

**THE XDR TUBERCULOSIS INCIDENT: A POORLY
COORDINATED FEDERAL RESPONSE TO AN
INCIDENT WITH HOMELAND SECURITY
IMPLICATIONS**

FULL HEARING
OF THE
COMMITTEE ON HOMELAND SECURITY
HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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JUNE 6, 2007
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**THE XDR TUBERCULOSIS INCIDENT: POORLY
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IMPLICATIONS**

Wednesday, June 6, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC.

The committee met, pursuant to call, at 10:04 a.m., in room 311, Cannon House Office Building, Hon. Bennie G. Thompson [chairman of the committee] presiding.

Present: Representatives Thompson, Sanchez, Markey, Harman, Lowey, Norton, Jackson Lee, Christensen, Etheridge, Langevin, Cuellar, Carney, Clarke, Green, Perlmutter, King, Shays, Souder, Lungren, Reichert, McCaul, Dent, Brown-Waite, Bilirakis and Davis of Tennessee.

Chairman THOMPSON. The Committee on Homeland Security will come to order. The committee is meeting today to receive testimony on *The Extensively Drug-Resistant Tuberculosis Incident: A Poorly Coordinated Federal Response to an Incident with Homeland Security Implications*.

Good morning. I would like to thank all of you for being here and thank our witnesses for appearing before us today on such short notice. I would also like to thank Mr. Langevin, the Chair of the Emerging Threats Subcommittee, for taking leadership on this issue.

Last week when news of this incident broke, he brought the issue to my attention and stressed the importance of today's hearing. I appreciate his leadership on biopreparedness and related issues for the committee.

Ladies and gentlemen, last week we dodged a bullet. That is pretty much how I feel after reviewing the efforts of the Centers for Disease Control and the Department of Homeland Security as they dealt with the case of the newlywed TB carrier Mr. Andrew Speaker over the last several months.

But before I get into the facts of this case, I have got a fundamental question that I want the administration to answer: When are we going to stop dodging bullets and start protecting Americans? As you know, we were just very fortunate in this situation. The 9/11 Commission asserted that the terrorist attacks in 2001 were the result of a failure of imagination by the Federal Government. Our intelligence components weren't talking to one another.

Intelligence information was stovepiped. There was a failure to connect the dots.

The Department of Homeland Security was created to enhance the synergy and efficiency of homeland security efforts by several agencies, putting them in one department, but since, we have learned that the Federal Government's ability to secure the homeland is still grossly deficient in some areas.

In 2005, the Department's response to Hurricane Katrina was characterized as a failure of initiative. Officials knew a hurricane was coming, and yet the Department's leadership failed to respond timely or effectively. Today I am wondering why we shouldn't characterize the actions of the Department and the CDC in a similar fashion.

I have asked the witnesses to provide us with a timeline of events that began with the testing of a TB sample and ending with Mr. Speaker sneaking his way back into the United States unimpeded. DHS states in their testimony today that there was a single point of failure in this case: human error on the part of the Border Patrol agent who let Mr. Speaker cross into the U.S.

But I have done my own timeline of actions and inactions of DHS and CDC, and it suggests that we should have connected more dots. Shrugging off a deeper analysis of this incident would only cause DHS to repeat its previous failures. For instance, after receiving the information about Mr. Speaker from CDC on May 22nd, why didn't the Atlanta office of Customs and Border Protection notify Customs and Border Protection headquarters or TSA officials about putting Mr. Speaker on the no-fly list? This would have ensured that Mr. Speaker's name was on the no-fly list prior to his departure from Prague. Why did CDC wait so long before divulging Mr. Speaker's identity to TSA? Even though they already shared his information with CBP, this delay resulted in Mr. Speaker's name being placed on a no-fly list after he had already crossed the border. Why did TSA officials argue 4 hours about the propriety of placing Mr. Speaker on the no-fly list? Why did CDC think that Mr. Speaker would turn himself in to Italian medical authorities? If he was such a serious public health risk at that time, why didn't the CDC dispatch a plane to get him? Why didn't the CBP agent at the Champlain border crossing prevent Mr. Speaker from entering the U.S?

I ask the witnesses, did these breakdowns result from a failure of initiative? It would be unfair, however, to characterize this as a total system failure. We saw a lot of ad hoc decisionmaking by a lot of very capable people throughout the different agencies who tried to do the right thing. Many of these informed decisions certainly helped the response effort. But the fact that the best decisions were made informally suggest that we still do not have adequate operational control over our components.

For instance, I was surprised to learn that it took TSA almost 4 hours to come up with a legal argument to place a nonterrorist on the no-fly list. The Department should have the awareness of its policies and procedures to be able to make that decision with greater speed.

DHS and CDC refer to an MOU in their testimony. Unfortunately, the committee has not been able to review that MOU to de-

termine whether procedures were properly followed. Better or at least more complete policies and procedures may have made a difference in preventing Mr. Speaker from coming across the border.

This committee will explore ways in which we can make improvements for the future. It is equally clear that the Federal Government must improve the way we communicate information about an infectious disease to the public. CDC's announcement last week caused minor hysteria throughout the United States and abroad. There was a lot of mischaracterization about the public health threat that Mr. Speaker posed to his fellow passengers.

One thing that I have learned over the course of the week is that TB is a common disease. Five percent of the U.S. population has it, as does one-third of the world's population.

So I would ask our witnesses to take some time to discuss XDR TB and the ways by which it can be communicated so that the American people can fully understand what risk, if any, Mr. Speaker posed to the public.

I want to conclude my remarks by saying that I am not here to point fingers, I am here to conduct oversight and improve the Department of Homeland Security. We had another failure of initiative here. Thankfully, it appears that we dodged the bullet, but that is not always going to be the case. It is time for folks at DHS and CDC to start taking some responsibility.

PREPARED STATEMENT OF THE HONORABLE BENNIE G. THOMPSON, CHAIRMAN,
COMMITTEE ON HOMELAND SECURITY

Ladies and gentlemen, we dodged a bullet.

That's pretty much how I feel after reviewing the efforts of the Centers for Disease Control and the Department of Homeland security as they dealt with the case of the newlywed TB carrier, Andrew Speaker, over the last several months. But before I get into the facts of this case, I've got a fundamental question that I want this Administration to answer:

When are we going to stop dodging bullets, and start protecting Americans?

The 9/11 Commission asserted that the terrorist attacks in 2001 were the result of a 'failure of imagination' by the Federal government:

Our intelligence components weren't talking to one another, intelligence information was stovepiped, and there was a failure to connect the dots.

The Department of Homeland Security was created to enhance the synergy and efficiency of homeland security efforts by several agencies under one department.

But since then we've learned that the Federal government's ability to secure the homeland is still grossly deficient. In 2005, the Department's response to Hurricane Katrina was characterized as a 'failure of initiative.' Officials knew a hurricane was coming, and yet the Department's leadership failed to respond timely or effectively.

Today, I'm wondering why we shouldn't characterize the actions of the Department and the CDC in a similar fashion. I've asked the witnesses to provide us with a timeline of events—that began with the testing of a TB sample and ended with Andrew Speaker sneaking his way back into the United States unimpeded. DHS states in their testimony today that there was a single point of failure in this case: human error on the part of the Border Patrol agent who let Mr. Speaker cross into the U.S.

But I've done my own timeline of the actions and inactions of DHS and CDC, and it suggests that we should have connected more dots. Shrugging off a deeper analysis of this incident will only cause DHS to repeat its previous failures. For instance:

- (1) After receiving information about Speaker from CDC on May 22, why didn't the Atlanta office of Customs and Border Protection notify CBP Headquarters or TSA officials about putting Speaker on the 'no-fly' list? This would have ensured that Speaker's name was on the no fly-list prior to his departure from Prague.
- (2) Why did CDC wait so long before divulging Speaker's identity to TSA? Even though they already shared his information with CBP, this delay resulted in

Speaker's name being placed on the no-fly list after he already crossed the border.

(3) Why did TSA officials argue for 4 hours about the propriety of placing Speaker on the no-fly list?

(4) Why did CDC think that Speaker would turn himself into Italian medical authorities? If he was such a serious public health risk, why didn't the CDC dispatch a plan to get him?

(5) Why didn't the CBP agent at the Champlain border crossing prevent Speaker from entering the U.S.?

I ask the witnesses: did these breakdowns result from a 'failure of initiative'? It would be unfair, however, to characterize this as a total system failure. We saw a lot of ad-hoc decision making by a lot of very capable folks throughout the different agencies who tried to do the right thing. Many of these informal decisions certainly helped the response effort.

But the fact that the best decisions were made informally suggests that we still do not have adequate operational control over our components:

For instance, I was surprised to learn that it took TSA almost 4 hours to come up with a legal argument to place a non-terrorist on the no-fly list. The Department should have the awareness of its policies and procedures to be able to make that decision with greater speed. DHS and CDC refer to a MOU in their testimony. Unfortunately, the Committee has not been able to review that MOU to determine whether procedures were followed properly.

Better—or at least more complete—policies and procedures may have made a difference in preventing Andrew Speaker from coming across the border. This Committee will explore ways in which we can make improvements for the future.

It's equally clear that the Federal government must improve the way we communicate information about an infectious disease to the public.

CDC's announcements last week caused minor hysteria throughout the U.S. and abroad. There was a lot of mischaracterization about the public health threat that Mr. Speaker posed to his fellow passengers.

One thing that I've learned over the course of the week is that TB is a common disease—5% of the U.S. population has it, as does 1/3 of the world's population. So I'd ask our witnesses to take some time to discuss 'XDR' TB and the ways by which it can be communicated, so that the American people can fully understand what risk—if any—Mr. Speaker posed to the public.

I am not here to point fingers. I am here to conduct oversight and improve the Department of Homeland Security. We had another failure of initiative here. Thankfully, it appears that that we dodged a bullet.

But that's not always going to be the case. It's time for the folks at DHS and CDC to start taking some responsibility.

TUBERCULOSIS INCIDENT TIMELINE AND UNRESOLVED QUESTIONS

Prepared by the House Committee on Homeland Security

(Last update: 6/5/07)

DATE

FACTS

Discrepancies in the Record

Questions about the Federal Response

Jan. 2007

In January, Andrew Speaker, a 31-year old Atlanta lawyer, fell and hurt his ribs. He received an X-ray, revealing an abnormality in the upper lobe of his right lung. This suggested tuberculosis. Speaker began meeting regularly with Fulton County health officials for treatment.¹

March 2007

In early March, Speaker underwent a procedure to get a sample of sputum from his lungs. By the end of the month, lab cultures revealed he had tuberculosis (TB).²

When should the CDC be notified about TB cases?

Did health officials spend this time testing Speaker's TB diagnosis for drug resistance?

Thurs, May 10

Health officials determined Speaker had a multiple-drug resistant (MDR) form of TB.³

According to press accounts, Fulton County health officials called the Georgia Division of Public Health on May 10, but gave the impression that the problem was “largely hypothetical.” GDPH then made a call to the Centers for Disease Control.⁴

Did the positive test for MDR-TB automatically trigger a test for Extreme Drug Resistant (XDR) TB?

When was CDC notified about Speaker’s case of MDR-TB? What is the formal procedure by which CDC is asked to perform this analysis?

It is reported that CDC was called in to test for XDR-TB on Thursday May 17.⁵ Was this the proper protocol to follow? If not, why wasn’t CDC asked to perform the analysis earlier?

Fri, May 11

Fulton County health officials gave Speaker a “verbal warning” of the danger and the “prohibition” against travel.⁶

According to Dr. Julie Gerberding, Director of the CDC, “the patient really was told that he shouldn’t fly.”⁷

Fulton County health officials attempted to hand-deliver a medical directive to Speaker telling him not to travel.⁸

In an interview with *The Atlanta Journal-Constitution*, Speaker said that Fulton County health officials told him they “preferred” he not travel.⁹

According to Speaker, “Everyone knew. . . The CDC knew, doctors knew, Kaiser knew. They said, ‘We would prefer you not go on the trip,’ And that’s when my father said, ‘OK, are you saying because he’s a risk to anybody or are you simply saying it to cover yourself?’ And they said, ‘We have to tell you that to cover ourselves, but he’s not a risk.’”¹⁰

According to a June 1 report, “Doctors say they told Speaker not to travel. Speaker said CDC and other health organizations advised him against travel but didn’t stop him.”¹¹

Dr. Steven Katkowsky, Director of Public Health and Wellness for Fulton County said, “certainly the recommendation would be that if you have an active infection with tuberculosis, you *ought not to be getting on a commercial airliner.*”¹²

On June 4, Dr. Katkowsky, said that the law presented “kind of a Catch-22” when it comes to restricting the activities of tuberculosis patients against their will. “A patient has to be noncompliant before you can intervene,” he said. “There’s no precedent for a court stepping in before a patient has proven himself to be non-compliant.”¹³

There appears to be confusion about what prohibitions health officials can place on an individual with an infectious disease. According to Dr. Gerberding, health officials “usually rely on a covenant of trust to assume that a person with tuberculosis just isn’t going to go into a situation where they would transmit disease to someone else.”¹⁴

State and local health officials claim that they could not have prevented Speaker from flying abroad. However, state officials may authorize isolation and quarantine within their borders. States derive this authority from the “police powers” doctrine in constitutional law, which allows state governments to enact laws and promote regulations to safeguard the health, safety, and welfare of its citizens. As a result of this authority, individual states are responsible for intrastate isolation and quarantine practices, and they conduct their activities in accordance with their respective statutes. State and local laws and regulations regarding the issues of compelled isolation and quarantine vary widely.¹⁵

Sat, May 12

Speaker departed Atlanta on Air France Flight 385.¹⁶

Sun, May 13

Speaker arrived in Paris.¹⁷

Mon, May 14

Speaker flew from Paris to Athens on Air France flight 1232.¹⁸

Wed, May 16

Speaker flew from Athens to Thira Island on Olympic Air flight 560.¹⁹

Thurs, May 17

CDC called in to test for XDR-TB.²⁰

Georgia Division of Public Health notified that Speaker had flown overseas.²¹

Was this the first time that CDC was contacted about testing Speaker’s TB sample? If so, why?

What office notified Georgia’s Division of Public Health that Speaker flew overseas? Did GDPH notify CDC about Speaker’s travel? (Note: this infor-

mation was most likely obtained by Speaker's doctors, who were aware that he was traveling, but it remains unclear who notified the CDC about Speaker's travel.)

Mon, May 21

Tests came back positive for XDR-TB.²²
Speaker flew from Mykonos to Athens on Olympic Air 655.²³
Speaker flew from Athens to Rome on Olympic Air 239.²⁴

Questions persist about the ability of the federal government to quarantine an individual. DHS officials told Committee staff that federal officials do not have the authority to quarantine.²⁵ *This is inaccurate.* The President may issue an executive order for federal isolation and quarantine for the following communicable diseases: cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, and SARS.²⁶ What are the policies and procedures to implement a quarantine/isolation, and what is the role of DHS?

Tues, May 22

The CDC Division of Global Migration and Quarantine contacted the Assistant Port Director for the Atlanta office of the Customs and Border Protection (CBP).²⁷

CDC notified CBP Atlanta that Speaker posed a public health risk. CDC requested that CBP Atlanta attach a message to Speaker's passport.²⁸

FOUO: An Atlanta CBP officer entered a Treasury Enforcement Communications (TECS) Lookout record on Speaker at 12:46 PM. The officer also entered a TECS Lookout for Speaker's wife, Ms. Cooksey.²⁹

FOUO: This text note on the TECS system included instructions to "place mask on subject, place in isolation, well ventilated room if possible." The note indicated that Speaker "has multiple resistant TB and is a public health risk."³⁰

The note contained instructions that CBP contact Dr. David Kim of CDC upon encountering Speaker.³¹

The Passenger Analysis Unit placed the text message on Speaker's passport.³²

Why did CDC wait a day to notify CBP about Speaker's condition? Didn't they know on May 21 that Speaker was no longer in the U.S.?

It is unclear why CDC notified the local Atlanta CBP office rather than CBP HQ in Washington. Was there a policy or procedure in place requiring CDC to notify a "local" CBP office? Was there a policy or procedure in place that would have required CBP Atlanta to notify CBP HQ? Why didn't CBP Atlanta pass to CBP HQ the information they entered into the TECS database at this time?

Similarly, neither CDC nor CBP contacted the Transportation Security Administration (TSA) at the time to place Speaker's name on the "no-fly" list. This shortcoming would have ramifications later, when Speaker's name was not added to the no-fly list until after he already crossed the Canadian border (due in part to concerns raised by the CDC about exposing sensitive information about a patient to DHS). Why didn't CBP Atlanta communicate Speaker's personal information up the chain to TSA?

The TECS database is designed to allow for unique notes to be entered onto a passport. In other words, this notice is a unique message, and does not contain reference to a numeric warning code. An issue for DHS to consider is whether a standard medical text message (such as "Code 42" or "Medical Incident Alert") would be more effective than the specific message that the CBP officer saw in this case.

Wed, May 23

Speaker received call from CDC while in Rome. He was told to cancel trip and return home. He was told he would be contacted by CDC the next day with travel information.³³

DHS identifies CDC physician David Kim as the individual who contacted Speaker in Rome. Dr. Kim was apparently working the Speaker case for Dr. Marvin Cetron of CDC's Division of Global Migration and Quarantine.³⁴

CDC told Speaker "we have tools to keep you from flying into the U.S."³⁵

On May 31, Speaker told *The Atlanta Journal-Constitution* that he was "aware" he was placed on a no-fly list, which is why he decided not to fly into a U.S. airport.³⁶

Dr. Kim told Speaker to turn himself into Italian health authorities the next morning and agree to go into isolation and treatment in that country for an indefinite period of time.³⁷

Speaker was told that hiring a private jet to fly back to the U.S. would have cost \$100,000.³⁸

According to DHS officials, CDC offered Speaker a private plane. They would have charged him \$50,000 for the flight.³⁹

Dr. Martin Cetron, Director for the DGMQ at the CDC, dispatched a former CDC employee working with Italy's health ministry to visit Speaker at his hotel and reiterate the message. By the time the former employee arrived at the hotel, Speaker was gone.⁴⁰

There is a controversy about why Speaker chose not to go to the Italian hospital. According to Speaker, he was afraid of the care he would receive. "Both of us [Speaker and his wife] worried if I turned myself [in] the next day that's it. It's very real that I could have died there. . . . People told me if I was anywhere but Denver, I'll die."⁴¹

Speaker was not actually placed on the "no-fly" list until May 24, after he already crossed the U.S. border from Canada. According to DHS officials, CDC suggested to Speaker that he was on the no-fly list ("we have ways of keeping you from the U.S."). Was this proper use of protocol?

DHS officials state that they did not receive a request from CDC regarding placing Speaker on the "no-fly" list until Thurs. May 24. Is this true?

Was the CDC under the impression that DHS placed Speaker on the "no-fly" list based on their conversation with CBP Atlanta on May 22? (Note: this is probably not the case, because CDC was in contact with Speaker on May 22 and probably did not consider him a flight risk until May 23.)

Notification of foreign governments is an important issue to resolve. What policies and procedures are in place to notify foreign health authorities (like the World Health Organization) in situations such as this? When was the Italian government notified?

Did anyone ever recommend or even think of using an air ambulance to transport Speaker back to the U.S. (as opposed to privately chartering an airplane that would have cost between \$50—100,000)? Why not?

Thurs, May 24

CDC contacted DHS Office of Health Affairs in "early afternoon" (around 1:00 PM) to request assistance in preventing Speaker from traveling via commercial air. According to DHS officials, CDC did not provide Speaker's name to DHS at this time.⁴²

CDC contacts World Health Organization (WHO) by phone to provide information on Speaker. CDC advised to provide details to *outbreak@who.int* (the usual recipient of outbreak alerts). Dept. of Health and Human Services sends official notification to WHO that CDC has determined the event meets reporting criteria for a "public health emergency of international concern" as defined in the revised International Health Regulations.⁴³

Speaker returned to North America aboard Czech Air Flight 0104 from Prague to Montreal.⁴⁴

FOUO: Speaker landed at approximately 3:27 PM.⁴⁵

Speaker wore a mask on the flight.⁴⁶

FOUO: At 3:35 PM, CDC provided Speaker's name to DHS for inclusion on the "no-fly" list.⁴⁷

FOUO: At 3:46 PM, TSA informed TSA representatives in Europe and International Principal Security Inspectors worldwide to inform carriers, embassies, and host government authorities that Speaker should not board a commercial flight because he has a dangerous, contagious disease.⁴⁸

DHS was in process of putting Speaker's name on the "no fly" list when it learned he was already on a plane headed to Montreal.⁴⁹

Speaker rented a car with U.S. plates.⁵⁰

FOUO: 6:17.17 PM: Speaker and wife arrive at the Champlain, N.Y. port of entry. License plate reader incorrectly reads license plate a Pennsylvania plate.⁵¹

FOUO: 6:17.27 PM: CBP officer manually corrects the plate as an Ohio plate, and receives a Customs Automated Operation System (CAOS) message to inspect the vehicle undercarriage.⁵²

FOUO: 6:17.28 PM: CBP officer scans wife's passport with the document reader, and receives a positive response. The TECS "Lookout" text message appears on the screen.⁵³ The TECS message advises the officer to refer wife for secondary inspection. The Lookout states that wife was traveling with Speaker, who has XDR-TB.⁵⁴

FOUO: 6:17.55 PM: CBP officer clears the wife's hit without referral to secondary inspection.⁵⁵

FOUO: 6:18.34 PM: CBP officer enters Speaker's name on the name query line, presses "enter," and receives a positive response. A TECS Lookout appears on the screen advising officer to refer Speaker for secondary inspection.⁵⁶

FOUO: 6:18.41 PM: Officer clears hit without referral to secondary inspection.⁵⁷ Speaker crosses the border into the U.S. at the Champlain, N.Y. border crossing.^{58N}

According to a May 30 article on CNN.com, Customs and Border Protection spokesman Kevin Corsaro said Speaker "did not appear sick to border agents."⁵⁹

According to DHS spokesman Russ Knocke, "there is some indication of deceitfulness on the part of the individual."⁶⁰

In a briefing with Committee staff, DHS officials stated that Speaker told CBP officers that "he only wanted to cross the border for the day."⁶¹

At 7:30 PM, TSA General Counsel gives approval for TSA Administrator Kip Hawley to place Speaker on the "no-fly" list. This was a point of contention for DHS for several hours (beginning at 3:30 PM when they were informed of Speaker's name by CDC) until the TSA General Counsel persuasively argued that Hawley could use U.S. Code 49 authority to place a "non-terrorist" on the "no-fly" list.⁶²

FOUO: Speaker's name appeared on a supplement to the "no-fly" list at 8:31 PM.⁶³ (Canadian officials inform Committee staff that at approximately 8:00 PM, Speaker's name appeared on the Canadian "no-fly" list.)⁶⁴

Speaker checked into a hotel in Albany, N.Y.⁶⁵

On May 31, Speaker told *The Atlanta Journal-Constitution* that he was "aware" he was placed on a no-fly list when he was in Rome, which is why he decided not to fly into a U.S. airport.⁶⁶ However, Speaker was not placed on the no-fly list at that time.

Speaker's name did not appear on the no-fly list until at least 2 hours after his arrival into the U.S. Canadian officials tell Committee staff that the Canadian no-fly list is identical to the U.S. no-fly list. Therefore, any time that the U.S. list is updated, the Canadian list will reflect that update. Canadian officials state that Speaker's name appeared on their list at 8:00 PM. This, of course, was after he already crossed the border.⁶⁷

Speaker's name was entered onto the "no-fly" list. There are several lists that his name could have been entered into, including: the Terrorist Screening Database (TSDB), the TSA no-fly list, the TSA "selectee" list, or the Interagency Border Inspection System (IBIS).⁶⁸ In fact, there was an effort within DES to enter him onto the TSDB (though this would be inappropriate because he did not pose a "terrorist threat").

Though DHS officials claim that Speaker was deceptive, Speaker claims that he has cooperated completely with authorities.

DHS (through the Atlanta CBP office) received information from CDC on May 22 about Speaker's identity and the fact that he posed a public health threat to the U.S. Why didn't DHS seek to place Speaker's name on the no-fly list at that time? What policies and procedures are in place to ensure that CBP officials in a field office are communicating this information to CBP HQ and to other agencies within DHS (like TSA)?

Did the CBP agent interview Speaker prior to allowing him entry? CBP spokesman Corsaro's statement that Speaker did not "appear to be sick" implies that CBP was given latitude to detain Speaker.

Why did the CBP agent manually enter Speaker's name into the "query line" instead of swiping his passport?

Does the National Treasury Employees Union (NTEU) agree with the facts that have been alleged by DHS regarding the actions of the CBP agent?

DHS officials state that after receiving the request from CDC to place Speaker on a "no-fly" list, there was considerable confusion about what list he could be placed on. DHS officials tell Committee staff that they couldn't add Speaker to the "no-fly" list or the "selectee" list because he wasn't a terrorist. Until 7:30 PM, officials were not sure that they had the authority to enter Speaker onto a list. Questions for DHS include (1) whether any "non-terrorist" has ever been placed on the "no-fly" list and (2) why it took so long to determine the TSA Administrator's authorities under U.S.C. 49?

What policies and procedures are in place to ensure that CBP agents have received adequate medical training? Do CBP agents have medical protective equipment?

Does CBP have a medical detainment procedure? Are there isolated and secure areas that CBP agents could have taken Speaker?

DHS spokesman Russ Knocke suggested that the failure by the CBP to detain the man was a result of not obtaining “real-time” passenger data for flights ending in Canada. This makes it “very difficult for us to know who might be traveling there.”⁶⁹N Given the fact that Speaker’s name wasn’t entered into the no-fly list until 8:00 PM, the fact that DHS could not obtain real-time passenger data would not have made a difference in detaining Speaker.

CBP said it has not changed its screening or security precautions as a result of the case.⁷⁰

Fri, May 25

National Targeting Center sends notification at 12:30 AM that Speaker was encountered at the Champlain, N.Y. port of entry but that he was not detained.⁷¹

DHS notifies Dr. David Kim at 2:00 AM that Speaker entered the U.S. through the Canadian border, but he was not detained.⁷²

Dr. Gerberding asserts that the CDC “made contact” with Speaker as he was traveling between Albany and New York City.⁷³

Speaker drove himself voluntarily to an isolation hospital (Bellevue) in New York City for evaluation.⁷⁴

Speaker enters “different door” at Bellevue so as to limit interaction with other patients.⁷⁵

Speaker was admitted and served a provisional quarantine order that lasted 72 hours while he was being assessed.⁷⁶

Event is discussed at the morning WHO outbreak coordination meeting. Because of implication for European countries, WHO/HQ informs WHO/EURO.⁷⁷

Speaker most likely called the CDC as he was traveling from Albany to New York City.

Why did the CDC send Speaker to New York City when he was a potential health risk? What safety procedures did they advise him to follow as he traveled from Albany to New York City? Why didn’t CDC go to get him before he could possibly infect other people?

Mon, May 28

CDC uses one of its planes to fly Speaker to Atlanta.⁷⁸

WHO/Stop TB receives further information about the status from CDC. WHO/Stop TB contacts TB focal points in Italy and Stockholm, and provides advice to Canada TB health authorities on WHO’s “Guidelines for Air Travel and TB Control.”⁷⁹

If CDC used one of its planes to fly Speaker from NYC to Atlanta, why couldn’t they have flown him from Europe? When can and does the CDC fly persons using its own travel assets or those of the Department of Health and Human Services?

Tues, May 29

Dr. Julie Gerberding holds a press conference announcing that the CDC had taken the rare action of issuing a federal public health isolation order for Speaker.⁸⁰

CDC recommends that those passengers who were seated close to Speaker on the two trans-Atlantic flights notify their health officials in their respective states or countries, and that such persons should then be tested for TB.⁸¹

CDC also recommended that other passengers be notified and offered the opportunity to be evaluated and tested, if desired.⁸²

Conference call between U.S., Canada, WHO/HQ, WHO/EURO, France, and Italy discussion of public health rationale for contact tracing.⁸³

How does an “isolation order” differ from a “provisional quarantine order”?

The CDC had a difficult time identifying passengers who sat next to the infected man, and relied on the media to spread the word about the flight. “We are still trying to get not just the manifest and the name and the country of citizenry but actual locating information for those individuals. This takes time, longer than we like and longer than is necessary in an era where we have to track emerging pathogens across air flights, and we hope that system will be fixed and streamlined and improved in the future, but that takes time, which is why we’re hoping that you will help us bring these folks forward so they could be evaluated.”⁸⁴

What procedures exist for federal agencies to contact passengers?

What international procedures are in place to notify CDC of the results of the testing?

Wed, May 30

DHS spokesman Russ Knocke said investigators were looking into how Speaker and his wife entered the U.S. when all border crossings had been given his name and told to hold him if he appeared.⁸⁵

CDC asks DHS to provide passenger manifests.⁸⁶

The CDC elects to share publicly the names of the flights, and information about specific seats in order to have those persons self-identify in order to receive very specific advice in terms of managing the risk.⁸⁷

The CDC begins contact tracing.⁸⁸ Contact tracing is the method used to control endemic contagious disease. A disease investigation begins when an individual is identified as having a communicable disease. An investigator interviews the patient, family members, physicians, nurses, and anyone else who may have knowledge of the primary patient's contacts, anyone who might have been exposed, and anyone who might have been the source of the disease. Then the contacts are screened to see if they have or have ever had the disease. The type of contact screened depends on the nature of the disease.⁸⁹

Conference call between U.S., Canada, WHO/HQ, WHO/EURO, PAHO, EC, ECDC, France, Italy, Greece, Czech Republic. Further discussions on details of the investigations.⁹⁰

Thurs, May 31

Speaker discharged from Atlanta Grady Memorial Hospital at 4:30 AM and transported to Denver by private plane.⁹¹

Speaker instructed to wear a mask along with all who come into contact with him.⁹²

Speaker arrives at National Jewish Medical and Research Center in Denver at 7:45 AM (MST).⁹³

Authorities in the U.S. and several European countries are tracking down about 50 people who sat near Speaker on his Atlanta-to-Paris flight on May 12, and 30 people on his Prague-to-Montreal return May 24. They will be offered testing to see if they are infected.⁹⁴

Speaker will go through a series of tests and be given two antibiotics, one oral and one intravenous.⁹⁵

CDC initiates a careful evaluation of Speaker's activities prior to his development of XDR TB in hopes of learning the source of exposure.⁹⁶

CDC establishes a webpage providing further information to airline travelers and other members of the public who are interested in this issue: <http://www.cdc.gov/tb/xdr/tb/>.⁹⁷

Speaker is identified as a 31 year old lawyer from Atlanta.⁹⁸

News reports reveal that Speaker's father-in-law works for the Centers for Disease Control and Prevention in Atlanta. The father-in-law, Robert C. Cooksey, is a microbiologist who has conducted research on tuberculosis for the National Center for Infectious Diseases.⁹⁹

The CBP agent who processed his entry on May 24 was placed on administrative duties while the investigation continues.¹⁰⁰

CBP Internal Affairs begins interviewing the agent who processed Speaker's entry.¹⁰¹

Fri, June 1

Homeland Security officials promise to examine systems for detaining sickened travelers, but they acknowledged "there would always be holes in the system."¹⁰²

Dr. Julie Gerberding states that Speaker "still does not appear to be highly infectious," and there is "no indication that his infectiousness has changed in the past few months."¹⁰³

WHO/EURO informs WHO/HQ about non-EU passengers to be traced. WHO/HQ contacts WHO/AFRO, WHO/EMRO, and PAHO to communicate names of passengers to be traced.¹⁰⁴

Sat, June 2

CDC said it has withdrawn the federal isolation order for Speaker because the order to detain him at the Denver hospital is enough to protect the public's health.¹⁰⁵

According to the CDC, officials have contacted 160 of the 292 US citizens who were on the same Atlanta-to-Paris flight as Speaker.¹⁰⁶

CDC says that the father-in-law of Speaker will be investigated to see how he was involved with the case.¹⁰⁷

Mon, June 4

Ted Speaker (Speaker's father) said he taped a meeting in which a doctor says three times that his son was not contagious though the doctors preferred that he not fly. The elder Speaker said he will release the tape at some point.¹⁰⁸

CBP announces policy updates to Committee staff: (1) supervisors will receive the same warnings that CBP agents receive on their screens; (2) agents will no longer be able to clear an "exact match" on identification (where a person's name, DOB,

and passport number identically match a TECS warning). This will always be referred to secondary screening.

¹Young, A. (2007, May 30). Atlantan quarantined with deadly TB strain; CDC issues rare isolation order; Air passengers warned. *The Atlanta Journal-Constitution*.

²Brown, D. (2007, May 31). Man With Rare TB Easily Eluded Safeguards. *The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

³Brown, D. (2007, May 31). Man With Rare TB Easily Eluded Safeguards. *The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁴Schwartz, J. (2007, June 2). *Tangle of Conflicting Accounts in TB Patient's Odyssey*. Retrieved June 4, 2007, from <http://travel.nytimes.com/2007/06/02/health/02tick.html>

⁵(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

⁶(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

⁷(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

⁸The Committee is currently attempting to acquire this letter. Young, A. (2007, May 30). Atlantan quarantined with deadly TB strain; CDC issues rare isolation order; Air passengers warned. *The Atlanta Journal-Constitution*.

⁹Brown, D. (2007, May 31). Man With Rare TB Easily Eluded Safeguards. *The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

¹⁰(2007, June 1). *Exclusive: TB Patient Asks Forgiveness but Defends Travel*. Retrieved June 1, 2007, from <http://www.abcnews.go.com/GMA/OnCall/story?id=3231184&page=1>

¹¹(2007, June 1). *Exclusive: TB Patient Asks Forgiveness but Defends Travel*. Retrieved June 1, 2007, from <http://www.abcnews.go.com/GMA/OnCall/story?id=3231184&page=1>

¹²Young, A. (2007, May 30). Atlantan quarantined with deadly TB strain; CDC issues rare isolation order; Air passengers warned. *The Atlanta Journal-Constitution*.

