you said the testing volume plummeted from more than 1.8 million per day when Trump left office in mid-January to 500,000 per day six months into the Biden administration, and you also say that you left a robust testing infrastructure that you had set up.

Why do you think testing fell off so dramatically?

A Number one, testing wasn't emphasized to the

American people. I was on the media all the time promoting testing and masking and other issues. It was almost like it completely disappeared from the media.

Do you know who the new testing czar was? I bet you don't. So it was completely de-emphasized. I think it was -- I think they put all their eggs in the basket of vaccines, and clearly vaccines were absolutely important. I 100 percent support vaccines. But testing wasn't emphasized.

Secondly, and very disturbing to me, was that the infrastructure wasn't sustained. So there was really, at least what I can tell publicly -- I have no -- nothing else but public record -- there was no sustained orders of testing, particularly of the rapid test, from January through like September.

And then when the fall surge came, you know, you saw reports by the CDC that there was a testing shortage. It was widely reported in the press and confirmed to me, at least, by people in the industry that many of the production lines that we had set up, particularly for the Abbott BinaxNOW -- which is a very manual thing, because you didn't have time to make instruments.

This was literally manually with people. And I went to all these places, and I know what they were doing. That -- and they were operating on literally no margin;

right? So when there were no orders, they shut down the lines.

So the testing infrastructure kind of involuted even before it -- even while the pandemic was still going on. So there was a big catch-up sort of in October and November that got us a new wave of tests right after we didn't need them anymore.

So I was particularly disturbed. The sort of national testing centers, we had already gotten that budget approved by the time I left. We could not complete that because, you know, the clock ran out. But it took, you know, eight or nine months to even get that awarded, much less started.

So I was particularly concerned because there was -- you know, there was variations in testing that occurred, because it's like anything else: When there's a lot of -- when there's a lot of outbreak, people want to get tested more.

So when the outbreaks -- there's a natural ebb and flow to this with variations, but tests really plummeted and the infrastructure really went under and that's why we were in such bad shape.

Our projections were that if we had continued with the infrastructure build, we would have had probably a billion tests per month by July or August. And you saw we were very little over the testing capacity that we had when we left.

And, again, I don't have all the inside information. When I was in office, we gave that to the media every single week: How many tests, what's our capacity, how many tests we have, what's the projection for the future. That was there. And you just didn't see that anymore.

So I'm interpolating, but clearly testing went down by 70 percent. The infrastructure was not invested in, and a lot of things that we built just senesced. Everybody got behind, and that's why there was such a flurry in the fall to try to catch up. And, again, it was a little bit too little too late.

Q You bring up your position. During the transition, did you read in a testing czar? Was one appointed beyond who took over for Dr. Birx, being Mr. Zients?

A There was. I did multiple transition meetings with the administration starting, you know, very early. And, you know, literally out of the 200 people on the task force for diagnostics and community testing, only three people left, so we left the entire infrastructure in place.

There were no cliffs, so contracts would run at least until April or May so they wouldn't have to worry about coming in and having a cliff.

We had money already allocated that they needed to press the button on, like another 60 million rapid tests

that was already budgeted. OMB approved it. I did not order those. That was an extra $300 million because there might have been other rapid tests approved and I wanted the Biden administration to be able to choose what they wanted. But literally all they needed to do was press the button on that.

We had put BinaxNOW on the GSA schedule, which I thought was brilliant because it guaranteed that every state -- no state needed to do a contract. All they needed was to go to the GSA and it was a guaranteed price at five dollars a pop, so states could buy as many of those as they wanted.

So I thought we left the system, you know, pretty well. And in terms of the testing czar, of course, none of us had the czar title, but Ms. Carol Johnson was the person taking over testing, and I briefed her virtually but personally in the January 10 to 15 kind of time frame, sometime around that time.

But I had already briefed, you know, many people on the transition team, you know, before that. But I did brief her personally and we had a discussion.

Q And so in your experience, obviously, being in the room, the transition did not hinder or hamper the testing infrastructure that Biden was -- Biden inherited?

A Look, you know, I'm an American first. I wanted

testing to be wildly successful under the Biden administration, so we did everything we could. And, again, people talked to me many times. In fact, Mr. Zients wanted to hire -- HHS wanted to hire me back in HHS to stay, which was not really appropriate, you know, given my previous position.

But Mr. Zients said he wanted me in D.C. and not to leave in case they needed any issues at least until the end of February. So I stayed in D.C. until the end of February to support the administration if they needed any help, and they didn't. They didn't call me after the inauguration.

And I knew that was the case because, you know, I think we left a well-oiled machine with no cliffs. I was very concerned about cliffs, right, because you don't want the administration to come in and like January 30 a contract expires.

And it takes the wheels of government time to move, so we were very careful to make sure that there were no cliffs. And there were a lot of -- I call them "push the button," you know, that they can just come in and hit the button, you know, depending on their choices.

So, you know, you want to leave well and you want to give the baton for the race at full speed and within the boundaries, and we really focused very hard, you know, on doing that.

Q Vanity Fair reported on October 22 -- yes, October 22, 2021, meeting with the Biden administration on increasing the amount of testing. The plan detailed the need for about 400 million tests going into the holidays and the New Year, and the tests were not ordered at that point in time. That was right up -- leading up to the Omicron variant.

Do you think the lack of infrastructure -- why do you think the Biden administration wouldn't order those tests?

A I can't speculate on why they wouldn't have ordered the tests. I mean, my mantra for the rapid test people is make as many as you can as fast as you can and I will buy every single one of them. We would distribute them, we would stockpile them, we would do anything, and we would continue that way.

So BinaxNOW was the first one. And, again, that BinaxNOW was the home test. There was nothing different; it just needed to have the data. So, as you know, we bought the first 150 million of those and then we bought the next 30 million too, and then we had another 60 million that we could have purchased.

And I don't know if they purchased any or not after we left. Those were -- that was the $300 million or 340 million we had OMB approve.

But my plan was to have been to continue to buy

every -- to guarantee the purchase of every single test so they would continue to ramp it up. So you wouldn't be ordering 400 million; you probably would have 4- or 500 million already in the stockpile, you know, by that time or distributed. Because at least it was clear -- and I think we have to look at it this way. It ain't over till it's over, and it clearly wasn't over in 2021.

So maybe that's not the right answer. You asked why wouldn't they have done it in September. I would have said I would have continued it all through the year, because you have to keep the infrastructure going.

And I don't know how much it cost to make a BinaxNOW, but, you know, there's very specific nitrocellulose that's ordered from a specific place in a western country that provides a sensitivity. There's monoclonal antibodies in there. There's gold nanoparticles on which the antibodies are put. There's all the manufacturing time to actually get that done.

So five dollars a test and a swab that's in there with a little media -- they had to be operating, you know, I imagine right at the margin. So if you don't continue to order, they're going to shut down and that's exactly what was reported in the media that, you know, they shut down the lines because there was no demand for it. And if there's no demand for it, you know, why make it. So...

Q In your letter to Chairman Clyburn, you also say "Why has CDC guidance under the Biden administration been so confusing and conflicted and seemingly politically driven delaying public disclosure of important data that were needed by the American people to make informed choices for themselves and their families?"

You worked very closely with the CDC while you were in the Trump administration. What do you think changed between the two administrations?

A You know, again, I only know from the outside, but sort of every bit of data seemed twisted for a purpose. You know, the data were the data, but the headlines and the moral of the story was always twisted towards a particular purpose. And I found that particularly disturbing.

The CDC had to have data on things like natural immunity. It was very clear from around the world that natural immunity was important.

And I want to be clear: I never recommend to anybody getting COVID instead of getting the vaccine. Please get the vaccine. And you could put that in bold letters on your transcript.

But if you've already had COVID, the focus of the immunization campaign should not be on those people. Don't keep beating them up. Focus on the people who are not immunized. Yes, focus on the people who had it, but it was

clear that their protection during Delta was four to five times greater by the final publication in MMWR on the California and New York data than those who had just gotten two vaccines.

So focus your efforts instead of, you know, demonizing the people who had had COVID and who are now victims. Focus on the people where you're really going to get the bang for the buck, and that is the unvaccinated people who had not been infected or certainly not infected in six months.

You know, we were told you don't need to wear a mask anymore, then you need to wear a mask. We were told that if you're vaccinated you're safe, and then you're not safe.

I think the CDC guidance has been -- well, let me just say I don't know what the reason is, but it's clear that even Dr. Walensky needed to take an outside look at the CDC because of all the problems they had.

And I do think, you know, that and other issues, like telling people they're going to get a booster at a certain date before the FDA actually clears it, led to a lot of confusion.

I'm not in the D.C. bubble anymore. I'm in Texas, and I speak to people who are just common working Americans, and I can tell you they've turned the CDC off completely. They don't listen to anything the CDC says. And I think that's a tragedy, because the CDC needs to have its luster restored,

and it's going to take a while before that happens.

Q What are the consequences of the normal Americans not trusting the CDC anymore?

A Well, if there's no one in the government you trust, then you turn to whoever you think you can trust. So I think not having a clear source of information makes people look for information in any place they can, and some of those are reputable and some of those are not.

You know, I'm sure some people don't like to listen to anything I say. A lot of people listen to what I say. So I try to still go on all forms of media, you know, CNN to Fox and everything in between, to try to give that information, but -- so that's where we were.

But if you don't -- when people stop trusting the CDC and the government sources -- and there's a lot of reason for that, and I think being transparent and admitting that you don't know certain things is still the best way to approach the American people instead of mandating things, giving them the information and letting them decide. I think those are all better ways.

But I think clearly the American people have progressively lost trust in the CDC, and that has led to a lot of the issues about vaccination, testing, and other things.

Q I want to talk about one specific example that

was reported last February that the CDC had accepted line-by-line edits from the teachers unions in their school reopening guidance, and the email suggests that teachers unions wanted specific language to trigger school closures. By that point -- you can correct me if I'm wrong -- that the science had shown that schools can remain open safely with proper mitigation measures.

Dr. Walensky in a letter told us that it's CDC's customary practice to engage with stakeholders who are end users of the agency's guidance and share draft guidance with them before it's finalized to produce the best possible product.

Can you explain the difference between engaging in stakeholders to ensure practicality and feasibility and accepting line-by-line edits?

A Well, let me say, first of all, that neither Dr. Redfield nor myself nor the task force ever advised closing schools. And, in fact, we focused -- I think Dr. Fauci on a couple of news interviews said to consider it, but it was never the position of the task force to close schools.

And, in fact, we had people like Dr. McCance-Katz, who ran SAMHSA, coming in and talking to governors about the absolute devastating and emotional and learning consequences of closing schools. So we never advocated for that.

We had to be watchful and, of course, that could change, but children are suffering dramatically because of school closures, particularly underserved communities.

So back to your -- the first question. It is absolutely the responsibility of government to get input, whether that's from a formal notice and comment period or informally from the stakeholders.

But I have -- and look, we did major things like the nutrition guidelines and the physical activity guidelines. We got formal input, you know, from everybody with opening comments, opioids.

But I am not aware ever and am shocked that a draft, a deliberative government draft, would be sent with an outside organization. That's sort of a no-no. This is deliberative, you know, things. You don't let people outside of the government line edit that.

Again, I don't know if it happened. I wasn't involved with the teachers union. But that would be very disturbing that an outside political group would be given line edits. That's very different than getting their input. I actually 100 percent believe they get their input.

And, again, I don't know what the ground truth was. I wasn't there. We never, to my knowledge, had any outside group see anything before it was published. We always got input from as many stakeholders as possible.

Q Do you think it's acceptable to take line-by-line edits under any circumstances, or should it still go through the CDC's normal review process?

A Maybe rephrase that.

Q If an outside group came to you with an edit, a suggested edit, would --

A So I don't think an outside group should ever have a suggested edit, meaning they see the document and edit it. I think their input needs to be taken seriously and discussed among the group, but I would never be in a situation where a government deliberative document, you know, pre-decisional and deliberate, those mean something in the government.

You have to have confidentiality to have open debate within the government, because not all things are black and white; right? There are shades of gray, and you need to be able to debate that.

So we took very seriously the deliberative process. We would never release that. So I would never get to a point of taking an edit or not, because that would have never happened.

Q Thank you. And in your letter to the chairman, you also say "Why did senior vaccine officials at the FDA resign reportedly because of anti-science pressure on the vaccine authorization process exerted by the Biden White

House?"

You alluded to this a little bit earlier, but President Biden announced the availability of boosters prior to it going through an FDA and CDC process.

Is that appropriate? Do you think that undermines credibility in the CDC and FDA?

A It absolutely does, because you had the President of the United States basically announcing that the executive agencies, the regulatory and scientific agencies, were going to do something on a certain date.

Just imagine what would have happened if President Trump in April said we're going to have all the vaccines done for you in September or October. There would have been a scream that would have shaken the buildings.

You know, that just -- and, again, I'm in touch with the daily people. That really said -- it reinforced -- and I'm not saying it's true, but it reinforced the impression that this was politics, not science, and therefore I don't trust what's coming out of it.

I think that was -- I just think that was a big, big mistake. And, again, there were some significant resignations at the FDA. I don't know the reasons for those resignations. I only know what was read.

But you should not get ahead of the FDA, and I don't think we ever did with that; right? I mean, we never talked

about a single test. I didn't place a single order, you know, publicly until it was officially authorized.

Now, the next day we would do something, right, but we wouldn't talk about it until that was done. I don't think we ever got ahead of the FDA with vaccines. We didn't do anything until they were authorized.

So I think that's treading on really dangerous territory, and it sort of reinforces the mistrust that certain segments of the population that we really need to try to reach.

Q Dr. Kraus, one of the two FDA officials to resign, wrote a piece in the Washington Post where he also talked about how the FDA stopped using their independent advisory panel to evaluate whether or not to recommend boosters for various age groups.

You were an acting commissioner of the FDA. Can you explain the importance of that panel?

A I think their decision is insane. It is absolutely insane not to use an advisory committee. And several members of the advisory committee publicly have said, we don't think -- you know, there's going to be disagreement, and it might not have come out the way --

There's two reasons to use an advisory committee. Number one is because you need their advice. I mean, these are the experts from throughout the country that have been

vetted. They don't have, you know, any skin in the game. They're trying to do what they think is right. So taking that advice is very important.

Secondly, this is all about communication and trust to the American people. Why would you ever bypass an external objective advisory committee when you're trying to convince the American people that it's the right thing to do?

So I would have had the advisory committee broadcast on every network I can publicly so that people could gain confidence, you know, in the decision of the federal government.

Look, you know, vaccinations, as imperfect as they are, are still our best defense against morbidity and mortality, and we have to do everything we can to promote trust. And I just thought -- and I'm going to use the word again. I think it's an insane -- it's not in the legal decision; right?

The FDA doesn't need to have an advisory committee. But I would have 100 percent had an advisory committee and made it as public as possible and as transparent as possible, because I want to get those extra 5 or 10 or 15 or 20 percent of the American people to agree voluntarily to get vaccinations to protect themselves and their family.

Q Do you think those actions, the announcement by President Biden and not using the advisory committees,

contributed to some hesitancy of Americans to get boosted?

A You know, I don't have a national poll; I just have empiric things, but I think it clearly does. Any time you bypass a normal system in the FDA, it raises questions. I can't quantify that. But I'm just saying that if the goal is to inspire as much confidence in the process as possible, then you continue the process and make it transparent. And that's what I would have done.

How much it would have helped, I don't know, but I would have definitely done that.

Q Your final rhetorical question in your letter is "How is it that Title 42 is to be revoked at the border, allowing noncitizens to enter the country freely but U.S. citizens returning home could be denied entry into their own country if they do not satisfy an artificial, outdated, and completely useless CDC testing requirement?"

You're referencing the Biden administration is still requiring Americans to test negative for COVID prior to returning to the United States from a foreign country. Is that requirement currently warranted under the scientific evidence?

A I believe it's not. The goal of that, as originally stated, I think, back in January of 2021 -- maybe it's December 2020, but it was around that time period -- was to try to decrease the introduction, the spread within

the country. Look at Omicron. If you talk about the number of cases, we were having 3 to 5 million new cases a day. So what's the point of testing Americans, you know, coming back when you already have this spread?

Secondly, the test on that day, even if that is important, you're only going to pick up potentially one-eighth to one-tenth of those who are really infected, because you're only negative on that day. You could turn positive the next day, the next day, the next day. So I'm just trying to --

And, you know, once you're positive, remember you could be positive for four, five, six weeks, meaning that we're stranding Americans around the world when they're no longer infected for no reason.

So, number one, it's really inconsistent. You don't need to be tested if you come at land crossings; right? And I don't know how many hundreds or thousands or millions of people cross every day.

If you're coming illegally into the country, you don't have to be tested. It's only Americans, including fully vaccinated Americans, that you might only pick up one out of eight or one out of 10 of them who are positive, who would only be a drop in the bucket even if they were.

So I think, you know -- and it bothers people a lot. It really bothers people a lot. I think Americans can go

with just about anything as long as they don't see inconsistency; right? If you tell me to wear a mask, I'm likely to do it unless my public officials go in public and not wear a mask at a restaurant. So they don't like inconsistencies or hypocrisy.

And I see this as outdated, abusive to American citizens, unnecessary, but normal Americans see it as just, you know, inconsistent, and they hate inconsistency. Why am I being treated unfairly for no reason at all?

And it's one of those little straws that break the camel's back. I think if we try to do things that are consistent, more consistent, then more Americans will sort of follow the things we really need them to follow and focus on the groups that really need to have it done.

Q Sticking with travel, a recent court order from Florida struck down the mask requirement for domestic airline travel. Generally, we've known for a while that airline filters, airline cabin areas, every two to three minutes, I think it's refiltered.

In response to the order Dr. Fauci said, "We're concerned about that. The court is getting involved in things that are unequivocally a public health decision. This is a CDC issue. It should not have been a court issue."

Do you agree with what it appears Dr. Fauci is

implying that CDC orders are above legal scrutiny?

A Dr. Fauci -- I interpret that as making a legal decision about who has the authority to do what. Last I heard, he has no training in that.

The court is making a decision about who has the authority to institute the mandate, not whether the mandate is necessary from a public health issue, and I think Dr. Fauci is confusing those issues.

I can tell you the moment that was lifted, I took my mask off in the plane.

Q Do you believe domestic airline travel is safe?

A Yes.

Q I want to shift gears again to the August 2020 testing guidance, which I'm sure we'll get lots of questions about.

In Chairman Clyburn's letter to you requesting this interview, he alleged that the August 24, 2020, testing guidance stated that individuals exposed to COVID-19 did not necessarily need a test was "contrary to the prevailing scientific consensus."

Did this guidance go through the interagency review process, through the task force review process?

