THE SILENT WAR: ARE FEDERAL, STATE AND LOCAL GOVERNMENTS PREPARED FOR BIOLOGICAL AND CHEMICAL ATTACKS?

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT EFFICIENCY, FINANCIAL MANAGEMENT AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

OCTOBER 5, 2001

Serial No. 107–95

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

81–522 PDF WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
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THE SILENT WAR: ARE FEDERAL, STATE AND LOCAL GOVERNMENTS PREPARED FOR BIOLOGICAL AND CHEMICAL ATTACKS?

FRIDAY, OCTOBER 5, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY, FINANCIAL MANAGEMENT AND INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the subcommittee) presiding.

Present: Representatives Horn, Putnam, Schakowsky, Maloney, and Cummings.

Also present: Representative Ehrlich.

Staff present: J. Russell George, staff director and chief counsel; Matt Phillips, professional staff member; Mark Johnson, clerk; Bonnie Heald, communications director; Jim Holmes, intern; David McMillen, minority professional staff member; and Jean Gosa, minority clerk.

Mr. HORN. A quorum being present, the hearing of the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations will come to order.

On September 11, 2001, the world witnessed the most devastating and horrific attacks ever committed on U.S. soil. Despite the damage and enormous loss of life those attacks caused, they failed to cripple the Nation. To the contrary, this Nation has never been more united in its fundamental belief in freedom and its willingness to protect that freedom.

The diabolical nature of these attacks was an unimaginable wake-up call to all Americans: We must be prepared for the unexpected. We must have the mechanisms in place to protect this Nation and its people from further attempts to cause such massive destruction.

Today, the subcommittee will examine the Nation's ability to respond to the possibility of a biological or chemical attack. Even though most experts believe that the likelihood of such an attack is relatively low, we must ensure that the Nation has an emergency management structure that is prepared to handle even the most remote possibility of such an attack.

The aftermath of the September 11th attacks clearly demonstrated the need for adequate communications systems and rapid deployment of well-trained emergency personnel. Yet despite bil-

lions of dollars in spending on Federal emergency programs, there are serious questions as to whether the Nation's public health system is equipped to handle a massive chemical or biological attack.

A September 2000 report from the General Accounting Office—and that is part of the legislative branch headed by the Comptroller General of the United States—GAO found that the 1999 outbreak of the West Nile Virus severely taxed the New York public health system. This outbreak, which was ultimately contained, affected hundreds of people. A biological attack could affect thousands more.

Today, the subcommittee will examine how effectively Federal, State and local agencies are working together to prepare for such emergencies. We want the people of this Nation to know that they can rely on these systems, should the need arise.

I want to note that we had hoped to have Mayor Giuliani with us today, but the city's ongoing needs, rightly, take a higher priority. At the conclusion of today's hearing, we will recess and reconvene at a later date to allow the Mayor an opportunity to contribute his expertise to this hearing. In addition, the subcommittee will be conducting similar hearings throughout the country.

We are fortunate to have witnesses today whose valuable experience and insight will help the subcommittee better understand the needs of those on the front-lines—representatives of the Nation's hospitals and its cities, counties and States. We want to hear about their capabilities and their challenges. And we want to know what the Federal Government can do to help.

We welcome all of our witnesses and we look forward to your testimony.

We'll start now with an opening statement from the ranking individual, Mrs. Maloney, and Ms. Schakowsky and we want to thank them for the help they've given us in gaining this particular group of individuals.

And so I now yield up to 5 minutes to Mrs. Maloney, the gentlewoman from New York.

[The prepared statement of Hon. Stephen Horn follows:]

Opening Statement
Chairman Stephen Horn
Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations
October 5, 2001

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We welcome all of our witnesses and look forward to their testimony.

Mrs. MALONEY. Thank you, Chairman Horn, and Ranking Member Schakowsky for holding this hearing. I would also like to thank our panel of witnesses.

Over the past few weeks I have been to Ground Zero many times in New York. The amount of destruction and devastation I have witnessed, more than any other assault on U.S. soil, is indescribable and overwhelming. While we have maintained our strength and resolve to rebuild and come back stronger than ever, I shudder at the thoughts of what-ifs: What if those planes had contained a chemical component or had the capability of releasing a biological weapon? How would our response teams have reacted? And could we have handled a two-pronged attack?

We now have to think of scenarios that would normally, in the past, have been unthinkable, in order to prepare for any type of attack that may come. The FBI disregarded a report of a man who showed up at a flight school wanting to learn how to steer a plane, but he didn't care about learning how to take-off or land. Now we have to take every threat seriously. As we quickly learned on September 11th, the world is different and this war is different than any we have fought in the past.

The terrorists are becoming more sophisticated and their network is widespread. They are using unconventional, unpredictable means. If they are willing to give up their lives, they can do enormous harm. And the enormous harm could include chemical or biological attacks that threaten the lives of millions of Americans.

I am concerned that despite all the carnage we've seen in the financial capital of the world, we are not making sufficient preparations for a worst-case scenario, that we are more complacent than we are prepared.

I am told that anthrax and smallpox represent two of the most likely forms of biological warfare. We have 7 to 10 million doses of smallpox vaccine and there are 280 million Americans. One vial of anthrax has the potential to kill tens of thousands of people in the New York City subway system. If anyone can convince me by the end of this hearing that we have the infrastructure in place to react to such an attack and prevent mass carnage, I will be pleasantly surprised.

I look forward to learning about our local, State and Federal Government's level of preparedness and ability to coordinate and cooperate with each other. It is important to identify the weaknesses in our infrastructure and then work to address them so we can improve our reaction in a time of crisis.

I am also interested in learning about the availability and effectiveness of vaccines and antibiotics for certain bioweapons. Are we partnering with our pharmaceutical companies to prepare for an attack or are we going about business as usual after September 11th? We must draw on all of our resources, both public and private, to detect and respond to all terrorism.

Again, I thank the chairman and the ranking member for calling this hearing, and I thank all of our panelists for being here. I hope that this will be the first of many hearings that will focus on this tremendously important issue to our country.

[The prepared statement of Hon. Carolyn B. Maloney follows:]

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STATEMENT OF CONGRESSWOMAN CAROLYN B. MALONEY

Committee on Government Reform
Subcommittee on Government Efficiency, Financial
Management and Intergovernmental Relations
" A Silent War: Are Federal, State, and Local Governments Prepared for Biological and Chemcial Attacks"
Friday, October 5, 2001
Room 2154, Rayburn House Office Building

Thank you Chairman Horn and Ranking Member Schakowsky for holding this hearing. I'd also like to thank our witnesses today.

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While we have maintained our strength and resolve to rebuild and come back stronger than ever, I shudder at the thought of the 'what ifs:' What if those planes had contained a chemical component or had the capability of releasing a biological weapon? How would our response teams have reacted and could we handle a two-pronged attack?

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As we quickly learned on September 11th, the world is different and this "war" is different than any we have fought in the past. The terrorists are becoming more sophisticated and their network is widespread. They are using unconventional, unpredictable means. If they are willing to give up their lives, they can do enormous harm.

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I am also interested in learning about the availability and effectiveness of vaccines and antibiotics for certain bioweapons. Are we partnering with our pharmaceutical companies to prepare for an attack? Or are they going about business as usual after September 11? We must draw on all of our resources, both public and private, to detect and respond to all forms of terrorism.

Again, thank you for calling this hearing.

Mr. HORN. I thank the gentlewoman.

We will now swear in the witnesses. This is an investigating committee, and we ask that you stand, raise your right hands. And this includes also the staff behind you; just take the oath, too, so we don't have to keep making changes. The clerk will then get the names of the support.

[Witnesses sworn.]

Mr. HORN. I will note for the record that all the witnesses and their support staff have taken the oath.

We start with a very interesting individual in particular. Our first witness has a very unique perspective to share with us, and that's Mrs. McHale, who was a victim of the chemical attack that occurred in Tokyo in 1995; and we appreciate very much her willingness to come before the committee and relate her experience.

Mrs. McHale, it's a pleasure to have you.

Mrs. MCHALE. Thank you, Mr. Chairman, members of the committee.

Mr. HORN. We're going to have to have the clerk maintain getting the microphone there with everybody.

We have a terrible system in this place, and you would think, with all the billions we give out to the executive branch, we don't give much to ourselves.

So here we are. OK.

STATEMENTS OF SANG-MI McHALE, SURVIVOR OF 1995 SARIN GAS ATTACK IN TOKYO; AMY SMITHSON, Ph.D., DIRECTOR, CHEMICAL AND BIOLOGICAL WEAPONS NONPROLIFERATION PROJECT, THE STIMSON CENTER; MARTIN O'MALLEY, MAYOR, CITY OF BALTIMORE; EDWARD T. NORRIS, COMMISSIONER, BALTIMORE CITY POLICE DEPARTMENT; DON LYNCH, EMERGENCY MANAGEMENT DIRECTOR, SHAWNEE CITY AND POTTAWATOMIE COUNTY, OK, AND FORMER EMERGENCY MANAGEMENT DIRECTOR, OKLAHOMA COUNTY, OK; DIANA BONTA, Dr.P.H., R.N., DIRECTOR DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA; JANET HEINRICH, Dr.P.H., R.N., DIRECTOR, HEALTH CARE AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE; AND LT. GEN. JAMES PEAKE, M.D., SURGEON GENERAL, U.S. ARMY

Mrs. MCHALE. My name is Sang-mi McHale. I am here to testify about my experience of being poisoned in the Tokyo subway in 1995, but first of all, I would like to express my deepest sympathy toward the victims and their families of the recent terrorist attacks. I would also like to express my greatest respect and support for the rescue workers and both State and municipal government officials who have been working tirelessly since the tragedy.

On the morning of March 20, 1995, I was on my way to Saint Luke's International Hospital in Tokyo for a prenatal checkup. I was 36 weeks pregnant. I had been living in Japan with two young children, since 1992, and with my husband who had been assigned to the U.S. Embassy in Tokyo as a staff assistant to Ambassador Walter Mondale. I arrived at the subway station around 8 a.m. The train arrived shortly after I reached the platform.

As I boarded, I saw on the floor by the door a rectangular package wrapped in a newspaper, a sticky looking transparent substance was oozing from it. I walked by the package and sat diagonally across from it. It was about 6 feet away. I don't remember a particular smell, but I somehow felt the air being thick.

Within a minute or two after the train started moving, I noticed that I was having difficulty breathing, and I started to cough. I remembered reading a little article earlier that week in the newspaper about a chemical substance in a train which made some passengers sick. I worried that exposure to my chemical might be harmful to my baby and decided to move to the next car. Even from the next car I could still see through the window both the substance and the other passengers. The passengers who remained in the last car were all covering their mouths, coughing hard and had reddened faces. They all appeared sick.

At the next station, as soon as the door opened, all the people from the last car rushed to get off except for an old man who was sitting directly across from the chemical substance. He was still in the seat and appeared unconscious. He had turned purple and soon went into convulsions. A passenger from the end car returned into the car and dragged him out. I later learned that this old man was one of the first victims to lose his life that morning.

At that moment, there was an announcement in the train that there had been a bomb incident on a different line and that all subways were halting service. We all gasped and hurried off the train. Luckily, the stairs to the street level were nearby. I found a public phone and called my husband. Placing a call was hard because my vision started getting blurry. Distinguishing the taxies from the regular cars was difficult as well. Many people were gathered at the intersection, some sitting on the curb and some people were helping the others.

Soon I started hearing sirens, and I remember seeing an ambulance nearby. I was lucky enough to get a taxi about 50 minutes later and went to the hospital. Again, I was lucky that I already had an appointment with a doctor, because I could see my doctor fairly quickly. He was alarmed at my condition and told me to stay in the hospital. I was soon given a room in a maternity ward and was placed on an IV. My symptoms included a fever, a headache, and blurry vision.

The Japanese authorities identified the chemical substance as Sarin rather quickly, I think, for by that afternoon I was given an antidote to Sarin, atropine. Apparently, the hospital had enough doses for all the patients who needed it.

I was released from the hospital 2 days later and quickly recovered except for miosis, darkened vision, which lasted about 2 months. After the incident, the hospital provided great care and conducted Sarin victim surveys, periodically monitoring the emotional distress among the patients, and offered counseling for those in need.

Several things helped me that day: First, the knowledge that a similar incident involving chemical substance occurred in a train before; second, my health consciousness just because I was pregnant, which made me move to that next car; third, my general be-

lief that Japan is actually much less safe than its reputation, which made me pay attention to my surroundings.

Last, I'm happy to report to you that I delivered a healthy baby boy 3 weeks later, after the incident, at the same hospital, and he is now a happy first grader.

I hope this has been helpful. Thank you very much.

Mr. HORN. It has been. We're very glad for your family, and we thank you very much. And if you can stay with us, we'd appreciate it.

Let us now go to Dr. Amy Smithson, the Director of Chemical and Biological Weapons Nonproliferation Project from the Stimson Center. So, Dr. Smithson.

Dr. SMITHSON. Good morning, Mr. Chairman, and thank you for the invitation to appear here today.

What you have just heard is the account of a woman who was exposed to the nerve agent, Sarin. Nerve agents were essentially discovered in the mid-1930's. In laymen's terms, what happens when you're exposed to very small amounts of this stuff is, your system short-circuits and death can occur very rapidly, within minutes. Other examples of nerve agents, aside from Sarin, would include VX and Tabun.

There are two other basic categories of chemical warfare agents, including blister agents where exposure can occur on the skin or through the lungs and the result is as the category would describe, heavy, heavy blistering and other side effects that can be much more serious. Examples of blister agents, which were used quite frequently during World War I, included mustard gas.

A third category of chemical weapons is called a blood agent, and examples of that agent include hydrogen cyanide.

Earlier, in an opening statement, I heard mention of one of the biological agents that is discussed quite frequently these days, anthrax.

There are two basic kinds of biological agents, and let's keep in mind that these are things that have to be alive when they reach the human lung in a very, very small particle size, 1 to 10 microns, in order to infect us and make us ill. And one of the rumors that keeps making the rounds these days is that crop dusters are well suited for the purposes of distribution of biological agents. Having spent quite some time with people who fly these aircraft, they assure me that this is not as easily done as is often portrayed today.

Crop dusters disperse materials in a micron size of 100 microns and above. And that is a far cry from the very small particle size that would be needed to infect us. So let's get things straight about crop dusters, please.

In terms of biological agents, they come in two basic categories: contagious and noncontagious. Anthrax would be the example that we have heard most often. There is a case down in Florida. But last year, when there was a case in North Dakota, the only people who took notice were those in health and public health communities. In our heightened state, I think there are a lot of persons who are afraid that this is a sign of something worse to come. I simply do not believe that to be the case.

Smallpox and plagues are examples of contagious biological warfare agents. And these do present a problem if indeed they were ever to be released, a very serious problem.

I'd like to return to the case of the cult that did this woman harm to illustrate how difficult it is to achieve a capability to disseminate these agents in a way that would cause mass casualties. Aum Shinrikyo was my nightmare case. This was a cult determined to acquire these capabilities and use these weapons.

They spent over $30 million on their chemical warfare program. They had a state-of-the-art chemical production facility. They had over 100 scientists and technicians in this program. And they could not figure out how to make the significant quantities of chemical agent that would really cause mass casualties of the type that we're seeing in New York City a couple of week ago. That's one thing we should keep in mind.

The biological warfare program was also quite significant. And they tried for several years to acquire this capability. But the thing we need to understand is that they flopped totally and utterly. Not only could they not acquire the lethal seed cultures, they were unable to disperse what they thought they had in a manner that would cause us to fall ill.

So let's look to what terrorists can do and the hurdles that face them in trying to acquire these types of capabilities, and not get carried away with hyperbole and with speculation.

In terms of what worries me, what worries me is, this country is peppered with over 850,000 facilities that work with hazardous and extremely hazardous chemicals. These facilities, if someone were to sabotage them, would have a very, very dangerous outcome. And there's information that has now been made publicly available about these facilities. And if there is one thing that I ask from you today it is that you take steps to make sure that information is contained.

The remarks that I will conclude with here are based on a study that I did surveying 33 cities across this country in their readiness to contend with a chemical or a biological disaster.

One thing you need to keep in mind when you think about what the Federal Government can do to help this country get prepared for this type of an event is that all emergencies are local, and that the lives that are saved will be lives saved by local rescuers. If you need to understand that point, remember what happened on September 11th at the Pentagon and at the World Trade Center. It wasn't some Federal rescue team that swooped in; it was the local firefighters, police, EMS and physicians. And if you are to get this country ready, I would encourage to you get the domestic preparedness program back on track.

The initial intent of this program was to get the locals ready. But last year, out of $8.7 billion spent in this program, only $311 million went to readiness in our communities across this country.

So with that, I see my time is up. I would be delighted to elaborate on the lessons that I learned in my survey from many people who I consider to be much more authoritative than myself.

Mr. HORN. We will have questions from our colleagues on both sides, so stick with us.

[The prepared statement of Dr. Smithson follows:]

Prepared Statement
Before the House Committee on Government Reform,
Subcommittee on Government Efficiency, Financial Management, and Intergovernmental Relations

5 October 2001

Amy E. Smithson, Ph.D.
Director, Chemical and Biological Weapons Nonproliferation Project
Henry L. Stimson Center

Mr. Chairman, members of the committee, allow me to thank you not only for the invitation to appear here today, but for asking several of the key questions that Congress and the Executive Branch must consider if this nation is to achieve heightened preparedness to cope with the aftermath of a terrorist attack. My guidelines from the committee indicated I should address the following questions:

- How are the federal, state, and local levels of government interacting on the terrorism preparedness issue?
- Where are there plans/programs in place? Where do vulnerabilities exist?
- How well are the various levels working together?
- How is the federal government supporting local efforts? Where is the federal government in the way?
- What can Congress do to improve things? What can the Executive Branch do?
- How can the new Office of Homeland Security be most effective?

Should Washington's policy makers not listen closely to the answers to these questions, I am concerned that they will spend taxpayer dollars unwisely in ways that make little preparedness difference.

My answers to these questions amplify the voices of front-line public safety and health officials from 33 cities in 25 states that I interviewed from February 1999 to September 2000. Since the publication of the report that resulted from these interviews, titled *Ataxia: The Chemical and Biological Terrorism Threat and the US Response*, my co-author Leslie-Anne

Levy and I continue to interact with front-line officials from these and other cities on an almost daily basis. These individuals draw upon their lengthy experience in responding to all manner of emergencies and disasters for a series of practical recommendations about how federal preparedness programs can be improved. In all candor—and these rescuers rarely mince words—front-line responders are dismayed at the disarray of the federal government's preparedness programs. Any time the subject of federal leadership of terrorism preparedness programs was broached, the local officials gave eerily similar replies, which can be paraphrased as: "They've been at this for five years and they still can't figure out who is in charge." I was told time and time again that "all the federal agencies constantly preach at us about everybody working together at the local level, but it doesn't take a rocket scientist to see they are fighting with each other tooth and nail over the money and missions."

The Case that Started the Hyperbole

Despite what you might have heard over the last couple of weeks, there are meaningful technical hurdles that stand between this nation's citizens and the ability of terrorist groups to engage in mass casualty attacks with chemical and biological agents. The technical obstacles are so high that even terrorists that have had a wealth of time, money, and technical skill, as well as a determination to acquire and use these weapons, have fallen short of their mark. Chapters two and three of *Ataxia* elaborate on this at quite some length, including a re-examination of the lessons that should be learned from the very terrorist group that got the hyperbole started, Aum Shinrikyo. To summarize, although the results of the cult's 20 March 1995 sarin gas attack were unfortunate enough—12 dead, 54 critically and seriously injured, and several thousand more so frightened that they fled to hospitals—Aum's large corps of scientists hit the technical hurdle that is likely to stymie other groups that attempt to follow in its wayward path. They were unable to figure out how to make their $10 million, state-of-the-art sarin production facility work and therefore were unable to churn out the large quantities of sarin that would be needed to kill thousands. As for Aum's germ weapons program, it was a flop from start to finish because the technical obstacles were so significant.

Preparing for More than Terrorism

Now, the sobering news. This country needs to be better prepared to contend with chemical and biological disasters regardless of whether terrorists ever manage to overcome these technical hurdles, for the following reasons. First, according to 1999 statistics from the Environmental Protection Agency, there are about 850,000 facilities in the United States working with hazardous or extremely hazardous substances. Many of these sites are located in urban areas, and transport of hazardous substances is a routine matter. Every year, over 60,500 accidents and incidents occur at these facilities or during the transport of these chemicals. In the past decade, about 95 percent of the counties in this nation have experienced this type of emergency. Accordingly, it stands to reason that US rescue crews and hospitals need to be well prepared to contend with chemical casualties. Also, the truth of the matter is that terrorists intent on causing mass casualties with chemicals could contemplate sabotaging one of these facilities rather than wrestling with the more complex warfare agents.

Readiness for a biological disaster is also essential because even if a future disease calamity never arrives courtesy of terrorists, mankind is still in a race against time to develop new medications before the natural mutation of pathogens renders impotent all of those currently on the shelves. For many a year, the nation's most esteemed scientists and public health watchdog organizations have talked of a looming global public health crisis that would plunge medicine back to the pre-antibiotic era. Human development that encroaches further on previously untouched ecosystems is rousing new diseases. Moreover, physicians increasingly find that their arsenal of medications is powerless against old diseases that keep resurfacing. Penicillin is no longer effective against 30 percent of *Streptococcus pneumoniae* cases, 11 percent of pneumonia cases are also resistant to third generation, cephalosporin antibiotics, and reports have begun to surface of cases that are not susceptible even to the newer fluoroquinolone treatments. Given the crystal clear data on how microbes are ganging up on mankind, the Institute of Medicine, the American Society of Microbiology, the now-defunct Office of Technology Assessment, and the World Health Organization, among other respected bodies, have given virtually identical counsel about the exigency of boosting medical research to counter the twin threats of emerging infectious diseases and antibiotic resistant disease strains. In sum, it is only a matter of time before a strain of influenza as virulent as the one that swept this country

in 1918 or some other disease reappears. The nation's public health capabilities and hospitals need to be readied.

Foundations of Preparedness

The bedrocks of chemical and biological disaster preparedness already exist at the local and state levels. Scattered across the country are some 650 city, county, and state hazardous materials (hazmat) response teams composed of specialists who contend on a regular basis with the aforementioned accidents and incidents. Laboratories and personnel at all levels of the nation's public health system would play a critical role in biological disaster response, particularly in the detection and control of an outbreak. Medical personnel, from paramedics to nurses and physicians, are essential for the treatment of both chemical and biological casualties. Law enforcement personnel would be important for security and criminal investigation missions after any such disaster. Finally, emergency management capabilities exist in the country's major cities and at the state level.

Over the last few years, many of those firefighters, police, paramedics, physicians, nurses, emergency managers, and public health officials have become better prepared to handle the specialized demands of a chemical or biological disaster, thanks to the Domestic Preparedness Program initiated in 1996 by Senators Sam Nunn (D-Georgia, ret.), Richard Lugar (R-Indiana), and Pete Domenici (R-New Mexico). This program's initial goal was to enhance unconventional terrorism response capabilities in the country's 120 largest metropolitan areas, through training, equipment, and planning programs.

The backbone of a federal response to a chemical or biological disaster was in place long ago. The Federal Response Plan, which dates to 1992, divvies up key response missions among federal departments and agencies. For example, the branches of government that would be at the forefront of a federal response would be the Federal Emergency Management Agency, the Department of Health and Human Services, and the Federal Bureau of Investigation. The essential role for the federal government to fulfill is mid- and long-term disaster recovery, which is mainly FEMA's bailiwick. In a major disease outbreak, HHS would trigger activation of civilian medical teams and the national pharmaceutical stockpile. In a chemical or biological disaster, some of the Defense Department's chemical decontamination units and medical

personnel could be called upon, depending upon the severity of the disaster and the sufficiency of civilian assets at the local, state, and federal level.

Also, recent federal allocations have spurred some critically needed improvements within the nation's public health system, perhaps the most vital player in the case of either a natural or man-made disease outbreak. The object of neglect for decades, the system has benefited from a badly needed infusion of funds that has expanded laboratory capabilities to detect the rarely seen diseases that could be employed if such an outbreak were to occur.

The Need for Federal and Congressional Coordination

Yet, as one might expect, there is always room for improvement. According to the survey that I conducted, local public safety and public health personnel in these cities assessed themselves as being more ready to deal with a chemical disaster than with a biological one. Chapter six of *Ataxia* contains more detail about where the particular problem areas are in each kind of disaster response. Federally, the main challenge is not that more assets need to be built but that federal involvement needs to be coordinated and streamlined. Dozens of federal entities have been fiercely competing for the missions and money associated with unconventional terrorism response, an unfortunate circumstance that has resulted in redundant capabilities, wasteful spending, and, at the local level, confusion as to which agency would spearhead the federal component of a response.

Perhaps it was inevitable that the launch of resource-rich programs with high-profile missions would be accompanied by considerable friction between the federal agencies involved. As the Domestic Preparedness Program training, equipment, and planning efforts unfurled, federal authorities preached the importance of local response agencies working hand-in-hand and claimed that they would do so themselves. Front-line rescuers, however, got the distinct impression that the federal agencies were locked in an intense competition for terrorism preparedness missions and money. Local suspicions of a federal turf battle could be confirmed when the federal partners spoke, as they did at a mid-April 1999 conference. A Pentagon official stated: "We have ramped up tremendously over the last eighteen months. We have new assets, like the [National Guard Civil Support] teams. Some of them make sense and some of them have just been generated through the process." Afterwards, a representative of the Federal Emergency Management Agency added: "We have a fairly small amount of money at stake here. We'd

certainly like to have more." Next, an official from HHS chimed in with, "We don't lack for authority. We lack for people and money." Small wonder then, that the locals found the federal "work together" sermon to be hypocritical. The locals continue to have trouble figuring out who is in charge among the many federal agencies and what the overall federal game plan is. Federal programs have varying time lines, slightly different goals, and conflicting views on priorities and how to accomplish certain response tasks. "The more federal agencies that got in the act, the more confusing it got because they each had their own approach," said a state official who watched the whole circus repeatedly come to town. "They weren't bad people or bad agencies, it was just their view of the world." The duplication of effort aside, these circumstances created practical problems locally. For example, the federal agencies did not standardize the terminology and content of their courses, which left the locals puzzling over the discrepancies in what they were taught.

Given that monies to combat terrorism have been buckshot across over 40 federal agencies, the pace and size of the expansion of federal programming led inevitably to efforts that not only waste taxpayer dollars but imperil the overall effectiveness of the federal government's programming to prepare for and respond to terrorism. Duplication of effort certainly exists in the plethora of research and development programs that were launched to find new detectors and other response equipment. Had Washington policy makers consulted experienced first responders before throwing money at the problem, they might have realized that these individuals do not need all of the equipment that is being developed in their name. For example, why is fancy, expensive decontamination equipment needed when front-line firefighters quickly recognized that they could configure their ladders and pumpers to create impromptu mass decontamination capacity? Another case in point was the creation of over 90 terrorism response training courses and several specialized training centers. Not only was training abundant, it was redundant. Befuddled local officials could hardly wade through all of the options. Meanwhile, no one in Washington refereed the explosion of courses or provided guidance about their quality.

In no small part, fractured congressional oversight has contributed to the mess at the federal level. Committee jurisdictions relevant to the unconventional terrorism issue range from armed services to government reform, transportation and infrastructure to the judiciary, commerce to veterans affairs. If the federal bureaucracy is to be streamlined and meaningful preparedness is to be achieved, Congress needs to coordinate much more rigorously its oversight

activities across committees of jurisdiction and exercise more discipline in the programs it authorizes.

Institutionalization: The Cost-Effective Route to Nationwide Readiness

The time-tested and commonsense alternative to the proliferation of training courses is the one that also underpins the all-hazards, echelons-of-response system that both states and cities know and advocate: institutionalization. If preparedness is truly to take hold nationwide on the front lines and be sustained in perpetuity, then it belongs in the local and state training academies, as well as in the nursing and medical schools. A few cities surveyed for *Ataxia* have already added a course at some or all of their responder academies, but a great many more indicated they had no plans to do so. Yet, institutionalization is the most cost-effective way to spread training geographically and build a tiered response capability.

The prerequisite for institutionalization is standards, and all of the response disciplines—fire, police, EMS, hospital care providers—expressed an abundance of frustration over the absence of standards and protocols to guide them. Standards command the attention of rescue and healthcare personnel because they are the backbone of accountability. Other standards are established at the state level, flowing from the responsibility of governors to ensure public safety. In some disciplines, major professional organizations articulate standards, a role played most strongly by the National Fire Protection Association and to a lesser by the International Association of Chiefs of Police. In the healthcare field, treatment protocols and standards of care evolve gradually through the publication of peer-reviewed journal articles. Eventually, a body such as the Accreditation Council for Graduate Medical Education arbitrates whether a new protocol will be taught in US residency programs. Adding a subject to the curricula of medical and nursing schools takes at least six years. Once standards and protocols are agreed, state academies, universities, and colleges may incorporate them. The National Governors Association could play a key role in seeing that standards are adopted nationwide.

Another benefit of institutionalization is that it would involve an important feature that has been lacking to date in training programs, namely the regular testing of professional knowledge and skills. Moreover, this approach also involves refresher courses that update materials and skills. After graduating from respective professional schools, rescue personnel and

healthcare providers are required to take a certain number of continuing education hours each year. First responders also take regular skills tests to remain certified.

Unconventional terrorism preparedness is on the radar screens of several of the above-named organizations. For instance, in 1998, the National Fire Protection Association issued a tentative interim standard on chemical terror attacks for EMS personnel, as well as for hazmat responders. Pre-hospital and hospital treatment protocols are being developed at a sluggish pace. No overarching structure is in place, however, to move any of these organizations or the state governments forward smartly to create and incorporate standards. Given the advantages that institutionalization offers, Washington could best demonstrate its seriousness about nationwide preparedness by bringing together the pertinent organizations in each discipline to lay the groundwork for institutionalization, complete with time lines. The federal government's job is to be the catalyst and convener that prods the tangle of entities involved in institutionalization to articulate and promulgate standards.

Six years after the onset of the domestic preparedness effort, the time has come for Washington to get out of the training business and turn it over to the appropriate organizations that will take preparedness forward more systematically and cost effectively. The hand-off should be concentrated in these organizations and curtailed elsewhere, so that various branches of the federal government, not to mention enterprising universities and contractors, stop churning out training programs at taxpayer expense. Without such reform, ineffective spending will continue at both the federal and local levels and training lacking in standards will be implemented unevenly, in pockets. Specification of standards and institutionalization of training clearly make more sense than that.

Refocusing Domestic Preparedness Efforts

Those who know first-hand the tremendous demands of responding to a disaster have a saying: "All emergencies are local." In a chemical or a conventional terrorist attack, the life-savers are not some federal response team that swoops in from across the country, but the local firefighters, police, paramedics, nurses, and physicians. Terrorist attacks in 1995 and just last month at the Pentagon and in New York City underscore the basic truth of who saves lives when natural or manmade calamity strikes.

In the moments after Aum Shinrikyo's sarin gas attack against the commuters in Tokyo's subway system on 20 March 1995, local transit workers, police, fire, and paramedics came to the aid of people gasping for air, some of whom were in need of quick administration of the nerve agent antidotes that saved their lives. The attack unfolded from 7:46 to 8:01 am. The first patients reached the nearest hospital less than 30 minutes later. The Japanese Self Defense Forces dispatched its special chemical defense units downtown at 10:10am. Although these units were located in the outskirts of Tokyo, the teams, caught in huge traffic jams, did not reach the attack scene until two and a half to roughly five hours later. The victims of the attack had long since been cleared from the scene.

So many survivors from the attacks on the World Trade Center spoke of being knocked to their knees by the force of the blast, of being surrounded by darkness and overcome by a sense of helplessness, and of beginning to succumb to the fumes when all of a sudden they saw a point of light. Then, they heard the voice and they grasped the hand extended to them. That hand belonged to a firefighter, the person who led them out of hell on earth. Even as the fires raged at the top of the twin towers, rescuers from across the Hudson River in New York City's outskirts mobilized and headed to the scene in accordance with pre-agreed plans. The bulk of the federal or state assets were far away in those critical early hours, when sadly far too few were pulled alive from the rubble by New York City's bravest and finest and their mutual aid partners.

These two tales of local heroism in the midst of unthinkable disaster speak loudly to the basic principle that should guide America's domestic preparedness activities. Indeed, that principle was very much in play in the original Domestic Preparedness Program legislation crafted after the events in Tokyo. Somewhere along the way, this effort to train and equip local responders veered way off course. Since the Domestic Preparedness Program began, talk inside the beltway has centered not on improving local response capabilities, but on how to enhance federal roles and capabilities. Accordingly, the federal government and its host of contractors have swallowed most of the domestic preparedness monies. In the year 2000, only $311 million out of the $8.7 billion spent on defense against terrorism went to enhancing the capacities of local emergency personnel to deal with unconventional attacks. If lives are to be saved in the aftermath of disasters, this ratio clearly has to be reversed.

A key part of the problem appears to be the refusal inside the beltway to accept the most appropriate roles for the federal government in a disaster response, mid- and long-term recovery.

Instead, the last several years have witnessed a frenzy of enhancing existing chemical and biological response teams or building new ones from scratch. Each of the teams built comes with its own logistical and administrative bureaucracy, an additional drain on resources that could be better invested in front-line readiness where lives can truly be saved.

Understanding all too well that unless federal assistance were pre-deployed for a major event the bulk would not arrive at the disaster site until roughly 48 to 72 hours after an incident, state and local personnel have to assume that they would be on their own during the critical hours immediately after an incident. In the Oklahoma City aftermath, the first wave of federal assistance did not roll in until fifteen hours after the bombing. More recently, New York State's National Guard Civil Support Team was activated, but did not reach the site until twelve hours after the twin towers collapsed. Then, the Civil Support Team proceeded to employ detectors to search for the presence of chemical agents or other hazards. What the Guard does not acknowledge in its press release about this deployment is that this task was being taken care of hours earlier by New York City's own Public Health and Environmental departments as well as by US Environmental Protection Agency personnel.

The refrain heard inside the beltway when the National Guard or federal response teams are criticized as redundant and unable to reach the site to accomplish their asserted missions is that enhancing federal response teams does not really cost much—just a few million dollars here and there. Such a rejoinder truly belies the fact that national policy makers have lost perspective on the purposes of the domestic preparedness program. A million dollars may be pocket change in the Pentagon's budget, but it is serious money on the front lines that can make a real preparedness difference. Moreover, a few million poorly spent in several programs adds up to a tidy lump sum. To illustrate the point, 2,333 hospitals or fire stations could be outfitted with basic decontamination capabilities for the cost of standing up one National Guard Civil Support Team. If the total 1999 budget for these National Guard teams had been used in such a fashion, 49,800 local rescue and health facilities could have been armed for mass casualty decontamination, a critical shortcoming in chemical disaster preparedness across the country.

