FDA U.S. FOOD & DRUG ADMINISTRATION

FCON COVID-19 Deployment
Oral History Interview
CAPT Timothy Jiggens, MSPH, REHS/RS, CIH

FCON History Committee
FDA History Office
Collaborative Oral History Project
Edited Transcript
Date of Interview: March 17, 2021

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Oral History Abstract

The FDA History Office and FCON Historical Committee interviewed Captain Timothy Jiggens as part of a collaborative oral history project documenting the Commissioned Corps deployments in response to COVID-19. CAPT Jiggens discussed his deployment as a Public Health Service officer in the USPHS Commissioned Corps. He was a member of the Operations Division, Billeting Group, where he staffed family housing for quarantined Wuhan evacuees and served as a Safety Officer. He saw some of the first cases to manifest among Wuhan evacuees. Jiggens also served as the Federal Site Lead at Ellis-Davis Field House Community-Based Testing Station, where approximately 9400 COVID-19 tests were conducted. He discussed his time with the IMT-NAT SOFR Technical Assistance Team, during which he traveled the country solving safety and infection control problems for deployed teams. His team developed a standardized assessment tool that other teams adopted for use.

Keywords

COVID-19, community-based testing, Wuhan, Technical Assistance Team (TAT), safety officer, Commissioned Corps, Public Health Service, billeting, repatriation, PPE

Citation Instructions

This interview should be cited as follows:

"Captain Timothy Jiggens Oral History Interview," History Office and FCON History Committee, U.S. Food and Drug Administration, Department of Health and Human Services, March 17, 2021."

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 is an addition to the FDA Commissioned Officers Network and FDA History Office collaborative COVID-19 Public Health Emergency Response Oral History Project. Today, we are speaking with Captain Timothy Jiggens. I am Vanessa Burrows from the FDA History Office calling in from Silver Spring, MD.

JS: And this is John Swann, also of the FDA History Office, speaking from Bethesda, Maryland.

VB: Lieutenant Commander Fields, would you please introduce yourself?

MF: And this is Lieutenant Commander Marcia Fields. I'm calling in from Richmond, Virginia, and I'm stationed in the Office of Regulatory Affairs.

VB: And Captain Jiggens, would you introduce yourself, please?

TJ: Sure, I'm Captain Jiggens, Environmental Health Officer, and stationed at White Oak in Silver Spring, Maryland, but in the telework posture, I'm in Chevy Chase, Maryland.

VB: Thank you very much. Captain Jiggens, how long have you been working with FDA?

TJ: I came to FDA -- I think it's been four years now. I came over to the Office of Management and moved my program and myself into the Office of Finance, Budget and Acquisitions, and then I detailed to the Office of Laboratory Safety (OLS) and came aboard permanently in OLS about 18 months ago. That's why I have to stop and think exactly when I came to FDA.

VB: Did you hold other federal positions before you came to FDA?

TJ: I have 23 years in the Corps, so I've done a couple tours at CDC, with NIOSH in Cincinnati, with National Center for Environmental Health in Atlanta. I was an officer in charge of the Coast Guard Safety Environmental Health Detachment in Honolulu, directed training for our inactive Reserve Corps, in the Office of Surgeon General back here in the National Capitol region. Spent a number of years with Federal Occupational Health in San Francisco, and then in Bethesda, and then finally came to FDA.

VB: Fantastic. Just for the record, could you please confirm the information we have about the deployments you've served on the COVID-19 public health emergency response, just very briefly up front, and then we'll get into details afterward.

TJ: Sure.

VB: But your first deployment, was it from February 8, 2020 to February 20, 2020?

TJ: Yes, that first spin was in February at Marine Corps Air Station Miramar, and that was quarantining repatriates from Wuhan. I started in operations and finished as a safety officer, which is my usual role. Late April to the end of May, I was a federal site lead at a community based testing station at Ellis Davis Fieldhouse in Dallas, Texas. And I forget the exact dates, but much of August, I was attached to the Incident Management Team National Safety Officer and was a member of the technical assistance team that went over several states solving safety and infection control problems.

VB: And could you just say very briefly a little bit about what your duties were (without going into great detail) for each of the deployments, what your general responsibilities or roles were?

TJ: Well, I started operating a hotel for repatriates in Miramar and spent most of that deployment as a safety officer, where I'm responsible for the health and safety for everyone at that response. And as federal site lead in Dallas, that was a federally organized, state managed, locally implemented I think is the phrase we used in that operation. So, every slice of the response, I was there, and I represented the federal team, and had a five member team, and we worked with the state of Texas and local providers to run that station in conjunction with a sister testing station in downtown Dallas. In August, basically, I was our roving expert and problem solver and went place to place and solved problems. And eventually, it was sort of a test concept, and we proved a lot of value and learned some lessons, recognized some patterns, and developed a tool that could be used, and some more proactive measures we could do as we mobilized teams. And so, we were TAT-1 (i.e., Technical Assistance Team), and I think TAT-30 is going out the door. We branded ourselves as Technical assistance Team because when a

safety officer shows up, people tend to tense up and circle the wagon sometimes, and this was all good cop stuff, trying to help and solve problems and help those site safety officers protect their people.

MF: Captain Jiggens, I'd like to talk to you a little bit about the timing of the notice that you received regarding the deployment and some of what you had to do personally. So, there is a series of three questions around this particular topic. So, when you first were informed of your deployment, how much advanced notice did you receive?

TJ: Well, my hot month, or my on-call month, in tier 3, was February, so we got our ready notice that February is coming and frankly we should expect to deploy in some manner or other. And right at the turn of the month mission assignments started coming in and teams started going out. Initially, I had information that I would be going out to the CDC airport screening effort, and I was getting worked up for that. And then notice came that we need to go immediately to repatriation effort, and the next day I was making travel arrangements. I got the call on the 6th. I would have left the next day, but I got the travel reservations about 3:30 in the morning, without letting me know that they would be coming, and for a 6:30 flight. So, I got up on the 7th and had already missed my flight that I had been unaware I had been ticketed for. So, I didn't get out to San Diego until the morning of the 8th. But yes, at that time, things were mushrooming pretty fast.

MF: Wow. It sounds like there were a lot of moving pieces going on in a short amount of time. Could you share with us how you prepared to transition out of your FDA duties, and if

you're willing, maybe commenting what you have to do mentally and physically to transition out of those duties?

TJ: Well, we had an officer, a good friend of mine, who hit his 30 years and retired out here in January, so I had started assuming some of his duties. We had a yearlong transition plan to kind of smoothly slide his desk onto mine. So, my professional life was kind of organized and scheduled out and in control. I'm an experienced responder. I've been responder of the year. well much of the last 10 years or so, I've been doing international responses with the US Agency for International Development, Office of Foreign Disaster Assistance -- they are like the overseas version of FEMA for our government response -- and with Peace Corps and a number of things with (inaudible - 0:09:56). So, being on-call and looking at what was going on in China, I was around for SARS, so I was personally and professionally ready, and the family was geared up, stacked, and you stay light on your feet.

I report aboard to San Diego still not knowing my role. They told me to get the biggest van I could, so I thought maybe I was doing logistics. And I got there, and they put me in the Operations Billeting Group. And the single adults were in the barracks and the on-base hotel was full of families. Most of the other officers were younger. I am the only guy with family, so I volunteered for the family shelter. So, it kind of evolved as this stood up, and it really wasn't until I got on site that I knew what my role would be.

