FCON COVID-19 Deployment
Oral History Interview
LT David M. Wilkinson, MS

FCON History Committee
FDA History Office
Collaborative Oral History Project
Edited Transcript
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Oral History Abstract

Vanessa Burrows and John Swann from the FDA History Office interviewed Public Health Service Lieutenant David Wilkinson as part of a collaborative oral history project to document the experiences of Public Health Service officers who are in the USPHS Commissioned Corps during the COVID-19 emergency response. LT Wilkinson discussed his deployments as a site safety officer at a COVID testing site in Orlando, FL, in March-April 2020, and as a biomedical engineer at a hospital run by the Indian Health Service in Phoenix, AZ in July-August 2020. LT Wilkinson works for the FDA as a medical device investigator and has prior experience as a bioenvironmental engineer in the Air Force.

Keywords

COVID-19; emergency response; FDA Commissioned Officers Network (FCON); Florida; Indian Health Service (IHS); Public Health Service (PHS); safety officer; community-based testing; biomedical engineering; medical devices

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Glossary

510(k)	Section of the Federal Food, Drug, and Cosmetic Act establishing a premarket notification requirement for medical devices that can demonstrate substantial equivalence to approved products
ACA	Affordable Care Act
ACF	Administration for Children and Families
ACS	Alternative Care Site
AEG	Agency Executive Group
AMSUS	Association of Military Surgeons of the United States
ASPR	Assistant Secretary for Preparedness and Response
ASPR TRACIE	Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange
BARDA	Biomedical Advanced Research and Development Authority
BOP	Bureau of Prisons
BSL Lab	Biological Safety Levels Laboratory
CAP Team	Capital Area Team, U.S. Public Health Service
CAPT	Captain, U.S. Public Health Service (O-6)
CBER	Center for Biologics Evaluation and Research, FDA
CBP	Customs and Border Protection Agency
CBTS	Community-Based Testing Site
CCHQ	Commissioned Corps Headquarters
CDC	Centers for Disease Control and Prevention
CDER	Center for Drug Evaluation and Research, FDA
CDR	Commander, U.S. Public Health Service (O-5)
CDRH	Center for Devices and Radiological Health, FDA
CFSAN	Center for Food Safety and Applied Nutrition, FDA
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CONOPS	Concept of Operations
CPR	Cardiopulmonary Resuscitation
CRAFT	COVID-19 Response Assistance Field Team
CTP	Center for Tobacco Products, FDA
CVM	Center for Veterinary Medicine, FDA
DART	Disaster Assistance Response Team
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DOD	Department of Defense
ECMO	Extracorporeal Membrane Oxygenation cardiovascular life support device
EHO	Environmental Health Officer
EMS	Emergency Medical Services
ER	Emergency Room
ESF	Emergency Support Function, FEMA
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Shelter, FEMA

FOIA	Freedom of Information Act
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIS	Indian Health Services Agency
HRSA	Health Resources and Services Administration
HSIN	Homeland Security Information Network
HSO	Health and Safety Officer
HVAC	Heating, Ventilation and Air Conditioning
ICS	Incident Command System
ICU	Intensive Care Unit
IMG	Incident Management Group
IMT	Incident Management Team
JIC	Joint Information Center
LCDR	Lieutenant Commander, U.S. Public Health Service (O-4)
LT	Lieutenant, U.S. Public Health Service (O-3)
MCAS	Marine Corps Air Station
MD	Medical Doctor
MMU	Monrovia Medical Unit (Liberia Ebola Response)
N95	Particulate filtering facepiece respirator, NIOSH rated "not-resistant to oil" filtering 95% of airborne particles
NCTR	National Center for Toxicological Research, FDA
NDMS	National Disaster Management System
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NIST	National Institute of Standards and Technology
NP	Nurse Practitioner
NPI	National Provider Number
OASH	Office of the Assistant Secretary for Health
OC	Office of the Commissioner, FDA
OFDA	Office of U.S. Foreign Disaster Assistance
OLS	Office of Laboratory Safety, FDA
OMB	Office of Management and Budget
OPDIV	Operating Division
OPM	Office of Personnel Management
ORA	Office of Regulatory Affairs, FDA
OSHA	Occupational Safety and Health Administration
PA	Physician Assistant
PAPR	Powered Air Purifying Respirator
PCR	Polymerase Chain Reaction (test)
PHS	Public Health Service
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RDF	Rapid Deployment Force
RedDOG	Readiness and Deployment Operations Group
RIST	Rapid Incident Support Team, U.S. Public Health Service
RN	Registered Nurse

RT-PCR	Reverse Transcription Polymerase Chain Reaction
SAMSHA	Substance Abuse and Mental Health Services Administration
SAT	Service Access Team/s, U.S. Public Health Service
Sitrep	Situation Reports
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOC	Security Operations Center
SOFR	Safety Officer
SOP	Standard Operating Procedure
TAT	Technical Assistance Team
TDY	Temporary Duty Assignment
TPN	Total Parenteral Nutrition
USACE	Army Corps of Engineers
VA	Veterans Administration

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Interview Transcript

VB: This interview is a contribution to the FDA Commissioned Officers Network and the FDA History Office's collaborative oral history project to document the experiences of commissioned officers in the COVID-19 emergency response. My name is Vanessa Burrows from the FDA History Office.

JS: And this is John Swann, also from the FDA History Office.

VB: And today we are speaking with Lieutenant David Wilkinson. Lieutenant Wilkinson, would you mind briefly introducing yourself?

DW: I am Lieutenant David Wilkinson, with the Public Health Service. I've been with PHS for a little over five years. I'm also a prior Air Force Officer. My position with the Public Health Service, I'm in the Engineer category. I am assigned to the Food and Drug Administration, or FDA, and I work for them as a Medical Device Investigator. For my deployments for Public Health Service, I deploy as a Safety Officer and as an Engineer. When I was in my prior Air Force service, I worked for them as a Bioenvironmental Engineer. I did that for three years. So, that's my brief background.

VB: Excellent. Thank you very much. So, if you wouldn't mind, just very briefly from the outset, would you give us an overview, just general description of the deployments you've

served so far in the COVID-19 response? About what time you were deployed, where to, and what your role was?

DW: Sure. My first deployment was to Orlando, Florida and my role was Site Safety Officer. The mission in Orlando, this deployment was in late March of 2020, ending in mid-April of 2020. It was a little over two weeks for that deployment. The mission there was early on in the pandemic, so our mission was to set up sites to conduct testing of COVID, to see if people were positive or negative for COVID, and the focus at that time was just to test emergency responders, like, fire, police and medical people, and also, then, to test people that were older, like 65 and over or people who had been exposed to someone who was positive. And there were over 200 people on that mission together, deployed there.

There were only two PHS officers at that time, myself as a Safety Officer, and there was also a Captain, or an O6 that was there, and she was an Administrator. And the other people that were deployed there were mostly National Guard from the State of Florida, everybody except for the two PHS officers were all state employees. The goal at the end of about two and half weeks, was to set this site up and then to turn it over to the state. So, when we left, it became a state site funded by FEMA, but we were trying to help them get it started. That's kind of what it was in a nutshell.

VB: And I'm sorry, could you say about what time you were deployed to do this?

DW: Yeah. The exact dates for my deployment were March 28th of 2020 until April 10th or 9th of 2020.

VB: Great, and could you briefly describe your second deployment too?

DW: My second deployment was to Phoenix, Arizona, and that deployment was from about mid-July to about mid-August. It was 33 days total, and that deployment was to Phoenix, and it was Indian Health Service. There was a big hospital there in Phoenix that was run by IHS, or Indian Health Service, and there were 16 PHS officers who deployed there including me. Two of the officers were engineers.