Challenges for the New Office of Homeland Security

The appointment of Governor Tom Ridge as Director of the new Office of Homeland Security would appear to be a constructive step that could put improved coordination and

streamlining of the federal response bureaucracy on a fast track. Conceptually, imposing oversight on the unwieldy terrorism bureaucracy makes tremendous sense, particularly given the readiness of Congress to increase terrorism preparedness spending in the aftermath of September 11th. In practice, that task will be extremely difficult, for the federal agencies will vie even harder for their slice of the pie and congressional oversight remains fractured. Governor Ridge will need three things if he is to succeed in reshaping federal efforts in a more constructive directive. First, he will require strong budgetary authority if he is to bring the federal agencies to heel. Second, he will require congressional cooperation. Third, but certainly not the least important, he will need sage advice if he is to help direct taxpayer dollars where they can do the most to improve preparedness nationwide. Governor Ridge's right hand advisor should be an individual with extensive local disaster response and management experience.

Working in tandem, Governor Ridge's office and Congress can assess the sufficiency of existing federal programs and response teams and begin to eliminate redundant and spurious ones. In the interim until an assessment of the sufficiency of existing assets is made, a government-wide moratorium on any new rescue teams and bureaucracies should be declared, with the exception of the enhanced intelligence, law enforcement, and airport security measures that are being contemplated. Governor Ridge should also move forward with the appropriate steps to see that preparedness training is institutionalized in local police and fire academies, as well as in medical and nursing schools nationwide. In addition, in coordination with the Health and Human Services Department, this office should articulate a plan for jump-starting federal efforts devoted to public health and medical community readiness. Such programming should feature regional hospital planning grants and additional tests of disease syndrome surveillance systems, followed by plans to establish such capabilities nationwide. Last, but certainly not least, Governor Ridge needs to work with Congress to develop a plan to sustain preparedness over the long term.

I will conclude with one more essential task to which each individual member of Congress must attend. Since September 11th, I have received numerous calls from offices on both sides of the Hill and both sides of the aisle, asking me to brief them on these issues and to help fashion legislation that would put Representative "X's" or Senator "Z's" stamp on the legislation that is taking shape. While I have responded as quickly as possible to such requests,

they are in some way indicative of the problem that Washington faces if it is to craft meaningful, cost-effective preparedness programs.

With all due respect, I would point out that while the attacks of September 11th occurred in New York City and Northern Virginia, they were attacks on this nation as a whole. Those who risked their lives that day to save the lives of others were not thinking about themselves or their future, they were selflessly acting in the interests of others. Put another way: this is no time for pet projects, whether they be to benefit constituents or a particular branch of government. This is not about job employment, it is about saving American lives. The future well-being of each American, I would contend, is equally important.

On behalf of the local public health and safety officials who have shared their experience and common sense views with me, I urge Congress to waste no time in passing legislation that brings the burgeoning federal terrorism preparedness programs and bureaucracies into line and points them in a more constructive, cost-effective direction. The key to domestic preparedness lies not in bigger terrorism budgets and more federal bureaucracy, but in smarter spending that enhances readiness at the local level. Even if terrorists never strike again in this country, such investments would be well worthwhile because they would improve the ability of hometown rescuers to respond to everyday emergencies.

Mr. HORN. Now I'd like to give a welcome by Mr. Ehrlich, the very able person representing the city and State of Maryland; and he is going to introduce the mayor of Baltimore and the commissioner of the Baltimore City Police.

And that's bipartisan, because Mr. Ehrlich is a Republican. Yes, they've had only one Republican mayor; as I remember, it has been all Democratic.

So we're glad to have you here, and the same for the Chief.

So, Mr. Ehrlich.

Mr. EHRLICH. Mr. Chairman, thank you. I appreciate this opportunity.

Ranking Member Schakowsky and Mr. Chairman, members of the committee, on July 18th, we thought at the time we had a major incident, and certainly for Baltimore, MD, it was major. That day, a 60-car CSX freight train, traveling to New Jersey, derailed under Howard Street in Baltimore, MD. Subsequent fires sent smoke billowing out of both ends of the tunnel, a cloud over Camden Yards. Fire caused water main breaks in the tunnel, literally flooding streets above.

The entire city was shut down. The U.S. Coast Guard shut down the Inner Harbor. Thirty thousand fans were removed from Camden Yards. Intense heat and fire were a problem, preventing our firefighters from initially getting to the flames. Our city's police and fire departments worked together with the mayor's office around the clock for the next few days, and the fire was subdued. It was a total team effort and a dire situation—a wonderful example of what cooperation can do.

In the aftermath of September 11th, our city, under the mayor's leadership, has done some things that could not have been thought of 3 weeks ago. We've hired a former New York City Police Department official to come up with a terrorism plan, which the mayor, I'm sure, will talk about. We've beefed up security at the city government buildings and around Penn Station. We brought in branches to protect Baltimore's own World Trade Center. Emergency medical personnel are now connected to major emergency rooms online with what Mayor O'Malley calls our, "first-time, real-time reporting time," that will help our health department track any unusual spikes in cold and flu symptoms that might warn of an attack.

I really appreciate these two gentlemen, friends of mine, great public servants, taking the time to come to speak to our committee, to our Congress, to our Nation today. Both are proactive, both are forward-thinking, both are aggressive, both are thoughtful, both understand the dimension of the problem that they particularly face today.

They need—they have to have cooperation from the Federal Government, all agencies of the Federal Government.

I had the opportunity to talk to Commissioner Norris and the mayor prior to this hearing. If the message in the past has been, "You protect your turf, we'll protect ours," those days are long gone. Let the message go out from September 11th forward that sort of mind-set is no more and cannot be the case in this new world we live in.

So, Mr. Chairman, I want to welcome my two friends and true leaders in a time of great national emergency, Mayor Martin O'Malley and Police Commissioner Ed Norris.

Mayor, thank you.

Mr. HORN. Welcome Mayor O'Malley. We look forward to your testimony.

Mr. O'MALLEY. Thank you, Mr. Chairman.

And thank you, Congressman Ehrlich, for your introduction and for being part of this committee's hearing today. I want to thank you for the opportunity to join you today, as we all try to struggle with this new unconventional war, which, I would submit to you, is one that is being fought on two fronts.

One of those fronts is far away from American soil. We have our soldiers on the ground, we have the best technology, the best and most rapid communication systems to forward intelligence to them, so they can accomplish their mission.

The other front is the one that all of us sadly witnessed in New York City and also in Washington. It is a front where we have already sustained many, many casualties, not only civilian casualties, but also casualties among our first responder local fire and police officers. And while much of the discussion and grief has been about the 6,000 lives lost, we should not lose sight of the fact that thanks to preparedness, thanks to the efficiency and bravery of those first responders, there were about 40,000 lives that were saved. And that is really the key to all of us who are in big cities.

You know, Baltimore is not unlike many other large cities in America in terms what we need to be doing right now, as quickly as possible, to protect as many lives as possible in our cities in the event that there are other attacks on our population centers. We're not the largest city, but we're not the smallest either; and we take our responsibility very, very seriously since we consider ourselves truly to be on the front of one of the two fronts in this war.

Baltimore, however, is in a unique position because of our proximity and history to come up to speed very quickly. And we've done that—and special thanks to Marc Morial and the Conference of Mayors for the work that they're doing to help all of us share best practices with one another.

Any of you who know American history and, particularly, the War of 1812 know that Baltimore does not wait for advice from Washington when it comes to matters of self-defense. Indeed, if we had, we would all be singing, "God Save the Queen," still. So we have moved forward ourselves, and we're very lucky to have been able to have some great resources around us.

Some of you may know that Baltimore was selected as a lead city in the chemical warfare improved response program, due to our proximity to Washington and also our proximity to the U.S. Army Soldier and Biological/Chemical Command in Aberdeen, MD.

Also Baltimore is home to the only center for civilian biodefense studies at Johns Hopkins University, and you'll shortly hear from our Police Commissioner, Ed Norris, formerly of the New York City Police Department, where they have done extensive work on civil preparedness in the wake of the first World Trade Center bombing.

And finally, I guess as Congressman Ehrlich mentioned, we had an emergency just back in July that was a chemical emergency. It

shut our city down for about 5 days. And Baltimore had a chance to test our readiness in a chemical incident when a CSX train, loaded with toxic chemicals, derailed and burst into flames, burning in a long tunnel that ran directly beneath our city. The fire was in the southern end of that tunnel, and it happened in the middle of a doubleheader at Camden Yards, which is located right at that exit of the tunnel.

Now, during that train fire, as is the case in virtually any crisis, local government was the first on the scene. In fact, the folks from the NTSB located down here in Washington, a mere half-hour drive away, did not show up until the next morning.

Local government is the first on the scene, and one thing that is immediately apparent is that you have to set up a unified command structure; and this command structure, in this case, was under our fire chief. It was effective. We coordinated fire, police, health, State Department of the Environment, as well as the Coast Guard and our State Department of Transportation; and it all went very well. Key to this was also that the Governor ordered the State agencies to defer to the local unified command structures.

Based on our experience, we learned a few things, and important things, that everybody should be asking. Who are your critical personnel? Where is the command center? What is the unified command? Do you have redundant communications? Are you talking to the public so that the public maintains an appropriate level of alert? What do your mutual assistance agreements set into motion?

At the same time, as well as our emergency folks handled that particular incident, when we watched with horror, with all Americans, what happened in New York and Washington, we realized we needed to do more. We need to do more. And we've set about doing several things on three different fronts, if you will, and every city in America needs to be doing this.

Those fronts are the three that break down, just in a thumbnail, into: security, emergency preparedness, and intelligence. I'm going to defer to Commissioner Norris to talk to you about the most worrisome one of all of those to me, which is criminal intelligence.

On security, we've been able to recruit from New York City Chief Lou Anemone, and we have been taking a series of steps to improve our preparedness, looking at public buildings, looking at the public infrastructure, looking at the private infrastructure.

It is absolutely alarming the degree to which our rail system is open to everyone. I'm talking—we are not unlike many other big cities. When you think of the amount of chemicals and armaments that move along our rail system that is clearly someplace where we could use some Federal help in pushing greater security measures. But we're looking at all of those sorts of things, as I said, the public buildings as well as the private infrastructure, bolstering police and security presence at water supplies.

On the emergency preparedness, we are continuing to coordinate with the Center for Civil Biodefense. We've worked with all of our hospitals so that the ones who had bioterrorism plans have now shared them with their colleagues. And on the intelligence front we have created a biosurveillance system in a matter of just 2 short weeks where we make sure that, in real time, we're looking at the symptoms being displayed in our emergency rooms, in our clinics,

that our paramedics are seeing, we're watching the number of dead animals that our animal control people pick up and we're looking at absentee rates.

It's simple. It hasn't cost millions and millions of dollars. The hospitals were willing to do it with local leadership. So we actually do have a pretty good intelligence network set up to identify it early.

My time is running out. I'm going to wrap up and defer to Commissioner Norris to go to the more worrisome side of this.

But in conclusion, I just want to again emphasize, as the doctor did before me, that I think we have models that work like the Chemical Warfare Improvement Response Program. Those models involve direct local funding.

You have to get the help to the first responders; and the first responders are not the States, they are the cities—direct local funding to the cities. I could talk to you at greater length about our equipment wants and desires, our vaccination wants and desires and things of that nature. And all of them are concerns, and none of us are where we want to be, where we hope to be.

But the biggest concern of all of these is the lack of criminal intelligence, the lack of a connection between the 3,000 local law enforcement officers under my command in the city of Baltimore and the 200 or so FBI agents who cover the entire metropolitan area. I would ask you to do whatever you can on that front.

Because, again, this is a war on two fronts: one where we don't skimp, where we have the best technology, the best communication, the best intelligence rushing to the front line; and another one which is our local front, where none of those things are rushing to the front lines of major cities' fire and police departments.

Thank you.

[The prepared statement of Mr. O'Malley follows:]

MARTIN O'MALLEY
Mayor
250 City Hall
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October 5, 2001

Testimony of Baltimore Mayor Martin O'Malley

Subcommittee On Government Efficiency, Financial Management & Intergovernmental Relations

Committee On Government Reform

Mr. Chairman. Members of the Subcommittee. Thank you for the opportunity to join you today. In acquainting myself with the Members of the Committee, I discovered that many of you bring unique insights to our nation's preparedness efforts.

In this time, we all have our crosses to bear – some heavier than others. But they will be lighter if we bear them together. I am eager to hear your insights into how we can better prepare for what we now know is a very real threat.

In many ways, Baltimore is a typical large city in terms of what we must do to protect our citizens from potential terrorist attacks. We have a few high-profile targets. We are not the largest city, but we're not the smallest city. And we take these issues far more seriously than we did before the tragedy of September 11th.

However, in some ways, Baltimore was in a unique position to come up to speed quickly on this issue. And we are sharing our experience with the US Conference of Mayors. On Tuesday, we will hold our second teleconference, sponsored by the Conference of Mayors and our President Marc Morial of New Orleans. The first dealt with biological weapons, and the second will deal with chemical weapons.

Some of you may know, we were selected as a lead city in the Chemical Warfare Improved Response Program, due to our proximity both to Washington, DC and the US Army Soldier and Biological Chemical Command (SBCCOM) in Aberdeen, Maryland. Baltimore also is home to the Center for Civilian Biodefense Studies at Johns Hopkins University – the only institution of its kind in the country.

We are fortunate to have a Police Commissioner, Edward Norris – from whom you will hear shortly – who, as a Deputy Police Commissioner, was involved in New York City's civil

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preparedness efforts in the wake of the first World Trade Center Bombing. Commissioner Norris has a nationwide network of law enforcement experts on which we have been able to draw.

Finally, Baltimore had a chance to test our readiness in a chemical incident this past July, when a CSX train loaded with toxic chemicals derailed and burst into flames – burning in a tunnel beneath our city for five days. The train fire is where I'll start.

During the train fire, as is the case in virtually any crisis, local government was the first on the scene. Baltimore's Fire Department arrived within minutes after being contacted by CSX. The Police Department, coordinating with the Fire Department and our Transportation Office, began to reroute traffic and secure areas that presented potential dangers – including Camden Yards, only a few hundred feet from the tunnel, where the second game of an Orioles doubleheader was scheduled to begin. And the Health Department began monitoring air quality.

One thing that was immediately apparent was the need for an effective incident command structure. Right away, we knew the accident was serious, but not how serious. Within hours, we had the convergence of every level of government: Baltimore's Fire, Police and Health Departments; the State Departments of Transportation, and the Environment; and the National Transportation Safety Board.

Given the rapidly changing state of information – which I believe is the case during any emergency situation – we needed to integrate all of these government agencies into a command structure capable of quickly receiving, evaluating, acting upon and disseminating information.

The fire was the most immediate problem that needed to be addressed, so our Fire Department assumed control of the accident scene until it was extinguished several days later. The Governor's order that State agencies to defer to local decision makers was critical in making this operation run smoothly.

Crisis breeds confusion, when what you need, right away, is clarity. The only way to quickly achieve clarity is to prepare – making as many decisions as possible in advance. In the event of an emergency, each level of government – and each agency – must prepare, coordinate, respond and adjust. They should know:

- Who are your critical personnel?
- Where should you assemble, with your peers from other agencies, to establish an initial command center?
- How can you remain in contact through an effective, redundant communications infrastructure – including cell phones, pagers, two-way radios and Blackberrys, in addition to landlines? You never know when your primary system might go down.
- Where will you meet to brief the press, providing instructions to protect public safety and reassurance that the situation is being addressed? Effective, timely communication – around the clock – is essential to keeping a city functioning.
- What do your mutual assistance agreements set in motion – between neighboring jurisdictions and different levels of government? They should be updated to be automatic at different levels of response, so that no time is wasted negotiating specific actions.

The CSX fire had one more complicating factor, which is probably not atypical of a potential terrorist attack. We were forced to work in multiple locations: Camden Yards at the south end of the tunnel, Mt. Royal at the north end, and a manhole in the middle of downtown that was directly above the burning train.

It is important to have an incident commander at each site – someone needs to have the authority to make an immediate decision, if needed, and take responsibility for safety. And there should be personnel from each participating agency to ensure effective coordination between each site and the central command center.

After five days, the fire was extinguished, and the chemicals were removed without any serious injuries. Although our firefighters clearly demonstrated that they had been effectively trained, there were instances where we felt our response should have been more tightly scripted. Right away, we set about updating all of our emergency response plans.

As a result of the train fire, we were better prepared on September 11th. We knew where to go. Our Police Department was the lead agency because the primary threat was to public safety. And we were better equipped to make decisions and disseminate information to the public.

But at the same time, watching in horror as first New York and then Washington came under attack, we realized how much we had to do – and how much citizens depend on their local government to protect them if, God forbid, the worst should happen.

The level of preparation and bravery demonstrated in New York was truly awesome. A complex where 50,000 people worked was essentially wiped from the face of the earth in a matter of minutes. About 6,000 people were killed, but 44,000 people were safely evacuated. Mayor Giuliani and his people deserve our awe and admiration.

In the days following September 11th, Commissioner Norris and the Hart-Rudman Commission Report provided me with an understanding of what it would take to achieve the level of readiness present in New York on the day of the attack. But the worst-case scenario was suddenly much worse. And cities will need to achieve a previously unimagined level of preparedness.

As all of you are demonstrating today by holding this hearing, we have a responsibility and duty to do everything we can to keep cities safe. Today, every big city mayor in America has a choice to make: Their city can be a hard target or a soft target, in the event of a terrorist attack. Baltimore is quickly becoming a hard target. And I'm glad to be here today, because I am trying to share what we are learning with anyone in a position to help. Obviously, Congress can make a major difference.

One of the first things we realized – based on our experience in the CSX tunnel fire – was that rail yards and tracks, filled with chemical tankers and munitions cars, represent one of our most vulnerable targets.

There is virtually nothing keeping either a terrorist or a lone kook from walking up to a toxic chemical tanker and blowing it up, releasing deadly gas into the air. There are no fences. There is no real security. There aren't cameras in tunnels.

Baltimore is like every other city on the East Coast in this vulnerability. Hazardous materials are shipped by rail within yards of residential neighborhoods. There were large apartment buildings

right next to the tunnel where our train fire burned. Commerce cannot stop, but this is one area where the federal government can make a significant impact.

Local and State governments have limited ability to influence interstate carriers like CSX and Norfolk Southern to increase their security measures. Today, our railroads are an inviting target, and it doesn't have to be the case. Please push them to do more.

We also have taken a series of steps to improve our preparedness within the past few weeks – with the goal of achieving a push-button level of readiness, where one event will trigger a chain of automatic responses from government agencies and private sector partners. I will leave most of the Police Department actions to Commissioner Norris, but since September 11th, we are focusing our efforts on three fronts:

1) **Security:**

- Holding daily security briefings with Police, Health, Fire, Public Works, Transportation and Information Technology Departments and State officials.
- Securing and protecting City's vulnerabilities, such as major buildings, water system, stadiums, major rail and interstate highway bridges and tunnels.
- Bolstering police and security presence at City buildings, including at water and wastewater facilities.
- Issuing an Executive Order requiring all City employees to display picture identification in all City buildings.
- Working with the chemical association of Baltimore to ensure that rail cars with dangerous hazardous materials are secured.
- Arresting and charging people who make bomb threats.

2) **Emergency Preparedness:**

- Consulting with a civil preparedness expert, former NYPD Chief Louis Anemone.
- Reviewing the findings of the Hart-Rudman Commission and its applicability to Baltimore – and consulting with Senator Hart.
- Coordinating closely with Center for Civilian Biodefense at Johns Hopkins University.
- Coordinating closely with U.S. Army Soldier and Biological Chemical Command ("SBCCOM") of the Department of Defense.
- Working closely with hospital CEO's on areas of preparedness and data collections.
- Developing transportation plans for road closures.
- Drafting standard operating procedures for each agency.
- Training personnel, including those who work in our water and wastewater facilities.
- Collecting and reviewing Baltimore City's existing mutual aid agreements with surrounding counties.
- Standardizing security and preparedness response with the State, as well as drafting upcoming legislation to create a statewide mutual aid agreement.
- Meeting with all public information officers, internally and from hospitals, to address communication issues and develop a communications plan.
- Meeting with press to discuss City's ongoing preparedness and dissemination of information in the event of an emergency.

3) Intelligence:

- Creating a web-based surveillance system to provide real time reporting from hospitals and ambulances, regarding infectious disease data and hospital bed availability.
- Testing reservoirs and the water system several times daily.
- Developing a statewide security intelligence network, working with other law enforcement agencies. As you may recall, one of the terrorist cells was based in Laurel, just a few miles south of our city.
- Meeting daily with Federal authorities to obtain intelligence.

This third area – intelligence – is where I have some concerns. The Federal Bureau of Investigation must recognize that effective police departments are a significant asset. The FBI has yet to ask our Police Department to follow-up on a single lead or tip. There are about 12,000 FBI agents, and they've received more than 100,000 tips. To me, this suggests that they are simply focusing on what they consider to be the "hottest" leads and taking their chances with the rest. Considering what we missed before September 11th, this is not a comforting thought.

Commissioner Norris has repeatedly offered our assistance – not just because of patriotism, but because we want to make sure our people are safe. But the FBI has yet to approach our Police Department to assist them with even the most basic of tasks, such as tracking down unreturned rental cars, or investigating people who recently have obtained pilots licenses, hazardous materials licenses or flight training. Law enforcement cooperation is not nearly what it should be, given what is at stake.

The steps I have outlined are just the beginning. Many of our preparedness efforts simply require making the time to complete tasks. But some of it is expensive. We do not have nearly enough equipment to protect our emergency response personnel. Communications equipment is necessary and very costly. And in the event of an emergency, our overtime costs will go through the roof, draining resources from other pressing needs.

While some functions are logically federal in nature (for example, maintaining a vaccine stockpile) other things can best be handled at the local level – if we are provided with adequate resources. The federal government must help put local governments in a position to succeed. Emergency preparedness cannot become another unfunded mandate, or eventually it will become unfunded, as priorities shift and dollars are spent elsewhere.

Moving forward, I believe the Chemical Warfare Improved Response Program operated under the most effective model. Given that so much emphasis must be placed on first response – which is almost always a local responsibility – funding for equipment and other priorities should go directly to local governments. This is what happened under the CWIRP, before funding was reduced. Passing these funds through State government would only result in implementation delays and, possibly, the diversion of funds for unnecessary administrative costs.

Life in the United States is different than it was just a few short weeks ago. You are right to focus on how we can best cooperate to rise to the challenge of our day. Although we all are certain our nation will prevail, these are uncertain times. And the most we can do... The best way we can protect the people we are privileged to serve is by eliminating as much of that uncertainty as possible through preparation.

Phone: 410.396.3835 fax: 410.576.9425 e-mail: mayor@baltimorecity.gov

In Baltimore, we are taking responsibility for doing as much as we can. We are not waiting for Annapolis. We are not waiting for Washington. That is the American way – neighbors take care of each other. If our city waited for advice on self-defense from Washington in the war of 1812, all of us would be singing "God Save the Queen."

However, that said, I am grateful that you are devoting your energies to this topic. Fighting terrorism and safeguarding our citizens is a national issue – it is a national challenge. And it will require our national resources to do all that we know can be done.

Thank you for the opportunity to testify here today. I am glad to answer any questions you might have.

Phone: 410.396.3835 fax: 410.576.9425 e-mail: mayor@baltimorecity.gov

Mr. HORN. Well, thank you, Mayor. I think you have given outstanding thinking and results, and that would be good advice for every mayor in the country. Hopefully—at your various national conferences, I would hope that you and some of the other mayors get that through to your fellow mayors.

As to the FBI, we will certainly be making some recommendations on that one to the attorney general, because I know exactly what you're talking about.

Commissioner, it's a great pleasure to have you with us. And we're delighted to have you. Now, you are in charge of the city police department. And I take it there is a separate fire department.

Mr. NORRIS. Yes, sir.

Mr. HORN. Because I would certainly like—what you know about the fire department and what they did would be very helpful in the record.

Mr. NORRIS. Mr. Chairman, Mr. Ehrlich, members of the subcommittee, thank you for giving me the chance to talk with you today.

The subcommittee has heard Mayor O'Malley describe the many steps being taken to carry out his responsibility for the overall safety and security of Baltimore. As police commissioner, I am the individual responsible to the mayor for preventing criminal actions that could lead to loss of life and property. I would like to focus on just one area he has mentioned, the area of collaboration and contact between the Federal authorities and local law enforcement.

There has been much discussion about the disconnect on Federal agencies that share responsibility for homeland security. What has not been discussed is the disconnect between Federal and local law enforcement.

My main point to you today is that I believe all levels of law enforcement must do a dramatically better job of collecting and sharing intelligence. If we don't, the chances are much greater that terrorists can operate at will and cause even bigger disasters in our country.

Neither we nor any other local law enforcement agency we know of has been asked to contribute manpower in any broadly coordinated way. For example, there are thousands of leads related not only to the September events, but to the continuing threats the attorney general has repeatedly warned us about. Local law enforcement has the manpower to followup on a very-high-volume of leads. The Federal agencies do not.

For example, the FBI has a total of 11,533 agents. There are nearly 650,000 police officers in this country. We want to help, and I think the Nation needs us to help. To prevent other terrorist incidents, pressure needs to be brought to bear on anyone who may be planning any attacks.

Local law enforcement, not Federal agencies, are in daily contact with literally millions of people every day. The NYPD, the department where I spent most of my career, and the last year as a deputy commissioner in charge of operations, has over 10 million documented interactions with citizens. Those include arrests, citations, field interviews, stop-and-frisk. They don't include the millions of other discussions officers routinely have with citizens.

We deal on a daily basis with network of registered informants. We can debrief prisoners about suspicious activities that may be terrorist in nature at the same time we debrief them about traditional crimes. But we have to know what the FBI knows about threats, tips and even just rumors. We have to know more about what there is to look for in our own communities, so we can protect our own people and be more effective gatherers of intelligence for the FBI.

While the FBI has done nothing to prevent us from doing this work on our own, they have given us nothing but a watch list to go on. In the week after the attack, the watch list had names, few dates of birth, no addresses, no place of employment, no physical descriptions and no photographs. By Friday of the same week, we got a revised list which contained more information, but still no pictures.

I do not understand this. When someone commits a murder, rape, robbery, you plaster his picture all over police stations and, whenever possible, in the media to help locate the individual before he commits a crime. Now we're looking for murderers of thousands who may become the murderers of millions. Why aren't we all working together to find the people the FBI is looking for?

In short, I think the rules of engagement for law enforcement have changed forever inside this country. It may have once made sense for Federal agencies to withhold from local police their information about developing cases. Today, we all need each other if we as a nation are going to successfully counter threats that can come from virtually anywhere, at any time, in any form, including those that could destroy whole cities.

To prevent recurrences of terrorism which could drive this Nation to panic and economic collapse, I believe we must do the following. Federal agencies must share all locally relevant information with the nearly 650,000 State and local police officers who could be helping them today, but who for the most part are not. Police chiefs should receive regular briefings on even highly classified information to help those chiefs better direct their own internal intelligence and counterterrorist efforts.

The Communications Assistance for Law Enforcement Act [CALEA], which was passed in 1994, but has never been fully implemented, must be enforced. CALEA requires telephone companies to ensure their systems and networks can accommodate Federal, State and local wiretaps in the face of changing telephone technology. Right now, we can't intercept certain digital telephone technologies, and that is keeping all of us dangerously in the dark.

In short, we must do all in our collective power not only to locate the collaborators of last month's hijackers, but also to deter all terrorists from operating against our still-vulnerable transportation systems infrastructure and people. I think the threat is so great that we should have every police officer in the America in this fight.

Like hundreds of firefighters in New York, my fellow officers at the NYPD showed their willingness to give their lives to save others. My officers in Baltimore are ready to do the same. I think we must be allowed to help. I believe the life of the Nation may depend upon it.

Mr. HORN. Thank you very much, Commissioner.

[The prepared statement of Mr. Norris follows:]

October 5, 2001

Testimony of Edward T. Norris
Police Commissioner, City of Baltimore

Subcommittee on Government Efficiency, Financial Management
& Intergovernmental Relations

Committee on Government Reform
U.S. House of Representatives

Mr. Chairman, members of the Subcommittee, thank you for giving me the chance to talk with you today.

The subcommittee has heard Mayor O'Malley describe the many steps being taken to carry out his responsibility for the overall safety and security of Baltimore. As Police Commissioner, I am the individual accountable to the Mayor for preventing criminal actions that could lead to loss of life and property.

I would like to focus on just one area he has mentioned – the area of collaboration and contact between federal authorities and local law enforcement

As you know, Mr. Chairman, there has been much discussion about the disconnect among federal agencies that share responsibility for homeland security. What has not been discussed is the disconnect between federal and local law enforcement.

My main point to you today is that I believe all levels of law enforcement must do a dramatically better job of collecting and sharing intelligence. If we don't, the chances are much greater that terrorists can operate at will and cause even bigger disasters in our country.

Neither we, nor any other local law enforcement agency we know of, has been asked to contribute manpower in any broadly coordinated way. For example, there must be thousands of leads related not only to the September events but to the continuing threats the Attorney General has repeatedly warned us about. Local law enforcement has the manpower to follow up a very high volume of leads. The federal agencies may not.

For example, according to the Bureau of Justice Statistics, the FBI has a total of 11,533 agents. There are nearly 650,000 local law enforcement officers in this country. We want to help, and I think the nation needs us to help.

To prevent other terrorist incidents, pressure needs to be brought to bear on anyone who may be planning any attacks. Local law enforcement – not the federal agencies – is in daily contact with literally millions of people every day. The NYPD -- the department where I spent most of my career, in the last years as Deputy Commissioner in charge of Operations -- has over 10 million documented interactions with citizens. Those interactions include arrests, citations, field interviews, stop and frisks. They do not include the millions of other discussions officers routinely have with citizens.

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In the week after the attack, the watch list had names, with a few dates of birth, no addresses, no places of employment, no physical descriptions, no pictures. By Friday of that same week, we got a revised watch list, which contained more information (including some addresses, places of employment and a few physical descriptions) but still no pictures.

I frankly do not understand this. When someone commits a murder, rape, or robbery, you plaster his picture all over police stations and, whenever possible, in the media to help locate that individual before he commits another crime. Now we're looking for the murderers of thousands who may become the murderers of thousands, even millions more.

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1. Federal agencies must share all locally relevant information with the nearly 650,000 state and local police officers who could be helping them today but who, for the most part, aren't.
2. Police chiefs should receive regular briefings on even highly classified information to help those chiefs better direct their own internal intelligence and counter-terrorist efforts.
3. The Communications Assistance for Law Enforcement Act (CALEA), which was passed in 1994 but has never been fully implemented, must be enforced. CALEA requires telephone companies to ensure that their systems and networks can accommodate federal, state, and local wiretaps in the face of changing telephone technology. Right now we can't intercept certain digital phone technologies, and that is keeping all of us dangerously in the dark.

In short, we must do all in our collective power not only to locate the collaborators of last month's hijackers, but also to deter all other terrorists from operating against our still vulnerable transportation systems, infrastructure and people.

I think the threat is so great we should use every police officer in America in this fight.

Like hundreds of firefighters in New York, my fellow officers at the NYPD showed their willingness to give their lives to do their duty. My officers in Baltimore are ready to do the same. I think we all must be allowed to help.

I believe the life of the nation may depend on it.

Mr. HORN. We're going to go through the next three and then one more, and then we'll go into Q&A.

Mr. Lynch is the Emergency Management Director, Shawnee City and Pottawatomie County, OK, former Emergency Management Director, Oklahoma County, OK.

So, Mr. Lynch, we're delighted to have you here. You went through the experience of the Federal building that was wiped out there.

Mr. LYNCH. Thank you, Mr. Chairman, and to Ranking Member Schakowsky, to the other honorable members of this committee, it is a great pleasure for me to come before you today to discuss the preparedness efforts for chemical and biological terrorist attacks in our country.

First, let me say that all Oklahomans, but especially my fellow emergency managers and allied emergency services personnel extend our deepest compassion and prayers to the emergency workers, victims, family members and citizens of those communities affected by the attacks on September 11, 2001. Every emergency worker in Oklahoma was ready to come to the aid of those communities impacted to repay in some way the support that you gave us in the Murrah Building incident.

While we wanted to respond physically, we knew that our presence would create an unnecessary logistical burden on the community. Therefore, we have sent our support financially, spiritually and emotionally to our brothers and sisters in New York, Pennsylvania and Virginia. We shall continue to do so as long as there is a need. We will always remember the heroism displayed in those communities.

I think it's important to point out, as my colleagues on the panel have done, that a lot of work has been done in the last 6 years to prepare our communities. Among those activities are, State and local emergency operations plans have been modified to include terrorism preparedness activities and mirror the Federal response plan.

No. 2, State and local emergency exercises have been changed to incorporate response forces working in and around terrorist activities.

No. 3, national, regional, State and local training programs have been created which integrate personnel from all levels of government into private sector and voluntary agencies active in disasters.

And No. 4, communities have received limited Federal and State support for equipment to use in response to these terrorist events.

The Nunn-Lugar-Domenici Act was a good starting point. However, somewhere along the way, the good intentions got slightly skewed under the Federal bureaucracy. Both Oklahoma City and Tulsa, OK, were on the list of the 120 cities to receive this training. In my capacity at the time, I participated in activities for both communities.

The actual training itself was outstanding. It was relevant, it was useful. However, getting there was inefficient. There were a lot of meetings that were held prior to the actual training itself. In fact, when it came down to doing the training and providing the equipment caches, what was promised was not delivered. I think

probably that's because the money went toward meetings instead of toward actual training programs.

All the quality training in the world, Mr. Chairman, as you have heard from everybody here, all the plans that are prepared are not valuable if you don't have the tools you've trained on to respond with, and if you don't have the capability to sustain and augment that training.

Both Oklahoma City and Tulsa were kind enough to include their neighboring Federal, State and local jurisdictions in the training programs. This not only helped spread the training to additional communities, but it helped foster teamwork and continuity of operations across jurisdictional boundaries.

Additionally, the FBI, the Federal Emergency Management Agency, the U.S. Public Health Service have all sponsored outstanding training programs that have helped communities achieve a higher-level of preparedness. Most of these programs have been open to participants from all disciplines.

However, we need more equipment. I cannot emphasize this enough. While Nunn-Lugar-Domenici provided some minimal equipment and prior hazardous materials training encouraged larger communities to equip firefighters to respond to potential chemical emergencies, many communities across this country, and particularly in the heartland, simply do not have all of the equipment that would be needed in a chemical or biological attack.

I have proposed the following recommendations: No. 1, funding for assistance to the firefighters program of the Federal Emergency Management Agency should be at least doubled for fiscal year 2002, and increased reauthorization for Federal fiscal years 2003 through 2007 of at least $1 billion per year should be passed.