A Yes, it went through the task force review process, and it was issued by the CDC independently.

Q What does the task force review process look

like?

A Related to this specifically?

Q Just generally. What would a standard review process look like?

A So it really -- you know, some guidances didn't get reviewed at all. But there's a difference between sort of a pure kind of infection control guidance and guidance that affects great swaths of America in terms of economics, food supply, individual liberty, schools. And that's why the task force had, you know, representatives from all over.

So when -- you know, the CDC is arguably – arguably -- and they've made a lot of mistakes, but arguably the definitive source on, quote, infection control. But that's where their span ends. So when it affected multiple segments of society, that's when the task force really reviewed it to get the broad -- the broad picture.

You know, if you wanted zero -- this was never suggested, but we could have gone into a current China Shanghai kind of lockdown, right? That gets you low cases, but it destroys America. So those are the kind of issues that were back and forth.

So in those kind of issues they clearly went to the task force to get broad input. When there was occasionally, like in this guidance, a lot of items that needed discussion, and I'm sure we'll get into more questions about

this, but in general, there was a lot of discussion on the technical issues among the docs on the task force, and when there was -- and it wasn't just limited to this. I can't really remember all of them. But the Vice President really wanted to get a consensus of the docs about what was the best recommendation that would go to the task force and then particularly the CDC, that would go back for CDC clearance. So often there would be a CDC document or a draft document or even a draft document from me that we'd try to get consensus among the docs and then bring that back to the agency as a working document that they'd go through their process.

So this specific guidance, there was a lot of discussion. There were a lot of items that were unclear and -- you know, because the science was not black or white.

So my role was to gain a consensus among the physician principals on the task force about what a consensus document would be that we could accept and then bring back to the Vice President as our recommendation that would ultimately be sent back to CDC to go through their clearance process, whatever changes, and then if it was significantly changed, I guess it would go back to the task force or they would just issue it. And that's what happened after I worked among the docs to get a consensus document, including line-by-line edits -- sent to everyone multiple times. Yes,

I'm Assistant Secretary. Yes, I'm the testing czar. But these things are so important.

And you're dealing with Birx, Fauci, Hahn, Dr. Atlas, Jerome Adams to some degree, that at that level I -- and I took it as my personal responsibility to be the, quote, secretary to make sure that everything was incorporated and I could ask questions back and forth.

So that's what happened with that.

Q Who were the doctors that reviewed this particular guidance?

A That I was working with on the consensus?

Q Yes.

A So it was Dr. Birx, Dr. Fauci, Dr. Redfield, Dr. Hahn and Dr. Atlas. I might have asked Jerome, the surgeon general, but he wasn't -- the surgeon general was intermittently present on the task force, but he wasn't -- and he might have been a member, but he was not sort of one of the core people who were there routinely, so I don't think he was involved in it.

But the people I said were clearly involved in it. And then, of course, I also included early on the Incident Manager for CDC at the time, who was Henry Walke, who was not on the task force, but he and Redfield worked so closely together, I didn't think I was violating anything by having the Incident Manager at CDC, you know, give the input as

this was going around and be churned.

Q Did any of those doctors that you just mentioned disapprove of the line that anyone -- that individuals exposed to COVID-19 did not necessarily need a test?

A There was not a single line edit to that on the turns of that and -- either by Dr. Fauci, Dr. Birx, Dr. Redfield, Dr. Hahn, or Dr. Walke. And there was not a single edit to that. And honestly, that wasn't an issue. Everybody understood that that was probably right. We were trying to prioritize testing to make sure that people who needed it could get it and get it in a timely fashion. This was part of an entire sort of midsummer strategy about prioritizing testing at ACLA, about prioritizing testing here, and we're just starting to get out the point of care tests at the nursing homes, so we're at a very important tipping point during that time.

Most of the discussion was about whether you could test out, like if you're in quarantine, can you test out after five or seven days. Those were the kind of issues that were really, you know, important.

But this was not -- this was not a controversial issue during, you know, the edits back and forth.

The other thing we were trying to do, which was -- which is very concerning, is that a lot of people who were exposed, I mean, really exposed, like, you know, in the same

room or in a bar, would get a test, and then think they were negative and just go out. So the point we were trying to make is no matter what happens, you still have to follow the mitigation guidelines. You need to quarantine for the days or whatever the mitigation was that the CDC was saying at the time. And a negative test is not a "get out of jail free" card, because you could be negative on day three and be positive for day four through 14. And we thought a lot of that was happening, so we were trying to dissuade people from that notion by saying, look, whether you test positive or negative, you've still got to do the CDC mitigation. If you're vulnerable or anybody else, then a positive test might mean something. You might get Remdesivir or antibodies or plasma or whatever it was. So that was the context of that.

But, no, nobody made any line edits to that whatsoever.

Q So it would be accurate to say that that line was the prevailing scientific consensus among the task force?

A Among the task force, absolutely, it was. And I think -- I think it was -- I think it was correct, even in retrospect.

It was highly misinterpreted and misrepresented by the media and by certain political forces.

But the purpose of the test is to drive action, and if the same action occurs whether you have a positive or a negative test, then it's a lower priority than for people who that test is going to mean something; right? You have to do -- you can't go to work in a nursing home or you're going to get Remdesivir or plasma or whatever it is.

So it's just true if a test does not change action, it's lower on priorities unless you're told otherwise by your doctor or public health official, which was put in there. And there could be lots of reasons that public health officials want people to get a test, like in, you know, outbreak scenarios or anything like that.

But that guidance, you know, absent the misinterpretation and the misrepresentation, I still believe that guidance was correct. And, again, it was not line edited by any of those individuals. And when it went back to CDC, CDC, you know, could have changed that. It went through their internal clearance process. They issued it the way it was.

Q One of the interpretations of that particular line was that it was to slow down or do less testing.

Was that line added to slow down or do less testing, like intentionally get fewer positive cases?

A 100 percent incorrect. It was meant to prioritize. But we were trying to increase testing every

way we could.

You know, just the month before -- month before, in July, we started emergency surge testing. We called it CBTS 4.0. Any place in the country that wanted an extra national site aside from the 7,700 we already had, all they had to do was call up and say we want a site. We did 650-something sites in 23 states starting in July. And, I mean, that's asymptomatic, door-to-door, everything. We went from Hawaii to Alaska. I don't know if we went to Alaska. I know we were in Hawaii and 23 states that did that.

We bought up every single point of care test that were the machine-based tests: BD and Quidel for nursing homes. Then at the end of August we started the 150 million BinaxNOW.

So we were trying to increase testing at every point. It was not meant whatsoever to decrease testing. It was meant, particularly at the sort of tipping point in the summer -- and remember, a lot of people were doing lifestyle testing: I wanted to go to the Bahamas, let me go get a test. So particularly the ACLA labs were getting a little bit behind in turnaround time, and they were still doing about half the testing in the country. So we really needed to prioritize that we did both from guidelines as well as specific pretty heavy-handed measures that I asked the ACLA labs that they needed to meet these requirements or their

reimbursement was going to be in danger to get the priorities right.

So if you had a lifestyle test -- and I'm just calling it that -- look, I support that, but if you want to go to the Bahamas, you can wait seven days for your test. If you're in a nursing home or you're sick, it has to be within 48 hours from the moment it's ordered to the moment it gets back. And we tracked that. Every single day I had the turnaround times from all the major commercial labs. Overall I had the means, I had the medians, and I had them from every single state, so I knew exactly what was happening from both Quest and Labcorp and then a category for the rest. So that was monitored and heavily managed.

And that's sort of what was going on at that time, right when we're at this tipping point of getting all the point of care things out there that was really going to, you know, change the ecosystem dramatically.

Q When that guidance came out -- you insinuated this -- there was a lot of media attention, a lot of political attention to it. And a few days later, Dr. Fauci said that he was in surgery when the guidance was approved.

Did he actually approve the guidance? Was he part of the scientific consensus?

A Yes, he was. And last I heard, he wasn't in surgery for 14 days. This went on for -- you know, I think

from August 4 or 5 or sometime around that to whenever it was done. So he had a couple turns of the crank.

When it was, quote, approved to the task force, he may have been in surgery, I don't remember if he was there or not. But the whole point was a consensus document, and he did not edit it and affirmatively approved it, cleared it before that time.

Q Thank you.

Mr. Benzine. We are close to our hour, and that is all I have. We can go off the record.

[Discussion held off the record.]

By Ms. Gaspar.

Q So during our previous hour, we were just starting to talk about the beginning of your role in the White House task force, and you had mentioned that shortly after you joined the structure that you were working on moved under the FEMA UCG. And I might be --

A You're right.

Q Okay. I want to get a little bit of an explanation from you on just that structure.

You mentioned several different task forces as part of it, and I want to just get a larger understanding of how that works.

So perhaps if you can walk us through what you recall about how that structure unfolded.

A So let me tell you what it was, and I don't know quite how it unfolded. I mean, there was planning before that in the PANCAP.

But the structure was basically the unified coordination group with the members I told you about, and that was sort of the decision-making group that dealt with very difficult issues that could not be handled at a lower level, like the incident commander.

There were maybe six task forces that were under that. Two of them related directly to me, the laboratory and diagnostics task force and then the community-based testing. So community-based testing was really all the drive-through sites and the 2.0 sites, which was all the retailers, the 3.0 and the emergents, so it was that entire situation.

There was a mitigation task force that was run -- so the lab diagnostics was run by Tammy Beckham, who was from my office at OASH but was a very experienced laboratory professional who had run major labs at Plum Island and other places. The communities-based testing was run by Rear Admiral Erica Schwartz, and she was actually the ordering physician for all those tests throughout the country.

There was a community mitigation that was led by CDC, and that was things like guidelines for masking, social distancing. They were really working that.

There was a modeling task force -- I believe that's

right. The names might be different, and FEMA has documented this -- that was really trying to, you know, do predictive models.

There was, of course, a PPE and supply task force that was run by Rear Admiral John Polowczyk. And don't ask me how to spell that, because it's very hard --

Ms. Gaspar. I'll tell you later.

A But Admiral P, as he was called.

And I'm not sure if it was a task force, but it was certainly a very important group about resource allocation.

I might have missed one or two, but there was six or seven task forces.

So literally every day there was a meeting that all the task forces reported to the UCG.

Then we had reports from every FEMA region in the country. That included the regional health administrator from HHS, which is my office, OASH. It included the ASPR representative that was there. It included the FEMA representatives. It was often in the region you had a -- the adjutant general from the National Guard. There might have been people from the local. So they all reported in.

And then we got DOD, NORTHCOM, INDOPACOM, the VA system. So this was sort of the situational awareness meeting for every day.

And then when there were issues -- and, of course, the

incident command, who was Josh Dozier of the NRCC. He was the director of the NRCC that all things came through, like resource requests. Like there's a specialized mechanism to request resources through FEMA, so we utilized all that. It was really important. A lot of that got done at the lower level, but, for example, the kinds of things the UCG would do would be in late March we had 12,000 ventilators in the stockpile. We had requests for about 114,000 ventilators. So the allocation of ventilators, we took as a life-and-death kind of situation. So we wanted to make sure that the UCG had the responsibility to make those allocations about where it went and when it went, and when there was concern like from governors, we took those calls. And we directly did that.

Another -- let me see. That would be one. Another example would be like where would we -- there was a limited amount of -- there's various levels of field hospitals that you could send from the DOD, and there are limited resources. So if you get a request, the UCG would make -- we wouldn't leave that to a lower level. We'd make that decision on an independent UCG meeting about whether we would approve that or not or approve a lower level. Those are the kinds of -- kind of decisions we made.

So that was really the operational group.

And you didn't ask the question, but I'm saying that

from now until eternity, if it's a national disaster of this, FEMA is the organization that needs to lead it. As good as HHS is, there's nobody that has the reach and the national sort of scale as FEMA. And I think that was a very, very important segment.

Now, the UCG was really the operational, you know, arm that did control. But we all were in the context -- and, again, this is sort of in the national command structure. There would often be a, quote, policy coordinating Committee and an incident response structure, and we kind of looked at the White House task force as that. So they were above that, above us, sort of as the strategic policy coordinating committee. At least that's how we looked at them in terms of the incident response framework.

Now, it was very helpful that, obviously, Pete Gaynor and I, officially or unofficially, were on the task force. And Admiral P, although he wasn't on the task force, he was literally at every meeting because the importance of supplies. So we had really good coordination across that.

But I don't know if I answered your question, but I was trying to give you the general structure of how -- and that started maybe March 19 or whatever, and it stayed that way until when that got sort of demobilized back to HHS like maybe in July or late June and July. In the summer.

Q That's helpful. Yes, you anticipated a few of

my follow-up questions, which the first was just to ask how this operational group interacted with the White House task force. So I think you've basically described it.

A Yes. And we always reported, you know, on the major issues, you know, to -- so we would always be on the agenda. You know, like Pete Gaynor would report, you know, where we sent -- you know, where sent medical units, what the requests were, where we sent them, you know, if there are any issues. I'd always report on testing. Bob Kadlec was frequently on the agenda, you know, to talk about other things. So we interacted that way.

And then, of course, I can -- you know, I was sort of -- independent of that, I was sort of a member of the task force to discuss all the other, you know, issues as well. So it was -- it was good that a couple of us were actually on the task force, and certainly Admiral P being -- spanning both, even though he wasn't on the task force, to help really with the communication.

Q So you've named a number of individuals, but other than those that you've talked about, who did you work with most closely within this operational group?

A Really the UCG and Josh Dozier as the -- and, of course, we worked with the task forces directly. Obviously worked very closely with laboratory and diagnostics and community-based testing. So I had a lot more interactions

with them aside from just these meetings. Because there was constant, you know, discussion about test supplies, allocation, you know, very early, very early with the ID Now. Like in March, the federal government, we bought 40 percent of the overall supply and were very involved in the allocation of all the other tests.

So I was working not only at the UCG level, but very intimately with the diagnostic stuff because I was, quote, the testing czar, coordinating that. And it was just a lot of -- it was very complex and -- in dealing with, you know, just a very complex system had not been mapped out before.

But that's really -- that's really it.

And I don't mean to minimize this, because it's not, like a joints communication group or something associated with that. So, obviously, you know, I worked with them some to make sure the messaging was correct about what was happening.

But that's really about it. I mean, Pete had a chief of staff and people helping him that we interacted with, but that was the basis interaction. Very much involved in the nuts and bolts of things with the diagnostic and lab, very much an UCG member for the rest of the interactions.

And, of course, I talked to governors all the time. Members too, but mostly, you know, governors, state health officials. You know, that was a constant, you know,

discussion. And governors felt free to call me and I talked to them all the time if they had issues.

We'll get to this later, but obviously the vice president -- I'm sure you'll talk about the task force, but the vice president often -- he was very involved in terms of, you know, wanting to know what was happening or he was very good about -- you know, Phil Murphy just called me, he has a problem, give him a call. So I would do that.

But that's sort of where we were.

Q So what were your most -- when you started in this role, what were the most urgent priorities in terms of scaling up or addressing the testing issues?

A Well, my first task was to do -- you know, we need drive-through sites up as quickly as possible. And there was sort of nothing built; right? So literally that -- between Friday and Sunday night, we had assembled a large group. We met Friday night initially in the west wing of the White House, but then the group got very big, so we just took over my suite at HHS, stayed there the entire weekend.

I called in a number of officers who had been doing the evacuations, so I had been running the testing and all the environmental health officers.

We had FEMA there because we decided very early we were going to use their pod system. I decided that on Friday night in Brooke Rollins's office in the basement of

the west wing, that they have a point of distribution system, which is what they do to distribute food and water, and we just decided that was sort of a mechanism that people understood at the local level. Like there was a role for security, a role for the locals, a role for the federal -- that we didn't have a whole lot of time to think about this, so we decided we were going to use this because it was known and we could build on it.

So we had FEMA there. Brad Smith and I really led that. Brad Smith was director of CMMI, but really he and were sort of -- I was sort of the medical/scientific; he was the operational guy to help do that.

We had a number of the volunteers -- I'll call them the volunteers -- who were assembled that were -- that worked as part of that.

So we really had to do everything involved with it. We had to decide the model. So we had groups working on individual things. Number one is how are you going to get it done, and that was really a combination of FEMA and our Public Health Service officers really modeling like what stations needed to be there and how -- you know, what would the flow be of that.

We had a group working on PPE, and I had a rear admiral who was really deciding what level of PPE do we need and how do we do -- how do we do that.

Very importantly, we had a supply group, because there were no -- there were no swabs. There were no media. We had to source all that, and we had to source all that and we were able to source that through public sort of levels, you know, during that weekend.

I'm not sure we had a separate group, but we had to get somebody to do the tests, so we got Labcorp and Quest.

And, of course, we had contracting officers and lawyers that were there all the time to kind of help. We had that group.

And then the entire patient experience. So we decided very early that we wanted to have this done, you know, from the patient point of view, so we had a group working on that that were working on communications, like what to give out. Because it wasn't just testing, but we wanted to educate, right, to educate people about what a test means, what do you need to do. So a communications group.

And also we made it -- and we contracted very early so that every person got concierge service. If you had a test, you literally got a call with your result from -- there was a commercial group that we contracted. So the public health people got it, but every person who went through got their test result and they got at least three calls before they got something written. So we tried to make it -- and then we built that over the weekend and sourced that over the

weekend.

Monday we did a test run someplace in Maryland. I think it was at a military base or something that we set up something and tested it. We had overhead drones looking at it, and we had everything on it. We started our first site on that Thursday.

I should also say that we didn't know where to put them, so literally on Saturday, I called CDC, Dan Jernigan, and I said, I need to know the major cities, the major locations that are hot spots now that are going to be in the next three weeks and I need that in an hour. Can't deliberate; we just need to know that. And got a list of them. Put those on a list. And then we started working with those health officials in the states and counties. This is what we're going to do; do you want this. And if you say no, I mean, I can't invade Maryland; right? You have to want this that we're going to be there.

And then, secondly, I need an address tomorrow of where this is going to be, because literally we put up 41 sites in the following two weeks.

So that was the first really large weekend. And we also identified, I mean, all the supply chain issues. I sent -- you know, there was only two suppliers of swabs. We didn't know that, because, again, if we'd been planning this for 15 years, we'd know the industry. So there was like 15

suppliers of swabs. We thought this was going to be great. But when you look back, they were only made at Copan in Italy or in Maine; right? So those were the only two suppliers.

So that Saturday night, for example, they were closing down Italy. The military sent either a C-17 or a 747 to Italy to rescue the shipments that were coming back to the United States.

So it was very high tempo. I just wanted to give you that.

But the first task was to really -- my first task, and it really was the right one, is to start creating that infrastructure.