¹³Schwartz, J. (2007, June 2). *Tangle of Conflicting Accounts in TB Patient's Odyssey*. Retrieved June 4, 2007, from <http://travel.nytimes.com/2007/06/02/health/02tick.html>

¹⁴(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

¹⁵Fact Sheet on Legal Authorities for Isolation/Quarantine, May 3, 2005, available at <http://www.cdc.gov/ncidod/sars/factsheetlegal.htm>

¹⁶(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

¹⁷(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

¹⁸Stobbe, M. (2007, May 31). *TB Patient Leaves Atlanta Hospital*. Retrieved May 31, 2007 from http://breakingnews.nypost.com/dynamic/stories/T/TUBERCULOSIS_INFECTION?SITE=NYNYP&SECTION=HOME

¹⁹Stobbe, M. (2007, May 31). *TB Patient Leaves Atlanta Hospital*. Retrieved May 31, 2007 from http://breakingnews.nypost.com/dynamic/stories/T/TUBERCULOSIS_INFECTION?SITE=NYNYP&SECTION=HOME

²⁰(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

²¹Schwartz, J. (2007, June 2). *Tangle of Conflicting Accounts in TB Patient's Odyssey*. Retrieved June 4, 2007, from <http://travel.nytimes.com/2007/06/02/health/02tick.html>

²²(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

²³ Stobbe, M. (2007, May 31). *TB Patient Leaves Atlanta Hospital*. Retrieved May 31, 2007 from http://breakingnews.nypost.com/dynamic/stories/T/TUBERCULOSIS_INFECTION?SITE=NYNYP&SECTION=HOME

²⁴ Stobbe, M. (2007, May 31). *TB Patient Leaves Atlanta Hospital*. Retrieved May 31, 2007 from http://breakingnews.nypost.com/dynamic/stories/T/TUBERCULOSIS_INFECTION?SITE=NYNYP&SECTION=HOME

²⁵ Department of Homeland Security Committee staff briefing with Dr. Jeffrey Runge, May 31, 2007.

²⁶ CDC Fact Sheet on Legal Authorities for Quarantine and Isolation, May 3, 2005, available at <http://www.cdc.gov/ncidod/sars/factsheetlegal.htm>

²⁷ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

²⁸ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

²⁹ The Treasury Enforcement Communications System (TECS) is a legacy system that is at least 20 years old. Ordinarily, the system is used to track an individual who may pose a terrorist or smuggling threat to the U.S. The TECS system feeds into the Automated Targeting System (ATS), the Department's computer system that scrutinizes a large volume of data related to a person crossing the U.S. border. Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

³⁰ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

³¹ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP) June 4, 2007.

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³³ Young, A. (2007, May 30) Atlantan quarantined with deadly TB strain; CDC issues rare isolation order; Air passengers warned. *The Atlanta Journal-Constitution*.

³⁴ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP) June 4, 2007

³⁵ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP) June 4, 2007

³⁶ (2007, May 31). *TB patient's name released; Father-in-law works at CDC*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/31/tb.flight/index.html>

³⁷ Young, A. (2007, May 30). Atlantan quarantined with deadly TB strain; CDC issues rare isolation order; Air passengers warned. *The Atlanta Journal-Constitution*.

³⁸ (2007, June 1). Exclusive: *TB Patient Asks Forgiveness but Defends Travel*. Retrieved June 1, 2007, from <http://www.abcnews.go.com/GMA/OnCall/story?id=3231184&page=1>

³⁹ Department of Homeland Security Committee staff briefing with Dr. Jeffrey Runge, May 31, 2007.

⁴⁰ Brown, D. (2007, May 31). Man With Rare TB Easily Eluded Safeguards. *The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁴¹ (2007, June 1). Exclusive: *TB Patient Asks Forgiveness but Defends Travel*. Retrieved June 1, 2007, from <http://www.abcnews.go.com/GMA/OnCall/story?id=3231184&page=1>

⁴² Department officials suggest that CDC was worried about releasing patient information. Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁴³ Email from World Health Organization to Committee staff, June 4, 2007, on file with Committee.

⁴⁴ Stobbe, M. (2007, May 30). Georgia traveler with tuberculosis is United States' first quarantine in decades. *The Associated Press State & Local Wire*.

⁴⁵ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007. See Flight Itinerary of U.S. Traveler with Extensively Drug-Resistant Tuberculosis (XDR TB) (May 30, 2007) available at <http://www.cdc.gov/tb/XDRTB/caseflighthistory.htm>

⁴⁶Department of Homeland Security Committee staff briefing with Dr. Jeffrey Runge, May 31, 2007.

⁴⁷Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁴⁸Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁴⁹Brown, D. (2007, May 31). *Man With Rare TB Easily Eluded Safeguards. The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁵⁰Department of Homeland Security Committee staff briefing with Dr. Jeffrey Runge, May 31, 2007.

⁵¹Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁵²*FOUO*: The message displays on the bottom of the screen. CAOS is a computer application that allows port managers to schedule, run, record, and report on enforcement operations. Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁵³*FOUO*: The text note included instructions to “place mask on subject, place in isolation, well ventilated room if possible.” The note indicated that Speaker “has multiple resistant TB and is a public health risk.” Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁵⁴Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁵⁵Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁵⁶Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁵⁷Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁵⁸Stobbe, M. (2007, May 30). Georgia traveler with tuberculosis is United States’ first quarantine in decades. *The Associated Press State & Local Wire*.

⁵⁹(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

⁶⁰Brown, D. (2007, May 31). *Man With Rare TB Easily Eluded Safeguards. The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁶¹Department of Homeland Security Committee staff briefing with Dr. Jeffrey Runge, May 31, 2007.

⁶³Only foreign airlines with a last point of departure to the U.S. are on the TSA “no-fly” distribution list. Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁶⁴Department of Homeland Security Committee staff briefing with Minister Roy Norton and First Secretary Bernard Li, Embassy of Canada, May 31, 2007.

⁶⁵Department of Homeland Security Committee staff briefing with Dr. Jeffrey Runge, May 31, 2007.

⁶⁶(2007, May 31). *TB patient’s name released; Father-in-law works at CDC*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/31/tb.flight/index.html>

⁶⁷Department of Homeland Security Committee staff briefing with Minister Roy Norton and First Secretary Bernard Li, Embassy of Canada, May 31, 2007.

⁶⁹Brown, D. (2007, May 31). *Man With Rare TB Easily Eluded Safeguards. The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁷⁰Brown, D. (2007, May 31). *Man With Rare TB Easily Eluded Safeguards. The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁷¹Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁷³Center for Disease Control and Prevention. (May 30, 2007). *Update on CDC Investigation Into People Potentially Exposed to Patient With Extensively Drug-Resistant TB*. <http://www.cdc.gov/od/oc/media/transcripts/t070530.htm>

⁷⁴(2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

⁷⁵ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁷⁶ (2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

⁷⁷ Email from World Health Organization to Committee staff, June 4, 2007, on file with Committee.

⁷⁸ (2007, May 30). *Man knew he had TB before flying to Europe*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/30/tb.flight/index.html>

⁷⁹ Email from World Health Organization to Committee staff, June 4, 2007, on file with Committee.

⁸⁰ Center for Disease Control and Prevention. (May 29, 2007). *Public health investigation seeks people who may have been exposed to extensively drug resistant tuberculosis (XDR TB) infected person*. <http://www.cdc.gov/od/oc/media/transcripts/t070529.htm>

⁸¹ Center for Disease Control and Prevention. (May 29, 2007). *Public health investigation seeks people who may have been exposed to extensively drug resistant tuberculosis (XDR TB) infected person*. <http://www.cdc.gov/od/oc/media/transcripts/t070529.htm>

⁸² Center for Disease Control and Prevention. (May 29, 2007). *Public health investigation seeks people who may have been exposed to extensively drug resistant tuberculosis (XDR TB) infected person*. <http://www.cdc.gov/od/oc/media/transcripts/t070529.htm>

⁸³ Email from World Health Organization to Committee staff, June 4, 2007, on file with Committee.

⁸⁴ Center for Disease Control and Prevention. (May 30, 2007). *Update on CDC Investigation Into People Potentially Exposed to Patient With Extensively Drug-Resistant TB*. <http://www.cdc.gov/od/oc/media/transcripts/t070530.htm>

⁸⁵ Brown, D. (2007, May 31). *Man With Rare TB Easily Eluded Safeguards*. *The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁸⁶ Department of Homeland Security Committee staff briefing with Department of Homeland Security officials (TSA, CMO, and CBP), June 4, 2007.

⁸⁷ Center for Disease Control and Prevention. (May 30, 2007). *Update on CDC Investigation Into People Potentially Exposed to Patient With Extensively Drug-Resistant TB*. <http://www.cdc.gov/od/oc/media/transcripts/t070530.htm>

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⁸⁹ Louisiana State University, Medical and Public Health Law Site, available at <http://biotech.law.lsu.edu/Books/lbb/x578.htm>.

⁹⁰ Email from World Health Organization to Committee staff, June 4, 2007, on file with Committee.

⁹¹ (2007, May 31) Grady Memorial Hospital News Briefing [Television broadcast]. Atlanta, Georgia: CNN news.

⁹² (2007, May 31) Grady Memorial Hospital News Briefing [Television broadcast]. Atlanta, Georgia: CNN news.

⁹³ Allstetter, W. (Speaker). (2007, May 31). CNN News Briefing from National Jewish Medical and Research Center [Television broadcast]. Denver, CO: CNN news

⁹⁴ Brown, D. (2007, May 31). *Man With Rare TB Easily Eluded Safeguards*. *The Washington Post*, p. A03. <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/30/AR2007053001962.html>

⁹⁵ Allstetter, W. (Speaker). (2007, May 31). CNN News Briefing from National Jewish Medical and Research Center [Television broadcast]. Denver, CO: CNN news

⁹⁶ CDC Capitol Hill Announcement, Update: Investigation of US Traveler with Extensively Drug Resistant Tuberculosis. May 31, 2007

⁹⁷ CDC Capitol Hill Announcement, Update: Investigation of US Traveler with Extensively Drug Resistant Tuberculosis. May 31, 2007

⁹⁸ CNN new development [Television broadcast], 2:00 pm May 31, 2007

⁹⁹ (2007, May 31). *TB patient's name released; Father-in-law works at CDC*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/31/tb.flight/index.html>

¹⁰⁰ (2007, May 31). *TB patient's name released; Father-in-law works at CDC*. Retrieved May 31, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/05/31/tb.flight/index.html>

¹⁰¹ Department of Homeland Security Committee staff briefing with Dr. Jeffrey Runge, May 31, 2007.

¹⁰² Schwartz, J. (2007, June 2). *Tangle of Conflicting Accounts in TB Patient's Odyssey*. Retrieved June 4, 2007, from <http://travel.nytimes.com/2007/06/02/health/02tick.html>

¹⁰³ (2007, June 2). Report: TB patient maintains he is married. Retrieved June 4, 2007, from <http://www.cnn.com/2007/HEALTH/conditions/06/01/tb.flight/index.html>

¹⁰⁴ Email from World Health Organization to Committee staff, June 4, 2007, on file with Committee.

¹⁰⁵ (2007, June 4). *TB patient's kin to be investigated*. Retrieved June 4, 2007, from <http://www.presstv.ir/detail.aspx?id=11974§ionid=3510203>

¹⁰⁶ (2007, June 4). *TB patient's kin to be investigated*. Retrieved June 4, 2007, from <http://www.presstv.ir/detail.aspx?id=11974§ionid=3510203>

¹⁰⁷ (2007, June 4). *TB patient's kin to be investigated*. Retrieved June 4, 2007, from <http://www.presstv.ir/detail.aspx?id=11974§ionid=3510203>

¹⁰⁸ McGhee, B. (2007, June 4). Parents of TB patient are "in hell." Retrieved June 4, 2007 from <http://www.chron.com/disp/story.mpl/ap/health/4859300.html>

Chairman THOMPSON. Without objection, I would like to offer statements of Representative Engel of New York, the Association of American Flight Attendants, and the American Thoracic Association into the record.

[The information follows:]

PREPARED STATEMENT OF THE HONORABLE ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Chairman Thompson and Ranking Member King, I wish to thank you for holding this important hearing today and for providing me the opportunity to submit testimony for the record. I am grateful for this opportunity and for your strong commitment to this important issue.

Last week the threat of extensively drug-resistant tuberculosis, or XDR-TB, hit close to home. The world over, people's eyes continue to be fixed on a globetrotting Atlanta attorney who traveled throughout Europe and returned to Canada, where he rented a car and successfully traversed the US border-all while sick and potentially infectious with XDR-TB. XDR-TB is a deadly strain of tuberculosis so resistant to antibiotics that it can't be treated within international guidelines. Its emergence has rightly been called a global threat to public health. Dr. Mario Raviglione, the director of the Stop TB Department at the WHO, has called it the worst thing he's ever seen. Today's hearing focuses on the federal response to this threat, presented in the form of an airline and cross-border traveler. The committee notes this response was "poorly coordinated."

While it is critical to have a well coordinated response to the risk presented by a single patient, some perspective is in order. This patient, who bypassed both airline security and U.S. Customs and Border Security agents, is merely one of an estimated 27,000 people who develop XDR-TB each year according to World Health Organization estimates. In addition to these, more than 400,000 people develop multi-drug resistant tuberculosis (MDR-TB), which is resistant to at least the two most effective TB drugs and is a precursor to XDR-TB. Tuberculosis is airborne so when one can access nearly any part of the globe in a day or two, there are sure to be more instances such as this. The risk is posed not so much by those who are diagnosed and identified but by those who are not. The federal response to XDR-TB must therefore address the problem at its root to ensure the proper control of tuberculosis by which the emergence of drug resistance is prevented in the first place. This approach not only reduces risk to the homeland, but it is cost effective as well: A study published in 2005 in the *New England Journal of Medicine* found that to invest in TB control abroad both saves the US taxpayers money and reduces TB illness and death domestically versus attempting to screen the disease at our borders.

It is critical to note that XDR-TB occurs nowhere in nature. It is completely manufactured, emerging when TB patients are not treated adequately and completely. It is a man-made problem caused by an array of factors including the misuse of antibiotics, inadequate funding for laboratory testing, inadequate access to needed drugs, and a dearth of investment in the research and development of new diagnostics, drugs and a vaccine. (The standard TB diagnostic test is over a century old, the newest TB drug came to market in the 1960s, and no effective vaccine exists.)

As a result, XDR-TB has been confirmed on all six inhabited continents, is a growing epidemic in southern Africa, and was already reported to be here in the

United States before the events of last week. Regular (non drug-resistant) TB is curable with drugs that cost just \$16 dollars in most developing countries. Cases of drug-resistant TB, however, can cost literally hundreds of thousands of dollars to cure with treatment that is far more difficult for both patients and practitioners. In the 1990s, New York City alone spent over a billion dollars to address a few hundred cases of MDR-TB. We (the global community) have the power to prevent drug-resistant TB and the power to treat and control regular TB, and yet, we have not chosen to do so on the scale that is necessary. The World Bank has found TB control to be among the world's most cost-effective health interventions and yet, funding for bilateral TB control programs has flat-lined since 2005.

Failing to improve our International TB control efforts will wield a devastating blow to our ability to manage what I believe is a mounting global health crisis. It is remarkable in this day and age, with treatment available, that TB is the biggest infectious killer of young women in the world. In fact, TB kills more women worldwide than all causes of maternal mortality. As you know, TB is also the biggest killer of people with AIDS worldwide. Someone in the world is newly infected with TB every second and TB accounts for more than one quarter of all preventable adult deaths in developing countries. The statistics are simply staggering.

I strongly believe that the global community, with the U.S. in the lead, must do more to adequately address this disease by investing in quality TB control programs using the groundbreaking Global Plan to Stop TB as a guide. It is for that reason that I have introduced the bi-partisan Stop TB Now Act of 2007 with my colleagues Heather Wilson and Adam Smith which will set forth what we believe is the U.S. fair share towards achieving the goals of the Global Plan. The Stop TB Now Act will strengthen US leadership on international TB control by providing increased resources for the development of urgently needed new TB diagnostic and treatment tools to USAID and the CDC. My bill calls for a U.S. investment of \$400 million for international tab control in FY08 and \$550 million in FY09.

I would like to thank the many global health groups that we have worked with on this legislation, who have also endorsed H.R. 1567: the RESULTS Educational fund, The American Thoracic Society and the Global Health Council.

If we do not make bold—and wise—investments in international TB control, not only will we fail to save millions of lives and miss out on the many accompanying benefits of controlling this killer, but this disease will also become far more difficult and costly to treat. Make no mistake: XDR-TB raises the specter of a completely incurable form of this airborne disease. We cannot allow this to happen.???

Moreover, we cannot allow the emergence of drug-resistant TB strains to undermine our fight against AIDS. The intersection between TB and HIV/AIDS is particularly chilling. People with HIV/AIDS have compromised immune systems, and therefore, TB and drug-resistant TB hit them especially hard. In 2004, more than 740,000 people who contracted TB were co-infected with HIV/AIDS. Globally, 90% of people living with AIDS die within 4 to 12 months of contracting TB if not treated.

We must all be concerned that with drug-resistant TB spiraling out of control, especially in HIV/AIDS patients in Africa, the reductions in mortality rates from HIV/AIDS thanks to Anti-Retroviral treatment are now in severe jeopardy. In the first reported outbreak of XDR-TB, all 44 patients tested for HIV were positive. Some of them even acquired XDR-TB in a support group for AIDS patients receiving antiretroviral therapy. If we do not take urgent action now, progress made on the front lines of the fight against HIV/AIDS is in very serious danger of being undermined by drug-resistant TB. As Nelson Mandela said in 2004, "We cannot win the battle against AIDS if we do not also fight TB."

The Stop TB Partnership's Global Plan to Stop TB projects that Africa will require \$19.4 billion to strengthen and maintain country-level TB control efforts through 2015. This represents nearly 44 percent of the global total needed for countries to find and properly treat people with TB. While significant resources are being provided and will be provided by African governments themselves, the remaining funding gap for Africa stands at \$11 billion over the next decade—with additional resources needed to scale up a response to drug-resistant TB. Yesterday the World Health Organization provided a briefing on its draft global response plan to XDR-TB. This plan should also be met with the full support it requires. XDR-TB is a wake-up call for the longstanding need to strengthen TB control and to build the necessary capacity in health services to respond to drug-resistant TB.

Again, my bill, the Stop TB Now Act of 2007, seeks to authorize the funding level required from the U.S. in order to meet the goals of the Global Plan to Stop TB and therefore be able to address this TB problem globally. Chairman Thompson and Ranking Member King, I wish to respectfully ask for your co-sponsorship of this im-

portant measure. I urge the Committee members in attendance today to cosponsor H.R. 1567 as well.

Thank you again holding this important hearing. As your efforts today to improve the federal response to XDR-TB with testimony by experts from the Centers for Disease Control and Prevention, the Department of Homeland Security and U.S. Customs and Border Protection will certainly not go unnoticed. We will all learn from the information gathered today, and, more importantly, we must act on it.

FOR THE RECORD

PREPARED STATEMENT OF PATRICIA A. FRIEND, INTERNATIONAL PRESIDENT,
ASSOCIATION OF FLIGHT ATTENDANTS-CWA, AFL-CIO

Thank you, Chairman Thompson for holding this important hearing. My name is Patricia A. Friend and I am the International President of the Association of Flight Attendants—CWA (AFA-CWA), AFL-CIO. AFA-CWA represents over 55,000 flight attendants at 20 different airlines throughout the United States and is the world's largest flight attendant union. We would like to submit the following statement for the record. Flight attendants, as the first responders in the aircraft cabin and as airline safety professionals, are very concerned possible transmission of communicable diseases onboard passenger aircraft.

Growing numbers of passengers are flying to and from regions of the world where tuberculosis (TB), avian flu, and other infectious communicable diseases are endemic. A 1998 report by the World Health Organization (WHO) estimated that “[a]pproximately one third of the world’s population is infected with *Mycobacterium tuberculosis*, and TB is the leading cause of death from a single infectious agent in adults worldwide.”¹

Anecdotally, passengers and crew report an association between infectious disease transmission and air travel. Certainly, these reports are consistent with the close proximity of cabin occupants, low ventilation rates on aircraft, and contact with potentially contaminated surfaces; however, for commonplace infections it is often difficult to substantiate these claims because of the latency period between infection and symptoms, and the challenge of contacting passengers and crew after any given flight.

The recently documented case of a passenger with multi-drug resistant TB flying unchecked on international flights is a wake up call about the risks of exposure to potentially lethal infectious diseases on commercial aircraft. This case reminds us that airlines need to be required to train their workers to better screen ill passengers before boarding, and to contain or at least minimize the spread of infection if such passengers are only identified in-flight. Airlines must also develop and implement action plans for notifying, testing, and treating individuals who may have been exposed and infected. Simple and proactive standards, as proposed below, will help to maintain the confidence of the flying public and will limit both the economic and human costs of infectious disease spread in the air.

Last week’s news of the passenger with TB is by no means the first such case; rather, there is a history of considerable interest in the risk of transmitting TB on aircraft. One of the more conclusive investigations was conducted by the US Centers for Disease Control and Prevention (CDC) and involved 802 (87%) of passengers and crew who had traveled on one of four flights with a person who had multi-drug resistant TB.² The infectious passenger flew on two outbound flights and then, one month later by which time the patient’s condition was reported to have worsened, on two return flights. On the first three flights, a total of 14 contacts had positive tuberculin skin prick tests, although of these, 13 had other risk factors for TB. However, on the last flight that lasted 8.75 hours, 15 contacts had positive tuberculin skin tests, and of these, six had no other risk factors for TB and were seated in the same cabin section as the index case, four within two rows of her. The observed pattern of infection within the cabin suggests the potential for “drift” of infected air between rows, and the absence of reported skin-test conversions in other cabin sections implies that bacteria were not transmitted through the aircraft’s air recirculation system.

A less conclusive investigation into the risk of TB transmission on aircraft involved 225 (73%) passengers and crew on a 14-hour flight with one person who was

¹Valway, S; Watson, J; Bisgard, C et al. (1998) “Tuberculosis and air travel: guidance for prevention and control.” WHO/TB/98.256

²Kenyon TA, Valway SE, Ihle WW, et al (1996) “Transmission of multi drug-resistant *Mycobacterium tuberculosis* during a long airplane flight”, NEJM 334:933–938

highly infectious.³ Of these, 184 had positive tuberculin skin prick tests for TB, although only nine had skin conversions. Of those nine, the possibility of transmission from the index patient could not be ruled out in three cases, although all three were sitting between 15 and 23 rows from the index patient, not a compelling finding. The authors concluded that the risk of TB transmission on aircraft was no greater than those in other confined settings, noting that "TB outbreaks often occur as a result of overcrowded conditions in poorly-ventilated facilities when there is prolonged close exposure to an infectious person."

Finally, a documented investigation into a pilot with active TB who had flown with 48 other pilots over a six-month period found no risk of transmission.⁴ It is possible that this reduced risk is explained by the approximate 20-fold increase in the supply rate of outside air in the cockpit, compared to the economy section of the cabin.

TB is not the only disease at risk of being spread on commercial flights. To this end, there are documented reports of cases of SARS^{5,6,7&8} meningococcal disease,⁹ measles,¹⁰ and colds/flu^{11,12&13} associated with air travel.

In the media, high efficiency particulate (HEPA) filters have been billed as the cure-all for airborne transmission of TB and other infectious diseases. Currently, there is no minimum requirement to install or properly maintain HEPA filters on aircraft; however, some of the major US airlines report that they have done so. Assuming that HEPA filters are installed and maintained properly, they should be effective at removing the bulk of small particulate from the portion of air that is recirculated, including bacteria. Viruses are smaller than the pores of a HEPA filter, but if they travel in clusters or on big water droplets (e.g., generated by a sneeze or cough), then they should be trapped by a properly fitted HEPA filter.

As front line first responders sharing the airplane cabin for up to 18 hour periods in close proximity to passengers who may be carrying infectious diseases (including the recent case of multi-drug resistant TB), flight attendants are understandably concerned. Passengers at risk of contracting infectious disease have been described as those sitting within a few rows of an infectious person, but flight attendants, by definition, are within a single row of every person in their section during a food or beverage service, at a minimum. Also, ill passengers may congregate near the lavatories which are typically located next to a galley where flight attendants are stationed to work. Finally, and perhaps most importantly, flight attendants are the authority in the cabin during a flight and must make decisions about how to best minimize the spread of infectious disease, not only to themselves, but to other passengers. To this end, AFA-CWA offers the following recommendations:

1. The first and most important line of defense is to prevent infectious passengers from boarding in the first place. This could be accomplished by the CDC expediting and expanding their proposed rulemaking on infectious disease control.¹⁴ As written, the proposed rule would expand the ability of public health authorities to obtain data on passengers carrying communicable infectious diseases which should allow for more rapid notification and quarantine, as necessary. In adopting the proposed rule, AFA-CWA recommends that the CDC require airlines to provide appropriate initial and recurrent training for all airline personnel who come in contact with passengers. Such training should include, but not be limited to, methods for workers to properly identify ill passengers pre-flight and in-flight, explicit instructions on who has authority to prevent ill passengers from boarding and on what basis, measures that workers can apply to protect the health of other airplane occupants if the ill passenger is not iden-

³ Wang PD (2000) "Two-step tuberculin testing of passengers and crew on a commercial airplane" *Am J Infect Control* 28:233-238

⁴ Parmet AJ (1999) "Tuberculosis on the flight deck" *Aviat Space Environ Med* 70:817-818

⁵ World Health Organization (4 April 2003) *Weekly epidemiological record* 78:97-120

⁶ World Health Organization (7 May 2003) WHO update 49

⁷ World Health Organization Communicable Disease Surveillance and Response (4 May 2003) Technical report on stability and resistance of SARS coronavirus

⁸ World Health Organization (22 May 2003) WHO update 62

⁹ CDC (15 June 2001) *Morbidity and Mortality Weekly Report* 50:485-9

¹⁰ CDC (9 Apr 2004) *Morbidity and Mortality Weekly Report* 53:1-2

¹¹ Whelan EA, Lawson CC, Grajewski B, et al (2003) "Prevalence of respiratory symptoms among female flight attendants and teachers" *Occup Environ Med* 62:929-934

¹² Nutik-Zitter J, Mazonson PD, Miller DP, et al (2002) "Aircraft cabin air recirculation and symptoms of the common cold" *JAMA* 28:483-486

¹³ Hocking MB and Foster HD (2002) "Upper respiratory tract infections among airline passenger (Letter to the Editor)" *JAMA* 288:2972

¹⁴ CDC (2005) Control of Communicable Diseases; Proposed Rule. Department of Health and Human Services. Federal Register, Vol 70(229)

tified until a flight is underway, and workers' rights and responsibilities for notification, testing, and medical care after a potential exposure.

2. Airlines should be required to provide a TB test to all prospective flight attendant hires to establish a baseline and minimize the spread of infection in the cabin. If the test is positive, then airlines should be required to provide a follow up chest x-ray to determine if the disease is active or latent. If the disease is latent, there is no reason to deny employment.

3. In the event of a confirmed case of an infectious passenger or crewmember, the airline should be required to notify all onboard crew and passengers using language approved by the CDC within 24 hours of the airline being informed, and must provide testing, treatment, and medical leave as necessary to all potentially affected airline personnel.

4. To enable crewmembers to minimize the spread of infection (or a bioterror threat) onboard if a suspected case is identified during a flight, airlines must be required to provide adequate stocks of personal protective equipment (e.g., disposable gloves, surgical masks and N-95 respirators, CPR masks with one-way valves, biohazard disposal bags, etc.) on every aircraft in locations that are accessible to flight attendants (i.e., not in the emergency medical kit, which can only be accessed by licensed medical personnel).

5. To reduce the risk of recirculating infectious agents in the aircraft air supply system, Congress should require that all recirculated air systems on commercial aircraft be fitted with HEPA filters, and that airline operators install, operate, and maintain these systems according to approved maintenance plans.

In closing, we thank Congress for considering these comments intended to protect the health of the traveling public and crewmembers, to maintain consumer confidence, and to minimize the economic impact posed by infectious disease transmission during commercial flights.

FOR THE RECORD

Prepared Statement for the Record for the House Homeland Security Committee Hearing, *The XDR Tuberculosis Incident: A Poorly Coordinated Federal Response to an Incident with Homeland Security Implications.*

On behalf of the undersigned organizations:

Aeras Global TB Vaccine Foundation

American Lung Association

American Public Health Association

American Thoracic Society

Infectious Diseases Society of America

We would like to thank Chairman Thompson for holding this important hearing and we appreciate the opportunity to submit a statement for the record. The recent incident involving a patient with extensively drug resistant (XDR) tuberculosis (TB) in the U.S. demonstrates the ease with which this disease travels across borders and serves as a timely warning of the public health and homeland security challenges we face in controlling TB in all forms.

Introduction

Tuberculosis (TB) is the second-leading infectious disease killer in the world, taking nearly 1.6 million lives per year. Currently, about a third of the world's population is infected with the TB bacterium.¹ The disease is predicted to kill millions more people in the next decade. TB is the leading global killer of women of reproductive age, ahead of HIV, heart disease and war and the leading killer of people with HIV/AIDS.

The rise in HIV infection levels and the neglect of TB control programs have caused a global resurgence of TB. Drug-resistant strains of TB, including multi-drug resistant (MDR) TB and extensively drug-resistant, (XDR) TB, have emerged and are spreading. While most TB prevalent today is a preventable and curable disease when international prevention and treatment guidelines are used, many parts of the world, such as Africa, are struggling to implement them, giving rise to more drug resistant TB, and, increasingly, XDR-TB.

We support enactment of the Comprehensive TB Elimination Act, sponsored by Reps. Green (D-TX), Wilson (R-NM) and Baldwin (D-WI) and Sens. Brown (D-OH) and Hutchison (R-TX), and the Stop TB Now Act, sponsored by Reps. Engel (D-NY), Wilson (R-NM) and Smith (D-WA), and Sens. Boxer (D-CA) and Smith (R-

¹Tuberculosis. World Health Organization (WHO) Factsheet No. 104, March 2006.

OR), to provide full funding for TB control as recommended by the Institute of Medicine 2000 report, *Ending Neglect: The Elimination of Tuberculosis in the U.S.* To strengthen domestic TB control, including efforts to prevent the spread of XDR TB in the U.S., we recommend a funding level of \$252. million in Fiscal Year 2008 for the program.

XDR-TB as a Global Health Crisis

XDR-TB has been identified in all regions of the world, including the U.S. The strain is resistant to two main first-line drugs and to at least two of the six classes of second-line drugs. Because it is resistant to many of the drugs used to treat TB, XDR-TB treatment is severely limited and the strain has an extremely high fatality rate. In one of the latest outbreaks in South Africa from late 2005 until early 2006, XDR TB killed 52 out of 53 infected patients.ⁱⁱ All of those who were tested were co-infected with HIV. The convergence of several factors threatens to result in XDR TB occurring on a much broader scale. The major factors include inadequate attention to and funding for basic TB control measures in high TB burden, resource-limited settings, which also have high HIV prevalence, and the lack of investment in new drugs, diagnostics and vaccines for TB.

TB Has Not Been Controlled in the U.S.

In the U.S., many people think tuberculosis (TB) is a disease of the past. This is untrue. Ten to 14 million Americans are infected with latent tuberculosis. TB occurs among foreign-born individuals nearly ten (according to the latest Centers for Disease Control and Prevention figures) times as frequently as among people born in the United States. Minorities are also disproportionately affected by TB. According to the CDC, although the overall rate of new TB cases is declining in the U.S., the annual rate of decrease in TB cases has slowed significantly, from about 7.3 percent (1993 to 2000) to 3.8 percent currently (2000—2006).

In the early 1990's New York city had a resurgence of TB that cost the city over \$1 billion. The 2000 IOM report, found that the resurgence of TB in the U.S. between 1985 and 1992 was due, in large part, to funding reductions and concluded that, with proper funding, organization of prevention and control activities, and research and development of new tools, TB could be eliminated as a public health problem in the U.S.

Resources Needed to Address XDR-TB

Currently, the extent of the global XDR TB burden remains unknown. Globally, supranational laboratory capacity must be built to enable drug susceptibility testing in all parts of the world. Immediate interventions require outbreak and cluster investigations to identify and interrupt the chains of transmission, and implementation of infection control precautions to protect healthcare workers, other patients, and their families. New rapid diagnostic tests must be deployed and promising new drugs against TB must be promptly evaluated for efficacy and safety, especially in those with virtually untreatable forms of XDR TB. Further investment must be made in developing new TB vaccines that will protect against all strains of TB, including those that are MDR and XDR.

The current funding level of \$136.4 million in FY07 for CDC's National Program for the Elimination of TB represents a 27% decrease over the past decade when adjusted for inflation. At the present funding level, CDC is ill-equipped to combat a significant outbreak of XDR-TB. The following specific resources are required to address the current unmet needs:

(1) Build state and local public health laboratory capacity to assess the XDR burden in the U.S. All MDR patient samples must be routinely tested for second line drug susceptibility, and all isolates must be genotyped to recognize outbreak patterns.

(2) Build supranational TB reference laboratory capacity for rapid surveys to evaluate susceptibility to first—and second-line anti-TB drugs and genotype isolates to guide planning for the global response.

(3) Improve the domestic and global preparedness and outbreak response capacity, and options for effective treatment of affected persons. This includes providing travel and technical support for subject-matter experts to identify and investigate outbreaks; building capacity to institute infection control measures in affected areas—with emphasis on healthcare settings where vulnerable HIV-infected persons congregate; and improving the use of anti-TB drugs and adherence measures that prevent the creation of drug resistance.

ⁱⁱ“Virulent TB in South Africa May Imperil Millions.” *New York Times*. 28 Jan. 2007. 21 Mar. 2007.

(4) Accelerate field testing of new methods to screen for drug resistance and for real-time culture and drug-susceptibility testing of clinical isolates from TB patients.

(5) Improve the capacity to conduct clinical research to evaluate the efficacy and safety of new promising compounds against drug-resistant forms of tuberculosis; and develop new drugs to target resistant microbes that can be safely used in conjunction with antiretroviral therapy.

Need for New TB Tools

New research on diagnostic and prevention/treatment tools and vaccines is urgently needed. The standard method of diagnosing TB was developed 100 years ago and fails to adequately detect TB in children and those co-infected with HIV/AIDS. Moreover, the newest class of drugs to treat TB is over 40 years old. The current TB vaccine, BCG, provides some protection against severe forms of TB in children, but is unreliable against pulmonary TB, which accounts for most of the worldwide disease burden. We support enactment of the Comprehensive TB Elimination Act, H.R. 1532, sponsored by Reps. Green (D-TX), Wilson (R-NM) and Baldwin (D-WI) and Sens. Brown (D-OH) and Hutchison (R-TX), and the Stop TB Now act, sponsored by Reps. Engel (D-NY), Wilson (R-NM) and Smith (D-WA), which will both expand research efforts into new tools to combat TB. The bill includes authorization for research at the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH) into new TB drugs, diagnostics and vaccines, including the "Blueprint for Vaccine Development." as recommended by the Advisory Council for Elimination of Tuberculosis.