No. 2, more pharmaceuticals are needed to be stockpiled. The current stockpile maintained by the Department of Health and Human Services is dangerously insufficient to handle more than two simultaneous events. Local communities need to be able to readily access these equipment caches within their jurisdiction. We can't wait for 8 hours or more for a supply to be flown in.

And the capability has to be developed at the local level. While there is great technical expertise at the Federal level, waits of up to 6 hours for a technical support team will not make it in those critical first few hours. So we have to develop this capability across our country.

In summary, Mr. Chairman, I believe that our communities should not be characterized in terms of gloom and doom. We have done a lot to help; the Federal and State governments have done a lot to develop emergency management systems. Likewise, the situation should not be characterized as shipshape.

While the foundation has been laid, now is the time to buildupon that foundation. The recommendations I have mentioned in this testimony and in my written prepared remarks I believe will guide us on a proper path to enhancing our preparedness and serving our citizens.

We recognize that true emergency management requires a partnership between the Federal, State and local governments, business and industry, individuals and families, and voluntary organizations active in disaster. While we at the local level are ready to

do all that we can to support the war against terrorism, we stand firmly behind the President and the Congress and we eagerly anticipate your assistance in this war.

I thank you for your willingness to investigate this matter and to help us with the task ahead. I thank you for the opportunity to address this committee.

Mr. HORN. Well, thank you very much, Mr. Lynch. We'll look forward to you in the question period.

[The prepared statement of Mr. Lynch follows:]

TESTIMONY OF
DONALD D. LYNCH, C.E.M. ®, O.C.E.M.
DIRECTOR OF EMERGENCY MANAGEMENT
CITY OF SHAWNEE AND POTTAWATOMIE COUNTY
OKLAHOMA

BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FINANCIAL MANAGEMENT, AND
INTERGOVERNMENTAL RELATIONS

OCTOBER 5, 2001

WASHINGTON DC

Mr. Chairman and the Honorable Members of the Committee, it is a great pleasure for me to come before you today to discuss preparedness efforts for chemical and biological terrorist attacks against our country. As a member of the emergency services family who responded to the bombing of the Alfred P. Murrah Federal Building in Oklahoma City on April 19, 1995, I was asked to share with you some of our experiences and the lessons learned. Since the Murrah Building bombing, I have had the privilege to work with other jurisdictions across the United States in the terrorism preparedness arena. I will also be sharing with you my observations from this work. I was also asked to address what Congress and the Executive Branch can do to improve the status of preparedness in our country.

First let me say, that all Oklahomans, but especially my fellow emergency managers and allied emergency services personnel extend our deepest compassion and prayers to the emergency workers, victims, family members, and citizens of those communities affected by the attacks on September 11, 2001. Every emergency worker in Oklahoma was ready to come to the aid of those communities impacted, to repay in some small way the support you gave us. While we wanted to respond physically, we knew that our presence would create an unnecessary logistical burden on the community. Therefore, we have sent our support financially, spiritually, and emotionally to our brothers and sisters in New York, Pennsylvania, and Virginia. We shall continue to do so as long as there is a need. We shall also always remember the heroism displayed in these communities.

Secondly, I think it is important to point out that much work has been done in the last 6 years to help our communities become better prepared for biological and chemical attacks. Among the activities that have taken place are:

1. State and local emergency operations plans have been modified to include terrorism preparedness activities and mirror the Federal Response Plan.
2. State and local emergency exercises have been changed to incorporate response forces working in and around terrorist events.
3. National, regional, state, and local level training programs have been created which integrate personnel from all levels of government, the private sector, and voluntary agencies active in disaster.
4. Communities have received limited Federal and state support for equipment that could be used in response to terrorism events.

At the Federal level, the Nunn-Lugar-Domenici Act initiative was a good starting point. However, somewhere along the way the good intentions got slightly skewed under the Federal bureaucracy. Both Oklahoma City and Tulsa, Oklahoma were on the list of 120 cities to receive training under the Act. In my capacity at the time, I participated in activities for both communities. The actual training itself was outstanding, relevant, and useful. However, getting to the actual delivery of the training I believe was inefficient. I don't believe that it was necessary to have Regional kick-off meetings to introduce the program, initial city visit meetings to announce the program, and elected officials briefings to announce the program prior to conducting the training. I feel this was particularly wasteful because of the number of people who came from the Federal agencies to give essentially the same presentation 3 times. Eleven people flew into Oklahoma City prior to implementing the program just to look over the facility. I am reasonably sure that the same method of operations occurred in the other 119 cities. In my opinion, all that money could have been better spent in providing those communities

with equipment. All the quality training in the world is not valuable if you don't have the tools you've trained on to respond with and if you don't have the capability to sustain and augment the training program. The equipment caches originally promised had to be downsized due to lack of funds. I can't help but believe that part of the cause for the shortfall was the inefficiency I have just described.

Both Oklahoma City and Tulsa were kind enough to include their neighboring Federal, State, and local jurisdictions in their training programs. This not only helped spread the training to additional communities, but helped foster teamwork and continuity of operations across jurisdictional boundaries.

Additionally, the Federal Bureau of Investigation, the Federal Emergency Management Agency, and the U.S. Public Health Service have sponsored outstanding training programs that have helped communities achieve a higher level of preparedness. Most of these programs have been opened to participants in all disciplines.

As I have stated, communities need more equipment. I cannot emphasize this enough. While Nunn-Lugar-Domenici provided some minimal equipment, and prior hazardous materials training encouraged larger communities to equip firefighters to respond to potential chemical emergencies, many communities simply do not have all of the equipment that would be needed in a chemical/biological attack. I propose the following recommendations:

1. Funding for the Assistance to Firefighters program of the Federal Emergency Management Agency (FEMA) should be at least doubled for Federal Fiscal Year 2002. An increased reauthorization for Fiscal Years 2003-2007 of at least $1 billion per year should be passed.

2. More pharmaceuticals need to be stockpiled. The current stockpile maintained by the Department of Health and Human Services is dangerously insufficient to handle more than 2 simultaneous events. Local communities need to be able to readily access these caches within their jurisdiction. We can't wait for 8 hours or more for a supply to be flown in.
3. Equipment needs to be developed to help first responders detect and identify the presence of suspected biological agents.
4. More laboratories and chemical detection equipment are needed for first responders. We can't wait for samples to be sent to a national laboratory for confirmation.
5. Emergency Managers and Emergency Services personnel need better access to the Federal Surplus and Excess Property programs. Emergency management and fire service agencies should have priority access to excess equipment. If taxpayer funds are used once to pay for equipment when purchased by the Federal government, then taxpayer funds should not have to be used again by State and local governments to pay handling fees for equipment when its declared surplus.
6. Grant programs of other Federal agencies should encourage the development and support of equipment purchases that will be consistent with and contribute to terrorism preparedness.

Several reports have been prepared and submitted to Congress that detail preparedness activities at the Federal level. Among those is a General Accounting Office report just released which highlights Federal bioterrorism research and preparedness activities. A

better level of coordination and communication between Federal agencies and to state and local governments needs to be accomplished. The National Domestic Preparedness Office (NDPO) created in the U.S. Justice Department was intended to help serve that function and act as a link between the Federal agencies and emergency responders. I knew the first NDPO Director, Tom Kuker from his assignment as Special Agent In Charge of the Oklahoma City office of the Federal Bureau of Investigation. Special Agent Kuker and his wife Special Agent Kathleen Kuker brought together elements of the response community from throughout the Oklahoma City metropolitan area to form a Domestic Terrorism Working Group and Joint Terrorism Taskforce. As NDPO Director, Tom and his staff worked diligently to bring together key players from throughout the country in both the private and public sectors. Unfortunately, about a year into the project, the vision was lost in the upper echelons of the Department and the NDPO ceased to function effectively.

I recommend that the Federal Emergency Management Agency (FEMA) be made, by law, the single-point-of contact for terrorism preparedness. FEMA has a long history of coordinating with Federal agencies on natural and man-made disasters. Terrorism preparedness is a natural extension of the concept of the all-hazards integrated emergency management system. FEMA also has an outstanding record of delivering quality preparedness programs and has the mechanism though its partnership with state, local, and tribal governments to effectively deliver those programs.

When examining response to disasters, emergencies, and terrorism events, one common thread is the failure of communications systems. If responders are to be able to respond efficiently, effectively, and safely, they must be able to communicate with each other.

Incompatible frequency assignments, outdated and inoperable equipment, and overloaded circuits are often cited as issues relating to communications failure.

On April 19, 1995 we experienced these problems in Oklahoma City. During the first 12 to 18 hours after the explosion, both the public switched and cellular telephone networks were overloaded in the area. Portable cell sites were brought in as well as hundreds of telephones from both cellular telephone companies serving the area. Even so, non-emergency communications tied up lines making coordination difficult at best. Police, Fire, Emergency Medical Services, Sheriff, Highway Patrol, Federal law enforcement, and other response agencies found that two-way radio proved the fastest and best method to relay information and make specific resource requests. However, the departments were all on different frequencies with no common capability. The Oklahoma City Police Department switched much of their communications to a common police channel enabling them to better communicate with their personnel but isolating them from other responding law enforcement units and agencies. We've heard of some of these same communications problems in New York City and Arlington County on September 11.

I propose the following recommendations:

1. The Federal Communications Commission needs to be mandated to maintain the current spectrum allocation level for public safety and military/National Guard use and to study radio spectrum interoperability between the Federal, State, and local governments for additional spectrum assignments for public safety. The Associated Public Safety Communications Officers (APCO) incorporated should be utilized as an expert consultant in developing this study and making recommendations for spectrum allocation.

2. Again equipment is needed at the State and local level. We have some rural fire departments and volunteer emergency management directors that can't even afford to purchase a radio.
3. Federal grant programs for communications systems including computer systems should have requirements for interoperability with other jurisdictions.
4. Funding should be allocated to the National Weather Service to augment the NOAA Weather Radio system by:
    A. Expanding transmitter coverage
    B. Increasing the ability of local jurisdictions to access the system for emergency public information.
    C. Developing and implementing the technology to divide county warning areas into ninths, thereby allowing warnings to be more effectively distributed.

NOAA Weather Radio is perhaps one of the most effective warning devices available. This expansion will provide a national system of warning the population of impending national, natural, and technological disasters. In Oklahoma City we recognized the utility of NOAA Weather Radio and created Operation Warn. Under the leadership of Emergency Manager John Clark, a group of emergency management and National Weather Service officials from the Oklahoma City Metropolitan area worked with Midland Radio and Wal-Mart to provide an outlet for distribution of up to 300,000 NOAA Weather Radio receivers in metro area Wal-Mart stores at cost for the next 3 years. So far in this first year over 20,000 radios have been purchased. That is 20,000 homes, schools,

critical facilities, and businesses that we can reach simultaneously to provide warning of impending disasters.

Technical expertise to deal with chemical and biological terrorism events is an area where the Federal government can provide and has provided valuable assistance to state and local governments. However, this technical expertise has to be readily accessible to first responders. There is a concept in the medical community called the "Golden Hour" which states that a patient experiencing a traumatic injury has the best chance for survival if they can receive treatment from a trauma center within the first hour following their injury. That's why numerous resources have been allocated to the emergency medical system in this country. Likewise, the technical expertise of Federal agencies has to be readily accessible to the first responder community. 'Wheels Up in 6 Hours" for a Federal agency response team is not extremely helpful in the first few critical hours of an event. I propose the following recommendations:

1. Expand and upgrade the Urban Search and Rescue program. Every state should have a qualified, trained, and fully equipped USAR team.
2. Establish a national collapse rescue program to supplement the USAR teams. Such a program would provide specialized equipment and staff to respond to buildings that have collapsed as a result of terrorism and other disasters.
3. Increase the number of Metropolitan Medical Response Teams and enhance their capabilities to deal with major incidents.
4. Fully fund and equip the National Guard Civil Support Teams.

5. Expand current systems such as the Rapid Response Information System, and Law Enforcement On-Line and develop new systems for transferring technical knowledge electronically.

For biological terrorism, the public health system is the critical component. Detection will most likely come from the physicians who see patients presenting with signs and symptoms. We have had a difficult time getting physicians included in our training and exercise programs. Many communities I have talked with have experienced similar circumstances. During the Murrah Building bombing and again following the F5 tornado strike in the area in May of 1999, most patients were transported to hospitals by private vehicle or self-referred. Most hospitals do not have sufficient decontamination capability for multiple patients presenting at the same time. Therefore, I recommend that the Department of Health and Human Services be assigned the tasks of

1. Working with the American Medical Association to emphasize the importance of physicians being involved in terrorism training and exercise programs in their communities.
2. Working with the Joint Commission on the Accreditation of Hospitals and Healthcare Organizations to strengthen accreditation requirements as they relate to hospital participation in terrorism training and exercise programs and decontamination capability.

Lastly, I have some recommendations that apply to personnel:

1. Everyone should have a family disaster plan and disaster supplies kit. It is everyone's responsibility to insure that their family is taken care of so they can respond and do their job.

2. First responders and their immediate families should receive vaccinations for anthrax and other biological agents. We can't expect first responders to respond if they are worried about their families contracting the biological disease.
3. Legislation regarding privacy must be changed to enable healthcare facilities to release to family members and emergency workers the names of victims who are being treated at their facilities. This will help reunite families quicker and spare victims families the agony of running from facility to facility in search of information about their loved ones.
4. Federal, State, and local funding for emergency management programs at the local level must be increased. Currently only 45 of the potentially 300+ jurisdictions in Oklahoma have paid emergency management staff. Similar circumstances exist in other states. If we are to get serious about preparedness, we have to get serious about paying personnel at the local level to coordinate and implement the preparedness programs.

In closing, when it comes to preparedness for terrorism events, I believe that our capabilities are not to be characterized as "gloom and doom." Communities have done a lot with the help of the Federal and state governments to develop emergency management systems that can be applied to all hazards especially including terrorism. Likewise, the situation should not be characterized as "ship shape." While the foundation has been laid, now is the time to build upon that foundation. The recommendations I have mentioned in this testimony I believe will guide us on the proper path to enhancing our preparedness and serving our citizens.

Mr. Chairman, we recognize that true emergency management requires a partnership between the Federal, State, and local governments, business and industry, individuals and families, and the Voluntary Organizations Active in Disaster. We at the local level are ready to do all that we can in the war against terrorism. We stand firmly behind the President and Congress. I thank you for your willingness to investigate this matter and to help us with the tasks ahead, and I thank you for the opportunity to address this esteemed body.

Mr. HORN. We now have the Honorable Diana Bonta, the director of the department of health services for the State of California. Before that she was director of the city of Long Beach's excellent health services, which is very rare for most cities in America.

So, Dr. Bonta.

Dr. BONTA. Good morning, Mr. Chairman and members. Thank you very much for the opportunity to be here this morning.

In addition to serving as director of the California Department of Health Services, I am the immediate past chair of the executive board of the American Public Health Association as well.

And thank you very much, Congressman Horn, for your ongoing support of local public health programs.

Since the tragic events of September 11th, national security has been become our national concern. In California, Governor Gray Davis has led the creation of the California Antiterrorism Center, which will enable all law enforcement agencies to share information on terrorist threats and activities.

Additionally, the Governor's Office of Emergency Services coordinates and responds to all types of hazards, including a biological or chemical terrorism event. OES facilitates and coordinates statewide efforts in planning and response by bringing together Federal, State, local, nonprofit organizations and key infrastructure officials through various forums, such as the State Strategic Committee on Terrorism and the Threat Assessment Committee of which the Department of Health Services is a member.

Also note, Governor Gray Davis has mobilized the California National Guard now to increase security at key airports.

In the aftermath of the terrorist attacks, there has been heightened awareness of potential biological and chemical threats to our communities; and many have asked, "Is the Nation prepared for a biological or chemical attack?" If such a horrific event were to occur, the safety certainly of every man, woman and child would depend on the public health system. This system must remain strong.

Traditional public health activities have focused on preventing the spread of communicable diseases and ensuring the safety of the air that we breathe, the water that we drink and the food that we eat. More recently, public health efforts have expanded to include disease prevention activities to promote healthier lives. It's a big job and it has been done very well.

Now, in addition to all of our other responsibilities, the public health system is faced with the intentional spread of disease. Public health resources would be significantly challenged following a biological or chemical attack.

In recent years, public health systems in the Nation's largest cities have become more involved in terrorism planning and preparedness use funds appropriated by Congress. Under this program, the Nation's 120 largest cities, including 18 in California, have received funds for training, exercises and equipment to enhance their capability to respond to incidents involving weapons of mass destruction, including biological or chemical terrorism. The program trains first responders, the firefighters, police, emergency management teams and medical personnel who will be on the front lines in case of any of these attacks occur in a U.S. city.

In addition, this effort has been enhanced over the past several years by funding from the Department of Health and Human Services, allowing for the development of the metropolitan medical response system in a dozen California cities. These funds have provided an essential first step in developing a coordinated response to bioterrorism that involves enforcement, law enforcement, public health and the medical communities.

In 1999, the Centers for Disease Control and Prevention [CDC], developed the chemical and biological terrorism response and preparedness program. California and several other States and large municipalities were awarded 5-year funding to develop responses and preparedness plans concentrating on five areas, which I'll summarize as preparedness and planning and readiness assessment; surveillance and epidemiology capacity; laboratory capacity, both for biological agents as well as chemical; and our health alert network/training system. These grants were intended to "kick start" all of this preparedness at both the State and local health department levels, and California received $2.5 million per year to develop the program. We were the only applicant to be funded in all 5 years in the country. And Los Angeles County, in addition, received $900,000 to assist them.

Since the start of this program, certainly California has made great strides in preparation for both biological and chemical terrorism. I can tell you that we've recently had training, for instance, in California. Just this week we had forums that involved hospitals, first responders, public health individuals, so that we would have additional training.

I'll summarize, then, that we need to continue to strengthen our systems throughout the State, and first and foremost, we need additional resources to ensure that the Federal, State and local public health infrastructure is strengthened.

Bioterrorism knows no State boundaries. With additional resources, we would do the following.

We would improve existing surveillance systems at the local level, especially at the local level.

We would further coordinate State and local planning activities.

We would provide ongoing technical training for State and local staff and for the primary care provider community in recognizing symptoms, treatment protocols and prophylactics involving bioterrorism agents.

We would conduct response-readiness and risk-assessment of the public health system through coordinated exercises.

We would expand the laboratory capability in chemical detection.

We would further develop prevention strategies. Risk-assessments must be conducted in many areas, such as food services, food production, nuclear and chemical industries, and water supply systems. Currently California is developing a guidance document for growers, food distributors and food service industry regarding a hazard assessment.

And last we would evaluate the legal and regulatory statutes to determine whether they provide sufficient authority for appropriate action during an emergency.

Mr. Chairman, members of the subcommittee, I appreciate your dedication to protecting the American public from these terrible

threats and the opportunity that you've given me today. I encourage the subcommittee to do everything possible to support Federal funding and assist us in these programs at the State and local level.

Thank you.

Mr. HORN. Thank you.

[The prepared statement of Dr. Bonta follows:]

Testimony by Diana M. Bontá, R.N., Dr.P.H., Director, California Department of Health Services

House Committee on Governmental Reform
Subcommittee on Governmental Efficiency, Financial Management, and Intergovernmental Relations
October 5, 2001

"The Silent War: Are Federal, State, and Local Governments Prepared for Biological and Chemical Attacks"

Good morning Mr. Chairman and members. Thank you for inviting me to testify on the critical issue of biological and chemical terrorism preparedness. My name is Diana Bontá and I am the Director of the California Department of Health Services. I am the past chair of the executive board of the American Public Health Association. In addition, I served from 1988 to 1999 as the Director of the City of Long Beach Department of Health and Human Services, one of California's 61 local health departments. Congressman Horn, I appreciate your ongoing support of local public health programs.

Since the tragic events of September 11th, national security has become our national concern. In California, Governor Gray Davis has led the creation of the California Anti-Terrorism Center, which will enable all law enforcement agencies to share information on terrorist threats and activities. Additionally, the Governor's Office of Emergency Services (OES) coordinates and responds to all types of hazards, including a biological or chemical terrorism event. OES facilitates and coordinates statewide efforts in planning and response by bringing together federal, state, local, non-profit organizations and key infrastructure officials through various forums, such as the State Strategic Committee On Terrorism (SSCOT) and Threat Assessment Committee (S-TAC), of

which the Department of Health Services is a member. Also, Governor Davis has mobilized the California National Guard to increase security at key airports.

In the aftermath of the terrorist attacks, there has been heightened awareness of potential biological and chemical threats to our communities. Many have asked, "Is the nation prepared for a biological or chemical attack?" If such a horrific event were to occur, the safety of every man, woman and child would depend on the public health system. This system must remain strong.

Our public health system is relatively young. It started at the end of the 19th century. Traditional public health activities have focused on preventing the spread of communicable diseases and ensuring the safety of the air we breathe, the water we drink and the food we eat. More recently, public health efforts have expanded to include disease prevention activities to promote longer, healthier lives. It's a big job that's been done very well.

Now, in addition to all of its other responsibilities, the public health system is faced with the intentional spread of disease by groups that are organized, skilled and well-funded. Public health resources would be significantly challenged following a biological or chemical attack. In the event of such an incident, law enforcement and the medical community stand ready to assist public health. This collaboration has been critical to our success to date in addressing the alleged threats of bioterrorism that we have experienced.

Since 1998 California has been the target of more than 100 hoaxes involving exposure to anthrax. Similar hoaxes have occurred in many communities around the United States. This experience has highlighted concerns by the public health community about the potential threat of chemical or biological agents. As a local public health official in the City of Long Beach, California, I experienced first-hand the challenge of responding to these phony threats.

The initial responses to these allegations of anthrax exposure were dramatic – mass decontamination of potentially exposed persons using showers or hoses out-of-doors in December weather, and the widespread—but unnecessary--dissemination of preventive antibiotics. Responding to just the first three hoaxes in Southern California cost more than $1.5 million. The disruption to business in the affected facilities--including a courthouse--was great.

That experience taught us much. It revealed the need to integrate risk assessment and planning into a bioterrorism response. As a result, the rapid development of response protocols, in concert with the Federal Bureau of Investigation, local health departments, and other state agencies, has eliminated the massive emergency responses that spawned further copycat threats and unnecessary field decontamination of healthy individuals.

In recent years public health systems in the nation's largest cities have become more involved in terrorism planning and preparedness using funds appropriated by legislation authored by Senators Nunn, Lugar and Domenici. Under this program, the nation's 120 largest cities—including 18 in California—have received funds for training, exercises and equipment to enhance their capacity to respond to incidents involving weapons of mass destruction, including biological or chemical terrorism. The program trains local "first responders"--the firefighters, police, emergency management teams, and medical personnel who will be on the front lines if a nuclear, biological, or chemical attack occurs in a U.S. city. In addition, this effort was enhanced over the past several years by funding from the Department of Health and Human Services allowing for the development of the Metropolitan Medical Response System in a dozen California cities.

These funds have provided an essential first step for developing a coordinated response to bioterrorism that involves enforcement, public health and the medical community.

In 1999, the Centers for Disease Control and Prevention developed the chemical and biological terrorism response and preparedness program. California and several other states and large municipalities were awarded five-year funding to develop response and preparedness plans concentrating on five focus areas:

- Preparedness Planning and Readiness Assessment: California is developing a terrorism response plan, assessing state and local public health capabilities, and conducting planning and training exercises with local, state and federal partners.

- Surveillance and Epidemiology Capacity: California is finalizing surveillance and epidemiology plans for biological terrorism and for chemical terrorism, and providing training to local health departments.

- Laboratory Capacity-Biological Agents: California has developed the capability of testing for all bioterrorism agents at the state laboratory facilities and is strengthening its local laboratory network.

- Laboratory Capacity-Chemical Agents: California is developing analytical capability for chemical agents in blood and body fluids and is providing extra capacity to CDC's chemical agents laboratory.

- Health Alert Network/Training: California is developing the rapid health electronic alert, communication, and training system that includes an automated notification system, and a secure web site and e-mail.

These grants were intended to "kick start" bioterrorism preparedness in state and local health departments. California received approximately $2.5 million per year to develop the program. California was the only applicant to be funded in all five focus areas. Los Angeles County received an additional $900K per year in a separate award for work in three focus areas.

Since the start of the CDC program, California has made great strides in biological and chemical terrorism preparedness. The state has begun expanding and developing new disease surveillance tools to detect evidence of terrorism as early as possible. Using its network of state and local laboratories, California has strengthened its public health system to provide diagnostic services for all major bacterial bioterrorism agents. Fortunately, ten years ago the state recognized its need for a new laboratory that would have the capacity to address new and emerging infectious diseases, as well as test for genetic diseases and toxic exposures. Considering the tragic events of last month, the investment in California's public health has proven invaluable. The first phase of the lab opened this year. It provides essential testing for bioterrorism agents and will serve as the western regional reference laboratory for chemical exposure diagnostics.

Under Governor Davis' leadership, California has built a strong partnership with state, local and federal agencies. Federal funds have been used for developing a communications network for early notification and response. Improved planning and coordination of efforts has been a significant achievement. We have used the existing State Emergency Management System as the backbone for developing biologic and chemical terrorism emergency response strategies. The state's response and preparedness programs are tested on a regular basis. A major exercise involving a simulated incident was just completed on October 2, and a series of hospital biologic and chemical terrorism response meetings are being held this week and next. California will also be conducting the third annual statewide hospital exercise in the fall, with participation at various levels by more than 400 of California's acute-care hospitals, local health departments, and local Emergency Medical Services agencies. The focus of this year's exercise will be the response to chemical terrorism at the local level and the effects of such events on the ability of hospitals to continue providing medical care.

To meet the challenge of fighting bioterrorism in the 21st century, the nation must invest in public health. First and foremost, we need additional resources to ensure that the federal, state and local public health infrastructure is strengthened. Bioterrorism knows no state boundaries.

With additional resources, we will do the following:

- Improve existing surveillance systems, especially at the local level. We must develop and expand rapid surveillance and detection systems using not only health care providers and laboratories, but also emergency responders, coroners, veterinarians and medical or pharmaceutical databases. Collecting this disease intelligence is just the first step. There is just as great a need to bring on professionals with epidemiological expertise to evaluate this information and interpret findings.

- Further coordinate state and local planning and activities. Effective communications systems and coordination of roles and responsibilities are essential. Training is needed for local public health workers, emergency medical crews and health care providers.

- Provide ongoing technical training for state and local staff, and for the primary care provider community, in recognizing symptoms, treatment protocols, and prophylaxis involving bioterrorism agents.
- Conduct response readiness and risk assessments of the public health system through coordinated exercises.

- Expand the laboratory capability in chemical detection.

- Further develop prevention strategies. Risk assessments must be conducted in many areas such as food service, food production, nuclear and chemical industries, and water supply systems. Currently, California is developing a guidance document for growers, food distributors, and food service industries regarding hazard assessment.

- Evaluate the legal and regulatory statutes to determine whether they provide sufficient authority for appropriate action during an emergency.

Mr. Chairman, members of the Subcommittee, I appreciate your dedication to protecting the American public from these terrible threats, and the opportunity you have given me to address you today. I encourage the subcommittee to do everything it can to support federal funding and assist biological and chemical terrorism preparedness programs at the state and local levels.

Thank you.

Mr. HORN. Now we have Janet Heinrich, who is the director of Health Care and Public Health Issues, U.S. General Accounting Office. Again, the General Accounting Office is the programmatic reviewer for the legislative branch. We're delighted to have Dr. Heinrich here.

Please proceed.

Dr. HEINRICH. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to be here today to discuss our ongoing work on public health preparedness for domestic bioterrorist attack.

Last week we did release a report on Federal research and preparedness activities related to the public health and medical consequences of a bioterrorist attack on a civilian population. I'd like to begin by giving a brief overview of the findings in our most recent report, and then address weaknesses in the public health infrastructure that we believe warrant special attention.

We identified more than 20 Federal departments and agencies as having a role in preparing for or responding to the public health and medical consequences after a bioterrorist attack. These agencies are participating in a variety of activities from improving the detection of biological agents and developing new vaccines to managing the national stockpile of pharmaceuticals.

Coordination of these activities across departments and agencies is fragmented. Our staff are struggling over there with a chart that we have prepared that gives examples of efforts to coordinate these activities at the Federal level as they existed before the creation of the Office of Homeland Security.

I won't walk you through the whole chart. Certainly, if you have questions, we'll try to answer them, but as you can see, a multitude of agencies have overlapping responsibilities in various aspects of bioterrorism preparedness. Bringing order to this picture will be a challenge.

Federal spending on domestic preparedness for terrorist attacks involving all types of weapons of mass destruction has risen even 310 percent since fiscal year 1998 to approximately $1.7 billion in fiscal year 2001. Funding information and research preparedness on a bioterrorist attack as reported to us by these Federal agencies generally shows increases from year to year, but from a generally low level in 1998.

For example, within HHS, CDC's bioterrorism preparedness and response program first received funding in fiscal year 1999. It's funding has increased from approximately $121 million to about $194 million in fiscal year 2001.

While many of these activities are designed to provide support for local responders, inadequacies in the public health infrastructure at the State and local levels may reduce effectiveness of the overall response effort.

Our work has pointed to weaknesses in three key areas: Training of health care providers; communication among the responsible parties; and capacity of hospitals and laboratories.

Because physicians and nurses and emergency rooms and private offices will most likely be the first health care providers to see patients following a bioterrorist attack, they need training to ensure

their ability to make astute observations of unusual symptoms and patterns and report them appropriately.

Most physicians and nurses have never seen cases of diseases such as smallpox or plague, and some by biological agents initially produce symptoms such as the ones I have today, of colds, influenza, other common illnesses that are very much like these other virulent diseases.

In addition, physicians and other providers are currently underreporting identified cases of diseases to the Infectious Disease Surveillance Systems.

Because the pathogen used in a biological attack could take days or weeks to identify, good channels of communication among the parties involved is absolutely essential to ensure as rapid a response as is possible.

Once the disease outbreak has been recognized, local health departments will need to collect information, collaborate closely with personnel across a variety of agencies, and bring in needed expertise and resources.

Past experiences with infectious diseases and the response have revealed a lack of sufficient and secure channels for sharing information. Our report last year on the initial West Nile virus outbreak in New York City found that as the public investigation grew, lines of communication were often unclear and efforts to keep everyone informed were cumbersome.

We have also heard people speak to the need for laboratory capacity and hospital capacity. We have seen the patient load of regular influenza season—patients overtax regular care facilities and emergency rooms in metropolitan areas are routinely filled and unable to accept patients in need of urgent care.

In conclusion, although numerous bioterrorism-related research and preparedness activities are underway in Federal agencies, we remain concerned about weaknesses in the public health and medical preparedness at the State and local levels.

And, Mr. Chairman, members of the committee, I would be happy to answer any questions.

Mr. HORN. Thank you very much. I am going to have one individual who has a problem, and it is General Peake, who is the Surgeon General of the Army. And his presence in the answering and questioning is very important for going through the panel that we have just heard.

And so if the clerk can get a chair for the general over here at the table. We will—OK, general, if you wanted to give us your presentation. And then we will start with our colleagues here on the questions.

LTG. PEAKE. Well, Mr. Chairman, Congresswoman Schakowsky, distinguished members. On behalf of Dr. Clinton, I thank you for the invitation to represent military medicine here today. The military health system really has a long history of supporting our Nation in time of domestic emergencies. That ability comes as a byproduct of our readiness to support our military in the defense of our country and in the protection of vital interests.

That mission requires active, guard and reserve medical soldiers trained to standard, prepared to work under austere and demanding environments, with an understanding of the spectrum of

threats that can be faced on the battlefields of the world, endemic diseases, trauma, chemical or biological or nuclear threats.

They train to work as teams in a task-organized manner with leaders who not only have technical skills, but organizational and planning skills that come through a progressive development process. They represent all of the skills of an integrated health care delivery system. They have equipment that can be moved as part of a self-sustaining task force and still provide high-quality and reliable medical care in austere and harsh conditions.

They have the back-up of world class laboratory support, access to unique capabilities such as aeromedical isolation teams, bioprotection for containment facilities, and world-class medical centers that are integrated through an air evacuation system that we practice.

The written testimony that has been submitted by Mr. Duehring describes in some detail the supporting role that we in the military have to FEMA and the Federal response plan, and more particularly, to the public health service under Emergency Support Function 8.

We can smoothly integrate into the incident command structure that is quite universally accepted in this country. We can task organize to bring individuals with special expertise, or teams with special capabilities, preventative medicine, mental health, facilities engineers or major units such as a hospital or a medical task force such as we had at Hurricane Andrew, with medical helicopter evacuation, primary care, hospitalization, a logistics battalion, a major military medical command headquarters commanded by a general officer.

That joint task force, civil support, is now a standing organization that can serve as an integrator of military assets assigned to include such medical units.

The most important thing that we bring, though, is where I started. That is the dedicated, trained and motivated soldiers like the National Guard soldier in New York who walked several miles from her office to her home, changed into her uniform and then went to where she knew her unit was supposed to go in emergencies. She did not have to be called. She was trained, and she just went. Charlie Company 342nd Forward Support Battalion New York Guard was part of the immediate set-up for emergency response because she lived there; she was part of that community.

The 101 Cav, New York Guard, was the first medical unit deployed at the disaster site on the 11th. They provided care to fellow Guardsmen for things like respiratory distress and eye injuries, keeping the rescue effort going.

And within 11 hours of the incident, one of our new, new New York Guard civil support teams, under the control of the Governor, had not only moved from Albany, NY, to New York City, but had gathered and tested environmental samples from Ground Zero, coordinated with local, Federal, and State officials, and were able to deem the site clear of nuclear, chemical, and biological contaminants. That sure made a positive impact on those that were working in that ongoing rescue effort.

At the Pentagon, active units were augmented by reserve units working with the incident commander on the scene. Sergeant

Delgado of the 311th Quartermaster Company from Puerto Rico was at the Pentagon leading his squad by September 16th, absolutely professional in the tough duty of recovering remains.

I am proud of the trained and ready soldiers of all of our components, their professionalism, honed through training for support of our wartime fighting mission provides an asset to augment the local response, the State response, the Federal response, to chemical or biological attack here at home.

I must tell you that your support of a robust military medical system is so important to keeping this capability. It is our direct care system that provides the training platforms where these soldiers of all components get their initial set of skills. And it is in that direct care system that skills are honed and maintained for the active force. And it is in those research laboratories like these you have already heard mentioned, USAMRIID, our Institute for Infectious Disease, that world-class scientists can examine militarily relevant medical threats which unfortunately now are civil relevant medical threats. And be available on a moment's notice to support this Nation.

So I thank you for the chance to be here today and for your support of military medicine. Thank you, sir.

Mr. HORN. Thank you, General.

I would like to know, for the record, in terms of the military hospitals, have we got compacts in any way where there would be, say, the FEMA for the State Governor and then the FEMA—a smaller one—is often there in a county such as Los Angeles with 10 million people? And Los Angeles County as well as to have also Los Angeles City, and something like this happens. And there is veterans hospitals, obviously.