All of us went there to help the hospital because they were short-staffed and they had one of the highest rates in the nation, New Mexico and Arizona, and the Indian reservations there had some of the highest rates in the nation at that time for people testing positive from COVID and from dying from COVID. They had people at that hospital that were leaving or quitting, and they were under-manned anyway, and we even had a few staff at the hospital who had died from COVID, as a result of getting it probably from their patients. So, our job was to go help them out and give them a boost for about a month, and there were two Engineers that were there, myself included.

I worked in Biomedical Engineering, that was my role. The other Engineer worked in Facilities, that's kind of the two areas of engineering that they needed help with, so one did one and one did the other. Getting my background as a Medical Device Investigator for FDA, it would have made more sense to focus on their equipment at their hospital. I spent about a month going all over their hospital, plus their places off-site or around their campus. I looked at over 2,000 pieces of equipment, or medical devices or equipment, just to examine it, focusing mostly on how it was maintained, and was it maintained properly, and how was it stored, and how was it

used, and working with their PM Program, or Preventive Maintenance Program, helping them get that up and running and also helping with their inventory management.

That's kind of what I spent my month there doing. I spent a little bit of time helping their Facility Engineer out as well, just working with him, running ideas by, as far as, like, what to maintain their hospital, because I do have a background in HVAC, and I'm a Mechanical Engineer, and I have a background in HVAC design. So, I and helped with that to, but the vast majority was with Biomedical.

VB: Thank you so much for that. Before we dig into learning more about your COVID-19 deployment, I just wanted to ask you about your experience with past deployments in other public health emergencies. Did you draw on any past experiences in your deployments in 2020 or are there any particularly notable ones you gained important skills or knowledge from that you feel like are worthy of mentioning?

DW: Those were my first two official PHS deployments. I've worked with FDA during hurricanes we've had and I've gone to local facilities with the Food and Drug Administration to check after hurricanes and see if they were impacted because of a hurricane. But those were FDA deployments rather than PHS. As I mentioned, I'm prior Air Force. During my Air Force time, I did not go overseas to deploy, like to Afghanistan or Iraq or elsewhere, but we did, at least once a quarter -- at least every three months, we did exercises for deployments, like putting on gas masks and going to these medical shelters or medical units, some cases the base I was on, other cases I would travel elsewhere around the nation and do drills and exercises.

I also worked with the Coast Guard as a civilian for a number of years between my Air Force and my Public Health Service time. And I worked in Health & Safety in the Coast Guard as well, as well as Facility Engineering, and I didn't deploy with them, but I went to a lot of remote locations with the Coast Guard. And all these kind of factored into my experience of how I managed deployments with PHS.

VB: So, turning to your COVID-19 deployments, could you sort of bring us back to spring of 2020 and tell us how you were first contacted about the deployment to Orlando. What your knowledge of the role you were going to play was and even, maybe, what concerns you had, given the state of the pandemic at that point in time?

DW: I was contacted on a Friday, telling me that I was going to get orders to deploy the next day. I kind of knew because the pandemic was ramping up, that PHS was going to be a big part of it, even before I deployed to Orlando. I knew that since January of 2020, we had PHS officers working on helping with COVID, so I kind of knew it was coming. But I got the official call on the day before saying I was going to go to Orlando and help them out with a testing site at that time, and that I was going to go as a Safety Officer, which is one of my duties with PHS. And that's pretty much when I learned about it. I knew it was there, that one other PHS officer that was going to be there too, that she was going to be my point of contact and I knew that she was already there. I guess - what's the other questions?

VB: Just, if you had any particular concerns, given how pandemic was escalating? And what preparations you had to make, in order to get ready to go and what you were anticipating you were going to do or find when you got there.

DW: This was much earlier in the pandemic, so preparations were simpler at that time. There was probably a lot of fear at that time, because at that time there wasn't much known about this disease, there wasn't much known about how it's spread and especially about how to manage it or treat it if we have it. There were no vaccines, of course, then, for either of my deployments. So there was concern. The rates at that time COVID death rates were still fairly low. They kind of picked up in the summer and became much higher. Whole W's of wash your hands and wear a mask, those became even more critical during my second deployment, but definitely, there was a lot of concern at that time for that. We had a lot of medical staff that were -- I was deployed with, including at least one Medical Doctor on site at all times, that actually I had the same room with and worked closely with, so we knew we had a lot of good people to work with there. So, I guess a lot of unknowns for the first deployment. It was really an unknown time. In later deployment there was a lot more known, we felt more like we knew what we were getting into, the first one we didn't, become more and more of a leap of faith.

JS: Lieutenant Wilkinson, I wonder if, -- you mentioned you heard about this on one day, and you were basically deployed the next day. And you said in January, it looked as though this was going to be something that involved, the Service. Do you recall ever receiving official word, from the PHS that all officers needed to be ready to go on a moment's notice, or was that just something you more or less assumed would be the case?

DW: Kind of both. First of all, there was a general broadcast that, "hey, be ready to go. This is, like, your moment to shine, this is your moment to make a difference." I mean, one of the reasons that I, myself, and I think many PHS officers serve is because this is kind of what we live for. It's like, if you're a firefighter and a house is burning, you kind of train for years to do that and you live for it. This is what I've been trained to do, so when I got the notice I was deploying, I was pretty happy I get to go help with this. Of course, we see that the Public Health Service, we see that our enemy is not, like -- we're not out there fighting people with guns. Our enemy is viruses, and germs, and people getting -- that's the enemy that we fight, and it's an ongoing fight that never ends, because this is just one pandemic but there's diseases around the world. This is a continuous thing since probably as long as humans have been around. But it's kind of a pleasure to be a part of that fight. It's like playing a sport, and you get to go into a game, you're excited to go train and practice, and you're on the bench and you get called in to the game, you're pretty happy to go, even if it's in short notice. But I pretty much expected this was going to happen. And when I got the call, I was pretty excited and pretty happy to do it.

VB: So, when you arrived in Orlando, could you just put us in that time and tell us what your team was like, and how far along the preparations were to create the testing site? Was it inside of a building or was it like a drive-up testing site? Just sort of bring us back to last March and tell us what the task at hand was when you arrived.

DW: When I arrived there, my point of contact was a Senior PHS Officer. I got my orders on a Friday, went out there on a Saturday. Most of the people had gotten there before me, they'd

gotten there Wednesday, about three or four days before I got there and they had already set everything up before I arrived, so that was already in place. The first person I met when I arrived there was, of course, the other PHS Officer, and got briefed from her about what was going on. The next morning, which would be Sunday morning, that's when I went on the site, and that's when I actually saw where everything was and got a really good look.

Actually, the day I got there, I went out there and just drove around. Everything was shut down at that time, it was dark, but I did kind of have a look around just to get an overview of what was going on there and just the site, so I kind of knew what I was getting into on Sunday. But Sunday, I got to see everything, and I met, of course, the PHS Officer again. We followed each other in different cars out there from the hotel.

The location where we deployed to in Orlando was at a big convention center, so we used a lot of the indoor space there for offices and stuff in there. We had these big rooms that we used for operations room and a medical room, and a support staff room. Different rooms had been set up. We had an Incident Commander there that was in charge of the entire incident -- I guess we'd call it the On-Scene Commander who's in charge of that particular site. And, as a Safety Officer, I reported directly to the On-Scene Commander. I was one of the three staff officers who reported to him.

I worked closely with the -- first person I really worked with besides the other PHS Officer was the Chief Medical Officer. I spent one day with him because my focus was health and safety which definitely tied to the medical mission there. And so, I spent a day just traveling in a vehicle with him all over the place and getting to know him and getting to know the site, and what was going on and what the needs were at the site. Getting an idea what the site was like,

the convention center was where a lot of the operations and things were going on in there, from logistics to all the operational stuff. The real work was happening outside.

