**U.S. Department of Homeland Security Testimony**

**U.S. House of Representatives**

**Committee on Homeland Security**

**June 6, 2007**

## Introduction

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

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

The story took a rare and unusual turn when the individual chose to travel overseas after the subsequent diagnosis, thus activating the processes to present an isolation order to the individual upon his reentry into the United States. The system created to effect such an isolation order involves the Department of Health and Human Services (HHS), (including its Centers for Disease Control and Prevention (CDC)) acting under the authority of the Public Health Service Act and the Department of Homeland Security (DHS). The system functioned properly in this case. However, there appears to have been a single point of failure in this case -- human error by an individual who may have failed to follow appropriate procedures. DHS continues to investigate this issue. While the investigation is pending, DHS has ensured that the individual is not carrying out inspection duties at the border.

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

The Committee has also expressed its concern, which the Department shares, about the implications of this incident for biodefense at our Nation's borders. We share the genuine concern over the fact that our borders are not impervious to infectious diseases, in spite of the best efforts of the CDC and DHS and its components. Unless draconian health screening techniques are routinely implemented at each port of entry as a standard operating procedure for the millions of people crossing the border, there will always be

opportunities for people who are ill to cross our borders undetected. The land border environment presents additional challenges because individuals claiming U.S. and Canadian citizenship are not always required to present passports that validate identity and citizenship. The Department is committed to addressing this security gap through implementation of the Western Hemisphere Travel Initiative (WHTI). Ultimately, the WHTI will provide technical enablers and controls to mitigate volume issues and ensure that high risk travelers are better identified at our ports of entry. WHTI implementation will enhance the screening process by increasing the number of travelers that can be efficiently queried at the time of entry through the ports of entry based on better documentation, identity and citizenship.

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

**The Incident in Question**

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

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

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

More detailed information can be provided in a classified briefing. However, as a result of this incident, CBP initiated a systems enhancement (effective June 5, 2007) that will help ensure that officers will follow appropriate procedures when processing persons of interest seeking to enter the United States. This systems change will allow CBP to better account for and control all referred persons of interest for secondary inspection. It will also require that such persons undergo additional questioning and examination to

determine whether they may be cleared or whether other appropriate action is warranted. The Department's long-term solution remains a WHTI enabled screening procedure that tackles the inherent problem of increasingly high traffic volume with improved query capabilities.

## Information Sharing – U.S. and Canada

In December 2001, former Secretary of Homeland Security Tom Ridge, then serving as Director of the White House Office of Homeland Security, signed a Smart Border Declaration with the Canadian Deputy Prime Minister. The Declaration set forth a 30-point action plan designed to enhance the security of the United States and Canadian shared border while continuing to facilitate the flow of legitimate travelers and cargo. This action plan resulted in initiatives to share information between the United States and Canada related to air travel, including Advanced Passenger Information/Passenger Name Record (API/PNR) Risk Assessments.

An essential goal of the API/PNR Risk Assessment Initiative is the concentration of inspection resources on high-risk travelers while facilitating the movement of legitimate members of the general traveling population. A risk assessment process evaluates passengers arriving into the United States or Canada.

## Current Health Screening Procedures at Ports of Entry and information Sharing Among CDC, CBP, and other DHS Components

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

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

HHS will consult with DHS to define steps necessary to obtain information expeditiously when either agency believes there is a public health emergency. The Departments agreed to assist one another in informing the traveling public of potential disease threats,

including assisting in the distribution and dissemination of CDC Travel Notices or Health Alert Notices if necessary and as resources permit.

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

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

**Passengers with Potential Public Health Threats and the Commercial Airlines**

Under the Aviation and Transportation Security Act, the Transportation Security Administration (TSA) has broad authority to assess and address threats to transportation and passenger security. Under this authority, TSA can direct airlines to deny boarding to an individual identified by the CDC as a threat; this includes individuals identified by the CDC as a public health threat. Based on the request from CDC/HHS, the Assistant Secretary of Homeland Security at TSA may determine that the presence of such an individual aboard a commercial passenger airline flight poses a threat not only to that flight but to the entire transportation system, should the disease spread to other passengers, flights and flight crews, and other modes of transportation used by those individuals.

TSA has a number of options where a person who poses a public health threat may attempt to use the commercial airline system. In the case of last week's incident, as soon as CDC recognized that the individual may have been attempting to fly on a commercial airliner to enter the United States against their CDC advice, TSA directly contacted the Transportation Security Administration Representatives (TSARs) in Europe and International Principal Security Inspectors (IPSIs) world-wide to inform carriers, embassies, and host

government authorities that the infected individual should not board a commercial flight. TSA also chose to use the existing infrastructure of its watch list system. Given the imminent travel of this infected individual, using the existing process was deemed the most expeditious way to alert the airlines to prevent the individual from boarding. At no time, however, was the infected individual identified as a terrorist. TSA has other means at its disposal to communicate threats to airlines immediately and direct them to implement specific security measures, such as the issuance of a Security Directive.

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

**Conclusion**

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

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

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