In the case of Washington, you have a very fine hospital here in the terms of Washington. But we also have a world-class hospital known as Walter Reed Medical Center.

And then you also have the Navy's Bethesda. Is there anything we have worked out with the cities, with the counties, with the States that are adjacent, so forth and would the military people take in the individual civilians that are either ill or gassed or whatever?

How are you going to work that out and have you worked that out?

LTG. PEAKE. Sir, it works through, as was mentioned, through the incident command center. So with the Pentagon as an example, we had our injured taken to many hospitals throughout the Washington, DC, area. Some went to Walter Reed, some went to Washington Hospital Center, to Arlington, to Inova and so forth. They were dispersed by the incident command center and the emergency support.

Almost every place that we have an installation there is an integration with the local community in terms of how that community would plan for dealing with an emergency or a disaster? I would agree that it varies across the country about how good that planning is, and there is room for improvement in that.

But we are always integrated. As you know, under the Stafford Act, the local installation commander can offer immediate response while we are waiting for the rest of the system to kick in.

Mr. HORN. Yeah, as I recall in California in 1906, the military were there to help on that situation where you had an earthquake and then fires, and then the gas pipes were broken and all of that, and the military were there to help on that.

And the civilians, on this recent mess at the Pentagon where this terrorist knocked out part of a wing, a lot of fire companies I am sure went to help you.

LTG. PEAKE. They did, sir. And they were in charge of that operation and we subordinated ourselves within—I happened to be on the cell phone with one of my officers en route to the Pentagon when he saw the plane go in. I was able to contact Walter Reed. We had surgical teams en route by the time the smoke was really starting to billow.

But when we got there, the civilian response folks were there, tremendously professional and we locked ourselves under them to be a part of the team effort.

Mr. HORN. One of the problems is to get a proper laboratory to know what is this toxic that is out there. Do we have that pretty well in terms of your hospital system?

LTG. PEAKE. Sir, there are a couple of answers to that. One, this civil support team that I referenced in my remarks has that kind of capability. And it is a relatively new capability, and it worked pretty well in this instance.

They are mobile, and they bring that equipment down. At the Pentagon we brought from the Center for Health Promotion Preventive Medicine immediately we launched some folks down to start sampling the air, soil and water in that—in the Pentagon environment so that we could know what was in the smoke, and reassure the 22,000 people that work there.

Regarding the laboratory business, we have committed ourselves to integrate with the CDC's network of laboratories around the country. We are upgrading the laboratories in our medical centers, in the six medical centers that the Army has to link in and be able to do the diagnostics on things like anthrax and brucellosis and so forth, and do that networked with the CDC.

Mr. HORN. Well, thank you. If you can stay with us for a while. I want to yield to the ranking member, Ms. Schakowsky, the gentlelady from Illinois.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I would appreciate the opportunity to make a short statement, and then to ask a couple of questions.

I really appreciate your holding this hearing today after the terrible events of September 11th. And the panel that has been put together, and I am sure the next one as well, is really excellent.

Over the last couple of years, a national security subcommittee on which I sit has participated in a number of hearings on this subject. But none has been more useful or more meaningful than the one that we have heard today with the witnesses that we have had the honor of hearing so far.

We have heard time and time again from experts in GAO and HHS and elsewhere that we need a comprehensive threat and risk-assessment for chemical and biological attacks.

Through this hearing today, we are developing a much clearer understanding of the strengths and weaknesses of our defenses. It

is my desire that we reach an understanding that both reassures the public that they are safe and provides us clear guidance of the appropriate Federal role in responding to the chemical and biological threats that may exist.

Earlier this week, the Secretary of Health and Human Services assured the public that our country was, in fact, prepared for any threat to our Nation's health. But, I am not sure that I share his confidence.

As some of our witnesses have explained, our public health system, good as it is, could have difficulty responding to a significant biological or chemical attack, not to mention even a major flu-like outbreak.

The capacity of our public and private hospitals is strained each year during flu season. A disaster with 10,000 injuries that requires hospitalization could be very difficult for that system to handle. We must question whether our system could handle such a situation.

The front lines in most disasters as we have heard so eloquently today, and I thank Dr. Smithson and Mayor O'Malley and all of the other witnesses for pointing this out so poignantly, is local government and local health care providers as well as State.

We see this again and again as towns and cities are struck by hurricanes, tornados and even disasters like we saw last month. The first there to tend to those in need are the local firemen, police officers, emergency medical personnel.

Any response we develop now as you have said as our witnesses must keep that fact in mind. Training and communications are key to disaster response and should be a major part of our planning and investment. We heard you.

The majority of that investment should be made at the State or local level with an appropriate level of coordination and assistance from the Federal Government.

Past experience has also shown that the public health system is the second line of response. Once the disaster scene is surveyed, the injured are moved to hospitals, it is often the case that the hospital capacity is reduced by the same disaster.

We have taken our public health system for granted for some time now. It has suffered as a result. Community cooperation is the third line of response. Once the level of damage is assessed, those hardest hit will have to call upon their neighbors for assistance. As we saw after the events of September 11th, every one wants to help.

We need to develop a network of community organizations, much like that under development by the Office of Emergency Preparedness at HHS. The goal is to provide every community with the preparation and resources to respond to a disaster. Those are just some of the many critical issues that we will need to assess, and many others you outlined for us today as we move to improve the emergency response infrastructure in this country so we are able to address the current shortfalls and the possibility of future threats to our health and security.

I would really appreciate being able to ask a few questions, Mr. Chairman. I want to make sure, Dr. Smithson, I heard you clearly. Were you saying in terms of crop dusters, because there was some

evidence that one of the terrorists at least was looking into the use of crop dusters that the particles that would be distributed really are too big to cause any kind of health risk?

Dr. SMITHSON. Yes. You have got me exactly right. This is a very closed community. There are small businesses. One of the things that isn't being discussed today is really the fact that Atta didn't even get a peek inside the cockpit. These are people that are required to have a 1-year apprenticeship just to learn how to fly these things and operate the sprayers behind them. And the sprayers would be suitable for chemical agent dispersal, I won't joke with you about that.

But for biological agent dispersal, you would have to go in there and change everything around. You can't even dial them down to the particle size required, very, very small particle size required for effective biological agent dispersal.

Ms. SCHAKOWSKY. But it can be useful for some sort of chemical?

Dr. SMITHSON. That is what crop dusters do. But again, if you just fly low a regular light aircraft, and the assumption is that somebody is going to jump into one of these things and get it successfully off the ground, it would be the difference between driving a little Miata sports car and driving a couple of 18-wheelers hitched together fully loaded. Things handle differently.

And there is no assurance that they will crash, but they are not going to be able to operate these things automatically and cause the havoc that seems to believe the assumption working in press circles today.

Ms. SCHAKOWSKY. No, but if they were able to get the training and were to load it with some sort of deadly chemical, and then fly it over some of—a densely populated area, it could, in fact, be a problem; is that not true?

Dr. SMITHSON. I would agree with you in that, but again the assumption is that it would be effective. In cities, there is micrometeorology that is going to come into play.

These crop duster pilots are trained to go way down and lay something right on the Earth and be effective in what they do. We are making several leaps of logic right now, and everything appears to be very frightening. I would encourage you, just as I have done, to spend time with people who have actually made these weapons so that you understand how technically difficult it is, with people who actually fly crop dusters so that you have an appreciation about this.

One of the things that is happening in this country is our citizens are getting their wits scared out of them by what they are hearing over the airwaves, often from people that don't seem to know their technical stuff.

Ms. SCHAKOWSKY. You did mention hazardous chemical facilities? Have you looked at all into nuclear power plants as a potential danger for a terrorist attack?

Dr. SMITHSON. No, ma'am. My jurisdiction is chemical and biological. However, in the survey of 33 cities that I took, talking with individuals just like this; the locals are very aware, in fact, I defy you to find a HAZMAT captain who does not know off the top of his or her head how many of these facilities are in their communities. In most of the locations where I went, they had already a

great appreciation of what these facilities were in terms of a danger to their citizens.

Listen, the chemical industry takes the security of these sites very seriously. But so do the local responders around them. And in many cases, they have already begun working with these facilities and other locations like sporting arenas and major buildings, landmarks, to enhance the security of those sites.

So there are things that are happening across this country in spots that will definitely protect Americans. What needs to be done here in the mindset that needs to be adjusted inside the Beltway, is that the preparation needs to be nationwide.

And that you need to institutionalize the training, not just train here and there. The Federal Government's role is mid to long-term recovery assistance, not rescue. Because right now you cannot fit any more rescuers on top of the rubble pile in New York City.

If you threw every Federal asset at it, it just wouldn't work.

Ms. SCHAKOWSKY. Then finally, speaking of Federal assets. All of you have spoken about the need for Federal assistance at the State and local level. If we were with—with our finite resources to put—to make a Federal investment, what would you think is the most important thing? Let me just kind of—if we can quickly go down the panel—the most important investment that we could make to guarantee the safety of our citizens against chemical and biological threats.

Mr. HORN. We are going to be three amendments to these questions.

Dr. SMITHSON. Institutionalization of the training in the Nation's fire academies, police academies, medical and nursing schools as well as in public health training. That is the only way you are going to raise the standard of readiness and preparedness across this country.

Mr. O'MALLEY. I mentioned before, yes, about Federal dollars. It is going to take Federal dollars. I really still do believe that for all of the other things we are talking about, that the disconnect in criminal intelligence is the biggest threat right now and the most dangerous one.

But I would piggyback on that just to add that protective equipment and the additional vaccinations and stockpiles around.

Mr. NORRIS. I agree with everything. Preventative equipment, stockpiles of vaccinations, but I can't stress enough that all of these things are carried out by human beings. What is missing right now is human intelligence. While these things are very, very important to mitigate once a disaster strikes, I think we need to just as seriously take the intervention before they strike and be tracking down the people that are trying to deliver whatever may come in this country. And that is really lacking.

I think most of the discussion I have heard at the top levels regarding equipment, the biochem. threats, nuclear threats and the like, the choice of terrorists around the world is still bullets and bombs. The World Trade Center was done with a very low-tech operation and we seem to be losing sight of that.

We are missing human intelligence and we need much more coordination with our Federal counterparts to arrest the people out

there right now who have been in this country for over a decade preparing to do this.

Mr. HORN. Let me add to that, and that is, some people are out getting gas masks and all of the rest of it. It has happened in Israel sometimes. But also there have been deaths when the individual didn't pull the cord for oxygen. What is your advice on that.

Mr. NORRIS. Very important. Just as the mayor was saying, one of the most important things is to be prepared when an attack occurs because a lot—Dr. Smithson said it best. People are being terrified. If air raid sirens go off in cities around America and people start to leave their homes when in fact maybe they should stay in place and things like that, people are buying gas masks, gas masks, well, we have them, police departments and fire departments. They have to be tested to OSHA specifications for seal.

You could put on a gas mask and still get killed if you run out the door, because they don't fit properly. And people are misleading themselves giving them some sense of comfort. But representing my city as the police chief, I still say we need to intervene in these acts before they occur.

You concentrate as much of our efforts that way as you are to the rescue efforts afterwards.

Mr. O'MALLEY. I can tell you that all 36 of the gas masks on stock in stores in the Baltimore area have sold out immediately, and none of them would do much good anyway when it comes to a biological attack.

Dr. SMITHSON. This is one of the aspects of the aftermath of September 11th that has saddened me the most. Americans have rushed to do things that they think will serve their interests, when in fact that may not be the case. If this gas mask that you purchased is not fitted, and if you are not instructed in how to use it and understand the changing of the canisters and how to make sure that it fits when you are running, then you have bought yourself some false protection.

Let us use common sense. If you do see a crop duster overhead, get inside, shut the windows, shut the doors and you will have provided ample protection for yourself. If you are still nervous about it, go jump into a shower. Ask fire folks. One of the most effective decontaminants is water.

In terms of stockpiling antibiotics, I am sure that Scott Lillibridge will touch on this in just few minutes. That is also false security. It could backfire on Americans.

If they start self-medicating themselves with the first dose—in the case of the sniffles that they get, the after affects could be that the medications won't work for them later when they really, truly need them.

So, I know Scott will get to this, too. I hope that America's physicians will get better educated on what is happening in the country and stop writing prescriptions right now.

Mr. HORN. Would any others like to respond?

Ms. SCHAKOWSKY. Any others want to respond? I also wanted to thank Mrs. McHale for that very dramatic testimony and sharing that information and to say how happy I am. I was waiting to hear about your child being born healthy.

Dr. BONTA. Mr. Chairman, I would like to address a question if I can. It is really difficult to pinpoint down the one single actual thing that if we had to eliminate it to just one, because all of the suggestions that have been here are good and we all have ideas that we think are important.

But if I had to narrow it down, I would say making sure that we get the right equipment for response into the hands of the local first responders. It is imperative that we have that. We have to have good communications equipment. We have to have good detection of surveillance equipment. We have to have good personal protective equipment for those folks too if we expect them to be able to do their job.

Mr. HORN. Let me ask one question before I turn to Mr. Cummings. That is that in the case of Baltimore, what was the toxin? And did you know how much—when did you first know which toxin it was, and had those individuals had violated the rules of the Department of Transportation to note on the storage there with the toxins so that the firemen going in would know, particularly under tunnels and so forth?

Tell us a little bit about what was the toxin and were they terrorists or were they just incidental accidents?

Mr. O'MALLEY. Well, on your last point we have yet to have a cause determined by the NTSB. So we don't know what the cause of it was at this point.

Recently we did arrest a person of Middle Eastern descent coming out of the tunnel with camera equipment and a knapsack and a hood. And whether that person was a probe or a kid that didn't get enough love from his dad early in life or what that was, we don't know.

But when this incident actually broke out and a fire was happening inside this tunnel, keep in mind this tunnel, it was built in the 1890's. It bankrupted the B&O Railroad. It was their last and greatest public works project. It is almost like a mile and a quarter-long brick oven with two entrances. We found a third one only because of memory.

So we knew right away from the manifest what was on the train. You can't be 100 percent sure that the people recording it on the manifest didn't make a mistake. So you really don't know what you are dealing with until you get inside and the order of things.

And the other curious thing was that although we knew what was on the train, without being able to get up inside the tunnel, we couldn't tell you where the fire was on the train.

In retrospect, we were fortunate in that the people assembling the train had indeed put buffers between some of the chemical cars so that there was not a chain reaction. I mean, there was, of course, a chain reaction in that the chemical fire was adjacent to a car containing trash and garbage and packed paper, so there was a reaction, but not the sort of combustible reaction there would have been had all of the chemicals been tied together.

I forget, the one that actually exploded was. And that was the one that had caused the fire. It ruptured an adjacent car that had hydrochloric acid in it. That basically ran out, diluted or was burned. The other car whose polysyllabic chemical name escapes me at this time, "methylethylbadstuff" we will say for the sake of

this hearing, was fortunately at the other end of the car. And our great fear—it was some sort of a chlorine agent. Our fear was that would rupture, that would somehow be in gaseous form and become a deadly gas.

And that was fortunately at the other end. There has been an uncoupling of the cars, so the cars that had jumped off the rail where the fire happened, you know, kind of came to a rest quickly. The other half of the car continued to roll a little bit on the back of the engine and so there was a separation of space.

But, keep in mind, when all of these suckers were pulled out of that tunnel late at night in front of our fire department and a very nervous mayor at about 2 a.m., they were all charred and looked like a bunch of hot-dogs being pulled out of a fire.

So I am sorry, I can't tell you exactly what the bad one was. But it was some sort of chlorine agent.

Mr. HORN. What is the situation of that particular tunnel or whatever?

Mr. O'MALLEY. Not unlike other tunnels, including one—you know, not unlike other tunnels in cities up and down the East Coast or rail yards or the tracks that go through them, those tracks are very much open. They are open to pedestrians. I mean, fortunately, thanks to Commissioner Norris and our assessment of vulnerabilities, the reason we apprehended the individual coming out of that tunnel was because we were keeping an eye on that tunnel and had additional security, had spoken to CSX.

But there is very little security around any of these rail yards. While it is true, as the doctor said, that the chemical companies take the security of their chemicals very seriously, they take it so seriously that most of the dangerous tankers are left out open on the yard instead of coming inside their plant, inside the chained gates. So this is a serious vulnerability for a lot of cities, Baltimore, Philadelphia and many other—industrial cities along the corridor.

We have identified it. Obviously, it is going to cost a bit of money to do the proper fencing, to do security cameras. The gentleman from the train company, as I asked him about great, simply security measures like that, said we have 23,000 miles of track in the United States, to which I answered, I am sure you do. And which percentage of that track runs through America's 20 largest population centers?

Mr. HORN. We thank you very much.

And now I want to yield 3 minutes to the gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, for your courtesy. And I certainly am very pleased to welcome the mayor of Baltimore, Mayor O'Malley, and certainly our police commissioner.

Mr. Chairman, Mayor O'Malley has done an outstanding job. I think his testimony today indicates that Baltimore is as prepared as we can be, and we can always use some help. And I think the mayor would agree with me on that. We can use resources, as we debate in the Congress about how we are doing, with these pocketbooks open and dealing with these emergency circumstances, I think it is very important that we keep in mind, that as Mayor O'Malley has said, we are indeed on the frontline of this.

Mr. Chairman, one of the things that I find so interesting, coming from our police commissioner, Commissioner Norris, who, too, is doing an outstanding job in our city, and the crime rate has gone down dramatically, it is shocking to the conscience that the cooperation that he talked, a lack of cooperation between our Federal agencies and our local police.

And, you know, when we think about all that we have heard, and all of the concerns that we have heard in the news media about how the FBI, DEA and all of the other Federal agencies, CIA, trying to track down the criminal element, the terrorists involved in this matter, and to not be working closely with our local police is very—I mean it should concern every single American who may be listening to this.

And so one of the things that we will do, Mr. Chairman, and the committee, subcommittee of this committee which I rank on, Criminal Justice, is I have asked Chairman Souder, and I hope that you will help me with this, to convene a subcommittee hearing or with the chairman of our overall committee, Congressman Burton, to ask the FBI to ask the other agencies, Federal Government law enforcement-type agencies, why don't people like Commissioner Norris have the kind of cooperation that he wants to have?

And so I think that while we have got great police and we saw it in New York, and we see it all over the country, people work every day, they knew their territories, just like Commissioner Norris said, they knew the people, they know every square inch of their cities, it seems logical to me that we would try to have that maximum cooperation.

Finally let me say this. I think that when, as I have listened today, I hope that we understand—it sounds like when I listen to the mayor, what he is basically saying is, look, you know, let us not put a blinder up to our eyes and then listening to Dr. Smithson, let us not put a blinder up to our eyes and act like one thing is going on, when actually it is another.

And let's be practical and deal with these things. And I think that is what—I hope that we in the Congress will listen to them very carefully, because what they bring to us are the practical—first of all, the information that is accurate, and then the practical solutions to the problem so that we will not be fooled.

Americans, I think, after September 11th, they thought that they had a level of security, which we quickly found out that we didn't. So the kinds of things that are coming forth today, Mr. Chairman, again, I thank you. It is the kind of information that we need to address the problems that we are confronting.

Again, I thank you for your courtesy.

Mr. HORN. I thank the gentleman. And as I said earlier today, Mrs. Maloney, the gentlewoman from New York has helped us on this, as many other things. And so I now yield 3 minutes. We are going to just have to keep going, because we want the second-tier to come and we would love you to have your role after you hear some of the second-tier.

So, Mrs. Maloney.

Mrs. MALONEY. First of all, I want to thank all of the panelists, particular to welcome my friend, Mayor O'Malley, with whom I

have had an opportunity to work on other important issues before this Congress.

I agree very much with the theme that many of you have put forward that all emergencies are local and the number of lives that will be saved is very much due to a local response. In New York it was New York's bravest and finest that were the first at the scene.

And on Monday, when I was at Ground Zero, it was still fire that was in charge of the scene. Yesterday, a member of what we call in New York the "Bucket Brigade," was in my office. This is the group of volunteers that supported the fire in removing debris by hand in buckets trying to look for lives.

And they told me that even when there was a notice to evacuate, because they were afraid a building was going to fall, that the firefighters and officers refused to leave the site. They kept looking, trying to save people and responding. To me they are the greatest heros in our country.

Later today we will be authorizing the intelligence committee. And I will certainly be bringing to the floor in my statements the items that you brought on better coordination. We definitely need to invest and strengthen our intelligence.

I would like to ask about smallpox. Many people who are experts in this have told me that there is a universal agreement that the smallpox virus is the single most dangerous raw material for a non-nuclear terror attack. One expert said it is almost like a smallpox and then everything else.

We eradicated it in 1978. It is supposed to exist, the virus, in two places, the CDC in Atlanta and in Russia. But I am told by some experts that they believe that many of these smaller countries have the smallpox virus. We know that it could kill, or in the past has killed up to a third of those infected. And the World Health Organization is trying to speed up responses.

Our own government has roughly 15 million doses of smallpox vaccine; has ordered 40 million more for delivery by the end of the year 2004. Many of my constituents in New York have called my office and asked for the smallpox vaccine.

I have called the National Institute of Health. They have told me that it is not available. Many experts believe that it is a threat. Russia apparently developed weapons that could put the virus on the tip of it and send it to our country.

And we have not really had a great control of some of their weapons after the cold war. I would like to ask some of our experts whether you think we should be developing more vaccine? Should our citizens have access to it? Even though we don't have enough for everyone, shouldn't some of the people that are asking for it be able to have access to it?

As a child, I was vaccinated, but I am told that anyone who was vaccinated many years ago is no longer covered or immune to a smallpox virus. I would like anyone on the panel who would like to comment on what we should be doing. Should we be developing more vaccine? Should we be distributing it? What should we be doing?

Dr. SMITHSON. A few years ago, I spent several weeks in the former Soviet Union interviewing the weaponeers who did this,

who figured out how to turn diseases into weapons of war. And the Soviet Union did that with over 50 diseases, including Marburg. It is true. They did weaponize smallpox. They manufactured tons of it, along with plague and anthrax.

And they put it on top of ICBM's aimed at Western populations centers. I think it would be foolhardy to assume that smallpox seed cultures only exist in one place in the former Soviet weapons complex, which consists of over 50 centers that were involved in the research, development testing and production of these weapons.

However, when I talked with the weaponeers there was one thing that they understood very clearly. Terrorists, they kept on telling me, are our common enemies, because Moscow has had its own encounter with terrorism.

Also, before that even happened, Aum Shinrikyo, the cult in Japan, had knocked on the National Health Institute doors for both chemical and biological weapons knowledge. I don't want to feed you a line here. I did interview weaponeers who knew colleagues who had gone to help Iraq and Iran and China and North Korea.

They had been invited to teach. But let us not make the assumption that is not all that they did. Let us also not make the assumption that these governments would automatically share something like smallpox with a terrorist group, because if it is anything that a weaponeer understands, it is the consequences of unleashing something like that on a population, even if it is the population of your enemy. Because that is something that goes around the world and would be very, very difficult to contain.

Let us also not make the assumption that smallpox is for sale on the streets of Moscow or any other place. In today's environment, there are so many rumors that are floating around. If I were to give you a remark on the other aspect of your question, it would be that if anybody should be getting smallpox vaccines in an emergency; it has to be the very people who are going to be there. We are expecting them to save our lives.

The medical personnel, both in hospitals and the paramedics and other technicians as well as the firefighters and police.

Mrs. MALONEY. Should we be vaccinating them now, in your opinion?

Dr. SMITHSON. I think I will leave that judgment call to others. It is not for me to advocate that. I don't feel that there is imminent danger that smallpox is going to be released on this country. I think before we go doing a lot of knee-jerk things, this is an atmosphere that breeds knee-jerk reaction, we need to carefully think through these matters.

And, by the way, I agree with what Governor—excuse me, I just promoted you, Mayor O'Malley said——

Mr. O'MALLEY. Thank you. I accept your nomination.

Dr. SMITHSON [continuing]. With what Mayor O'Malley said. It is not just the frontline personnel, it is also their families, because they have to be assured that their family is going to be OK if something bad happens.

Mr. O'MALLEY. I think the long-term issue of prophylaxing your emergency responders, though, it is just that—it is slightly longer-term issue, but it is a very important issue. We assume that when the calls go out, everybody goes and they do their duty. And we

have seen the courage. And many and most probably will. But ask people to—in these sorts of things, to leave their families behind is a tough thing to ask human beings to do in these times of emergency.

But I would think that given the level of vaccinations that we currently have, that go doing them all over the country in a knee-jerk way would not be a wise use of the limited vaccines we have on smallpox.

Dr. SMITHSON. Right. The thing is, we need to assure these people now what the priorities are going to be, that they would be the first to receive these medications, simply because they will have to save us.

Mrs. MALONEY. Can I ask one brief show of hands on one brief question, Mr. Chairman.

Mr. HORN. Yes.

Mrs. MALONEY. I would like a show of hands, because we have to get on to other people, as the chairman said, of how many people agree with Secretary Thompson's statement that he stated on 60 Minutes on Sunday? "We are prepared to take care of any contingency, any consequence that develops for any kind of bioterrorism attack."

Do you agree with this statement of being prepared? Raise your hand if you agree you are prepared for all of this.

Raise your hand if you think we are not prepared.

Mr. HORN. Well, wait a minute.

Mr. O'MALLEY. I think it is all a matter of degrees. I don't think that we are prepared for many, many things. And I think, depending on the degree of it, we would quickly find that preparation outstripped by about——

Mr. HORN. I remember where the previous administration had warehouses all over the place on the flu and nobody ever used them. And that is why we need doctors to know, and chemists to know if any of this is—otherwise, I don't believe in sort of scaring the living daylights out of people. Because—I would like Ms. Bonta to respond.

Dr. BONTA. I think it is dependent upon degrees. Because certainly we have experience in the United States where some local public health departments are still in buildings that were made for the polio epidemic.

In 1988 when I was with the city of Long Beach, we were in just such a building. We had a rotary telephone and we had two computers that staff were even not fully trained in how to use. We have moved a long way throughout the country, and certainly in California we have the advantage of having years and years of preparing for earthquake preparedness and other natural disasters. But this is a unique situation in which we need more work on communication, on training, on laboratory preparedness and having disease surveillance and epidemiology.

LTG. PEAKE. I would just say, ma'am, you know, I am a doc. And so you are the one doc in the ER, and three or four people come in, that is a mass casualty. It is a matter of degree. And the issue is having the systems back-up that can pull the things together where you need it, when you need it, to be able to make that response.

And I think that has sort of been a consistent theme as I have heard here.

Mr. HORN. Thank you. And we thank you. And our last questioning goes to Mr. Kanjorski, the gentleman from Pennsylvania, 3 minutes.

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

I want to make a few observations to the panel, because I have been sort of monitoring the channels over the last several weeks on television. It seems that if anybody has written a book lately, in the extreme has been a guest. And they make all of those proposals. And then I have been talking to constituents that have a legitimate reason to try and make an analysis and a judgment of how they should carry on their daily lives.

And what I am most interested in is the lack of our system for having a central clearinghouse operation to adequately inform people as to what the risks and various categories are, some—what the symptomologies are and what disadvantages of taking proactive action.

One member of the health community made a great point the other day. Vaccines, for instance, have a percentage of detrimental effects on society. If you were to inoculate the entire country, even though it may be one half percent a negative effect, you are talking about a million and a half people that may suffer irreparable injury as a result of just taking the shot itself.

A lot of people aren't aware of that. They think that it is a sure cure. The other things that they aren't aware of is the difficulty of delivering the longevity of life of some of those biotechnology methodologies that would be used in germ warfare and also in gas warfare; what the chances are of getting the proper nozzles on a crop duster.

I guess what I am most interested in, and the observation I would make over the last 3 weeks, is that we in government and in leadership have a tendency to underestimate the intelligence and rationale of the American people. They don't want, even the Secretary of HHS, to come out and make a pronouncement. They want to know the basis on which his pronouncement was made so they can analyze in their own mind what their chances of having an exposure would be.

In order to bring the level of that type of understanding up, are you aware of anything that we are doing to create a national institute of reliability, if you will, for this information, whether it be on the Internet, should we do it in the national broadcast—what is the educational factor here?

Because we just have entirely too many people that are in a State of anxiety that shouldn't be there, are giving up their normal course of life and business and having a major impact on our economy and other things.

I just came from a session, Mr. Chairman, where we talk about security. And after we got to $25 or $30 billion in expenses of changing railroad lines and doing all kinds of things, which are probably intelligent things to do, I realized that we could on our way to spending ourselves into bankruptcy in trying to take care of every contingency that could happen knowing fully well, the open country that we are, we can't accomplish that.

So do you have any ideas? I'll just ask the panel: What could we do to provide a level of intelligence and information that would meet the needs of the average American who wants to be informed as to what to do and do away with the rumor mills that are out there that are paralyzing us?

Mr. O'MALLEY. Your point is—I think it is an excellent point. One of things we have tried to do through the conference of mayors is inform each other and try to encourage well informed local officials to talk about these things.

We had a teleconference with about 200 cities that chimed in, and our guests—and the first one was last week. And it was done with—on bioterrorism, going through the likely agents. I mentioned the Hopkins Center for Civil Biodefense Studies. It is www.hopkins-biodefense.org, I think.

And we are going to be doing one next week on chemical readiness. So it would probably be a good idea to have some sort of 800 number or something in cities that people could call. But fortunately, I think the Internet, I think you are right. I think a lot of Americans are educating themselves.

But we need to do a better job. And I don't think it does any of us any good to not discuss it. I know there are some local elected officials who feel like, "Oh, my goodness, if I go on camera or talk about this, I might make it worse."

Indeed if they are uninformed they may make the hysteria worse. So I think it is incumbent on us locally to get the word out and do it through our local affiliates.

Mr. HORN. That is very well answered.

I would like to now play musical chairs where the group in the back, our panel two, and if some of you could stay around, we would like that.

Let us start here with Scott Lillibridge, special assistant to Secretary Thompson. Second one is Bruce Baughman, FEMA. Craig Duehring from the Department of Defense. Mr. Fogg, New Hampshire Office of Emergency Management. Mark Smith, Washington Hospital Center, and Kyle Olson, vice president and senior associate.

We will start with Mr. Scott Lillibridge, M.D., special assistant to the Secretary for National Security and Emergency Management Department of Health and Human Services which is headed by one of the best cabinet members I have ever known, that is Mr. Thompson. He is on top of it. And I am delighted to have one of his special assistants here.

So, Mr. Lillibridge, proceed to give us a summary of your excellent—all of you had wonderful papers, and that automatically goes in the record. But we would just like to see an overview from you at this point.

STATEMENTS OF SCOTT R. LILLIBRIDGE, M.D., SPECIAL ASSISTANT TO THE SECRETARY FOR NATIONAL SECURITY AND EMERGENCY MANAGEMENT, DEPARTMENT OF HEALTH AND HUMAN SERVICES; BRUCE BAUGHMAN, DIRECTOR, PLANNING AND READINESS DIVISION, FEDERAL EMERGENCY MANAGEMENT AGENCY; CRAIG DUEHRING, PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR RESERVE AFFAIRS, DEPARTMENT OF DEFENSE; WOODBURY FOGG, DIRECTOR, NEW HAMPSHIRE OFFICE OF EMERGENCY MANAGEMENT, CO-CHAIR, TERRORISM COMMITTEE, NATIONAL EMERGENCY MANAGEMENT ASSOCIATION; MARK SMITH, M.D., WASHINGTON HOSPITAL CENTER, REPRESENTING THE AMERICAN HOSPITAL ASSOCIATION; AND KYLE B. OLSON, VICE PRESIDENT AND SENIOR ASSOCIATE, COMMUNITY RESEARCH ASSOCIATES

Dr. LILLIBRIDGE. Thank you, Mr. Chairman and members of the subcommittee. I am Scott Lillibridge, special assistant for the Secretary of Health and Human Services, Tommy Thompson, for National Security Issues and Emergency Management.

I appreciate the opportunity to appear before you today to discuss the issues and the role in State and local government preparedness to respond to acts of terrorism, including biological terrorism and chemical terrorism. I would like to take heart in the comments that I have heard today from plain-speaking Amy Smithson about preparedness, the comments from Dr. Bonta about State and local preparedness in the public health sector, and of course, Baltimore for taking matters into their own hands, once again. Thank you.

At any rate, I would like to acknowledge that our State and local public health programs comprise the foundation of an effective national strategy for preparedness and emergency response. Preparedness must incorporate not only the immediate responses to threats such as biological terrorism, it must also encompass the broader components of public health infrastructure which provide the foundation for immediate and effective emergency responses.

These components include, one, a well-trained, well-staffed, fully prepared public health work force. Two, a laboratory capacity to produce timely and accurate results for diagnostics and public health investigations.

Three, we need epidemiology or disease detective work including surveillance for infectious diseases which provide the ability to detect health threats urgently.

Four, we need secure accessible information systems that can help us analyze essential information, communicate it rapidly, and analyze trends and interpret data.

And last, of course, we need an effective communication system. I believe several members today spoke to the issue of important public health information and relating that accurately to the public.

Currently States lack an optimum public health infrastructure at both the State and the local level. We will need to discuss and make planning on the long-term as part of our overall preparedness effort.

I would like to begin talking about HHS activities and preparedness and response, and start with the Centers for Disease Control activities.

The HHS CDC has used funds provided—has provided funds for the past several years from Congress to begin the process of improving expertise, facilities and procedures of State and local health departments to respond to biological and chemical terrorism and other acts of terrorism.

For example, over the past 3 years the agency has awarded more than $130 million in cooperative agreements to 50 States, one territory and four major metropolitan health departments, and has created a bioterrorism preparedness response program and other components that anchor as part of that overall program, including stockpiles, chemical preparedness, health information, and a health alert network.

We must continue our work with our State and local public health systems to make sure that they are more prepared. This requires interaction of State departments of health with State emergency managers to fully integrate the States' capacity to effectively distribute life-saving medications to victims, whether it be a biological or a chemical attack.

The HHS Office of Emergency Preparedness is also working on a number of projects to assist local hospitals and medical practitioners to deal with the effects of biological, chemical and other terrorist acts.

Since fiscal year 1995, for example, the Office of Emergency Preparedness has been developing local metropolitan medical response systems [MMRS]. Through contractual relationships with local communities, MMRS uses existing emergency response systems, emergency management, medical and mental health providers, public health departments, law enforcement and public health departments, to provide an integrated unified response to a mass casualty event.

As of September 30, 2001 the OEP, Office of Emergency Preparedness has contracted with 97 municipalities to develop MMRS systems.

The fiscal year 2002 budget includes funding for an additional 25 MMRS systems. MMRS contracts require the development of local capacity, capabilities for mass immunization, prophylaxis in the first 24 hours following an identified disease outbreak, and the capability to distribute material deployed to the local site from the National Pharmaceutical Stockpile.