We had three different areas of the site. The first area was a pre-screening area where the cars would all line up. About 7:00 in the morning, the people there would show up and the guards would pre-screen people. But, from what I heard, people would show up at 3:00 or 4:00 in the morning. There would be cars lined up even hours before we'd open. So, by the time we opened at 7:00, there were already cars going back for a few blocks, quite a long way. So, if you weren't there by 7:00 in the morning, you probably weren't going to get through that day, because there were very few testing sites, and there were a lot of people that wanted to get tested, with very few sites. So that was a pre-screening area.

Once people get to the pre-screening area, they would go to a screening area where they would fill out paperwork with nurses, and they would get checked with a thermometer. Then, once they get to the screening area, then they would go to an actual testing area which was in a parking garage, and that's where they would get the swab up their nose, and they would get a sample, and they would get tested, and that test would go into a cooler, and it would go to a lab, and about three days later they would get results. They didn't have the quick sampling at that time, that didn't exist yet. That's kind of an overview of what the site was like and what I did when I arrived.

VB: So, just curious. You mentioned that there were very few other testing sites around. Can you give us a sense of the general area and people that this site served? How far around Orlando would people come from?

[00:19:50]

DW: I understand, to put it in perspective, in the state of Florida, with a population of around 20-plus million, 22 million people, I think, at that time, we had three testing sites in the state, one in central, one in south, and one in north. Of course, now, there's all kinds of testing sites everywhere. Even the town I live in, we have at least two that I know of that are free to the public. So, now it's really easy, but back then there was very few. So, Orlando is in central Florida, and then Miami's in south Florida, and the north one, I think, was in Jacksonville, which covered northern Florida. So, we served a lot of people from a long way. Some people would drive an hour or more just to get there, but most people were within closer distances. But there wasn't a lot, then, to be tested. There wasn't very many kits out there at that time.

VB: So, this was really one of the first testing services that was available for many Floridians, then, it sounds like. I realize that you were serving in your capacity as a Safety Officer, but I was just wondering, did you have any interactions with the patients that came to be tested or was it more behind the scenes?

DW: I was kinda both, but mostly behind the scenes. I mean, my day-to-day work is, I would spend about three times a day, usually morning, afternoon and evening, I would travel. Before the sites opened up, I was assigned a golf cart with the Safety Officer and I would drive that golf cart around everything. I would make it my goal every morning before they opened up, to check everything, just to put my eyes on everything to see what's going on, and talk to everybody and say how do you feel? How are you doing? Do you have water? When I first got there, they

were missing a lot of things. Hand washing was required but there were a lot of places that were missing hand washing stations. Bathrooms were not close by. There wasn't soap or the sanitizer. And, again, this is in the pandemic, so this maybe wasn't well-known, but those are concerns I have.

Even things like people being able to drink water, and enough to hydrate, and make sure people can take breaks, and those are all concerns and things I would check into, and when I found them, I would put them in a daily safety report and submit it to the On-Scene Commander every day. And I would talk to the people there, and say, "hey, this is what you need," and would try to find things and help them, or "logistics, can you get these things out to people so they can be taken care of?" And they were pretty responsive. I was pretty happy how responsive they were.

I even covered things like not just only the nurses and people on the guard, the people on site, but even the police officers that were out there to control this -- there were cop cars everywhere, just to make sure that nothing crazy would happen, and people wouldn't get out of control. And I remember, one day, I saw a cop car that was disabled, so I went and help the police with their disabled cop car. I didn't think it was part of my duty, but I thought, I can't ignore that, even though the police, at that time, a little bit separately worked with the city or the county government, but it was kind of fun to help them. The car overheated that was kind of an interesting experience.

And I guess, to answer your question about helping people, or working with the patients, we had one incident where we had a person that, was at the screening area and got really sick, and they pretty much called it an emergency, and -- I know that I told you that I worked with the on-scene doctor. Well, the on-scene doctor rushed there to help them, and the ambulance came

and helped as well. So, I didn't deliver first aid to the people, they had plenty of nurses and a doctor to do that, but I did have to do a safety report for the incident that happened and find out what happened, what went wrong, so I had to collect all this information which, as an investigator for the FDA, I feel pretty comfortable doing inspections and investigations of what happened with this person. And they lived and stuff, but I still had to do the safety report. And it was nice to have a doctor on scene, that was pretty helpful. It was actually an ER doctor, so he was pretty on top of it.

VB: So, was this patient -- it wasn't a COVID-related illness, it was something different?

DW: It might have been COVID. It does seem like there was a lot of COVID symptoms. She wasn't tested. Because of the symptoms, she was just taken straight to the hospital.

VB: And I guess that's the end of the story? I mean, you wouldn't have been informed about what they found out at the hospital afterward?

DW: No, I wasn't informed afterward. I was there when she was being treated. I was right beside the doctor and a couple nurses. I was right there the whole time, taking notes and documenting everything that was said and was going on. If I was by myself -- I am basic life support certified. I can do first aid, CPR, I can do that kind of stuff. I'm not a doctor or a nurse. We had those people that were there to do all that work anyway, that are way more knowledgeable than I am, medically, but I just did the safety part. But you're right, once they were in an ambulance and they left the site, I don't know what happened or what their status was.

JS: So, it sounds like the site was really well organized. I gather, then, that the people there to get tested followed directions? There were really no substantial problems that you noticed, as far as moving the people through the process and so on, right?

DW: It was not really a big problem. One of the challenges I had, actually, as a Safety Officer was that the CDC, or Centers for Disease Control and Prevention, has these recommendations for how you're supposed [to put] your PPE on. PPE is Personal Protective Equipment, like face shields, masks, or N95 masks, aprons. And the people that are doing these screening -- the nurses are doing that, and I would observe them very carefully to see how they were putting this on, or how they were donning and doffing them, taking them on or putting them on and taking them off. And I did notice that among the nurses that were there, some of them were really good at putting this stuff on and off, they had it down to an art. You can tell they worked in this type of environment because they were very good at it, and they were very quick at it. I observed the doctor doing it, and he was probably the fastest one I've seen of all. The ER docs, they put the stuff on just within a few seconds and do it very well.

I did notice that some of the nurses there didn't know how to do it at all, they would do it backwards, they would do it in the wrong order, they would take it off and not wash their hands after. I just found a lot of -- I found problems with a small number of the nurses that were there, but one of my main objectives when I was there was to bring things to their attention of the head nurses, and of the On-Scene Commander, and have -- I gave briefings on here's how to don and doff it correctly, and demonstrations on how it's supposed to be done, and make sure you wash your hands and do all these things you're supposed to do. And there was a little bit of challenge

in getting a few of them to do it. And I was pretty much told by the On-Scene Commander that if I would report people that were not following the procedure that I directed them to do, that he would fire them on the spot.

Anyways, that wasn't necessary, even the ones that struggled with it, they ended up getting it down and it didn't become an issue that had to be addressed in that way. That was one of the challenges of a Safety Officer, because at that time we didn't want to transmit the disease, because if one of the nurses was seeing the patients, and then they got the virus, that can spread like wildfire among all those responders. So, we were really nervous that that would be like a weak link in our armor that would get through. As far as I know, when all of us left, not one of us tested positive, as far as I know, for the virus. I think we did good at not getting sick even though we were exposed to sick patients. So, at the end of the day, it was -- had good outcomes and I was like -- as a Safety Officer, that's one of my biggest concerns, was that we're not going to be careful enough or we're going to get the virus. So, I was all over that.

JS: Was it your sense that the site was more than adequately prepared with PPE? That you didn't have to go around re-using, or anything like that?

DW: That was a concern, and I worked with logistics and I talked to the other PHS Officer, she was an administrator, so she was actually in charge of making sure they had all the money, all the equipment, everything we needed, and I followed it pretty closely. There was never a time that we ran out of it, that was never an issue, we always had enough. But we definitely kept close tabs on it to make sure we didn't run out of it, and we'd try to be careful with not overusing it, which is something else I would actually talk to them about. I saw some people that would

take it off [too quickly], and they would use it once, and they would just toss it right away, where the procedure didn't call for that. They were too careful, in some cases. And I would bring up concerns, saying, "hey, I don't want to run out of it because it could become a safety issue later if you're not careful, don't overuse it when you don't need it." But we never ran out of it, thankful we had enough for all the staff that needed it.