And by the way, there were about 20 drive-through sites that were already up by states at that time, so we completely supplied them, even though we didn't run them, you know, federally with U.S. Public Health Service office deploying and doing that. We supplied them. So that was really the first week to get that up and running, and that gave us a good idea of what the supply, chain issues were and were going to be for the rest of the pandemic.

Q At that point, how did you -- or did you set goals for the number of sites or the number of tests that you thought the country was going to need either in the short term or over a longer period of time?

A No. We did -- we did not have enough information to know how many we were going to need. We were trying to understand the -- number one, remember, there was still like, you know, a few hundred cases a day. So the initial goals we set were literally orders of magnitude over what had been done beforehand. Like I remember even for the first couple weeks, we secured enough to do like 200,000 tests, which was unimaginable at that time. So we were really aiming big, but we didn't really know what we needed at that time. It was very much to understand where we were, to prioritize with what we had, and to gain -- you know, to gain knowledge, again, of the industrial base, the ecosystem, what was out there, contacting every manufacturer, you know, what's the plan, working with the FDA, what the EUA is.

But the goal in my first week was to get that 41 -- turned out to be 41 sites. But we didn't have a goal -- we didn't have a goal for how many we wanted. But we got the sites that were the major outbreak sites from CDC. And we worked with the FEMA officials about getting a few sites per area, and that's what we came up with. So Detroit, New Orleans, you know, New Jersey. Basically, what the CDC told me, that's what we took.

Q Got it. So the CDC basically determined the site distribution?

A Well, no. I asked them --

Q Okay.

A -- where the hot spots were or were going to be.

Q Okay.

A And then we work with the states to make sure that they wanted what we wanted --

Q I see.

A -- and then we work with the locals about where specific they were.

But the CDC had to give us the big picture, like you need to be in Detroit because Detroit is going to explode. You need to be in New Orleans.

So they did that, because we started with the science, right, where do we need to point, and then we had work with the state and locals because, again, you can't just go set up things. This has to be, it's federally supported, state managed, you know, locally administered. So that was sort of the FEMA mantra.

But, you know, talking to the FEMA people, they all knew about the pod system; right? So it was very much more complicated, because we had PPE, we had to test people, we had cross-contamination issues. You know, we had to ship these things. So it was very much more complicated.

But they knew the pod and could understand. And so a lot of the locations where they would have put pods like if

it was a natural disaster, they knew where those locations were that were easy to get to, that you can control the security.

So it was relatively easy for them to say yes, and then we have these preplanned sites and this is where we want them.

Q What were the primary constraints on the availability of testing at that point? In other words, was it the swabs? Was it the laboratory capacity? Was it personnel? Was it a combination of all of those things?

A During the first week, it was actually PPE.

Q Okay.

A You know, swabs became much more important later, but because we were doing nasopharyngeal swabbing, the limitations on -- and I think it was some calculation. Don't hold me to the exact number. But if we would have run those sites at full capacity, we would have used 80 percent of the strategic national stockpile on PPE in four weeks. So that's the degree.

So initially it was PPE that limited it. That's why I became immediately obsessed about getting out of the nasopharynx and getting into the anterior nares, because then you didn't have to do PPE because people could self-swab.

So that's one of those issues -- and that's what I

told the FDA. I never interfered with their mechanism, but I said, my number one priority is to prove that anterior nares swabs work or don't work. If they don't work, we can't use them. Then we have a huge problem. But I've got to have this and you've got to make this your priority.

And I let everybody know that in the healthcare plans and the manufacturers, and they were ultimately able to send the data in to the FDA showing that the anterior nares worked, and the FDA allowed that. And then we completely switched up, and then PPE was no longer a limiting factor. And that was by early April.

Nobody understands that PPE was actually the limiting factor to testing, to the national testing program. I'm not saying individually at labs. We can talk about that. But to my -- to the major national program, it was PPE.

Q I'm going to hand you documents. We'll mark it. This is Exhibit 1. And this is a document that contains a pack of White House coronavirus task force agendas.

So a couple notes about this as you're flipping through it. These were produced to us from our request to the National Archives. We do not know whether it's a complete set of all agendas. So the fact that there's a date missing doesn't mean that a meeting didn't necessarily happen on that day.

In some cases, there appear to be duplicates, and one

may be a draft and one is probably a final. There's some handwriting, because that's how we received them. We don't know who it belongs to, nor is it necessarily relevant. No reason to think it's yours.

And then we've added an index and page numbers just to make it a little bit easier to follow.

A Thank you.

[Exhibit 1 was marked for identification.]

Q So I assume you generally recognize this type of document as you flip through these agendas. Your name appears quite a few times through the series. I definitely don't want to ask about all of them, but maybe it would be helpful as a point of reference for a few different events that were happening.

So one agenda that I want to turn to is on page 22. The numbers are at the top. So this reflects a meeting that appears to have taken place on March 21.

A Yes.

Q So you are listed as giving a testing update with --

A This is -- I'm sorry. Saturday, March 21?

Q That's correct.

A 10 a.m. Okay.

Q Yes. And I think this is actually the second appearance of your name, although I will note that there is

a gap. We have a gap in several days between Thursday, March 12, which is, I believe, the day you were asked to join the task force, and then March 18. So it's possible you could have been at earlier meetings.

A So I know I was not at a task force meeting until after that Sunday press conference.

Q Okay.

A You know, Vice President Pence came to my office on that Saturday, like the 13th or whatever it was, for an update with the secretary. But I know -- I don't know when I started, but it was certainly after that Sunday. So I would not have been on earlier ones.

Q Also, I wanted to know, first of all, looking at this March 21 agenda -- and I should just maybe note the date -- not the day before, but the agenda before, which was Thursday, March 19. You are listed as giving a testing update on your own. So that's actually the first time we saw your name on an agenda.

A Uh-huh.

Q But -- all right. Here you're listed as giving an update with Jared Kushner.

What was Mr. Kushner's role on the effort at this point?

A I don't know -- first of all, I don't remember this meeting. I would say he was a facilitator for me. I

don't know what his role was, but I can tell you my interaction with him was very much -- you know, he was facilitating things, like making sure, you know -- which is very helpful -- like making sure we had contracting officers right there with us.

That doesn't normally happen in that. You know, he'd say things like whatever you need, I will make sure you get them. Don't worry about the money; we will find it.

It was very much that kind of interaction. And, again, independent of whatever his relation was, he was an assistant to the president, which is a very high-level official.

So, again, on the first day, Birx and he were the two people that came in and talked about needing a national testing level.

But I would say he was really a facilitator. And I want to use -- it may have -- it may have connotations that I don't mean to connote, but it's important to have top cover. Like, you know, we were in an emergency situation, and if we needed to send a C-17 to Italy, like, I was not going to get gutted six months from then for having done that because we were all trying to act in the best interest, and if I didn't get those swabs out.

So he really kind of helped make sure that we knew that at the highest level of government, whatever we needed

was going to be supported.

That's really -- that's really, you know, the interaction that we had.

And, you know, if he heard a problem somewhere -- because, you know, at that time we were getting input through a lot of different mechanisms. So he would like alert us, like, you know, Governor Cuomo needs something, call Governor Cuomo. That kind of thing.

But that happened all over. There would be input to the secretary, to the chief of staff. And in general, they tried to send it to the operational level to deal with that, of which, you know, Brad Smith and I were it.

Q I see. You just said something a second ago that Mr. Kushner and Dr. Birx talked on your first day about a national testing level. What were you referring to there?

A So that, again, my first day as coordinator and I mentioned that before when you said who said we need a national drive-through.

Q Oh, right.

A It was Dr. Birx, but Dr. Birx and Jared Kushner came to HHS, and it was in that context that they basically said we need this, and I understand you're the new guy, go do it.

Q Thank you.

You also referenced a little earlier volunteers at

FEMA. There has been a variety of reporting on Mr. Kushner having assembled a group of volunteers that worked at FEMA.

Are you familiar with that?

A Yes.

Q Did you see them in operation?

A Yes. They were in my office the first weekend. I'm not saying all of them, but that was -- we had a number of them from the private sector who had shown up, and we put them on our task forces and worked. So for a lot of the early time that week, they were working on the standing up the testing.

Q I see. So they integrated with your team and with the career employees who were handling this work?

A Yes.

Q About how many of them?

A I'm going to make an estimate, and it could be off by a factor of two or three, but I'm going to say maybe 15, something like that --

Q Okay.

A -- that were working.

And, again, I don't know the full scope, but I know we had at various -- we had a significant group of them that we integrated in.

When I talked about the working groups, like communications and stuff like that that were working, you

know, with the groups in my offices at HHS.

Q Did you know any of them individually?

A It depends. I mean, I worked with some of them.

Q Do you remember any of their names?

A Nat Turner. Nat was the head of Flatiron Health, and I think a variety of people came from Flatiron.

Probably the person I worked the most with and I think she eventually got brought on was Blythe Adamson, Dr. Blythe Adamson, who was an infectious disease epidemiologist and modeler. She was really critical for us early on.

I'm sorry. I don't remember the names of other people, because they were distributed. But Nat was, you know, Nat was head of Flatiron and a lot of people were there and he got introduced to me and we talked a lot. And, again, Blythe was super important earlier on. I think she may have been at Flatiron or she may have been somewhere else.

Q Do you remember where anyone else was from, even if not their name?

A I think there were several from Flatiron. I think a couple may have come from Brad Smith's former company in Nashville. I think that's true, but it wasn't a concern at the time.

Q How long did they stay working with you all?

A It varied; right? There were some who stayed for a week --

Q Okay.

A -- and there were some who stayed longer, although they weren't necessarily working with me. They might have been distributed.

And people like Blythe, she had an office in the west wing eventually. I don't know if she was hired, but she had a badge. So there were people who were brought on more formally. So I guess I would say it really depended.

I worked with them primarily during that first week and maybe some at FEMA when we moved operations to FEMA. But then that was about it for me.

Q Does the name Dennis Robb ring a bell to you?

A I don't remember that name at all.

Q There was a --

A If you can provide context, maybe, but I really don't remember that name.

Q You know, I don't have too much.

A I don't know that name. I don't know that name.

Q Yes. He was, I think, the CEO of Health Trust -- I actually don't have the full title. But in any case, there's been varying reporting about that name. I'm just curious.

A I don't remember that person at all.

Q And I know there were other people. I believe there were other people that worked on straight-up PPE

supply chain issues that maybe you interacted with less.

A Yes, and some of them may have been in that original, you know, testing group when we were working on PPE. But I know there were some that were working on PPE with Admiral P that I didn't work with.

I'm just saying my interaction was primarily that weekend and the several days after that when we were trying to get this national, you know, drive-through system in place.

Q So there was -- you're probably familiar with this. In July, Vanity Fair put out an article about Jared Kushner's -- the group of volunteers he had assembled and in part their role in working on testing. Do you remember that?

I can give you a copy of it.

A Vaguely. And I don't want to have read a Vanity Fair article right now.

Q You don't have to read the whole article. In fact, I will just read you a couple of segments because I just want to get your assessment of whether these statements are true and consistent with your experience.

So Vanity Fair reported in this article that Mr. Kushner had assembled a group that had, quote, teamed up with several top experts from the diagnostic testing industry together and hammered out the outline of a national

testing strategy. The group, working night and day, using the encrypted platform, emerged with a detailed plan obtained by Vanity Fair.

And then skipping ahead, it goes on to say: "Rather than have states fight with each other for scarce diagnostic tests and limited lab capacity, the plan would have set up a system of national oversight and coordination to search supplies, allocate test kits, lift regulatory and contractual roadblocks, and establish a widespread surveillance -- virus surveillance system by the fall to help pinpoint subsequent outbreaks.

"Some of those who worked on the plan were told that it would be presented to President Trump and likely announced in the Rose Garden in early April, but no nationally coordinated testing strategy was ever announced. The plan, according to a participant, just went poof into thin air."

Does that sound like anything you were familiar with?

A Not at all, because the groups that I worked with, they were totally integrated with what I was doing. They worked as part of our group. They certainly would have not been doing an independent national testing plan.

What you described was exactly what we did. I mean, starting in March, we started buying all the critical supplies, buying tests, allocating tests. States did not

fight with each other. Beginning at the end of April, literally states were putting in orders to us and we would give them exactly what they did. It took us a few weeks to get the supply chains right, like for swabs and media and everything else. But that's exactly what we did.

So I am not aware, and I would doubt the existence extremely seriously, that there was sort of an independent plan that was worked on outside of what we were doing.

And, again, aside from the -- you may have to read that again, but aside from the national molecular surveillance, which is really a CDC issue, all those things were part of what, you know, we were doing and operationalizing.

Remember beginning end of April, early May, we had worked with every single state on their plans, providing them the resources. We were allocating all the point of care tasks. We were allocating the Cepheid machines, then the point of care, I.D. Now, and we were literally taking orders for swab and media and sending them weekly to central points of distribution at the states.

So I think I answered what you said. I'm not aware of anything that was sort of a shadow process or an independent process. It was all -- it was all -- it was all organized.

And I'm just going to say that Jared Kushner and I -- I met him maybe once or twice before, but we -- I did meet

him once or twice before. But we never talked more than maybe two paragraphs totally in the three years. But we had a very professional working relationship. He was not working around me; he was working through me. So -- and that continued throughout the pandemic.

So, you know, I think I was one of his trusted partners. This would not have happened independent of me or my core group.

Q Something else reported in that same article separately was that the volunteers that Mr. Kushner had assembled purchased -- or actually entered into a contract to purchase 3.5 million coronavirus tests from a company named Cogna Technology Solutions, owned by Group 42.

Does that sound familiar to you?

A So I don't -- I don't know that name at all or that test. I mean, I worked with Abbott and Roche and all of those big ones. So I don't know that. I've never actually heard of that test before. And if I did, I certainly forgot it, because we never -- you know, I never interacted with their CEO or anything.

And, you know, I can't affirm or deny that specific thing, but I can tell you in my experience with my group, you know, they were civilians. They were not part of the government, and they couldn't commit the government to anything. That's why we had contracting officers there.

So, I mean, I don't know about the specific circumstance. Maybe true, maybe not true. I can only tell you that there were clear boundaries, and I knew what they were. And, again, that's why we had contract -- only a contracting officer can commit the government to funding, as you well knew, and that's why they were collocated with us, mostly from the DOD side, but they were still -- you know, they still had their warrants and could contract.

Q And that reporting also said that the purchase reportedly was going to cost $52 million.

A I'm sorry. I don't know.

Q So just shifting gears a little bit.

You talked about the scaling up of the federal testing sites?

A Yes.

Q At a certain point, I understand that the responsibility for sites was transitioned back to states to manage; is that right?

A No, that's really not right.

Q Okay. Well, you tell me your construction, please.

A Okay. I know that's what -- so the 41 initial drive-through sites were never meant to be permanent. You know, it was a one-size-fit-all. U.S. Public Health Service officers deployed there. It was still mostly using local

individuals.

I mean, we had three to five Public Health Service officers per shift, sort of a lead person, a safety officer. There were various roles. But central sites, and only 41 of them don't go very far.

So the plan was always to replace them, and replace them by retail sites, which were the federal sites. So CBTS 2.0 was 2800 sites. These were all under federal contract, right, that all you had to do if you met any criteria by the CDC or by the local, you walked in, you got tested, and the federal government paid per test. So this was the federal program that replaced that.

The CBTS 1.0, let me get back to your question, because yes, we wanted to phase them out. They were meant to be temporary, because replacing 41 with 2800 that were not, you know, localized.

And the Biden administration got into this too and they wanted to have big mass vaccination sites. It doesn't work very well; right? It's better to have 100 distributed sites than one big site.

So that's what we were doing, replacing them, but we did intend to phase them out. Probably two-thirds of the sites begged us to phase them out, because we had to be a one-size-fit-all. You know, I couldn't contract with UT Southwestern in Dallas.

I'm not saying that as a specific example or whatever it was in New Mexico. It was cookie cutter. They had had to go to Labcorp and Quest. We had to follow this. Our own doctors were the order.

So, again, two-thirds of the sites wanted to transition so they could be under local control, and a few sites really -- really, I think, made a spectacle out of it.

But that's what you're referring to. So yes, we did phase them out, I think, by July in an amicable way. Whenever any site really complained, we extended it and we did what they needed to do.

But, again, when you say "phase out federal sites," it really is replace 41 with 2800. And then in CBTS 3.0, up to over 7,000 sites and all the FQHCs.

Q If you turn in Exhibit 1, the agenda packet, to page 41, this reflects an April 9 task force meeting. And there's Item 5 on the agenda lists your name next to "community-based testing sites transition plan."

So my question is only that I assume this is what you're referring to here?

A Let me get to the page. Page 41?

Q Page 41, which should be the April 9, 2020, 3:00 p.m. meeting.

A I don't remember the specific meeting, but it was early -- it was probably the first week in April that we

set up the 2.0, which is the retail sites. So it was meant to grow, but there was limited -- there was always going to be limited utility of federally run drive-through sites, and yes, we were transitioned to a much larger program. I don't remember the specific agenda, but that was the right time frame.

Q The time frame is consistent?

A The time frame to get the 2.0, the retail sites up, because the retail sites could not start early in March. They were just not ready for that. And they were not -- they really couldn't happen in a robust way until we had the self-swabbing, which happened in the first week in April, so that kind of opened up all of that.

Q Okay. I want to actually show you another document. We'll mark this as Exhibit 2.

[Exhibit 2 was marked for identification.]

Q So we pulled the chart of daily reported coronavirus tests in the U.S. from the beginning of March 2020 to January 20, 2021. So this is a lot of information on a single page, and I'm only showing it to you as really a point of reference, because it illustrates, I think, some trends that are helpful to guide our discussion.

For example, from mid-March, right around when you took on the role, until July, there is a pretty consistent upward trend. Then there's pretty much a flattening until

September and then a continuous upward trend until November, where it gets a little bit bumpy again.

So I wanted to get your sense as sort of the -- you know, things that were going on to -- that led to these trends. Obviously you were doing a lot to expand supply during these early most.

What happens in July when it sort of flattens out? What's your assessment of what changed at that point?

A I don't think anything changed. We were still pushing the system, but there were some variations depending on what the status of the outbreak was and when people -- when things started to tamp down a little bit in terms of infection, people just didn't get as much tested.

So this is part of sort of the variation that you see and you've seen continuously even to the current day. As the outbreak gets worse, people get more tested. As the outbreak gets less, they get less tested.

Also, during that August and September time period we were -- remember, we were putting out a lot of the point of care tests to the nursing homes.

Q Right.

A And that wasn't reported. Remember, superimposed on all this was the point of care tests that in general were not reported. Certainly --

Q Those are not on this chart, in other words?

A That's right. They don't make it to the general. So I think we started the nursing home program in July.

But in general, and you see this like in November; right? There's a dip in the holidays. There's always an upsurge before people traveling.