Local medical staff are trained to recognize disease symptoms so that they can initiate treatment, and the local capability to manage the remains of the deceased are also included in this effort. We have important lessons learned from the recent September 11th activities.

First of all, I would like to talk about the response and just highlight a few things that I think are quite exciting. Second, we were able to respond to two sites with medical emergency teams in a matter of hours and provide assistance onsite and some cases minutes to hours. And involved on-the-ground assistance in both Virginia, near the Pentagon, and in New York City.

Our stockpile became operational for the first time in terms of deployment, and with a timeline of 12 hours or less we actually got it there in 7 hours. That was one of the few things able to fly and move during that time of crisis with complex coordination with the Federal Aviation Administration and the national security community of the United States.

We had teams in place. Shortly surveillance was enhanced, particularly in New York City. Our disease detectives from the Centers for Disease Control were onsite amplifying surveillance, and working with State and local communities, building on the infrastructure, largely since West Nile, to enhance local public health capacity.

A number of important activities have been undertaken by the Secretary of Health and Human Services since September 11th. And they include meeting with pharmaceutical agents, accelerating vaccine production, and taking aggressive steps to accelerate the development of—long-term development of our national pharmaceutical stockpile.

On the long-term overview, as an indication of the Nation's preparedness for bioterrorism, I would like to review a little bit about the lessons learned from the Top Off 2000 exercise in May 2000.

This national drill provided scenarios related to weapons of mass destruction, to a mass destruction attack against our population. It involved the cooperation at the State and local level, FEMA, Department of Justice, HHS, Department of Defense, and many other vital community sectors that would play a role in an actual response.

While much progress has been made to date, the number of important lessons that have been, from that event have begun to shape our overall views of preparedness. And they are as follows.

It is clear from the health perspective, and there are many ways to look at this, but from the health perspective, improving the public health infrastructure, both at the statute and local level remain a critical focus of our terrorism preparedness and response efforts. Such preparedness is indispensable for reducing the Nation's vulnerability to terrorism from infectious agents and from other potential emergencies through the development of these broad public health capacities, again, State and local capacities.

Second, it would also be extremely important to link emergency management services and health decisionmaking at the most local levels for the purpose of rapidly addressing the needs of larger population, particularly a population affected by bioterrorism or other chemical terrorism events.

I would like to conclude and say a few things on behalf of our department, that the Department of Health and Human Services is committed to ensuring the health and medical care of our citizens, and we have made substantial progress to date in enhancing the Nation's capability to respond to a bioterrorism event.

But there is more we can do to strengthen our readiness. I was glad to see through a show of hands that people were neither convinced that we were ready nor not ready. I think that is an important indication that the issue of preparedness is a long-term endeavor and will require us to broaden the depth and the breadth

of our preparedness activities along all fronts in this war against terrorism.

Priorities include strengthening our local and State public health surveillance capacity, continuing to enhance our national pharmaceutical stockpile, and helping our local hospitals and medical professionals better prepare to respond to a biological or a chemical attack.

Mr. Chairman, that concludes my prepared remarks, and I would be pleased to answer any questions that you or members of the subcommittee may have. Thank you very much.

Mr. HORN. Thank you very much.

[The prepared statement of Dr. Lillibridge follows:]

Testimony
Before the Subcommittee on Government Efficiency, Financial Management, and Intergovernmental Relations, Committee on Government Reform
U. S. House of Representatives

Bioterrorism: The HHS Role in State and Local Preparedness

Statement of
Scott R. Lillibridge, M.D.
Special Assistant to the Secretary for National Security and Emergency Management
Department of Health and Human Services

For Release on Delivery
Expected at 10:00 am
on Friday, October 5, 2001

Mr. Chairman and Members of the Subcommittee, I am Scott R. Lillibridge, Special Assistant to the Secretary of HHS for National Security and Emergency Management. I appreciate the opportunity to appear before you this morning to discuss the Department of Health and Human Services (HHS) role in State and local government preparedness to respond to acts of terrorism involving biological or chemical agents.

State and local public health programs comprise the foundation of an effective national strategy for preparedness and emergency response. Preparedness must incorporate not only the immediate responses to threats such as biological and chemical terrorism, it also encompasses the broader components of public health infrastructure which provide the foundation for immediate and effective emergency responses. These components include:

1. A well trained, well staffed, fully prepared public health workforce;
2. Laboratory capacity to produce timely and accurate results for diagnosis and investigation;
3. Epidemiology and surveillance, which provide the ability to rapidly detect heath threats;
4. Secure, accessible information systems which are essential to communicating rapidly, analyzing and interpreting health data, and providing public access to health information;
5. Communication systems that provide a swift, secure, two-way flow of information to the public and advice to policy-makers in public health emergencies;
6. Effective policy and evaluation capability to routinely evaluate and improve the effectiveness of public health programs; and

7. Preparedness and response capability, including developing and implementing response plans, as well as testing and maintaining a high-level of preparedness.

Currently, most states need public health infrastructure improvements in order to effectively prepare for and respond to possible future attacks. In addition, health officials must ensure that critical public health functions continue despite the diversion of resources to any existing emergency.

Preparedness and Response

The CDC has used funds provided by the past several congresses to begin the process of improving the expertise, facilities and procedures of state and local health departments to respond to biological and chemical terrorism. For example, over the last three years, the agency has awarded more than $130 million in cooperative agreements to 50 states, one territory and four major metropolitan health departments as part of its overall Bioterrorism Preparedness and Response Program. In addition, CDC currently funds 9 states and 2 metropolitan areas specifically to develop public health preparedness plans for their jurisdictions. Many of these states and cities have participated in exercises to test components of their plans. We must continue to work with our state and local public health systems to make sure they are more prepared. This will require the interaction of state departments of health with state emergency managers to fully integrate the state's capacity to effectively distribute life-saving medications to victims of a biological or chemical terrorism event.

The HHS Office of Emergency Preparedness is also working on a number of fronts to assist local hospitals and medical practitioners to deal with the effects of biological, chemical, and other terrorist acts. Since Fiscal Year 1995, for example, OEP has been developing local Metropolitan Medical Response Systems (MMRS). Through contractual relationships, the MMRS uses existing emergency response systems – emergency management, medical and mental health providers, public health departments, law enforcement, fire departments, EMS and the National Guard – to provide an integrated, unified response to a mass casualty event. As of September 30, 2001, OEP has contracted with 97 municipalities to develop MMRSs. The FY 2002 budget includes funding for an additional 25 MMRSs (for a total of 122).

MMRS contracts require the development of local capability for mass immunization/prophylaxis for the first 24 hours following an identified disease outbreak; the capability to distribute materiel deployed to the local site from the National Pharmaceutical Stockpile; local capability for mass patient care, including procedures to augment existing care facilities; local medical staff trained to recognize disease symptoms so that they can initiate treatment; and local capability to manage the remains of the deceased.

Lessons Learned from Preparedness Exercises

An indication of the Nation's preparedness for bioterrorism was provided by the congressionally mandated Top Officials (TOPOFF) 2000 Exercise in May 2000. This national drill involved scenarios related to a weapons-of-mass-destruction-attack against our populations. However, the exercise simulating a plague outbreak in Denver is most important to our discussion today. This exercise involved the state and local community, FEMA, DOJ, HHS,

DOD and many other vital community sectors that would play a role in ab actual response. While much progress has been made to date, a number of important lessons from that event have begun to shape our plans about bioterrorism preparedness and response in the health and medical area. They are as follows:

- Improving the public health infrastructure remains a critical focus of the bioterrorism preparedness and response efforts. Such preparedness is indispensable for reducing the Nation's vulnerability to terrorism using infectious agents and other potential emergencies through the development of broad public health capacities.
- We need to increase the current very limited surge capacity in our healthcare system. Local health care systems must be able to expand their health care capacity rapidly in the face of mass casualties. This must be part of our overall preparedness effort for infectious diseases and other major health emergencies.
- Local communities will need assistance with the distribution of stockpile medications and will greatly benefit from additional planning related to epidemic response.
- It will be extremely important to link emergency management services and health decision making at the state and local level for the purpose of rapidly addressing the needs of large populations affected by an epidemic. Training health workers to understand emergency management tools like the Incident Command System (ICS) is an example of the type of effort that will be important in closing this gap.
- Ensuring that the proper legal authorities exist to control the spread of disease at

the local, state and Federal level and that these authorities can be exercised when needed. This will be important to our efforts to control the spread of disease.

- Lastly, Federal "response partners" in the health and medical arena need to design response contingencies that specifically address the needs of victims of large-scale epidemics

Conclusion

The Department of Health and Human Services is committed to ensuring the health and medical care of our citizens. We have made substantial progress to date in enhancing the nation's capability to respond to a bioterrorist event. But there is more we can do to strengthen the response. Priorities include strengthening our local and state public health surveillance capacity, continuing to enhance the National Pharmaceutical Stockpile, and helping our local hospitals and medical professionals better prepare for responding to a biological or chemical terrorist attack.

Mr. Chairman, that concludes my prepared remarks. I would be pleased to answer any questions you or members of the Subcommittee may have.

Mr. HORN. And our second presenter is Bruce Baughman, Director of Planning and Readiness Division of the Federal Emergency Management Agency [FEMA].

Mr. BAUGHMAN. Good morning, Mr. Chairman, members of the subcommittee. I'm Bruce Baughman. I'm Director of Planning and Readiness for the Federal Emergency Management Agency. It's my pleasure to represent Director Allbaugh at these important hearings on biological and chemical terrorism.

The mission of FEMA is to reduce the loss of life and property and assist in protecting the Nation's critical infrastructure from all types of hazards. When disaster strikes, we provide a coordination and management framework to responding Federal agencies and a source of funding for State and local governments.

The Federal Response Plan is the heart of that management framework. It reflects the labor of an interagency group that meets in Washington and in all 10 of our FEMA regions to develop an interagency capability to respond as a team. This team is staffed by 26 departments and agencies and the American Red Cross, and is organized into interagency functions based upon the authorities and expertise of the member organizations and the needs of our counterparts in State and local government.

Our plan is designed to augment, not supplant, the response systems of State and local government. Since 1992, the response plan has been a proven framework for managing major disasters and emergencies regardless of cause. It works. It worked in Oklahoma City. It worked at the World Trade Center. We're basically coordinating the responding teams of 14 agencies responding to that event.

However, biological and chemical attacks present a unique challenge. Of the two, I am more concerned about biological terrorism. A chemical attack is very similar to a large-scale HAZMAT incident. Through the National Response Center, the National Contingency Plan, the Environmental Protection Agency and the Coast Guard, managed systems that can act, local, State and Federal responders, and the chemical industry, these systems are used routinely in HAZMAT incidents. EPA and the Coast Guard are also the primary agencies for hazardous material function under our plan.

The model we will use, it is our intent to use this model in the event of a chemical attack. However, to make this model robust and functional, we need to provide additional training for first responders at the State and local level and equipment.

In an undetected biological attack, first responders would be doctors, hospital staff, animal control workers, instead of police, fire and emergency medical personnel. Connections between nontraditional first responders and the larger Federal response is not routine. The Department of Health and Human Services is the critical link between the health and medical community and the larger Federal response. FEMA works closely with the Public Health Service as the primary agency for health and medical under the Federal Response Plan. We rely on them to bring the right expertise to the table when we meet to discuss potential biological events and how they will spread and the sources and techniques that will be needed to control them.

We are making progress. As Scott mentioned, Exercise TOPOFF in May 2000 involved a chemical attack on the East Coast followed by a biological attack in the Midwest. We have incorporated these lessons learned in the exercise into our response procedures. This process is active and ongoing. It takes time and resources to identify, develop and incorporate changes into the system.

In January 2001, the FBI and FEMA jointly published the U.S. Government's Interagency Domestic Terrorism Concept of Operation, or CONPLAN. The Departments of Health and Human Services, Defense, Energy and the Environmental Protection Agency were part of that plan. Together, the CONPLAN and the Federal Response Plan provide the framework for managing the response to the causes and consequences of terrorism.

On May 8th, the President asked that the Vice President oversee the development of a coordinated national effort regarding domestic preparedness. The President also asked that the Director of FEMA create an Office of National Preparedness to coordinate Federal programs dealing with preparedness for and response to terrorists' use of weapons of mass destruction. In July, the Director formally established the office at the FEMA headquarters and had staff elements in each of the 10 FEMA regions.

On September 21st, in the wake of the horrific terrorist attack at the World Trade Center and the Pentagon, the President announced the establishment of the Office of Homeland Security and the Office of the—in the White House to be headed by Governor Ridge of Pennsylvania. The office will lead, oversee and coordinate the national strategy to safeguard the country against terrorism and to respond to the attacks that may occur. It is our understanding that the office will coordinate a broad range of policies and activities related to the prevention, deterrence and preparedness and response. The office includes the—a Homeland Security Council comprised of key Federal departments and agencies, including the Director of FEMA.

We expect to provide significant support to this office in our new role as the lead Federal agency for consequence management.

Mr. Chairman, you convened this hearing to ask about our preparedness to work with State and local government agencies in the event of a biological and chemical attack. Terrorism presents tremendous challenges. We rely heavily on the Department of Health and Human Services to coordinate the efforts of the health and medical community to address biological hazards. We also rely on the Environmental Protection Agency and the Coast Guard to coordinate the efforts of the hazardous material community to address chemical hazards. They need your support to increase the national inventory of response resources and capability. FEMA needs your support to ensure that the system that the Nation uses 65 times a year to respond to major disasters has the tools and the capacity to adapt to a biological and chemical attack on any other weapon—or any other weapon of choice.

Thank you, Mr. Chairman. I would be happy to answer any questions at this time.

Mr. HORN. Well, I thank you.

[The prepared statement of Mr. Baughman follows:]

STATEMENT OF

BRUCE P. BAUGHMAN

DIRECTOR

PLANNING AND READINESS DIVISION

READINESS, RESPONSE, AND RECOVERY DIRECTORATE

FEDERAL EMERGENCY MANAGEMENT AGENCY

BEFORE THE

SUBCOMMITEE ON GOVERNMENT EFFICIENCY, FINANCIAL MANAGEMENT, AND INTERGOVERNMENTAL RELATIONS

COMMITTEE ON GOVERNMENT REFORM

U.S. HOUSE OF REPRESENTATIVES

OCTOBER 5, 2001

Introduction

Good morning, Mr. Chairman and Members of the Subcommittee. I am Bruce Baughman, Director of the Planning and Readiness Division, Readiness, Response, and Recovery Directorate, of the Federal Emergency Management Agency (FEMA). Director Allbaugh regrets that he is unable to be here with you today. It is a pleasure for me to represent him at this important hearing on biological and chemical terrorism. I will describe how FEMA works with other agencies, our approach to dealing with acts of terrorism, our programs related to terrorism, and new efforts to enhance preparedness and response.

Background

The FEMA mission is to reduce the loss of life and property and protect our nation's critical infrastructure from all types of hazards. As staffing goes, we are a small agency. Our success depends on our ability to organize and lead a community of local, State, and Federal agencies and volunteer organizations. We know who to bring to the table and what questions to ask when it comes to the business of managing emergencies. We provide an operational framework and a funding source.

The Federal Response Plan (FRP) is the heart of that framework. It reflects the labors of interagency groups that meet as required in Washington, D.C. and all 10 FEMA Regions to develop our capabilities to respond as a team. This team is made up of 26 Federal departments and agencies and the American Red Cross, and organized into interagency functions based on the authorities and expertise of the members and the needs of our counterparts at the state and local level.

Since 1992, the Federal Response Plan has been the proven framework time and time again, for managing major disasters and emergencies regardless of cause. It works during all phases of the emergency life cycle, from readiness, to response, recovery, and mitigation. The framework is successful because it builds upon the existing professional disciplines and communities among agencies. Among Federal agencies, FEMA has the strongest ties to the emergency management and the fire service communities. We plan, train, exercise, and operate together. That puts us in position to manage and coordinate programs that address their needs. Similarly, the Department of Health and Human Services (HHS) has the strongest ties to the public health and medical communities, and the Environmental Protection Agency (EPA) has the strongest ties to the hazardous materials community. The Federal Response Plan respects these relationships and areas of expertise to define the decision-making processes and delivery systems to make the best use of available resources.

The Approach to Biological and Chemical Terrorism

We recognize that biological and chemical scenarios would present unique challenges. Of the two I am more concerned about bioterrorism. A chemical attack is in many ways a large-scale hazardous materials incident. EPA and the Coast Guard are well connected to local hazardous materials responders, State and Federal agencies, and the chemical industry. There are systems and plans in place for response to hazardous materials, systems that are routinely used for small and large-scale events. EPA is also the primary agency for the Hazardous Materials function of the Federal Response Plan. We can improvise around that model in a chemical attack.

With a covert release of a biological agent, the 'first responders' will be hospital staff, medical examiners, private physicians, or animal control workers, instead of the traditional first responders such as police, fire, and emergency medical services. While I defer to the Departments of Justice and HHS on how biological scenarios would unfold, it seems unlikely that terrorists would warn us of a pending biological attack. In exercise and planning scenarios, the worst-case scenarios begin undetected and play out as epidemics. Response would begin in the public health and medical community. Initial requests for Federal assistance would probably come through health and medical channels to the Centers for Disease Control and Prevention (CDC). Conceivably, the situation could escalate into a national emergency.

HHS is a critical link between the health and medical community and the larger Federal response. HHS leads the efforts of the health and medical community to plan and prepare for a national response to a public health emergency. FEMA works closely with the Public Health Service, as the primary agency for the Health and Medical Services function of the Federal Response Plan. We rely on the Public Health Service to bring the right experts to the table when the Federal Response Plan community meets to discuss biological scenarios. We work closely with the experts in HHS and other health and medical agencies, to learn about the threats, how they spread, and the resources and techniques that will be needed to control them. By the same token, the medical experts work with us to learn about the Federal Response Plan and how we can use it to work the management issues, such as resource deployment and public information strategies. Alone, the Federal Response Plan is not an adequate solution for the challenge of planning and preparing for a deadly epidemic or act of bioterrorism. It is equally true that, alone, the health and medical community cannot manage an emergency with biological causes. We must work together.

In recent years, Federal, state and local governments and agencies have made progress in bringing the communities closer together. Exercise Top Officials (TOPOFF) 2000 in May 2000 involved two concurrent terrorism scenarios in two metropolitan areas, a chemical attack on the East Coast followed by a biological attack in the Midwest. We are still working on the lessons learned from that exercise. We need time and resources to identify, develop, and incorporate changes to the system between exercises. Exercises are critical in helping us to prepare for these types of scenarios. In January 2001, the FBI and FEMA jointly published the U.S. Government Interagency Domestic Terrorism

Concept of Operation Plan (CONPLAN) with HHS, EPA, and the Departments of Defense and Energy, and pledged to continue the planning process to develop specific procedures for different scenarios, including bioterrorism. The Federal Response Plan and the CONPLAN provide the framework for managing the response to an act of bioterrorism.

Synopsis of FEMA Programs

FEMA programs are focused mainly on planning, training, and exercises to build capabilities to ***manage*** emergencies resulting from terrorism. Many of these program activities apply generally to terrorism, rather than to one form such as biological or chemical terrorism.

Planning

The overall Federal planning effort is being coordinated with the FBI, using existing plans and response structures whenever possible. The FBI is always the Lead Agency for Crisis Management. FEMA is always the Lead Agency for Consequence Management. We have developed plans and procedures to explain how to coordinate the two operations before and after consequences occur. In 1999, we published the second edition of the FRP Terrorism Incident Annex. In 2001, the FBI and FEMA published the United States Government Interagency Domestic Terrorism Concept of Operations Plan (CONPLAN).

We continually validate our planning concepts by developing plans to support the response to special events, such as we are now doing for the 2002 Olympic Winter Games that will take place in Utah.

To support any need for a Federal response, FEMA maintains the Rapid Response Information System (RRIS). The RRIS provides online access to information on key Federal assets that can be made available to assist state and local response efforts, and a database on chemical and biological agents and protective measures.

In FY 2001, FEMA has distributed $16.6 million in terrorism consequence management preparedness assistance grants to the States to support development of terrorism related capabilities, and $100 million in fire grants. FEMA is developing additional guidance to provide greater flexibility for states on how they can use this assistance.

FEMA has also developed a special attachment to its all-hazards Emergency Operations Planning Guide for state and local emergency managers that addresses developing terrorist incident annexes to state and local emergency operations plans. This planning guidance was developed with the assistance of eight Federal departments and agencies in coordination with NEMA and the International Association of Emergency Managers.

FEMA and the National Emergency Management Association (NEMA) jointly developed the Capability Assessment for Readiness (CAR), a self-assessment tool that enables States and Territories to focus on 13 core elements that address major emergency

management functions. Terrorism preparedness is assessed relative to planning, procedures, equipment and exercises. FEMA's CAR report presents a composite picture of the nation's readiness based on the individual State and Territory reports.

FEMA's Comprehensive Hazardous Materials Emergency Response Capability Assessment Program (CHER-CAP) helps communities improve their terrorism preparedness by assessing their emergency response capability. Local, State, and Tribal emergency managers, civic leaders, hospital personnel and industry representatives all work together to identify problems, revise their response plans and improve their community's preparedness for a terrorist event. Since February 2000, a total of 55 communities have been selected to participate, initiated, or completed a sequence of planning, training, and exercise activities to improve their terrorism preparedness.

Training

FEMA supports the training of Federal, State, and local emergency personnel through our National Fire Academy (NFA), which trains emergency responders, and the Emergency Management Institute (EMI), which focuses on emergency planners, coordinators and elected and appointed officials. EMI and NFA work in partnership with State and municipal training organizations. Together they form a very strong national network of fire and emergency training. FEMA employs a "train-the-trainer" approach and uses distance-learning technologies such as the Emergency Education Network via satellite TV and web-based instruction to maximize our training impact.

The NFA has developed and fielded several courses in the *Emergency Response to Terrorism (ERT)* curriculum, including a Self-Study course providing general awareness information for responding to terrorist incidents that has been distributed to some 35,000 fire/ rescue departments, 16,000 law enforcement agencies, and over 3,000 local and state emergency managers in the United States and is available on FEMA internet site. Other courses in the curriculum deal with Basic Concepts, Incident Management, and Tactical Considerations for Emergency Medical Services (EMS), Company Officers, and HAZMAT Response. Biological and chemical terrorism are included as integral parts of these courses.

Over one thousand instructors representing every state and major metropolitan area in the nation have been trained under the ERT program. The NFA is utilizing the Training Resources and Data Exchange (TRADE) program to reach all 50 States and all major metropolitan fire and rescue departments with training materials and course offerings. In FY 2001, FEMA is distributing $4 million in grants to state fire-training centers to deliver first responder courses developed by the NFA.

Over 112,000 students have participated in ERT courses and other terrorism-related training. In addition, some 57,000 copies of a Job Aid utilizing a flip-chart format guidebook to quick reference based on the ERT curriculum concepts and principles have been printed and distributed.

NFA is developing a new course in FY 2002 in the Emergency Response to Terrorism series geared toward response to bioterrorism in the pre-hospital recognition and response phase. It will be completed with the review and input of our Federal partners, notably HHS and the Office of Justice Programs.

EMI offers a comprehensive program of emergency management training including a number of courses specifically designed to help communities, states, and tribes deal with the consequences of terrorism and weapons of mass destruction. The EMI curriculum includes an Integrated Emergency Management Course (IEMC)/Consequences of Terrorism. This 4-½ day course combines classroom training, planning sessions, and functional exercises into a management-level course designed to encourage communities to integrate functions, skills, and resources to deal with the consequences of terrorism, including terrorism. To foster this integration, EMI brings together 70 participants for each course that includes elected officials and public health leaders as well as representatives of law enforcement, emergency medical services, emergency management, and public works. The course provides participants with skill-building opportunities in preparedness, response, and recovery. The scenario for the course changes from offering to offering. In a recent offering, the scenario was based on an airborne anthrax release. Bioterrorism scenarios emphasize the special issues inherent in dealing with both infectious and noninfectious biological agents and stresses the partnerships between local, state, and Federal public health organizations.

Exercises

In the area of exercises, FEMA is working closely with the interagency community and the States to ensure the development of a comprehensive exercise program that meets the needs of the emergency management and first responder communities. FEMA is planning to conduct Phase II of a seminar series on terrorism preparedness in each of the ten FEMA Regional Offices. In addition, exercise templates and tools are being developed for delivery to state and local officials.

New Efforts to Enhance Preparedness and Response

In response to guidance from the President on May 8, 2001, the FEMA Director created an Office of National Preparedness (ONP) to coordinate all federal programs dealing with weapons of mass destruction consequence management, with particular focus on preparedness for, and the response to the terrorist use of such weapons. In July, the Director established the ONP at FEMA Headquarters. An ONP element was also established in each of the ten FEMA Regional Offices to support terrorism-related activities involving the States and localities.

On September 21, 2001, in the wake of the horrific terrorist attacks on the World Trade Center and the Pentagon, the President announced the establishment of an Office of Homeland Security (OHS) in the White House to be headed by Governor Tom Ridge of Pennsylvania. In setting up the new office, the President stated that it would lead, oversee and coordinate a national strategy to safeguard the country against terrorism and respond

to attacks that occur. It is our understanding that office will coordinate a broad range of policies and activities related to prevention, deterrence, preparedness and response to terrorism.

The new office includes a Homeland Security Council comprised of key department and agency officials, including the FEMA Director. FEMA expects to provide significant support to the office in its role as the lead Federal agency for consequence management.

Conclusion

Mr. Chairman, you convened this hearing to ask about our preparedness to work with State and local agencies in the event of a biological or chemical attack. It is FEMA's responsibility to ensure that the national emergency management system is adequate to respond to the consequences of catastrophic emergencies and disasters, regardless of cause. All catastrophic events require a strong management system built on expert systems for each of the operational disciplines. Terrorism presents tremendous challenges. We rely on our partners in Department of Health and Human Services to coordinate the efforts of the health and medical community to address biological terrorism, as we rely on EPA and the Coast Guard to coordinate the efforts of the hazardous materials community to address chemical terrorism. Without question, they need support to further strengthen capabilities and their operating capacity. FEMA must ensure that the national system has the tools to gather information, set priorities, and deploy resources effectively in a biological scenario. In recent years we have made tremendous strides in our efforts to increase cooperation between the various response communities, from fire and emergency management to health and medical to hazardous materials. We need to do more.

The creation of the Office of Homeland Security and other efforts will enable us to better focus our time and effort with those communities, to prepare the nation for response to any incident.

Thank you, Mr. Chairman. I would be happy to answer any questions.

Mr. HORN. We have a little problem here as usual. We're sent here to vote, and we're now down to the 10-minute bit. And that is the 10-minute warning. And so we're going to go into recess until 12:35, 12:40, and right below us in the basement is the splendid, fine, wonderful restaurant known as the Rayburn cafeteria. So we'll be glad to see you back here, and we'll get to work at 12:35.

[Recess.]

Mr. HORN. The agriculture bill now passed in the House of Representatives, and we are out of recess, and at 12:35 we will start now with Craig Duehring, the Principal Deputy Assistant Secretary of Defense for Reserve Affairs of the Department of Defense. Mr. Duehring, we're glad to have you here.

Mr. DUEHRING. Good afternoon, Mr. Chairman. Thank you for the invitation to testify before you today on the Department of Defense's continuing efforts to ensure a strong national defense against domestic terrorists using weapons of mass destruction, or simply WMD. America's National Guard and Reserves are critical to our Nation's capability to support an enhanced and integrated Federal, State and local response to incidents involving weapons of mass destruction.

We're going to use the term "consequence management" quite often. At DOD we define WMD consequence management as emergency assistance to protect public health and safety, restore essential government services and provide emergency relief to those affected by the consequences of an incident involving WMD agents, whether they are released deliberately, naturally or accidentally. DOD normally provides such assistance only in response to requests from the appropriate lead Federal agency to support specific State and local authorities in mitigating the consequences of a domestic, nuclear, chemical, biological, radiological or high-yield explosive incident.

My testimony today will provide a brief description of DOD's role in Federal response preparations, as well as an overview of the initiatives we have undertaken to better prepare us to provide the support requested. Presidential decision directives established 3 years ago directed the U.S. Government to enhance its plans and policies to protect against unconventional threats to the homeland and Americans overseas. Since then there has been a concerted effort to identify and streamline Federal agency coordination mechanisms to address the growing possibility of asymmetrical assaults on U.S. vulnerabilities at home and abroad.

These efforts focus primarily on establishing policies and programs to enhance the Nation's preparations to thwart and, if that fails, respond to terrorists' use of weapons of mass destruction or cyber-warfare. Federal agency consequence management responsibilities and the need for extensive interagency coordination and response to a significant terrorist incident here or at home have been delineated in the documents that were presented 3 years ago, but which today still serve as the basis for all current Federal disaster response plans.

Today Federal response to a WMD incident in the United States will likely involve many agencies of the U.S. Government, each bringing specialized talents and expertise honed in the execution of larger programs designed for purposes other than terrorist attacks.

No one agency possesses all the talents, but a few such as the FBI, FEMA and HHS know they have lead responsibilities to coordinate our Federal response to national emergencies.

The Federal Response Plan articulates that distribution of the responsibilities and authorities for cooperation and coordination for disaster response. In the event of an incident, we recognize that those closest to the problem are going to be the first to respond, but the presumption is that in the event of a catastrophic incident, those State and local capabilities may be quickly overwhelmed. If a civilian authority requests Federal support, the lead Federal agency, FBI, or FEMA, for example, is likely to request support from many other Federal agencies including the Department of Defense.

We have undertaken a number of steps within the department to address how we will support the Nation in responding to incidents involving weapons of mass destruction. First, we have sought to define more clearly what the department's role should and should not be. We do not call consequence management homeland defense, but refer to it rather as civil support. This reflects the fundamental principle that DOD is not in the lead, but is there to support the lead Federal agency in the event of a domestic disaster contingency.

Four principles guide DOD's response in the event of a domestic WMD contingency. First, there will be an unequivocal chain of accountability and authority for all military support to civil authorities. Second, DOD's role is to provide support to the lead Federal agency. Third, though our capabilities are primarily war-fighting capabilities, the expertise that we have gained as a result of the threats that we have faced overseas can be leveraged in the domestic arena as well. DOD also brings communications, logistics, transportation and medical assets, among others, that can be used for civil support. And fourth, our response will necessarily be grounded in the National Guard and Reserves as our forward-deployed forces for domestic operations.

The National Guard and Reserves will play a prominent support role for State and local authorities in consequence management. DOD has assigned full-time National Guard WMD civil support teams in 27 States to provide as part of a State emergency response capability the first wave of support to overwhelmed local incident commanders in dealing with incidents involving weapons of mass destruction. We will soon announce the stationing of five new teams authorized by Congress last year in five additional States, bringing the total to 32 civil support teams.

These teams are comprised of 22 highly skilled, full-time, well-trained and equipped Army and Air National Guard personnel. These teams provide specialized expertise and technical assistance to the local incident commander in, first, facilitating on-scene communications and command and control among the different responding agencies; second, exchanging technical data and information with military laboratory experts on weaponized chemical and biological agents; and finally, helping to shape or revise the local incident commanders' response strategy based on the specific chemical, biological or radiological agents found at the scene.

The WMD civil support teams are unique because of their Federal-State relationship. They are federally resourced, federally trained, and expected to operate under Federal doctrine, but they will perform their mission primarily under the command and control of the Governors of the States in which they are located. Operationally they fall under the command and control of the adjutants general of those States. As a result, they will be available to respond to an incident as part of a State response, well before Federal response assets would be called upon to provide assistance.

During fiscal year 2002, DOD will also continue to train and sustain 100 chemical decontamination and 9 reconnaissance platoon-sized elements in the Army Reserve. Medical patient decontamination teams in the National Guard and Air Force Reserve will receive additional training in domestic response, casualty decontamination. They will be provided with both military and commercial off-the-shelf equipment and will receive enhanced training in civilian HAZMAT procedures.

I have more information dealing with the domestic preparedness program and also with WMD advisory panel.

Mr. HORN. Why don't we put it in the hearing, without objection, so it can be distributed.

Mr. DUEHRING. Yes, sir. And I'll be happy to answer any questions that you have.

[The prepared statement of Mr. Duehring follows:]

Not for publication
until released by
Committee on Government Reform
United States House of Representatives

Role of the National Guard, Reserve and Military Health System
in the Event of Biological or Chemical Terrorist Attacks

By

Mr. Craig W. Duehring

**PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE
FOR RESERVE AFFAIRS**

Submitted to the

Government Efficiency, Financial Management and Intergovernmental Relations Subcommittee
Committee on Government Reform
U. S. House of Representatives

October 5, 2001

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United States House of Representatives

Good morning, Mr. Chairman and other distinguished members of this subcommittee. Thank you for the invitation to testify before you today on how the National Guard and Reserves would interface with state and local officials in the aftermath of a chemical or biological attack in the United States. I will also address the preparedness of our Military Health System to assist state and local governments in the event of a biological or chemical terrorist attack. My colleague, Lieutenant General Peake, Surgeon General of the Army, is also here to answer any questions you may have regarding the Military Health System.

The horrific events of Sept. 11th highlighted our nation's vulnerabilities to determined zealots bent on carrying out heinous acts of terrorism. While President Bush, Attorney General Ashcroft, and Secretary Rumsfeld are taking necessary steps to deter and prevent terrorism within the United States, we must consider and prepare ourselves for the very real possibility that these zealots may choose chemical or biological weapons in their next campaign of terror.

The Department of Defense has a wide array of capabilities within our Armed Forces that can be made available to support federal, state and local authorities in dealing with the consequences of a terrorist incident. When disaster strikes, the Reserve Components provide vital capability in the areas of security, search and rescue, water purification, emergency power, communications, temporary shelter, mortuary services, air traffic control and transportation. Every year National Guard, Reserve, and Active Forces respond to domestic emergencies across the nation, from firefighting and riot control to support of citizens victimized by tornadoes, floods and earthquakes.

Located in over 4500 communities across America, our National Guard and Reserves are uniquely suited to help state and local authorities prepare for and respond to chemical or biological incidents in their jurisdictions. They are familiar with emergency response plans and procedures, and they often have close links with the fire, police, and emergency medical personnel who will be first on the scene. As a result, the National Guard and Reserves comprise a highly effective source of trained and ready manpower and expertise. My testimony today focuses on how the National Guard and Reserves will work with federal, state and local authorities in the event of a domestic chemical or biological event.

Both Guardsmen and Reservists bring critical technical skills and resources to bear during domestic emergencies. Whether fighting forest fires, protecting our communities from the ravages of floods, or assisting federal, state and local authorities in recovering from a terrorist attack, the National Guard and Reserves are ready and trained to preserve life, protect property, and restore essential community services.

Although National Guard and Reserve forces have similar capabilities in responding to emergency situations, there are significant differences in the statutes that apply to their employment. The National Guard operates under different authorities than the Reserves with respect to conditions of employment, command and control structures, and capabilities.