VB: So, Lieutenant Wilkinson, could you walk us through what the interactions with patients were like at the testing site? And in particular, I mean, you mentioned this one patient that might have, in fact, been symptomatic with COVID. What happened when a patient would arrive at the testing site, demonstrating symptoms? I mean, if they were not obviously, warranting calling an ambulance, what was the procedure for referring the patient that maybe seemed to be symptomatic with COVID?

DW: The procedure was, if a person was symptomatic, then they were supposed to go to a hospital. The assumption was, at that time, is if you were symptomatic, you were assumed positive and [needed to] go get treated and go get taken care of. The rates, at that time were not very high in March and April. [Later] in 2020, they got a lot higher later, but again, the assumption was, if you're symptomatic, then you go get treated. That was the only patient that I was aware that was positive.

I guess some other interesting thing was that we were really careful about who we would see in the pre-screening area. So, people would come there and try to get pre-screened, and of course it was, like, for fire fighters, police, you know, doctors or older people, but we had some people that would try to get pre-screened that would not meet those criteria, and they would get

turned away. And sometimes they could be in line for two or three hours and then, finally, they get pre-screened, and they're told, you know, you don't meet the criteria, you can't get tested. And people, once in a while, would get pretty upset and not be too happy – "you didn't tell me earlier what you actually posted," and the rule that people would try to come anyway. And I guess we had police and we had National Guard (though the nurses were the one to do the screening), but some [patients] weren't too happy with what they were told, and they were escorted off by police in a few cases. That wasn't my job, that's stuff I got to observe or see.

VB: I could imagine, after waiting for hours, them voicing frustrations and I'm sure that was not a pleasant scene.

DW: The National Guard provided most of the bodies, or most of the people to run the place, but they didn't want to the Guard being the ones to tell them you can't come. So they had the civilians do all that, just to tell them they didn't pass the pre-screen, they've got to leave, unless they got upset, but then they weren't equipped to handle angry people, but that's when then the Guard or the police would step in and do that. We also had a few people that would come -- people were supposed to be bringing in cars only, and I know one guy I saw that went through on a motorcycle which was a bit awkward. Or people that had these convertibles and things, that weren't supposed to go through, but –

VB: Did they have to be turned away?

DW: We equipped them -- we gave them face masks. We didn't want to turn those people away. We found a workaround, gave them a face mask, face shield. Guess it was using up a little of our PPE, but it addressed the safety issue without having to turn them away, because they met all the other requirements. But, in some cases --

VB: So, in general, was it your sense that people who came for testing, did they need to be tested in order to report for work, or to travel, or things like that? Were they skeptical of the epidemic at that point, or were they practicing the common-sense public health measures? I realize this was quite early in the pandemic, and perhaps it wasn't common practice yet to wear masks, and so forth, but, just curious what sort of clientele came?

DW: You're referring to the people who came for testing, right, rather than the responders?

VB: Yeah. The people who came for testing.

DW: I mentioned a few cases that were kind of maybe upset and angry, but those were the exception. I mean, I think 99 percent of the people that came were very compliant. Wasn't much of a problem. We also had people that would come there (I guess, as a point of interest) that would not speak English, that would speak Portuguese, or speak Russian, or speak Spanish -- mostly Spanish, but we had other languages, too. And they would get communicated with. We had nurses there, or others that would be able to translate safety messages and that went pretty smoothly, that wasn't an issue either.

VB: So, you referenced the Incident Commander a couple of times, and I'm taking that as an indication that you were following the incident command structure in the chain of duty or chain of command. But the fact that there were so many National Guardsmen and mixed with, I'm assuming, also, maybe some local, officials or, staff. Was the reporting structure very clear? Did it work smoothly? Was there any confusion about who to bring questions to or who was to report to whom?

DW: It was simple, and it was I think it was effective. Yeah, we ran the full ICS system. We had an On-Scene Commander that was the guy in charge where I was deployed, it involved 200-plus of us. We had the same type of setup in Miami, and Jacksonville, and all around the nation, so that's how the whole incident was, like, at Washington D.C. headquarters level. So we had one person -- I never met that person, but whoever they were, they were in headquarters, and they ran all the sites. But the person in charge of our site was running it, and every morning we had a meeting after I started working there.

I started, probably, at 6:00, 7:00 in the morning, I was there pretty early on. Pretty much, before the sun came up, I was already working, as well as many other people who were already working. But about, maybe 8:30 in the morning, 9:00 in the morning, we'd have a meeting every day with all the Section Chiefs and all the general staff. In other words, [under] the ICS system everybody would meet there. This was a unified command, so we had not only federal and state, but we had local police and we had other people that would come in and join our meetings every day.

But the lines of communication were -- I think they were pretty clear, especially as far as the ICS system goes. It wasn't much confusion. And I guess I had an advantage, though,

because as a Safety Officer, I reported directly to the On-Scene Commander, so I had access to everybody pretty easily and I was pretty mobile. I was all over the place. I would work with logistics, I'd work with operations, I worked with medical, I was pretty mobile, I got around quite a bit, so it wasn't much of a problem from where I sat or what position I worked in.

VB: Well, that's good to hear. It does sound like the processes and the reporting structures that you guys put into place seemed to work really effectively, and I imagine really empowered the site to meet the need. I wanted to shift, if it's okay with you, to talking about your second deployment and back to the question about how you found out that you were going to be deploying to Phoenix, and how you prepared for your departure, and moving away from your FDA role to your emergency response role, and what you understood what your duties were going to be in the Phoenix deployment?

[00:40:00]

DW: My Phoenix deployment, I got a little more notice, I guess, but a call saying, "hey, you're probably going to deploy out of the area soon." I lived in Florida, this was in Arizona, so the actual orders came a day before I deployed again, but, again, I kind of had some heads up with saying you're probably going to be leaving soon. I knew I was going to go as an engineer, but I didn't know where I was going to be working. I knew I was going to be an engineer at a hospital, but I didn't know what I was going to be doing there or who I was deploying with. I did get a few contact people.

Anyways, the next day, I went out there, it was on a Saturday. I flew to Phoenix in July to deploy. Checked into a hotel, which, actually, unlike my first deployment which went a lot smoother, the second deployment was a little more of a headache in the beginning because the hotel on my orders -- they said, here's your orders, here's your plane tickets, here's your rental, here's all your information, your hotel where you're going to stay at. And then while I was on the plane, they changed my hotel. So, by the time I actually arrived there they had my hotel all changed and I didn't have access to my government computer, and that's where my new orders were, and so I checked into the wrong hotel. The hotel that I went to, they actually said, "oh, your reservations were cancelled." I said, "well, I'm not cancelling." It was like 11:00, close to midnight that I got the hotel. So, I didn't want to go find another hotel to be in, so I figured I'll just go here for a night, no problem, and figure out the next day.

When I got to Phoenix, by the way, it was interesting. I came to Phoenix, and when I got off the plane, it just got dark, and when I got off the plane it was 116 degrees Fahrenheit out. So, it was very hot outside, even in the dark. Like, oh boy, this is going to be a hot deployment. Anyways, going back, when I checked into the hotel. The next day, on a Sunday, I contacted another one of my contacts to find out, okay, you went to the wrong hotel, you should have gone to the other hotel, and this was another PHS Officer, and she came and picked me up and helped me get moved over to the correct hotel, which went smoothly. The hotel, of course, charged me for the one night I was there. I got to the correct hotel, and they said you missed your check-in, you didn't tell us you weren't coming, so they wanted to charge me for that extra night. So, I was going to be in a situation where I was going to get charged for two different hotels for the same night. Luckily, the second one I moved into, they just said, well, you went to the wrong

hotel, it was just a mix-up, so I didn't get double charged, so they worked that out, so I was glad for that.