MF: Right. So, you said something that is really meaningful to me as a junior officer, and that is that your personal life was under control. So, I think that helps in any kind of transitional situation, especially in deployment. If you're always working towards having that stability in the

home, it makes work life balance easier to accomplish, and then your family, especially in the situation of what is going on, they were prepared for you to have to be ready to go whenever called upon. So, I'd like to know if did you feel like you had to wear two hats of both your FDA duties and your deployment duties during this particular or any of the deployments that you're speaking on today?

TJ: I did. It's a matter of juggling. There are a number of duties that I can delegate or pass on to people. We're a relatively small office and only one deep in most positions (inaudible 12:23). And certain things like contracting are authorities I have that other people don't necessarily have. So, there were aspects of the day job I had keep on after hours. And some deployments are like that, and some aren't.

MF: Thank you. You also mentioned that you're an experienced responder, so I do have a series of three more questions that are kind of around the theme of the deployment logistics. And the first one is if you have any type of insight on how your assignment is or was determined for any of them that you'd like to share?

TJ: Well, the Miramar deployment was a short fuse need, and when it popped up, they needed folks who could go immediately. So, that's all I got there, and that's how I ended up in operations as a safety officer. If I say SOFR, it is often how we refer to the safety officer.

[Recording paused to resolve audio issues].

MF: Captain Jiggens, do you have any insight on how your assignments were determined?

TJ: For Miramar, it was a matter of being immediately available. Remember, that was kind of a rapidly evolving situation, and when they got people off the planes and into lodging, the staff assignment is pretty thin, and they quickly realized that they're going to need help caring for a couple hundred plus people. So, they're calling out for people who could go immediately, and I raised my hand as somebody who could go immediately and was gone. As far as Dallas and being a site lead, there certainly seemed to a number of each senior EHOs (environmental health officers, my category) who were site leads. But I don't have a great deal of insight into the CBTS (Community-Based Testing Sites). It was kind of an operational plan that evolved as it stood up. From the first iteration to the time I got there quite a bit was changed on the fly. But there seemed to be a lot of us older environmental health officers who were selected as site leads. And as far as being on the TAT, as I said I'm an experienced responder, and had some successes and got some good work done at times with COVID. And so, the Readiness and Deployments Group (RedDOG) reached out to me directly to ask if I and my experience would be available to tackle this roving problem-solver kind of mission.

MF: Okay. And as you've already alluded to previously being an experience responder, you've sort of answered part of this next question already, but related to the Dallas community based testing site, it was already established what the specific goals were, but at any point, did you have any input because you were a site lead, specific to what your duties were or what your assignments were? And if not Dallas, the other deployments as well. Was there any time when

you had specific input to what you were going to do during an assignment or maybe contributed for it to evolve into something else that originally the mission didn't take into consideration?

TJ: Let's see. Yeah, I mean, Miramar was an interesting one. Brian Czarnecki (ph) was the safety officer when I got there, and an outstanding young officer. He went on to be on the Diamond Princess repatriation mission. I understand he was awarded a meritorious service medal with valor for some of the outstanding work he did. He was responder of the year for our category a couple years ago. Just an outstanding young officer.

So, I reported aboard the billeting group, and sought him out and said, "Hey, I'm an experienced SOFR. I'm here at your disposal. If you have any extra duties or you need any extra help, let me know." And went on to be the best front desk clerk I could be at our lodging. And in my spare time, we started working on how we were going to evacuate a population ranging from infants to frail and elderly transplant patients. There were very few English speakers, and things like that. And with my safety officer hat on, thought "what can we do around here to pitch in and make things easier for the SOFR?" And we kind of consulted. And, my experience from Ebola and with the Coast Guard, and doing EPI (epidemiologic) studies at CDC, I had experience and insight that I shared with Brian. And at times, bounced ideas off each other and considered different courses of action. So, when he got the call to go to Japan, it was really easy and natural for me to step up into the SOFR position and just make a seamless hand off. So, I was a safety officer for the second two-thirds of that perhaps. And as safety officer, you've got a great deal of responsibility and delegated authority from the incident commander.

[00:19:49]

So, to a large degree, it's my job to do as I see fit to go protect everybody. And I liked to get out and see everybody in their workplace twice a day. So, I'd patrol out to our different locations and come in late to see the night people or come in early to see them before they go home and just be out and about and see everybody and keep an eye on when we have separated elements for when we're discharging people. We had groups scattered all over the base and some small groups away from the main body, that was really someone I want to keep an eye on. And as safety officer, you've got freedom to do those things. So, once I got to the safety officer role, I got a great deal of input in what we do and how we do it, from PPE posture to standard operating procedures. I sat regularly on planning meetings and the operations meetings, so I could give input on the operations we were doing or thinking of doing and how they should be done.

As a site lead in Dallas, in some sense it's a very prescribed role because we developed a fairly formal organization from the top, and it had to be, because there's so many layers involved. But on a tactical level our site started working with our local implementing partner to get out to nursing homes. And then, that ramped up to be a significant portion of our testing and they really affected our operations. As local site lead, hashing out those issues with the incident command, the IMT partners, our liaisons at ASPR and HHS, I was the guy to speak for those of the five officers on the ground and our federal slice of that pie.

And on the TAT mission there was another fantastic junior officer, Lieutenant Catherine McNamara. She and Brian actually both worked over here at NIH, down the road from me. She was a wonderfully skilled officer. I think it was her seventh COVID deployment. But we were basically turned loose to make our own way. So, we sketched out our first few days of the places

we want to get to in Texas where we started, and once we got going, it was a matter of chasing problems and making itineraries on the fly. We were changing travel every night, heading out this problem or that problem. We would swing by Laredo on our way to the airport in San Antonio, so we could fly out to Baton Rouge, that kind of thing. So, we had a great deal of autonomy to size up what needed to be done and get over there and do it.

MF: Great. Thank you for that. The last two questions that I have for you are related to your feelings around the situation as it was unfolding and as a responder to a COVID pandemic. So, what concerns did you have from the first COVID deployment?

TJ: I've been first in for a number of deployments. When I was with the first wave with OFDA, when WHO declared (a Public Health Emergency of International Concern), the embassy ordered departure (of non-essential personnel), and the NGOs left and things really hit the skids in Liberia in early August. So, I've been at the formative stage where there's lots of questions. There's unknown unknowns. There's things we know we're not sure of. There's things we have no idea; we don't even know yet. And so, frankly, I'm comfortable in that environment. My job as a safety officer -- I am, by profession, a risk manager. Always surveying for risks, trying to characterize risks, trying to put boundaries on risks that are poorly characterized, trying to keep an open mind so we don't get surprises. And certainly, with remembering how SARS went, we were cognizant of a lot of known unknowns and a lot of uncertainties as we worked through this repatriation mission.

We were the first to have cases manifest in our cohort. So, we had a number of health protection issues and risk communication issues to solve on the fly. I worked with CDC to

develop some written communications and kind of an outreach system both post-deployment and post-exposure for what people should do based on their exposure scenario. And, of course, the guidance on the different exposure scenarios was evolving rapidly. So, it's just kind of constantly dancing on a ball and trying to keep on top of a dynamic situation. But, when you're early in a deployment, that's common.

Certainly, I look back now, and I think a lot of the discussions Brian and I had about the issues we were considering, protecting our responders and our discussions with the CDC, and with the greater response, and as different groups with different points of view try to decide a best course of action. And we had some pretty deep discussions at times among and between organizations about what is going to be the best course of action here. And certainly, I look back now and realize there was a lot we didn't know. There were a number of assumptions that we were making at the time, or that were briefed to us of what we know about the disease. Looking back there were facts we thought we knew that turned out to be wrong. But Brian and I, I look back at the decisions we made to protect our people, and we were right across the board. We made conservative decisions and I think every decision we made panned out properly.