The Reserves operate under the control of the active component or "regular" military forces. These federal military forces typically respond to requests for DoD assistance from a lead federal agency (for example, the FBI or FEMA) during presidentially declared emergencies. Generally, these requests fill special needs or augment state and local level emergency management responders at or near the incident site who may be overwhelmed. If attacks involve the use of chemical or biological agents, casualties may be significant—and Reserve component medical expertise and equipment will likely be needed to both assist state and local health service agencies, and to augment the Department of Health and Human Services' and Department of Veterans Affairs emergency medical support operations. Today, over seventy percent of the Department of Defense's military medical capabilities are assigned to the Army Reserve, Naval Reserve and Air Force Reserve.

The Reserves also possess more than sixty percent of the Department's capability in military chemical-biological detection and decontamination, with the Army Reserve providing the bulk of this capability. These assets will be essential in providing technical expertise and advice to state and local authorities in understanding the nature of a chemical or biological attack and helping to effectively minimize its effect on people, property and public safety.

The Army National Guard and the Air National Guard, on the other hand, may operate under either state control or federal control, depending on the circumstance. The National Guard, while serving in a state active duty status, represents the military force of the state and is controlled by its elected chief executive officer, the governor. It is important for state authorities to be seen as

partners with, and not subordinate to, Federal authorities, as recognized in the Terrorism Annex of the Federal Emergency Management Agency's (FEMA) Federal Response Plan. In fact, the plan stipulates that state governments, as opposed to the Federal Government, will have primary responsibility for Weapons of Mass Destruction (WMD) consequence management.

For example, if a domestic biological or chemical incident occurs, the appropriate local medical, firefighter, emergency management or law enforcement official manages the first response. Once the local on-scene incident commander determines that the scope of the incident exceeds the resources and capabilities at that level, state assistance is requested.

The Governor, through the State's Adjutant General, controls National Guard forces in peacetime. The Governor can call the State's Guard members into action to mitigate local or statewide emergencies, such as severe storms, floods, earthquakes, or civil disturbances.

In the event of a terrorist attack, those closest to the problem will be the first to respond. However, the presumption is that if the attack results in catastrophic consequences, state and local capabilities will likely be quickly overwhelmed. If the Governor requests federal support from the President, and the President declares an emergency, a lead federal agency will be designated by the President to direct and coordinate support from other federal agencies (including DoD) to assist state and local responders in responding to the incident.

There is a clearly defined operational structure for the National Guard to respond to emergency situations. As a key component of a Governor's state emergency response force, the National Guard will usually be the first military asset on the scene once deployed for disaster or emergency situations. In 23 states, the State Adjutant General also serves as the State Emergency Management Officer. The State Emergency Management Officer is directly responsible for the planning, operating and executing all state assets for emergency situations. This situation strengthens the effectiveness of emergency response throughout the state and ensures close collaboration and communication between the National Guard and state and local authorities. It also positions the National Guard to facilitate multi-jurisdictional opportunities to jointly train, plan, and exercise with state-based federal, state and local disaster and emergency response agencies.

During the past three years, the Department has established new or strengthened existing capabilities within the National Guard and Reserve to better support federal, state and local authorities in dealing with the consequences of a terrorist event. 27 Weapons of Mass Destruction (WMD) Civil Support Teams have been established to date. We will soon announce the stationing of the 5 additional teams authorized by Congress last year, for a total of 32 Civil Support Teams.

These teams provide specialized expertise and technical assistance to the local incident commander in:

1) Facilitating on-scene communications and command and control among the different responding agencies;
2) Exchanging technical data and information with military laboratory experts on weaponized chemical and biological agents; and
3) Helping to shape/revise the local incident commander's response strategy based on the specific chemical, biological and radiological agents found at the scene.

These WMD Civil Support teams are comprised of 22 highly skilled, full-time, trained and equipped Army and Air National Guard personnel. These teams are unique because of their federal-state relationship. They are federally resourced, federally trained, and operate to support a federal doctrine. But, they will perform their mission primarily under the command and control of the governors of the states in which they are located. Operationally, they fall under the command and control of the Adjutants General of those states for which they have geographic responsibility to respond. As a result, they will be available to respond to an incident as part of a state response, well before federal response assets would be called upon to provide assistance.

If the situation were to evolve into an event that, due to extended operational demands, overwhelmed state and local response assets, the governor could request the President to issue a declaration of national disaster emergency and to provide federal assistance. Other WMD Civil Support teams may be federalized to relieve and further sustain the communications, command and control, and technical support established by the first WMD Civil Support team.

The President of the United States can also activate the National Guard to participate in federal missions. Generally speaking, when federalized for this purpose, Guard units are commanded not by their state Governors, but by the Commander in Chief (CINC) in whose area they operate. These are the CINC, Joint Forces Command (for the continental United States), CINC, Pacific Command (for Hawaii, Alaska, Guam and the Marshall Islands), and CINC, Southern Command (for Puerto Rico and the Virgin Islands.)

Shifting gears a bit, I will now focus on the process by which military medical resources may be used to assist state and local governments in a disaster situation and to identify some of the health and medical assets we can bring to the disaster scene to lend needed assistance. However, before I get into those descriptions, I would like to briefly offer you a summary of what the Military Health System is and why it exists.

The military medical departments' primary mission is to support their combat forces in war and in peacetime to maintain and sustain their well being in the accomplishment of National Military Objectives. The military medical mission is "to provide top quality health services, whenever needed, and to support military operations." Subsequently, military medical readiness is defined as all actions and preparation necessary to respond effectively and rapidly to the entire spectrum of potential military operations—from major regional conflicts, to smaller scale contingency operations, to humanitarian support missions. Military readiness involves both Active and Reserve forces, and is accomplished through a strategy that seamlessly ensures a health and fit force, prevention of casualties from

operational threats, and responsive combat casualty care and management. The Military Health System (MHS) must fully integrate its military medical readiness mission with its beneficiary mission to provide quality, cost-effective medical services and support to military families, retirees and their families worldwide. Through the conduct of the MHS beneficiary mission, readiness is promoted in the military medical departments through the maintaining of a fit force; continuous surveillance of health risks pre-, during and post-deployment; the provision of clinical training for medical providers; enhancing recruiting and retention of quality service members; and otherwise fostering quality of life for military families by ensuring access to a world class health care system.

The Military Health System (MHS) consists of 76 hospitals and more than 400 medical clinics worldwide serving an eligible population of 8.3 million. In addition, we maintain medical units capable of deploying with our Armed Forces to provide the preventive and resuscitative care that our troops may require in the conduct of operational contingencies. We emphasize the maintenance of a healthy, hyper-fit force prepared for the rigors of these contingencies, and the prevention of injury and illness. We identify potential hazardous exposures, track immunizations, and record health encounters with information systems designed to provide a continuous life-cycle surveillance that supports the health and fitness of the fighting force.

Concurrently, we provide a comprehensive healthcare delivery system for our service members, retirees, survivors, and family members. This system not only provides a training platform to maintain the technical skills of military

clinicians, but also ensures our ability to directly influence the quality of care provided we deliver to our beneficiaries. Our primary responsibility is to provide medical support for our deployed forces, but those capabilities are inextricably linked to our hospital and clinic operations. A robust healthcare delivery system is a strategic lynchpin that ensures a healthy and fit force for National Command Authority-directed contingencies, provides the medical architecture capable of providing combat health support in missions ranging from humanitarian civic assistance to high intensity conflict.

The U.S. military has a history of successfully providing support and assistance to domestic civil authorities during emergencies and other instances of national concern. Examples you may recall include the military's response to natural disasters within the United States, such as hurricanes and earthquakes. The task of supporting civil authorities in a time of crisis is not a new responsibility for either DoD or military medicine.

The process for involving the Federal Government in support of a chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) event follows closely the process for involvement with domestic natural or man made disasters. Should the local and state assets be overwhelmed, the Governor may request Federal assistance under the Federal Response Plan. Twenty-eight federal agencies, including DoD, support this plan.

Because of our constant vigilance and need to be prepared to support operational forces in any location around the world, military medicine can rapidly

mobilize health and medical assets in support of virtually any crisis. Some of these capabilities include field hospitals, specialized medical augmentation teams, field laboratory diagnostic capabilities, medical evacuation, public health, vector control, patient tracking, veterinary support, medical logistics support, and mass casualty care. Additionally, we have our stationary military medical treatment facilities located around the nation that have inpatient capabilities. Specific medical tasks for the Military Health System in a CBRNE incident include triage and stabilization, health and risk assessment, and other life sustaining and supporting measures.

Finally, DoD is a partner with Federal agencies that provide support of validated requirements emerging from FEMA's Federal Response Plan for Emergency Support Function 8, "Health and Medical Services." This includes making available, if requested, a robust bed expansion capability that can be activated by the National Disaster Medical System (NDMS).

The National Disaster Medical System is a Federal system designed to provide a coordinated medical response in time of war, national emergency, or major domestic disaster resulting in mass casualties. Patients are evacuated to designated locations throughout the United States for care that cannot be provided locally. They are placed in a national network of hospitals that have agreed to accept patients in the event of a major disaster. Agencies sharing responsibilities with DoD include the Department of Health and Human Services (DHHS), FEMA, and the Department of Veterans Affairs (VA). The Assistant Secretary of Defense for Health Affairs may activate NDMS in support of military contingencies when

casualties exceed the combined capabilities of the VA/DoD Contingency Care System. The Director of FEMA or the Assistant Secretary of Health (Department of Health and Human Services) may activate NDMS in response to a domestic conventional disaster. Under the latter circumstances, DoD components, when authorized, will participate in relief operations to the extent compatible with U.S. national security interests.

We will continue to leverage the wartime capabilities of the men and women in our Armed Forces for domestic consequence management in support of civil authorities. Above all, we will work to ensure that Active, Guard and Reserve forces are readily accessible to support domestic civil emergencies, and that they are trained to seamlessly function as part of the incident command system used by the nation's first responder community.

Our goal is to support America's fire, police, and emergency medical personnel as rapidly as possible with capabilities and tools that complement and enhance their response, not duplicate it. Our ongoing efforts, which leverage the best military technology and expertise available, will help us achieve that goal.

In summary, Mr. Chairman and Distinguished Members of the Subcommittee, the Department of Defense has tremendous capability to support federal, state and local agencies in the event of a biological or chemical terrorist attack. The mechanisms for providing that support are well understood and have been exercised more vigorously in the last few years. The events of September 11, 2001 have invigorated many federal, state and local authorities to review and

update their plans in the event of a domestic terrorist attack using chemical or biological weapons. Communications between and among these critical emergency response elements across federal, state and local levels have improved dramatically, and need to be continuously exercised.

It has been my distinct pleasure to be here today, and I thank you again for the opportunity to testify. Lieutenant General Peake and I welcome any questions you may have.

Mr. HORN. Well, I have one right now. I noticed in the paper this morning that Deputy Secretary of Defense Wolfowitz is the—mentioned the Posse Comitatus situation, and I wonder, was the Reserve involved in that particular situation?

Mr. DUEHRING. I'm not aware of what that particular situation is. I am aware of the Posse Comitatus, and when the National Guard operated in a State setting, in a call-up by the Governor, of course, then their rules are different than if they were Federalized. So I'd have to give you kind of a general answer. I can't be specific because I don't really know what it was they were referring to.

Mr. HORN. Well, I can understand that, but I think it said he had a 71-page memo on the subject.

I happen to agree with him. I read that 30 years ago. So it isn't new to me, but I would like to have anything you have to put at this point in the record.

Mr. DUEHRING. Yes, sir.

Mr. HORN. Thank you.

We'll go to Mr. Fogg, who is the director of the New Hampshire Office of Emergency Management and co-chair of the Terrorism Committee, National Emergency Management Association. Mr. Fogg.

Mr. FOGG. Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear. I am here today representing the National Emergency Management Association, NEMA, whose members are the Directors of Emergency Management for the States and territories. We're the ones responsible to our Governors for disaster mitigation, preparedness, response and recovery. This includes responsibility for terrorism, consequence management and preparedness in each of our States. We each serve as the central coordination point for our State's response activities and interface with Federal agencies.

I serve as the current co-chair of NEMA's Terrorism Committee along with Peter LaPorte, the director from the District of Columbia Emergency Management Agency. NEMA's Terrorism Committee has been actively engaged for a number of years on this topic.

I also serve as chairman of the Northeast States Emergency Consortium [NESEC], comprised of the Emergency Management Directors for the six New England States, plus New York, plus New Jersey.

And I'd like to begin by thanking you all for recognizing the importance of preparing for acts of terrorism. We need and appreciate your support for what we must accomplish.

We've taken an all-hazards approach to disaster preparedness, and I want to emphasize that, all-hazards approach, and, therefore, we're able to integrate into our domestic preparedness efforts those proven systems we already use for dealing with natural and technological disasters. We also recognize clearly the value of prevention and mitigation in minimizing the consequences of disaster, and we incorporate those considerations in all our planning.

NEMA has developed a list of recommended enhancements to be incorporated into a nationwide strategy for attaining better preparedness for catastrophic events. The full text of these recommendations is included in the attached NEMA white paper for your reference.

I'd like to highlight the highest priority items in my testimony today, and before I do that, I'd just like to make the point that the lessons learned from the September 11th attacks are not brand new ideas. Many are concepts we've been working on for years and just have not yet had the resources to fully implement.

Now is the time for Federal, State and local governments to take action. It is not the time to prepare reports or criticize past actions or issue sweeping new directives. You have our detailed written testimony, which is fairly comprehensive, but the committee asked us to focus on how the Federal Government can best work with State and local governments to deal with chemical and biological terrorist attacks, so I'll limit my comments to that issue.

There are four main points. No. 1, our Nation requires an overall national, not Federal, national domestic preparedness strategy that is developed collaboratively with full involvement by local, State, Federal and private partners, and it is built upon existing all-hazards plans and systems. This national preparedness strategy must be a pillar of our national and homeland security strategy; that is, the preparedness component and the law enforcement component together comprise our all security strategy. We should base that strategy on tried and proven all-hazards systems, particularly the Federal Response Plan, the Incident Command System and our Emergency Management Assistance Compact [EMAC], that 41 of our States and territories have adopted, with others in process.

We need the Federal Government to be a catalyst, an enabler, not a controller, and we also need to use the system. Don't bypass the States in their role in coordinating statewide and regional plans. Oftentimes we hear about going directly to the municipalities, and that is great. It gets money where it needs to go, but it leaves the States out of their coordinating role, and we need to be very careful with that.

Two, our Nation's preparedness for catastrophic events would be well served by strengthening our regional capabilities. Strong consideration should be given to developing that strategy by strengthening our regional capabilities to provide a rapid, flexible response capable of dealing with multiple mass casualty events occurring in different places at the same time. If we put all our resources in one place, we could get in trouble real quick.

Our Federal agencies can help by delegating decisionmaking authority to their regional offices. Some do that quite well now. Director Allbaugh at FEMA is pushing that concept, and that has worked well in the past.

Mr. HORN. Let me ask at that point, is that the Federal Government regional areas? There are about 10 they've blocked out over the last 30 years, and you want to operate within that area?

Mr. FOGG. That's correct, sir, that's correct. Delegate the authority to make decisions and make plans to that level. And what that does is develop those relationships, that trust and credibility that is so important in crisis situations, and understanding each other's resources, constraints, methods of—modus operandi, if you will, and it eliminates the who's in charge in the turf, and we found that out. That was one of the major lessons learned from our TOPOFF Exercise. And we hosted one of the venues in New Hampshire.

Those agencies who had developed those relationships and used them succeeded. The others did not.

We would encourage broader use of existing regional relationships, and I will just cite NESEC as an example, at Northeast States Emergency Consortium. The details are in the written testimony, but it's been done at very little incremental cost. We expanded on existing structure, and it's a good use of Federal support.

The other thing we should do is develop our international relationships. I think we've overlooked that in the Federal emergency management field.

Three, medical surge capacity is the main key to dealing with mass casualty events, regardless of cause. The most noticeable hole in our system is our limited ability to access and deliver surge capacity rapidly to the site of a mass casualty event. We have some impressive national capabilities, but we need more local and regional capacity close to home to deal with true mass casualties until a cavalry can get there. We need one of those disaster and medical assistance teams widely dispersed. There are some parts of our country that now are not covered very well by that system. We need to fill those gaps, and we need faster access to military reserve medical units with their own deployable equipment. And I really want to wave the flag on that one.

We need to assist the health care industry in restoring a surge capacity to our hospitals. The pressures of managed care have virtually eliminated that surge capacity, and we need to work together to restore some of it.

Four, the other real key to preparedness is timely sharing and dissemination of critical intelligence information to those who really need to know. Commissioner Norris said it very well this morning. But don't leave the State police and the county sheriffs out. All levels have got to be involved in sharing of pertinent intelligence. Again, for the same reason, the State folks need to be able to sort that out on a statewide level and work with their local counterparts and Federal counterparts to direct resources where they need to go.

And the other main issue about the intelligence issue is—and it is about—it lets the health care system and the other first responders have a heightened awareness about the potential symptoms. It gives them a heads-up, gives them a little warning, and it lets them avoid being second victims and to contain the spread and effect of the agent.

And last, on sharing the intelligence, use the compartmented need-to-know system that the military uses. It works quite well. But we need to have greater reciprocity of security clearances between Federal agencies. Right now if you've got a FEMA clearance, you can't see DOD stuff. If you've got a DOD one, you can't see Health and Human Services stuff. We need to clean that up so we can share intelligence effectively.

Let me summarize. No. 1, we need a clear national domestic preparedness strategy built collaboratively at all levels, local, State, Federal and private. Two, we need to consider strongly strengthening our regional capacities. Three, we need to increase our mass

casualty surge capability, especially regionally and locally. And four, we need to improve intelligence-sharing across the board.

I want to end by emphasizing——

Mr. HORN. That has been the suggestion, and I think we're going to have to go to your two other colleagues to——

Mr. FOGG. OK. I just have one more sentence here. I want to end by emphasizing that we should buildupon the proven systems that we have in place and not reinvent the wheel. Add a spoke or two, maybe even combine some, and definitely make the wheel turn faster, but please, let's not come up with a new wheel. And remember, this is not just about terrorism. It is about all-hazards preparedness. Thank you.

Mr. HORN. Well, thank you. That was very lucid.

[The prepared statement of Mr. Fogg follows:]

STATEMENT OF

WOODBURY FOGG, P.E.
DIRECTOR
OFFICE OF EMERGENCY MANAGEMENT
STATE OF NEW HAMPSHIRE

ON BEHALF OF

NATIONAL EMERGENCY MANAGEMENT ASSOCIATION

BEFORE the HOUSE GOVERNMENT REFORM SUBCOMMITTEE
ON GOVERNMENT EFFICIENCY, FINANCIAL MANAGEMENT, AND
INTERGOVERNMENTAL RELATIONS

OCTOBER 5, 2001

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to appear before you today to offer comments on preparedness for chemical and biological attacks. My name is Woody Fogg and I am the Director of the Office of Emergency Management for the State of New Hampshire.

I am here today representing the National Emergency Management Association (NEMA) whose members are the directors of emergency management for the states and territories. We are responsible to our governors for disaster mitigation, preparedness, response and recovery. This includes responsibility for terrorism consequence management and preparedness at the state level by serving as the central coordination point for all state response activities and interface with federal agencies when federal assistance is requested.

I have the privilege of serving as the current Co-Chair of NEMA's Terrorism Committee along with Peter La Porte, the Director of the District of Columbia Emergency Management Agency. NEMA's Terrorism Committee has been actively engaged for a number of years on this topic on behalf of the states. I also serve as Chairman of the North East States Emergency Consortium (NESEC), comprised of the Emergency Management Directors for the six New England states plus New York and New Jersey.

I'd like to begin this afternoon by thanking Chairman Horn and Ranking Member Janice Schakowsky and the members of the Subcommittee for recognizing the importance of preparing for acts of terrorism. We need and appreciate your interest and support for what we must accomplish.

Over the last 23 days since September 11, 2001, our nation has been reevaluating our preparedness for acts of terrorism. Particularly at the state level, we have been assessing the preparedness levels our federal, state, and local governments and our private sector partners must attain to deal with incidents of terrorism, including chemical and biological attacks.

Long before the recent events, NEMA had established itself as a leader in providing input to Congress and federal agencies on issues of domestic preparedness. States have been in the forefront of preparing for and responding to all types of disasters, both natural and man-made. We take an all-hazards approach to disaster preparedness and have integrated into our domestic preparedness efforts those proven systems we already use for dealing with natural and technological disasters. We also recognize clearly the value of prevention and mitigation in minimizing the consequences of disaster and we incorporate those considerations in all our efforts.

NEMA's members have been working diligently since September 11, 2001 to develop a list of recommended enhancements to be incorporated into a nation-wide strategy for attaining better preparedness for catastrophic events. The full text of these recommendations is included in the attached 'NEMA White Paper' for your reference. I would like to highlight the highest priority items in my testimony today.

LESSONS LEARNED AND TIME FOR ACTION

The lessons learned from the 11 September attacks are not brand new ideas. Many are concepts we have been working on for years and just have not been able to fully implement. The immediate lessons learned also include the suggestions of the state emergency management directors from New York, Pennsylvania, and Virginia.

Now **is** the time for federal, state, and local governments to take action. It is **not** the time to prepare reports or criticize past actions. We should all follow New York City Mayor Rudolph Guiliani's comments to the United Nations. He said, "Now is the time ...to unite our strength ...this is not a time for further study or vague directives."

REGIONALLY-BASED CAPACITY BUILDING

First, we need for the federal government to support state and local governments in taking a regional approach to building capacity to deal with catastrophic events. This concept is already used among state and local governments in some regions. We took this approach in the North East years ago, using the federally funded National Earthquake Hazard Reduction Program as a vehicle. We formed the North East States Emergency Consortium (NESEC) and broadened its focus from earthquakes alone to 'All Hazards'. We work closely with FEMA's Regional Office as well as with those of all our other Federal partners to craft regional plans, coordinate training and exercises on a regional basis and unashamedly plagiarize each others' successful programs.

Our regional planning is invaluable since we can develop common, flexible preparedness strategies which capitalize on sharing limited resources.

In the same vein, we have also reached out to our international partners and developed an International Emergency Management Assistance Compact which includes the five Eastern Canadian Provinces in our regional preparedness program. This agreement is now before Congress for ratification. Your support would be appreciated. Of particular interest are the Canadians' extensive resources in pharmaceuticals and medical capabilities that would clearly help in a chemical or biological event.

In short, the regional approach gives us a flexible response capability, both regionally and nationally, which can adapt to catastrophic events as they occur and most effectively use the limited resources we share. We don't all have to have all the needed capabilities and yet we can respond to multiple simultaneous events in different parts of the region or the nation. Even more valuable are the personal trust and credibility that develop and the deeper understanding we gain of each player's capabilities, constraints and operating systems. Those have stood us in good stead during actual emergencies and challenging training exercises. We were well prepared as a region to provide whatever assistance was needed to support the response and recovery at the New York City and Pentagon sites or any other event that may have occurred.

MEDICAL SURGE (MASS CASUALTY) CAPABILITY

To effectively address chemical and biological events, as well as weapons of mass destruction (WMD), our medical surge capacity must be strengthened.

The emergency management, medical and public health professions must work with lawmakers on all levels to ensure that each region has a certain minimum surge capacity to deal with mass casualty events.

Hospitals should agree to provide defined and standardized levels of resources, capabilities and assistance to handle mass casualties, especially those contaminated by chemical and biological agents. Funding for equipment and supplies to accomplish this mission should be provided to develop this additional capability, in exchange for agreeing to participate as a local receiving hospital and as part of the U.S. Public Health Service's National Disaster Medical System (NDMS).

The incremental costs to the health care system of developing and maintaining mass casualty emergency response capacity are significant. Funding to cover those costs not available from any other sources must be provided by the federal government.

This means that for-profit hospitals and clinics must have an incentive to participate since business plans and the managed care approach make it difficult to justify paying for capabilities like decontamination units if they would be used only sporadically. Also, poison control centers have a role in assisting in response and their funding streams need to be addressed since budget crunches have forced many regional operations to consolidate or down-grade their activities.

States also need assistance to fully implement the National Pharmaceutical Stockpile Plan. While the final TOPOFF Exercise report is not yet available, one of the lessons we learned was that the federal government could only get the pharmaceutical push package to the Mobilization Centers. There were insufficient plans in place to then get the pharmaceutical "push pack" broken down into useable packages and distributed from the airport to the population in immediate need. This is being addressed, but demands emphasis and funding.

We must ensure that the medical treatment reaches the patients in the hardest hit areas quickly. I would further suggest that we look to keeping multiple stockpiles in regionally centralized locations near transportation assets needed to rapidly move those push packages. There should also be back-up stockpiles in several locations around the country to bolster the national surge capacity and to enable a flexible response to multiple events.

Providing this regionally based medical surge capacity in the health care community will take some time. In the interim, the best truly rapid response surge capacity we do have is a combination of the VA health care system, the Disaster Medical Assistance Teams and the military Reserve Component medical units. We particularly need to ensure that those military Reserve assets are trained, equipped and empowered to provide rapid medical capacity under "imminent and serious" conditions. They are, in many cases, the closest deployable assets.

We need to change our focus and begin thinking of health professionals as first responders. State and Local Disaster Medical Assistance Teams should be

developed across the country with standardized equipment, personnel and training. These teams would serve as the first line of response to support impacted communities within impacted states, and could be required to respond outside the state as a mutual aid resource upon request. Self contained capability to respond outside the team's jurisdiction would be best provided by military Reserve Component assets available in each state.

Additionally, the current 60 U.S. Public Heath Service NDMS Disaster Medical Assistance Teams (DMAT) should be uniformly enhanced for Weapons of Mass Destruction (WMD) response, including focus on personnel protection and training for WMD. Currently, only four of the teams have been upgraded and equipped to serve as National Medical Response Teams (NMRTS).

TOPOFF EXERCISES

As referenced before, one of the best demonstrations of the need for better federal coordination on a regional basis was last year's TOPOFF exercise. TOPOFF was a Congressionally mandated "no-notice" national exercise that was designed to assess the nation's crisis and consequence management capabilities by exercising the plans, policies, procedures, systems and facilities through Federal. State and local responses to a challenging series of "no-notice" integrated, geographically-dispersed terrorist threats and acts. Exercises were conducted in Portsmouth, New Hampshire, Denver, Colorado and Washington, D.C. Clearly, one of the biggest issues was the question of who was in charge of the scene, both in Portsmouth and Washington, D.C. We need to ensure that valuable federal, state, and local relationships and trust are built before a

disaster. TOPOFF was a valuable learning experience and we encourage TOPOFF II, as well as a continuing series of regional and national exercises to continually refine and improve the system. Plans are nothing without exercises to assess and develop their effectiveness.

INTELLIGENCE SHARING

The key the relationship building that I have discussed is intelligence sharing. We should not have to worry about turf battles. The right people need to know information key to responding and preparing at all times. This means reciprocity for security clearances, no matter what department or level of government personnel is representing. For example, if a credible threat existed for a biological agent that created flu-like symptoms in the Boston metropolitan area, health care professionals, emergency management personnel, fire, police, EMS and other first responders should be alerted to the threat and to watch for symptoms. The state health alert network could best serve as a collection point for symptoms that were shown in patients and the network could immediately detect patterns. I simply cannot overstress the need for information sharing – it saves lives in all chemical and biological threat events.

EMAC

An existing system we need to take advantage of for all domestic preparedness planning is the Emergency Management Assistance Compact (EMAC). EMAC is an interstate mutual aid agreement that allows states to assist one another in responding to all kinds of natural and man-made disasters. EMAC offers a quick and easy way for states to send personnel and equipment to help disaster relief efforts in other states. There are times when state and local resources are

overwhelmed and federal assistance is inadequate, inappropriate, too far away or unavailable. Out-of-state aid through EMAC helps fill such shortfalls. There are 42 state members of EMAC and two territories that are members of EMAC and other state and territories are considering joining. Currently, emergency managers from several states are providing technical assistance to New York through EMAC. EMAC support is in place at the state emergency operations center and in New York City and has been used in conjunction with the federal emergency support team. A system like this enables experts to be used across jurisdictions and regions based on the nature of a particular event.

STATE COORDINATION

Coordination with the states is a critical issue that I would like to reiterate that requires attention. Too often, each of the federal agencies deals directly with their state counterpart thereby creating a stovepipe effect for funding that limits states' abilities to leverage federal funding to its maximum benefit and to ensure at least a minimum statewide preparedness and response capability.

The nation's governors recently designated a state agency single point of contact to coordinate the Department of Justice terrorism grants program. There has been a significant amount of movement in the last few years in domestic preparedness, and much of that movement has been in the Department of Justice through the Office of State and Local Domestic Preparedness Support and the National Domestic Preparedness Office. In fiscal year 1999, the Office of Justice Programs was provided funding through the Senate Appropriations Subcommittee on Commerce, Justice, State, and the Judiciary for equipment and planning grant program. At the state level, the program requires a single

point of contact for the nation's governors and the mayor of the District of Columbia to administer the grant. Forty-two governors and the District of Columbia designated the state emergency management agency.

NEMA and the National Governors' Association have worked very closely on positions on domestic preparedness policy and programs impacting the states. In fact, NEMA partnered with NGA and the Office of Justice Programs to hold a series of four regional terrorism policy forums throughout the country to bring together teams of state officials to discuss terrorism policy issues, share best practices, and develop recommendations for states, regions and the nation to improve terrorism preparedness. As recently as July 2001, we hosted a national policy forum with the National Governors' Association to address final recommendations and assess current initiatives in domestic preparedness on the federal, state, and local level. This issue is very important to the nation's governors and they are very committed to coordination on the state level and improving coordination on the federal level on domestic preparedness issues.

These same state emergency management agencies, in many cases, also administer FEMA terrorism grant funding. We are strongly encouraging that all federal programs and funding should be coordinated through the governor's designated single point of contact for the state terrorism preparedness program. We look forward to working with the new Office of National Domestic Preparedness in FEMA and Governor Ridge's new Office of Homeland Security in this mission to create and implement the national strategy. We hope that state emergency managers and first responders from the state and local level will be invited to participate in the national preparedness strategy.

Currently, The Department of Justice needs assessment process requires states to develop strategic plans which would also go a long way to assuring the federal government that state planning and assessment of state capacity is an ongoing process in the states. All states are currently in the process of conducting needs assessments. NEMA recommends that any planning requirements by the Office of Domestic Preparedness not be a duplication of the current DOJ requirement, but rather build off plans and programs underway or already in place in the states. We would also recommend that DOJ should immediately release the FY00 and FY01 equipment funds in order to begin implementation of preparedness plans and to enhance our capabilities, and then require a basic statewide strategy in order to receive the FY02 funds. NEMA believes it would be extremely helpful to allow states to administer the equipment programs and greater flexibility with the approved equipment list would further help. We specifically would like to see the funds used for the purchase of necessary equipment for hospitals and the health care industry, regardless of private sector ownership of these critical "first receiver" response system components. Congress could help by increasing the funding for these grants to provide for detection, personnel protection and decontamination equipment for the nation's emergency response agencies. Finally, we need to assure that federal training and maintenance money must be included in any national terrorism response plan. This funding must include money for federal, state, and local governments to exercise together.

We would also ask that not only would the national strategy respect the principals of federalism, but would allow for state and local governments to

address unique communities and constituencies. In particular, state and local governments are often called "laboratories of democracy" because of their ability to experiment quickly with policy and to find true best practices that would work for other state and local jurisdictions as well as the federal government.

In terms of establishing voluntary minimum standards for the terrorism preparedness programs of state and local governments, NEMA offers itself as a resource in this area. Our organization, along with other stakeholder groups such as National Governors' Association, National Conference of State Legislatures, National League of Cities, International Association of Fire Chiefs, FEMA and others, is in the process of developing and implementing an Emergency Management Accreditation Program (EMAP). EMAP is a voluntary standards and accreditation program for state and local emergency management programs that is based on NFPA (National Fire Protection Association) 1600 Standard for Disaster/Emergency Management and Business Continuity Operations (an ANSI or American National Standards Institute) approved standard) and FEMA's Capability Assessment of Readiness (CAR). Consequence management preparedness, response and recovery standards are being developed in conjunction with those for the traditional emergency management functions. NEMA suggests that standards already being developed through EMAP be considered in the development of minimum standards for training, exercises and equipment. Additionally, EMAP acceptance would provide the natural mechanism for federal and state agencies to meet the requirements of the Government Performance Results Act (GPRA). The voluntary standards that are implemented must also apply to federal military units that will integrate into state and local response operations.

CONCLUSION

In summary, NEMA supports efforts to improve federal coordination on domestic preparedness, especially with chemical and biological preparedness. Again, we ask that the federal government should take the lead and designate a single lead on the domestic preparedness issue that directly consults with state and local governments. The National Emergency Management Association offers to partner with Congress, the Administration, and the federal government to develop the national domestic preparedness strategy – one that can be implemented effectively by all levels of government.

The greater safety of the nation is at stake and all responders and policymakers at the federal, state, and local need to work together to ensure that we are prepared for an incident of domestic terrorism. Lives are at stake and we need to be prepared to the best of this nation's ability. We pledge our cooperation to continue to work with you and this committee to ensure our nation is at the highest level of preparedness to deal with a terrorist event. Thank you again for inviting NEMA to present testimony on this important issue. I would like to thank the Committee for their dedication on this issue. We look forward to working with you, the Administration, and local responders to make this country a safer place for all.

Mr. HORN. Dr. Smith, Mark Smith is from the Washington Hospital Center, very distinguished institution in Washington, representing the American Hospital Association. Dr. Smith.

Dr. SMITH. Thank you, Mr. Chairman. I'm Mark Smith, the chair of emergency medicine at Washington Hospital Center in Washington, DC, and I'm here today on behalf of the American Hospital Association's nearly 5,000 hospitals, health systems, networks and other health care provider members. We appreciate the opportunity to present our views on hospital readiness for a potential terrorist attack utilizing chemical, biological or radiologic weapons, as well as explosives, incendiaries and other more traditional means of destruction.

The special responsibilities of hospitals in a terrorist attack is to treat, manage and mitigate the acute medical consequences that occur, and as this great Nation enters into a war on terrorism, the American people and government officials need to have confidence in our hospitals and our systems of health care, and I have no doubt that American hospitals will rise to the occasion just as they did on September 11th, hospitals in New York and New Jersey, Virginia and Washington, DC, who relied on their training, their experience and their prior disaster planning. They performed outstandingly. The hospital system worked.

Here at Washington Hospital Center, the regional burn center for Suburban Maryland the District of Columbia and Virginia, we treated 15 survivors from the Pentagon. Many of the victims were severely burned. On September 11th, we were all part of a seamless single system of rescue, fire, police, EMS, hospital, and it was not only those hospitals that directly cared for the victims. Our region's vast network of hospitals responded. At Washington Hospital Center that morning, we received offers of aid and assistance from Malcolm Grove Medical Center, University of Maryland Medical Center, Johns Hopkins, and MedStar Health's Baltimore hospitals, offers of personnel, ventilators, medical supplies and hospital beds, whatever was needed.