Global TB Control Efforts

The World Health Organization declared TB a global health emergency in 1993. The Stop TB Partnership released the Global Plan to Stop Tuberculosis 2006–2015 at the World Economic Forum in January 2006. If all elements of the plan are implemented, an estimated 14 million lives will be saved between 2006 and 2015. The components of the plan and corresponding implementation strategies are as follows:

1. Pursue high-quality directly-observed treatment strategy (DOTS) expansion and enhancement through:

- (a) Political commitment with increased and sustained financing
- (b) Case detection through quality-assured bacteriology
- (c) Standardized treatment, using internationally recommended drug regimens and quality-assured drugs with appropriate supervision and patient support
- (d) Monitoring and evaluation system, and impact measurement

2. Address TB/HIV, MDR-TB and other challenges

- (a) Implement collaborative TB/HIV activities
- (b) Prevent and control MDR-TB
- (c) Address prisoners, refugees and other high-risk groups and situations

3. Contribute to health system strengthening

- (a) Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems.
- (b) Share innovations that strengthen systems, including the Practical Approach to Lung Health (PAL)
- (c) Adopt innovations from other fields

4. Engage all care providers

- (a) Public-public and public-private mix (PPM) approaches
- (b) Implement the International Standards for Tuberculosis Care (ISTC)

5. Empower people with TB, and communities

- (a) Advocacy, communication, and social mobilization
- (b) Community participation in TB care
- (c) Implement the Patient's Charter for Tuberculosis Care

6. Enable and promote research

- (a) Program-based operational research
- (b) Research to develop new diagnostics, drugs and vaccines

Conclusion

The best way to prevent the future development of drug-resistant strains of tuberculosis is through establishing and supporting effective tuberculosis control programs in the U.S. and globally. As we provide resources to respond specifically to the XDR TB emergency, we must keep in mind the ongoing need for consistent support of global TB control programs through the U.S. Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC).

To strengthen domestic TB control, including efforts to prevent the spread of XDR TB in the U.S., we recommend a funding level of \$252 million in Fiscal Year 2008 for the program and enactment of the Comprehensive TB Elimination Act,

H.R.1532, sponsored by Reps. Green (D-TX), Wilson (R-NM) and Baldwin (D-WI) and Sens. Brown (D-OH) and Hutchison (R-TX).

To combat TB globally, we support enactment of the Stop TB Now Act, sponsored by Reps. Engel (D-NY), Wilson (R-NM) and Smith (D-WA), and an appropriation of \$300 million for the Global Fund to Fight AIDS, TB and Malaria in Fiscal Year 2008. Enactment of the Stop TB Now Act and the Comprehensive TB Elimination Act will provides researchers and public health officials the tools needed to help eliminate TB in the U.S. and around the world.

We appreciate the opportunity to submit this statement for the record.

Chairman THOMPSON. The Chair now recognizes the Ranking Member of the full committee, the gentleman from New York, Mr. King for an opening statement.

Mr. KING. Thank you, Mr. Chairman. Thank you for yielding. I certainly support the holding of this hearing today because it does raise very substantive and very profound questions as to exactly how our defenses are in order; how they are not in order; how this individual Mr. Speaker was able to take two transatlantic flights, visit five countries, and make his way across the Canadian border into the United States.

It is especially significant, going beyond this one individual, in that we do know we could well be faced with a terrorist attack by use of infectious diseases. So this has very serious implications for the United States, something that has to be addressed, why there was not better communication between the CDC and the various entities in homeland security, and what the protocols will be to prevent this in the future.

I would say, though, since the Chairman mentioned incidents beyond this particular case in his critique of the Department of Homeland Security, we did see this last weekend in New York where the JFK plot was stopped. I was very involved in dealing with the FBI and the NYPD in New York, and they specifically stated the enormous contributions they received from the Department of Homeland Security, especially Customs and Border Protection, ICE, TSA, air marshals. All of that was involved in taking down of that case.

Also, the other reality is we have gone 69 months since September 11th without being attacked, so I think we have to keep all of this in perspective.

Having said that, none of that diminishes from the issue that we face here today is why this individual was basically allowed to traverse the globe, especially since it was thought that he had a very serious strain of TB. Whether he does or not, I guess, is an unanswered question. The reality is at least faced with the hypothetical case, the government did not do the job we were supposed to do.

So I am very interested and looking forward to the testimony today to see what went wrong and how we protect it for the future. But in doing that I think we should keep in perspective what has been achieved and also give credit where credit is due, and certainly the taking down of the JFK plot in which DHS was very much involved deserves to be on the record if we are going to go beyond this specific case.

With that I yield back the balance of my time.

Chairman THOMPSON. Other members of the committee are reminded under committee rules, opening statements may be submitted for the record.

Chairman THOMPSON. In addition, Dr. Gerberding is testifying over at the Senate, and we expect very shortly that she will come and join our panel of witnesses.

I welcome our panel of witnesses: Dr. Jeffrey Runge, the Assistant Secretary For Health Affairs and Chief Medical Officer at the Department of Homeland Security. Dr. Runge is an emergency physician and former emergency medical technician, and prior to DHS he was the Administrator of the National Highway Traffic Safety Administration.

Our second witness is Mr. Ralph Basham, Commissioner of Customs and Border Protection at the Department of Homeland Security. Mr. Basham previously served as the Director of U.S. Secret Service and Director of the Federal Law Enforcement Training Center.

Mr. Ahern, you are just the backup for Mr. Basham.

Thank you very much. Without objection, the witnesses' full statements will be inserted into the record. I now ask each witness to summarize his statement for 5 minutes, beginning with Dr. Runge.

**STATEMENT OF JEFFREY RUNGE, CHIEF MEDICAL OFFICER,
DEPARTMENT OF HOMELAND SECURITY**

Dr. RUNGE. Thank you, Mr. Chairman.

Chairman Thompson, Ranking Member King, members of the committee, thank you for the chance to share with you some of the policy, procedures and processes that we have in place with our Federal partners to enhance our Nation's biodefense at the borders. We take the role of this committee very, very seriously, and I appreciate the candidness with which I have been able to share information with your staff and the report that we have, Mr. Chairman.

DHS is aware that the committee is acutely interested in the details and implications of our interactions with our Federal partners in dealing with a person with an infectious disease crossing our borders. We appreciate the opportunity to address this case with you and the actions that we have taken since that time to improve our biodefense posture and to respond to your questions. It is extremely important to note that due to the diligence and the diligent actions of the CDC and its divisions, this subject no longer poses a threat to our public's health. We are happy to play a part in assisting Dr. Gerberding and her team in discharging their duties to protect America's health, which we do over 200 times in a year, in addition to working with them in extensive joint planning for pandemic influenza and other threats to our Nation.

When this individual chose to travel overseas against medical advice, and CDC became aware of the potential for disease spread, CDC reached out to activate processes that we already have in place through agreements and procedures among our agency's various components. Within a very short time of the CDC's request, DHS components were able to put into effect procedures at the U.S. points of entry and with 250 or so airlines that share information with DHS.

The system worked as intended. Although we have identified several processes that we have to improve upon, the problem for DHS was not in the system. As my written testimony said, Mr. Chair-

man, there appears to have been a single point of human failure in this case, which Commissioner Basham, Assistant Commissioner Ahern can address.

This committee has also expressed its concern which we at the Department share about the implications of this incident for bio-defense at our Nation's borders. We share the genuine concern over the fact that our borders are not impervious to infectious diseases in spite of the best efforts of CDC and DHS and its components.

Short of Draconian and economically damaging health-screening techniques being routinely implemented at each port of entry, for the millions of people crossing the border there will always be opportunities for people who are ill to cross our borders undetected.

Having said that, our citizens have every right to expect that when we know of a person who poses a risk, we should be able to enforce CDC's isolation and quarantine authority at the border. For other illnesses that can readily be detected because of fever or other outward signs, it is reasonable to expect us to meet that challenge with tools and training and partnerships with State and local authorities. But for those that cannot be readily detected with available tools and training, we want the committee to appreciate the formidable challenge that that presents both to those who enforce the law at the border and those who are responsible for isolation and quarantine.

The great majority of our 326 ports of entry are manned by law enforcement officials from CBP who have received no advanced medical training, although each does receive training in various diseases both for recognition and for self-protection.

Mr. Chairman, you and your staff have made it clear to me that you expect our Office of Health Affairs to assist CBP and the other components in discharging their health-related responsibilities, and we intend to do so as we grow and man up.

Mr. Chairman, this concludes my opening statement, and I would ask that the Department's written statement be submitted entirely for the record.

Chairman THOMPSON. Thank you very much. Thank you for your testimony.

[The statement joint statement of Dr. Runge, Mr. Ahern, and Mr. Basham follows:]

JOINT PREPARED STATEMENT OF DR. JEFFREY RUNGE AND JAYSON P. AHERN, AND W,
RALPH BASHAM

Introduction

Thank you Mr. Chairman for the opportunity to share with the Committee some of the policy, procedures and processes we have in place with our Federal partners for the Nation's biodefense across our borders.

DHS is aware that the Committee is acutely interested in the details and implications of the recent interactions with a patient infected with extensively drug resistant tuberculosis (XDR-TB). We appreciate the opportunity to address this case with you and the actions we have taken to improve our biodefense posture. While this case is indeed interesting, it is extremely important to note that it poses no ongoing threat to public health in the United States. This case involves one patient who was diagnosed with tuberculosis during a medical examination by his personal physician and was subsequently identified by public health authorities as a potential transmission risk after the diagnosis of MDR-TB, and later the XDR-TB was confirmed.

The story took a rare and unusual turn when the individual chose to travel overseas after the subsequent diagnosis, thus activating the processes to present an isolation order to the individual upon his reentry into the United States. The system created to effect such an isolation order involves the Department of Health and

Human Services (HHS), (including its Centers for Disease Control and Prevention (CDC)) acting under the authority of the Public Health Service Act and the Department of Homeland Security (DHS). The system functioned properly in this case. However, there appears to have been a single point of failure in this case—human error by an individual who may have failed to follow appropriate procedures. DHS continues to investigate this issue. While the investigation is pending, DHS has ensured that the individual is not carrying out inspection duties at the border.

The fact that a failure occurred underscores the need to implement additional failsafe mechanisms. U.S. Customs and Border Protection (CBP) has already made changes to its procedures designed to prevent this particular failure from occurring again. This was indeed a lesson learned and not simply a lesson observed.

The Committee has also expressed its concern, which the Department shares, about the implications of this incident for biodefense at our Nation's borders. We share the genuine concern over the fact that our borders are not impervious to infectious diseases, in spite of the best efforts of the CDC and DHS and its components. Unless draconian health screening techniques are routinely implemented at each port of entry as a standard operating procedure for the millions of people crossing the border, there will always be opportunities for people who are ill to cross our borders undetected. The land border environment presents additional challenges because individuals claiming U.S. and Canadian citizenship are not always required to present passports that validate identity and citizenship. The Department is committed to addressing this security gap through implementation of the Western Hemisphere Travel Initiative (WHTI). Ultimately, the WHTI will provide technical enablers and controls to mitigate volume issues and ensure that high risk travelers are better identified at our ports of entry. WHTI implementation will enhance the screening process by increasing the number of travelers that can be efficiently queried at the time of entry through the ports of entry based on better documentation, identity and citizenship.

Currently, however, CBP officers are only able to query approximately 50 percent of land border crossers by requesting documents with machine readable zones (as noted previously, because individuals claiming U.S. and Canadian citizenship are not yet required to present documents denoting identity and citizenship) or by flat-fingering the query. In addition, the great majority of our 327 ports of entry are manned by law enforcement officials from CBP who have received no advanced medical training. CBP officers do have procedures to follow when a U.S. citizen or non-U.S. citizen appears to be ill and in need of medical attention at the border, and each is trained in those procedures. These procedures involve consulting medical personnel. Federal medical resources at the borders come from the CDC's Division of Global Migration and Quarantine (DGMQ), which provides that service at approximately 20 ports of entry. Even though steps were taken to fortify ports of entry with medical staff, even fully staffed quarantine stations are not in a position to perform routine health screening on all passengers crossing the border as a standard operating procedure. It is important to stress that individuals will not necessarily exhibit symptoms of illness and that CBP officer must make their best assessment within a limited period of time.

The Incident in Question

On May 22, 2007, CBP Port of Atlanta received information from the CDC regarding an individual, who traveled to Europe on May 12, 2007, noting that he is a carrier of a drug resistant form of tuberculosis.

A shift muster, a daily briefing for shift employees on significant policy and operational matters, was distributed and briefed to CBP Officers at all locations.

On May 24, 2007, at 1818 hours, the individual arrived at the land border crossing at the Champlain, NY port of entry in a rental vehicle, accompanied by his wife.

More detailed information can be provided in a classified briefing. However, as a result of this incident, CBP initiated a systems enhancement (effective June 5, 2007) that will help ensure that officers will follow appropriate procedures when processing persons of interest seeking to enter the United States. This systems change will allow CBP to better account for and control all referred persons of interest for secondary inspection. It will also require that such persons undergo additional questioning and examination to determine whether they may be cleared or whether other appropriate action is warranted. The Department's long-term solution remains a WHTI enabled screening procedure that tackles the inherent problem of increasingly high traffic volume with improved query capabilities.

Information Sharing—U.S. and Canada

In December 2001, former Secretary of Homeland Security Tom Ridge, then serving as Director of the White House Office of Homeland Security, signed a Smart Border Declaration with the Canadian Deputy Prime Minister. The Declaration set

forth a 30-point action plan designed to enhance the security of the United States and Canadian shared border while continuing to facilitate the flow of legitimate travelers and cargo. This action plan resulted in initiatives to share information between the United States and Canada related to air travel, including Advanced Passenger Information/Passenger Name Record (API/PNR) Risk Assessments. An essential goal of the API/PNR Risk Assessment Initiative is the concentration of inspection resources on high-risk travelers while facilitating the movement of legitimate members of the general traveling population. A risk assessment process evaluates passengers arriving into the United States or Canada.

Current Health Screening Procedures at Ports of Entry and information Sharing

Among CDC, CBP, and other DHS Components As part of CDC's authority to prevent the introduction, transmission, and spread of communicable diseases into the United States, its possessions, and territories, CDC is authorized to isolate and/or quarantine arriving persons reasonably believed to be infected with or exposed to specified quarantinable diseases and to detain carriers and cargo infected with a communicable disease. DHS has agreed to assist CDC in the execution and enforcement of these authorities, primarily in the enforcement of CDC-issued quarantine orders, and through collaboration with other Federal, State, and local law enforcement entities.

HHS and DHS executed a Memorandum of Understanding in October, 2005 that details the roles and responsibilities of each Department and agency to mitigate the entry of infectious diseases at the Nation's borders. (within HHS this memorandum implemented through the CDC.) Since the CDC's DGMQ cannot possibly cover every port of entry, successful screening depends on CBP officers having access to simple, usable tools and protocols to identify travelers who may be infected with a quarantinable disease. By the same token, CBP has law enforcement powers to aid CDC in carrying out its authorities and has access to data that CDC needs to perform its public health duties.

HHS will consult with DHS to define steps necessary to obtain information expeditiously when either agency believes there is a public health emergency. The Departments agreed to assist one another in informing the traveling public of potential disease threats, including assisting in the distribution and dissemination of CDC Travel Notices or Health Alert Notices if necessary and as resources permit.

DHS has agreed that its personnel will assist with surveillance for quarantinable or serious communicable diseases of public health significance among persons arriving in the United States from foreign countries, with the understanding that DHS personnel may not have medical training and therefore are not expected to physically examine or diagnose illness among arriving travelers. Surveillance by DHS personnel would generally consist of the recognition and reporting of overt visible signs of illness or information about possible illness provided to them in the course of their routine interactions with arriving passengers, and does not include eliciting a medical history or performance of a medical examination. In situations where a significant outbreak of a quarantinable disease is detected abroad, CDC may request that DHS personnel assist with active surveillance, using a number of methods to assess the risk that individual passengers, arriving from affected countries or regions, are carrying a quarantinable disease. CDC will ensure that a quarantine officer or designated official with public health training will be available to assist in the evaluation of individuals identified through active surveillance.

CDC has statutory authority to require reporting of ill travelers, conduct certain public health inspections of carriers and cargo, and impose certain entry requirements for carriers and cargo that may pose a communicable disease threat. DHS will aid CDC in the enforcement of its statutory authority regarding quarantine rules and regulations pursuant to operational guidelines to be developed by mutual agreement of the parties. Such guidelines will include emergency measures to be taken when a carrier or vessel is determined, after leaving a foreign port, to be carrying a passenger or passengers with a quarantinable or serious communicable disease.

Passengers with Potential Public Health Threats and the Commercial Airlines

Under the Aviation and Transportation Security Act, the Transportation Security Administration (TSA) has broad authority to assess and address threats to transportation and passenger security. Under this authority, TSA can direct airlines to deny boarding to an individual identified by the CDC as a threat; this includes individuals identified by the CDC as a public health threat. Based on the request from CDC/HHS, the Assistant Secretary of Homeland Security at TSA may determine that the presence of such an individual aboard a commercial passenger airline flight

poses a threat not only to that flight but to the entire transportation system, should the disease spread to other passengers, flights and flight crews, and other modes of transportation used by those individuals.

TSA has a number of options where a person who poses a public health threat may attempt to use the commercial airline system. In the case of last week's incident, as soon as CDC recognized that the individual may have been attempting to fly on a commercial airliner to enter the United States against their CDC advice, TSA directly contacted the Transportation Security Administration Representatives (TSARs) in Europe and International Principal Security Inspectors (IPSIs) worldwide to inform carriers, embassies, and host government authorities that the infected individual should not board a commercial flight. TSA also chose to use the existing infrastructure of its watch list system. Given the imminent travel of this infected individual, using the existing process was deemed the most expeditious way to alert the airlines to prevent the individual from boarding. At no time, however, was the infected individual identified as a terrorist. TSA has other means at its disposal to communicate threats to airlines immediately and direct them to implement specific security measures, such as the issuance of a Security Directive.

The fact that the introduction or spread of a communicable disease through the transportation system is not necessarily a threat involving criminal violence or other unlawful interference with transportation does not preclude TSA from exercising its authority to address such a threat. The security of the transportation system involves protection of the system from any threat that may disrupt transportation or endanger the safety of individuals in transportation. In the case of biological threats to the transportation system and its passengers, such as the introduction of a communicable disease, it may be impossible to determine whether the source of the threat is intentional human action, human failure, or a natural occurrence. TSA's authority is not limited to dealing only with threats of intentional terrorist acts against the transportation system. TSA is charged with assessing all threats to transportation and executing such actions that may be appropriate to address those threats.

Conclusion

In summary, let me restate that DHS will proactively exploit the lessons learned from this incident to strengthen our homeland defenses and response to infected air travelers. We also look forward to streamlining collaboration with HHS/CDC, the Department of State, and State and local public health authorities to jointly combat the growth of global infectious disease threats, including pandemic influenza. DHS apparently had a single point of failure, but that has been corrected and has resulted in structural improvements to border security thanks to decisive action by CBP leadership.

We are encouraged that the U.S.-E.U. information sharing of Passenger Name Records for public health purposes contributed to CDC's efforts to contact travelers who may be at risk for disease transmission. We look forward to strengthening U.S.-Canadian cooperation and communication on API/PNR and have already reached out to continue negotiations. The TSA acted quickly to provide assistance to CDC in this case, and has already begun to explore expeditious ways of communicating "pop-up" threats to commercial air carriers. Finally, my office, the Office of Health Affairs, leads the ongoing efforts to fulfill the Department's responsibilities for Bio-defense, including enhanced biosurveillance, and emergency preparedness and response, in close coordination with our Federal partners.

Thank you for the opportunity to present the Department of Homeland Security's testimony today. My colleagues and I are available to respond to your questions.

Chairman THOMPSON. I now recognize Mr. Ralph Basham to summarize his statement for 5 minutes.

STATEMENT OF W. RALPH BASHAM, COMMISSIONER, CUSTOMS AND BORDER PROTECTION, DEPARTMENT OF HOMELAND SECURITY

Mr. BASHAM. Thank you, Mr. Chairman, ranking Member King and distinguished members of the committee. I am here before you today to discuss the role of U.S. Customs and Border Protection and the Federal Government's efforts in late May to track down a U.S. citizen now identified in the media as Andrew Speaker who was traveling with his wife internationally while he was infected with a rare strain of tuberculosis.

Joining me here today, as you stated, is Assistant Commissioner for Office Field Operations Jay Ahern, who has the responsibility over all of our ports of entry. Together we hope to provide you with what happened when a CBP officer encountered the traveler and his wife crossing the land border with Canada at the Port of Champlain, New York, and allowed them to enter the United States contrary to CBP instructions. We will also update you on our resulting follow-up actions.

Let me state at the outset to this committee and the American people CBP had an opportunity to detain Mr. Speaker at the border, and we missed. That missed opportunity is inexcusable, and it appears at this stage to be largely the result of a CBP officer failing to follow procedures and instructions. That failure is felt collectively by all of CBP's leadership and all of the frontline employees whose good work and reputation are tarnished by his actions.

There is no criticism that can be leveled today or in coming weeks by outsiders harsher than the blame and frustration we have already turned upon ourselves since the discovery of Mr. Speaker's reentry into the United States.

The failure to detain this traveler unfortunately overshadows and negates a lot of good work done in this particular case by CBP employees both before and after the encounter in Champlain.

The work of other employees began in Atlanta on May 22nd when CDC brought the information to local CBP officials before the May 24th encounter. On the 22nd, a nationwide alert was placed in our electronic system that gave us the necessary information to intercept the traveler. Despite not knowing how or where he would attempt to enter, we continued our effort looking for Mr. Speaker's travel into the United States in the event he chose an alternate time, date and method of travel.

When it was determined by our National Targeting Center that the traveler had entered, we alerted the CDC within hours of the entry. Our efforts continued last week with CBP employees using our tools and information to identify Mr. Speaker's travel pattern and track down other passengers from his flight potentially at risk for tuberculosis from exposure to him.

This also overshadows all the good work of CBP officers on a daily basis. Just to put this incident in context, on that day of May 24th, at the port of Champlain, New York, we processed entry of 1,296 passenger vehicles, 1,378 commercial trucks, and responded to numerous alerts that were properly referred for secondary inspection. Nationwide on average, on an average day, CBP processes 1.1 million passengers and pedestrians, almost 71,000 trucks, rail and sea containers, over 240,000 incoming international air passengers, 327,000 incoming privately owned vehicles, and 85,300 shipments of goods. What should have been a textbook success story to demonstrate how our systems work effectively was overshadowed by the failure to stop this one traveler.

There is no excuse or acceptable explanation to offer for failing to stop this individual at the border. I do not believe that it can be explained by any lack of tools or training. The actions of the individual officer and supervisors in Champlain are being fully investigated, and appropriate action will be taken. It is understood by all employees in CBP that we are responsible for our actions. Be-

cause there is a required administrative process, we may not be able to say as much today as I would like, especially in an open hearing, with respect to action that may be taken against the individual officer; however, I cannot offer any defense for the individual actions that lead to the failure to interdict and detain this individual upon entry into the United States. To my mind those actions appear to be indefensible, and in a closed briefing we would be happy to show you and the Members more detail on what took place in those critical few moments in Champlain.

We have taken some immediate steps to implement enhancements to our information technology systems and protocols at our ports of entry to further reduce the possibility that an officer on primary inspection could ignore or clear a public health alert in the same manner again. We can discuss these matters in further detail during questioning.

I would say a word in defense of the human element on the front line of America's borders and in all law enforcements that has been critically questioned during the past 2μweeks. While the human element can be a weakness, it also is a source of our greatest strength. A great many of the threats we intercept on a daily basis at our ports of entry are caught not because of known alerts or a watch list already in a computer, but due to the training and experience of our frontline officers in dealing with the unknown. The unknown threat is still our greatest vulnerability.

We were presented with such a threat in the Millennium bomber, who was intercepted at the border with a car trunk containing explosives on his way to blow up a terminal at LAX in 1999. This is an example of an alert customs inspector who acted not because the traveler was a known threat or on a watch list or alert but because the inspector relied upon her training, experience and intuition to determine that something just wasn't right on that entry.

It is important that despite this most recent failure we not lose sight of the value of the human element in inspectional work nor overreact in trying to turn our officers into robots devoid of the ability to exercise the appropriate judgment and discretion.

Those who signed up to protect the homeland understand that we are expected to take the right action every single time. When we hit the mark, there will be precious little news because it was just doing our job; and when we slip, even once, it makes headlines. We accept that standard of 100μpercent success, that standard of 100 percent success without complaint, because the mission is so important.

Mr. Chairman, I have spent my 37 years in law enforcement. I am no stranger to the concept of being judged by the unforgiving standard of 100 percent success, the concept that everyone must unfailingly perform the duties and responsibilities of his or her position in order to meet that standard and the consequences of failure. In my previous job as Director of the Secret Service, what kept me up at night was knowing that no matter how elaborate the protection scheme we could design, no matter how much technology was available or how many redundancies we could build in, at the end of the day a single agent or uniformed officer's failure to take the proper and expected action at a key moment could literally cost the life of the President of the United States.

Since becoming Commissioner of U.S. Customs and Border Protection, I have emphasized the theme of integrity, and I preach its importance to our field employees many times by explaining that CBP is like a chain which is only as strong as its weakest link, and that the neglect and failure of even a single employee intentionally or otherwise can undermine the efforts of all.

Our review thus far indicates that this is exactly what happened in this case. Again, I can offer no defense for what happened that day in the Champlain port of entry, and I will not offer any hollow promises today that human failings will never again occur among the 44,000 employees charged with the critical and complex mission of securing our Nation's borders. Similarly, I cannot guarantee that CBP will hit 100 percent success 100 percent of the time.

But this incident has reinvigorated our focus on the mission of protecting American people, causing us to reexamine how we perform that mission and reinforce in a way words cannot the critical importance of every single employee in doing their duty.

Thank you, Mr. Chairman. I would be happy to take your questions.

Chairman THOMPSON. Thank you very much, Mr. Basham, for your testimony.

Chairman THOMPSON. I would like to remind the Members that Dr. Gerberding is expected momentarily, and at what point she comes, we will ask unanimous consent to have her testimony from CDC.

In the interim we will start with the questioning of our witnesses. I will allow myself 5 minutes to start.

In my testimony I mentioned about a memorandum of understanding between DHS and CDC. We now have that as of a few minutes ago, and we will share that with other Members as quickly as possible.

What I would like to go through, Mr. Basham, if I can, is whether or not you think the Atlanta CBP office provided real-time action once it was notified of this situation.

Mr. BASHAM. Mr. Chairman, as was stated, I believe you have the timeline, on the 22nd when CDC came to CBP Atlanta office and explained the situation with regard to Mr. Speaker and basically was inquiring as to whether or not we could track Mr. Speaker's travel, and explained that Mr. Speaker had, in fact, left the country, at that time our office in Atlanta decided to put an alert in our system and to try to make—if he tried to reenter the United States, that we would have that information so that we would be able to intercept or interdict him when he came in.

At that point in time, it was understood by the Atlanta office that we had an individual who was compliant and was following the instructions of CDC. We were not told at that time the danger of or the lack of danger of this individual and his travel. So when we put that alert in the system, which alerted all of our ports of entry, we felt confident that if Mr. Speaker tried to reenter the country, we would be able to intercept him.

Chairman THOMPSON. At what point were you provided information that Mr. Speaker was potentially dangerous?

Mr. BASHAM. When he actually did reenter the United States.

Chairman THOMPSON. You just said at the point that the Atlanta office was notified that he was a danger, and I am just trying to follow up, at what point did someone tell you that he was potentially a danger?

Dr. RUNGE. Maybe I can put a fine point on that, Mr. Chairman. CDC came to CBP because of its concern that he was, in fact, an infectious disease risk, but at that time they had been in conversations with him and did not know him to be a flight risk.

CBP has reservation information through their system and expected him back on a certain day, and they really had no reason to believe that he would try to evade the situation if he reentered the United States.

Mr. BASHAM. I would say, Mr. Chairman, that we were told that day that he had XDR tuberculosis. That was entered into the alert. When we placed the alert in the system on the 22nd, the instruction, very clear instruction, was that anyone who encountered this individual was to refer that individual for secondary inspection, to put a mask on that individual, to isolate that individual, and to ventilate that individual, and to notify the CDC, Dr. Kim I believe was the name.

So those instructions went in on the 22nd, and I am not sure exactly what the time was.

STATEMENT OF JAYSON P. AHERN, ASSISTANT COMMISSIONER, OFFICE OF FIELD OPERATIONS, CUSTOMS AND BORDER PROTECTION, DHS

Mr. AHERN. The alert went in on the 22nd at 11:30 after we were contacted by the CDC. It should be noted that Mr. Speaker departed the country on May 12th. At that time CDC, because of the close working relationship with our port officials in the Port of Atlanta, they did come and talk about the situation, and we did make a determination it was best to put within our border system of lookouts a Treasury enforcement communication system, not to be confused with watch listing or no-fly listing. Our border lookout system was executed for the individual coming back in the country through Atlanta, JFK or LAX, or, as he ultimately did, in Champlain, New York. So it is a nationwide system that was executed at Atlanta locally.

At that point in time, that is then flagged for it that individual is encountered coming back into that country. Further we started to conduct sweeps daily to see if the individual's flight reservation through our automated targeting system to target people through the air venue reflected there was a return flight coming to the United State to Atlanta on June 5th. That continued to show through our twice-daily reservation checks and showed no alternative or deviation from that original record at that point in time, nor for the next 2 days when he actually arrived at the land border crossing.

Chairman THOMPSON. So, in essence, you had no knowledge as to his travels until he got to the border crossing.

Mr. AHERN. That is correct. The reservation that was existing in the system through the passenger name record that we use for targeting individuals of potential travel concern, as we have talked about before in some of the hearings, and for other settings, this

is a system we use to see what return travel or any deviations from the travel.

Without going into the methods and means of it, we would be happy to in a closed setting, it gives us the ability to see on that reservation if it is modified or whether individuals are linked to that particular system. However, it won't go further.

My point is that the individual did not modify or change that particular reservation. That remained in the system, and a new reservation was executed to show that within Europe and ultimately the Canada flight.

Chairman THOMPSON. I guess the question is with the new reservation, our system is not designed to pick up a new reservation?

Mr. AHERN. That is correct. That is certainly something—as we continue to look through our agreements with the European Union and other national, international parties, we need to take a look at our global sharing—I think it is a critical point that we need to have greater visibility—and to the transportation patterns so that we can target and better secure.

Chairman THOMPSON. Now, is CBP doing this or TSA?

Mr. AHERN. At this particular point in time, this is CBP looking at the reservation. We certainly do, through our National Targeting Center, have many different Federal agencies here in northern Virginia. TSA and the Federal air marshals are part of that process.

Chairman THOMPSON. So is the protocol for the regional office to work it or push it to headquarters and let headquarters make the decision?

Mr. AHERN. I think clearly as far as what we need to do is when we have a piece of tactical information like this, that for an agency we have a relationship with, my sense is in my 31 years of experience we need to get that lookout in the system. I think as we go forward, and Dr. Runge may want to talk further about this, is we need to bring a lot of it up to the national level and certainly having some information with our National Operations Center to make sure we have the overarching DHS umbrella with all components fully engaged at early onset. Those oftentimes are hard to predict when you have a case that happens with great routine for different types of lookouts on a regular basis throughout the country. We need to put a better process in place, at the same time having a measure put in place immediately.

Chairman THOMPSON. Thank you.

I yield 5 minutes to the Ranking Member from New York Mr. King.

Mr. KING. Thank you, Mr. Chairman.

Commissioner Basham, as I understand it from the Chairman's questioning, CDC came to CBP on May 22nd, but TSA was not notified until May 24th. Should there be better coordination among the CDC, CBP and TSA, especially since the CBP and TSA are under the same roof?

Mr. BASHAM. I would clearly—in hindsight, Mr. King, we could have done a better job of coordination, but looking at it through the lens of that office on that day, at that point in time, as I said before, the expectation was that this individual was going to return to the United States on a flight on June 5th. I believe it was an Air France flight. And we had already begun to put in a plan

where we would coordinate our efforts with TSA, with ICE, and with CDC upon Mr. Speaker's arrival back into the United States.

So on that day there was no reason to expect that this was not going to be anything other than this individual either coming back on a commercial flight or a flight that was going to be arranged, a charter flight that could be arranged by CDC. So it was a local issue at that point in time, sir, and in retrospect, in the events as they played out, we could have probably done a better job in the communication.

Dr. RUNGE. Congressman King, can I add? You are absolutely correct, there should have been better coordination. But I want to put in a caveat to that, and that is that there are literally a couple hundred of these lookouts that CDC communicates with CBP that really don't rise to a certain threshold. We do rely on the judgment of the field officers in whatever agency to decide when something needs to get bumped upstairs. That will probably change as a result of this.

There is no question that when an interagency interaction takes place, that it should take place through the National Operations Center. We have had some very productive conversations about that over the last week or so and have reached that agreement. In fact, when we were notified, frankly, 2 days later when CDC learned that he was not as compliant as they thought he would be, we immediately convened a conference call with the Transportation Security Operations Center, the National Operations Center, the CDC's operation center to discuss the issue, and that, in fact, lead to TSA's involvement and his addition to a no-fly situation. So you are absolutely correct that going forward we will do that.

Mr. KING. Rather than, leaving Monday-morning quarterbacking aside, from a lessons-learned perspective, if we are talking about someone who has such a virulent disease, and since September 11th we have been taught to think outside the box, rather than assume he is going to come back the way he is scheduled to, does it make sense, especially in a case like this, talking about a deadly disease, we assume the worst and that we send out an APB and put everyone on notice, especially when TSA and CBP are under the same roof?

Let me ask you, Dr. Runge, obviously you are new in your position, but when I look at the testimony here from CDC where it says that perhaps one in three people in the world at least had a latent exposure to tuberculosis, which I guess runs into the billions, I am trying to do some fast math in my head, and we are dealing with millions and millions of people coming into our country every year by airplanes and other means, certainly by plane. Do you think more should be put in place?