MF: Great. So, you definitely have given us some insight that the concerns that would be associated with a COVID deployment would be with probably any situation where there's lots of uncertainty initially when you're going in. But you've mentioned, as a risk manager, you were able to identify or recognize those concerns would be prevalent, but it sounds like you all made some logical decisions given the information that you had in order to protect your people. So, my last question is you mentioned characterizing risks and putting boundaries around them. What are your impressions of the public health emergency at the point in time whenever you

were first deployed? So, with your first deployment, how would you characterize the public health emergency, maybe from a risk management perspective or maybe just response to the pandemic in general? What were your impressions with your first deployment?

TJ: Well, remember at the time CDC was telling us, “we don’t think this is airborne,” or “we don’t think asymptomatic spread is an issue.” We were checking fevers as a surveillance tool. And as far as we knew, it wasn’t circulating in the population. So, in some sense, it seemed like we were out early and were trying to prevent an outbreak, but I know from being involved in EPI (epidemiologic) studies and medical surveillance -- and from our experience with spongy data and untrustworthy assumptions in Ebola -- it felt like this was the tip of a big iceberg. During my first deployment was when the first community acquired case without a known contact cases arose. There was this sense that this was going to be a big deal. This is the sort of thing like yellow fever or the Spanish flu, this is the sort of thing we exist for and it was going to be a big deal. Over a year later and we’re -- you know, I got my first shot yesterday -- we’re still in the middle of this.

JS: Captain Jiggens, this is John Swann. You’ve done a terrific job of giving us a very effective high-level view of what were you involved in in all these deployments. Keeping in mind that the people who will be reading these transcripts will have a varying level of familiarity with what public health service officers do in deployment, some of your other officers will be reading this, but also people who don’t really have an idea of what goes on in a deployment. So, it would be helpful if you could kind of give a sense of day-to-day activities, what everyday life is like on these three deployments you were on. I’m sure there’s no such thing as a typical day,

but if you could maybe give us some examples of the nature of the activities and the routines you developed on these deployments I think would be very helpful to people that are new to this and want to know more about it, if they could hear a little bit about your experiences on each of these.

TJ: Sure, sure. Well, at the start of San Diego, I was on the billeting crew, and so in an operation like that we were sort of at a contained site and there's a daily routine of meetings with command staff who is planning and running the operation. We typically have a 7 a.m. all hands meeting and pass the word and the plan of the day and what needs to be known and spend a day trying to meet people's basic needs. We have stashes of donated supplies and purchase supplies and trying to keep the babies in diapers and interface with the disaster medical assistance team, the medical team, inside each site. We've got food and supplies coming and going. People are trying to do laundry and the machine is broken down or somebody's power is out in their room, and you've got to try and arrange a way to safely get that repaired.

These sites were on a Marine Corps base and each site is ring fenced and we have US Marshals to keep people out who don't need to be in and keep the people in who don't need to be out. And they're trying to live their life for a couple of weeks. And if you can imagine just packing your bag and going out to a hotel for a couple weeks, there's just lots of needs you're going to have. And we would get donations and try to get games, and bikes, and things set up for the kids and keep the playground available for them to play in and sit down and try and work out with our few English speakers how we could evacuate our building safely, and where we would evacuate them to and how we would coordinate with the DMAT, and how we could do that at night with a skeleton crew, just trying to meet daily needs and be prepared for anything.

At the start, we had a few helpful souls who spoke two or three languages and English, and we had phones to translate. And it took about a week until we started getting officers who spoke Mandarin and Cantonese. And that helped a bunch being able to speak with people. As a safety officer, there's a slate of meetings where you're plugged into the command. You're there as the commander's representative and there's command and general staff meetings, and planning meetings, and operations meetings, and you've got to have that eye on everything that is happening and is going to happen in the command post as far as the running of the operation. But I am a big believer in getting out and seeing people, seeing what they're doing, and how our SOPs and our PPE posture is being implemented, and how well it's working and hearing people's ideas, problems they have with the implementation -- these masks fog, or we can't get enough gloves, or when we do these fever checks, this ensemble of PPE is particularly problematic, but if we could do that, that could help us a great deal. You've just got to get out and see people in their workplace. So, between meetings I would try and get out and see people. Come in early and see those night people we always forget about. Stay late, and we'd see those night people we'd always forget about. And you've got the day-to-day of -- you know, the bane of safety officer is the dented rental cars. Had a couple of those to deal with. When we had cases manifest, we had some more issues to consider. There's just always something.

We had a contract cleaning crew from the Base that did a lot of sanitizing of high touch surfaces, and one of them was on a respirator and were in a significant ensemble of PPE for the task, frankly. And she succumbed to heat stress, so we had to manage that medical case on board our site. And then, the next day, OSHA came in the door and wanted to see me. You know, it's a contract. It's not actually our people, but in all my years, I've never had an OSHA inspector flash their badge and come aboard my response. So, there's just always something to

deal with, and if you don't have a steady diet of surprises in situations then you're probably not engaged enough as a SOFR. You've got to have your nose in everybody's business.

JS: Well, that's a good point. Well, it sounds like you were pretty busy 24 hours a day. Was there any sense of a kind of shift that you might occupy or were you basically on-call regardless of the time of day?

TJ: Well, I was the SOFR. I had a couple of fit testers working for me who went up to LAX when Brian rotated out and we started sending people over to Japan. So, they were still mine, but they were in LAX and they were serving a lot of fit testing for a lot of people passing through LAX. So, I got a couple more fit testers, and then eventually Jan and Chris did come back. So, I had a staff with a certain skill set. They're from the DMAT teams. But I'm the safety officer and this was largely a daytime operation, and the building had to run at night and those were my former work mates, and we worked far from the places. So, I was generally the first there, last to leave kind of guy, just overlap and see everybody.

JS: Can you compare that experience to your subsequent deployments in terms of routine and responsibilities?

TJ: Sure. Well, being a site lead, a federal site lead, at Dallas, again, you're plugged into a cadence of meetings and certain situations that come up. And there's a great deal of managing relationships between organizations and reporting numbers and situations up the chain and solving problems as they arise. So, in a lot of ways it's a similar cadence and routine to being a

safety officer. And, the local incident command, much of it was run by firefighters. I'm a former EMT and I love hanging with the firefighters, so we got along great and just plugged seamlessly into their organization and worked as this multilevel team to get the job done. And we got weather surprises, and plus there's things to manage, and we managed them and try and set things up, so it's as easy as possible for our people to do their job safely. We added on, expanded, we rotated our operation 90 degrees, just to avoid some wind problems. We changed our operations. The nursing homes came to be a priority, and we pivoted to support them in a way that was unequivocally unique to us in Dallas.

[00:40:04]

So, in a lot of ways, it was similar to being a safety officer in an incident command system. Just a level up if you will. With the TAT there was a little bit of an on the road adventure aspect to that. We just often weren't sure where we'd be in a day or two. There's a meeting cadence to plug into by phone when we could, but we would roll in, make arrangements with our next place, and roll in, and meet and greet a little bit, and a site visit, and walk and talk and see their operation and meet the host facility and talk to responders. And sometimes come at night and find those night shift nurses, and pharmacists, and people that we don't always see. Just get out and about, see what we need to see, hear what we need hear, and try to advise them on here's the problems we see, and here is what we think you can do about it, and we fixed this one when we saw it, and here's something else you want to get on, and this isn't happening yet, but you want to avoid this happening, because that would be bad, and do what we could, built

some skills from that SOFR, shared some experiences we learned at the last place with that guy and move on to the next place, find our place to stay, a flight, drive there.