America's hospitals were ready for the foreseeable, but now we must plan for what once seemed extraordinary. To date the AHA has created a disaster readiness site on its Web page, engaged in frequent communication about biological and chemical preparedness with hospitals across America and sent out two advisories on hospital readiness. Preparedness work that had occurred quietly behind the scenes during the past several years is coming out at the public view, such as the District of Columbia Hospital Association's Mutual Aid Plan led by Dr. Joe Barbera, or the ER–1 Readiness Project at the Washington Hospital Center to develop the design specifications for an all-risks emergency department, one that has national capability built into it to manage the medical consequences of these terrorism disasters and epidemics.

To meet the new challenges that we now face, our recommendations include the following: First, integration of hospitals with police, fire, EMS and public health needs to occur to a much greater level than exists today. Although not traditionally thought of as such, hospitals are, in fact, one of the core elements of a community's public safety infrastructure. Hospital is the final destination

of every public service agency when injury, illness or acute exposure occurs.

Two, hospitals need to increase inventories of drugs, antibiotics to combat the effects of chemical and biological weapons such as anthrax, nerve gas.

Hospitals need to increase reserves of ventilators, monitors, stretchers, all the basic equipment and supplies needed to treat victims of a mass disaster event.

Hospitals need much more robust systems for communicating in real-time with other hospitals and with public service agencies in order to better coordinate care for victims. Information provides light, and we are often in the dark.

Hospitals need improved systems of surveillance detection and reporting in order to identify potential biologic outbreaks as early as possible.

Hospitals need backup water supplies or auxiliary power sources and adequate fuel storage. We need our hospitals to be secure and safe under all conditions.

Hospitals need to be able to utilize nurses and health care personnel who are not licensed locally, but who are licensed in other parts of the country.

Hospitals need enhanced stability that currently exists to decontaminate contaminated patients and then to expeditiously care for them.

In order to implement those recommendations, we need people, health care workers, and right now American hospitals are facing a severe work force shortage. Hospitals nationwide have 126,000—this shortage cuts right to the heart of communities across America and to our ability to be ready for any need. Legislation has been introduced to address the work force shortage, and we urge its passage.

Our Nation's nurses, doctors and health care workers answered the call on September 11th and stand ready to do so again, whenever and wherever it comes. But let me leave you with my final—the summation thought, which is that America's hospitals need to be considered and treated for what they, in fact, really are, an integral part of our public safety infrastructure.

Thank you.

[The prepared statement of Dr. Smith follows:]

Testimony
of the
American Hospital Association
before the
Subcommittee on Government Efficiency,
Financial Management and Inter-Governmental Relations
of the
Committee on Government Reform
of the
United States House of Representatives
on

The Silent War: Are Federal, State and Local Governments Prepared for Biological and Chemical Attacks?

October 5, 2001

Mr. Chairman, I am Mark Smith, M.D., Chairman of the Department of Emergency Medicine at The Washington Hospital Center in Washington, DC. I am here today representing the American Hospital Association (AHA) and it's nearly 5,000 hospitals, health systems, networks, and other providers of care. We appreciate this opportunity to present our views on an issue that is dramatically affecting hospitals and communities across America: readiness for a potential terrorist attack utilizing chemical, biological or radiological (CBR) weapons.

September 11 introduced a new consciousness to the collective American mind. We find ourselves faced with the task of preparing for new threats that once seemed unimaginable. Among those threats is the potential use of CBR against our citizens.

HOSPITAL DISASTER PLANS

To answer these and other threats, hospitals nationwide, like those that directly responded to the September 11 tragedies, have disaster plans in place that have been carefully developed and tested. The plans are multi-purpose and flexible in nature because the number of potential disaster scenarios is large. As a result, hospitals maintain an "all-hazards" plan that provides the framework for managing the consequences of a range of events. Hospitals conduct at least two drills a year: one may be focused on an internal event, such as a complete power failure. Another must be focused on an external event, such as a major highway crash, a hurricane or an earthquake. A hospital near an airport, for example, might focus on responding to an airplane crash, while a hospital near a nuclear plant or an oil refinery would focus on responding to the consequences of incidents at those sites. It is important to remember that all incidents are local, and that local agencies and organizations must work together so that response mechanisms are tailored to the needs of their community.

A good example of how hospitals worked with their communities to prepare for a wide range of possibilities was the change of the calendar to the year 2000. Throughout 1999, hospitals across the nation engaged in a major preparedness effort: Y2K readiness. While Y2K was easier to address than mass casualty readiness, because it had a known time ...

midnight of December 31 ... and place ... the hospital ... the consequences were unknown. Hospitals were ready.

Mass casualty preparedness is similar, because the possibilities are many. But it is also different because of its uncertainty. No one can accurately predict when an incident will occur, where it will occur, or what will be its cause and consequences. That is why the all-hazards plan, tailored to suit the needs of each individual hospital and its community, has provided an excellent framework for doctors and nurses forced into action by a wide range of events. Nowhere was this better reinforced than on September 11.

SEPTEMBER 11: HOSPITAL REACTION

When hospitals in New York received the call to expect thousands of injured patients, triage teams were immediately set up, rehabilitation centers were transformed into auxiliary emergency rooms, and hundreds of off-duty nurses and doctors swarmed the hospital to offer assistance. Hospitals in New Jersey and Connecticut were also at the ready. In Washington, readiness paid off as regional hospitals in Virginia, the District of Columbia and Maryland launched into their disaster modes. And in Pennsylvania, facilities in the southwest part of the state were ready to provide care for victims of the airplane crash there. When the emergency plan went into effect, everyone was in their place, doing their jobs. Nurses, doctors, and others, working side by side, communicating effectively, relying on teamwork and training to assist the incoming wounded.

Different cities, different hospitals, hundreds of miles away from each other, each responding efficiently to a direct hit of terrorism. Each reacted in a positive, planned manner that not only saved lives, but also proved that America's health care heroes are dedicated, caring professionals who are ready for the worst of circumstances. Yhe health care professionals and volunteers at all the sites were prepared to treat far more patients than actually came to them. Death tolls were simply too high, and health care workers grieved that they couldn't do more.

LEARNING TOOLS

It is important to realize each incident is used to improve our preparedness. Disaster managers use the term "after action analysis" to describe the types of activities that are conducted to study what happened, what worked and what did not. The AHA and its state, regional and metropolitan associations work with our member hospitals to share throughout the field critical information that can be derived from responses to events. The following are important facts that we already know:

- By definition, a mass casualty incident would overwhelm the resources of most individual hospitals. Equally important, a mass casualty incident is likely to impose a sustained demand for health care services rather than the short, intense peak customary with many smaller scale disasters. This adds a new dimension and many new issues to readiness planning for hospitals.

- Hospitals, because of their emergency services and 24-hour a day operation, will be seen by the public as a vital resource for diagnosis, treatment, and follow up for both physical and psychological care.

- To increase readiness for mass casualties, hospitals have to expand their focus to include planning within the institution, planning with other hospitals and providers, and planning with other community agencies.

- Traditional planning has not included the scenario in which the hospital may be the victim of a disaster and may not be able to continue to provide care. Hospital planners should consider the possibility that a hospital might need to evacuate, quarantine or divert incoming patients.

- Readiness could benefit from exploring the concept of "reserve staff" that identifies physicians, nurses and hospital workers who are retired, have changed careers to work outside of health care, or now work in areas other than direct patient care (e.g., risk management, utilization review). The development of a list of candidates for a community-wide "reserve staff" will require that we regularly train and update the reserves so that they can immediately step into various roles in the hospital, thereby allowing regular hospital staff to focus on taking care of incident casualties.
- Hospital readiness can be increased if state licensure bodies, working through the Federation of State Medical Boards, develop procedures allowing physicians licensed in one jurisdiction to practice in another under defined emergency conditions.

Nursing licensure bodies could increase preparedness by adopting similar procedures or by adopting the "Nursing Compact" presently being implemented by several states.

BIOTERRORISM

The threat of chemical, biological and radiological agents has become a focus of counterterrorism efforts because these weapons have a number of characteristics that make them attractive to terrorists. Specifically, biological agents pose perhaps the greatest threat. Dispersed via the air handling system of a large public building, for example, a very small quantity may produce as many casualties as a large truckful of conventional explosives, making acquisition, storage and transport of a powerful weapon much more feasible. Some CBR agents may be delivered as "invisible killers," colorless, odorless and tasteless aerosols or gases.

The distinguishing feature of some biological agents—such as plague or smallpox--is their ability to spread. The victim may even become a source of infection to additional victims. The effects of viruses, bacteria and fungi may not become apparent until days or weeks after initial exposure, so there will be no concentration of victims in time and locale to help medical personnel arrive at a diagnosis. Exposure to biological agents may cause a variety of symptoms, including high fever, skin blisters, muscle paralysis, severe pneumonia, or death, if untreated.

HOSPITAL READINESS

Because September 11 redefined the meaning of disaster, hospitals are now upgrading their existing readiness plans to meet the new needs of their communities. Since the risk of chemical and biological attacks is now an obvious concern, hospitals are reassessing their current plans. The AHA so far has sent two Disaster Readiness Advisories to all of America's hospitals with information and resources to help them in this effort.

The following are among the key items that we believe need to be addressed to help hospitals as they update their disaster plans to meet the challenges of a threat that, until recently, seemed hypothetical: an attack using chemical, biological or radiological agents.

Medical and pharmaceutical supplies – Hospitals must be properly stocked with antibiotics, antitoxins, antidotes, ventilators, respirators, and other supplies and equipment needed to treat patients in a mass casualty event.

Communication and notification – There is a need for greater coordination of public safety and hospital communications, the ability of different entities to communicate with each other on demand. In addition, alternative and redundant systems will be required in case existing systems fail in an emergency.

Surveillance and detection – Improving hospital laboratory surveillance and the epidemiology infrastructure will be critical to determining whether a cluster of disease is related to the release of a biological or chemical agent. The ability to rapidly identify the agent involved is vital.

Personal protection – Hospital supplies of gloves, gowns, masks, etc. would quickly be used up during an attack, and equipment like canister masks is rarely kept in adequate numbers to meet demands of a large casualty attack.

Hospital facility – Among the capabilities hospitals will need in the event of an attack: lockdown ability; auxiliary power; extra security; increased fuel storage capacity; and large volume water purification equipment.

Dedicated decontamination facilities – Hospitals need a minimal capability for small events and the ability to ramp-up quickly for a larger event.

Training and drills – Staff training is needed at all levels for all types of potential disasters. Additional disaster drills beyond the two per year required by JCAHO, particularly community-wide drills, would enhance the level of hospital readiness.

Mental health resources – Mass casualty events trigger escalated emotional responses. Hospitals must be ready to treat not only patients exhibiting these symptoms, but others, such as family members, emergency personnel and staff.

COMMUNICATION / TRANSPORTATION ISSUES

To truly solidify response readiness, the federal government should help establish an emergency communication and transportation strategy. During the recent attacks, street

closings and clogged roads impeded EMS workers as they tried to reach the affected areas, and hindered quick access to hospitals. No-fly zones were implemented to prevent other air attacks, but those zones hindered med-evac helicopters and other air transports that shipped blood and bandages to hospitals in dire need. Hospitals need assistance from Federal Aviation Administration officials to keep the skies open to critical medical aircraft.

In addition, any biochemical attack will require the coordination of local, state and federal agencies. In response, the Centers for Disease Control and Prevention have invested in and upgraded state-of-the-art labs to identify and monitor reports of suspicious cases of illness across the country. Working in conjunction with state and local epidemiologists, they will communicate their findings to government agencies.

READINESS RESOURCES

Realistically, America can never afford to prepare every hospital in the country for every possibility of attack. However, the federal government can provide assistance to help ensure that hospitals and their local agencies are best able to respond to potential attacks. These funds would be earmarked to meet the challenges outlined above, including inventories of the necessary drugs and equipment needed to help victims of terrorist attacks. Communities need the funding to assist their hospitals and expand their emergency relief teams, as well as to establish or implement new systems of readiness.

HOSPITAL CHALLENGES

There is no more important strategy in this domestic war on terrorism than to help our hospitals reach a state of readiness. But if America's hospitals are to enhance their readiness for a new world of possibilities, they must have in place the people they need to do the job. However, America's hospitals are experiencing a workforce shortage that will worsen as "baby boomers" retire. Currently, our health systems have 126,000 open positions for registered nurses, for example. The United States Department of Health and Human Services predicts a nationwide shortage of 400,000 nurses by 2020. There also are shortages of other key personnel, such as pharmacists. This shortage cuts to the core of America's health care system, because dedicated, caring people are the heart of health care.

Fortunately, Congress has recognized the importance of this issue. Legislation has been introduced that can help hospitals attract and maintain the health care workforce that is needed to ensure that our patients receive the right care, at the right time, in the right place. For example, the Nurse Reinvestment Act (S.706/H.R. 1436) offers the right step to ensure health care professionals avert the collision course we face with lack of hospital staff.

CONCLUSION

The United States has been thrust into a new era. Our hospitals have always been ready for the foreseeable. Now we must plan for the previously inconceivable. Hospitals are

upgrading existing disaster plans, and continue to tailor their disaster plans to suit the individual needs of the community in the face of new threats.

America can be comforted that, as we have witnessed over the last few weeks of our national tragedy, highly trained, caring doctors, nurses and other professionals are the heart of our health care system. They perform heroic, lifesaving acts every day. And, in the face of the unexpected, they can be depended on to rise to the needs of their communities.

The AHA has worked closely with the administration on this important issue, especially with Sec. Thompson. We look forward to working with Congress as we help ensure that the people we serve get the care they need in any and all circumstances.

Mr. HORN. Can you give us that nurse estimate? Is it 128,000?
Dr. SMITH. 126,000.
Mr. HORN. 126,000. Thank you very much.

And now we go to—maybe Mrs. Maloney would like to introduce him—Kyle Olson, vice president, senior associate, Community Research Associates.

Mrs. MALONEY. His resume is quite long, quite distinguished. He's been at the head of this issue for many decades. Many of you may have already met him, as I did, originally from his many statements on television, 60 Minutes, Dateline, Frontline. He's been on the front- line on this issue, and I'm pleased that he's been a constituent of mine, and I am very delighted that he was able to join us, and I thank you, Mr. Chairman, for allowing him to be part of the panel. I always find his insights incredibly important on this important issue. Thank you for coming.

Mr. OLSON. Thank you, ma'am.

Mr. HORN. Mr. Olson, you're vice president and senior associate to the Community Research Associates. Is that sort of a consulting firm to hospitals?

Mr. OLSON. Well, by way of disclosure, I will acknowledge that I have been, am now, and hopefully after my remarks today will continue to be a scum-sucking government contractor. My firm has worked with the Department of Justice, Department of Defense, State and local governments for a number of years, particularly in the area of WMD training, preparedness and other support. I will also acknowledge that my remarks today have not been reviewed, probably a mistake on my part, by any of those entities.

Again, I want to thank you for the opportunity to speak today and offer my thoughts on the biological and chemical terrorism problem to this committee. In the aftermath of the tragic events of September 11th, the specter of terrorists' use of weapons of mass destruction has gone from being a remote possibility that is probably worth planning for to one more aspect of what has become a national nightmare. Many have looked at the threat posed by chemical and in particular biological weapons for the very first time in the last few weeks, while others, including many of today's witnesses, have been working on this problem for a long time.

Today you, me, all of us are being asked by the American public for an answer that will put, frankly, this grim genie back into the bottle and let us get back to our lives. Unfortunately, there is no silver bullet that is going to slay this monster, nor ensure that it is going to stay in the grave once it's put there. Even as we focus on Osama bin Laden and his organization, we have to confront the truth. He is not the first nor will he be the last man to covet weapons of mass destruction. After we run him to ground, we will still have to deal with the potential that these weapons, created in the middle of the last century, will wreak havoc on the new. To that end, it is important that the answers be simple, that they be complete.

It has been suggested that the efforts made to ready cities of this Nation to respond to WMD terrorism have been lacking. They've been characterized as a mile wide and an inch deep. This much is true. We could have done more. We can always do more. Navy exercises could have been more demanding. Maybe the training could

have been more complete. Yet it is also true that the Nunn-Lugar-Domenici training and exercise program introduced thousands of first responders to a threat that they had never even thought about. New problems demanded new responses and new ideas from police, fire and emergency managers, and they worked those problems in the context of that program. As a result, there is no doubt we are far better prepared today than we were 5 years ago, particularly for potential chemical use.

On the other hand, the argument has been made all too convincingly that our health establishment is still ill-equipped to deal with bioterrorism. I don't argue that point. Over the course of the last 4 or 5 years, the element of emergency services that has been most consistently a no-show at these integrated training and exercises has been the medical community. For whatever reason, time constraints, budgetary limitations, skepticism, in many cities the doctors have not been in the tent, and now we are seeing evidence that this is changing. Yesterday's news out of Florida suggests that this foxhole conversion comes none too soon. Serious work remains to be done.

For example, while it is true that we have Federal stockpiles of drugs, we do not have plans that have been tested for distribution of those drugs in the event of a major biological event. We have plans on paper that have not been field-tested by and large.

But before we join those who fully discount our preparations, consider this. When the World Trade Center fell, New York City activated an emergency response system that had for years deliberately tested itself against the darkest WMD scenarios, chemical, biological, even radiological. New York's leaders understood perhaps better than the rest of us that the world's first city was terrorism's potential primary target, and so they prepared themselves. They took advantage of Federal training, exercises, equipment, funding and other help. They pushed, they grabbed, they shook the money tree. They played Federal agencies against each other. They enjoyed using those duplicative programs that everybody complains about, and at the end of the day, after a lot of work and a lot of soul-searching, the city's emergency management system was structured to deal with an event that could leave 5,000 or more New Yorkers dead.

New York's planners invented ways to work around the loss of power, communications, transportation. They even confronted the possibility of losing scores of men and women from the city's now legendary fire and police departments. Because they did all these things and thought their way through all these horrible ideas, New York City was better prepared than any city on Earth when those towers fell. Observers have noted that the city didn't quit. It wept. We all wept. But New York got up and fought, and I believe beyond the spirit of the city's people that the training helped. No, september 11th was not sarin, and it wasn't smallpox, but it was mass destruction. The responders in New York had been encouraged to think about the unthinkable, and when it became real, those same responders' actions saved more than 20,000 lives.

A similar story played out here in Arlington, VA, where the capital-area responders after years of preparation managed an efficient, professional response in the attack on the Pentagon.

As we discuss where the Nation must go in the days ahead, as Congress and the administration consider how to invest our hope and our treasure, I hope we can appreciate that the efforts of the past 5 years have not been wasted. They haven't been perfect. What government program ever has been? But they have not been wasted.

Much of the criticism directed against the current hodgepodge of Federal agencies arrayed against terrorism is, I would argue, a little bit out of date. There truly has been a shake-out over the last couple of years with a broader understanding of the way things are supposed to work. It is a little bit wider appreciated now. It's not a streamlined system, but its functions have become more sophisticated and better targeted over the last several years. We still have overlaps, there are still food fights at budget time, but responder agencies at the State and local level have in many cases a pretty good idea of where to go to get help.

A major restructuring in the middle of everything else that is going on right now holds out the potential for confusion rather than clarity. I don't know that the best course for this government is to pursue a single homeland defense counterterrorism agency that tries to do everything well and ends up doing many things poorly. I actually tend to believe that competition among competing ideas is a pretty good idea.

I've seen the wiring diagrams. I know there's urgency to rearrange the deck chairs, but I also know that the small successes of the first few days of the last few weeks in this bizarre, necessary twilight world we are embarking upon stemmed from earnest to frequently clumsy efforts to make a difference. As you consider the path forward, as we all wrestle with the unimaginable, let's remember the instructions given to physicians when they enter into practice: First, do no harm. Thank you.

Mr. HORN. Thank you.

[The prepared statement of Mr. Olson follows:]

TESTIMONY OF
KYLE B. OLSON
VICE PRESIDENT

COMMUNITY.RESEARCH.ASSOCIATES

October 5, 2001

Thank you, Mr. Chairman, for this opportunity to provide my thoughts on the biological and chemical terrorism problem to the members of this Committee. I have had unique opportunities to observe the transformation of America's thinking on this topic over the past fifteen years. Initially as an industry representative in the negotiation of a treaty banning chemical weapons, then as a consultant on strategies for disposing of Iraqi and Soviet nerve agent, and more recently as an analyst and consultant on strategies for responding to terrorist use of weapons of mass destruction, I have had a ring-side seat at the evolution of our fears. It has been fascinating, a journey often driven by accident and calamity, culminating in the present discussion.

In the aftermath of the tragic events of 9-11, the spectre of terrorist use of weapons of mass destruction has gone from being a remote possibility, probably worth planning for, to one more aspect of the national nightmare. Many have looked at the threat posed by chemical and, in particular, biological weapons for the first time, while others, including most of today's witnesses, have been working on the problem for a long time. Today, you, me, all of us, are being asked by the American public for an answer that will put this grim genie back into the bottle, and let us get back to our lives.

The answers we can offer, however, are not particularly happy ones. There is no silver bullet that will slay this monster, and insure that it does not rise again to threaten us. Even as we focus on Osama bin Laden and his organization, we must confront the truth: he is not the first nor will he be the last to covet weapons of mass death. After we run him to ground, we will still have to deal with the potential of weapons created in the middle of the last century to wreak havoc on the new. To that end, it is important that the answers be, if not simple, then at the very least complete.

It has been suggested that the efforts made to ready cities in this nation to respond to WMD terrorism have been lacking, a mile wide and an inch deep. This much is true. We could have done more. We can always

do more. Maybe the exercises could have been more demanding, maybe the training more complete.

Yet it is also true that the Nunn-Lugar-Domenici training and exercises introduced thousands of first responders to a threat they had never even thought about. New problems demanded new ideas from police, fire, and emergency managers, and they worked those problems. As a result, there is no doubt that we are far better prepared than we were five years ago, particularly for chemical use.

The argument is made, all too convincingly, that our health establishment is still ill-equipped to deal with bioterrerorism Frankly, I will not argue that point. Over the course of the last few years, the element of emergency services that has most consistently been a no-show at training and exercises has been the medical community. For whatever reason – time constraints, budgetary limitations, skepticism – the doctors have not been in the tent. Now we are seeing evidence that this is changing. Yesterday's news out of Florida suggests this foxhole conversion comes none too soon.

Yet while we discount these preparations, try not to lose sight of the fact that when the World Trade Center fell, New York City activated an emergency response system that had deliberately set itself against the grimmest of bioterrorism and chemical weapons scenarios. New York understood its vulnerability. The city's leaders recognized that the world's first city was potentially terrorism's primary target. And so they readied themselves. They took advantage of Federal training, exercises, equipment funding, and other help. They pushed and grabbed and shook the tree and took all they could get, exploiting duplicative programs and playing one Federal agency against another. And at the end of the day, after a lot of work and a lot of soul searching, the city's emergency management system was structured to deal with events that could leave 5000 New Yorkers dead. They invented ways to work around the possibility of losing power, telephones, transport. They even confronted the possibility of losing scores of men and women from the City's now-legendary Fire and Police Departments.

Because they did all these things and thought their way through all these horrible ideas, New York City was better prepared than any city on Earth when the towers were destroyed. Observers have noted that New York City didn't quit. Certainly, it wept. We all wept. But New York got up and fought. And I believe – beyond the indomitable spirit of that city's people – the training helped. No, it wasn't sarin, and it wasn't smallpox, but it was most certainly mass destruction. The responders of New York had been encouraged to think about the unthinkable. When the unthinkable

became real, those same responders took the necessary actions that certainly saved more than 20,000 lives.

As we discuss where this nation must go in the days ahead, as Congress and this Adminstration consider where to invest our hopes and our treasure, I hope we can appreciate that the efforts of the past five years have not been wasted. They haven't been perfect. Name the government program that is. But they have not been wasted.

I don't know that the best course for this government is a single "Homeland Defense/Counterterrorism agency" solution, that tries to do everything well and ends up doing many things poorly. I tend to believe that a little competition among competing ideas produces the best products. I've seen the wiring diagrams, and I know there is an urgency in some circles to re-arrange the deck chairs. But I also know that the small successes of the last few weeks, in these first, early stages of this bizarre, necessary, twilight war, stemmed from those earnest, if frequently clumsy efforts to make a difference.

As we consider the path forward, as we wrestle with the unthinkable, let us also remember the instructions given to physicians as they enter into practice: First, do no harm.

Thank you.

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Mr. HORN. Let's start the questioning. I'm going to take 5 minutes, and I'd like to know from Mr. Lillibridge and Mr. Duehring, Mr. Fogg and Mr. Olson in particular in educating people through professional conferences that go on all over America, are we giving training from the Federal side and having people at these conferences so they can bring people up to the level that they ought to be if they're going to really be useful? I just wondered how we're using the grant money.

Dr. LILLIBRIDGE. Thank you, Mr. Chairman. I would also ask after a few minutes that I be dismissed, I have some other pressing engagements, but I'd like to answer that question as best we can.

We could always do more, but let me tell you what's in progress and what's been done along that avenue.

First, we've worked with both the Department of Defense to do satellite broadcasts to reach as many as 18,000 health providers at a time. These have been highly successful and have dealt with both chemical and biologic weapons response on the health and medical sector.

The second thing is that we've also partnered with the major guilds, professional organizations, and there are a huge number of preparedness efforts in terms of training at these annual and regional meetings, and those are ongoing.

Recently we've also looked forward to the partnership at HHS with FEMA on linking emergency management and training at the State, local level in terms of integrating our capacities in those areas.

Mr. HORN. Well, we'll just go down the line. Mr. Baughman, any thoughts on this as to grants and how we get that—people across the country, be it hospital administrators, doctors, also in our medical schools and our public health schools, and I suspect the—I would hope the public health schools in America would certainly have a course on terrorism and all the rest?

Mr. BAUGHMAN. I think one of the things we do need to do is to work closer with our public health partners at the State and local level. At the Federal level—and we can talk about the State level—we work at that level, but what is lacking right now is guidance, guidance to put out to State and health providers, local health providers on what they ought to be doing.

An example is right now. What—the word that we ought to be putting out to the American public on what should we be doing as far as protection and guidance. As a matter of fact, we had a dialog with HHS the day before yesterday on this, but I think what State and local health providers are hungry for is a lot more guidance on what they ought to be doing to make their health care network more robust in light of a WMD-type scenario.

Mr. HORN. Mr. Duehring.

Mr. DUEHRING. Well, sir, the training that the Department of Defense does is oriented pretty much toward practical hands-on application for our own people, and that is continuing. That is ongoing. We have, of course, wartime commitments that parallel the threat that you have here in the United States, and I addressed that very briefly in my opening comments.

Now, in addition to that, under the 1997 defense authorization bill, called the Nunn-Lugar-Domenici Act, we were tasked initially

to go out and conduct training with communities, and there has been references today about the training that had gone on in New York. That was part of that program. We actually trained leaders of these various cities and 105 communities. But the provisions of that bill have now expired. So, to my knowledge, the only other agency that is involved now would be the Department of Justice, and they may have a little more to add, if they are here.

Mr. HORN. Mr. Fogg.

Mr. FOGG. From a State level, I would say that the National Governors Association, FEMA, through the Emergency Management Institute, all of our other Federal partners have been providing good training, and we've been delivering it. The problem—and we've been getting a lot of guidance in terms of planning, you know, how to do planning, and of course we have a pretty good—we know how to do that ourselves, but the problem is we need to link and coordinate those various offerings from all the different agencies and coordinate them so we get the best bite at a local responder's limited time. Most of them are volunteers. There's plenty of training out there, but focusing it, coordinating it so they get the best use of their time so we can attract them is an important thing.

And last, I would say the place we really need to concentrate some effort is on exercising. We can have great plans, we can have great training, but if we don't exercise them, you know, to get people used to working with each other and understanding what is going on, we're missing the boat, and we're not spending enough money and enough time exercising.

Mr. HORN. I'm going to recess that question. I see Mr. Lillibridge does have a chance to get away and do certain things, but could you tell me on what's apparently yesterday's news about an anthrax case in Florida? Was there one? Do we know? Is CDC looking at it or what?

Dr. LILLIBRIDGE. Thank you, Mr. Chairman. Let me update on that and give you an indication of how the public health system works, where we are in that case, and what we know today.

As you know, yesterday the press reported there was an apparent anthrax case in a single individual who was thought to be noncommunicable and thought to be sporadic in nature. That means one of those cases that occur from time to time.

We have a robust State and local health department, and many accolades to the department—the Florida Department of Health in their early response. Remember, they're into a 3-year preparedness effort with their lab and their surveillance activity, and as we hone our surveillance activity, we're going to be more aware of these outlier kinds of cases.

What we know is that the case was entered into the hospital on October 2nd, and within 24 hours the State had done some preliminary investigation, was able to confirm laboratory testing on this, and confined this to a single case at the local facility in—near Miami. The prognosis of that person is unclear at this time; however, the test was reconfirmed at CDC in a partnership with our—according to our plans, with our State and local partners.

CDC, disease detectives and laboratorians are working with the State health department to see if there is any additional cases or

any additional facts that would help determine where this case came from.

As of this morning—and I talked with the people on the ground just before coming to this hearing and asked if there was any indication that there was a widespread outbreak or any other information that might relate to this hearing, because we might be asked, and the answer was no. But I will assure you disease detectives are on the ground from both the Florida State Health Department and the Centers for Disease Control, and we'll keep you updated as information is developed.

Mr. HORN. At this point, there's no second case.

Dr. LILLIBRIDGE. At this point we are advised by the FBI that this does not seem to be a biological agent attack. We are not finding secondary cases. This person was—became ill nearly a week ago, and by that time we certainly should see additional cases if this was going to be a widespread problem.

Again, we'll keep you updated and keep the public updated as information is known.

Mr. HORN. When was the last anthrax case in this country?

Dr. LILLIBRIDGE. Well, we have information from 1955 to 1978. We have a total of 11 cases that were documented. Now, remember, as you enhance surveillance, we don't find all these cases until you begin looking, but at any rate we have information on 11 cases, and the last 1 in 19—clearly 1978, and recently this case in Florida. Most of these are occupational or related to something you're doing with animals, hides and that sort of thing, but, again, those occurred in the absence of a bioterrorism attack.

Mr. HORN. Thank you.

Dr. LILLIBRIDGE. Thank you, Mr. Chairman.

Mr. HORN. You're quite welcome.

Let's pick up here now with Dr. Smith on——

Dr. SMITH. Training and education.

Mr. HORN [continuing]. How we educate and train people.

Dr. SMITH. I think what is important to understand is that training and education, medical training, medical education, it's not a one-time affair. It occurs in multiple venues, national meetings, grant rounds. In fact, 2 days ago the Washington Hospital Center department of medicine put on a grant rounds on biological agents. It was standing room only, and I suspect a similar thing is happening in hospitals across the country.

What we need are resources, knowledge, material, and I must say, the CDC has done a terrific job on its Web site. The material that is there is outstanding and has been a resource for many of us, as well as the material that the military has put out with its little handbooks on bio and chemical agents. So I think what we're going to see is that there's going to be an explosion of courses and talks on this subject.

Mr. HORN. Is anybody on public television doing a, say, 1-hour on it or something like that?

Dr. SMITH. I don't know, but I suspect they probably are.

Mr. HORN. You ought to head in their direction.

Dr. SMITH. Thank you.

Mr. HORN. Mr. Olson, anything else on this?

Mr. OLSON. Mr. Chairman, just a couple of thoughts. First of all, there is a robust or a fairly robust training program that did indeed migrate from the Department of Defense to the Department of Justice, and, again, by way of disclosure, my firm has a small part of that, but that doesn't mean it's not any good.

And the program is designed to reach out to carry the training to the people when they're in the States, local jurisdictions in recognition to the point that's been made abundantly clear throughout the day, that the first responders are the first line of defense, and that is absolutely true.

But I also just want to point out my very real appreciation of the fact that the medical community in Washington, DC, led by George Washington University Medical Center and the Washington Medical Center, those are actually a couple of institutions that are right out there in the lead. They have taken the point on this thing. I think they point a very important direction for the medical community in this country.

However, I do go back to my initial point, which is that I do not believe that is representative, unfortunately, at this point, of where the Nation's medical communities—they're just a little bit behind the power curve at this point.

Mr. HORN. Thank you.

I now yield to the ranking member, Ms. Schakowsky, the gentlewoman from Illinois.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I'm sorry that Dr. Lillibridge left. And I was pleased with his comments that there was still much more to do, because while I think it's important for us not to unnecessarily alarm people and to overreact, at the same time I think it is not a good idea. I know that the Secretary of HHS has been assuring the public that our country is perfectly prepared and sounded as if in all instances for any threat to our Nation's health, and I think we have to take a very clear and thoughtful look at this approach to it, and I appreciate all of your comments.

Two of you—and I don't remember—mentioned Nunn-Lugar and the funding that it provides for the domestic work to defend against weapons of mass destruction and provide training, not to mention securing the Russian stockpile of nuclear weapons. My understanding is that in this budget, in the defense authorization bill, that there is a $40 million cut in Nunn-Lugar. Even at the same time as we have about an $8 billion increase in national missile defense, there's been a cut. Clearly, this bill was crafted before this threat.

How important is this program and is this funding stream to the work that you're doing? Anyone can answer.

Mr. Olson.

Mr. OLSON. Congresswoman—and I don't want to speak too far on this because I wasn't involved in the agency perspective in these things—but the cut in Nunn-Lugar, the program was essentially designed to reach out to the 120 or so largest cities. That program is actually pretty well completing that cycle of work. It was a cycle of training followed by a series of chemical and biological exercises.

With the goal of completing the 120 cities, that training program and that exercise program, again, was transitioned from the De-

partment of Defense to the Department of Justice. And has been rolled into other training initiatives which are being managed by that agency. Now those programs are still, frankly, under development to some extent at this point. Nunn-Lugar is continuing, I believe through the next year or so. All of the cities that were promised training will receive that training, and then, if you will, the next generation of training and exercises will follow. Exactly what shape that is, I think is still under development, though. But there is a commitment within DOJ to continue training and exercise work.

Ms. SCHAKOWSKY. So there is no loss of actual implementation due to the reduced funding? Just seems to me, if we're looking at where we most usefully put our resources, that kind of effort does need to continue. I want to be assured, then, that it is.

Mr. OLSON. My understanding and—again, as a scum-sucking contractor, my hopes are that this level of effort will continue. I would probably direct you to get a better sense of the detailed planning from the Department of Justice's Office for Domestic Preparedness, which has the mandate for continuing that training and exercise program.