So that's my explanation. It mostly went with -- and you can track this pretty carefully. When the disease outbreak got worse, people got more tested. When it slacked off a little bit, there was less demand for testing.

Ms. Mueller. Has that same trend continued to present?

THE WITNESS. Yeah, I think it does. I think it has. I think you saw that with Omicron. And it's common sense; right? When there's more out there, people get more concerned and they get more testing.

BY Ms. Gaspar.

Q Were there philosophical difference -- maybe "philosophical" is too strong a word.

But were there differences among the views of members of the White House task force or others in the operational structure about how to think about testing strategically?

A Go ahead.

Q I can be more specific.

A That's a really broad question. I mean, there's

a lot of opinions on just about everything as we went through, right, and that's why you have differences of opinion to try to make the best decisions.

Q Well, for example, so Dr. Birx recently published a book, and she wrote that "there was a refusal to strategically embrace antigen tests," and she attributes that to CDC and FDA and says that their positions impacted CMS and private insurers' decisions as well and that embracing more antigen tests could have made a difference by increasing supply.

Is that a type of view that was discussed and debated?

A First of all, I didn't read the book yet, so I don't know.

Everybody on the task force was very pro antigen testing. I don't -- you know, the CDC is a big organization, but certainly Redfield, Walke, Jernigan, Schuchat, everybody was on board with antigen testing.

The issues with the antigen testing was mostly the concern of -- you know, and I'm going to put them in quotation marks. I'm going to call them "lab snobs," and I called them "lab snobs," that really believed that the only appropriate test was a molecular PCR test done by a nasopharyngeal swab that was sent to a central laboratory because that was -- it wasn't the gold standard; it was a standard.

So we had more issues with getting acceptance from the people who only believed that what was the, quote, gold standard for an individual diagnosis was the only thing that could be used from a public health point of view. And we needed to do a lot of work to remedy that kind of thought process, including regulatory work through the FDA.

So, honestly, you know, the FDA was -- the FDA was pretty good. I mean, when we -- when we -- when we explained the issue in about congregate settings, remember they modified their EUA to say, look, it's okay to do this, even asymptomatically, because it's important from the public health.

The CDC really supported antigen testing. I'm doing this more contemplatively, because I asked them and they modeled what is better, a PCR test with a four-day turnaround and a higher sensitivity or an antigen test that is much less sensitivity but an immediate turnaround done twice a week, and they were very clear that antigen tests were superior from a public health standpoint.

So I guess the answer is I don't know of any disagreement about antigen tests among the principals on the task force, nor the people I work with at CDC and FDA. FDA has 20,000 people. CDC has 12,000.

But I saw it more from the public health laboratory establishment in the states that really didn't understand

what we were trying to do and had to do a lot of work against that.

Q There were also a number of entities that throughout the spring and early summer of 2020 published strategic plans on combating the conservative. I'm not going to go through the details of them, but the Rockefeller Foundation had one, ADI had one.

I think Harvard published one that called for between tens of millions and maybe a billion tests per week, sort of thinking about testing at a very, very large scale that would capture more of the asymptomatic cases than just, you know, for purposes of diagnosis.

Were those kinds of plans considered?

A Yes, of course.

Q Okay.

A And I just want to remind you, you didn't have that testing in 2021 either. In fact, testing dropped by 7 to 8 percent when I left as testing czar.

But yes, we looked at all those plans. Most of those groups, particularly the Rockefeller, were straight up with us. We discussed them for weeks before they published them. And the Rockefeller was actually the most realistic in saying, look, we're doing pretty good with what we have. I couldn't wave a wand and have a billion tests or 100 million tests a week. They were just not there.

So despite whatever we can do and invest because, again, this wasn't a 15-year plan. This was starting with the pandemic. I regularly talked to the principals at Harvard, you know, to understand where they were coming from.

So, in general, most of these plans I had discussed and interacted before they came out. The ones that tended to be more sensational but came out, I called them individually, all the leaders, to understand, you know, where they were, how could we improve what we're doing. I did not have all the answers, and I did not pretend to. If you're an ICU physician, you get humble pretty quickly.

So I called everyone. Mike Mina was on my speed dial, who was both a critic but also a very big supporter of what my team was trying to do. I relied on him for information.

So yes, I talked to all of these folks, and it wasn't -- a lot of it wasn't a matter of what we wanted to do as what could be done, given the actual, you know, considerations of reality of where we were in the process.

And, again, I'm not trying to be political here, but, you know, the Biden administration faced the same sort of thing in 2021. You know, we don't have a billion tests a week or a month or even close to that, and people wouldn't use them anyway.

So you have to deal with realities, and we were

dealing with reality. We were making as many as we could as fast as we could and trying to shift from PCR to point of care as much as possible, because that's where the public health advantage was going to be yielded.

Q And by considerations of reality, I think you just said it, that you mean constraints on the supply chain or lab capacity or personnel or whatnot?

A Yes, exactly. Exactly right. You can't have point of care tests until you have point of care tests; right? And the first ones were made by machine. You had to stick it in a machine. That's BD and Quidel.

And, again, we bought all of them, every single one, and prioritized those to nursing homes and to certain other really important areas.

But we couldn't have antigen tests until BinaxNOW, because we didn't know whether they worked. They had to be authorized; right? Putting junk tests out that were not authorized was not going to help people. So we couldn't do it until it was done.

And, again, it was literally -- you know, with every manufacturer, we had a specific two- or three-member team that worked with that manufacturer if not a daily basis, on a weekly basis. What do you need, how can we help, do we need the DPA, what supplies, were there constraints, do you need money. And I talked to CEOs of all those companies on

a regular basis.

So it wasn't a matter -- it wasn't a matter of trying to accelerate them. It's just the physical limitations. There's only -- there's only so much X in the world and we have to build the industry to do that.

Cepheid, just for an example, the gene expert, brilliant machine. PCR sort of point of care, not really, but for small areas like, you know, outposts in Alaska, small metropolitan areas, it was great. It was authorized early. It was very sensitive.

But in that cartridge was all these micropumps and specialized plastics, and there was no way to scale that up. If I put a billion dollars into Cepheid, they couldn't have done it any quicker because it was just the complexity of the process was not scalable.

The things that are scalable are point of care antigen tests, and we knew from day one and Dr. Birx was -- you know, starting in March, my first day, we got to have antigen tests, and we were all about that. And that was a major push.

Q On June 1, 2020, there was an announcement that you would be stepping down from your role as the so-called testing czar, returning to your post at HHS. In reality, I'm not sure that you actually did step down from that role. Can you tell us what happened?

A We were moving from FEMA back to HHS. It was a bit unclear about the process --

Q Okay.

A -- and the roles.

Cases were down a lot. The one thing that was clear was I was fully deployed to FEMA; right? So I basically set foot at HHS only to get some materials, but I was fully deployed to FEMA in response. So I was going to be at HHS in assuming some of my previous responsibilities.

And it was really a point where I was unclear whether I was going to continue or not. It was literally, you know, four or five months with three or four hours of sleep a night. Given everything, like everybody in response, I was getting a little burnt out and had certain frustrations.

So it was unclear what I was going to do moving forward, and I had discussions with the people involved and decided to -- even though I resumed a few of my responsibilities back at HHS, that I would remain on point for testing.

And like the responsibilities like -- I was very dedicated to ending HIV in America, and, you know, not being able to go to the President's Advisory Council on HIV/AIDS really bothered me personally because I really felt that this was something we could really do.

So doing things like that and getting back with sickle

cell -- I still did not run the office like there was no pandemic, but I did participate in some of those activities.

But after discussing with the secretary and Dr. Birx, I decided that it was best for me and, more importantly, it was important for the country that I stay on, so I did.

Q The UCG structure -- I don't want to say it disbanded if that's not the right word --

A It did. So there was a different UCG that was formed that was basically -- that was on the HHS side. So it got transferred from Kadlec, Gaynor, Jernigan, and myself to Azar, Gaynor, and Birx. So that was the UCG structure that was at HHS, and I was no longer a part of that. But I still was the lead for testing and, you know, ran those -- ran those task forces.

Q And was the reason for that because the cases were down or was there another reason?

A Both. I'm going to give you my interpretation here is that the cases were down and FEMA was overtly concerned. They just had their worst hurricane and wildfire season the year before, and those really required a huge amount of FEMA resources and the NRCC, which is sort of their command and control.

So a combination of cases being down. A lot of the things -- it's not like we solved all the issues, but we had all the processes. We knew the supply chains. We had a

machine by that time; right? Even in testing we had an absolute machine going that it was felt that it could move back to HHS at that time. That was not my decision. I don't know whose decision it was.

But it was always on a very light trigger that if things started to get bad, we could always move back to FEMA if we needed it. But at HHS, that was the structure.

Q Did the White House task force start meeting less frequently around that time as well?

A Yes, it did.

Q For the same reasons, or do you know?

A I don't know. But we did -- you know, clearly the cases were down. And, again, I'm not saying we solved all the issues. We will never solve all the issues. Every time you solve one, there's another one. You see that to the current day.

But a lot of the -- for example, when we started we had no idea how many ventilators there were in the country, where they were being used. You know, that was set up.

PPE was going to every nursing home, every hospital. There was a system there.

We knew where every test was being manufactured, where it was going, where every machine was. All that was done.

So I'm not saying -- but it is a fact that the task force met less. The docs probably didn't, because we met --

when I say the docs, we met frequently, and I don't know if it's in her book, but every morning -- I started every morning at 6:15 with about 150-page PowerPoint from Dr. Birx's office that reviewed all the data for the day, where the outbreaks were, you know, everything that was going on down in Metroplex, and I also generated a testing report every day that talked about the number of tests.

And, again, we didn't have -- you can't get turnaround times for everything just because of the way things were ordered, but I knew the turnaround times for all the ACLA labs, which is 50 percent of testing, all the ones for our federal sites. So we reviewed that every day and frequently had discussions.

So the task force as a whole, you are correct, met less. The docs were still, you know, every morning churning data, talking about things, talking about issues.

Ms. Gaspar. We are up to our hour.

[Recess]

By Mr. Benzine.

Q We can go on the record.

Dr. Giroir, I want to ask you a few questions about data function research and the origins of COVID.

A Okay.

Q So, in your opinion, is this a fair definition of gain-of-function research: A type of research that

modifies a biological agent so that it confers new or enhanced activity to that agent?

A Yeah, that's a fair definition.

Q Are you aware of Dr. Peter Daszak of EcoHealth Alliance?

A Yes.

Q In their year five progress report on an NIH-funded grant, they stated: "We continued in vivo infection experience of diverse bat SARS-related coronaviruses on transgenic mice expressing human ACE2.

Mice were infected with four strains of SARS-related coronaviruses with different spike proteins, including full-length recombinant virus of SARS-related Wuhan Institute of Virology 1 and three tenure viruses with the backbone of WIV1 and spike proteins from three other bat coronavirus.

All the four viruses caused lethal infection in human ACE2 transgenic mice with the mortality rate varied among four groups. 14 days post-infection, five out of seven mice infected with WIV1 remained alive, while only two out of eight mice infected with one of the full-length tenures survived. These results suggest that the pathogenicity of that tenure is higher than others."

Does that sound like a gain-of-function experiment?

A It does.

Q Why?

A Well, it's sort of the definition of what I would consider a gain-of-function experiment. You're manipulating genes within a virus. These are genes not natural to a virus or certainly not natural to that virus. You're testing it in a mouse system that's expressing human receptors.

So I can't say the underlying goal, but the implied goal is to determine which ways we could mess with this virus to make it more infective against a human surrogate, meaning a transgenic mouse.

Now, whether that was their goal to find the most lethal or they were trying to figure out the pathogenesis, that created viruses that were more pathogenic in a human system, and it's the kind of dangerous research that we should be concerned about.

Q I want to introduce Minority Exhibit A.

[Minority Exhibit A as marked for identification.]

Q This is a screenshot of NIH's gain-of-function research involving potential pandemic pathogens website, last updated July 12, 2021.

And the definition that I read you in the beginning is the first line under the section entitled Gain-of-Function Research.

A Okay.

Q I will go to Minority Exhibit B.

[Minority Exhibit B was marked for identification.]

Q This is the same website last updated October 20, 2021, without a gain-of-function definition in it.

On October 20, 2021, NIH reported the experiment that I just read to you to Congress, and the same day stripped the definition of game-of-function research off their website.

A So this is the -- I'm sorry. This is the one that you just gave me was after this one is what you're saying?

Q Correct.

A Okay.

Q Can you think of any reason to change the definition of gain-of-function research overnight?

A Well, I could think of lots of reasons, but I wasn't involved in this, and I wasn't actually aware that this happened until you just showed it to me. So I don't think I could comment.

Obviously it's a bit of a coincidence, right, that that happened at the same time.

What is EPPP research?

Q Enhanced potential pandemic pathogen.

A Okay. I'm not -- the gain-of-function research definition would be a standard one that we would all be generally comfortable with. There are some variations around this.

I'm not -- I haven't read the EPPP research, and I actually didn't know they took it off the website.

Q All right. That's perfectly all right.

Are there -- can you explain some of the dangers of unregulated or underregulated gain-of-function research?

A I mean, I don't know how I can say how concerning it is, because modern tools of biology allow even mediocre scientists, to be quite honest, to mix and match different traits to create -- and I use the term -- I don't know if it's been used before, but I call it this way because they're scripted -- Frankenstein organisms that are pieced together that could create pathogens that could end the human species or end the human species as we know it.

And as the technology gets more widespread, the possibility occurs. And, again, it doesn't have to be a nefarious actor trying to create a pathogen as a bioweapon, and there are plenty of those.

It could just be a researcher in his or her -- I'm going to say it -- ivory tower who's, you know, in a naive and maybe idealistic way trying to work on their little

piece of the world but, you know, accidentally or intentionally creating something that could have dramatic consequences.

So you really are talking about survival of the species, of the human species kind of consequences. At least hundreds of millions or billions of deaths. So I hope there's unanimity to understand that the processes need to be serious. They need to be transparent.

And I'll say this, which I hope that everyone hears, that you can't leave it just to the scientists, because the scientists, even while well-meaning, are in their own little ivory tower bubble. It has to be a much more transparent and holistic review process.

Q I want to step back a little bit. So you used to work at DARPA. Did you work on bioweapon research at DARPA?

A We worked on defense against bioweapons. The U.S. did not and, to my knowledge, does not have an offensive program. We abide by our treaty obligations.

But yes, we worked on bioweapons defense, and that was one of my primary responsibilities. That's what DARPA engaged me to do before I went to the agency and when I went to the agency.

Q So you would consider yourself an expert in doing this research of concern on gain-of-function

technology?

A Yes. I am not capable of going into the laboratory right now. Ten years ago I was. I was certainly capable of doing this personally. But I consider myself a relative -- certainly a relative expert in this area.

I chaired the chem and biological subcommittee of the threat reduction advisory committee, Track, at DTRA which is the organization that advises on nuclear and other threats to the secretary of defense. I chaired that Committee on Cambio. I was the interagency representative from the DOD on bioweapons defense, and I keep up in that.

So, again, I don't want to tell you that I'm technically able to go into the lab and do this anymore. I'm not. But I consider myself an expert from my background.

Q Thank you.

Do you think the U.S. should reevaluate its regulation of gain-of-function research, particularly overseas?

A Yes.

Q Do you think the U.S. taxpayer dollars should fund gain-of-function research outside the United States?

A I'm not an expert on what taxpayer function -- you know, what the taxpayer should or should not be doing. That's what the people in these halls do.

I can say that gain-of-function research outside of

the U.S. should only occur, if at all, under extraordinarily limited circumstances where there is complete transparency, complete access to scientists, complete access to records.

And when I'm talking about that, that means it occurs like in the UK, in Australia, in countries that we would share our defense secrets with. It can't occur diffusely throughout the world. There's too much risk.

Q Would a place that it can occur include China?

A The top of my list would be Iran, North Korea, and China. And China would lead because of their technical capabilities.

Q On -- I'm going to switch gears again.

On February 1, 2020, Dr. Fauci and Dr. Collins had a conference call with various international scientists.

Are you aware of this call?

A I'm only aware from the media and the reports that have come out. I was not aware of that, you know, at the time, and I was not part of that.

Q So you weren't invited to the call?

A No, I was not.

Q According to the emails and the notes, some of the scientists thought COVID-19 possibly came from a lab and was possibly engineered and could even possibly have been a bioweapon.

Are you aware of any of those notes or emails?

A I'm aware of it, and I assume it was -- a lot of this was published in the popular -- not popular press, but the public press. So that's my awareness.

In my official government role, I was never privy to those or had any information about them.

Q I'm going to introduce Minority Exhibit C.

[Minority Exhibit C was marked for identification.]

Q This is a letter from ranking members James Comer and Jim Jordan to Secretary of Health and Human Services Becerra. It contains transcripts of what were redacted email back-and-forth of those scientists after that conference call.

If I could direct you to page 2 of the appendix.

A Okay.

Q Number 3 up top under Dr. Mike Farzan says he's bothered by the furin site and has a hard time explaining that as an event outside the lab.

Are you now aware of what a furin cleavage site is? Were you aware of it prior to the pandemic? And if so, what is the significance?

A So I think it sums it up here. I was aware of that before the pandemic. I'm still not an expert in it, but it would be a typical laboratory manipulation in order to change the infectivity of a virus to human cells.

And I am not the expert on this, whether this is naturally -- can occur in nature or of the frequency which it occurs in nature. I can say that it is a typical technique that would be used in a laboratory under such manipulation and gain-of-function or pathogenicity research.

Q A little further down, Dr. Bob Garry, at the bottom of the page, says: "I really can't think of a plausible natural scenario… I just can't figure out how this gets accomplished in nature… Of course, in the lab it would be easy."

He also says "I aligned COVID-19 with the 96 percent bat coronavirus at the Wuhan Institute of Virology. Except for the receptor binding domain, the spike proteins are identical at the amino acid level -- well, all but the perfect insertion of 12 nucleotides that adds the furin site."

I think that kind of supplements what you just said, is that a furin site is a common laboratory experience?

A That's right. It's a common laboratory technique that could be used to manipulate the pathogenicity of organisms. I know that. That's true.

The other things, I can't really comment on.

Q Was COVID-19 a more pathogenetic virus than we've seen before?

A Yes. Clearly. Clearly.

Ms. Callen. I'm Ashley Callen, for the record.

By Ms. Callen.

Q Dr. Redfield testified before us, and he said that the virus itself demonstrates that at some point it took a detour to the lab because of its infectiousness vis-a-vis humans.

Do you agree with that?

A So I'm going to rephrase it, because I know what Bob has said and I agree with this.