It was planes, trains, and automobiles to go town to town, state to state, meet a new group of people, see a new facility and a different set of problems and start to spot patterns and share some experience from site to site, and they did this and it worked well for them and I think it might work well for you, so here's how to implement it and you might consider it, and just kind of start to snowball those lessons learned, mentor some of those SOFRs, some experienced people, a lot of people in new roles. Particularly, as this response dragged on. Early on there's a lot of frequent flyers that you see again and again. We always say, "hey, man, see you at the next hurricane." But as this went on, we're digging deeper and deeper into the bench, and there were a lot of people at their first deployments. And it's our chances to mentor some of those junior officers.

So, they're not going to have to learn lessons the same hard way we learned them a generation ago. And certainly, the safety officer -- we dovetail into behavioral health. We want people to feel safe and secure. That's our jobs we're trying to do. And part of that is dealing with and listen to people who don't feel safe and secure. And sometimes they have reason to. Sometimes they don't. Sometimes it's speaking to them. Sometimes it's listening to them. But, there's been a big behavioral health support on this operation and in years past, it's almost collateral duty. When you're working with Fukushima, or Ebola, or things like that, you know technically a lot more about these risks and these hazards than the people suffering them. And you have some answers. They have questions and concerns. And there's always a great deal of risk communication as a safety officer and it blends right into hand holding, and listening, and encouraging.

So, to have this significant behavioral health push, it kind of gave us -- it's a part of what we do. But to be able to interface with a broader, coherent effort helped a lot. We did hear repeatedly as we started getting around the country and were going to trouble spots. And we got a few shoutouts from the behavioral health folks that were talking to people, getting calls from people and hearing how much responders appreciated having this team of experts comes to their place and help tighten things up and address their concerns and mitigate some risks. So, that was real gratifying when we would hear that on some of the calls that behavioral health was hearing from officers and responders that benefit of our safety work.

JS: Well, a couple things occurred to me. It sounds like in August you didn't have much time to put your feet up wherever you ended up. You were on the move there to other locations. But it also sounds like you really had to be prepared for all varieties of unforeseen circumstances wherever you were. Is that fair to say? I mean, you've mentioned a number of examples from moving camps around to depending on the direction of the wind. Do you have particular other situations that posed a particular predicament as these sort of unanticipated circumstances developed?

TJ: Anticipation is part of risk management. We're going to anticipate, recognize, evaluate, and control risks. And a lot of junior EHOs have heard me say we get good by doing different things in different places for different people. So, having done a variety of roles in a variety of agencies in a variety of geographies, a good EHO has a big toolbox and can be ready for anything. We saw a wide variety of facilities. There was one facility -- was it Rio Grande City? It was hardly a hospital, and it really was an outpatient clinic with a few delivery rooms. And

they had just come off having idling ambulances to house people. They had several responders and travel nurses and the manager there was the only staff left because everybody had basically fled. And they weren't equipped for any acuity of care.

So, DOD was there assisting as well, and we had tents, and holes cut in walls, and plastic sheeting, and pumps, and air movers, trying to make this medical office building into a contained ICU ward. And there was a lot of health protection issues, a lot to consider how we can do this safely. And our team was reaching the end, and we looked and that's where we said, well, given what we're trying to do in the facility, and our ability to protect people in a situation like this, we need to consider whether we want to reload this team or not. And here are the reasons why we think we shouldn't. And the next team that came in and strung it's people along the border, we didn't restaff that facility. DOD had their footprint. But right as we were fixing to leave, I think we ended up with a handful of cases in our DMAT teams along the border there.

They were working in some of these facilities who were just pushing to the limits to try to make a safe place to care for COVID patient. As we were running around the country, and particularly when we got to Florida, some fantastically equipped and appointed facilities to care for people. Down in the Rio Grande, it was a fairly resource sparce environment. Transfers were going as far as Oklahoma and Colorado, and there was just no place to put people nearby. And some of these facilities and staffs were pushed to such limits.

Typically, when you're working in disaster or you're doing hospital medicine. There's a lot of situations where we sort of train for say disaster triage, disaster decision making. We have PPE procedures that we'll implement only when the situation gets dire--when we're extending use or considering reuse. And this event was the first time I've had to make those sort of resource-constrained risk management decisions.

Typically, it may take time, but we can get what we need. We have what we need. And there were times and places in this disaster -- now, if you remember the rush for toilet paper, for respirators, for gloves? There was such a demand on some critical commodities, we had to change the way we protected people. We had to make decisions on a different basis from what we had made before. So, that was the aspect of this one. This is a worldwide disaster really. Even in Liberia, or Sierra Leone, or Guinea, you can reach back to the infinite supplies of the United States. You could get anything shipped over from Europe. There were no unaffected areas to reach back into for this disaster. It was all of us everywhere. So, eventually, that began to change – to take colors off our palette. Decisions just started coming off the table as far protecting people.

JS: So, even as to an experienced officer like yourself, this was not the sort of thing that you normally see when you were deployed. As you characterized, some sites were better equipped than others, but there was a time when you really had to make decisions, right?

TJ: I had to deal with local resource constraints, because they've been on an island or in the middle of a hurricane, or tsunami, or something, but it's local and somewhere else, there is what you need. There is an amount of time, or money, or logistics getting there. This was an everywhere disaster, so there's no fallback area. There's no rear to this battle. Every place was in this battle.

And to an extent, when you're in a hurricane, the local populous sometimes they're competing for some the same supplies. Everybody is trying to get more water, or work gloves, or chainsaws, or whatever. But you can drive 60 miles away, or you can ship it from Minnesota

or whatever. That option wasn't here with all of America. Everybody ordering on Amazon, the entire world pulling supplies from the supply chain. That aspect, that's the different thing about this disaster.

VB: Captain Jiggens, encountering various restraints with access to PPE and other resources, did you coordinate with the FDA Joint Information Center at all about supply chain issues or particular areas where you were encountering a lack of access?

TJ: No, ma'am. And that wouldn't be my role. There's somebody at a desk at a computer in the Incident Management Team who frankly has a bigger and better picture than me. I'm looking at my little piece on the ground and it might be multiple little pieces scattered across the country, but I still don't have a big picture. There's other people who do and who have responsibility like that. But, that's not me.

JS: But there were people at these sites you could ask, could accrue the needed material, right?

TJ: And, I mean, the logisticians worked miracles in getting things to people and overcoming issues. At times, as we went place to place, sometimes we ferried some items. Often people coming and going ferrying PPE. There's always a lot of unsung heroes on the logistics side. And if you're watching it on the news, you don't see them and you don't realize, but if you're inside disaster, you know that those are the folks that keep you alive. And this is such a dynamic situation and the distribution of our people kept changing, and the supply chains were so fragile

and overstretched. And even our guidance in PPE postures was evolving as we learned more. So, they had real moving targets, and there's just a lot of unsung heroes on the logistics side.

JS: The other thing I wanted to ask about, and this really applies more to the last deployment, is the travel aspect of this particularly involving plane travel, if that's necessary. That must have presented some challenges or concerns, no doubt.

TJ: I mean, certainly after 9/11 or flying into West Africa during Ebola, those were harder, if you will. At the time, Southwest was doing a good job of spacing out seats for self-protection people. That was about the time the airlines I think we were requiring masking, but we were wearing N-95's on the plane. With our expertise, that seemed the prudent thing to do. And flying airlines that would guarantee some spacing in the seats where we could. At the start of that deployment, the airports were pretty quiet, but it actually picked up a fair bit at the end. The planes got noticeably fuller and the airports, more crowded over that two or three week period. So, that was August timeframe.

JS: Okay, thank you.