Ms. SCHAKOWSKY. I wanted to quickly ask about our public health infrastructure; and while I applaud the response that there was, it seems to me that had there been—and we all wish there were, actually—more injured than there were dead, whether or not our system could respond.

But what I'm concerned about, New York I think was, as you said, Mr. Olson, probably more prepared than anyone else. Had it been elsewhere, it seems that there are many public health offices that are without even some of the basics. The doctor from the State of California was saying that her local office, before this job, was like that, unequipped with fax machines and computers and not updated.

How big a problem is that around the country, that we don't have this kind of infrastructure? And do we have the communications systems nationally that can transmit information about an anthrax case, or this or that, that would be needed to coordinate a response?

Anybody respond to that?

Mr. OLSON. I will just offer one thought, ma'am.

Penicillin and streptomycin pretty much killed the public health service. Once we shifted to an antibiotic-based approach to medicine, we tended to walk away from any of the things that we had done back in the era of polio, tuberculosis, smallpox. At that time we had a very robust system, because our only options were to identify outbreaks early and then rely upon techniques like quarantine to control them.

Once we found we could defeat these diseases, we essentially—I won't say we dismantled, but we tended to ignore. The phrase "benign neglect" comes to mind. I think it became a less pressing investment in terms of public infrastructure.

We are now, I think, recognizing that we have to reconstitute that. I'm not suggesting that we're going to go back to having armies of public health nurses. There are new technologies, new ways of doing things; and I know the medical community is addressing

those surveillance technologies. The Internet is a powerful tool. But the public health system is not what we would like to think it is.

Ms. SCHAKOWSKY. And, Dr. Smith, how do we increase the numbers to the extent that we need to in terms of nursing shortages, etc?

Dr. SMITH. It's part of the legislation that has been introduced, support for nursing schools, scholarships, all the different ways you encourage people to go into a profession that is the backbone of our health care system. And like most things, it's going to require a multiplicity of efforts.

Mr. HORN. Go ahead. We have all the peace and quiet now. They're all adjourned.

Dr. SMITH. I think that we have to look at the reasons why there has been such—there is now a shortage. It really is going to become one of the great health care crises in this country. If you look at the age spectrum of nurses right now, the ones who are working are slanted toward the older age group. We do not have the younger nurses coming in that we are going to need to sustain all of us when we get to an age where we're going to need them even more.

Ms. SCHAKOWSKY. Thank you.

Mr. HORN. Mrs. Maloney, the gentlewoman from New York.

Mrs. MALONEY. I want to thank all of the panelists, particularly Mr. Baughman, and publicly acknowledge for my constituency, New York City, and express our appreciation for the ongoing leadership, assistance, help that FEMA is giving to New York City. Director Allbaugh has spent a great deal of time there. We appreciate, really, all of your professional expertise and assistance and help.

I appreciate the comments of all of the panelists. I particularly want to thank you for the comments about how well New York responded to the crisis that we had. The command central for emergencies was completely destroyed in the attack on the World Trade Center. It was in one of the buildings that later collapsed. And within 3 days, the city totally rebuilt an alternative command center down at Pier 92, which I think speaks well for the resourcefulness and strength and determination of the American people.

I'd like to ask any of the panelists to comment on this question. It's my understanding that if there was an anthrax outbreak in one of our cities and it turned out to be widespread, that the Federal Government would immediately get involved and would tap the emergency medical warehouses at one of the eight sites—at one of the eight sites around the country. How quickly could these supplies be distributed and how coordinated are the various governments to ensure quick delivery as well, since we know that different people would possibly be getting sick at different times?

And if anyone would like to respond to that question, I would——

Mr. BAUGHMAN. There are now 10 caches, there were 8. We've just beefed that up to 10.

Mrs. MALONEY. There are 10.

Mr. BAUGHMAN. The caches can be to the city, or cities, in a matter of hours. The problem we found in Top Off, that I think still exists is, the ability of the local government to do the distribution and inoculation, the local health care system. That was a problem

if you saw the GAO report in Top Off. So that is what I think is the long pole in the tent right now.

Mrs. MALONEY. Would anyone else like to comment on how we address this problem?

Mr. BAUGHMAN. By the way, in addition to that, we work with HHS. We are surging the national stockpile as far as pharmaceuticals in addition to that.

Mr. HORN. I might add on Mrs. Maloney's question, if there is anyone from the first panel and if they'd like to comment on any of the testimony here of the second panel, please come forward and just read your name into it, so the reporter of debates will be able to know who said it—if you're still around.

So go ahead.

Mrs. MALONEY. Anyone else care to comment?

Dr. SMITH. The distribution is a real issue. Most jurisdictions are only now thinking about how to do it. And they have very little experience in doing something similar. And if you look—one of the tenets of response in a disaster is the doctrine of daily routine. You try to do in a disaster extensions of what you do in your day-to-day job because that's how you're going to perform the best. If we're trying to do something that is totally new and totally different, it's going to be much more difficult to effect, and——

Mrs. MALONEY. Earlier, Dr. Smithson responded to my request about buying antibiotics and possibly a gas mask by saying that it was totally unnecessary. And I have to ask if it gives people a sense of security and buys them peace of mind, what's wrong with having antibiotics in your medicine cabinet that some doctors say could be helpful in case of a chemical or biological attack?

And I ask anyone to respond.

Mr. OLSON. Mrs. Maloney, Congresswoman, this is when it actually hits close to home. I've been working in this area for about 15 or 16 years. And I can sit back and look at this thing very rationally and very calmly and say, well, OK, the best strategy is to rely on the public health system, to count on the surveillance system to be heightened to a higher level, you know, to recognize that there are those, now, 10 caches of pharmaceuticals. Yet when I go home at night, my wife is asking me, what can I do to protect my daughters? What can I do—I need to do something.

And given that, I guess I'll take exception with my good friend, Dr. Smithson, from the earlier panel. I don't necessarily see anything wrong, if it makes you feel better, go out and buy a gas mask, why not—$50, $100, if it makes you feel better that you've got that on the shelf? Odds are you're never going to pull that thing down, but you're never going to hurt yourself with it either.

If you go to your doctor and get a prescription for antibiotics, if he knows you and gives you a meaningful prescription and gives you some good advice on what and when, why not? There are very few things that an individual can do. This is a mission for government and collective response.

But I tend to fall on the side of those people who are saying, you know, look at the Israelis. They have been living on the edge for 50 years and they do these things. We've been on the edge for 3 weeks. If it buys us a little peace of mind in these very uncertain

times, I'm not sure I'm going to stand up and tell somebody don't do it.

Mrs. MALONEY. What I find somewhat troubling from the presentations we've heard today is, everyone says, "Don't worry, be calm," and yet the testimony is saying that we have these caches, but we don't have in place a way to distribute it, or antibiotics or vaccines, in a quick way; and we don't really have the surveillance or the intelligence.

We don't have the coordination between the FBI and the local response people. And you're telling us basically that we don't have the health care workers that are trained, and they're not vaccinated yet for certain things that some people are saying may happen? And yet you're telling us not to be concerned.

So the question that I get asked the most when I go home is the question that Mr. Olson's children are asking him and his wife is asking him, "What can we do for civil defense?" When I go home to my community meetings, people know we're at risk. It's common sense.

Who would ever have dreamed that anyone would fly and turn our airplanes into a weapon of mass destruction against our own Department of Defense and our own financial center? Absolutely unbelievable. They even had one man who was saying, "Just train me to fly a plane; I don't want to know how to land, I don't want to know how to take off." That was reported, and no one knew what to do with it because no one could ever imagine that this could happen.

So I think that we have to imagine or think that something horrible may happen. And my question is, what can we do for civil defense back in our own homes?

Mr. Olson mentioned Israel. Israel has trained for many years for civil defense, having had many terrorist attacks in their own country. Are there programs or models that they have that we could implement here in our own country? And what can we tell our constituents when they say, what can we do back in our own city or our own farm or wherever they are to protect ourselves in the event of one of these terrible attacks?

Mr. BAUGHMAN. I think there's a couple of things. First off, one of the things that we're working on right now is to set up a joint information center with all of the agencies that have expertise in this particular area to talk about what we need to be telling the American public and when we ought to be telling the American public. A lot of it is just information. But how do we get the information down to folks like Woody and the fire chief to get that information out? Right now, we don't have real good dissemination systems.

For example, while in the law enforcement arena you do have a means of passing law enforcement sensitive data, there is no means that we have readily available to pass it down to the firefighter on the street that needs that information.

So how do we get that out? That is one of the things that has been pointed out that has caused problems in past disasters. We, right now, have got some things in the works to look at some short-term fixes for that. But that is a long-term pole in the tent that I think we need to come up with a solution to.

Mrs. MALONEY. But before you even get to the firefighter or fire officer in a real disaster, many people will not have the opportunity to talk to anyone except their immediate family. And my question is, what do we say to these people who are saying, what do we do for our own defense, that we can do ourselves to protect ourselves, because we don't have enough police or firemen out there in the event that—if something happened quickly?

Mr. BAUGHMAN. There is a list of protective action guides that many hospitals have, many health care systems have, that we could quickly put together to deal with a situation like this. In some cases, we have already done that.

Mrs. MALONEY. We should be getting that out now to the public.

Mr. BAUGHMAN. That is correct. We should.

Dr. SMITH. I think it's a very real question. And the answer has got to be based on facts, and the answer may turn out to be something we're going to do, things we never did before.

The truth is the—a number of the bioagents have an incubation period. And during that incubation period where you are asymptomatic, if you were to take a simple antibiotic you can prevent yourself from getting the disease. It's a reasonable question to ask when you're in a high-risk area, whether you should have a supply of doxycycline, which is the drug, around.

There are always problems with taking antibiotics—with side effects, with outdated drugs. That's why the answer is not simple. But it definitely has to be considered. Quite frankly, many of my health care colleagues have personal stocks of doxycycline and ciprofloxacin. If you abide by the Golden Rule that you should do unto others as you do unto yourself, we should be considering this.

Mr. OLSON. I've been watching the news over the last couple of weeks. I would much rather see people out there buying some antibiotics than buying guns. It's going to make a much bigger impact.

Ms. SCHAKOWSKY. Thank you. I thank the gentlelady for yielding.

I think that individuals do want information. We do it for planning escape routes from our own home in case of fire, evacuation plans from buildings and those kinds of things. But I think, and I would recommend—and I don't know if it's up to FEMA or to HHS. I think people are also looking for collective ways of what to do, and there may be a nongovernmental organizational infrastructure that people could be plugged into in an effective way, that we might want to make suggestions to people, ways that we can help our local fire departments or ways that we can get involved in—we have it for fighting crime neighborhood watch groups, communications systems.

I'm not really sure. But I think some thought is useful. Because people are lining up to give blood; people want to do something. I think there may be constructive ways that ordinary people in their communities can play a really constructive role, who would welcome those suggestions and would even implement them themselves at a local level if they were good ideas.

Mrs. MALONEY. Reclaiming my time, I have just one last, brief question. I'd like every panelist to answer it.

And it's, what is the No. 1 thing you think we should focus on in preparing for chemical and biological attacks? What's the No. 1

thing we should focus on? Just go down the line and give us your thoughts.

Mr. OLSON. Medical community. We need to train doctors to recognize these things; we need to teach them what to do when they recognize them. And we need to ensure that the systems that exist in the very best hospitals for surveillance and communication are present across the board.

Dr. SMITH. Creation of a much more robust information and communication infrastructure that will permit integration across agencies, among hospitals, people.

Mr. FOGG. Sharing of intelligence, that's the best way to prevent it, minimize it, in the first place.

Complete implementation of the health alert network, that's a great idea. We've got well—gotten well down the road, but we need to get the rest of the way. We need buy-in from everybody. That's something the public should be informed about and supportive of.

And last, medical surge capacity at the local and regional level.

Mr. DUEHRING. From a defense angle, if you want just one issue, training. Training is a very perishable commodity, because you can train one person today and that person may be gone tomorrow. With such a large program like this, we have to always make sure we are organized and funded to be able to train our people and continuously train them so that whenever the next crisis occurs, wherever it occurs, that we're there to help them.

Mr. BAUGHMAN. I'm going to voice my organizational bias. I think we've got to have a strong emergency management system from local government to State government, up. Our system and Woody's system at the State level integrates all the State agencies.

Responding to a situation like that is not a single agency. In New York City, we responded with 14 Federal agencies to that one incident. So you've got to have HHS, you've got to have EPA, Coast Guard, DOD, and the other agencies integrated in that process.

Down at the State and local level, you need to have fire, hazmat and public works integrated in that response. Right now, we are putting very little money into emergency management at the State and local level.

Mr. HORN. I'm glad you mentioned that, because the Comptroller General of the United States has a very good crew in the GAO, General Accounting Office; and we're looking just at those to see if those places—by State and region. And we'll be doing that over the next 2 months to—there are the pieces there, but again, the communications sometimes are lacking.

Let me ask my last question, I'm sure, and that's—Mr. Duehring is the Principal Deputy Assistant Secretary of Defense for Reserve Affairs. And I note here in Dr. Smithson's testimony on the New York City terrorist attacks, she said that the New York State National Guard's civil support team did not reach the site until 12 hours after the collapse of the Twin Towers. What caused the delay?

Mr. DUEHRING. There were a couple of things that happened. No. 1, they were notified and alerted immediately. Within 90 minutes they had moved to a staging area and were ready to go. Of course, as a lot of people know with the things that happened after 90 minutes, the communications were destroyed and the people who were

tasked to actually call out the team were killed. So there was a bit of confusion.

And they were summoned eventually. They responded. They did their work, I believe, in a 17-block area searching for possible contaminants of some type. They determined the area was free and clear.

They withdrew and actually were recalled two other times to assist in communications, because the teams have some unique equipment installed in their vans which allows them to actually marry together various communications systems that the fire department or the EMT's or whoever happens to be there might have; and when they can't talk to each other, they can through this unit.

So they were very valuable. It was a unique situation driven by the events of the time.

Mr. HORN. Have any of you had a role for the AmeriCorps? A lot of us pushed that 10 years ago, and it came out of a group of university presidents, that we thought this was a good idea. Have any of you used it? And should they be used?

Mr. FOGG. Yes, we have. We've used AmeriCorps folks rather extensively in the State of New Hampshire—not specifically for biological/chemical preparedness, but all-hazards preparedness—by having them work with some engineers, do review for critical facilities in the State and assess their vulnerability and measures we can take to improve their survivability, not only to man-made issues, but to natural disasters, hurricanes, earthquakes, snowstorms, ice storms, that sort of thing as well.

They have been extremely valuable in that process.

Mr. BAUGHMAN. Likewise, we use AmeriCorps too on natural disasters. We haven't worked out a role for them in this type of environment.

Mrs. MALONEY. Will the gentlemen yield for one quick question on September 11th? I want to respond to your comments on communications.

On September 11th I drove home and went to what was then command center at One Police Plaza. The No. 1 thing they said they needed was communications, all communications were down. They really couldn't talk to each other.

And one of the things I did was call Chairman Young and his staff because he was involved with defense; and I know he shipped a load of satellite phones down, which is what they were asking for.

So my question to you, learning from the World Trade Center disaster and your comments earlier that the response time—the early days are when you save people, each day that goes by, the opportunity to recover someone diminishes. One of the things the rescue workers have told me is that what really strapped them for days was the inability to communicate, that you literally had to walk to a person to communicate with them. There was very little communication.

And I just ask—maybe not for this panel, but maybe to get back to the chairman—your ideas of what we could do to improve communications. Did the satellite phones work? Were they—is that what we should have ready at FEMA to deliver quickly?

You know, I just didn't know how to get them, so I called Chairman Young; I thought, if anybody has got them, defense has got them.

In other words, how do you respond to that one problem that you were mentioning? And really I heard at Ground Zero the night of September 11th one of the biggest challenges was the inability to communicate. And it went on for days, weeks, that the communication system wasn't working.

Mr. BAUGHMAN. The problem was, cell phones were useless, as they normally are in any major disaster, because the usage goes—on the cells goes up to saturate. The public switch network was affected, so it was sporadic at best. Satellite communications and high-frequency radio were the only means of communications at the time.

We do, and if a request comes to us, we can tap into any 1 of the 26 agencies. DOD is one of those national communications systems, and their national communications center has about 27 agencies that have telecommunications assets that can be brought to bear. Satellite communications or sat phones, getting that to the area, shouldn't have been a problem. If the request is put in the right channels, we can get in there.

Mr. HORN. On that point, the Army, as you know, over the last few years, has started moving communications and generally computing different things that a soldier does. And it does that with one person on the battlefield. And it seems to me, some of the domestic agencies might want to look at the communications side of that, because I have heard a lot of complaints about the 999's, and either we ought to have more operators or more satellites or something.

I remember at my university in Long Beach we had an exercise there and nobody could talk to each other—and in all of L.A. County. Now, that's 10 million people there, and no other part of the United States has 10 million within that particular jurisdiction. And they were told, well, all the licenses are on the East Coast.

And I don't know how much that has been changed, because nobody's brought it to me if they have. But we need some linkage there in terms of getting that.

I don't know if FEMA is familiar with that. If not, let's all go to the FCC.

Mr. BAUGHMAN. Yes, sir. As a matter of fact, one of the things we're doing is, we are in the process of doing some catastrophic planning. Terrorism is one of the scenarios. We are putting a lot of time and effort into that in the upcoming year, primarily in five scenario areas. The L.A. Basin is one of those to take a look at, each 1 of our 12 functional areas, and what we need to do to enhance telecommunications, health and medical, in that particular area following a catastrophic event.

Dr. SMITH. Would you permit me 90 seconds to respond to one of the points of my colleague to the left about the lack of involvement of the medical community in this planning, because I think it's an important issue?

I think it's important to realize where there has been—why it has occurred. In my view, it is not because of the disinterest of physicians to participate. In many cases, the medical community is

simply not asked. We have been excluded by the public safety agencies because we're not considered a public safety agency. It's all police, fire and EMS.

The second point is that hospitals have lots of things on their plate. Their primary mission is taking care of individual patients. That's their job. And that's actually what they get paid for. No insurance payer pays for emergency preparedness. We're sort of at the margins.

In fact, Ms. Schakowsky asked about, why the nursing problem? Part of the problem is money. Because we don't have money to pay maybe the salaries that we need to pay to attract people. So that we have to figure out a way to support hospitals, which are really the only private sector in this quadrant of police, fire and EMS. The other three are all in the public sector.

Mr. HORN. Yes. Mr. Olson.

Mr. OLSON. We're going to step outside and drop the gloves in a second. But whereas that may, in fact, be the case in some locals, there have certainly been other opportunities where the public health sector, the private health community, was specifically invited and again opted not to participate. There are no simple answers.

I'm not even suggesting that there is a lack of desire to do something. I acknowledge every one of the structural problems that was identified by Dr. Smith just now. I think that, nonetheless, the bottom line for all of us now—and I heard it down the way here—it's not to go back and beat each other up over what we didn't do in the past, it's to identify what we need to do together in the future.

Mr. HORN. Yes. Mr. Fogg.

Mr. FOGG. I would have to say that our experience has been extremely positive. Once—and I guess we did it from the emergency management profession. But in New Hampshire, we asked and actually our three States Maine, Massachusetts and New Hampshire, together, as a result of the Top Off exercise, reached out to the medical community. And I've been very pleased with the response we've received.

We recognize that there are gaps there. We recognize the economic concerns. And we're trying to work together in spite of those constraints to improve the medical surge capability.

I've been very impressed at the response and the progress we've made already. But can we do it without additional help? No. We need help.

Mr. OLSON. I would indicate that I think Top Off is an example of one case where it definitely worked with the medical community in not only the Northeast, but also in Colorado and Denver and others did come together and did play well. But that was a very high-profile, very long-term effort that took a lot of effort to make that happen.

Again, that's in the past. Let's move forward.

Mr. HORN. Whatever happened to Vermont? You didn't seem to mention Vermont.

Mr. FOGG. I'm glad you asked, because right now the best cooperation we're getting, once we started that after Top Off, has been our upper valley in New Hampshire that actually reaches up into Vermont in the watershed along the Connecticut River. The

cross-coordination between the Vermont medical community and the New Hampshire one, spearheaded primarily by Dartmouth Medical Center in Hanover, right on the border, has been astounding. We have reached out to public health services on a national level.

I feel really good about what we're doing there. We just need time and a little more resources to get where we want to go.

Mr. HORN. Well, thank you. Any other thoughts before we gavel this down?

Well, if not, I'm going to thank the staff that put this hearing together, and the hearings about to come all over the country. J. Russell George, staff director and chief counsel; Matt Phillips, on my left, is the professional staff member that put all the pieces together for this hearing; Mark Johnson, our clerk; Bonnie Heald, communications director; and Jim Holmes, our intern. And the minority staff: David McMillen, professional staff; Jean Gosa, minority clerk, and two faithful, hard-working court reporters, namely Julie Thomas and Mark Stuart. And we thank you all. It's a tough one.

So we are now going to recess the committee until we go to New York.

[Whereupon, at 1:58 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Elijah E. Cummings and additional information submitted for the hearing record follow:]

Congressman Elijah E. Cummings
Introduction Martin O'Malley
Mayor of Baltimore City
at the
Government Efficiency, Financial Management, and Intergovernmental Affairs
Subcommittee Hearing
"A Silent War: Are Federal, State, and Local Governments Prepared for Biological and Chemical Attacks?"

October 5, 2001

Thank you, Mr. Chairman.

I am proud to introduce the Mayor of Baltimore, Martin O'Malley. Mayor O'Malley was elected the youngest mayor in Baltimore's history, November 2, 1999. His top priorities have been to improve public safety, education, and economic development in Baltimore.

In addition to maintaining a focus on these priorities, Mayor O'Malley has taken the initiative to make Baltimore a model of civil preparedness. His experience in handling the derailment accident this summer has provided him with the foundation to move Baltimore in this direction.

Mayors and local officials are on the front line and must ensure that our cities are

prepared for biological and chemical attacks.

Cities must stay prepared by being alert. We must focus on enhancing our national security by ensuring that emergency plans and procedures are set. This can be accomplished by working with the Centers for Disease Control and other health care facilities. The City of Baltimore has worked with the Center for Civilian Biodefense at Johns Hopkins and the local public health infrastructure to prepare emergency medical personnel for rapid response. Our public health infrastructure, local firefighters, and police departments must be properly trained to respond in a crisis at a moments notice.

With that said, I am pleased Mayor O'Malley has led the US Conference of Mayors in its effort to educate mayors on what they can do to protect citizens. The Conference of Mayors has been working together on how best to prepare for a possible future attack.

In the wake of terrorist attacks in the United States, it is only appropriate that the country's mayors come together to share information on urban preparedness and I hope that we all come together -- federal, state, and local governments -- to ensure

the American people that we are doing our best to guarantee their security.

Thank you.

STATEMENT FOR THE RECORD

of

THE COMMISSIONED OFFICERS ASSOCIATION of the U.S. PUBLIC HEALTH SERVICE

on

A Silent War: Are Federal, State and Local Governments Prepared for Chemical and Biological Attacks

Presented to the

HOUSE COMMITTEE ON GOVERNMENT REFORM

Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations

Submitted by:

Michael W. Lord
Executive Director
Commissioned Officers Association
of the U.S. Public Health Service

October 5, 2001

Introduction

The Commissioned Officers Association (COA) of the U.S. Public Health Service appreciates the interest of this Subcommittee in the very important issue of bioterrorism. We are pleased that this Subcommittee recognizes the vulnerability of the nation to acts of bioterrorism by fringe groups and rogue nations, and is willing to take a leadership role in seeing to it that the various governmental agencies (local, state and federal) are asking the necessary questions and taking the necessary steps to ensure the nation is prepared if the unthinkable should occur.

COA believes the threat of bioterrorism is a serious one, and the Federal Government must have a clear, coherent and coordinated plan to deal with potential incidents that could impact upon the safety and health of large numbers of Americans. COA also strongly supports the enhancement of the Nation's public health infrastructure at all levels of government. In our view, such an effort is necessary irrespective of the magnitude of the bioterrorism threat we may face. Too often the bulk of Federal health funds has been expended for direct health care costs or to support biomedical research, while Federal expenditures for public health programs have lagged far behind. Consequently, we would urge this Subcommittee to examine not only the ability

of our public health agencies to respond to bioterrorism, but also to review their ability to meet the current demands being placed upon them.

The Commissioned Corps of the U.S. Public Health Service

In our view any planning that takes place with regard to response to an incident of bioterrorism "must" take into consideration the capabilities of the Commissioned Corps of the U.S. Public Health Service. This view has been supported on a number of occasions, most recently by Secretary Thompson in testimony before the Senate Appropriations Committee, Subcommittee on Commerce, Justice, State, and the Judiciary this past May 9th. In that hearing he stated:

> In order to advance an orderly and comprehensive approach to the many issues involved in such preparation (for a bioterrorism event), I will appoint a special assistant within the Immediate Office of the Secretary to lead the department's bioterrorism initiative. This person will report to me directly. I plan to call a national meeting of HHS agencies to evaluate the status of bioterrorism activities and report back to Congress on our efforts. In addition, the new special assistant will support the Surgeon General's efforts to revitalize the Public Health Service Commissioned Corps and its Readiness Force. Let me assure you that this is a top priority for me and for my entire department.

Congress has also noted that the Commissioned Corps has much to offer in the area of bioterrorism. In 1998 the Senate Armed Services Committee, in the Committee Report that accompanied the Department of Defense Authorization Act for Fiscal Year 1999, observed: "The Committee notes the efforts underway within the Department of Defense to develop the means to respond to acts of terrorism involving weapons of mass destruction. In this regard, the committee directs the Secretary of Defense to ensure the assessment of needs and

capabilities includes an analysis of the capabilities that exist within the Commissioned Officer Corps of the U.S. Public Health Service, who, as members of the uniformed services, might be easily integrated into Department of Defense plans to respond to emergencies involving weapons of mass destruction."

The Commissioned Corps has a history of deploying with the military that goes well beyond mobilization in times of war. In such instances the uniform and rank structure of the Commissioned Corps, as noted by the Senate Armed Services Committee, has indeed facilitated the relationship among the services.

This Committee came to a similar conclusion. In the report accompanying the Appropriations Bill for the Departments of Labor, HHS and Education for Fiscal Year 1999, the Committee stated: "In developing plans for bioterrorism countermeasures, the Committee notes the standing personnel and reserves of the Public Health Service are a valuable resource that ought to be well-integrated."

The Commissioned Corps, as a uniformed service, brings some unique capabilities to the public health and emergency response arenas, making these officers especially well-suited for the public health response required in the aftermath of a bioterrorism incident. As noted in a February 1998 Report

prepared by a Special Advisory Committee of esteemed public health professionals headed by Former Surgeon General C. Everett Koop, "... expertise which is resident in the Corps to deal with biological and chemical agents is a critical resource that can be called upon in the event of terrorist attack." Tab A briefly describes some of the important characteristics of the Commissioned Corps, among them:

- public health training and experience;
- on call **24 hours a day**, like their military counterparts;
- available for assignment to accommodate changing public health needs and priorities;
- an exceptional track record in the area of emergency response;
- presence in 49 of 50 states, with large concentrations of officers in nearly every region of the country, thereby allowing for an expedited response.

The Commissioned Corps is also a rich source of epidemiologists whose expertise will be critical as part of a bioterrorist response.

In August 1997 Minnesota's former governor, Arne H. Carlson sent a letter to then-DHHS Secretary Shalala praising the outstanding assistance provided by Commissioned Corps task forces to the citizens of Minnesota in the aftermath of the devastating spring floods. Governor Carlson noted that one of the lesser publicized, but serious impacts of the flooding was an estimated 2500 flooded private wells, requiring the restoration of safe water supplies for many of Minnesota's citizens. He observed that "(t)he three task forces entered the state fully equipped and thoroughly organized to operate with a minimum of state involvement", and they brought the long, dirty and sometimes dangerous work

to a successful conclusion in six weeks. Tab B further details the emergency response capability of the Commissioned Corps based upon actual experience since the late 1980's.

One special component of the Commissioned Corps (cited by Secretary Thompson in his May 9th testimony before the Senate Appropriations Committee, Subcommittee on Commerce, Justice, State, and the Judiciary) is the Commissioned Corps Readiness Force (CCRF), which was created by the Office of the Surgeon General in 1994 to improve the DHHS ability to respond to public health emergencies. The CCRF is a cadre of nearly 1500 PHS active duty officers who are uniquely qualified by virtue of their education, skills and experience to respond to public health emergencies, and who can be mobilized quickly for this purpose.

The Commissioned Corps is also a vital part of the Nation's emergency response capacity through its role with Disaster Medical Assistance Teams (DMATs), which consist of both federal and private sector personnel. One of these DMATs (PHS-1) is comprised primarily of Commissioned Corps Officers (approximately 80%). This team has been stationed at high profile national events to provide the initial public health response in the event of a bioterrorism incident.

In 1999 the first *National Symposium on Medical and Public Health Response to Bioterrorism* was held in Arlington, VA. During a panel discussion of a smallpox scenario, Mr. Jerome H. Hauer, then Director, Office of Emergency Management, New York City, stated that in the event of a smallpox outbreak in New York, he would require hundreds of investigators in the metropolitan area. In addition, he noted the requirement for personnel to provide smallpox vaccinations, observing that the vaccination process is complex, and the average health care provider is not trained in this area.

Mr. Hauer's needs can most certainly be met by the Commissioned Corps. With hundreds of public health professionals stationed within a short drive of New York City, a rapid response can be achieved. The variety of locations nationwide where Commissioned Corps officers are stationed permits the mobilization of a large number of Commissioned Corps officers anywhere in the country in a very short period of time. Furthermore, with some improvements to the administration and training of the inactive reserve component of the Commissioned Corps (discussed below), an additional response capacity, or a backfill capacity, as circumstances require can be made available. The medical expertise also resides within the Commissioned Corps to staff alternate care facilities as needed (e.g. hospitals to handle small pox cases).

While the Commissioned Corps is currently the best available source of public health expertise, a few modest initiatives will make it even better. Some of the initiatives may require legislation, while others may simply require policy changes within the Department of Health and Human Services. Clearly, however, oversight from this Committee is crucial to ensure that the necessary steps are taken. The following are some of the actions that would enhance the ability of the Commissioned Corps to respond to a bioterrorism incident:

- Clarification of the ability to mobilize the Commissioned Corps under a single operational control in the event of an incident involving a weapon of mass destruction. The Surgeon General, the uniformed leader of the Commissioned Corps, administers the Corps and as such is responsible for formulating Commissioned Corps policy. However, Commissioned Officers are assigned to agencies both within and outside the Department of Health and Human Services. This diversity in assignments is a clear advantage, and one of the great strengths of the Commissioned Corps. However, those agencies to which officers are assigned retain significant control over the work performed by their officers. There should be no question that the Surgeon General has authority to direct all PHS officers to respond to a bioterrorism incident, regardless of the agency to which the officers are assigned.

- Provide additional training. The public health background these officers bring to the bioterrorism scenario is a significant advantage. However, it is important that, as in any specialized area, the officers receive ongoing training to develop/maintain their expertise.

- Formalize the Inactive Reserve program. This issue was touched upon above. Unlike the inactive reserve components of the other services, the Commissioned Corps program has been run on an informal basis, with a somewhat loose affiliation by the members. Nearly all members of the PHS inactive reserve have served at least two years on active duty and thus are familiar with Federal programs and procedures. The potential of this program has been recognized by many in Congress, including the House Appropriations Committee that directed a study to ascertain the viability of establishing an Office of Reserve Coordination to administer the program.

> Without question the inactive reserve program, and public health in general, could be dramatically enhanced if even modest resources were committed to the maintenance of the reserve program and to the training and utilization of inactive reserve officers.

Once again, the Commissioned Officers Association very much appreciates this opportunity to submit its views to this distinguished Subcommittee. We look forward to addressing further details of these and other issues with you and the Subcommittee staff.

THE FACTS ABOUT THE COMMISSIONED CORPS

THE COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE . . .

- is an active duty force of approximately **5600 health care professionals** comprised of physicians, nurses, scientists, dentists, engineers, sanitarians, pharmacists, veterinarians, dietitians, therapists and health services officers who serve in nearly all 50 states and more than 550 locations worldwide.

- provides officers to serve in the **eight agencies of the Public Health Service** (largest number of officers serve in the Indian Health Service, but other PHS agencies, including the National Institutes of Health, the Centers for Disease Control and Prevention, and the Food and Drug Administration, also rely heavily on the Corps), plus non-PHS agencies, including the **U.S. Coast Guard** (whose uniformed medical services are staffed exclusively by Corps members), the **Federal Bureau of Prisons**, the **EPA**, and the **Immigration and Naturalization Service**.

- is one of the seven **uniformed services**, whose members can be called to duty **24 hours a day** to respond to public health crises and emerging needs, and can be **directed** to other duty assignments to accommodate changing public health needs and priorities. In recent years Commissioned Corps officers have been involved in:

  - **leading** the successful **global campaign to eradicate smallpox** (including a massive immunization program);
  - **investigating** and **identifying** the emerging **AIDS epidemic**;
  - **providing clinical services** for Haitian, Cuban and Southeast Asian refugees;
  - **identifying** and **isolating** three separate acute **hemorrhagic fever** viruses (Ebola, Lassa, and Marburg) in Africa;
  - **identifying** and **isolating** the infectious agent responsible for the **Hanta Virus** in the American Southwest;
  - **providing** and **coordinating emergency services**: at the Oklahoma City Federal Building Bombing ('95); during the Alaska ('94), California ('94-'95), Southeast ('94-'95), Midwest ('93-'94), Southwest ('92, '93-'94), Northern Plains States ('97) and Ohio ('98) Floods; following Hurricanes Hugo ('89), Iniki ('92), Andrew ('92) and Georges ('98); in the aftermath of the Loma Prieta ('89) and Northridge ('94) Earthquakes; following the Northeast ice storms ('98); for Kosovar refugees ('99).

- is **administered** and **managed** by the **Surgeon General**, its **uniformed leader**.

TAB A

Emergencies to Which Commissioned Officers Have Responded Since 1989

1989

Loma Prieta Earthquake
Hurricane Hugo
Exxon Valdez

1990

Desert Shield

1992

Desert Storm
Typhoon Zelda
Typhoon Axel
Southwest Flood
Hantavirus
Hurricane Andrew
Hurricane Iniki

1993

Typhoon Omar
Milwaukee Water System
Cuban Neuropathies
Hurricane Emily
Midwest Flood
Southwest Flood

1994

Alaska Floods
Northridge Earthquake
Siberian Oil Fires
Winter Ice Storms
Haitian Immigration
Cuban Interdiction
Rwanda, Africa
California Floods
S.East Floods

1995

Kobe, Japan Earthquake
Tokyo, Japan Gas
Oklahoma City Bomb
Zaire Ebola
Diphtheria/NIS

1997

North Dakota/Minnesota Flood

1998
Northeast Ice Storms
Ohio Flood
Hurricane Georges

1999

Kosovar Refugees

TAB E

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