I know they have to get TB tests, but I think you have a year after your test before you have to take another one coming into the country. Again, trying to anticipate something in the future, do you feel apart from any terrorist connotations at all, do we have enough protections and should be more coordination between you and the CDC?

Dr. RUNGE. That is a great question, sir. The CDC and we do coordinate, in fact, very well, particularly at the action officer level, and we will do better at communicating more at the senior level.

The issue of the ubiquitousness of TB is quite interesting, and it does speak to the fact that the transmissibility is relatively low in casual contact, and, in fact, it is minimal, I would say, and that people who come into casual contact with people who have TB really have nothing to worry about. It is being in a closed space like an Army barracks, or college dorm or shelter, or a multiple-family situation in which people are living in very close contact in which we see the risk is raised.

The literature says that flights of less than 8 hours are really not of a concern, but those that are more than 8 hours in the proximity of someone, people should—they have an increased risk of contracting the disease.

So the other thing I should point out is that we don't decide, DHS does not decide for itself, who we quarantine and isolate. We are the law enforcement agent for the CDC's authorities, and we take cues from them. That is an important distinction. And they are really the experts with respect to disease transmission, and we will take their advice.

Mr. KING. Thank you very much. Yield back, Mr. Chairman.

Chairman THOMPSON. Thank you very much, Mr. Chairman.

I now yield 5 minutes to the gentlelady from the Virgin Islands Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. Thank you for holding this hearing, and I also want to thank the Chairman, Chairman Langevin, for his leadership on this issue.

Mr. Chairman and colleagues, this is not just about one man or one family with someone who has active TB. This is whether we as a country almost 6 years after 9/11 are prepared to deal with the potential biologic threat or an agent of bioterrorism that is introduced into our country or another country in this world.

We have appropriated over \$5 billion for Bioshield, over \$6 billion for avian flu that may or may not come anytime soon. At the same time, despite the call from many of us, we have virtually ignored the simple public health measures that would be the first line of defense no matter what the agent is.

Also in the prior two Congresses, we basically ignored the fast cures legislation which would have directed research to speed up identification processes and the development of new vaccines and countermeasures for agents we may or may not have seen before. And I have only held off reintroducing this legislation from assurances under Secretary Jay Cohen that such research was being given priority already. I would recommend the committee take a look at whether that is occurring and to what extent.

We are very lucky that it seems as though this gentleman is not contagious, and so far as we know, it has just been one person. So today I am hoping we get some answers that will restore the faith of the American people that they will be protected against diseases introduced to harm them, and assurance that the needed investment will be made in a strong, well-staffed, well-trained, informed public health system once again.

So my first question, I guess, and I am looking forward to having Dr. Gerberding here because I have more questions for her, is what is in the 2008 budget for hospitals and public health departments? Do you know offhand? It has never been adequate.

Dr. RUNGE. Your questions are always very insightful on these issues, and I haven't got an answer for that. That would be more appropriate for Dr. Gerberding or perhaps someone else from HHS.

Mrs. CHRISTENSEN. Well, Mr. Basham, our prior information had said that the name of Mr. Speaker went on the list, the no-fly list, which I assume means more than just a no-fly list; it includes all of the lists that would come up at a border; that it was on the 24th of May that it went on the list. You are saying it was on the 22nd?

Mr. BASHAM. Mr. Speaker's name went into our alert system, which, the Commissioner pointed out earlier, is not the no-fly list, nor the watch list. It is a Treasury enforcement communication system that goes out to all of our ports of entry, and it alerts our officers on individuals and gives the name, date of birth. And that went out in—I believe he said it was 11 a.m. on the 22nd.

On the 23rd a notification went out that—when we discovered that he was traveling with his to-be wife Ms. Cooksey, a notification went out on the 23rd through the same system to be on the lookout for Ms. Cooksey in the event she tried to reenter the U.S.

Mrs. CHRISTENSEN. Mr. Basham, you gave a lot of statistics about what had been processed at the Canadian-U.S. border and what is processed every day. Were you in any way suggesting that you are understaffed at those borders?

Mr. BASHAM. No, I am not suggesting that we are understaffed, particularly in this situation. All of the information, all of the training that was necessary—this individual was an 18-year veteran, and, as I said, there is no excuse on that individual allowing that person into the country and not referring that person to secondary.

This situation has nothing to do with staffing. It is a clear and blatant disregard, in my opinion, of an individual that just decided to make a decision contrary to the instructions that was given to him.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMPSON. Thank you very much.

We now yield the gentleman from Indiana Mr. Souder for 5 minutes.

Mr. SOUDER. Thank you, Mr. Chairman.

I first feel compelled to put on the record that while many of the agents are the same, the fact is Diana Dean and her colleagues at Port Angeles were Customs employees. This happened before the creation of the Department of Homeland Security that they caught the Millennium bomber. The Department has been restructured, and many of us have had concerns. While many of the people are the same, they are not structured the same.

Dr. Runge said no advanced medical training and that we need more medical training. This was not a question of medical training. I mean, it is place mask on subject, place in isolation, well-ventilated room if possible. Subject has multiple resistant TB, public health risk, contact the public health service, and the name of the contact, and then the phone numbers to contact.

As you said, it is a clear violation. This isn't a medical knowledge question, this is a question of we have trouble catching anybody. If we actually catch them, will we keep them? And sometimes I wonder if the Department of Homeland Security, rather than right

now the top people running around arguing for amnesty, they ought to be paying attention to the Department itself in securing the border. What you have done in the middle of the immigration debate is undermine the American confidence that you have control of the border.

The fact is that TB, just taking that, this isn't unknown. I visited a detention center in Florence, Arizona. We have a set-aside there at the detention center for people with TB. There is a clinic there. We are watching TB on a regular case basis.

Mr. Basham, you said this is a singular failure to enforce. Now, before this incident, my understanding is your agency showed a tape to my staff and the other staff here on the Border Subcommittee that showed agents sitting and waving people across the border. And tapes exist, as I know from going to the border crossings, and I presume does a tape exist in this case as well of this agent?

Mr. BASHAM. Yes.

Mr. SOUDER. Are you aware of this other tape shown that this was not—the other cases weren't a TB case, but not an isolated incident. Are you aware of the existence of that tape?

Mr. BASHAM. I am not.

Mr. AHERN. Congressman, the tape that you are referring to is something we use as an internal training tape going back to last summer. It isolated some areas we needed to improve upon with our performance. It needs to be put in its proper context, and I believe that was why it was shown to the staff in an off-line setting.

We do have a tape of this particular circumstance as well, and it was not an instance of anybody waving anyone through. There was well over a minute and a half the individual spent with the individuals coming across the border. The lookout was in the system clearly, and it was a failure to act.

Mr. SOUDER. Just like the other people on the tape were a failure to act. Can you use the tape to fire individuals not only in this case, but in other places where you have this tape, you have people waving people through? We have this problem, as you know, and we have worked many years in narcotics with even agents paid off, that lookouts watch to see favorable agents, some who may occasionally be lazy, some who may be bought off. We have that problem in the United States, not the same problem Mexico has. This isn't impugning the character. They are frustrated with lazy or bought-off people who are undermining the whole agency.

The question is can you use the tape to fire an individual if you catch them?

Mr. AHERN. Certainly in the internal investigations work, which I won't be able to comment on in this particular circumstance, all the evidence will be reviewed in the final administrative proceeding of the individual, and it certainly could be a critical piece of evidence in that process.

Mr. SOUDER. So it is not banned from being used as part of a case to dismiss someone.

Mr. AHERN. I wouldn't know why it would be.

Mr. SOUDER. There was a 6-1/2-hour gap until the National Targeting Center identified the individual. Could you explain a little bit how this works? This person was supposed to go to secondary,

then the name, if it is a match of a license plate, got kicked. Does this mean we will always have like 6-1/2 hours until we get tipped off that somebody is headed to an airport or has a bomb in their car if the agent, in fact, fails? I mean, we are going to have people fail, and your job is to try to keep it minimal.

Mr. BASHAM. In this particular situation, as we discussed earlier, that individual's name—the individual's name went into the system on the 22nd and 23rd. The information that we had up until the 24th was that the individual, Mr. Speaker and Ms. Cooksey, were going to be arriving back in the United States on June 5th.

Mr. SOUDER. That is not my question. At 6:18:41 the officer cleared it without referral, and then at 12:45 a.m., the National Targeting Center picked it up.

Mr. BASHAM. That is because what the Assistant Commissioner was talking about earlier, they instituted sweeps of the system beginning on the 22nd to determine whether or not this individual chose to reenter the United States at other time or another place or in another method. So these sweeps were going on about twice a day.

When they did the sweep at 12:32 in the morning, that is when they discovered that Mr. Speaker had entered the country.

Mr. SOUDER. So there is not an instantaneous or even within an hour that if somebody comes through on a terrorist watch list, the agent misses him, it gets into the system, there is not a thing that pops up that says we missed this guy, gets on it. Twice-a-day sweep is what you are telling me.

Mr. BASHAM. Let me have Mr. Ahern address this.

Mr. AHERN. To put it in perspective, what the National Targeting Center was doing was the automated targeting system, which has been discussed before this committee before, and it is a critical piece of use of systems for us, we were sweeping against the airline reservation to find out if there had been any modifications to it. ATS being such a valuable system, it also pulls in border crossing history as well.

At that point in time the National Targeting Center, when they were doing the ATS sweep, found there had been an entry at the Champlain port 6:18p.m., and this was at 0032 the following morning, so there was about a 6-hour difference certainly.

But one of the features we are putting in at the port is the ability or the inability for the record to be missed in the future. There will not be an ability for the officer to clear that record. We are building some additional redundancies that we would happy to talk about in further off-line settings because they are law-enforcement-sensitive. Please be assured we are looking at adding additional measures so we can't have a single failure.

Chairman THOMPSON. Thank you very much. The gentleman's time has now expired.

Now recognize the gentelady from California for 5 minutes, Ms. Harman.

Ms. HARMAN. Thank you, Mr. Chairman. I apologize to you and other colleagues and our witnesses for stepping out. Unfortunately I had a direct conflict with another committee. But I was here to hear your opening statement and to talk to the witnesses in advance.

First let me say that I find it very disappointing that the CDC has not yet shown up here. My understanding is that Dr. Gerberding was going to be out of town, but her deputy accepted, and now it turns out both she and her deputy are testifying in the Senate. I think we deserve equal time, and one of them should be here now. That empty chair is a visible reminder of the fact that CDC has a lot of work to do here. So I am very disappointed.

My impression from talking to the witnesses in advance and from the reading that I have done on this matter is that a lot of blame is being put on this particular CBP agent who didn't do his job well enough, although he was an 18-year veteran. I would just like to suggest that the blame game is not a good way to handle this, and I did mention that to the witnesses.

I think we had a meltdown here; not that everything went wrong, but that a lot of things went wrong, and this could have been much more serious, because had this fellow had a real—and he could have—communicable disease—his form of TB apparently wasn't communicated to anyone or hasn't been yet, but had it been, or had it been smallpox or something else, we could have right this minute a national—major national emergency both in health terms and economic terms. So I think that the potential here is very serious.

My question to these witnesses is if your sister or your wife or your mother had been seated next to Mr. Speaker on this airplane going to Europe or his airplane returning to Canada, what would you say to them? Would that affect your view?

Dr. RUNGE. Congresswoman Harman, it is important to understand that in this particular case, the individual left the country before anyone knew about it. I would say to my family member sitting next to that person, it is unfortunate that this person chose to be irresponsible not to comply with clear instructions from his doctor.

Moreover, let me point out that the treatment of TB across this country is really based on a relationship between physicians and patients and an area of trust. People can abscond with an infectious disease any time. So it is unfortunate that he was not more forcefully kept from flying in the first instance.

Ms. HARMAN. I know that is what you feel, but let me just take this a step further. Your sister or your mother or whomever comes down with some very drug-resistant disease, having been seated next to someone who somehow fell through the cracks of our system. And you are in the hospital with this person who may have a life-threatening disease, and you are going to say, gee, sorry, sometimes these things happen, or would you say something else?

Let me just ask the other two witnesses. Would you feel differently about it if it personally affected one of your close family members?

Mr. BASHAM. Well, I certainly would try as best I could to explain what happened, and why it happened and that the failure for us to stop this individual from traveling is inexcusable.

Ms. HARMAN. Thank you.

Mr. BASHAM. I can't make an excuse for that. I can't make an excuse for us not interdicting this individual when he came back into the United States. Obviously this has told us that we have got

a lot of work to do here. We have got a lot of communication that we need to improve upon, as Dr. Runge has mentioned before. We are engaged with the CDC. We are engaged with the Canadian government now to talk about how we can better improve the territorial boundaries of North America. This has resulted, in my opinion, in an awakening that we need to do a better job. And I am not going to sit here and say that the system worked because we know that we can improve upon the system. It may have worked the way it was designed at the time. But now we recognized it was not good enough, and we are working very hard to ensure that that communication that Dr. Runge talked about is not at the local level. It does go to the national level, that we do put a national response to something—an event like this in the future.

Ms. HARMAN. Mr. Chairman, my time has expired, but if the last witness has an answer I would hope you would accommodate that.

Mr. AHERN. I would be happy to. First, let me answer the first question you posed, which is how I would feel. I would certainly make sure that if it was a family member of mine that they not overreact to something that could or could not be a health risk. I would want them to follow the appropriate medical care to determine accurately if there is a concern. But to your question how would I personally feel, I feel very personally concerned with the performance of our frontlines people and how this agency performed. I am the responsible person for this organization, for our ports of entry. We did not execute well enough. So I feel very personally concerned with how we performed.

Ms. HARMAN. Thank you. Thank you, Mr. Chairman. I appreciate that last answer very much.

Chairman THOMPSON. Thank you very much. And I would like to comment on Ms. Harman's reference to Dr. Gerberding. If in fact she is held over at the Senate, we will in all probability recess the hearing and reschedule it in as fast a time as possible so that the committee can get the benefit of the CDC's testimony as we look at this overall issue.

I would like to recognize the gentlelady from Florida for 5 minutes, Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman, and I certainly thank our panel for being here. It is very easy to do Monday morning quarterbacking. And when I first heard about this story, I remembered that when I was very young my father had TB. He was in a sanitarium at that time. We took TB very seriously. And for this to happen I think indicates that the American public still should not feel that safe with our current system. I have a couple questions about the person who actually pressed the clear button. And, you know, when I come to a red light or a stop sign, I wish I had that clear button. Or when the officer, you know, stops me if I am going a little too fast, I wish I had had a little button I could press that says, it is OK. Her speeding was acceptable. How close to the end of the employee's shift did this happen? And what is the average workweek for those officers who are screening the incoming passengers?

Mr. BASHAM. The actual contact occurred—I believe it was at 6:18 in the evening. And it is my understanding the individual was on the 4:00 to midnight shift. So this was early in this individual's

shift. And so any indication that this may have been fatigue-driven, and it is my understanding that it is not an inordinate workweek. They are not working 80 hours a week. They are working a normal 4:00 to 12:00 shift, generally speaking, unless there is a need for coming in on a day off. So 6:18 and 2 hours into a shift.

Ms. BROWN-WAITE. I appreciate that information. But you still didn't answer my question as to how much overtime this person had before that day.

Mr. AHERN. We haven't looked at the entire workweek schedule of how many hours he had actually worked in that entire week, whether it was overtime or just his regular 40-hour shift. We certainly would provide the detail after the hearing. It is a question for the record. We would be happy to answer if you would like that.

Ms. BROWN-WAITE. OK. And for probably Dr. Runge, how effective is the no-fly list at stemming international spread of disease when only airlines that have the U.S. as the final point of arrival participate in that?

Mr. RUNGE. It is my understanding—

Ms. BROWN-WAITE. Would you turn on your microphone, please?

Mr. RUNGE. It is my understanding that—well, in fact when we discussed this with the chief of intelligence for TSA—and he has been around quite a long time—we could not remember another case that someone who has been put onto what they have as an adjunct to the no-fly list for health reasons. So we have no history in this regard. This was in fact a novel case. Speaking hypothetically, the fact that information is shared only with those airlines that do have connection into the United States, it varies among airlines. Some airlines actually put it into their entire system so that if there is only one flight into the U.S., that they receive the information, it goes into their entire record. Others only control the certain flight that goes into the U.S. So it is variable.

Ms. BROWN-WAITE. I appreciate that answer. One final question and probably, Dr. Runge, it would be addressed to you but if anyone else wants to jump in, please feel free to. The revised international health regulations which were actually adopted in 2005 will not be enacted I understand until some time next week. They actually strengthen the authority of the World Health Organization and the national public health authorities in providing for more coordinated international responses to infectious disease outbreaks, including the detection and control of for example TB in this case. Can you tell me if these revised regulations would have changed what occurred in this case? And could they possibly have altered the course of events?

Mr. RUNGE. I do not believe that if they had been enacted sooner it would have in any way changed this course of events. The responsible party for the notification of the W.H.O. is the Department of Health and Human Services. They are through their operation center here in Washington. It is my understanding that they did in fact report this case under the IHR even though the—sorry—the international health regulations have not gone into effect yet.

Ms. BROWN-WAITE. And they are going to go into effect next week, that is correct?

Mr. RUNGE. I thought it was June 15. I saw another reference that is July 15. But we will nail that down. We have a task group at DHS that is in my office that is pulling people from CBP and TSA and Policy to look at how we are going to implement our responsibilities under the IHR and that that process is ongoing.

Ms. BROWN-WAITE. And let me just also comment that I believe that the new procedures of having a supervisor also review whether or not someone should come into the country if they are on the watchlist is an excellent one. And I am sorry that it took this situation for the Department to set that up. But certainly you were quick to act, and we appreciate that.

Mr. RUNGE. Thank you.

Ms. BROWN-WAITE. Thank you. And I yield back my time, Mr. Chairman.

Chairman THOMPSON. Thank you very much.

Dr. Runge, one of the questions that continues to haunt this whole issue is why TSA waited so long in its deliberation as to whether or not they could or could not do it. Can you share with the committee any knowledge you have of that deliberation?

Mr. RUNGE. Yes, Mr. Chairman. The Acting Deputy Administrator for TSA actually made the decision within about 2 hours after we received the name from the CDC. There were some issues—because the person is not a terrorist, there were some issues as to how he could be entered physically on the list. And there was a conference of lawyers taking place from the Department of Justice and the Department of Homeland Security and TSA, and possibly others, to make sure that the authorities that the Department has—and TSA knew that it had to enter someone on the no-fly list even though they were not a terrorist—were in fact able to be followed. And so I believe we received the name from the CDC around 3:30 in the afternoon and by 5:30 the Deputy Administrator had made the decision. At 7:30 or so the electrons began to flow out from the Office of Intelligence to all of the airlines and all of the points of information sharing that TSA has.

Chairman THOMPSON. Thank you very much. And I think you referenced 2 hours. But if we look at the timeline I think it is 4 hours before an ultimate decision was reached in this entire process by TSA.

Mr. RUNGE. TSA actually reached the decision within 2 hours. It took the confab of lawyers from the other departments a while to become comfortable with that, and in fact he was added at about 7:30. So that is where the 4 hours—

Chairman THOMPSON. Another 2 hours.

Mr. RUNGE. Right.

Chairman THOMPSON. All right. OK. And I will yield to the gentleman from Pennsylvania, Mr. Carney, for 5 minutes.

Mr. CARNEY. Thank you, Mr. Chairman. I would like to thank the panel for attending. I wish Dr. Gerberding was here, but we will proceed as we can. Please forgive my ignorance on this one, Mr. Basham, but what was the border guard's explanation for this incident?

Mr. BASHAM. Without trying to get into the specifics of what this individual's reaction may have been, I can just say that he apparently made the determination that the information that he read

was inaccurate, was not accurate, and that he looked at the individual and decided the individual didn't look sick.

Mr. CARNEY. Did the individual—did Mr. Speaker say, hey, I am not sick, this is wrong?

Mr. BASHAM. It was never—the question was never raised as far as we know, Jay, with Mr. Speaker. And in fact it is to my understanding Mr. Speaker said we are on a mini vacation up in Canada and we are returning to the United States from Canada.

Mr. CARNEY. Mr. Ahern?

Mr. AHERN. I would add at this point there has been a very active internal investigation. There have been sworn affidavits taken. The individual is afforded a certain amount of privacy in that process. And we need to let the process unfold. Unfortunately, I don't think we can get into a lot of the details of what was said in that encounter. I know it has been reviewed by internal affairs, by senior management, it has gone before a discipline review board and appropriate action will be followed up on. I think we cannot discuss further, certainly in this forum, the particular details of what was actually the conversation or primer.

Mr. CARNEY. I look forward to reading the report when it is available to us.

You know, it seems that we pick up lessons learned in this sort of thing after an event. Now, we don't have lessons learned or the plans in place to anticipate these things. How often does the CDC and DHS and TSA actually train for these kinds of things, hold training exercises?

Mr. RUNGE. It is interesting that you raise the question, Congressman Carney. We actually are engaged deeply in a planning process right now on border management during the pandemic. So we have put together a multi-agency team, actually including the Association of State and Territorial Health Officials, the Association of City and County Health Officials and others we know are going to have to help in this instance to decide on roles and responsibilities in managing these border issues during a pandemic. Now, I have to say, even that effort would not have contemplated this particular instance. However, this is what—a lesson learned, I guarantee you this is a lesson learned, not just a lesson observed. We have taken steps to make sure that the information does not simply reside at the local field office level but gets up to where it can be coordinated across the agencies.

Mr. CARNEY. So in other words, you haven't trained on this yet?

Mr. RUNGE. That—well.

Mr. CARNEY. Say, for example, we get a suicide biological bomber instead of a C4 dynamite bomber. We haven't trained to that sort of thing at all?

Mr. RUNGE. A procedure would be put in place in that instance where if the individual is known, yes. There is ample training on that issue, and the American public deserves to have that person intercepted. You know, again, with that sort of information, if it is a person who we don't know who it is and when they are coming and so forth, then the intelligence community works with the Customs and Border Protection and CIA and FBI, and so forth, to try to set up a risk-based algorithm to deal with a situation like that. But yes, that is absolutely trained.

Mr. CARNEY. Have there been training exercises prior to this event for something similar to this?

Mr. AHERN. We need to do more training. We need to do some more exercise clearly. And I think we have got that process, as Dr. Runge outlined. But I think one of the important things I would suggest for your consideration is these individuals knew each other, the CDC official and the CBP official in Atlanta. They are actually collocated in the office suite. They were able to walk in because of their interaction, not only in this exercise but on a daily basis to be able to know that we do have a situation for border lookouts that could be used to go ahead and identify concerns and also to look for flight reservations. We have that through our MOU within DHS and HHS. That is an ongoing process. Certainly as we now take a look at this after the fact, we need to take a look at doing more planning and more exercising, more preparation work for these types of things. I think certainly we do. Those would be much more applicable in a broader national event. This is a good opportunity for us to go back and learn.

Mr. RUNGE. With your particular concern about TSA, the fact that it took us a while to make sure that everybody was legally OK speaks to the fact that no, we had not rehearsed this.

Mr. CARNEY. Right. That was my point exactly. Thank you, Dr. Runge. I yield back, sir.

Chairman THOMPSON. Thank you very much. We yield 5 minutes to the gentleman from Connecticut, Mr. Shays.

Mr. SHAYS. Thank you. Dr. Runge, your comment, the person was not a terrorist. Would it be inaccurate for me to say that he was a potential walking biological weapon?

Mr. RUNGE. I would not characterize him that way.

Mr. SHAYS. Why not?

Mr. RUNGE. Well, if we speak to this person directly, you know, TB is transmissible. We don't worry about it on flights that are less than 8 hours. We don't worry about it with casual contact. I think that would be a little hyperbole.

Mr. SHAYS. So then why did you have a warning? Place mask in on subject. Place in isolation or ventilation room if possible. Subject has multiple resistant TB, public health risk and so on.

Mr. RUNGE. Yes. That is the prudent medical action to take with anyone who is identified as having active TB.

Mr. SHAYS. So this is all hype that was generated by the press?

Mr. RUNGE. I do think that ordinarily this type of case would have and most likely is on a more—these cases are dealt with without CNN, without Fox News, without the involvement of the networks every day.

Mr. SHAYS. I don't understand your comment. They are dealt without—what is your point?

Mr. RUNGE. Well, the point is that the way this would ordinarily play out is that the individual is identified. If there are people who are at risk of transmission, the CDC—epidemiological intelligence officers go through a very specific format.

Mr. SHAYS. —think this was a contagious.

Mr. RUNGE. No, sir. Let me finish, please. They go through a very specific set of protocols in order to find the contacts by phone by next of kin. They do epidemiological tracing. TB takes months

to play out. So contact tracing here was not an emergency. So I don't want to respond to your characterization of hype, but I believe that this could have been done in fact without it being in the press.

Mr. SHAYS. I don't understand that for the life of me. So we shouldn't have notified folks in Europe because this man was not a threat? Was he a threat or wasn't he a threat?

Mr. RUNGE. We believe that he was an infectious disease threat to those on the flight who were sitting within a few rows.

Mr. SHAYS. I just have to tell you, if I was on that flight and I heard your response, I would be absolutely outraged. I have a lot of—if I could have made the comment in the opening statement, I would have said congratulations, DHS. There were three or four bombings in Thailand by Muslim terrorists. We don't have any around. You guys are doing a good job. But you have a few weaknesses. So I was in the mindset when it came to this hearing to say, you know, you guys deserve to be congratulated. When I hear your response now, I am thinking there is a huge disconnect. And maybe it is my problem or maybe it is DHS's problem. The bottom line is, if I was on that plane, if my daughter was on that plane, if my wife was on that plane, frankly, I would find it outrageous that he was on the plane. And I would find it outrageous that somehow even this—you know 2 hours there and another 2 hours, I mean it is like—it is like there is—we are talking like this, and I am pretty unhappy that the Centers for Disease Control isn't here. It would have been helpful because what I am trying to understand is, is this a contagious disease and should this person have gone over to Europe? The answer should be no, correct?

Mr. RUNGE. That is correct.

Mr. SHAYS. Why? Because he was potentially carrying a contagious disease. Now I don't care, frankly, if it is a terrorist carrying the contagious disease or a citizen who doesn't give a darn about anybody else. I would treat them frankly the same way because the result could be the same way. Tell me what is wrong with my logic.

Mr. RUNGE. Actually with that part of your logic absolutely nothing. In fact to characterize it that way is perfectly fine. In fact, local health authorities have the authority to stop someone from traveling. They have the authority to in fact confine someone.

Mr. SHAYS. Why did he go to Canada instead of fly right into the United States?

Mr. RUNGE. That is not an appropriate question for me, sir.

Mr. SHAYS. Well, he did go to Connecticut. That is—I mean he did go to Canada, correct?

Mr. RUNGE. Yes. We assume—

Mr. SHAYS. And the place that he wanted to get to was the United States.

Mr. RUNGE. Yes. We assume it was for the purpose of evasion.

Mr. SHAYS. Absolutely. And so he made it—and so I congratulate DHS on the ability to stop people flying into the United States. So that is a plus, not a negative. The guy thought he had to go to Canada. Now, that raises a heck of a lot of concerns. But he knew that what he was doing was wrong. He knew that he was carrying a potentially contagious disease, and frankly the way I look at it was

he was a walking biological weapon. And I would like our people to think that way when we have citizens who are willing to endanger others. That is the way I would like them to think.

Thank you.

Chairman THOMPSON. Thank you very much. We yield 5 minutes to the gentleman from North Carolina, Mr. Etheridge.

Mr. ETHERIDGE. Thank you, Mr. Chairman. And I would like to associate myself with the comments of my colleagues and especially the gentleman from Connecticut. Let me follow that line of questioning a little further because the Washington Post has characterized Mr. Speaker's actions and the Federal response as a bizarre cat-and-mouse game. I am inclined to be a little bit more concerned than that, I guess, and a bit more critical because we now know he was a known carrier of an extensive drug resistant tuberculosis. He leaves the United States. He travels across to Europe. It is now apparent that he intentionally or it appears that he intentionally meant to evade. You said earlier that we couldn't track if he changed from one airline to another and made a change. And I do hope that is being corrected or has already been corrected. Because if I make a reservation on an airline to travel from point A to point B and I change my reservation, they know it, the airlines know it. My question is why don't we know it and why can't we deal with it?

second, the efforts to put him on a no-fly list and an actual border alert that apparently a person at the border ignored the information. It is reported in the press—and I would like to hear your response on this because this really is your area of jurisdiction. He said he didn't look sick. The last time I checked, that is not the job of a border agent. They are not medical officers. If you get an order you are supposed to follow it out.

So my question is this, because he either didn't know what he was supposed to do or he wasn't following the protocol that you are supposed to provide or we hadn't given him the information. So the CDC and the TSA and the CBP determined what your statutory capacity of doing in the public health, had we looked at, what we are going to do in the future. We can't correct what has already happened. I recognize that. My question is, have we dealt with the problem so that we won't have that kind of problem in the future? And second, how are emergency response plans being modified in response to what you have learned from this incident? Because as Mr. Shays said, this person could very well have been a walking biological problem. If he got through in this situation my grave concern is, the response and the responsibility we have, I fly a lot, as do many of my colleagues and people across this country. Now they check me when I go to the airport to see if I am carrying a nail file, if I am carrying a bit too much gel—I flew last week. They took my hair spray and my hair gel and my toothpaste. Somebody needs to make sure when I got on that plane that the people are safe and that is our problem. So I would like to hear your comment on that, please.

Mr. BASHAM. If I could just address your first point on knowing whether Mr. Speaker changed airline reservations.

Mr. ETHERIDGE. Yes, sir.

Mr. BASHAM. That was the very purpose for the sweep that the National Targeting Center was conducting on a daily basis to determine whether or not Mr. Speaker did not intend to come back on June 5 on the Air France flight but that if he changed his reservation, the sweeps we were doing would have picked up that information and so we could have notified the proper ports. So that system now—in terms of foreign carriers.

Mr. ETHERIDGE. You are just sweeping for him coming directly to the States?

Mr. BASHAM. Let me ask Jay to answer that.

Mr. AHERN. The current reservations were for flights destined to the United States or any modifications from that existing record. If the individual completely books an entirely different record with another airline that is not destined for the United States, we are blind to that and that is not looked at.

Mr. ETHERIDGE. Is that being looked at to be fixed?

Mr. AHERN. We are looking at that. We have a got lot of negotiations going on with the European Union.

Mr. ETHERIDGE. Do you have a timeline for that?

Mr. AHERN. It is going to take very intensive negotiations, legal issues, sovereignty issues, and we have to take a look at privacy concerns as well.

Mr. ETHERIDGE. And the safety of passengers on those.

Mr. BASHAM. I will comment, Mr. Congressman, in fact that we are working as we speak with our Canadian counterparts, and the Secretary or the DHS is going to be discussing this issue with them in—I think this month or on a trip up there on this issue of trying to secure the territorial borders of North America. So it is—

Mr. ETHERIDGE. North and south.

Mr. BASHAM. Yes. Yes.

On your second point, fixing it. I believe Dr. Runge did mention earlier in his comments that working with DHS and the HHS—and I will let you expand upon that. Now in terms of your CBP, we have instituted after this event processes that are now in place that would not permit an officer at the port of entry to clear an individual who is a name match. That has to go, automatically has to go to a secondary for further inspection. And then in terms of their emergency response, I am going to let Dr. Runge address that.

Mr. RUNGE. Congressman, so I understand, the question is about how the interaction takes place at the border between health authorities and CBP?

Mr. ETHERIDGE. Yes, sir.

Mr. RUNGE. There are around 18 or 19 quarantine stations that exist at the busiest ports of entry that are manned in fact by CDC quarantine officers from the Division of Global Migration and Quarantine, and they are on call for CBP officers who see someone who does not look right and there have been, you know, hundreds of referrals in that situation. For those ports of entry where there are not CDC officers stationed, there are memoranda of agreements with local public health and local health authorities that if a CBP officer doesn't like the way someone looks or if he has a rash that looks like smallpox, if he is bleeding from his eyes in the case of a hemorrhagic fever they will refer them to secondary, put them in

isolation and adhere to those protocols of calling public health, and emergency responders are a part of that as well.

Mr. ETHERIDGE. Mr. Chairman, my time has expired. I hope someone will follow up on the question as it relates to that protocol though for the person who has a known record and still gets through.

Mr. RUNGE. We will be happy to discuss that with you.

Chairman THOMPSON. Thank you very much. I would yield for the sake of the question to the gentlelady from California, Ms. Harman.

Ms. HARMAN. I thank you for that, Mr. Chairman. As you know, I chair our Intelligence Subcommittee and I heard the exchange between you and Dr. Runge and I don't think our record is clear without asking one more question here. You were asking him whether TSA made an effort to include Mr. Speaker's name on the terrorist screening database, and I think the response was that you spoke to Charlie Allen—not mentioned by name—the head of the intelligence.

Mr. RUNGE. This was TSA intelligence.

Ms. HARMAN. OK. So it was TSA intelligence, so it wasn't Charlie Allen. You spoke to TSA intelligence and this was a first-time problem but my question—and I think it needs to be answered for the record—is if you did put his name on the terrorist screening database, was this an appropriate use of that database?

Mr. RUNGE. Congresswoman Harman, we will get back to you on the specifics of that. We should let TSA answer the specifics of the question. But I can tell you that—since Secretary Hawley has been very careful to say this was an adjunct to the no-fly list. So there is not a requirement that he has to be on the terrorist screening database, but that in fact the TSA Administrator has the authority to add someone to the no-fly list for other reasons. But he would prefer to characterize it as an adjunct to the no-fly list. If the counselor behind me is nodding, I am very happy.

Ms. HARMAN. I think we should get that question carefully answered for our record, Mr. Chairman, because it does matter how this is done. All of us wanted this guy to be stopped. But what tools are used is very relevant. Thank you, Mr. Chairman, for taking my question out of order.

Chairman THOMPSON. And I assure you we will make sure the Department has an opportunity to respond. We will now recognize the gentleman from Florida, Mr. Bilirakis, for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. Mr. Basham, again can you tell us what the status of the officer is currently?

Mr. BASHAM. As Mr. Ahern stated a few moments ago, that officer is currently on administrative leave and we are in the process of doing a thorough investigation of the actions of that day by all parties. And at this time I am afraid I can't state exactly what his current status is.