VB: Captain Jiggens you made allusions several times at this point, to various other responses you were deployed on and how those experiences sort of either informed or paralleled various deployments you served in the COVID response, and I wonder if you could maybe comment on how this response was different than the others. Aside from the fact that it was so protracted. For instance, the innovations you had to devise in order to conform to the resource constraints

that you mentioned. What was so different about the COVID response compared to your lengthy experience as a responder?

[00:59:20]

TJ: Those and the number of new folks out in the field was new to this. So, there was a lot of mentoring, and peer coaching, and professional development to do on the fly. Those of us who were at 9/11, we see each other and that's kind of that watershed moment, you know? My first and third deployment, a lot of that was working in and around the NDMS folks, so a lot of DMAT people and swapped names with the old timers who you talked to and found out, oh, you've got to talk to this guy on our team. You started dropping names of people and finding out at this stage who has passed on.

And for all these new lieutenants and lieutenant commanders, getting their feet wet on this, it's going to have that same effect. This is going to be where they cut their teeth. This is going to be where they have might have been -- FDA sends a lot of officers out, because we have a lot of officers who have desk-based jobs or there's six, or eight, or twelve people doing a similar function versus out on the reservation, you've got one doc covering three clinics. That doc can't go anywhere. So, FDA typically sends a lot of officers out in the field. And you can be inspecting blood banks, or food manufacturers, or reviewing drug applications. But it's different when you've got to go out in the field and those ODUs that you've been wearing to the office, now you're out in the field and you've got cargo pockets packed full of things that you might need and things evolving on the fly.

That first deployment is always kind of drinking from the fire hydrant. Often you have new people, and you have a few new people and a lot of experienced people too, sort of break them in. This one, there were a lot of new people getting their first deployment and a lot of people like Katherine sitting next to me was on her seventh deployment at the time. We'd had some vacancies (at my home office). I'd been covering a number of positions. In our third deployment, our environmental compliance manager left, and I had to cover his job for the FDA, and I couldn't go out again. I really do miss it. But there's just a generation of young officers to help them have a good, productive, and safe experience in this. I think of this -- it's not really since 9/11 that we've had this kind of culture changing response. In 2044, these guys are going to be O-6's and they'll be talking about this.

VB: I'm really grateful to hear your perspective on that, because I think in undertaking this project we've been thinking so much about the critical contributions that the Corps is making to the response and thinking less about what a formative experience it's going to be for an entire generation of officers. So, I'm just grateful for that perspective going forward.

Staying with the compare and contrast question I asked earlier, I'm curious--I see some parallels, and you mentioned them earlier, to the Ebola response, particularly in terms of sort of psychological factors, fear, and access to information, and I wonder if, in your various deployments, you've found either uneven, or incomplete, or even resistance to COVID guidelines about protective public health measures?

TJ: I don't have much to say about sort of the broader politicization of say mask wearing here, but as a safety officer, there's always cowboys you have to reign in. And dealing with

them tactfully is a challenge that a safety officer has to manage, and that's one place in particular I was able to mentor a number of junior officers with challenges like that. The people who do disaster response, the people on the DMAT teams, the people on the ODFA DARTs, disaster assistance response teams, the people who do this, often they're hard charging individuals, and they want to get out and do good. And human beings, when you protect people for a living, you learn a lot about our cognitive biases and how our brains think about risk -- that we judge familiar risks and unfamiliar risks differently. We judge risks we have control over and risks we don't have control over differently. Our brains have kinks and twists in how they judge risk, and they add emotion, and adrenaline, and people who have some experience. There's a lot of soft skills to being a safety officer. And as a junior officer, you can learn the theory and you can take the classes, but there's experience you have to gain in dealing with people, because ultimately your job is so much about relationships and working with people. And I've got a lot of that experience, and particular with the last deployment. That's why it was so gratifying to go place to place to place and meet so many junior officers and work with some of the NDMS folks, and many officers -- we had engineers, and nurse practitioners, and people who are EHOs in safety officer roles at times. And to spread some of that experience and help them along with things I've learned.

One thing that comes to mind with Ebola, I ultimately had four trips to West Africa, but in between then did a lot of work stateside. I was in charge with working with CBP, rolling out the training and equipping of the airport screening teams, and training those guys, and rolling out some train to trainers for border patrol EMTs, and CBP Office of air and marine paramedics. And the questions and concerns I got that I fielded from people were the same in Sierra Leone as they were in New York City. People in very different walks of life, living in very different

situations. Sierra Leone, they're asking, "If I play football with these people, they sweat on me, am I going to get it?" And in New York, they're asking, "Hey, man, if I play basketball with these guys and they sweat on me, am I going to get it?" "And if I sit in a taxi after the person and maybe they were sick, am I going to get it?" And in New York they're like, "If I sit on the train and maybe somebody was sick and they didn't know it, am I going to get it?" People had the same questions and same concerns. And ultimately, I've got the same facts to give them. Sometimes, they have to be couched in a different cultural competency. But, there's patterns you see across people and how they interface with risk and how they deal with it. And you see patterns among personalities, and you just develop a set of tools and experiences to deal with different people and different situations, because if you do it long enough, you see things again, and again, and again.

VB: Thank you for that. I wanted to ask -- and you touched on this earlier, so I don't mean to ask you to repeat yourself -- but I did want to specifically ask how your responsibilities and experiences in your routine FDA tour of duty, how did any of those experiences translate or assist you in any of the deployments that you served in the COVID-19 response?

TJ: Well, in FDA, I protect people for a living, so it's just a little different aspect of the same job. At FDA I focus on chemical safety and lasers, industrial hygiene, chemical hygiene, safe storage, and disposal, and it tends to be more chemistry focused if you will. We have certified biosafety professionals who know biosafety far better than I do, and if you're going to get into the nitty gritty details of BSL-3 labs, there's people who know that far better than I. But when you get on the fields, it really helps to know a lot of things. And certainly, coming to FDA and

interfacing more from OC (Office of the Commissioner), we work with all the centers. And so, it's all getting up to speed on biosafety, so that's valuable.

When I first came to FDA, I came here to do enterprise risk management which is at the strategic level managing risks for the agency. And before OLS, office of lab safety, I was working for the chief financial officer, which is kind of a funny place for an EHO to be. But enterprise risk management comes out of internal controls and the world of accounting. And it's kind of that risk management applied to the agency as a whole and moving toward risk base budgeting and planning. Actually the other folks had an accounting background, and I was the everything else guy.

But, there's still high level strategic planning risk that would affect the agency's ability to carry out its mission. So, coming to OLS was a chance to get back into kind of hands on, protecting people on the job, being in the lab and working with the center, the occupational safety and health officers, to look at this person and their work situation, and the risks of what they're exposed to, and how we can mitigate those in a way that allows them to still carry out their jobs. So, here at OLS I got back into that hands-on protecting of people, so my skills were polished up when it was time to go out in the field and protect people.

VB: I'd really like to learn a little bit more about your routine interactions during your deployments and the network of people that you had to coordinate with from up and down the hierarchy and across the spectrum. You mentioned at the beginning of our conversation that your Dallas deployment was federally organized, state managed, locally implemented, and it sounds like in that sort of a structure, you touch everything, right? So, I wonder if you could tell

us just a little bit more about who you interacted with in each of your deployments and what the ecosystem of the local response on those deployments was like.

TJ: Okay. So, in San Diego, we were very much a self-contained world on MCAS Miramar. We had our two facilities and our command post, and that was largely our world. And we were actually trying during much of that time to get more of a network going across the safety officers at the IMTs (Incident Management Teams). We were so busy, but we were never able to get a good deal of interaction between the sites. I know when we first started standing up -- sort of seeing the FDA mail traffic -- I reached out to every EHO. I said in an email, "Hey, what do you know? Where are you going? Let's keep in touch." And tried to set up that bit of a back-channel network, so we could just talk EHO stuff. But as that one carried out, my role was there in San Diego. With being in Dallas, our site was paired under command with a sister site downtown.