But, once I got moved over, I guess that Monday morning I went to the hospital and did my in-briefing and all my check-in work there to get my, like, ID cards and get my temporary passports to get logged on to the Indian Health Service computer system. Sunday, I spent the day just figuring out logistics, where I'm supposed to go, and meeting different people I'm supposed to meet. Now, my other Engineer, we talked, and we were together. I got there on a Saturday night. Some people got there on a Sunday. Some people got there different times. Some people got there before I did, so we got there at different times. But, again, they were a really good team of people to work with. There were 16 of us, and we all worked pretty closely together and seemed to really enjoy working together, and I was thankful for their help in getting logistical stuff figured out. It was definitely a good group of people that really helped each other out.

VB: Was your team pretty consistent during your entire deployment, or did people rotate on and off while you were there?

DW: All 16 of us were there the entire 30-something days, we didn't change anybody out. Nice thing about that is you get to know people, and you get to work with them, and the longer you work together, the easier and easier it gets. You know all the people, you know what they're doing, and you know who to go to, it was pretty convenient. When we finished our 30-plus days, they brought in a whole new team of people, so all of us left and every one of us was replaced. They brought in 16 new people that replaced us, so we had, like, one day to overlap each other so

the 16 of us left and then 16 new people came in and we did the transition to them, to our successors. So, we had a day to do that, and we were the first group to go there. We had no predecessors. There was no PHS officers there before we were, so we started a new mission.

JS: So, during this transition period of one day, was that sufficient time to convey to those who were relieving all of you, you know, the information they needed to start their deployment as efficiently as possible, or was there just not enough time to do that?

DW: I thought it was adequate. I mean you get to meet and greet people, you get to see them, you got to brief them and saying what was going on, and give them any inside information -- not just only the work you're doing here, like, "yeah, I know a good place to eat around here," "I know the dining hall," "you get 10 meals and you saved money because you're getting a 10 meal ticket," "here's a restaurant or a shopping mall here if you want anything." Logistical stuff like that can be really helpful, passing to them, as well as, of course, all the information about the site you're on or the job you're doing. I guess there's never enough time. If you had a week that'd be better, but I thought a day was at least okay to get the basic information across.

I guess a difference too, is we were embedded with the other hospital staffs. I worked in biomedical engineering, so we had one leader of that group that was in the hospital that was a civilian, and we had five technicians that worked there that ran the day-to-day stuff. I went there to do special projects. And, likewise, we had an Engineer Commander, actually a PHS Officer who was there as an O-5 (as a Commander), to run the entire engineering and logistics of the hospital. But we all went there to help them out, and just to kind of plug into what they were doing, and do things that they couldn't take on, and kind of had to do some extra work.

So, a part of the transition wasn't just that they were the people at the hospital, they didn't leave, they stayed. So, just the PHS officers that were coming and going, we came and left. If it was more, if we were running the whole show, then I would say a day would not have been long enough. But because of the people, the many civilians that were staying behind that were providing the continuity, I think that made a big difference. Otherwise, we would have needed more than a day if we were having to run everything. Like, in the Air Force, you have longer than a day to overlap people, you usually have up to a week, at least a few days when in that case, you're talking 100 percent turnover.

VB: So, you, had mentioned before that you knew before arriving in Phoenix that this was one of the hardest hit areas in the country, and that this particular hospital had lost staff, both to attrition and to death. What was the morale like? How were the hospital staff feeling when you arrived?

DW: They seemed pretty happy that they were getting help, because they seemed undermanned and overwhelmed. I know going back to your last one. I went all over the hospital, including the areas that had COVID patients. I went in COVID rooms several times to look at their equipment and in some cases look at the stuff in the rooms, but I think morale was good. I mean, people were nervous, they were busy, they were tired, but we had a mission to do, too. This was a time of need, we had to get it done. So, I think, in some ways when you had these tough circumstances, that can kind of draw people together. In some ways it increases morale.

I know, in my Air Force experience, when you're deployed, and it was all drills and exercises, but the saying is, when you're in a fight or you're in a battle, all of a sudden you become really close to people really fast. You know, when you're in a foxhole with someone or it doesn't seem to matter who you're with, you just become real close to people real quick and your morale can get real high because that's what you're trained to do. Now, in the case of PHS, it's kind of the same thing, though you're kind of excited to do what you're doing and you're happy to be there. I think the people I worked with, they were happy to have me there and excited to try to do our job to keep people safe. All of us, we were pretty much -- we have pretty good health. I think if I got COVID, I might get hospitalized but it'd be unlikely I would die -- I mean, I could, but the people we were most concerned with are the people that have a lot of medical conditions and medical issues, or that were much older, because those are the people that are mostly dying from this, and those are the people who we mostly wanted to protect. And many of the patients in the hospital were in that position, and those are the people who we really were there to help, and there was some risk that just comes with the job.

VB: So, when you guys arrived, did you feel like -- other than the sense of relief and, that the hospital staff obviously had with your support -- did they have a good understanding of the role that you guys were going to play, or how you were going to work together once your team arrived?

DW: Kind of both. They kind of generally knew what we were there for. But I think with all the officers that came to help, it kind of was dependent on what our skillsets were, and our past experience was. I think their initial intention was -- when the two engineers were there, that we

would both help with facility, I think was their initial intention. But once we got there and they kind of did a quick interview and saying, "what's your background, what are your skills, what are your experiences"? And they learned that I had worked with medical devices with the Food and Drug Administration, and that was my background, then they knew they had a need in biomedical, and that's where they put me. And biomedical was still another overall engineering group, so I was still under the same commander that was there, but they kind of put you where your skills best fit in because they had a lot of needs. They could have brought four engineers there and they could have put us all to work full-time, no problem. There were plenty of things to do.

So they just tried to match us best where our skills fit in, but it was very easy to find things to do. There was lots of work to do. We were usually there early and stayed late, and would go home and try to get more things done (inaudible - 00:53:10). We were there, and I guess working hard makes the time go by quicker, plus you can make a bigger difference. So, morale was high, I think, especially with the PHS officers that were employed there, and the staff seemed happy we were there, and they kind of knew how we'd fit in. They were quite welcoming.

I was a little bit nervous when I went there that I would walk around the hospital and people would think I don't belong here. I was nervous that that could happen. I experienced none of that. Everywhere I went, people were, like, "oh, thank you for coming, thank you for helping us, thank you for deploying here," and they were really very, very good to work with. I'm very grateful. I didn't know it'd be that nice, but it worked out pretty well. I guess when you have a common enemy -- which, in this case, is the virus, you know -- it draws people

together really quick, and they were really friendly there too, so it was a pretty good experience in that regard.

VB: So, you mentioned that there was plenty of work to be done. How much input or decision making were you allowed in determining what work needed to be done? Did you get to identify rooms or types of equipment that you should target, or were you instructed where to concentrate? How did that work out?

DW: Kind of both. When the overall commander of this unit gave me -- saying, "hey, I got a lot of need in bio, we've got a lot of equipment," that's because they were way understaffed, and they said that they knew that their equipment wasn't being maintained properly, it was out of calibration, even their inventory was off. They needed to get a handle on it, and they said, just help me out in this area, and they kind of gave me general guidance of what to do, but they had a lot of other things on their plate too. If I went there and they had to spend their whole time babysitting me, I wouldn't have been much good to them. So, they gave me just general directions and said, " you do what you; just help any way you can," and I did.

So, I pretty much did their main thing they wanted done, which is they wanted an inventory of all their equipment, they wanted that for sure. They wanted a clear handle on their inventory because what they had was off, they didn't know what they had. And so, I got their main objective done. But while I was there, I kind of took it upon myself to look at the PM, the Preventive Maintenance thing. While I'm there, I'm just going to see if the PMs being done. In most cases it was, and some cases it was not done, and their equipment could be out of calibration, or it was just not maintained properly. In some cases, it wasn't stored properly.