Mr. BILIRAKIS. OK. You mention in your testimony that this situation underscores the need to implement additional fail-safe mechanisms. Elaborate on that, if you will, please.

Mr. BASHAM. I am going to ask Mr. Ahern if he will address that.

Mr. AHERN. I think one of the things we talked about with many of your staffs on Monday this week, we talked about some of the fixes that were going in place. In this open setting here I am frankly not comfortable with talking about some of the law enforcement system enhancements and redundancies we will be taking to our systems and have been made effective midnight Monday evening. We would be happy to go into great detail and show those to you and show you the screens as they existed on this particular account, show you the video that occurred. But in this setting I am frankly not comfortable talking about the specific fixes to the law enforcement databases that we have. I regret that.

Mr. BILIRAKIS. It is my understanding that a text message appeared on the CBP officer's computer screen but no alarm sounded. Alarms apparently only sound when a person is armed or considered dangerous. Isn't one man with an infectious potentially as dangerous as one man with a gun, shouldn't there have been a real alarm instead of a text advisory?

Mr. BASHAM. I think the question of the degree of threat with respect to disease or with a weapon, the alarm on a person who is armed and considered dangerous is for safety purposes for the officer that is at—it is to notify the people basically and secondary that they need to respond. That doesn't mean the person is going to use the weapon. But the idea there is the safety of the officer and the people that may be there.

In terms of whether the gun is more—is less a danger than an individual with an infectious disease, Dr. Runge, I guess I am going to have to ask you to comment on that.

Mr. RUNGE. I am not sure. We don't have any data on the relative danger of somebody who is armed and dangerous versus somebody with tuberculosis. That is a really tough question to answer. I would say that the danger to the officers is clearly more imminent by somebody who has a gun than somebody who has an infectious disease almost no matter how infectious it is. And that would be a call for CBP management. Certainly we would be happy to weigh in with scientific data on relative risk, and we will play however they want to but that is an administrative call.

Mr. AHERN. If I might add to that a little more from the operator's perspective, certainly we need to make sure as well over 400 million people come into this country every year, over 300 of which come across our land borders from Canada and Mexico. What we need to make sure is that we are assessing risk appropriately and engaging appropriately. I would submit that as we go forward with our system change, we need to be very thoughtful in how we deploy those changes so that we don't have complete chaos with unnecessarily alarming people for the immediacy of executing a threat which I would submit to you that a weapon would versus certainly the deadly aspect of someone having an infectious disease could have that certain end game but the immediacy of engaging and having officer safety, public safety in that immediate area, I believe we need to assess those risks on a different tiered basis. Some of those thoughtful things are in place. We are going to enhance those even further with some of the changes we would be happy to talk further with you.

Mr. BILIRAKIS. Thank you, Mr. Chairman. It is my hope that the Department will be more proactive instead of reactive based on this occurrence in the future.

Thank you.

Chairman THOMPSON. Thank you very much. One thing I want to make sure we get on the record is the system before this issue we are discussing today occurred, is it that when an individual who was put on the screen, that that notice would only hit on that screen and there was no backup?

Mr. BASHAM. Are you asking the alert, whether it was only on that screen?

Chairman THOMPSON. The alert.

Mr. BASHAM. When that individual's name matched the name that was on the alert, that notification also goes on a screen in secondary. And then it is the determination of that frontline officer as to what action they are going to take with respect to that individual. So it appears on the primary screen, but it also is—there is a message at the bottom and, Jay, maybe you can explain it in more detail. But there is a message at the bottom of the screen in secondary saying there had been a name match at that particular point.

Chairman THOMPSON. Mr. Ahern?

Mr. AHERN. The Commissioner explained it very accurately and those are some of the additional enhancements that we will be bringing to the system as we go forward that will explain in great detail.

Chairman THOMPSON. The question going to—maybe it is not an alarm. But if there is already a secondary backup to this system, was it not timely enough to still catch this individual at the border? Is that not the reason for a secondary notification?

Mr. AHERN. Enhancements need to be made on that front and those are some of the fixes that we are putting in place, sir.

Chairman THOMPSON. Well, can you tell me—that secondary, are you looking at that secondary employee too?

Mr. AHERN. We are looking at the totality of all the circumstances, all the facts and all the individuals.

Chairman THOMPSON. OK. Well, let me be a little more specific. The guard is on administrative leave for whatever reason pending an investigation. We now have testimony that there was a backup to the system, a secondary notification. Now, are we looking at the individual—is that individual who was responsible for viewing secondary notifications, is that person on administrative leave?

Mr. AHERN. We are looking completely at the entire set of facts as one individual that is on administrative leave at this point as we continue to do our internal investigation.

Chairman THOMPSON. You know, I am—

Mr. BASHAM. The answer to your question, Mr. Chairman, is that person—no one else other than Mr.—the officer at primary is on administrative leave at this point.

Chairman THOMPSON. But there are other individuals who should have been notified simultaneously of that hit?

Mr. BASHAM. That is exactly what Mr. Ahern is referring to, as we are looking at all of the actions on that day and who failed to perform or who did perform and how they performed.

Chairman THOMPSON. Well, and back to some other comments about the blame game. You know, we put a lot of things on this one guard at the border. But now it appears that there are some other people along the way on this one particular instance that should be in the same boat. And what I would—at some point either in a classified briefing or what have you, would like to follow up on Mr. Bilirakis' line of questioning because he kind of previewed my inquiry based on that.

I now yield 5 minutes to the gentleman from Colorado, Mr. Perlmutter.

Mr. PERLMUTTER. Thank you, Mr. Chairman. And I guess after listening to this testimony and reading your remarks, reading the timeline, I mean the good news here, this was a comedy of errors and not a tragedy of errors. I mean, this is about as close to a real-life test, and it really was a test as anything. You know, but what it illustrates is a number of vulnerabilities in our system. Here is a couple, understandably scared by their potentially dangerous situation. In fact, Mr. Speaker's remarks to the press, I guess, people told me if I was anywhere but Denver I will die. So they are going to try to find a way to get him—or he is going to try and his wife is going to try to find a way to get him to Denver, some fashion or another. And here is a couple, you know, without—they are sort of on the innocent side of the continuum as opposed to somebody who wants to come into our country and intentionally do us harm through a medical kind of device or you know an illness or a gun or something like that. And I mean this just shows some very serious problems. I mean we have been picking on you two from, you know, the border guard, the CBP. You know quite frankly I think the medical side of this. I am angrier at the medical side, and I am generally a pretty charitable guy.

I am going to ask a couple questions. Very happy that we busted the JFK kind of a system. But you know there are spy novels out there that talk about people coming across with an Ebola type of a virus or somebody being infected, you know, and that is how they are going to do our country harm. We had an opportunity to save other countries, you know, a lot of aggravation by keeping Mr. Speaker in our country and sending him to Denver and then we had the opportunity to keep him out of the country, and we failed on both counts. This is a rhetorical question, and I appreciate Dr. Runge's comments about hyperbole in the rhetoric. But in this instance we really—this is bad news. This is, you know, in the War on Terror, we are asking our homeland security community to play ball in the big leagues, and this was T-ball and we still struck out. We couldn't communicate with our friends in Greece, Italy or Canada in a timely fashion. So, you know, what does this incident say about our efforts in the broader war on terror? And I guess, Mr. Basham, I am going to turn it to you first and then I would like to hear from the doctors on this.

Mr. BASHAM. Mr. Congressman, let me just say that in the war on terror, and without getting into detail in this particular forum, a whole different set of protocols and processes are in place and would have been in place. So to compare this particular incident with our ability to deal with a terrorist I think perhaps is not a fair way of looking at this incident.

Mr. PERLMUTTER. And let me tell you why I put it in that frame. Recently in Colorado the TSA has a red team. OK. And their red team goes in and it is designed to test the system, to see where we are vulnerable or where we are not, where we have solid defense. And really it is about a con game. Who can get through the human element, you know, who can say, geez, I am, you know, I am Andrew Speaker. I am a lawyer from Atlanta. I am just a regular guy. I am not sick. You know, and you get a contact with him and then you have a contact with his wife and both of them somehow talk their way through that. That is how the red team works when it tries to get through our airport systems. And so I don't want people to have to be robots. You know, and I want them to be able to use their discretion and their talents. But here, you know, something really went awry down at CDC. The father-in-law is involved with CDC, there are comments from CDC sort of slowly winding their way. I mean we had—there were like 10 places to stop this guy, and every one of them failed. So it is not the war on terror but, boy, it is a good test of the system and we didn't do a very good job and you have admitted that.

I would like to talk to Dr. Runge and Dr. Gerberding to see what your reaction is.

Mr. RUNGE. If I could make one point, Congressman Perlmutter, and that is you bring up the information of systems that need to be in place so that these sorts of human errors or human faults can't enter in and torch the rest of the system. And this is a good chance to talk about information sharing with our partners. Secretary Chertoff was in Europe last week discussing the issue of sharing passenger name records. I think we share a goal to do more efficient connections between the Advanced Passenger Information System with Canada. Certainly you know if you say here's the reaction, here's an ideal world, certainly if they had access to the records that CBP put forth, the person would have been interdicted in Montreal and wouldn't have had an opportunity to come across the Lake Champlain border.

I want to associate myself with your comments. Yes, we need better systems in place and yes, we need better international cooperation with our partners, and that is well known by our leaders.

Chairman THOMPSON. Thank you very much. Before Dr. Gerberding has an opportunity to answer, I would like to ask unanimous consent to have her written testimony entered into the record for the committee's benefit. Thank you. Dr. Gerberding, welcome.

[The statement of Dr. Gerberding follows:]

PREPARED STATEMENT OF JULIE L. GERBERDING, MD, MPH

Good morning, I am Dr. Julie Gerberding, Director of the Centers for Disease Control and Prevention within the Department of Health and Human Services (HHS). Chairman Thompson, Ranking Member King, and other distinguished Members of the Committee, it is my pleasure to be here to discuss with you HHS/CDC's ongoing investigation of a U.S. traveler recently diagnosed with extensively drug resistant tuberculosis.

Before I begin to describe the specifics of this investigation, I wanted to briefly provide some background information on tuberculosis (TB) and the drug-resistance of TB.

Definition:

Tuberculosis is an airborne infectious disease that is spread from person to person, usually through coughing, sneezing, speaking, or singing. In the late 19th and early 20th centuries, until the introduction of streptomycin in the 1940's, TB was one of the leading causes of death in the United States. Currently, the World Health Organization (WHO) reports that one in three people in the world are infected with dormant or latent TB. TB is a slow growing bacterium that often takes weeks to culture. Only when the bacteria become active do people become ill with TB. Bacteria become active as a result of anything that reduces the person's immunity, such as HIV, advancing age, or some medical conditions. TB bacteria can also become active in individuals that are not immunocompromised. Currently, TB that is not resistant to drugs can be treated with a six to nine month course of "first-line drugs" (the most effective), including isoniazid and rifampin; this treatment cures over 95 percent of patients. However, since people in many resource-poor countries lack access to appropriate treatment, nearly nine million people in the world develop TB disease each year and about 1.6 million die.

TB that is resistant to at least isoniazid and rifampin is called multidrug-resistant (MDR) TB. MDR TB requires treatment for 18–24 "second-line drugs" that are much less effective, often poorly tolerated by the patient, and far more costly. The cure rate is 70–80 percent under optimal conditions, but is usually closer to 50 percent. Many countries with a high TB burden find it impossible to treat MDR TB patients because of the cost of second-line drugs, and the more sophisticated laboratory services to diagnose resistance to drugs, and more intensive programmatic support required to administer the drugs. Extensively drug-resistant TB (XDR TB) is a subset of MDR TB caused by strains of bacteria that are resistant to the most effective first—and second-line drugs. Reported mortality rates among persons with XDR TB are extremely high. Among non-immunocompromised persons, reports indicate that less than 30 percent of patients can be cured, and more than half of those with XDR TB die within five years of diagnosis. Among immunocompromised persons, illness is more severe, and mortality rates are even higher and death occurs within a shorter time.

The risk of transmitting any type of TB can depend on several factors, including the extent of disease in the patient with TB, the duration of exposure, and ventilation. Both regular TB and drug-resistant TB bacilli become aerosolized when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These bacilli can float in the air for several hours, depending on the environment. Persons who breathe air containing these TB bacilli are at risk for becoming infected.

Scope of the Problem:

In response to anecdotal reports from physicians who were finding cases of TB that were unresponsive to the first-line and second-line TB drugs, in 2005 HHS/CDC and WHO jointly conducted a survey, with support from the U.S. Agency for International Development, which examined about 18,000 patient specimens tested during 2000 to 2004 by Supranational Reference Laboratories. Researchers examined the drug-resistant isolates, and found that 10 percent of the MDR TB isolates actually met the definition for XDR TB. XDR TB was identified in 17 countries from all regions of the world, most frequently in the former Soviet Union and other Asian countries. However because many countries do not routinely test all isolates for resistance to second line drugs, the precise global incidence of XDR TB remains uncertain. Because of the ease with which drug resistance can occur (due to the use of second-line drugs in suboptimal conditions, changes in program focus away from TB case management, interruptions in drug availability because of supply management/resource availability/patient drug noncompliance, high HIV prevalence), XDR TB could be much more widespread than this survey shows. The ability of the disease to develop resistance to treatments and to travel easily across borders makes worldwide TB control efforts critical.

TB and the Threat to the United States:

Between 1993 and 2006 in the United States, there were 49 cases of XDR TB reported to HHS/CDC. By comparison, 13,767 TB cases (a rate of 4.6 cases per 100,000 persons) were reported in the United States in 2006 (the most recent year of aggregate annual reporting). The 2006 TB rate was the lowest recorded since national reporting began in 1953. While the total number of MDR and XDR TB cases is relatively small, their impact on U.S. TB control programs can be significant in terms of human capital and financial resources. One patient with MDR or XDR TB requires a minimum of 18–24 months of treatment. Recently collected data show that in-patient costs alone can average \$500,000 per case.

XDR TB continues to be widely distributed geographically abroad and is cause for public health concern in the United States, though the overall domestic risk of XDR TB currently appears to be relatively low. However, due to the ease with which TB

can spread, and given its significant health consequences, XDR TB will continue to pose a serious risk to the U.S., as long as it exists anywhere.

TB Prevention and Control: Public Health Partnerships in Action

Generally, TB is a condition that is detected and treated by medical care practitioners. As with other infectious diseases, state, local, and territorial health departments serve important functions to support and augment the medical care system. These "front line" public health agencies are in direct contact with medical care providers and patients, providing important TB control services such as laboratory support, surveillance, contact tracing, and patient counseling. These agencies also generally possess legal authority to isolate or quarantine patients in those rare instances where traditional doctor-patient relationships or other means have failed to protect the community.

At the Federal level, HHS/CDC serves several critical roles in controlling TB. First, HHS/CDC provides leadership and scientific support for TB control efforts, both nationally and internationally, including our global efforts to eliminate TB and stem the emergence of XDR TB as a health threat. Secondly, HHS/CDC provides approximately \$100 million annually in support to State, local, and territorial health departments for TB control efforts. Third, State and local public health departments routinely test samples of respiratory secretions from patients in order to diagnose tuberculosis and for some state laboratories, including Georgia, HHS/CDC routinely conducts second line drug susceptibility testing. HHS/CDC receives isolates from approximately 20 state laboratories each year as part of those laboratories' regular referral process. Each year HHS/CDC conducts drug susceptibility tests for approximately 1,000 samples. Fourth, HHS/CDC has the capacity to assist state or local authorities with its scientific resources. HHS/CDC may also use its federal legal authorities to prevent the introduction, transmission, and spread of communicable diseases from foreign countries into the United States or between U.S. states. As I will describe, HHS/CDC's involvement in the recent case spanned all of these roles.

The Current XDR TB Investigation: Locate, Isolate, Transport, Investigate

The following narrative is based on information assembled and reviewed in time for this testimony. The ongoing HHS/CDC investigation involves a U.S. citizen with potentially infectious XDR TB who traveled to and from Europe on commercial flights. In late March, the patient was diagnosed with TB by his doctor. Once diagnosed, Fulton County Health Officials became involved in managing the potential public health risk to others.

On May 10th, the Fulton County Health Department became aware that the patient's TB strain was resistant to the first-line of antibiotic treatments. This same day, the county health department met with the patient and his family to inform them of the diagnosis of MDR TB. Our understanding, from conversations with the county health officials, is that they orally advised the patient to forego his planned travel abroad. On the evening of May 10th, the Georgia Health Department emailed HHS/CDC's Atlanta Quarantine Station and reported that they were aware of an MDR TB patient (patient was not identified) that may intend to travel in three weeks. HHS/CDC exchanged emails with the Georgia Health Department with options to prevent travel including written notification under local authority. In the days following this meeting, Fulton County Health Officials attempted to serve the patient with written notice advising that the patient not travel, but the patient could not be located at either his residence or business.

It should be noted that normally when a patient has tuberculosis, he or she voluntarily complies with recommended treatment and recommendations to ensure that they don't put themselves in situations where they could potentially expose others to a serious health threat. Public health practitioners have a high success record using voluntary means of information and advice. In fact, the vast majority of TB patients comply with treatment recommendations, including remaining in isolation units in hospitals or in isolation at home until infectiousness has resolved without the need to invoke state or local legal authorities. It is extremely rare that Federal quarantine or isolation authority is required to manage domestic TB cases.

On May 18th after the patient left the United States, HHS/CDC's Division of Global Migration and Quarantine was notified that the patient traveled internationally against medical advice and his whereabouts were unknown. At this point, HHS/CDC's public health mission focused on locating the patient, isolating him, ensuring safe transportation and contact tracing. Between May 18th through the 22nd, HHS/CDC worked with Fulton County health department, Georgia State Department of Health, commercial airlines and the patient's family to locate him. In addition, on

May 22nd, HHS/CDC laboratories determined that the patient had the rarer and deadlier subtype of XDR TB.

On May 22nd, HHS/CDC quarantine officials requested that the Customs and Border Protection (CBP) Atlanta office arrange to have the patient detained upon re-entry to the US. On both May 22nd and 23rd, HHS/CDC spoke with the patient in Rome, Italy and informed him of his XDR TB diagnosis; explained the severity of the disease; instructed him to terminate all travel and to cease use of commercial air carriers; and initiated conversations about the need for isolation, treatment, and travel alternatives. Despite assurances from the patient that he would not travel, it was discovered, on May 24th, that the patient had checked out of his hotel.

With the patient's exact location and intention to travel unknown, HHS/CDC contacted the Transportation Security Administration (TSA) on May 24th and requested them to exercise their authority to prevent the patient from boarding a commercial aircraft and thereby mitigating the risk of transmitting the disease on another long-distance commercial flight destined for the U.S. On May 25th, HHS/CDC learned from CBP that the patient had traveled via commercial airliner from the Czech Republic to Canada and subsequently reentered the U.S. the previous evening. HHS/CDC then notified the Public Health Agency of Canada and requested they initiate efforts to get the passenger manifest of the patient's inbound flight to North America. HHS/CDC called WHO in Geneva on May 24th and the HHS Secretary's Operations Center, the designated Focal Point for the United States under the revised International Health Regulations (2005), officially notified the WHO Secretariat of the case on May 25, even though the Regulations do not come into force for the United States until July 17, 2007.

On May 25th, after repeated prior attempts, HHS/CDC officials made contact with the patient on his cell phone and directed him to report immediately to the Bellevue Hospital in New York City where he would be served a quarantine order for isolation and be evaluated. He followed this direction, and at Bellevue was served a Federal order of provisional isolation and medical examination authorizing medical evaluation and respiratory isolation for 72 hours for extensively-drug resistant tuberculosis (XDR TB). The patient was later safely transported to Grady Hospital in Atlanta, Georgia via HHS/CDC aircraft and was issued a Federal order that mandated continued isolation on arrival in Atlanta, GA. As part of this process, the patient was advised that he could request an administrative hearing to review the order but he did not request such a hearing. On May 31st, he was safely transported by private airplane to National Jewish Medical Center in Denver, Colorado accompanied by his wife and a CDC quarantine officer. On June 2nd, HHS/CDC rescinded the Federal quarantine order for isolation because Denver health officials assumed public health responsibility for this patient. The patient is currently under the quarantine authority of Denver County.

HHS/CDC is currently investigating the source of the patient's XDR TB. HHS/CDC is conducting an epidemiological investigation to look back at the patient's activities prior to his diagnosis in hopes of learning the source of the exposure. The patient has a history of travel to numerous locations outside of the United States. Sequences of DNA from the patient's TB strain do not match any currently on file in HHS/CDC's TB fingerprinting library. HHS/CDC is making efforts to compare it with TB fingerprinting libraries in other countries.

HHS/CDC Recommendations for Passengers:

Though the risk of transmission to the other passengers on the flights the patient took is low, it is not zero. In accordance with the WHO TB and Airline Travel Guidelines, and to ensure appropriate follow-up and care for persons who may have been exposed to XDR TB, HHS/CDC has recommended that passengers aboard the two transatlantic flights longer than 8 hours in duration who were seated in the same row as the patient, those seated in the two rows ahead and the two rows behind, and cabin crew members working in the same cabin should be evaluated for TB infection. This includes initial evaluation and testing with re-evaluation 8-10 weeks later. Because undiagnosed, latent TB exists in the general population, it is reasonable to expect that some of the passengers will test positive because of a previous exposure to TB, and not because of exposure on the flight in question. While we believe that passengers seated outside the immediate vicinity of the patient are at extremely low risk of contracting XDR TB, given the serious consequences and limited treatment options of XDR TB, we are notifying all U.S. residents and citizens on these flights and encouraging these individuals to seek TB testing and evaluation.

HHS/CDC is taking the lead in contact tracing of the U.S. citizens on these flights and is coordinating with other countries for the contact tracing of their citizens. As of June 5th, HHS/CDC has had direct contact with 245 of the approximately 276

US citizens and residents on Air France 385. Of the 26 high priority passengers, seated in the same row, two rows in front or two rows behind the patient, HHS/CDC has spoken directly with 24 of these individuals.

Isolation and Quarantine, An HHS–DHS Partnership:

To contain the spread of a contagious illness, public health authorities rely on many strategies. Two of these strategies are isolation and quarantine. Both aim to control exposure to infected or potentially infected persons, and both may be undertaken voluntarily or compelled by public health authorities. The two strategies differ in that isolation generally applies to persons who are known or suspected to have a communicable disease, and quarantine generally applies to those who have been exposed to a communicable disease but who may or may not become ill. Isolation is a standard procedure used in hospitals today for patients with tuberculosis (TB), and in most cases isolation is voluntary; however, many levels of government (Federal, state, and local) have basic authority to compel isolation of infected people to protect the public. State and local governments have primary responsibility for isolation and quarantine within their borders and conduct these activities in accordance with their respective laws and policies.

The Department of Health and Human Services has authority under section 361 of the Public Health Service Act to prevent the introduction, transmission, and spread of communicable diseases from foreign countries into the United States and between states. HHS/CDC, through its Division of Global Migration and Quarantine, is authorized to detain, medically examine, or conditionally release persons suspected of carrying certain specified communicable diseases. The communicable diseases for which Federal isolation and quarantine are authorized are established by Presidential order and currently include infectious TB, cholera, diphtheria, plague, smallpox, yellow fever, viral hemorrhagic fevers, severe acute respiratory syndrome (SARS), and influenza with pandemic potential.

HHS/CDC relies primarily upon DHS for the enforcement of isolation and quarantine orders at the borders, but may also rely on other federal law enforcement agencies and state and local law enforcement. By statute, our DHS partners at the borders—Customs and Border Protection (CBP) and Coast Guard officers—aid in the enforcement of rules and regulations relating to quarantine and isolation. Violation of Federal regulations regarding quarantine and isolation constitute a criminal misdemeanor, punishable by fine and/or imprisonment. Federal public health authority includes the authority to release persons from quarantine or isolation on the condition that they comply with medical monitoring and surveillance.

HHS/CDC maintains a close partnership with DHS and its agencies. DHS and HHS signed a memorandum of understanding (MOU) in 2005 that establishes specific cooperation mechanisms as part of a broad framework for cooperation to enhance the Nation's preparedness against the introduction, transmission, and spread of quarantinable and serious communicable diseases from foreign countries into the States, territories, and possessions of the United States. DHS has charged the Homeland Security Institute with facilitating the implementation of the MOU and HHS/CDC's Division of Global Migration and Quarantine is collaborating in this effort. Concurrently, HHS/CDC has conducted table top exercises at ports of entry in cooperation with DHS' component agencies and state and local partners to develop and refine communicable disease response plans.

The partnership between CBP and HHS/CDC is particularly vital, as CBP officers act as HHS/CDC's "eyes and ears" on the ground. In addition to assisting with the enforcement of Federal quarantine and isolation, HHS/CDC helps to train CBP officers to identify and respond to travelers, animals, and cargo that may pose an infectious disease threat. CBP also assists quarantine officials with the distribution of health risk communication materials for the traveling public, such as notices that alert travelers of possible exposure to communicable disease threats abroad and offer guidance on steps they can take to protect themselves.

Next Steps, What More Can Be Done:

With the support of Congress and the President, and in accordance with the recommendations of the Institute of Medicine (IOM), HHS/CDC is investing in building a Quarantine and Migration Health System that meets the needs of the 21st Century. HHS/CDC is enhancing the numbers and competencies of staff, training, physical space, and utilization of technology to meet the Quarantine System's evolving, expanding role. This has included the creation of additional quarantine stations at airports and other major ports of entry into the United States. HHS/CDC has expanded this critical public health infrastructure to 20 stations and is focusing on fully staffing these stations.

By continuing to expand the capacity of the U.S. Quarantine and Migration Health System through science, partnership, and preparedness, HHS/CDC will be

better equipped to play an active role in worldwide biosurveillance, to coordinate nationwide response to global microbial threats of public health significance and to protect the U.S. public from communicable disease threats. The President has requested an additional \$10 million dollars in FY 2008 to support the further enhancement and expansion of the Quarantine and Migration Health System.

In addition, HHS/CDC has been working to update interstate and foreign quarantine regulations [42 CFR Parts 70 & 71] to codify procedures that more completely reflect the 21st century implementation of disease containment measures such as isolation and quarantine, and that strengthen the nation's public health security at ports of entry. On November 30, 2005, HHS/CDC published a notice of proposed rulemaking (NPRM) to update the interstate and foreign quarantine regulations [42 CFR Parts 70 & 71]. Once adopted, these changes will represent the first significant changes to these regulations in 25 years.

Key provisions proposed include: more explicit due process protections for written orders and an administrative review hearing; expanded reporting of ill passengers on board air carriers; and requirements that will facilitate the timely transmittal of passenger and crew contact information to HHS/CDC to ensure quick notification of exposure to communicable disease threats. These procedures are expected to expedite and improve HHS/CDC operations by allowing immediate medical follow-up of potentially infected passengers and their contacts. HHS/CDC received over 500 pages of comments from approximately 50 organizations and individuals regarding the proposed rule. HHS/CDC is currently addressing issues raised during the public comment periods, including working with DHS to most efficiently share contact information, and developing a draft final rule.

To control TB, HHS/CDC and its partners must continue to apply fundamental principles including: (1) State and local TB programs must be adequately prepared to identify and treat TB patients so that further drug resistant cases can be prevented; (2) TB training and consultation must be widely available so that private health care providers recognize and promptly report tuberculosis to the public health system; (3) State and local public health laboratories must be able to efficiently perform and interpret drug susceptibility and genotyping results in TB specimens; and (4) CDC and local health authorities must work collaboratively to ensure that isolation and quarantine authorities are properly and timely exercised in appropriate cases.

The prospects for development of new TB drugs also are promising and those efforts must continue. There are at least 4 new anti-TB compounds entering human trials while others are in advanced preclinical testing. These new compounds represent new drug classes that may offer promise for treating resistant cases.

Conclusion:

We have begun a careful review of our protocols and capabilities. First and foremost, we are reminded that infectious diseases are not a thing of the past, and that we need to continually adapt our prevention and response capabilities in an era of increasing threat and globalization. We are reminded that almost all infectious disease cases are effectively handled within our existing systems of care by patients, clinicians and local public health authorities, and that it is important to continue to reinforce and augment these existing roles and relationships. Our public health protection network assisted us in responding to this event in a more timely and coordinated manner. Public health officials continue a long tradition of working together on every level to identify, contain and mitigate the spread of communicable diseases in US communities and abroad.

The case also reminds us that there are a number of existing channels that we can leverage more effectively in the future. Through the Global Health Security Action Group—a group of senior policy officials, top scientists, and media experts from the ministries of health of G-7 nations, Mexico, the World Health Organization and the European Commission—we can quickly convene relevant public health officials via phone and video conferences to convey information on cases like this to our key allies in a more timely and effective way.

In an age of global air travel, infectious diseases can, and do, cross geographic borders every day. People can be infected with a disease and have few visible indications, people can vary in terms of how infectious they are, it is often not possible to rapidly test and confirm whether a person has an infectious disease, and people's health status can change quickly and unpredictably. We will never be in a position where we can guarantee that infectious people will not cross borders, but we will work to ensure that the measures available are as effective as possible. And so too this case reinforces the need to advance our efforts to modernize our Quarantine and Migration Health System and update Federal quarantine regulations; improve our information technology and communications capabilities; and define and exer-

cise our capabilities and relationships with international, Federal, state, and local partners so that we are prepared to deal with situations that pose a threat to public health. We believe the lessons learned from this case will improve HHS/CDC's ability to protect the nation's health in our ever-changing global environment.

Dr. GERBERDING. Thank you, sir. And I apologize to the committee for not being able to be here at the beginning. It was hard to be in two places at the same time. And I thought we could work it out timewise, but it was not successful. There were some delays on the Senate side. So I am very sorry and I would be happy to meet with any of you at some other time if that would be helpful to clear up what I don't have time to address today.

You asked the question, I think, about what does this mean, what does this mean in terms of our overall ability to keep the bad guys out of the country—

Mr. PERLMUTTER. Or let our bad guys go to another country and do some damage to them.

Dr. GERBERDING. I understand what you are saying. One thing that I would like to point out is that there is a difference between a terrorist and an infectious person. Our medical approach is to generally give the patient the benefit of the doubt. And in the time that I have been the CDC Director, 72,000 people with tuberculosis have been diagnosed in this country and I have never had to file a Federal order. We have been able generally to work with patients, get them to do the right thing to protect our people. Sometimes they have to be put in an isolation order or quarantine order at the local level.

But we have never had a situation like this where we had a patient who had compelling reasons to go against medical advice. We made decisions based on the theory that the patient would cooperate. That was in retrospect a wrong matrix for making decisions in this case, and if we had to do it all over again knowing what we know now, we would have acted much earlier. Actually, had we initiated the notifications earlier, in this example it wouldn't have made any difference based on what the current capacity is to exercise the watch and the no-fly capabilities. But nevertheless we were not expecting the patient to make the decisions that he made. And that is a very sad lesson for all of us to learn at CDC.

Mr. PERLMUTTER. OK. Thank you, Mr. Chair.

Chairman THOMPSON. Thank you very much. We now recognize the gentleman from California for 5 minutes, Mr. Lungren.

Mr. LUNGREN. Thank you very much Mr. Chairman. Sixty-three years ago is a rather important day, may have changed our lives. It was D-Day. My dad was waiting as medical officer to go off to Normandy. The day before President Eisenhower wrote this note:

Our landings in the Cherbourg-Havre area have failed to gain a satisfactory foothold and I have withdrawn the troops. My decision to attack at this time and place was based on the best information available. The troops, the airmen and the Navy did all that bravery and devotion to duty could do. If any blame or fault attaches to the attempt, it is mine alone.

He wrote that in case we failed so that he would take all the blame. And the difference between that generation and our generation unfortunately is the difference between taking responsibility and accountability and blaming someone else. Mr. Speaker is the

person who bears the initial responsibility for here and I would have to disagree with you, Doctor, to say he had compelling reasons not to follow advice. He had self-absorbed reasons. He wanted to have his wedding in Europe. His first response as reported in the press is I am an intelligent, well-educated person. Well, evidently intelligence and good education doesn't give you common sense or concern for other individuals.

Now I have heard us say that this is different than terror, and I understand it is different than terror. But we have been told that he has multiple drug resistant TB. Now either that means something or it doesn't. Are we to think that multiple drug resistant TB is not a serious concern? And that multiple drug resistant as a string of adjectives to describe TB doesn't mean that it is something that ought to be taken seriously? I think not. And my concern is this, we have lauded the Department for the great work done by the customs officer on the border of the United States with Canada a few years ago to stop a terrorist from coming in who wanted to blow up LAX. That was great work by an officer right there on the line. She used her intelligence, she used her background, she used her decision making to stop a threat to the United States.

In this case, based on what I have seen, if the facts are as they appear to be, we had someone who failed that test. Now there ought to be different treatment between someone who saves us from an attack and someone for whatever reason ignores a statement that says that basically you are supposed to immediately put this person secondary. You are supposed to immediately use protective gear. You are not to let the person in.

Now I don't know about you, and I understand I am a lawyer. I plead guilty, and we have to worry about the rights and we can't say too much, and by God we don't want to punish someone too much. I mean, we are lucky that this person is not communicable right now or at least we don't think he is. Or if you are satisfied that he isn't, then why are we having these people tested who were on the airplane with him?

I remember TB as a serious thing. I had a guy in my high school had spent something like 3-1/2 months in the hospital when we were in high school. It is serious stuff. So all I can say is if the facts are what they are I would hope you would consider firing this person and the other people involved because this is much with the FBI about the national security letters. I have asked the President and I have asked the FBI, has anybody been disciplined for the errors that were made in the NSL? And I hear this, we are looking at it. What message does that send to the employees other than to say we are going to make sure we follow every single thing, not going to let their names be known, can't talk about it here. We will let you know in a confidential briefing but we have to make sure that everybody is protected here.

What about the public? What about the public? All I want to know is I want a statement from you, are you going to take action with respect to the people involved? And will there be action, completed action with respect to their employment, whatever that means under the system you are allowed to operate.

Mr. BASHAM. The answer is yes.

Mr. LUNGREN. And when?

Mr. BASHAM. We are in the process now of conducting a thorough review of what happened. The individual that you are speaking of is currently—his weapon has been taken away.