So, during my time, we started visiting each other and trying to share some lessons learned between the sites. Each of them had some common problems. We had some unique constraints. We were in a parking lot subject to the weather, but we had space. They were in a structure. They were protected, but they had some real space constraint. So, we had some different challenges. But the CBTS, we had regular, at times, nightly calls with all the team leads across the country and getting top-down information and a big picture of what's going on, what's coming down the pike. Being in a leadership role, there's times to manage down and times to manage up and time for managing sideways with the other site. So, it was sort of thinking, and working in every direction.

We had a deputy commander for our site, an old time firefighter paramedic, Captain Corson (ph). And I got along great with him, plugged into him and his people and the local implementing partner, and just lots of communication, and coordination, and working together, just logistic issues of getting samples in and out, trying to keep enough ice packs. It was starting to get hot. Keeping samples cool was a problem. Every problem had a local piece, and a state piece, and a federal piece to it. With being on the TAT team, we were working for Joe Cocciardi, just a legend in the safety officer field. And he's the IMT NAT, the incident management team national safety officer and, that's who we were working for.

So, we were plugged into that national level management structure. And our role there at that level was a lot of getting information. And then, at the operations level and meeting with the operations people on a national level, pushing the information out to them, because we were on the field, and we were actually going place to place and getting information and seeing things. And that's why they tried this concept to get some safety officers down to get some eyes and ears, and birddog problems, and solved problems down at that local level. And some of the impact we had was that we had these teams working in local facilities. And there was a federal team host facility interface. And often times there were inputs we could put there at that interface that would improve how we could protect our people. But you would drop and get introduced to this new little slice of the world, and everything going on there in that unique situation, and the next day, reorient to a new town, sometimes a new state, completely different situation, different facility, different people, different organization, different federal team, just a whole new world, and reboot, reload, and figure out what's going on, size it up, and get information out to the national level that maybe they can't see. And then next day do it over again.

[01:19:44]

VB: As you moved from one local context to another, did you find that with your non-federal partners, did they acclimate to the response structure well? Was there any friction? Was there any confusion about the hierarchy for decision making or what roles everyone should play or who to consult about a certain question?

TJ: Every place was different. So, there's places yes, and some places no, places we're working alongside DOD teams in a facility, the corporate travel nurses were out in waves. And that's kind of true of any disaster. There's always people, and groups, and organizations that aren't familiar to working with each other. And that's the huge benefit of the standard incident command system that we use to run disasters. It's a common framework for everyone to plug into and know roles. And that's what we do in HHS, and ASPR, and PHS.

And there's a hospital ICS, HICS, is what we called it, sort counterpart. And that was one of our findings, one of the things we pushed up to the national level, one of the things we started to encourage as we went different places. The host facilities that stood up a HICS and were proactively managing event just were much better off than the hospitals that were trying to do normal operations faster. So, we tried to encourage that. And a couple of facilities did stand up a HICS after we left. We said, this would be the benefit and there's a lot of this that's predigested and decided. You don't have to reinvent wheels. This is how you can start to implement, and a couple of places did that after we left.

And I can think of once place in particular where we'd done it: in Rio Grande City. They were just starting, and we were able to help them implement and really start to get ahead of things, get more proactive than reactive. Because if you can anticipate and recognize and proactively manage risk to your people. You're just in a much better place than if you're kind of staying on your heels reacting to surprises, to logistical challenges, to patient surges.

VB: So, you mentioned earlier that one distinct factor in this response was the need for behavioral health support throughout. And I was wondering if in a more informal way considering the fact that this was (I assume) like all emergency responses, but also in unique ways immensely stressful situations, and you had so many officers on first time deployments where I imagine it's the first encounter with this sort of level of stress. What outlets did you have for sort of stress management or stress relief in a less formal way? Did you have time after your duty hours to go out for a beer or two, to sit down and chat? What sort of supports did you have within your team?

TJ: Well, for me personally, I certainly like to exercise, and so lots of pushups on the floor. I've got my rubber bands with me, and I'm pretty adept at putting hotel furniture into use to get some exercise. And I spend a lot of time listening in on calls, doing pushups, and just trying to stay active and keep the body working, because the body's the mind and the mind's the body and if you can get some sleep, and some regular food, and some exercise your body is not preying on your mind. But for me, part of it is since I'm sort of at the tip of spear of risk and risk management, it's not disconcerting. I remember one particular moment, I'm just patrolling down the street, going site to site, seeking out my people in their workplaces and keeping my eyes and

ears on them and just walking down the street pumping my fist, going this is so cool, this is so awesome. I love this. So, I'm not out there under stress. Some of us come alive when we do this and it's a euphoric stress.

But, particularly within the Corps and with a big disaster like this, we have a lot of clinical people (e.g., in clinical categories), who don't have a day-to-day clinical job that we're sending out to the field in clinical roles. And we have some clinicians, like nurse practitioners who are working as a nurse at this facility. Or we have nonclinical people who are doing patient care assistant level duties that's not their bailiwick. So, this is a new situation and this is enveloping us, and we have our hometowns and our families to worry about. With those folks, you have to listen and find out what's going on. And a lot of it is you have to take the time to listen. And some folks, it's just that I'm not their team safety officer, I'm not their team commander, I'm just an outside person that can kind of unburden, a little outside the chain of command a bit.

And then sometimes we can help their team commander and the way they're relating to their people or addressing or managing their people. This is the safety impact of this organizational dysfunction we have in this place. When it's something like Miramar and we're a self-contained world, people feel reassured when they see a proactive, energetic safety officer getting into everything everywhere, they feel like their back is covered. And they can relax a bit and do their job with more security. But, if you think of what was going on for the public management of this -- restaurants, and gyms, and some of the places we might normally blow off steam, they weren't available. There's no indoor dining, or the hotel gym was closed, or that sort of thing. So, certainly, some people's normal outlets weren't there this time.

VB: Thank you. And I'm glad you emphasized the fact that just having -- I mean, aside from all of the nitty gritty and material things that officers do in response situations -- the fact that just having them there really inspires confidence. I'm glad to have captured that.

TJ: Sure. And the Corps has really gone all out. I mean, the behavioral health support to this, just the scope and scale of this is tremendous, and it's new. When we deployed to 9/11, our team commander brought along, Sandy, our mental health professional. And that paid dividends. That was huge. That was a stressful response. And that was my first. Heading out on 9/11 to the Pentagon, the World Trade Center, and having a mental health professional embedded in our team, I think, paid really big dividends. So, I'm a believer in mental health, and they're my natural partner. They're alongside me in this, and we both have input on each other's jobs really. We benefit each other when we work together.

JS: Captain Jiggens, I just wanted to follow up just briefly with one thing you mentioned. And I'm sure is common to all deployments, perhaps, but when you have a situation where an officer is deployed to carry out responsibilities that is not their everyday life when they're not in deployment, particularly those thrown into clinical situations. So, what sort of things are on their mind? Is it a question of confidence or is it something that you might hear about? Again, as not a person involved in their direct team, but someone that they might need an officer who is experienced in this and what you might hear from them about.