It is one of the primary reasons for my opinion in that it is not typical -- in fact, it's unprecedented for a coronavirus like this to come out of the chute so highly infectious human to human.

There's normally months or years of transmission from animal to human, animal to human, lots of history with people being infected by antibody titers and other things before it hits that human-to-human cycle.

So I know Bob feels very strongly and I agree him that this is entirely atypical and most consistent -- pending other evidence. I mean, it's been years, but there could be other evidence -- but there's really no evidence of that infectivity cycle from animals to human, nor even an animal that we've discovered who actually has this beforehand, despite two years of obliterating all the animals of China.

So based on that, it's most consistent with something

that has been evolved in a laboratory, either directly or indirectly, so that it's highly infectious with humans, and then the moment it got out, it was just a wildfire.

Q And he says it actually can't now infect bats. Is that your understanding?

A I don't know that, actually. I don't doubt Bob, but I don't know that as a fact.

Q I asked him why he thought -- I mean, it seems to us that you're somewhat in the minority on this, and you testified on the panel with some other experts, but it's like you, Dr. Redfield, a very few other doctors actually speaking out and, you know, saying what you just -- what you're saying here today. And I'm just wondering if you have any thoughts on why that is.

Because I think you're right. I just wish more -- you know, these doctors that we're talking about in these appendices --

A I hate to speculate too much, but it was sort of a constant when I was in government. There is sort of a science party line, and I think a lot of people fall into that. A lot of people fall into it because they're worried about their own research careers.

And, you know, science, unfortunately, is very political, and your funding is often -- you got to be at the right institution doing the right kind of work with the

right kind of thing. So I think people feel vulnerable and afraid to speak out.

And then, secondly, I think they worry that -- you know, there is no such thing as good and evil, bad and good. Science has great things, but there's also bad parts to it and things we need to worry about.

And I think a lot of people worry that if they attack a certain part of the science establishment and mechanism that they're attacking everything and that will ultimately hurt, quote, science, and certainly they will be ostracized from the community.

So I have not -- I've always been as blunt and as honest as I can, and, you know, I love science. I'm a scientist. I was NIH-funded. I believe in science. I read Science Magazine every day, all the articles. But we've got to call it the way it is.

And there are countries that have offensive bioweapons programs. There are countries that have offensive chemical weapons programs. And dual use research in the context of those programs is just, you know, a bomb waiting to off.

And that's why I think I am not sure this came from the laboratory. I believe it is much more likely than not, given the preponderance of the evidence. But no matter whether it came from a laboratory or not, we absolutely need to be transparent, have the review processes.

And I mean this honestly, and I'll say it again: Do not leave it to the scientists, scientific community alone to regulate themselves because -- and I'm part of that community. You need, you know, the nuclear proliferation community, you need the ethics community, you need the policy community, you need the minority community who's going to suffer the most from the virus if it gets out. You need all those at the table as you move forward. Congress needs to oversee this. Full stop.

Q Could there be, in your opinion, a national security purpose for the United States funding some research in those countries you named -- Iran, China, North Korea? Could there be a national security purpose?

And I guess you would say -- I'm guessing you would caveat it and say yes, but we have to have transparency, openness, and all those things you talked about.

A Yeah, I don't -- I would be -- you know, I'd have to look in the individual circumstances. I would be very, very hesitant to perform any of that within those, those countries. To be timely, I was involved at DARPA at the time that the Ukrainian labs, for example, were funded.

Those were not offensive bioweapons labs. We were providing a work program to transition them from offensive biological weapons to important research that was not bioweapons so they wouldn't brain drain to North Korea and

Iran. That was a program throughout Russia, because those scientists were going to places and bringing their weapons and their knowhow.

So on the margin, I think those kind of things. But I think when we're doing this kind of hard-core work, it really needs to be limited to very like-minded allies that we would share intelligence with, like Australia, like the UK, you know, to some degrees, Israel.

If we're not going to share intelligence with them, we shouldn't be supporting this kind of research. That's just my own opinion.

Q Thank you. Going back to Dr. Redfield, Dr. Redfield also thinks that we will know the origins of the virus someday. He thinks China, quote -- I think he said "will come clean," end quote.

What are your thoughts on whether we'll know the origins of COVID-19?

A My opinion is we're never going to get to a hundred percent point, but it's going to be either preponderance of the evidence suggests, and I think that's where we are right now. You know, to really know, you'd have to have the records of the laboratory and the scientists and the early infectivity pattern, and I personally just don't see --

I have a lot of respect for Chinese scientists. I've

worked with Chinese scientists. I've done bilateral things. I've had international meetings with Chinese scientists. I don't think it's them; I think it's the Chinese Communist Party that dominates, and I just don't think you're ever going to see that. With their culture, to say that it was our fault, I just don't see that within the culture of the Chinese Communist Party.

Again, I want to distinguish between very good well-meaning scientists in China and physicians who might work with and the complete domination by the Chinese Communist Party. I don't think those kind of records are ever going to come out. Just my opinion.

Ms. Callen. Thanks.

By Mr. Benzine.

Q So we saw from one of the majority exhibits, the task force agendas that Dr. Fauci attended often, when things started to get ramped up, we started to learn, I think, that the virus was really infective. There was a lot of human-to-human transmission. Did Dr. Fauci ever bring up any of these notes from this call from the task force?

A Never.

Q Why don't you think he did that?

A I don't know. I mean, I can't speculate, but that was, that was -- that was never brought up in any task force meeting.

Now, again, I started, you know, in mid-March, but it certainly wasn't brought up at any time that I was there.

Q Did you have conversations with Dr. Fauci between February 1 and mid-March?

A Yes.

Q Was it brought up at any of those conversations too?

A No.

Q If we can flip to page 4. This is an email from Dr. Collins to Dr. Jeremy Farrar, Dr. Fauci, Dr. Tabak. And at the end it says "The voices of conspiracy will quickly dominate, doing great potential harm to science and international harmony."

In your opinion, what do you think "international harmony" means?

A I have no clue what Francis meant with that. "International harmony" meaning -- I don't know -- international relations. It's hard for me to speculate what Francis was meaning by that more than what any normal person would infer.

I mean, the international scientific collaboration or cooperation, I guess.

Q That would be my guess too. So it was regarding a conversation about the Wuhan Institute of Virology, so I would imagine it was not trying to harm whatever global

scientific progress they thought they were making?

A That's right.

By Ms. Callen.

Q Did you ever hear Dr. Fauci or Dr. Collins say, Oh, let's not talk about China or a laboratory being the source of this virus because we don't want to upset the Chinese Communist Party?

A I never heard either of them say that. And, again, you know, I dealt with Francis fairly frequently, but only on scientific issues. And Tony -- that did not -- that did not come up. We did not have conversations about the origins, per se.

Q Okay. So you all never discussed, even in the context of like messaging, briefings, kind of steering clear of China? Do you recall that at all?

A I don't recall us discussing that. I know some of the things he said publicly. I don't recall ever having any discussion about that, and I would remember that, because I had sort of strong feelings to the opposite, that we needed to keep everything on the table.

And, you know, I think it would have been very helpful, even if it was a remote possibility, for somebody to raise their hand and -- in January and say hey, there's some gain-of-function research going on there, right, 3 kilometers away.

You might want to know what this was. I mean, that's the time, you know, put the big boy pants on and say we could be the source of the problem. I never heard that.

Q So when you talk about the things you heard Dr. Fauci say, what are you talking about specifically that you disagreed with?

A Well, public comments about this couldn't be from the Wuhan lab; it has all the signatures of a natural infection. It was just way too early to comment about that. The only thing we knew early, there are like absolute fingerprints of human genetic manipulation.

Now, if you don't have those fingerprints, it doesn't mean it wasn't manipulated or it doesn't mean it wasn't evolved in the laboratory. But what we knew early on is it didn't have those definite fingerprints, like made here from direct. And that's the only thing we knew.

We didn't know anything else about whether it could have been engineered in a stealthy way, which is very typical. You could do these kinds of sequences in a stealthy way. So it doesn't have the natural fingerprint of engineering, but it still could have been engineered.

It could still could have been evolved in a laboratory, meaning we're not engineering at all. We're going to let the virus do what it normally does, infect, infect, and get worse and worse and worse and evolve.

By billions of copies of virus, we're going to get the ones that are worse. None of those could have been ruled out, and we were -- not we. He seemed to be ruling that out very early, and I would have objected to that.

Q Did you ever hear anybody object to Dr. Fauci's assertions back then?

A I can't say I did. And let me put this in the framework, once I got -- you know, I had to deploy my people. We had to go to -- we had to go to Wuhan. We had to go to Japan, no matter where it started, so I was worried about that.

By the time I got really involved in the task force, I was worried about increasing testing, getting ventilators, allocating supplies.

I know this sounds crass, but at the time, I didn't go to any intel briefings on this because I was too focused on what I was doing, and we did not have overt conversations at the task force level or, to my knowledge, in any of the doctors groups.

Now, sometimes Birx met with Fauci, you know, independently or Fauci and Redfield. It could have gone on there, but not when I was attending.

Q So the first time you found out that NIH had funded some research at the Wuhan Institute for Virology, it was through the media, or did you learn that in the course

of your job? Do you remember?

A I think it was after I really left office because then I started focusing on -- so I was very interested in the WHO reports and really started looking at that. You know, not finding an animal source despite, you know, all the work that went on was pretty important.

Secondly, the discounting of the possibility of the lab -- you know, it's a huge report where they did extensive work looking at -- you know, I think they looked at, you know -- is it 80 or a hundred species from all around there, but it would only have like two paragraphs about the Wuhan lab, you know, just dismissing it without the same rigor.

Then I started going back and just reading about the work to understand, and like when I read a couple of the papers, it's like, well, this is gain-of-function research. I don't even understand what the question is.

I can't say that they knew they were doing it, but it was published. It was right there. And when you start looking at some of the NIH abstracts. So you could find the abstracts of the work on the NIH website. You can't do all the results, but it's like this is dangerous stuff; right. This is really dangerous stuff. I'm even more concerned about this being a possibility than I was before.

I did not focus on this when I was in office. This was not a major topic for me. I'm not saying it was a major

topic for the country, but I had to do my job no matter where it came from, and that's what I was focusing on.

Ms. Callen. Thank you.

By Mr. Benzine.

Q After this call, four participants wrote a paper in Nature Medicine on February 17, 2020, that concluded: "Our analysis clearly show that COVID-19 is not a laboratory construct or a purposefully manipulated virus."

Are you aware of that paper?

A Yeah, I am.

Q On February 17, 2020, or even today, could we affirmatively make that statement?

A No. Absolutely not. Again, at that time, the only thing we could be certain of, there were none of those absolute fingerprints that could say it was genetically manipulated in the laboratory, but you could genetically manipulate it by a lot of ways that doesn't leave fingerprints.

So that's the only thing we could say is there was no obvious, overt, 100 percent fingerprints that it was made in the laboratory, and that's it.

Q After this letter came out, Dr. Garry, one of the participants in the call and one of the authors of the paper, told a reporter that the consensus on the call was to -- "Don't write a paper at all. It's unnecessary. Or,

two, if you do write a paper, don't mention the lab origins. That will just add fuel to the conspiracists."

Does that sound like the normal scientific paper writing process?

A No, it really doesn't.

Q Why not?

A Because generally you lead with the science and let the debate come. But you really start with the data. You can discuss things, but you don't -- you don't write science with a political objective, and you certainly don't write your opinion with a political objective.

And, you know, sometimes conspiracy theories are true. Right? Sometimes they aren't. Sometimes they're true. And you just need to know. And I'm not sure if there was a -- you know, I have no idea what they're talking about conspiracy, but, you know, hypothesizing that a novel coronavirus that's never been found in nature that is immediately infective to humans occurs 3 kilometers away from a secretive laboratory in Wuhan with ties to a bioweapons program that was doing that coronavirus research, making that link is not conspiracy. I mean, you'd be irresponsible if you didn't look at that possibility.

And you didn't ask this question, but -- and I know I shouldn't answer things, but, you know, lab leaks happen. They happen in the best of countries, not just China, when

you have this infective virus.

So I never stated and I don't think anybody of us stated that we thought this was an intentional attack that started in Wuhan, but lab leaks, they happen. They've happened in the U.S. They've happened in the UK. They've happened around the world. It is a risk of this type of research.

And that's really all I have to say. When you do this kind of research on highly infective organisms, it only takes one person to get infected, particularly in a city of 10 million or 7 million people, to start a global pandemic.

Q That paper prior to being published in Nature was sent to Dr. Fauci and Dr. Collins for comments, suggestions, and questions.

Is that normal that outside scientists would send papers to government scientists for edits?

A I would say it's not normal, but to me it's not terribly abnormal, because, you know, Tony does run the National Institutes of Allergy and Infectious Diseases, and it wasn't a pure science paper. It was more of an opinion paper.

I don't -- it's not like the teachers union directly editing CDC guidance. This is more of an opinion coming into it. I don't -- I actually don't read too much into that at this stage.

Q If we go to page 12 of the appendix.

A Okay.

Q Another email from Dr. Collins to Dr. Fauci with Dr. Tabak, Dr. Lane, and Dr. Burklow cc'd.

And it reads -- it has a URL to an article that says: "Fox's Bret Baier sources increasingly confident coronavirus outbreak started in Wuhan lab."

And then Dr. Collins writes: "Wondering if there is something NIH can do to help put down this very destructive conspiracy, with what seems to be growing momentum. I hoped the Nature Medicine article" – he's referencing the one on February 17 – "on the genomic sequence of SARS CoV-2 would settle this. But probably didn't get much visibility. Anything more we can do? Ask the National Academy to weigh in?"

This reads to me like NIH set up the Nature Medicine article by the "anything more we can do."

Do you agree?

A Do I agree that it sounds like the NIH set it up?

Q Yeah.

A Well, I'm just going to say it's very disturbing, because -- and this is one of the more disturbing emails to me, because the response should be maybe there's something there and we need to take a second

look. The goal of a being a scientist is to try to evaluate the data and reassess it.

And, you know, the first thing I would have done is not kind of pile on and see what more we can do to beat down this, but to reassess whether this could possibly be true, especially since my institute -- you know, my National Institutes of Health -- was funding research in the area.

So I think it's very disturbing because it's a nonscientific point of view. And I like Francis Collins a lot. I work with Francis a lot on many tough issues. This sounds like a lobbyist than scientist.

Q So the first line, "wondering if there's something NIH can do to help put down this very destructive conspiracy" -- is it NIH's job to put down what is a scientific hypothesis?

A Well, it's a rhetorical question, but the obvious answer is no. The goal of science is to seek truth by providing evidence or contrary evidence and then making inferences from that. It shouldn't have an objective above that, particularly in areas of, you know, safety, like patient safety, integrity of scientific processes. And something like this, which, you know, millions of people died with the virus, it's important to understand where it came from and how to prevent it.

Q What are the -- what are the ongoing benefits

and future benefits of understanding the origins of this virus?

A Well, we have a million dead Americans, and I think everybody in this country who's had a person in their family die or a person in their family suffer who's been affected by it, who's lost their jobs, whose children did not go to school deserves to have the answers and not just -- you know, there's a healing power to answers, and it's there.

Number two, you can debate about accountability, because that's outside of my expertise.

But number three, this is all about preventing future pandemics. And there are things that can be done if this came from a laboratory to prevent future pandemics. For example, there are no international standards for BSL-4 laboratories. There are none.

I can guarantee you whether China did this – you know, was making a biological weapon or not, they did not intend for it to leak out of the laboratory. So if it came from a laboratory, it would spur more action to have like international standards. Why don’t we have international safety standards for BSL-4 laboratories that people can work with?

So why don't we have -- there could be more routine monitoring programs of people who are there. So there's a

lot that we can do to prevent this from happening in the future.

But if we say, oh, it's just a natural virus and it's going to happen again, then we're not going to be -- we're not going to have the momentum to do those kinds of -- those kinds of things.

I would similarly say, even though I don't believe it came from a wet market, you know, we ought to work -- because those are risk factors too. Not the wet markets like we'd go down and have a farmer's market, but a wild animal live wet market. So I think there's good agreement between China and the U.S. that these things are dangerous.

And by the way, they're not in the global health security agenda, the GHSA, on the self-inspections. That's not part of any of those routines. So the BSL-4 concepts, the wet market concepts -- these are all things that if we know what the origin is from, it gives us much more momentum and credibility to move towards those international standards.

Q Do you think if the federal government had known some of these opinions in these emails on February 1, 2020, it would have altered any future response?

A I really don't know, because we knew the genetic sequence at that point in time, and we were starting -- so we were starting to gain knowledge. I think if we could

have traced it back to the Wuhan lab and understood more of those experiments, it might have given us a little bit more understanding.

But I think by February 1 we were already seeded in hundreds of cities with this being spread. I really am not sure it would have made a difference. Maybe people who are much more into molecular virology can testify whether knowing that could have made a difference in response, but we still needed to develop tests. We needed to develop vaccines. We still needed antivirals. We still needed all those things.

And I think by February the horse was out of the barn, you know, coming on the third -- on the third turn of the track. I mean, it was pretty far along by that point, and we needed to do the same thing.

Like I said, for testing, whether it came from a lab or not, I still had to do the same things. It did not affect my daily work of what I needed to get done tomorrow, next week, next month, you know, three months from now.

By Ms. Callen.

Q Do you agree that this email that Mitch read from Dr. Collins, do you think it's fair to say that Dr. Collins is silencing scientific debate or attempting to?

A Yes, it does.

Q Okay.

A And I'm just going to say that's atypical for him, but it sure sounds like that in this regard. I've never heard him be this way on any other issue, and I've worked with him a lot. And that's concerning.

Q What do you think his motives would be for trying to silence debate on this topic? NIH?

A I'm not going to talk about Francis, because I don't know what his motives are. I'm going to say in general there's a lot of stake in the reputation of the NIH and the reputation of science.

And if the NIH doesn't -- you know, like I said, you know, everything has good and bad to it, and I think we have to be transparent that the NIH is a great institution, but there could be some real problems with it. And I think if you admit that, that's not going to take down the whole institution.

I know that people at senior levels at NIH are very concerned with the reputation of the institution, its continued funding, and things like that.

I cannot speculate on Francis and I won't. I respect Francis. I've worked with Francis and I respect Francis. This email is extremely concerning and very different than he would have acted, I think, in any other circumstance.

And we've talked about a lot of issues. This is way out, five standard deviations away, and I think you have to

ask why is that.

Q Thank you.

Speaking of reputation of institutions --

Ms. Callen. Sorry, Mitch, if I'm --

Q -- but I want to switch to CDC. I think CDC has taken a great deal of -- or has taken on a great deal of reputational harm. You know, Senator Collins talked about the lack of trust in the CDC.