Also, I got copies of their manuals. I would look at their manuals and say, okay, what does their manual say has got to be done? Because then looking at their manual versus their actual PM program, because their PM program directions said check every six months, but their manuals might say check every two years, and I'd bring them and was saying, "hey, you said check every six months, you guys are checking it way more often than you need to." Or, in some cases, they would check it too infrequently. So, depending on what I'd find, I'd look for the things and see what else could be done.

JS: As you mentioned earlier in the interview, you were looking at quite a lot of equipment here at the hospital. So, in addition to your inventory work, I'm curious if you encountered many issues, even serious issues with day-to-day equipment that the staff depended on and if so, what kind of solutions were needed to be arranged to address those things?

DW: I didn't find anything that, like, was malfunctioning -- I think, if it was malfunctioning, that the people there would have or should have known it was not working. I didn't run into that too much. If stuff was out of calibration, if I found things that were out of calibration -- every day I would bring a list once a day to the guy in charge of that biomedical engineering unit, and saying, "look, here's the equipment I found out of calibration." If it was way out of calibration, I would just tell him immediately -- especially if it was a more critical piece of equipment -- or I wouldn't wait 'til the end of the day, I would just say "this is out of calibration, you need to fix it or need to calibrate it." And of course, I would tell the nurses on staff that were using the equipment, saying this is out of calibration, you probably want to not use this unless that's all

you have. Just be aware, it might not give you a correct reading. So, I'd tell them right away or at least at the end of the day.

Probably a bigger concern I had was, sometimes their equipment was not stored very well. They would kind of put it in closets. It was pretty crowded. It was an old building and they would have old bathrooms or an old closets and would sometimes they would shove things in there -- which cannot be a good way to store equipment -- and I would bring that to their attention too which I think was helpful. I don't think it's a problem with the people willingly not taking care of it, just that, it was understaffed, to say it that way, and people were pretty busy there. But I found people to be very cooperative and very helpful to work with, I was thankful for that. When I brought things to peoples' attention, they took constructive criticism very well. I never had an issue with bringing something up and they would get mad about it, I never had that happen. They would take the constructive criticism pretty well and they would fix it, or put tags on it, or take care of it. And, again, they were pretty helpful that someone was actually out there looking and paying attention to all this.

JS: Yeah. Well, I guess, a well-functioning HVAC system is important anytime, but particularly at a time like this, with the situation you were in. I know you addressed that on your own, on what did you find with that? And were there tweaks or more substantial changes that needed to be made to improve its performance?

[00:59:50]

DW: That was probably the more urgent of the issues, actually, was the HVAC systems. I was involved a little bit of it. As I mentioned earlier in the interview, I'm a mechanical engineer, and my focus for my bachelor's degree was HVAC systems, thermal flow systems. My master's degree was also air quality management, so very much HVAC-related, so I have a lot of education in that area, and I've worked with an industrial hygienist as well, so this is something I've done before and part of my work history. The other guy I was deployed with, the other engineer that was with me, he was also an HVAC engineer too, so our backgrounds were actually similar in that regard. We actually drove together, I worked very closely with him every day. We came and left together, we drove to and from the clinic together, we met after hours, we talked throughout the day and he focused only on facilities and I focused mostly on -- but I'd run stuff by him sometimes too, as far as their HVAC systems.

And this was a really old building, and we found some problems with their HVACs, like where their intakes and exhausts were -- like, when you put an exhaust right next to an intake, that's not a good thing to do. In some cases, their rooms weren't ventilated properly, and there were some big issues, and we'd find some workarounds, at least temporary workarounds. And the other engineer, he actually had a P License -- a Professional Engineering License -- and he actually did some designs pretty much laid out, "here's a redesign you can do to fix your mechanical systems," but that wasn't something we had in our timeframe, we couldn't within a month, go to a contract and hire a place to do that, but he got things ready to make those changes and he mostly found the temporary workaround to try to make it safer. But there were concerns with that building. It needed some adjustments and changes.

VB: So, not to shift back to talking about the equipment in the hospital but, you mentioned that they've, in some cases struggled to maintain the equipment for lack of sufficient staff. Did they have enough equipment? Were they lacking any critical pieces of equipment? I mean, I know earlier last spring, there was a lot of concern about lack of ventilators and considering how hard-hit this area was, I'm wondering, did they have a sufficient number of ventilators for patients in the hospital or any other medical devices that were necessary to treat COVID patients?

DW: My concern was not with the lack of equipment. My concern was just the opposite, with too much equipment. They had too much stuff, and they wouldn't track it, or record it. Having too much of a good thing could be not good, because then you don't take care of what you got. Or you have old stuff that's kind of outdated and obsolete, and you really need to excess it and get rid of it, and get it out of your inventory, and toss it, and so that was a bigger concern than having too little of it.

I didn't run across anything where I thought they were missing equipment, or missing ventilators. I didn't seem to be a problem at the hospital. I think their most critical equipment, they definitely took a lot better care of. But, I guess, to credit their on-site people, they seemed to prioritize things like ventilators, that are most critical things. I never ran into problems with the maintenance of those things. They prioritized and took the best care of those. The lesser important stuff, they didn't. That was stuff that more fell through the cracks, or they get too much of it and that was one of the problems. But thankfully, their ventilators worked well, as far as I could see.

VB: Well, that's good to hear. You had mentioned earlier that you in some cases, conducting the inventory or doing equipment inspections, you had to enter rooms with patients that were sick with COVID. That must have been concerning. Did you have any interactions with patients in general or were your interactions largely with the hospital staff and your team?

DW: Mostly with the team. There was some with hospital staff, too. Usually I would work with the Lead Nurse on whatever floor I was on, or whatever area I was in, I would contact the Lead Nurse and I worked with the Lead Nurse. Some cases, I worked with the Respiratory Therapist or Physical Therapist. In some cases, the places weren't run by nurses, they were run by some kind of specialist, and I'd work with that specialist. I tried to avoid interacting with the patients, just because I didn't want to scare them, you know? I didn't want to come in there and stress them or make them scared. It's like people that come in and clean their room, like those people that come in as janitors and they clean the rooms, they don't interact with patients, they just go in there and clean the room, and do their job and leave. I tried to make myself as invisible as I could, to the patients so I don't add any more -- I would see their nurses and doctors, I'd be working with them. I'd be in there, and the doctors are talking to them, but I didn't get involved in their patient care and try to insert myself there, at least, as little as little as possible.

VB: So, I wonder, I mean, one of the things that strikes me as remarkable about PHS officers is their ability to do what's needed in a particular situation. And so, here we have, in your case, in March and April, you're playing the role of this safety officer at a testing facility and then, a couple months later, you're playing the role of a biomedical engineer in a hospital. And I think

particularly in a situation where it calls for all hands-on deck and pitching in wherever you can, I'm really curious how you shift hats from playing that one role to playing a different role. Do you have any tricks to doing that, or is it a challenge or, does it come naturally? Just curious about how you are able to move fluidly between your different roles.

DW: I think it's a mindset. Whatever job, or career, or background that gives you special skills or abilities, and it's good to utilize those whenever possible, but I think it's a mindset to say that you're there to help, and you're there to make a difference, and whatever that is, you do it. If the need is engineering or safety, then you do it. If it means to get a broom and sweep the floor, you do it. You know, it's whatever needs to be done. So, I think a lot of it is the mindset.