TJ: Well, there were two issues here. One was our knowledge of the disease and our posture to protect people were evolving throughout all of this. It was a novel virus. There were things

we knew in May we didn't know in February. There were things we knew in August that we didn't know in May. There are things that have evolved since August. So, when things change, when our PPE posture changes or we start to implement limited use of PPE, do things we don't normally do, it is disconcerting to some people because it actually makes some people wonder, "well, was what we were doing before safe? How do I know this is safe now? How do I know you won't change your mind and have something else to do tomorrow?" So, helping folks understand that we have known unknowns that we're hedging conservatively against -- that we're constantly on an outlook for those unknown unknowns, so we can anticipate them, and they don't surprise us. To give people a little insight into how many resources the Corps and HHS has arrayed to protect them, because they don't always know how many people are out there trying to watch their back.

But, the separate issue of -- and originally I went to the World Trade Center and the Pentagon as an EMT, because before 9/11 industrial hygienists like me and safety officers did not have such a large role. And particularly as an industrial hygienist, there weren't many roles for me to fill. So, I trained as an EMT. I went to 9/11 as a clinician, so I know a little bit and I maintained that on a part-time basis in the Coast Guard clinic for a while, so I understand where they're coming from. If you've been a clinician, if you've been a nurse out on the wards, you know when you're sharp and in practice and when you kind of come back to it and you catch up with how the profession changed, and how things have changed, people want to do a good job. People don't want to make mistakes. When you're a clinician, you understand the impact of some of your mistakes and sort of the risks of trying to practice your clinical profession in a facility that's new to you, supporting an organization that you don't know. It's a really big challenge we put people into, and people rose to the challenge. It was really cool to see.

But, there's a human aspect where you have to person-to-person spend some time. And if we have a couple dozen on a team, there's going to be a number of people who are just high and tight and squared away, and out of a couple different people, you're going to have a person or two just by personality traits who are going to have a lot on their mind and could really use some time in their day in their workplaces sometimes, or sometimes it's better out of their workplace to parse through some of these issues at their pace. So, and that can take a chunk of your time as a safety officer. It's part of what makes for long hours going place to place. Sometimes we have one opportunity. I'm here, on your ward, if we're going to stand in the hallway and talk for 45 minutes and that's what it takes, then this is my one chance to do that for you. So, we had to strike when the iron was hot with these opportunities to find the folks who need support and provide that support.

JS: That perspective is very helpful. And so, another thing we're hoping to do through these oral histories is -- and this is very important as well -- is capturing through the eyes of officers like yourself the experience the patients and families went through and obviously the sorts of things you were involved in in all your deployments. I'm sure you have a very interesting perspective on that for the time that there was quarantine in your first deployment to the way the patients you encountered in all your deployments, in Dallas, and Florida, and Louisiana, and so on. So, I'm wondering – and of course, we don't want to violate any privacy concerns -- but I do wonder if you could share what you observed and particularly any interesting stories of interactions you had with patients or their families from your very first deployment?

TJ: I didn't have many direct interactions with the people we were testing or the people our teams were caring for. But the start of my first deployment, when I was at the front desk, we were their people's lifeline, if you will, to the world. And it was a real challenge because we had this huge language barrier. I know we had a little boy who spoke English; his mom didn't, and I remember sitting down and getting out the game of battleship, and he could get it and try to explain through a maybe 4-year-old boy with his mom and pointing and grunting how you play a game of battleship.

JS: That's great.

TJ: We had a number of people who were spouses' independents, and they had the legal right to repatriation, but many of them had not necessarily been to the United States. This was their first trip or the first trip that they can remember since they were infants. But people were -- I don't want to say fish out of water, but they had left their world behind and they were in this little tiny bubble in San Diego.

[01:39:45]

And like I said, I'm a safety officer; running a hotel front desk is not something I've necessarily been prepared for. None of us doing that for a living. We're pharmacists, and engineers, and such. So, it was just as human beings doing what we could to make this work for these people. There were a lot of challenges and the people were supportive, they were really kind, and grateful, and understanding. There were needs we couldn't meet, or couldn't meet quickly, or

still couldn't find somebody's bag with all the belongings they had brought with them and those kinds of things, or this person can't drink milk; we don't have nondairy milk, or soy milk, or anything. Just challenges come up trying to give these people two weeks in relative comfort and not have it devolve into something like a prison situation of feeling like they were locked there for two weeks. That was not like any deployment situation I've had. That was a different set of challenges and a different experience and some different cultural competencies to try and learn and deal with.

JS: Recognizing the language barrier, of course, but how did either within families or between unrelated people, during this period of quarantine, how was this received by those that were affected?

TJ: The language barrier was a problem to be managed. People didn't seem offended or seem disappointed that we had limited translation. We had a few contract translators, but they were very busy with the clinical folks doing fever and symptoms checks and such. So, we had relatively little access to them. But the people who did speak English really pitched in to help us. When we didn't have someone available, people were really understanding and patient working as we both kind of felt our way along in some way with phones speaking mechanically, or pointing, or starting to learn please, and thank you, and boy, and girl, and starting to learn little bits. They started to learn milk, or diaper, and there was a lot of just good will and good effort on both sides. It couldn't have been more than a week before we started getting bilingual officers, because I think we learned that with the Puerto Rico hurricane, we have a lot of officers

who speak Spanish or speak Mandarin. And so, once we got them on the line, that helped a great deal.

VB: I know you said you didn't have much direct interaction with the patients in Dallas, but did you get a sense of who the clientele were that were coming in to the CBTS? I'm trying to figure out the timing, because for a while there last winter it was really hard to get a test. So, was this testing site providing a huge need that didn't exist before?

TJ: We were ramping up at this time and testing capacity was just coming online nationwide. We had demographic reports to spell out of every day. And where we were placed, we were placed there to target underserved populations. So, we had medical staff and people to get tested priority because they were seeing patients, so they were first responders. But aside from that group, the bulk and the nursing homes, of course, was an elderly population. But the people driving into the lanes were certainly overwhelming Hispanic and African American. We had a lot of issues with undocumented people giving us false information. And then, we couldn't follow up with test results. So, that was a challenge, because people would give us false information and we couldn't reach them with results. And we had a fair number of people with that issue. And we were cognizant of it, but we had little ability to address it, if you will.

VB: That sounds extremely frustrating and especially if some of those results were positive and you couldn't reach the people that needed to know.

TJ: We had a lot of cars that would roll up and especially some of the bigger vehicles, you might have six, or seven, or eight people in a vehicle and it would be grandma, and the family, and the grandkids, and the great-grandkids. With little kids, they can't swab themselves, so we had a dedicated lane with a nurse in full PPE ensemble to swab kids. And at the time they were still doing the nasopharyngeal swab. I think we moved to front-of-nares swabs (inaudible - 1:47:21) while we were there, if I remember. But the NP swab is uncomfortable and it's hard for little kids. But that was a heavily bilingual effort because we had a lot of people speaking Spanish. We did have a car roll up and the guy asked the screen if alcohol would affect the test. And she said, "Have you been drinking?" He said, "Yeah, we have." So, we had a DUI in our testing lane.

Another issue we that they would come to me as the federal representative -- because we're doing these tests under Admiral Schwartz's (ph) license -- so as the federal site lead I was in custody of those tests. I can pick our tests up and take them downtown to ship. But the local partner can't pick up our tests and transport them. They're in my custody. And so, the loss to follow ups or people trying to find tests, those problems would come to me to solve. But several times there were employment agencies with the meat packing plants. And those are typically a number of undocumented people. And these employment agencies want to interface and have test results and inject themselves into the process, but this is sensitive medical information, and they don't have a right to see that. So, that was a recurring issue to manage and to educate.

VB: So, you did so many different things that I hesitate to ask you to make a comparison across these deployments, but over the past year, while so much was shut down and so many people were isolated, you had this unique experience of being able to be in different places

around the country and see how different Americans experience the pandemic. And I wonder if you have any observations you'd like to share about what was the same and what was different in different regions or across time.