I think that was after they put out guidance last summer saying that children should wear masks outdoors at summer camp. And some -- you know, it's been widely reported that CDC has gone back and forth on lots of different things. And apolitical people have criticized CDC.

So I'm just wondering, you know, we are or we used to be the Committee on Oversight and Government Reform. We dropped the government piece of that, but Republicans like to focus on the government.

So wondering, you know, what you think we should be doing vis-a-vis CDC to gain back that public trust that they've lost.

A How many hours do you have?

Q How many do you have, sir?

A So I'm going to start at a macro level, and you can go down. But I think there's two fundamental problems -

- maybe two or three fundamental problems, and they're linked.

The CDC has become like an independent academic institution in their ivory tower. They have almost no urgency and almost zero operational capability. And that was shown in the pandemic.

Before CDC tries to improve maternal health, which is really HRSA's role, and have a thousand people working on that, they need to understand now to control infectious diseases.

So I think they've become way too academic in the sense of we're going to investigate this and take six months and publish about it. When I took over as the opioid policy leader, thank God Redfield was working on this, but when I looked for new statistics on opioid deaths in 2018, they were giving me 2015.

They were three years behind and couldn't understand why I needed this like today, what happened in the last six months.

Q Yeah, Dr. Redfield talked about that.

A He started to try to reform this by bringing in operational people from the field, like the Jay Butlers of the world who had been the Alaska SHO, state health official.

But they're very academic, and operationally they were

a disaster. In terms of knowing how to actually transport patients from Wuhan, you know, how to set up any kind of testing sites, how to interact with the public sector.

So I think a lot of the reform needs to make CDC more operationally capable. Like before they do anything else, they have to know how to control an outbreak and to put on PPE and to do the kind of basic things that are involved with that before they do anything else.

And it's a cultural thing. I want to make the distinction, the people at CDC are generally excellent. The culture of the institution needs to be completely, you know, refitted and redone.

The second thing -- and I learned this from the budget Committee -- is Congress does have the power of the purse, but everything is so compartmentalized that there's very little flexibility in the CDC budget, and there's really not a whole lot of flexible money at the CDC director's level.

I wouldn't give them more money if they don't fix the culture, right, because if you don't fix the culture and the operational capabilities, it's all for naught.

But once those things are fixed, there needs to be more direction by focusing on the core tasks, moving things to other institutes. And I put maternal health. You know, maternal fetal health is very important to me, but HRSA's maternal fetal bureau is, bar none, there.

They have the FQHCs. They fund all the things. There's no reason to have that kind of duplication, just as an example, when the CDC needs to focus on the kind of global epidemics.

Getting back to the private sector, the CDC works with the public health labs, the NIH works with academic institutions, but nobody works with the public sector. To be more externally facing and work with the public sector, which I felt dramatically during testing; right. CDC's -- their only goal was to get some tests to the public health labs. It wasn't to solve the national problem of testing.

So look: CDC is a great organization. I have literally read the MMWR since high school, and I mean that. Kind of reflects maybe geekily on me, but I've always been involved in this.

But they do need -- and it's going to take more from Jim Macrae from HRSA doing – in a week review of CDC. It's going to take a really significant rebooting of the organization to restore it to the luster it once had.

Q We were surprised to learn that a lot of the CDC employees worked remotely during the biggest public health crisis in our nation's history, arguably.

Do you have an awareness of that?

A Yes. From what I was aware, that the chief of staff and the deputy chief of staff were mostly remote, and

I think it was 90 percent of CDC employees were working remotely. And probably the ones that weren't, were up here working with us.

I think it just reflects -- if in the largest pandemic in a hundred years that took a million American lives, when 90 percent of the CDC don't have to show up for work, I think you've got a problem.

Q I agree.

Since you worked at DARPA, I wanted to ask you: Do you think DARPA's model is or you're a PM for a while and then you have to sort of move out so that there's -- is that correct?

A That's correct.

Q There's constant churn at DARPA?

A Correct.

Q Would that be helpful for CDC, do you think, or do you have any opinions on that?

A So there are going to be people who work their lives there. One thing I'm really interested in is from the public health officer, the officer's perspective. There are people who spend their whole life there, and I think that's really bad.

I think they need to do, like the military, a joint assignment, to go to the military health service, to go to someplace where they have operational capability or you

can't be promoted above 04 or 05.

I think that's true for many organizations, but for CDC I think that really needs to happen.

I do think they need to bring in more people from the outside. And, again, I don't know the opinion of Jay Butler, but Jay Butler was a front line person in Alaska. They brought him in and he brought real operational capability, like what really happens in the field. I think that's really important.

And I think, you know, there's a board of like scientific advisors for the CDC. I think there needs to be a board of like operational advisors that have true operators. I mean people from the DOD, the intel community, the states that assure that CDC is not just academically ready so in six months we could write a paper, but operationally ready so that if we need to evacuate somebody from Wuhan, they actually have a clue what they're doing. And they didn't in this circumstance.

Ms. Callen. Okay. Thank you.

By Mr. Benzine.

Q Sorry. I have a follow-up and then I'm going to try to run through mine as quickly as possible.

A Okay.

Q To your knowledge, did the CDC and the intel community have any interaction?

A To my knowledge, no.

Q Okay. Obviously you think they should?

A Oh, yes, absolutely. There needs to be a data fusion intel with the intel community, the DOD, et cetera, et cetera. If the satellites did see hospital parking lots fill up in October and November in Wuhan, we needed to know that. And I needed to know that in my position, and I didn't.

Q Thank you.

You were -- I might get the title wrong, so correct me -- the administration's representative to the WHO?

A Yes. So I represented the U.S. along with the Secretary at different times to the WHO, the World Health Assembly. I was nominated in November '18 -- in November of 2018 to be the U.S. representative to the Executive Board of the World Health Organization.

That's a Department of State position. It is often the CDC Director. It must be an M.D., I believe, and I was nominated. I was ultimately confirmed for that in May 2020. So that's the official title, yes.

Q At the beginning of the pandemic, we didn't have anyone on the WHO Executive Board? When were you nominated? Were you pending confirmation at that time?

A I was nominated in 2018. I was -- went through the process. I was sent back to start over again by the

leader of the Senate in 2019. I went partially through the process again. I got sent back again to start the process all over to be renominated.

So there are, I think, 36 seats on the Executive Board of the World Health Organization. The U.S. has seats two out of three years. Tedros reports to the Executive Board. The Executive Board gets all the knowledge.

The only country of those 36 that did not have a representative on the Executive Board was the United States, and I was supposed to be there. And I have a lot of second thoughts about what could have happened, potentially, if I would have been in that seat, and that haunts me a little bit.

Q In the summer of 2020, President Trump announced that he was going to withdraw, if that's the correct term, from the WHO, and it gained a lot of press attention and attention from congressional Democrats on the hill.

If you know, who advised withdrawing from the WHO?

A So can I answer a different question first?

Q Sure.

A I'm not really sure that we were going to withdraw. I did not know that for sure. I never had a direct conversation with the President about that. I certainly worked with NSC and other people in State about that.

But as late as September, I put an entire slate of reforms on behalf of the United States to the World Health Organization that had been blessed by the NSC Office of Global Affairs and it literally almost copied and pasted by Germany and France. Germany and France did not want to support our resolution because of all the politics, but basically they put the same proposal in independently.

So we were actively engaged in trying to reform the WHO as late as September. So, you know, one day we need to find out whether the President was really going to pull out or whether he was keeping leverage to get these reforms, which we need, and everybody understands WHO needs reforms.

So who advised the President? You know, I don't know who talked to the President about this. I can tell you from the task force, and it surprised me a lot, that Dr. Birx was one of the leading advocates for pulling out of the WHO. And some of those discussions happened, you know, in the task force, and I found that really surprising and shocking, but nonetheless it was the case.

I was never supportive of pulling out of the WHO. And I'm sure their internal deliberative and all that kind of stuff White House, but wrote a lot of memos about why I felt we needed to stay in the WHO.

And, again, I do not know whether we were actually going to pull out or whether this was leverage for the

reforms that were blessed by the White House for me to put in September.

Q Thank you.

From January 14 -

By Ms. Callen.

Q Really quickly, what is your understanding of why Dr. Birx advised pulling out of the WHO?

Mr. Benzine. I'm going to step in there.

Q From January 14, 2021, to February 10, 2021, the WHO sent a team to China to investigate the origins of COVID-19.

Are you aware of that, and have you read the corresponding report?

A Yeah, I read the report.

Q I think that's the report you mentioned that they tested like 90 different species and 90,000 animals and all sorts of --

A Yeah. That's one of the reasons that really tipped me over much more to believing that this was probably a lab leak than a natural response, a natural occurrence.

Q The WHO team was comprised of 17 international scientists and 17 Chinese scientists, and there was one American on the team, and it was Dr. Peter Daszak of EcoHealth Alliance, who we talked about a little bit earlier.

A Yes.

Q Understanding the research and the relationship that Dr. Daszak was doing in and had with China, do you think he had a conflict of interest that he should have disclosed before being on that team?

A He had a complete conflict of interest. I don't know whether he disclosed it, and I don't know who would have supported that, because he clearly had a conflict of interest to that.

Q Do you think it was appropriate for him to be on the WHO investigative team?

A If you're the Chinese Communist Party, absolutely. If you're the United States, no.

Q The United States submitted three names to be part of the study. Does that sound right?

A That is correct.

Q My understanding is that it was a virologist who was an expert in viruses that had to be studied in high-security laboratories, a senior veterinarian, and a medical epidemiologist.

Does that sound right?

A It sounds right. So I was not involved in picking them, but the Office of Global Affairs, OG at HHS, sort of ran those names by me to get my blessing, if you will. And they were all career people. I think one was

from the NIH, one was from the CDC, and I don't remember where the other one was from. But they were nonpolitical completely. They were absolutely qualified.

And not that I needed to bless them, but I blessed them, and those were the names that were submitted. And I don't remember who the names were at this point.

Q Do you remember if any of the three were Peter Daszak?

A No, they were not. Not at all.

Q The names were submitted. Were any of the names -- obviously, none of the names were accepted. Do you know why?

A I do not. I do not have that, although Office of Global Affairs said it was unprecedented that in such a time when there was some kind of committee like this that one out of the three -- that none of the three were accepted by the WHO. I didn't have that experience, but they told me this was absolutely unprecedented.

Q Do you think the Chinese government vetoed the inclusion of the three U.S. scientists?

A It's certainly possible. I don't know that. It's a possibility. It's a possibility.

And "veto" can be in quotation marks, but I don't know that, but it's possible.

I think they had -- I think they had the rights to

determine who was on the committee. I believe that's true -- or certainly had input into who was on the committee, so it's certainly possible.

I don't think there would be any reason that Tedros or anybody, Mike Ryan or anybody at WHO would have vetoed these people, because they were career scientists who were not political at all.

Q Investigators after the fact said they were given no access to lab data, original safety protocols, personnel safe logs, experiment logs, the WIV's virus database, or the WIV's animal breeding logs.

Do you think those data logs are important to discovering the origins?

A Essential.

Q Why would the Chinese government not allow access to those logs?

A Again, I hate to speculate, but if you have nothing to be afraid of, you'd be transparent about it. If I had to guess, and it's only a guess, it's a combination of -- you know, there might have been smoking guns there and also there's probably a covert weapons program that's run out of there.

I'm not the first one to say that. It's integrated with military, and they don't want us to know what's going on in their covert programs. And there might be a lot of

inferences by looking at those kind of logs.

Q President Biden and Secretary of State Anthony Blinken said, "The U.S. has real concerns about the methodology and the process that went into the report, including the fact that the government in Beijing apparently helped write it."

Does that concern you as well?

A I was very pleased for Secretary Blinken to say that, and I share the same concerns.

Q If -- beyond the other issues that went into the report potentially vetoing U.S. scientists, not allowing access to the lab and data, does the Chinese Communist Party help writing the report make the report invalid on the theory of the lab leak?

A You know, I think it does, because -- for all the obvious reasons. This is not what you would normally do in a scientific -- in a scientific report. So it's just concerning. There's so many red flags all over the place. It's just very concerning.

Q They listed -- and this will be my last question. I'm a little bit over time.

They listed four possibilities for the origins: Direct zoonotic transfer to humans, which would be the wet market kind of scenario --

A Right.

Q -- introduction through an intermediate host, introduction through frozen food, and then a lab leak as extremely unlikely, and the lab leak was the only one that they suggested not investigating further.

Do you think there's any credence to that?

A No. And the amount of time they spent on the lab leak was just very superficial, and they just dismissed it sort of a priori.

We know it didn't come from frozen foods. And there's not a single shred of evidence that it's a direct from the wet market or through an indirect host. None of that has been -- none of that has been shown.

Look, I'm the first one -- if two years from now they find the animal, they trace everything, but they haven't, and there's no evidence from it. And referring back to Dr. Redfield, so it was clearly they wanted to dismiss that.

What really bothered me is the degree of rigor that they approached the other possibilities versus the degree of rigor with the lab leak was just night and day. It's like they didn't even want to deal with it.

They didn't want to discuss it. They didn't want to consider it, where they did a real good job looking for the other sources and couldn't find it. I mean, they were very rigorous about looking for animals and there just wasn't anything there.

And I think there was a quote in there -- and I may get the years wrong -- but it said they didn't even find a virus within 30 years of evolution or 40 years of evolution that could come to this one. And those are pretty important comments; right? Not only wasn't there, but there was nothing even evolutionary close to what we saw.

And that's really when I got really -- I read that report because I was waiting for that report, and that got me more involved in trying to understand and to go back to read all the papers from EcoHealth Alliance and all that stuff. When that report came out, I really got interested and a little shocked by it.

Mr. Benzine. Thank you. Our time has expired. We can go off the record.

[Discussion held off the record.]

By Ms. Gaspar.

Q Going back on the record. I just want to touch very quickly, just moving ahead here.

In late summer of 2020, early fall, a lot of people anticipated that there would be a surge in coronavirus cases in the winter.

Did you share that view?

A I didn't disagree with that view, but I didn't have a primary opinion on it. I know Dr. Birx felt that way, and we were sort of planning in that regard as a

possibility.

So, again, I didn't have a predictive -- I didn't personally have a prediction about that. But yes, that was definitely a discussion.

Q Did you take steps to check the testing strategy or otherwise prepare for an increase in demand in anticipation of that?

A Yes.

Q What did you do?

A It was basically trying to get the point of care tests out, and that was our major focus, number one, to protect the elderly in nursing homes. And then secondly, to -- when BinaxNOW, again, we brought all 150 million.

The strategy was to take 50 million of those to the vulnerable population, so that was nursing homes, assisted living, tribal nations, even HBCUs, because, you know, young African-American students were not particularly at risk, but they tended to go home to multigenerational households, so Grandpa and Great-Grandma all got sick when they went home. So 50 million went to vulnerable.

And then we sent about 100 million to the governors on a weekly basis with strong advice on how to use them, but they could use them, you know, as they wanted to. But we advised them for asymptomatic screening, for critical workers, potentially for schools if they wanted to.

And we also did school pilots with the Rockefeller. And then at the same time we started our emergency search sites, which is CBTS 4.0. So we started that, I think, in July, but that went through the entire fall.

So basically we had a nationwide sort of contractor that within 48 hours, if I got a call -- when I said "I" -- or someone on the task force requesting it -- we were able to put an emergency search site to do anywhere between 10- to 50,000 tests on the community.

So that's what we were preparing, preparing for.

Ms. Callen. I'm going to hand it over to Beth.

By Ms. Mueller.

Q I'm going to hand you three exhibits, which we will mark 3 through 5.

A Okay.

Q I think you'll find these pretty familiar, but just for the record, Exhibit 3 is a July 17, 2020, document titled "Overview of Testing for SARS CoV-2."

[Exhibit 3 was marked for identification.]

Q Exhibit 4 is the August 24, 2020, "Overview of Testing for SARS CoV-2 COVID-19."

[Exhibit 4 was marked for identification.]

Q And Exhibit 5 is "Overview of Testing for SARS CoV-2 COVID-19 Testing Overview."

[Exhibit 5 was marked for identification.]

Q Please pull out the July 17, 2020, version.

A Okay.

Q Do you remember this guidance?

A I --

Q At a high level?

A At a high level, I tried to look back, but none of these are ever on the websites anymore, so -- I mean, I remember it at a high level.

Q Prior to issuance, did you have any involvement in reviewing, commenting on, or approving this guidance?

A Let me look at it for a second.

Q Of course.

A Let me answer this. I can answer it generally that from the moment I took over testing, I was involved in all the CDC guidance in one way, shape, or another.

So the original guidance for the drive-through testing sites were literally written by me and Bob Redfield and subsequently went through CDC.

So this was -- and, again, remember there was a testing task force that had CDC members there within FEMA.

So in terms of review at the White House task force level, I don't remember this guidance going to the task force level, but I was involved with the CDC on all of these in a very synergistic way. And remember for testing I was actually in charge of the CDC, so I was sort of acting in

the place of the Secretary or above the Director.

But Bob Redfield and I were extremely collegial and worked together on this.

So I don't know if that answers your question.

Q That's helpful. Thank you.

We mentioned --

You can now put that to the side and take out the next version of the guidance, which was marked as Exhibit 4. This is the August 24 guidance.

A Yes.

Q You testified earlier that you were involved in the update of this guidance; is that correct?

A Yes.

Q What was your role specifically?

A My role is that Bob Redfield and I brought an early draft of an update -- first of all, I was involved because of why we needed to update the guidance. In order to prioritize tests, in order to make sure that people didn't get a negative test and then go out in the wild, to sort of lay the groundwork for the point of care testing that was coming.

So I was involved in really understanding why we needed to sort of update the guidance.

And then there was an early, very early draft of the guidance that was sort of -- like this kind, that was worked

cooperatively by Bob Redfield, me, and CDC -- again, this was not a "me" or "they." We were all working together on that -- that Bob Redfield officially brought to the task force.

There was a lot of discussion about that, both from the infectious disease point of view, but from the overall point of view, and there were some disagreements about that. And the Vice President wanted us to give a consensus task force to reach agreement. I mean, you don't need to debate these things in front of the Vice President. It was clear that there were scientific issues.

So I took the role of getting input from the principals primarily, meaning Dr. Redfield and Dr. Walke from CDC. Even though he wasn't part of the task force, Dr. Walke was synergistic. Scott Atlas, Deb Birx, Tony Fauci, and Steve Hahn were the core group that I tried to get consensus on, which involved multiple iterations round and round.

Ultimately, that was given back to Dr. Redfield. Dr. Redfield put that through CDC clearance for changes or whatever else, and the CDC issued that. It was very clear that I was gaining consensus from the task force docs, but that was the base document that CDC would work on to go through their clearance process. So that describes it.