I guess, going back, again, to my prior Air Force time, that's what they put in their heads really well, too. You're an Air Force officer, whatever needs to be done is your job. And I deployed into hospitals in the Air Force, and we'd do these drills like mass casualty drills, and I'm there as an Engineer for Health and Safety, Industrial Hygiene, working in this field hospital in the Air Force, and they'd do a mass casualty drill. I'm not there as a medical provider, I'm not there as a nurse or a doctor, or anything like that. And all of a sudden they say, "this is an emergency, all hands on deck," and all of sudden, my engineering roles don't even matter anymore. Some physician would say "here's some splints, this guy's got a broken arm, put him in a splint." "Here, I've got to put this guy on a surgery bed, carry this guy on a litter and move him to a surgery room and, help unload him, or help this person move." I even had jobs where I would have to log people into the hospital, and figuring out what their blood types were, what their ages were, so we can track who was in the hospital.

I know, one time, I was called to do security for a -- I'm not a security person, but it's like, "okay, now you're the police for the hospital." Then they had a drill where guy went nuts in this hospital I was in, on purpose. He was doing an acting role. And we had this guy that was Special Forces doing training with us, and all of a sudden, he purposely went nuts in ballistics, and started to cause all kinds of chaos. I remember apprehending him. Me and the other office security person apprehended him, each grabbed this guy's arm, and said okay, you're coming with us, we're going to escort you out. The guy was kind of a small dude, but, boy, this guy was strong, and he threw us off like two ragdolls. And then, two more people came that were security, so now there was four of us jumping this one guy to try to tackle him, he threw all four of us off like ragdolls, like, who is this person? And then we run after him and wrestled him to the ground and ended up subduing him. He kind of let us, I think, because, again, this guy's a Special Forces. He's a Pararescue, which is like the Air Force Special Forces, but the point I learned from all my Air Force drills was, you go there, and you do whatever needs to be done, and if it's outside of my field, it's outside of my field.

And that same thing applies for PHS training. I deployed with an O-6, was my first deployment. It was a captain, which is an O-6 and it's a high rank in the Public Health Service, and I remember working with her and she was an Administrator. She had a lot of high-level duties, but there were days where she'd be out with the logistics people, doing inventory, you know, and just physically counting numbers of devices. It needed to be done, and she was a body, and she went and did it. So, I saw examples of people I deployed with too, that had that same mindset that the Air Force had, that's all the same mindset for any uniformed services. You just go there, and there's a job to be done and you do it. It doesn't matter your rank, doesn't

matter your background, and if you have the ability to do it, then go do it, if possible. Hopefully that kind of answers your question.

VB: Absolutely and thank you. Actually, thank you for providing the examples from your pre-PHS days, too. So, I wanted to ask your first deployment was pretty early on in the emergency response, and your second one was during a pretty stressful time after one of the first major spikes at the beginning of last summer. And, of course, the pandemic has changed significantly since then, but as someone who was on the front lines in the response, I was just wondering if you could offer any reflections on how the response changed from your first deployment to your second deployment, or even since then? And just anything that particularly stood out to you about if there was anything different about the nature of the response, or about your fellow officers, so on and so forth.

DW: Well, early on in the pandemic, you didn't know what was going on, and it was a lot more uncertainty, and that made it, I guess, more challenging because you just couldn't tell what you were getting into. It's like, the second deployment, we had a lot more certainty to it, but it was scarier in the sense that the numbers were way higher than they were for the first deployment, and that made it tough. Also, weather didn't help any either. When you're deploying and, you know, Phoenix in mid-July, you're dealing with very hot weather, and that added quite a challenge sometimes. So, weather can become a factor.

I'd love to deploy again. If I had a chance, I'd be quite happy to stick my hand up and volunteer and go out there again. But it'd be different now, the rates are coming down, we've got immunizations now, we have a little better treatments than we did before, we have a better

understanding of it. So, it'd be a more comfortable position to deploy now, in the sense of just having that knowledge and stuff and make it a little bit easier. But I guess I was in a situation in that you've got a job and you go do it. It's why we wear a uniform, and why we do what we do, and it's pretty fun.

VB: You've got me worried about Phoenix now. I'm sure you've seen bad heat in Florida, and if it was that much worse than Phoenix, I'd hate to know what that feels like. Aside from the weather, based on your experiences, can you compare what the response seemed like? And I realize that they're very different settings – in a community testing facility and then in hospital. But, can you offer us some insight into what you noticed that was different about the pandemic or the response to the pandemic in Florida versus Arizona? Just to help us get a view of what it was like around the country?

DW: Well, the people I worked with in Florida were first responders -- fire, police, medical that were generally young and healthy. We also had people come there that were older at that response, but it was mostly the responders, primarily. The place in Phoenix was definitely different in the sense that it was the Indian Health Service, they can serve Native Americans from anywhere in the country. But the primary native tribe is the Navajo Nation within the Phoenix area, although they'll treat anybody from any tribe, but it's primarily the Navajo Nation that get treated there. And the people I worked with in that Indian Health Service hospital were and the people that came in there as patients were mostly older people that were pretty sick, and I guess my heart went out to them.

You see I was in this hospital, working and seeing people in these patient rooms, and they're struggling to breathe, and they're on these respirators, they're really having trouble, and people die every day. It's the reality. And, at that time, too, you couldn't have any visitors. You know the people that go in these hospitals, and they're very sick, and some cases, they're dying or they could die anytime, but their family and friends can't come and visit them. I'd be in there with them, but I couldn't do what their family couldn't do, it's kind of really awkward that here's a stranger in there, checking their equipment in their room, but their spouse or their kids couldn't come in there. And my heart really went out to them.

So, it was a lot more sobering feeling. I guess it became a lot more real compared to the first deployment. Other than that person I told you went to the ambulance, I think she was okay, I don't think it was life-threatening as far as I could tell and as far as the ER doctor I worked with that respond -- probably wasn't life threatening. That's probably the closest I really came to being pretty shaky and nervous, thinking I don't want this person to get hurt, but they were probably fine. But I worked in the Phoenix hospital, and it was a lot more sobering to know that these people you're working with, some of them could die, and they definitely were struggling, and it was a very sobering experience.

JS: When you were in Phoenix, were some members of the staff still testing positive for COVID? Was it spreading to the staff still, or had that been more prior to your arrival?

DW: Both. When I was there, the primary, or the most staff tested positive was emergency room. I spent at least a handful of days in the emergency room, and there were staff within that area that were positive. So it was very real. Not only the patients, but even the staff people there

were testing, too. That was kind of scary, just to know which coworker you're with could be sick or could get you sick. So, yeah, they were testing positive. And I told you a few had died.

VB: It must have been really upsetting and hyper real to be in that context. You know, most of us have this experience of the pandemic where we're very isolated. We know that the hospitals were overwhelmed, and that there's obviously an extreme, loss of life over the last 14 months but to be there and witnessing it must have been a very heavy and sobering experience, particularly watching emergency responders contract the virus. It must have been very upsetting.

DW: It's like there was all these drills and exercise, like, with the Air Force. The Air Force, I did many drills, and in Public Health Service you do some, but you say exercise, exercise, exercise. Like, they might say, in the Air Force, a dirty bomb just went off, or a chemical weapon just hit, and they'll say exercise, exercise. Just saying it, when you say exercise, it means it didn't really happen, but you had to act as if it did happen. And of course, they always tell you, when you exercise, you play it as if it's real, as if it really happened, you've got to play it that way, because how you exercise is how you'll do it when it really happens.

[01:20:00]

You know, if you're sloppy in exercise, you'll be sloppy when it really does happen. But still, you know it's an exercise. You know you're not getting exposed to real radiation because it's just an exercise. Even when you pretend like it is, you put all your gear on, you do your response as if it really was. But when it's the real thing -- like, when I was in the Phoenix

hospital -- it's not an exercise, it's not some drill, it's the real, actual thing. And these people that you're working with are not some actors, they're not some people that are role playing it, it's the real thing. It's like I said, it's sobering. It wakes you up and it really helps you see the importance of what you do, and definitely take it very seriously. But it's my pleasure to do it. I think pretty much any PHS officer would be quite happy to do what they do and be there in the fight or the game. You're happy to be there doing what you can to help. If it saves even one life or helps one person, it makes all the difference.