Mr. LUNGREN. Let me ask you, you say you are looking at it. Let me ask you, if someone gets an alert or whatever you call it on the—that came up that tells him to stop the person, do secondary search, what authority does that person have to ignore that? Because he or she says, oh, he looked pretty good to me. What authority do they have to ignore that?

Mr. BASHAM. He doesn't have the authority to ignore it. He chose to ignore it. His instructions were very clear. You have in front of you what he should do. He did not do it.

Mr. LUNGREN. I mean, it is not a question of not understanding the language. It is fairly clear. It is straightforward, tells you what to do.

Mr. BASHAM. I have got 12 grandchildren, Mr. Congressman. I don't know of any one of them that would not have known what to do in that situation.

Mr. LUNGREN. I am sorry to get emotional about this. But some of us have been defending you guys for a long time, thinking you are doing great work in other areas. We see great work done by somebody up in Vancouver to stop a terrorist attack, and then we see this. And frankly I do not see the sense of urgency about taking this and resolving this and making it clear to the public that we have resolved. But let's remember first and foremost, the person who is responsible for this is Mr. Speaker, who decided on his own to ignore because he wanted to have a wedding in Europe. And then took evasive action because somehow somebody told him he might be on the no-fly list and snuck back into the United States and, had it not been for an inerrant or an errant action by one of your employees, would not have gotten here. And this guy wants sympathy. This guy shouldn't get sympathy.

Frankly, I hope there is some laws that we can use against him. I am sorry, but some of the responses you had to Mr. Shays to suggest that this is not that big a deal really upset me. This is a big deal. We are lucky, we are lucky that for some reason at this stage he is not communicating this disease to others.

So hopefully this is like the test that none of us wanted to have, but we have and it shows what we have got to do and it means we have to do a lot.

Thank you very much, Mr. Chairman.

Chairman THOMPSON. Thank you very much. We now yield 5 minutes to the gentleman from Rhode Island, Mr. Langevin.

Mr. LANGEVIN. Thank you, Mr. Chairman. Thank you, Mr. Chairman. I think Mr. Lungren and Mr. Perlmutter and others of my colleagues have expressed all of our frustrations about this issue. It is truly a catastrophic failure, in my opinion, that has taken place because this issue has as much to do with preventing a terrorist from entering the country as it does with the effect that it has on our public health system in protecting us against a public health threat. And this has done irreparable damage as far as I and many others are concerned.

I have so many questions I almost don't know where to begin but I want to start—because I want to get to Dr. Gerberding—I want

to start though with Mr. Basham, Mr. Ahern. With respect to training and how we prevent this type of thing from happening again—first of all, how frequently do border agents get these text messages on their systems, first of all? And the second question is, with respect to training, how often do agents get refresher training? I mean this is clearly not a situation where you can just train someone once and then be left to their own devices—and Mr. Basham, you would know this in your previous role as Director of the Secret Service. The Secret Service is a great model because they always have to be on, they always have to be fresh. They go through frequent training. They are on for a certain period of weeks and they go through training again to make sure that they are sharp always. So I would like you to relate that to this experience and how our CBP agents kept fresh and how much retraining do they do?

Mr. BASHAM. In this particular instance, the officer that we are speaking of, I believe has had training, passenger training on a yearly basis that instructs them on how to deal with these sorts of situations. I believe that is the case. In terms of—let me just say, as the Director of the Secret Service, as I said, I understand the significance of what one individual, the impact that they can have with respect to what the Secret Service's mission is. I have been in this position for a year, one year now, and I am just going to say this. CBP agents and officers take a back seat to no one when it comes to the dedication and commitment to getting this job done. That is the unfortunate piece of this issue, is that this one individual has tainted that in my mind. They know what their responsibility is, and that is about protecting America against all threats. And the training that they receive is intended for them to be prepared to deal with all threats, including this threat.

Mr. LANGEVIN. So there is built in training and retraining throughout their time in the service?

Mr. AHERN. Yes. Thank you, Congressman.

Certainly my experience is 31 years, I started on the border with Mexico back in the 1970's. One of the most fundamental responsibilities the primary office has is using the lookout system. That is very clear; that is a very fundamental core part of the function, of what occurs.

As the commissioner stated, certainly what we do on an annual refreshing basis is to provide training for—not to be medical professionals or to actually aid them in making diagnoses—it is more for personal safety, and also be able to deal with isolating the individual—on blood-borne pathogens and TB on an annual basis, as well as training on an influenza pandemic. We have been doing that on an annual basis for several years now. This is a core function of what goes on.

Obviously, I am not sure that this is a training issue or retraining requirement. I think there is a failure to act here that we will deal with very swiftly internally.

Mr. LANGEVIN. How frequently do border agents get these types of text messages, by the way?

Mr. AHERN. As the commissioner stated in his opening statement, I believe it was in the 40-number range for this particular port, Champlain, which is a moderate-sized location.

We see significant numbers of alerts throughout the country on a daily basis, well into the thousands. So this is not an unfamiliar or occasional occurrence that occurs; this is a fundamental core value.

Mr. LANGEVIN. Thank you.

Dr. Gerberding, I know my time is running out, but first of all, I think this incident highlights the Federal Government is not fully prepared to respond when individuals have highly contagious communicable diseases. I want to turn my attention to the quarantine issue. We need increased coordination I believe among Federal agencies such as CDC and DHS, as well as the ability to isolate and/or quarantine these people, especially when they are uncooperative.

My question is, I understand the President can issue an executive order for quarantine and isolation on very specific diseases, but to Dr. Gerberding, Dr. Runge, please describe what other procedures are occurring for the Federal Government to issue an isolation order or provisional quarantine order.

Also, what is the role of DHS and the CDC when these orders are issued?

Dr. GERBERDING. I think I can answer that in a fairly straightforward way.

The primary responsibility for isolation of sick people or quarantine of exposed people lies with the local or State jurisdiction. They have the legal authority and the accountability for doing that, and from time to time they exercise that authority.

When a State needs help and asks for help, when there is an issue of interstate movement or risk of importation, we can exercise our Federal authorities on top of whatever State authorities exist; and that is exactly what happened in this case. I exercised my authority as the CDC Director to issue a Federal order of isolation to this patient as soon as his feet touched the soil in the U.S. Obviously, I can't execute or make that order when he is not here in my jurisdiction.

The one question that we have about this authority is that it does not specifically address exportation. Our quarantine laws were designed to keep people out, and in this case, the threat was from someone leaving and exposing others in our global network at risk.

We believe we may be able to use our existing authorities, but we need a legal clarification that it was permissible for me to issue a Federal order at the onset.

Mr. LANGEVIN. I hope we will get that clarification.

Dr. GERBERDING. Absolutely. We have already requested and are working on—that was actually something in play before this event even took place.

Mr. LANGEVIN. I know my time has expired, Mr. Chairman.

Do you have an MOU with other public health counterparts around the world so that if you issue that kind of order, even though it is not in your jurisdiction, you can communicate that with your counterparts in foreign countries that they could then use their discretion to exercise that?

Dr. GERBERDING. Our country is a member of the World Health Assembly. The World Health Organization has developed international health regulations that will ironically go into effect June

of this year, but we have been respecting those health regulations and they do have provisions for intergovernmental cooperation in these situations.

The truth is, having just developed these guidelines and getting 193 member countries to agree to them is the first step. Now they have to be operationalized, they have to be exercised.

I think what we have just been through in the last 2 weeks is a great case study of how we are going to have to create the procedures and the processes to take these guidelines and turn them into something that actually works for all member countries.

But there is a World Health Organization process and it will get a lot better shortly as we step to the plate and try to address these details.

Mr. LANGEVIN. Clearly, it can't happen soon enough.

Dr. GERBERDING. I couldn't agree with you more, sir. We really came up against a good idea. But how do you execute this and what are the relationships?

I want to quickly also say, CDC has a memorandum of understanding with the Customs and Border Patrol, as well as an HHS memorandum of understanding with Homeland Security for our interagency collaboration. It is the Coast Guard and the CBP officers who have the responsibility for enforcing the order that CDC makes. So when we needed law enforcement support for a quarantine order, we turn to Homeland Security to provide that law enforcement arm. CDC is not a law enforcement agency.

We worked very hard to work on this agreement to train and work together to execute that effectively.

Mr. LANGEVIN. I thank the Chair for his indulgence. Thank you, Chairman.

Chairman THOMPSON. Thank you. I now recognize the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. I thank the ranking member as well. These are important hearings, and I thank the witnesses for your testimony. This is not going to be a "gotcha" session, hopefully, as it relates to me, but I do want you to understand that, in my opinion, Mr. Speaker is a wake-up call. He really is.

We have to do some introspection, we have to ask ourselves some very tough questions. If we treat Mr. Speaker as an aberration, we will probably fail our Nation. We cannot allow this to be treated as a one-time occurrence. My suspicion is that you will not, but I think that has to be said.

Mr. Speaker obviously wanted to have his wedding cake and eat it too, and that is very unfortunate because he put a lot of people at risk in so doing. And it is unfortunate that we cannot have empirical data to support a comment that was made by the doctor because, Doctor, I am not sure that this is an occurrence that is a one-time occurrence because we have no way of knowing how many people have been told by their physicians, do not travel, who have actually traveled. I don't know that empirical data is available to substantiate the notion that this is a one-time occurrence.

You indicated that in all of your years this is the first time you have had to file for a certain type of order. However, there are other circumstances that may not have come to your attention, and I think the question has to be posed: Is trust enough?

Is trust enough in the world that we live in today? Is trust between the physician and the patient enough to protect the broader society from a person who may have a deadly communicable disease? Is trust enough?

Doctor, I ask if you would please respond as quickly as possible.

Dr. GERBERDING. Sir, trust is not enough. It is absolutely, unequivocally not enough.

Mr. GREEN. If trust is not enough, Doctor—excuse me for interceding, but my time is short and I have other questions. If trust is not enough, then the question becomes, what system do we put in place to prevent the person who is informed that you have a communicable disease, what system goes into place, into action such that that person cannot travel internationally? First question. I have some local concerns as well, but internationally what do we do?

Dr. GERBERDING. There are quarantine authorities and isolation authorities, as I mentioned. A local health officer can place a patient in voluntary isolation, meaning here is what we recommend, or require isolation.

Mr. GREEN. Is that authority discretionary?

Dr. GERBERDING. It is determined by the local health authorities' assessment of the risk.

Mr. GREEN. It is done on a case-by-case basis?

Dr. GERBERDING. Absolutely.

Mr. GREEN. It is discretionary.

Do we need to modify the system such that some of the discretion is extracted, such that we can be assured that a person who has a communicable, deadly disease is not boarding international flights?

Dr. GERBERDING. Mr. Green, I wish I could say that there was a way to accomplish what you are proposing, but people can leave and come into our country with communicable diseases by bypassing the system if they are asymptomatic. It is impossible for border agents to be able to detect every symptomatic person.

Mr. GREEN. Let's talk about the person who is known to have a deadly communicable disease. Let's talk about that person for this paradigm. How do we stop that person?

Dr. GERBERDING. Our borders have never been hermetically sealed.

Mr. GREEN. Let's not get to the border. Let's talk about the trust between the doctor and the patient, because that is the genesis of the problem, the trust factor.

Are we in a society where we can continue to allow people to be trusted who have communicable diseases of this magnitude?

Dr. GERBERDING. Seventy-two thousand times in the last 50 years we have been able to trust the patient, minus a handful of people that did not cooperate and needed to be isolated. We have to balance—

Mr. GREEN. Wouldn't that be 72,000 that we know of?

Dr. GERBERDING. I thought that is what you were asking me.

Mr. GREEN. There are many other circumstances that we don't know of.

Let me move on quickly and say this. The Border Patrol agent failed us, but we also failed him. We failed him because somehow

we have given him this stereotype of what a sick person looks like. And my suspicion is that if this person had different characteristics, we may have had a different outcome. That is my suspicion. My suspicion is that Mr. Speaker chose to go to Canada because he had his beliefs about the type of reception he would get making his way across a certain border point as opposed to another point.

So we failed him. He may take the heat, he may be the fall guy, but there is a failure in a system that promotes the notion that people who are sick probably look a certain way and probably have certain characteristics.

Mr. Chairman, I thank you. I have gone beyond the time and I yield back.

Chairman THOMPSON. Thank you very much, Mr. Green.

We now yield to the gentlelady from Texas for 5 minutes, Ms. Jackson Lee.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman. Let me add my appreciation to you and your staff for the prompt, efficient and quick way that we have been able to address this question.

I believe this committee takes the life-or-death issues that we have to address very seriously. And I would like to join the chairman in including TSA in this debate, in this oversight, in possibly some forum, whether it be a briefing or hearing; because as I am looking at the timeline, we are seeing that they are obviously intertwined into this. I say that as I pose questions.

Let me welcome Dr. Gerberding and others here and let me take my line of questioning to simply say that it is tragic to say, but we have been given a gift. The gift is that we were able to survive what would have been a catastrophic event that could have generated thousands upon thousands of deaths.

The thing that frightens me and gives me great pause is that all of us have defended the representation or the question, are we safer today than we were before 9/11. These kinds of mishaps say to the American people that we are not, and it disturbs me; but more importantly it gives me pause and it gives me a great sense of failure that we who have this responsibility have failed the people who invest in us, who have confidence in us, and it goes across the board.

So I am looking for answers that would suggest that we do more celebration of the success stories and less of the mea culpa.

This seems to be one that was avoidable. These are not circumstances that we were unfamiliar with. We had the coordinates in place, we had the agencies in place.

Now all we hear is, we might need new laws, we weren't connected, we didn't give the right information, we didn't know who to give it to. This timeline presented by able staff indicates that.

So let me begin. My colleagues need to know that Mr. Speaker fell down in January and determined something was wrong and had an x-ray. But in early March, Speaker underwent a procedure to determine the status of his lungs. It was not until Thursday, May 10th—now, maybe there is something that was left out—that the health official determined that he had a multiple drug-resistant, MDR, form of TB. The whole month of April is gone.

Sounds like my building in Houston where people are coming in with passports and saying that they sent them 13 weeks ago and

they haven't got a reflection, but let me compliment the passport people working 24 hours a day and 7 days a week. There is that gap.

So I ask that first question to you, Doctor. I think there was a failure between you and the Fulton County, I assume, Health Department, which speaks to the relationships the CDC has with our local health departments. Why did it take that long?

Dr. GERBERDING. In this case, the problem is not with the public health system, it is with the bacteria. Tuberculosis is a very slow-growing organism. When the patient had the samples taken in March, they were brought to the laboratory. When they began to show tuberculosis, they were sent to the State health lab, which is the appropriate procedure.

Eighteen days after the procedure was done to obtain the sample, there was the first diagnosis of tuberculosis, but then you have to go through the susceptibility testing, and that can take up to 21 to 28 days.

So there is always a long time frame from the time that you get the sample from the patient until the time that you know you have a—

Ms. JACKSON LEE. Let me interrupt because those of us who are not medical professionals would probably fall victim to yielding and saying, she is right.

Let me just say that we don't have that kind of time, not to do the appropriate testing, but I believe in light of the atmosphere in which we live, at least the notification, the beginning notification of the individual that they are in testing, something is wrong, and begin at least some form of putting them in a mind-set that they may be a danger.

I don't believe that was done.

Dr. GERBERDING. When the patient was diagnosed as having tuberculosis, the patient was started on treatment, but it takes a long time to do the extensive drug susceptibility tests that were done; and that is the timeline between when he knew he had TB versus when he knew he had drug-resistant TB.

This brings up a very important point, though, and I am glad you mentioned it because we are treating tuberculosis in the 21st century like it is the 19th century. We should have faster diagnostics everywhere, better drugs to treat the disease.

Ms. JACKSON LEE. We should be able to—and forgive me for reclaiming my time, because it is short. We should have a better sense in place to coordinate between the local health authorities, the patient and the testing process.

I still believe that intervention should have been sooner to frame for Mr. Speaker, you may have a serious issue and we need to address it and we need to have you be aware, frankly, that your travel may be limited. I don't think we did enough.

And I really need to move on because of the time.

Dr. GERBERDING. Very quickly, I believe the patient was notified of his drug-resistant status when the State lab knew it.

Ms. JACKSON LEE. We have a time frame that suggests he got a letter when he was already out of town and no one could reach him.

Dr. GERBERDING. He attended a family meeting and was given the information first by his clinician and then reviewed at the family meeting.

Ms. JACKSON LEE. Then what did the public health facilities do regarding his actions?

Dr. GERBERDING. They actually hosted the meeting and were responsible—

Ms. JACKSON LEE. So are you suggesting that because you don't have stronger laws, you could do nothing more than host a meeting and allow someone to say they had to go on a honeymoon? There lies again a question of whether or not we are safer today than we were before 9/11, because if we have nothing in place—you hosted a meeting; what was the action that you could take?

Dr. GERBERDING. I can't speak to the mind of the health officer involved, but in Georgia you are required to demonstrate that the patient has defied a medical order in order to issue an isolation order under quarantine. So the reason the officer was delivering that advisory to the patient in writing was to make it very clear what the written—

Ms. JACKSON LEE. Is that the letter that came after he had already left?

Dr. GERBERDING. Exactly.

Ms. JACKSON LEE. There lies the crux. Let me go to the Border Protection operation—

Chairman THOMPSON. The gentlelady's time has expired.

Ms. JACKSON LEE. May I ask this last question?

Chairman THOMPSON. One question.

Ms. JACKSON LEE. Thank you very much.

I think your system was completely broken, and beyond reading the fact that the English was clear—"place mask on subject, place in isolation"—it is my understanding that TSA got the information after all of the, if you will, damage was done. This gentleman was back in Montreal, and frankly the lawyer for TSA did not get permission until 7:30. Who knows where the person would have been?

My question is what is—what orchestrated the failure of communication in DHS between Customs and Border Protection, TSA, et cetera. One of the issues is the sharing of intelligence. What led to that failure of intelligence and communication?

Mr. BASHAM. Thank you.

Mr. BASHAM. First of all, let me just say that at the time that CBP was given the information on Mr. Speaker, there was no indication that Mr. Speaker was not going to be compliant with the orders of CDC; and that was that he was going to return to the United States on the 5th of June.

Up until the point where we determined that he actually had crossed the border, we were under the impression that he was still intending to return on that date; and we were doing sweeps on a daily basis to make a determination of whether or not his travel plans would have changed. At that point in time, we had no reason to involve TSA in this process as long as this person was compliant.

CDC was talking to him. I believe, Doctor, that was the case. That individual decided he was not going to comply.

Ms. JACKSON LEE. Let me end—

Chairman THOMPSON. Excuse me.

Ms. JACKSON LEE. I am just thanking him for his answer. I yield back.

Chairman THOMPSON. I now recognize the gentleman from Texas, Mr. Cuellar.

Mr. CUELLAR. Mr. Chairman, I have no questions at this time. Thank you.

Chairman THOMPSON. I now recognize the gentlelady from New York, Ms. Clarke.

Ms. CLARKE. Thank you very much, Mr. Chairman. I just want to really associate myself with the comments of my colleagues thus far, because this is truly a remarkable event that is taking place, and I kind of take it a little bit personally.

With three major airports within miles of Brooklyn, that I represent, and in fact the State of New York being landlocked with the Canadian border, the spread of disease through travel is of great concern to me; and frankly this is a breach in the security of—this type of breach in the security of our Nation is just unconscionable.

As this committee and the appropriate government agencies and the media continue to investigate what occurred, I hope we avoid finding scapegoats and instead keep the focus on understanding how to fix the system where it has failed.

Let's make no mistake: The system failed. What is so bizarre about this event is the fact that this man, Mr. Speaker, was aware that he needed to turn himself in and intentionally evaded the authorities. And we enabled it.

I would like to know from those of you who are sitting here today, if a similar situation were to occur today, how the DHS and CDC would handle it differently, one? And two, is the infrastructure in place to prevent a person from flying even after changing flights?

Three, what stops a person from traveling to the U.S. who may carry a highly contagious and communicable disease? Four, what would the CDC have been prepared to coordinate with the international community and the U.S. to contain, quarantine and treat the thousands of people around the globe who could have been exposed and contracted this highly communicable disease?

Those four questions I need answers to.

Dr. RUNGE. Thank you very much, Representative Clarke. I will take the first one.

CDC and DHS have had a long history of working together very well at the field office level even before there was a DHS. The MOUs that Dr. Gerberding referred to and the chairman referred to are in place, they are being operationalized. But the lesson we have learned from this—and as late as this morning, Secretary Chertoff and Secretary Levitt spoke about this—is that we are not going to keep such information at the field level. If we don't elevate it to the National Operations Center, then there are tools that we are leaving on the table for CDC to use.

If we look in retrospect and if that had occurred a bit earlier, they would have been given more tools quicker to respond to this episode.

So it is very much—although we work very well in planning—we are working together on pandemic planning, and we have many,

many activities together—this does clearly set out a need for using the tools that we actually have in place through our operations center, through the watch desk that we have 24/7/365 to coordinate with TSA and CBP and the operations center level at HHS.

We are very cognizant of that and are putting that in place.

Mr. BASHAM. I believe your point as well was, are there systems in place that would prevent this from occurring again. Let me just say that being 100 percent right 100 percent of the time, I couldn't sit here and tell you that we are going to be able to accomplish that. That is certainly a goal that we have.

But we have initiated new processes at our ports of entry that would not allow, will not allow that which occurred in Champlain, New York, to occur again. There are backup systems that we have in place that would ensure he could not ignore that direct order.

In terms of our ability to make a determination around the world whether someone changes an airline reservation, I have to say, we don't have an international system in place. We need to work on that, we need to work with our European partners, we need to work with our Canadian partners to further enhance our ability to be able to do just what you are talking about. Right now that does not—without getting into great detail, we don't have that.

Dr. GERBERDING. In retrospect, as I mentioned, we realize that by giving this patient the benefit of the doubt, we put other people, especially passengers, at risk of exposure to this bacteria; and we believe that we absolutely need to be prepared to take more rapid steps to notify, as Dr. Runge said, not just at the field level, but to the national operations centers, so that the whole compendium of tools—had we done that in this particular case, it would not have made any difference in the patient's ability to get into the United States, but we don't want to ever be there again.

Ms. CLARKE. I know my time has expired, Mr. Chairman.

I raised a question of outbreak. I raised the question of outbreak because that could have been the natural progression of this particular incident. Thank God it is not, as far as we know, but think about all of the locations that this gentleman traveled through. He went to France, Italy, Greece, New York, started in Atlanta. He could have infected thousands. They could have then infected hundreds of thousands.

I don't know that we are prepared as a nation to take on the quarantining and the testing that something of this magnitude points to. And I am raising it because I want us to be prepared, should this ever happen again, for what the consequences could be to our Nation and to the world in which we live.

Thank you very much, Mr. Chairman.

Chairman THOMPSON. Thank you very much. The time has expired.

I now recognize the gentlelady from California for 5 minutes, Ms. Sanchez.

Ms. SANCHEZ. Thank you, Mr. Chairman. I am sorry that I missed the earlier testimony and some of the questions from my colleagues. I apologize. I was doing body armor over in the Armed Services Committee this morning, a hot topic today.

The problem I see is, no matter how many safeguards we put in, it always comes down usually to an individual, an individual hav-

ing the right training. We all see it every time we go through the airport system and the security system, that we are treated in different airports in different ways and different manners by different people; and it comes down to this training of our people who are responsible for many of these very important things.

It seems that there were a lot of breakdowns in the system, but one was—my understanding—the gentleman who said, this guy doesn't look sick. Now how much training are we providing to our people at the border, and do we need more, do we need an additional class in something like this or—I mean, the next time it will be something different.

So I would ask you, what do we need to do to ensure that our people are up and trained at these ports of entry?

Mr. BASHAM. Well, let me just say, Congresswoman, this is not an issue of the training that this person had, which in fact he did have on a yearly basis. He did receive training. This was clear disregard of a very clear instruction as to what to do with this person. It was not about whether he had the ability to make a medical assessment, which he is not there to do in the first place. He is there to follow instructions; he failed to follow instructions. We are taking appropriate action on that individual.

But let me just say that we have, in fact, built in additional safeguards at our ports of entry that would prevent that individual from being able to make that decision independently, that they can't at this point in time disregard a clear order to refer that person to secondary. They don't have that option when they have an exact name match.

Ms. SANCHEZ. Great. What about placement of a nonterrorist on the no-fly list? Had that occurred before or is this something new?

Dr. RUNGE. Representative Sanchez, we had spoken a bit earlier—in the memory of the Director of Intelligence for TSA, this was the first time in his memory that anyone who was a nonterrorist had been put on what we are referring to as an adjunct to the no-fly list, so we don't confuse it with those who are in fact terrorists. That is actually why it took a bit of time, about 4 hours, before it went out after we received the name from CDC.

So this is probably a first. And actually—I think they did quite well actually to get the airlines notified within about 4 or 5 hours.

Ms. SANCHEZ. The person who took that call from CDC—when CDC said, we have a problem here, and you should be stopping anybody who gets on a plane, who is this guy—what was the time frame there? And because this was the first time, did the people handling this know that they had jurisdiction or ability to put this person on an adjunct list?

Dr. RUNGE. As a matter of fact, yes. The CDC contacted my office at about 1:00 with the information that this had turned into something that appeared to be a noncompliance situation, that no longer was he going to keep his reservation and follow the instructions of the person he had been communicating with, but in fact he had absconded.

Dr. Lange in my office quickly convened a conference call with TSA and with CBP and CDC through the National Operations Center to discuss next steps. The CDC inquired as to whether the TSA could put him in a no-fly situation. The answer was "yes."

The CDC then called us back with the name of the individual, and at that point, within a short period of time, the Deputy Administrator for TSA made the decision that on her authority—that is, a separate piece of legislation beside the terrorism one that you all have granted TSA—they could enter this person on a no-fly list.

There was a confab of attorneys from Justice and DHS to decide exactly the right way to do this, to make sure that it could be done, since it was a novel situation; and that decision was reached over a couple hours of time, and he was added to the no-fly list about 7:30 p.m.

I just point out, he crossed the border the same day about an hour and a half earlier.

Ms. SANCHEZ. I have one last question.

It seems to me—and, Mr. Ahern, I had the privilege of being with Homeland Security out in Rome where this had just happened at the time, and you have very capable people there, by the way.

It appears to me that Mr. Speaker was evading. Are there laws on the books to go after somebody who puts somebody at risk in that way? Because to go to Poland from Rome and to go to Canada to come into the U.S.—and I think, as I walked in, Mr. Green said, he went to Canada, the assumption there, I think was, he didn't go through Mexico because we have a much tighter security point there; and that points to one of our weaknesses.

But are there laws or do we need to go back and take a look at somebody who could potentially infect so many people in the world?

Dr. GERBERDING. I think I can answer that, in part.

If the patient is under a Federal isolation order, we certainly have legal recourse. The patient was not under an isolation order because he left the country before it could be issued.

He could have been placed in isolation by the Ministry of Health in Italy, and if we had appreciated, as you said, that he was evading the situation, we certainly would have pushed for that earlier in the course of events.

But there are different legal authorities in different nations, and the Nation of jurisdiction is the Nation in which the person is currently present, and that does complicate things. But we can, through the authorities in the agreements that homeland security is creating, at least prevent people from flying from one location to another. I know that system is in the process of being strengthened.

Ms. SANCHEZ. Thank you, Mr. Chairman. I think maybe we have to take a look at tightening that.

Chairman THOMPSON. I agree.

I will now yield 5 minutes to the gentleman from Massachusetts, Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman. Let's think about it from the other perspective.

Mr. Basham, would you be happy if a Canadian citizen had landed at JFK? The Canadians knew that he had a resistant strain of tuberculosis, and they did not notify you that this threat was now out into New York City; and at 3:00 that afternoon they are not telling you, and it is now some time that is going to lapse.

Would you be happy with the Canadian Government if they did not tell you anything?

Mr. BASHAM. Congressman, I would be very unhappy if I thought they knew and had that information on the travel of that individual and did not notify.

We didn't have the information, Mr. Congressman, that he was going to be flying into Montreal and making a land entry in Champlain, New York, so there—we need to strengthen some other points in our data-sharing. But we—had we known that this individual was going to land in Montreal, we would have in fact alerted the Montreal officials, and I am sure they would have taken action.

Mr. MARKEY. When did you notify U.S. officials that he was in Montreal, that he was in Canada?

Mr. BASHAM. He entered at Champlain, New York, at 6:18 on the 24th. Due to our sweeps at our National Targeting Center, we—

Mr. MARKEY. When did you know he was in Canada?

Mr. BASHAM. We didn't know he was in Canada until we had already realized that he had crossed the border and we notified CDC that he was, in fact, in the United States.

Mr. MARKEY. In the United States.

I am just trying to understand this. The Border Patrol already had this in their computer at the point at which he had crossed; is that correct or am I wrong on that?

Mr. BASHAM. What happened on the 22nd of May: We entered Mr. Speaker's information on his travel and the fact that if Mr. Speaker arrived at one of our points of entry, very clear instructions that he was to be referred for secondary inspection, and then a series of cautions would be put in place—put a mask on him, put him in a ventilated area, isolation, and then notify the CDC.

We were tracking the airline reservation systems and the data that we had at our NTC.

At 12:32 a.m. on the 25th in one of these—when we were sweeping the system to try to determine whether Mr. Speaker had in fact entered one of our ports, that is when we realized that he had, in fact, entered on the 24th at 6:18.

We then immediately made the notification to CDC, who then, as I understand it, reached out and contacted Mr. Speaker and gave him instructions.

Mr. AHERN. I think it would be important—

Mr. MARKEY. Did you notify the Canadian public health officials when you notified all U.S. points of entry? Did you notify them simultaneously?

Mr. AHERN. If I could add to the commissioner's question.

Mr. MARKEY. No, I need the answer to this question. Thank you.

Mr. AHERN. We did notify through the Canadian authorities within 15 minutes after we realized he had entered the United States. Those would be our counterparts within the Customs/Border authorities on the—

Mr. MARKEY. How about the public health officials in Canada?

Mr. AHERN. They were not notified by us. We did not know the individual was going there, thus posing a health risk to Canada. So I would defer to CDC.

Dr. GERBERDING. Shortly thereafter, but I can't tell you what time—we can get that for the record—Dr. Butler Jones, who is the Canadian counterpart, and I were also communicating by email during this time.

Mr. MARKEY. Can I ask if the father-in-law, Dr. Cooksey, has had an x-ray to determine whether or not he has TB?

Dr. GERBERDING. I don't know the details of Dr. Cooksey's medical history myself, but he has stated that he has been tested for tuberculosis and is negative.

Mr. MARKEY. Have you been able to determine that he has been tested?

Dr. GERBERDING. We have initiated an internal review at CDC to look at a number of issues around his involvement in this situation, and we also have reached out to the Inspector General to make sure that we have an objective assessment of all of these details. So we are very interested in understanding exactly what his situation and role is.

Mr. MARKEY. Do you know when he had the x-ray to determine if he has TB?

Dr. GERBERDING. At this point, I don't have details of his medical history or documentation. I am relying on his written statements. But that is exactly why we are doing this internal review.

Mr. MARKEY. Is it possible that something can cause a false-negative TB skin test?

Dr. GERBERDING. You can have a false-negative TB skin test if they are improperly conducted. But this person has been a person who has worked in the laboratory for more than 30 years, and I think we have confidence that skin testing would have been appropriate in this case. It is part of our Occupational Safety and Health program at CDC that people who work in laboratories have to go through periodic testing by our officers who are in a position to do these.

Mr. MARKEY. Is it possible Mr. Speaker got TB from his father-in-law?

Dr. GERBERDING. No. We have absolutely no reason to suspect that. We actually have 25,000 isolates of TB in our laboratory that we have completely fingerprinted, and we have compared those to the patient's isolate and there are absolutely no matches.

Mr. MARKEY. Thank you, Mr. Chairman.

Chairman THOMPSON. Thank you very much.

Several members have asked for a second round of questions, especially since Dr. Gerberding was a little late coming in. For those who wish to remain, please do so.

Dr. Gerberding, one of the things a lot of us are concerned about is, now that you have had an opportunity to review this incident, what would you do differently now if a similar incident occurred?

Dr. GERBERDING. There are three main areas that we think we can improve. The first relates to our ability to support the State in isolating the patient before he leaves the country, and we have already initiated the process of assessing our current authority to prevent exportation, as well as any additional support for that that we would need in the future.

A second dimension relates to the speed of our notifications, both the speed of our notifying to Homeland Security, the speed of our notification to the World Health Organization and affected ministers of health. In this case, we definitely could have sped up our notification process, but unfortunately in this case, even if we had done notifications early, it would not have mattered because the

systems were not in place to find the patient and prevent him from doing exactly what he did.

The third area that I think is very important, which is basically a CDC issue, but it will come up again, is that our government does not have a mechanism to support the transfer of patients with communicable respiratory diseases safely, efficiently and affordably under these circumstances. The options for any citizen right now who come down with a communicable respiratory disease while traveling include, number one, pay out of your pocket for a Medivac to come home; number two, pay the DOD to bring you home in their equipment with their isolator; number three, stay where you are in isolation until you are treated long enough to be noninfectious, which for usual TB is a couple of weeks; number four, pay out of your pocket; and lastly, number five, our State Department has loans for people to get assistance in paying for their travel to come home.

We believe in a situation like this, where it wasn't just about the patient's illness, but he was posing a threat to others—not just Americans, but others—that we should assume an ethical responsibility to help the patient get home affordably, and so we need an aircraft that has respiratory isolation capability in it.

CDC does have a plane. We talked at length about any possible configuration of that plane that would allow us to protect the pilots, the law enforcement officials, his wife and other passengers on the plane.

Now, on a long flight, which from Rome would have been a long flight back to the United States, we could not safely fly him on our aircraft. So we have learned a lesson that we need to invest in the capacity to reengineer our plane so that we can get patients with this kind of condition home. We may need authorities to spend Federal dollars to transport patients in these issues, and we will—we just came from the Appropriations Committee to ask that question.

But I think had we been able to guarantee the patient an affordable mechanism to get home, he would have been unlikely to evade us in Europe, and we could have avoided at least the second half of the contact tracing and the exposure trackdown that we had to do.

It is unfortunate, and I can tell you that the whole issue around CDC aircraft and why we have them and how much they cost has been of great interest to some members of the press, but for me as a CDC Director, I must tell you this is a capability we have to have at the agency, and in many cases it has saved lives.