So when the press release said I had the pen, I had a

pen, but I was coordinating the edits of all the individuals who were on that. And, again, that's not something I felt I could have a lower-level staff person do, given the level of importance of the guidance and the level of the people that were interacting.

Q That was very helpful. I'm going to unpack that a little bit with a few follow-up questions.

A Sure.

Q You mentioned that the purpose of -- the reason for updating the guidance was to prioritize testing for the vulnerable.

Is it fair to say that there were still insufficient tests to meet demand or need at that time, thus requiring that prioritization?

A Can I put a fine point on that?

Q Of course.

A We had a lot more tests, and they were distributed in the right way, that if they would have been utilized, we had plenty. So our supply was bigger than our demand.

What we saw was people relying much more on the ACLA laboratories, so instead of using the tests that were there -- and, again, we didn't have many point of care tests, so that couldn't do it -- they were shifting more and more to the ACLA labs, primary Labcorp and Quest.

And as I told you, every morning I knew down to two decimals points and to the states where the turnaround times were coming.

So what we were seeing is because a lot of people were getting tested just because they felt like getting tested and -- you know, I'm going on summer vacation or a lot of -- and I'm saying lifestyle testing, like I need a test to go to the Bahamas -- we were starting to get delays in the critical populations.

So that particularly Quest at the time was having not two- or three-day turnaround, but four-, five- and six-day turnaround, and that was going to be absolutely troublesome to the at-risk population. So we were trying to focus on that.

And also, again, trying to -- two other things is number one, focus that a negative test doesn't mean you're okay, because it's a natural thing. Oh, I got exposed; well, my test is negative.

And no matter how many times you tell people you can still get it over 14 days, once they have that negative test, it's like I'm good. So we're trying to dissuade that because of the asymptomatic spread.

And another issue which was very important in that is unless you were just doing surveillance, you know, that the public health were doing surveillance and you were under

that, we really felt if you were concerned enough to go get a test, you needed to self-isolate, that even if you weren't exposed for 15 minutes within 6 feet, if you felt concerned enough that I needed to go get a test, that you needed to wait until that test was negative before you let yourself out of isolation.

So these were all the issues. I forgot your original question, but these were all the issues that were kind of surrounding at the time that we were trying to get ahold of.

So we had plenty of tests, but it was a reliance on the ACLA laboratories, particularly to the point of care that we were seeing at the time.

You know, as more and more tests, you're always going to hit step functions and where they were, and that was the step function we were at.

Q So is it fair to say perhaps there were sufficient tests, but the ones that the public was relying upon were maybe a little choked at that time period?

A "Choked" is a good word. And the way to alleviate that was to set the prioritization for the ACLA labs saying what kind of test you have to do when. In other words, lifestyle test can be seven days or above. Critical tests need to be within 48 hours. And then there's an intermediate group.

And also trying to clarify for the American people who

is really -- you can make the argument that everybody should be tested all the time, and there is a good argument for that, but given the resources that were there at the time, what were the priorities that were going to make a difference in saving lives, and that's what we tried to do.

Q Were there members of the task force who were advocating for broader surveillance testing like you just mentioned?

A Yeah, me and Dr. Birx.

Q You mentioned that this prioritization was the reason that the decision was made to revise the guidance.

A Let me just clarify that. There is not -- there is not a contradiction between prioritizing, but also doing surveillance testing. Surveillance testing is not -- you know, you get sort of an idea just by seeing who's testing and who's positive. But surveillance testing is not just haphazard send a whole bunch of tests and let everybody do it. It's really looking at focus populations.

So there is a way to do surveillance testing and focus testing at the same and, indeed, when we sort of required states, even though we didn't have congressional authority to do so, to submit a testing plan before they got their money, every state had to have a surveillance plan on how they would do asymptomatic surveillance. But that's different than just willy-nilly testing everybody.

I'm sorry to interrupt you. I just wanted to make that point. Because at first level, that could seem inconsistent, but it's not at all.

Q That's helpful. Thank you.

You mentioned that this prioritization was a significant reason that galvanized you and Dr. Redfield to try to update the guidance; is that right?

A Yes.

Q Who had the original idea, and how did that sort of come about?

A The original idea to?

Q Take me through -- was there a conversation between you and Dr. Redfield or others?

A I think it really started with Dr. Redfield and I. I don't -- I honestly don't remember how that came about, but we were constantly, you know, asking about does the guidance need to be updated. I was particularly concerned at that time -- that ultimately didn't happen, but that the CDC guidance is written more like for experts, that we needed more just user-friendly CDC guidance -- instead of five pages, like five lines. And that's what I originally wanted to do. And I think Dr. Redfield was leaning in that direction too.

So I don't remember how it got -- how it really got started, but it was sort of a continuous -- you know, every

few weeks we were, you know, working on -- do we need to update, what's the status, where do we go, because things were changing like that. So I don't know how it started.

But this was all highly collaborative. Bob and I talked to each other every single day, literally every single day.

Q Was Dr. Atlas part of these initial conversations?

A The initial conversations, no.

Q Did he later come in and have a role in the decision to update the guidance?

A Not to update the guidance, but what the guidance said when it was updated, yes.

Q What was his perspective?

A So he -- I'm going to generalize his perspective, but he was certainly part of the edits, part of the edits to the guidance. So after that initial task force meeting that I said that there was a lot of discussion, my recollection is Bob and I, right after the task force, went and had a private meeting with him for probably two hours in trying to synthesize all the ideas.

He was -- he was -- he basically had -- I'm going to generalize this -- is that, number one, he wanted to be focused as much as possible on protecting the vulnerable groups, but less emphasizing testing of people who are

asymptomatic and who were not going to be -- not going to be -- generally not harmed by having the virus, so young healthy people. He was less concerned about that and more concerned about, you know, isolating them and quarantining them.

I'm going to say if I had to characterize it at a high level, that was basically his point of view. And obviously there were a lot of subpoints that came out of that.

Q Did you agree with those points of view?

A Some I agreed with and some I disagreed with.

Q Which did you agree with?

A So I agreed that we needed to focus on protecting the vulnerable.

And I'm going to tell you what I disagreed with too is that -- I don't know how it came about, but he really felt like the vulnerable were located in a few locations that you could fence them, and that just wasn't the case. That most of the vulnerable are not in nursing homes. They're living in the community. They're chronically ill. And it was really impossible.

And, again, I don't mean to put words in her mouth, but I think Dr. Birx and I agreed on this pretty strongly is that we had to protect those in nursing homes, but the great majority of the vulnerable need to be protected by protecting the overall community.

So that led us to much more emphasis on wider spread, community testing and surveillance, even among the young and healthy. Nothing personal: I don't care about you so much looking at you. If you go home to Grandma, I really worry about Grandma. Right? That's just the way life is.

So I think those were -- you know, and these were debatable issues, which is why the Vice President kind of sent us to have a consensus document that we could all, you know, get behind, knowing that whatever we wrote still had to be do-able by the American people; right? You can't write an ivory tower document that no one will do. So that's kind of, you know, what it was. I would say at a high level, that really describes it.

Q You mentioned, I believe, that Dr. Atlas was less concerned about isolating and quarantining asymptomatic low-risk people; is that right?

A Yes.

Q Did you agree with that?

A I did not.

Q Okay. Was that policy reflected in the updated testing guidance in August?

A It was certainly a topic of debate in the guidance about what degree, to what degree -- to what degree nonvulnerable groups should be tested. And like I said, we came to, after multiple drafts -- I think there were

probably 14 or 15 of them -- we came to an agreement on the wording that was there.

Q In her book, Dr. Birx wrote, and I quote:

"In a task force meeting, Atlas expressed agreement with the President on our needing new testing guidance posted to the CDC website and said he would be the person to make this happen."

Do you remember that?

A I do not remember that at all, because I never heard him something like he would be the person to make that happen. He clearly had an opinion and was participating, but I never heard that. If that was in a task force meeting I think I would -- I don't remember that.

Q Was President Trump directing that the testing guidance be updated in some way?

A No. I mean not -- not to me whatsoever. He was not attending task force meetings at that time or rarely attending them, and we never had a conversation in the Oval Office about that.

So from my perspective, I never heard that, and it wasn't the origin of our updating the guidance.

Q You mentioned that you held a pen on coordinating commonsense changes to the document.

A Yes.

Q Who drafted the original first draft of the

updated testing guidance?

A Dr. Redfield and myself.

Q Did anyone else play a role?

A In drafting that? There were -- I don't remember, but Bob always relied on people at the CDC, you know, Henry, Dr. Walke, and maybe a few other people.

But, again, our first draft of the guidance was very minimalistic, and it was sort of a change in form to be much more public-facing, like I literally mean like five or six lines about who really needs to be tested and when or what you need to do, as opposed to a multipage document.

And I think you know that tension. There's always a tension between communicating to the public and trying to have an encyclopedia. And I think we felt at the time -- I know I felt at the time, and he agreed, that we really wanted to have a much more consumer-friendly, that anybody could read these and understand what they should do. That got morphed into all of these things by the end of it.

And I'm not saying it was wrong. I'm just saying the original draft was very consumer-friendly and one, two, three, four, five, six, period.

Q You mentioned earlier as well that there was a lot of discussion around the guidance. Who raised those issues that you were mentioning earlier?

A So I'm going to say Dr. Atlas certainly raised

issues with the simple form of that. But there were other people in the room. I can't tell who it was, but it wasn't solely Scott Atlas. There was other discussions, but certainly he did raise issues.

And the first thing I needed to help resolve and understand -- not really resolve, but understand what his points of view were, which -- you know, your mind plays different -- I believe it was sort of right after that, but I remember distinctly going with Bob Redfield, sitting with Atlas.

I think he had an office like way up in the spire of the west wing, so I remember it because I had never been up so many stairs that high, that we sat around the table for an extended period of time trying to understand his point of view, and I was sort of scribing for that.

And the first revision back was to Atlas and Bob saying did I capture what we talked about. Atlas made comments, Bob made comments, and then I started circulating it to the wider group.

I'm sorry. These are all first name people. Bob is a first name people. You know it's Redfield, not Bob Kadlec.

Q Thank you.

A I'm sorry.

Q What concerns did Dr. Atlas raise with the document at that time or issues?

A Again, I'm going to speak generally that he was very concerned about unnecessarily removing healthy people from society who had a very low risk of being harmed themselves, so what's the purpose of doing that. And that was sort of inextricably linked to the notion that you could fence off the vulnerable.

And, again, I disagreed with some of the things he said, but he had a lot of really good points. So that was sort of the fundamental, I think, tension, if I could use the word, right, and it's appropriate tension between those two things.

The thing that, again, was much more on Deb's mind and on my mind was the vulnerable that you couldn't fence off, you know, in nursing homes. I knew I could take care of them reasonably well and Seema Verma could take care of them, but most elderly and vulnerable live in the community, and that's what we were trying to fix.

It's not that I didn't care about young healthy people. He's right. You know, most young healthy people got a cold, particularly early on. Unless you got severe disease, you could have risk of long COVID, but it was very low. But they were not the primary concern. They were not dying. It was the vulnerable.

So that was sort of the general grouping of what I was saying was his -- he was much more concerned about

unnecessary lockdowns at a societal or personal level because of -- for those reasons.

Q Do you recall if he made changes?

A Pardon me?

Q Do you recall if he made changes in response specifically to his comments?

A If we made changes?

Q Yes.

A Well, yeah, we did. Because the first -- as I said, there was a very simple first draft and then Bob and I met with him, and then there was a long list of changes that were partially Scott's, but -- and I don't know him that well on a first-name basis. It's not like Bob Redfield that we worked for years together.

But Atlas, part of it was his, but part of it was the summation of the discussion among the three of us that was in his office. So that got sort of detailed in the next draft of it.

Q You mentioned that Dr. Birx was concerned about the inability to roll off the elderly and the vulnerable that might live in the community.

Did she have other concerns with the draft of the August 2020 guidance beyond that?

A Well, that was an overall concern. She did make some comments on it, but, you know, the item that seems to

have been brought up in the public release from this Committee about if you're exposed and asymptomatic, you do not necessarily need a test -- she made zero edits or comments on that version on that clause. Neither did Dr. Fauci. Neither did Dr. Redfield, who was sort of part of the origin of that.

He added later, which I agree with -- I think it came from CDC about -- you know, we always said you don't need unless you're a vulnerable group or around a vulnerable group, but he also put "But, of course, if your doctor or public health officials say go get tested, go get tested."

But Dr. Birx did not make comments to that line. And, again, at that time most of the issue, I think, was about can you test out of quarantine. In other words, if you're young and healthy and have a negative test, can I actually let you out?

And we didn't have the data, really, at that time, but that's where a lot of the back-and-forth was about. But the "you do not necessarily need a test" was not edited by any of those docs on the first pass.

Dr. Birx never affirmatively cleared the last version. Even though I asked multiple times, she just didn't respond, but everybody else affirmatively cleared it.

And that brought it to the task force. We said we reached agreement. Then it went back to Dr. Redfield to go

through internal CDC clearance, which they could have posted it or not, and they ultimately, you know, posted it. I don't remember how long a period of time between the doc going back there and when they posted it, but that was posted by them.

Q Did anyone ever raise concerns that the revised guidance might lead to a decrease in testing?

A No, not until after it was posted.

Q Who raised that after it was posted?

A There was -- there was a tremendous misinterpretation and misrepresentation of this guidance. You know, like we're trying to stop asymptomatic testing. That was never true, because we always were supporting surveillance testing. And, in fact, that was part of the -- you know, the May plans. We talked about surveillance testing.

But it got interpreted, and it was sort of a wild flurry about they're saying don't test asymptomatic people. We didn't say that, but that's the way it got interpreted. And once that started getting interpreted that way and sort of proselytized in that way, we were concerned that people might actually think we were trying to deprioritize asymptomatic testing, surveillance testing, which we were not.

But what we were saying -- and it was true -- that if

you were exposed, whether you tested or not, you need to do all the mitigation procedures that CDC had, and a positive test or a negative test doesn't affect you, because you had to do the same thing.

And if a test, positive or negative, did not affect what you were doing or your outcome, then it's by definition a lower priority. But if your doc said get tested, if your public official said to get tested, if you're a member of the vulnerable group, if you work as a first responder, all that needed to be tested, and that's what we were trying to convey.

So we were not concerned that it was going to decrease testing until sort of the spin happened and we saw how it was being interpreted, and then we were really concerned about it.

Q We will come back to that in a minute.

I just wanted to follow up on one thing you just mentioned. You said that the final document was cleared by all of the doctors except by Dr. Birx, and she didn't respond to her messages.

Did she previously say that she couldn't support the guidance?

A No.

Q No?

A No. She had -- she had a chance to review it.

This was all in track changes. She made a few comments on it, but -- you know, that were not -- I think she thanked me for taking the initiative to it, and she did not make any dead edits whatsoever to the "you don't necessarily need a test."

So she didn't clear the final document, although I asked her to do that, but she absolutely had a chance to edit it, and there was no edits that she made that we didn't take into consideration and put into my memory.

I generally went around as after the final document, can I get not just your edits, but an affirmative clearance to the last document, and I got that from the main docs, but, again, Dr. Birx did not do that. And I think I indicated that in my correspondence back to Staff Sec, Derek Lyons, that we had all worked on it and it was affirmatively cleared by everyone except by Dr. Birx, who didn't respond.

Staff Sec and I had a lot of discussions, and because I was taking much longer, they expected it to be done, but we needed to get it done as right as possible.

Q In her recent book, Dr. Birx wrote of the task force meeting where the final testing guidance was discussed: "When Brett presented the task force with the final draft, I spoke up again, saying clearly, I don't approve this. I can't.

Scott Atlas stepped in and again went after me saying

that I was wrong about testing, wrong about the asymptomatic spread. He concluded that the statements that he made in our heated Oval Office exchange that his views represented the presidential position and policies. Angry and under control, I said again, 'I can't approve this.'

"The vice president stepped in to say, 'I really want to set consensus on this.'

'I can't approve this,' I said. 'I can't keep CDC from issuing this. I don't have oversight of them.'" And then she continues, "'It can't go out on the White House website as something the task force endorsed.'"

Do you remember that?

A I do not. I do remember that kind of it's the President's policy kind of thing interchange between Dr. Atlas and Dr. Birx. What I remember is it wasn't related to this at all. But there was an interchange like that, but I do not remember her saying that.

She was not in the task force meeting. She was on the road somewhere, so she was not present at that meeting, to my recollection. I do not remember her saying that.

Q Just to clear up what might be ambiguous, you said you do remember that kind of interchange between Dr. Atlas and Dr. Birx. Was that at a different time or was it about a different document?

Mr. Barstow. I'm going to step in here.

[Discussion held off the record.]

A I don't remember specifically what it was about, but it wasn't in the context of this testing guidance. It wasn't in response to this testing guidance.

And there was, you know, there was some -- there were some passionate interchanges between some of the docs on the task force, mostly Dr. Birx and Dr. Atlas, and that's okay. The Vice President said iron sharpens iron. He appreciated disagreements, but we needed to go back and work it out.

Q You mentioned that after the guidance was issued, it was misinterpreted and it caused some concerns; is that correct?

A Yes.

Q You and the members of the task force?

A Yes.

Q Other than the issue that you mentioned, that some were misunderstanding about who should get tested and when, were there other concerns raised at that time?

A I don't remember. That was the one that was really dominant about asymptomatic testing. And I remember it because I'd been on the bandwagon about how important it is to do asymptomatic and surveillance testing.

We just put out the -- you know, the May state plans. We had to talk about surveillance testing, asymptomatic testing, and we've been beating on that. So I felt it was

really ironic that we were being accused of doing something against what we had been preaching about beforehand.

I remember that as the main issue. I don't remember that there was much controversy about other issues, but clearly saying you don't necessarily need to be tested unless you're part of this or you're advised to was interpreted as "don't get tested."

In fact, a lot of the media -- and I can't quote one -- but was saying the administration says if you're asymptomatic, do not get -- you know, don't, you don't -- don't get tested. You don't need a test. That's not what we said.

Now, part of that has to be our fault because the people misinterpreted, but it was really -- could have been amplified in a much different way. And we saw that was causing confusion. It was an unnecessary -- even though those -- even though I do believe the CDC recommendations were correct, it was the better part of valor to change them to something that would tamp this down so we can continue on in our goal to increase testing and move forward, so...

Q Do you recall whether there was any concern or confusion around whether asymptomatic people who were in close contact with a confirmed case, if they had to quarantine?

A I don't think there was any confusion about

that. That was our -- that was our -- that was the policy, you know, at the time. If you're in close contact, it was onerous, but you needed to quarantine for 14 days unless you were a critical infrastructure worker. Then you really need to monitor for symptoms, then mask up. I think that was pretty clear.