TJ: Certainly, there's a time factor and there's definitely a geographic factor. It was striking at times going place to place on the TAT mission. We went out to Baton Rouge and Shreveport, and in Louisiana there were medical people who weren't masking. So, there was a lot of place-to-place variation. We're a nation of 50 states and 50 different experiments, and there's definitely some heterogeneity going place-to-place and how states were managing this. And certainly, going from the Rio Grande Valley and then going to Miami and Fort Lauderdale, the disparity and the resources available were striking at times. Certainly in San Diego, we were kind of self-contained in our little world. So, other than being at the hotel, we were on base and that was our universe, so we were in a little bit of a bubble for that one.

VB: Did you get a sense at all that the sort of local reaction to the pandemic, whatever nature it may have been, did it impact the morale for officers in that particular group? Maybe like discernable phases in the pandemic we could probably pull out? Did you at any point detect that there was a particularly low moment or that it seemed like maybe the clouds were clearing a little or something along those lines?

TJ: With testing and how things were managed in Texas and with the Memorial Day holiday, there were times when we were sort of bracing for this wave that we anticipated. I know going place-to-place, particularly with the teams in Louisiana, there was frustration that we were taking

significant precautions to protect out people, and we had people caring for symptomatic, very ill patients, so we had people who were very actively managing the risk. They had it right up in their faces. And then, sometimes, I did hear from team members who were frustrated that in the community people were dining unmasked in groups and doing things like that, that would seem to be contributing to our workload, if you will.

VB: I could see how that could be a frustrating occurrence, and I do remember Memorial Day being sort of an adventure of what was going to come down the line.

JS: Sorry, I just want to clarify one thing, though. There was more than sufficient PPE in Louisiana, so that it was available to medical personnel who needed it, correct?

TJ: Mm-hmm.

JS: Okay, thank you.

TJ: There were times where as we tried to conserve PPE that we implemented things like limited reuse. But actually, kind of related to that, what was an issue for some of our responders and was sort of something to talk through and deal with is we control the posture of our people and how they're going to gown up, and when they're going to glove, and how they're going to protect themselves. But they're working alongside a host facility with a different set of rules and procedures. And we were very often more conservative than the facility we were supporting. So, sometimes our people were working right next to people who would be unmasked at a

nursing station or would do patient care with just a surgical mask, where our person might have an N-95 mask, gloves, and face shield. So, the different postures in the same work setting was an issue to deal with. We don't control the host facility. We do this, take care of our people, and we can advise them with say what we think or what we think is prudent, but they are ultimately free to protect their people in the way they see is fit. So, for some people that was difficult to be gowned up next to somebody who wasn't, for example.

VB: So, each of these deployments were so full force and such a total experience. When it came time for you to rotate off your assignment, how did you prepare to shift your duties and how did you prepare to resume your routine duties at FDA?

TJ: With San Diego, we actually did close down, and then they reopened that for another wave later. So, part of operations and planning is demobilization. I left that one; I rotated out as we were demob[iliz]ing that facility. And when I came back from that, we were still on campus. It was not long after that, that we went to the maximum telework posture. With Dallas, when we got there, we were going to be the last federal team. It was going to shift to a state and local operation. So, we did a fair bit of work and planning toward demobilizing. And then, they extended that and we welcomed another team and broke in another team. And then, coming back from that was back to telework. When I came back from San Diego, I think I got the next be ready to deploy call days or a couple weeks later. Ultimately, maybe four or five times I got a call asking "are you ready to deploy in the next 12 to 24 hours?" Yes, I am. And you wouldn't hear anything until a week or two later and I'd get another call, "Are you ready to deploy in the next 12 to 24 hours?" Yes, I am. And so, that whole time between the first two deployments I

was kind of ready to go again. So, other than continuing to slide some of Rob's duties onto my desk as we prepared for his impending retirement, it was kind of a keep my powder dry stage.

And then, coming back -- and particularly, in that deployment -- maybe starting at 9:30 at night, I had time to keep up with some of my FDA duties, the contract management, some of the things that I had to do to keep my job running. But a number of things were just deferred and set aside that I'd have to get back to when I got back. For the TAT mission, that was kind of a bolt out of the blue, but it's rolled up. You recognize that we were going to be going and again.

[02:00:02]

And it was getting to be a bit of an operational issue early, it seemed. There were a number of us who were frequent flyers that were getting called again and again. And it took a bit of time to shift to drawing across the entire Corps and getting everybody up off the bench. So, my partner on the third deployment, that was her seventh deployment. And I think she went a few times after that. And as we went site to site, I met clinicians who were on their fifth, sixth, and seventh deployment. So, there were a number of people who were going again and again.

A hurricane sort of ramps up and there's a few days and then it moves to recovery and then the deployments stop. And with this and the scope and with the epi curve, you didn't come home and put everything away like, "oh, that's done." There's going to be another call coming. And you during my third deployment, like I said, our environmental compliance manager left. So, at that point there's too many things that I have to be here at FDA to do on a daily basis to go out again. So, we started that transition while I was gone, we started that transition while I was in the field. And coming back from that, it was apparent that I was going to be back home for

the foreseeable future. So, that point we're not all shifting gears, but my personal situation, or at least my professional situation, changed where I had to shift to dedicated to FDA duties.

VB: Do you still get contacted from any of the officers that are currently deployed with questions or other matters that they need your input on?

TJ: No. A number of us keep in contact and talk. That's the neat thing about deployments, you make new friends all over, across categories and agencies. But there's a lot of resources within the response, so folks don't need to reach back to me for technical issues. And once you get out of the day-to-day what you know and what you're cognizant of just gets stale. But no, I can't say I'm fielding calls from people in the field. But I have gotten a couple of feelers about deployments and I'm mission critical to my office now.

VB: Well, Captain Jiggens, are there any stories that we didn't get an opportunity to discuss, or you'd like to bring up or any final thoughts you'd like to make sure we capture?

TJ: So, run through what we've discussed and what all happened. I sent you a couple things, and there's one picture I didn't send you. It's a New York Times picture, but we had a number of reporters in our quarantine cohorts and we were releasing folks. And we had one of our buses loaded up and as it got ready to pull away, I just kind of stepped forward and kept everybody back, because I'm a safety officer. I'm always thinking like that. And I didn't know at the time, but this New York Times reporter snapped a picture of the back window of the bus as they left. So, I'm standing there front and center in uniform. And then I started getting texts from people,

"Hey, you're in the New York Times." So, she did this story about her time in quarantine, and this picture is me standing there front and center, keeping everybody from getting run over by the bus.

VB: That's wonderful.

TJ: And the one photo I sent that is one of those little memories you make. We do a fever and symptom check twice a day. We had clinical teams doing surveillance trying to catch any cases earlier to our cohort. So, when our cohort for release passed their last fever and symptom check, they cleared quarantine. And at the time, we weren't masking in public or anything. So, at that time, CDC would call and let me know that this group passed their last fever and symptom check, and I could get on the radio and tell our team they're released from quarantine; they're basically general public. We can take off our PPE now. And the people would gather up and throw their masks in the air like a high school graduation because they didn't have to wear them anymore. So, that's one of the pictures I sent to you where folks around palm trees and barracks and tossing their masks up in the air, because they're done with them.

JS: Yeah, it was a great picture.

VB: Well, Captain Jiggens, thank you so much for speaking with us today. It's been really illuminating and it's going to be very valuable for the record.

TJ: Thanks for having me.

VB: I'm going to stop recording now.

[END OF INTERVIEW]

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