VB: And I'm sure that the staff at the hospital were extremely appreciative of you being there and helping out. I'm just curious, you know the protracted nature of this response and just the sheer frightening nature of the disease and so forth, we know that it's created a mental health toll both for patients and for responders, and that the Corps has provided, in certain instances, mental health services to officers and also provisioned or rostered mental health professionals, in different roles, in different locations. And I was just wondering, were there any mental health professionals that were assigned to the post in Phoenix or, on the other side of that, were you aware of any mental health services available to officers on your team?

DW: No, but we have what's called Corps Care, and Corps Care takes care of any officers that are deployed anywhere, not just for the COVID but for anything you're deployed for, they'll help you, whether it's mental or physical health, they'll take care of you and they'll reach out to you. So that resource was always available. Among the 16 people that I deployed with when I went to Phoenix, I think there was four people that were focused on mental health. Their mission wasn't to take care of the officers that deployed, their mission was to provide mental

health for the patients that came into the hospital. So, people of different backgrounds came in there, and I told you that were two engineers, there were four people that were mental health, so we had different people of various backgrounds.

And as I said, we met as a group. The other engineer and I, we met at least twice a day, even three or four times -- we'd meet throughout the day or at least a couple times a day. As an entire group, we'd meet usually at least once a day, and every evening at the end of our work shift we'd all go to this courtyard area in the hotel where we all stayed, and we'd all have one big meeting with all 16 of us together -- or most of us, because some people had worked different shifts, they'd work a night shift. And so, we -- as many of us could get together, we'd get together on a -- in the evening and just talk about our day, and talk about what's going on, and what our challenges were, and what we could do to help each other.

So, we had people, I guess, within our group that were experts with mental health but, you know, any of could provide help to each other in that regard. And it was definitely a big team thing, it was really nice to go with a team of people that you really liked and trusted, it made it fun, both in the Air Force time and in the Public Health Service time. When you're deployed with people, you develop close friendships very quickly, and you learn to appreciate people you're with, whatever skills or personality that they bring to the table, you're thankful for their help because you're kind of going through whatever you're going through, they're going through it with you, and you're working long days, they're working long days, you're working in this setting, they're working in this setting. So, it was pretty fun.

Also, as I went around the hospital, as I told you, I went around the hospital to look at equipment, and during that time I'd see my fellow PHS officers in mental health, and I'd go and talk to them, or I'd go into a lab. We had lab officers who would deploy, and I would talk to the

lab officers. So, throughout the day, just unexpectedly meeting these other people was always a pleasure to do. And, of course, they had a Safety Officer -- we had two Safety Officers that were assigned to this place, which was my job in a previous deployment, so it was kind of fun to see someone take that role on other than me. It was kind of fun to have that conversation. But it was good, it's a good group of people and a good team makes a big difference. It was fun. I didn't see any complications or problems of people going nuts or crazy. We held together pretty well, and we were trained to do what we did.

VB: I'm just glad to hear that you had support there for you and that you guys had such strong morale and teamwork to provide support to. I wanted to ask you about transitioning from your deployment back to your FDA role and if, at the time you left Phoenix, if you were given guidance about whether or not you should quarantine or if you took any time off between your deployment and returning to your normal tour of duty or just in general, what it was like to go from such a weighty experience to return to your FDA life?

DW: It's definitely a shift. I mean, when you're deployed, especially in the evening, you kind of miss your home, your family, your own bed, your own people you normally work with. But, at the same time, of course, you're quite happy to be out there. But, it's definitely a shift to go from deployment setting to coming home. We all got tested, all 16 of us got tested for the long testing, it wasn't the rapids, it was the one with the swab all over the nasal. We had to wait like three days to verify that we were not positive, and all of us were negative. So, when we departed, we knew we tested negative. After we got our final test, we didn't go back to the hospital anymore because we didn't want to get tested and then go back to the hospital and get

exposed, and then go home and bring that to our families. So, we got tested on a Saturday, then we found out our results on a Tuesday, and then came home on a Tuesday.

So, we knew we weren't positive, but once we got back, just out of an abundance of precaution, I took a few days of administrative leave and just took a few days off and filed my travel paperwork to get reimbursed. And then, when I went back to work a few days later -- I got back on a Tuesday, and I think I took the rest of the week off. I took like three days off -- a couple days of administrative leave and maybe a day of annual leave, or something. So I took a few days off. If you're gone for, I think it's like 28 days, they give you two days of respite leave, and then I took one day of the admin leave, so I took the rest of that week off. Then, the following week, I teleworked for another couple weeks. So, I work with FDA, but I worked from home for a few weeks, which I'm happy I have a job, I'm able to do that. So, that's kind of out of an abundance of precaution, not because I really had to, just to be extra careful.

And the Corps Care checked on us. They would call you every day or text you and say, "are you okay, and do you have any symptoms," and just to verify you're okay. At the end of a couple weeks after your deployment, they would call you and just talk to you and like interview you and see if you're okay.

VB: So, in transitioning back to FDA, I mean, you're teleworking now. Were you doing any remote inspections, or were you just doing other work in the interim?

DW: Just doing other work in the interim, like complaint responses, checking recalls, reviewing procedures or rating procedures, signing up, or volunteering for different committees and different things like that. Right now, the state of Florida is red right now. FDA came up

with these color codes like red, yellow and green. And if it's red, it means you can't do inspections, only if it's an absolute emergency. And as soon as it gets to yellow, then I can start doing inspections, at least locally. I definitely am looking forward to going back and doing my medical device inspections but, as of yet, I'm still waiting for that to happen.

And I was going to say, from that deployment to Phoenix, the engineer that I deployed there with, even to this day, we still contact each other periodically, just to stay in touch. So it was nice to deploy with someone I worked with, and so closely, and all the things we had in common made it kind of fun. So, you definitely develop some relationships, even people I deployed with in the Air Force, I still keep in contact with them too, with at least a few of them. So, it's quite interesting.

VB: That's wonderful. Have you learned if you're going to be deployed again and, if so, where to? Are you allowed to share that? I don't know if it's protected information.

DW: I was told, like, all hands-on deck for going to the border, for assisting with the unaccompanied minors at the border. I know a lot of PHS officers are going down there and helping with that. And I was supposed to go for the month of April, but I had some dental work that they were doing to get my teeth fixed, and so I wasn't allowed to go because of that. I'm hoping to go when that first group will be done at the end of April. I'm hoping to go at the end of this week, in early May, and get to go to help with that. There will be a lot of work, but I like it. I like deploying, the work is actually fun to me. But hopefully I get to go again pretty soon and help with whatever is needed next. It's an example of stuff that's not engineering-related, per se, like when I deployed in a hurricane or I deploy for some kind of emergency response, I'd

go there, help with either the safety or looking at facilities and seeing how they're holding up from a hurricane. You know, so I would go there with my college training and my experience, but in this case, going to the border, I'm not sure what I'd be doing there, but doesn't matter. Whatever they need, I'll be happy to do it. It might be like, logging people in or maybe helping with planning, or whatever is needed, and it'd be a good opportunity, good way to help people out help and help humanity. Hopefully I get to go soon.

VB: Well, if you are deployed next month, I wish you a safe and successful mission, and thank you for your service in the past and in the future, and also just want to thank you for taking the time to talk to us today and participate in this project to help document the role of PHS officers in this response. So, thank you very much, Lieutenant Wilkinson.

DW: Thank you for taking the time to interview me. This has been fun and yeah, PHS is all over the world doing all kinds of really neat and important things to help out, so quite the great opportunity. I'm sure we're all thankful to get to do what we do, we get to wear a uniform, it's a good deal.

VB: Well, I'm going to go ahead and stop the recording now.

[END OF INTERVIEW]

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