And, again, part of the underlying understanding that whether your test is positive or negative, you still needed to do that. So it didn't change your behavior unless you were vulnerable or one of the groups that we talked about. But a normal individual who's not a first responder, vulnerable, all those kinds of things, whether you tested positive or negative, you still needed to do that.

Q So after the guidance was published, after you saw that it was being misinterpreted in the press, what happened next?

A Well, we tried to message a lot about what we were trying to say and what we were not trying to say. And I had been on media a lot and continued to be on media. I can't quote the times because I don't go back, but I know we really tried to do messaging. I was meeting with press independently like on Mondays and Tuesdays from HHS. We'd have 80 or a hundred on the phone.

So we really tried to explain to the best we could what we were trying to do. And Bob Redfield was out there,

you know, trying to do that. So that was our initial response, to try to turn the messaging, and also to talk to the media directly, whom I had a really good relationship with, you know -- away from the -- you know, away from the Rose Garden or the press room.

Like I had an hour or an hour and a half with 80 or a hundred media every week, and it was mostly really based on these are the numbers, these are the science, this is what we're doing. So we tried to work those channels to fix that.

Q Dr. Birx told us that after you spoke to the press and said that there was consensus at the task force around the guidance that she had a further conversation with you.

Do you remember that?

A Yes, I do.

Q What did you discuss?

A She said -- it was absolutely my assessment that we had a consensus on this, and I had the email trails where she had a chance to modify all the things. She did not modify that at all, and she clearly went through the entire document, because she's very meticulous, and she made comments on other parts -- I mean, not significant comments that we didn't incorporate.

So in my mind, absolutely we had consensus on this

document. When I said we had consensus on the document, I believed it, and then she told me she never approved it. And I said you had a chance to edit it. There was no edits on that. I've multiply pinged you to affirmatively clear it. There was no response. And that's when it went to Staff Secretary.

But I gave her the benefit of the doubt because I respected Dr. Birx. We worked together. And in future interviews I never said that she was part of the consensus, even though I felt and still feel today that she had an opportunity to review it. She did not make any changes in that part of the document. And quite honestly, it wasn't one of the major topics of debate at that time.

So I felt everybody had a chance to contribute. She did not change that. She was neutral on the affirmative clearance at the end, and therefore it went to Staff Sec and therefore it went to CDC.

CDC could have changed anything from there that they wanted to. And I'm telling you, I think I would have remembered Dr. Birx saying it at the task force, and I -- you know, that, in my mind, if it happened, it certainly didn't happen that way or in a form that I was there.

But she did talk to me that -- wanted to be clear that I shouldn't say that she was part of it, and I respected that and never said that again.

Q Ultimately, as we know, the guidance was updated and a new updated version was released --

A Correct.

Q -- on September 18.

Were you involved in making that updated version?

A Yes.

Q What was your involvement?

A Bob Redfield talked to me and said we -- because we had been talking all along, and he really felt that even though we were, quote, right in the previous guidance, you know, if guidance is being misinterpreted and being, you know, looked at it the wrong way, then the guidance isn't right.

Even if it is right technically and scientifically, if it's being misinterpreted and there's a risk of jeopardizing parts of the testing program, which I was working every single day to move, that we needed to update it. We talked about what he wanted to do. I said yes.

And we also decided -- and I took this because I was the, quote, testing czar -- that I approved him issuing that in my testing czar role without going back to the task force, because we had already been through three weeks of it.

We had -- you know, trying to get it updated the first time, we had been through several weeks of trying to message

it, and, you know, I felt if somebody wanted to fire me because I approved it even though I didn't maybe necessarily have the authority to do that, but I approved it. I said go post it, and he posted it.

Q Were you concerned that you could be fired for approving this?

A I didn't care, really. I mean, I cared for the country, but, you know, this was an all-out pandemic with -- you know, every night I'd go to bed knowing two to three thousands of Americans were going to die the next day, and my duty was to do everything I could to protect them, and I was a testing czar, quote, and it clearly needed to be done.

I felt we were right. I felt we tried to ameliorate it. It wasn't that we bypassed it, but it was questionable whether it should have gone through or not, and I said, no, I support you. Just post it and we'll deal with it.

Q Were you concerned if it went to the task force that it wouldn't be approved?

A So I don't know about that, but I was concerned about going through another two to three weeks of process and everything else, and I thought the time was really at that time to get done. And Dr. Birx felt that way, Bob Redfield felt that way, and I felt that way.

I don't know how Tony or anybody else felt about it, but we felt that way, so we took the initiative and changed

it. And we did, and it was posted and, you know, hopefully put -- you know, we had a lot more work to do and there were a lot more people who needed care and who were going to die, and we just needed to move on from that. And it was the right thing to do.

Q Did you receive any pushback or did anyone raise any concerns to you after you updated the guidance?

A Atlas was not happy about it. He was not happy about that and raised some issues about why did you do this and we talked about all kinds of things. But it was just him, and it was in a task force meeting. The Vice President and nobody else batted an eye. We just moved forward. And then it was done.

Q Did anyone else express any displeasure about the decision?

A They really didn't. And I personally got no blowback or any issues whatsoever.

And, again, I was dealing mostly with the Vice President at the time from the task force, and the Vice President had been, you know, extraordinarily supportive of trying to do the right thing at the right time. So there was no -- there was no black -- blowback or any kind of issues after it was issued. Again, the CDC had the authority to issue it, I affirmed it, and we went on from there.

Q I'd like to look at a couple drafts.

I'll mark this as Exhibit 6.

[Exhibit 6 was marked for identification.]

Q This is a document entitled "Considerations for COVID-19 Diagnostic Testing." It's dated August 4, 2020, with a handwritten notation, CDC G/SWA 85.

Do you recognize this document?

A I recognize the document. I don't know when in the sequence this was. You probably have the emails and know -- I think this is probably -- I don't know this document with the scratch-throughs. I'm not sure about this, but --

So we had our original document. Then we had the meeting with Dr. Atlas and Bob Redfield and I, and I sort of made a new document on top of that. I think Dr. Atlas probably edited that document that I drew up after that meeting.

And this is either that document or Bob Redfield's editing of that document. It was somewhere in that early -- in that early chain. And you probably have it, but I don't -- this form of the document, I have emblazoned in my mind because it was so intense trying to get this done for a couple weeks.

Q I'll point you to first to the bottom of the first page. You'll see a bullet that starts "if you have no

symptoms."

A Yes.

Q It appears that the -- all the subsequent bullets are just describing how someone with no symptoms, what they should do; is that right?

A Yeah, it looks that way.

Q It says, for instance, "you do not necessarily need a test." And a little bit below that it says "you should self-isolate for 14 days if possible," and that's stricken out.

Do you see that?

A Yes.

Q Do you recall if that was a change that Dr. Atlas made or if it was someone else?

A I don't really recall that. I would think it's probably Dr. Atlas, but I can't recall that specifically.

I was very clear on what drafts went to what people, so, I mean, that is knowable. I just don't know it. It's probably Atlas, but I can't guarantee that.

Q Did you agree with that proposed change?

A No.

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

A No. That's why I disagreed with it. I thought -- I thought at the time -- and, again, there was a lot of

debate about this, like can you test out. But if you were exposed, it was the CDC guidance, and I agreed with it, that you needed to quarantine for 14 days if possible, unless you were parts of the other groups that needed to mask.

Q So after this, is it fair to say you continued to exchange drafts with Dr. Redfield, Dr. Atlas, and others on the task force?

A Just the docs. Just the doctors on the task force. This was -- you know, this was really a medical scientific one, not something -- you know, we were meant -- the task at hand was to give the best scientific medical consensus to the tank force. So --

And, again, I always have to asterisk this as Henry Walke was part of the group too, even though he wasn't on the tank force. As the Incident Manager, he should have -- you know, I didn't want to throw something over the transom to him. I wanted him involved in the process as it went on. And I didn't feel that was a violation of anything.

Q I'm going to hand you another document which I will mark as Exhibit 7.

[Exhibit 7 was marked for identification.]

Q This is a document entitled "Considerations for COVID-19 Diagnostic Testing." It's dated August 6, 2020.

I'd just like to briefly direct you to the second page.

A Yeah.

Q It says: "If you've been in close contact within 6 feet of an infected person for at least 15 minutes, you should assume you are infected and self-isolate for 14 days at home if possible," and that's stricken out again.

Do you recall who made this change?

A I'm sorry. I lost you. Are you talking about the 14-day isolation?

Q Yes.

A Could you just say that again, because -- I'm sorry -- I was zoning out on this.

Q Of course. It says: "You should assume you're infected and self-isolate for 14 days at home if possible," and it's stricken out, which I understand to mean that it's been deleted.

Is that your understanding?

A In that draft, stricken out. This looks a little bit different, but -- it's hard to know the sequence of these, but yes, it was deleted. And this might have been -- I don't know -- compared the drafts.

But we went back and forth on a lot of these issues. It was a deliberative, iterative process; right?

It didn't mean we accepted that, but on that draft, it was obviously deleted.

Q Can I point you back to the August 24 guidance

that was actually issued?

A Yes.

Q If you look at the second page where, again, it says: "If you've been in close contact within 6 feet of a person with a COVID-19 infection."

Does it say that you should self-isolate for 14 days?

A No, it doesn't.

Q Why not?

A I don't know why not. It says -- the final version that I submitted to Staff Sec had the isolation for 14 days on it. So the final version that we submitted had that on that. That version did not have it on that.

I do not know -- I do not know the origin of that change. It happened after I was -- I don't want to say washed my hands of the document, but after I had done my job and brought it back to the Staff Sec and to CDC.

Reading it at the time, it doesn't say 14 days, but it says you've still got to obey all CDC mitigation issues in there. So I interpreted that as meaning that since we were talking about whether you needed to say 14 days or 10 days, instead of putting the specific, they just referred you back to another -- you know, whatever the mitigation was at that time, that's what you should do. That's the way I interpreted it.

But the last version that I submitted had -- I don't

know what clause it was, but it basically said you need to isolate for 14 days.

Q Do you know who made that change after --

A I do not know.

Q Did you ask anyone about it?

A I did not. That was a version that went back to -- I think the version -- that's the version that CDC ultimately posted, and I don't know the specific discussion around that clause at that time because I was not part of it.

Q The document does mention isolating for 10 days in other sections. For instance, it says it -- "if you do not have COVID-19 symptoms and have not been in close contact with someone known to have a COVID-19 infection but decide to get tested, you should self-isolate at home until your test results are known."

It similarly says the 10 days if you have symptoms of COVID-19.

Do you think by putting that explicit language in the other sections but not for the close contact asymptomatic section that that could be confusing?

That was not a good question, but hopefully you understand my meaning.

A I thought being explicit about 14 days was the recommendation I would have made to the CDC. The CDC posted

it, you know, as it is. So, you know, I think being as explicit as possible was the goal. I interpreted it as the CDC -- you know, the CDC changed these isolation times and how long you need to stay and all that.

I assume they were trying to not have to go through another month of testing guidance and just refer back to like a document. That's the way I interpreted it. But, again, that's interpolation. I had no primary knowledge of that.

Q Did you at any time perceive a sentiment among members of the Trump Administration that testing was leading low-risk people who are asymptomatic to quarantine?

A That testing was leading low risk asymptomatic people to quarantine.

Are you talking about people who are positive?

Q Or that were -- that perhaps didn't know it because they -- prior to getting tested they wouldn't have known it unless they got tested.

A Who had not been exposed or exposed? I'm sorry. I'm just trying to --

Q Let me rephrase that.

Was there a concern that quarantines would keep the people locked down and maybe impact the economy?

A Some people may have had that concern, but it wasn't -- it wasn't a concern of mine and it wasn't a

concern of the -- I'm going to say the traditional doctors on the task force, because, you know, being out of service for 14 days is sort of a minimal hit as opposed to spreading it to a hundred people, which is -- it's much worse. So we were not -- I can say I was never concerned and nobody explicitly or implicitly, in my mind, raised an economic issue by a 14-day --

You know, the much more issue was about the critical infrastructure workers. Because, you know, if you were exposed as a healthcare worker, there would be no healthcare workers left, because everybody was exposed. So it was how to get them back into the workforce.

So I would say that if it was a concern, it was not voiced or implied to me. Again, I only know my experience. I don't know other people's experience. It could have been expressed to Deb Birx, who was in the White House, but it certainly wasn't to me.

Ms. Mueller. Thank you. I'm going to pass it over to Jen.

By Ms. Gaspar.

Q A couple quick questions.

The letter you received from Chairman Clyburn also included a request for documents related to your role in the federal government's response to the pandemic, and I just wanted to ask if you took any steps to search for documents

that were potentially responsive to that request.

A Yes.

Q And what did you do with those? Did you identify any responsive documents?

A I did.

Q And what did you do with them?

A They were all -- and there weren't very many, but were they official, like HHS. That would have been like a few emails and a few documents. I was contacted or -- I don't know whether I was contacted, but we were in contact. I was instructed to load those all up to HHS, because they were all HHS documents, and they would handle the document production with the Committee.

So everything I had, they already had. But they knew what I had, because I uploaded them to the box.

Q So you've now provided them all to HHS?

A I did. Sort of immediately.

Q And while working at HHS, did you ever use any personal devices to communicate about official business, whether cell phones, email accounts, messaging apps, et cetera?

A Never. And if I were accidentally communicated by my private, I moved them immediately over. I know the rules of the game, and I try to act according to those rules, so I never, ever used private things that were not

discoverable and available to everyone.

Q Did you ever become aware of anybody who you worked with -- not your immediate reports, but directly using personal email accounts or perhaps messaging applications like Signal, Telegram, or ProtonMail to conduct official business?

A I don't know of that. I mean, there were messages, but they were like on the official messaging app that was put on by HHS. Is that iMessage or something? I don't know. Whatever it was.

But whatever was provided to me is what I used. I don't even know what those other things are, Proton or other things.

Q Did you ever bring hard copy documents home with you while you were serving on task force?

A Did I bring what?

Q Hard copy documents home with you?

A Yes.

Q Like agendas that were printed out, for example?

A Agendas, no. On the task force, no. I frequently brought-- yeah, I might have brought an agenda or two home. But I mostly brought -- because sometimes the task force used to go to 5:00, 6:00, 7:00 at night, and sometimes I went to the office; sometimes I went directly home from that.

But I often would keep the -- so the famous 150-page morning briefing with Dr. Birx, that got condensed into a data summary of maybe 15 charts that was presented to the vice president, and I often brought like that home with me.

These were not classified documents or anything, but they were more data things, because sometimes you just can't visualize all this on a laptop. It was good to have it, you know, there in front of me.

Q And I'm only asking to find out if those would have been included in the documents you gave to HHS.

A I never -- I didn't have those in my personal possession. I mean, I would bring them home, but I'd bring them back to the office and shred them. They were not home to file; they were just transiently to get me ready for the next day or something like that.

Ms. Mueller. Okay. I don't think we have any further questions.

Mr. Benzine. One quick one, and I can sit here.

By Mr. Benzine.

Q Dr. Giroir, you said the guidance, the August 24 guidance, did include the 14-day recommendation, and it was unclear where that fell off. But it said the guidance said you should strongly adhere to CDC mitigation protocols.

Was it your understanding that these protocols included quarantine and isolation?

A Yes.

Mr. Benzine. That's all we have.

[Discussion held off the record.]

[Proceedings adjourned at 4:03 PM]

Congressional Interview Corrections:
Brett P. Giroir, MD

Correct wording is indicated after line reference

1. Lines 183-4: Vice Chancellor for Research
2. Line 184: seven State of Texas agencies
3. Line 191: health policy
4. Line 193: A. Alfred Taubman Research Institute
5. Line 230: my role as the Assistant Secretary
6. Line 251: February 2019
7. Line 256: at the end of 2019 (not “February”)
8. Line 263: Commissioned Corps
9. Line 526: missions (not “meals”)
10. Line 534: Director of Commissioned Corps Headquarters
11. Line 539: She as the headquarters director, and myself
12. Line 551: assistant secretaries (not “secretaries”)
13. Line 601: to the secretary’s office
14. Lines 637-638: Corps (as in “Commissioned Corps”, not “core”)
15. Line 668: lead federal agency (not “primary”)
16. Line 681: iterations
17. Line 788: Cepheid
18. Line 847: under the FEMA UCG
19. Line 850-851: These lines referred to an alarm that went off on my phone, not the subject of the interview.
20. Line 934: or “LDTs” (not “on LDTs”
21. Line 944: CDC
22. Line 977: needed

23. Line 1102: polymerase (not “preliminary”)
24. Line 1121: depending on the test (not “role”)
25. Line 1125: for the early PCR tests
26. Line 1136: for (not “or”)
27. Line 1140: to the CDC (not Public Health Service)
28. Line 1595: deliberative
29. Line 1624: with people, daily
30. Line 1626: they (not “I”; this is referring to the people I see daily, not to me)
31. Line 1674: it’s not an illegal decision (referring to skipping an advisory committee)
32. Line 1722: infectious (not “infected”)
33. Line 1895: if you are vulnerable or have risk factors…
34. Line 2022: emergency surge sites (not “emergent”)
35. Line 2153: basic
36. Line 2179: and had been running testing (not “I had been running testing”)
37. Line 2712: the ordering physician
38. Line 2875: 70-80% (not 7-8%)
39. Line 2918: were read in a machine (not made in a machine)
40. Line 2923: we couldn’t have antigen tests that didn’t require a reader instrument until Binax NOW.
41. Line 3190: TRAC
42. Line 3193: Chem-Bio (not “Cambio”)
43. Line 3353: to go off
44. Line 3414: their fault (I was referring to the Chinese admitting it was their fault)
45. Line 3493: there were no unambiguous fingerprints of human genetic manipulation
46. Line 3503: change “natural” to “typical.” This will make the statement more understandable to the reader. I don’t want to confuse natural virus with my meaning of a typical fingerprint of human engineering.
47. Line 3609: this infectious of a virus

48. Line 3669: like a lobbyist rather than a scientist

49. Line 3874: going to take more than Jim Macrae…

50. Line 3903: Public Health Service officers

51. Line 3937: data fusion cell

52. Line 3986: by the NSC and the Office of Global Affairs at HHS

53. Line 4003-4005: I am not sure of the internal deliberative discussions within the White House, but I wrote a lot of memos….

54. Line 4056: OGA

55. Line 4210: emergency surge sites (not “search”)

56. Line 4291: the Vice President wanted us (the docs) to reach a consensus on the recommendations and then bring that back to the full Task Force

57. Line 4712: delete “dead”. It was just “edits”

58. Line 4789: unless you are part of a vulnerable group, or…

59. Line 5020: to the Task Force (not “tank” force)

60. Line 5023: Task Force

61. Line 5116: interpretation (not “interpolation”)