In this case, it could have saved at least half of the problems that we are dealing with today.

So those are the three main lessons that we are focusing on.

Chairman THOMPSON. So at what point internally will you look at this situation? Or have you just moved the entire review over to the IG?

Dr. GERBERDING. No, sir. Last Tuesday afternoon, I assembled the entire CDC team for a formal after-action report, actually conducted by a former three-star general used to exercising and training people, General Pete Taylor; and we went through, stem to stern, what happened up to that point and what lessons we needed to learn so we could begin actioning those lessons already.

We will continue to have these after-action reviews because, for us, this is an ongoing investigation; we have to find all these passengers. By the way, we have found 92 percent of them so far. We have to find all these passengers, test them now and test them again in several weeks to make sure they didn't acquire tuberculosis and so on and so forth.

So we are still in investigation here. I know you all are trying to end the DHS part, but we have got months to go before we are done.

So the CDC agency after-action will happen inside our agency. I am sure we will be doing this together with Homeland Security in the future, as well as the internal review and the additional review we have requested around the circumstances of the father-in-law from the Inspector General.

Chairman THOMPSON. Thank you.

I yield 5 minutes to the gentleman from Indiana, Mr. Souder.

Mr. SOUDER. Thank you, I wanted to clarify, Dr. Gerberding, was this the first individual case you have ever given to Homeland Security?

Dr. GERBERDING. Yes, sir, I believe it is. Because I am the only CDC Director that has interfaced with Homeland Security; it was created after I became the Director. This is the first time that we have requested these procedures be undertaken.

Mr. SOUDER. The person behind you seems to be suggesting that might not.

Dr. GERBERDING. Let me clarify my answer. In terms of creating a no-fly order, yes. But in terms of interacting with CBP, we do that continuously.

Mr. SOUDER. What about on the border? As opposed to no-fly, what about alert to the Border Patrol?

Dr. GERBERDING. CDC has quarantine offices that are literally side by side with the CBP, and I have actually just come from one in the Pacific Rim. I visited Miami, New York, Washington, Minneapolis, Los Angeles. I have been in these quarantine stations, and the first thing I notice, this is a team. The CBP people are there with the CDC quarantine officers and they work these things at a staff level all the time.

Mr. SOUDER. Has there ever been a warning that would come up on a screen to Homeland Security before?

Dr. GERBERDING. There has been one other situation that was also an individual who has tuberculosis.

Mr. SOUDER. We caught him and held him?

Dr. GERBERDING. We haven't had to catch and hold at the border yet.

Mr. SOUDER. So this was the first one where they interfaced with CBP.

Do you give other types of less specific, rather than watching this person? We are concerned about—at one point we were looking at bird flu fairly closely.

Dr. GERBERDING. We still are.

Mr. SOUDER. In tracking that, do you give information to Dr. Runge and CBP of what they should be looking for, and does this appear on anybody's screen?

And I have training questions, but that is another subject. I want to know what your interface is with them that goes to actionable intelligence for the agents.

Dr. GERBERDING. It happens at every level.

It happens in the field, as I just mentioned, staff-to-staff in the specific quarantine environment. It happens to the regional network of airports and ports that fall into that network of responsibility. But it certainly also happens in Washington, happens operation center-to-operation center. So we are very connected throughout our respective organizations.

Mr. SOUDER. I mentioned earlier that I visited in Florence, Arizona, a detention center for OTMs, other than Mexicans. There in the health area we have a tuberculosis isolation ward, because people for a period of time are going to be together. Are you familiar with that?

Dr. GERBERDING. I have not visited the facility.

Mr. SOUDER. Dr. Runge, do we have other places along the border? Is it just for the OTMs, the other than Mexicans? Or what kind of—explain that to me because clearly it is enough of a problem, we have a fair number of people that go through isolation.

There were one or two individuals there when I was there. This suggests it is a fairly common occurrence on the southwest border because only a small percentage of them are OTMs.

And we don't catch everybody, in case anybody didn't know that.

Dr. RUNGE. You are correct. The Immigration Health Service, the Immigration and Customs Enforcement division DHS uses for the detention facilities at the border, are the health care deliverers for everybody whether they have TB or any other illness on the border. There are about 400, I believe, physicians and nurses who are part of the Immigration Health Service that we at DHS utilize, from the United States Public Health Service. There are TB detention facilities in at least several of the facilities, and I can't tell you the exact number.

Mr. SOUDER. When we deport an individual who has been in isolation, do we tell that country that we are deporting them back to?

Dr. GERBERDING. Absolutely.

Mr. SOUDER. I am concerned, as well, that we didn't tell Canada that one of the premises of the whole homeland security/border protection that we are trying to work on the north border and south border is the North American perimeter.

The Canadians are very justifiably upset that we only give them information on a need-to-know, if the person lands in your country and does damage, we will let you know that we knew. That doesn't fly, so to speak.

I am concerned about Italy, but I am really concerned because we have the longest unprotected border in the world with Canada.

Dr. Gerberding, do you view Canada differently? Are you more active with them with bird flu, the tracking that we are doing in Alaska, through Canada, in the bird flight. Same thing with Greenland, we have to have that cooperation—particularly with Canada.

Dr. GERBERDING. The Canadian Health, we are sister agencies and we share training. We have participated in joint tabletops. We are very seamlessly networked.

Mr. SOUDER. Why do you think they didn't get this warning?

Dr. GERBERDING. I have to defer to the border warning as an issue that is not CDC's to own; but we didn't know if the patient was going to be in any one of the 193 countries.

Mr. SOUDER. Why wouldn't Canada—and Mexico, for that matter—be an unusual concern to the United States? Because if they are going to come into the U.S., the only way would be somewhere near us to cross; and why wouldn't the CDC be sharing this information in particular with Canada and Mexico?

Dr. GERBERDING. We were following the World Health Organization international health regs, which require us to report to the World Health Organization and they, in turn, make the decisions—

Mr. SOUDER. That would be something I would suggest, that there needs to be a high priority where we have a strategy—

Dr. GERBERDING. Exactly.

At the time the patient was actually flying to Canada, we assumed that the next morning we were going to be negotiating with him how he was going to get home. And so at that time I was not speculating—and I wish I had speculated, in retrospect—if he is not going to come in through the U.S., what would be the other likely ways, and of course Canada and Mexico would be obvious.

Mr. SOUDER. Is there any discussion in CBP about how to protect agents so they don't have a disincentive to release? In other words, this is a potentially highly contagious TB. He has a warning on his screen. This could have been bird flu.

We, in effect, are hoping they are patriotic American citizens to do this, but depending on what we have in the border stations, they are at risk.

Mr. AHERN. I think in this circumstance I would not agree. I think the lookout showed very specific actions to take to be able to isolate, ventilate, place the mask.

We also have personal protective equipment for our officers, as well, so they can handle these situations; and frankly, that is what the annual training that is provided to them is, basically personal protection.

I would like to go back to your last point, if I might, with Canada. Certainly, as has been discussed in this hearing previously, there was no indication the individual was traveling through Canada.

Mr. SOUDER. Let me—the problem here is that it isn't a question of whether there are indications of going through Canada, that we have these embedded groups, that there is no indication that a cocaine dealer is going to go through Canada; but we swap the information that we have got a person on the loose, so to speak.

If there is a terrorist coming from Pakistan, we don't wait until we see if they come through Canada, so that they can help us on the Canadian side; we tell them the information before they get there on the assumption they might. Because if we have a North American perimeter, they have got to have the same information at their airports and border crossings and ways to get into Canada or—in effect, we have to tighten up the north border. There are hundreds of miles with nothing on it.

Our assumption is the Canadians are going to have the same amount of information, with very few classified cases, that we do; and what you are saying is, if we knew they were going through

Canada. Well, that works for drugs, terrorists. Do we only tell the Canadians if we think they are going through Canada?

Mr. AHERN. I think what you point out is exactly the point I wanted to make in reference earlier, but not in enough detail.

It is clear we need to have greater access to information for flights and people coming into North America, not just the United States. We need to expand what we currently get on a very limited basis with Canada so we have complete visibility.

With that come a lot of issues. I am not trying to be a bureaucrat, giving you excuses here; I am trying to lay out some of the issues with the negotiation, sovereignty, information-sharing issues that we are going to work through as we go forward. We have already begun those discussions in the last couple of days with Canada on this particular issue.

As was even asked by the Congresswoman from New York earlier, about what more could we be doing throughout Europe, again each one of these agreements has to be negotiated through a group like the EU or individually on a binational basis. The reservation system we have are on individuals coming directly through the United States; it is clear that we need to have greater visibility into the global transportation chain, so we can identify people of risk who are looking to evade.

We need to work on that with all deliberate speed so we can shore up some of those vulnerabilities.

Chairman THOMPSON. Thank you. We have been more than hospitable.

Mr. Basham, one question to that: What if the guard who allowed Mr. Speaker to come in said, I did it because I didn't have the protective gear that I should have had in my location?

Mr. BASHAM. You are asking if he made that statement?

Chairman THOMPSON. Have you surmised that everything that this guard needed to protect himself from this TB situation was available to him at his station?

Mr. BASHAM. Yes, that was available to him. And actually the only response that this officer needed to take was to push a button that referred this individual to secondary for immigration. Those individuals would then have had the proper equipment and knew the proper response. They have all received the proper training.

So I am quite confident that that individual at that location had exactly what he needed in order to carry out his clear responsibility.

Chairman THOMPSON. I don't want to dicker with you, but some people are saying to us that that officer did not have a mask available to him at that site.

Mr. AHERN. I would say, certainly on the primary, he may not have had one available, but the instructions refer to secondary. It would begin that process at that point in time.

Again, without getting into the individual's actions—and, Congressman Lungren, I want to first assure you, we are moving with very fast speed, and I would be happy to provide further detail. We are not being bureaucratic in our answers or evasive, but there are rights and processes available to the individual. But I can assure you, from my review of the circumstances thus far, that is not the circumstance in this particular case at all.

Chairman THOMPSON. Well, I guess the point that I want to raise is that I want to make sure all our employees—if a notice goes up that says, “place mask on subject, place in isolation,” that we in fact also would have similar equipment available to the employee that is expected to put the mask on the particular person we are trying to stop.

I think there is a question as to whether or not that mask was available to that particular guard. Again, if the mask is not there, then I hope we have solved the problem going forward to make sure that all our guards have everything they need to do their job.

I now yield 5 minutes to the gentlelady from the Virgin Islands.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I will try to be brief in my questions. Dr. Gerberding, I guess, and maybe some of the other—Dr. Runge might want to answer also.

In my reading it seems that there is a lot of variation between the States in quarantine protocols and procedures, and I am wondering if you have guidelines that you share or do we need to do something more to standardize those procedures.

I notice that CDC has relinquished its quarantine to Denver, and I am wondering if Colorado has one of the better or one of the weaker quarantine procedures.

Dr. GERBERDING. All of the States have the capacity to isolate people with tuberculosis or quarantine them, but they do differ under the mechanisms for doing that and the criteria for stopping and starting.

We have not recently reviewed that across the board. In general in our country, because of something called the model public health law project, all of our States have inventoried their capacities needed for preparedness and have initiated regulatory and statutory improvements in that. So we are at a point now where we can re-inventory and see if there is anything that needs to be cleaned up.

Dr. GERBERDING. I doubt we will ever get 100percent consistency. That is why we need the Federal authority to override on what the States can do, so that we are there when their system doesn't work or when they need our help, we can use our authorities to step in and protect people.

Mrs. CHRISTENSEN. OK. A couple of questions have been asked about the long time it takes to get the cultures and the results of the susceptibility to antibiotics. I celebrated my 35th reunion a couple of years ago from medical school. And when I was in medical school it still took the same amount of time. Can you just help me to—is anything being done to reduce the time that it takes to get a TB result?

Dr. Gerberding, thank you so much for giving me a chance to make this point. I said before we are fighting TB with 19th century methodologies. There are ways to speed up the identification of at least isoniazid resistance and some of the first-line drugs. But that equipment is expensive and many of our State health departments cannot afford the latest and greatest technology.

Mrs. CHRISTENSEN. Which gets me back to my budget question.

Dr. GERBERDING. I think that there are budget questions in terms of domestic tuberculosis control here. As we develop different techniques they are inevitably going to be, at least on the front end, more expensive. And we have the haves and have-nots. I was

just in Guam, for example, another one of our territories, obviously, and they have no capacity to test for drug resistance anywhere in the Pacific Rim right now and they cannot send samples anywhere to have them tested.

Mrs. CHRISTENSEN. The countries they are close to have some of the highest rates of TB.

Dr. GERBERDING. Exactly. So we have some real gaps in our authorities and responsibilities and investments in this area. Having just come back, I am involved in trying to identify—and working with Dr. Castro, sitting behind me—to see if we can do a better job of supporting this capability everywhere.

But having said that, we can never do the tests faster than the bacteria grows. And in this particular patient, his first sample took 18 days to grow. So it is a slow grower and that meant it took a long time to find out it was XDR.

Mrs. CHRISTENSEN. And my last question will be—I haven't heard what was shared with the Italian Government, OK. I think I have come to understand that we can only—our list only applied to flights coming to the U.S., so that is why we didn't know the person who was traveling to Canada. But what was shared with the Italian authorities that could have prevented this?

Dr. GERBERDING. We are running into time line issues between time in Rome and time in Atlanta. So forgive me if I am not precise in this. But we first reconnected with the patient when he was in Rome at about 12:30 a.m., his time, on May 23. And at that time we had some conversations in the middle of the night for him about what should happen, what should he do. The next day we reached a member of the Ministry of Health who runs a program there for training purposes, who has a former CDC TB expert, and we asked for her advice. And then Dr. Castro, following that, notified the Deputy Minister of Health in Italy that we had the situation and that we may be needing their assistance to isolate the patient.

The TB expert was planning to come and visit with the patient the next morning, and he had already left. So that was our informal mechanism of connection.

We also notified the World Health Organization on the 24th. The WHO said, you know, right now the patient is not here, but we don't know where he is. This is not an incident of international public health emergency, but when you know more, let us know more, and then we will initiate formal contact with Ministries of Health. And the next day we got the itinerary, thanks to DHS, and we were able to go back and reconvened the conference call of the health ministers in the places where he had traveled and explained to them what was going on. So it was a 24-hour delay before the health minister was formally notified through the deputy mission. But I think, again as I said earlier, we were treating this person as if he was going to cooperate with our recommendations and our advice, and for the second time he proved us wrong.

Mrs. CHRISTENSEN. Thank you. Thank you, Mr. Chairman.

Chairman THOMPSON. Thank you very much. Mr. Lungren, Mrs. Lowey is going to run to a meeting. If you could bear with us for a little while, I will try to get—she has some dynamic New York questions to ask.

Mrs. LOWEY. I wanted to thank the Chairman and my colleague. And I apologize, Dr. Gerberding, I was here earlier listening to the testimony—you know life here on the Hill. So if I could just ask you a few questions and then in the time allotted respond as you will.

One problem I have had with the response is that on May 17 public health officials knew that Speaker had disregarded their request by flying to Europe 5 days earlier. And when Speaker chose to travel to Europe against either the recommendations or orders of public health officials, alarms should have immediately been sounded across the board.

First question: Why would CDC or any DHS agency trust Speaker to just remain in Rome after contacting him on May 23? Why wasn't someone there, even if from the Italian Government, which my colleague referenced, immediately? And on May 24, Speaker drove from Champlain to Albany, stayed the night, drove to New York City the next day. It is my understanding that someone from CDC spoke to Speaker via cell phone between Albany and New York. By then we knew he had traveled back to the United States against the wishes of CDC and DHS and then he misled a CBP officer at the Champlain crossing. This is clearly an individual who couldn't be trusted.

Why were the New York State Police not contacted, at least to escort Speaker to Bellevue Hospital? If CBP knew what kind of car Speaker was driving and his license plate, wouldn't he have been relatively easy to pick up? Why do you now trust Speaker, who posed a public health risk, to drive himself voluntarily to the largest and most densely populated city in the country? And if Speaker were a suspected terrorist, not just a public health risk, would local first responders have been contacted?

So I appreciate the fact that you are having an in-depth investigation, but these issues to me are so obvious, I find it extraordinary that you responded the way you did.

Dr. GERBERDING. First, let me admit that we distinguish how a terrorist should be treated from how a patient should be treated. And we are very medically minded at CDC, and I think our default premise is that we will trust the patient until we have good reason not to. And as I said earlier in my testimony here—

Mrs. LOWEY. Don't you have good reason not to?

Dr. GERBERDING. Exactly. That is the important point here. We at CDC learned about the patient on—that the patient may be in Greece or Europe, wherever, on May 18. We initiated an investigation to find out if that was true or not. Our first step was to call Delta Airlines, which was what he had been ticketed on, to find out did he travel, when did he travel, and so on and so forth. They had no record of him leaving the country. So we were not sure whether he was in the United States or whether he was abroad. He could have eloped in Georgia, for example, because of these issues and the medical advice that he was given.

So when we took steps to try to put him on the CBP—give me the right words—watch list, lookout. Lookout. We knew that they would be looking for him if he crossed one of our borders, but also that they would sweep periodically to see if he was listed on any flight itineraries that might help us recognize him.

When he returned from Italy—first of all, when he arrived in Italy we did make contact with him in the middle of the night, as I mentioned. And I think in retrospect that is the point at which we should have said, look, we cannot trust this person. He may say all the right things but he is not likely to follow our instructions, or we can't guarantee that he is following our instructions. So I think in retrospect a more aggressive intervention at that point is something that we wish we had done.

The fact that we were thinking that he was going to receive care and that we had initiated help, and we were trying to be as helpful as we could, dissuaded us from taking, I think, the aggressive steps that in retrospect I believe we should have taken. The patient flew into Canada. We were notified several hours after he crossed the border, and we met him as he entered New York City with the order of quarantine, which was the authority we need in order to engage law enforcement, arrest him, and otherwise interact with him.

We had notified New York State and city health authorities that this was in play and engaged their help. And everyone agreed that this plan made sense, and so he—in this case was extremely cooperative. We were in touch with him throughout his progress, and fortunately he did cooperate.

Mrs. LOWEY. I don't know if anybody else has a comment. OK. Well, I understand there is an in-depth investigation. But I guess what disturbs me, Mr. Chairman—and we see this with many hearings we have had—until there is an emergency, until there is an incident, we don't see appropriate procedures in place. So I would hope that as a result of this—and you said we would treat this person different from a terrorist. But if a terrorist wants to come in—and you recall what we did with anthrax, and we are very concerned about avian flu coming into New York City with this kind of strain, and I don't have the knowledge you have of TB or avian flu or another serious illness, and we don't know what the future is—could be a grave threat to all of us. So I hope this does get the in-depth investigation it appears to be having.

Dr. GERBERDING. May I just comment, sir?

Chairman THOMPSON. Yes.

Dr. GERBERDING. I would like to just make two quick points. First of all there have been 72,000 people diagnosed with tuberculosis in the United States since I have been the CDC director, and we have never had to do this before. So most people do cooperate. And the spirit of giving a person the benefit of the doubt is something that has been generally a reasonable approach. In this case, we should not have continued that assumption as time went forward.

But the second point is that when the patient came into New York City, I think like the passengers on the airplanes who have a reason to be concerned, they were in confined spaces with him for long periods of time, that is why we are investigating him; but I just want to for the public reassure that brief contact or being close to a person with even this deadly strain of TB for brief periods of time is not a health hazard. And we don't want people to be unnecessarily alarmed about exposure risk for this instance, and to just remind people that it is an airborne disease that does re-

quire prolonged shared breathing space. That is why we couldn't use the CDC plane to bring him here, but we could use the CDC plane to fly him down to Atlanta. If this were a pandemic influenza, very different story. And I think your point is very well taken.

Mrs. LOWEY. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMPSON. The gentlelady's time has expired. Recognize the gentleman from California for as much time as he may consume.

Mr. LUNGREN. Thank you very much.

Dr. Gerberding, you said you had 70-some thousand cases of TB since you have—or there have been since you have been director of CDC, and this is the first one you have had to issue an alert on. Is this the first one where the person that had the TB had a father-in-law that worked at CDC who also worked in the area of TB?

Dr. GERBERDING. I can't answer that. But I do know this—because I don't know the health histories of all the people at CDC—but this is the first time I have had to issue a Federal isolation—

Mr. LUNGREN. I understand. But my point is, you say we should have acted sooner, and we didn't know he had gone to Europe and we were trying to find out where he was. Wouldn't it be something to just ask his prospective father-in-law who is working in your operation?

Dr. GERBERDING. The father-in-law was also traveling, so he was apparently at the wedding or with the patient or someplace, because he was not at work. He was not reachable on his cell phone until he returned to the United States.

Mr. LUNGREN. Nothing was done differently because you had a high-ranking employee who happened to be involved with this individual?

Dr. GERBERDING. Actually, this has to do with the division of responsibilities at CDC. But the quarantine officer responsible for this investigation works at Hartsfield Airport. He was not aware that the father-in-law was a CDC employee when he initiated the steps of this investigation. So there is a separation of information in our organization on that one dimension.

Mr. LUNGREN. In your investigation, I presume you are going to ask the father-in-law as to what advice he gave the son-in-law with respect to whether he could travel?

Dr. GERBERDING. Those are exactly the kinds of questions that I am sure will be looked to in the internal review. But what we really have here is a man who has been a fine scientist at CDC, who had two compelling responsibilities: one to his job and to the government and to his division, and the other to his family.

Mr. LUNGREN. I understand that. I keep hearing this, and I empathize. But you know, we got 18, 19, 20-year-olds who are serving this country in Iraq and Afghanistan. We have examples where young men have thrown themselves on hand grenades to protect others. We have got people out there who have some real guts. They have compelling reasons to want to live and to want their families to see them. And you know there is a lack of responsibility here, certainly with Mr. Speaker.

And I just wonder if there is a lack of responsibility and accountability with respect to his father-in-law who knew more about TB than I know, who knows more about TB than 99.9 percent of Americans.

Now, let me ask you about this, because I am just becoming aware of this expression of XDR which stands for multiple drug-resistant TB, correct?

Dr. GERBERDING. Multiple drug-resistant TB is a less severe form of tuberculosis. XDR means extensively drug resistant. It means we basically have lost first-line and most of the second-line drugs.

Mr. LUNGREN. He is XDR?

Dr. GERBERDING. He is XDR.

Mr. LUNGREN. Why is that a compelling health risk?

Dr. GERBERDING. There are three dimensions of risk in this situation. The first is how infectious is he. He is not at zero risk for transmitting but, fortunately, has stayed at low risk.

Mr. LUNGREN. But based on what we knew at the time, the alert went out that he ought not to be traveling.

Dr. GERBERDING. What we knew at the time was that he had been smear-negative and culture-positive, that he hadn't been on effective treatment for what he had. We knew that his chest x-ray was abnormal. We knew he had a very slow-growing organism, and the questions about the time to detect this information. So the assessment at that time was that he was not at high risk of transmitting, but it was not a zero risk.

Mr. LUNGREN. Then why didn't you send your plane to go get him and bring him back?

Dr. GERBERDING. The CDC plane is not configured to isolate a passenger with a communicable disease from the pilots, the law enforcement agents, that would be necessary for the passenger.

Mr. LUNGREN. That is why I am a little confused. You suggested that people who were on the plane with him from Europe to Canada are not at high risk. But if they are not at high risk, why would the pilots in the plane that you would use from CDC be at an unacceptable risk?

Dr. GERBERDING. We make our decisions based on science.

Mr. LUNGREN. I understand. But do you see what I am trying to say?

Dr. GERBERDING. It is very important because we use the science to use the distinction how long can the passenger be in the plane and not transmit to others, and who in the plane is at risk. So a long flight from Europe when—at that time he had been 2 months without TB treatment, we didn't know whether he had become more infectious. That is a health threat and that is why we were investigating the patients.

Now we are focusing on the people who are two rows in front, two rows in back. That is where the science says risk exists. But when we needed to fly him from New York to Atlanta, it is a short flight. The flight from Atlanta to Denver is a short flight. We had law enforcement engaged, we had him in a mask, and we were able to mask the other passengers.

Mr. LUNGREN. I understand that. We are talking about you wouldn't send him on a plane from Europe to the United States because that was a long flight, correct?

Dr. GERBERDING. Correct.

Mr. LUNGREN. But yet he was on a long flight from Europe to Canada.

Dr. GERBERDING. Right. That is why we are contacting the passengers and testing them.

Mr. LUNGREN. No, no, no. I understand that. I am just trying to say, we are contacting them because we think it is serious enough for them to look at. We don't want to get them in a crisis mode because everything you have looked at so far apparently shows he was not in a communicable state.

Dr. GERBERDING. That is not correct.

Mr. LUNGREN. I am confused. I am really confused.

Dr. GERBERDING. Let me try to explain to you. There are degrees of infectiousness. This patient is at the lower spectrum, but not at zero. There are passengers on the plane who could have acquired TB from him under the circumstances of a long flight into Canada. With everything we know about him today, that is still the case.

In our country 17 percent of all tuberculosis is acquired from a person who has his degree of infectiousness. So he is communicable.

Mr. LUNGREN. So my question is, knowing what you know now, OK, would you make the same decision with respect to sending the CDC plane for him to bring him back from Europe to the United States?

Dr. GERBERDING. Absolutely not. I would not put the passengers in that plane at risk for more than 8 hours to travel with this individual.

Mr. LUNGREN. So it continues to be a serious problem?

Dr. GERBERDING. It is a serious problem.

Mr. LUNGREN. Let me just ask you—and the Chairman is being very kind on the time—but in our public knowledge today, unfortunately we don't consider TB to be very serious. I mean the average person would not think of that in the same terms as we did 40 years ago. When you saw people going to the hospital, it was more well known.

And this also goes to the question of why we treat this differently than we do terrorist groups because this is a medical condition. We have concepts of rights of privacy. We have concepts of someone being able to go to a doctor without everything being revealed. But we make an exception in communicable diseases such as TB. This could have been avoided if this gentleman had acted responsibly.

What message to the public would you give with respect to how we have to ask our individual citizens to be responsible when they have been identified with a communicable disease, even though—as you say, the various stages of it. And all of us want to—we all love denial when we have been told that we have a disease. So we will assume that we have the least serious form of it.

And if you give someone an option saying, well, we recommend you don't travel because we think it might be this, but we can't assure you, what statement would you make so the public out there would have some sense of the seriousness of that, so that in the future, other Mr. Speakers would say, you know something, to protect my fellow Americans—or if I am going to Europe, Europeans, anybody—I am going to take this burden for 2 months.

Dr. GERBERDING. You know most of the 72,000 people I mentioned took the approach you recommended. When there are exceptions that is why we have our authorities. But I think we—when this is all said and done, we are going to be able to look at the true impact of this set of decisions on this individual and his family. They should be, you know, enjoying a honeymoon or whatever in a much safer context. We are going to look at the cost of all of this effort in terms of person hours and we are going to look at how difficult this has been for passengers who should never have to be thinking about acquisition of an infectious disease on an airplane.

And I think that this has had a tremendous impact on all of us, including the workers at DHS and CDC and health organizations around the world. We will learn a lot. And we have already learned a lot. But I think it is a very sobering reminder of our individual responsibility, absolutely, but also our collective responsibility to continue to strengthen our network.

Let me just say one thing. If citizens could do one thing to help us today, the one thing that citizens could do would be to cooperate with completing the information about their address, their telephone number, and their e-mail when they travel, preferably electronically when we get there. But we really need to have systems that allow us to know who is on what plane and how to find them very, very quickly. So as a citizen, please take that little piece of paper or provide the most accurate information you can when you fly, because it might save your life.

Mr. LUNGREN. You brought up some questions about budget we have to consider. You have talked about things that we can do and we must do. And I hope that we proceed in that. But we can't give a false hope to average citizens that they can get away with being irresponsible because we are going to come save them and that we will take care of it no matter what they do. And I know you didn't intend that, but I just want to make sure people understand we will do things we have to do.

This is a tremendous learning experience. But at bottom, people have to take responsibility for themselves and have to be held accountable. Thank you.

Dr. GERBERDING. It is a network of shared responsibility and everybody has to do their part. Thank you.

Chairman THOMPSON. Thank you very much. We now recognize the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. And again I thank all of the witnesses.

Doctor, we opened the door for you to make some comments earlier about the technology that is available and the lack of availability of the technology in terms of the ability to diagnose the illness. I would like to open another door for you because it is my understanding that we have approximately 1.6 million people worldwide with TB. Is that about a fair assessment?

Dr. GERBERDING. Actually about a third of the world has been exposed and infected with tuberculosis. They are not all sick.

Mr. GREEN. Diagnosed.

Dr. GERBERDING. They have been infected with TB at some point in their lives.

Mr. GREEN. I understand. But my question to you is, those that have been diagnosed, is that about 1.6 million that we know of?

Dr. GERBERDING. Our expert says 9 million per year.

Mr. GREEN. Nine million people. And the treatment for this extreme case is a multiplicity of drugs, probably three or four, taken over some prolonged period of time. And you have to take it under the supervision of some medical specialist; is this true?

Dr. GERBERDING. In general, tuberculosis is treated with three or four drugs for 6 to 9 months. This extreme drug-resistant TB may have to be treated for years, it may require surgery, and we don't have very many drugs that will be effective at all. So this is very, very hard to treat.

Mr. GREEN. Exactly. So here is where I would like to allow you to just give us some of your insight. It has been said that this is—TB, generally speaking, is a poor person's disease; that because poor people have it and they can't get the treatment, that it tends to persist; and the people who have the ability to make the difference don't do the research because it is just not cost effective for them to do so. Any truth to this?

Dr. GERBERDING. I think we all believe in the public health world that TB and malaria are neglected in terms of the amount of research that is being done on them compared to the burden of illness, if you look at it from a global view. We are just seeing an increase in the investments now. But as I said, we are practicing 19th century medicine with a 21st century disease here.

Mr. GREEN. My final comment and opportunity for you to respond is this: Is it not true that the best way for us to deal with this—this is sort of a secondary, tertiary, or quaternary approach that we are taking—the best way to deal with it is at the source, the places in the world where we know that the disease itself is being promulgated. Is that not the best way? And, if so, should we not try to do more to help the developing countries and the world to cope with and manage and to eradicate this disease?

Dr. GERBERDING. The World Health Organization, in collaboration with CDC and a lot of others places has a program called the Stop TB Program. And it is a plan that says we can eliminate the transmission of this disease in the world. It is a hard job because it is everywhere right now. But in order to do that successfully, we have got to invest in new diagnostic tools, new drugs, and, most importantly, we desperately need a vaccine.

So the ultimate solution to this problem would be a better vaccine than the old-fashioned one that we are using in some parts of the world right now. It is not an impossible task. But it is going to take a long road ahead, and one of the most important barriers to success is going to be having drugs that allow us to treat drug-resistant TB.

Mr. GREEN. Thank you. I yield back.

Chairman THOMPSON. Thank you very much. We now recognize the gentleman from Colorado, Mr. Perlmutter, for 5 minutes.

Mr. PERLMUTTER. Thank you, Mr. Chairman. I really just had a couple questions since we are talking about Colorado. I read his quote, you know, that is in my timeline about "if I don't get to Denver I am going to die." What is that all about?

Dr. GERBERDING. You know Denver Jewish has a fine reputation for tuberculosis treatment and management. It is just really the center of excellence. There are many other places in the country that can also very effectively treat tuberculosis. But this gentleman was interested in having the gold standard, and National Jewish certainly meets that criteria.

Mr. PERLMUTTER. I am curious if, Commissioner, you think that—maybe someone has asked this, I apologize, I had to leave—whether or not something like this where you have sent strict instructions to your border enforcement folks, whether this would have happened on the southern border?

Mr. BASHAM. I can't say with any assurance that this could not have happened on the southern border. But I can tell you that the men and women that are out there on the front lines completely understand that they have a responsibility for stopping any threat that enters this country.

I believe this was one individual's independent decision, and we regard—we don't turn our back on the northern border. I mean, we consider the northern border to be as much of a responsibility and a challenge and a threat that could come from anywhere. So it doesn't matter where that individual would have crossed, we have a responsibility to stop that individual. We had the information. I think that 99.9—no. With the exception of this individual, I believe everybody else who had that information would have referred that person to secondary, and then when in secondary, they would have taken the proper precautions to make the alerts to CDC and handled that individual as a health risk.

Mr. PERLMUTTER. Last question, and again sort of on the rhetorical side. I don't want to export our problems to somebody else. I don't want to import theirs. If we have a citizen—and this is just more for information purposes—a citizen of the United States who has some illness like this drug-resistant tuberculosis, and they are in a foreign country—I mean do we just leave them there, or is there some way to get them back to our country in a way that is—you know, we have precautions and you know, safety—but get them back here to be treated? And this, from what we see here, was going to cost this guy an arm and a leg. And, you know, I don't know if that is the problem or what.

Dr. GERBERDING. Let me say what I know about options for the situation. The patient could pay out of his own pocket. Some people can do that. But it would require an air ambulance, and that is why it was so expensive because we need to isolate his air. The DOD has an aircraft that has an isolator in it and we checked to see if that could be made available, and it could, but we would have to reimburse the Department of Defense to do that. His private insurer, who paid for him to fly to Colorado, may have assumed responsibility to bring him home from Europe as well. We didn't have a chance to really flesh that out because he left before we had a complete picture there.

The CDC has an aircraft. We really wanted to try to bring him home in it because it would have been the simplest thing to do, but it wasn't safe for the law enforcement agents, the pilots, or the other passengers that would have been necessary to accompany

him on a long trip, which this would have been a long trip from Rome to Atlanta.

The last resource—and may have been the one we looked at short of finding a respiratory isolation—that we could provide was—the State Department deals with this kind of thing all the time. Travelers abroad don't have the means to get home, for whatever reason, including a communicable disease, they need a Medevac. And they have a program there to provide assistance to travelers who need this kind of help.

So had he followed the instructions to contact the embassy, and he was specifically given this information, he might have been able to find, as many many other travelers have found, an alternative way to come home.

So there were alternatives. I think what we would like in the future when it involves a disease that is potentially this consequential to the public health, an XDR TB, or the first case of H5 N1, or one of the things that is on the WHO's list of public health emergencies, we would like to be able to know that CDC could use an aircraft that we run basically, that has the appropriate isolation capabilities so that we can take that issue off the table. We don't have that capability right now. But we had asked for it and we are hoping that we will have both the authority and the resources to equip an aircraft to be able to provide that capability to us.

Our CDC aircraft has been very controversial. People wonder, why are you spending so much money on these airplanes? We need to keep our strategic national stockpile ready. We have to be able to fly anywhere 24/7 to support the deployment of our stockpile assets. So those two planes are needed for readiness, and we cannot count on them to fly to Europe to pick up a sick patient.

In this case our other CDC plane, which we use for a variety of nonstockpile-related missions, if we could make an adjustment in the air handling there—we have a plan, we know what engineering needs to be done, the aircraft company is willing to support us in this, and we have done inspections. We have had NIOSH in to investigate what is needed to be able to do this safely. We just need the final step of approval and go-ahead.

But I need to really, for the record here and for the public, say that as the CDC director I can't think of any agency who has more reason to be able to fly aircraft to save people's lives outside of the Department of Defense than this agency does. And we have proven many times that when we have used our aircraft, we have made a tremendous public health difference, whether it is sending botulism toxin or rabies vaccine or solving the problem in Panama with the cough syrup. We save lives with these efforts. It is expensive, but it is like insurance, and I think people deserve that level of support.

Mr. PERLMUTTER. I see my time has expired. I have a dozen other questions, but I—

Chairman THOMPSON. We have been very lenient, but we are actually going to put them in writing to the witnesses.

Thank you very much. Let me thank the witnesses for their generosity and time to the committee, as well as their valuable testimony, and the members for their questions. The members of the committee may have additional questions for the witnesses, and we

ask that you would respond expeditiously in writing to those questions.

Hearing no further business, the committee stands adjourned.
[Whereupon, at 1:34 p.m., the committee was adjourned.]

Appendix: Additional Questions and Responses

QUESTIONS FOR THE RECORD FROM THE HONORABLE BENNIE G. THOMPSON,
CHAIRMAN

RESPONSES FROM DR. JULIE L. GERBERDING

These answers are based on the information developed and identified by CDC to date.

1. Current U.S. public health policy requires that the CDC be apprised when MDR-TB appears also to be extensively drug resistant, so that CDC can provide laboratory confirmation of XDR-TB. Given the increasing incidence and prevalence of all types of TB, including MDR-and XDR-TB, should the CDC be apprised sooner? If so, how?

CDC Response: Please note that the number of new cases of TB has been declining every year in the U.S. The number of TB cases that are found to be drug-resistant is relatively the same every year.

Currently, CDC receives reports of all verified cases of tuberculosis. CDC provides laboratory confirmation of XDR TB, as needed. Upon request, CDC performs *drug susceptibility testing* for *Mycobacterium tuberculosis* isolates referred from state or other authorized health facilities that may not have the capacity to test themselves or that may want a second confirmatory test. CDC epidemiologists are satisfied that cultures received for drug susceptibility testing are sent to CDC in a timely manner. CDC's drug susceptibility testing relies on growth of TB bacilli, which is a notoriously slow-growing bacteria. The process requires 1 month to complete. However, when performed properly, it allows laboratorians to quantify the portion of the bacteria in the isolate that are resistant to a drug, which is important for predicting if a TB treatment regimen is likely to fail.

Question 2.: Should advanced laboratory diagnostics for XDR-TB be distributed to state public health laboratories so that they can conduct these tests at the state level? If so, would the CDC create an XDR-TB laboratory protocol to be put through the Laboratory Response Network, or would the CDC use a different mechanism to disseminate?

CDC Response: Ideally, all states should have the capacity to conduct second-line drug susceptibility testing or the capacity to refer isolates for this testing. Not all state public health laboratories conduct these tests because drug susceptibility testing for the second-line drugs is a difficult procedure to standardize and maintaining the proficiency to perform these tests reliably when only a few tests are performed each year is challenging and expensive. Proficiency to perform these tests requires an understanding of many elements, including origin of and criteria for drug resistance, potency and stability of drugs during laboratory manipulation, antimycobacterial activity of drugs when incorporated into different media, and reading, interpreting and reporting of results. To assist state public health laboratories with obtaining the necessary information on susceptibility to second-line drugs, states may submit isolates to the CDC laboratories for drug susceptibility testing to second-line drugs. About 20 of the state public health laboratories take advantage of this service.

National guidelines recommend second-line drug-susceptibility testing for strains with rifampin resistance or resistance to any two anti-TB drugs (National Committee on Clinical Laboratory Standards, Susceptibility Testing of Mycobacteria, Nocardiae, and Other Aerobic Actinomycetes; Approved Standard. NCCLS document M24-A [ISBN 1-56238-500-3]. 2003). These recommendations were reiterated by CDC in a recent MMWR published in March 2007. CDC communicates these and other guidelines to TB control programs through the CDC Morbidity and Mortality Weekly Reports and Recommendations, "Dear Colleague" letters, communication between program consultants and grantees, and educational webinars.

Question 3.: Due to the nature of the TB organism and the small amounts of the organism in clinical specimens, it was difficult for all of the organizations testing for TB at the local, state, and federal level to grow the organism quickly and in sufficient quantities to even allow for drug resistant testing to occur. How close is the CDC to creating testing protocols that will allow for testing with much smaller amounts of the organism, as well as other advanced procedures that would allow for quicker growth, and diagnostics that would allow for quicker identification?

CDC Response: Currently, culture-based tests are the standard, validated methods for drug-susceptibility testing of *M. tuberculosis* isolates. Protocols for rapid tests for detecting rifampin (a first-line drug) resistance (based on detecting mutations associated with this particular drug) have been validated and are available in a number of public health laboratories. However, public health departments may opt not to use this test because of the resources required to validate the findings, or they do not have sufficient numbers of cases to make this worthwhile.

However, this does not address the problem of the need for rapid second line drug tests. Rapid, molecular based tests have not yet been developed to detect resistance to the second-line anti-tuberculosis drugs because we have not yet identified the mutations that are associated with resistance to each of the second line drugs. Basic research is still needed to identify the genetic basis of resistance to each of the second-line drugs. The National Institutes of Health and CDC are funding and participating in such basic research as well as in translational research to use this information to develop reliable rapid diagnostic tests.

Question 4.: At what point was contact tracing begun by the state of Georgia? When was that information obtained by the CDC and incorporated into its contract-tracing activities, if at all?

CDC Response: A contact investigation was initiated by the Fulton County TB Control Program following the patient's first visit to the Fulton County TB clinic on April 25, 2007. CDC and the State of Georgia began working together on contact tracing related to the case on May 28, 2007.

Question 5.: What procedures exist for federal agencies such as CDC to contact passengers on airlines? It is our understanding that CDC could not effectively obtain passenger data, and finally asked the Department for help to obtain the information. However, there is no protocol in place for such a query. What protocols should be put in place to get CDC such passenger information?

CDC Response:

Procedures:

Contact tracing is a public health tool used by CDC and Quarantine (DGMQ) to notify travelers of their exposure to communicable disease threats during commercial flights (or on other conveyances). It is a time-intensive and laborious process. CDC does not have direct access to passenger manifests or traveler contact information and must rely on the cooperation of airlines, federal partners, and other ministries of health to obtain passenger information.

When CDC is notified (usually by a state department of health) that a person with a communicable disease entered the U.S. or traveled between states, CDC initiates a contact tracing investigation so that passengers and crew believed to be at risk of infection are notified and appropriate public health measures are implemented. Initial steps in this process are to verify disease diagnosis and risk of communicability and to verify travel information (e.g., travel dates, carrier name, flight number, departure date and city, arrival date and city, ill passenger seat number).

Once CDC has confirmation of the disease and the flight information, protocols to obtain passenger data are followed. Because no federal mandate requires that airlines collect, store and provide passenger contact information to CDC in case of a public health event, CDC reaches out to many different potential sources of passenger contact data and compile relevant information.

To obtain a manifest for international flights arriving in the U.S., CDC must issue an order requesting the manifest from the airlines. To do this, CDC has developed a formal Manifest Order and a protocol that is followed when requesting passenger data from the air industry. The formal Manifest Order, signed by the CDC Director, requires the airline to provide CDC with passenger names and seat numbers. It allows both the airline and CDC to share personal data while respecting patient privacy. CDC also relies on Memoranda of Understanding (MOU) signed between HHS/DHS (2005) and CDC/CBP (2007), which allow for the sharing of passenger data held by DHS agencies. Steps to obtain passenger contact data from CDC partners include:

1. Notify the air carrier that they should begin to compile necessary data and inform them that a formal Manifest Order from CDC will be forthcoming
2. Serve the air carrier the formal Manifest Order that states the carrier is obligated to provide data (that it has available) to the CDC

Often manifests only contain the name of the passenger and the seat number, so CDC also requests Customs Declaration Forms from Customs and Border Protection (CBP) (inbound international flights only), on which passengers are required to provide a U.S. destination or residence. It is important to note that the Customs Declaration Forms request only the address while in the U.S., not telephone numbers, so contacting individuals by using this information remains a challenge. CDC also requests that CBP provide additional passenger data from its Advanced Passenger Information System (APIS) and Passenger Name Records (PNR) databases.

In addition to the steps described above, CDC, primarily through its collaborative response to the Polonium incident in the UK, has also begun to work with the Department of State to obtain additional contact information for passengers who are US citizens. A protocol for obtaining such information is being formalized.

CDC manually reviews the passenger information it receives from the various sources to determine the passenger's contact information. This information is then compiled into an electronic database and reviewed for quality assurance (e.g., frequently the address and phone number provided by airlines refer to the booking or billing agencies and not the passenger). Data are then imported into CDC's secure eManifest data system, which automatically sorts passengers by states and sends a secure notification and passenger contact information to the state public health agencies. Each state is then responsible for notifying passengers identified as living in their jurisdiction. For passengers who are foreign nationals, CDC notifies the foreign embassies, consulates or Ministries of Health and provides whatever contact information is available. The outcomes of these notifications and actions taken are then reported back to CDC.

Contact investigation for the TB case:

For this case, the contact tracing investigation began May 25 when CDC learned the patient's full itinerary. CDC learned on May 18 that the patient had traveled internationally; however, his exact itinerary was not known. During May 18–25, efforts were focused on preventing the patient from continuing travel, exploring options for his safe return to the U.S., and determining his travel itinerary. CDC learned of his return to the U.S. on May 25, and contact tracing was initiated that day.

The process for requesting manifests noted above is used when flights are U.S. carriers. In this situation none of the flights the case took were U.S. carriers or had landed in the U.S., so CDC had to rely on foreign governments to obtain names of passengers on those flights. On May 25, CDC requested that Public Health Canada initiate efforts to obtain the manifest of the patient's inbound flight to Montreal. Canada promptly received the manifest from Czech Air and began matching manifest names with their customs declarations. On May 30, they confirmed that no U.S. citizens or residents were on board Czech flight 0104 other than the patient and his wife.

On May 25, CDC also spoke directly with French health authorities and requested assistance in obtaining the manifest from Air France for the outbound flight from Atlanta to Paris. CDC also requested assistance from Transportation Security Administration (TSA) in obtaining the manifest information for those flights. TSA offered to work with their French counterparts to obtain the manifest and passenger contact information for Air France.

Recognizing that the process of CDC's reaching out to passengers can be time consuming and ineffective, the flights of concern were released publicly through a Health Alert Notice and press conference on May 29. These notices included CDC phone numbers for affected passengers to call so they could be directed for evaluation and testing.

On May 31, CDC received the following manifest and passenger information:

- Via TSA, Air France Flight 385 manifest which included the entire list of all 435 passengers. The list did not differentiate between U.S. citizens or residents and non-U.S. citizens or residents and did not contain contact information.
- Via European Centre for Disease Prevention and Control (ECDC)- a list of the 26 U.S. citizens and residents seated either in the same row or two rows behind or in front of the case. This list included any contact information that French Health Authorities were able to obtain.
- Via Delta (Delta is a Code Share with Air France), passenger locating information on those U.S. passengers who made reservations through Delta.

- Via DHS (CBP), contact information for U.S. citizens and residents on Air France 385 (APIS records of the 2 flights).

Due to poor data quality and completeness, CDC requested assistance from the U.S. Department of State to obtain additional contact information for U.S. citizens and residents. CDC also contacted foreign embassies or consulates located in the U.S. for assistance in obtaining additional contact information for foreign nationals residing in the U.S.

Improving the Process:

CDC is working on a variety of activities to improve its ability to request and receive timely passenger contact information.

- Operationalization of the MOU with DHS: Memoranda of understanding between HHS/CDC (2005) and CDC/CBP (2007) are in place to ensure rapid sharing of information between government agencies to facilitate contact tracing on international flights. CDC and DHS have had a series of meetings to discuss and draft standard operating procedures (SOPs) by which to operationalize these MOU. These SOPs will ensure the quick exchange of information and will address when and whom to contact in case of a public health threat on an international flight.
- Quarantine Regulations: In 2005, CDC/HHS proposed changes to 42 CFR Parts 70 and 71 that would update and clarify interstate and foreign quarantine regulations. Included in the proposed changes are requirements for airlines to collect passenger contact information and transmit it to the Federal government. CDC is currently finalizing this rule.
- eManifest: In response to the Severe Acute Respiratory System (SARS) outbreak, CDC developed the eManifest system, a robust, web-based secure system that can rapidly access passenger contact information provided by airlines to facilitate emergency public health investigations by state and local health departments. In 2004, CDC signed an MOU with Delta Airlines to develop and pilot test strategies that might later be shared with all U.S. carriers around three areas: airline passenger/crew data capture and contact tracing, emergency response, and communications and education. Currently, only a few airlines submit electronic manifest data, which are often incomplete; therefore CDC still relies on other sources of data to obtain reliable contact information and manual entry of these data into an electronic database, which can then be imported into eManifest.
- Passenger Locator Forms: CDC uses Passenger Locator Forms when illnesses are identified during travel. These forms are distributed to passengers who have been potentially exposed to a communicable disease, allowing CDC to contact them to provide relevant public health messages and/or coordinate necessary treatment and care. These forms are scannable to allow rapid conversion of paper forms to electronic data which can be imported into the eManifest system

Question 6.: The finding of MDR-TB by the Georgia State Public Health Laboratory caused them to alert the CDC so that it could test for XDR-TB. Was this the proper protocol to follow? What is the formal procedure by which CDC is asked to perform this analysis? Should CDC have been asked to perform the testing earlier?

CDC Response: CDC is a reference laboratory that routinely assists state and local public health laboratories conduct testing, particularly drug susceptibility testing, on M. tuberculosis isolates. State public health laboratories may request CDC assistance at any time. The Georgia State Public Health Laboratory is one of about 20 state public health laboratories that rely on the CDC laboratory to assist in drug susceptibility testing for second-line drugs. The Georgia laboratory followed the established, appropriate procedure in alerting CDC that this culture be tested.

Question 7.: Why did a CDC staff member physically go to the Georgia State Public Health Laboratory to pick up the specimen? Was this the proper protocol to follow? Does the CDC dispatch its own personnel to physically pick up TB specimens from public health laboratories throughout the Nation and its territories? If not, what caused the CDC to decide it needed to physically pick up the specimen this time (acknowledging the very small distance to drive between the main campus of CDC and the Georgia State Public Health Laboratory)?

CDC Response: In response to the threat of MDR TB, CDC increased funding to strengthen public health laboratories and placed emphasis on providing prompt and reliable laboratory results. When an isolate is identified that requires priority testing, CDC works with the state public health laboratories to conduct that testing as rapidly as possible. In almost all cases, the most time-effective and cost-effective

method for getting an isolate to the CDC laboratory is for the state public health laboratory to send it to CDC using one of the commercial overnight delivery systems. An exception is the Georgia state public health laboratory for which the most efficient method is courier. On occasion, one of the CDC laboratory employees stops by the public health laboratory to pick up specimens since the lab is in close proximity to CDC's campus.

Question 8. How does an "isolation order" differ from a "provisional quarantine order"?

CDC Response: Based on authority contained in section 361 of the Public Health Service Act (42 U.S.C. § 264), CDC may apprehend, detain, or conditionally release individuals arriving into the United States from a foreign country or moving from one state into another who are reasonably believed to be infected with or exposed to certain specified communicable diseases. On November 30, 2005, HHS published a Notice of Proposed Rulemaking proposing updates to communicable disease regulations found at 42 CFR parts 70 and 71. 70 Fed. Reg. 71,892 (Nov. 30, 2005). As part of this process, HHS proposed new procedures for the issuance of a "provisional quarantine order" and a "quarantine order." While not yet finalized, CDC followed administrative procedures similar to those in the proposed rule. A provisional quarantine order imposes a public health restriction that, for example, may include, isolation, quarantine, medical monitoring and reporting, or some other form of public health intervention. Such an order is temporary in nature and may be superseded by a permanent order that continues the public health restriction until the individual is no longer considered to be infectious.

Question 9: There appears to be confusion about what prohibitions health officials can place on an individual with an infectious disease. According to Dr. Gerberding, health officials "usually rely on a covenant of trust to assume that a person with tuberculosis just isn't going to go into a situation where they would transmit disease to someone else." At this point, does CDC believe that a covenant of trust should be the basis of national and international public health policy?

CDC Response: In the vast majority of situations when a patient is diagnosed with an infectious disease and told not to travel, the patient operates under a covenant of trust. The state health department advises the patient, explains what needs to be done to provide protection, and the patient generally cooperates. If the patient does not cooperate, the state has the legal authority to isolate or quarantine the individual. Each individual state is responsible for intrastate isolation and quarantine, and the states conduct these activities in accordance with their respective statutes. These authorities vary a great deal by state. In Georgia, for example, a court order is necessary for a patient to be isolated involuntarily, and the patient must first demonstrate that he is not compliant with medical advice. Therefore, in this case the state could not issue such an order until the patient actually did something that was against medical advice. If a state felt that it could not adequately isolate a patient, it could contact CDC to determine whether Federal quarantine authorities could be used. Federal authorities allow CDC to act in the event of inadequate local control, if the patient has a specified communicable disease and is moving between states, or if the patient has a specified communicable disease and represents a public health threat to other persons who may then be moving between states.

This TB case raised a number of issues that CDC is examining. One issue is whether state laws need to be strengthened to give states the ability to restrict the movement of patients before they demonstrate noncompliance with a medical order. If a state believes the patient has a strong intent to put others at risk, the health authorities of that state need to have the authority to take action absent documentation of intent to cause harm. CDC has been supporting work being done by Georgetown University and Johns Hopkins University to develop the Turning Point Model State Public Health Act and the Model State Emergency Health Powers Act. These Acts were developed as planning tools to assist state, local, and tribal governments in assessing their current public health laws and to identify areas that may need updating or improving.

Secondly, the underlying issue that this case raised is how to maintain the balance between the needs of the patient and protecting the public's health. In this situation, CDC constantly gave the patient the benefit of the doubt, failing to use the most aggressive measures earlier in the process; however, in future such situations CDC does not want to go so far in the opposite direction that the result is unnecessarily restricting the movement of people. This balance will be difficult to attain. CDC is reviewing the lessons learned from this case and ensuring transparency in decisions, their timing, and how lessons can be applied in the process.

CDC is also examining the application of its quarantine authority to situations of patients moving out of the country. Historically, the use of quarantine has been devoted to keeping people out and containing them. This case represents the first time that CDC has had to address preventing a person in the United States from leaving.

Question 10.: Why the CDC chose to notify the local Atlanta CBP remains unclear. Department officials admit that CDC did not notify Customs and Border Patrol HQ in Washington. Why did the CDC notify the local Atlanta CBP and not simultaneously communicate with the Department of Homeland Security—the Office of Health Affairs, CBP HQ, or any other Departmental entity?

CDC Response: CDC quarantine stations have developed strong partnerships with their local DHS partners and typically work directly with them at the local level. The Atlanta Quarantine station took the lead on the initial part of the investigation until it was determined that additional resources and broader expertise were needed.

As a result of this case and at the request of HHS and DHS leadership, a team of individuals from DHS, HHS Washington, and CDC (DGMQ and DTBE staff) met to review the response to the recent XDR-TB case and to develop standard operating procedures (SOPs) for future such responses. The SOPs are intended to formalize actions in three areas:

1. CDC/DGMQ requests for DHS assistance in taking actions to protect the public from infectious threats during travel and at U.S. ports of entry;
2. Internal CDC/DGMQ procedures for determining the need for requesting DHS assistance, recognizing that DHS actions to protect the public's health may restrict an individual's movement; and
3. CDC/DGMQ communications with international partners around the issue of public health threats and the crossing of international borders.

The meeting resulted in draft SOPs for immediate use; these drafts are being revised in response to critical review. This is just one component of CDC's evolving partnership with DHS counterparts at ports of entry.

Question 11.: According to Department of Homeland Security officials, CDC suggested to Speaker that the federal government had ways of keeping him from entering the U.S. Was this proper use of protocol? Does CDC believe that this threatening statement caused Speaker to become frightened and disregard CDC directives to either stay in Italy to seek medical attention or find a safe way to get back to the U.S. that would prevent others from being exposed?

CDC Response: On May 22, a CDC quarantine officer spoke with the patient in Rome, Italy, and informed him of his XDR TB diagnosis; explained the severity of the disease; instructed him to terminate all travel and to cease use of commercial air carriers; and initiated conversations about isolation, treatment, and travel alternatives. The patient was offered assistance in finding appropriate airborne isolation facilities in Italy and agreed to cancel his planned travel to Florence the following day.

On May 23, the same officer spoke with the patient in Rome and informed him that CDC would help him get the best care at a hospital in Rome (which had been identified) while options for safe return were explored, including air ambulance options. The patient was instructed to call American Citizens Services in Rome, and this contact information was provided to him. In addition, CDC explained that a former CDC staff member and TB expert working with Italian Ministry of Health would meet with the patient the next day to provide assistance. The patient provided hotel information for where he was staying so the Italian health official could visit with him the following day. During this call the patient was told he was on a CBP watch list and that airlines had been notified. The patient was informed of these procedures, not as a punitive threat, but to remind him that CDC was taking the situation very seriously. Again, he indicated that he did not plan to travel and would meet with the Italian health official the following day.

Question 12.: When was the use of an air ambulance or other modes of transportation recommended and/or discussed with Speaker to transport Speaker back to the U.S. (as opposed to privately chartering an airplane that would have cost about \$50,000)?

CDC Response: When the CDC official spoke with the patient in Rome on May 23, a number of different options were discussed to safely repatriate the patient, including air ambulance and chartering a private plane. The patient also asked whether the CDC plane was an option.

On the afternoon and again in the evening of May 24, CDC officials convened to discuss options for transporting the patient back to the United States. The appropriateness of transportation via DOD or the CDC airplane, the safety and health of crew and pilots, and CDC's legal authorities in this setting were all examined. However, before any decision could be finalized regarding the use of the CDC plane or other means of transportation, CDC learned that the patient had already flown commercially into Canada and then re-entered the United States via rental car, and thus, the discussion of the use of the CDC plane for a trans-Atlantic flight was discontinued.

Question 13.: Dr. Gerberding has indicated that the decision not to utilize the CDC jet to transport Speaker was made based on scientific evidence indicating that transporting patients with TB for flights over eight hours would be dangerous to others riding in the same airplane. However, the flight could have been split into legs. For example, flight time from Rome to London is 2.5 hours. Flight time from London to Reykjavik is 3.0 hours. Flight time from Reykjavik to New York City is 6 hours. Flight time from New York City to Atlanta is 3.0 hours. Please provide the scientific justification for not utilizing the CDC aircraft for flights of less than eight hours duration. When can and does the CDC fly person using its own travel assets or those of the Department of Health and Human Services?

CDC Response: Breaking down the flight into shorter flight segments would not have substantially lowered the overall risk to the co-travelers or pilots (assuming they were all on board with the patient) throughout each leg of the journey. The risk increases cumulatively as more time is spent in close proximity with someone who can transmit the infections. So, if all persons were on each leg of the journey together, then the risk would have been basically the same as in one long journey, or perhaps even greater given the additional time needed for multiple-take offs and landings. In theory, the risk of each individual would have been potentially lower if you had no co-travelers or caregivers accompanying the patients and a different crew of pilots available for each leg of the flight. This was not the case, however, and logistically would have posed its own challenges. In addition, frequent ground stops would have potentially increased the number of potentially exposed persons on the ground, especially if the plane had to be serviced, or entered for any reason, or if the patient had to exit the plane for any reason.

The use of the CDC plane to transport a sick person from one location to another must comply with Federal Travel Regulations, be recommended by the CDC Director, and have HHS Assistant Secretary for Administration and Management (ASAM) approval. Using the plane for this purpose also requires approval from the General Counsel if any non-Federal travelers will be traveling on the CDC plane. Careful consideration is also given to the current medical condition of the patient and the safety of the crew and attendants before a decision is made related to the transport of an ill or infectious patient.

Question 14.: Was the CDC under the impression that the Department placed Speaker on the "no-fly" list based on the CDC conversation with CBP Atlanta on May 22?

CDC Response: On May 22, CDC quarantine officials contacted the Atlanta Customs and Border Protection and requested the patient be placed on the CBP watch list. CBP confirmed that the patient's information had been placed on its watch list later in the day.

After speaking to the patient on May 22 and 23 and learning that he intended to return to the U.S. in early June, quarantine officials contacted Delta and Air France to request that he be prevented from boarding.

Once it was learned that the patient had left Rome and his exact location and intention to travel were unknown, CDC contacted the Transportation Security Administration (TSA) on May 24 to request the patient be placed on a no-fly list to prevent the patient from boarding a commercial aircraft destined for the U.S.

The patient was put on the no-fly list at 15:15 EDT on May 24, 2007.

Question 15.: Notification of foreign governments is an important issue to resolve. What policies and procedures are in place to notify foreign health authorities (like the World Health Organization) in situations such as this?

CDC Response: The International Health Regulations, which went into effect in June, 2007, provide policies and procedures to notify foreign health authorities. CDC followed the International Health Regulations and notified the World Health Organization and Italy on May 24. On May 25, WHO notified France, the Czech Republic, Greece, and Italy.

Question 16.: European governments were notified by WHO. Did the CDC itself also notify any European government (especially in those countries on Speaker's wedding and honeymoon itinerary)? If so, when?

CDC Response: Although CDC's Division of Global Migration and Quarantine was notified by the GA Department of Health on May 18 that the patient may have traveled internationally, Georgia Health Officials were unable to provide an itinerary or confirm his whereabouts. During May 18–22, CDC staff communicated with the Fulton County Health Department, GA DOH, the airlines and the patient's family members to seek additional information about the patient's travel itinerary. The attempts were unsuccessful.

On the evening of May 22 EDT (May 23 in Rome), CDC learned that the patient was in Rome. Later that same day, Italy was notified through informal channels. CDC reached out to a former CDC staff member, a TB expert who works for the Italian MOH, and she confirmed that she notified Italian authorities on May 23. Dr. Ken Castro, Director of the Division of Tuberculosis Elimination, formally notified Italy on May 24. On May 24, CDC notified WHO; and on May 25, WHO subsequently notified France, the Czech Republic, Greece, and Italy. On May 25, CDC notified the Public Health Agency of Canada and requested that the manifest be requested for the patient's inbound flight to North America. On May 25, CDC spoke directly with French Health Authorities, alerted them to the situation, and requested assistance in obtaining the manifest from Air France.

Question 17.: Did CDC ever suggest to Speaker that he turn himself into the U.S. embassy in Rome? If so, did the CDC also notify the State Department that they had given Speaker this option, so that they communicate this to the embassy and prepare their medical personnel for Speaker's arrival?

CDC Response: The patient was instructed to call, but not physically go without calling first, to the American Citizens Services (ACS) in Rome, explain his situation, and seek their assistance in repatriation. This instruction was given to him very late in the evening (Rome time). Before CDC could contact ACS in Rome the following day7, the patient had left the hotel.

Question 18.: What international procedures are in place to notify CDC (and vice versa) of the results of the testing? Would Italian health officials have had to start all over again with TB testing, or could Speaker's medical information been transferred easily? What role if any would WHO have played in the testing?

CDC Response: CDC would not routinely be notified about the results of such testing by physicians in another country, but in cases where CDC is collaborating with other health authorities the information likely would be shared. Physicians with responsibility for treating a patient usually want to run and analyze test results themselves prior to treating the patient. However, physicians routinely consult with one another on test results as well as treatment options once patient permission has been documented. WHO would not have had a direct role in patient testing.

Question 19.: Why did the CDC send Speaker to New York City when he was a potential health risk? What safety procedures did CDC advise him to follow as he traveled from Albany to New York City? Why didn't CDC go to get him before he could possibly infect other people?

CDC Response: Once CDC officials reached the patient on his cell phone, officials determined that the risk for both the patient and the public was significantly less if he traveled directly to a nearby hospital to be evaluated than if he were to drive all the way to Atlanta, which would likely have meant numerous stops and a possible hotel stay. During this call, CDC officials instructed the patient to report directly to the isolation hospital in New York (Bellevue Hospital), where he would be served a quarantine order for isolation and evaluation. He was also given specific instructions as to how to protect the public from possible exposure, including the wearing of face masks and staying out of crowded public areas. He followed this direction, and at Bellevue was served a Federal order of provisional isolation and medical examination, authorizing medical evaluation and respiratory isolation for 72 hours for infectious TB.

Question 20.: Please describe the communications between the CDC and HHS as this situation unfurled. Who made the decision for the CDC to have a press conference warning the public about Speaker?

CDC Response: CDC kept HHS informed as the situation developed using existing chain of command structures to facilitate operations and communication (CDC Director's Emergency Operations Center to the DHHS Secretary's Operation Center). CDC held a press conference to alert passengers on the Air France and Czech

Air flights that they may have been exposed to a person infected with extensively drug resistant tuberculosis (XDR TB).

QUESTIONS FOR THE RECORD FROM THE HONORABLE MIKE ROGERS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

These answers are based on the information developed and identified by CDC to date.

Question 1.: What modeling and simulation capabilities does CDC have to identify the migration of contaminants inside facilities and conveyances?

Much of CDC's modeling and simulation capabilities to identify the migration of contaminants inside facilities and conveyances is being done through two ongoing projects, "Computational Fluid Dynamics in Control Technology" and "Aircraft Cabin Airflows." Together, these projects have partnered with Boeing Commercial Airplanes, national laboratories, and universities (including the FAA Center of Excellence for Aircraft Cabin Environmental Research) to answer questions about how particles are transported by the airflow patterns on a commercial airliner. Specifically, the Boeing 767 was studied, both experimentally and through modeling. The particles at issue here are droplets expelled by the infected passenger. Several journal articles and technical reports have resulted. The tools developed in these projects can be applied to XDR-TB. CDC also has an ongoing collaborative relationship in bioterrorism prevention and preparedness work with Sandia National Labs (which partners with LLNL) and Pacific Northwest National Labs.

The aircraft involved in the current incident are likely to have somewhat different cabin airflow patterns than the Boeing 767. However, through consultation with Boeing engineers, informed estimates can be made that relate the previous research to the current aircraft. We are also able to construct a model of any aircraft cabin, using computational fluid dynamics (CFD). The details of the cabin geometry, such as seats and ventilation inlets, would require information from the manufacturer of the aircraft. A complete particle transport CFD model would be several months in the making.

Question 2.: Is there value in CDC knowing when a contamination has occurred, rather than for people to come forward with symptoms?

For tuberculosis, there are years of study that indicate that the primary mode of transmission is from person-to-person and there is no existing evidence that would suggest that the general environment of aircraft or other facilities, for example, environmental surfaces would play a role in the transmission of tuberculosis. A recent study, conducted by British Airways suggests that the aircraft is a low-risk setting for environmental transmission of TB. Where transmission has occurred it usually involved close contacts and highly infectious individuals. Therefore, there is no supporting evidence that would necessitate any changes to the routine cleaning practices currently used on aircraft or other transportation facilities. Environmental transmission has been associated with healthcare facilities and certain medical procedures. In these instances, contaminated medical devices (primarily attributed to inadequate cleaning and disinfection or sterilization of medical equipment) have played a role in healthcare-associated TB cases.

Question 3.: How long does an aircraft or facility remain infectious after it has been contaminated? For example, how long would a facility that was contaminated by highly pathogenic influenza or anthrax remain contaminated?

The possible duration of persistence after contamination is organism-dependent. In addition, the relevance of "contamination" varies with the organism in question, since even though an organism might persist, it may have zero potential for delivery to a susceptible person in a manner that would lead to infection. If an aircraft were contaminated by a highly pathogenic strain of avian influenza virus from a passenger who had been confirmed subsequently as infected, the potential infectiousness of any "contamination" would depend upon many factors. If the passenger had been coughing, surfaces in an area of 1—2 meters (about 6 feet) from the passenger could become contaminated. The concentration of H5N1 virus in expelled large droplets or small particle droplet nuclei is unknown. The persistence of viability of expelled respiratory secretions on surfaces depends upon several factors including the concentration of virus, temperature, and humidity. If the passenger had not been coughing, the area of contamination would be minimal. There is currently no evidence to suggest that inanimate objects or contact with human respiratory secretions has resulted in H5N1 virus transmission to people. However, routine hygiene should incorporate appropriate cleaning of surfaces in the aircraft that are likely to be contaminated by ill passengers at any time.

Anthrax spores present a special case because they are able to persist in the environment for years. Decontamination strategies for intentionally released anthrax spores should not be generalized to other less durable organisms such as respiratory pathogens.

Question 4.: In your view, how valuable is the ability to cleanse or decontaminate conveyances such as aircraft and facilities after exposure?

Environmental surfaces become soiled with respiratory secretions and other potentially infectious material wherever humans are present. Therefore routine hygiene should include appropriate cleaning of surfaces that are likely to be contaminated by ill individuals. In a passenger aircraft, surfaces that are easily contaminated include arm rests, tray tables, and lavatory surfaces. These frequently touched surfaces should be the focus of routine cleaning to reduce potential for transmission of respiratory and other pathogens. Cleaning agents must be both demonstrated to be effective in inactivating microorganisms and compatible with the maintenance requirements for the materials on the aircraft. When an ill passenger is identified, e.g., an individual suspected or confirmed to have had avian influenza, cleaning should focus on the listed surfaces within about 6 feet of where the individual was seated, and on the lavatory facilities the individual may have used. Efforts should always be made to assist any passenger with respiratory symptoms to cover their coughs and contain their respiratory secretions with tissues, and to use proper hand hygiene during and after the flight. Special decontamination strategies may be useful when faced with a situation such as an intentional release of anthrax spores.

